AGENDA

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

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 NORTH LAKE AVENUE, SUITE 810
PASADENA, CA 91101

THURSDAY, JULY 13, 2017 - 9:00 A.M.**

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

COMMITTEE MEMBERS:

William de la Garza, Chair
Vivian H. Gray, Vice Chair
Alan Bernstein
Ronald Okum
David Muir, Alternate

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of June 15, 2017

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement adopt a "Watch" position on Senate Bill 562, which would enact the Healthy California Act. (Memorandum dated June 30, 2017)

IV. FOR INFORMATION

A. Status of Requests for Proposals for State and Federal Legislative Advocacy Services Concerning Health, Benefit, and Plan Administration Issues
Steven P. Rice, Chief Counsel

B. Staff Activities Report for June 2017
C. LACERA Claims Experience
D. Legislation
- Health Care Reform
- Healthy California Act (SB 562)

V. REPORT ON STAFF ACTION ITEMS

VI. GOOD OF THE ORDER

(For information purposes only)

VII. ADJOURNMENT

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

****Although the meeting is scheduled for 9:00 a.m., it can start anytime thereafter, depending on the length of the Board of Retirement meeting preceding it. Please be on call.**

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.

Persons requiring an alternative format of this agenda pursuant to Section 202 of the Americans with Disabilities Act of 1990 may request one by calling Cynthia Guider at (626)-564-6000, from 8:30 a.m. to 5:00 p.m. Monday through Friday, but no later than 48 hours prior to the time the meeting is to commence. Assistive Listening Devices are available upon request. American Sign Language (ASL) Interpreters are available with at least three (3) business days notice before the meeting date.

MINUTES OF THE MEETING OF THE

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

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

THURSDAY, JUNE 15, 2017, 10:30 A.M. – 11:15 A.M.

COMMITTEE MEMBERS

PRESENT: Vivian H. Gray, Vice Chair
Alan Bernstein
Ronald Okum
David L. Muir, Alternate

ABSENT: William de la Garza, Chair

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Marvin Adams
Shawn R. Kehoe
Joseph Kelly

STAFF, ADVISORS, PARTICIPANTS

Cassandra Smith
Johanna Fontenot
Barry Lew

Aon Hewitt

Kirby Bosley
Susie Lee

The meeting was called to order by Chair Gray at 10:30 a.m. Due to the absence of Mr. de la Garza, the Chair announced that Mr. Muir, as the alternate, would be a voting member of the Committee.

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of May 11, 2017

Mr. Bernstein made a motion, Mr. Okum seconded, to approve the minutes of the regular meeting of May 11, 2017. The motion passed with Ms. Gray abstaining.

II. PUBLIC COMMENT

III. ACTION ITEMS

A. As submitted by Barry W. Lew, Legislative Affairs Officer: Provide direction to staff regarding a potential LACERA Legislative Proposal – Correction of Errors and Omissions. (Memorandum dated June 1, 2017)

Mr. Muir made a motion, Ms. Gray seconded, to recommend to the Board of Retirement that LACERA seek legislation to allow the correction of the error of law for those members whose disability retirement was affected during a two year period beginning in 2013. The motion passed unanimously.

IV. FOR INFORMATION

A. Staff Activities Report for May, 2017

The staff activities report was discussed.

B. CIGNA & Anthem Blue Cross Claims Experience

The CIGNA & Anthem Blue Cross Claims Experience reports through April 2017 were discussed.

C. Federal Legislation

- Aon Hewitt Washington Report

Submitted for information only.

V. REPORT ON STAFF ACTION ITEMS

The Committee requested that staff look into taking a position on California legislation SB 562, the single-payer health plan bill.

VI. GOOD OF THE ORDER

(For information purposes only)

VII. ADJOURNMENT

The meeting adjourned at 11:15 a.m.

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

LACERA

June 30, 2017

TO: Insurance, Benefits and Legislative Committee
William de la Garza, Chair
Vivian H. Gray, Vice Chair
Ronald Okum
Alan Bernstein
David Muir, Alternate

FROM: Barry W. Lew
Legislative Affairs Officer

Cassandra Smith
Director, Retiree Healthcare

FOR: July 13, 2017 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Senate Bill 562—The Healthy California Act**

Author: *Lara [D] and Atkins [D]*
Sponsor: *California Nurses Association | National Nurses United*
Introduced: *February 17, 2017*
Amended: *May 26, 2017*
Status: *In ASSEMBLY. Read first time. Held at desk. (06/01/2017)*

Staff Recommendation: *Watch*

RECOMMENDATION
That the Insurance, Benefits and Legislative Committee recommend that the Board of Retirement adopt a "Watch" position on Senate Bill 562, which would enact the Healthy California Act.

LEGISLATIVE POLICY/ENGAGEMENT POLICY STANDARD
As currently defined in the Legislative Policy (page 9), a "Watch" position indicates that the proposal does not affect LACERA and its stakeholders but would be enacted under a law that covers LACERA such as the County Employees Retirement Law of 1937 or the California Public Employees' Pension Reform Act of 2017. This definition does not precisely align with the nature of SB 562. However, the Legislative Policy (page 5) further provides that its specific terms are not intended to limit the Board's flexibility "to take a position or other action." In addition, the Board's Policy on Engagement (page 2) provides that the Board has the "full range of tools" to express its views, including on proposals relating to health care (pages 4 and 5). Therefore, since the bill is currently dead for the 2017 legislative session but may be considered in 2018, staff recommends a "Watch" position. Staff believes this recommendation is consistent with the letter and spirit of the Board's Legislative and Engagement Policies.

STATUS OF BILL AND OTHER INFORMATION

Staff has inquired with staff at the Legislative Affairs and Intergovernmental Relations (LAIR) Branch of the Los Angeles County Executive Office. LAIR staff indicated that they have been tracking and analyzing the bill as well as gathering feedback from affected departments. There is no existing policy approved by the Board of Supervisors to support proposals related to the establishment of a single-payer health system; therefore, the County does not have a position on SB 562. A County position on this measure would require action by the Board of Supervisors.

SB 562 passed the Senate on June 1, 2017 and moved on to the Assembly. However, in March, Governor Brown expressed skepticism regarding the feasibility of the bill due to the financial and implementation challenges in establishing a universal health care system in California.[1] On June 23, 2017, Assembly Speaker Anthony Rendon released a statement indicating that SB 562 was "woefully incomplete" and that there were flaws in the bill that needed to be addressed. Speaker Rendon made the decision that SB 562 will remain in the Assembly Rules Committee until further notice.[2]

As a result of remaining in the Assembly Rules Committee, SB 562 will not meet any of the legislative deadlines required to move forward in 2017 and will thus carry over into the 2018 legislative session.

SUMMARY

SB 562, as amended on May 26, 2017, would create a universal single-payer health care program and health care cost control system for all California residents.

ANALYSIS

Governance

The Healthy California Act would establish the Healthy California (HC) program to be governed by the Healthy California Board. The HC Board would be an independent public entity that is not affiliated with any agency or department. The HC Board would consist of nine members who are residents of California. Four would be appointed by the Governor, two appointed would be appointed by the Senate Committee on Rules, and two would be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services would be a voting, ex-officio member of the board.

The appointed members would serve four-year terms. The appointed members would be required to have demonstrated and acknowledged expertise in health care. The

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[1] Myers, J. (2017, March 22). California Gov. Jerry Brown on paying for universal healthcare: 'How do you do that?' *Los Angeles Times*. Retrieved from www.latimes.com

[2] Rendon, A. (2017, June 23). *Speaker Rendon statement on health care*. [Press release]. Retrieved from https://speaker.asmdc.org/press-releases/speaker-rendon-statement-health-care

composition of the appointed members on the HC Board would consist of at least one representative of a labor organization representing registered nurses, at least one representative of the general public, at least one representative of a labor organization, and at least one representative of the medical provider community.

There would also be a public advisory committee established by the Secretary of California Health and Human Services that would advise the board on policy matters. The committee would consist of 22 members primarily from the health care industry; it would also include members from organized labor and small and large businesses. The committee members would also serve four-year terms.

