IN PERSON & VIRTUAL BOARD MEETING



December 2, 2026, AT 8:30 AM*

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE MEETING

*The Committee meeting will be held prior to the Board of Retirement meeting scheduled prior.

TO VIEW VIA WEB

https://lacera.gov/leadership/board-meetings

TO PROVIDE PUBLIC COMMENT

Members of the public may address the Board orally and in writing. To provide Public Comment, please visit the above link and complete the request form.

Attention: If you have any questions, you may email PublicComment@lacera.gov.



LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION
300 N. LAKE AVENUE, SUITE 650, PASADENA, CA

AGENDA

A REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE

COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:30 A.M., WEDNESDAY, DECEMBER 2, 2026

This meeting will be conducted by the Insurance, Benefits and Legislative Committee and Board of Retirement both in person and by teleconference under California Government Code Sections 54953.8.3.

Any person may view the meeting in person at LACERA's offices or online at https://LACERA.gov/leadership/board-meetings.

The Committee may take action on any item on the agenda, and agenda items may be taken out of order.

COMMITTEE TRUSTEES:

Les Robbins, Chair
Aleen Langton, Vice Chair
Shawn R. Kehoe, Trustee
Ernesto J. Pantoja, Trustee
Jason E. Green, Alternate Trustee

I. CALL TO ORDER

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB 707 Teleconference Locations

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of September 2, 2026

B. Approval of the Minutes of the Regular Meeting of October 7, 2026

III. APPROVAL OF THE MINUTES (Continued)

C. Approval of the Minutes of the Regular Meeting of November 4, 2026

IV. PUBLIC COMMENT

(Members of the public may address the Committee orally and in writing. To provide Public Comment, you should visit https://LACERA.gov/leadership/board-meetings and complete the request form.

If you select oral comment, we will contact you via email with information and instructions as to how to access the meeting as a speaker. You will have up to 3 minutes to address the Committee. Oral comment requests will be accepted up to the close of the Public Comment item on the agenda.

If you select written comment, please input your written public comment within the form as soon as possible and up to the close of the meeting. Written comment will be made part of the official record of the meeting. If you would like to remain anonymous at the meeting without stating your name, please leave the name field blank in the request form. If you have any questions, you may email PublicComment@lacera.gov.)

V. REPORTS

A. **Engagement Report for November 2026**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

B. **Staff Activities Report for November 2026**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

C. **LACERA Claims Experience**
Tanya Sun, Segal Consulting
(Presentation)

D. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Information Only)

VI. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

VII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

VIII. GOOD OF THE ORDER
(For Information Purposes Only)

IX. ADJOURNMENT

The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.

Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee less than 72 hours prior to the meeting, will be available for public inspection at the time they are distributed to a majority of the Committee, at LACERA's offices at 300 North Lake Avenue, Suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday *and will also be posted on lacera.gov at the same time,* Board Meetings | LACERA*.*

Requests for reasonable modification or accommodation of the telephone public access and Public Comments procedures stated in this agenda from individuals with disabilities, consistent with the Americans with Disabilities Act of 1990, may call the Board Offices at (626) 564-6000, Ext. 4401/4402 from 8:30 a.m. to 5:00 p.m. Monday through Friday or email PublicComment@lacera.gov, but no later than 48 hours prior to the time the meeting is to commence.

MINUTES OF THE REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:31 A.M. – 8:56 A.M., WEDNESDAY, SEPTEMBER 2, 2026

This meeting was conducted by the Insurance, Benefits & Legislative Committee both in person and by teleconference under California Government Code Section 54953.8.3.

COMMITTEE TRUSTEES

PRESENT: Aleen Langton, Vice Chair

Shawn R. Kehoe, Trustee *(arrived at 8:47 a.m.)*

Ernesto J. Pantoja, Trustee

ABSENT; Les Robbins, Chair

Jason E. Green, Alternate Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

J.P. Harris, Trustee *(arrived at 8:38 a.m.)*

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Luis A. Lugo, Chief Executive Officer

STAFF, ADVISORS AND PARTICIPANTS (Continued)

JJ Popowich, Chief Benefits Officer

Jessica Baxter, Chief Administrative Officer

Barry W. Lew, Legislative Affairs Officer

Segal Consulting
Stephen Murphy, Sr. Vice President
Michael Szeto, Sr. Actuarial Associate

I. CALL TO ORDER

This meeting was called to order by Chair Langton at 8:31 a.m.

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB 707 Teleconference Locations

There were no requests received.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of August 5, 2026

Trustee Kehoe made a motion, Trustee Langton seconded, to approve the minutes of the regular meeting of August 5, 2026. The motion passed by the following roll call vote:

Yes: Langton, Kehoe, Pantoja

No: None

Absent: Robbins, Green

(This Item was handled out of order, after Item VI-D.)

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. NON-CONSENT ITEMS

A. **Legislative Proposal—Prepaid Card Account**
Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement sponsor legislation for the 2027 legislative year to extend or repeal the sunset date of LACERA's prepaid card program.
(Memo dated August 19, 2026)

Trustee Kehoe made a motion, Trustee Pantoja seconded, to approve staff recommendation. The motion passed by the following roll call vote:

Yes: Langton, Kehoe, Pantoja

No: None

Absent: Robbins, Green

(This Item was handled out of order, after Item VI-D.)

VI. REPORTS

A. **Engagement Report for August 2026**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

The engagement report was discussed. This item was received and filed.

B. **Staff Activities Report for August 2026**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

The staff activities report was discussed. This item was received and filed.

VI. REPORTS (Continued)

C. **LACERA Claims Experience**
Michael Szeto, Segal Consulting
(Presentation)

The LACERA Claims Experience reports through July 2026 were discussed. This item was received and filed.

D. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Information Only)

Segal Consulting gave an update on federal legislation. This item was received and filed.

VII. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

There was nothing to report.

VIII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

There was nothing to report.

IX. GOOD OF THE ORDER
(For Information Purposes Only)

There was nothing to report.

X. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 8:56 a.m.

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

MINUTES OF THE REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:31 A.M. – 9:06 A.M., WEDNESDAY, OCTOBER 7, 2026

This meeting was conducted by the Insurance, Benefits & Legislative Committee both in person and by teleconference under California Government Code Section 54953.8.3.

COMMITTEE TRUSTEES

PRESENT: Les Robbins, Chair

Aleen Langton, Vice Chair

ABSENT: Shawn R. Kehoe, Trustee

Ernesto J. Pantoja, Trustee

Jason E. Green, Alternate Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

J.P. Harris, Trustee *(arrived at 8:36 a.m.)*

Wayne Moore, Trustee

Lisa Proft, Alternate Ex-Officio *(arrived at 8:41 a.m.)*

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Luis A. Lugo, Chief Executive Officer

Jessica Baxter, Chief Administrative Officer

JJ Popowich, Chief Benefits Officer

Barry W. Lew, Legislative Affairs Officer

Segal Consulting
Tanya Sun, Vice President and Health Actuary
Michael Szeto, Sr. Actuarial Associate

I. CALL TO ORDER

This meeting was called to order by Chair Robbins at 8:31 a.m.

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB 707 Teleconference Locations

There were no requests received.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of September 2, 2026

As there was not a quorum present, no action was taken on this item, and it will be moved to the November Insurance, Benefits and Legislative Committee.

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. NON-CONSENT ITEMS

A. **Provide Voting Directions on SACRS 2027 Legislative Platform**
Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee:

1. Recommend that the Board of Retirement direct its voting delegate to vote YES on sponsorship by the State Association of County Retirement Systems (SACRS) of its legislative proposals for the SACRS 2027 legislative platform;

2. Discuss and provide feedback to staff on these legislative proposals, in particular the substantive proposals; and

3. Recommend that the Board of Retirement discuss and provide feedback to staff on these legislative proposals, in particular the substantive proposals.

(Memo dated September 23, 2026)

As there was not a quorum present, no action was taken on this item, and it will be taken to the November Board of Retirement meeting, with no Committee recommendation.

VI. REPORTS

A. **Engagement Report for September 2026**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

The engagement report was discussed. This item was received and filed.

B. **Staff Activities Report for September 2026**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

The staff activities report was discussed. This item was received and filed.

VI. REPORTS (Continued)

C. **LACERA Claims Experience**
Tanya Sun, Segal Consulting
(Presentation)

The LACERA Claims Experience reports through August 2026 were discussed. This item was received and filed.

D. **Federal Legislation**
Michael Szeto, Segal Consulting
(For Information Only)

Segal Consulting gave an update on federal legislation. This item was received and filed.

VII. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

There was nothing to report.

VIII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

There was nothing to report.

IX. GOOD OF THE ORDER
(For Information Purposes Only)

There was nothing to report.

X. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 9:06 a.m.

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

MINUTES OF THE REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:32 A.M. – 8:57 A.M., WEDNESDAY, NOVEMBER 4, 2026

This meeting was conducted by the Insurance, Benefits & Legislative Committee both in person and by teleconference under California Government Code Section 54953.8.3.

COMMITTEE TRUSTEES

PRESENT: Les Robbins, Chair

Aleen Langton, Vice Chair

ABSENT: Shawn R. Kehoe, Trustee

Ernesto J. Pantoja, Trustee

Jason E. Green, Alternate Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

Bobbie Fesler, Trustee *(arrived at 8:42 a.m.)*
(Teleconference Due to Just Cause under Section 54953.8.3)

Elizabeth Ginsberg, Trustee

J.P. Harris, Trustee

Wayne Moore, Trustee

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Luis A. Lugo, Chief Executive Officer

Jessica Baxter, Chief Administrative Officer

JJ Popowich, Chief Benefits Officer

Barry W. Lew, Legislative Affairs Officer

Segal Consulting
Tanya Sun, Vice President and Health Actuary
Michael Szeto, Sr. Actuarial Associate

I. CALL TO ORDER

This meeting was called to order by Chair Robbins at 8:32 a.m.

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB 707 Teleconference Locations

A physical quorum of the Committee was not present at the noticed meeting location; however, a physical quorum of the Board of Retirement was present. There was one request received from Trustee Fesler, as a member of the Board of Retirement only, related to childcare under Section 54953.8.3(c)(1). Trustee Fesler confirmed there were no individuals 18 years or older present at the teleconference location.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of September 2, 2026

As there was not a quorum present, no action was taken on this item, and it will be moved to the December Insurance, Benefits and Legislative Committee.

III. APPROVAL OF MINUTES (Continued)

B. Approval of the Minutes of the Regular Meeting of October 7,2026

As there was not a quorum present, no action was taken on this item, and it will be moved to the December Insurance, Benefits and Legislative Committee.

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. REPORTS

A. **Engagement Report for October 2026**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

The engagement report was discussed. This item was received and filed.

B. **Staff Activities Report for October 2026**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

The staff activities report was discussed. This item was received and filed.

C. **LACERA Claims Experience**
Tanya Sun, Segal Consulting
(Presentation)

The LACERA Claims Experience reports through September 2026 were discussed. This item was received and filed.

D. **Federal Legislation**
Michael Szeto, Segal Consulting
(For Information Only)

Segal Consulting gave an update on federal legislation. This item was received and filed.

VI. ITEMS FOR STAFF REVIEW

(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

There was nothing to report.

VII. ITEMS FOR FUTURE AGENDAS

(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

There was nothing to report.

VIII. GOOD OF THE ORDER

(For Information Purposes Only)

There was nothing to report.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 8:57 a.m.

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
NOVEMBER 2026
FOR INFORMATION ONLY

PPIC Statewide Survey: Californians and Their Government
The Public Policy Institute of California released its latest statewide survey ahead of the November 3 election. The findings are based on its survey of 1,728 California adult residents. The survey was conducted from October 22-26, 2026, and each respondent took about 14 minutes to complete it. The following are key findings from the survey:

- Elections
    - Xavier Becerra(D) led Steve Hilton (R) by a 24-point margin (61% to 37%) in the governor's race. (Becerra went on to win the governor's race by 65.6% to 34.4%, defeating Hilton by 31.2 points.)
    - Democratic candidates led Republican candidates in local House district races by a 28-point margin (63% to 35%). Most people favored their own party's candidates, while independents favored the Democratic candidates.
    - Fifty-eight percent of respondent were more enthusiastic about voting than usual for Congress this year.
    - Majorities said they would vote yes on Proposition 1 (Housing Bond, 60%) and Proposition 2 (Rainy Day Fund, 61%). Prop 1 passed with 61.08%, and Prop 2 passed with 61.3%.
- Forty-six percent would vote yes on Proposition 40 (One-time wealth tax). Prop 1 failed with 47.9% to 52.1%.
- Top state issues chosen by Californians
    - Cost of living, economy, inflation: 45%
    - Housing costs, availability: 12%
    - Government in general: 8%
    - Half of Californians chose cost of living and housing costs as the most important issues facing California. Majorities of adults and likely voters think the state is headed in the wrong direction and expect bad times financially in the next 12 months.
    - About 47% of adults and 49% of likely voters approve of former Governor Newsom's job performance.
    - Majorities of adults and likely voters think their incomes are not keeping up with inflation.

  - Sixty-three percent of likely voters have a great deal or a lot of confidence in California's voting system.

- Top national issue chosen by Californians
  - Economy, unemployment, jobs: 26%
  - Threats to democratic values and norms: 18%
  - Corruption: 14%
  - About half of Californians name economic conditions and threats to democracy as the most important problems facing the nation. Majorities of adults and likely voters think the nation is heading in the wrong direction and expect bad times financially in the next 12 months.
  - Twenty-one percent of adults and 26% of likely voters approve of President Trump's job performance. About 1 in 4 adults and likely voters approve of the job the US Immigration and Customs Enforcement (ICE) is doing, and a similar share approve of the US military action against Iran.
  - About 3 in 10 are satisfied or somewhat satisfied with the way US democracy is working. Sixty-five percent of likely voters are very confident or somewhat confident that their votes for Congress will be accurately cast and counted during the election. (Source)

NASRA Public Fund Survey for FY 2025

The National Association of State Retirement Administrators released its most recent Public Fund Survey, which is an online compendium of key characteristics and trends affecting the nation's largest public retirement systems. The following are the key findings in the most current survey:

- Funding levels reached their highest point since FY 2009. The aggregate funding level rose to 78.8 percent, and the median plan is 80.0 percent funded.
- Asset growth continues to outpace liability growth: Median growth in actuarial assets has exceeded median liability growth every year since FY 2017. In FY 2025, median asset growth was about 6.0 percent, whereas liability growth was 3.8 percent.
- Payroll growth has slowed from 7.0 percent to 5.6 percent but remains above most plans' assumed payroll growth of 2 to 4 percent.
- Median employer contribution rates have leveled off to roughly 15 percent of pay since FY 2022.

- Median investment returns for every period from 1 to 30 years now meet or exceed the 7.0 percent median investment return assumption. (Source)

Connecticut Teachers Pensions Reach Highest-ever Funding Level

Connecticut's Teachers' Retirement Fund (TRF) has reached its highest funding level ever, reflecting a major turnaround after decades of underfunding. Connecticut Education Association President Kate Dias credited educator advocacy, responsible fund management, and the state's commitment to meeting its pension obligations, noting that the fund is now approaching full funding and helping ensure retirement security for teachers.

The Connecticut Retirement Plans and Trust Funds earned a 15.1% return in FY 2026, exceeding the assumed 6.9% return rate for the fourth consecutive year. State Treasurer Erick Russell reported that pension funding has increased by $11 billion, strengthening retirement security while reducing pressure on future state budgets. He attributed the gains to a disciplined, diversified long-term investment strategy.

Governor Ned Lamont highlighted the fund's dramatic improvement, rising from about 30% funded a decade ago to nearly 70% funded today, placing it among the top quarter of public pension funds nationally. Both Lamont and Russell emphasized the importance of continuing to make required contributions and avoiding the historic underfunding that weakened the system for roughly 70 years. Officials expect the fund's funding ratio to approach 70% when year-end figures are finalized. (Source)

Nashville City Weighs Retirement Buyouts Ahead of 2028 Budget

Nashville Mayor Freddie O'Connell has proposed a voluntary retirement incentive program to help reduce operating costs as the city prepares for another tight budget year. Under the proposal, employees eligible for a normal, unreduced pension would receive $1,000 for each year of service, while those eligible for an early, reduced pension would receive $500 per year of service.

