LIVE VIRTUAL COMMITTEE MEETING

MAY 5, 2022 AT 8:00 AM*

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE MEETING

*The Committee meeting will be held following the Committee meeting scheduled prior.

TO VIEW VIA WEB

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

TO PROVIDE PUBLIC COMMENT

You may submit a request to speak during Public Comment or provide a written comment by emailing PublicComment@lacera.com. If you would like to remain anonymous at the meeting without stating your name, please let us know.

Attention: Public comment requests must be submitted via email to PublicComment@lacera.com.

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

NOTICE OF MEETING AND AGENDA

SPECIAL MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 NORTH LAKE AVENUE, SUITE 810
PASADENA, CA 91101

THURSDAY, MAY 5, 2022 - 8:00 A.M.

This meeting will be conducted by the Insurance, Benefits and Legislative Committee by teleconference under California Government Code Section 54953(e).

Any person may view the meeting online at
http://lacera.com/leadership/board-meetings

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

COMMITTEE MEMBERS:

Les Robbins, Chair
Vivian H. Gray, Vice Chair
Shawn R. Kehoe
Wayne Moore
Herman B. Santos, Alternate

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of April 6, 2022

II. PUBLIC COMMENT

(Written Public Comment – You may submit written public comments by email to PublicComment@lacera.com. Correspondence will be made part of the official record of the meeting. Please submit your written public comments or documentation as soon as possible and up to the close of the meeting.

Verbal Public Comment – You may also request to address the Committee at PublicComment@lacera.com before and during the meeting at any time up to the end of the Public Comment item. We will contact you with information and instructions as to how to access the meeting as a speaker. If you would like to remain anonymous at the meeting without stating your name, please let us know.)

III. NON-CONSENT ITEMS

A. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend that the Board of Retirement adopt a "Support" position on Assembly Bill 1971, which would make various administrative amendments to the County Employees Retirement Law of 1937. (Memorandum dated April 22, 2022)

IV. FOR INFORMATION

A. Engagement Report for April 2022
Barry W. Lew, Legislative Affairs Officer

B. Staff Activities Report for April 2022
Cassandra Smith, Director, Retiree Healthcare

C. Medical and Dental Claims Audit Findings
Amber Turner, Segal Consulting

- Anthem Medical Plan Audit
- Cigna Dental Plan Audit

D. LACERA Claims Experience
Stephen Murphy, Segal Consulting

E. Federal Legislation
Stephen Murphy, Segal Consulting

(for discussion purposes)

V. ITEMS FOR STAFF REVIEW

VI. GOOD OF THE ORDER

(For information purposes only)

VII. 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.

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.com, but no later than 48 hours prior to the time the meeting is to commence.

MINUTES OF THE MEETING OF THE

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

GATEWAY PLAZA - 300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

WEDNESDAY, APRIL 6, 2022, 8:30 A.M. – 8:50 A.M.

This meeting was conducted by the Insurance, Benefits & Legislative Committee by teleconference under the Governor's Executive Order No. N-29-20.

COMMITTEE MEMBERS

PRESENT: Les Robbins, Chair
Vivian H. Gray, Vice Chair *(arrived 8:35 a.m.)*
Shawn R. Kehoe
Wayne Moore
Herman B. Santos, Alternate

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Alan Bernstein
JP Harris
Keith Knox
William Pryor

STAFF, ADVISORS, PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare
Santos H. Kreimann, Chief Executive Officer
Luis Lugo, Deputy Chief Executive Officer
JJ Popowich, Assistant Executive Officer
Laura Guglielmo, Assistant Executive Officer
Steven P. Rice, Chief Counsel
Barry W. Lew, Legislative Affairs Officer

STAFF, ADVISORS, PARTICIPANTS (continued)

Stephen Murphy, Vice President
Segal Consulting

Richard Ward, Sr. Vice President
Segal Consulting

Stephanie Messier, Vice President
Segal Consulting

The meeting was called to order by Chair Robbins at 8:30 a.m. As Ms. Gray had not yet joined the meeting, the Chair announced that Mr. Santos, as the alternate, would temporarily be a voting member of the Committee.

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of March 2, 2022

Mr. Kehoe made a motion, Mr. Robbins seconded, to approve the minutes of the regular meeting of March 2, 2022. The motion passed unanimously.

II. PUBLIC COMMENT

III. CONSENT ITEMS

A. Recommendation as submitted by Steven P. Rice, Chief Counsel: That, under AB 361 and Government Code Section 54953(e)(3) of the Brown Act, the Insurance, Benefits & Legislative Committee (IBLC) consider whether to find that the Governor's COVID-19 State of Emergency continues to directly impact the ability of the IBLC to meet safely in person and that the County of Los Angeles and other agencies still recommend social distancing such that the IBLC shall hold teleconference meetings for the next 30 days, so long as the State of Emergency remains in effect, and if so, direct staff to comply with the agenda and public comment requirements of the statute. (Memorandum dated March 25, 2022)

Mr. Santos made a motion, Mr. Robbins seconded, to approve the recommendation. The motion passed unanimously.

IV. NON-CONSENT ITEMS

A. Recommendation as submitted by Cassandra Smith, Retiree Healthcare Director: That the Committee recommend the Board of Retirement authorize staff to allow a temporary one-time waiver of the 6-month waiting period for eligible members electing to transfer to SCAN's new expanded service areas. (Memorandum dated March 14, 2022)

Mr. Moore made a motion, Mr. Kehoe seconded, to approve the recommendation. The motion passed unanimously.

(Ms. Gray arrived following the vote on Non-Consent Item A)

B. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend that the Board of Retirement adopt a "Support" position on Assembly Bill 1824, which would provide clarification and technical updates to the County Employees Retirement Law of 1937. (Memorandum dated March 25, 2022)

Mr. Kehoe made a motion, Mr. Moore seconded, to approve the recommendation. The motion passed unanimously.

C. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement adopt a "Support" position on Assembly Bill 1944, which would not require a nonpublic teleconference location to be identified or accessible to the public. (Memorandum dated March 28, 2022)

Mr. Moore made a motion, Mr. Kehoe seconded, to approve the recommendation. The motion passed unanimously.

D. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement (1) Approve a visit with Congress by Board trustees as designated by the Chair of the Board of Retirement and by staff as designated by the Chief Executive Officer during the week of May 23, 2022 in Washington D.C.; and (2) Approve reimbursement of all travel costs incurred in accordance with LACERA's Trustee Travel Policy. (Memorandum dated March 29, 2022)

IV. CONSENT ITEMS (Continued)

Mr. Kehoe made a motion, Ms. Gray seconded, to approve the recommendation. The motion passed unanimously.

V. FOR INFORMATION

A. Engagement Report for March 2022
Barry W. Lew, Legislative Affairs Officer

The engagement report was discussed.

B. Staff Activities Report for March 2022
Cassandra Smith, Director, Retiree Healthcare

The staff activities report was discussed.

C. LACERA Claims Experience
Stephen Murphy, Segal Consulting

The LACERA Claims Experience reports through February 2022 were discussed.

D. Federal Legislation
Stephen Murphy, Segal Consulting

(for discussion purposes)

Segal Consulting gave an update on federal legislation.

VI. ITEMS FOR STAFF REVIEW

There was nothing to report.

VII. GOOD OF THE ORDER

(For information purposes only)

VIII. ADJOURNMENT

The meeting adjourned at 8:50 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.**

LACERA

April 22, 2022

TO: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Vivian H. Gray, Vice Chair
Shawn R. Kehoe
Wayne Moore
Herman Santos, Alternate

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: May 5, 2022 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Assembly Bill 1971—County Employees Retirement Law of 1937**

Author: *Cooper [D]*
Sponsor: *State Association of County Retirement Systems*
Amended: *April 18, 2022*
Introduced: *February 10, 2022*
Status: *Read second time. Ordered to third reading. (04/21/2022)*

Staff Recommendation: *Support*

RECOMMENDATION
That the Insurance, Benefits and Legislative Committee recommend that the Board of Retirement adopt a "Support" position on Assembly Bill 1971, which would make various administrative amendments to the County Employees Retirement Law of 1937.

LEGISLATIVE POLICY STANDARD
The Board of Retirement's legislative policy standard is to support proposals that provide the Board with increased flexibility in its administration of retirement plans and operations or enable more efficient and effective service to members and stakeholders.

SUMMARY
AB 1971 is an omnibus bill that contains additions and amendments to the County Employees Retirement of Law of 1937 (CERL) that provide administrative flexibility and more efficient and effective service to members and stakeholders, including proposed amendments submitted by LACERA to the State Association of County Retirement Systems' (SACRS) legislative platform.

BACKGROUND
Although these provisions are also sponsored by SACRS and were intended to be included in AB 1824 (Committee on Public Employment and Retirement), which is also sponsored by SACRS, these provisions are considered substantive, potentially

controversial, and not technical in nature. Consequently, they are included separately in AB 1971.

The Co-Chairs of the SACRS Legislative Committee and the SACRS lobbyists met with various stakeholders regarding the version of the bill as introduced on February 10, 2022. Based on those discussions and feedback, a number of provisions were removed from that version of the bill.

ANALYSIS

Family Leave (31646)

A member who returns to active service following an uncompensated leave of absence on account of illness may purchase up to 12 consecutive months of service credit for that period of illness.

A member who returns to active service following an uncompensated leave of absence due to parental leave may purchase up to 12 consecutive months of service credit for that period of absence. This provision is subject to adoption by the board of supervisors.

The bill would add that a member who returns to active service following an uncompensated leave of absence due to the serious illness of a family when the absence is covered under the Family and Medical Leave Act of 1993 or the California Family Rights Act may purchase up to 12 consecutive months of service credit for that period of absence. This provision is subject to adoption by the board of supervisors.

Temporary Mandatory Furlough (31646.2)

The bill would provide that a retirement board may grant a member who is subject to a temporary mandatory furlough the same service credit and compensation earnable to which the member would have been entitled in the absence of the temporary mandatory furlough. The retirement board may require additional member or employer contributions that the board determines are necessary to fund these benefits on an actuarially sound basis.

Post-retirement Service Without Reinstatement (31680.16)

The bill would provide that a retired person may serve without reinstatement from retirement or loss or interruption of benefits for part-time service on a state, county, city, district, or other board or commission of a political subdivision. It would provide limits on the hours of service and any associated salary or stipend. Such a provision currently exists only for retirees serving part-time on state boards or commissions.

Disability Application and Service Retirement (31725.7, 31760)

A member who files an application for disability may, if eligible, apply for a service retirement allowance pending the determination of their disability application. If granted a disability retirement, appropriate adjustments are made to the member's retirement allowance retroactive to their disability effective date. If the member should die before a

determination is made but is later granted a disability retirement, the beneficiary may change the optional or unmodified type of allowance that the member was receiving.

The bill would provide that this provision also applies to a member retired for service who subsequently files an application for and is found eligible for disability retirement.

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE recommend that the Board of Retirement adopt a "Support" position on Assembly Bill 1971, which would make various administrative amendments to the County Employees Retirement Law of 1937.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachments
Attachment 1—Board Positions Adopted on Related Legislation
Attachment 2—Support and Opposition
AB 1971 (Cooper) as amended on April 18, 2022

cc: Santos H. Kreimann
Luis Lugo
JJ Popowich
Laura Guglielmo
Steven P. Rice
Frank Boyd
Ricki Contreras
Carlos Barrios
Allan Cochran
Shari McHugh, McHugh Koepke & Associates
Naomi Padron, McHugh Koepke & Associates

BOARD POSITIONS ADOPTED ON RELATED LEGISLATION

AB 2376 (Chapter 134, Statutes of 2016) clarified the definition of Plan D for purposes of a prospective plan transfer and the applicability of the reciprocal provision on nonconcurrent retirement to Plan E members. The Board of Retirement adopted a "Support" position.

AB 992 (Chapter 40, Statutes of 2015) clarified the ability of members to change their retirement option after being granted a disability retirement. The Board of Retirement adopted a "Support" position.

AB 2474 (Chapter 741, Statutes of 2014) made various amendments to the County Employees Retirement Law of 1937 to conform with the California Public Employees' Pension Reform Act of 2013. The Board of Retirement adopted a "Support" position.

AB 2473 (Chapter 740, Statutes of 2014) made various amendments to the County Employees Retirement Law of 1937 to conform with federal law. The Board of Retirement adopted a "Support" position.

SB 13 (Chapter 528, Statutes 2013) made various technical and clarifying amendments to the County Employees Retirement Law of 1937 and California Public Employees' Pension Reform Act of 2013. The Board of Retirement adopted a "Support" position.

AB 1380 (Chapter 247, Statutes 2013) amended various provisions of the County Employees Retirement Law of 1937 to conform with the California Public Employees' Pension Reform Act of 2013. The Board of Retirement adopted a "Watch" position.

SB 996 (Chapter 792, Statutes of 2012) clarified that for purposes of disability retirement the presumption of heart trouble is a rebuttable presumption. The Board of Retirement adopted a "Support" position.

AB 1902 (Chapter 86, Statutes of 2010) provided technical and clarifying amendments to the provisions of Plan E related to prospective plan transfers and disability retirement, reciprocity, and the crediting of service. The Board of Retirement adopted a "Support" position.

SB 1479 (Chapter 158, Statutes of 2010) provided technical and clarifying amendments to the County Employees Retirement Law of 1937 related to the commencement of membership, exclusion from membership based on monthly compensation rate, advance payments of employer contributions from districts, and compliance with Internal Revenue Service procedures. The Board of Retirement adopted a "Watch" position.

AB 1354 (Chapter 188, Statutes of 2010) amended the County Employees Retirement Law of 1937 to conform with federal law on tax qualification requirements and benefits

related to deaths due to military service. The Board of Retirement adopted a “Support” position.

AB 1355 (Chapter 9, Statutes of 2009) updated cross-references related to the calculation of survivor allowances and made other technical changes. The Board of Retirement adopted a “Watch” position.

SUPPORT
State Association of County Retirement Systems (*Sponsor*)

OPPOSITION
None on file.

AMENDED IN ASSEMBLY APRIL 18, 2022

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 1971

Introduced by Assembly Member Cooper

February 10, 2022

An act to amend Sections ~~31525,~~ 31646, 31725.7, ~~31730, 31760, and 31838.5~~ *and 31760* of, and to add Sections 31646.2 and 31680.16 to, the Government Code, relating to public employees' retirement.

LEGISLATIVE COUNSEL'S DIGEST

AB 1971, as amended, Cooper. County Employees Retirement Law of 1937.

The County Employees Retirement Law of 1937 (CERL) authorizes counties to establish retirement systems pursuant to its provisions in order to provide pension and other benefits to county and district employees. CERL generally vests responsibility for management of a retirement system created pursuant to its provisions in a board of retirement (board). ~~CERL authorizes a board to make regulations that are not inconsistent with its provisions and these regulations become effective when approved by the applicable board of supervisors.~~

~~This bill would specify other provisions with which the above-described regulations are required to be consistent and would remove the requirement of approval by the board of supervisors as a necessary condition for them to become effective.~~

CERL authorizes a member who returns to active service following an uncompensated leave of absence on account of illness or parental leave to receive service credit for the period of the absence upon the payment of the contributions, as specified. CERL prescribes limits on these benefits and processes for making contributions. CERL authorizes

the provision of service credit to members in other specified instances while generally providing that a person is not entitled to service credit for time the person was not in service.

This bill would allow a member who returns to active service following an uncompensated leave of absence because of the serious illness of a family member when the absence is eligible for coverage, as specified, to receive service credit for the period of the absence, upon the payment of the member and employer contributions that would have been paid during that period, together with the interest that would have been earned. The bill would prescribe requirements for, and limits on, this benefit and would condition its operation on approval by resolution, as specified, by the county board of supervisors.

This bill would authorize the board to grant members who are subject to a temporary mandatory furlough the same service credit and compensation earnable or pensionable compensation to which the members would have been entitled in the absence of the temporary mandatory furlough. The bill would authorize the board to condition this grant on specified factors.

CERL generally prohibits a member retired from service from being paid for service rendered to a county or district after retirement, subject to certain exceptions, and prescribes requirements for reinstatement into a retirement system upon reemployment. CERL and the California Public Employees' Pension Reform Act of 2013 authorize reemployment of, and service by, retired members in certain capacities after retirement without reinstatement into the applicable retirement system, and prescribe limits on this service.

This bill would authorize a person who is retired ~~under CERL~~ *and receiving a retirement benefit from a county system* to serve without reinstatement for service on a part-time ~~state, county, city, district, or other political subdivision~~ board or ~~commission.~~ *commission operating under a participating agency of the same county retirement system.* The bill would prohibit a retired person ~~serving~~ *acting* in this capacity from acquiring benefits, service credit, or retirement rights with respect to the service and would prescribe limits on the ~~hours of service and the associated~~ salary or stipend ~~for the part-time service.~~ *for service with the board or commission.*

CERL regulates disability retirements and authorizes a retirement board to grant a service retirement allowance pending the determination of the entitlement to disability retirement. If a member is found eligible for disability retirement, CERL requires that appropriate adjustments

be made in the member's retirement allowance retroactive to the effective date of their disability retirement. CERL prohibits this authorization from being construed to authorize a member to receive more than one type of retirement allowance for the same period of time or to entitle a beneficiary to receive benefits which the beneficiary would not otherwise have been entitled to receive.

This bill would apply specified provisions in this regard to a member retired for service who subsequently files an application for disability retirement and, if the member is found to be eligible for disability retirement, would require appropriate adjustments to be made in the retirement allowance retroactive to the effective date of the disability retirement. ~~The bill would also require that, if a member with a disability retirement is subsequently determined not to be incapacitated, and the person's employer does not offer to reinstatement, the person's retirement allowance is to be reclassified to a service retirement in the same amount and subject to any applicable future cost of living adjustments. The bill would require, in this regard, that the optional or unmodified type of allowance selected by at the time of retirement for disability be binding as to the service retirement.~~

CERL authorizes a member or a retired member, until the first payment of a retirement allowance is made, to elect to have the actuarial equivalent of a retirement allowance, as of the date of retirement, applied to a lesser retirement allowance payable throughout life in accordance with specified optional settlements.

This bill would authorize a member retired for service who is subsequently granted a disability retirement to change the type of optional or unmodified allowance that they elected at the time the service retirement was granted, as specified.

~~CERL authorizes the granting of reciprocal benefits to members with service in other retirement systems that have entered into agreements to provide such benefits, provided that the member satisfies specified requirements. CERL prohibits these provisions from being construed to authorize a member credited with service in multiple entities who is eligible for a disability allowance to receive an amount that results in a disability allowance greater than the amount the member would have received had all the member's service been with only one entity. CERL requires, in this connection, that each entity calculate its respective obligations based upon the member's service with that entity and adjust its payment on a pro rata basis.~~

~~This bill would require, with regard to disability allowances subject to reciprocity to be adjusted on a pro rata basis, as described above, if one entity does not reduce the amount it pays a member, then another entity is to reduce the allowance it pays the member by as much as necessary to ensure that the member does not receive a disability allowance greater than the amount the member would have received had all the member's service been with only one entity.~~

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 31525 of the Government Code is amended to read:~~

~~31525. The board may make regulations not inconsistent with this chapter, the California Public Employees' Pension Reform Act of 2013 (Article 4 (commencing with Section 7522) of Chapter 21 of Division 7 of Title 1), and any other provisions of law applicable to county retirement systems.~~

~~SEC. 2.~~

SECTION 1. Section 31646 of the Government Code is amended to read:

31646. (a) A member who returns to active service following an uncompensated leave of absence on account of *the member's* illness may receive service credit for the period of the absence upon the payment of the contributions that the member would have paid during that period, together with the interest that the contributions would have earned had they been on deposit, if the member was not absent. The contributions may be paid in a lump sum or may be paid on a monthly basis for a period of not more than the length of the period for which service credit is claimed. Credit shall not be received for any period of such an absence in excess of 12 consecutive months.

(b) (1) A member who returns to active service following an uncompensated leave of absence on account of parental leave may receive service credit for the period of the absence upon the payment of the contributions that the member and the employer would have paid during that period, together with the interest that the contributions would have earned had they been on deposit, if the member was not absent. For purposes of this subdivision,

parental leave is defined as any time, up to one year, during which a member is granted an approved maternity or paternity leave and returns to employment at the end of the approved leave for a period of time at least equal to that leave. The contributions may be paid in a lump sum or may be paid on a monthly basis for a period of not more than the length of the period for which service credit is claimed. Credit shall not be received for any period of such an absence in excess of 12 consecutive months.

(2) This subdivision shall not be operative until the board of supervisors, by resolution adopted by majority vote, makes the provisions applicable to that county and applies it to parental leave that commences after the adoption by the board of supervisors.

(c) (1) A member who returns to active service following an uncompensated leave of absence on account of the serious illness of a family member when the absence is eligible for coverage under the federal Family and Medical Leave Act of 1993 (29 U.S.C. Sec. 2601 et seq.) or the Moore-Brown-Roberti Family Rights Act, commonly referred to as the California Family Rights Act, as described in Section 12945, may receive service credit for the period of the absence upon the payment of the contributions that the member and the employer would have paid during that period, together with the interest that the contributions would have earned had the contributions been on deposit, if the member was not absent. For purposes of this subdivision, "leave of absence on account of illness of a family member" means any time, up to one year, during which a member is granted an approved leave to care for a seriously ill family member and returns to employment at the end of the approved leave for a period of time at least equal to that leave. The contributions required to receive the service credit may be paid in a lump sum or may be paid on a monthly basis for a period of not more than the length of the period for which service credit is claimed. Credit shall not be received for any period of such an absence in excess of 12 consecutive months.

