IN PERSON & VIRTUAL BOARD MEETING

AUGUST 6, 2025 AT 8:00 AM*

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE MEETING

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

TO VIEW VIA WEB

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

TO PROVIDE PUBLIC COMMENT

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

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

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

AGENDA

A REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE

COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

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

8:00 A.M., WEDNESDAY, AUGUST 6, 2025

This meeting will be conducted by the Insurance, Benefits and Legislative Committee and Board of Retirement both in person and by teleconference under California Government Code Sections 54953(b), (f).

Any person may view the meeting in person at LACERA's offices or online at https://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.

Teleconference Location for Trustees and the Public under California Government Code Section 54953(b)
6953 Cedar Park Avenue, Philadelphia, PA 19138

COMMITTEE TRUSTEES:

Les Robbins, Chair
Ronald Okum, Vice Chair
Aleen Langton, Trustee
Wayne Moore, Trustee
Shawn R. Kehoe, Alternate Trustee

I. CALL TO ORDER

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER AB 2449, California Government Code Section 54953(f)

A. Just Cause
B. Action on Emergency Circumstance Requests
C. Statement of Persons Present at AB 2449 Teleconference Locations

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of July 10, 2025

IV. PUBLIC COMMENT

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

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

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

V. REPORTS

A. **Engagement Report for July 2025**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

B. **Staff Activities Report for July 2025**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

C. **Annual Anthem Blue Cross and Cigna Audits**
Cassandra Smith, Director, Retiree Healthcare
Amber Turner, Segal Consulting
(Presentation) (Memo dated July 17, 2025)

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

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

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

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

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

IX. ADJOURNMENT

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

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

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

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

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

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

8:30 A.M. – 8:47 A.M., THURSDAY, JULY 10, 2025

This meeting was conducted by the Insurance, Benefits & Legislative Committee both in person and by teleconference under California Government Code Section 54953(f)

COMMITTEE TRUSTEES

PRESENT: Les Robbins, Chair

Ronald Okum, Vice Chair

Aleen Langton, Trustee

Wayne Moore, Trustee

Shawn R. Kehoe, Alternate Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

Elizabeth Ginsberg, Trustee

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Luis A. Lugo, Deputy Chief Executive Officer

STAFF, ADVISORS AND PARTICIPANTS (Continued)

JJ Popowich, Assistant Executive Officer

Laura Guglielmo, Assistant Executive Officer

Steven P. Rice, Chief Counsel

Barry W. Lew, Legislative Affairs Officer

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

I. CALL TO ORDER

This meeting was called to order by Chair Robbins at 8:30 a.m.

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER AB 2449, California Government Code Section 54953(f)

A. Just Cause
B. Action on Emergency Circumstance Requests
C. Statement of Persons Present at AB 2449 Teleconference Locations

There were no requests received.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of June 4, 2025

Trustee Okum made a motion, Trustee Langton seconded, to approve the minutes of the regular meeting of June 4, 2025. The motion passed by the following roll call vote:

Yes: Okum, Langton, Robbins

No: None

Abstain: Moore

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. REPORTS

A. **Semi-Annual Report on Approved Engagements**
Barry W. Lew, Legislative Affairs Officer
(For Information Only) (Memo dated July 1, 2025)

The semi-annual report on approved engagements was discussed. This item was received and filed.

B. **Engagement Report for June 2025**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

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

C. **Staff Activities Report for June 2025**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

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

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

The LACERA Claims Experience reports through May 2025 were discussed. This item was received and filed.

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

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

VI. ITEMS FOR STAFF REVIEW

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

There was nothing to report.

VII. ITEMS FOR FUTURE AGENDAS

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

There was nothing to report.

VIII. GOOD OF THE ORDER

(For Information Purposes Only)

There was nothing to report.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 8:47 a.m.

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

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
JULY 2025
FOR INFORMATION ONLY

How Scaling Back Public Pensions Puts Government Revenues at Risk
The National Conference on Public Employee Retirement Systems (NCPERS) has an analysis that shows how public pensions support state and local economies through investment of pension fund assets and retiree spending. The following are the key findings of the analysis based on 2023 data:

- Public pensions contributed $2.9 trillion in economic output: $1.9 trillion from investment of pension fund assets and $980.7 billion from retiree spending.
- Public pensions generated $661.9 billion in state and local tax revenues--$445.2 billion more than the $216.7 billion contributed by taxpayers.
- For every dollar taxpayers contributed to public pensions in 2023, they generated $13.41 in economic activity.

The following are key data points specific to California:

- Estimated Economic and Revenue Contributions of Pension Asset Investments (in thousands)
    - Pension Assets: $1,259,488,116
    - Economic Impact of Investments of Assets: $1,007,433,687
    - Revenue Attributable to Investment of Assets: $260,317,817
- Impact of Spending of Pension Checks on State and Local Economies and Revenues (in thousands)
    - Total Payments: $73,198,175
    - Economic Impact of Pension Checks: $182,995,438
    - Revenue Attributable to Pension Checks: $47,283,467
- State and Local Revenues Attributable to Pension Checks and Investment of Pension Assets Compared with Taxpayer Contributions to Pension Funds (in thousands)
    - Total State and Local Revenue from Public Pensions: $307,603,284
        - Investment of Pension Assets: $260,317,817
        - Spending of Pension Checks: $47,285,467
    - Taxpayer Contribution to Public Pensions: $49,466,469

- Net State and Local Revenue from Pension Pensions: $258,136,815

(Source) (Source)

NCPERS Annual Public Retirement Systems Study
Since 2011, the National Conference on Public Employee Retirement Systems (NCPERS) has conducted an annual Public Retirement Systems study for data on the fiscal, operational, and business practices of public pension funds. The study is a resource that provide insights into public sector retirement trends. The following are key findings in the 2025 report:

- The average funded ratio over the past five years ranged from 71% to 79%. Systems with fiscal year-ends in the first half of 2024 reached a funded ration of 83.1%.
- Receiving the full actuarially determined contribution is key to better funding outcomes. These systems report funded ratios that are 20 percentage points higher than systems that do not receive the full contribution.
- One-year investment returns averaged 9.47%.
- Combined investment manager and administrative expenses have risen from 57 basis points to 73 basis points from 2020 to 2024.
- Assumed rates have declined from an average of 7.13% in 2021 to 6.67% in 2024, as plan assumptions have gotten more conservative.
- Three in four systems provided COLAs in their most recent fiscal years. Half of the COLAs paid were exactly 3.0%.
- The average amortization period is 18.5 years, a three-year low.
- Relatively few respondents have implemented AI to manage their retirement systems. Existing uses include improving communication and service for members and automating administrative tasks.

(Source) (Source)

MissionSquare 2025 State and Local Government Workforce Survey Results
MissionSquare Research Institute has released new findings from its annual workforce survey, which looks at current state and local recruitment, retention, benefits, and HR practices. The following are the survey's highlights:

- Recruitment became less challenging in 2024 and saw continued improvement in 2025.

- Fewer governments reported needing to reopen recruitments due to an insufficient number of qualified applicants.
- Targeted hiring bonuses continued to be offered by about one-third of government employers.
- More governments reported being very or somewhat successful in recruiting new generations of employees.
- Degree requirements continued to be dropped for some positions, especially in state government. Two-thirds of those dropping degree requirements reported an increase in applicants without an impact to the quality of applicants.
- Gig hiring continued at approximately the same levels as in 2020 and 2022, with about 5% relying on it for 5% or more of their total staffine.gg needs.
- Fewer governments reported competitive compensation as a very important priority. Workforce diversity, equity, and inclusion and creating a more flexible workplace (e.g., job sharing, outsourcing, retiree hiring) declined in importance. However, hybrid and flexing scheduling remain common.
- With aging of the workforce, more governments rated succession planning as very important. However, 61% reported not having the likely components of a succession planning program in place.

(Source) (Source) (Source)

Bipartisan Bill to Improve Benefits for Federal Firefighters
A bipartisan bill—the **Federal Firefighters Families First Act**—introduced by Sens. Ruben Gallego (D-Ariz.) and Bernie Moreno (R-Ohio), aims to improve working conditions for over 10,000 civilian federal firefighters, primarily employed by the Departments of Defense and Veterans Affairs. These firefighters protect federal personnel, facilities, and military infrastructure, in contrast to federal wildland firefighters who work at the Department of the Interior and Forest Service.

The legislation proposes capping mandatory workweeks at 60 hours, down from the current 72, and reducing mandatory overtime from 19 to 7 hours weekly. In comparison, state and local firefighters work fewer hours in a week but earn higher pay, which impacts recruitment and retention at the federal level, which the Government Accountability Office has reported.

It also seeks to include overtime pay in retirement benefit calculations under the Federal Employees Retirement System (FERS), addressing a long-standing pay disparity with state and local firefighters. The bill is designed to combat burnout, improve recruitment

and retention, and ensure fair compensation. It has received support from major federal employee unions and firefighter associations. (Source)

2024 Congressional Statistics on Social Security

The Social Security Administration maintains benefits statistics for each state. The following are a breakdown of beneficiaries and monthly benefits in California in 2024:

- Total beneficiaries: 6,544,000
    - Retired workers: 5,120,435
    - Disabled workers: 498,873
    - Widow(ers) and parents: 350,365
    - Spouses: 266,063
    - Children: 308,264
- Total monthly benefits: $11,859,914,000
    - Retired workers: $9,908,872,000
    - Widow(ers) and parents: $610,120,000
- Beneficiaries aged 65 or older: 5,499,127 (84% of total beneficiaries)
- Beneficiaries affected by WEP and/or GPO in California: 353,888
    - GPO only: 63,307
    - WEP and GPO: 39,537
    - WEP only: 251,044

(Source) (Source)

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
JULY 2025
FOR INFORMATION ONLY

Centers for Medicare and Medicaid Services (CMS) Medicare Part D Retiree Drug Subsidy (RDS) Reconciliation Plan Year 7/1/2023 – 6/30/2024

In coordination with our carriers, staff has initiated the subsidy payment request process for the following Retiree Drug Subsidy (RDS) applications for Fiscal Year 2023–2024:

- Anthem Blue Cross
- Cigna Medical HMO
- Kaiser Permanente
- LACFF Local 1014 Firefighters

Background:

The RDS program, established under Medicare Part D of the Medicare Modernization Act, allows eligible employers and unions with qualifying prescription drug plans to receive federal subsidy payments for retiree drug costs.

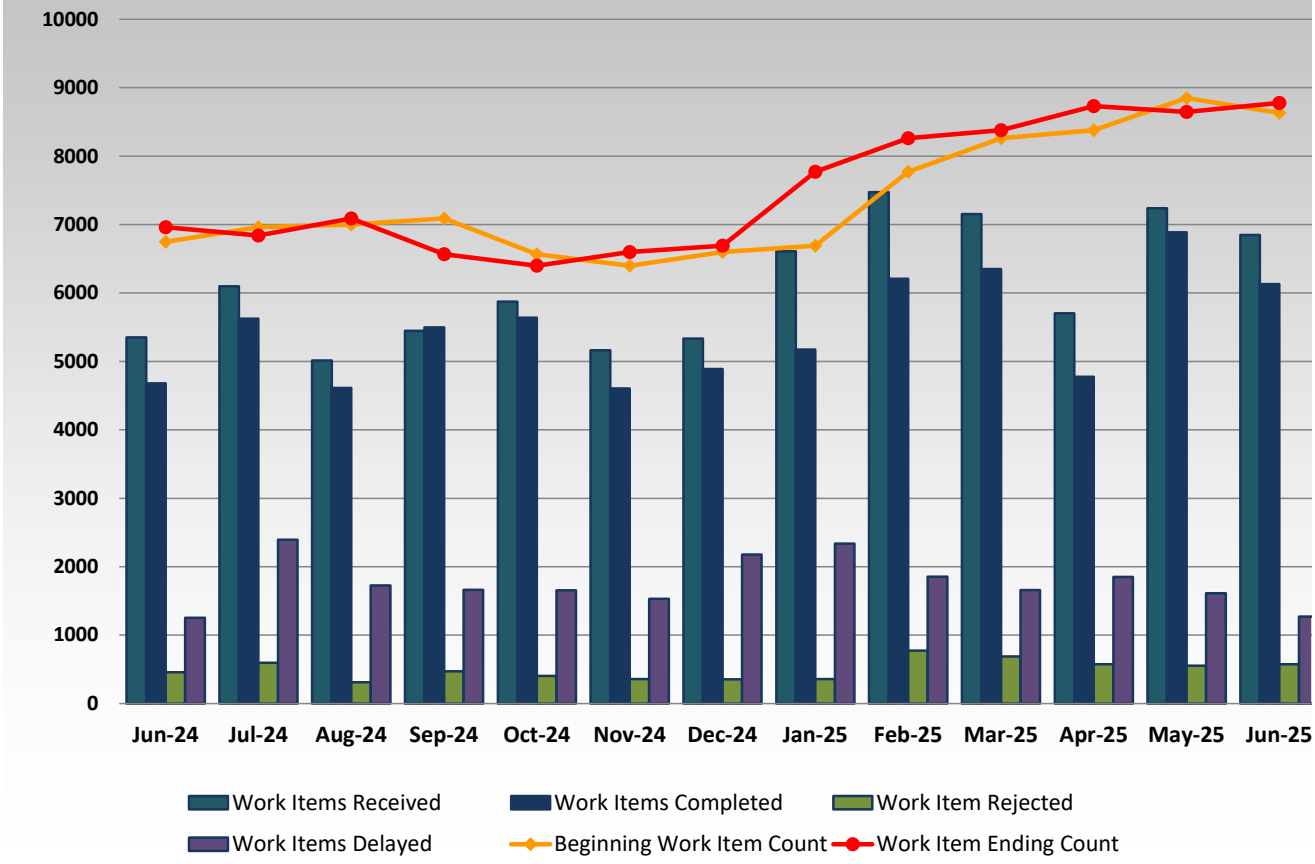
We will continue to keep the Board informed of our progress.

Retiree Healthcare Division

Trend Report

JUNE 2024 - JUNE 2025

Updated: 7/21/2025

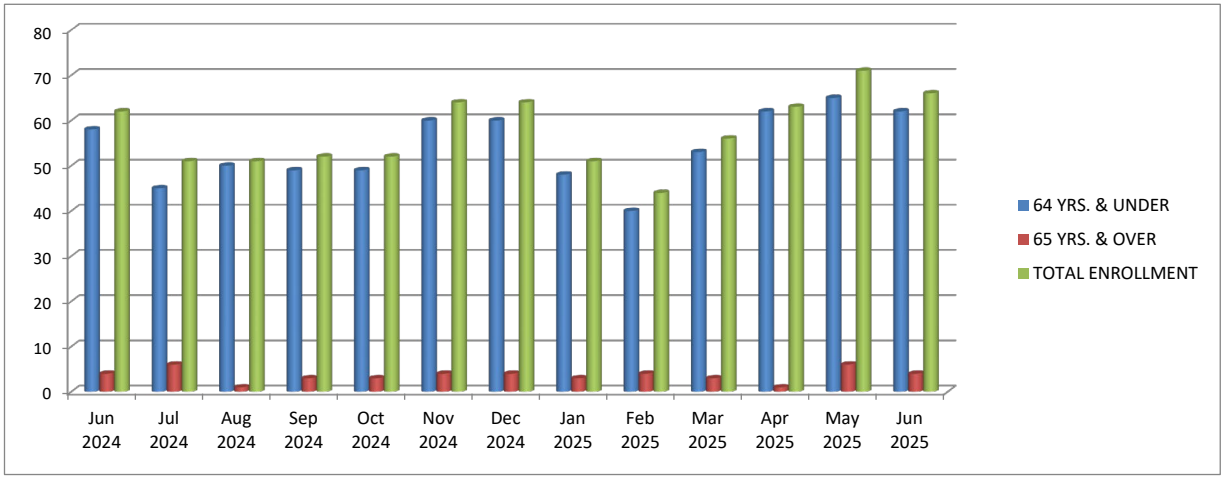


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Jun-24	6749	5351	4681	458	1252	6961
Jul-24	6961	6098	5624	596	2396	6839
Aug-24	7000	5013	4611	313	1725	7089
Sep-24	7089	5447	5498	470	1663	6568
Oct-24	6568	5873	5640	403	1654	6398
Nov-24	6398	5163	4606	358	1530	6597
Dec-24	6597	5335	4889	353	2177	6690
Jan-25	6690	6611	5173	358	2337	7770
Feb-25	7770	7474	6208	775	1854	8261
Mar-25	8261	7153	6349	687	1660	8378
Apr-25	8378	5702	4776	574	1849	8730
May-25	8849	7237	6888	553	1612	8645
Jun-25	8633	6847	6128	574	1272	8778

Retirees Monthly Age Breakdown
JUNE 2024 - JUNE 2025

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
Jun 2024	58	4	62
Jul 2024	45	6	51
Aug 2024	50	1	51
Sep 2024	49	3	52
Oct 2024	49	3	52
Nov 2024	60	4	64
Dec 2024	60	4	64
Jan 2025	48	3	51
Feb 2025	40	4	44
Mar 2025	53	3	56
Apr 2025	62	1	63
May 2025	65	6	71
Jun 2025	62	4	66



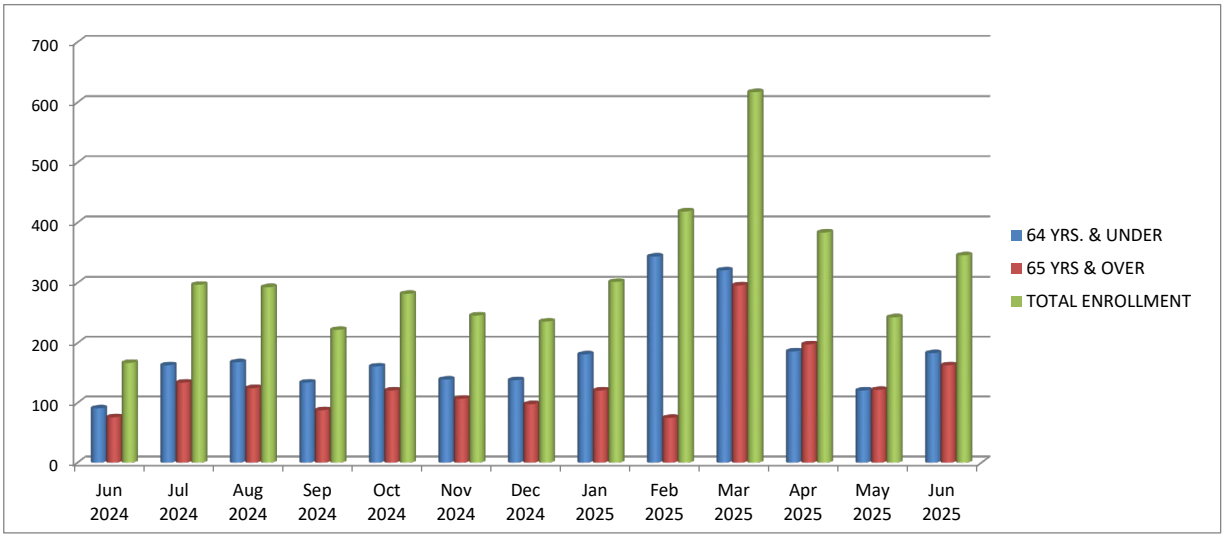
PLEASE NOTE:

- **Next Report will include the following dates: July 1, 2024 through July 31, 2025**

