Approved: July 29, 2026

EMPLOYEE BENEFITS PROGRAM COMMITTEE MEETING (VIRTUAL)
ACWA JPIA
2100 Professional Drive
Roseville, CA 95661
(800) 231-5742

April 30, 2026

MEMBERS PRESENT

Chair: Randall Reed, Cucamonga Valley Water District
Vice Chair: Scott Ratterman, Calaveras County Water District
Karen Alves, Glenn-Colusa Irrigation District
Dina Nolan, Madera Irrigation District, joined at 9:02 AM
Patrick Sanchez, Vista Irrigation District
Laures Stiles, San Luis & Delta-Mendota Water Authority
Pam Tobin, San Juan Water District[1]

MEMBERS ABSENT

Karen Gish, Amador Water Agency

STAFF PRESENT

Chief Executive Officer: Adrienne Beatty
Sonya Baker, Benefits Systems Analyst II
Chimene Camacho, Senior Executive Assistant to the CEO
Veronica Cobian, Senior Benefits Administrator
David deBernardi, Director of Finance
Adam Dedmon, Employee Benefits Manager
Michele Dye, Employee Benefits Specialist
Ben Hayden, Lead Benefits Analyst
Jennifer Jobe, Deputy Executive Officer
Joe Rumenapp, Information Technology Manager
Olivia Sayad, Administrative Assistant II
Jillian Sciancalepore, Administrative Assistant III *(Recording Secretary)*
Dan Steele, Finance Manager
Michelle Stites, Benefits Administrator II

OTHERS IN ATTENDANCE

Kellie Murphy, Johnson Schachter & Lewis, A Professional Law Corporation, Interim General Counsel
Melody McDonald, San Bernardino Valley Water Conservation District
J Bruce Rupp, Humboldt Bay Municipal Water District

[1] Director Tobin attended remotely but did not participate in the meeting in her capacity as a member of the Committee or vote on any action item.

Brent Hastey, Reclamation District 784
Chris Kapheim, Kings River Conservation District
David Wheaton, Citrus Heights Water District
Rob Bachler, Principal & Consulting Actuary, Milliman
Katie Davanaugh, Senior Human Resources Analyst, Municipal Water District of Orange County
Tom Sher, Benefits Consultant/Senior Vice President, Alliant Insurance Services, Inc.
Holden Sweeden, Associate Actuary, Milliman

WELCOME, CALL TO ORDER, ANNOUNCEMENT OF QUORUM, AND INTRODUCTIONS

Chair Reed welcomed everyone in attendance, with a special welcome to the Committee's newest member, Pam Tobin, and called the meeting to order at 9:00 AM. He announced there was a quorum. He requested the Employee Benefits Program Committee and staff to introduce themselves.

PLEDGE OF ALLEGIANCE

Chair Reed led the Pledge of Allegiance.

ANNOUNCEMENT OF RECORDING OF MEETING

Chair Reed announced that the meeting would be recorded to assist in preparation of minutes. Recordings are kept 30 days following the meeting, as mandated by the Ralph M. Brown Act.

PUBLIC COMMENT

Chair Reed noted that, as the agenda stated, members of the public would be allowed to address the Employee Benefits Program Committee on any agenda item prior to the Committee's decision on that item. Comments on any issues on the agenda, or not on the agenda, were also welcome. None were noted.

ADDITIONS TO OR DELETIONS FROM THE AGENDA

Chair Reed asked for any additions to, or deletions from, the agenda. None were noted.

I. CONSENT AGENDA

Chair Reed called for approval of the Consent Agenda:

> M/S/C (Ratterman/Stiles) (Alves-Yes; Nolan-Yes; Sanchez-Yes; Stiles-Yes; Tobin-Not Participating; Ratterman-Yes; Reed-Yes): That the Employee Benefits Program Committee approve the minutes of the July 15, 2025, meeting, as presented; and approve an excused absence for any Committee member.

II. ADMINISTRATION

Report on Meetings Attended on Behalf of the JPIA
None.

Membership Report

Mr. Dedmon began by reviewing the total number of covered employees across all benefit programs (9,623) and the recent members that have either been added or terminated from the Program. He also reported that the total number of lives covered across all benefit programs is 20,737, drawing special attention to both the self-funded Anthem PPO and CDHP medical plans, which together account for just over half of the lives in the Program.

III. PROGRAM UPDATES

State of the Market

Mr. Sher shared an overview of the state of the market and the factors impacting rates and healthcare costs. Multiple sources suggest that the projected cost of care during 2026 is going to increase by 9%, and some of the factors driving increases include chronic conditions such as cancer, circulatory, and musculoskeletal, a shortage in Primary Care Physicians, increased usage of weight loss medications (GLP-1), and regulatory risks such as a cost shifting between public and private health plans. He reviewed the trends driving increases in high-cost claims, including more serious diagnoses, rapidly rising cancer treatment costs, higher salaries for medical personnel, and inflation.