(2) This subdivision shall not be operative until the board of supervisors, by resolution adopted by majority vote, makes the provisions applicable to that county and applies it to leave that commences after the adoption by the board of ~~supervisors~~ *supervisors.*

~~SEC. 3.~~

SEC. 2. Section 31646.2 is added to the Government Code, to read:

31646.2. (a) The board may grant a member who is subject to a temporary mandatory furlough the same service credit and compensation earnable or pensionable compensation to which the member would have been entitled in the absence of the temporary mandatory furlough. The board may condition this grant on the receipt of additional member or employer contributions, or both as applicable, that the board determines are necessary to fund any benefits granted under this section on an actuarially sound basis.

(b) For the purposes of this section, "temporary mandatory furlough" means the time during which a member is directed to be absent from work without pay for up to one quarter of the member's normal working hours, provided that these reduced working hours shall not be in place for longer than two years.

~~SEC. 4.~~

SEC. 3. Section 31680.16 is added to the Government Code, to read:

31680.16. ~~A~~ *(a) This section shall apply to a retired person who is receiving a retirement benefit from a county retirement system and is appointed or elected to a board or commission operating under a participating agency of the same county retirement system.*

(b) A person who is retired under this chapter may serve *on a board or commission* without reinstatement from retirement or loss or interruption of benefits under this chapter or the California Public Employees' Pension Reform Act of 2013 (Article 4 (commencing with Section 7522) of Chapter 21 of Division 7 of Title 1), provided the ~~service~~ *appointment or election* is ~~on~~ *to* a part-time ~~state, county, city, district, or other political subdivision~~ board or commission. A retired person whose ~~employment~~ *service* without reinstatement is authorized by this subdivision shall not acquire benefits, service credit, or retirement rights with respect to the ~~employment. Part-time service authorized by this section is limited to less than 20 hours per week, and any salary or stipend for the part-time service shall~~ *appointment or election. The authorization provided by this section is limited to an appointment or election to a part-time board or commission for which any*

salary or stipend for serving does not exceed sixty thousand dollars ($60,000) annually.

~~SEC. 5.~~

SEC. 4. Section 31725.7 of the Government Code is amended to read:

31725.7. (a) Except as provided in subdivision (a), at any time after filing an application for disability retirement with the board, the member may, if eligible, apply for, and the board in its discretion may grant, a service retirement allowance pending the determination of their entitlement to disability retirement. If the member is found to be eligible for disability retirement, appropriate adjustments shall be made in their retirement allowance retroactive to the effective date of their disability retirement as provided in Section 31724.

(b) Notwithstanding subdivision (a), this section shall also apply to a member retired for service who subsequently files an application for disability retirement with the board. If the member retired for service is found to be eligible for disability retirement, appropriate adjustments shall be made in their retirement allowance retroactive to the effective date of their disability retirement, as provided in Section 31724.

(c) This section shall not be construed to authorize a member to receive more than one type of retirement allowance for the same period of time nor to entitle any beneficiary to receive benefits which the beneficiary would not otherwise have been entitled to receive under the type of retirement which the member is finally determined to have been entitled. In the event a member retired for service is found not to be entitled to disability retirement, they shall not be entitled to return to their job as provided in Section 31725.

(d) If the retired member should die before a final determination is made concerning entitlement to disability retirement, the rights of the beneficiary shall be as selected by the member at the time of retirement for service. The optional or unmodified type of allowance selected by the member at the time of retirement for service shall also be binding as to the type of allowance the member receives if the member is awarded a disability retirement.

(e) Notwithstanding subdivision (d), if the retired member should die before a final determination is made concerning entitlement to disability retirement, the rights of the beneficiary

may be as selected by the member at the time of retirement for service, or as if the member had selected an unmodified allowance. The optional or unmodified type of allowance selected by the member at the time of retirement for service shall not be binding as to the type of allowance the member receives if the member is awarded a disability retirement. A change to the optional or unmodified type of allowance shall be made only at the time a member is awarded a disability retirement and the change shall be retroactive to the service retirement date and benefits previously paid shall be adjusted. If a change to the optional or unmodified type of allowance is not made, the benefit shall be adjusted to reflect the differences in retirement benefits previously received. This paragraph shall only apply to members who retire on or after January 1, 1999.

~~SEC. 6. Section 31730 of the Government Code is amended to read:~~

~~31730. (a) If the board determines that the beneficiary is not incapacitated, and their employer offers to reinstate that beneficiary, their retirement allowance shall be canceled forthwith, and the beneficiary shall be reinstated in the county service pursuant to the regulations of the county or district for reemployment of personnel.~~

~~(b) If the board determines that the beneficiary is not incapacitated, and their employer does not offer to reinstate that beneficiary, notwithstanding any requirement of this chapter regarding eligibility therefor, the beneficiary's retirement allowance shall be reclassified to a service retirement in the same amount and subject to any applicable future cost of living adjustments. The optional or unmodified type of allowance selected by the beneficiary at the time of retirement for disability shall be binding as to the service retirement.~~

~~SEC. 7.~~

SEC. 5. Section 31760 of the Government Code is amended to read:

31760. (a) Except as provided in subdivisions (b) and (c), until the first payment of any retirement allowance is made, a member or retired member, in lieu of the retirement allowance for the member's life alone, may elect to have the actuarial equivalent of their retirement allowance as of the date of retirement applied to

a lesser retirement allowance payable throughout life in accordance with one of the optional settlements specified in this article.

(b) Notwithstanding subdivision (a), a member who applies for disability and is subsequently granted a service retirement pending a determination of entitlement to disability may change the type of optional or unmodified allowance that they elected at the time the service retirement was granted, subject to the provisions of Section 31725.7.

(c) Notwithstanding subdivision (a), a member retired for service who applies for, and is subsequently granted, a disability retirement may change the type of optional or unmodified allowance that was elected at the time the service retirement was granted, subject to the provisions of Section 31725.7.

~~SEC. 8. Section 31838.5 of the Government Code is amended to read:~~

~~31838.5. No provision of this chapter shall be construed to authorize any member, credited with service in more than one entity and who is eligible for a disability allowance, whether service connected or nonservice connected to receive an amount from one county that, when combined with any amount from other counties or the Public Employees' Retirement System, results in a disability allowance greater than the amount the member would have received had all the member's service been with only one entity.~~

~~In cases of service-connected disability allowances only, the limitation on disability allowances provided for in this section shall apply to service-connected disability allowances payable to those who, after being employed with another county or an entity within the Public Employees' Retirement System, become employed by a second public entity on or after January 1, 1984.~~

~~Each entity shall calculate its respective obligations based upon the member's service with that entity and each shall adjust its payment on a pro rata basis. If, however, another entity does not reduce the amount it pays the member, an entity subject to this section shall reduce the allowance it pays the member by as much as necessary to ensure that the member does not receive a disability allowance greater than the amount the member would have received had all the member's service been with only one entity.~~

O

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
APRIL 2022
FOR INFORMATION ONLY

Alaska To Consider Reviving Pension Plan

Alaska abolished its pension plan for new employees in 2006 and replaced it with a 401(k)-style retirement system. Over the years, various proposals have been put forth to reverse the decision. The state is now struggling to hire and retain employees during the "Great Resignation" and is again considering a proposal to reinstate its pension plan.

Its House Bill 55 would create a pension plan for police and firefighters. The bill passed the House last year and is now in the Senate. The new pension plan would require 8% contributions and retirement at age 55 with 20 years of service. An actuarial analysis commissioned by the state found that the program would cost $4 million to $7 million per year. Supporters say that is less than the cost of hiring and training replacement public safety workers who tend to leave the state because there is no pension plan.

Besides public safety workers, Alaska teachers are also advocating for a reopening of the closed teachers' pension plan. In contrast to the public safety pension plan, the teachers' plan could cost as much as $70 million per year. Each teacher who left the state cost their district mover $20,000 to recruit, hire, and train a replacement. For rural teachers, their top concerns are salary, cost-of-living adjustments, and retirement security. (Source)

Oklahoma House Votes to Reinstate Pension Plan

In 2014, the Oklahoma Legislature and Governor pushed through reforms that phased out the state's pension plan for a 401(k)-type plan. Recently, the Oklahoma House of Representatives voted to bring back the pension plan due to the challenges of state agencies in recruiting and retaining employees. Since 2014, the Oklahoma Public Employee Retirement System (OPERS) has been operating two retirement systems with higher administrative costs. OPERS is the second largest of the state's pension funds and the only one that switched to a defined contribution plan. (Source)

New Jersey Pension Plans and COLA

In 2011, Governor Chris Christie suspended cost-of-living adjustments (COLA) as part of the pension reforms he signed into law. New Jersey pension funds are now faced with a choice between providing COLAs today with a price tag of $3.6 billion or waiting a couple more decades before its plans reach a funding level (80%) sufficient to provide COLAs for state employees covered under the plans. The following is a list of fiscal years during which the plans are projected to reach 80% funding:

- Public Employees' Retirement System: 2044
- Teachers' Pension and Annuity Fund: 2039

- Police and Fireman's Retirement System: 2043
- State Police Retirement System: 2040
- Judicial Retirement System: 2047

Local employees seem to fare better with 2028 for local police and fire employees and 2035 for other local employees. (Source)

Kansas PERS Funding

The Kansas recently approved an $854 million contribution to the Kansas Public Employees Retirement System (KPERS). The contribution will increase the plan's funded ration above 80% with the aim of saving the state hundreds of millions of dollars in the next five years. However, the contribution does not include funding for cost-of-living adjustments (COLA). KPERS retirees have not received a COLA since the 1990s. (Source)

Ohio State Teachers Retirement System

The Ohio State Teachers Retirement System saw 29% returns in fiscal year 2021, much of which was driven by alternative assets and domestic equities. As a result of these high returns, the Ohio STRS board recently approved a one-time 3% cost-of-living adjustment for employees who retired before June 1, 2018.

Ohio STRS is currently 80.1% funded. Pension reform measures were put in place after the Great Recession to hold down unfunded liabilities, such as increasing eligibility requirements. In August 2023, teachers will be required to have 35 years of service to receive pension benefits. This requirement has been gradually increasing since 2012, when only 30 years of service were required. (Source)

> Staff Note: As reported in the October 2021 Engagement Report, Ohio STRS is currently facing a special state audit over complaints related to a report entitled *The High Cost of Secrecy: Preliminary Findings of Forensic Investigation of State Teachers Retirement System of Ohio.* The report was commissioned by the Ohio Retired Teachers Association and conducted Edward Siedle, a former Securities and Exchange Commission attorney.

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
APRIL 2022
FOR INFORMATION ONLY

Centers for Medicare and Medicaid Services (CMS) Medicare Part D Retiree Drug Subsidy (RDS) Applications for Plan Year 7/1/2022 – 6/30/2023

We are pleased to inform the Board that staff, carriers, and Segal successfully completed the CMS Retiree Drug Subsidy program application process for the new 2022/2023 RDS Applications by the CMS deadline of May 2, for the following plans:

- Anthem Blue Cross
- Cigna Medical
- Kaiser
- Local 1014

As a background, in 2003, the Medicare Modernization Act (MMA) was signed into law by President George W. Bush. This law created Medicare Part D to incentivize employers to continue to cover prescription drug costs for their Medicare eligible retirees, the MMA created the Retiree Drug Subsidy (RDS) program. Under this program, the CMS reimburses Plan Sponsors the equivalent of 28% of all allowable Retiree Drug expenses that fall between the federally designated Cost Threshold amount and the Cost Limit.

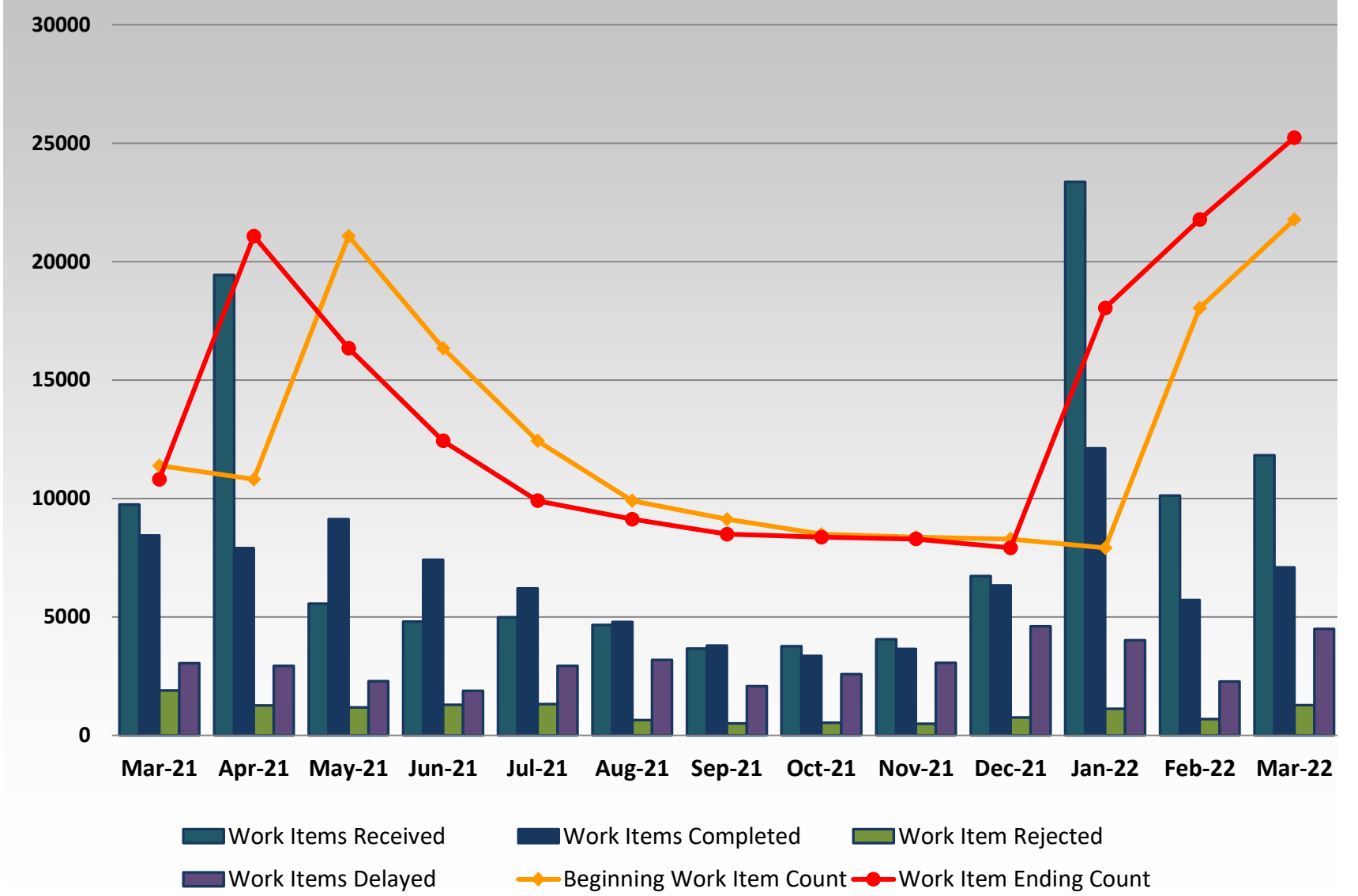
Kudos to staff, carriers, and Segal's actuary for their support and assistance in completing this annual project.

Retiree Healthcare Division

Trend Report

MARCH 2021 - MARCH 2022

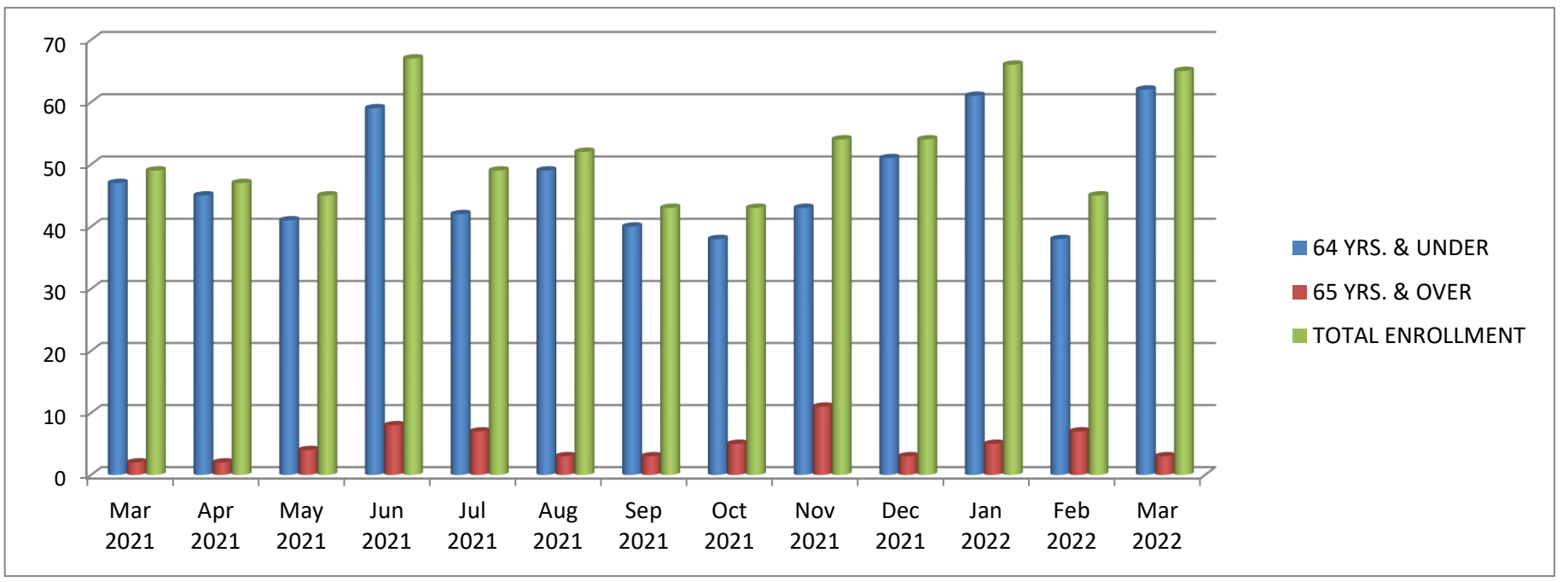
Updated 4/20/2022



	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Mar-21	11385	9749	8436	1890	3046	10808
Apr-21	10808	19437	7902	1262	2932	21081
May-21	21081	5563	9121	1175	2288	16348
Jun-21	16348	4797	7421	1289	1884	12435
Jul-21	12435	4989	6205	1315	2940	9904
Aug-21	9904	4663	4790	649	3193	9128
Sep-21	9128	3659	3789	504	2079	8494
Oct-21	8494	3758	3355	529	2579	8368
Nov-21	8368	4064	3655	487	3068	8290
Dec-21	8290	6721	6335	758	4606	7918
Jan-22	7918	23364	12115	1117	4012	18050
Feb-22	18050	10131	5715	691	2272	21775
Mar-22	21775	11821	7090	1271	4489	25235

Retirees Monthly Age Breakdown
MARCH 2021 - MARCH 2022

Disability Retirement			
MONTH	**64 YRS. & UNDER**	**65 YRS. & OVER**	**TOTAL ENROLLMENT**
Mar 2021	47	2	49
Apr 2021	45	2	47
May 2021	41	4	45
Jun 2021	59	8	67
Jul 2021	42	7	49
Aug 2021	49	3	52
Sep 2021	40	3	43
Oct 2021	38	5	43
Nov 2021	43	11	54
Dec 2021	51	3	54
Jan 2022	61	5	66
Feb 2022	38	7	45
Mar 2022	62	3	65