Eligibility varies by employee group. General government employees can qualify for normal retirement at age 60 with sufficient service or age 65 with at least five years of service. Police and fire employees qualify at younger ages. Employees eligible for early retirement also qualify under separate age and service requirements. Metro Nashville Public Schools employees are excluded.

City officials estimate about 1,500 employees are eligible for early retirement and 900 for normal retirement. Based on participation rates from similar programs in 2004 and 2012, the Department of Finance projects approximately $10 million in savings for fiscal year 2028. The city is not targeting a specific number of retirements and participation is optional.

The proposal will go through three council readings, with final consideration expected in December. If approved, eligible employees could apply between Dec. 16 and Jan. 21 and retire by Feb. 26. (Source)

Staff Note: The Los Angeles Superior Court currently is implementing a Voluntary Separation Incentive Program (VSIP). This program only applies to employees of the Superior Court and offers a $35,000 one-time payment for court employees with at least 5 years of continuous service credit.

In 1992, the Board of Supervisors approved implementation of an Early Separation Program (ESP), which applied to county employees. The ESP offered two additional years of service credit, a deferred cash severance paid over 5 annual installments rather than in one lump sum, or a combination of both.

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
NOVEMBER 2026
FOR INFORMATION ONLY

United Healthcare UCLA Contract Ending

On November 5, 2026, LACERA's assigned United Healthcare (UHC) account manager informed staff that UCLA will be ending its UHC contract effective January 1, 2027. UHC reports that 135 LACERA retirees are affected. UHC will mail each impacted member a notice identifying their reassigned provider.

Because other providers are available to these members, the 6-month waiting period will apply if a member requests a medical plan change.

United Healthcare UCI Health Contract Ending

Staff also learned that UCI Health, formerly Premier Health Services, will end its Medicare HMO contract in Southern California effective January 1, 2027.

On November 4, 2026, letters were mailed to the 84 LACERA retirees affected by this closure. The letters notify members that they are being reassigned to new primary care providers (PCPs).

2027 Medicare Part B Premium Announced

On November 17, 2026, the Centers for Medicare & Medicaid Services (CMS) finally released the 2027 Medicare Part A and Part B premiums, deductibles, as well as the 2027 Medicare Part D income-related monthly adjustment amounts.

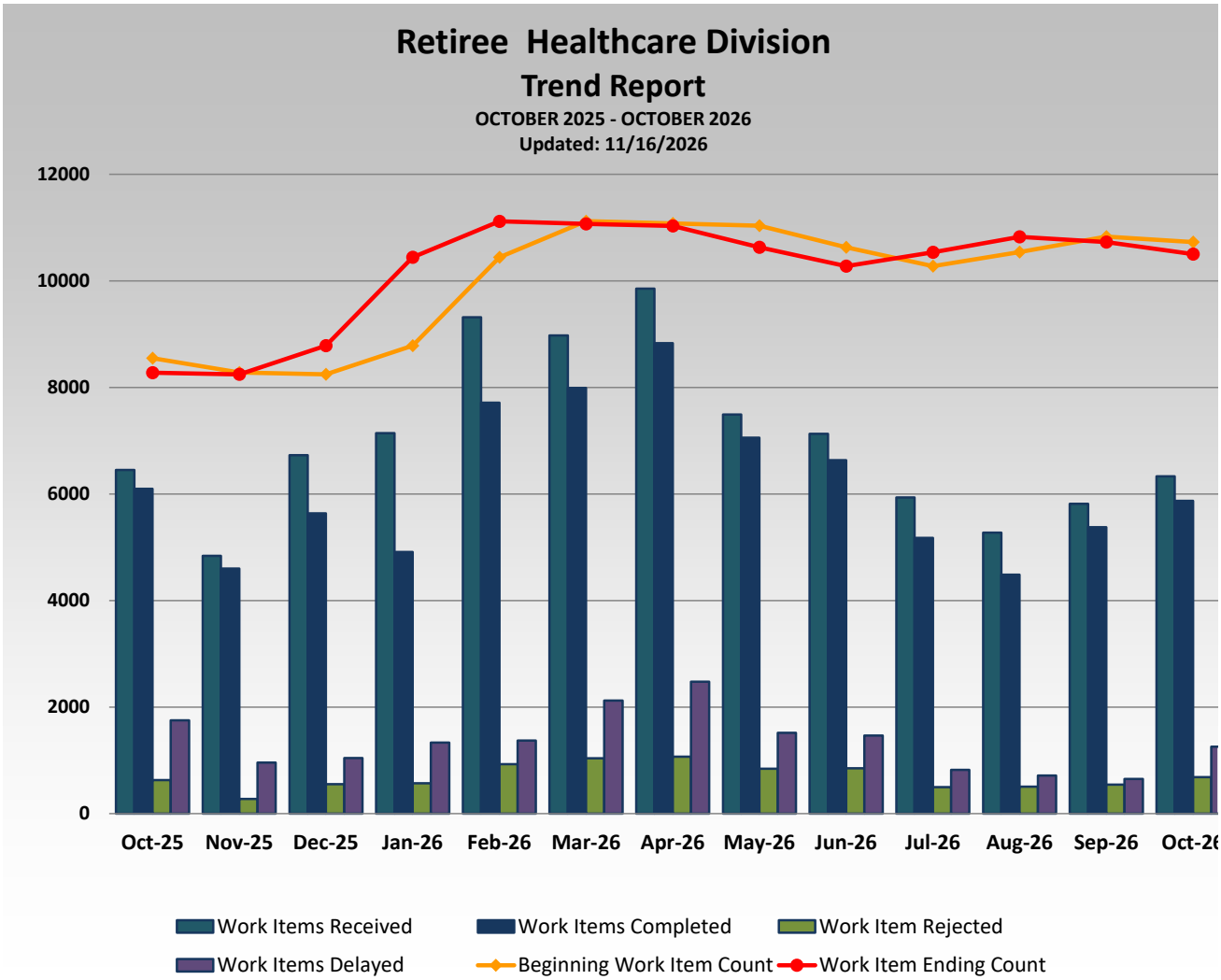
The standard monthly premium for Medicare Part B premium will be $209.40 for 2027, an increase of $6.50 from $202.90 in 2026. The increase in the 2027 Part B standard premium and deductible is mainly due to projected increases in healthcare spending.

Because the 2027 Medicare Part B premium amount was announced late, we cannot place it on the Board of Supervisors agenda until January 12, 2027. Members will keep receiving their current Part B reimbursement until then, and a one-time adjustment will follow once the Board approves the new standard reimbursement amount. The chart below shows Part B and income related premium amounts one can expect.

Chart: Medicare Part B Income-Related Monthly Adjustment Amounts

Medicare Part B monthly premiums have been based on an individual's income since 2007. These income-related monthly adjustment amounts affect roughly 9% of people with Medicare Part B. The 2027 Part B total premiums for high-income beneficiaries with full Part B coverage are shown in the following table:

Part B			
Beneficiaries who file individual tax returns with modified adjusted gross income:	**Beneficiaries who file joint tax returns with modified adjusted gross income:**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
Less than or equal to $112,000	Less than or equal to $224,000	$0.00	$209.40
Greater than $112,000 and less than or equal to $141,000	Greater than $224,000 and less than or equal to $282,000	$83.70	$293.10
Greater than $141,000 and less than or equal to $177,000	Greater than $282,000 and less than or equal to $354,000	$209.40	$418.80
Greater than $177,000 and less than or equal to $212,000	Greater than $354,000 and less than or equal to $424,000	$335.00	$544.40
Greater than $212,000 and less than $500,000	Greater than $424,000 and less than $750,000	$460.60	$670.00
Greater than or equal to $500,000	Greater than or equal to $750,000	$502.40	$711.80

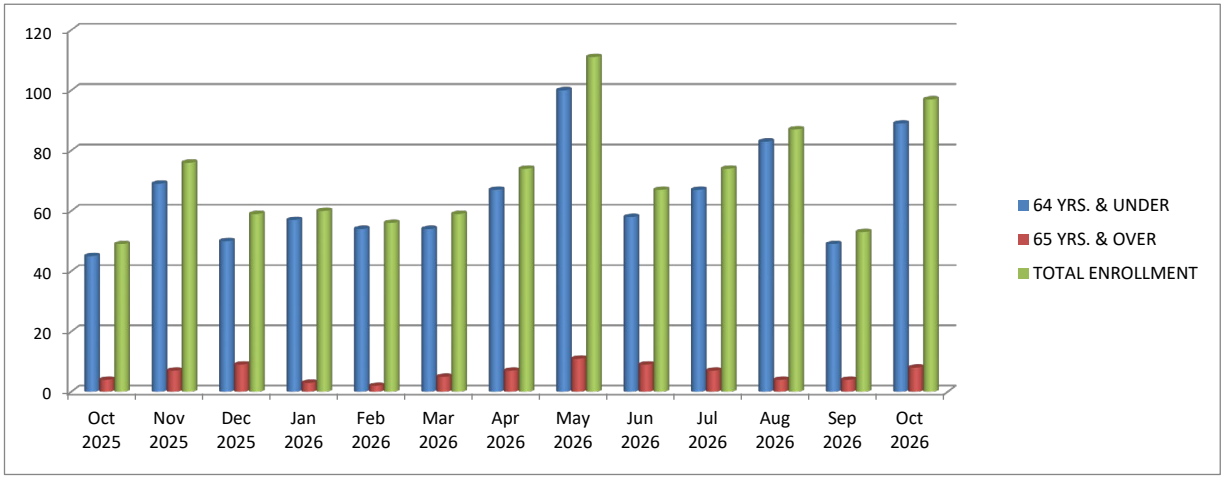


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Oct-25	8550	6452	6098	630	1751	8274
Nov-25	8278	4840	4600	274	959	8244
Dec-25	8245	6729	5637	552	1045	8785
Jan-26	8785	7142	4912	571	1332	10444
Feb-26	10444	9315	7715	926	1370	11118
Mar-26	11121	8975	7989	1039	2121	11068
Apr-26	11077	9854	8832	1070	2476	11029
May-26	11037	7491	7057	842	1515	10629
Jun-26	10630	7130	6632	852	1465	10276
Jul-26	10277	5933	5175	498	822	10537
Aug-26	10540	5275	4483	504	713	10828
Sep-26	10832	5815	5374	543	652	10730
Oct-26	10730	6330	5871	685	1255	10504

Retirees Monthly Age Breakdown
OCTOBER 2025 - OCTOBER 2026

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
Oct 2025	45	4	49
Nov 2025	69	7	76
Dec 2025	50	9	59
Jan 2026	57	3	60
Feb 2026	54	2	56
Mar 2026	54	5	59
Apr 2026	67	7	74
May 2026	100	11	111
Jun 2026	58	9	67
Jul 2026	67	7	74
Aug 2026	83	4	87
Sep 2026	49	4	53
Oct 2026	89	8	97

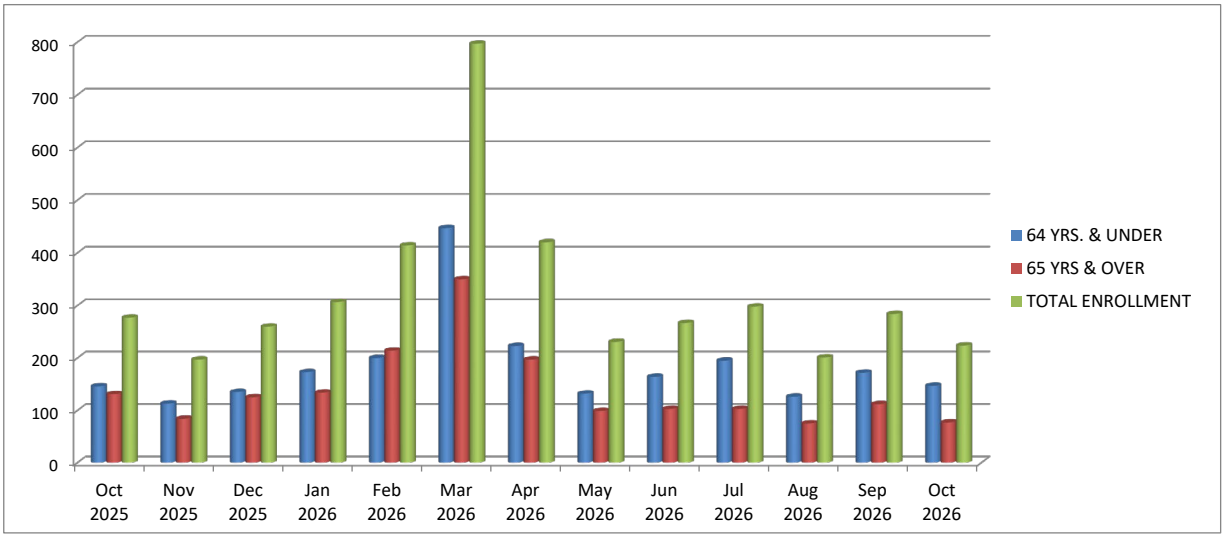


PLEASE NOTE: Next Report will include the following dates: November 1, 2025, through November 30, 2026.

Retirees Monthly Age Breakdown
OCTOBER 2025 - OCTOBER 2026

Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
Oct 2025	146	131	277
Nov 2025	113	84	197
Dec 2025	135	125	260
Jan 2026	173	134	307
Feb 2026	200	214	414
Mar 2026	447	350	797
Apr 2026	223	197	420
May 2026	132	99	231
Jun 2026	164	103	267
Jul 2026	195	103	298
Aug 2026	126	75	201
Sep 2026	172	112	284
Oct 2026	147	77	224



PLEASE NOTE: Next Report will include the following dates: November 1, 2025, through November 30, 2026.