Implications for LACERA. No later than two years after the effective date of the Healthy California Act, the HC Board would be required to develop proposals that would be of interest to LACERA's retiree population.

LACERA currently makes available a long-term care insurance program to its retirees. On December 15, 2016, LACERA approved Life Secure as the carrier for its long-term care insurance program. LACERA serves as a facilitator between the carrier and retired members and does not have any liability for the policies issued.

One proposal by the HC Board would involve the development of a program for long-term care coverage and its funding, both of which would be consistent with the principles of HC. In developing the proposal, the HC Board would consult with an advisory committee appointed by the chairperson of the HC Board (distinct from the board's own public advisory committee) consisting of consumer representatives, long-term care providers, organized labor, and other interested parties.

Some LACERA retired members may relocate outside of California after retirement. HC effectively bifurcates the LACERA retiree population into those who reside in California and those who reside out of state.

As such, another proposal by the HC Board would involve the accommodation of employer retiree health benefits. There are two aspects to this proposal. The first is to accommodate members of HC who subsequently live as retirees out of state. The second is to accommodate people who have earned or accrued retiree health benefits while residing in the state prior to the implementation of HC and subsequently live as retirees out of state. Although HC would also provide for out-of-state health care services, they would be in situations where an HC member is temporarily out of state as opposed to a retiree living out of state.

It appears that retiree health benefits may continue to be entered into under an employer-employee contract, if the HC program takes effect. However, SB 562 does not explicitly discuss collective bargaining between employers and employees with respect to health care benefits, whether for active or retired employees or for public sector versus private sector employers.

SB 562 does provide that HC would not preempt any city, county, or city and county from adopting additional health care coverage for the *residents* of that city, county, or city and county. However, that additional coverage would be based on geography rather than on an employment relationship with a city, county, or city and county. (In contrast, SB 840 (Kuehl, 2006), a prior single-payer bill that was vetoed, provided that employees are not precluded from receiving additional benefits under a collective bargaining agreement.)

Eligibility for Coverage

All California residents are eligible to become members of HC. A "resident" is defined as an individual whose primary place of abode is in the state, regardless of the individual's immigration status.

HC members would not be required to pay any fee, payment, or any other charge for enrollment or membership in HC. Members also would not be required to pay any premium, copayment, coinsurance, deductible or any other form of cost sharing for HC benefits.

Implications for LACERA. Retired members of LACERA are eligible to participate in LACERA's retiree health care program. Members pay premiums that are subsidized based on years of service credit. Members with 10 years of service credit pay 40 percent of the plan premium or 40 percent of the benchmark plan premium, whichever is less. For each additional year of service credit over 10 years, members receive an additional 4-percent subsidy, up to a maximum of 100 percent for 25 years of service credit. Members are responsible for any premiums that exceed the benchmark amounts.

Depending on the LACERA retiree health care plan in which they are enrolled, members may also be responsible for copayments, coinsurance, or deductibles. If receiving health care benefits under the HC program, LACERA retired members would not be required to pay any premiums, copayments, coinsurance, deductibles, or any other form of cost sharing. However, as discussed above, it is unclear at this point how LACERA retirees who reside out of state would receive benefits under HC.

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Benefits

The covered health benefits include all medical care determined to be medically appropriate by the member's health care provider. (The bill analysis by the Senate Committee on Health notes that "medically appropriate" is a broader coverage standard than "medical necessity" and may negatively affect cost control.)

Covered health care benefits include, but are not limited to the following: inpatient and outpatient medical and health facility services; inpatient and outpatient professional health care provider services; diagnostic and evaluative services; medical equipment, appliances, and assistive technology; inpatient and outpatient rehabilitative care; emergency care services; emergency transportation; medical transportation for disabled or low-income individuals; immunizations and preventive care; health and wellness education; hospice care; skilled nursing facility care; home health care; mental health services; substance abuse treatment; dental care; vision care; prescription drugs; pediatric care; prenatal and postnatal care; podiatric care; chiropractic care; acupuncture; therapies shown by the National institutes of Health or National Center for Complementary and Integrative Health to be safe and effective; blood and blood products; dialysis; adult day care; case management and case coordination; health-care-related language interpretation and translation; certain ancillary health care and social services previously covered under the Welfare and Institutions Code; and any additional health care services authorized to be added to the HC program.

Covered health care benefits also include health care services under various federal or federally-funded programs such as the Children's Health Insurance Program, Medi-Cal, Medicare, and essential health benefits mandated by the Affordable Care Act as of January 1, 2017.

> Implications for LACERA. LACERA would need to analyze to what extent the benefits currently offered by its retiree health care plans align with the benefits offered by HC. Under HC's single-payer system, a carrier may not offer benefits or cover any services for which coverage is offered to individuals under the HC program. However, a carrier may offer benefits to cover health care services that are not offered to individuals under HC.

Delivery of Care

Any health care providers licensed to practice in California and otherwise in good standing are qualified to participate in the HC program. The providers must be legally authorized to perform the covered health care services. The health care services must be provided in California. However, the HC Board would also establish procedures for situations where HC members are temporarily located out of state and require health care services.

An HC member may choose to receive services from any participating provider or may enroll with an integrated health care delivery system.

Care coordination, which includes administrative tracking and medical recordkeeping services, would be provided to HC members. Care coordinators may include health care practitioners, certain licensed entities, a health care organization, a Taft-Hartley health and welfare fund, or any approved non-for-profit or governmental entity. HC members would not be required to have a referral from a care coordinator to see any health care provider, but health care providers would not be reimbursed for providing services unless the HC member is enrolled with a care coordinator.

In general, health care providers would be paid on a fee-for-service basis, although the HC Board may establish other payment methodologies. Integrated health care delivery systems that provide comprehensive, coordinated services would be able to choose reimbursement on a capitated system operating budget or a noncapitated system operating budget.

Under the HC program, a carrier may not offer benefits or cover any service for which coverage is offered to individuals by HC. Carriers, as defined by the bill, include private health insurers and health care service plans. However, carriers may offer benefits to cover health care services not offered to individuals by HC.

> Implications for LACERA. Retired LACERA members who are not eligible for Medicare are currently are enrolled in health plans that are indemnity plans and health maintenance organizations (HMOs). However, under HC, carriers may not offer benefits or cover any services for which coverage is offered under HC. Under HC's single-payer system, the HC program—rather than a carrier—would pay a participating provider for covered services received by the member.
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> If the LACERA retiree health care plans offer benefits not covered by HC, it would be a question of what those benefits are and what kind of insurance market exists to provide those benefits. If there is not an insurance market and those extra benefits must be provided (for example, as mandated by the 1982 County/LACERA Funding Agreement), would a plan sponsor be able to self-fund those benefits? (This scenario would be analogous to situations where a LACERA member's pension benefit exceeds the benefit limitations under Section 415 of the Internal Revenue Code, and a replacement benefit plan is used to provide the promised benefit.)
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> Retired LACERA members who are eligible for Medicare and are HC members would receive Medicare benefits through the HC program as HC seeks federal waivers, approvals, and funding necessary to enable HC members to receive benefits that they would have received under a federal program.

Funding

In establishing a universal single-payer health care program, SB 562 contemplates providing health care services that are also covered under federal health programs such as Medicare, the Affordable Care Act, any federally matched public health program, and any other programs that provide payment for health care services. To that end, SB 562 would seek all federal waivers, approvals, and funding necessary to operate HC.

The Healthy California Trust Fund would be created to hold the funds to be utilized for the HC program.

Since SB 562 has a fiscal impact, it was required to be heard in the Senate Committee on Appropriations. A committee staff analysis was provided to members of the Appropriations Committee.

At the same time, the California Nurses Association, which is the sponsor of SB 562, also funded a research project that estimated the costs of HC and ways to fund it. The project was conducted by the Political Economy Research Institute at the University of Massachusetts Amherst.

Attachment 3 provides a comparison of the estimated fiscal impact analyzed by the Appropriations Committee and the Political Economy Research Institute (PERI).