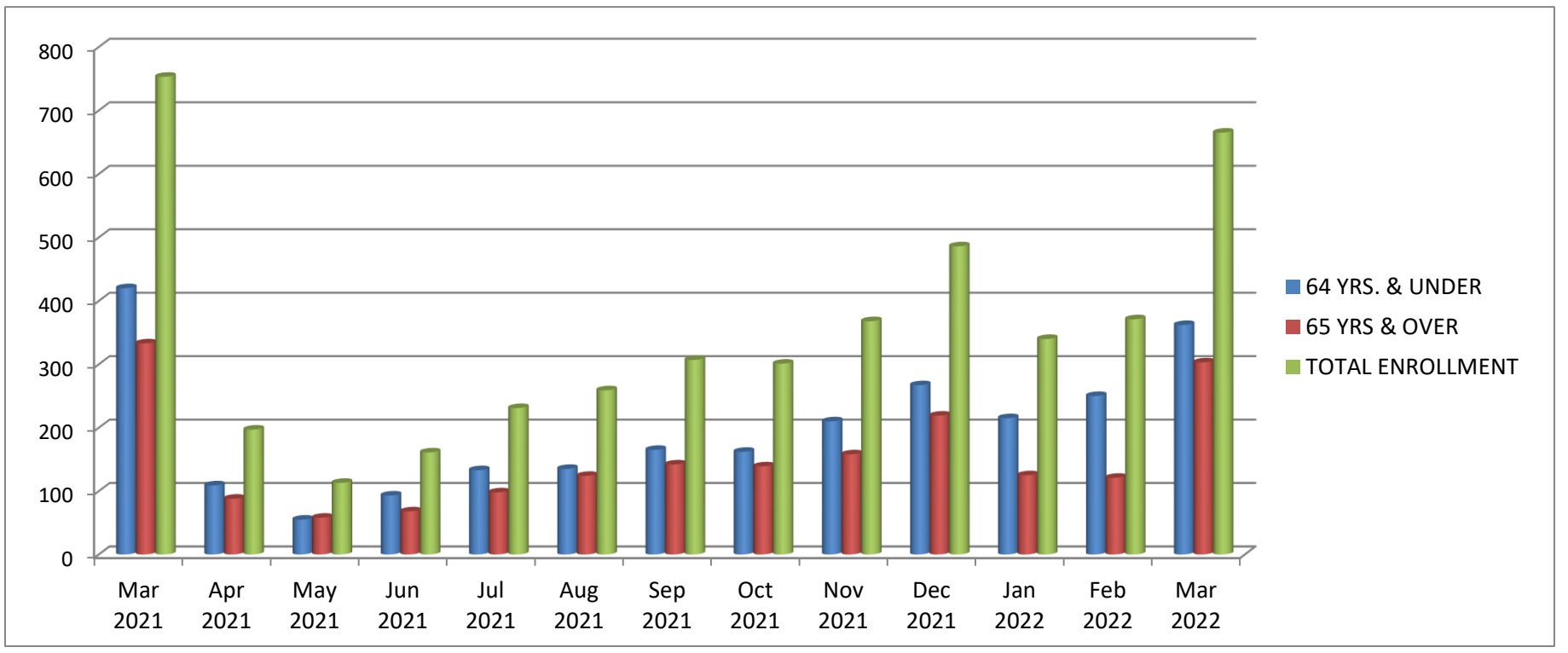


PLEASE NOTE:

- **Next Report will include the following dates: April 1, 2021, throught April 30, 2022.**

Retirees Monthly Age Breakdown
MARCH 2021 - MARCH 2022

Service Retirement			
MONTH	**64 YRS. & UNDER**	**65 YRS & OVER**	**TOTAL ENROLLMENT**
Mar 2021	420	333	753
Apr 2021	109	88	197
May 2021	55	58	113
Jun 2021	93	68	161
Jul 2021	133	98	231
Aug 2021	135	124	259
Sep 2021	165	142	307
Oct 2021	162	139	301
Nov 2021	210	158	368
Dec 2021	267	219	486
Jan 2022	215	125	340
Feb 2022	250	121	371
Mar 2022	362	303	665



PLEASE NOTE:

- **Next Report will include the following dates: April 1, 2021, through March 30, 2022.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 4/30/2022

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	7191	$1,070,688.09	2	$148.30
241	133	$19,537.70	0	$0.00
242	867	$135,220.60	0	$0.00
243	4266	$1,319,528.35	1	$59.40
244	15	$2,105.00	0	$0.00
245	60	$8,379.30	0	$0.00
246	18	$2,052.00	0	$0.00
247	149	$23,923.20	0	$0.00
248	11	$2,874.50	1	$43.00
249	55	$17,272.70	0	$0.00
250	17	$4,785.20	0	$0.00
Plan Total:	**12,782**	**$2,606,366.64**	**4**	**$250.70**
CIGNA - PREFERRED with RX				
321	31	$4,410.90	0	$0.00
322	5	$800.50	0	$0.00
324	21	$6,344.20	0	$0.00
327	2	$275.00	0	$0.00
329	2	$566.90	0	$0.00
Plan Total:	**61**	**$12,397.50**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	13	$1,911.00	0	$0.00
397	3	$424.70	0	$0.00
398	6	$1,890.80	0	$0.00
403	11494	$1,663,293.38	3	$90.60
413	1601	$248,186.43	0	$0.00
418	6021	$1,805,153.20	0	$0.00
419	241	$32,353.90	0	$0.00
426	243	$35,161.20	0	$0.00
427	42	$5,056.60	0	$0.00
445	2	$340.20	0	$0.00
446	1	$127.50	0	$0.00
451	38	$5,105.60	0	$0.00
455	5	$915.30	0	$0.00
457	9	$3,034.50	0	$0.00
458	1	$170.10	0	$0.00
459	1	$340.20	0	$0.00
462	78	$11,370.40	0	$0.00
465	6	$933.80	0	$0.00
466	30	$9,044.00	0	$0.00
472	30	$4,301.00	0	$0.00
476	3	$393.00	0	$0.00
478	18	$5,903.20	0	$0.00
479	1	$144.60	0	$0.00
482	78	$12,867.20	0	$0.00
486	3	$427.10	0	$0.00
488	42	$13,245.80	0	$0.00
491	1	$148.50	0	$0.00
Plan Total:	**20,011**	**$3,862,243.21**	**3**	**$90.60**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 4/30/2022

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	294	$43,432.30	0	$0.00
613	85	$24,902.10	0	$0.00
Plan Total:	**379**	**$68,334.40**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1865	$277,078.70	1	$36.50
702	378	$57,721.32	0	$0.00
703	1230	$378,200.00	0	$0.00
704	95	$16,220.30	0	$0.00
705	37	$11,349.70	0	$0.00
Plan Total:	**3,605**	**$740,570.02**	**1**	**$36.50**
Grand Total:	**36,838**	**$7,289,911.77**	**8**	**$377.80**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 4/30/2022

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	7191	$1,070,688.09	2	$148.30
241	133	$19,537.70	0	$0.00
242	867	$135,220.60	0	$0.00
243	4266	$1,319,528.35	1	$59.40
244	15	$2,105.00	0	$0.00
245	60	$8,379.30	0	$0.00
246	18	$2,052.00	0	$0.00
247	149	$23,923.20	0	$0.00
248	11	$2,874.50	1	$43.00
249	55	$17,272.70	0	$0.00
250	17	$4,785.20	0	$0.00
Plan Total:	**12,782**	**$2,606,366.64**	**4**	**$250.70**
CIGNA - PREFERRED with RX				
321	31	$4,410.90	0	$0.00
322	5	$800.50	0	$0.00
324	21	$6,344.20	0	$0.00
327	2	$275.00	0	$0.00
329	2	$566.90	0	$0.00
Plan Total:	**61**	**$12,397.50**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	13	$1,911.00	0	$0.00
397	3	$424.70	0	$0.00
398	6	$1,890.80	0	$0.00
403	11494	$1,663,293.38	3	$90.60
413	1601	$248,186.43	0	$0.00
418	6021	$1,805,153.20	0	$0.00
419	241	$32,353.90	0	$0.00
426	243	$35,161.20	0	$0.00
427	42	$5,056.60	0	$0.00
445	2	$340.20	0	$0.00
446	1	$127.50	0	$0.00
451	38	$5,105.60	0	$0.00
455	5	$915.30	0	$0.00
457	9	$3,034.50	0	$0.00
458	1	$170.10	0	$0.00
459	1	$340.20	0	$0.00
462	78	$11,370.40	0	$0.00
465	6	$933.80	0	$0.00
466	30	$9,044.00	0	$0.00
472	30	$4,301.00	0	$0.00
476	3	$393.00	0	$0.00
478	18	$5,903.20	0	$0.00
479	1	$144.60	0	$0.00
482	78	$12,867.20	0	$0.00
486	3	$427.10	0	$0.00
488	42	$13,245.80	0	$0.00
491	1	$148.50	0	$0.00
Plan Total:	**20,011**	**$3,862,243.21**	**3**	**$90.60**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 4/30/2022

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	294	$43,432.30	0	$0.00
613	85	$24,902.10	0	$0.00
Plan Total:	**379**	**$68,334.40**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1865	$277,078.70	1	$36.50
702	378	$57,721.32	0	$0.00
703	1230	$378,200.00	0	$0.00
704	95	$16,220.30	0	$0.00
705	37	$11,349.70	0	$0.00
Plan Total:	**3,605**	**$740,570.02**	**1**	**$36.50**
LOCAL 1014				
804	180	$38,204.20	0	$0.00
805	201	$39,803.20	0	$0.00
806	659	$249,756.16	0	$0.00
807	48	$10,001.80	0	$0.00
808	17	$6,443.19	0	$0.00
812	253	$46,219.80	0	$0.00
813	2	$340.20	0	$0.00
Plan Total:	**1,360**	**$390,768.55**	**0**	**$0.00**
Grand Total:	**38,198**	**$7,680,680.32**	**8**	**$377.80**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	496	$438,002.72	$65,170.35	$373,715.44	$438,885.79	($5,298.42)	$433,587.37
202	262	$454,897.50	$38,891.92	$421,214.33	$460,106.25	($1,736.26)	$458,369.99
203	76	$150,866.10	$30,212.41	$114,775.79	$144,988.20	$0.00	$144,988.20
204	25	$28,365.75	$8,328.16	$21,172.22	$29,500.38	$0.00	$29,500.38
SUBTOTAL	**859**	**$1,072,132.07**	**$142,602.84**	**$930,877.78**	**$1,073,480.62**	**($7,034.68)**	**$1,066,445.94**
Anthem Blue Cross I							
211	613	$783,134.85	$47,726.62	$737,955.01	$785,681.63	($7,640.34)	$778,041.29
212	243	$559,994.64	$31,258.64	$526,440.94	$557,699.58	$0.00	$557,699.58
213	67	$181,373.02	$21,764.76	$173,143.56	$194,908.32	$0.00	$194,908.32
214	23	$38,744.19	$4,649.28	$37,463.97	$42,113.25	$0.00	$42,113.25
215	2	$861.78	$34.48	$827.30	$861.78	$0.00	$861.78
SUBTOTAL	**948**	**$1,564,108.48**	**$105,433.78**	**$1,475,830.78**	**$1,581,264.56**	**($7,640.34)**	**$1,573,624.22**
Anthem Blue Cross II							
221	2,281	$2,914,789.71	$159,733.98	$2,775,735.61	$2,935,469.59	($6,366.95)	$2,929,102.64
222	2,020	$4,677,332.28	$121,041.23	$4,448,423.23	$4,569,464.46	$1,273.39	$4,570,737.85
223	881	$2,390,333.98	$98,861.74	$2,305,006.54	$2,403,868.28	$8,121.18	$2,411,989.46
224	195	$328,483.35	$33,589.43	$306,685.63	$340,275.06	$8,422.65	$348,697.71
SUBTOTAL	**5,377**	**$10,310,939.32**	**$413,226.38**	**$9,835,851.01**	**$10,249,077.39**	**$11,450.27**	**$10,260,527.66**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	7,223	$3,751,391.16	$521,469.36	$3,265,267.86	$3,786,737.22	($15,457.11)	$3,771,280.11
241	133	$222,122.42	$21,880.69	$203,556.99	$225,437.68	$0.00	$225,437.68
242	866	$1,455,399.14	$89,346.38	$1,332,388.26	$1,421,734.64	($0.08)	$1,421,734.56
243	4,284	$4,427,363.14	$488,195.76	$3,943,370.59	$4,431,566.35	($14,179.82)	$4,417,386.53
244	15	$13,931.40	$2,024.69	$11,906.71	$13,931.40	$0.00	$13,931.40
245	59	$56,654.36	$6,445.56	$57,585.24	$64,030.80	$0.00	$64,030.80
246	17	$37,209.24	$3,100.77	$27,906.93	$31,007.70	$0.00	$31,007.70
247	152	$314,211.36	$17,033.55	$293,043.45	$310,077.00	$0.00	$310,077.00
248	11	$15,859.03	$1,124.55	$14,734.48	$15,859.03	$0.00	$15,859.03
249	57	$82,178.61	$6,401.27	$72,893.88	$79,295.15	$0.00	$79,295.15
250	17	$27,465.88	$840.13	$26,625.75	$27,465.88	$0.00	$27,465.88
SUBTOTAL	**12,834**	**$10,403,785.74**	**$1,157,862.71**	**$9,249,280.14**	**$10,407,142.85**	**($29,637.01)**	**$10,377,505.84**
CIGNA Network Model Plan							
301	250	$413,952.50	$107,040.04	$306,912.46	$413,952.50	($3,311.62)	$410,640.88
302	71	$215,215.20	$52,163.09	$157,073.91	$209,237.00	$0.00	$209,237.00
303	6	$21,176.94	$5,790.53	$11,856.92	$17,647.45	$0.00	$17,647.45
304	12	$26,363.04	$12,347.73	$14,015.31	$26,363.04	$0.00	$26,363.04
SUBTOTAL	**339**	**$676,707.68**	**$177,341.39**	**$489,858.60**	**$667,199.99**	**($3,311.62)**	**$663,888.37**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
CIGNA Preferred w/ Rx - Phoenix, AZ							
321	31	$11,919.19	$1,445.69	$10,473.50	$11,919.19	$0.00	$11,919.19
322	5	$8,588.90	$687.11	$7,901.79	$8,588.90	$0.00	$8,588.90
324	21	$15,980.58	$2,222.07	$13,758.51	$15,980.58	$0.00	$15,980.58
327	2	$4,517.70	$451.77	$4,065.93	$4,517.70	$0.00	$4,517.70
329	2	$2,685.82	$0.00	$2,685.82	$2,685.82	$0.00	$2,685.82
SUBTOTAL	**61**	**$43,692.19**	**$4,806.64**	**$38,885.55**	**$43,692.19**	**$0.00**	**$43,692.19**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,537	$1,816,005.24	$155,346.05	$1,688,814.31	$1,844,160.36	$1,173.13	$1,845,333.49
403	11,500	$3,028,179.60	$285,547.20	$2,741,313.41	$3,026,860.61	($9,426.54)	$3,017,434.07
404	528	$622,828.73	$14,457.97	$596,596.50	$611,054.47	($2,354.74)	$608,699.73
405	1,228	$1,446,360.94	$19,465.23	$1,428,072.57	$1,447,537.80	($3,259.54)	$1,444,278.26
411	1,855	$4,363,193.16	$197,348.60	$4,203,256.72	$4,400,605.32	$4,676.52	$4,405,281.84
413	1,599	$2,301,702.61	$111,761.79	$2,170,815.58	$2,282,577.37	($2,853.94)	$2,279,723.43
414	79	$187,400.00	$2,436.20	$208,218.80	$210,655.00	($2,342.50)	$208,312.50
418	5,991	$3,112,644.48	$227,311.59	$2,833,144.61	$3,060,456.20	($6,188.16)	$3,054,268.04
419	241	$347,784.03	$4,321.47	$341,489.62	$345,811.09	($1,431.21)	$344,379.88
420	116	$272,221.84	$1,126.44	$271,095.40	$272,221.84	$0.00	$272,221.84
421	10	$11,731.30	$1,783.16	$12,294.40	$14,077.56	$0.00	$14,077.56
422	258	$604,233.42	$2,716.72	$603,858.69	$606,575.41	$0.00	$606,575.41
423	4	$9,370.00	$0.00	$9,370.00	$9,370.00	$0.00	$9,370.00
426	241	$349,090.80	$2,632.51	$312,163.01	$314,795.52	$0.00	$314,795.52
427	40	$60,110.82	$1,373.97	$50,149.59	$51,523.56	$0.00	$51,523.56
428	49	$114,965.27	$844.65	$114,120.62	$114,965.27	($2,346.23)	$112,619.04
429	3	$7,040.22	$0.00	$7,040.22	$7,040.22	$0.00	$7,040.22
430	150	$351,858.00	$3,800.07	$348,057.93	$351,858.00	$0.00	$351,858.00
431	4	$9,384.92	$0.00	$9,384.92	$9,384.92	($2,346.23)	$7,038.69
SUBTOTAL	**25,433**	**$19,016,105.38**	**$1,032,273.62**	**$17,949,256.90**	**$18,981,530.52**	**($26,699.44)**	**$18,954,831.08**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Colorado							
450	4	$4,112.68	$781.41	$3,331.27	$4,112.68	$0.00	$4,112.68
451	37	$11,664.48	$1,362.91	$9,994.61	$11,357.52	$0.00	$11,357.52
453	8	$18,183.12	$0.00	$18,183.12	$18,183.12	$0.00	$18,183.12
454	1	$3,068.62	$361.56	$2,707.06	$3,068.62	$0.00	$3,068.62
455	5	$6,635.65	$0.00	$6,635.65	$6,635.65	$0.00	$6,635.65
457	9	$5,453.28	$1,272.44	$4,180.84	$5,453.28	$0.00	$5,453.28
458	1	$2,287.97	$0.00	$2,287.97	$2,287.97	$0.00	$2,287.97
459	1	$1,626.09	$65.04	$1,561.05	$1,626.09	$0.00	$1,626.09
SUBTOTAL	**66**	**$53,031.89**	**$3,843.36**	**$48,881.57**	**$52,724.93**	**$0.00**	**$52,724.93**
Kaiser - Georgia							
441	3	$3,396.99	$0.00	$3,396.99	$3,396.99	$0.00	$3,396.99
442	7	$7,926.31	$0.00	$7,926.31	$7,926.31	$0.00	$7,926.31
445	2	$3,095.60	$0.00	$3,095.60	$3,095.60	$0.00	$3,095.60
446	1	$3,095.60	$0.00	($3,095.60)	($3,095.60)	$0.00	($3,095.60)
461	13	$14,720.29	$1,381.43	$12,206.53	$13,587.96	$0.00	$13,587.96
462	77	$33,030.66	$4,641.22	$27,542.50	$32,183.72	($1,270.41)	$30,913.31
463	2	$4,513.34	$1,128.33	$3,385.01	$4,513.34	$0.00	$4,513.34
465	6	$9,286.80	$928.68	$8,358.12	$9,286.80	$0.00	$9,286.80
466	29	$25,168.20	$838.94	$24,329.26	$25,168.20	$0.00	$25,168.20
SUBTOTAL	**140**	**$104,233.79**	**$8,918.60**	**$87,144.72**	**$96,063.32**	**($1,270.41)**	**$94,792.91**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Hawaii							
471	6	$5,649.66	$0.00	$7,532.88	$7,532.88	$0.00	$7,532.88
472	29	$14,062.80	$2,137.54	$10,518.98	$12,656.52	$468.76	$13,125.28
473	1	$1,819.99	$546.60	$1,273.39	$1,819.99	$0.00	$1,819.99
474	4	$7,500.92	$0.00	$5,625.69	$5,625.69	$0.00	$5,625.69
475	2	$5,617.68	$203.56	$5,414.12	$5,617.68	$0.00	$5,617.68
476	3	$4,207.11	$1,935.26	$2,271.85	$4,207.11	$0.00	$4,207.11
477	1	$2,753.60	$458.54	$2,295.06	$2,753.60	$0.00	$2,753.60
478	18	$16,731.36	$2,268.04	$14,463.32	$16,731.36	$0.00	$16,731.36
479	1	$2,280.75	$0.00	$2,280.75	$2,280.75	$0.00	$2,280.75
SUBTOTAL	**65**	**$60,623.87**	**$7,549.54**	**$51,676.04**	**$59,225.58**	**$468.76**	**$59,694.34**
Kaiser - Oregon							
481	4	$4,618.64	$854.45	$3,764.19	$4,618.64	$0.00	$4,618.64
482	78	$37,390.08	$6,557.62	$30,832.46	$37,390.08	($489.96)	$36,900.12
483	1	$1,347.32	$73.93	$1,273.39	$1,347.32	$0.00	$1,347.32
484	4	$9,205.28	$300.44	$8,904.84	$9,205.28	$0.00	$9,205.28
486	3	$4,878.06	$650.41	$4,227.65	$4,878.06	$0.00	$4,878.06
488	42	$39,930.24	$5,457.16	$34,473.08	$39,930.24	$0.00	$39,930.24
489	1	$1,096.82	$0.00	$1,096.82	$1,096.82	$0.00	$1,096.82
491	1	$1,568.18	$0.00	$1,568.18	$1,568.18	$0.00	$1,568.18
498	2	$4,987.96	$397.84	$4,590.12	$4,987.96	$0.00	$4,987.96
SUBTOTAL	**136**	**$105,022.58**	**$14,291.85**	**$90,730.73**	**$105,022.58**	**($489.96)**	**$104,532.62**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
SCAN Health Plan							
611	290	$83,378.40	$17,271.30	$64,405.50	$81,676.80	$0.00	$81,676.80
613	83	$48,091.20	$7,403.82	$35,095.38	$42,499.20	$0.00	$42,499.20
SUBTOTAL	**373**	**$131,469.60**	**$24,675.12**	**$99,500.88**	**$124,176.00**	**$0.00**	**$124,176.00**
UHC Medicare Adv.							
701	1,860	$632,189.55	$72,812.67	$553,148.23	$625,960.90	($4,710.30)	$621,250.60
702	372	$608,281.74	$30,461.91	$569,837.13	$600,299.04	$0.00	$600,299.04
703	1,224	$819,821.70	$81,423.57	$735,738.23	$817,161.80	($1,329.80)	$815,832.00
704	99	$181,361.00	$11,498.28	$173,489.94	$184,988.22	$0.00	$184,988.22
705	37	$32,632.89	$2,046.17	$30,586.72	$32,632.89	$0.00	$32,632.89
706	1	$362.92	$14.52	$348.40	$362.92	$0.00	$362.92
SUBTOTAL	**3,593**	**$2,274,649.80**	**$198,257.12**	**$2,063,148.65**	**$2,261,405.77**	**($6,040.10)**	**$2,255,365.67**
United Healthcare							
707	498	$640,385.45	$54,756.01	$603,382.70	$658,138.71	$1,268.09	$659,406.80
708	469	$1,097,509.08	$54,493.16	$1,059,262.05	$1,113,755.21	$0.00	$1,113,755.21
709	366	$1,012,997.25	$58,573.90	$948,932.85	$1,007,506.75	($38.19)	$1,007,468.56
SUBTOTAL	**1,333**	**$2,750,891.78**	**$167,823.07**	**$2,611,577.60**	**$2,779,400.67**	**$1,229.90**	**$2,780,630.57**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	74	$91,318.22	$3,504.63	$85,345.53	$88,850.16	$0.00	$88,850.16
802	323	$718,684.69	$20,292.23	$702,842.52	$723,134.75	($2,225.03)	$720,909.72
803	343	$900,251.52	$25,249.05	$869,753.19	$895,002.24	$0.00	$895,002.24
804	182	$224,593.46	$5,306.30	$257,455.02	$262,761.32	($41,363.32)	$221,398.00
805	201	$447,231.03	$11,125.12	$436,105.91	$447,231.03	($39,803.20)	$407,427.83
806	661	$1,470,744.83	$36,134.36	$1,356,891.49	$1,393,025.85	($254,206.22)	$1,138,819.63
807	48	$125,982.72	$629.92	$127,977.44	$128,607.36	($10,001.80)	$118,605.56
808	17	$44,618.88	$209.97	$44,408.91	$44,618.88	($6,443.19)	$38,175.69
809	25	$30,850.75	$3,899.52	$26,951.23	$30,850.75	$0.00	$30,850.75
810	12	$26,700.36	$2,981.53	($15,305.04)	($12,323.51)	$0.00	($12,323.51)
811	1	$2,624.64	$0.00	$2,624.64	$2,624.64	$0.00	$2,624.64
812	253	$312,209.59	$22,928.14	$291,749.51	$314,677.65	($48,687.86)	$265,989.79
813	2	$4,450.06	$0.00	$4,450.06	$4,450.06	($340.20)	$4,109.86
SUBTOTAL	**2,142**	**$4,400,260.75**	**$132,260.77**	**$4,191,250.41**	**$4,323,511.18**	**($403,070.82)**	**$3,920,440.36**
Kaiser - Washington							
393	6	$7,454.04	$596.32	$6,857.72	$7,454.04	$0.00	$7,454.04
394	13	$5,664.10	$1,089.25	$4,574.85	$5,664.10	$0.00	$5,664.10
395	3	$9,252.00	$293.35	$2,019.65	$2,313.00	$0.00	$2,313.00
396	1	$3,867.64	$1,160.58	$2,707.06	$3,867.64	$0.00	$3,867.64
397	3	$4,519.08	$0.00	$4,519.08	$4,519.08	$0.00	$4,519.08
398	6	$5,180.40	$1,001.54	$4,178.86	$5,180.40	$0.00	$5,180.40
SUBTOTAL	**32**	**$35,937.26**	**$4,141.04**	**$24,857.22**	**$28,998.26**	**$0.00**	**$28,998.26**
Medical Plan Total	**53,731**	**$53,003,592.18**	**$3,595,307.83**	**$49,238,608.58**	**$52,833,916.41**	**($472,045.45)**	**$52,361,870.96**