Retirees Monthly Age Breakdown
JUNE 2024 - JUNE 2025

Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
Jun 2024	91	76	167
Jul 2024	163	134	297
Aug 2024	168	125	293
Sep 2024	134	88	222
Oct 2024	161	121	282
Nov 2024	139	107	246
Dec 2024	138	98	236
Jan 2025	181	121	302
Feb 2025	344	75	419
Mar 2025	321	296	617
Apr 2025	186	198	384
May 2025	121	122	243
Jun 2025	183	163	346



PLEASE NOTE:

- **Next Report will include the following dates: July 1, 2024, through July 31 2025.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 7/31/2025

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	7804	$1,335,800.40	0	$0.00
241	131	$22,783.60	0	$0.00
242	998	$171,907.00	0	$0.00
243	4721	$1,646,405.86	0	$0.00
244	14	$2,898.80	0	$0.00
245	58	$11,127.90	0	$0.00
246	15	$2,484.10	0	$0.00
247	173	$32,052.80	0	$0.00
248	14	$4,418.40	0	$0.00
249	90	$32,236.10	0	$0.00
250	17	$5,733.50	0	$0.00
Plan Total:	**14,035**	**$3,267,848.46**	**0**	**$0.00**
CIGNA - PREFERRED with RX				
325	1	$104.90	0	$0.00
0	0	$0.00	0	$0.00
0	0	$0.00	0	$0.00
0	0	$0.00	0	$0.00
Plan Total:	**1**	**$104.90**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	23	$3,613.70	0	$0.00
397	2	$329.60	0	$0.00
398	12	$4,810.00	0	$0.00
403	12347	$2,058,990.38	0	$0.00
413	1528	$271,095.20	0	$0.00
418	6448	$2,210,426.97	1	$51.50
419	211	$32,897.70	0	$0.00
426	251	$42,855.80	0	$0.00
445	2	$370.00	0	$0.00
451	37	$6,507.40	0	$0.00
455	6	$1,110.00	0	$0.00
457	18	$6,403.70	0	$0.00
459	2	$740.00	0	$0.00
462	87	$15,478.00	0	$0.00
465	3	$555.00	0	$0.00
466	27	$9,430.00	0	$0.00
472	28	$4,903.20	0	$0.00
476	4	$690.50	0	$0.00
478	14	$5,140.00	0	$0.00
479	1	$144.60	0	$0.00
482	82	$13,664.80	0	$0.00
486	4	$740.00	0	$0.00
488	32	$10,641.30	0	$0.00
491	1	$148.50	0	$0.00
492	1	$185.00	0	$0.00
Plan Total:	**21,171**	**$4,701,871.35**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 7/31/2025

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	282	$45,688.80	0	$0.00
613	99	$32,237.30	0	$0.00
620	26	$7,031.80	0	$0.00
621	13	$8,678.00	0	$0.00
622	17	$7,193.00	0	$0.00
623	6	$2,059.80	0	$0.00
Plan Total:	**443**	**$102,888.70**	**0**	**0**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	2228	$384,980.60	0	$0.00
702	404	$74,297.30	0	$0.00
703	1440	$505,808.80	0	$0.00
704	104	$18,257.70	0	$0.00
705	52	$20,100.30	0	$0.00
Plan Total:	**4,228**	**$1,003,444.70**	**0**	**$0.00**
Grand Total:	**39,878**	**$9,076,158.11**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 7/31/2025

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247	173	$32,052.80	0	$0.00
248	14	$4,418.40	0	$0.00
249	90	$32,236.10	0	$0.00
250	17	$5,733.50	0	$0.00
Plan Total:	**14,035**	**$3,267,848.46**	**0**	**$0.00**
CIGNA - PREFERRED with RX				
325	1	$104.90	0	$0.00
Plan Total:	**1**	**$104.90**	**0**	**$0.00**
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Medicare Part B Reimbursement and Penalty Report

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622	17	$7,193.00	0	$0.00
623	6	$2,059.80	0	$0.00
Plan Total:	**443**	**102,889**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	2228	$384,980.60	0	$0.00
702	404	$74,297.30	0	$0.00
703	1440	$505,808.80	0	$0.00
704	104	$18,257.70	0	$0.00
705	52	$20,100.30	0	$0.00
Plan Total:	**4,228**	**$1,003,444.70**	**0**	**$0.00**
LOCAL 1014				
804	205	$49,799.50	0	$0.00
805	241	$52,057.80	0	$0.00
806	755	$304,246.00	0	$0.00
807	66	$13,726.70	0	$0.00
808	24	$10,063.80	0	$0.00
812	262	$53,945.00	0	$0.00
813	2	$370.00	0	$0.00
Plan Total:	**1,555**	**$484,208.80**	**0**	**$0.00**
Grand Total:	**41,433**	**$9,560,366.91**	**1**	**$51.50**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	417	$508,898.46	$75,029.09	$432,648.99	$507,678.08	($2,233.84)	$505,444.24
202	211	$506,914.84	$42,667.39	$457,040.13	$499,707.52	($11,892.98)	$487,814.54
203	81	$219,629.07	$33,168.77	$206,998.51	$240,167.28	$2,711.47	$242,878.75
204	27	$42,360.84	$8,713.71	$25,935.74	$34,649.45	$0.00	$34,649.45
SUBTOTAL	**736**	**$1,277,803.21**	**$159,578.96**	**$1,122,623.37**	**$1,282,202.33**	**($11,415.35)**	**$1,270,786.98**
Anthem Blue Cross I							
211	518	$820,926.40	$52,076.54	$784,159.46	$836,236.00	$0.00	$836,236.00
212	214	$611,590.60	$31,151.11	$552,639.01	$583,790.12	$0.00	$583,790.12
213	82	$276,446.60	$22,857.41	$253,589.19	$276,446.60	$0.00	$276,446.60
214	24	$50,330.88	$4,361.99	$45,968.89	$50,330.88	$0.00	$50,330.88
215	2	$1,069.92	$171.19	$898.73	$1,069.92	$0.00	$1,069.92
SUBTOTAL	**840**	**$1,760,364.40**	**$110,618.24**	**$1,637,255.28**	**$1,747,873.52**	**$0.00**	**$1,747,873.52**
Anthem Blue Cross II							
221	2,489	$3,944,567.20	$197,476.39	$3,822,854.65	$4,020,331.04	$4,754.40	$4,025,085.44
222	2,071	$5,918,710.90	$130,795.62	$5,652,938.56	$5,783,734.18	$2,857.90	$5,786,592.08
223	974	$3,283,646.20	$141,343.21	$3,076,484.89	$3,217,828.10	$0.00	$3,217,828.10
224	255	$534,765.60	$54,100.61	$482,334.10	$536,434.71	$8,103.14	$544,537.85
SUBTOTAL	**5,789**	**$13,681,689.90**	**$523,715.83**	**$13,034,612.20**	**$13,558,328.03**	**$15,715.44**	**$13,574,043.47**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	7,859	$5,052,551.10	$639,469.19	$4,473,035.19	$5,112,504.38	($10,452.52)	$5,102,051.86
241	131	$269,504.99	$22,918.14	$258,662.45	$281,580.59	$0.00	$281,580.59
242	1,006	$2,069,633.74	$119,850.84	$1,885,424.39	$2,005,275.23	($2,057.29)	$2,003,217.94
243	4,752	$6,084,508.32	$612,293.89	$5,439,173.49	$6,051,467.38	($10,705.75)	$6,040,761.63
244	14	$16,125.62	$3,695.10	$15,736.35	$19,431.45	$0.00	$19,431.45
245	59	$67,957.97	$6,854.71	$65,635.75	$72,490.46	$0.00	$72,490.46
246	15	$38,490.75	$4,105.68	$34,385.07	$38,490.75	$0.00	$38,490.75
247	178	$456,756.90	$20,528.39	$438,627.21	$459,155.60	$0.00	$459,155.60
248	14	$25,047.12	$2,290.03	$22,757.09	$25,047.12	$0.00	$25,047.12
249	91	$162,806.28	$12,523.59	$148,493.61	$161,017.20	$0.00	$161,017.20
250	17	$34,087.04	$2,606.65	$31,480.39	$34,087.04	$0.00	$34,087.04
SUBTOTAL	**14,136**	**$14,277,469.83**	**$1,447,136.21**	**$12,813,410.99**	**$14,260,547.20**	**($23,215.56)**	**$14,237,331.64**
CIGNA Network Model Plan							
301	213	$431,808.51	$105,489.11	$320,503.47	$425,992.58	$0.00	$425,992.58
302	53	$194,038.30	$45,941.92	$148,096.38	$194,038.30	$0.00	$194,038.30
303	6	$25,938.42	$5,702.82	$15,912.53	$21,615.35	$0.00	$21,615.35
304	12	$32,282.28	$12,149.92	$20,132.36	$32,282.28	$0.00	$32,282.28
SUBTOTAL	**284**	**$684,067.51**	**$169,283.77**	**$504,644.74**	**$673,928.51**	**$0.00**	**$673,928.51**
CIGNA Preferred w/ Rx - Phoenix, AZ							
325	1	$966.90	$193.38	$773.52	$966.90	$0.00	$966.90
SUBTOTAL	**1**	**$966.90**	**$193.38**	**$773.52**	**$966.90**	**$0.00**	**$966.90**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,647	$2,323,538.19	$149,422.91	$2,147,186.58	$2,296,609.49	$2,761.92	$2,299,371.41
403	12,412	$3,620,083.92	$314,163.02	$3,305,179.00	$3,619,342.02	($4,885.59)	$3,614,456.43
404	446	$609,695.38	$9,569.17	$596,025.12	$605,594.29	($4,101.09)	$601,493.20
405	1,463	$2,069,164.79	$18,216.58	$2,048,119.55	$2,066,336.13	$2,828.66	$2,069,164.79
411	2,042	$5,745,248.68	$224,615.09	$5,414,553.75	$5,639,168.84	$27,777.68	$5,666,946.52
413	1,540	$2,609,422.20	$112,985.52	$2,481,283.04	$2,594,268.56	$1,694.43	$2,595,962.99
414	48	$132,950.40	$332.37	$124,438.89	$124,771.26	$0.00	$124,771.26
418	6,450	$3,710,814.00	$260,049.36	$3,429,997.86	$3,690,047.22	($3,470.94)	$3,686,576.28
419	216	$356,549.04	$4,357.85	$352,111.29	$356,469.14	$0.00	$356,469.14
420	95	$258,975.70	$1,308.50	$257,667.20	$258,975.70	$0.00	$258,975.70
421	9	$12,696.93	$1,015.75	$11,681.18	$12,696.93	$0.00	$12,696.93
422	280	$788,788.00	$1,577.57	$786,251.87	$787,829.44	$0.00	$787,829.44
426	253	$429,591.47	$4,007.28	$418,931.15	$422,938.43	$0.00	$422,938.43
428	41	$113,707.76	$554.67	$113,153.09	$113,707.76	$0.00	$113,707.76
430	142	$400,533.72	$3,102.74	$397,430.98	$400,533.72	($2,820.66)	$397,713.06
SUBTOTAL	**27,084**	**$23,181,760.18**	**$1,105,278.38**	**$21,884,010.55**	**$22,989,288.93**	**$19,784.41**	**$23,009,073.34**
Kaiser - Colorado							
450	5	$7,109.00	$568.72	$3,696.68	$4,265.40	$0.00	$4,265.40
451	38	$11,320.20	$1,412.04	$10,503.96	$11,916.00	$0.00	$11,916.00
453	8	$25,174.32	$2,654.07	$22,520.25	$25,174.32	$0.00	$25,174.32
455	6	$10,270.20	$924.32	$9,345.88	$10,270.20	$0.00	$10,270.20
457	18	$10,580.40	$1,058.04	$9,522.36	$10,580.40	$0.00	$10,580.40
459	2	$4,003.20	$80.06	$3,923.14	$4,003.20	$0.00	$4,003.20
SUBTOTAL	**77**	**$68,457.32**	**$6,697.25**	**$59,512.27**	**$66,209.52**	**$0.00**	**$66,209.52**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Georgia							
441	3	$5,342.61	$588.21	$4,754.40	$5,342.61	($1,560.52)	$3,782.09
442	7	$12,466.09	$1,372.49	$11,093.60	$12,466.09	($1,560.52)	$10,905.57
445	2	$4,373.48	$0.00	$4,373.48	$4,373.48	$0.00	$4,373.48
461	16	$28,493.92	$5,179.88	$28,215.95	$33,395.83	$0.00	$33,395.83
462	87	$36,006.69	$4,478.02	$33,172.09	$37,650.11	$0.00	$37,650.11
463	5	$17,768.70	$4,908.15	$12,860.55	$17,768.70	$0.00	$17,768.70
465	3	$6,560.22	$349.88	$6,210.34	$6,560.22	$0.00	$6,560.22
466	27	$22,132.98	$1,623.09	$20,509.89	$22,132.98	$0.00	$22,132.98
SUBTOTAL	**150**	**$133,144.69**	**$18,499.72**	**$121,190.30**	**$139,690.02**	**($3,121.04)**	**$136,568.98**
Kaiser - Hawaii							
471	5	$4,814.20	$577.71	$4,236.49	$4,814.20	$0.00	$4,814.20
472	28	$12,523.00	$2,039.46	$10,483.54	$12,523.00	$0.00	$12,523.00
473	1	$2,222.50	$637.70	$1,584.80	$2,222.50	$0.00	$2,222.50
474	4	$7,670.72	$0.00	$7,670.72	$7,670.72	$0.00	$7,670.72
475	2	$5,745.04	$0.00	$5,745.04	$5,745.04	$0.00	$5,745.04
476	4	$5,608.36	$1,233.84	$4,374.52	$5,608.36	$0.00	$5,608.36
477	1	$3,177.34	$319.44	$2,857.90	$3,177.34	$0.00	$3,177.34
478	14	$12,411.00	$602.82	$11,808.18	$12,411.00	$0.00	$12,411.00
479	1	$2,661.75	$0.00	$2,661.75	$2,661.75	$0.00	$2,661.75
SUBTOTAL	**60**	**$56,833.91**	**$5,410.97**	**$51,422.94**	**$56,833.91**	**$0.00**	**$56,833.91**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Oregon							
481	1	$1,414.96	$707.48	$707.48	$1,414.96	$0.00	$1,414.96
482	83	$46,911.60	$5,934.61	$40,411.79	$46,346.40	($565.20)	$45,781.20
483	5	$8,661.05	$1,117.40	$7,543.65	$8,661.05	$0.00	$8,661.05
484	4	$11,287.68	$0.00	$11,287.68	$11,287.68	$0.00	$11,287.68
486	4	$7,888.64	$0.00	$7,888.64	$7,888.64	$0.00	$7,888.64
488	32	$35,916.80	$5,207.92	$28,464.08	$33,672.00	$0.00	$33,672.00
491	1	$1,930.86	$0.00	$1,930.86	$1,930.86	$0.00	$1,930.86
492	1	$2,289.41	$0.00	$2,289.41	$2,289.41	$0.00	$2,289.41
SUBTOTAL	**131**	**$116,301.00**	**$12,967.41**	**$100,523.59**	**$113,491.00**	**($565.20)**	**$112,925.80**
SCAN Health Plan							
611	285	$81,883.35	$17,246.86	$61,082.59	$78,329.45	$0.00	$78,329.45
613	100	$56,662.00	$9,440.76	$29,383.72	$38,824.48	$0.00	$38,824.48
SUBTOTAL	**385**	**$138,545.35**	**$26,687.62**	**$90,466.31**	**$117,153.93**	**$0.00**	**$117,153.93**
SCAN Health Plan, AZ							
620	26	$7,470.06	$1,614.67	$10,452.35	$12,067.02	$0.00	$12,067.02
621	13	$7,366.06	$1,767.86	$11,831.02	$13,598.88	$0.00	$13,598.88
SUBTOTAL	**39**	**$14,836.12**	**$3,382.53**	**$22,283.37**	**$25,665.90**	**$0.00**	**$25,665.90**
SCAN Health Plan, NV							
622	19	$5,458.89	$683.80	$10,752.30	$11,436.10	$0.00	$11,436.10
623	6	$3,399.72	$1,358.96	$15,911.94	$17,270.90	$0.00	$17,270.90
SUBTOTAL	**25**	**$8,858.61**	**$2,042.76**	**$26,664.24**	**$28,707.00**	**$0.00**	**$28,707.00**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
UHC Medicare Adv.							
701	2,235	$865,950.75	$96,784.71	$771,992.64	$868,777.35	($1,162.35)	$867,615.00
702	406	$842,916.90	$43,516.12	$808,153.89	$851,670.01	$0.00	$851,670.01
703	1,441	$1,105,102.90	$102,175.73	$995,947.07	$1,098,122.80	$0.00	$1,098,122.80
704	107	$253,274.35	$9,348.46	$232,622.36	$241,970.82	$0.00	$241,970.82
705	52	$55,005.60	$3,335.97	$55,678.15	$59,014.12	$0.00	$59,014.12
706	1	$483.66	$19.35	$464.31	$483.66	$0.00	$483.66
SUBTOTAL	**4,242**	**$3,122,734.16**	**$255,180.34**	**$2,864,858.42**	**$3,120,038.76**	**($1,162.35)**	**$3,118,876.41**
United Healthcare							
707	583	$989,176.10	$120,961.73	$793,946.61	$914,908.34	$1,503.18	$916,411.52
708	512	$1,587,338.24	$151,668.97	$1,256,916.72	$1,408,585.69	$0.00	$1,408,585.69
709	388	$1,426,404.40	$158,182.30	$1,132,199.00	$1,290,381.30	$0.00	$1,290,381.30
SUBTOTAL	**1,483**	**$4,002,918.74**	**$430,813.00**	**$3,183,062.33**	**$3,613,875.33**	**$1,503.18**	**$3,615,378.51**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	85	$123,399.60	$4,732.71	$115,763.37	$120,496.08	$174.21	$120,670.29
802	340	$889,994.20	$26,281.06	$861,095.51	$887,376.57	$2,617.63	$889,994.20
803	425	$1,312,289.50	$48,045.36	$1,267,517.56	$1,315,562.92	$9,077.54	$1,324,640.46
804	207	$300,514.32	$10,597.80	$306,857.49	$317,455.29	($51,436.26)	$266,019.03
805	243	$636,084.09	$14,868.14	$618,598.32	$633,466.46	($51,983.70)	$581,482.76
806	756	$1,978,928.28	$41,358.55	$1,904,406.35	$1,945,764.90	($307,947.11)	$1,637,817.79
807	67	$206,878.58	$3,581.79	$203,296.79	$206,878.58	($13,541.70)	$193,336.88
808	24	$74,105.76	$1,976.16	$72,129.60	$74,105.76	($10,063.80)	$64,041.96
809	16	$23,228.16	$2,438.94	$20,789.22	$23,228.16	$0.00	$23,228.16
810	10	$26,176.30	$3,088.80	$23,087.50	$26,176.30	$0.00	$26,176.30
811	6	$18,526.44	$2,840.73	$15,685.71	$18,526.44	$0.00	$18,526.44
812	262	$380,361.12	$22,995.79	$359,746.22	$382,742.01	($53,390.00)	$329,352.01
813	2	$5,235.26	$0.00	$5,235.26	$5,235.26	($370.00)	$4,865.26
SUBTOTAL	**2,443**	**$5,975,721.61**	**$182,805.83**	**$5,774,208.90**	**$5,957,014.73**	**($476,863.19)**	**$5,480,151.54**
Kaiser - Washington							
393	5	$10,062.65	$2,138.65	$7,924.00	$10,062.65	$0.00	$10,062.65
394	23	$9,611.93	$977.90	$7,798.21	$8,776.11	$0.00	$8,776.11
395	3	$11,253.78	$2,680.08	$8,573.70	$11,253.78	$0.00	$11,253.78
397	2	$4,313.28	$0.00	$4,313.28	$4,313.28	$0.00	$4,313.28
398	12	$9,933.84	$1,523.20	$9,238.46	$10,761.66	$0.00	$10,761.66
SUBTOTAL	**45**	**$45,175.48**	**$7,319.83**	**$37,847.65**	**$45,167.48**	**$0.00**	**$45,167.48**
Medical Plan Total	**57,950**	**$68,547,648.92**	**$4,467,612.03**	**$63,329,370.97**	**$67,796,983.00**	**($479,339.66)**	**$67,317,643.34**

