CRCEA Fall Conference – Via Benefits Presentation

Retirement without compromise – honoring the promise, securing the future

Kathy Foster
Christian Goodman

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Discussion topics

1. Landscape of retiree healthcare in California and across the country
2. Medicare market and legislative update
3. Educational overview on Medicare
4. Sustainable strategies that bring immediate value – a case study

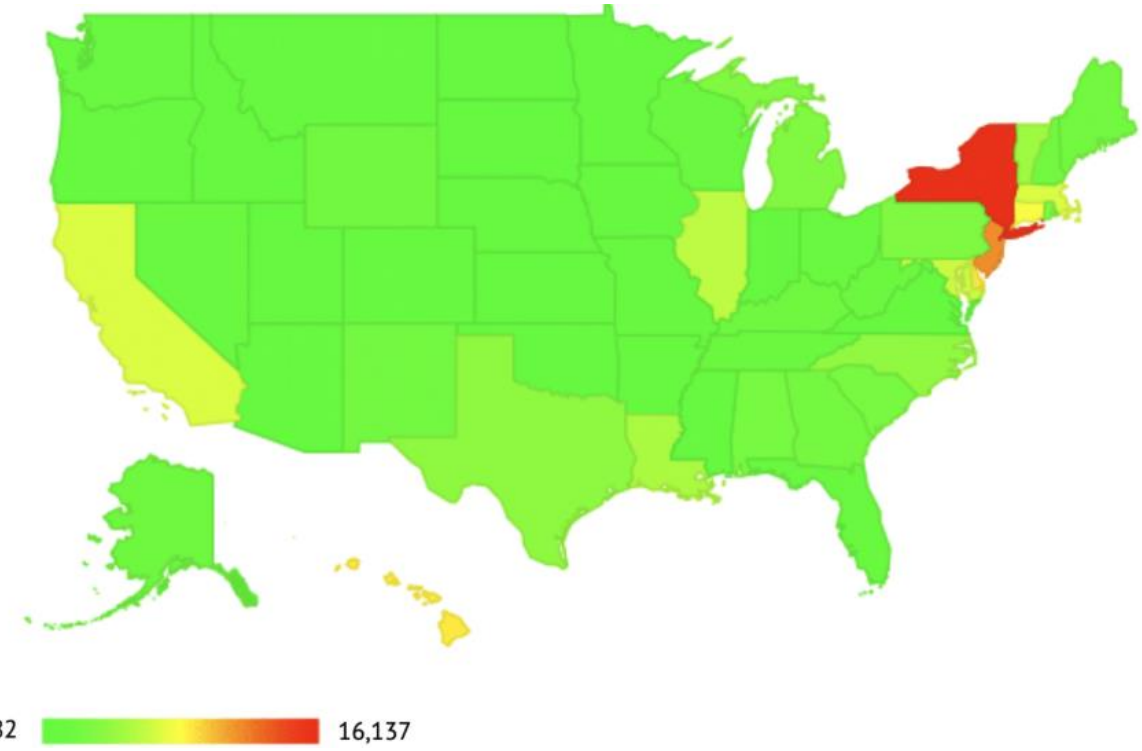
Retiree healthcare landscape

Public Sector OPEB Debt across the country

Total State and Local OPEB Debt by State

State	OPEB Debt	Population	OPEB Per Capita
California	$183,492,566,331	39,512,223	$4,644
Illinois	$73,679,046,562	12,671,821	$5,814
Massachusetts	$47,523,075,688	6,892,503	$6,895
New Jersey	$101,478,261,992	8,882,190	$11,425
New York	$316,210,238,646	19,453,561	$16,255
Texas	$110,797,246,407	28,995,881	$3,821

Net State and Local Government OPEB Liabilities Per Capita by State



Source: *Survey of State & Local Government OPEB Liabilities, February 22, 2021*

Unfunded OPEB liabilities and their impact on a National level

Rising OPEB Liabilities

OPEB liabilities have grown due to medical inflation and an aging retiree population, increasing the long-term financial burden.

Low Funding Levels

States have very low assets set aside, with only 9.2% funding ratio compared to pension systems' 71%, causing a financing gap.