Medical and Dental Vision Insurance Premiums
May 2022

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	25,429	$1,307,967.76	$140,079.58	$1,184,391.28	$1,324,470.86	($3,865.02)	$1,320,605.84
502	23,620	$2,529,451.82	$192,969.85	$2,337,251.00	$2,530,220.85	($2,193.16)	$2,528,027.69
503	10	$632.20	$73.36	$685.28	$758.64	$0.00	$758.64
SUBTOTAL	**49,059**	**$3,838,051.78**	**$333,122.79**	**$3,522,327.56**	**$3,855,450.35**	**($6,058.18)**	**$3,849,392.17**
CIGNA Dental HMO/Vision							
901	3,669	$170,270.64	$20,140.55	$152,309.48	$172,450.03	($927.40)	$171,522.63
902	2,717	$258,738.75	$20,218.36	$241,938.67	$262,157.03	$0.00	$262,157.03
903	2	$93.82	$20.64	$73.18	$93.82	$0.00	$93.82
SUBTOTAL	**6,388**	**$429,103.21**	**$40,379.55**	**$394,321.33**	**$434,700.88**	**($927.40)**	**$433,773.48**
Dental/Vision Plan Total	**55,447**	**$4,267,154.99**	**$373,502.34**	**$3,916,648.89**	**$4,290,151.23**	**($6,985.58)**	**$4,283,165.65**
GRAND TOTALS	**109,178**	**$57,270,747.17**	**$3,968,810.17**	**$53,155,257.47**	**$57,124,067.64**	**($479,031.03)**	**$56,645,036.61**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Anthem Blue Cross Prudent Buyer Plan		
$630.26	201	Retiree Only
$1,239.88	202	Retiree and Spouse/Domestic Partner
$1,399.26	203	Retiree, Spouse/Domestic Partner and Children
$810.01	204	Retiree and Children
$172.06	205	Survivor Children Only Rates
Anthem Blue Cross Plan I		
$904.25	211	Retiree Only
$1,630.31	212	Retiree and Spouse/Domestic Partner
$1,923.10	213	Retiree, Spouse/Domestic Partner and Children
$1,196.44	214	Retiree and Children
$299.58	215	Survivor Children Only Rates
Anthem Blue Cross Plan II		
$904.25	221	Retiree Only
$1,630.31	222	Retiree and Spouse/Domestic Partner
$1,923.10	223	Retiree, Spouse/Domestic Partner and Children
$1,196.44	224	Retiree and Children
$299.58	225	Survivor Children Only Rates
Anthem Blue Cross Plan III		
$365.20	240	Retiree Only with Medicare
$1,167.61	241	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross I)
$1,167.61	242	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross II)
$726.87	243	Retiree and Spouse/Domestic Partner - Both with Medicare
$653.93	244	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross I)
$653.93	245	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross II)
$1,456.25	246	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross I)
$1,456.25	247	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross II)
$1,015.45	248	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross I)
$1,015.45	249	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross II)
$1,138.02	250	Member, Spouse/Domestic Partner, Child (3 with Medicare)

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
CIGNA Network Model Plan		
$1,143.49	301	Retiree Only
$2,064.71	302	Retiree and Spouse/Domestic Partner
$2,438.35	303	Retiree, Spouse/Domestic Partner and Children
$1,517.57	304	Retiree and Children
$378.87	305	Survivor Children Only Rates
CIGNA Medicare Select Plus Rx (Available in the Phoenix, AZ area only)		
$328.00	321	Retiree Only with Medicare
$1,249.22	322	Retiree and Spouse/Domestic Partner/Domestic Partner - One with Medicare
$651.00	324	Retiree and Spouse/Domestic Partner -Both with Medicare
$702.09	325	Retiree and Children
$1,622.87	327	Retiree, Spouse/Domestic Partner and Children - One with Medicare
$1,025.09	329	Retiree, Spouse/Domestic Partner and Children - Two with Medicare
Kaiser		
$774.10	401	Retiree Only ("Basic")
N/A	402	Retiree Only ("Supplement")
$235.64	403	Retiree Only ("Senior Advantage")
$894.95	404	Retiree Only ("Excess I")
$795.39	405	Retiree Only - ("Excess II")
$1,408.39	406	Retiree Only ("Excess III")
$1,543.20	411	Retiree and Family (All family members are "Basic")
N/A	412	Retiree and Family (One family member is "Supplement"; others are "Basic")
$1,004.74	413	Retiree and Family (One family member is "Senior Advantage"; others are "Basic")
$1,664.05	414	Retiree and Family (One family member is "Excess I"; others are "Basic")
N/A	415	Retiree and Family (Two or more family members are "Supplement")
N/A	416	Retiree and Family (One family member is "Senior Advantage"; others are "Supplement")
N/A	417	Retiree and Family (One family member is "Excess I"; others are "Supplement")
$466.28	418	Retiree and Family (Two or more family members are "Senior Advantage")
$1,125.59	419	Retiree and Family (One family member is "Excess I"; others are "Senior Advantage"
$1,784.90	420	Retiree and Family (Two or more family members are "Excess I")
N/A	421	Survivor Children Only Rates
$1,564.49	422	Retiree and Family (One family member is "Excess II"; others are "Basic")
$2,177.49	423	Retiree and Family (One family member is "Excess III"; others are "Basic")

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser (continued)		
N/A	424	Retiree and Family (One family member is "Supplement'; others are "Excess II")
N/A	425	Retiree and Family (One family member is "Supplement"; others are "Excess III")
$1,026.03	426	Retiree and Family (One family member is "Senior Advantage"; others are "Excess II")
$1,639.03	427	Retiree and Family (One family member is "Senior Advantage; others are "Excess III")
$1,685.34	428	Retiree and Family (One family member is "Excess I"; others are "Excess II")
$2,298.34	429	Retiree and Family One family member is "Excess I"; others are "Excess III")
$1,585.78	430	Retiree and Family (Two or more family members are "Excess II")
$2,198.78	431	Retiree and Family (One family member is "Excess II"; others are "Excess III")
$2,811.78	432	Retiree and Family (Two or more family members are "Excess III")
Kaiser Colorado		
$793.06	450	Retiree Only ("Basic" under age 65)
$327.27	451	Retiree Only ("Senior Advantage")
$1,754.57	453	Retiree and Family (Two family members are "Basic")
$2,369.25	454	Retiree and Family (Three or more family members are "Basic")
$1,115.33	455	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic")
$649.55	457	Retiree and Family (Two family members are "Senior Advantage")
$1,857.56	458	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$1,437.60	459	Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic")
Kaiser Georgia		
$847.24	440	Retiree Only ("Basic" over age 65 with Medicare Part B only
$847.24	441	Retiree Only ("Basic over age 65 with Medicare Part A only)
$847.24	442	Retiree Only ("Basic over age 65 without Medicare Part A or Medicare Part B)
$361.11	443	Retiree Only ("Basic" over age 65 - Medicare eligible who is classified as having renal failure)
$1,203.35	444	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part B only)
$1,203.35	445	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part A only)
$1,203.35	446	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 without Medicare Part A and B)
$847.24	461	Retiree Only ("Basic" under age 65)
$361.11	462	Retiree Only ("Senior Advantage")

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser Georgia (continued)		
$1,689.48	463	Retiree and Family (Two family members are "Basic")
$2,531.72	464	Retiree and Family (Three or more family members are "Basic)
$1,203.35	465	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$717.22	466	Retiree and Family (Two family members are "Senior Advantage")
$2,045.59	467	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$1,559.46	468	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
$1,915.57	469	Retiree and Family (Three or more family members are "Senior Advantage"; one is "Basic")
$2,045.59	470	Retiree and Family (Three or more family members are "Basic"; one is "Senior Advantage"
Kaiser Hawaii		
$795.16	471	Retiree Only ("Basic" under age 65)
$346.45	472	Retiree Only ("Senior Advantage")
$1,381.42	473	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$1,585.31	474	Retiree and Family (Two family members are "Basic")
$2,375.47	475	Retiree and Family (Three or more family members are "Basic")
$1,136.61	476	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$2,171.58	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)
$687.90	478	Retiree and Family (Two family members are "Senior Advantage"
$1,722.87	479	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)
Kaiser Oregon		
$806.67	481	Retiree Only ("Basic" under age 65)
$465.92	482	Retiree Only ("Senior Advantage")
$1,205.27	483	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$1,608.34	484	Retiree and Family (Two family members are "Basic")
$2,410.01	485	Retiree and Family (Three or more family members are "Basic")
$1,267.59	486	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
N/A	487	Retiree Only (Medicare Cost "Supplement" program)
$926.84	488	Retiree and Family (Two family members are "Senior Advantage")
$1,110.84	489	Retiree Only (Over age 65 with Medicare Part A only)
$1,205.27	490	Retiree Only (Over age 65 with Medicare Part B only)

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

Kaiser Oregon (continued)

$1,571.76	491	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 with Medicare Par A only)
$1,666.19	492	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)
$2,069.26	493	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$1,728.51	494	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
$2,405.54	495	Retiree and Family (Two family members are over age 65 without Medicare Part A or Medicare Part B)
$2,216.68	496	Retiree and Family (Two family members are over age 65 with Medicare Part A only)
$2,216.68	497	Retiree and Family (One family member is "Basic"; one is over age 65 with Medicare Part A only)
$2,006.94	498	Retiree and Family (One family member is "Basic"; one is over age 65 without Medicare Part A or Medicare Part B)

Kaiser Rate Category Definitions

"Basic" - includes those who are under age 65

Medicare Cost ("Supplement")

-Includes people who have both Part A and Part B of Medicare, who were enrolled in Kaiser's Medicare supplement ("M" coverage) before July 1, 1987, and who chose to stay in that Kaiser arrangement.
-It is not open to new enrollments.
-People who have left it cannot return to it.

"Senior Advantage"

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

"Excess I"

-Is for participants who have Medicare Part A only.

"Excess II"

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

"Excess III"

-Is for participants in the Excess Plan who either have Medicare Parts A and B and have not assigned their Medicare benefits to Kaiser or have not provided their Medicare status to LACERA. Premium is above the Anthem Blue Cross I and II Benchmark rate.
and II Benchmark.

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

SCAN Health Plan

$304.00	611	Retiree Only with SCAN
$603.00	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.)

United Healthcare Medicare Advantage (UHCMA)

(For both members and dependents who are enrolled in UHCMA, or a family combination of UHCMA/UHC)

$293.62	701	Retiree Only with Secure Horizons
$1,203.81	702	Retiree and 1 Dependent - One with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$582.24	703	Retiree and 1 Dependent - Both with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$1,360.59	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)
$739.02	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)
$261.24	706	Survivor Children Only Rates

United Healthcare (UHC)

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

$915.18	707	Retiree Only
$1,671.68	708	Retiree and 1 Dependent
$1,982.16	709	Retiree and 2 Or More Dependents

Local 1014 Firefighters

$914.03	801	Member Under 65
$1,648.06	802	Member + 1 Under 65
$1,944.04	803	Member + 2 Under 65
$914.03	804	Member with Medicare
$1,648.06	805	Member + 1; 1 Medicare
$1,648.06	806	Member + 1; 2 Medicare
$1,944.04	807	Member + 2; 1 Medicare
$1,944.04	808	Member + 2; 2 Medicare

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Local 1014 Firefighters (continued)		
$914.03	809	Surviving Spouse Under 65
$1,648.06	810	Surviving Spouse + 1; Under 65
$1,944.04	811	Surviving Spouse + 2 Under 65
$914.03	812	Surviving Spouse with Medicare
$1,648.06	813	Surviving Spouse + 1; 1 Medicare
$1,944.04	814	Spouse + 1; 1 Medicare
$1,648.06	815	Surviving Spouse + 1; 2 Medicare
CIGNA Indemnity - Dental/Vision		
$46.55	501	Retiree Only
$99.61	502	Retiree and Dependent(s)
$57.81	503	Survivor Children Only Rates
CIGNA HMO - Dental/Vision		
$39.02	901	Retiree Only
$81.07	902	Retiree and Dependent(s)
$39.56	903	Survivor Children Only Rates

***Benchmark premiums are bolded.**

Los Angeles County Employees Retirement Association

Group Dental and Medical Benefits - Audit Results

Audit Period: July 1, 2020 through June 30, 2021

May 5, 2022/ Amber M. Turner, MBA, PMP

Segal

Agenda

Cigna Dental Audit - Overview

- Results
- Key Findings

Anthem Medical Audit - Overview

- Statistical Results
- Target Results
- Key Findings
- Additional Errors and Plan Intent Findings
- LACERA– Follow-up Items

Cigna Dental Audit - Overview

- Cigna provided data files for all dental claims processed and paid during the 12-month audit period of July 1, 2020 through June 30, 2021, representing $32,227,920.93 in benefit payments. The objective of the review was to ensure claims were paid in accordance with LACERA's plan provisions, including the following components:
  - An Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures; and,
  - A random, stratified sample of 225 claims, which represented total of $92,730.52 (0.28% of total payments), were sampled providing statistical validity in processing accuracy levels with comparison to performance guarantees and industry standards.

- The auditors completed an electronic form for each sampled claim; this worksheet served as the primary documentation on which the report is based upon. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets". These worksheets (1–225) are further distinguished with an alphabetic character (A-I) that identifies the respective payment tier in the statistical analysis. The auditors reviewed each claim from receipt to release for check disbursement in order to identify any variances in procedures and benefit determination. Given the current pandemic, Segal conducted the audit remotely through virtual system access.

Cigna Dental Audit - Results

The sample of 225 random, statistical claims identified three (3) errors. Two (2) underpayments totaling -$3.20 and one (1) overpayment in the amount of $1,580.00. Cigna surpassed the performance guarantee standards for the audit period in all the categories (Financial, Payment, Overall, and Time-to-Process).

Results of the statistical achievements are as follows:

Category	Statistical Achievement	Performance Guarantees	Industry Standard
Financial Accuracy (dollar value)	99.98%	99.00%	99.00%
Payment Accuracy (free from financial error)	98.89%	95.00%	95.00%
Procedural Accuracy (free from processing error)	100.00%	N/A	97.00%
Overall Processing Accuracy (free from error)	98.89%	97.00%	95.00%
Time-to-Process[1] (within 10 business days)	95.81%	93.00%	95.00%

*The electronic calculation, based on 14 calendar days, supports achievement in time-to-process goals.

- N/A= Not Applicable

Cigna Dental Audit – Key Findings

The Key Findings for the Cigna Dental Audit are as follows:

- Coinsurance application applied to two (2) claims at 20% for code D1999 for personal protective equipment. **(Amount Underpaid: -$3.20)**
  - Cigna agreed with Segal on this findings and generated a financial impact report and noted 3,019 claims were affected in the amount of -$4,830.40. As of January 5, 2022 these claims were adjusted.

- Cigna processed a claim as primary when the spouse had other insurance. **(Amount Overpaid: $1,580.00)**
  - Cigna agreed with Segal on this finding and noted that the claim was sent for third-party liability adjustment on November 15, 2021.

Anthem Medical Audit - Overview

- Anthem provided data files for all medical claims processed and paid during the 12-month audit period of July 1, 2020 through June 30, 2021, representing $125,592,492.60 in benefit payments. The objective of the review was to ensure claims were paid in accordance with LACERA's plan provisions, including the following components:
  - An Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures; and,
  - A random, stratified sample of 220 claims, which represented total of $4,417,216.96 (3.51% of total payments), were sampled providing statistical validity in processing accuracy levels with comparison to performance guarantees and industry standards.
  - A target sample of 35 claims, which represented total of $59,123.07 (0.04% of total payments), identified through an electronic analyses of all claims designed to explore potential duplicate payments and/or sample various benefit applications (i.e., deductibles, employee cost-shares, limitations, and exclusions).

- The auditors completed an electronic form for each sampled claim; this worksheet served as the primary documentation on which the report is based upon. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets". These worksheets (1–220) are further distinguished with an alphabetic character (A-K) that identifies the respective payment tier in the statistical analysis. Worksheets T1–T35 include a "T" to distinguish the "target" sampling of claims identified through electronic analyses. The auditors reviewed each claim from receipt to release for check disbursement in order to identify any variances in procedures and benefit determination. Given the current pandemic, Segal conducted the audit remotely through virtual system access.

Anthem Medical Audit – Statistical Results

The sample of 220 random, statistical claims identified four (4) errors. Two (2) overpayments totaling $39,850.35 and two (2) underpayments in the amount of -$1,151.92. , Anthem surpassed the performance guarantee standard in the Time-to-Process and Procedural Accuracy categories but failed to meet the performance guarantee in the category of Financial Accuracy through this audit. Results of the statistical achievements are as follows:

Category	Statistical Achievement	Performance Guarantee	Industry Standards
Financial Accuracy (dollar value)	96.05%	99.00%	99.00%
Payment Accuracy (free from financial error)	98.86%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (free from error)	98.86%	N/A	95.00%
Time-to-Process* (within 14 calendar days)	95.54%	90.00%	95.00%
(within 30 calendar days)	98.57%	N/A	100.00%

*The electronic calculation, based on 14 calendar days, supports achievement in time-to-process goals.

- N/A= Not Applicable

Anthem Medical Audit – Statistical Results (cont.)

- In addition to the four errors, nine (9) out-of-sample (OOS) errors were identified. The nine (9) errors included one (1) overpayment for $39,850.35, three (3) underpayments totaling -$5.67, and five (5) procedural errors. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

Anthem Medical Audit – Target Results

Due to the nature of target sampling, these results are not included within the statistical achievement calculations.