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 11/30/2026

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	8173	$1,524,651.00	0	$0.00
241	127	$23,345.70	0	$0.00
242	1099	$215,211.00	0	$0.00
243	4986	$1,904,750.86	0	$0.00
244	15	$2,640.30	0	$0.00
245	66	$12,942.90	0	$0.00
246	14	$2,661.50	0	$0.00
247	187	$35,990.00	0	$0.00
248	11	$3,431.70	0	$0.00
249	104	$46,112.70	0	$0.00
250	16	$5,957.00	0	$0.00
Plan Total:	**14,798**	**$3,777,694.66**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	26	$5,055.10	0	$0.00
397	2	$347.50	0	$0.00
398	16	$6,492.80	0	$0.00
403	12749	$2,341,164.73	0	$0.00
413	1588	$303,718.00	0	$0.00
418	6705	$2,554,604.57	1	$51.50
419	193	$33,361.10	0	$0.00
426	252	$46,781.80	0	$0.00
445	2	$405.80	0	$0.00
451	41	$7,512.40	0	$0.00
455	7	$1,420.30	0	$0.00
457	19	$7,426.40	0	$0.00
459	2	$811.60	0	$0.00
462	96	$18,351.70	0	$0.00
465	2	$405.80	0	$0.00
466	26	$9,920.60	0	$0.00
472	26	$4,927.00	0	$0.00
476	3	$550.40	0	$0.00
478	16	$6,333.30	0	$0.00
482	72	$13,198.60	0	$0.00
486	5	$960.10	0	$0.00
488	33	$12,508.00	0	$0.00
493	1	$202.90	0	$0.00
Plan Total:	**21,882**	**$5,376,460.50**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 11/30/2026

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	385	$73,875.50	0	$0.00
613	162	$61,827.30	0	$0.00
620	30	$5,545.90	0	$0.00
621	14	$5,564.60	0	$0.00
622	25	$5,497.00	0	$0.00
623	11	$4,151.20	0	$0.00
Plan Total:	**627**	**$156,461.50**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	2315	$439,743.20	0	$0.00
702	422	$81,888.60	0	$0.00
703	1437	$560,409.30	0	$0.00
704	124	$25,019.00	0	$0.00
705	54	$21,201.40	0	$0.00
Plan Total:	**4,352**	**$1,128,261.50**	**0**	**$0.00**
Grand Total:	**41,659**	**$10,438,878.16**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 11/30/2026

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	8173	$1,524,651.00	0	$0.00
241	127	$23,345.70	0	$0.00
242	1099	$215,211.00	0	$0.00
243	4986	$1,904,750.86	0	$0.00
244	15	$2,640.30	0	$0.00
245	66	$12,942.90	0	$0.00
246	14	$2,661.50	0	$0.00
247	187	$35,990.00	0	$0.00
248	11	$3,431.70	0	$0.00
249	104	$46,112.70	0	$0.00
250	16	$5,957.00	0	$0.00
Plan Total:	**14,798**	**$3,777,694.66**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	26	$5,055.10	0	$0.00
397	2	$347.50	0	$0.00
398	16	$6,492.80	0	$0.00
403	12749	$2,341,164.73	0	$0.00
413	1588	$303,718.00	0	$0.00
418	6705	$2,554,604.57	1	$51.50
419	193	$33,361.10	0	$0.00
426	252	$46,781.80	0	$0.00
445	2	$405.80	0	$0.00
451	41	$7,512.40	0	$0.00
455	7	$1,420.30	0	$0.00
457	19	$7,426.40	0	$0.00
459	2	$811.60	0	$0.00
462	96	$18,351.70	0	$0.00
465	2	$405.80	0	$0.00
466	26	$9,920.60	0	$0.00
472	26	$4,927.00	0	$0.00
476	3	$550.40	0	$0.00
478	16	$6,333.30	0	$0.00
482	72	$13,198.60	0	$0.00
486	5	$960.10	0	$0.00
488	33	$12,508.00	0	$0.00
493	1	$202.90	0	$0.00
Plan Total:	**21,882**	**$5,376,460.50**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 11/30/2026

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	385	$73,875.50	0	$0.00
613	162	$61,827.30	0	$0.00
620	30	$5,545.90	0	$0.00
621	14	$5,564.60	0	$0.00
622	25	$5,497.00	0	$0.00
623	11	$4,151.20	0	$0.00
Plan Total:	**627**	**$156,461.50**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	2315	$439,743.20	0	$0.00
702	422	$81,888.60	0	$0.00
703	1437	$560,409.30	0	$0.00
704	124	$25,019.00	0	$0.00
705	54	$21,201.40	0	$0.00
Plan Total:	**4,352**	**$1,128,261.50**	**0**	**$0.00**
LOCAL 1014				
804	220	$61,538.70	0	$0.00
805	256	$59,652.00	0	$0.00
806	813	$367,817.20	0	$0.00
807	61	$12,945.10	0	$0.00
808	28	$14,852.20	0	$0.00
812	270	$62,371.35	0	$0.00
813	3	$608.70	0	$0.00
814	1	$202.90	0	$0.00
Plan Total:	**1,652**	**$579,988.15**	**0**	**$0.00**
Grand Total:	**43,311**	**$11,018,866.31**	**1**	**$51.50**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	379	$478,825.56	$64,974.29	$403,797.19	$468,771.48	$0.00	$468,771.48
202	200	$502,276.81	$44,893.46	$435,114.92	$480,008.38	$0.00	$480,008.38
203	79	$223,405.60	$24,210.96	$190,816.93	$215,027.89	$2,792.57	$217,820.46
204	26	$42,009.24	$8,618.17	$31,037.41	$39,655.58	$1,615.74	$41,271.32
SUBTOTAL	**684**	**$1,246,517.21**	**$142,696.88**	**$1,060,766.45**	**$1,203,463.33**	**$4,408.31**	**$1,207,871.64**
Anthem Blue Cross I							
211	480	$840,286.75	$49,758.75	$768,004.85	$817,763.60	($6,930.20)	$810,833.40
212	208	$649,987.52	$34,749.38	$612,113.20	$646,862.58	$0.00	$646,862.58
213	77	$283,855.88	$26,072.88	$264,525.60	$290,598.48	$0.00	$290,598.48
214	26	$59,614.62	$3,164.13	$58,743.36	$61,907.49	$0.00	$61,907.49
215	3	$1,753.02	$210.36	$1,542.66	$1,753.02	$0.00	$1,753.02
SUBTOTAL	**794**	**$1,835,497.79**	**$113,955.50**	**$1,704,929.67**	**$1,818,885.17**	**($6,930.20)**	**$1,811,954.97**
Anthem Blue Cross II							
221	2,539	$4,416,269.95	$208,009.63	$4,175,341.87	$4,383,351.50	($8,662.75)	$4,374,688.75
222	2,111	$6,649,872.32	$146,377.53	$6,336,804.81	$6,483,182.34	$0.00	$6,483,182.34
223	1,009	$3,738,050.16	$140,232.39	$3,493,116.99	$3,633,349.38	$3,686.44	$3,637,035.82
224	277	$635,124.99	$57,509.98	$615,223.55	$672,733.53	$6,878.61	$679,612.14
225	2	$1,168.68	$93.49	$1,075.19	$1,168.68	$0.00	$1,168.68
SUBTOTAL	**5,938**	**$15,440,486.10**	**$552,223.02**	**$14,621,562.41**	**$15,173,785.43**	**$1,902.30**	**$15,175,687.73**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	8,220	$5,776,455.36	$716,042.67	$5,091,960.75	$5,808,003.42	($2,809.56)	$5,805,193.86
241	127	$285,662.37	$19,973.83	$265,688.54	$285,662.37	$0.00	$285,662.37
242	1,095	$2,485,487.55	$128,992.56	$2,369,606.81	$2,498,599.37	$0.00	$2,498,599.37
243	5,009	$7,023,343.34	$693,736.25	$6,285,176.59	$6,978,912.84	($11,399.50)	$6,967,513.34
244	15	$18,885.15	$1,687.06	$17,198.09	$18,885.15	$0.00	$18,885.15
245	67	$84,353.67	$5,640.32	$78,713.35	$84,353.67	$0.00	$84,353.67
246	15	$42,086.10	$2,356.83	$36,923.53	$39,280.36	$0.00	$39,280.36
247	191	$547,119.30	$19,247.41	$488,591.53	$507,838.94	$0.00	$507,838.94
248	11	$21,515.67	$3,200.66	$18,315.01	$21,515.67	$0.00	$21,515.67
249	105	$205,376.85	$18,190.50	$206,746.05	$224,936.55	$0.00	$224,936.55
250	16	$35,076.00	$2,849.92	$32,226.08	$35,076.00	$0.00	$35,076.00
SUBTOTAL	**14,871**	**$16,525,361.36**	**$1,611,918.01**	**$14,891,146.33**	**$16,503,064.34**	**($14,209.06)**	**$16,488,855.28**
CIGNA Network Model Plan							
301	187	$427,805.28	$108,957.72	$309,745.32	$418,703.04	$0.00	$418,703.04
302	46	$189,073.34	$47,451.06	$141,622.28	$189,073.34	($8,220.58)	$180,852.76
303	7	$33,974.78	$6,277.87	$17,989.83	$24,267.70	$0.00	$24,267.70
304	9	$27,179.19	$10,120.22	$17,058.97	$27,179.19	$0.00	$27,179.19
SUBTOTAL	**249**	**$678,032.59**	**$172,806.87**	**$486,416.40**	**$659,223.27**	**($8,220.58)**	**$651,002.69**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,728	$3,019,974.96	$195,815.64	$2,739,537.62	$2,935,353.26	$1,723.73	$2,937,076.99
403	12,770	$3,903,770.07	$330,262.84	$3,580,880.30	$3,911,143.14	($4,109.47)	$3,907,033.67
404	416	$722,242.87	$9,515.07	$697,214.23	$706,729.30	$0.00	$706,729.30
405	1,501	$2,589,042.46	$18,099.23	$2,592,909.65	$2,611,008.88	($5,171.19)	$2,605,837.69
411	2,040	$6,316,906.00	$240,077.62	$5,943,966.78	$6,184,044.40	$3,062.00	$6,187,106.40
413	1,562	$2,628,480.00	$107,102.99	$2,462,391.10	$2,569,494.09	$0.00	$2,569,494.09
414	40	$122,480.00	$734.88	$118,683.12	$119,418.00	$0.00	$119,418.00
418	6,696	$4,031,910.48	$281,295.64	$3,774,056.70	$4,055,352.34	($5,383.80)	$4,049,968.54
419	199	$402,031.74	$4,686.98	$397,344.76	$402,031.74	$0.00	$402,031.74
420	83	$254,146.00	$1,469.76	$252,676.24	$254,146.00	($3,062.00)	$251,084.00
421	9	$15,513.57	$620.55	$14,893.02	$15,513.57	$0.00	$15,513.57
422	259	$799,182.00	$3,184.48	$777,625.52	$780,810.00	($3,062.00)	$777,748.00
426	249	$509,105.52	$3,313.21	$491,650.49	$494,963.70	$0.00	$494,963.70
428	33	$101,046.00	$367.44	$100,678.56	$101,046.00	$0.00	$101,046.00
430	133	$407,246.00	$2,143.40	$408,164.60	$410,308.00	$0.00	$410,308.00
SUBTOTAL	**27,718**	**$25,823,077.67**	**$1,198,689.73**	**$24,352,672.69**	**$25,551,362.42**	**($16,002.73)**	**$25,535,359.69**
Kaiser - Colorado							
450	4	$5,687.20	$284.36	$5,402.84	$5,687.20	$0.00	$5,687.20
451	42	$12,511.80	$1,483.54	$11,028.26	$12,511.80	$0.00	$12,511.80
453	8	$25,174.32	$549.79	$24,624.53	$25,174.32	$0.00	$25,174.32
455	7	$11,981.90	$924.32	$11,057.58	$11,981.90	$0.00	$11,981.90
457	19	$11,168.20	$1,034.53	$10,133.67	$11,168.20	$0.00	$11,168.20
459	2	$4,003.20	$80.06	$3,923.14	$4,003.20	$0.00	$4,003.20
SUBTOTAL	**82**	**$70,526.62**	**$4,356.60**	**$66,170.02**	**$70,526.62**	**$0.00**	**$70,526.62**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Georgia							
440	1	$1,780.87	$48.32	$1,732.55	$1,780.87	$0.00	$1,780.87
441	3	$5,342.61	$144.96	$5,197.65	$5,342.61	$0.00	$5,342.61
442	6	$10,685.22	$289.92	$10,395.30	$10,685.22	$0.00	$10,685.22
445	2	$4,399.46	$0.00	$4,399.46	$4,399.46	$0.00	$4,399.46
461	15	$26,713.05	$2,977.11	$23,735.94	$26,713.05	$0.00	$26,713.05
462	96	$40,978.56	$5,489.42	$35,489.14	$40,978.56	$0.00	$40,978.56
463	4	$14,214.96	$3,277.67	$10,937.29	$14,214.96	$0.00	$14,214.96
465	2	$4,399.46	$0.00	$4,399.46	$4,399.46	$0.00	$4,399.46
466	26	$21,988.72	$1,674.53	$20,314.19	$21,988.72	$0.00	$21,988.72
SUBTOTAL	**155**	**$130,502.91**	**$13,901.93**	**$116,600.98**	**$130,502.91**	**$0.00**	**$130,502.91**
Kaiser - Hawaii							
471	7	$7,423.99	$296.96	$7,127.03	$7,423.99	$0.00	$7,423.99
472	26	$11,686.74	$1,762.02	$9,924.72	$11,686.74	$0.00	$11,686.74
474	3	$6,339.42	$0.00	$6,339.42	$6,339.42	$0.00	$6,339.42
475	2	$6,331.42	$0.00	$6,331.42	$6,331.42	$0.00	$6,331.42
476	3	$4,506.18	$0.00	$4,506.18	$4,506.18	$0.00	$4,506.18
478	16	$14,255.68	$997.89	$13,257.79	$14,255.68	$0.00	$14,255.68
SUBTOTAL	**57**	**$50,543.43**	**$3,056.87**	**$47,486.56**	**$50,543.43**	**$0.00**	**$50,543.43**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Oregon							
481	8	$12,943.04	$388.29	$12,554.75	$12,943.04	$0.00	$12,943.04
482	73	$44,512.48	$6,231.73	$38,280.75	$44,512.48	$0.00	$44,512.48
484	3	$9,683.28	$308.46	$9,374.82	$9,683.28	$0.00	$9,683.28
486	6	$13,317.84	$0.00	$13,317.84	$13,317.84	$0.00	$13,317.84
488	33	$39,980.16	$6,396.83	$33,583.33	$39,980.16	$0.00	$39,980.16
493	1	$3,829.52	$143.08	$3,686.44	$3,829.52	$0.00	$3,829.52
SUBTOTAL	**124**	**$124,266.32**	**$13,468.39**	**$110,797.93**	**$124,266.32**	**$0.00**	**$124,266.32**
SCAN Health Plan							
611	387	$111,654.67	$19,397.35	$94,553.56	$113,950.91	$0.00	$113,950.91
613	161	$91,701.72	$14,876.05	$76,259.61	$91,135.66	$0.00	$91,135.66
SUBTOTAL	**548**	**$203,356.39**	**$34,273.40**	**$170,813.17**	**$205,086.57**	**$0.00**	**$205,086.57**
SCAN Health Plan, AZ							
620	30	$8,610.90	$1,383.49	$7,227.41	$8,610.90	$0.00	$8,610.90
621	14	$7,924.84	$1,596.28	$6,328.56	$7,924.84	$0.00	$7,924.84
SUBTOTAL	**44**	**$16,535.74**	**$2,979.77**	**$13,555.97**	**$16,535.74**	**$0.00**	**$16,535.74**
SCAN Health Plan, NV							
622	26	$7,462.78	$1,245.70	$7,078.17	$8,323.87	$0.00	$8,323.87
623	11	$6,226.66	$1,018.90	$5,207.76	$6,226.66	$0.00	$6,226.66
SUBTOTAL	**37**	**$13,689.44**	**$2,264.60**	**$12,285.93**	**$14,550.53**	**$0.00**	**$14,550.53**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
UHC Medicare Adv.							
701	2,313	$1,005,379.56	$108,912.23	$902,529.05	$1,011,441.28	($1,816.45)	$1,009,624.83
702	413	$993,470.16	$38,379.79	$929,316.38	$967,696.17	$0.00	$967,696.17
703	1,434	$1,233,746.48	$114,385.96	$1,128,798.08	$1,243,184.04	($1,715.92)	$1,241,468.12
704	124	$334,017.50	$8,711.19	$327,978.45	$336,689.64	$0.00	$336,689.64
705	54	$64,098.54	$4,391.91	$60,893.64	$65,285.55	$0.00	$65,285.55
SUBTOTAL	**4,338**	**$3,630,712.24**	**$274,781.08**	**$3,349,515.60**	**$3,624,296.68**	**($3,532.37)**	**$3,620,764.31**
United Healthcare							
706	1	$546.03	$21.84	$524.19	$546.03	$0.00	$546.03
707	511	$993,580.98	$150,761.08	$804,457.70	$955,218.78	$0.00	$955,218.78
708	423	$1,521,478.14	$200,143.01	$1,239,487.48	$1,439,630.49	$0.00	$1,439,630.49
709	303	$1,276,281.89	$180,436.01	$1,022,457.93	$1,202,893.94	$228.64	$1,203,122.58
SUBTOTAL	**1,238**	**$3,791,887.04**	**$531,361.94**	**$3,066,927.30**	**$3,598,289.24**	**$228.64**	**$3,598,517.88**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	73	$110,503.75	$5,631.15	$101,845.10	$107,476.25	$0.00	$107,476.25
802	344	$938,913.60	$30,460.11	$908,453.49	$938,913.60	$0.00	$938,913.60
803	437	$1,406,960.83	$49,130.90	$1,361,049.52	$1,410,180.42	$3,219.59	$1,413,400.01
804	220	$333,025.00	$9,748.53	$323,276.47	$333,025.00	($63,052.45)	$269,972.55
805	259	$706,914.60	$19,269.56	$690,374.44	$709,644.00	($59,652.00)	$649,992.00
806	813	$2,219,002.20	$47,819.11	$2,171,183.09	$2,219,002.20	($367,817.20)	$1,851,185.00
807	62	$199,614.58	$2,318.10	$187,637.71	$189,955.81	($12,945.10)	$177,010.71
808	28	$90,148.52	$2,060.54	$88,087.98	$90,148.52	($14,852.20)	$75,296.32
809	13	$19,678.75	$908.25	$18,770.50	$19,678.75	$0.00	$19,678.75
810	7	$19,105.80	$3,220.69	$15,885.11	$19,105.80	$0.00	$19,105.80
811	5	$16,097.95	$1,931.76	$14,166.19	$16,097.95	$0.00	$16,097.95
812	271	$410,226.25	$21,828.22	$391,425.53	$413,253.75	($63,128.23)	$350,125.52
813	3	$8,188.20	$0.00	$8,188.20	$8,188.20	($608.70)	$7,579.50
814	1	$3,219.59	$1,030.27	$2,189.32	$3,219.59	($202.90)	$3,016.69
SUBTOTAL	**2,536**	**$6,481,599.62**	**$195,357.19**	**$6,282,532.65**	**$6,477,889.84**	**($579,039.19)**	**$5,898,850.65**
Kaiser - Washington							
393	4	$8,774.12	$1,843.92	$6,930.20	$8,774.12	$0.00	$8,774.12
394	26	$11,720.28	$2,136.68	$10,935.94	$13,072.62	$0.00	$13,072.62
395	2	$8,178.52	$1,928.64	$6,249.88	$8,178.52	$0.00	$8,178.52
397	2	$4,693.02	$0.00	$4,693.02	$4,693.02	$0.00	$4,693.02
398	16	$14,296.96	$1,787.11	$12,509.85	$14,296.96	$0.00	$14,296.96
SUBTOTAL	**50**	**$47,662.90**	**$7,696.35**	**$41,318.89**	**$49,015.24**	**$0.00**	**$49,015.24**
Medical Plan Total	**59,463**	**$76,110,255.37**	**$4,875,788.13**	**$70,395,498.95**	**$75,271,287.08**	**($621,394.88)**	**$74,649,892.20**