Medical and Dental Vision Insurance Premiums
August 2025

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	27,220	$1,529,764.00	$152,041.31	$1,396,569.29	$1,548,610.60	($2,051.11)	$1,546,559.49
502	25,027	$2,949,682.22	$216,968.72	$2,730,736.24	$2,947,704.96	($2,231.23)	$2,945,473.73
503	10	$693.00	$22.17	$670.83	$693.00	$0.00	$693.00
SUBTOTAL	**52,257**	**$4,480,139.22**	**$369,032.20**	**$4,127,976.36**	**$4,497,008.56**	**($4,282.34)**	**$4,492,726.22**
CIGNA Dental HMO/Vision							
901	4,391	$204,620.60	$20,781.87	$186,563.54	$207,345.41	$186.16	$207,531.57
902	3,295	$314,507.75	$22,570.91	$293,746.56	$316,317.47	$571.55	$316,889.02
903	3	$141.63	$35.88	$105.75	$141.63	$0.00	$141.63
SUBTOTAL	**7,689**	**$519,269.98**	**$43,388.66**	**$480,415.85**	**$523,804.51**	**$757.71**	**$524,562.22**
Dental/Vision Plan Total	**59,946**	**$4,999,409.20**	**$412,420.86**	**$4,608,392.21**	**$5,020,813.07**	**($3,524.63)**	**$5,017,288.44**
GRAND TOTALS	**117,896**	**$73,547,058.12**	**$4,880,032.89**	**$67,937,763.18**	**$72,817,796.07**	**($482,864.29)**	**$72,334,931.78**

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.**

LACERA

July 17, 2025

TO: Insurance, Benefits & Legislative Committee
Les Robbins, Chair
Ronald Okum, Vice Chair
Aleen Langton
Wayne Moore
Shawn Kehoe, Alternate

FROM: Cassandra Smith, Director
Retiree Healthcare Division

FOR: August 6, 2025 Insurance, Benefits, & Legislative Committee

SUBJECT: **ANNUAL ANTHEM BLUE CROSS AND CIGNA AUDITS**

As part of LACERA's administration of LACERA's Retiree Healthcare Benefits Program (RHCBP), our fiduciary duty is to ensure that our health plans are processing incurred claims in accordance with the group benefits. To ensure compliance of our contractual agreement by the health plans, we conduct an annual audit of claims in order to identify any discrepancies or inaccuracies in billing and payments made for group participants by our vendor partners.

LACERA has historically included within our Healthcare Consultants contract, as part of their Statement of Work, an annual claims audit of the LACERA-administered Indemnity Medical and Dental plans. Our indemnity plans are Anthem Blue Cross (I, II, III, and Prudent Buyer) medical and Cigna Indemnity dental (Cigna) PPO plans. Anthem Blue Cross and Cigna dental plans are the only identified plans due to the way claims are submitted and paid; via paper/electronic claim submissions for payment. HMO medical plans such as Kaiser Permanente, SCAN, and United Health billings are handled very differently, in that there are no paper claim submissions.

LACERA's healthcare consultant typically begins the annual audit process in late June. The auditor conducts a random selection of claims incurred during the identified period to be audited which assists LACERA with monitoring benefit compliance and to identify any discrepancies or inaccuracies in billing and payments made on claims for payment that assist with fulfilling LACERA's duty of administering the healthcare program and cost.

Staff would like to express our appreciation to the Segal team for their collaboration and continued guidance in LACERA's maintaining retiree healthcare cost and the program management.

Reviewed and approved:

Luis A. Lugo
Deputy Chief Executive Officer

Attachments

Los Angeles County Employees Retirement Association

Analysis of Anthem Blue Cross Medical Claims Processing and Payment Procedures

Audit Period: July 1, 2023, through June 30, 2024

Final Report

April 22, 2025 / Amber M. Turner, MBA, PMP

Segal

1501 West Fountainhead Parkway
Suite 370
Tempe, AZ 85282-1936
segalco.com

April 22, 2025

Cassandra Smith
Director, Retiree Healthcare Program
Retiree Healthcare Division
Los Angeles County Employees Retirement Association

Re: Analysis of Medical Claims Processing and Payment Procedures
July 2023 - June 2024

Dear Cassandra:

On behalf of the Los Angeles County Employees Retirement Association (LACERA), Segal's Benefit Audit Solutions Practice (Segal) completed a review of the medical health benefit plan administered by the Anthem Blue Cross (Anthem), for the period of July 1, 2023 through June 30, 2024. The audit includes an assessment of Anthem adjudication procedures, a random sampling of stratified statistical claims, and a targeted claim selection.

The following report presents the details and results of the review process.

Once you have reviewed this report, please let us know if you have any questions.

Sincerely,

Amber M. Turner

Amber M. Turner, MBA, PMP
Senior Consultant, Audits

cc: Stephen Murphy, Segal
Michael Szeto, Segal

Table of Contents

Section 1 — 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 Employees Retirement Association (LACERA) group medical benefits. Amber Turner and Michael Hosen of Segal's Benefit Audit Solutions (BAS) Practice conducted the remote audit during the week of October 28, 2024.

The audit encompassed a total sample of 255 claims consisting of 220 Stratified and 35 Target samples for the audit period of July 1, 2023 through June 30, 2024. The 255 sample claims equaling $5,487,731.41; or 3.32% by cost, of the $165,338,311.72 total claims for the audit period.

- $4,505,978.09 for the random, stratified statistical claim sample (220) statistical claims; and,
- $981,753.32 for the target claim sample (35) claims.

Overall, Segal identified $28,226.42 in overpayments and -$3,670.17 in underpayments, which are outlined under the Key Findings and Recommendation section.

Segal's audit included the following review components.

- A random, stratified sample of 220 statistical medical claims to measure validity in the financial dollar value and incidence; and,
- A 35-target claim selection identified through electronic analysis of all claims designed to explore potential duplicate payments and/or sample various benefit applications (i.e., deductibles, employee cost-share, limitations, and exclusions).
- A measurement of the time-to-process claims from receipt of claim to the initial date processed for payment or denial.
- An adjudication procedure review to assess day-to-day processing guidelines and claim control measures.

Statistical achievement categories

As illustrated in the chart below, Anthem met the performance guarantees for financial, procedural, and time-to-process accuracy but fell below industry standard for payment and overall accuracy. The audit period Accuracy Results do not include target and/or out-of-sample claims.

Performance Guarantees Table

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	99.62%	99.00%	99.00%
Payment Accuracy (Free from financial error)	88.42%	NA	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (Free from error)	88.42%	NA	95.00%
Time-to-Process			
(within 10 business days)	99.11%	90.00%	95.00%
(within 20 business days)	99.18%	NA	100.00%

Note: Time-to-process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.

NA = not applicable

Key findings and recommendations

The following issues summarize the primary findings identified by Segal's auditors during the claims review. 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 January 13, 2025 for its review and comment. Anthem provided its formal response to the audit report on February 10, 2025 and an additional amended response on March 21, 2025, which can both be found in Section 7 of this report.

Statistical and Target Audit Findings Summary Chart

Medical Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Number of Sample Claims
Issue 1: Medicare Coordination of Benefits (COB)	$3.92	-$113.48	16
Issue 2: Out-of-pocket/Deductible Overapplied	$0.00	-$552.86	17
Issue 3: Plan Payment Limitation	Error Removed	$0.00	0
Issue 4: Outpatient Coinsurance	$625.40	$0.00	1
Issue 5: Hearing Aids Limitation	$24,795.10 & 2 Procedural Errors	-$150.00	8
Issue 6: Acupuncture Limitation	$867.70	$0.00	8
Issue 7: Foot Orthotic Exclusion	$1,934.30	$0.00	5
Issue 8: Surgery Cost Sharing	$0.00	-$2,853.83	9
Total	**$28,226.42**	**-$3,670.17**	**64**

An Out-of-Sample finding is identified as a claim that is not sampled but identified through a sampled member's claims history.

Details regarding the identified deviations can be found in the claim sample error table in Sections 3 and Section 4 of this report.

Anthem stated it has acknowledged overpayments amounting to $27,323.38 and underpayments totaling $1,788.37.

Recommendations

Based upon the review, Segal recommends:

- Issue 1: Medicare Coordination of Benefits (COB) – Claims are not correctly coordinated with Medicare. Anthem disagreed to this issue as of March 21, 2025. Segal notes that this is a repeated error that was identified in previous audits for LACERA. As of March 21, 2025, Anthem is noting the claims were handled correctly according to specific arrangements for both professional and outpatient facility claims. As the plan document notes that Anthem will pay the 100% difference between Medicare's allowable charge and Medicare's paid amount, the amount residual for Anthem to pay is the member's responsibility (cost sharing), which in the cases of the claims identified in error were underpaid leaving the member with an amount left to make payment on. As this is a direct impact to the members and has occurred multiple times, Segal recommends that LACERA request the financial impact to the members from Anthem and for LACERA to discuss the plan intent regarding the Medicare coordination for Plan III with Anthem.
- Issue 2: Out-of-pocket/Deductible Overapplied – Due to the integration of pharmacy benefits in the maximum out-of-pocket overapplication of the cost sharing and deductible was identified. Anthem agreed to this issue. Segal notes that this is a repeated error that was identified in previous audits for LACERA. In March of 2024, Anthem introduced a new process to identify claims that fall into this category of overapplication but noted that the adjustment of the claims is still a manual process. Segal recommends that LACERA request that Anthem review its process with LACERA and that mutually agreeable timelines for adjustments are established.
- Issue 3: Plan Payment Limitation – Further information was supplied to Segal by Anthem to dissolve this issue. No further intervention is necessary.
- Issue 4: Outpatient Coinsurance – Outpatient coinsurance was not applied to a hospital clinic visit. Anthem agreed to this issue. As it was determined only one claim was identified during the review and the claim was manually adjudicated, Anthem provided coaching to its processor. Anthem noted that the claim can be re-adjudicated to apply cost sharing to the member at LACERA's discretion. No further intervention is necessary on this claim issue.
- Issue 5: Hearing Aids Limitation – Hearing aids were paid over the $300.00 payment limitation. Anthem agreed to this issue. Segal notes that this is a repeated error that was identified in previous audits. Segal recommends that LACERA requests from Anthem the root cause, impact, and solution for this issue.
- Issue 6: Acupuncture Limitation – Acupuncture was paid over the $30.00 payment limitation. Anthem agreed to this issue. Segal notes that this is a repeated error that was identified in previous audits. Segal recommends that LACERA requests from Anthem the root cause and solution for this issue.

- Issue 7: Foot Orthotic Exclusion – Foot orthotics, which are listed as an exclusion outside of having a diagnosis of diabetes, were paid. Anthem disagreed with this issue. Segal notes that this is a repeated error that was identified in previous audits. Segal recommends that LACERA discuss this issue with Anthem and determine if a plan document update is necessary.
- Issue 8: Surgery Cost Sharing – Surgery cost that were to pay at 100% applied cost sharing. Anthem agreed to this issue. Segal notes that this is a repeated error that was identified in previous audits. Anthem provided coaching to its processors as all were manual adjudication issues. As this is a direct impact to the members and has occurred multiple times, Segal recommends that LACERA request the financial impact to the members from Anthem and for Anthem to provide LACERA with a root cause and solution.

Section 2 — Audit Details

Anthem provided an electronic data file of all medical claims processed and paid during the 12-month period of July 1, 2023 through June 30, 2024. The objective of the review was to ensure that claims were paid in accordance with the LACERA's plan provision.

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.

Review process

Anthem provided a copy of the sampled claim submissions and access through its Claim System. 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. 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 (COB) and subrogation provisions were enforced, where applicable.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Proper medical authorization is on file, as applicable.
- 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 stop-loss notifications were filed timely, as applicable.
- 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 if benefits were not assigned).
- Time-to-process for processing of claims was within industry standards or established performance guarantees.

The 2022 and 2023 Summary Plan Descriptions (SPD) served as references for the statistical and electronic analyses; please note that a full list of resources documents has been added to the appendix. For the target claims selection, reports from the electronic analysis provided a list of suspected errors that required the auditor's manual review to refine the analysis and identify and patterns of concern, a selection of claims was chosen to confirm suspected errors and identify appropriate query revisions.

All questions and potential errors were presented to Anthem's representatives; outstanding responses post-audit were provided on all but two responses. On January 7, 2025, Anthem notified Segal to move forward with the report and the formal response will include the two outstanding responses.

Section 3 — Statistical Review

The selection of 220 random claims for plan year July 1, 2023 through June 30, 2024 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

Below is the stratification table utilized for the audit.

Strata	Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar-Amount in Selection	Dollar-Amount in Strata
A	$0.01–$19.99	254,435	38	$417.10	$2,926,304.63
B	$20.00–$39.99	251,248	38	$1,025.81	$7,088,296.59
C	$40.00–$219.99	258,023	39	$4,051.47	$24,535,125.02
D	$220.00–$674.99	59,568	20	$7,479.16	$21,480,892.29
E	$675.00–$1,749.99	21,621	15	$17,479.73	$25,252,913.22
F	$1,750.00–$3,499.99	6,054	10	$23,293.18	$14,568,618.14
G	$3,500.00–$7,499.99	3,273	10	$48,297.89	$16,526,248.31
H	$7,500.00–$14,999.99	1,109	10	$92,608.09	$11,485,203.14
I	$15,000.00–$44,999.99	862	15	$365,859.96	$21,260,463.61
J	$45,000.00–$213,999.99	220	15	$1,376,546.93	$17,645,328.00
K	$214,000.00–$406,691.55	10	10	$2,568,918.77	$2,568,918.77
Total		**856,423**	**220**	**$4,505,978.09**	**$165,338,311.72**

Statistical claim sample error table

The review of 220 statistical sample claims for the audit period of July 1, 2023 through June 30, 2024 identified seventeen (17) in-sample errors:

- Three (3) overpayments totaling $629.32; and,
- Fourteen (14) underpayments totaling -$113.48.

In addition to the above errors, fifteen (15) out-of-sample (OOS) underpayments totaling -$381.02 were identified. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

Segal requested that Anthem initiate adjustment and recovery for claims identified in the following table and provide financial impact reports and adjustments when noted in the table below. Anthem's responses are summarized and italicized with formal response found in Section 7 of this report.

Statistical Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
Issue 1: Medicare COB					
10A	-$1.79	**Auto**	Claims incorrectly coordinated benefits with the other insurance. *Anthem disagreed with these errors during the remote review and noted that it will only pay 20%.* Segal disagreed with Anthem and noted that Page 6 (Plan III in state) and Page 5 (Plan III out-of-state) of the plan document it is noted that "We will pay 100% of the difference between Medicare's Allowable Charge(s) and the amount Medicare pays for medically necessary Part	*Anthem claims IT team is currently conducting a thorough investigation into the identified issue. Additional information and updates will be provided as soon as they become available.* *Anthem's updated response on March 21, 2025: Upon further examination, it was found that Medicare claims for LACERA are handled according to specific arrangements for both professional and outpatient facility claims. In the case of professional claims, the*	**Segal notes that this is a repeated error that was identified in previous audits for LACERA.** **As of March 21, 2025, Anthem is disagreeing with the error and noting that the claims were handled correctly and according to specific arrangements for both professional and outpatient facility claims. As the plan document notes that Anthem will pay the 100% difference between Medicare's allowable charge and**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			B services and supplies". As such, Anthem should pay the full patient responsible as noted by Medicare. Segal requested that Anthem review this page of the plan document and determine if a financial impact report should be generated to assess financial impact for this issue.	*payment structure allows Anthem to cover 20% of the Medicare allowance. For outpatient facility claims, Anthem is responsible for the full Medicare patient responsibility. Anthem has verified that each claim in the sample was processed correctly.*	**Medicare's paid amount, the amount residual for Anthem to pay is the member's responsibility (cost sharing), which in the cases of the claims identified in error, were underpaid leaving the member with an amount left to make payment on. As this is a direct impact to the members and has occurred multiple times, Segal recommends that LACERA request the financial impact to the members from Anthem and for LACERA to discuss the plan intent regarding the Medicare coordination for Plan III with Anthem.**
11A	-$1.09	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
22A	-$22.08	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
28A	-$16.71	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
30A	-$0.83	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
35A	-$1.93	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
36A	-$1.37	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
44B	-$2.93	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
64B	-$2.98	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
73B	-$1.22	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
74B	-$0.69	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
92C	$0.82	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
100C	$3.10	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
114C	-$8.02	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
120D	-$26.13	**Auto**	See worksheet 10A for explanation. *Anthem did not provide a response regarding this error during the remote review and noted it will respond within its formal response to the audit report.*	*The Anthem claims IT team is currently conducting a thorough investigation into the identified issue. Additional information and updates will be provided as soon as they become available.*	See worksheet 10A for explanation.
127D	-$25.71	**Auto**	See worksheet 10A for explanation.	See worksheet 10A for explanation.	See worksheet 10A for explanation.
Issue 2: Out-of-pocket/Deductible Overapplied					
63B – OOS	OOS: -$0.55	**Auto**	The annual deductible and/or out-of-pocket was overapplied. *Anthem agreed to these errors during the remote*	*This plan includes pharmacy integration, where pharmacy claims are recorded as history claims through the data transmission between*	**Segal notes that this is a repeated error that was identified in previous audits for LACERA. Segal recommends that LACERA request that**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			review and noted that it is due to the comingling of the cost sharing with the pharmacy. As this is a reoccurring error and corrective action was provided in years previous, Segal requested that Anthem provide the reason as to why corrective action steps are still not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal requested that Anthem provide financial impact reporting for this issue and adjust the claims and refund the members.	*Anthem and the pharmacy vendor. During this process an overage in out-of-pocket may occur. A manual workflow has consistently been in place to detect and correct these overages.* *In March 2024, Anthem implemented a new reporting system to identify overages. However, the process for capturing and correcting these discrepancies remains manual, which may occasionally result in delays in adjusting member files. Anthem is aware of this potential issue and continues to review opportunities to enhance the process. All identified cases are currently under review to address any overages.*	**Anthem review its process with LACERA and that mutually agreeable timelines for adjustments are established.**
93C – OOS	OOS: -$5.05	**Auto**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
136E – OOS	OOS: -$3.27	**Auto**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
142E – OOS	OOS: -$8.78	**Auto**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
165G – OOS	OOS: -$4.61	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
179H – OOS	OOS: -$50.36	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
186I – OOS	OOS: -$34.66	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
187I – OOS	OOS: -$18.59	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
192I – OOS	OOS: -$13.65	**Auto**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
197J – OOS	OOS: -$118.77	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
199J – OOS	OOS: -$3.39	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
201J – OOS	OOS: -$6.42	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
204J – OOS	OOS: -$51.72	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
209J - OOS	OOS: -$1.83	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
213K - OOS	OOS: -$59.37	**Manual**	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.	See worksheet 63B – OOS for explanation.
Issue 3: Plan Payment Limitation					
181I - OOS	Error Removed	**Auto**	The lifetime maximum payment benefit was over applied. *Anthem did not provide a response for this issue during the remote review and noted it will respond within its formal response to the audit report.* Segal recommended that Anthem review this issue and provide the root cause	*Anthem disagrees. After thorough review, we have determined that the lifetime maximum was not overapplied, and there is no overpayment in the amount of $421,994.78. In the audit report, Segal noted that the major medical paid amount accumulator surpassed the $1 million lifetime maximum. This accumulator is used to track the benefit reserve for*	**Upon further information supplied by Anthem, Segal determined it was appropriate to dissolve this issue. No further intervention is necessary.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			as well as adjust the members account, as applicable.	*claims that apply secondary coverage. The benefit reserve represents the amount Anthem saves by coordinating with the primary payer. It is calculated by deducting the amount Anthem pays as a secondary payer from the amount it would have paid had Anthem been the primary payer.* *Importantly, while these benefit reserve savings are not applied to the LACERA plans, LACERA has requested that these savings be tracked.*	
Issue 4: Outpatient Coinsurance					
188I	$625.40	**Auto**	Outpatient coinsurance for a hospital clinic visit was not applied. *Anthem agreed to this error during the remote review.* Segal requested that Anthem provide the root cause of this error as well as apply corrective action.	*Anthem agrees to a manual processing error. Refresher training has been provided to the team. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.*	**As it was determined only one claim was identified during the review and the claim was manually adjudicated, Anthem provided coaching to its processor. Anthem noted that the claim can be re-adjudicated to apply cost sharing to the member at LACERA's discretion. No further intervention is necessary on this claim issue.**

Description	Amount
3 Overpayments	$629.32
14 Underpayments	-$113.48
15 OOS Underpayments	-$381.02

Segal does not guarantee the accuracy of the claims adjudication of the medical benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Anthem's medical claims adjudication. The results in this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

Section 4 — Target Review

Segal performed an electronic review of all claims processed and paid during the audit period of July 1, 2023 through June 30, 2024. The electronic review was designed to identify potential deficiencies in the benefit delivery system.