The two analyses differ in their conclusions of the additional tax revenues required to fund HC. The Appropriations Committee estimates $200 billion (although $50 to $100 billion would consist of new spending since existing spending is about $100 to $150 billion), and the Political Economy Research Institute estimates $106 billion. For comparison, the California state budget for 2017-18 is $123 billion.

> Implications for LACERA. The proposals for funding HC outlined in Attachment 3 involve using a payroll tax, sales tax, or gross receipts business tax. It is assumed that LACERA members who are active employees would be subject to the payroll tax since they would be California residents who are eligible to be members of HC; they would be subject to the sales tax as consumers. As the County of Los Angeles would not be considered a business, it does not appear to be subject to a gross receipts tax. The Appropriations Committee analysis and the PERI analysis do not discuss funding from public sector sources that currently sponsor health care plans for public sector employees. For example, how would the funds in the LACERA Other Postemployment Benefits Trust be treated under the HC program?

Operative Date

As a result of being held in the Assembly Rules Committee for the rest of 2017, SB 562 will carry over into 2018. If enacted in 2018, SB 562 would be effective January 1, 2019.

However, the provisions of SB 562 will not become operative until the date that the Secretary of California Health and Human Services notifies the Secretary of the Senate and Chief Clerk of the Assembly in writing that he or she has determined that the Healthy California Trust Fund has the revenues to fund the costs of implementing HC.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE recommend that the Board of Retirement adopt a "Watch" position on Senate Bill 562, which would enact the Healthy California Act.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachments
Attachment 1—Board Positions Adopted on Related Legislation
Attachment 2—Support And Opposition
Attachment 3—Fiscal Analysis
SB 562 as amended on May 26, 2017

BOARD POSITIONS ADOPTED ON RELATED LEGISLATION

SB 840 (2006, vetoed) would have established the California Health Insurance System to be administered by the California Health Insurance Agency under the control of the Health Insurance Commissioner. The bill would have made all California residents eligible for specified health care benefits and authorized the California Health Insurance System, on a single-payer basis, to negotiate and set fees for health care services and pay claims for those services. The Insurance, Benefits and Legislative Committee received and filed the recommendation to recommend a position to the Board of Retirement.

SUPPORT

California Nurses Association/National Nurses United (source), California Insurance Commissioner Dave Jones, 13 Pages Progressive Alliance for Government Ethics and Sanity, 28ers, 9to5 Working Women, A New Path, Alameda Progressives, Albany City Council, Albany Democratic Club, Alliance of Californians for Community Empowerment Institute, Alliance San Diego, AM Green Construction, American Association of Community Psychiatrists, American Civil Liberties Union, American Federation of Musicians Local 47, AFSCME Council 57, AFSCME Retirees Chapter 36, Americans for Democratic Action, Southern California, Arbeter Ring/Workmen's Circle, Arlington Community Church, Art Between Us, Asian Pacific American Labor Alliance, Asian Pacific Environmental Network, Bagg Lady Handbags, Bay Area Chapter of Resource Generation, Bay Area Veterans of the Civil Rights Movement, Bay Rising, Bell Everman, Inc., Bend the Arc, Berniecrats Labor Alliance Chartered Democratic Club of Yolo County, Biomech Incorporated, Breast Cancer Action, Business Alliance for a Healthy California, Butte County Health Care Coalition, Cabrillo College Federation of Teachers, AFT 4400, California Alliance for Retired Americans, California Association of Marriage and Family Therapists East Bay Chapter, California Capital Chapter of Physicians for a National Health Program, California Center for Rural Policy, California Council of Churches IMPACT, California Democratic Party State Central Committee San Gabriel Valley, California Domestic Workers Coalition, California Faculty Association - San Francisco State University Chapter, California Federation of Teachers, AFT, AFL-CIO, California Foundation for Independent Living Centers, California Health Professionals Student Alliance, California Healthy Nail Salon Collaborative, California Labor Federation, AFL-CIO, California National Organization for Women, California One Care, California Partnership, California Physicians Alliance, California Public Health Association-North, California School Employees Association, California Teachers Association, California Youth Empowerment Network, Californians United for a Responsible Budget, Campaign for a Healthy California, Caring Across Generations, Catalina’s List, Central Valley Indivisible, Central Valley-Sierra Progressives, CEO to CEO, Chinese Progressive Association, City and County of San Francisco, City Designworks, City of Berkeley, City of El Cerrito, City of Emeryville, City of Los Angeles, City of Oakland, City of Richmond, City of Richmond- Laurel Park Neighborhood Council, City of West Hollywood, Clergy & Laity United for Economic Justice, Clinica Romero, Code Pink, Communications Workers of American District 9, Community Health Councils, Concilio Latino of West Contra Costa County, Congresswoman Karen Bass, Consider the Homeless, Consumer Federation of California, Contra Costa AFL-CIO Labor Council, County of Marin Board of Supervisors, County of Nevada Board of Supervisors, County of San Clara Board of Supervisors, County of San Francisco Board of Supervisors, Courage Campaign, Courageous Resistance of Humboldt, CREDO Action, Cutting Edge Capital, Decus Biomedical, Dell Arte International, Democracy for America-Marin, Democratic Action Club of Chico, Democratic Club of Carlsbad-Oceanside, Democratic Club of Santa Maria Valley,

Democratic Club of Southern Sonoma County, Democratic Party of Contra Costa, Democratic Party of Orange County, Democratic Socialists of America – Los Angeles, Democratic Socialists of America, Orange County Chapter, Democratic Socialists of America, San Francisco, Democratic Socialists of America, Ventura County Chapter, Democratic Women's Club of San Diego County, Democratic Women's Coalition of Tuolumne County, Disability Action Center, Divine Feminine Yoga, Douglas L. Applegate Law Office, East Bay Democratic Socialists of America, East Bay Single Payer Coalition, East Contra Costa Democratic Club, Easter Hill United Methodist Church, Eastlake Bonita Center for Human Rights, Ecological Farming Association, El Cerrito Progressives, Elder Care Providers' Coalition, Elsdon Organizational Renewal, Empowered Investments, Encore, Far Leaves Tea, First They Came for the Homeless, For Grace, Forward Together, Fresno Economic Opportunities Commission, Friends Committee on Legislation, Giraud Photography, Inc., Give Something Back Office Supplies, Glenview Area Groups for Action, Gray Panthers of San Francisco, Green Party of Alameda County, Green Party of Contra Costa County, Green Party of San Bernardino County, Green Party of Santa Clara County, Green Party of Yolo County, Haight Ashbury Neighborhood Council, Haiks German Autohaus, Hand in Hand, Harvey Milk LGBT Democratic Club, Health Care for All - Alameda County, Health Care for All - California 15 Chapters, Health Care for All - Contra Costa County, Health Care for All - Los Angeles Chapter, Health Care for All - Marin, Health Care for All - Nevada County Chapter, Health Care for All - Sacramento Valley Chapter, Health Care for All - San Fernando Valley Chapter, Health Care for All - San Gabriel Valley County, Health Care for All - Santa Barbara County Chapter, Health Care for All - Santa Clara County Chapter, Healthy California, Human Agenda, Humanist Society of Santa Barbara, Hunger Action Los Angeles, Independent Living Resource Center San Francisco, Indivisible Claremont, Indivisible East Contra Costa County, Indivisible Ladera, Indivisible Mader, Indivisible Orange County, Inland Coalition for Immigrant Justice, Inland Empire Immigrant Youth Collective, Inland Greens, International Longshore & Warehouse Union Southern California, J. Glynn & Company, Jane Thomas Press, Jobs with Justice San Francisco, Justice for All Ventura County, Justice for Palestinians, Kate Harris Consulting, KNA Copy Centre, Korean Community Center of the East Bay, Kramer Translations, La Jolla Democratic Club, Labor United for Universal Healthcare, Laguna Woods Democratic Club, Lake County Democratic Central Committee, Lamorinda Peace and Justice Group, Latina/Latino Roundtable, Latino Coalition for a Healthy California, Law & Mediation Office of Leslie A. Levy, Law Offices of Douglas L. Applegate, Lawyers for Good Government, League of Women Voters of California, Legal Services for Children, Lonely Liberals Indivisible of San Luis Obispo County, Long Beach Gray Panthers, Loving Way Midwifery, Low-Income Self Help Center, Lucille Design, Maddala Music, March and Rally Los Angeles, Martin Luther King Coalition of Greater Los Angeles, McGee-Spaulding Neighbors in Action, Media Alliance, Merced Collective Action Network, Mi Familia Vota, Mini-Vacation Massage, Mobilize the Immigrant Vote, Monkey Out, Voters In, Monkey Wrench Brigade, Mountain Bears

