LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Benefits Administration Committee Agenda
REGULAR MEETING
TUESDAY, MARCH 10, 2026
9:00 A.M.
LACERS BOARDROOM
977 N. Broadway
Los Angeles, CA 90012

Chair:

Thomas Moutes

Committee Members:

Janna Sidley

Sung Won Sohn

Manager-Secretary:

Todd Bouey

Executive Assistant:

Ani Ghoukassian

Legal Counsel:

City Attorney's Office Public Pensions General Counsel Division

ACCESS TO LACERS BOARD AND COMMITTEE MEETING REPORTS

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I. PUBLIC COMMENTS AND GENERAL PUBLIC COMMENTS ON MATTERS WITHIN THE COMMITTEE'S JURISDICTION AND COMMENTS ON ANY SPECIFIC MATTERS ON THE AGENDA

II. APPROVAL OF MINUTES FOR THE MEETING OF FEBRUARY 10, 2026 AND POSSIBLE COMMITTEE ACTION

III. INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA) – ADDITIONAL INFORMATION

IV. HEALTHCARE TRENDS

V. DISCUSSION OF MEMBERS' EXPERIENCE RELATED TO ANTHEM'S PHARMACY SERVICES AND POSSIBLE COMMITTEE ACTION

VI. OTHER BUSINESS

VII. NEXT MEETING: The next Benefits Administration Committee meeting is not scheduled at this time and will be announced upon scheduling. Please continue to view the LACERS website for updated information on public access to Board/Committee meetings.

VIII. ADJOURNMENT

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Board of Administration Agenda
SPECIAL MEETING
TUESDAY, MARCH 10, 2026
9:00 A.M.
LACERS BOARDROOM
977 N. Broadway
Los Angeles, CA 90012

President:

Annie Chao

Vice President:

Janna Sidley

Commissioners:

Thuy Huynh

Susan Liem

Thomas Moutes

Gaylord "Rusty" Roten

Sung Won Sohn

Manager-Secretary:

Todd Bouey

Executive Assistant:

Ani Ghoukassian

Legal Counsel:

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VIII. ADJOURNMENT

Agenda of: MAR. 10, 2026

Item No: II

MINUTES OF THE REGULAR MEETING
BENEFITS ADMINISTRATION COMMITTEE
LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM

February 10, 2026

9:33 A.M.

PRESENT:	Chair:	Thomas Moutes
	Committee Members:	Janna Sidley Sung Won Sohn
	Executive Assistant:	Ani Ghoukassian
	Legal Counselor:	Miguel Bahamon
	Manager-Secretary:	Todd Bouey

The Items in the Minutes are numbered to correspond with the Agenda.

I

PUBLIC COMMENTS AND GENERAL PUBLIC COMMENTS ON MATTERS WITHIN THE COMMITTEE'S JURISDICTION AND COMMENTS ON ANY SPECIFIC MATTERS ON THE AGENDA – Chair Moutes asked if any persons wished to speak on matters within the Committee's jurisdiction, and there were no public comment cards submitted.

II

APPROVAL OF MINUTES FOR THE MEETING OF DECEMBER 9, 2025 AND POSSIBLE COMMITTEE ACTION – Committee Member Sidley moved approval, and adopted by the following vote: Ayes, Committee Members Sidley, Sohn, and Chair Moutes -3; Nays, None.

III

2026 LACERS WELL UPDATE, WORKPLAN, BUDGET AND POSSIBLE COMMITTEE ACTION – Kristal Baldwin, Senior Benefits Analyst I, and Alejandra Zuniga, Benefits Analyst, presented and discussed this item with the Committee for 31 minutes. Committee Member Sidley moved approval, and adopted by the following vote: Ayes, Committee Members Sidley, Sohn, and Chair Moutes -3; Nays, None.

IV

OTHER BUSINESS – Chair Moutes requested the next Benefits Administration Agenda include a discussion on the issues with Carelon, which may include a survey or other method to determine the extent of the problems.

V

NEXT MEETING: The next Benefits Administration Committee meeting is not scheduled at this time and will be announced upon scheduling. Please continue to view the LACERS website for updated information on public access to Board/Committee meetings.

VI

ADJOURNMENT – There being no further business before the Committee, Chair Moutes adjourned the meeting at 10:05 A.M.

_____
Thomas Moutes
Chair

_____
Todd Bouey
Manager-Secretary

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

REPORT TO BENEFITS ADMINISTRATION COMMITTEE **MEETING: MARCH 10, 2026**
From: Todd Bouey, General Manager **ITEM: III**

for TB

SUBJECT: **INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA) - ADDITIONAL INFORMATION**

ACTION: ☐ CLOSED: ☐ CONSENT: ☐ RECEIVE & FILE: ☒

Recommendation

That the Committee receives and files this report.

Executive Summary

At the December 9, 2025, Benefits Administration Committee (BAC) meeting, a historical overview of the Medicare Part B reimbursement program and income-related monthly adjustment amount (IRMAA[1]) was presented to the Benefits Administration Committee. Staff discussed the changes to the Los Angeles Administrative Code (LAAC) since the Medicare Part B Reimbursement Program for LACERS Retired Members was established in 1983. The Committee requested additional analysis in three areas:

- Benchmarking against other retirement systems that reimburse IRMAA, including their rationale and any actuarial cost studies.
- Evaluation of IRMAA inflation trends.
- Comparison of Medicare plan costs versus non-Medicare plan costs.

This report provides the requested research and analysis.

Discussion

LACERS continued the research and analysis of IRMAA-related information sought by the BAC. Three retirement systems that reimburse IRMAA were contacted to determine whether actuarial cost studies were conducted when they began reimbursing IRMAA. Analysis of the inflationary increases of IRMAA was also conducted. Lastly, a review of the costs of LACERS Medicare Plans and non-Medicare Plans was prepared by LACERS Health Plan consultant, Keenan & Associates.

Other Retirement Systems

[1] IRMAA is a surcharge on top of the basic/standard Medicare premium rates for Part B and Part D if a person's modified adjusted gross income for the two years prior is above annual thresholds determined by the Centers for Medicare & Medicaid Services (CMS).

The information listed below indicates that although the three retirement plans reimburse IRMAA, no statutory or policy changes were made to allow such reimbursements, as the applicable authoritative language already permitted them. Therefore, no additional actuarial studies were conducted.

New York City

New York City (NYC) reimburses the full Medicare Part B and IRMAA premiums, but not Part D IRMAA or penalties, to Medicare-eligible retirees and their spouses as set by the New York City Administrative Code. The NYC Administrative Code, which was amended prior to IRMAA, states that "the City shall reimburse covered employees in an amount equal to one hundred percent of the Medicare Part-B premium rate applicable to that year". No changes to the language have been made, as this would require a modification of the City Charter and would need to be approved by the New York City Council and all unions; therefore, no actuarial study was conducted.

Los Angeles Department of Water and Power (LADWP)

The Los Angeles Department of Water and Power provides the health benefits for its active and retired employees. The Medicare Part B reimbursement program was effective before IRMAA was introduced. LADWP provides Medicare Part B reimbursement, including IRMAA, to eligible Members only if the subsidy towards the cost of the health care plan equals or exceeds the cost of the health care plan premium plus the Medicare Part B premium. No changes have since been made to the Administrative Code; therefore, no additional actuarial study was conducted.

California Public Employees' Retirement System (CalPERS)

The CalPERS Health Benefits Program is governed by the Public Employees' Medical and Hospital Care Act (PEMHCA). Under PEMHCA Section 22879, State of California and California State University annuitants and their eligible dependents may receive reimbursement for Medicare Part B premiums, excluding any penalties. Annuitants who have retired from public agencies are not eligible for this CalPERS reimbursement.