Financial Impact on Governments

Unfunded OPEB liabilities create budget pressures, credit risks, and lead to benefit cuts and tax increases by public employers.

Healthcare cost inflation and premium increases

Rising Healthcare Costs

Healthcare costs have increased by 125.8% since 2000, outpacing general inflation and increasing retiree expenses.

Impact on Retiree Benefits

Higher healthcare costs lead to increased premiums and financial burdens on public sector retiree health benefits.

MAPD Premium Increases

Group MAPD plan premiums increased by 31% on average in 2025, with some plans rising 75% or more.

CMS Funding Changes

Decreasing CMS funding and aging demographics are driving premium increases and higher cost pressures.

Medicare update

2026 CMS Final Notice

1 **MA (medical) payment rates to rise on average 5.06%**

- Well above the Advance Notice adjustment of 2.23%
- Greater than 2025 average increase of 3.70%

2 **Significant continuing changes in Part D from the IRA including:**

- Implementation of first set of drugs with negotiated prices
- New “selected drug subsidy” payable to Part D plans on these negotiated drugs

3 **Voluntary 3-year demonstration program starting in 2025 to stabilize market premiums for PDPs**

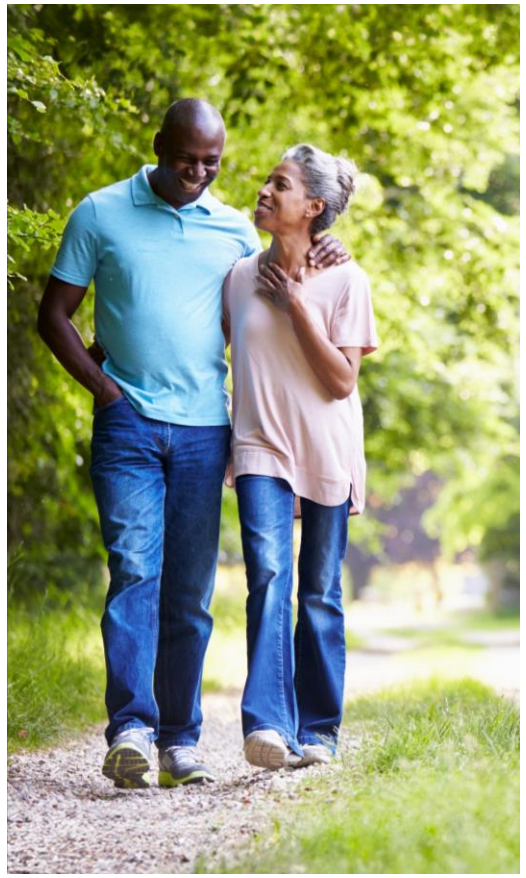
- Resulted in direct subsidy payments for PDPs, including EGWPs, higher by about $175 PMPY than for integrated MAPD plans

4 **CMS adopted a new “risk normalization” adjustment for 2025 that raises risk scores for standalone PDPs (including EGWPs) while lowering risk scores for drug benefits under integrated MAPD plans**

- Resulted in about a 12% risk score differential in 2025 favoring PDP over MAPD, with accordingly higher direct subsidy payments for PDP
- Differential will grow substantially in 2026 to favor PDP over MAPD by more than 30%, or roughly $500 PMPY

Medicare Marketplace update

Medicare Marketplace landscape



- **Continued strengthening of the Medicare marketplace**
  - Medicare Advantage enrollment reaches 35m; a majority of seniors are enrolled in MA plans with $0 premiums
  - Dramatic improvements to Part D coverage including the new $2,100 OOPM (for 2026) and federal actions to reduce PDP premium cost
- **Medicare is relatively quiet on the legislative front** as tax and budget negotiations focus more on changes to Medicaid and the ACA market
- **Net effect:** favorable Medicare individual market conditions expected to continue into 2026, further shrinking the rationale for sponsoring group post-65 plans

Educational overview of Medicare

Medicare overview

Original Medicare
(approx. 80% coverage)

Part A	Part B
Hospital	Medical

Supplemental

Medicare Supplement (Medigap)

Plans are identified by letters A – N

+

Part D

Prescription

You cannot have both a **Medigap** and a **Medicare Advantage** plan

You must pay your Medicare **Part B** premium when enrolled in either type of plan

Medicare Advantage (MAPD)

Part C

Combines Part A & Part B

Includes Part D

Prescription

Includes Additional Benefits

Vision, Dental, Hearing, etc.