Democratic Club, Mt. Diablo Peace and Justice Center, Multi-Faith ACTION Coalition, Musicians Union Local 6, National Association of Retired and Veteran Railway Employees, National Association of Social Workers, National Association of Social Workers-Fresno County, National Economic and Social Rights Initiative, National Union of Health Care Workers, Nevada County Democratic Women's Club, Nevada County Green Party, No Coal in Oakland, North Bay Jobs with Justice, Oakland Livable Wage Assembly, Oakley, California Mayor Sue Higgins, Occupy Torrance, One Page Plan, Organizacion en California de Lideres Campesinas, Inc., Otis Chiropractic Neurology, Inc., Our Developing World, Our Revolution, Our Revolution, Long Beach, Our Revolution, West San Fernando Valley, Pacific Palisades Democratic Club, Pacifica Social Justice, Painters & Allied Trades District Council 36, Peace and Freedom Party of California, People Power of Marina Del Ray, Peralta Retirees Organization, Physicians for a National Health Program CA, Pilipino Workers Center of Southern California, Pomona Valley Democratic Club, Poverty Matters, ProData Solutions, Progressive Action for Glendale, Progressive Asian Network for Action, Progressive Asset Management, Progressive Democrats of America - California, Progressive Democrats of America - Greater Palm Springs Area, Progressive Democrats of America - Lake County Chapter, Progressive Democrats of America - Orange County Chapter, Progressive Democrats of America - San Francisco Chapter, Progressive Democrats of America - Santa Monica Chapter, Progressive Democrats of America - Ventura County Chapter, Project Inform, Rancho Penasquitos Democratic Club, Resource Generation, Richmond Progressive Alliance, Riverside All of Us or None, Riverside County Young Democrats, Riverside Temple Beth El, San Francisco Berniecrats, San Francisco Green Party, San Francisco Labor Council, San Francisco Latino Democratic Club, San Joaquin Valley Democratic Club, San Jose Peace and Justice Center, San Mateo Central Labor Council, Santa Barbara Women's Political Committee, Santa Clara County Board of Supervisors, Santa Clara County Green Party San Francisco Berniecrats, Santa Cruz for Bernie, Santa Cruz Indivisible, Santa Rosa Democratic Club, School of the America Watch Los Angeles, Senior and Disability Action, Sierra Foothills Democratic Club, Sign Display and Allied Crafts Local Union No. 510, Silicon Valley Independent Living Center, SoCal 350 Climate Action, Social and Economic Justice Coalition, Social Justice Alliance of the Interfaith Council of Contra Costa, Sol2Economics, South Bay Labor Council, Steve Giraud Photography, Strike Debt, Sue's Hair Salon, Sunflower Alliance, TDA Investment Group, Tenants Together, The Democracy Project, The Latina/Latino Roundtable, The Refill Shop, Therapists for Single Payer, Together to End Solidarity Santa Cruz, Trout in Hand Productions, Tuolumne County Democratic Central Community, Tuolumne County Democratic Club, UFCW, Local 5, Unitarian Universalist Justice Ministry of California, United Democrats of El Dorado County, United Electrical, Radio, and Machine Workers of America Western Region, United Steelworkers, Local 2801, United Steelworkers, Local 675, UNITE-HERE, AFL-CIO, University Council American Federation of Teachers Local 1474, University Professional and Technical Employees, Local 9119, Uprise

Campaigns, Veterans Democratic Club of LA County, Veterans for Peace, South Bay Chapter, Vision y Compromiso, Voices for Mothers and Others, Wellstone Democratic Renewal Club, Word Spark Writing & Editing, Yes We Can Democratic Club, Yolo MoveOn, Numerous individuals

OPPOSITION
America's Health Insurance Plans, Anthem Blue Cross, Association of California Insurance Companies, Association of California Life & Health Insurance Companies, Bay Area Council, BizFed, Los Angeles County Business Federation, Blue Shield of California, California Association of Health Plans, California Association of Health Underwriters, California Business Roundtable, California Chamber of Commerce, California Farm Bureau Federation, California Framing Contractors Association, California League of Food Processors, California Manufacturers & Technology Association, California Medical Association, California Professional Association of Specialty Contractors, California Retailers Association, California Taxpayers Association, California Trucking Association, Camarillo Chamber of Commerce, El Centro Chamber of Commerce and Tourist Bureau, Fresno Chamber of Commerce, Greater Riverside Chambers of Commerce, Greater San Fernando Valley Chamber of Commerce, Health Net, Howard Jarvis Taxpayers Association, Independent Insurance Agents and Brokers of California, Kaiser Permanente, Long Beach Chamber of Commerce, Molina Healthcare, Murrieta Chamber of Commerce, National Association of Insurance and Financial Advisors of California, National Federation of Independent Business, North Orange County Chamber of Commerce, Oceanside Chamber of Commerce, Orange County Business Council, Oxnard Chamber of Commerce, Redondo Beach Chamber of Commerce and Tourist Bureau, Santa Maria Valley Chamber of Commerce, South Bay Association of Chambers of Commerce, Southwest California Legislative Council, Torrance Chamber of Commerce, Valley Industry and Commerce Association, Western Growers Association, Yuba-Sutter Chamber of Commerce

	Appropriations Committee	**Political Economy Research Institute**
Total costs per year	$400 billion	$331 billion[1]
Federal, state, and local funding	$200 billion	$225 billion[2]
Additional tax revenues required	$200 billion (Existing spending is $100 to $150 billion; therefore, new spending would be $50 to $100 billion.)	$106 billion
Source for additional tax revenues	Payroll tax: 15 percent (no cap on wages subject to tax)	Gross receipts tax of businesses: 2.3 percent Sales tax: 2.3 percent
Alternative source for additional tax revenues		Payroll tax for employers and employees: 3.3 percent each (6.6 percent total) Sales tax: 2.3 percent

[1] The Political Economy Research Institute estimates a cost of $404 billion under California's existing health care system. It also estimates a savings potential of 18 percent derived from changes in structure (administration, pharmaceutical pricing, and Medicare rates) and service delivery as a result of implementing a single-payer system. ($331 billion = $404 billion x 0.82)

[2] The Political Economy Research Institute cites a research study by the UCLA Center for Health Policy Research that 71 percent of total health care spending in California comes from public funding sources. The PERI excludes 3 percent of state and local government tax subsidies for employer-sponsored insurance that would not be operating under Healthy California. The resulting 68 percent is applied against costs of $331 billion. ($225 billion = $331 billion x 0.68)

AMENDED IN SENATE MAY 26, 2017

AMENDED IN SENATE APRIL 17, 2017

AMENDED IN SENATE MARCH 29, 2017

SENATE BILL No. 562

Introduced by Senators Lara and Atkins
(Principal coauthors: Senators Galgiani and Wiener)
(Principal coauthors: Assembly Members Bonta and Gomez)
(Coauthors: Senators Allen, McGuire, and Skinner)
(Coauthors: Assembly Members Chiu, Friedman, Kalra, McCarty, Nazarian, Mark Stone, and Thurmond)

February 17, 2017

An act to add Title 22.2 (commencing with Section 100600) to the Government Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 562, as amended, Lara. The Healthy California Act.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. PPACA required each state, by January 1, 2014, to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill, the Healthy California Act, would create the Healthy California program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that the program cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including, but not limited to, the state's Children's Health Insurance Program (CHIP), Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to the Healthy California program, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would also provide for the participation of health care providers in the program, require care coordination for members, provide for payment for health care services and care coordination, and specify program standards. The bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the Healthy California program. The bill would create the Healthy California Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would create the Healthy California Board to govern the program, made up of 9 members with demonstrated and acknowledged expertise in health care, and appointed as provided. The bill would provide the board with all the powers and duties necessary to establish the Healthy California program, including, but not limited to,

determining when individuals may start enrolling into the program, employing necessary staff, and negotiating and entering into any necessary contracts. The bill would also require the Secretary of California Health and Human Services to establish a public advisory committee to advise the board on all matters of policy for the Healthy California program.