Medical and Dental Vision Insurance Premiums
December 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	28,154	$1,583,830.88	$154,141.57	$1,436,561.39	$1,590,702.96	($2,251.73)	$1,588,451.23
502	25,826	$3,047,097.84	$222,639.87	$2,830,590.83	$3,053,230.70	($953.20)	$3,052,277.50
503	13	$901.55	$38.84	$862.71	$901.55	$0.00	$901.55
SUBTOTAL	**53,993**	**$4,631,830.27**	**$376,820.28**	**$4,268,014.93**	**$4,644,835.21**	**($3,204.93)**	**$4,641,630.28**
CIGNA Dental HMO/Vision							
901	4,600	$215,010.93	$21,274.52	$193,783.04	$215,057.56	$46.63	$215,104.19
902	3,466	$332,348.87	$22,284.90	$309,108.35	$331,393.25	($191.06)	$331,202.19
903	2	$94.52	$15.12	$79.40	$94.52	$0.00	$94.52
SUBTOTAL	**8,068**	**$547,454.32**	**$43,574.54**	**$502,970.79**	**$546,545.33**	**($144.43)**	**$546,400.90**
Dental/Vision Plan Total	**62,061**	**$5,179,284.59**	**$420,394.82**	**$4,770,985.72**	**$5,191,380.54**	**($3,349.36)**	**$5,188,031.18**
GRAND TOTALS	**121,524**	**$81,289,539.96**	**$5,296,182.95**	**$75,166,484.67**	**$80,462,667.62**	**($624,744.24)**	**$79,837,923.38**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Anthem Blue Cross Prudent Buyer Plan		
$1,220.38	201	Retiree Only
$2,402.44	202	Retiree and Spouse/Domestic Partner
$2,711.47	203	Retiree, Spouse/Domestic Partner and Children
$1,568.92	204	Retiree and Children
$331.92	205	Survivor Children Only Rates
Anthem Blue Cross Plan I		
$1,584.80	211	Retiree Only
$2,857.90	212	Retiree and Spouse/Domestic Partner
$3,371.30	213	Retiree, Spouse/Domestic Partner and Children
$2,097.12	214	Retiree and Children
$534.96	215	Survivor Children Only Rates
Anthem Blue Cross Plan II		
$1,584.80	221	Retiree Only
$2,857.90	222	Retiree and Spouse/Domestic Partner
$3,371.30	223	Retiree, Spouse/Domestic Partner and Children
$2,097.12	224	Retiree and Children
$534.96	225	Survivor Children Only Rates
Anthem Blue Cross Plan III		
$642.90	240	Retiree Only with Medicare
$2,057.29	241	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross I)
$2,057.29	242	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross II)
$1,280.41	243	Retiree and Spouse/Domestic Partner - Both with Medicare
$1,151.83	244	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross I)
$1,151.83	245	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross II)
$2,566.05	246	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross I)
$2,566.05	247	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross II)
$1,789.08	248	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross I)
$1,789.08	249	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross II)
$2,005.12	250	Member, Spouse/Domestic Partner, Child (3 with Medicare)

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
CIGNA Network Model Plan		
$2,027.27	301	Retiree Only
$3,661.10	302	Retiree and Spouse/Domestic Partner
$4,323.07	303	Retiree, Spouse/Domestic Partner and Children
$2,690.19	304	Retiree and Children
$670.42	305	Survivor Children Only Rates
Kaiser		
$1,410.77	401	Retiree Only ("Basic")
$291.66	403	Retiree Only ("Senior Advantage")
$1,367.03	404	Retiree Only ("Excess I") *"Closed to New Entrants"*
$1,414.33	405	Retiree Only - ("Excess II")
$2,813.54	411	Retiree and Family (All family members are "Basic")
$1,694.43	413	Retiree and Family (One family member is "Senior Advantage"; others are "Basic")
$2,769.80	414	Retiree and Family (One family member is "Excess I"; others are "Basic") *"Closed to New Entrants"*
$575.32	418	Retiree and Family (Two or more family members are "Senior Advantage")
$1,650.69	419	Retiree and Family (One family member is "Excess I"; others are "Senior Advantage" *"Closed to New Entrants*"
$2,726.06	420	Retiree and Family (Two or more family members are "Excess I") *"Closed to New Entrants"*
N/A	421	Survivor Children Only Rates
$2,817.10	422	Retiree and Family (One family member is "Excess II"; others are "Basic")
$1,697.99	426	Retiree and Family (One family member is "Senior Advantage"; others are "Excess II")
$2,773.36	428	Retiree and Family (One family member is "Excess I"; others are "Excess II")
$2,820.66	430	Retiree and Family (Two or more family members are "Excess II")
Kaiser Colorado		
$1,421.80	450	Retiree Only ("Basic" under age 65)
$297.90	451	Retiree Only ("Senior Advantage")
$3,146.79	453	Retiree and Family (Two family members are "Basic")
$4,249.55	454	Retiree and Family (Three or more family members are "Basic")
$1,711.70	455	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic")
$587.80	457	Retiree and Family (Two family members are "Senior Advantage")
$3,043.28	458	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$2,001.60	459	Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic")

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser Georgia		
$1,780.87	440	Retiree Only ("Basic" over age 65 with Medicare Part B only
$1,780.87	441	Retiree Only ("Basic over age 65 with Medicare Part A only)
$1,780.87	442	Retiree Only ("Basic over age 65 without Medicare Part A or Medicare Part B)
$413.87	443	Retiree Only ("Basic" over age 65 - Medicare eligible who is classified as having renal failure)
$2,186.74	444	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part B only)
$2,186.74	445	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part A only)
$2,186.74	446	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 without Medicare Part A and B)
$1,780.87	461	Retiree Only ("Basic" under age 65)
$413.87	462	Retiree Only ("Senior Advantage")
$3,553.74	463	Retiree and Family (Two family members are "Basic")
$5,326.61	464	Retiree and Family (Three or more family members are "Basic)
$2,186.74	465	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$819.74	466	Retiree and Family (Two family members are "Senior Advantage")
$3,959.61	467	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$2,592.61	468	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
$1,225.61	469	Retiree and Family (Three or more family members are "Senior Advantage"; one is "Basic")
$3,959.61	470	Retiree and Family (Three or more family members are "Basic"; one is "Senior Advantage"
Kaiser Hawaii		
$962.84	471	Retiree Only ("Basic" under age 65)
$447.25	472	Retiree Only ("Senior Advantage")
$2,222.50	473	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$1,917.68	474	Retiree and Family (Two family members are "Basic")
$2,872.52	475	Retiree and Family (Three or more family members are "Basic")
$1,402.09	476	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$3,177.34	477	Retiree and Family (One family member is "Basic" under age 65; one is over age 65 without Medicare Part A or Medicare Part B)
$886.50	478	Retiree and Family (Two family members are "Senior Advantage"
$2,661.75	479	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser Oregon		
$1,414.96	481	Retiree Only ("Basic" under age 65)
$565.20	482	Retiree Only ("Senior Advantage")
$1,732.21	483	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$2,821.92	484	Retiree and Family (Two family members are "Basic")
$4,228.88	485	Retiree and Family (Three or more family members are "Basic")
$1,972.16	486	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$1,122.40	488	Retiree and Family (Two family members are "Senior Advantage")
$1,732.21	490	Retiree Only (Over age 65 with Medicare Part B only)
$1,930.86	491	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 with Medicare Par A only)
$2,289.41	492	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)
$3,379.12	493	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$2,529.36	494	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
$3,456.42	495	Retiree and Family (Two family members are over age 65 without Medicare Part A or Medicare Part B)
$2,739.32	496	Retiree and Family (Two family members are over age 65 with Medicare Part A only)
$2,780.62	497	Retiree and Family (One family member is "Basic"; one is over age 65 with Medicare Part A only)
$3,139.17	498	Retiree and Family (One family member is "Basic"; one is over age 65 without Medicare Part A or Medicare Part B)
Kaiser Washington		
$2,012.53	393	Retiree and Family ("Basic" under age 65)
$417.92	394	Retiree Only ("Senior Advantage")
$3,751.26	395	Retiree and Family (Two family members are "Basic")
$6,275.96	396	Retiree and Family (Three or more family members are "Basic")
$2,156.64	397	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic")
$827.82	398	Retiree and Family (Two family members are "Senior Advantage")
$4,681.34	399	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$3,352.52	400	Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic")

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

Kaiser Rate Category Definitions

"Basic" - includes those who are under age 65

"Senior Advantage"

-Includes participants who are age 65 or older and who have assigned both Medicare Part A and Part B to Kaiser.

"Excess II"

-Is for participants in the Excess Plan who either have Medicare Part B only or are not eligible for Medicare.

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
SCAN Health Plan		
$287.31	611	Retiree Only with SCAN
$566.62	613	Retiree and 1 Dependent - Both with SCAN (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child. Both Retiree and Dependent must have Medicare.)
SCAN Health Plan – Arizona (Maricopa, Pima, Pinal Counties)		
$287.31	620	Retiree Only
$566.62	621	Retiree and Spouse/Domestic Partner or Retiree and One Child. Both Retiree and eligible dependent must be enrolled in Medicare Parts A & B.
SCAN Health Plan – Nevada (Nye and Clark Counties)		
$287.31	622	Retiree Only
$566.82	623	Retiree and Spouse/Domestic Partner or Retiree and One Child. Both Retiree and eligible dependent must be enrolled in Medicare Parts A & B
United Healthcare Medicare Advantage (UHCMA) (For both members and dependents who are enrolled in UHCMA, or a family combination of UHCMA/UHC)		
$387.45	701	Retiree Only with Secure Horizons
$2,076.15	702	Retiree and 1 Dependent - One with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$766.90	703	Retiree and 1 Dependent - Both with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$2,367.05	704	Retiree and 2 or More Dependents - One with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
$1,057.80	705	Retiree and 2 or More Dependents - Two with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
$483.66	706	Survivor Children Only Rates

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

United Healthcare (UHC)

(For members and dependents under age 65 [no Medicare])

$1,696.70	707	Retiree Only
$3,100.27	708	Retiree and 1 Dependent
$3,676.30	709	Retiree and 2 Or More Dependents

Local 1014 Firefighters

$1,451.76	801	Member Under 65
$2,617.63	802	Member + 1 Under 65
$3,087.74	803	Member + 2 Under 65
$1,451.76	804	Member with Medicare
$2,617.63	805	Member + 1; 1 Medicare
$2,617.63	806	Member + 1; 2 Medicare
$3,087.74	807	Member + 2; 1 Medicare
$3,087.74	808	Member + 2; 2 Medicare
$1,451.76	809	Surviving Spouse Under 65
$2,617.63	810	Surviving Spouse + 1; Under 65
$3,087.74	811	Surviving Spouse + 2 Under 65
$1,451.76	812	Surviving Spouse with Medicare
$2,617.63	813	Surviving Spouse + 1; 1 Medicare
$3,087.74	814	Spouse + 1; 1 Medicare
$2,617.63	815	Surviving Spouse + 1; 2 Medicare

CIGNA Indemnity - Dental/Vision

$56.20	501	Retiree Only
$117.86	502	Retiree and Dependent(s)
$69.30	503	Survivor Children Only Rates

CIGNA HMO - Dental/Vision

$46.60	901	Retiree Only
$95.45	902	Retiree and Dependent(s)
$47.21	903	Survivor Children Only Rates

***Benchmark premiums are bolded.**

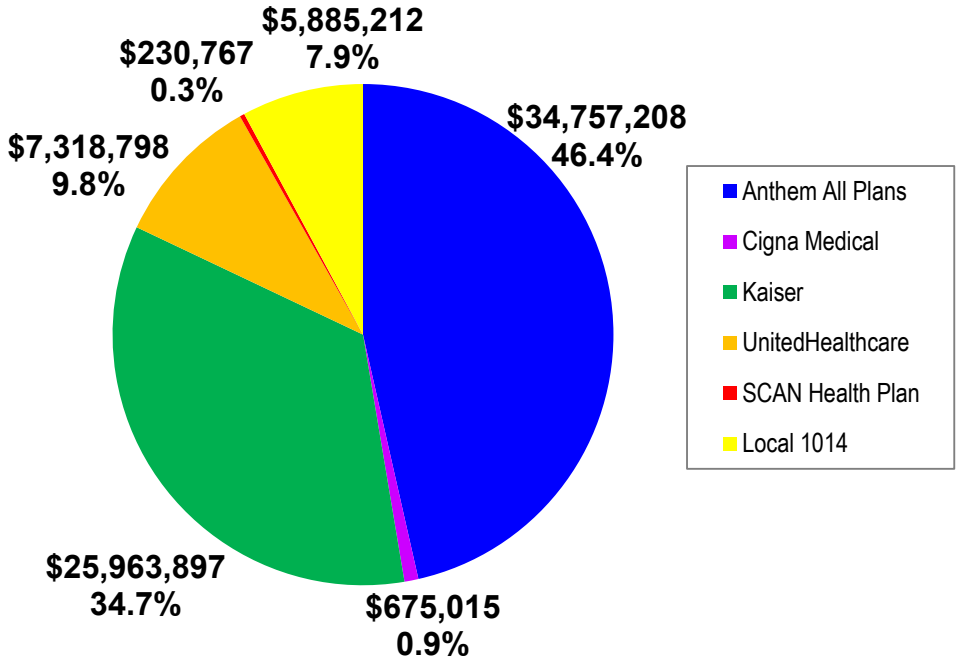
Los Angeles County Employees Retirement Association