What is the difference?

Medicare Supplement

- Typically higher premiums than Medicare Advantage; more predictable, often lower out-of-pocket expenses
- Guaranteed issue (does not require underwriting) for certain cases (e.g., just turning 65, group plan terminating)
- Premiums may vary by age, location, gender, tobacco use and health (unless guaranteed issue applies)
- No network restrictions; provider must accept Medicare
- Enroll in separate Part D Prescription Drug Plan (PDP)

Medicare Advantage

- Lower premiums than Medicare Supplements – many $0 premium plans available
- Copays or coinsurance may apply for services
- Annual enrollment period
- Same premium for all based on geographical location
- Always guaranteed issue
- Networks apply (HMO and PPO)
- Most include Part D Prescription Drug coverage
- May include additional benefits such as dental and vision coverage, meals and transportation benefits, Over the counter drug allowances, Part B give back, gym membership

Sustainable strategies and a case study

Background on private Medicare retiree exchange solutions

PLAN OPTIONS FOR MEDICARE RETIREES

Medicare Supplement

Medicare Advantage (with and without prescription drugs)

Part D Prescription Drug Plans

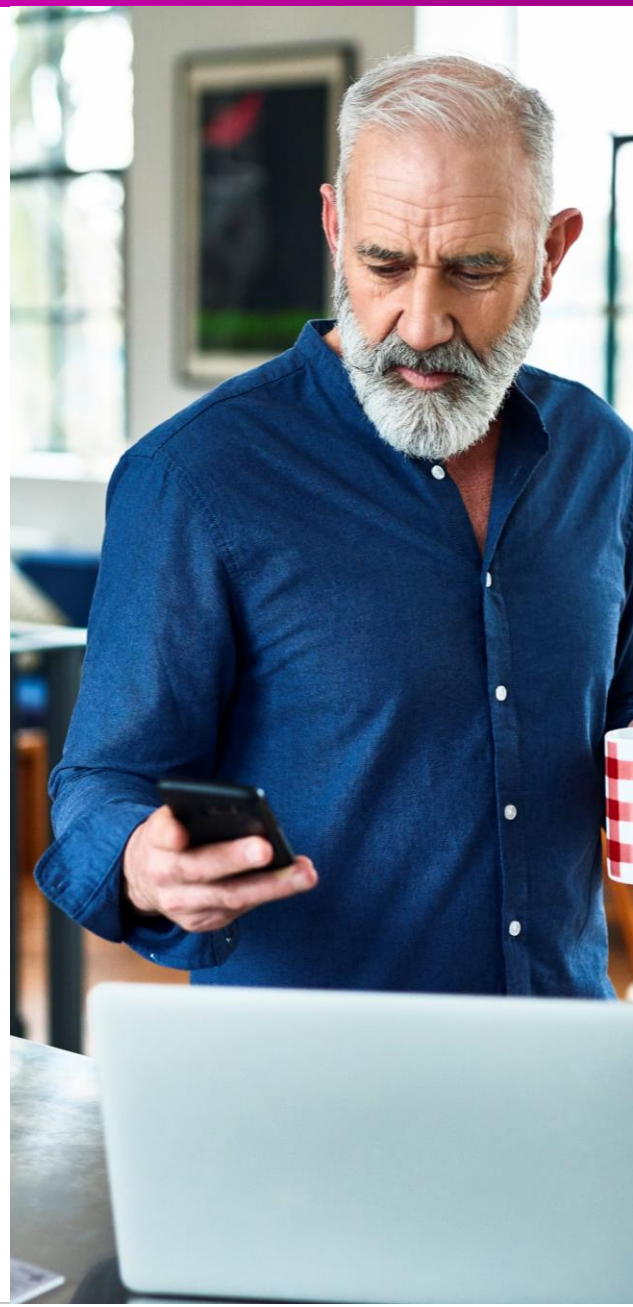
Dental

Vision

- Existed almost 20 years
- Common, well-established delivery mechanism for retiree health benefits in the private sector
- Becoming more common in the public sector. Alternative to provide meaningful, long-term and sustainable retiree health care programs
- Medicare marketplaces are highly efficient with competitive pricing. Insurance carriers compete for participants and market share (52 million Americans)
- Access to the government subsidies and pharmaceutical manufacturing discounts included in Medicare Part D prescription drug plans