Government Code 22879 was added to PEMHCA in 1977, well before IRMAA provisions were adopted by the Social Security Administration (SSA). The language of Government Code 22879 requires that the State reimburse Medicare Part B premiums, so CalPERS was required to include IRMAA reimbursements when they were added to Medicare Part B premiums in 2007; therefore, no additional actuarial study was conducted. CalPERS submits annual financial information to the Department of Finance and the State Controller's Office, which includes, among other items, the cost of Medicare standard and IRMAA premium reimbursements.

Inflationary Increases

IRMAA

The IRMAA premiums and income brackets were first introduced in 2007 and have been adjusted annually since then. The IRMAA premiums are based on the true cost of Medicare Part B, as actuarially determined by the Centers for Medicare and Medicaid Services (CMS). For example, a Member with the basic Medicare Part B premiums pays for 25% of the cost, while a Member with a Level 5 IRMAA

pays for 85% of the cost of Medicare Part B. IRMAA brackets are adjusted based on the percentage of increase in the Consumer Price Index for all urban consumers (United States city average). In 2019, an additional IRMAA income bracket was added.

The 2026 IRMAA Income Brackets for an individual are displayed in the table below:

2026 Individual Modified Adjusted Gross Income	2026 IRMAA	2026 Total Medicare Part B Premium and IRMAA
< $109,000	$0.00	$202.90
$109,000 – $137,000	$81.20	$284.10
$137,000 – $171,000	$202.90	$405.80
$171,000 – $205,000	$324.60	$527.50
$205,000 – $500,000	$446.30	$649.20
< $500,000	$487.00	$689.90

The Medicare Part B Basic Premium and IRMAA annual increases have been outpacing the maximum Cost of Living Adjustment of 3% for Tier 1 and 2% for Tier 3. The following table shows the Medicare Part B Basic premium and maximum IRMAA amounts in 2007, when IRMAA was introduced, and the current 2026 amounts:

	2007	2026	% Increase	Avg. Annual % Increase
Basic Part B	$93.50	$202.90	117.0%	6.2%
Highest IRMAA	$161.40	$689.90	327.4%	17.2%

The Medicare Part B Basic Premium and IRMAA amounts are expected to continue increasing through 2034. According to the 2025 Social Security and Medicare Boards of Trustees Annual Report, the 2034 Medicare Part B Basic Premium is estimated at $347.50, an increase of $144.60 or 71.3% from the 2026 premium. The highest 2034 IRMAA premium is estimated at $1,181.50, an increase of $491.60 or 71.3% from 2026.

<u>IRMAA Impact Analysis of City of Los Angeles Salaries and Retirement Allowance</u>

LACERS' review of City of Los Angeles employee classifications and corresponding 2007, 2012, and 2026 salaries shows a clear upward trend in the number of Members whose compensation levels place them at risk of IRMAA assessments, even when considering only their highest salary with 30 years of Service Credit.

- 2007 (IRMAA implementation year): Employees earning $123,000+.
  Impact: Approximately 184 classifications and 572 Members, primarily General Managers and Assistant General Managers.

- 2012 (addition of "basic" to the LAAC): Employees earning $131,000+.
  Impact: Approximately 205 classifications and 678 Members, expanding to include Chiefs and Engineers.

- 2025 (current projection): Employees earning $165,000+.
  Impact: Approximately 410 classifications and 2,235 Members, now encompassing Senior Analysts and Manager-level staff.

While IRMAA is based on total taxable income, including sources beyond salary, the salary-only analysis indicates that regular compensation growth alone has significantly increased the number of LACERS Members subject to IRMAA. This trend suggests continued expansion of the affected population absent policy or structural changes.

Costs of Medicare Plans

LACERS engaged its Health Consultant, Keenan & Associates, to evaluate the relative cost of Medicare coverage compared to LACERS' Medicare plan premiums. Keenan conducted a premium analysis across all Medicare plans for both Retiree-Only and Retiree-Plus-One tiers, adjusting each plan for the estimated Medicare cost. Combination rates that include both Medicare and non-Medicare Members were excluded from the review.

The analysis indicates that the total estimated cost of coverage for Retiree-Only and Retiree-Plus-One, which covers approximately 10,165 Members, is $19.6 million per month. Of this amount, the Centers for Medicare and Medicaid Services (CMS) is estimated to pay $15.0 million on behalf of LACERS Retired Members. This reflects an approximate 77% cost offset attributable to CMS. Consequently, LACERS' Medicare plan premiums account for only 23% of the total Medicare cost, underscoring the significant financial advantage of Medicare enrollment within the LACERS health program.

Cost Study Results

On June 13, 2023, an actuarial cost study for the reimbursement of the basic Part B premium and IRMAA was conducted and presented to the Board. The actuarial cost study parameters were to provide the cost of providing the basic Part B premium reimbursement to Retirees with Part B-only coverage, and the cost of providing reimbursement for each of the five IRMAA bracket levels based on LACERS' census data as of the valuation ending June 30, 2022.

The study used the Members' retirement income from LACERS' defined benefit plan, as opposed to the Members' Modified Adjusted Gross Income (MAGI), since LACERS does not have access to Retired Members' MAGI.

The costs of adding the reimbursements are described in the following table.

June 2023 Actuarial Cost Study for Part B-Only Reimbursement and IRMAA

Type of Reimbursement	Estimated Cost
IRMAA only	$54.2 million increase in the Unfunded Actuarial Accrued Liability (UAAL) and $5.8 million increase in the Actuarially Determined Contribution (ADC)

Part B-Only Member* reimbursement	$36.6 million in UAAL and $3.1 increase in ADC
Combined IRMAA and Part-B only	$90.8 million in UAAL and $8.9 million increase in ADC

**Members employed prior to April 1, 1986.*

Conclusion

The research confirms that other systems reimbursing IRMAA did so under existing statutory authority and did not conduct cost studies. IRMAA costs have increased substantially since 2007 and are projected to continue rising at rates that exceed LACERS' COLA provisions. Actuarial analysis indicates that expanding reimbursement to include IRMAA and/or Part B-only coverage would materially increase both UAAL and ADC.

Additional information about IRMAA that were previously presented to the Board can be found in the following reports:

1. June 13, 2023 – Board Administration Item X - B – Presentation of the Cost of Medicare Part B Premium and Income-Related Adjustment Amount: https://www.lacers.org/sites/main/files/file-attachments/board_agenda_combined_63.pdf?1686248657

2. September 26, 2023 – Board of Administration Report Item VIII – D IRMAA and Medicare Part B Only Reimbursement Member Feedback: https://www.lacers.org/sites/main/files/file-attachments/board_agenda_09.26.23_-_combined.pdf?1695316403

3. December 9, 2025 – Benefits Administration Committee Report Item III Historical Overview of the Medicare Part B Reimbursement Program and IRMAA

   https://www.lacers.org/sites/main/files/file-attachments/bac_agenda_20251209_combined.pdf?1764872440

Prepared By: James Kawashima, Senior Benefits Analyst II, and Karen Freire, Chief Benefits Analyst, Health, Wellness, and Buyback Division

TB/DWN/KF/jk

Attachment: Keenan Report - 2026 Healthcare Plan, Medicare versus Non-Medicare Comparative Analysis

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

BAC Meeting: 03/10/26
Item: III
Attachment: 1

LACERS
Benefits Administration Committee

2026 Healthcare Plan
Medicare vs. Non-Medicare Comparative Analysis

March 10, 2026

Presented by: Bordan Darm, Vice President

LACERS Medicare vs. Non-Medicare Comparative Analysis

LACERS' retirees undergo an adjustment when they move from commercial / under 65 (U65) coverage to Medicare coverage

- Once eligible for coverage, retirees must:
  - Enroll with Medicare (timely to avoid penalties)
  - Pay for Medicare Part B basic ($202.90 monthly in 2026)
  - Choose a LACERS' sponsored Medicare health plan
- Additional requirements:
  - Members who are assessed Income-Related Adjustment Amount (IRMAA) for Medicare Part B and Medicare Part D must pay for the additional assessment to remain in LACERS plans.
  - Members who were employed on or after April 1, 1986 will include Medicare Part A and Members who were employed prior will only receive Medicare Part B, unless enrolled with a spouse with Medicare Part A. LACERS provides for Medicare Part A equivalent under the commercial plans approved by Medicare.
- Many of the LACERS' sponsored Medicare health plans offer enhanced benefits that are not available to LACERS' retirees under the commercial U65 coverage.
- Differences in cost and plan design create disparity between LACERS' coverage for U65 retirees and Medicare retirees.