This bill would prohibit health care service plans and health insurers from offering health benefits or covering any service for which coverage is offered to individuals under the program, except as provided. The bill would authorize health care providers, as defined, to collectively negotiate rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies using a 3rd-party representative, as provided.

This bill would prohibit this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the Healthy California Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its Internet Web site.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

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

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) All residents of this state have the right to health care. While the federal Patient Protection and Affordable Care Act (PPACA) brought many improvements in health care and health care coverage, it still leaves many Californians without coverage or with inadequate coverage.

(2) Californians, as individuals, employers, and taxpayers, have experienced a rise in the cost of health care and health care

coverage in recent years, including rising premiums, deductibles, and copays, as well as restricted provider networks and high out-of-network charges.

(3) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plan's economic needs rather than consumers' health care needs.

(5) To address the fiscal crisis facing the health care system and the state, and to ensure Californians can exercise their right to health care, comprehensive health care coverage needs to be provided.

(6) It is the intent of the Legislature to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state.

(b) (1) It is further the intent of the Legislature to establish the Healthy California (HC) program to provide universal health coverage for every Californian based on his or her ability to pay and funded by broad-based revenue.

(2) It is the intent of the Legislature for the state to work to obtain waivers and other approvals relating to Medi-Cal, the state's Children's Health Insurance Program, Medicare, the PPACA, and any other federal programs so that any federal funds and other subsidies that would otherwise be paid to the State of California, Californians, and health care providers would be paid by the federal government to the State of California and deposited in the Healthy California Trust Fund.

(3) Under those waivers and approvals, those funds would be used for health coverage that provides health benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(4) Those programs would be replaced and merged into the HC program, which will operate as a true single-payer program.

(5) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the state use state plan amendments and seek waivers and approvals to maximize, and

make as seamless as possible, the use of federally matched public health programs and federal health programs in the HC program.

(6) Thus, even if other programs such as Medi-Cal or Medicare may contribute to paying for care, it is the goal of this act that the coverage be delivered by the HC program, and, as much as possible, that the multiple sources of funding be pooled with other HC program funds and not be apparent to HC program members or participating providers.

(c) This act does not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit.

(d) (1) It is the intent of the Legislature not to change or impact in any way the role or authority of any licensing board or state agency that regulates the standards for or provision of health care and the standards for health care providers as established under current law, including, but not limited to, the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, as applicable.

(2) This act would in no way authorize the Healthy California Board, the Healthy California program, or the Secretary of California Health and Human Services to establish or revise licensure standards for health care providers.

(e) It is the intent of the Legislature that neither health information technology nor clinical practice guidelines limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

(f) (1) It is the intent of the Legislature to prohibit the HC program, a state agency, a local agency, or a public employee acting under color of law from providing or disclosing to anyone, including, but not limited to, the federal government, any personally identifiable information obtained, including, but not limited to, a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(2) This act would also prohibit law enforcement agencies from using the HC program's funds, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or

enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

(g) It is the further intent of the Legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

SEC. 2. Title 22.2 (commencing with Section 100600) is added to the Government Code, to read:

TITLE 22.2. THE HEALTHY CALIFORNIA ACT

Chapter 1. General Provisions

100600. This title shall be known, and may be cited, as the Healthy California Act.

100601. There is hereby established in state government the Healthy California program to be governed by the Healthy California Board pursuant to Chapter 2 (commencing with Section 100610).

100602. For the purposes of this title, the following definitions apply:

(a) "Affordable Care Act" or "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(b) "Allied health practitioner" means a group of health professionals who apply their expertise to prevent disease transmission, diagnose, treat, and rehabilitate people of all ages and in all specialties. Together with a range of technical and support staff, they may deliver direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples include, but are not limited to, audiologists, occupational therapists, social workers, and radiographers.

(c) "Board" means the Healthy California Board described in Section 100610.

(d) "Care coordination" means services provided by a care coordinator under Section 100637.

(e) "Care coordinator" means an individual or entity approved by the board to provide care coordination under Section 100637.

(f) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(g) "Committee" means the public advisory committee established pursuant to Section 100611.

(h) "Essential community providers" means persons or entities acting as safety net clinics, safety net health care providers, or rural hospitals.

(i) "Federally matched public health program" means the state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the state's Children's Health Insurance Program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(j) "Fund" means the Healthy California Trust Fund established under Section 100655.

(k) "Health care organization" means an entity that is approved by the board under Section 100640 to provide health care services to members under the program.

(*l*) "Health care service" means any health care service, including care coordination, that is included as a benefit under the program.

(m) "Healthy California" or "HC" means the Healthy California program established in Section 100601.

(n) "Implementation period" means the period under subdivision (f) of Section 100612 during which the program is subject to special eligibility and financing provisions until it is fully implemented under that section.

(o) "Integrated health care delivery system" means a provider organization that meets both of the following criteria:

(1) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventive care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.

(2) Is compensated by Healthy California using capitation or facility budgets for the provision of health care services.

(p) "Long-term care" means long-term care, treatment, maintenance, or services not covered under the state's Children's Health Insurance Program, as appropriate, with the exception of short-term rehabilitation, and as defined by the board.

(q) "Medicaid" or "medical assistance" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The state's Children's Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(r) "Medicare" means Title XVIII of the *federal* Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(s) "Member" means an individual who is enrolled in the program.

(t) "Out-of-state health care service" means a health care service provided in person to a member while the member is physically located out of the state under either of the following circumstances:

(1) It is medically necessary that the health care service be provided while the member physically is out of the state.

(2) It is clinically appropriate and necessary, and cannot be provided in the state, because the health care service can only be provided by a particular health care provider physically located out of the state. However, any health care service provided to an HC member by a health care provider qualified under Section 100635 that is located outside the state shall not be considered an out-of-state service and shall be covered as otherwise provided in this title.

(u) "Participating provider" means any individual or entity that is a health care provider qualified under Section 100635 that provides health care services to members under the program, or a health care organization.

(v) "Prescription drugs" means prescription drugs as defined in subdivision (n) of Section 130501 of the Health and Safety Code.

(w) "Program" means the Healthy California program established in Section 100601.

(x) "Resident" means an individual whose primary place of abode is in the state, without regard to the individual's immigration status.

100603. This title does not preempt any city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than this title.

100604. To the extent any provision of California law is inconsistent with this title or the legislative intent of the Healthy California Act, this title shall apply and prevail, except when explicitly provided otherwise by this title.

Chapter 2. Governance

100610. (a) The Healthy California Board shall be an independent public entity not affiliated with an agency or department. The board shall be governed by an executive board consisting of nine members who are residents of California. Of the members of the board, four shall be appointed by the Governor, two shall be appointed by the Senate Committee on Rules, and two shall be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services or his or her designee shall serve as a voting, ex officio member of the board.

(b) Members of the board, other than an ex officio member, shall be appointed for a term of four years. Appointments by the Governor shall be subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of his or her successor. Vacancies shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in health care.

(2) Appointing authorities shall also consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care.

(3) Appointments to the board by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall be composed of:

(A) At least one representative of a labor organization representing registered nurses.

(B) At least one representative of the general public.

(C) At least one representative of a labor organization.

(D) At least one representative of the medical provider community.