Stop Loss History and Philosophical Discussion

Ms. Beatty shared that JPIA regularly evaluates whether to purchase stop loss coverage for its self-funded medical program, which is designed to protect against unusually high-cost individual or aggregate claims. This decision is made annually, weighing the cost of premiums against the potential benefits to the pool. From 2016 to 2022, JPIA maintained stop loss coverage for its Anthem PPO program, with attachment points set at $500,000 from 2016-20 and $750,000 from 2021-22, at an annual cost ranging from $1.5 million to $3 million. In 2023, JPIA decided not to renew this coverage, citing several key reasons: premiums were rising significantly each year regardless of actual high-cost claims, JPIA had a robust reserve balance of about $96 million (approximately 120% of projected 2022 program year costs), and historical analysis showed that premiums paid had exceeded reimbursements received over time. As a result, JPIA accepted the risk of paying all high-cost claims directly, knowing that its financial reserves would be used to fully absorb annual fluctuations and that this approach could likely result in long-term savings.

Ms. Beatty shifted her focus to 2024, when JPIA experienced its most expensive year for high-cost claims, with three claims exceeding $2 million and another three over $1 million, totaling approximately $14.3 million. Had stop loss coverage with a $750,000 attachment point been in place, around $10.1 million of these costs would have been transferred to the stop-loss carrier, resulting in a net cost transfer of about $6.8 million after accounting for estimated premiums. Excluding a single $6.1 million claim, the net savings would have been roughly $1.5 million, with approximately $4.8 million transferred to the stop-loss carrier. In 2025, there were no high-cost claims over $2 million, but five high-cost claims over $1 million, for a total plan cost of $6.3 million, suggesting that claims over $1 million are now more common, prompting reconsideration of the $750,000 Attachment Point.

Mr. Sher discussed stop loss coverage types (specific vs. aggregate) and industry practices, explaining that the smaller the group, the more variability there can be in results, whereas with larger groups, such as JPIA, claims experience is more credible, reducing the likelihood of exceeding a particular threshold for specific or aggregate insurance.

Ms. Beatty provided a comparative analysis of commercial versus CWIF stop loss coverage and the potential risks associated with each option. Retrospective modeling showed that using CWIF for stop loss at a $1.5 million attachment point could have reduced contributions relative to commercial coverage at a $750,000 attachment point, and resulted in approximately $3 million of additional reserves after factoring in additional claims that would have been paid between $750,000 and $1.5 million. CWIF can also benefit the JPIA by allowing the pool to retain control over coverage design and avoid carrier practices such as excluding high-cost claimants at renewal.

Actuarial Review of Stop Loss Coverage Through California Water Insurance Fund (CWIF)

Mr. Bachler and Mr. Sweeden from Milliman provided an overview of the approach taken for stop-loss rate development, coverage options, and results, which ultimately showed potential cost savings and control benefits compared to commercial insurance for 2026 and beyond. Rate development involved two components: (1) manual, which used industry benchmarks and JPIA group characteristics while adjusting for geographical area, group demographics, and observed provider reimbursement, and (2) experience, which used JPIA claims experience to create an experience rate. This process involved using historical catastrophic claims from 2024 and 2025 independently, applying a trend assumption to bring costs to 2026 expected levels, limiting costs to a calculated “pooling point” to avoid overreacting to extreme outliers (or lack thereof), taking a weighted average of each year’s observed costs, and adding back the appropriate cost of the applied pooling point. At this point, both the manual and experience rates are blended to generate a final rate, with a weight applied to the experience rate, called “credibility.” Credibility will decrease as the stop-loss deductible increases and will increase as group size increases or as the number of data years available increases. The result is a rate that best reflects JPIA’s historical experience without overreacting to good or bad historical experience.

Milliman’s actuarial report evaluated coverage options at attachment points of $1.5 million, $1.75 million, and $2 million, estimating that claims above these options would be fairly rare, even for a pool the size of JPIA. However, with each year that passes, the likelihood of experiencing these high-cost claims increases under the assumption of previous trends. The report also evaluated aggregate limits on captive liability of $5 million, $7.5 million, and $10 million, which would cap the total dollars CWIF will pay out in a program year. Results showed that the contribution's impact on overall plan costs remains modest, with CWIF stop loss estimated to add about $1 million to projected costs of $120 million, resulting in a less than 1% increase at a $2 million attachment point and a 90% confidence level.