This report is illustrative and contains general Medicare plan information that may not be included in LACERS plan. It outlines the differential in pricing

Key Observations

- **Medicare Advantage and Supplement Plans:** MA, MAPD, and Supplement plans have the most comprehensive benefits covering 75% to nearly 100% of the plan cost
- **Medicare vs Non-Medicare Estimated Values:** Medicare plans are slightly richer than Non-Medicare plans (~10%+)
- **Medicare vs Non-Medicare Rates:** Once the CMS reimbursement component is factored in (adjusted for star rating differentials), Medicare and Non-Medicare rates are generally comparable with the Non-Medicare rates slightly higher
  - The higher rates may be attributed to CMS utilizing Medicare pricing compared to the commercial carriers' provider discounting contracts
- **Variable Costs:** Once a retiree is Medicare eligible, there are additional cost for retirees such as Part B basic premium (which is indexed from income 2 years prior, IRMAA), Part D costs and premium cost for retirees with less than 13-20 years of service credits (depending on the plan enrolled).

Estimated Value of Commercial (U65) and Medicare Coverage

Estimated Value of Medicare Coverage

Coverage Type	Estimated Value	Evidence Basis	Notes
Medicare Part A	≈65–70%	Cost-sharing structure with large deductibles & coinsurance	
Medicare Part B	≈80%	Statutory 80/20 coinsurance after deductible	Clear and consistent
Medicare Advantage (Part C)	≈75–95%+	Must cover Parts A & B; Maximum Out-of-Pocket (MOOP)	Often richer coverage than Medicare Part A & B
Medigap Supplements	≈90–100%	Covers the 20% coinsurance and most gaps in Parts A & B	Boosts estimated value for Medicare Part A & B coverage; minimizes out-of-pocket costs

The value of each plan is based on a tier reference (Bronze 60%, Silver 70%, Gold 80%, and Platinum 90%)
Percentages are based on the level of coverage provided by the carrier. A 90% means the individual will need to pay 10% of cost

Medicare Coverage – Part A

Medicare Part A

- Medicare Part A (hospital insurance) does not have an officially published actuarial value like ACA marketplace plans. However, its cost-sharing structure allows us to be characterized as:
- Part A has large deductibles and per-period coinsurance (e.g., $1,736 deductible[1] and daily coinsurance beginning on day 61 of a stay for 2026).
- Despite high deductibles, it covers the majority of inpatient hospital costs once those cost-sharing thresholds are met.
- Part A's estimated value is moderate, typically in the mid-60% to low-70% range, because beneficiaries still face significant exposure via deductibles and coinsurance.

Part A Benefit Features	2026 Amount	Details / Conditions
Inpatient (IP) hospital deductible[1]	$1,736	Applies to the first 60 days
Daily IP hospital coinsurance (days 61–90)	$434 per day	Applies after the 60-day deductible
Daily hospital coinsurance (lifetime reserve days, days 91–150)	$868 per day	Up to 60 lifetime reserve days; afterwards, patient pays all costs.
Skilled Nursing Facility (SNF) coinsurance (days 21–100)	$217 per day	$0 cost for First 20 days, after qualifying 3-day IP stay.

[1] These deductibles are general deductibles and are not applicable to the LACERS plan

Medicare Coverage – Part B

Medicare Part B

- Medicare doesn't publish a formal actuarial value for Part B,
- Its statutory cost-sharing makes the estimated value clear:
  - After meeting the deductible,
  - Medicare Part B pays 80% of Medicare-approved charges
  - The beneficiary pays 20% of Medicare-approved charges
  - Part B effectively has an estimated value of ~80%

Part B Benefit Features	2026 Amount	Details / Conditions
Annual Deductible	$283[1]	Must be paid before benefits are covered
Coinsurance	Beneficiary pays 20%[2]	After deductible
Covered Services: Physician visits, outpatient hospital, durable medical equipment, preventive care, lab tests	Medicare Pays 80%	After deductible

[1] Only applicable to LACERS Medicare Supplement Plan
[2] This is for general benefits, the 20% is not paid by Members in LACERS Plan

Medicare Coverage – Medigap Supplement

Medigap Supplement Plans

- Medigap plans are standardized and significantly increase the estimated value by filling Medicare's deductibles and coinsurance.
- Medigap plans are designed specifically to cover the 20% coinsurance from Part B, Part A deductibles, and other gaps.
- Some Medigap plans (e.g., Plan G, Plan N) cover nearly all patient cost-sharing.
- Medigap plans typically bring the estimated value to 90–100%, depending on the plan:
    - Plan G: nearly 100% estimated value except for the Part B deductible.
    - Plan N: slightly lower estimated value because of copays but still ~90–95%+ effective coverage.

Medigap Supplement Benefit Features	Details / Conditions
Standardized nationwide	Benefits identical across insurers for each plan letter (A–N).
Covers costs Original Medicare doesn't	Helps pay deductibles, coinsurance, copayments.
Guaranteed renewable	As long as premiums are paid, coverage continues annually.
Foreign travel emergency	Many plans cover 80% of approved emergency costs abroad.

Medicare Advantage (MA) Coverage – Part C

Benefit Feature	2026 Details
Basic Coverage Requirement	Must cover **all services provided under Medicare Part A and Part B**.
Prescription Drug Coverage (Part D)	Most MA plans include integrated **drug coverage (MA-PD)**.
Extra Supplemental Benefits	Most plans offer **vision, dental, and hearing benefits**; some provide OTC allowances, transportation, meals, and remote access technology. Please note: These are all generic and not all applicable to LACERS' Plans. For example, only LACERS Anthem Preferred PPO offers OTC allowance.
Out-of-Pocket Maximum (MOOP)	Mandatory annual limit on out-of-pocket costs for Part A/B services; typical 2026 range: **$3,000–$9,200** for in-network services.
Cost-Sharing	Plans may apply **copays and coinsurance**, such as $20 primary care visit or 20% coinsurance for hospital stays (varies by plan).
Plan Types Available	LACERS currently offers **HMO** and **PPO plans**. Other Medicare plans types are available outside of LACERS, such as **PFFS** (Private Fee-for-Service) and **SNP** (Special Needs Plans)
Additional 2026 Enhancements	New **supplemental benefit expansions** focused on preventive care.

- Most MA plan designs have an estimated value between 75%–97% dependent on benefits
- CMS does not publish an explicit actuarial value for MA plans

Medicare Prescription Drug Coverage - Part D

Medicare Part D – Prescription Drug Coverage

1. **Annual Out-of-Pocket Maximum (OOP):** $2,100 on all prescription drug spending. After OOP plan pays 100% of drug costs for the year.
2. **Annual Part D Deductible:** Maximum $615 deductible for 2026 (plans may charge less). Annual Part D deductible is not applicable to LACERS.
3. **Coverage gap (doughnut-hole) eliminated in 2025:** Plans must provide consistent cost-sharing throughout the year.
4. **Prescription Payment Plan (Monthly Smoothing):** Enrollees may spread out-of-pocket drug costs over the year in predictable monthly payments rather than paying full costs upfront. Does not reduce total cost but improves affordability and cash-flow.
5. **Free Recommended Vaccines:** All ACIP-recommended vaccines are free under Part D: no deductible, no copayment, and no coinsurance.
6. **Manufacturer Price Discounts / Drug Price Negotiation for 2026:** includes Medicare drug price negotiation, leading to reduced prices for certain high-cost drugs. Manufacturer discount programs that reduce beneficiary costs earlier in the year.
7. **Standard Cost-Sharing Structure (After Deductible): E**xact copays/coinsurance can vary by plan:
   - Typically includes tier-based copays or coinsurance (e.g., low copays for generics, higher for specialty drugs)
   - Members progress through a) Deductible, b) Initial coverage (copays/coinsurance), and c) Catastrophic coverage ($2,100 OOP cap)
8. **Coverage Options:** Part D coverage is available in two ways:
   - Stand-alone Prescription Drug Plan (PDP) – used with Medicare PART A & B.
   - Medicare Advantage with drug coverage (MA-PD) – integrated medical + drug coverage.