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

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

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 sample error table

The review of 35 target sample claims for the audit period of July 1, 2023 through June 30, 2024 identified twenty-nine (29) in-sample errors affecting twenty-seven (27) claims:

- Seventeen (17) overpayments totaling $27,137.42;
- Ten (10) underpayments totaling -$3,003.83; and,
- Two (2) procedural errors.

In addition to the above errors, five (5) out-of-sample (OOS) errors were identified. The five (5) errors included three (3) overpayments for $459.68 and two (2) underpayments totaling -$171.84. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

Segal requested that Anthem initiate adjustment and recovery for claims identified in the following table and provide financial impact reports and adjustments when noted in the table below. Anthem's responses are summarized and italicized with formal response found in Section 7 of this report.

Target Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
Issue 5: Hearing Aids Limitation					
T1	-$150.00 & Procedural Error	**Manual**	Hearing aids were first overpaid but then adjusted to underpay the $300.00 benefit. Additionally, the amount billed was keyed incorrectly by the processor. *Anthem agreed to this error during the remote review*. Segal requested that Anthem adjust the claim in error and provide coaching to its processors regarding the $300.00 hearing aid limitation	*Anthem agrees to a manual processing error. Refresher training has been provided to the claims team and the sample claim will be placed into the adjustment process.*	**As Anthem is taking action to correct this claim, no further intervention is necessary.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			and quality obligations when manually adjudicating claims.		
T2	$1,384.20	**Manual**	Hearing aids paid more than the $300.00 limitation. *Anthem agreed to this error during the remote review.* Segal requested that Anthem adjust the claim in error and provide coaching to its processors regarding the $300.00 hearing aid limitation as well as provide an action plan for avoiding this problem going forward as it is a reoccurring issue identified in the previous audit.	*Anthem agrees to a manual processing error. Refresher training has been provided to the claims team. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.* *In April 2024, Anthem instituted the practice of conducting quarterly claims reports to identify claims that exceed the hearing aid benefit maximum. These reports undergo a thorough review, and claim adjustments are executed in accordance with our established overpayment and recovery guidelines.*	**Segal notes that this is a repeated error that was identified in previous audits. Segal recommends that LACERA requests from Anthem the root cause, impact, and solution for this issue.**
T3	$3,195.00	**Manual**	See worksheet T2 for explanation.	See worksheet T2 for explanation.	See worksheet T2 for explanation.
T4	$4,195.00	**Manual**	See worksheet T2 for explanation.	See worksheet T2 for explanation.	See worksheet T2 for explanation.
T5	$4,947.20	**Manual**	See worksheet T2 for explanation.	See worksheet T2 for explanation.	See worksheet T2 for explanation.
T6	$4,947.20	**Manual**	See worksheet T2 for explanation.	See worksheet T2 for explanation.	See worksheet T2 for explanation.
T7	$4,690.00 & Procedural Error	**Manual**	Hearing aids paid more than the $300.00 limitation and did not apply coinsurance at 50%. *Anthem agreed to this error during the remote review.*	See worksheet T2 for explanation.	See worksheet T2 for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			Segal requested that Anthem adjust the claim in error and provide coaching to its processors regarding the $300.00 hearing aid limitation and cost sharing as well as provide an action plan for avoiding this problem going forward as it is a reoccurring issue identified in the previous audit.		
T8	$1,436.50	**Manual**	See worksheet T2 for explanation.	See worksheet T2 for explanation.	See worksheet T2 for explanation.
Issue 6: Acupuncture Limitation					
T9	$53.64 & OOS: $177.17	**Manual**	Acupuncture paid over the $30.00 payment limit. *Anthem agreed to these errors during the remote review.* Segal requested that Anthem adjust the claim in error and provide coaching to its processors regarding the $30.00 acupuncture limitation as well as provide an action plan for avoiding this problem going forward as it is a reoccurring issue identified in the previous audit.	*Anthem acknowledges the assigned errors, with the primary cause identified as the manual processing of acupuncture claims. Refresher training has been provided to the claims team. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.*	**Segal notes that this is a repeated error that was identified in previous audits. Segal recommends that LACERA requests from Anthem the root cause and solution for this issue.**
T10	$70.00	**Manual**	See worksheet T9 for explanation.	See worksheet T9 for explanation.	See worksheet T9 for explanation.
T11	$32.38 & OOS: $68.01	**Manual**	See worksheet T9 for explanation.	See worksheet T9 for explanation.	See worksheet T9 for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
T12	$165.00	**Manual**	See worksheet T9 for explanation.	See worksheet T9 for explanation.	See worksheet T9 for explanation.
T13	$87.00 & OOS: $214.50	**Auto**	See worksheet T9 for explanation.	*Anthem agrees that acupuncture services were paid in error. We are working with our claims IT team to determine the root cause of this error. Additional information and updates will be provided as soon as they become available.* *Anthem's updated response on March 21, 2025: Upon further review of sample T13, it was determined that the claim was processed correctly in line with Anthem's standard coordination of benefits. Since the member's primary insurance is through a different Anthem plan, the LACERA Anthem plan is considered secondary, and the claim was processed according to the primary plan's allowance. Although the plan allows a maximum of $30 per day for acupuncture, Anthem is still obligated to cover the coordination of benefits allowance.*	See worksheet T9 for explanation.
Issue 7: Foot Orthotics Exclusion					

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
T14	$411.20	**Manual**	Foot orthotics, which are an exclusion were paid. *Anthem disagreed with these errors during the remote review and noted that coverage is not limited to a diabetic diagnosis.* Segal referenced page 48 (Plan II out of state) and page 49 (Plan II In State) of the plan document under what is not covered under the medical plan that notes Foot Orthotics. Segal requested that Anthem clarify its position on this benefit as it contradicts the plan documents.	*Anthem disagrees to the errors assessed for foot orthotics. The services reported for each target sample are covered under plan benefits and are not restricted to a diabetic diagnosis. Consequently, the sample claims have been processed correctly in accordance with the plan's provisions. If this does not align with LACERA's intended benefits, Anthem's account management team is available to discuss potential benefit options.*	**Segal notes that this is a repeated error that was identified in previous audits. Segal recommends that LACERA discuss this issue with Anthem and determine if a plan document update is necessary.**
T15	$328.96	**Manual**	See worksheet T14 for explanation.	See worksheet T14 for explanation.	See worksheet T14 for explanation.
T16	$354.14	**Auto**	See worksheet T14 for explanation.	See worksheet T14 for explanation.	See worksheet T14 for explanation.
T17	$480.00	**Auto**	See worksheet T14 for explanation.	See worksheet T14 for explanation.	See worksheet T14 for explanation.
T18	$360.00	**Manual**	See worksheet T14 for explanation.	See worksheet T14 for explanation.	See worksheet T14 for explanation.
Issue 2: Out-of-pocket/Deductible Overapplied					
T21 – OOS	OOS: -$162.79	**Manual**	The annual deductible was overapplied. *Anthem agreed to these errors during the remote review and noted that it is due to the*	*This plan includes pharmacy integration, where pharmacy claims are recorded as history claims through the data transmission between Anthem and the pharmacy*	**Segal notes that this is a repeated error that was identified in previous audits for LACERA. Segal recommends that LACERA request that Anthem review its**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			comingling of the cost sharing with the pharmacy. As this is a reoccurring error and corrective action was provided in years previous, Segal requested that Anthem provide the reason as to why corrective action steps are still not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal requested that Anthem provide financial impact reporting for this issue and adjust the claims and coordinate refunds to the members.	*vendor. During this process an overage in out-of-pocket may occur. A manual workflow has consistently been in place to detect and correct these overages.* *In March 2024, Anthem implemented a new reporting system to identify overages. However, the process for capturing and correcting these discrepancies remains manual, which may occasionally result in delays in adjusting member files. Anthem is aware of this potential issue and continues to review opportunities to enhance the process. All identified cases are currently under review to address any overages.*	**process with LACERA and that mutually agreeable timelines for adjustments are established.**
T31(A) - OOS	OOS: -$9.05	**Auto**	See worksheet T21-OOS for explanation.	See worksheet T21-OOS for explanation.	See worksheet T21-OOS for explanation.
Issue 8: Surgery Coinsurance					
T23	-$700.40	**Manual**	Coinsurance was applied to physician and surgery claims when not applicable. *Anthem agreed to these errors during the remote review.* Segal requested that Anthem provide the root cause of this issue and generate financial	*Anthem acknowledges the assigned errors, with the primary cause identified as the manual processing of physician surgery claims. Refresher training has been provided to the claims team and the sample claims will*	**As this is a direct impact to the members and has occurred multiple times, Segal recommends that LACERA request the financial impact to the members from Anthem and for Anthem to provide**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			impact reporting as systematic processing of claims for this issue was identified. Additionally, Segal requested that Anthem coordinate refunds to the members as well as additional coaching to its processors for this issue.	*be placed into the adjustment process.*	**LACERA with a root cause and solution.**
T24	-$682.40	**Manual**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T25	-$442.20	**Manual**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T26	-$402.46	**Manual**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T27	-$450.30	**Manual**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T28	-$99.31	**Auto**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T29	-$45.47	**Manual**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T30	-$9.05	**Manual**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T31 (b)	-$22.24	**Auto**	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.

Summary of Target Sample Findings

Description	Amount
17 Overpayments	$27,137.42
3 OOS Overpayments	$459.68
10 Underpayments	-$3,003.83

Description	Amount
2 OOS Underpayments	-$171.84
2 Procedural Errors	

Segal does not guarantee the accuracy of the claims adjudication of the medical benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Anthem's medical claims adjudication. The results in this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

Section 5 — 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 medical claims processed during the audit period of July 1, 2023 through June 30, 2024 revealed Anthem processed 99.11% of the claims within fourteen (14) calendar days and 99.18% within thirty (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. Industry standards indicate 95% of all claims should be processed within fourteen (14) calendar days. Best practice, which follows U.S. Department of Labor, Employee Benefits Security Administration (EBSA), requires 100% within thirty (30) calendar days.*

Segal's electronic calculations of all claims processed within the audit period did not allow for distinction of multiple processing events; therefore, Segal can conclude that there are no issues with the time to process.

* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits.pdf.

Section 6 — Adjudication Procedures Review

The objective of the review is to ensure that proper procedures are in place to ensure claims control measures. The processing guidelines were described in the Adjudications Procedures Review and evidenced within the 220 statistical and 35 target claim samples or confirmed through discussion with Anthem'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 Plan costs.

- LACERA's claims are processed by a designated group of Anthem processors.
  - Anthem's Member Service Representatives are trained to process and assist with claims processing and adjustments.
  - If excess claims are submitted, designated staff who process claims regularly can aid the designated claim processors.
  - Processors who work from home are required to have a HIPAA compliant work area and sign a work-from-home agreement.
    - Prior to being allowed to work from home, Anthem's manager inspects the workspace.
    - Random inspections are conducted periodically throughout the year.
- On average, Anthem receives 81,080 claims monthly for LACERA.
  - 98.11% of LACERA's claims are submitted electronically.
    - 97.8% of Anthem's claims companywide are submitted electronically.
  - 90.22% of LACERA's claims are auto adjudicated.
    - 91.43% of Anthem's claims companywide are auto adjudicated.
- Eligibility information is submitted to Anthem by LACERA by email.
  - Anthem reconciles this information on a monthly basis.
- For possible third-party liability (TPL) claims, Anthem submits a questionnaire to the member based on diagnosis codes received on claims.
  - Anthem's claim system also has the capability to automatically identify possible TPL claims.
  - The minimum dollar amount to initiate TPL claim recoveries is $750.00.
- If additional information is necessary to adjudicate claims, Anthem's claim system has the capability to automate letters.
  - The following letters can be automatically generated:
    - Explanation of Benefits
    - Letter regarding other insurance
    - Provider remittance

    - Requests for medical records
- Per California mandate, Anthem continues to cover in-network COVID testing and the associated visit at 100%.
  - As of November 11, 2023, Anthem resumed normal cost sharing for out-of-network COVID testing.
- Facility and Professional Claims that are paying more than $40,000 are sent for a high dollar claims review.
  - Claims paying higher than $300,000 undergo a secondary end-to-end audit completed by an audit lead or senior auditor to confirm accuracy.
- The following criteria may trigger a case management referral.
  - Inpatient admission of 10 days or greater
  - NICU admissions
  - High risk on readmission predictive model
  - Carelon's oncology management triggers to help Anthemidentify and engage members with cancer sooner
  - An unplanned hospital admission by a member who was recently followed in care management (within the previous 30 days)
  - Catastrophic illnesses and injuries
  - High-dollar claims (greater than $75,000)
  - Potential transplant candidates
  - Specialty high-cost drugs
- Anthem's financial operations department manages overpayment recoveries.
  - All overpayments over the amount of $30.00 are pursued.
- Anthem utilizes the FAIR Health database to determine reasonable and customary allowances.
- The following subcontractor provides service to Anthem Blue Cross for LACERA's claims:
  - Excela
    - Location: India, Philippines, Colorado, and Texas
    - Services: Mail pickup, batching and prepping imaging, and data entry

Section 7 — Anthem's Formal Response to the Draft Report

Anthem

Anthem Blue Cross
Customer Audit Services
220 Virginia Avenue
Indianapolis, IN 46204

February 10, 2025

Amber Turner, MBA, PMP
Senior Consultant, Audits
500 North Brand Blvd, Suite 1400
Glendale, CA 91203-3338

RE: Los Angeles County Employees Retirement Association Medical Claim Audit

Dear Ms. Turner:

Anthem Blue Cross (Anthem) reviewed the audit report prepared by Segal on behalf of Los Angeles County Employees Retirement Association (LACERA). The audit was conducted remotely during the week of October 28, 2024. The audit encompassed a total sample of 255 claims consisting of 220 Stratified and 35 Target samples for the audit period of July 1, 2023, through June 30, 2024.

Executive Summary
Segal has identified $450,221.20 in overpayments $3,670.17 in underpayment. During the audit, Out of Sample (OOS) errors were also uncovered. OOS claims refer to the claims that have not been selected as sample claims by Segal for the audit purpose but are identified through the claim history of a sampled member. These claims don't contribute to the financial accuracy aspect of the audit.

It should be noted that Anthem has acknowledged overpayments amounting to $27,323.38 and underpayments totaling $1,788.37. Anthem's response to Segal's findings and recommendations are presented below.

Statistical Claim Sample

Issue 1: Medicare COB

Samples 10A, 11A, 22A, 28A, 30A 35A, 36A, 44B, 64B, 73B, 74B, 92C, 100C, 114C, 120D and 127D: Claims incorrectly coordinated benefits with the other insurance. Segal disagrees with Anthem and notes that Page 6 (Plan III in state) and Page 5 (Plan III out-of-state) of the plan document it is noted that "We will pay 100% of the difference between Medicare's Allowable Charge(s) and the amount Medicare pays for medically necessary Part B services and supplies". As such, Anthem should pay the full patient responsible as noted by Medicare. Segal requests that Anthem review this page of the plan document and determine if a financial impact report should be generated to assess financial impact for this issue.

Anthem's Response: *The Anthem claims IT team is currently conducting a thorough investigation into the identified issue. Additional information and updates will be provided as soon as they become available.*

Issue 2: Out-of-pocket/Deductible Overapplied, Out-of-Sample Errors

Samples 63B, 93C, 136E, 142E, 165G, 179H, 186I, 187I, 192I, 197J, 199J, 201J, 204J, 209J, and 213K: The annual deductible and/or out-of-pocket was overapplied. Anthem agreed to these errors during the remote review and noted that it is due to the comingling of the cost sharing with the pharmacy. As this is a reoccurring error and corrective action was provided in years previous, Segal requests that Anthem provide the reason as to why corrective action steps are still not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal requests that Anthem provide financial impact reporting for this issue and adjust the claims and refund the members.

Anthem's Response: *This plan includes pharmacy integration, where pharmacy claims are recorded as history claims through the data transmission between Anthem and the pharmacy vendor. During this process an overage in out-of-pocket may occur. A manual workflow has consistently been in place to detect and correct these overages.*

In March 2024, Anthem implemented a new reporting system to identify overages. However, the process for capturing and correcting these discrepancies remains manual, which may occasionally result in delays in adjusting member files. Anthem is aware of this potential issue and continues to review opportunities to enhance the process. All identified cases are currently under review to address any overages.

Issue 3: Plan Payment Limitation, Out-of-Sample Error

Sample 181I: The lifetime maximum payment benefit was over applied. Segal recommends that Anthem review this issue and provide the root cause as well as adjust the members account, as applicable.

Anthem's Response: *Anthem disagrees. After thorough review, we have determined that the lifetime maximum was not overapplied, and there is no overpayment in the amount of $421,994.78. In the audit report, Segal noted that the major medical paid amount accumulator surpassed the $1 million lifetime maximum. This accumulator is used to track the benefit reserve for claims that apply secondary coverage. The benefit reserve represents the amount Anthem saves by coordinating with the primary payer. It is calculated by deducting the amount Anthem pays as a secondary payer from the amount it would have paid had Anthem been the primary payer.*

Importantly, while these benefit reserve savings are not applied to the LACERA plans, LACERA has requested that these savings be tracked.