(d) Each member of the board shall have the responsibility and duty to meet the requirements of this title, the Affordable Care Act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through the program, and to ensure the operational well-being and fiscal solvency of the program.

(e) In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of California.

(f) (1) A member of the board or of the staff of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health care provider, a health care facility, or a health clinic while serving on the board or on the staff of the board. A member of the board or of the staff of the board shall not be a member, a board member, or an employee of a trade association of health facilities, health clinics, or health care providers while serving on the board or on the staff of the board. A member of the board or of the staff of the board shall not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a health care practice.

(2) A board member shall not receive compensation for his or her service on the board, but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(3) For purposes of this subdivision, "health care provider" means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act.

(g) A member of the board shall not make, participate in making, or in any way attempt to use his or her official position to influence the making of a decision that he or she knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

(2) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(h) There shall not be liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, for or on account of an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this title or affairs related to this title.

(i) The board shall hire an executive director to organize, administer, and manage the operations of the board. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

(j) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(k) The board may adopt rules and regulations as necessary to implement and administer this title in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

100611. (a) The Secretary of California Health and Human Services shall establish a public advisory committee to advise the board on all matters of policy for the program.

(b) The members of the committee shall include all of the following:

(1) Four physicians, all of whom shall be board certified in their fields, and at least one of whom shall be a psychiatrist. The Senate Committee on Rules and the Governor shall each appoint one member. The Speaker of the Assembly shall appoint two of these members, both of whom shall be primary care providers.

(2) Two registered nurses, to be appointed by the Senate Committee on Rules.

(3) One licensed allied health practitioner, to be appointed by the Speaker of the Assembly.

(4) One mental health care provider, to be appointed by the Senate Committee on Rules.

(5) One dentist, to be appointed by the Governor.

(6) One representative of private hospitals, to be appointed by the Governor.

(7) One representative of public hospitals, to be appointed by the Governor.

(8) One representative of an integrated health care delivery system, to be appointed by the Governor.

(9) Four consumers of health care. The Governor shall appoint two of these members, one of whom shall be a member of the disabled community. The Senate Committee on Rules shall appoint a member who is 65 years of age or older. The Speaker of the Assembly shall appoint the fourth member.

(10) One representative of organized labor, to be appointed by the Speaker of the Assembly.

(11) One representative of essential community providers, to be appointed by the Senate Committee on Rules.

(12) One member of organized labor, to be appointed by the Senate Committee on Rules.

(13) One representative of small business, which is a business that employs less than 25 people, to be appointed by the Governor.

(14) One representative of large business, which is a business that employs more than 250 people, to be appointed by the Speaker of the Assembly.

(15) One pharmacist, to be appointed by the Speaker of the Assembly.

(c) In making appointments pursuant to this section, the Governor, the Senate Committee on Rules, and the Speaker of the

Assembly shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(d) Any member appointed by the Governor, the Senate Committee on Rules, or the Speaker of the Assembly shall serve a four-year term. These members may be reappointed for succeeding four-year terms.

(e) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was initially selected or appointed. The Secretary of California Health and Human Services shall notify the appropriate appointing authority of any expected vacancies on the public advisory committee.

(f) Members of the committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and shall receive one hundred dollars ($100) for each full day of attending meetings of the committee. For purposes of this section, "full day of attending a meeting" means presence at, and participation in, not less than 75 percent of the total meeting time of the committee during any particular 24-hour period.

(g) The public advisory committee shall meet at least six times per year in a place convenient to the public. All meetings of the committee shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

(h) The public advisory committee shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

(i) Appointed committee members shall have worked in the field they represent on the committee for a period of at least two years prior to being appointed to the committee.

(j) It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the committee and that is not generally available to the public.

100612. (a) The board shall have all powers and duties necessary to establish and implement Healthy California under

this title. The program shall provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

(b) The board shall, to the maximum extent possible, organize, administer, and market the program and services as a single-payer program under the name "HC," "Healthy California," or any other name as the board determines, regardless of which law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. In implementing this title, the board shall avoid jeopardizing federal financial participation in the programs that are incorporated into Healthy California and shall take care to promote public understanding and awareness of available benefits and programs.

(c) The board shall consider any matter to effectuate the provisions and purposes of this title. The board shall have no executive, administrative, or appointive duties except as otherwise provided by law.

(d) The board shall employ necessary staff and authorize reasonable expenditures, as necessary, from the Healthy California Trust Fund to pay program expenses and to administer the program.

(e) The board may do all of the following:

(1) Negotiate and enter into any necessary contracts, including, but not limited to, contracts with health care providers, integrated health care delivery systems, and care coordinators.

(2) Sue and be sued.

(3) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the state, and any municipality, county, or other political subdivision of the state.

(4) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions to be adopted by the board by regulation.

(5) Share information with relevant state departments, consistent with the confidentiality provisions in this title, necessary for the administration of the program.

(f) The board shall determine when individuals may begin enrolling in the program. There shall be an implementation period that begins on the date that individuals may begin enrolling in the program and ends on a date determined by the board.

(g) A carrier may not offer benefits or cover any services for which coverage is offered to individuals under the program, but may, if otherwise authorized, offer benefits to cover health care services that are not offered to individuals under the program. However, this title does not prohibit a carrier from offering either of the following:

(1) Any benefits to or for individuals, including their families, who are employed or self-employed in the state but who are not residents of the state.

(2) Any benefits during the implementation period to individuals who enrolled or may enroll as members of the program.

(h) After the end of the implementation period, a person shall not be a board member unless he or she is a member of the program, except the ex officio member.

(i) No later than two years after the effective date of this section, the board shall develop the following proposals:

(1) The board shall develop a proposal, consistent with the principles of this title, for provision by the program of long-term care coverage, including the development of a proposal, consistent with the principles of this title, for its funding. In developing the proposal, the board shall consult with an advisory committee, appointed by the chairperson of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, members of organized labor, and other interested parties.

(2) The board shall develop proposals for both of the following:

(A) Accommodating employer retiree health benefits for people who have been members of HC but live as retirees out of the state.

(B) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state prior to the implementation of HC and live as retirees out of the state.

(3) The board shall develop a proposal for HC coverage of health care services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

100613. The board may contract with not-for-profit organizations to provide both of the following:

(a) Assistance to consumers with respect to selection of a care coordinator or health care organization, enrolling, obtaining health care services, disenrolling, and other matters relating to the program.

(b) Assistance to health care providers providing, seeking, or considering whether to provide health care services under the program, with respect to participating in a health care organization and interacting with a health care organization.

100614. The board shall provide grants from funds in the Healthy California Trust Fund or from funds otherwise appropriated for this purpose to health planning agencies established pursuant to Section 127155 of the Health and Safety Code to support the operation of those health planning agencies.

100615. The board shall provide funds from the Healthy California Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for a program for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care or those individuals providing services to health care providers to deal with third-party payers for health care, whose jobs may be or have been ended as a result of the implementation of the program, consistent with otherwise applicable law.

100616. (a) The board shall provide for the collection and availability of all of the following data to promote transparency, assess adherence to patient care standards, compare patient outcomes, and review utilization of health care services paid for by the program:

(1) Inpatient discharge data, including acuity and risk of mortality.

(2) Emergency department and ambulatory surgery data, including charge data, length of stay, and patients' unit of observation.

(3) Hospital annual financial data, including all of the following:

(A) Community benefits by hospital in dollar value.

(B) Number of employees and classification by hospital unit.

(C) Number of hours worked by hospital unit.

(D) Employee wage information by job title and hospital unit.

(E) Number of registered nurses per staffed bed by hospital unit.

(F) Type and value of healthy information technology.

(G) Annual spending on health information technology, including purchases, upgrades, and maintenance.

(b) The board shall make all disclosed data collected under subdivision (a) publicly available and searchable through an Internet Web site and through the Office of Statewide Health Planning and Development public data sets.

(c) The board shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the Healthy California program to promote and protect public, environmental, and occupational health, including cooperation with other data collection and research programs of the Office of Statewide Health Planning and Development and the California Health and Human Services Agency, consistent with this title and otherwise applicable law.