Benefit Design and Estimated Values

Estimated Value of LACERS' Benefit Plans

Commercial (U65) Plans

- LACERS offers three plans to retirees under age 65; 1) Anthem PPO, 2) Anthem HMO, and 3) Kaiser HMO.

Medicare Plans

- LACERS offers four carriers and seven plans to eligible retires (1 Medicare Supplement plan and 5 Medicare Advantage plans)

Estimated Values

- Based on the benefit design information shown in the chart, Keenan estimated the value of each plan based on the tier reference (Bronze 60%, Silver 70%, Gold 80%, and Platinum 90%)
- Percentages are based on the level of coverage provided by the carrier. A 90% means the individual will need to pay 10% of cost
- The U65 plans scored in a range from 78% to 92%, while the Medicare plans scored in a value range from 85% to 99%.

LACERS In-Network Benefits	Anthem (U65) PPO	Anthem (U65) HMO	Kaiser (U65) HMO	Anthem Medicare Advantage PPO	Anthem Medicare Supplement	Kaiser Senior Advantage HMO	SCAN Medicare Advantage HMO	UHC Medicare Advantage HMO
Estimated Value	**≈ 78%–80%**	**≈ 88%–92%**	**≈ 88%–91%**	**≈ 94–99%**	**≈ 92–97%**	**≈ 90%–95%**	**≈ 89%–93%**	**≈ 85%–90%**
Note: Medicare Plans include Medicare Coverage	Upper Silver, Low Gold	Upper Gold, Low Platinum	Upper Gold, Low Platinum	Platinum Range	Middle Platinum	Middle to Low Platinum	Upper Gold, Low Platinum	Upper Gold, Low Platinum
Calendar Year Deductible								
Individual	$750	$0	$0	$0	$283	$0	$0	$0
Family	$1,500	$0	$0	$0	Not applicable	$0	$0	$0
Aggregate / Embedded	Embedded	Aggregate	Aggregate	Aggregate	Embedded	Aggregate	Aggregate	Aggregate
Coinsurance	90%	100%	100%	100%	20% Anthem 80% Medicare	100%	100%	100%
Annual Out-of-Pocket Maximum					Deductible Excluded			
Individual	$5,000	$500	$500	$0	Not applicable	$500	$3,400	$6,700
Family	Not applicable	$1,500	$1,500	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Aggregate / Embedded	Embedded	Aggregate	Aggregate	Aggregate		Embedded	Embedded	Embedded
Office Visit	Before Deductible				After Deductible			
Primary Care Physician	$20	$20	$20	$0	20%/80%	$15	$10	$15
Specialist	$20	$20	$20	$0	20%/80%	$15	$10	$15
Urgent Care	$20	$20	$20	$0	20%/80%	$15	$10	$15
Emergency Room	Deductible and Coinsurance	$100	$100	$0	20%/80%	$50	$50	$50
Prescription Drug								
Generic	$10	$10	$15	$0-$5	$0-$5	$15	$5-$10	$10
Brand-Formulary	$30	$30	$35	$25	$25	$15	$20	$20
Brand Non-Formulary	$50	$50	Not Applicable	$50	$50	Not Applicable	$20	$50

Premium Comparison Adjusted for Medicare (CMS) Payments

- Keenan conducted a monthly premium comparison by plan for both the Retiree only and Retiree + 1 dependent tiers. Medicare plans were adjusted for the estimated cost of Medicare for each plan. Combination rates involving U65 (U) and Medicare (M) members were not evaluated.
- When viewed with the CMS values, the premiums between U65 and Medicare eligible retirees are more in line.
- Notable difference is Medicare rates are non-negotiable compared to Commercial rates are subject to provider negotiations.
- Please note: Amounts shown were calculated based on the 2026 averages for California adjusted for star ratings and other factors. Actual data is confidential and proprietary to each carrier.

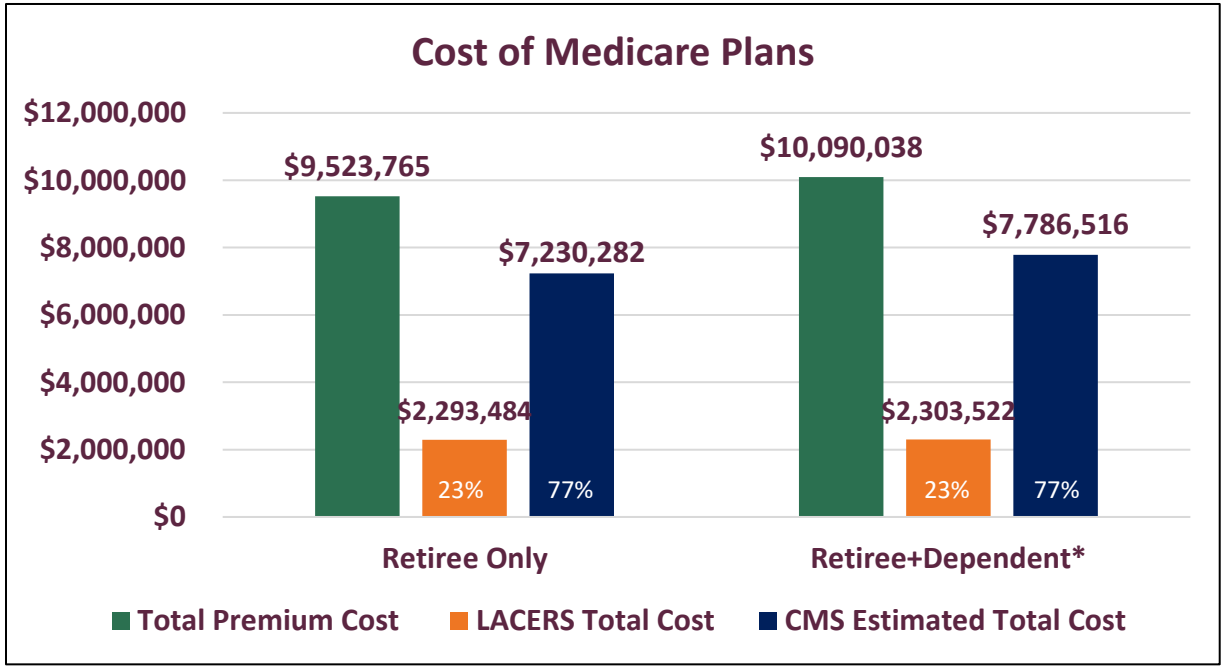
LACERS	< age 65 or with Medicare Part B only			w/ Medicare Part A & B						
Premium Comparison Adjusted for Medicare Coverage	Anthem PPO (US)	Kaiser HMO	Anthem HMO	Anthem PPO Medicare Advantage	Anthem Medicare Supplement Plan	Kaiser HMO Senior Advantage	SCAN HMO Medicare Advantage	UHC CA HMO Medicare Advantage	UHC AZ HMO Medicare Advantage	UHC NV HMO Medicare Advantage
Estimated Value	**≈ 78%–80%**	**≈ 88%–92%**	**≈ 88%–91%**	**≈ 94–99%**	**≈ 92–97%**	**≈ 90%–95%**	**≈ 89%–93%**	**≈ 85%–90%**	**≈ 85%–90%**	**≈ 85%–90%**
Retiree Only	**U**	**U**	**U**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
Monthly Premiums	$ 1,874.52	$ 1,161.91	$ 1,496.99	$ 440.13	$ 633.04	$ 263.98	$ 226.93	$ 364.61	$ 397.08	$ 297.40
CMS Estimated Value	$ -	$ -	$ -	$ 1,092.96	$ 923.33	$ 1,103.52	$ 1,103.52	$ 1,087.68	$ 1,087.68	$ 1,087.68
Total Value	$ 1,874.52	$ 1,161.91	$ 1,496.99	$ 1,533.09	$ 1,556.37	$ 1,367.50	$ 1,330.45	$ 1,452.29	$ 1,484.76	$ 1,385.08
Retiree +1 Dependent	**UU**	**UU**	**UU**	**MM**	**MM**	**MM**	**MM**	**MM**	**MM**	**MM**
Monthly Premiums	$ 3,744.01	$ 2,323.82	$ 2,988.95	$ 875.23	$ 1,261.13	$ 527.96	$ 448.83	$ 724.19	$ 789.13	$ 589.77
CMS Estimated Value	$ -	$ -	$ -	$ 2,185.92	$ 1,846.66	$ 2,207.04	$ 2,207.04	$ 2,175.36	$ 2,175.36	$ 2,175.36
Total Value	$ 3,744.01	$ 2,323.82	$ 2,988.95	$ 3,061.15	$ 3,107.79	$ 2,735.00	$ 2,655.87	$ 2,899.55	$ 2,964.49	$ 2,765.13