Issue 4: Outpatient Coinsurance

Sample 188I: Outpatient coinsurance for a hospital clinic visit was not applied. Segal requests that Anthem provide the root cause of this error as well as apply corrective action.

Anthem's Response: *Anthem agrees to a manual processing error. Refresher training has been provided to the team. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.*

Target Claim Sample

Issue 5: Hearing Aids Limitation

Sample T1: Hearing aids were first overpaid but then adjusted to underpay the $300.00 benefit. Additionally, the amount billed was keyed incorrectly by the processor. Segal requests that Anthem adjust the claim in error and provide coaching to its processors

regarding the $300.00 hearing aid limitation and quality obligations when manually adjudicating claims.

Anthem's Response: *Anthem agrees to a manual processing error. Refresher training has been provided to the claims team and the sample claim will be placed into the adjustment process.*

Sample T2, T3, T4, T5, T6, T7, and T8: Hearing aids paid more than the $300.00 limitation. Segal requests that Anthem adjust the claim in error and provide coaching to its processors regarding the $300.00 hearing aid limitation as well as provide an action plan for avoiding this problem going forward as it is a reoccurring issue identified in the previous audit.

Anthem's Response: *Anthem agrees to a manual processing error. Refresher training has been provided to the claims team. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.*

In April 2024, Anthem instituted the practice of conducting quarterly claims reports to identify claims that exceed the hearing aid benefit maximum. These reports undergo a thorough review, and claim adjustments are executed in accordance with our established overpayment and recovery guidelines.

Issue 6: Acupuncture Limitation

Samples T9, T10, T11, and T12: Acupuncture paid over the $30.00 payment limit. Segal requests that Anthem adjust the claim in error and provide coaching to its processors regarding the $30.00 acupuncture limitation as well as provide an action plan for avoiding this problem going forward as it is a reoccurring issue identified in the previous audit.

Anthem's Response: *Anthem acknowledges the assigned errors, with the primary cause identified as the manual processing of acupuncture claims. Refresher training has been provided to the claims team. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.*

Sample T13: *Anthem agrees that acupuncture services were paid in error. We are working with our claims IT team to determine the root cause of this error. Additional information and updates will be provided as soon as they become available.*

Issue 7: Foot Orthotics Exclusion

Samples T14, T15, T15, T16, T17, and T18: Foot orthotics, which are an exclusion were paid. Segal references page 48 (Plan II out of state) and page 49 (Plan II In State) of the plan document under what is not covered under the medical plan that notes Foot Orthotics. Segal requests that Anthem clarify its position on this benefit as it contradicts the plan documents.

Anthem's Response: *Anthem disagrees to the errors assessed for foot orthotics. The services reported for each target sample are covered under plan benefits and are not restricted to a diabetic diagnosis. Consequently, the sample claims have been processed correctly in accordance with the plan's provisions. If this does not align with LACERA's intended benefits, Anthem's account management team is available to discuss potential benefit options.*

Issue 2: Out-of-pocket/Deductible Overapplied, Out-of Sample Errors

Samples T21 and T31A: The annual deductible was overapplied. As this is a reoccurring error and corrective action was provided in years previous, Segal requests that Anthem provide the

reason as to why corrective action steps are still not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal requests that Anthem provide financial impact reporting for this issue and adjust the claims and coordinate refunds to the members.

Anthem's Response: *This plan includes pharmacy integration, where pharmacy claims are recorded as history claims through the data transmission between Anthem and the pharmacy vendor. During this process an overage in out-of-pocket may occur. A manual workflow has consistently been in place to detect and correct these overages.*

In March 2024, Anthem implemented a new reporting system to identify overages. However, the process for capturing and correcting these discrepancies remains manual, which may occasionally result in delays in adjusting member files. Anthem is aware of this potential issue and continues to review opportunities to enhance the process. All identified cases are currently under review to address any overages.

Issue 8: Surgery Coinsurance

Sample T23, T24, T25, T26, T27, T28, T29, T30, and T31B: Coinsurance was applied to physician and surgery claims when not applicable. Segal requests that Anthem provide the root cause of this issue and generate financial impact reporting as systematic processing of claims for this issue was identified. Additionally, Segal requests that Anthem coordinate refunds to the members as well as additional coaching to its processors for this issue.

Anthem's Response: *Anthem acknowledges the assigned errors, with the primary cause identified as the manual processing of physician surgery claims. Refresher training has been provided to the claims team and the sample claims will be placed into the adjustment process.*

Thank you for providing Anthem the opportunity to respond to this audit report. Anthem representatives are available to discuss the results of this audit with Segal and LACERA upon request and we look forward to working with Segal and LACERA in the future.

Sincerely,

Shaniqua Johnson

Shaniqua Johnson
External Audit Facilitator, Senior
Customer Audit Services

cc: Karima Carr, Elevance Health
Marijane Gadbury, Elevance Health
Menchie Hall, Anthem
Nicole Harber, Anthem
LaTosha Harwell, Elevance Health
Gerry Hayes, Anthem

Anthem's updated response on March 21, 2025

Issue 1-Samples 10A, 11A, 22A, 28A, 30A 35A, 36A, 44B, 64B, 73B, 74B, 92C, 100C, 114C, 120D and 127D

Upon further examination, it was found that Medicare claims for LACERA are handled according to specific arrangements for both professional and outpatient facility claims. In the case of professional claims, the payment structure allows Anthem to cover 20% of the Medicare allowance. For outpatient facility claims, Anthem is responsible for the full Medicare patient responsibility. Anthem has verified that each claim in the sample was processed correctly.

Issue 6-Sample T13

Upon further review of sample T13, it was determined that the claim was processed correctly in line with Anthem's standard coordination of benefits. Since the member's primary insurance is through a different Anthem plan, the LACERA Anthem plan is considered secondary, and the claim was processed according to the primary plan's allowance. Although the plan allows a maximum of $30 per day for acupuncture, Anthem is still obligated to cover the coordination of benefits allowance.

Elevance Health

LaTosha Harwell, MBA
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SAFE SPACE ALLY
Pronouns: She, her, hers

APEX
African American Professional Exchange

Appendix A

Source documentation

The information below is a list of all documentation used as part of the review process for the medical health benefit review.

- Summary Plan Description, effective July 1, 2023, for the following plans:
  - Plan II In State
  - Plan III In State
  - Prudent Buyer
- Summary Plan Description, effective July 1, 2022, for the following plans:
  - Plan I In State
  - Plan I Out-of-State
  - Plan II In State
  - Plan II Out-of-State
  - Plan III In State
  - Plan III Out-Of-State
  - Prudent Buyer

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Los Angeles County Employees Retirement Association

Analysis of Evernorth Health Services Dental Claims Processing and Payment Procedures

Audit Period: July 1, 2023, through June 30, 2024

Final Report

April 22, 2025 / Felicia Zhang

Segal

#5923873v9/04218.206

Segal

Felicia Zhang
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Troy, MI 48084-3104
segalco.com

April 22, 2025

Cassandra Smith
Director, Retiree Healthcare Program
Retiree Healthcare Division
Los Angeles County Employees Retirement Association

Re: Dental Claims Audit- July 2023 - June 2024

Dear Cassandra:

On behalf of the Los Angeles County Employees Retirement Association (LACERA), Segal's Benefit Audit Solutions Practice (Segal) completed a review of the dental health benefit plan administered by the Evernorth Health Services (Evernorth), also known as Cigna Healthcare (Cigna) for the period of July 1, 2023 through June 30, 2024. The audit includes an assessment of Evernorth's adjudication procedures and a random sampling of stratified statistical claims.

The following report presents the details and results of the review process.

Once you have reviewed this report, please let us know if you have any questions.

Sincerely,

Felicia Zhang
Senior Health Benefits Data Analyst

cc: Stephen Murphy
Michael Szeto

Table of Contents

Section 1 — Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Evernorth Health Services (Evernorth), also known as Cigna Healthcare (Cigna), in its administration of the Los Angeles County Employees Retirement Association group dental benefits. Felicia Zhang and Jacob Jackson of Segal's Benefit Audit Solutions (BAS) Practice conducted the remote audit during the week of October 28, 2024.

The audit encompassed a total sample of 225 claims for the audit period of July 1, 2023 through June 30, 2024. The 225 sample claims equaling $88,911.60; or 0.23% by cost, of the $39,034,767.78 total claims for the audit period.

Overall, the review of the statistical sample of 225 claims did not identify any errors.

Segal's audit included the following review components.

- A random, stratified sample of 225 dental claims to measure validity in the financial dollar value and incidence.
- A measurement of the time-to-process claims from receipt of claim to the initial date processed for payment or denial.
- An adjudication procedure review to assess day-to-day processing guidelines and claim control measures.

Statistical achievement categories

As illustrated in the chart below, Evernorth met the performance guarantees and industry standards for Financial, Payment, Procedural, and Overall Processing Accuracies but fell below the 10-business day and 20-business day performance guarantee for Time-to-Process, per Segal's calculation.

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Performance Guarantees Table

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	100.00%	99.00%	99.00%
Payment Accuracy (Free from financial error)	100.00%	95.00%	97.00%
Procedural Accuracy (free from processing error)	100.00%	NA	95.00%
Overall Processing Accuracy (Free from error)	100.00%	97.00%	95.00%
Time-to-Process			
(within 10 business days)	91.33%	93.00%	95.00%
(within 20 business days)	94.68%	98.00%	100.00%

Note: Time-to-process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.

NA = not applicable

Segal requested that Evernorth provide its performance guarantee achievement for time-to-process as Segal's calculation did not include multiple processing events (i.e., adjustments).

**Evernorth confirmed with adjustments included, Evernorth met 96.30% for 10 days and 98.80% for 20 days thus a penalty is not due to the time-to-process.*

Section 2 — Audit Details

Evernorth provided an electronic data file of all dental claims processed and paid during the 12-month period of July 1, 2023 through June 30, 2024. The objective of the review was to ensure that claims were paid in accordance with the LACERA's plan provision.

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 (1-225) 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.

Review process

Evernorth provided a copy of the sampled claim submissions and access through its Dentacom System. 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. 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, frequency review decisions, x-ray reports, etc.) is on file for claims paid and verified when necessary.
- Coordination of benefits (COB) provisions was enforced, where applicable.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Benefits were paid under the proper classification, diagnostic, and dental procedure codes as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, coinsurance, and annual limitation maximums were applied.
- 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 if benefits were not assigned).
- Time-to-process for processing of claims was within industry standards or established performance guarantees.

The 2023 Summary Plan Descriptions served as references for the dental claims review; please note that a full list of resources documents has been added to the appendix.

All questions and potential errors were presented to Evernorth's representatives daily; there were no questions or potential errors outstanding post-audit.

Section 3 — Statistical Review

The selection of 225 random claims for plan year July 1, 2023 through June 30, 2024 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

Below is the stratification table utilized for the audit.

Strata	Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar-Amount in Selection	Dollar-Amount in Strata
A	$0.01–$49.99	12,559	17	$652.93	$410,091.94
B	$50.00–$59.99	7,259	10	$541.52	$396,923.26
C	$60.00–$89.99	26,257	30	$2,169.80	$1,974,354.73
D	$90.00–$119.99	24,898	28	$2,897.45	$2,595,351.79
E	$120.00–$159.99	22,422	30	$4,099.46	$3,094,725.22
F	$160.00–$289.99	32,185	40	$8,499.20	$6,788,362.96
G	$290.00–$749.99	23,195	30	$14,174.74	$10,571,855.25
H	$750.00–$974.99	4,560	10	$8,915.19	$3,910,706.99
I	$975.00–$1,249.99	4,163	10	$11,009.80	$4,602,865.95
J	$1,250.00–$1,649.99	3,339	10	$13,972.80	$4,667,550.98
K	$1,650.00–$2,901.60	10	10	$21,978.71	$21,978.71
Total		**160,847**	**225**	**$88,911.60**	**$39,034,767.78**

Statistical claim findings

The review of the statistical sample of 225 claims for the audit period of July 1, 2023, through June 30, 2024 did not identify any errors.

Section 4 — Time-to-Process Achievement

Results from the electronic analysis of all dental claims processed during the audit period of July 1, 2023 through June 30, 2024 revealed Evernorth processed 91.33%% of the claims within fourteen (14) calendar days (10 business days), which fell below the 10-business day performance guarantee of 93.00%, and processed 94.68% of the claims within thirty (30) calendar days (20 business days), which fell below the 20-business day performance guarantee of 98.00%.

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial. Industry standards indicate 95% of all claims should be processed within fourteen (14) calendar days. Best practice, which follows U.S. Department of Labor, Employee Benefits Security Administration (EBSA), requires 100% within thirty (30) calendar days.*

Segal's electronic calculations of all claims processed within the audit period did not allow for distinction of multiple processing events.

Segal requested that Evernorth provide its performance guarantee achievement for time-to-process as Segal's calculation did not include multiple processing events (i.e., adjustments).

Evernorth confirmed with adjustments included, Evernorth met 96.30% for 10 days and 98.80% for 20 days thus a penalty is not due to the time-to-process.

* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits.pdf.

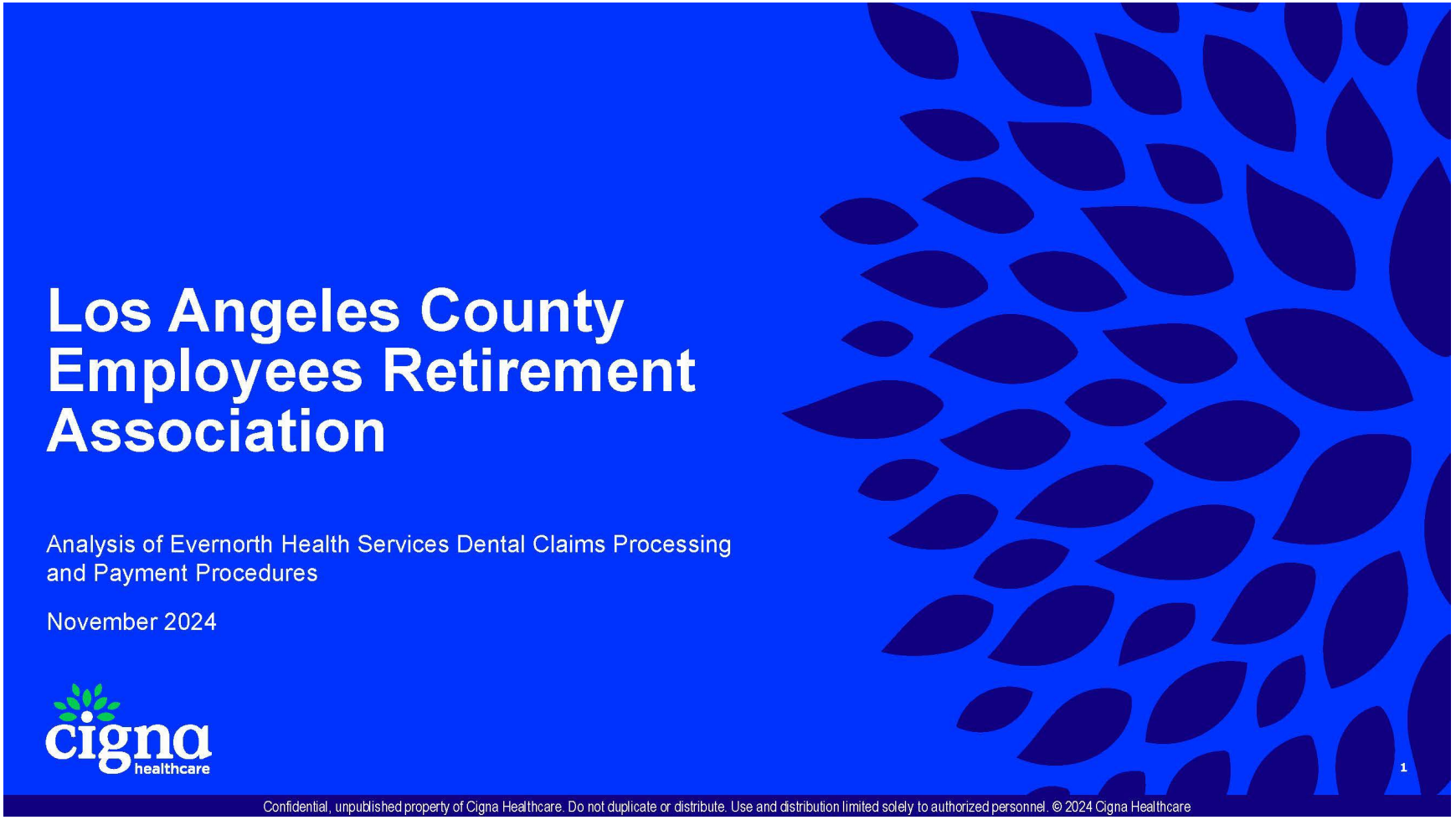
Section 5 — Adjudication Procedures Review

The objective of the review is to ensure that proper procedures are in place to ensure claims control measures. The processing guidelines were described in the Adjudications Procedures Review and evidenced within the 225 statistical claim samples or confirmed through discussion with Evernorth'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 Plan costs.

- LACERA's claims are processed by a designated claim processing team at Evernorth who are Work at Home (WAH) and located across the US. There are currently seven (7) claim processors on the Evernorth's designated team.
- On average monthly, Evernorth receives approximately 15,650 claims per month for LACERA.
  - 70.7% of LACERA claims are auto-adjudicated by Evernorth.
    - 81.28% of claims are auto-adjudicated business wide through Evernorth.
  - Business wide, Evernorth receives 89.55% of dental claims through electronic submission.
- Evernorth's Special Investigations Unit (SIU) analytics team uses multiple approaches to monitor and identify suspect patterns of behavior and schemes (e.g., link analysis, trend analysis, outlier analysis, social analytics, geospatial analytics, predictive modeling).
  - In addition to internal monitoring, Cigna also utilizes the following programs to identify suspected fraudulent claims.
    - Dedicated Data Mart (Healthcare Fraud Shield)
    - Geospatial Analytics (ArcGis)
    - Social Media Monitoring (Synthesio)
    - Link Analysis (i2)
    - P&R Dental Fraud and Abuse Detection
    - RatStats
    - Statistical Sampling Software
    - Multiple Control Models (SAS Miner, SAS Enterprise Guide, SQL)
    - Other Enabling Technologies (Teradata Studio, Toad, CA Workstation, Tableu, Cognos)
- Evernorth reports suspicious fraudulent provider claims activity to law enforcement, leadership within NHCAA (National Health Care Anti-Fraud Association), Health Care Fraud Prevention Partnership, and other fraud focused organizations. If evidence of fraud is identified, a referral may be made to the state's Department of Insurance. This process has not been adjusted since Segal started auditing.

- Evernorth does not require pre-determinations but recommends pre-determinations for any services billed over $200.00.
- LACERA's Members eligibility information is received via paper, email, and phone calls from LACERA.
  - Evernorth's eligibility analyst review records to ensure that the records match the dental benefit option for each member.
- Evernorth's system has the ability to automatically identify potential coordination of benefits (COB).
  - COB investigations are triggered in the following instances:
    - If a claim is received for a dependent/spouse and other insurance investigation has not been updated within the past 12 months.
    - If a claim has an indication of other insurance.
    - Receipt of another insurance's explanation of benefits.
    - When a plan is changed.
      - If other insurance information is not received within 55 days, Evernorth denies the claim (except in the case of North Carolina where members are allowed 90 days).
- Two external vendors are utilized for services related to LACERA's claims.
  - Firstsource is utilized for dental mail room and data entry.
  - Cotiviti (formerly HMS/Accent) is utilized for overpayment recoveries.