(d) Prior to full implementation of the program, the board shall provide for the collection and availability of data on the number of patients served by hospitals and the dollar value of the care provided, at cost, for all of the following categories of Office of Statewide Health Planning and Development data items:

(1) Patients receiving charity care.

(2) Contractual adjustments of county and indigent programs, including traditional and managed care.

(3) Bad debts.

100617. (a) Notwithstanding any other law, Healthy California, any state or local agency, or a public employee acting under color of law shall not provide or disclose to anyone, including, but not limited to, the federal government any personally identifiable information obtained, including, but not limited to, a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status for law enforcement or immigration purposes.

(b) Notwithstanding any other law, law enforcement agencies shall not use Healthy California moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

Chapter 3. Eligibility and Enrollment

100620. (a) Every resident of the state shall be eligible and entitled to enroll as a member under the program.

(b) (1) A member shall not be required to pay any fee, payment, or other charge for enrolling in or being a member under the program.

(2) A member shall not be required to pay any premium, copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits.

(c) A college, university, or other institution of higher education in the state may purchase coverage under the program for a student, or a student's dependent, who is not a resident of the state.

Chapter 4. Benefits

100630. (a) Covered health care benefits under the program include all medical care determined to be medically appropriate by the member's health care provider.

(b) Covered health care benefits for members shall include, but are not limited to, all of the following:

(1) Licensed inpatient and licensed outpatient medical and health facility services.

(2) Inpatient and outpatient professional health care provider medical services.

(3) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(4) Medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for individual use.

(5) Inpatient and outpatient rehabilitative care.

(6) Emergency care services.

(7) Emergency transportation.

(8) Necessary transportation for health care services for persons with disabilities or who may qualify as low income.

(9) Child and adult immunizations and preventive care.

(10) Health and wellness education.

(11) Hospice care.

(12) Care in a skilled nursing facility.

(13) Home health care, including health care provided in an assisted living facility.
(14) Mental health services.
(15) Substance abuse treatment.
(16) Dental care.
(17) Vision care.
(18) Prescription drugs.
(19) Pediatric care.
(20) Prenatal and postnatal care.
(21) Podiatric care.
(22) Chiropractic care.
(23) Acupuncture.
(24) Therapies that are shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective.
(25) Blood and blood products.
(26) Dialysis.
(27) Adult day care.
(28) Rehabilitative and habilitative services.
(29) Ancillary health care or social services previously covered by county integrated health and human services programs pursuant to Chapter 12.96 (commencing with Section 18986.60) and Chapter 12.991 (commencing with Section 18986.86) of Part 6 of Division 9 of the Welfare and Institutions Code.
(30) Ancillary health care or social services previously covered by a regional center for persons with developmental disabilities pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.
(31) Case management and care coordination.
(32) Language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers.
(33) Health care and long-term supportive services currently covered under Medi-Cal or the state's Children's Health Insurance Program.
(34) Covered benefits for members shall also include all health care services required to be covered under any of the following provisions, without regard to whether the member would otherwise be eligible for or covered by the program or source referred to:

(A) The state's Children's Health Insurance Program (Title XXI of the *federal* Social Security Act (42 U.S.C. Sec. 1397aa et seq.)).

(B) Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(C) The federal Medicare program pursuant to Title XVIII of the *federal* Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(D) Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(E) Health insurers, as defined in Section 106 of the Insurance Code, pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code.

(F) Any additional health care services authorized to be added to the program's benefits by the program.

(G) All essential health benefits mandated by the Affordable Care Act as of January 1, 2017.

Chapter 5. Delivery of Care

Article 1. Health Care Providers

100635. (a) (1) Any health care provider who is licensed to practice in California and is otherwise in good standing is qualified to participate in the program as long as the health care provider's services are performed within the State of California.

(2) The board shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under the program for members who require out-of-state health care services while the member is temporarily located out of the state.

(b) Any health care provider qualified to participate under this section may provide covered health care services under the program, as long as the health care provider is legally authorized to perform the health care service for the individual and under the circumstances involved.

(c) A member may choose to receive health care services under the program from any participating provider, consistent with provisions of this title, the willingness or availability of the provider, subject to provisions of this title relating to

discrimination, and the appropriate clinically relevant circumstances.

(d) A person who chooses to enroll with an integrated health care delivery system, group medical practice, or essential community provider that offers comprehensive services, shall retain membership for at least one year after an initial three-month evaluation period during which time the person may withdraw for any reason.

(1) The three-month period shall commence on the date when a member first sees a primary care provider.

(2) A person who wants to withdraw after the initial three-month period shall request a withdrawal pursuant to the dispute resolution procedures established by the board and may request assistance from the patient advocate, which shall be provided for in the dispute resolution procedures, in resolving the dispute. The dispute shall be resolved in a timely fashion and shall not have an adverse effect on the care a patient receives.

Article 2. Care Coordination

100637. (a) Care coordination shall be provided to the member by his or her care coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with regulations of the board and with the statutory requirements and regulations of the care coordinator's licensure.

(b) Care coordination includes administrative tracking and medical recordkeeping services for members, except as otherwise specified for integrated health care delivery systems.

(c) Care coordination administrative tracking and medical recordkeeping services for members shall not be required to utilize a certified electronic health record, meet any other requirements of the federal Health Information Technology for Economic and Clinical ~~Health,~~ *Health Act,* enacted under the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), or meet certification requirements of the federal Centers for Medicare and Medicaid Services' Electronic Health Records Incentive Programs, including meaningful use requirements.

(d) The care coordinator shall comply with all federal and state privacy laws, including, but not limited to, the federal Health

Insurance Portability and Accountability Act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), the Insurance Information and Privacy Protection Act (Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1 of the Insurance Code), and Section 1798.81.5 of the Civil Code.

(e) Referrals from a care coordinator are not required for a member to see any eligible provider.

(f) A care coordinator may be an individual or entity that is approved by the program that is any of the following:

(1) A health care practitioner that is any of the following:

(A) The member's primary care provider.

(B) The member's provider of primary gynecological care.

(C) At the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment to the member for that condition.

(2) An entity licensed pursuant to any of the following provisions:

(A) Health facility, Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(B) Health care service plan, Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(C) Long-term health care facility, as defined in Section 1418 of the Health and Safety Code, or a program developed pursuant to paragraph (1) of subdivision (i) of Section 100612, or a long-term health care facility with respect to a member who receives mental health care services.

(D) County medical facility, Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(E) Residential care facility for persons with chronic, life-threatening illness, Chapter 3.01 (commencing with Section 1568.01) of Division 2 of the Health and Safety Code.

(F) Alzheimer's day care resource center, Chapter 3.1 (commencing with Section 1568.15) of Division 2 of the Health and Safety Code.

(G) Residential care facility for the elderly, Chapter 3.2 (commencing with Section 1569) of Division 2 of the Health and Safety Code.

(H) Home health agency, Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(I) Private duty nursing agency, Chapter 8.3 (commencing with Section 1743) of Division 2 of the Health and Safety Code.

(J) Hospice, Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(K) Pediatric day health and respite care facility, Chapter 8.6 (commencing with Section 1760) of Division 2 of the Health and Safety Code.

(L) Home care service, Chapter 13 (commencing with Section 1796.10) of Division 2 of the Health and Safety Code.

(M) Mental health care provider, pursuant to Division 4 (commencing with Section ~~4000~~ *4000)* of the Welfare and Institutions ~~Code).~~ *Code.*

(3) A health care organization.

(4) A Taft-Hartley health and welfare fund, with respect to its members and their family members. This provision does not preclude a Taft-Hartley health and welfare fund from becoming a care coordinator under paragraph (5) or a health care organization under Section 100640.

(5) Any not-for-profit or governmental entity approved by the program.

(g) (1) A health care provider shall only be reimbursed for services if the member is enrolled with a care coordinator at the time the health care service is provided.