Costs of Medicare Plans

- Keenan conducted a premium analysis across all Medicare plans for both Retiree Only and Retiree Plus One tiers, adjusting each plan for the estimated Medicare cost. Combination rates include both Medicare and non-Medicare members were excluded from the review*.
- Total estimated cost of coverage for retirees and dependents is $19.6 million. Centers for Medicare and Medicaid Services (CMS) is estimated to pay $15.0 million on behalf of 10,165 LACERS members or approximate 77% cost offset attributable to CMS. Consequently, LACERS' Medicare plan premiums represent only 23% of the total Medicare cost, a significant financial advantage of Medicare enrollment in LACERS' health program.

** Population in this analysis does not include 1,582 Survivors, 618 Retirees in Dual-care plan, and 127 Retirees with more than one dependent*

	Retiree Only	Retiree + Dependent*	Total
Total Premium Cost	$9,523,765	$10,090,038	$19,613,804
LACERS Total Cost	$2,293,484	$2,303,522	$4,597,006
CMS Est Total Cost	$7,230,282	$7,786,516	$15,016,798
Total Est Savings	**$7,230,282**	**$7,786,516**	**$15,016,798**



CMS Required Monthly Premium for Parts A, B, and D

CMS (Medicare) Premium requirements

- If retirees register timely for Part A, no premiums are required (otherwise penalties may apply)
- 2026 Part B Basic premium is $202.90 for all individuals
- If an individual has an adjusted gross income greater than $109,000, IRMAA applies (additional premiums are required for Parts B and D)
- Relief for retirees with low adjusted gross income is available through a variety of programs.

Modified Adjusted Gross Income for Retirees Filing Federal Tax Returns*				Part B Basic Premium	Part B IRMAA** Premium	Part D IRMAA Premium	Total CMS Monthly Premium
Individual/Separate Tax Return		Joint Tax Return					
$ Range >:	$ Range to <=:	$ Range >:	$ Range to <=:				
$ -	$ 109,000	$ -	$ 218,000	$202.90	$0.00	$0.00	$202.90
$ 109,000	$ 137,000	$ 218,000	$ 274,000	$202.90	$81.20	$14.50	$298.60
$ 137,000	$ 171,000	$ 274,000	$ 342,000	$202.90	$202.90	$37.50	$443.30
$ 171,000	$ 205,000	$ 342,000	$ 410,000	$202.90	$324.60	$60.40	$587.90
$ 205,000	$ 500,000	$ 410,000	$ 750,000	$202.90	$446.30	$83.30	$732.50
$ 500,000	> $500,000	$ 750,000	>$750,000	$202.90	$487.00	$91.00	$780.90

* Two-year lag on tax filing (2024 basis for 2026 Part B Cost), ** IRMAA - Income-related monthly adjustment amount

General Assumptions

- Analysis is based on most common enrollment for Retiree only and Retiree + Dependent tiers (UU and MM only, UM or MU were not analyzed)
- Additionally, 3-party tiers (family) and survivor coverage were not analyzed
- CMS data is based on 2025 average CMS reporting adjusted by 5.6% indexed for 2026 (source: CMS), plan design, and geographic factors.

Next Steps

- Should LACERS want to model any cost disparities or aggregated cost impacts LACERS will need to provide a census including:
  - Retiree tenure
  - Benefit level identifier (Tier 1 or 3, survivor benefits, etc.)
  - Dependent tier election (U, UU, UUU, M, MM, MMM, or any combination)
  - Coverage elected
  - Current medical and dental subsidies

Appendix

Los Angeles City Employees' Retirement System (LACERS)
Estimated Medicare Cost Analysis

Retiree Only * Premium Type	Anthem Adv PPO	Anthem Supplement	Kaiser Adv HMO	SCAN Adv HMO	UHC Adv HMO - CA	UHC Adv HMO- AZ	UHC Adv HMO - NV
LACERS Premiums	$440.13	$633.04	$263.98	$226.93	$364.61	$397.08	$297.40
CMS Estimated	$1,092.96	$923.33	$1,103.52	$1,103.52	$1,087.68	$1,087.68	$1,087.68
Total Value	**$1,533.09**	**$1,556.37**	**$1,367.50**	**$1,330.45**	**$1,452.29**	**$1,484.76**	**$1,385.08**
Retiree 1 Party	2,647	185	3,311	228	183	19	38
Total Cost	$4,058,089.23	$287,928.45	$4,527,792.50	$303,342.60	$265,769.07	$28,210.44	$52,633.04
LACERS Cost	$1,165,024.11	$117,112.40	$874,037.78	$51,740.04	$66,723.63	$7,544.52	$11,301.20
CMS Estimated Cost	$2,893,065.12	$170,816.05	$3,653,754.72	$251,602.56	$199,045.44	$20,665.92	$41,331.84
Estimated Savings	$2,893,065.12	$170,816.05	$3,653,754.72	$251,602.56	$199,045.44	$20,665.92	$41,331.84

Total Cost	**$9,523,765.33**
LACERS Total Cost	**$2,293,483.68**
CMS Estimated Total Cost	**$7,230,281.65**
Total Estimated Savings	**$7,230,281.65**

Retiree + Dependent* Premium Type	Anthem Adv PPO	Anthem Supplement	Kaiser Adv HMO	SCAN Adv HMO	UHC Adv HMO - CA	UHC Adv HMO- AZ	UHC Adv HMO - NV
LACERS Premiums	$875.23	$1,261.13	$527.96	$448.83	$724.19	$789.13	$589.77
CMS Estimated	$2,185.92	$1,846.66	$2,207.04	$2,207.04	$2,175.36	$2,175.36	$2,175.36
Total Value	**$3,061.15**	**$3,107.79**	**$2,735.00**	**$2,655.87**	**$2,899.55**	**$2,964.49**	**$2,765.13**
Retiree 2 Party	985	83	2,087	191	163	23	22
Total Cost	$3,015,232.75	$257,946.57	$5,707,945.00	$507,271.17	$472,626.65	$68,183.27	$60,832.86
LACERS Cost	$862,101.55	$104,673.79	$1,101,852.52	$85,726.53	$118,042.97	$18,149.99	$12,974.94
CMS Estimated Cost	$2,153,131.20	$153,272.78	$4,606,092.48	$421,544.64	$354,583.68	$50,033.28	$47,857.92
Estimated Savings	$2,153,131.20	$153,272.78	$4,606,092.48	$421,544.64	$354,583.68	$50,033.28	$47,857.92