Premium & Enrollment

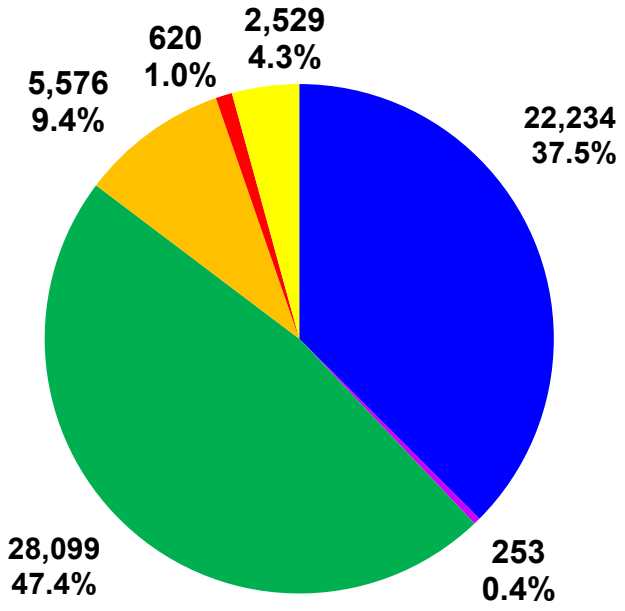
Coverage Month Ending October 2026

Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$34,757,208	46.4%	22,234	37.5%
Cigna Medical	$675,015	0.9%	253	0.4%
Kaiser	$25,963,897	34.7%	28,099	47.4%
UnitedHealthcare	$7,318,798	9.8%	5,576	9.4%
SCAN Health Plan	$230,767	0.3%	620	1.0%
Local 1014	$5,885,212	7.9%	2,529	4.3%
Combined Medical	**$74,830,897**	**100.0%**	**59,311**	**100.0%**
Cigna Dental & Vision (PPO and HMO)	**$5,172,549**		**61,846**	

Monthly Premium



Retirees

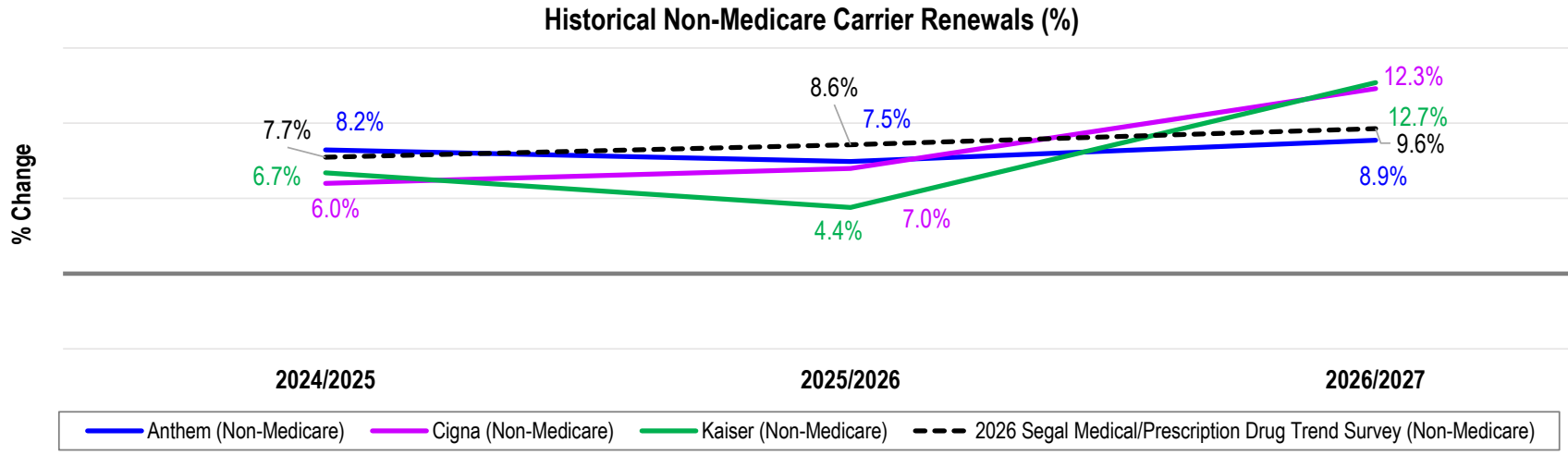


Note: Premiums **include** LACERA's Administrative Fee of $8.00 per member, per plan, per month.

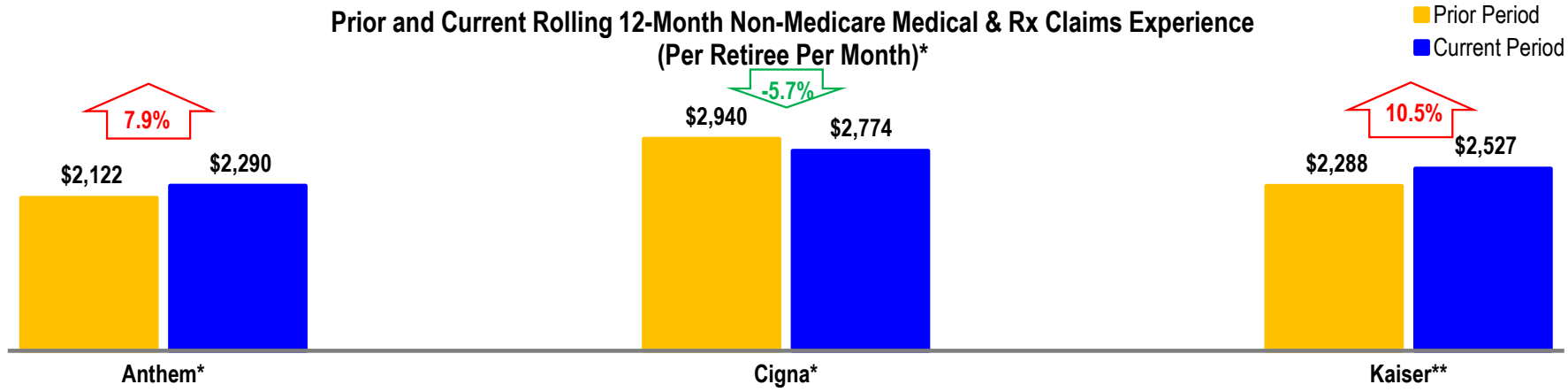
Los Angeles County Employees Retirement Association

Claims Experience by Carrier

Coverage Month Ending October 2026



Note: Segal's Annual Medical/Prescription Drug Trend Survey blends multiple calendar year trends to reflect LACERA's fiscal plan year.



* Based on Most Recent Claims Experience through Coverage Month.

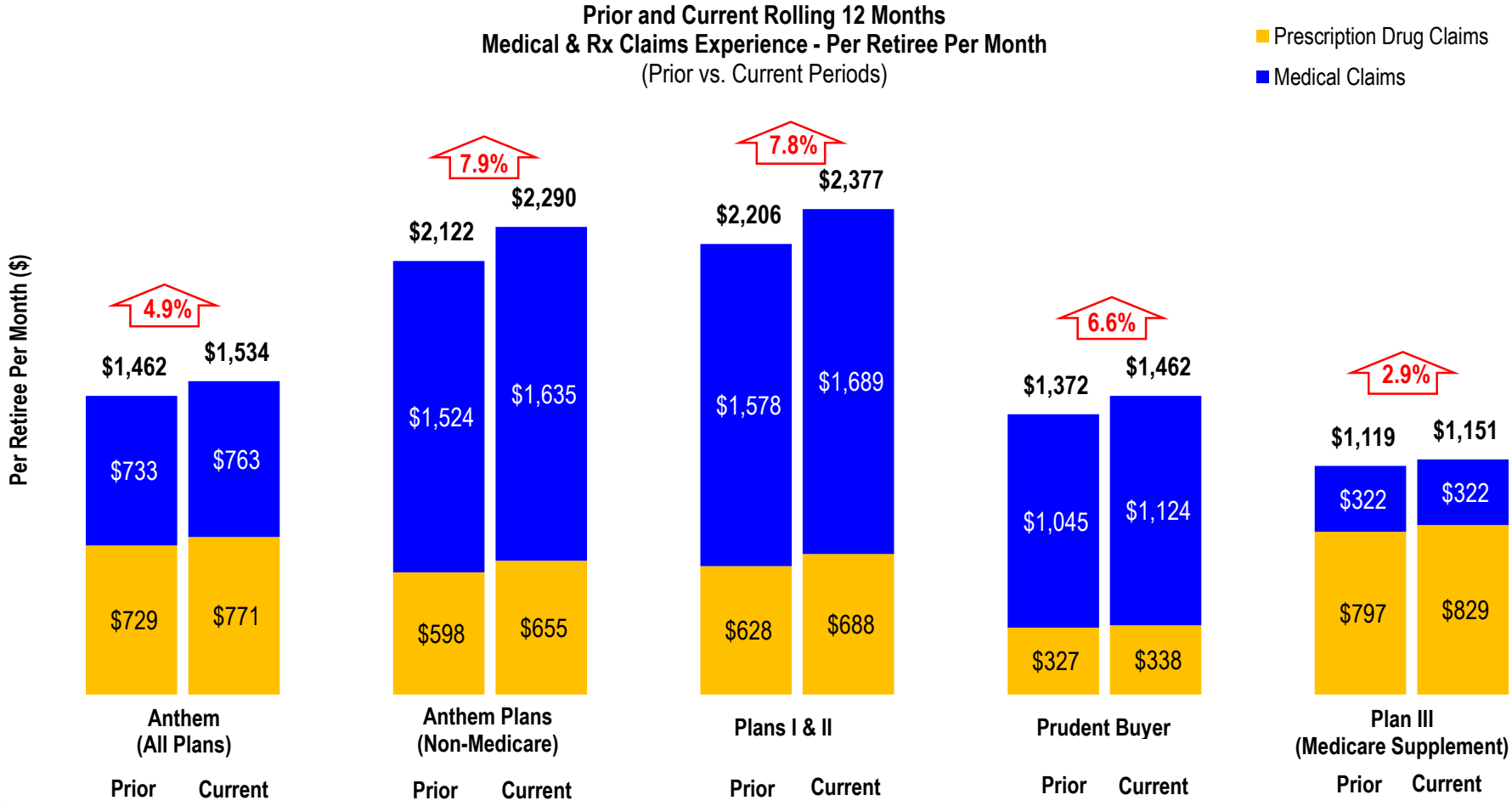
** Kaiser Claims Experience through August 2026.

Note: Figures above include gross claims only, and do not include rebates or pooling credits.

Los Angeles County Employees Retirement Association

Anthem Claims Experience By Plan

Coverage Month Ending October 2026



Note:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Figures above include gross claims only, and do not include rebates, pooling credits, or ITS surcharges.
3. Prudent Buyer pharmacy claims are retroactively updated due to the timing of Anthem PBM's receipt of recorded claims.
4. Anthem applies ITS surcharges for Plans I-III, and Prudent Buyer, which historically adds an estimated 0.5% to 0.6% towards claims.

Blended (Medical & Rx) Trend	2024/2025	2025/2026	2026/2027
Non-Medicare (80% Medical / 20% Rx)	7.7%	8.6%	9.6%
Medicare (20% Medical / 80% Rx)	6.2%	8.1%	7.4%

Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month Ending October 2026

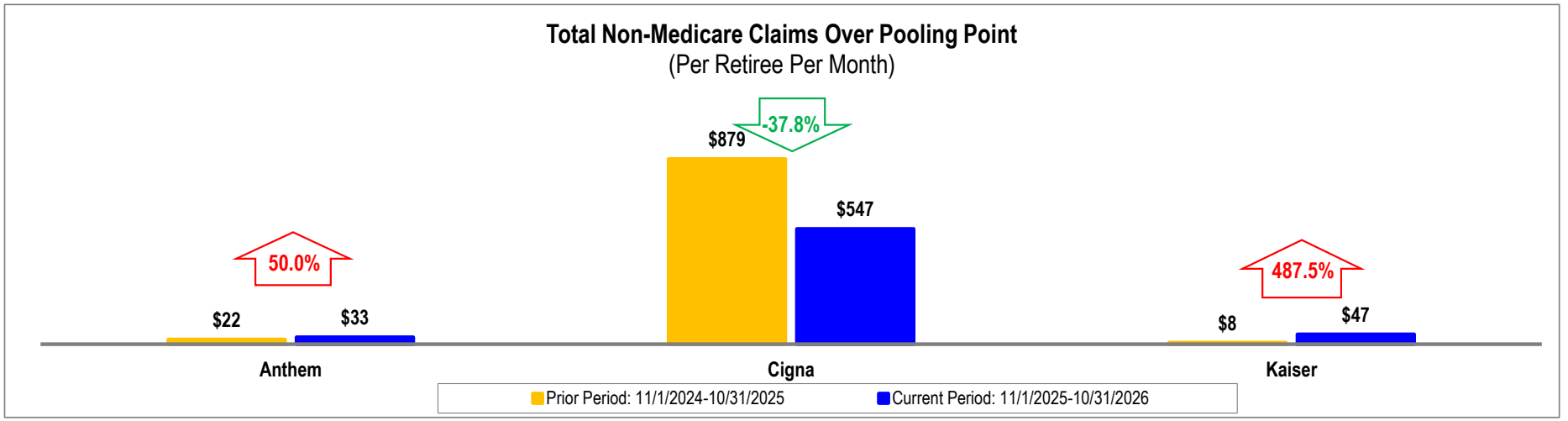
- Kaiser insures approximately 27,000 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in California.

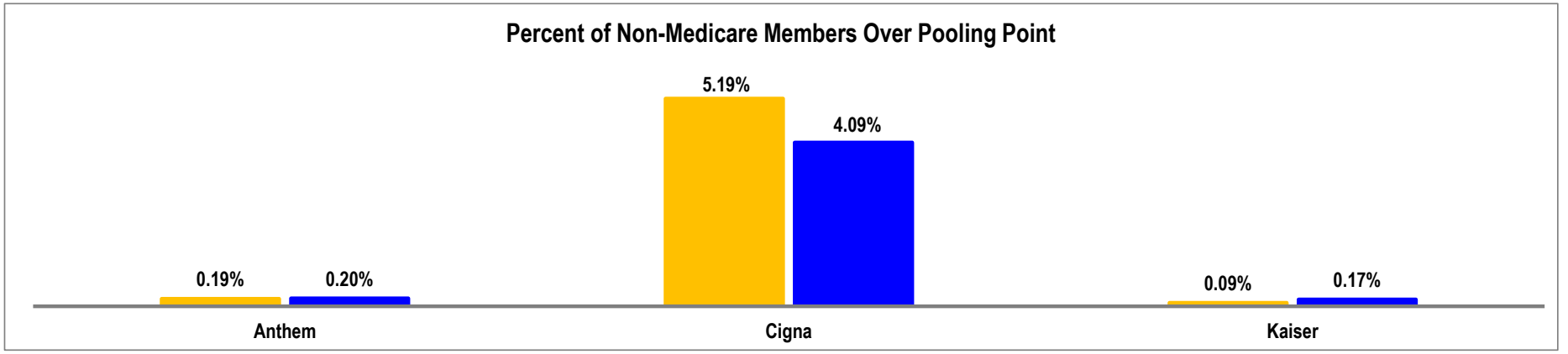
Category	Current Period 9/1/2025 - 8/31/2026	Prior Period 9/1/2024 - 8/31/2025	Change
Average Contract Size	**1.83**	**1.82**	**0.55%**
Average Members	**12,791**	**12,641**	**1.19%**
Inpatient Claims Per Member Per Month	$358.84	$313.79	14.36%
Outpatient Claims Per Member Per Month	$608.93	$556.88	9.35%
Pharmacy Per Member Per Month	$184.11	$173.84	5.91%
Other Per Member Per Month	$230.66	$215.95	6.81%
Total Claims Per Member Per Month	**$1,382.54**	**$1,260.46**	**9.69%**
Total Paid Claims	**$214,713,102**	**$191,200,169**	**12.30%**
Large Claims over $725,000 Pooling Point			
Number of Claims over Pooling Point	12	6	
Amount over Pooling Point	$3,969,749	$681,247	482.72%
% of Total Paid Claims	**1.85%**	**0.36%**	
Inpatient Days / 1000	1,049.1	700.9	49.68%
Inpatient Admits / 1000	100.5	96.0	4.69%
Outpatient Visits / 1000	16,877.5	16,841.3	0.21%
Pharmacy Scripts Per Member Per Year	14.0	14.3	-2.10%

Los Angeles County Employees Retirement Association

High Cost Claimants (Anthem, Cigna, & Kaiser)

Coverage Month Ending October 2026





Stop-Loss & Pooling Points Overview:

Plan sponsors mitigate the financial risk associated with individual large claimants through reinsurance. Claims exceeding the specified individual pooling threshold are deducted from the carrier's renewal calculation. The pooling credit is offset by the carrier's pooling expense, which is applied to all policyholders.