Ultimately, the Committee agreed to pursue updated Milliman rate analyses for 2027 across attachment points and aggregate limits to inform future decisions.

Review of Reserve Fund Balance

The Committee examined the Program's Reserve Fund balance, its volatility, and projections to maintain financial stability amid fluctuating healthcare costs. The Reserve Fund Target is set at $39 million to balance risk protection and generate investment income. Ms. Beatty reviewed with the Committee that the Program's current Fund balance is approximately $54 million, well above the industry-standard target of 15% in reserves. The philosophy the Committee has embraced is a slow, methodical approach to rate subsidization, so that monies in the Fund that exceed the Target can be used over a significant period to subsidize rates for as long as possible, particularly in the current environment of sharply rising medical inflation costs. Ideally, once the Fund balance is reduced to the Target, the annual rate increase will match whatever the current annual medical cost trend is, and the Fund balance will remain funded at the 99% confidence level for use in future catastrophic event(s). It should be noted that careful monitoring of the Fund balance and usage is part of a holistic equity management process that includes the continual evaluation of potential benefits of re-engaging a stop loss layer of coverage.

2025 Risk Management Review

Mr. Dedmon discussed with the Committee the performance of the self-funded Anthem medical plan, focusing on cost trends, high-cost claims, and the management of chronic conditions through targeted interventions.

Regarding Anthem PPO and CDHP utilization, Mr. Dedmon informed the Committee that the high-cost claimant trend decreased by 13.6% in 2025, lowering PMPM costs by 4%. This was largely driven by non-high-cost claimants, spouses, and the musculoskeletal system health condition category. Excluding pharmacy, the medical-only high-cost claim trend declined by less than 1%, underscoring pharmacy's significant impact. The top five spend categories remain consistent: cancer, musculoskeletal, circulatory, injury and poisoning, and health status conditions, with chronic conditions accounting for 40% of spend due to high pharmacy costs associated with them. In addition, the management of GLP-1 drugs for diabetes and weight loss is carefully controlled to avoid cost inflation. 99% of the plan's GLP-1 spend is for diabetes treatment, with 50% of diabetic members prescribed GLP-1s. GLP-1s for weight loss are generally not covered except when medically necessary. Prior authorization and formulary management steer usage to cost-effective drugs, requiring patients to try generics before approving expensive brand drugs.

Mr. Dedmon provided updates and engagement metrics on the Program's point solutions, which are targeted to specific conditions or needs to improve user care and achieve overall cost savings for the plans. These point solutions include Carrum Health (surgical and oncology benefit) and Hinge Health (physical therapy), which both showed growing engagement and positive rate on investment; and Progyny (fertility, surrogacy, and adoption assistance), which at the end of 2025 resulted in five successful single

births out of five IVF treatments, reducing the risk of multiple births and neonatal intensive care costs.

2027 and Beyond Plan Designs

Mr. Dedmon informed the Committee that efforts to improve member support and plan design aim to increase utilization of cost-saving programs and enhance the user experience. A short-term goal is to upgrade the health navigator program from Anthem Health Guide to enhanced versions Total Health Select or Complete, featuring dedicated family advocates. Advocates proactively manage members' care needs, help connect to appropriate services like Hinge or Modern Health, and increase utilization of point solutions. A recommendation on a specific enhanced navigator plan is expected to be presented to the Committee during the July Committee meeting. A long-term goal is to develop comprehensive data analytics capabilities across all plans to improve strategic decision-making. Current Anthem reporting meets immediate needs, but longitudinal data integration will enable better cost and utilization insights over time.

Dental Program Update

Mr. Dedmon reminded the Committee that three new dental plans were introduced last year, targeting rural areas facing dentist shortages. Nine agencies adopted the enhanced service offering, providing a better experience and access for employees in remote regions where Delta Dental network contractions impact care availability. The program is expected to grow slowly as word spreads among affected agencies.

IV. STAFF UPDATES

Employee Benefits Department Update

Mr. Dedmon informed the Committee that the addition of Michele Dye (Jackie Rech's replacement), Employee Benefits Specialist, has enhanced member support, including health fairs and direct assistance for plan changes and complex inquiries.

In addition, both Mr. Dedmon and Ms. Jobe have increased in-person visits with member agencies, visiting 14 in 2025 and continuing in 2026 with 2 to date (focusing on larger member agencies by employee count). Visits focus on understanding plan performance, identifying issues, gathering member input, and sharing best practices.

V. UPCOMING MEETINGS

The Employee Benefits Program Committee is scheduled to meet next on Wednesday, July 29, 2026, at 1:00 PM.

The Employee Benefits Program Committee meeting adjourned at 10:46 AM.