- Review of the target sample of 35 medical claims in the 12-month audit period of July 1, 2020, through June 30, 2021, identified fourteen (14) in-sample overpayment errors totaling $12,125.77.

- In addition to the 14 overpayment errors, nine (9) out-of-sample (OOS) errors were identified. The nine (9) errors included one (1) overpayment for $39,850.35, three (3) underpayments totaling -$5.67, and five (5) procedural errors. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history

Anthem Medical Audit – Key Findings

- The individual deductibles were over applied but the out-of-pocket maximum was not met on 5 claims. The individual deductibles were over applied but the out-of-pocket maximum was met on 4 claims. (Samples: 9 claims, Error Type: 5 Procedurals, Amount Underpaid on 4 claims: -$14.80)
  - *Anthem agreed to these errors during the remote review.*
  - **As this is a reoccurring error every year, Segal recommends that LACERA monitor the situation as this error has the potential to cause members to incur higher out-of-pocket expenses.**

- The Incorrect coordination of benefits with Medicare led to underpayments. (2 claims, Amount Underpaid: -$1,151.92)
  - *Anthem agreed to these errors during the remote review and has adjusted these claims.*

- A claim for workers compensation was paid. (1 claim, Amount Overpaid: $612.00)
  - *Anthem noted that an investigation into this claim was initiated.*
  - **Segal recommends that LACERA monitor the workers compensation claims progress.**

Anthem Medical Audit – Key Findings (cont.)

- Claims were paid for a terminated member. (1 Sample Claim, Amount Overpaid: $29,820.00, Amount Overpaid OOS: $39,850.35)
  - *Anthem disagrees with the error assessed. Anthem paid with the eligibility information on file at the time of processing. Anthem received the termination request on April 29, 2021. Claims incurred within 60 days of the termination notification are eligible for adjustment. The incurred date is beyond 60 days of the notification; therefore, the claim is not eligible for adjustment.*

  –**Segal upholds this error and recommends that LACERA discuss with Anthem termination timelines.**

- Three (3) claims for acupuncture were paid over $30.00 in-network and one (1) claim did not apply 50% coinsurance out-of-network. (4 claims, Amount Overpaid: $1,016.61)
  - *Anthem agreed to these errors during the remote review and adjusted the claims.*

Anthem Medical Audit – Key Findings (cont.)

- Three (3) orthotic claims were paid for diagnosis other than diabetes. (3 claims, Total Overpaid: $1,246.11)
  - *Anthem disagreed and noted Per the benefit plan design, the diagnosis codes M79671 (pain in right foot) and M79672 (pain in left foot) are not listed as an exclusion. Foot orthotics are covered for diabetes but are not limited to the diabetes diagnosis. If this is not the benefit intent of LACERA, Anthem's account manager is available to discuss.*
    - *Segal recommends that LACERA review its benefit intent with Anthem to ensure accurate benefit exclusions are applied.*
- Hearing aids on three (3) claims were paid over the amount of $300.00. (3 claims, Total Overpaid: $6,850.00)
  - *Anthem agreed to these errors during the remote review and adjusted the claims.*
- Five (5) duplicate claims were paid. (5 claims, Total Overpaid: $3,013.05)
  - *Anthem agreed to these errors during the remote review and adjusted the claims.*

LACERA Audit – Follow-up Items

- Individual deductible and out-of-pocket maximums exceeding the maximum.
  - As this is a reoccurring error every year, Segal recommends that LACERA monitor the situation as this error has the potential to cause members to incur higher out-of-pocket expenses.
- Workers Compensation claim paid.
  - Segal recommends that LACERA monitor the workers compensation claims progress.
- Terminated members claim timelines.
  - Segal upholds this error and recommends that LACERA discuss with Anthem termination timelines.

Los Angeles County Employee Retirement Association

Analysis of Anthem Blue Cross Medical Claims Processing and Payment Procedures

Audit Period: July 1, 2020, through June 30, 2021
Final Report

April 6, 2022 / Amber M. Turner, MBA, PMP

Segal

Anthem Medical Claims Audit – Final Report

Section I – Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Anthem Blue Cross (Anthem) in its administration of the Los Angeles County Employee Retirement Association (LACERA) group medical benefits. Amber Turner and Jennifer Lagua of Segal's Benefit Audit Solutions Practice conducted the remote audit during the week of November 8, 2021. The audit was conducted via remote system access to Anthem's WGS system. The audit encompassed a review of a total of two hundred and fifty-five (255) sample claims (220 statistical claims and 35 target claims) for the audit period of July 1, 2020, through June 30, 2021. $4,476,340.03 ($4,417,216.96 for the random, statistical claim sample and $59,123.07 for the target claim sample), or 3.56% by cost, of the total $125,592,482.60 paid claims for the audit period were evaluated.

Scope of Services

Anthem provided an electronic data file of all medical claims processed and paid during the 12-month period of July 1, 2020, through June 30, 2021. The objective of the review was to ensure that claims that were paid in accordance with LACERA's plan provisions. Segal's audit included the following in-house and remote review components:

- An adjudication procedures review to assess day-to-day processing guidelines and claim control measures;
- A random, stratified sample of 220 statistical medical claims to measure validity in the financial dollar value and incidence (number) accuracy of all benefit payments processed during the audit period; and,
- A target sample of 35 claims identified through an electronic analyses of all claims designed to explore potential duplicate payments and/or sample various benefit applications (i.e., deductibles, employee cost-shares, limitations, and exclusions).
- Time-to-Process achievement was measured from the date a claim is first received to the initial date processed for payment or denial for all claims for the audit period of July 1, 2020, through June 30, 2021.

The auditors completed a form for each sampled claim serving as the primary documentation on which the report is based. To maintain patient confidentiality, claims addressed within this report are referred to as "Worksheets". These worksheets (1–220) are further distinguished with an alphabet character (A-K) that identifies the respective payment tier in the statistical analysis. The auditors reviewed each claim from receipt to release for check disbursement to identify any variances in procedures and benefit determination.

Worksheets T1–T35 include a "T" to distinguish the "target" sampling of claims identified through electronic analyses. These claims were reviewed for the attribute selected for validation (i.e., copayment application, duplicate payment, benefit provision, etc.). Due to the focused review and

selection of these claims, they are excluded from the overall calculation of processing performance.

Random, Stratified Statistical Results

Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third-party administrators (TPAs) nationwide. Standards include acceptable performance levels for administration of fully-insured, self-insured, corporate, public, and multiemployer plan benefits.

During the 12-month audit period of July 1, 2020, through June 30, 2021, medical benefit payments for 688,714 medical claims totaled $125,592,492.60 in the file. Sampled benefit payments for 220 random, stratified claims totaled $4,417,216.96 (3.51%).

The random, stratified statistical audit sample was selected through analyses performed by our actuarial staff to provide statistical validity in both the dollar value and incidence of errors. The statistical sample was expected to identify less than a 3% error rate, which would then provide a 95% confidence level with ±3% precision.

A basic principle of the sampling technique is that the stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to performance guarantees and industry standards.

Accuracy Results

Review of the statistical sample of 220 medical claims in the audit period of July 1, 2020, through June 30, 2021, identified four (4) in-sample errors:

- **Two (2) overpayments totaling $30,432.00; and,**
- **.Two (2) underpayments totaling -$1,151.92.**

In addition to the above errors, nine (9) out-of-sample (OOS) errors were identified. The nine (9) errors included one (1) overpayment for $39,850.35, three (3) underpayments totaling -$5.67, and five (5) procedural errors. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

As seen in the following chart, Anthem surpassed the performance guarantee standard in the Time-to-Process and Procedural Accuracy categories but failed to meet the performance guarantee in the category of Financial Accuracy through this audit. Additionally, the 30-day Time-to-Process achievement is below the industry standard, however it may be explained by multiply processing events (i.e., claims that were processed within the correct timeframe but then later adjusted), which are not factored in the calculation.

Please note that the Accuracy Results do not include OOS or target claims.

Category	Statistical Achievement	Performance Guarantee	Industry Standards
Financial Accuracy (dollar value)	**96.05%**	99.00%	99.00%
Payment Accuracy (free from financial error)	98.86%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (free from error)	98.86%	N/A	95.00%
Time-to-Process* (within 14 calendar days)	95.54%	90.00%	95.00%
(within 30 calendar days)	98.57%	N/A	100.00%

* Time-to-process achievement has been calculated on 100% of the claims population for the audit period and does not take adjustments into account.

Target Sample Results

In addition to the random, statistical claim sample, Anthem supported a target sample of 35 claims. Target claims were selected through a series of electronic analyses to identify and confirm the accuracy of specific plan provisions and exclusions.

During the 12-month audit period of July 1, 2020, through June 30, 2021, medical benefit payments for 668,714 medical claims totaled $125,592,492.60 in the file. Sampled benefit payments for 35 targeted claims totaled $59,123.07 (0.04%).

Segal's selection focused on single claims and patterns that would present the greatest financial risk to the Plan. Claims were sampled from the following categories:

- Potential duplicate payments;
- Reimbursement of Plan exclusions, limitations, and prior authorizations;
- Patient out-of-pocket expenses (i.e. deductible, copay and coinsurance); and,
- Plan variables not represented in the random selection.

The auditors manually reviewed the electronic results and the patient history for the sampled claims via remote access on order to validate the processing event or identify the root cause of the error; as applicable.

Target Results

Review of the target sample of 35 medical claims in the 12-month audit period of July 1, 2020, through June 30, 2021, identified fourteen (14) in-sample overpayment errors totaling $12,125.77.

In addition to the above errors, one (1) out-of-sample (OOS) underpayment identified for -$9.13.

Further information regarding these errors is provided in Section III of this report.

Key Findings and Recommendations

The following bullet points summarize the primary findings identified by Segal's auditors during the claims review. Segal recommended that Anthem adjust any payments identified in error. Anthem's responses to the findings from the remote review are summarized and italicized throughout the report. Anthem was presented with a draft report on February 2, 2022, for its review and comment. Anthem provided its formal response to the draft report on February 28, 2022. Anthem's full response can be found in Section VI of this report.

- The individual deductibles were over applied but the out-of-pocket max was not met. (Samples: 10A, 53B, 67B, 101C, 118D, Error Type: Procedural)

  Anthem agreed to these errors during the remote review.

  As this is a reoccurring error every year, Segal recommended that Anthem provide corrective action steps that will be in place to reduce this error type.

  Anthem's Response: *Anthem notes that the errors occurred when a pharmacy claim overapplied the deductible. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force Management generates an over applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If a pharmacy claim caused the exceed, Anthem will work with the PBM partner to have them refund the member the exceeded pharmacy amount. The sample claims were inadvertently missed during the adjustment process. Anthem will review the member's claim history, and applicable claims will be adjusted.*

  Segal recommends that LACERA monitor the situation as this error has the potential to cause member disruption.

- Incorrect coordination of benefits with Medicare led to underpayments. (Samples: 127D & 144E, Amount Underpaid: -$1,151.92)

  Anthem agreed to these errors during the remote review.

  Anthem's Response: *Anthem notes that the claims are currently in adjustment status and additional education to its processors for the handling of these claims was provided.*

- The out-of-pocket maximums were overapplied. (Samples: 147E, 205J, 209J, and T21, Amount Underpaid: -$14.80)

  Anthem agreed to these errors during the remote review.

  As this is a reoccurring error every year, Segal recommended that Anthem provide corrective action steps that will be in place to reduce this error type.

  Anthem's Response: *See Anthem's response for Samples 10A, 53B, 67B, 101C, 118D.*

  Segal recommends that LACERA monitor the situation as this error has the potential to cause member disruption.

- A claim for workers compensation was paid. (Sample: 154E, Amount Overpaid: $612.00)

  Anthem noted that an investigation into this claim was initiated.

  Anthem's Response: *Currently, there is an open investigation, Anthem has confirmed that this case is an accepted worker's compensation case and requesting payment from the providers for this case.*

  Segal recommends that LACERA monitor the workers compensation claims progress.

- Claims were paid for a terminated member. (Sample: 191I, Amount Overpaid: $29,820.00, Amount Overpaid OOS: $39,850.35)

  Anthem disagreed with this error during the remote review and noted that at the time the claim was processed the member was active. Although eligibility ended on September 1, 2020, and the claim date started on September 16, 2020, the eligibility was not updated until April 29, 2021.

  Segal noted that although the member's eligibility was not updated until April 2021, the claim should be adjusted to a denied status and reflect as a non-eligible member.

  Anthem's Response: *Anthem disagrees with the error assessed. Anthem paid with the eligibility information on file at the time of processing. Anthem received the termination request on April 29, 2021. Claims incurred within 60 days of the termination notification are eligible for adjustment. The incurred date is beyond 60 days of the notification; therefore, the claim is not eligible for adjustment.*

  Segal upholds the error.

- Acupuncture was paid over $30.00. (Samples: T1, T3, T5, Amount Overpaid: $962.61)

  Anthem agreed to these errors during the remote review.

  Anthem's Response: *Anthem notes that these claims have been placed in the adjustment process.*

  Segal notes that no further intervention by LACERA is necessary for these claims.

- Acupuncture did not apply coinsurance at 50%. (Sample: T2, amount Overpaid: $54.00)

  Anthem agreed to this error during the remote review.

  Anthem's Response: *Anthem notes that the claim has been placed in the adjustment process.*

  Segal notes that no further intervention by LACERA is necessary for this claim.

- Orthotics were covered for diagnosis other than diabetes. (Sample: T9, T10, & T11, Amount Overpaid: $1,246.11)

  Anthem disagreed to this error to the remote review and noted that the diagnosis of pain in the foot is covered.

  Anthem's Response: *Anthem disagrees with the error assessed. Per the benefit plan design, the diagnosis codes M79671 (pain in right foot) and M79672 (pain in left foot) are not listed as an exclusion. Foot orthotics are covered for diabetes but are not limited to the diabetes diagnosis. If this is not the benefit intent of LACERA, Anthem's account manager is available to discuss.*

  Segal recommends that LACERA review its benefit intent with Anthem to ensure accurate benefit exclusions are applied.

- Hearing aids were paid over the amount of $300.00. (Samples: T15 & T17, Amount Overpaid: $6,850.00)

  Anthem agreed to both errors but notes that Sample T15 was adjusted on July 23, 2021.

  Segal noted that although T15 was adjusted, the adjustment occurred outside of the audit period.

  Anthem's Response: *Anthem notes that the claims has been placed in the adjustment process.*

  Segal notes that no further intervention by LACERA is necessary for these claims.

- Duplicate claim payments were made. (Samples: T25, T29, T32, T34, & T35, Amount Overpaid: $3,013.05)

  Anthem agreed to these errors during the remote review.

  Anthem's Response: *Anthem noted that these claims have been placed in the adjustment process.*

  Segal notes that no further intervention by LACERA is necessary for these claims.

	Audit Findings	
Issue	**Financial Impact**	**# of claims**
Deductible Overapplied	$0	5
Incorrect Medicare Coordination	-$1,151.92	2
Out-of-Pocket Overapplied	-$14.80	4
Workers Compensation Payment	$612.00	1
Member Termination	$69,670.35	2
Acupuncture Over $30.00 Paid	$962.61	3
Acupuncture Applying Incorrect Coinsurance	$54.00	1
Orthotics	$1,246.11	3
Hearing Aids Over $300.00	$6,850.00	2
Duplicate Claim Payment	$3,013.05	5
Total Overpaid	**$82,408.12**	**17**
Total Underpaid	**-$1,166.72**	**6**
Total Procedural	**$0**	**5**

Section II – Statistical Claims Sample

Anthem provided a data file of all medical claims processed and paid during the 12-month audit period of July 1, 2020, through June 30, 2021, which was utilized for sampling purposes.

During the 12-month audit period of July 1, 2020, through June 30, 2021, medical benefit payments for 688,714 medical claims totaled $125,592,492.60 in the file. Sampled benefit payments for 220 random, stratified claims totaled $4,417,216.96 (3.51%).

Relevant claims processing information was verified through Anthem's responses to the Adjudication Procedures questionnaire, remote review discussions, auditors' observations, and the individual claims review.

Stratification

The selection of 220 random claims for the 12-month audit period of July 1, 2020, through June 30, 2021, was stratified by dollar amount to provide large claims representation that is more valid in determining financial accuracy levels. The methodology of Segal's stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allows a quantifiable degree of confidence, whereby results obtained in the audit sample are a true reflection of the way all claims were processed during the audit period.

A basic principle of the sampling technique is the premise that stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to industry standards.

Stratification Table

Strata	Dollar Range of Strata	Number of Claims in		Dollar Amount in	
		Range	Selection	Selection	Strata
A	$0.01 - $19.99	213,275	45	$542.76	$2,370,522.76
B	$20.00 - $39.99	187,891	40	$1,029.50	$5,140,141.46
C	$40.00 - $89.99	124,696	30	$1,595.81	$7,589,738.50
D	$90.00 - $249.99	104,310	25	$3,616.02	$14,969,957.05
E	$250.00 - $749.99	35,996	20	$8,252.97	$14,861,672.71
F	$750.00 - $1,949.99	15,157	10	$14,975.28	$18,754,939.76
G	$1,950.00 - $5,499.99	5,075	10	$34,083.55	$15,809,421.90
H	$5,500.00 - $17,499.99	1,569	10	$94,911.38	$14,624,644.43
I	$17,500.00 - $47,499.99	582	10	$253,121.72	$15,879,531.64
J	$47,500.00 -$174,999.99	153	10	$746,387.76	$12,333,222.18
K	$175,000.00 -$760,684.55	10	10	$3,258,700.21	$3,258,700.21
Total		**688,714**	**220**	**$4,417,216.96**	**$125,592,492.60**

Review Process

Anthem provided a copy of the sampled claim submissions and access through its WGS claim system. The auditors recalculated and reviewed each claim manually from initial receipt to final benefit determination seeking evidence of compliance with established adjudication procedures and benefit provisions; each patient's claim history was reviewed to confirm proper application of plan deductibles and benefit maximums. In addition to verifying the amount paid, evidence of the following processing tasks was explored.

- Claims were paid only on behalf of eligible individuals based on records contained in the claims system.
- Documentation (i.e., provider bills, physician statements, utilization review decisions or penalty findings, surgical reports, etc.) is on file for claims paid and verified when necessary.
- Coordination of benefits and subrogation provisions were enforced, where applicable.
- Proper application of age, gender, and disease specific edits.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Proper medical necessity was investigated as defined by the Plan.
- Benefits were paid under the proper classification, diagnostic, and procedure codes as an incorrect entry may affect payment accuracy or future benefit determinations.

- Appropriate benefit limitations, deductibles, copayments, coinsurance, and out-of-pocket maximums were applied.
- As appropriate, high dollar claims were considered for care management and applicable stop-loss notifications were timely filed.
- Claims system logic for examiner edits and auto-adjudication capabilities.
- Arithmetic calculations were correct.
- Duplicate submissions were properly denied.
- Payment was made to the proper party (i.e., the provider of service if benefits were assigned; claimant is benefits were not assigned).
- Turnaround time for processing of claims was within industry standards or established performance guarantees.

All questions and potential errors were presented to Anthem's representatives daily; additional supporting documentation was provided through January 27, 2022.

Statistical Claim Findings Table

Review of the statistical sample of 220 medical claims in the audit period of July 1, 2020, through June 30, 2021, identified four (4) in-sample errors:

- **Two (2) overpayments totaling $30,432.00; and,**
- **.Two (2) underpayments totaling -$1,151.92.**

In addition to the above errors, nine (9) out-of-sample (OOS) errors were identified. The nine errors included one (1) overpayment for $39,850.35, three (3) underpayments totaling -$5.67, and five (5) procedural errors. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

Anthem should initiate claim adjustments for the claims identified in error on the following table.