Total Cost	**$10,090,038.27**
LACERS Total Cost	**$2,303,522.29**
CMS Estimated Total Cost	**$7,786,515.98**
Total Estimated Savings	**$7,786,515.98**

Total Cost for Retiree-Only and Retiree-plus-dependent =	**$19,613,803.60**
Total Estimated Savings =	**$15,016,797.63**

* Population in this analysis does not include 1,582 Survivors, 618 Retirees in a Dual-care plan, and 127 Retirees with more than one dependent

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

BAC Meeting: 03/10/26
Item: IV

LACERS
Benefits Administration Committee

2026 Healthcare Trends

March 10, 2026

Presented by: Bordan Darm, Vice President

Table of Contents

Executive Summary

2025: A Transformational Policy and Market Reset

2025 marked a fundamental shift in U.S. health care policy—from decades of coverage expansion toward aggressive cost containment

- Policymakers leaned heavily on operational levers to slow healthcare spending, accelerating adoption of AI, digital health, automation, and prevention-focused care models.
- Payers, providers, and states faced tightening margins driven by persistent high utilization, rising medical costs, and growing pharmacy system strain.

Key Forces

- **HR1 & OBBBA (One Big Beautiful Bill Act) dominated state agendas,** compressing policy calendars and shifting states from innovation to execution
- **Fiscal constraints shaped state decisions,** forcing tradeoffs in rate setting, LTSS (Long-Term Services and Supports) strategy, and value-based care ambitions
- **Medicaid Managed Care deprioritized innovation**, focusing instead on eligibility operations, compliance, and complex care management
- **Medicare Advantage experienced significant margin pressure,** prompting benefit tightening, geographic retrenchment, and growth in D (Dual) and C (Chronic) -SNPs (Special Needs Plans)

2025: A Transformational Policy and Market Reset

Key Forces (continued)

- **CMS Innovation Center accelerated long-horizon reform,** including ACCESS and TEMPO—reshaping future commercialization paths for virtual care and digital therapeutics.
- **ACO programs continued their evolution** (MSSP → REACH → LEAD), with growing emphasis on long-term care integration and specialty-care models.
- **Drug pricing, PBM, and pharmacy economics destabilized,** with Part D exits and reimbursement strain signaling deeper structural reform ahead.
- **Private capital became cautious,** then re-energized late-year by new Innovation Center models and state procurements.
- **AI became a competitive necessity,** shifting from experimentation to deployment across administrative and clinical workflows.
- **Hospitals and home-based/post-acute providers faced sustained financial pressure,** with SNFs receiving relative regulatory relief but Home Health absorbing new rate cuts.

2026: Commercial Medical & Prescription Drug Coverage

Pre-65 Healthcare Coverage Trends

- **2026 Trends – Commercial Medical/Drug Coverage**
  - Significant cost inflation above CPI and COLA
  - Rapid growth in high-cost therapies
  - Major regulatory shifts and tariffs
  - Continued consolidation of health care providers and insurers
    - Hospital Closures and Consolidations: Many are unable to remain profitable since COVID
- **Employers and Plan Sponsors Strategy**
  - Aggressive cost containment management
  - Selective benefit designs and wellbeing initiatives
  - Clinical and condition target programs
  - Expanded use of technology
- **Pharmacy**
  - Cost continues to outpace medical trend (particularly GLP-1 and specialty therapies)
  - Significant impact on premiums and employer budgets
  - Regulatory changes for more pricing transparency for PBMs (Pharmacy Benefit Manager)
  - New players coming to the market – Mark Cuban, Amazon RxPass/Pillpack, Trump Rx

2026: Medicare Medical & Prescription Drug Coverage

Medicare Healthcare Coverage Trends

- **Market:** Insurers continue to be limited in this market segment, particularly in certain states
- **Part A (Hospital Insurance) Changes**
  - Deductibles and coinsurance rise across the board (hospital, SNF, lifetime reserve days)
  - Premiums increase for those without sufficient work credits
- **Part B (Medical Insurance) Changes**
  - Notable increases in both the monthly premium and annual deductible
  - High-income enrollees face sharply higher IRMAA surcharges
  - Coverage itself remains unchanged—costs are the primary area of adjustment
- **Part C (Medicare Advantage) Changes**
  - Premiums minor decrease, but out-of-pocket maximums increase, and plan choices reduced
  - Benefits remain stable, though supplemental offerings tighten
- **Part D (Prescription Drugs) Changes**
  - Historic drug price negotiations dramatically reduce costs for 10 major medications
  - Out-of-pocket cap increases modestly; premiums fluctuate; plan options contract sharply

Outlook: What Will Shape the Market

Defined by operational intensity, regulatory follow-through, and strategic repositioning across payers, providers, and states. Next year favors organizations with strong compliance infrastructure, high-fidelity data capabilities, and readiness for accelerated AI-enabled transformation.

Top Trends to Watch in 2026

- **Rural Health Transformation Program (RHTP) awards become the clearest early indicator** of state priorities, vendor archetypes, and care-delivery models likely to scale
- **State Medicaid** programs continue navigating major eligibility, administrative, and systems changes, constraining capacity for innovation
- **Medicaid Managed Care strategies consolidate around cost avoidance,** LTSS carve-in considerations, PBM restructuring, and procurement readiness
- **Medicare Advantage remains under pressure,** with stabilization depending on the 2027 rate notice, risk-mix dynamics, and carrier retrenchment effects
- **Value-based care is primed for a "thaw,"** driven by ACCESS and advanced ACO models; providers preparing now will capture disproportionate advantage
- **ACCESS becomes a defining differentiator,** especially for virtual care and digital therapeutics—rewarding organizations with strong Part B operational, RCM, audit, and evidence capabilities
- **Dementia, caregiver support, and LTSS financing gain traction,** surfacing new opportunities for vendors delivering sustainable, pre-Medicaid solutions

Outlook: What Will Shape the Market

Top Trends to Watch in 2026 (continued)

- **Program of All-Inclusive Care for the Elderly (PACE) expansion intensifies** across competitive states outside California
- **Drug-pricing pilots:**
    1. **Guarding U.S. Medicare Against Rising Drug Costs (GUARD),**
    2. **Global Benchmark for Efficient Drug Pricing (GLOBE),**
    3. **Better Approaches to Lifestyle and Nutrition for Comprehensive Health (BALANCE), and**
    4. **Generating cost Reductions for U.S. Medicaid (GENEROUS) reshape pharmacy economics,** with winners defined by contracting agility and policy responsiveness
- **AI deployment enters a disciplined phase,** rewarding organizations that select auditable, high-ROI use cases (prior authorization, risk adjustment, reporting automation)
- **Capital becomes a strategic enabler,** driving scale in home-based care, LTSS, facility conversions, and tech platforms

2026 Healthcare Trends on Commercial (Pre-65) Medical and Prescription Drug Coverage

Commercial Medical & Prescription Drug Coverage

1. Medical Cost Trend: High and Persistent Inflation

Commercial medical plans will continue to experience significant cost escalation in 2026:

- Medical cost trend projected at 8.5% for group plans matching 2025 and remaining at a 15-year high.
- Group-sponsored insurance costs also expected to rise by 8.5%, driven by hospital operating expenses, behavioral health utilization, and new high-cost drugs.
- Median medical trend of ~9%, marking the highest annual projection in over a decade; trends similar across PPO/POS, HDHP, and HMO/EPO.