Anthem and Cigna figures are based on the most recent Claims Experience through Coverage Month. Kaiser's figures are based on Claims Experience period between September through August.

Pooling Points by Carrier:

1. Anthem's pooling points are $500,000 for Plans I & II, and $250,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $725,000.

Los Angeles County Employees Retirement Association

Anthem Lifetime Max Accumulation Status By Plan

Coverage Month Ending October 2026

	Prior Calendar Year: December 2024 [1,2]			Current Calendar Year: December 2025 [3,4]		
Lifetime Claim Amount [5]	**Plans I & II**	**Prudent Buyer**	**Combined**	**Plans I & II**	**Prudent Buyer**	**Combined**
$2.00M-$2.25M	0	0	**0**	0	0	**0**
$1.80M-$2.00M	0	0	**0**	0	0	**0**
$1.60M-$1.80M	0	0	**0**	0	0	**0**
$1.40M-$1.60M	0	0	**0**	0	0	**0**
$1.20M-$1.40M	0	0	**0**	0	0	**0**
$1.00M-$1.20M	7	0	**7**	8	1	**9**
Total	**7**	**0**	**7**	**8**	**1**	**9**
	Prior Month: September 2026 [3,6]			**Most Recent Month: October 2026 [3,7]**		
Lifetime Claim Amount [5]	**Plans I & II**	**Prudent Buyer**	**Combined**	**Plans I & II**	**Prudent Buyer**	**Combined**
$2.00M-$2.25M	0	0	**0**	0	0	**0**
$1.80M-$2.00M	0	0	**0**	0	0	**0**
$1.60M-$1.80M	0	0	**0**	0	0	**0**
$1.40M-$1.60M	0	0	**0**	0	0	**0**
$1.20M-$1.40M	2	0	**2**	2	0	**2**
$1.00M-$1.20M	10	0	**10**	12	0	**12**
Total	**12**	**0**	**12**	**14**	**0**	**14**

The number of members reported will fluctuate period to period due to multiple factors including migration from an Anthem plan to another LACERA-administered plan or members passing away.

[1] Includes two years of historical data.

[2] Based on data provided by Anthem on January 22, 2025.

[3] Includes two months of historical data.

[4] Based on data provided by Anthem on January 14, 2026.

[5] Members identified by Anthem as terminated were excluded from the counts above.

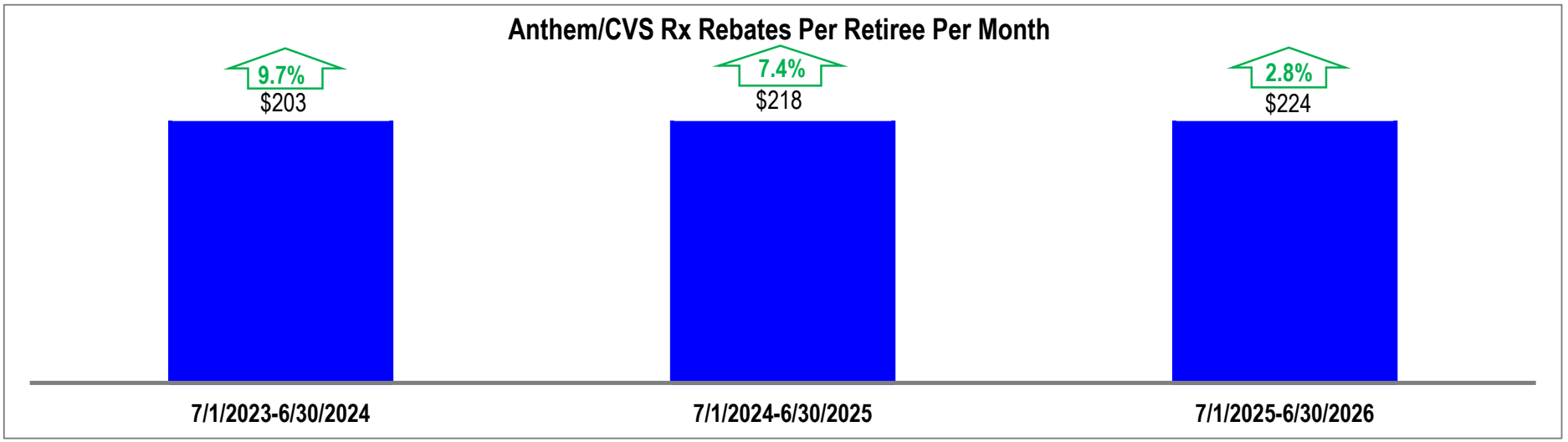
[6] Based on data provided by Anthem on October 16, 2026.

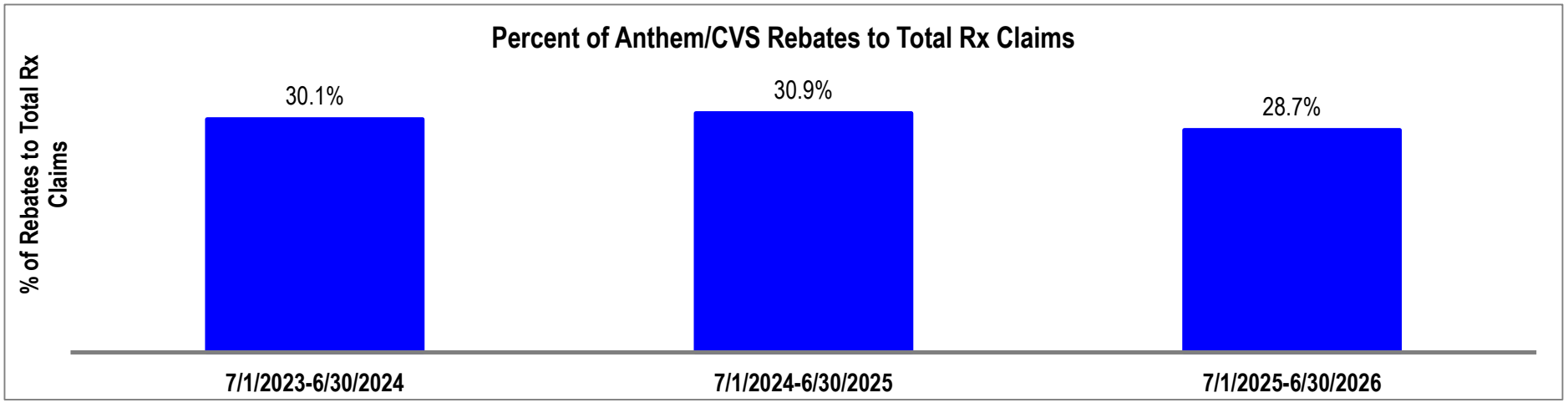
[7] Based on data provided by Anthem on November 16, 2026.

Los Angeles County Employees Retirement Association

Prescription Drug Rebates (Anthem)

Coverage Month Ending October 2026





Rebates Overview:

Pharmacy Benefit Managers negotiate volume-based rebates with drug manufacturers of brand medications. Manufacturer rebates are passed on to plan sponsors and are used to offset pharmaceutical claims expenses.

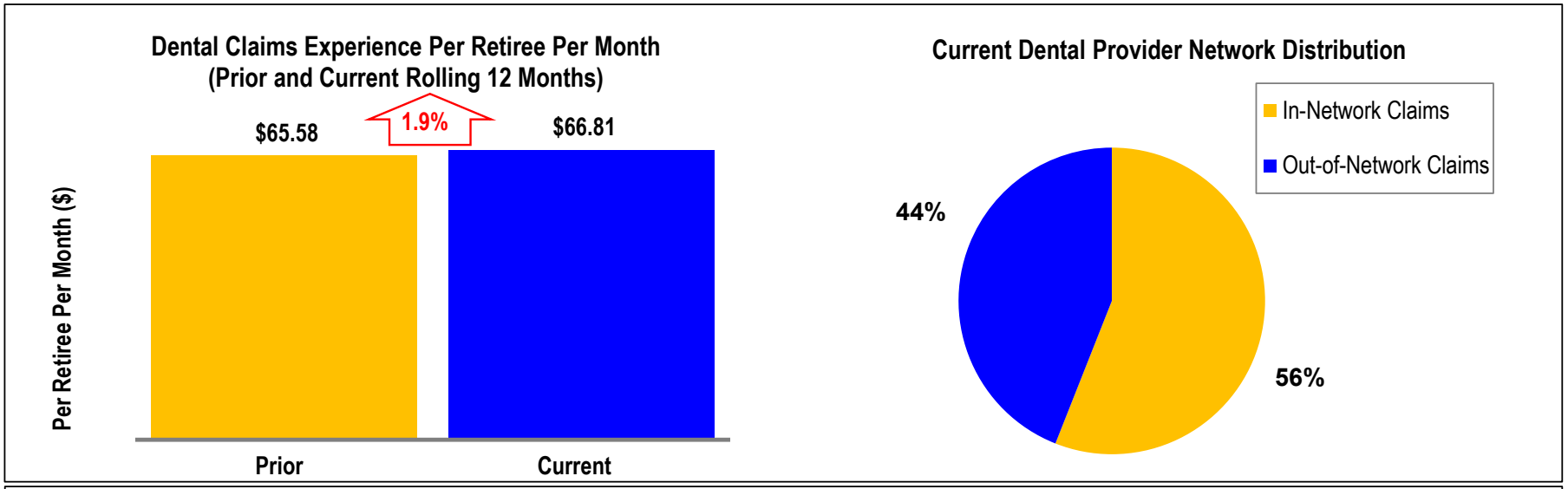
Note:

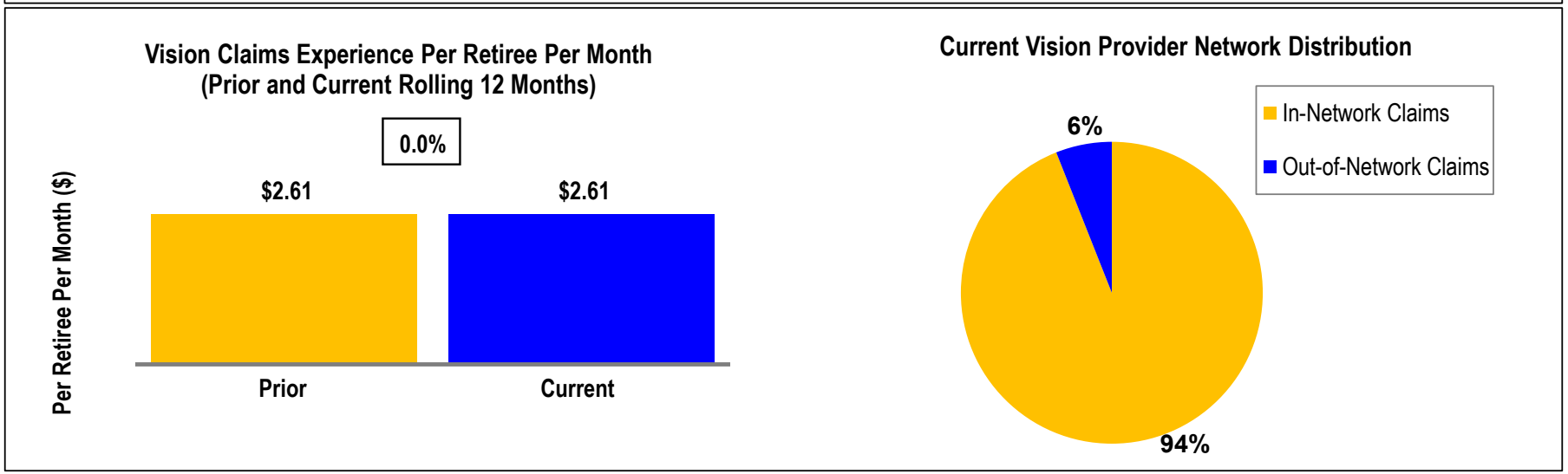
1. Prescription Claims and Rebates Data were provided by CVS.
2. Anthem Prudent Buyer prescription drugs are provided by CarelonRx and are not included in the charts above.

Los Angeles County Employees Retirement Association

Cigna Dental & Vision Claims Experience

Coverage Month Ending October 2026





Notes:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Dental Claims Experience reflects passive use of Cigna's PPO Dental Network.

Segal

Compliance News | November 12, 2026

FSA vs. HSA vs. HRA Comparison Chart

As a health plan sponsor, Flexible Spending Arrangements (FSAs), Health Savings Accounts (HSAs) and/or Health Reimbursement Arrangements (HRAs) can be effective components of your overall health plan, but only if you understand how they work and the differences (and similarities) among them.

That's where this chart can help you. It breaks down at a glance the key elements of FSAs, HSAs and HRAs, including the tax status of employer contributions, maximum contribution levels, and more.

Download the chart to learn more.

What's new?

In November 2027, we added the Flexible Spending Account (FSA) contribution limit for 2027 and the FSA carryover maximum for 2027.

Get the Chart



First Name*

Last Name*

Email*

Job Title*

Organization*

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Comparison of Key Elements of FSAs, HRAs and HSAs

November 2026

Plan Feature	Flexible Spending Accounts (FSAs)	Health Reimbursement Arrangements (HRAs)[1]	Health Savings Accounts (HSAs)[2]
Account creator	Employer	Employer	Employer or individual
Permissible contributors	Employer and employee	Employer only	Employer and employee (but no contributions for those enrolled in Medicare)
Tax status of employer contributions	Contributions are excludable from the employee's income. Employer contributions are not subject to FICA or FUTA.	Same	Same
Pre-tax salary reduction	Permitted	Not permitted — HRAs are exclusively employer-funded	Permitted subject to maximums
Taxation of account earnings	Generally, not taxable	Account is not usually funded	Generally, not taxable
Vesting	No requirements	No requirements	Fully vested
Funding	Not required by IRC (could be required under ERISA)	Not required	Funding and trust are both required and subject to specific requirements.
Portability	None	None	Individual money is portable and may be rolled over into another HSA no more frequently than once in a 12-month period.
Maximum contribution level	For 2026, the maximum salary reduction is $3,400.[3] For 2027, the maximum salary reduction will be $3,500.[4]	Set by employer For the plan year beginning on or after 1/1/20, plan sponsor may offer an "excepted benefit" HRA, with a maximum contribution of $1,800 (indexed starting in 2021).[5] The amount is $2,200 for 2026.[6] In 2027, the amount will be $2,250.[7]	For 2026, the maximum contribution is $4,400 (individual)/ $8,750 (family).[8] For 2027, the maximum contribution will be $4,500 (individual)/$9,000 (family).[9]
Catch-up contributions	Not allowed	Not allowed	$1,000 catch-up contribution allowed if age 55 or older and not enrolled in Medicare

[1] Approved in Notice 2002-45 and Revenue Ruling 2002-41.

[2] Created by Section 223 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

[3] Announced in Revenue Procedure 2025-32.

[4] Announced in Revenue Procedure 2026-35.

[5] "Excepted benefit" HRA and "individual coverage" HRA permitted under final rule published in the June 20, 2019 Federal Register.

[6] Announced in Revenue Procedure 2025-19,

[7] Announced in Revenue Procedure 2026-24.

[8] Announced in Revenue Procedure 2025-19,

[9] Announced in Revenue Procedure 2026-24.