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
Deductible Overapplied				
10A	Out-of-Sample : Procedural	The individual deductibles were over applied but the out-of-pocket max was not met. (Auto and Manual Adjudication) *Anthem agreed to these errors during the remote review.* **As this is a reoccurring error every year Segal**	*Anthem agrees with the errors assessed. The errors occurred when a pharmacy claim overapplied the deductible. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force Management generates an over*	**Segal recommends that LACERA monitor the situation as this error has the potential to cause member disruption.**
53B	Out-of-Sample : Procedural			
67B	Out-of-Sample : Procedural			

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
101C	Out-of-Sample : Procedural	**recommended that Anthem provide corrective action steps that will be in place to reduce this error type.**	*applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If an RX claim caused the exceed, we will work with the PBM partner to have them refund the member the exceeded RX amount. The sample claims were inadvertently missed during the adjustment process, the member's claim history will be reviewed, and applicable claims will be adjusted.*	
118D	Out-of-Sample : Procedural			
Incorrect Medicare Coordination				
127D	-$18.77	Incorrect coordination of benefits with Medicare led to underpayments. (Manual Adjudication)	*127D: Anthem agrees with the error assessed. The error occurred when the processor failed to correctly coordinate Medicare benefits. Our internal*	**Segal notes that no further intervention by LACERA is necessary for these claims.**
144E	-$1,133.15			

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
		Anthem agreed to these errors during the remote review.	*guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. The claim has been placed in the adjustment process.* *144E: Anthem agrees with the copayment error assessed and disagrees with the coinsurance error assessed. The copayment error occurred when the processor failed to apply the applicable $300.00 copayment for an emergency room visit. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims.* *According to the LACERA benefit plan design, emergency room visits are subject to a $300.00 copay and 10% coinsurance. If this is not LACERA's benefit intent, Anthem's account*	

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
			representative is available to discuss. An adjustment will not be made to this claim as it is outside of the timeframe to request a refund.	
Out-of-Pocket Overapplied				
147E	Out-of-Sample : -$2.88	The out-of-pocket maximums were overapplied. (Auto and Manual Adjudication) *Anthem agreed to these errors during the remote review.* **As this is a reoccurring error every year Segal recommended that Anthem provide corrective action steps that will be in place to reduce this error type.**	*Anthem agrees with the error assessed. The error occurred when a pharmacy claim overapplied the out-of-pocket maximum. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force Management generates an over applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If an RX claim caused*	**Segal recommends that LACERA monitor the situation as this error has the potential to cause member disruption.**
205J	Out-of-Sample : -$0.14			
209J	Out-of-Sample : -$2.65			

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
			the exceed, we will work with the PBM partner to have them refund the member the exceeded RX amount. The sample claims were inadvertently missed during the adjustment process, the member's claim history will be reviewed, and applicable claims will be adjusted.	
Workers Compensation Payment				
154E	$612.00	A claim for workers compensation was paid. (Manual adjudication) *Anthem noted that an investigation into this claim was initiated.*	*Currently, there is an open investigation, Anthem has confirmed that this case is an accepted worker's compensation case and requesting payment from the providers for this case.*	**Segal recommends that LACERA monitor the workers compensation claims progress.**
Member Termination				
191I	$29,820.00 Out-of-Sample: $39,850.35	Claims were paid for a terminated member. (Manual Adjudication) *Anthem disagreed with this error during the remote review and noted that at the time the claim*	*Anthem disagrees with the error assessed. Anthem paid with the eligibility information on file at the time of processing. Anthem received the termination request on April 29, 2021. Claims incurred within 60 days of the*	**Segal upholds the error.**

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
		was processed the member was active. Although eligibility ended on September 1, 2020, and the claim date started on September 16, 2020, the eligibility was not updated until April 29, 2021. **Segal noted that although the member's eligibility was not updated until April 2021, the claim should be adjusted to not pay to reflect a non-eligible member.**	*termination notification are eligible for adjustment. The incurred date is beyond 60 days of the notification; therefore, the claim is not eligible for adjustment.*	
Total	**2 overpayments** **1 out-of-sample overpayment** **2 underpayments** **3 out-of-sample underpayments** **5 OOS procedural errors**			**$30,432.00** **$39,850.35** **-$ 1,151.92** **-$ 5.67**

Section III – Target Claim Sample

Segal performed an electronic review of all medical claims processed and paid during the audit period of July 1, 2020, through June 30, 2021. The electronic review was designed to identify potential deficiencies in the benefit delivery system; however, the analysis was not intended to identify data entry errors (i.e., incorrect patient, date of service, or provider) or creative billing practices of the provider.

During the 12-month audit period of July 1, 2020, through June 30, 2021, medical benefit payments for 668,714 medical claims totaled $125,592,492.60 in the file. Sampled benefit payments for 35 targeted claims totaled $59,123.07 (0.04%).

The random nature of statistical sampling does not ensure every benefit provision or plan variation was identified in the selection. Therefore, the electronic analyses included exploration of scenarios that could suggest a systematic error in programing and/or administrative procedures with focus given to patterns suggesting a greater financial impact to the Plan. Segal's query process was defined by the following categories:

- Potential duplicate payments.
- Reimbursement of Plan exclusions, limitations, and prior authorizations.
- Patient out-of-pocket expenses (i.e., deductible, copay, and coinsurance).
- Plan variables not represented in the random selection.

The SPD served as the auditors' references for the electronic analyses. Electronic reports provided a list of suspected errors that required the auditor's manual review to refine the analysis and identify any patterns of concern; a selection of claims was chosen to confirm suspected errors and identify appropriate query revisions.

The remote review of target claims focused on the attribute(s) selected to gain confidence and to understand how a change in query programs could present more accurate results (e.g., minimize the number of false-positives evidenced in such electronic reviews).

Target Claim Findings Table

Review of the target sample of 35 medical claims in the 12-month audit period of July 1, 2020, through June 30, 2021, identified fourteen (14) in-sample overpayment errors totaling $12,125.77.

In addition to the above errors, one (1) out-of-sample (OOS) underpayment identified for -$9.13.

Anthem should initiate claim adjustments for the claims identified in error on the following table.

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
Acupuncture Over $30.00				
T1	$662.62	Acupuncture was paid over $30.00. (Manual Adjudication) *Anthem agreed to these errors during the remote review.*	*Anthem agrees with the error assessed. In each of the instances, a processor incorrectly exceeded the $30.00 allowance per acupuncture visit. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. These claims have been placed in the adjustment process.*	**Segal notes that no further intervention by LACERA is necessary for these claims.**
T3	$224.99			
T5	$75.00			
Acupuncture Applying Incorrect Coinsurance				

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
T2	$54.00	Acupuncture did not apply coinsurance at 50%. (Manual Adjudication) *Anthem agreed to this error during the remote review.*	*Anthem agrees with the error assessed. The error occurred when the processor incorrectly applied the in-network benefit level for acupuncture visits. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. The claim has been placed in the adjustment process.*	**Segal notes that no further intervention by LACERA is necessary for this claim.**
Orthotics				
T9	$328.96	Orthotics were covered for diagnosis other than diabetes. (Manual Adjudication) *Anthem disagreed to this error to the remote review and noted that the diagnosis of pain in the foot is covered.*	*Anthem disagrees with the error assessed. Per the benefit plan design, the diagnosis codes M79671 (pain in right foot) and M79672 (pain in left foot) are not listed as an exclusion. Foot orthotics are covered for diabetes but are not limited to the diabetes diagnosis. If this is not the benefit intent of LACERA, Anthem's account manager is available to discuss.*	**Segal recommends that LACERA review its benefit intent with Anthem to ensure accurate benefit exclusions are applied.**
T10	$540.60			
T11	$376.55			

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
Hearing Aids Over $300.00				
T15	$6,550.00	Hearing aids were paid over the amount of $300.00. (Manual Adjudication) *Anthem agreed to both errors but notes that Sample T15 was adjusted on July 23, 2021.* **Segal noted that although T15 was adjusted, the adjustment occurred outside of the audit period.**	*Anthem agrees with the error assessed. The error occurred when the processor incorrectly allowed more than the $300.00 hearing aid maximum. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. The claim has been placed in the adjustment process.*	**Segal notes that no further intervention by LACERA is necessary for these claims.**
T17	$300.00			
Out-of-Pocket Overapplied				
T21	Out-of-Sample : -$9.13	The out-of-pocket max was overapplied. (Auto and Manual Adjudication) *Anthem agreed to this error during the remote review.* **As this is a reoccurring error every year Segal recommended that Anthem provide corrective action**	*Anthem agrees with the error assessed. The error occurred when a pharmacy claim overapplied the member's deductible and out-of-pocket maximum. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force*	**Segal recommends that LACERA monitor the situation as this error has the potential to cause member disruption.**

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
		steps that will be in place to reduce this error type.	*Management generates an over applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If an RX claim caused the exceed, we will work with the PBM partner to have them refund the member the exceeded RX amount. The sample claims were inadvertently missed during the adjustment process, the member's claim history will be reviewed, and applicable claims will be adjusted.*	
Duplicate Payment				
T25	$1,408.00	Duplicate claim payments were made. (Manual Adjudication)	*Anthem agrees with the errors assessed. The issue was caused by a manual processing*	**Segal notes that no further intervention by LACERA is necessary for these claims.**
T29	$1,484.00			
T32	$52.68			

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Anthem's Response**	**Segal's Final Comment**
T34	$47.08	*Anthem agreed to these errors during the remote review.*	*error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. These claims have been placed in the adjustment process.*	
T35	$21.29			
Total	**14 overpayments** **1 OOS underpayment**			**$12,125.77** **-$ 9.13**

Section IV - Time-to-Process Achievement

There were no concerns with the time-to-process measurement for non-adjusted claims. Results from the electronic analysis of all claims processed during the audit period (July 1, 2020, through June 30, 2021) revealed that Anthem processed 95.54% of the claims within 14 calendar days and 98.57% within 30 calendar days.

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial; subsequent adjustments were measured from receipt of the new information to the benefit determination date with processing measured as the longest interval. Measurements included routing delays due to internal review (i.e., documentation review, quality audit).

Industry standards indicate 95% of all claims should be processed within 14 calendar days. Best practice, which follows Department of Labor regulations, requires 100% within 30 calendar days.

Section V – Adjudication Procedures Review

The following processing guidelines were described in the Adjudications Procedures Review completed by Anthem and evidenced within the 220 statistical claims and 35 target claims or confirmed through discussion with Anthem personnel. While the list did not capture all administrative procedures and system functions, it does support that established guidelines are in place to control Plan costs.

- LACERA claims are processed by a dedicated Anthem unit. Claims are systematically assigned to queues within the work unit and is managed by the claims managers.
- In addition to the dedicated LACERA claims staff, Anthem fully trains all its Member Services Representatives (MSRs) to process claims and make adjustments. There are also designated processors who process claims regularly and can provide assistance if there is excess inventory for the LACERA account.
- Anthem's off-premises workers must be able to work in a HIPAA-compliant work area. Anthem's Associates sign a work-from-home agreement that includes specifics about their workspace and processes to protect PHI. Associates who work from home use a virtual private network (VPN) security process to access the Anthem network. Prior to working from home, Anthem's staff's workspace is inspected by a manager. Random inspections are performed periodically throughout the year.
- Anthem receives approximately 77,000 claims monthly for LACERA.
  - 93% of those claims received for LACERA are received electronically.
  - 88% of those claims for LACERA are auto adjudicated.
- On the job injuries are investigated by sending the member a questionnaire to complete. Query for these claims is based on diagnosis codes received through claim submissions.
- Coordination of benefits questionnaire is sent to members on an annual basis to inquire if other coverage exists.
- Internal audits are conducted daily by Anthem and by Anthem's corporate office personnel monthly.
  - Audits are performed on a prepayment and post payment basis.
  - Audits are performed on a random stratified basis as well as on a random non statistical basis.

Section VI – Anthem's Formal Response to the Draft Report

Anthem Blue Cross and Blue Shield
Customer Audit Services
220 Virginia Ave
Indianapolis, Indiana 46204

February 28, 2022

The Segal Group, Inc.
Attn: Amber M. Turner
2727 Paces Ferry Rd SE
Building 1 Suite 1400
Atlanta, GA, 30339

Re: Los Angeles County Employee Retirement Association (LACERA) Medical Claims Audit Report

Dear Ms. Turner:

We have reviewed the summary and findings of the Los Angeles County Employee Retirement Association (LACERA) medical claims audit, conducted remotely the week of November 08, 2021.

Our responses to the findings and recommendations related to the claim audit are presented below:

Statistical Claim Findings

Deductible Overapplied

- **Audit #10A, #53B, #67B, #101C, and #118D**
  Out-of-sample: Procedural The individual deductibles were over applied but the out-of-pocket max was not met. (Auto and Manual Adjudication)

  Anthem's Response: *Anthem agrees with the error assessed. The error occurred when a pharmacy claim overapplied the deductible. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force Management generates an over applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If an RX claim caused the exceed, we will work with the PMB partner to have them refund the member the exceeded RX amount. The sample claims were inadvertently missed during the adjustment process, the member's claim history will be reviewed, and applicable claims will be adjusted.*

Incorrect Medicare Coordination

- **Audit #127D**
  Incorrect coordination of benefits with Medicare led to underpayments. (Manual Adjudication)

Anthem's Response: *Anthem agrees with the error assessed. The error occurred when the processor failed to correctly coordinate Medicare benefits. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. The claim has been placed in the adjustment process.*

- **Audit #144E**
  On this claim, a processor applied the incorrect copayment and coinsurance. Error value: $657.43.

  Anthem's Response: *Anthem agrees with the copayment error assessed and disagrees with the coinsurance error assessed. The copayment error occurred when the processor failed to apply the applicable $300.00 copayment for an emergency room visit. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims.*

  According to the LACERA benefit plan design, emergency room visits are subject to a $300.00 copay and 10% coinsurance. If this is not LACERA's benefit intent, Anthem's account representative is available to discuss. An adjustment will not be made to this claim as it is outside of the timeframe to request a refund.

Out-of-Pocket Overapplied

- **Audit #147E**
  The out-of-pocket maximums were overapplied. (Auto and Manual Adjudication)

  Anthem's Response: *Anthem agrees with the error assessed. The error occurred when a pharmacy claim overapplied the out-of-pocket maximum. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force Management generates an over applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If an RX claim caused the exceed, we will work with the PMB partner to have them refund the member the exceeded RX amount. The sample claims were inadvertently missed during the adjustment process, the member's claim history will be reviewed, and applicable claims will be adjusted.*

- **Audit #205J and 209J**
  The out-of-pocket maximums were overapplied. (Auto and Manual Adjudication)

  Anthem's Response: *Anthem agrees with the error assessed. The error occurred when a pharmacy claim overapplied the deductible. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force Management generates an over applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If an RX claim caused the exceed, we will work with the PMB partner to have them refund the member the exceeded RX amount. The sample claims were inadvertently missed during the adjustment process, the member's claim history will be reviewed, and applicable claims will be adjusted.*

Workers Compensation Payment

- **Audit #154E**
  A claim for workers compensation was paid. (Manual Adjudication)

  Anthem's Response: *Currently, there is an open investigation, Anthem has confirmed that this case is an accepted worker's compensation case and requesting payment from the providers for this case.*

Member Termination

- **Audit #191I**
  Claims were paid for a terminated member. (Manual Adjudication)

  Anthem's Response: *Anthem disagrees with the error assessed. Anthem paid with the eligibility information on file at the time of processing. Anthem received the termination request on April 29, 2021. Claims incurred within 60 days of the termination notification are eligible for adjustment. The incurred date is beyond 60 days of the notification; therefore the claim is not eligible for adjustment.*

Target Claim

Acupuncture Over $30.00

- **Audit #T1, #T3, and T5**
  Acupuncture was paid over $30.00. (Manual Adjudication)

  Anthem's Response: *Anthem agrees with the error assessed. In each of the instances, a processor incorrectly exceeded the $30.00 allowance per acupuncture visit. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. These claims have been placed in the adjustment process.*

Acupuncture Applying Incorrect Coinsurance

- **Audit #T2**
  Acupuncture did not apply coinsurance at 50%. (Manual Adjudication)

  Anthem's Response: *Anthem agrees with the error assessed. The error occurred when the processor incorrectly applied the in-network benefit level for acupuncture visits. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. The claim has been placed in the adjustment process.*

Orthotics

- **Audit #T9, #T10, and #T11**
  Orthotics were covered for diagnosis other than diabetes.

Anthem's Response: *Anthem disagrees with the error assessed. Per the benefit plan design, the diagnosis codes M79671 (pain in right foot) and M79672 (pain in left foot) are not listed as an exclusion. Foot orthotics are covered for diabetes but are not limited to the diabetes diagnosis. If this is not the benefit intent of LACERA, Anthem's account manager is available to discuss.*

Hearing Aids Over $300.00

- **Audit #T15**
  Hearing aids were paid over the amount of $300.00. (Manual Adjudication)

  Anthem's Response: *Anthem agrees this claim was paid in excess of the $300.00 hearing aid maximum. Anthem would like to note that this error was identified through Anthem's internal audit process and adjusted for correct processing on July 23, 2021 prior to the remote review of this audit. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims.*

- **Audit #T17**
  Hearing aids were paid over the amount of $300.00. (Manual Adjudication)

  Anthem's Response: *Anthem agrees with the error assessed. The error occurred when the processor incorrectly allowed more than the $300.00 hearing aid maximum. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. The claim has been placed in the adjustment process.*

Out-of-Pocket Overapplied

- **Audit #T21**
  The out-of-pocket maximum was overapplied. (Auto and Manual Adjudication)

  Anthem's Response: *Anthem agrees with the error assessed. The error occurred when a pharmacy claim overapplied the member's deductible and out-of-pocket maximum. The over accumulation is due to the timing of the pharmacy accumulation notification. Anthem's Work Force Management generates an over applied (exceeds) report every time we process the daily batch RX claim file, received from the PBM vendor, and assign them to the accumulator team to be worked. Once assigned to the accumulator team, a first in last out approach is taken. If a medical claim has caused the exceed, a medical claim will be adjusted. If an RX claim caused the exceed, we will work with the PMB partner to have them refund the member the exceeded RX amount. The sample claims were inadvertently missed during the adjustment process, the member's claim history will be reviewed, and applicable claims will be adjusted.*

Duplicate Payment

- **Audit #T25, #T29, #T32, #T34, and #T35**
  Duplicate claim payments were made. (Manual Adjudication)

Anthem's Response: *Anthem agrees with the errors assessed. The issue was caused by a manual processing error. Our internal guidelines have been checked for clarity and the processor has been provided additional education on the handling of such claims. These claims have been placed in the adjustment process.*

We appreciate the opportunity to respond to this report. Anthem is available to discuss the report and responses with Segal and LACERA.

Sincerely,

Sent Via E-mail

Danielle McGregor
External Audit Manager, Customer Audit Services

cc: Marijane Gadbury, Anthem
LaTosha Harwell, Anthem
Michael Saavedra, Anthem
Lisa Adams, Anthem

Los Angeles County Employees Retirement Association

Analysis of Cigna Health and Life Insurance Company Dental Claims Processing and Payment Procedures

Audit Period: July 1, 2020 through June 30, 2021
Final Report

February 2, 2022 / Amber M. Turner, MBA, PMP

Segal

Cigna Dental Claims Audit – Final Report

Section I – Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Cigna Health and Life Insurance Company (Cigna) in its administration of the Los Angeles County Employees Retirement Association (LACERA) group dental benefits. Amber Turner of Segal's Benefit Audit Solutions Practice conducted the remote audit during the week of October 18, 2021 via system access through Cigna's Dentacom claims adjudication system. The audit encompassed a total sample of 225 claims for the 12-month audit period of July 1, 2019 through June 30, 2020.

Scope of Services

Cigna provided data files for all dental claims processed and paid during the 12-month audit period of July 1, 2019 through June 30, 2020, representing $32,227,920.93 in benefit payments. The review objective was to ensure claims were paid in accordance with LACERA's plan provisions, including the following components:

- A stratified sample of 225 random claims providing statistical validity in processing accuracy levels with comparison to performance guarantees and industry standards;
- Time-to-Process achievement was measured from the date a claim is first received to the initial date processed for payment or denial for all claims during the audit period; and,
- An Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures.

The auditor completed an electronic form for each sampled claim; this worksheet served as the primary documentation on which the report is based upon. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets". These worksheets (1–225) are further distinguished with an alphabetic character (A-I) that identifies the respective payment tier in the statistical analysis. The auditor reviewed each claim from receipt to release for check disbursement in order to identify any variances in procedures and benefit determination.

Statistical Results

Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third-party administrators (TPAs) nationwide. Standards include acceptable performance levels for administration of fully-insured, self-insured, corporate, public, and multiemployer plan benefits.

During the 12-month audit period of July 1, 2020 through June 30, 2021 dental benefit payments for 137,692 claims totaled $32,227,920.93 in the file. Sampled benefit payments for 225 random, stratified claims totaled $92,730.52 (0.28% of total payments for the review period).

The stratified, statistical audit sample was selected through analyses performed by our actuarial staff to provide statistical validity in both the dollar value and incidence of errors. The statistical sample was expected to identify less than a 3% error rate, which would then provide a 95% confidence level with ±5% precision.

A basic principle of the sampling technique is that the stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to performance guarantees and industry standards.

Accuracy Results

Review of the statistical sample of 225 claims for the audit period of July 1, 2020 through June 30, 2021 identified three (3) errors:

- **Two (2) underpayments in the amount of -$3.20; and,**
- **One (1) overpayment in the amount of $1,580.00.**

Further details are provided in Section II of this report.

As seen in the following chart, Cigna surpassed the performance guarantee standards for the audit period in all the categories (Financial, Payment, Overall, and Time-to-Process).

Category	Statistical Achievement	Performance Guarantees	Industry Standard
Financial Accuracy (dollar value)	99.98%	99.00%	99.00%
Payment Accuracy (free from financial error)	98.89%	95.00%	95.00%
Procedural Accuracy (free from processing error)	100.00%	N/A	97.00%
Overall Processing Accuracy (free from error)	98.89%	97.00%	95.00%
Time-to-Process[1] (within 10 business days)	95.81%	93.00%	95.00%

[1] Time-to-Process achievement was calculated on 100% of the claims population for the audit period and does not take adjustments into account.

Further details on the time-to-process achievement can be found in Section III of this report.

Key Findings and Recommendations

The following bullet points summarize the primary findings identified by Segal's auditor during the claims review. Cigna's responses to the findings from the remote review are summarized and italicized throughout the report. **Segal recommended that Cigna provide financial impact reports to identify all claims paid in error with multiple events or system adjudication.** Cigna was presented with a draft report on November 12, 2021 for its review and comment. Cigna's written responses were delivered to Segal on November 24, 2021 and are paraphrased in italics throughout this report; their entire response is included in Section V.