Section 6 — Evernorth's Formal Response to the Draft Report



Audit Overview

- Cigna would like to thank both LACERA and Segal for the opportunity to respond to the dental claim audit report provided.
- The claim review was conducted virtually the week of October 28, 2024.
- Scope Details –
  - Scope period July 1, 2023, through June 30, 2024
  - Claim Quality sample consisting of 225 random stratified dental claims
- Cigna can confirm a total of zero (0) errors were identified during the audit.

Metric	WTW Reported Accuracy
Financial Accuracy	**100.00%**
Payment Accuracy	**100.00%**
Processing Accuracy	**100.00%**

- Cigna appreciates the recognition of our adherence to performance guarantees concerning Financial, Payment, and Overall Processing accuracies, as well as the compliance with the 10-business day performance guarantee highlighted in the audit conducted by Segal. We also value Segal's acknowledgement of Cigna's established guidelines aimed at managing plan costs for LACERA through the Adjudication Procedures Review. Cigna regards LACERA as a valued client and Segal as a trusted business partner, and we sincerely appreciate the opportunity to share the findings of this audit with LACERA.

cigna healthcare

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Thank you for your partnership

Appendix A

Source documentation

The information below is a list of all documentation used as part of the review process for the dental health benefit review.

- LACERA Cigna Dental Preferred Provider Insurance Summary Plan Description, effective July 1, 2023
- LACERA Cigna Dental Choice Summary Plan Description for Texas Retirees, effective July 1, 2023

Los Angeles County Employees Retirement Association

Group Dental and Medical Benefits Audit Results

Audit Period: July 1, 2023, through June 30, 2024

August 6, 2025/ Amber M. Turner, MBA, PMP

Segal

Agenda

Dental Claims Audit

- **Results**

Medical Claims Audit

- **Results**
- **Key Findings**
- **Next Steps**

Cigna Dental Audit - Results

Cigna provided data files for all dental claims processed and paid during the 12-month audit period of July 1, 2023, through June 30, 2024, representing $39,034,767.78 in benefit payments.

Cigna surpassed the performance guarantee standards for the categories of Financial, Payment, Procedural, Time-to-Process and Overall Accuracy. The dental audit did not identify any findings. Segal recommends LACERA continue to monitor the dental claims for any changes in this status.

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	100.00%	99.00%	99.00%
Payment Accuracy (Free from financial error)	100.00%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (Free from error)	100.00%	N/A	95.00%
Time-to-Process			
(within 10 business days)	91.33%	90.00%	95.00%
(within 20 business days)	94.68%	N/A	100.00%

Note: Time-to-process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.

Anthem Medical Audit - Results

Anthem provided data files for all medical claims processed and paid during the 12-month audit period of July 1, 2023, through June 30, 2024, representing $165,338,311.72 in benefit payments. The review of 255 claims (220 Stratified and 35 Targeted) identified $28,226.42 in Overpayments and -$3,670.17 in Underpayments.

Anthem met the performance guarantees for financial, procedural, and time-to-process accuracy but fell below industry standard for payment and overall accuracy. Targeted and out of sample claims are not included in the statistical accuracy.

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	99.62%	99.00%	99.00%
Payment Accuracy (Free from financial error)	88.42%	NA	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (Free from error)	88.42%	NA	95.00%
Time-to-Process			
(within 10 business days)	99.11%	90.00%	95.00%
(within 20 business days)	99.18%	NA	100.00%

Note: Time-to-process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.

Anthem Medical Audit – Key Findings

The following chart represents the issues identified within the medical claims audit. To note, all of the issues listed below, except for outpatient coinsurance, were identified in previous LACERA audits.

Medical Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Number of Sample Claims
Issue 1: Medicare Coordination of Benefits (COB)	$3.92	-$113.48	16
Issue 2: Out-of-pocket/Deductible Overapplied	$0.00	-$552.86	17
Issue 3: Plan Payment Limitation	Error Removed	$0.00	0
Issue 4: Outpatient Coinsurance	$625.40	$0.00	1
Issue 5: Hearing Aids Limitation	$24,795.10 & 2 Procedural Errors	-$150.00	8
Issue 6: Acupuncture Limitation	$867.70	$0.00	8
Issue 7: Foot Orthotic Exclusion	$1,934.30	$0.00	5
Issue 8: Surgery Cost Sharing	$0.00	-$2,853.83	9
Total	**$28,226.42**	**-$3,670.17**	**64**

Medical Next Steps

- **Issue 1: Medicare Coordination of Benefits (COB) –** Anthem disagreed with Segal during the remote review and noted that Anthem provided 20% of Medicare's allowed amount as payment for the supplemental plan. Segal disagrees with Anthem and notes that LACERA's plan document (Plan III) states that LACERA will pay 100% of the difference between Medicare's Allowable Charge(s) and the amount Medicare pays for medically necessary Part B services and supplies. Segal recommends that LACERA discuss this issue with Anthem.

- **Issue 2: Out-of-Pocket/Deductible Overapplied –** Anthem agreed to these errors and have identified pharmacy comingling as the determining factor of the overage. Starting March of 2024, Anthem implemented a new reporting process to better streamline adjustments. Anthem noted that the adjustment portion of the claims is still a manual process. Segal recommends that LACERA continue to monitor this issue as it is a reoccurring issue from previous audits as well as confirm that members are being reimbursed for the overapplication of cost sharing.

- **Issue 5: Hearing Aids Limitation –** Hearing aids were paid over the $300.00 payment limitation. Anthem agreed to this issue. Segal notes that this is a repeated error that was identified in previous audits. Anthem noted last audit that starting in April 2024, Anthem will run quarterly reporting to review trends and identify opportunities, as needed. Annually, Anthem will determine if ongoing reporting is necessary. Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.

Medical Next Steps

- **Issue 6: Acupuncture Limitation –** Acupuncture was paid over the $30.00 payment limitation. Anthem agreed to this issue. Segal notes that this is a repeated error that was identified in previous audits. Anthem noted last audit that starting in April 2024, Anthem will run quarterly reporting to review trends and identify opportunities, as needed. Annually, Anthem will determine if ongoing reporting is necessary. Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.

- **Issue 7: Foot Orthotics Exclusion –** Anthem disagreed with this issue during the remote review and noted that coverage for this benefit is extended beyond a diabetic diagnosis. Segal recommends that LACERA discuss this reoccurring benefit issue with Anthem and determine if a plan document update is necessary.

- **Issue 8: Surgery Cost Sharing –** Surgery cost that were to pay at 100% applied cost sharing. Anthem agreed to this issue. Segal notes that this is a repeated error that was identified in previous audits. Anthem provided coaching to its processors as all were manual adjudication issues. As this is a direct impact to the members and has occurred multiple times, Segal recommends that LACERA request the financial impact to the members from Anthem and for Anthem to provide LACERA with a root cause and solution.

- **Issue 3: Plan Payment Limitation & Issue 4: Outpatient Coinsurance –** As Anthem resolved both issue three and four by providing additional information to dissolve Issue 3 and re-adjudicating the claim on Issue 4, no further intervention is necessary for these issues**.**

LACERA

Los Angeles County Employees Retirement Association

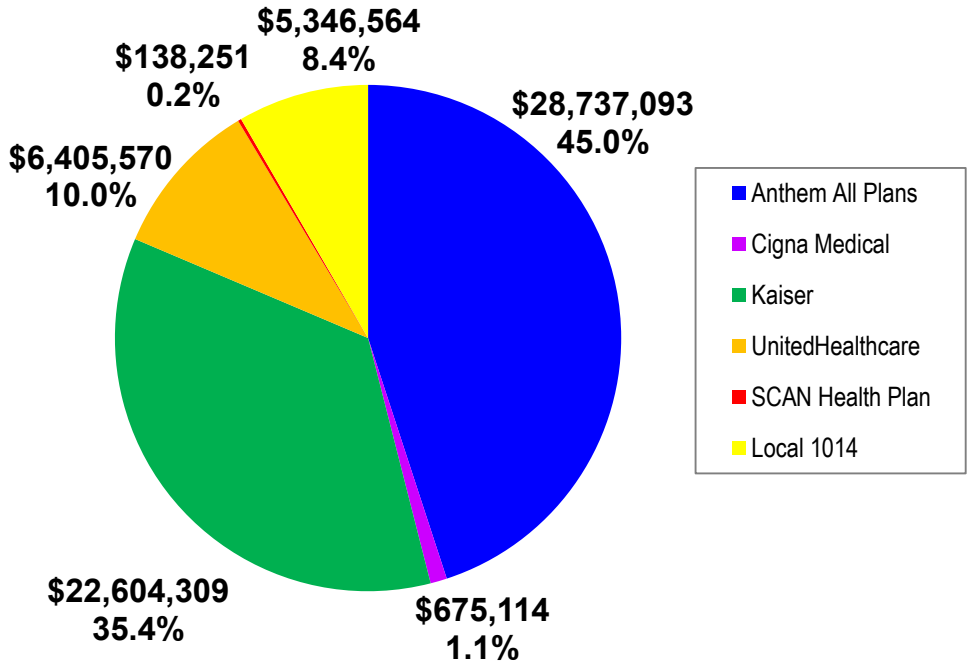
Premium & Enrollment

Coverage Month Ending June 2025

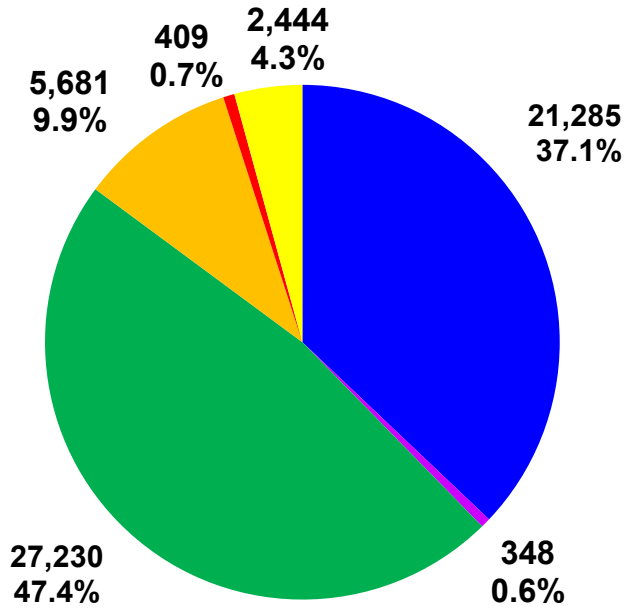
Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$28,737,093	45.0%	21,285	37.1%
Cigna Medical	$675,114	1.0%	348	0.6%
Kaiser	$22,604,309	35.4%	27,230	47.4%
UnitedHealthcare	$6,405,570	10.0%	5,681	9.9%
SCAN Health Plan	$138,251	0.2%	409	0.7%
Local 1014	$5,346,564	8.4%	2,444	4.3%
Combined Medical	**$63,906,902**	**100.0%**	**57,397**	**100.0%**

Cigna Dental & Vision (PPO and HMO)	**$4,829,510**		**59,627**

Monthly Premium



Retirees

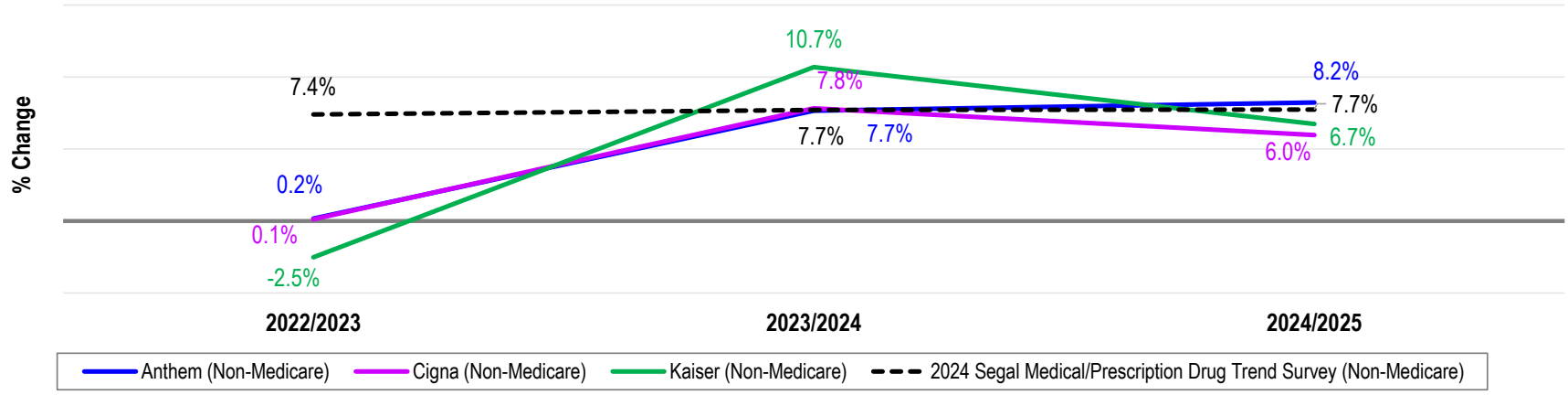


Note: Premiums **include** LACERA's Administrative Fee of $8.00 per member, per plan, per month.

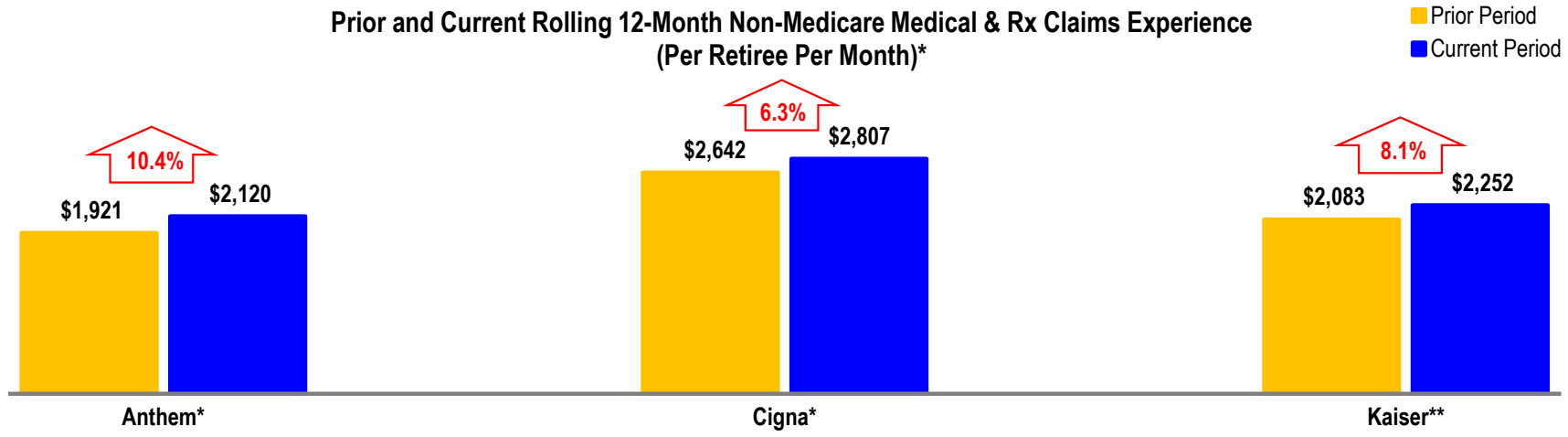
Los Angeles County Employees Retirement Association

Claims Experience by Carrier

Coverage Month Ending June 2025



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

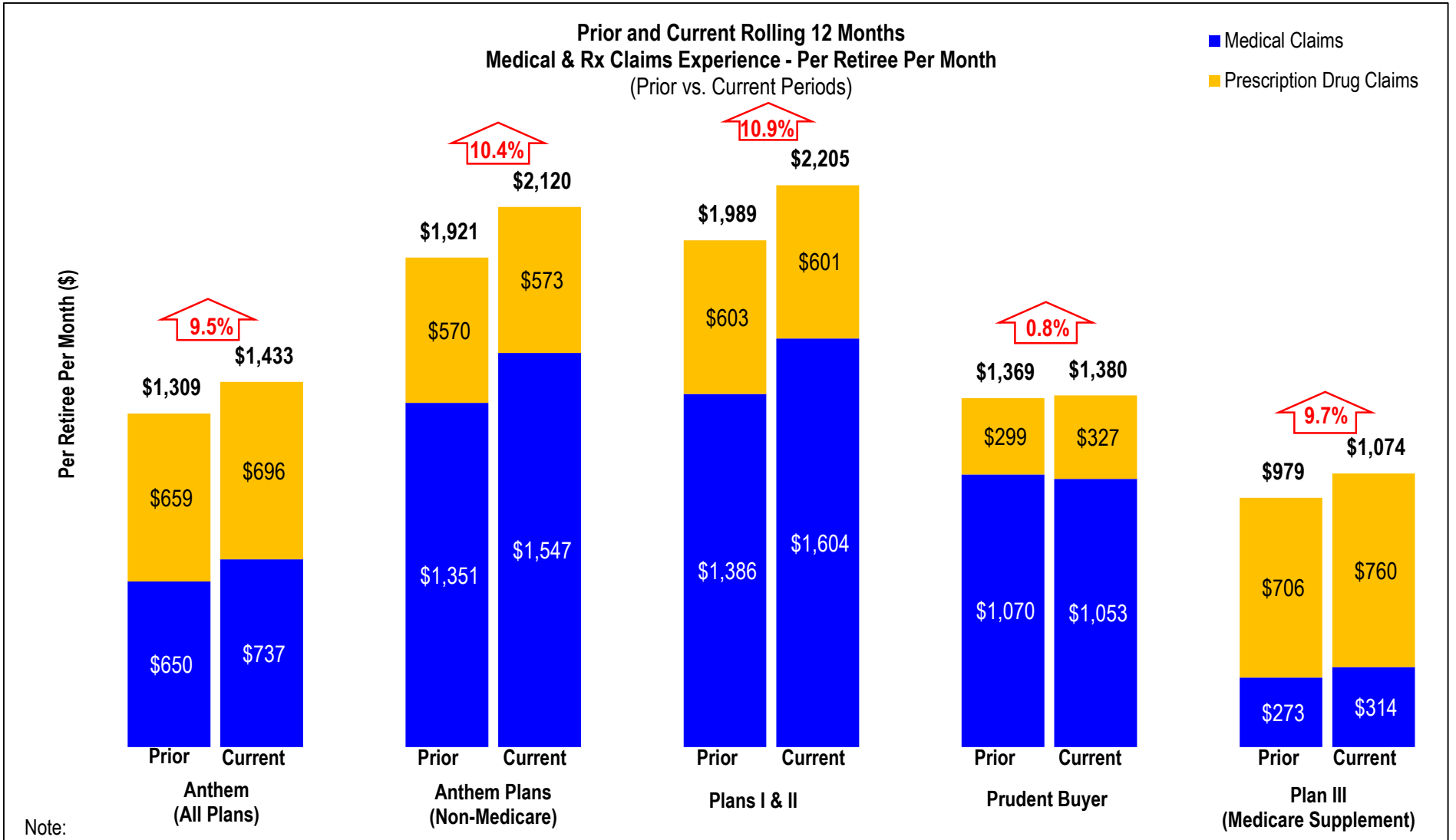


*Based on Most Recent Claims Experience through Coverage Month.
**Kaiser Claims Experience through May 2025.
Note: Figures above include gross claims only, and do not include rebates or pooling credits.