Drivers:

- Rising hospital labor and supply costs.
- Increased behavioral health utilization: 45% surge in claims (2023–24) and expected 10–20% trend in 2026.
- Growing use of advanced therapeutics, including GLP-1s and other specialty drugs.

Commercial Medical & Prescription Drug Coverage

2. Employer Strategy Shifts for 2026

Employers face steep cost growth and are adjusting benefits accordingly:

- 51% of large employers plan to increase deductibles, copays, or shift costs to employees in 2026, up from 45% in 2025.
- 35% of large employers will offer non-traditional medical plan options (e.g., narrow networks, variable copay plans) to promote high-value care.
- Small group ACA plans show a median proposed premium increase of ~11% for 2026.

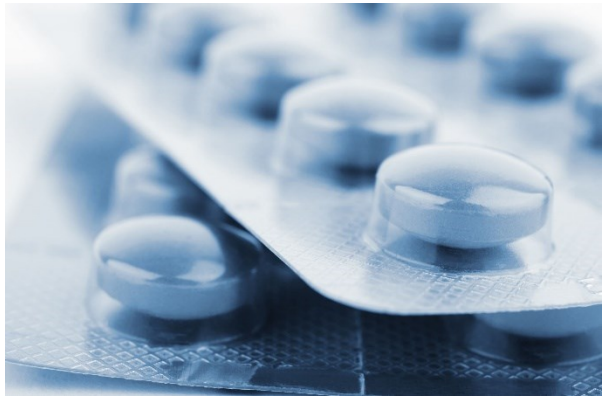
Key themes for employers:

- More aggressive cost containment and plan design disruption.
- Heightened focus on quality, navigation, and advocacy services for complex chronic conditions.

Commercial Medical & Prescription Drug Coverage

3. Specialty & Prescription Drug Trends: Double-Digit Growth

Pharmacy spend remains the largest and fastest-growing component of health plan costs in 2026



Specialty Drugs Dominate

- Specialty drug trend to be 1% point higher than overall outpatient drug trend
- Specialty medications is over half of total pharmacy spend, utilization continues to rise

GLP-1 Medications Exhibit "Spend Tsunami"

- GLP-1 drugs (Ozempic, Wegovy, Mounjaro, Zepbound) doubled pharmacy spending from 9% to 17% in two years
- Expected to be the top pharmacy spend category, driving affordability concerns

Gene & Cell Therapies

- U.S. annual spending on gene/cell therapies expected to reach $25.3B in 2026, with per-treatment costs up to $4.25M
- 73% of plans expect moderate-to-major budget impact

Biosimilar Expansion

- Biosimilars are the top cost drug cost deflator, with adoption increasing since 2024
- Expected to contribute meaningful price competition but adoption remains inconsistent

Commercial Medical & Prescription Drug Coverage

4. Regulatory & Policy Shifts with Big 2026 Implications

Medicare Drug Price Negotiation (IRA)

- Maximum Fair Price (MFP) begins Jan 2026 for 10 high-spend Part D drugs (e.g., Eliquis, Xarelto, Entresto, Enbrel, Stelara).
- Negotiated prices expected to reduce out-of-pocket costs by $1.5B annually in 2026.
- Commercial plans may adjust formularies in response to manufacturer pricing shifts.

PBM Reform Accelerates

- The Consolidated Appropriations Act of 2026 includes major PBM transparency reforms:
- Semiannual reporting of rebates, spread pricing, and steering behaviors
- Expanded audit rights
- Any-willing-pharmacy network requirements starting 2029
- Employers increasingly pursue transparent/unbundled PBM models; (~10% currently).

Tariffs & Global Pricing Rules

- A 100% tariff on branded/pharmaceutical imports (effective Oct 2025) impacts pricing.
- “Most-Favored Nation” pricing rules affects Medicaid may influence commercial market.

Commercial Medical & Prescription Drug Coverage

5. Benefit Design & Technology Trends in 2026

Employers increasingly adopt narrow networks, value-based formularies, increased copays, and cost-sharing reforms.

AI plays a growing role in:

- Formulary optimization
- Fraud, waste, and abuse detection
- Predictive analytics for high-cost claimants

Rising use of digital therapeutics, remote monitoring, and genomic-informed prescribing.

2026 Healthcare Trends in Medicare Medical and Prescription Drug Coverage

Medicare Part A (Hospital Insurance) Coverage

2026 Part A: Key Trends	
1.	Higher Inpatient Hospital Deductible • The Part A inpatient hospital deductible increases to $1,736 in 2026 (up from $1,676 in 2025).
2.	Increased Daily Coinsurance Amounts • Hospital days 61–90: $434/day (up from $419/day). • Lifetime reserve days: $868/day (up from $838/day). • Skilled Nursing Facility (SNF) days 21–100: $217/day (up from $209.50)

3.	Premium Changes for Those Without Full Work Credits
	• Most beneficiaries still pay $0 premium because they have 40+ quarters of Medicare-covered employment. For those who must pay:
	  ○ Reduced premium (30–39 quarters): $311/month (up $26 from 2025).
	  ○ Full premium (<30 quarters): $565/month (up $47 from 2025).

4.	Coverage Structure Remains Stable • No major coverage changes for inpatient hospital, SNF, hospice, or home health—2026 shifts are primarily cost-driven adjustments.

Medicare Part B (Medical Insurance) Coverage

2026 Part B: Key Trends	
1.	Standard Premium Increases Significantly • 2026 standard premium: $202.90/month, up from $185.00 in 2025 (+$17.90)
2.	Higher Annual Deductible • 2026 Part B deductible: $283, up from $257 in 2025.

3.	Drivers of Cost Increases
	• CMS attributes Part B increases to:
	  ○ Higher projected service utilization
	  ○ Price inflation for outpatient services
	  ○ Savings from reduced cost on “skin substitutes” (biosynthetic materials)

4.	IRMAA (Income-Related Premium Surcharges) Rising for High Earners • Part B premium surcharges apply to ~8% of beneficiaries (i.e. individuals with MAGI $109,001–$137,000 will pay a total monthly Part B premium of $284.10).
5.	Coverage Structure Unchanged • Coverage for physician services, outpatient care, durable medical equipment, and preventive services remains stable; changes apply only to cost-sharing.

Medicare Advantage (Part C) Medical Coverage: 2026 Trends

1

Premiums & Benefits Generally Stable

CMS projects average Medicare Advantage (MA) premiums to decline from $16.40 in 2025 to $14.00 in 2026, with benefits such as dental, vision, and hearing remaining stable.

2

Slight Decline in Plan Availability

Available MA plans will decrease modestly from 5,633 in 2025 to approximately 5,600 in 2026.

99% of beneficiaries will still have access to MA options and 97% will have 10+ plan choices.

3

Out-of-Pocket Costs Rising

Median maximum out-of-pocket (MOOP) is increasing from $5,400 in 2025 to $5,900 in 2026, a rise of 9.3% and nearly $900 over two years.

4

Fewer Low-MOOP & Total Choices

Fewer MA plans will offer MOOPs below CMS limits, and there will be 335 fewer non–special needs plans available.

5

Supplemental Benefits Shifting

While core supplemental benefits stay common, fewer MA plans offer:

- Over-the-counter allowances (66% in 2026 vs. 73% in 2025)
- Meal benefits (57% vs. 65%)
- Remote access technologies (48% vs. 53%)
- Transportation (24% vs. 30%)

Medicare Advantage (Part C) Medical Coverage: 2026 Trends

1

Major Price Reductions on 10 High-Cost Drugs

Beginning January 1, 2026, Medicare implements drug price negotiations (IRA):

Lower negotiated prices apply to 10 high-cost Part D drugs, including Eliquis, Jardiance, Januvia, Xarelto, Enbrel, Entresto, Imbruvica, Farxiga, Stelara, and NovoLog/Fiasp.