- Coinsurance application applied to two (2) claims at 20% for code D1999 for personal protective equipment. (Samples: 2A & 58B, Auto Adjudication, Amount Underpaid: -$3.20)

  Cigna agreed to this error during the remote review.

  These claims were auto adjudicated and directly impacted the members out-of-pocket payment; therefore, Segal recommended that Cigna generate a financial impact report for all claims with code D1999 that applied cost sharing.

  Cigna stated that it completed a financial impact report and an additional 3,019 claims totaling -$4,830.40 were identified for this error type. Cigna is currently in the process of adjusting these claims and provided an estimated completion date of December 15, 2021.

  Segal recommends that LACERA follow-up with Cigna to confirm adjustments were finalized for the members impacted through this benefit application error.

- Cigna processed as primary when the spouse has other insurance. (Sample: 217I, Manual Adjudication, Amount Overpaid: $1,580.00)

Cigna agreed to this error during the remote review.

Segal recommended that Cigna adjust the claim to apply the correct coordination of benefits.

Cigna noted that a refund request was forwarded to Cotiviti on November 15, 2021 and is currently pending recovery. Additionally, Cigna has provided coaching and education to the individual processor regarding this claim error.

Segal notes that no further intervention is necessary.

	2020 Audit Findings		Financial Impact Reporting by Cigna[1]	
Issue	**Financial Impact**	**# of claims**	**# of claims Financial Impact**	**# of claims**
D1999 code applied coinsurance	-$3.60	2	-$4,830.40	3,019
Secondary paying as primary	$1,580.00	1	Not Requested[2]	Not Requested[2]
Total Underpaid	**-$3.60**	**2**	-$4,830.40	3,019
Total Overpaid	**$1,580.00**	**1**	Not Requested[2]	Not Requested[2]

[1]Additional amounts identified through Cigna's financial impact report

[2] Financial impact reports were not requested for claims that were manually completed or did not have multiple instances of error

Section II – Statistical Claims Sample

Cigna provided a data file of all dental claims processed and paid during the 12-month audit period of July 1, 2020 through June 30, 2021, which was utilized for sampling purposes.

Dental benefit payments for 137,692 dental claims totaled $32,227,920.93 in the file. Sampled benefit payments for 225 random, stratified claims totaled $92,730.52 (0.28% of total payments).

Relevant claims processing information was verified through Cigna's responses to the Adjudication Procedures questionnaire, remote review discussions, auditor's observations, and the individual claims review.

Stratification Table

The selection of 225 random claims for the audit period of July 1, 2020 through June 30, 2021 was stratified by dollar amount in order to provide large claims representation that is more valid in determining financial accuracy levels. The methodology of Segal's stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allows a quantifiable degree of confidence, whereby results obtained in the audit sample are a true reflection of the way all claims were processed during the audit period.

A basic principle of the sampling technique is the premise that stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to industry standards.

Stratification Table

Strata	Dollar Range of Strata	Number of Claims in		Dollar Amount in	
		Range	Selection	Selection	Strata
A	$0.01 - $89.99	42,920	55	$3,233.77	$2,630,095.51
B	$90.00 - $149.99	37,471	50	$5,635.53	$4,363,218.76
C	$150.00 - $239.99	22,917	35	$6,474.40	$4,286,084.40
D	$240.00 - $389.99	13,089	25	$7,784.01	$3,927,354.89
E	$390.00 - $624.99	8,515	15	$7,649.83	$4,228,322.51
F	$625.00 - $999.99	7,028	10	$8,415.28	$5,570,431.97
G	$1,000.00 - $1,499.99	4,862	10	$11,805.70	$5,876,077.10
H	$1,500.00 - $1,549.99	873	15	$22,500.00	$1,309,608.90
I	$1,550.00 - $3,000.00	17	10	$20,232.00	$36,726.89
Total		**137,692**	**225**	$93,730.52	$32,227,920.93

Review Process

Cigna provided copies of the sample claim submissions and access to its Dentacom claims system for the auditor's reference as each claim was manually reviewed and recalculated from initial receipt to final benefit determination. Evidence of compliance with established adjudication procedures and plan provisions was explored for each claim; the sampled patients' claims history was reviewed to confirm proper application of deductibles and calendar year maximums.

Identification of potential financial and non-financial errors were documented and discussed with Cigna's representative daily. Evidence of the following processing tasks was explored:

- Claims were paid in strict accordance with plan provisions;
- Documentation (e.g., provider bills, pre-determinations, etc.) was on file for claims paid and verified when necessary;
- Claims were paid only on behalf of eligible individuals, based on eligibility data in Cigna's claims system;
- Amounts paid were within the designated non-contracted allowances or discounted fees based on schedules utilized. Segal did not determine dental/clinical necessity; however, the auditor confirmed if claims were reviewed or referred as appropriate;
- Benefits were paid under the proper benefit classification and procedure codes, as an incorrect entry may affect payment accuracy or future benefit determinations;
- Appropriate benefit limitations, deductibles, and coinsurance levels were applied;

- Coordination of benefits (COB) provisions were enforced, where applicable;
- Duplicate claims were properly denied; and,
- Time-to-process achievements for processing of claims was within established performance guarantees.

All questions and potential errors were presented to Cigna's representatives daily; additional supporting documentation was provided through November 4, 2021.

Statistical Claim Findings Table

Review of the statistical sample of 225 claims for the audit period of July 1, 2020 through June 30, 2021 identified three (3) errors:

- Two (2) underpayment errors totaling -$3.20; and,
- One (1) overpayment error totaling $1,580.00.

Cigna should initiate overpayment recovery for the claims identified in the following table and provide financial impact reports where indicated.

<table>
<tr><th colspan="5">Statistical Sample Findings</th></tr>
<tr><th>Worksheet</th><th>Under/ Overpayment</th><th>Initial Error</th><th>Cigna's Response</th><th>Segal's Final Comment</th></tr>
<tr><td>2A</td><td>-$1.60</td><td rowspan="2">Coinsurance application applied to two claims at 20% for code D1999 for personal protective equipment. (Auto Adjudication)

Cigna agreed to this error during the remote review.

These claims were auto adjudicated and directly impacted the members out-of-pocket payment; therefore, Segal recommended that Cigna generate a financial impact report for all claims with code D1999 that applied cost sharing.</td><td rowspan="2">The reimbursement of the $8.00 dental PPE courtesy payment for claims processed 6/15/20 – 8/1/20 was not handled as intended due to LACERA's non-standard benefits.

A claim detail report was pulled for the impacted time period; an additional 3,019 claims totaling $4,830.40 in underpayments was identified.

Adjustments are in the process of being completed with an expected completion date of December 15th,2021.</td><td rowspan="2">Segal recommends that LACERA follow-up with Cigna to confirm adjustments were finalized for the members impacted through this benefit application error.</td></tr>
<tr><td>58B</td><td>-$1.60</td></tr>
</table>

Statistical Sample Findings				
Worksheet	**Under/ Overpayment**	**Initial Error**	**Cigna's Response**	**Segal's Final Comment**
217I	$1,580.00	Cigna processed the claim as primary when the spouse had other insurance. (Manual Adjudication) *Cigna agreed to this error during the remote review.* **Segal recommended that Cigna adjust the claim to apply the correct coordination of benefits.**	*A refund request was forwarded to Cotiviti on November 15, 2021 and is currently pending recovery.* *Reinforcement coaching and education provided to individual processor and reviewed with the claims processing team during quality huddles on November 18, 2021. Coaching included the following:* - *Review of sample claim* - *Review of the Coordination of Benefits Dental SOP* - *Review of the Scanned & Electronic Claims SOP*	**No further intervention is necessary.**
Total	**2 underpayments** **1 overpayment**		**-$3.20** **$1,580.00**	

Section III - Time-to-Process Achievement

Overall, there were no concerns with the time-to-process measurement for non-adjusted claims. Results from the electronic analysis of all dental claims processed during the audit period of July 1, 2020 through June 30, 2021 revealed that Cigna processed 95.81% of the claims within 14 calendar days (10 business days), exceeding its performance guarantees of 93.00% of claims within 10 business days.

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial; Electronic calculations do not allow for distinction of multiple processing events (i.e., adjustments).

Industry standards indicate 95% of all claims should be processed within 14 calendar days. Best practice, which follows Department of Labor (DOL) regulations, requires 100% within 30 calendar days.

Section IV – Adjudication Procedures Review

The following processing guidelines were described in the Adjudications Procedures Review completed by Cigna and evidenced within the 225 statistical claims or confirmed through discussion with Cigna's personnel. While the list did not capture all administrative procedures and system functions, it does support that established guidelines are in place to control claims adjudication.

- LACERA's claims are adjudicated by a designated Cigna team located in Texas and Pennsylvania.
- As multiple staff members are trained to handle the LACERA account, Cigna is able to adjust schedules to meet the needs of planned time off and staff absences.
- Cigna's staff who work from home must follow Cigna's security protocols and a manager audit of the home can be performed at its discretion. Outside of working hours, highly sensitive, restricted, and proprietary information must be stored in a locked container. Work-at-home employees must shred highly sensitive, restricted, and proprietary information before disposing with other waste material.
- 66.62% of these claims for LACERA are auto adjudicated.
  - Companywide Cigna auto adjudicates 78.08% of claims.
- Eligibility records and updates are received by Cigna for LACERA via paper, email, and phone calls.
  - The Cigna eligibility analyst audits the records monthly to make sure that the state matches the dental benefit option for each member.
- Cigna performs monthly internal audits with an average of 250 claims per quarter.
  - Selection of claims is completed with stratified random sampling.
  - Outcomes of these audits are utilized to report performance guarantees.

Section V – Cigna's Formal Response to the Draft Report

Steven P. Fallgren
Senior Account Manager
Sales Department
CA License No. 0C91825

400 North Brand Boulevard
Glendale, California 91203
Tel (818) 546-5363
stevenpaul.fallgren@cigna.com

November 15, 2021

Cassandra Smith
Director
LACERA
300 N. Lake Avenue, Suite 650
Pasadena, CA 91101

RE: LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA)
Cigna Account Number: 3211348
Dental Plan Audit (Claims Paid July 1, 2020 through June 30, 2021)

Dear Cassandra;

Thank you for the opportunity to respond to the findings of the final report from the dental plan audit of Cigna HealthCare's Claim Administration Services completed the week of October 18th, 2020 by Segal Consulting on behalf of LACERA. We reviewed the audit findings and want to share our commitment to resolve any outstanding issues or questions.

Cigna values our relationship with LACERA and Segal Consulting. We look forward to meeting with you in the near future to discuss the audit findings and recommendations in more detail. In the meantime, please do not hesitate to contact me with any questions.

Sincerely,

Steven P. Fallgren
Senior Account Manager

Cc Sonia Ledesma, Cigna
Susan Cabarloc, Cigna
Cindy Yanaga, Cigna

CIGNA RESPONSE TO LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA)

SEGAL CONSULTING EVALUATION OF CIGNA

Executive Summary

Segal Consulting conducted a remote review October 18th 2021 – October 22nd, 2021 via system access of Los Angeles County Employees Retirement Association (LACERA) claims processed by Cigna. The sample consisted of 225 random dental claims processed and paid during the 12 month audit period of July 1, 2020 through June 30, 2021. Total benefit payments of $32,227,920.93 were paid on behalf of eligible employees and their dependents. Segal's sample and analysis represents benefit payments in the amount of $99,744.62.

The objectives of the audit included the following components:

- An Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures; and,
- A stratified sample of 225 claims providing statistical validity in processing accuracy levels with comparison to performance guarantees and industry standards.

Cigna has reviewed the report submitted by Segal Consulting and appreciates the insights and feedback shared.

Segal Consulting's recommendations have been thoughtfully considered and Cigna's response is provided in the detailed information that follows.

Audit Overview

The audit consisted of a Random, Stratified Sample of 225 dental claims and an Operational Questionnaire.

Sample Summary:

Platform	Scope Period	Total Volume of Paid Claims	Total Volume of Claim Payments	Audit Type	Audit Claim Sample Volume	Audit Sample Claim Payments
Dental	07/01/2020 - 06/30/2021	137,692	$32,227,920.93	*Random stratified* *Dental*	225	$92,730.52

Performance Measurements

Quality Metric	Segal Consulting Recognized Audit Results	Cigna Recognized Audit Results	Performance Guarantee	Recognized Industry Standard
Financial Accuracy	99.98%	99.98%	99.0%	99.0%
Payment Accuracy	98.89%	98.89%	n/a	97.0%
Procedural Accuracy	98.89%	98.89%	97.0%	95.0%

*Segal recognized Industry Standard

CIGNA RESPONSE TO LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA)

SEGAL CONSULTING EVALUATION OF CIGNA

Audit Results

Dental Claim Audit Findings: Cigna can confirm a total of:

- Three (3) In-sample errors
  - Overpayment of $1580.00
  - Underpayments of $3.20

The overpayment has been forwarded to Cigna's recovery vendor, Cotiviti, for appropriate recovery efforts. The underpayments have been adjusted accordingly.

Manual Processing Errors:

Error Detail	Cigna Remediation
Sample : 217 **Coordination of Benefits (COB) Application** Claim was processed as primary when the spouse has other coverage. In-sample Overpayment: $1580	1. Refund request was forwarded to Cotiviti on November 15, 2021 and is currently pending recovery. 2. Reinforcement coaching and education provided to individual processor and also reviewed with the claims processing team during quality huddles on November 18, 2021. Coaching included the following: - Review of sample claim - Review of the Coordination of Benefits Dental SOP - Review of the Scanned & Electronic Claims SOP

Benefit Plan Exception/Courtesy Payment Errors:

Error Detail	Cigna Remediation
Sample : 002 **Sample : 058** **Incorrect Coinsurance Level Applied** During the pandemic, Cigna extended $8 courtesy payments for PPE for in-network providers for claims processed June 15th, 2020 – August 1st, 2020. The coinsurance level was incorrectly applied at 80% instead of 100%, resulting in payments less than $8. In-sample Underpayment: $3.20	1. Reimbursement of the $8.00 dental PPE courtesy payment for claims processed 6/15/20 – 8/1/20 was not handled as intended due to LACERA's non-standard benefits. 2. A claim detail report was pulled for the impacted time period; an additional 3,019 claims totaling $4,830.40 in underpayments was identified. 3. Adjustments are in the process of being completed with an expected completion date of December 15th 2021.

CIGNA RESPONSE TO LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA)

SEGAL CONSULTING EVALUATION OF CIGNA

Conclusion

Cigna recognizes LACERA as a valued client and Segal Consulting as a valued business partner. Cigna sincerely appreciates the ability to share the findings of this audit with LACERA.

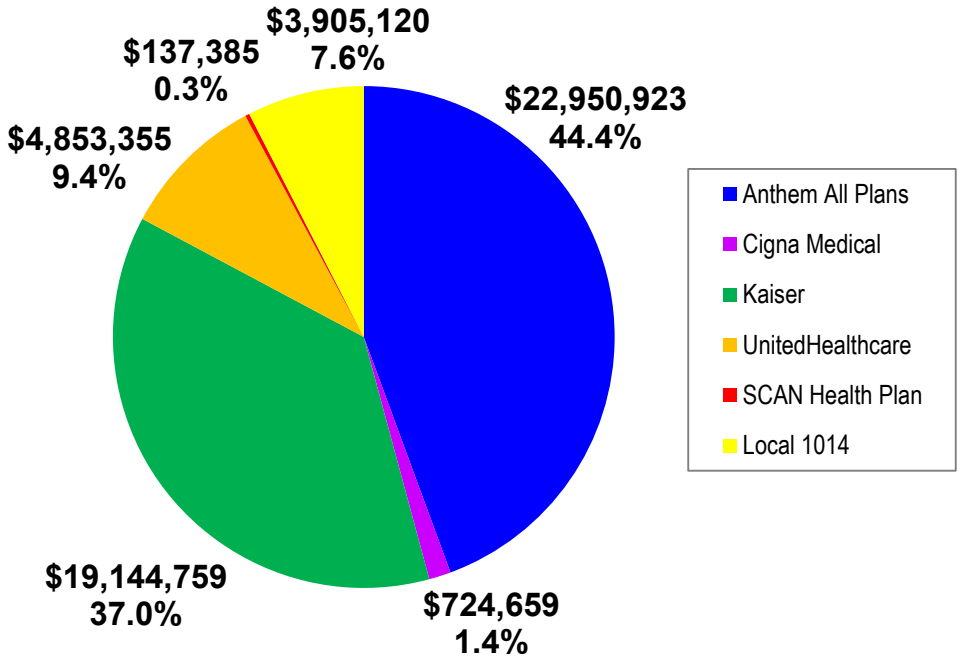
Los Angeles County Employees Retirement Association

Premium & Enrollment

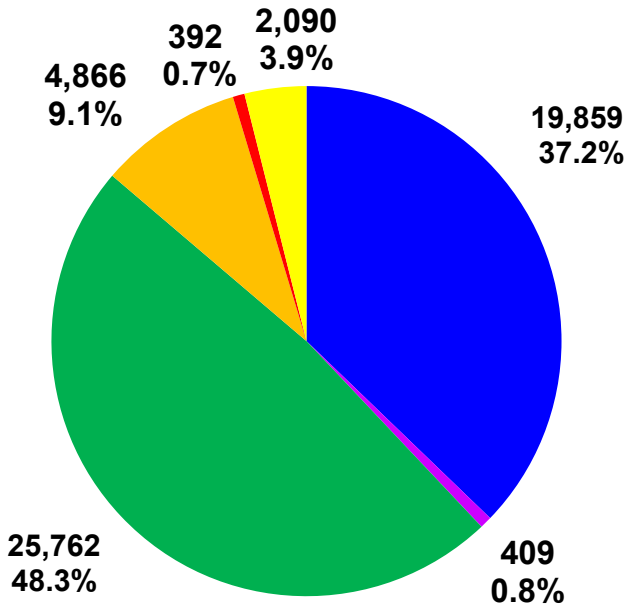
Coverage Month Ending March 2022

Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$22,950,923	44.4%	19,859	37.2%
Cigna Medical	$724,659	1.4%	409	0.8%
Kaiser	$19,144,759	37.0%	25,762	48.3%
UnitedHealthcare	$4,853,355	9.4%	4,866	9.1%
SCAN Health Plan	$137,385	0.3%	392	0.7%
Local 1014	$3,905,120	7.6%	2,090	3.9%
Combined Medical	**$51,716,202**	**100.0%**	**53,378**	**100.0%**
Cigna Dental & Vision (PPO and HMO)	**$4,240,883**		**55,059**	

Monthly Premium



Retirees

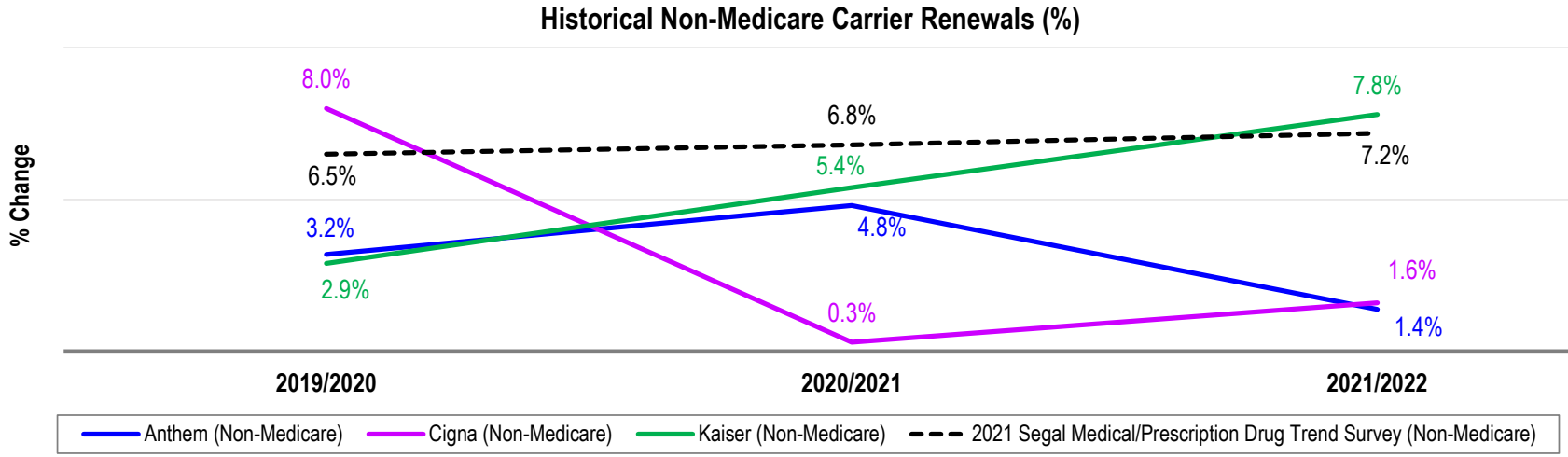


Note: Premiums **include** LACERA's Administrative Fee of $8.00 per member, per plan, per month.