Plan Feature	Flexible Spending Accounts (FSAs)	Health Reimbursement Arrangements (HRAs)[1]	Health Savings Accounts (HSAs)[2]
Carry-forward of amounts from year to year	Employer may either allow a carryover or offer a 2½ month grace period.[10] The maximum carryover was initially $500. The maximum carryover is 20% of the maximum salary reduction[11] ($680 in 2026[12] and $700 in 2027[13]).	Permitted — Plan may cap amount of carry-forward	Required
High-deductible health plan (HDHP)	Not required	Not required	For 2026, the minimum deductible is $1,700 (individual)/ $3,400 (family),[14] For 2027, the minimum deductible will be $1,750 (individual)/$3,500 (family).[15] Preventive care expenses do not have to be subject to the deductible.
Out-of-pocket maximum for HDHP	NA	NA	For 2026 the maximum is $8,500 (individual)/$17,000 (family).[16] For 2027 the maximum will be $8,700 (individual)/$17,400 (family).[17] Special rules for network plans.
Other eligibility requirements	NA	Plan sponsor may offer (1) an HRA paired with individual market coverage (an "individual coverage" HRA), but may not give an employee/member the choice between this type of HRA and a traditional group health plan; or (2) an "excepted benefit" HRA, which must be offered along with a traditional group health plan (but employee/ member is not required to enroll in the group plan.)	Cannot be covered by another health plan which provides coverage for benefits covered under the HDHP; with certain exceptions — accident, disability, dental, vision, long-term care or other permitted insurance such as workers' compensation, specific disease or hospital reimbursement insurance
Rules for those enrolled in Medicare	NA	An "individual coverage" HRA may be paired with individual market coverage or with Medicare Parts A and B or Part C.	Those enrolled in Medicare cannot contribute, but can receive distributions
Reimbursable medical expenses	Medical expenses under IRC §213(d); prescription required to reimburse over-the-counter medications (but not insulin) beginning 1/1/11	Same HRAs that are paired with other group coverage that does not meet the 60% minimum value standard will have to limit the expenses that are reimbursable.	Same

`[9] For more information about the creation of the carryover option, refer to IRS Notice 2013-71. For guidance on the grace period, see IRS Notice 2005-42.

[11] The formula for determining the maximum carryover was established in IRS Notice 2020-33. Revenue Procedure 2020-45 established the maximum salary reduction and carryover amount for 2021.

[12] Announced in Revenue Procedure 2025-32.

[13] Announced in Revenue Procedure 2026-35.

[14] Announced in Revenue Procedure 2025-19,

[15] Announced in Revenue Procedure 2026-24.

[16] Announced in Revenue Procedure 2025-19,

[17] Announced in Revenue Procedure 2026-24.

Plan Feature	Flexible Spending Accounts (FSAs)	Health Reimbursement Arrangements (HRAs)[1]	Health Savings Accounts (HSAs)[2]
Reimbursement of health insurance premiums	Generally, no	For an HRA paired with group coverage: certain health (e.g., COBRA and retiree health premiums) and long-term care insurance reimbursable For an HRA paired with individual market coverage (or Medicare): individual market premiums or Medicare premiums (including Medigap) reimbursable For an "excepted benefit" HRA: premiums for excepted benefits (e.g., dental and vision) or for short-term limited-duration insurance reimbursable	Certain health and long-term care insurance, including COBRA, premiums while receiving unemployment compensation, and retiree medical for individuals 65 or over (but not Medigap plans)
Distribution for non-medical expenses (including cash-outs)	Not allowed	Not allowed	Subject to tax and 20% penalty, with certain exceptions
Nondiscrimination	Required under IRC §§105 and 125 (if included in cafeteria plan)	Required under IRC §105	If not offered through a cafeteria plan, comparable contributions requirement — employer contributions (if any) must be comparable (same dollar amount or same percentage of deductible) across certain groups of employees,[18] effective 1/1/07, employers may provide lower HSA contributions to highly compensated employees
Reimbursement order	FSA always last unless HRA document states otherwise	FSA always last unless HRA document states otherwise	Cannot have HRA and FSA that cover same expenses as the HDHP
Coverage period	Generally, 12 months	Plan sponsor determines	NA
"Universal coverage rule"	Applies	Does not apply	Does not apply
Expense substantiation	Plan must substantiate	Plan must substantiate	Only individual must substantiate, not plan or trustee
COBRA	Applies	Applies	Does not apply to HSA under IRC — ERISA unclear; would apply to HDHP

[18] For more information about the IRS rules on comparable contributions, see Notice 2013-54 and Notice 2015-87, which address the impact of the ACA on HRAs.

This chart does not include "Archer MSAs." Although Archer MSAs are still in existence, they have very limited applicability because they are only available to small employers and the self-employed. In addition, only employers or employees can make contributions to Archer MSAs (not both) and employee contributions cannot be pre-tax.

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Compliance News | November 12, 2026

ACA Dollar Amounts and Percentages

Many ACA provisions contain numbers or percentages that are indexed to various measures of inflation, and the federal government announces new numbers throughout the year.

To help you stay on top of all of the ACA amounts you need to know for your group health plan, we've got handy summary charts that we update whenever new numbers come out.

Get the Charts



Download Now

What's new?

In November 2027, we added:

- The Flexible Spending Account (FSA) contribution limit for 2027 and the FSA carryover maximum for 2027
- The Federal Poverty Level safe harbor available to employers seeking to minimize the employer penalty for plan years beginning January 1, 2027

Subscribe for updates

We'll update the ACA percentages and dollar amounts chart as new information comes out of the government.

Make sure you're on top of the latest numbers, as well as other compliance news affecting group health plans: join our mailing list.

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Affordable Care Act Dollar Amounts and Percentages

Many provisions in the Affordable Care Act contain numbers or percentages that are indexed to various measures of inflation. The government announces new numbers at different times of the year and in different publications. The table below assembles these amounts in one place and is current as of November 6, 2026.

Indexed Amounts Affecting Group Health Plans

Item	2022	2023	2024	2025	2026	2027
Out-of-pocket (OOP) limit for non-grandfathered plans[1]	Individual: $8,700 Family: $17,400 (See announcement.)	Individual: $9,100 Family: $18,200 (See announcement.)	Individual: $9,450 Family: $18,900 (See announcement.)	Individual: $9,200 Family: $18,400 (See announcement.)	Individual: $10,600 Family: $21,200 (See announcement.)	Individual: $12,000 Family: $24,000 (See announcement.)
Flexible spending account (FSA) maximum salary reduction	$2,850 (See announcement.)	$3,050 (See announcement.)	$3,200 (See announcement.)	$3,300 (See announcement.)	$3,400 (See announcement.)	$3,500 (See announcement.)
FSA maximum carryover amount[2]	$570 (See announcement.)	$610 (See announcement.)	$640 (See announcement.)	$660 (See announcement.)	$680 (See announcement.)	$700 (See announcement.)
Employer shared responsibility penalty – 4980H**(a)**[3]	$2,750 (See answers to FAQs.)	$2,880 (See answers to FAQs.)	$2,970 (See announcement.)	$2,900 (See announcement.)	$3,340 (See announcement.)	$3,780 (See announcement.)
Employer shared responsibility penalty – 4980H**(b)**[4]	$4,120 (See answers to FAQs.)	$4,320 (See answers to FAQs.)	$4,460 (See announcement.)	$4,350 (See announcement.)	$5,010 (See announcement.)	$5,670 (See announcement.)

[1] For *2014 only*, the Affordable Care Act's OOP limits were the same as the OOP maximums applicable to a Health Savings Account (HSA) offered with a high-deductible health plan (HDHP). (Space constraints prevent us from showing columns of 2014–2021 data in the table above. Separate documents show data for 2014–2017 and 2018–2021.) For 2015 and beyond, the Affordable Care Act's OOP limits are not indexed to the HSA/HDHP amounts. The HSA/HDHP amounts are shown at the bottom of the next page for ease of reference.

[2] An employer may either allow a carryover or offer a 2½-month grace period.

[3] The employer shared responsibility penalty is found in section 4980H of the Internal Revenue Code. There are two branches of the employer shared responsibility penalty. The 4980H(a) penalty is based on the total number of full-time employees. It is triggered if the employer fails to offer coverage to a certain percentage of its full-time employees and one full-time employee receives subsidized Exchange/Marketplace coverage.

[4] The 4980H(b) penalty is based on the number of full-time employees who are not offered affordable, minimum value coverage by the employer and who receive subsidized Exchange/Marketplace coverage instead of employer coverage.

Item	2022	2023	2024	2025	2026	2027
Affordability of group health plan coverage: test applied **by Exchange/Marketplace** when determining if offered coverage is affordable	Not affordable if cost of employee-only coverage exceeds 9.61% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 9.12% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 8.39% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 9.02% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 9.96% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 10.22% of household income (See announcement.)
Affordability of group health plan coverage: safe harbors **available to employers** seeking to minimize employer penalty	W-2, rate of pay and FPL safe harbors use 9.61% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 9.12% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 8.39% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 9.02% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 9.96% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 10.22% in the calculation (See announcement.)
100% of the FPL (for single person living in one of the 48 contiguous states or Washington, DC),[5] which Exchange/Marketplace uses when calculating premium assistance tax credit	$13,590 (See announcement.) See separate table on page 3 for the FPL safe harbor calculation.	$14,580 (See announcement.) See separate table on page 3 for the FPL safe harbor calculation.	$15,060 (See announcement.) See separate table on page 3 for the FPL safe harbor calculation.	$15,650 (See announcement.) See separate table on page 3 for the FPL safe harbor calculation.	$15,960 (See announcement.) See separate table on page 3 for the FPL safe harbor calculation.	TBD

The 2017 Tax Law reduced the individual-mandate penalty to zero. Consequently, the affordability of group health plan coverage test applied by federal government in determining if individual or family is exempt from the individual mandate is not applicable.

HSA/HDHP

Item	2022	2023	2024	2025	2026	2027
Minimum deductible	Individual: $1,400 Family: $2,800 (See announcement.)	Individual: $1,500 Family: $3,000 (See announcement.)	Individual: $1,600 Family: $3,200 (See announcement.)	Individual: $1,650 Family: $3,300 (See announcement.)	Individual: $1,700 Family: $3,400 (See announcement.)	Individual: $1,750 Family: $3,500 (See announcement.)
Maximum contribution[6]	Individual: $3,650 Family: $7,300	Individual: $3,850 Family: $7,750	Individual: $4,150 Family: $8,300	Individual: $4,300 Family: $8,550	Individual: $4,400 Family: $8,750	Individual: $4,500 Family: $9,000
OOP maximum	Individual: $7,050 Family: $14,100	Individual: $7,500 Family: $15,000	Individual: $8,050 Family: $16,100	Individual: $8,300 Family: $16,600	Individual: $8,500 Family: $17,000	Individual: $8,700 Family: $17,400

[5] Revised federal poverty guidelines are usually released in late January of each year. They apply to Exchange/Marketplace calculations of the premium assistance tax credit for the following year (e.g., the FPL published in the January 17, 2020 *Federal Register* ($12,760) is used to calculate the premium assistance tax credit for 2021). Higher amounts apply to individuals living in Alaska and Hawaii.

[6] A catch-up contribution of $1,000 is allowed if the individual will be age 55 or older at the end of the year and is not enrolled in Medicare.

Affordability of Group Health Plan Coverage: FPL Safe Harbor Available to Employers Seeking to Minimize Employer Penalty

Plan Year[7]	100% of FPL for Single Individual Working in 48 Contiguous States or Washington, DC	Applicable Multiplier[8]	Maximum Affordable Monthly Premium for Self-Only Coverage
Plan year beginning January 1, 2022	$12,880	9.61%	$103.14
Plan year beginning February 1–December 1, 2022	$13,590	9.61%	$108.83
Plan year beginning January 1, 2023	$13,590	9.12%	$103.28
Plan year beginning February 1–December 1, 2023	$14,580	9.12%	$110.81
Plan year beginning January 1, 2024	$14,580	8.39%	$101.94
Plan year beginning February 1–December 1, 2024	$15,060	8.39%	$105.29
Plan year beginning January 1, 2025	$15,060	9.02%	$113.20
Plan year beginning February 1–December 1, 2025	$15,650	9.02%	$117.64
Plan year beginning January 1, 2026	$15,650	9.96%	$129.89
Plan year beginning February 1–December1, 2026	$15,960	9.96%	$132.46.
Plan year beginning January 2027	$15,960	10.22%	$135.93
Plan year beginning February 1–December1, 2027	TBD	TBD	TBD

[7] Employers may use any FPL in effect within six months before the start of the plan year. Higher levels apply to individuals working in Alaska and Hawaii.

[8] For links to the announcements of the applicable multiplier for each year, see the "Affordability of group health plan coverage: safe harbors available to employers seeking to minimize employer penalty" row on the previous page.

Affordable Care Act Fee

Fee	2022	2023	2024	2025	2026	2027
Comparative effectiveness research fee (PCORI[9]) — extended by Congress until 2029[10]	$2.79 per person (for a calendar-year plan, the amount paid by 7/31/22 for the 2021 plan year) (See announcement.)	$3.00 per person (for a calendar-year plan, the amount paid by 7/31/23 for the 2022 plan year) (See announcement.)	$3.22 per person (for a calendar-year plan, the amount paid by 7/31/24 for the 2023 plan year) (See announcement.)	$3.47 per person (for a calendar-year plan, the amount paid by 7/31/25 for the 2024 plan year) (See announcement.)	$3.84 per person (for a calendar-year plan, the amount paid by 7/31/26 for the 2025 plan year) (See announcement.)	TBD

For more information about the amounts in these tables, including links to relevant IRS guidance and how the amounts affect your plan, please contact your Segal consultant. Segal can be retained to work with plan sponsors and their legal counsel on compliance issues.

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[9] PCORI stands for the Patient-Centered Outcomes Research Institute that is partially funded through the comparative effectiveness research fee. This fee is based on the plan year (not the calendar year). The chart illustrates the amount and payment deadline for a calendar-year plan.

[10] The Further Consolidated Appropriations Act enacted in December 2019 (Public Law 116-94) extended these fees through plan years ending on or before 9/30/29.

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Compliance News | November 19, 2026

Retiree Health Plan Sponsors: 2027 Medicare Increases



The Centers for Medicare & Medicaid Services (CMS) has released the Medicare Part B premiums and deductible and the Part A deductible and coinsurance that will take effect on January 1, 2027. The standard monthly Part B premium and the Part B deductible for all Medicare beneficiaries will both increase by just over 3 percent. The Medicare Part A inpatient deductible and coinsurance for hospital stays and care in a skilled nursing facility will increase by just over 2 percent.

Sponsors of group health plans that cover retirees need to know this information when reviewing their coverage for Medicare-eligible retirees, including those enrolled in Medicare Advantage plans.

Standard Part B premium and deductible

Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items. According to the announcement, the standard monthly Part B premium will be $209.40, an increase of $6.50. In 2027, the annual deductible for Medicare Part B beneficiaries will be $292.00, an increase of $9.00.

CMS stated that the increase in the 2027 Part B standard premium and deductible is mainly due to projected increases in healthcare spending.

Part B Premium and Deductible

	2026	2027
Standard monthly Part B premium	$202.90	$209.40
Medicare Part B deductible	$283.00	$292.00

Part B and Part D premium adjustments for high-income individuals

High-income Medicare-eligible individuals who enroll in the Part B and D programs are required to pay income-related monthly adjustment amount (IRMAA) premiums. The IRMAA is calculated based upon an enrollee's modified adjusted gross income and income tax filing status. The income-adjusted premiums for 2027 are shown in the table below.

The Part D IRMAA is in addition to the individual's Part D premium. CMS projects the average base monthly premium for standard Part D coverage will be $41.33 for 2027, up from $38.99 in 2026. Note that beneficiaries with income at or below $112,000 (individual return) or $224,000 (joint return) pay only the standard Part B premium of $209.40 and no Part D IRMAA.