These lower prices are estimated to save beneficiaries $1.5 billion in 2026.

2

Significant Reduction in Out-of-Pocket Costs for Negotiated Drugs

Average out-of-pocket spending for these 10 drugs will drop about 50% for many enrollees.

3

Out-of-Pocket Maximum Cap Increases Slightly

The Part D annual out-of-pocket cap rises from $2,000 in 2025 to $2,100 in 2026.

4

Stand-Alone Part D Plan Availability Shrinks

31% fewer stand-alone Part D plans (PDPs) in 2026 compared to 2025, with average PDP choices dropping by 38% per region.

5

Premium Shifts

Stand-alone Part D premiums expected to decline modestly from $38 in 2025 to $34 in 2026. 47% of PDP members may see higher cost based on plan-level.

6

Deductible Increases

Standard Part D deductible increases to $615 (from $590 2025).

7

Insulin & Vaccines Remain Affordable

Insulin continues to be capped at $35/month, and most vaccines remain $0 copay.

Medicare Advantage (Part C) Medical Coverage: 2026 Trends

1

Inflation Reduction Act (IRA) Driving Transformative Reform

2026 marks the first year Medicare directly negotiates drug prices, with discounts of 38%–79% off 2023 list prices.

Additional sets of negotiated drugs will be added annually (15 more in 2027, 20 in 2029, etc.).

2

Part D Market Compression

Fewer Enhanced Alternative Plans and overall contraction in the PDP market.

3

Financial Model Adjustments

Federal program changes (like rollback of the Premium Stabilization Demonstration) and inflation forces contribute to some premium increases and plan design shifts.

2025 Healthcare Initiatives and Recap

Shift in U.S. Health Policy Priorities

Policy Shift to Cost Containment

- In 2025, US health policy shifted focus from coverage expansion to cost containment and operational reforms

Adoption of AI and Digital Health

- Policymakers promoted AI and digital health innovations to improve operational effectiveness and reduce costs

Challenges in Pharmacy Sector

- Pharmacy faced pricing transparency, distribution bottlenecks, and access disparities prompting regulatory actions

Financial Strain on Providers and Payers

- Providers and payers experienced financial pressures due to high utilization and strained care delivery models

State-Level Impacts of HR1 and "One Big Beautiful Bill Act" OBBBA

Policy and Operational Shift

- States had to realign policies and operations due to HR1 and OBBBA mandates, focusing heavily on compliance and system updates

Financial and Budget Constraints

- Mandates increased budget forecasting demands, tightening fiscal resources and influencing Medicaid rate setting and funding allocations

Impact on Medicaid Innovation

- Due to workload and fiscal pressures, Medicaid innovation slowed as agencies prioritized compliance, care management, and program integrity

Evolution in Medicare Advantage Market Dynamics

Market Margin Compression

Sustained margin compression in 2025 influenced plan behaviors and capital deployment decisions significantly.

Strategic Plan Adjustments

Health plans streamlined benefits and tightened administration to focus on profitable geographic and product areas.

Growth in Special Needs Plans

Dual Eligible and Chronic Condition SNPs grew by targeting high-need beneficiaries to improve health outcomes.

Regulatory and Partnership Dynamics

Expanded provider-plan partnerships and CMS regulatory signals emphasize risk mitigation and quality improvements.

Innovation Center Acceleration and Care Model Transformation

Technology-Integrated Care Models

- CMS introduced multi-year payment and care models integrating advanced technology to enhance accountability and care outcomes

Extended Demonstration Timelines

- Longer demonstration periods gave stakeholders insight into future payment systems and CMS's commitment to modernization

ACO Evolution and Integration

- Accountable Care Organizations advanced toward integrating long-term care, community partnerships, and advanced analytics

Specialty Care Model Focus

- Specialty models like TEAM and nested bundles emphasized aligning performance measures with complex patient needs

Drug Pricing, Pharmacy Economics, and Emerging Systemic Pressures

Federal Drug Pricing Reforms

- New federal reforms introduced in 2025 increased scrutiny on drug pricing, affecting PBMs and reimbursement models

Medicare Part D Market Volatility

- Medicare Part D experienced significant plan withdrawals and terminations, highlighting consolidation pressure

Emerging Consumer Access Models

- Direct-to-consumer drug access models grew as patients sought alternatives amid cost fluctuations and formulary changes

Need for Operational Modernization

- Pharmacy sector requires adaptive contracting, transparency, and modernization to manage systemic pressures effectively

2026 Healthcare Expectations

State Medicaid Strategies and RHTP Signals

Operational Challenges in Medicaid

- State Medicaid agencies face complex HR1 compliance, eligibility redetermination, and modernization with limited resources in 2026

Rural Health Transformation Program

- RHTP reveals state priorities for care models, regional focus, and vendor partnerships influencing rural healthcare delivery

Vendor and Payer Alignment

- Vendors and payers must align with states to enhance compliance, reporting, and LTSS carve-in decisions effectively

Medicare Advantage and Value-Based Care

Regulatory Influence on Medicare Advantage

- CMS rules and Innovation Center models will impact coding, authorization, and value-based contracting strategies in 2026

Plan Exit and Network Capacity

- National carriers exiting markets raises challenges for remaining plans to absorb members and sustain networks

Margin Stabilization Factors

- Financial margins will rely on advance rate notices, case-mix changes, and readiness for new payment models

Growth in Value-Based Care

- Expanded ACOs, ACCESS programs, and specialty payment models will drive growth in accountable care strategies

Virtual Care, ACCESS Adoption, and Technology Integration

ACCESS and Virtual Care Growth

- ACCESS enables Medicare Fee-for-Service pathways, driving virtual care adoption and remote digital health models by 2026

Clinical Evidence and Revenue Integration

- Successful ACCESS adoption requires robust clinical evidence and seamless integration with Part B billing and revenue cycle processes

AI-Driven Automation in Workflows

- AI automation scales in prior authorization, risk adjustment, denials management, and state reporting workflows to optimize compliance and finances

Emerging Digital Therapeutics

- Digital therapeutics, remote monitoring, and tech-enabled care coordination expand their role within federal healthcare innovation frameworks

Drug Pricing Reform, PBM Restructuring, and Financial Enablers

Transformational Drug Pricing Models

- Federal demonstration models test new approaches to drug affordability, transparency, and reimbursement realignment

PBM and Pharmacy Network Changes

- Shifts in formulary strategy, utilization management, and pharmacy networks reshape long-term care and specialty markets

Finance as Innovation Enabler

- Finance supports home care scaling, LTSS models, facility conversions, and capital-intensive healthcare technologies

Integration of Policy and Delivery

- Financing, policy, and delivery modernization define adoption and evolution of healthcare innovation models

Long-Term Care, Dementia Services, and Caregiver Support

Policy Focus on LTC and Dementia

- In 2026, LTC and dementia services will receive increased policy and procurement attention due to demographic changes

Caregiver Support Infrastructure

- Strengthening caregiver infrastructure and expanding access to dementia-specific interventions are key priorities

Integrated Care Models

- Scalable models integrating LTC, social supports, and community services will align with federal and state goals

PACE Program Growth

- PACE program expansion continues in multiple states, fueled by competitive requests for proposals and shifting investments

Looking Forward

Summary

Organizations that win in 2026 will share three characteristics:

- **Operational excellence** across compliance, eligibility, reporting, and administrative readiness
- **Strategic technology adoption,** especially AI and evidence-aligned digital health models
- **Financial and contractual agility** to adapt to evolving pharmacy, MA, and Medicaid economics
- 2026 is not simply another year of transition—it is a market reset that rewards disciplined execution, data-driven strategy, and the ability to operationalize reform

Next Step for LACERS:

- Recognize the trends impacting LACERS and be prepared to apply and respond to changes
- Review with LACERS' carrier partners to learn and understand their adaption of 2026 trends
- Continue to monitor trends

Questions