Retiree exchange — how it works

1. Employer provides subsidy via the Health Reimbursement Arrangement (HRA) ~ retirees use their HRA account to get reimbursed for any premiums or eligible out of pocket costs
2. Communications strategy including change management provided by exchange provider
3. Transition delivered by experienced account management team including implementation manager, communications leader, data lead and health care strategist
4. Retirees can choose from a wide variety of plans and carriers for medical, prescription, dental and/or vision coverage
5. Each retiree works with a licensed benefits counselor who guides them through evaluation of plan options, helps with enrollment and is available for ongoing support



Sample Medicare plan comparison

Plan Information	Lowest cost Medigap Supplement Plan G with sample drug plan Wellcare Classic (PDP)	Sample Medicare Advantage Prescription Drug Plan (MAPD) Aetna Core 2 (PPO)	Sample Medicare Advantage Prescription Drug Plan (MAPD) SCAN Classic (HMO)
Monthly Premium	$210 + $17 = $227	$46	$0
Deductible (medical)	Part B deductible = $257	$0	$0
Out-of-Pocket Max (medical/Rx)	None / $2,000	$4,900/ $2,000	$1,500 / $2,000
Network Type	No Network	PPO	HMO
Primary Care Visit	$0	$0 Copay	$0 Copay
Specialist Visit	$0	$30 Copay	$0 Copay
Inpatient	$0	$375 days 1 to 6, $0 days 7 to 90	$100 days 1 to 5, $0 day 6 to 90
Emergency Room	$0	$125	$125
Prescription Drug deductible	$590	$0	$90
Prescription Drug:	$0 / $5 / 21% / 35% / 25%	$0 / $0 / 22% / 25% / 25%	$0 / $0 / $42 / 50% / 30%
Additional Benefits:	None	Dental, Vision, Hearing, Fitness, OTC ($30 per quarter), Meals	Dental, Vision, Hearing, Fitness, OTC ($75 per quarter), Meals

- Premium and coverage details based on plans available in 2025 for non-smoker female in Alameda County, CA (94501)
- Pharmacy tiers (where applicable): 1. generic preferred; 2. generic non-preferred; 3. brand preferred; 4. brand non-preferred; and 5. specialty

Addressing common objections

Common questions and answers

Q

Will I have to change doctors, hospitals and pharmacies?

Q

I have a pre-existing condition — can I be turned down or restricted?

Q

Isn't group insurance always less expensive than individual insurance?

Q

Don't my spouse and I need to be on the same plan?

Answer: No

Case study:
Alameda County Employees' Retirement Association (ACERA)

The challenge

Retiree health options and costs had become unattractive to retirees

Given rising medical costs, the funds required to subsidize ACERA's retiree health benefits were shrinking at a considerable rate.

Inadequate customer service

Case study:
Alameda County Employees' Retirement Association (ACERA)

The solution

ACERA partnered with Via Benefits for Retiree Individual Marketplace with an HRA to subsidize healthcare costs

The solution includes one-on-one guidance to select the best plan based on budget, lifestyle and needs

The results

Retirees saved an average of **$300 to $1,500** per year

ACERA saved nearly **$2M** in the first year

98% retiree satisfaction with the service

Key takeaways

- **Municipalities across California and the country struggle to provide sustainable retiree medical programs due to increasing costs**

- **Primary drivers of increasing costs**
  - Aging populations
  - Longer life expectancy
  - Medical inflation

- **Several California Counties have transitioned to the individual marketplace with great success, preserving benefits for retirees while lower annual and long-term actuarial costs**

Thank you!

Kathy Foster
Former Assistant CEO, ACERA

Christian Goodman
Director, Via Benefits, Public Sector Strategy and Sales Leader
Christian.Goodman@wtwco.com
(313) 300-3714