Los Angeles County Employees Retirement Association

Anthem Claims Experience By Plan

Coverage Month Ending June 2025



Note:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Figures above include gross claims only, and do not include rebates, pooling credits, or ITS surcharges.
3. Prudent Buyer pharmacy claims are retroactively updated due to the timing of Anthem PBM's receipt of recorded claims.
4. Anthem applies ITS surcharges for Plans I-III, and Prudent Buyer, which historically adds an estimated 0.5% to 0.7% towards claims.

Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month Ending June 2025

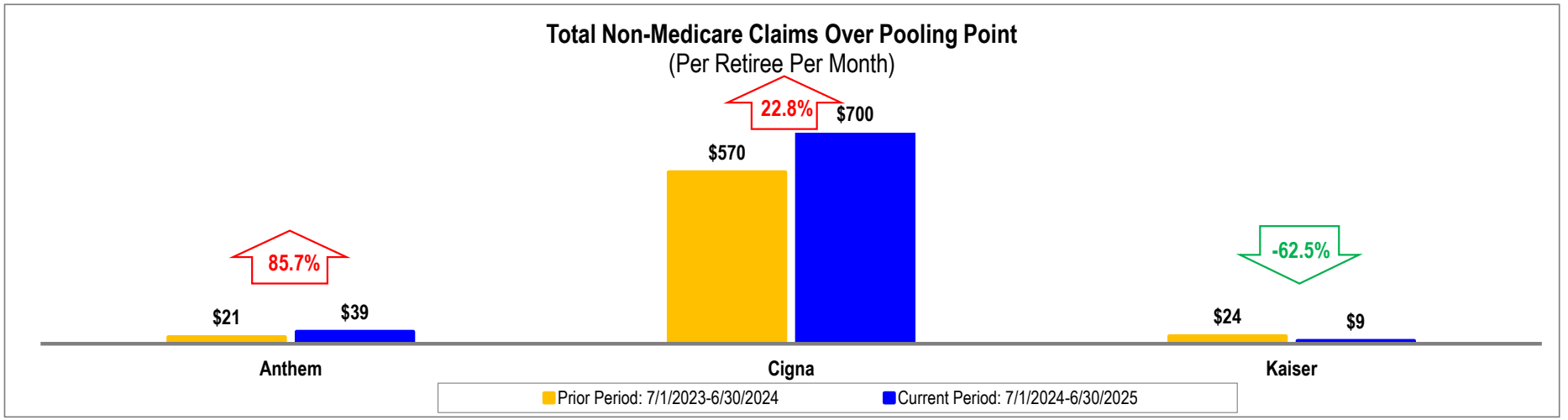
- Kaiser insures approximately 26,500 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in California.

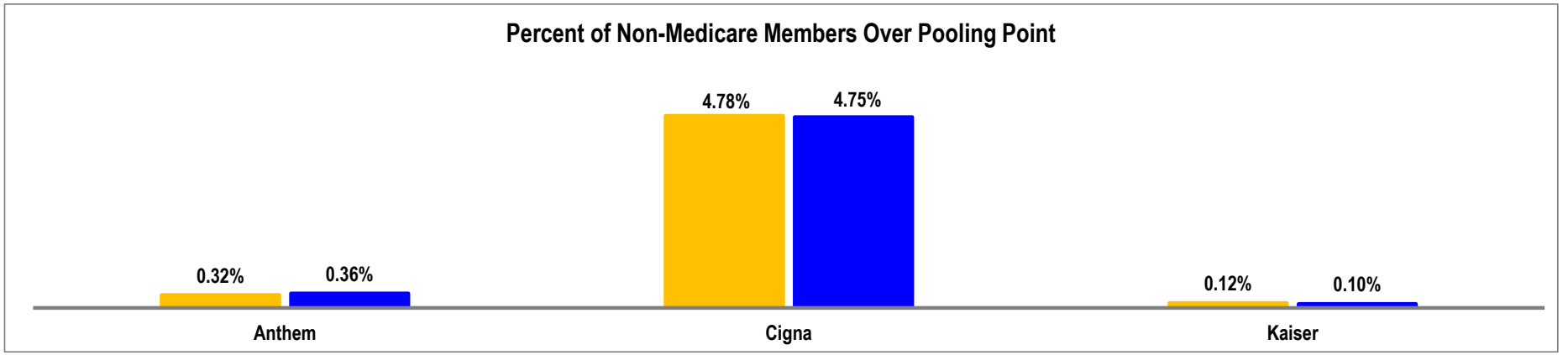
Category	Current Period 6/1/2024 - 5/31/2025	Prior Period 6/1/2023 - 5/31/2024	Change
Average Contract Size	**1.82**	**1.83**	**-0.55%**
Average Members	**12,606**	**12,560**	**0.37%**
Inpatient Claims Per Member Per Month	$308.30	$325.17	-5.19%
Outpatient Claims Per Member Per Month	$545.74	$472.63	15.47%
Pharmacy Per Member Per Month	$171.38	$154.34	11.04%
Other Per Member Per Month	$212.53	$189.24	12.31%
Total Claims Per Member Per Month	**$1,237.95**	**$1,141.38**	**8.46%**
Total Paid Claims	**$187,271,687**	**$171,935,220**	**8.92%**
Large Claims over $600,000 Pooling Point			
Number of Claims over Pooling Point	7	8	
Amount over Pooling Point	$718,600	$1,988,505	-63.86%
% of Total Paid Claims	**0.38%**	**1.16%**	
Inpatient Days / 1000	683.3	733.9	-6.89%
Inpatient Admits / 1000	96.0	90.4	6.19%
Outpatient Visits / 1000	16,634.7	15,877.7	4.77%
Pharmacy Scripts Per Member Per Year	14.2	13.4	5.97%

Los Angeles County Employees Retirement Association

High Cost Claimants (Anthem, Cigna, & Kaiser)

Coverage Month Ending June 2025





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 June through May.

Pooling Points by Carrier:

1. Anthem's pooling points are $400,000 for Plans I & II, and $300,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $600,000.

Los Angeles County Employees Retirement Association

Anthem Lifetime Max Accumulation Status By Plan

Coverage Month Ending June 2025

	Prior Calendar Year: December 2023 [1,2]			Current Calendar Year: December 2024 [1,3]		
Lifetime Claim Amount [4]	**Plans I & II**	**Prudent Buyer**	**Combined**	**Plans I & II**	**Prudent Buyer**	**Combined**
$900K-$999K	19	1	**20**	15	1	**16**
$800K-$899K	27	2	**29**	18	1	**19**
$700K-$799K	29	3	**32**	27	2	**29**
$600-$699K	53	2	**55**	61	0	**61**
$500-$599K	82	4	**86**	78	8	**86**
Total	**210**	**12**	**222**	**199**	**12**	**211**

	Prior Month: May 2025 [5,7]			Most Recent Month: June 2025 [6,7]		
Lifetime Claim Amount [4]	**Plans I & II**	**Prudent Buyer**	**Combined**	**Plans I & II**	**Prudent Buyer**	**Combined**
$900K-$999K	10	0	**10**	9	0	**9**
$800K-$899K	13	1	**14**	14	1	**15**
$700K-$799K	29	2	**31**	29	2	**31**
$600-$699K	49	2	**51**	49	2	**51**
$500-$599K	81	8	**89**	82	8	**90**
Total	**182**	**13**	**195**	**183**	**13**	**196**

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

[1] Includes two years of historical data.

[2] Based on data provided by Anthem on September 17, 2024.

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

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

[5] Based on data provided by Anthem on June 18, 2025.

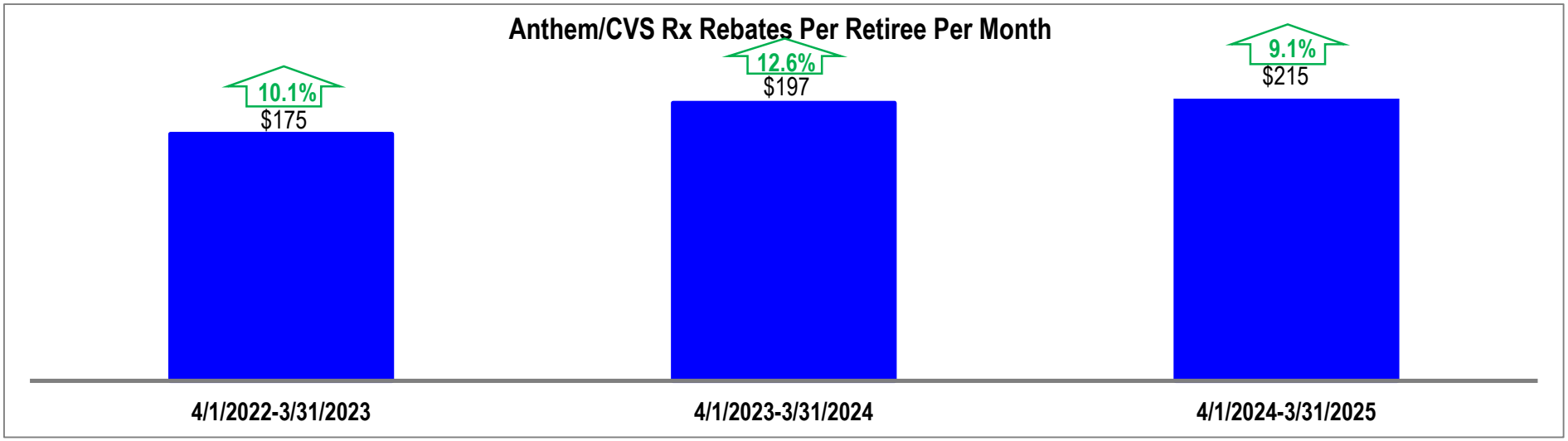
[6] Based on data provided by Anthem on July 17, 2025.

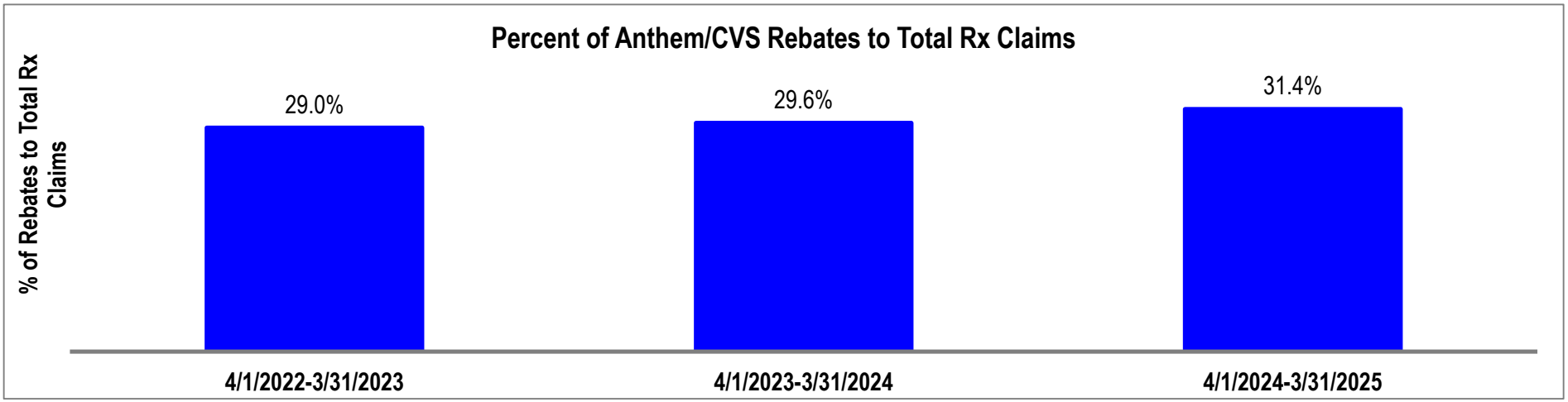
[7] Includes two months of historical data.

Los Angeles County Employees Retirement Association

Prescription Drug Rebates (Anthem)

Coverage Month Ending June 2025





Rebates Overview:

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

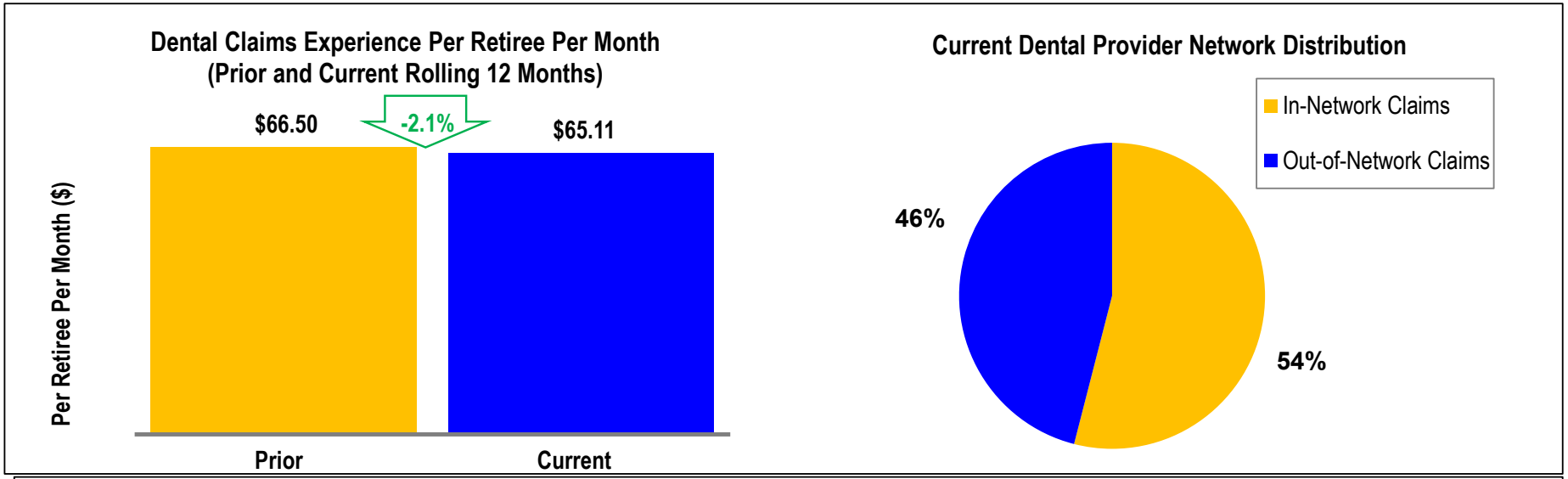
Note:

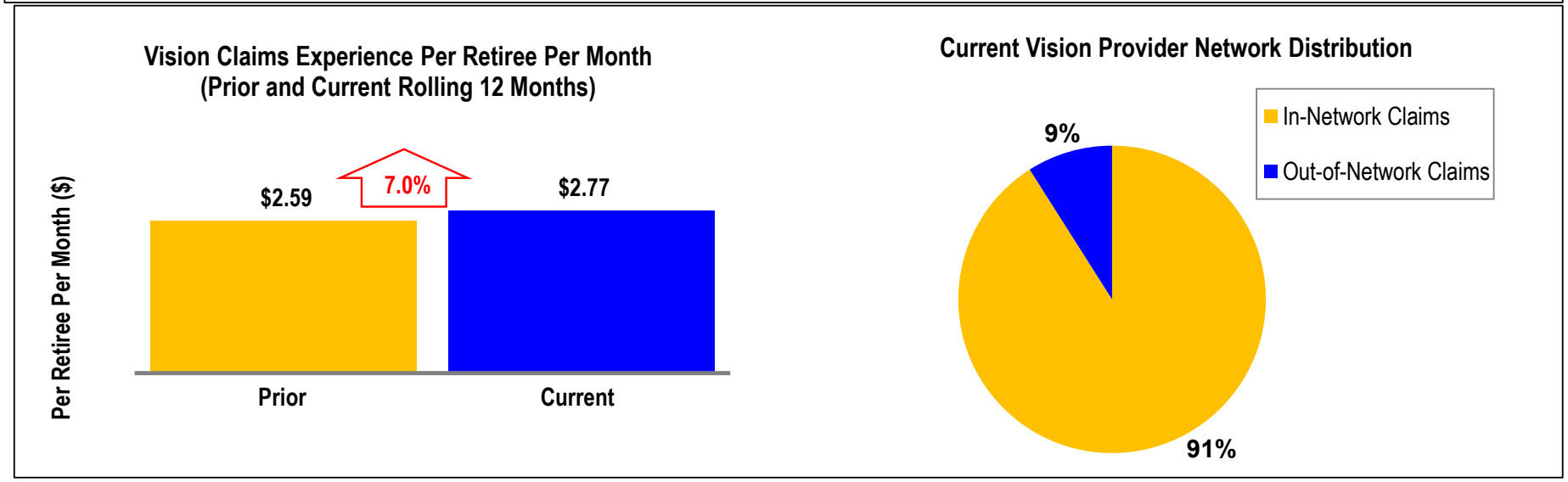
1. Prescription Claims and Rebates Data were provided by CVS.
2. Anthem Prudent Buyer prescription drugs are provided by CarelonRx and are not included in the charts above.

Los Angeles County Employees Retirement Association

Cigna Dental & Vision Claims Experience

Coverage Month Ending June 2025





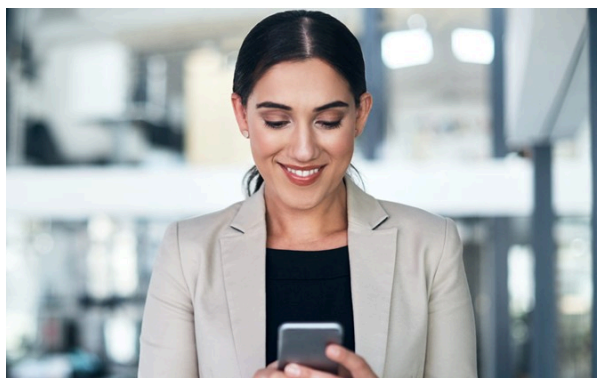
Notes:

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

Segal

Compliance News | July 9, 2025

ERISA Preempts State PBM Law



Group health plan sponsors have watched with concern as states passed laws that attempt to regulate pharmacy benefit managers (PBMs) and could require significant changes to a self-insured plan's benefits. On June 30, 2025, the U.S. Supreme Court dealt a blow to these state efforts by announcing it would not review a lower court decision holding that an Oklahoma law regulating PBMs was preempted by ERISA.

This decision is an important ruling that strengthens ERISA preemption and will be a significant factor in whether future state PBM laws will apply to ERISA-governed group health plans.

Background on state PBM laws and ERISA preemption

All states have passed laws to regulate PBMs. Generally, ERISA preempts state laws that relate to ERISA plans. Whether ERISA preempts all or part of these state laws has been a key issue for sponsors of group health plans.

In 2019, Oklahoma passed the Oklahoma Patient's Right to Pharmacy Choice Act (the Act), that took several steps to regulate PBM behavior. The PBM industry challenged the Act. In 2023, in *Pharmaceutical Care Management Association (PCMA) v. Mulready*, the 10th Circuit Court of Appeals held that ERISA and Medicare preempted the state law.