Income-Related Adjustments to Part B Premiums and Part D Premium Monthly Adjustment Amounts

Income Ranges for Individual Return Tax Filing Status*	Income Ranges for Joint Return Tax Filing Status	Monthly Adjustment Amounts for Part B Premium	Total Monthly Part B Premium	Part D Premium Monthly Adjustment Amounts
$112,001 to $141,000	$224,001 to $282,000	$83.70	$293.10	$15.40
$141,001 to $177,000	$282,001 to $354,000	$209.40	$418.80	$39.70
$177,001 to $212,000	$354,001 to $424,000	$335.00	$544.40	$64.00
$212,001 to $499,999	$424,001 to $749,999	$460.60	$670.00	$88.30
$500,000+*	$750,000+*	$502.40	$711.80	$96.40

* Married beneficiaries with incomes of more than $112,000 and less than $388,000 who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following Part B monthly premium adjustment in 2027: $460.60 (resulting in a total monthly premium of $670.00). (The Part D monthly adjustment for these couples will be $88.30.) Married beneficiaries with income of $388,000 or more who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following premium adjustment in 2027: $502.40 (resulting in a total monthly premium of $711.80). (The Part D monthly adjustment for these couples will be $96.40.)

Part B coverage option for Medicare enrollees who have had a kidney transplant

Medicare enrollees who receive a kidney transplant lose eligibility for full Medicare coverage after 36 months. They can elect to pay a premium to continue Part B coverage of only immunosuppressive drugs. In 2027, the standard monthly immunosuppressive drug premium will be $125.70.

High-income beneficiaries will pay a higher premium for this coverage, as shown in the following table. Note that beneficiaries with income at or below $112,000 (individual return) or $224,000 (joint return) pay only the standard premium of $125.70.

Income-Related Adjustments for Part B Immunosuppressive Drug Coverage

Income Ranges for Individual Return Tax Filing Status*	Income Ranges for Joint Return Tax Filing Status	Monthly Adjustment Amounts	Total Monthly Premium
$112,001 to $141,000	$224,001 to $282,000	$83.70	$209.40
$141,001 to $177,000	$282,001 to $354,000	$209.40	$335.10
$177,001 to $212,000	$354,001 to $424,000	$335.00	$460.70
$212,001 to $499,999	$424,001 to $749,999	$460.60	$586.30
$500,000+*	$750,000+*	$502.40	$628.10

* Married beneficiaries with incomes of more than $112,000 and less than $388,000 who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following premium adjustment in 2027 for Part B immunosuppressive drug coverage: $460.60 (resulting in a total monthly premium for that coverage of $586.30). Married beneficiaries with income of $388,000 or more who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following premium adjustment in 2027 for Part B immunosuppressive drug coverage: $502.40 (resulting in a total monthly premium for that coverage of $628.10).

Part A deductible and coinsurance

Part A pays for inpatient hospital, skilled nursing facility, hospice and certain home healthcare services.

Part A Deductible and Coinsurance

	2026	2027
First-day Part A hospital deductible	$1,736.00	$1,776.00
Daily Part A coinsurance for the 61st through 90th day of a hospital stay*	$434.00	$444.00
Daily Part A coinsurance for hospital stays longer than 90 days	$868.00	$888.00
Daily Part A coinsurance for the 21st through 100th day in a skilled nursing facility	$217.00	$222.00

* There is no cost-sharing requirement for the second through 60th day of a hospital stay.

Many public plans and employers have current and future retirees who do not have, or will not qualify for, zero-premium Part A coverage. Alternative market opportunities and strategies exist to provide benefits to these retirees in a more effective manner.

Action items

The premium increase is potentially significant, particularly for low-wage beneficiaries and for plan sponsors that reimburse all or part of an individual's Part B premium. Plan sponsors that reimburse a portion of these premiums for Medicare-eligible retirees should ensure that plan documents clearly state the terms for premium reimbursement. Terms that are vague or unclear should be clarified. Plan sponsors should also determine whether they will pay any part of the IRMAA premiums.

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Segal

Compliance News | November 19, 2026

Final Rule on Pharmacy Benefit Manager Fee Disclosure

The DOL published a final rule designed to increase transparency regarding pharmacy benefit management services and compensation arrangements. The rule requires pharmacy benefit managers (PBMs) and affiliated brokers and consultants to provide specific disclosures regarding services, fees and compensation to fiduciaries of certain large, self-funded group health plans, as well as to provide related information upon request.



The final rule grants plan fiduciaries broad audit rights to support plans in verifying the accuracy of the disclosures and includes an important administrative exemption for responsible plan fiduciaries when a service provider fails to comply with the regulation.

The final rule is applicable for plan years beginning on or after July 1, 2027, therefore January 1, 2028, for calendar-year plans.

The final rule will provide plan sponsors with significantly greater visibility into PBM compensation and financial arrangements. With more detailed and standardized information, plan sponsors will be better positioned to assess the reasonableness of current and prospective contracts with PBMs and other covered service providers (CSPs). Plan sponsors should have greater ability to evaluate offers from different service providers, negotiate terms that are most aligned with the best interests of plan participants and maintain visibility and control over existing relationships.

Background on PBM disclosure requirements

The DOL issued a proposed fee disclosure rule in January 2026. Shortly after that, on February 3, 2026, the Consolidated Appropriations Act of 2026 (CAA) was signed into law, enacting additional reforms to PBM practices. (Our February 11, 2026 insight, "New Requirements for PBM Reporting and Fee Disclosures," discusses both the proposed rule and the PBM reforms under the CAA.) Specifically, the CAA made changes to ERISA by amending ERISA Section 408(b)(2)(B) and adding new ERISA Sections 408(b)(2)(C) and 726.

The disclosures required under new Section 726 of ERISA overlap in certain respects with, and complement, the disclosures under the DOL fee disclosure rules, which the DOL addresses in the fee disclosure final rule.

The CAA also includes broader PBM reforms applicable to both self-funded and insured group health plans and issuers through amendments to ERISA, the Public Health Service Act and the Internal Revenue Code, which are generally administered by the Departments of Labor, Health and Human Services and the Treasury (collectively, the Departments). The CAA also amends ERISA Section 408(b)(2) to provide that for plans subject to ERISA, PBMs must pass 100 percent of all rebates, fees, alternative discounts and other remuneration to the group health plan or insurer.

In addition to CAA amendments to ERISA Section 408(b)(2) relating to PBM disclosures, the statute also requires third-party administrators and certain other entities providing services to group health plans to disclose all direct and indirect compensation received by the service provider to the group health plan sponsor. However, the scope of the Department's final rule is limited to disclosures and specifically disclosures by providers of pharmacy benefit management services and affiliated providers of consulting or brokerage services. The CAA also includes additional PBM reforms that apply to Medicare and Medicaid. Future regulatory guidance is expected to further implement the reforms enacted under the CAA applicable to plans and insurers, along with additional PBM reforms that apply to Medicare and Medicaid.

The final rule on PBM fee disclosures

The Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure final rule was published in the *Federal Register* on November 2, 2026. The final rule implements updated standards under Section 408(b)(2) of ERISA, which governs activities that are prohibited transactions under ERISA, unless certain requirements are met. The final PBM fee disclosure rule is an outgrowth of Executive Order 14273 directing initiatives to lower drug prices (discussed in our April 23, 2025 insight, "Executive Order Seeks to Lower Prescription Drug Prices") and builds upon the proposed rule. The final rule applies to ERISA-covered plans and is designed to give fiduciaries of certain large, self-insured group health plans greater transparency into PBM compensation and financial arrangements to assess the reasonableness of service arrangements under ERISA.

The DOL revised certain provisions under the proposed PBM fee disclosure rule to better align the implementation and enforcement of the DOL fee disclosure requirements with the CAA. Specifically, the rule applies to the self-funded plan of "specified" large employers (generally those with at least 100 employees) and to self-insured "specified" large plans (generally those with at least 100 participants). Employers with fully insured plans that meet the size specifications can opt in to receive the required reporting.

As detailed below, the rule requires PBMs and affiliated brokers and consultants to provide certain plans with initial and ongoing information about the services being provided and related fees and compensation. Certain additional information must be made available upon request, and plans have audit rights to support monitoring the accuracy and completeness of the required disclosures.

In the final rule, the DOL explains that in contrast to the retrospective disclosures and drug spending and utilization disclosures required under Section 726 of ERISA, the disclosure requirements under the DOL fee disclosure rule (required initially and upon renewal with additional semiannual reporting) serve a distinct function aimed at improving transparency for purposes of large self-insured group health plan contracting practices involving providers of pharmacy benefit management services. The DOL also points to congressional amendments to ERISA Section 408(b)(2)(B) as consistent with the DOL fee disclosure rule and highlights that the CAA provided specific authority to the DOL to issue regulations addressing time, manner and content of the 408(b)(2) disclosures.

The final rule applies to PBMs and PBM-affiliated brokers and consultants providing pharmacy benefit management services (collectively, CSPs) that serve large, self-insured group health plans and expect to receive at least $1,000 in compensation. Under the final rule, PBM services include rebate negotiations, formulary and network management, and performing utilization review and management. PBM services can also include claims processing, appeals, recordkeeping and compliance functions but only when performed in connection with the core PBM activities.

Along with the final rule, the DOL issued a resource called Top 5 FAQs about the final rule and a Fact Sheet that presents an overview of the final rule.

Initial disclosures

CSPs must provide initial written disclosures to plan fiduciaries before entering into, extending or renewing a contract or arrangement. For renewals or extensions, disclosures must be provided at least 90 days in advance. These initial disclosures must provide a description of:

- **Services covered under the contract.** This includes PBM services or advice, recommendations or referrals regarding those services.
- **Direct compensation.** Direct compensation from the plan covers compensation in total and by service.
- **Indirect compensation.** This refers to payments a CSP receives from sources other than the plan, specifically:
  - Manufacturer payments, including rebates, fees and other remuneration both in the aggregate and for each drug on the formulary
  - Spread compensation for each pharmacy channel, both in the aggregate and for each drug on the formulary
  - Pharmacy recoupments, such as expected claw-backs and other recoupments
  - Price protection arrangements

For each category, the CSP must disclose the compensation it reasonably expects to receive, payment sources, the related services and any other payment arrangements.

- **Other compensation.** Any other compensation reasonably expected to be received in connection with PBM services, including who pays, the related services and the arrangement under which it is paid must be disclosed.

- **Formulary placement incentives.** Manufacturer-related formulary incentives, including how they benefit the plan, must be disclosed. If the CSP retains manufacturer payments, it must identify available therapeutically equivalent alternatives (including biosimilar biological products) and explain why omitted products were excluded. The CSP also must disclose its authority to change the formulary, provide advance notice of material changes and disclose the plan's right to terminate the contract.
- **Drug pricing methodology.** This refers to the net price the plan pays for each formulary drug by pharmacy channel, after rebates, fees, discounts and other remuneration. If the net price cannot be determined, the CSP must disclose the pricing methodology and an objective means for the plan to verify it.
- **Statement of fiduciary status.** This statement must identify whether the CSP or any affiliate, agent or subcontractor provides services as an ERISA fiduciary.
- **Statement of audit right.** This statement must describe the plan's audit rights and procedures for requesting an audit.

Ongoing disclosures

The final rule aligns its ongoing disclosure framework with the CAA by requiring semiannual disclosures, with quarterly reporting available upon a plan's request. To support ongoing fiduciary oversight of the CSP arrangements, the CSP must provide semiannual disclosures (or quarterly, upon the plan's request) reporting compensation actually received and compensation expected to be received for the reporting period.

Disclosures are due within 30 days after the end of each reporting period. The reporting must include an explanation for any compensation category that materially exceeds the initial estimate (any 5 percent difference between actual compensation and amounts disclosed in the initial disclosures), including the amount and reason for the overage.

Information upon request

Upon written request, a CSP must provide any information relating to its contract or arrangement that is needed for the plan to comply with ERISA reporting and disclosure requirements, such as Form 5500 and Prescription Drug Data Collection (RxDC) reporting. The information must be provided sufficiently in advance of applicable filing deadlines unless extraordinary circumstances beyond the provider's control prevent timely disclosure.

Plan fiduciary audit rights

The final rule gives plans audit rights, including the ability to select any auditor, obtain records, claims and transaction-level data, and to require the PBM to acknowledge audit requests within 10 business days and provide requested information within 60 calendar days (absent extraordinary circumstances).

The rule states that while plans must periodically monitor service providers and ensure their compensation remains reasonable, they are not required to conduct an audit. In the absence of any signals that a service provider's compensation, fees or reporting fail to comply with the rules, a fiduciary may justifiably conclude that the cost of an audit outweighs its potential value. However, plans should monitor for any potential signs that a service provider may be failing to comply, signaling that an audit may be warranted.

Manner of disclosure

The disclosures from CSPs to plan fiduciaries must be:

- **Provided in plain language.** Disclosures must be clear, concise, free of misrepresentations and specific enough for plans to assess the reasonableness of the arrangement. Undefined jargon, generic industry terms and legalese generally are not permitted unless tied to objective definitions or guidance that is publicly available or provided to the plan by the CSP upon request.
- **Expressed as a monetary amount.** If the actual monetary amount is not reasonably ascertainable, it may be estimated using good-faith assumptions based on contract terms, historical utilization, rebate experience or other available information.
- **In a machine-readable format upon request.** At the request of a plan fiduciary, the CSP must provide compensation disclosures in a standard machine-readable format within a reasonable time to support fiduciary analysis, benchmarking and oversight. Service agreements cannot restrict a fiduciary's ability to request this format.
- **Shareable.** CSPs generally cannot restrict a plan's use of required disclosures or its ability to share them with advisers, consultants, attorneys, auditors or regulators. Reasonable confidentiality agreements may be required to

prevent redisclosure and limit use to plan-related purposes.

Administrative class exemption

Failure to satisfy the rule's disclosure or audit requirements may cause the arrangement to lose the protection of ERISA's prohibited transaction exemption. A fiduciary may qualify for an administrative exemption if it reasonably believed the PBM was compliant before discovering the failure and then takes the required corrective steps, including requesting correction and reporting unresolved noncompliance to the DOL. The rule advises that if the failure is not cured within 90 days, the fiduciary must determine whether to continue or terminate the arrangement and document that decision. The exemption does not alter the fiduciary's ongoing duties of prudence and loyalty under ERISA.

Applicability

The final rule is applicable for plan years beginning on or after July 1, 2027 (for calendar-year plans, January 1, 2028,). Although the CAA amendments to ERISA Section 408(b)(2)(B) became effective on February 3, 2026, the DOL has provided transition relief. To support coordination of implementation, the DOL clarified that between February 3, 2026 and the applicability date of the final rule, it will not treat a CSP as having failed to make the required disclosures to a responsible plan fiduciary under ERISA Section 408(b)(2)(B) as long as the CSP made disclosures based on a good-faith interpretation of its obligations under the law.

Similarly, prior to the applicability date of the final rule, the DOL will not treat a responsible plan fiduciary as having engaged in a prohibited transaction in entering into a contract or arrangement with a CSP, provided the fiduciary acted in accordance with a good-faith interpretation of their obligations under ERISA to determine the reasonableness of the contract or arrangement.

Next steps for sponsors of group health plans

Most plans rely on third-party PBMs and affiliated consultants and brokers. Plan sponsors should begin to identify the service providers they work with that are implicated by this law and discuss preparedness for compliance with the new requirements. Plan sponsors may consider revisions to requests for proposals and contract language with CSPs to account for compliance with the new rule.

Fiduciaries will need to review and monitor the required disclosures once they are available. Plans may evaluate PBM services, fees and compensation to help negotiate reasonable terms on behalf of the plan. Plans can assess whether additional information or audits are warranted and take appropriate action when compliance issues arise. Oversight of the disclosures as required by the final rule will be a central part of fiduciary governance. Therefore, plans should develop an approach to monitoring CSP compliance that includes a process for performing and documenting oversight of service providers. Plan sponsors should continue to watch for additional PBM-reform-related guidance under the CAA.

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