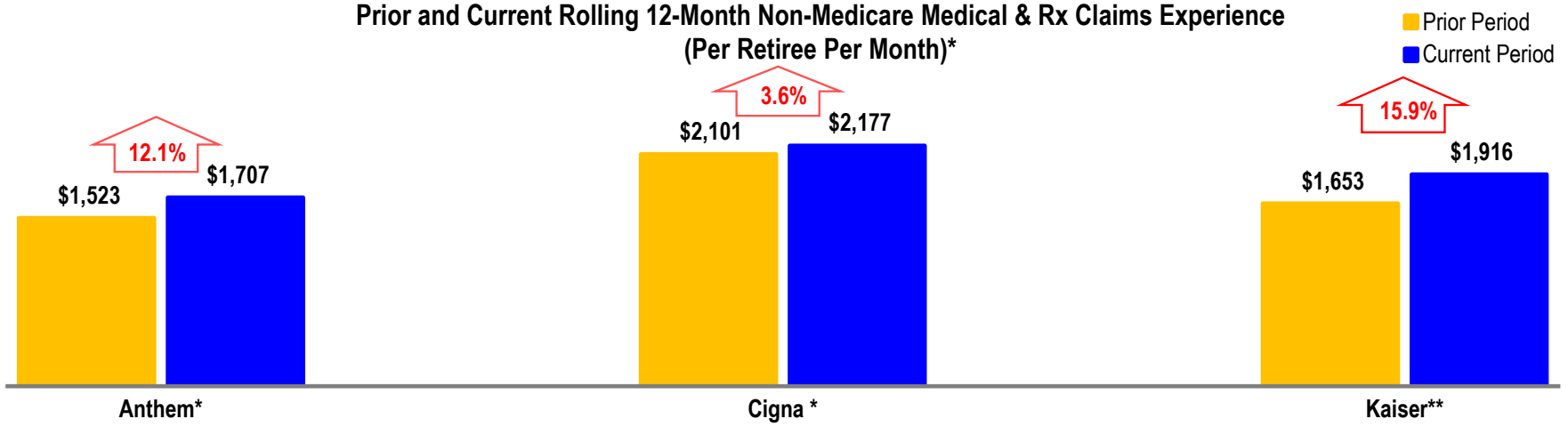
Los Angeles County Employees Retirement Association

Claims Experience by Carrier

Coverage Month Ending March 2022



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

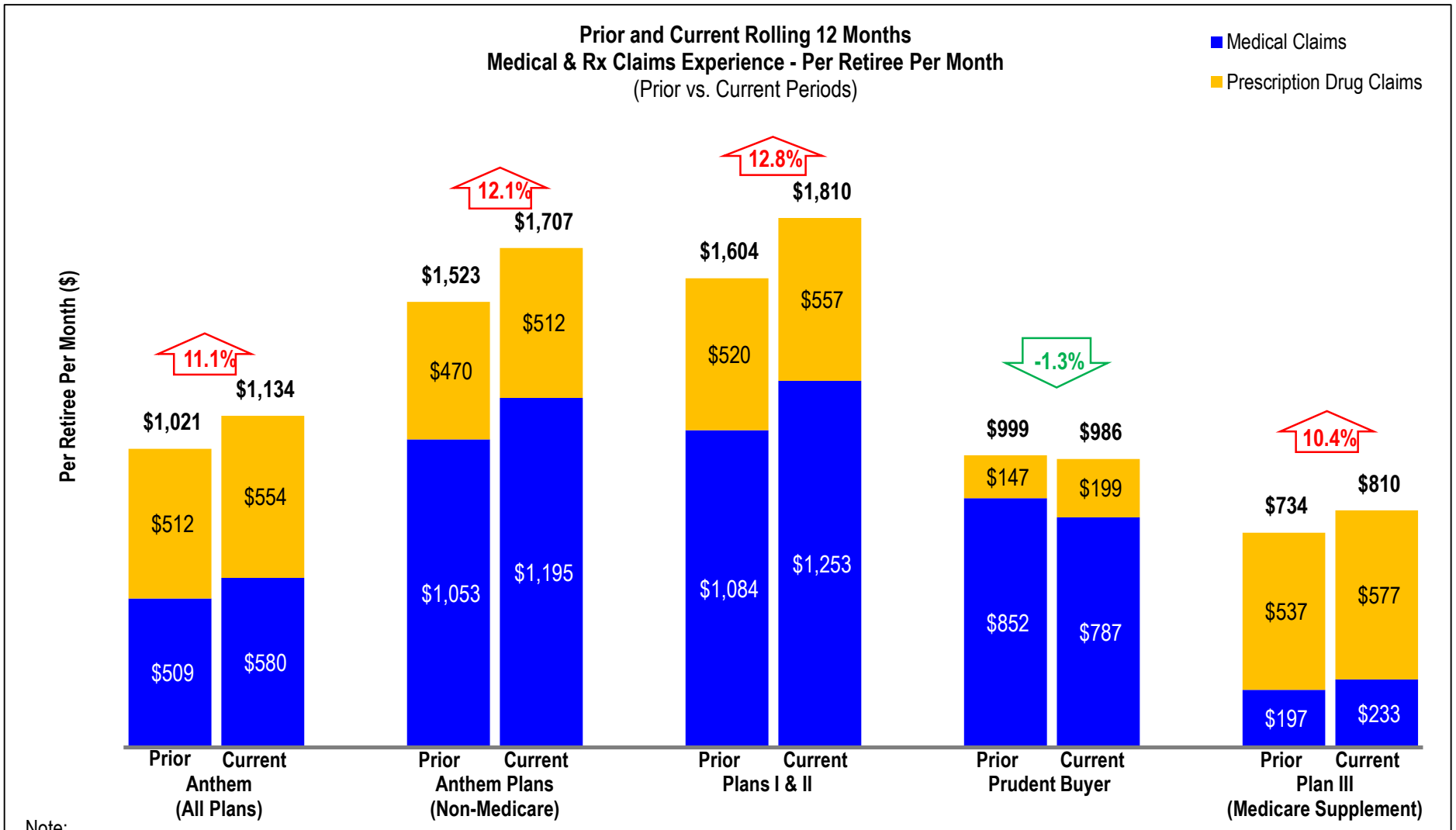


*Based on Most Recent Claims Experience through Coverage Month.
**Kaiser Claims Experience through January 2022.
Note: Figures above include gross claims only, and do not include rebates or pooling credits.

Los Angeles County Employees Retirement Association

Anthem Claims Experience By Plan

Coverage Month Ending March 2022



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 add an estimated 0.5% to claims.

Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month Ending March 2022

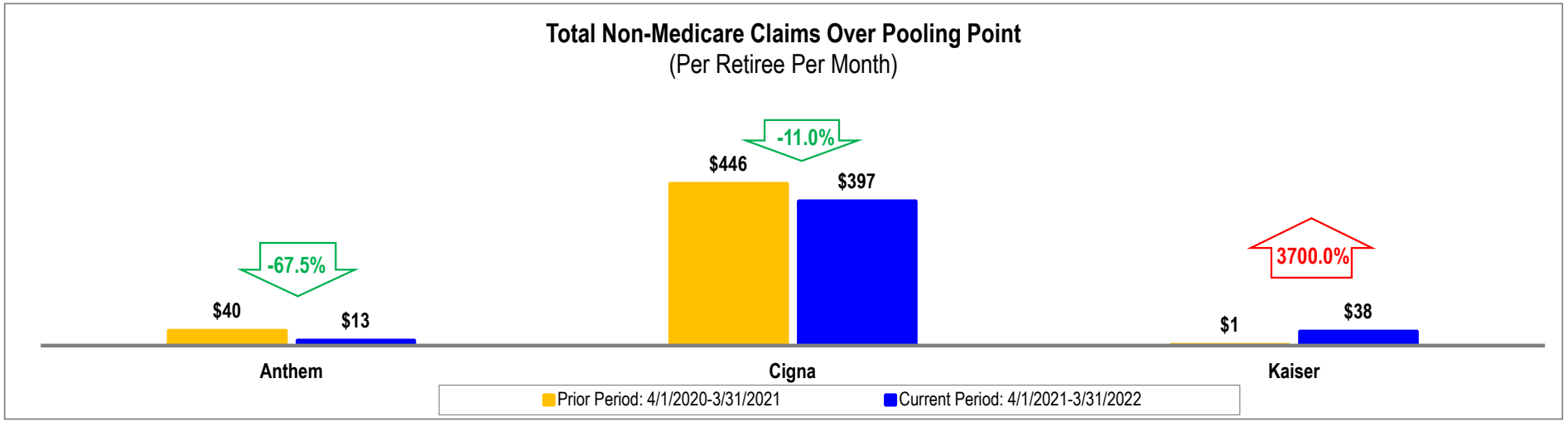
- Kaiser insures approximately 25,000 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in Southern California.

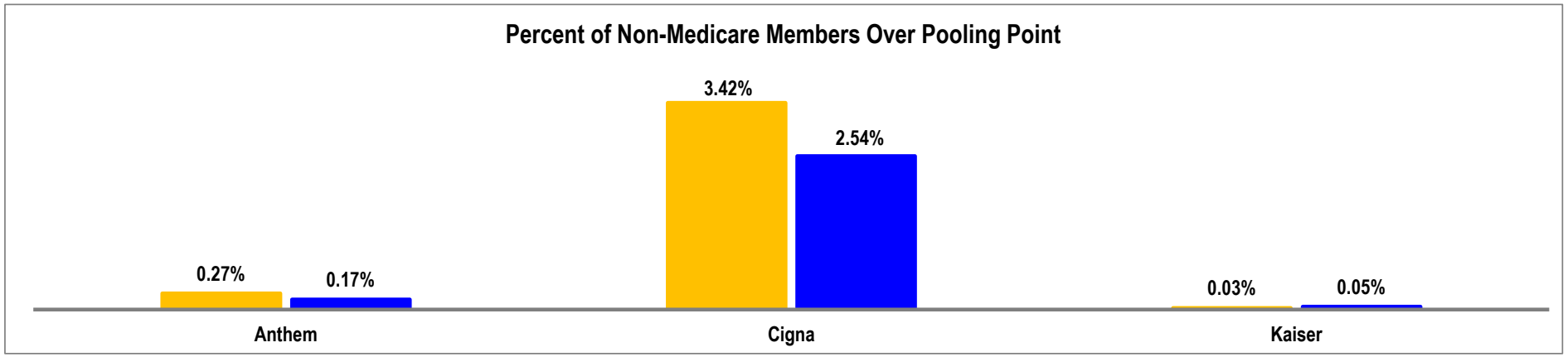
Category	Current Period 2/1/2021 - 1/31/2022	Prior Period 2/1/2020 - 1/31/2021	Change
Average Contract Size	**2.37**	**2.39**	**-0.84%**
Average Members	**8,788**	**8,865**	**-0.87%**
Inpatient Claims Per Member Per Month	$208.82	$174.34	19.78%
Outpatient Claims Per Member Per Month	$353.98	$292.81	20.89%
Pharmacy Per Member Per Month	$117.28	$110.29	6.34%
Other Per Member Per Month	$129.70	$114.38	13.39%
Total Claims Per Member Per Month	**$809.78**	**$691.82**	**17.05%**
Total Paid Claims	**$85,391,825**	**$73,598,412**	**16.02%**
Large Claims over $475,000 Pooling Point			
Number of Claims over Pooling Point	2	1	
Amount over Pooling Point	$1,683,123	$40,913	4013.92%
% of Total Paid Claims	**1.97%**	**0.06%**	
Inpatient Days / 1000	352.1	348.8	0.95%
Inpatient Admits / 1000	47.0	51.9	-9.44%
Outpatient Visits / 1000	14,270.5	11,314.7	26.12%
Pharmacy Scripts Per Member Per Year	10.3	10.2	0.98%

Los Angeles County Employees Retirement Association

High Cost Claimants (Anthem, Cigna, & Kaiser)

Coverage Month Ending March 2022





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 February through January.

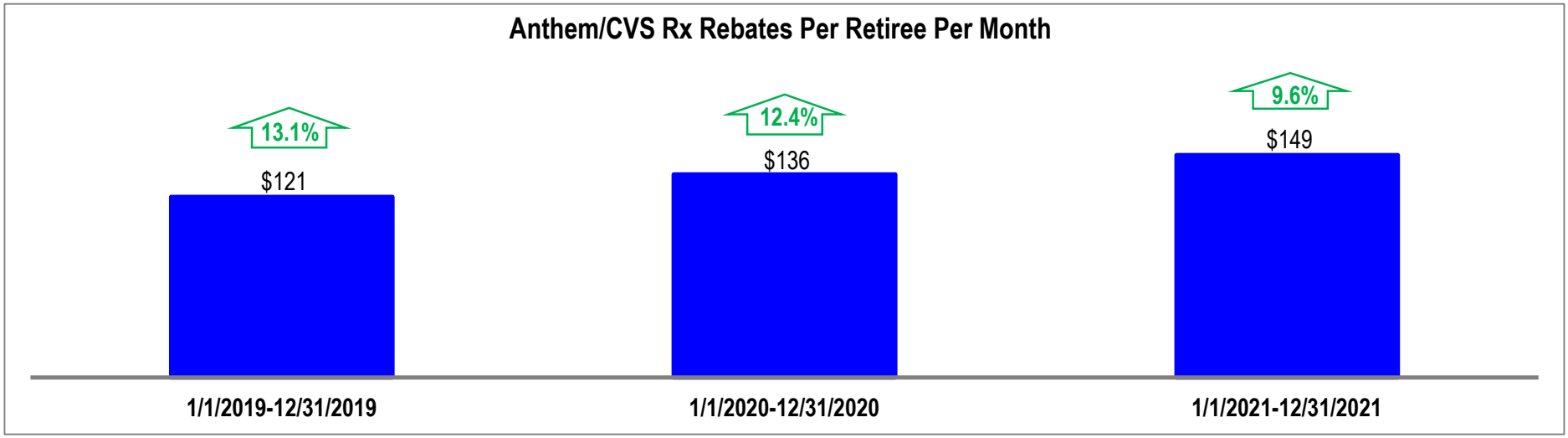
Pooling Points by Carrier:

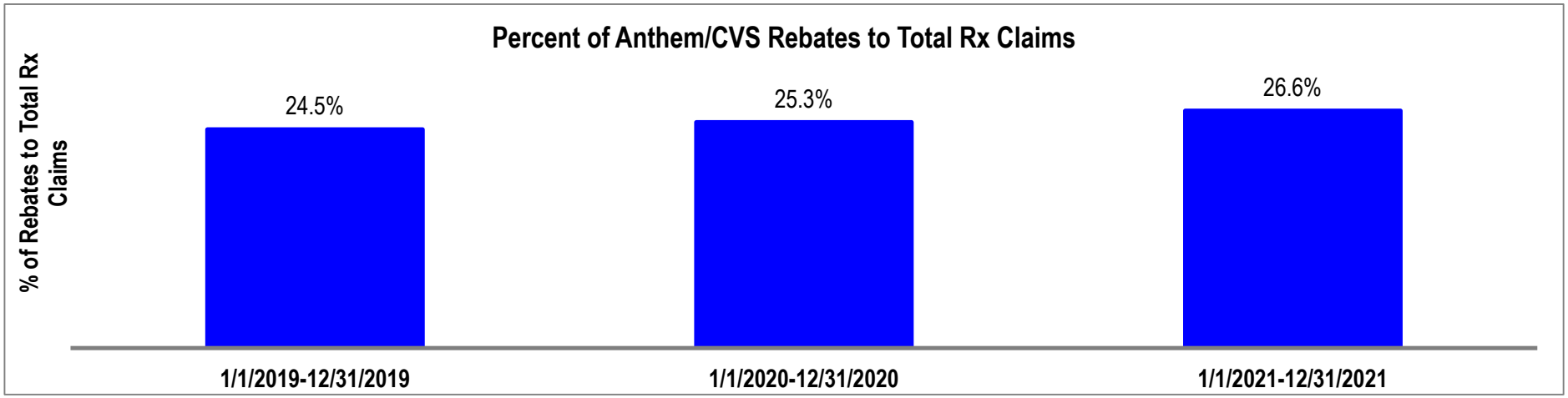
1. Anthem's pooling points are $350,000 for Plans I & II, and $300,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $500,000.

Los Angeles County Employees Retirement Association

Prescription Drug Rebates (Anthem)

Coverage Month Ending March 2022





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.

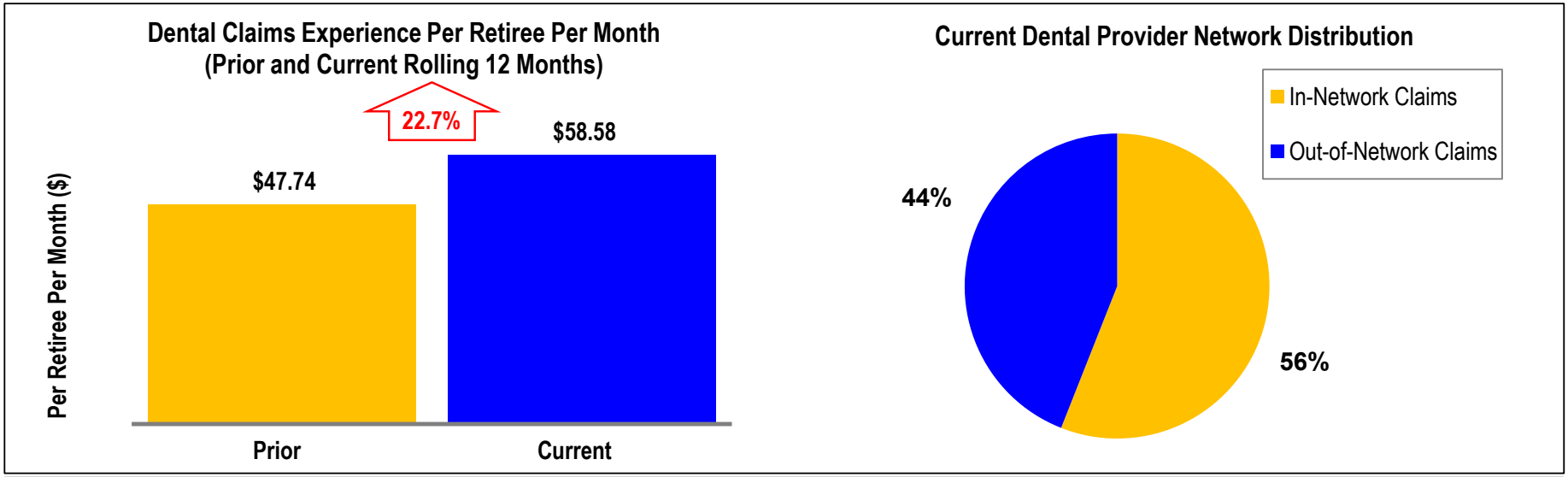
Note:

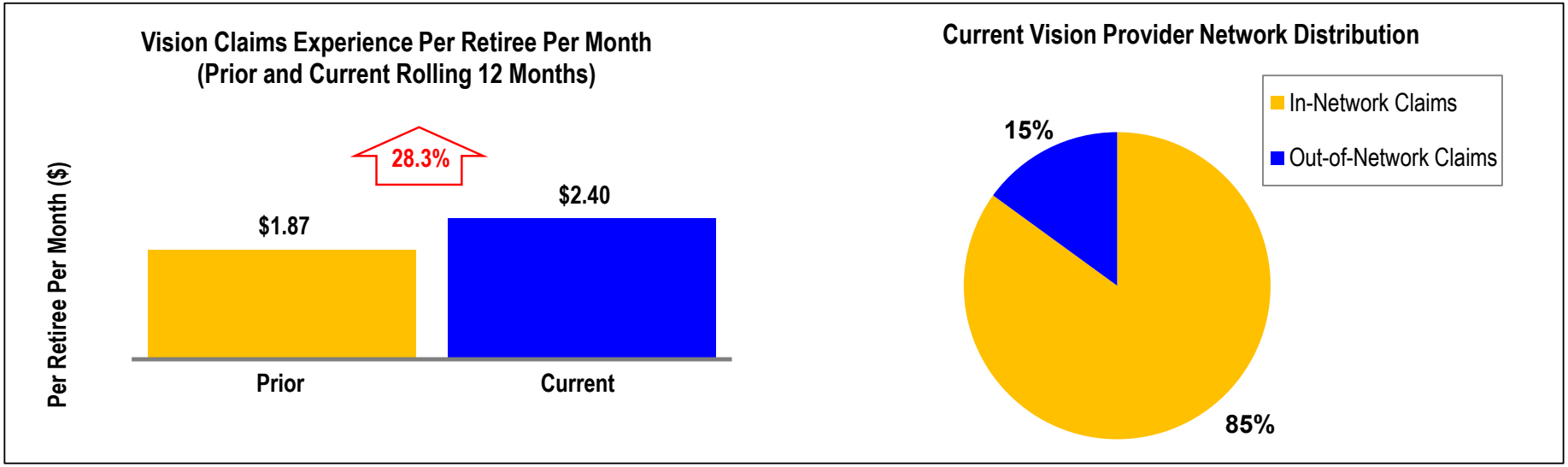
1. Prescription Claims and Rebates Data were provided by CVS.
2. Anthem Prudent Buyer prescription drugs are provided by Express Scripts Inc. and are not included in the charts above.

Los Angeles County Employees Retirement Association

Cigna Dental & Vision Claims Experience

Coverage Month Ending March 2022





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.