The 10th Circuit found the Oklahoma law to be preempted by ERISA because its provisions regulated central matters of plan administration and interfered with nationally uniform plan administration. The court also held that Medicare Part D preempted portions of the Act that were already regulated by the Part D prescription drug program.

The provisions held to be preempted under ERISA were:

- Network restrictions that mandated access to brick-and-mortar pharmacies based on where individuals reside, which could be different than the pharmacy networks applicable for a group health plan's participants
- Prohibitions on restricting an individual's choice of in-network provider (e.g., retail or mail order) and promotion of network pharmacies by using cost-sharing and copayment reductions — prohibitions that were generally interpreted to prohibit mail-order pharmacy benefit incentives
- Any-willing-provider provisions that require plans to accept any provider into a pharmacy network who meets network standards
- Prohibitions on basing a pharmacy license on the probation status of a licensed pharmacist

In February 2024, Oklahoma filed a petition for a *writ of certiorari* requesting that the U.S. Supreme Court review the 10th Circuit decision. On May 27, 2025, the U.S. Solicitor General filed a brief arguing that the petition should be denied. On June 30, 2025, the Supreme Court dismissed Oklahoma's petition, thus ending any review of the decision and allowing the 10th Circuit decision to stand.

The 10th Circuit opinion is binding on states in that circuit: Colorado, Kansas, New Mexico, Oklahoma, Utah, Wyoming and portions of Montana and Idaho. Although the appellate court's decision is not binding in other circuits, it and the fact that the Supreme Court refused to review it could be persuasive in other jurisdictions.

Implications for plan sponsors of the Supreme Court's decision not to take the *Mulready* case

State efforts to regulate PBMs have taken a variety of approaches. Based on the *Mulready* decision, it appears attempts to force plans to eliminate incentives for mail-order programs, accept any pharmacies into their networks and abide by state regulations to determine network adequacy would not survive an ERISA preemption challenge. This would likely apply to any state regulations that interfere with plan operations or administration.

However, other state laws affecting PBMs could survive preemption. In *Rutledge v. PCMA,* the PBM industry challenged an Arkansas law that required that the reimbursement rates that PBMs pay to pharmacies be tied to the pharmacy's acquisition costs. In December 2020, the U.S. Supreme Court held that the Arkansas law was merely a cost regulation, and did not impact plan administration. Consequently, the Arkansas law was **not** preempted by ERISA. Although the Arkansas law had the effect of changing the costs plans paid for prescription drugs, it did not affect their benefits or plan operations.

Based on the two court decisions, it appears that while states may be able to enact legislation that regulates payment or compensation for prescription drugs, they may not require that ERISA plans adopt certain benefit designs, network rules, administration or plan operations requirements.

However, there may be some state law PBM regulations that are in a gray area. For example, one state law has prohibited PBMs from owning a pharmacy. Another would prohibit spread pricing agreements. While the Supreme Court has provided an answer in the Oklahoma case, it is likely that there will continue to be litigation addressing the issue of ERISA preemption and how states can regulate PBMs.

Plan sponsors should continue to monitor both state PBM laws and federal efforts to enact PBM regulation as this area of law continues to develop. Plan sponsors should consult with their legal counsel on whether and how these decisions apply to their plan.

Segal

Compliance News | July 10, 2025

ACA Dollar Amounts and Percentages

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

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

Get the Chart

Download Nov

What's New?

In June 2025, we updated the charts to include revised maximum annual limits on cost-sharing for 2026, which increased from $10,150 to $10,600 for individual coverage and from $20,300 to $21,200 for family coverage.

The Department of Health and Human Services announced these revised limits on June 25, 2025, as part of final rules on the ACA Exchanges.

Subscribe for updates

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

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

Subscribe Nov

Affordable Care Act Dollar Amounts and Percentages

Many provisions in the Affordable Care Act contain numbers or percentages that are indexed to various measures of inflation. The government announces new numbers at different times of the year and in different publications. The table below assembles these amounts in one place and is current as of June 26, 2025.

Indexed Amounts Affecting Group Health Plans

Item	2021	2022	2023	2024	2025	2026
Out-of-pocket (OOP) limit for non-grandfathered plans[1]	Individual: $8,550 Family: $17,100 (See announcement)	Individual: $8,700 Family: $17,400 (See announcement)	Individual: $9,100 Family: $18,200 (See announcement)	Individual: $9,450 Family: $18,900 (See announcement)	Individual: $9,200 Family: $18,400 (See announcement)	Individual: $10,600 Family: $21,200 (See announcement)
Flexible spending account (FSA) maximum salary reduction	$2,750 (See announcement.)	$2,850 (See announcement.)	$3,050 (See announcement.)	$3,200 (See announcement.)		
FSA maximum carryover amount[2]	$550[3] (See announcement.)	$570 (See announcement.)	$610 (See announcement.)	$640 (See announcement.)	$660 (See announcement.)	
Employer shared responsibility penalty – 4980H**(a)**[4]	$2,700 (See answers to FAQs.)	$2,750 (See answers to FAQs.)	$2,880 (See answers to FAQs.)	$2,970 (See announcement.)		
Employer shared responsibility penalty – 4980H**(b)**[5]	$4,060 (See answers to FAQs.)	$4,120 (See answers to FAQs.)	$4,320 (See answers to FAQs.)	$4,460 (See announcement.)		

[1] For *2014 only*, the Affordable Care Act's OOP limits were the same as the OOP maximums applicable to a Health Savings Account (HSA) offered with a high-deductible health plan (HDHP). (Space constraints prevent us from showing columns of 2014–2020 data in the table above. Separate documents show data for 2014–2016 and 2017–2020.) For 2015 and beyond, the Affordable Care Act's OOP limits are not indexed to the HSA/HDHP amounts. The HSA/HDHP amounts are shown later in this chart for ease of reference.

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

[3] Starting with carryovers from 2020, the maximum carryover is 20% of the maximum salary reduction. The formula for determining the maximum carryover was established in IRS Notice 2020-33. Under the Consolidated Appropriations Act of 2021, for plan years ending in 2020 and 2021, FSAs can be amended to allow: (1) carryovers (to the next year) of up to the full unused amounts remaining in the account at the end of each such year; or (2) extension of the grace period for up to 12 months after the end of such plan year. Additionally, the plan may permit a participant who ceases to participate in an FSA in calendar year 2020 or 2021 to continue to receive reimbursements through the end of the plan year in which participation ceased (including any grace period adopted by the plan).

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

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

Item	2021	2022	2023	2024	2025	2026
Affordability of group health plan coverage: test applied **by Exchange/Marketplace** when determining if offered coverage is affordable	Not affordable if cost of employee-only coverage exceeds 9.83% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 9.61% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 9.12% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 8.39% of household income (See announcement.)	Not affordable if cost of employee-only coverage exceeds 9.02% of household income (See announcement.)	
Affordability of group health plan coverage: safe harbors **available to employers** seeking to minimize employer penalty	W-2, rate of pay and FPL safe harbors use 9.83% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 9.61% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 9.12% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 8.39% in the calculation (See announcement.)	W-2, rate of pay and FPL safe harbors use 9.02% in the calculation (See announcement.)	
100% of the FPL (for single person living in one of the 48 contiguous states or Washington, DC),[6] which Exchange/Marketplace uses when calculating premium assistance tax credit	$12,760 (See announcement.) See separate table on the next page for the FPL safe harbor calculation.	$12,880 (See announcement.) See separate table on the next page for the FPL safe harbor calculation.	$13,590 (See announcement.) See separate table on the next page for the FPL safe harbor calculation.	$14,580 (See announcement.) See separate table on the next page for the FPL safe harbor calculation.	$15,060 (See announcement.) See separate table on the next page for the FPL safe harbor calculation.	$15,650 (See announcement.) See separate table on the next page for the FPL safe harbor calculation.

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

HSA/HDHP

Item	2021	2022	2023	2024	2025	2026
Minimum deductible	Individual: $1,400 Family: $2,800 (See announcement.)	Individual: $1,400 Family: $2,800 (See announcement.)	Individual: $1,500 Family: $3,000 (See announcement.)	Individual: $1,600 Family: $3,200 (See announcement.)	Individual: $1,650 Family: $3,300 (See announcement.)	Individual: $1,700 Family: $3,400 (See announcement.)
Maximum contribution[7]	Individual: $3,600 Family: $7,200	Individual: $3,650 Family: $7,300	Individual: $3,850 Family: $7,750	Individual: $4,150 Family: $8,300	Individual: $4,300 Family: $8,550	Individual: $4,400 Family: $8,700
OOP maximum	Individual: $7,000 Family: $14,000	Individual: $7,050 Family: $14,100	Individual: $7,500 Family: $15,000	Individual: $8,050 Family: $16,100	Individual: $8,300 Family: $16,600	Individual: $8,500 Family: $17,000

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

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

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

Plan Year[8]	100% of FPL for Single Individual Working in 48 Contiguous States or Washington, DC	Applicable Multiplier[9]	Maximum Affordable Monthly Premium for Self-Only Coverage
Plan year beginning January 1, 2021	$12,760	9.83%	$104.53
Plan year beginning February 1–December 1, 2021	$12,880	9.83%	$105.51
Plan year beginning January 1, 2022	$12,880	9.61%	$103.14
Plan year beginning February 1–December 1, 2022	$13,590	9.61%	$108.83
Plan year beginning January 1, 2023	$13,590	9.12%	$103.28
Plan year beginning February 1–December 1, 2023	$14,580	9.12%	$110.81
Plan year beginning January 1, 2024	$14,580	8.39%	$101.94
Plan year beginning February 1–December 1, 2024	$15,060	8.39%	$105.29
Plan year beginning January 1, 2025	$15,060	9.02%	$113.20
Plan year beginning February 1–December 1, 2025	$15,650	9.02%	$117.64

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

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

Affordable Care Act Fee

Fee	2021	2022	2023	2024	2025	2026
Comparative effectiveness research fee (PCORI[10]) — extended by Congress until 2029[11]	$2.66 per person (for a calendar-year plan, the amount paid by 7/31/21 for the 2020 plan year) (See announcement.)	$2.79 per person (for a calendar-year plan, the amount paid by 7/31/22 for the 2021 plan year) (See announcement.)	$3.00 per person (for a calendar-year plan, the amount paid by 7/31/23 for the 2022 plan year) (See announcement.)	$3.22 per person (for a calendar-year plan, the amount paid by 7/31/24 for the 2023 plan year) (See announcement.)	$3.47 per person (for a calendar-year plan, the amount paid by 7/31/25 for the 2024 plan year) (See announcement.)	

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

This resource is for informational purposes only and does not constitute legal, tax or investment advice. You are encouraged to discuss the issues raised here with your legal, tax and other advisors before determining how the issues apply to your specific situations.

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

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

Segal

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Budget Act Provisions that Affect Employee Benefits

On July 4, 2025, President Trump signed into law tax and budget reconciliation legislation that will have a profound impact on Americans. The legislation dramatically increases funding for border control and defense spending, increases the debt ceiling, and permanently extends many of the tax cuts that were enacted in 2017 in the Tax Cuts and Jobs Act (TCJA).

Of critical importance, the legislation, formally known as the "One Big Beautiful Bill" Act (the Act, Public Law No: 119-21), does not include any changes to the taxation of or deduction for health benefits, an issue that is a concern to plan sponsors. It also does not change the tax incentives for retirement benefit plans.

Employee benefit plan sponsors will need to review several parts of the Act, particularly those related to Health Savings Accounts (HSAs) and certain other fringe benefits. They also should be aware of other health-related portions of the Act that may have an impact on both participants and overall health spending trends.

Provisions of the Act related to employee benefits

Health Savings Accounts

Three provisions in the Act make it easier to use HSAs:

- **Telehealth services.** The Act permanently and retroactively permits plan sponsors that offer high-deductible health plans (HDHPs) paired with HSAs to cover telehealth services before the HDHP deductible is met. This provision has been enacted in previous sessions of Congress, but was allowed to expire as of December 31, 2024, as we discussed in our December 24, 2024 insight. The Act permanently allows (but does not require) HDHPs to cover telehealth and other remote services before the deductible is met, effective for plan years beginning after December 31, 2024.
- **Bronze and catastrophic plans qualify as HDHPs.** For those who obtain coverage on the ACA health insurance Marketplace/Exchange, the Act provides that, effective for months beginning after December 31, 2025, HSA-qualified HDHPs include bronze and catastrophic plans. Previously, only certain silver plans qualified as HDHPs.
- **Direct primary care service arrangements**. The Act creates a new provision designed to assist individuals who belong to a concierge primary care physician practice that charges a fee to access unlimited primary care. Effective for months beginning after December 31, 2025, the Act allows individuals who are members of a "direct primary care" service to contribute to an HSA. The direct primary care service would not be treated as a health plan that would disqualify the individual from contributing to an HSA.

The Act defines a direct primary care service arrangement as consisting solely of primary care services provided by primary care practitioners if the sole compensation for such care is a fixed periodic fee. Fees must not exceed $150 per month for an individual or $300 per month for more than one person. Additionally, services cannot include procedures that require the use of general anesthesia, prescription drugs (other than vaccines), and laboratory services not typically administered in an ambulatory primary care setting. The Treasury Department will issue regulations or guidance on this issue, in consultation with the Department of Health and Human Services (HHS).

Furthermore, the Act allows fees paid for direct primary care service arrangements to be treated as medical expenses that can be payable from the HSA.

The Act does not contain additional provisions to expand HSA access that were in the bill passed in the House, including provisions that would have permitted individuals in Medicare Part A to contribute to an HSA.

Changes to fringe benefit taxation

The Act modifies several exclusions for employer-provided fringe benefits for tax years beginning after December 31, 2025:

- **Bicycle commuting expense reimbursement terminated.** The Act terminates the exclusion for qualified bicycle commuting reimbursement. For transportation benefits other than bicycle commuting, the Act adds an additional year of inflation adjustment.
- **Moving expenses reimbursement terminated.** The Act terminates the exclusion for qualified moving expenses reimbursement and the deduction for moving expenses, except for active-duty members of the Armed Forces and members of the Intelligence Community.
- **Student loan reimbursement payments exclusion made permanent.** Current law permits tax-free employer educational assistance payments up to $5,250 annually. The Act makes this exclusion permanent. It also indexes the $5,250 maximum exclusion for taxable years beginning after December 31, 2025.
- **Dependent care assistance exclusion increased.** Under current law, the maximum exclusion for an employer-provided Dependent Care Assistance Program (DCAP) under Internal Revenue Code Section 129 is $5,000 ($2,500 for a married individual filing separately). The Act increases the exclusion to $7,500 annually ($3,750 for a married individual filing separately), effective for taxable years beginning after December 31, 2025.

The Act also enhances the child and dependent care tax credit, which may be claimed as a credit against tax liability by an individual in lieu of taking the DCAP exclusion.

Increases to tax credits for employer-provided childcare and paid family and medical leave

Under IRC Section 45F, employers are eligible to receive a nonrefundable tax credit of up to $150,000 per year based on 25 percent of qualified childcare expenses they provide to employees. The Act permanently increases the maximum credit, creates a separate credit amount for qualified small businesses, and indexes the maximum credit amounts for inflation. Effective for amounts paid or incurred after December 31, 2025, the maximum credit will increase from $150,000 to $500,000 ($600,000 for small businesses) with those dollar amounts being indexed for inflation; and the percentage of qualified childcare expenses covered will increase from 25 to 40 percent (50 percent for small businesses). The Act also allows small businesses to use a third-party intermediary to provide childcare services on their behalf.

Under IRC Section 45S, employers that provide paid family and medical leave can claim a tax credit, which is a percentage of wages paid to employees while on family and medical leave. The percentage of wages is 12.5 percent and increased based on the amount paid to a qualifying employee that exceeds 50 percent of the employee's wages, with a maximum of 25 percent. To claim the tax credit, employers must have a written policy in place that provides for at least two weeks of paid family and medical leave annually to all full-time employees, with paid leave equal to at least 50 percent of the wages normally paid to the employee. The tax credit is available to employers in all states; however, amounts required under state law or paid for by the state are not taken into account in determining the credit.

The Act makes permanent this paid family and medical leave tax credit and enhances it for taxable years beginning after December 31, 2025. First, the Act allows employers to claim the credit if they have a stand-alone insurance policy for paid family leave benefits. It also lowers the minimum employee work requirement to receive the credit from one year to six months.

Trump Accounts and the pilot contribution program

The Act creates a new tax-preferred savings account for children under age 18 called the "Trump Account." Beginning January 1, 2026, these accounts will operate like individual retirement accounts that allow earnings to grow on a tax-free basis. Parents, relatives or other entities may contribute up to $5,000 annually after tax (indexed for inflation) up to age 18, with exceptions to the maximum for certain entities.

Children who are born from 2025 through 2028 will be automatically enrolled and receive a one-time deposit of $1,000 from the federal government into their account.

Under a new IRC Section 128, employers may contribute to an employee's child's account on a tax-free basis. The employer must have a separate written plan document to make such contributions, and the plan is subject to nondiscrimination rules under IRC Section 129. Employers may contribute up to $2,500 for each employee, and that amount is indexed beginning in 2027.

The accounts must be held by a financial institution and invested in a qualified equity index fund. Further regulatory guidance will be forthcoming from the Treasury Department.

Taxation of tips and overtime

The Act provides temporary changes to the taxation of tips and overtime from 2025 through 2028. It temporarily allows an above-the-line deduction of up to $25,000 for qualified tips, which is phased out at higher incomes. It also allows an above-the-line deduction of up to $12,500 ($25,000 for a joint return) for qualified overtime compensation.

ACA subsidies, Medicaid and Medicare

The Act has a significant impact on the U.S. health system generally because it imposes $1 trillion in cuts to Medicaid and ACA programs. The legislation is estimated to cut Medicaid funding by $940 billion over 10 years, according to an analysis by the Congressional Budget Office (CBO). Medicaid cuts will come in the form of new work requirements, more frequent eligibility verification, new cost-sharing copayments for certain Medicaid beneficiaries and limits on state provider taxes.

The Act also reduces support for the ACA Exchanges/Marketplace by more than $200 billion, including changing premium assistance tax credit eligibility and verification rules. Together, the CBO estimates that these changes would cause 11.8 million people to become uninsured over 10 years.

Separate from these cuts, the Act failed to extend the enhanced ACA subsidy expansion, initially part of COVID relief, beyond December 31, 2025. These enhanced subsidies significantly lower the cost of coverage on the ACA Exchanges and resulted in Exchange enrollment increasing to almost 25 million in 2025. Furthermore, the expiration of the enhanced subsidies is expected to result in an increase in premiums for Exchange coverage. As a result, the CBO analysis indicates that 5.1 million people would become uninsured due to the failure to extend these enhanced subsidies. Unlike some of the Medicaid changes, which generally begin in 2027, these ACA subsidies will be eliminated in 2026, resulting in individuals losing Exchange coverage as early as January 2026.

Implications for plan sponsors

Plan sponsors should work with their professional service providers to ensure that they understand the new law and accommodate the changes it requires into benefit systems and policies. Employers may wish to consider operational and tax strategy changes in light of the Act's provisions.

Additionally, plan sponsors should also be aware of the possibility that individuals who lose coverage could seek to enroll in employment-based plans, if they have previously avoided them because of high employee premium contributions. Dependents who previously did not enroll in employment-based coverage because of cost may seek to enroll in 2026 if ACA Exchange premiums increase significantly. Plan sponsors may see requests for new enrollments both at open enrollment and as a special enrollment when coverage is lost.