(2) Every member shall be encouraged to enroll with a care coordinator that agrees to provide care coordination prior to receiving health care services to be paid for under the program. If a member receives health care services before choosing a care coordinator, the program shall assist the member, when appropriate, with choosing a care coordinator.

(3) The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members have the right to change their care coordinators on terms at least as permissive as Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) relating to an individual

changing his or her primary care provider or managed care provider.

(h) A health care organization may establish rules relating to care coordination for members in the health care organization that are different from this section but otherwise consistent with this title and other applicable laws.

(i) This section does not authorize any individual to engage in any act in violation of the provisions of Division 2 (commencing with Section 500) of the Business and Professions Code.

(j) An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

(k) (1) The board shall develop and implement procedures and standards, by regulation, for an individual or entity to be approved as a care coordinator in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is incompetent to be a care coordinator or has exhibited a course of conduct that is inconsistent with program standards and regulations, or that exhibits an unwillingness to meet those standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards adopted by the board shall be consistent with professional practice, licensure standards, and regulations established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, as applicable.

(3) In developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the board shall consult with the Mental Health Services Division of the State Department of Health Care Services and the Director of Developmental Services.

(*l*) To maintain approval under the program, a care coordinator shall do all of the following:

(1) Renew its status every three years pursuant to regulations adopted by the board.

(2) Provide to the program any data required by the Office of Statewide Health Planning and Development pursuant to Division 107 (commencing with Section 127000) of the Health and Safety

Code that would enable the board to evaluate the impact of care coordinators on quality, outcomes, and cost of health care.

Article 3. Payment for Health Care Services and Care Coordination

100639. (a) The board shall adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services.

(b) Health care services provided to members under the program, except for care coordination, shall be paid for on a fee-for-service basis unless and until another payment methodology is established by the board.

(c) Notwithstanding subdivision (b), integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated system operating budget or a noncapitated system operating budget that covers all costs of providing health care services.

(d) The program shall engage in good faith negotiations with health care providers' representatives under Chapter 8 (commencing with Section 100660), including, but not limited to, in relation to rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies. Those negotiations shall be through a single entity on behalf of the entire program for prescription and nonprescription drugs.

(e) (1) Payment for health care services established under this title shall be considered payment in full.

(2) A participating provider shall not charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and shall not

solicit or accept payment from any member or third party for any health care service, except as provided under a federal program.

(3) However, this section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(f) The program may adopt, by regulation, payment methodologies for the payment of capital-related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities that are health facilities pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Any capital-related expense generated by a capital expenditure that requires prior approval shall have received that approval in order to be paid by the program. That approval shall be based on achievement of the program standards described in Chapter 6 (commencing with Section 100645).

(g) Payment methodologies and payment rates shall include a distinct component of reimbursement for direct and indirect graduate medical education.

(h) The board shall adopt, by regulation, payment methodologies and procedures for paying for health care services provided to a member while the member is located out of the state.

Article 4. Health Care Organizations

100640. (a) A member may choose to enroll with and receive program care coordination and ancillary health care services from a health care organization.

(b) A health care organization shall be a not-for-profit or governmental entity that is approved by the board that is either of the following:

(1) A county integrated health and human services program under Chapter 12.96 (commencing with Section 18986.60) and Chapter 12.991 (commencing with Section 18986.86) of Part 6 of Division 9 of the Welfare and Institutions Code.

(2) A regional center for persons with developmental disabilities under Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.

(c) (1) The board shall develop and implement procedures and standards, by regulation, for an entity to be approved as a health

care organization in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity is incompetent to be a health care organization or has exhibited a course of conduct that is inconsistent with program standards and regulations, or that exhibits an unwillingness to meet those standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards adopted by the board shall be consistent with professional practice and licensure standards established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, as applicable.

(3) In developing and implementing standards of approval of health care organizations, the board shall consult with the Mental Health Services Division of the State Department of Health Care Services and the Director of Developmental Services.

(d) To maintain approval under the program, a health care organization shall do both of the following:

(1) Renew its status at a frequency determined by the board.

(2) Provide data to the California Health and Human Services Agency, as required by the board, to enable the board to evaluate the health care organization in relation to the quality of health care services, health care outcomes, and cost.

(e) The board may adopt narrowly focused regulations relating solely to health care organizations for the sole and specific purpose of ensuring consistent compliance with this title.

(f) This title may not be construed to alter in any way the professional practice of health care providers or their licensure standards established pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(g) Health care organizations shall not use health information technology or clinical practice guidelines that limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

Chapter 6. Program Standards

100645. Healthy California shall establish a single standard of safe, therapeutic care for all residents of the state by the following means:

(a) The board shall establish requirements and standards, by regulation, for the program and for health care organizations, care coordinators, and health care providers, consistent with this title and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including requirements and standards for, as applicable:

(1) The scope, quality, and accessibility of health care services.

(2) Relations between health care organizations or health care providers and members.

(3) Relations between health care organizations and health care providers, including credentialing and participation in the health care organization, and terms, methods, and rates of payment.

(b) The board shall establish requirements and standards, by regulation, under the program that include, but are not limited to, provisions to promote all of the following:

(1) Simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable.

(2) In-person primary and preventive care, care coordination, efficient and effective health care services, quality assurance, and promotion of public, environmental, and occupational health.

(3) Elimination of health care disparities.

(4) Consistent with the Unruh Civil Rights Act (Section 51 of the Civil Code), nondiscrimination with respect to members and health care providers on the basis of race, color, ancestry, national origin, religion, citizenship, immigration status, primary language, mental or physical disability, age, sex, gender, sexual orientation, gender identity or expression, medical condition, genetic information, marital status, familial status, military or veteran status, or source of income; however, health care services provided

under the program shall be appropriate to the patient's clinically relevant circumstances.

(5) Accessibility of care coordination, health care organization services, and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English.

(6) Providing care coordination, health care organization services, and health care services in a culturally competent manner.

(c) The board shall establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with the Healthy California program health care services and ancillary services currently provided by other programs, including, but not limited to, Medicare, the Affordable Care Act, and federally matched public health programs.

(d) Any participating provider or care coordinator that is organized as a for-profit entity shall be required to meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program paid to those entities shall not be calculated to accommodate the generation of profit, revenue for dividends, or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

(e) Every participating provider shall furnish information as required by the Office of Statewide Health Planning and Development pursuant to Division 107 (commencing with Section 127000) of the Health and Safety Code and permit examination of that information by the program as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental, and occupational health.

(f) In developing requirements and standards and making other policy determinations under this chapter, the board shall consult with representatives of members, health care providers, care coordinators, health care organizations, labor organizations representing health care employees, and other interested parties.

Chapter 7. Funding

Article 1. Federal Health Programs and Funding

100650. (a) The board shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate the program consistent with this title.

(b) (1) The board shall apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal programs that provide federal funds for payment for health care services that are necessary to enable all Healthy California members to receive all benefits under the program through the program, to enable the state to implement this title, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the Healthy California Trust Fund, created pursuant to Section 100655, and to use those funds for the program and other provisions under this title.

(2) To the fullest extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to Healthy California in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs.

(3) The board may require members or applicants to provide information necessary for the program to comply with any waiver or arrangement under this title. Information provided by members to the board for the purposes of this subdivision shall not be used for any other purpose.

(4) The board may take any additional actions necessary to effectively implement Healthy California to the maximum extent possible as a single-payer program consistent with this title.

(c) The board may take actions consistent with this article to enable the program to administer Medicare in California, and the program shall be a provider of supplemental insurance coverage (Medicare Part B) and shall provide premium assistance drug

coverage under Medicare Part D for eligible members of the program.

(d) The board may waive or modify the applicability of any provisions of this section relating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement under this section or to maximize the federal benefits to the program under this section, provided that the board, in consultation with the Director of Finance, determines that the waiver or modification is in the best interest of the state and members affected by the action.

(e) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare shall not cause any member to lose any health care service provided by the program or diminish any right the member would otherwise have.

(f) (1) Notwithstanding any other law, the board, by regulation, shall increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(2) The board may act under this subdivision, upon a finding approved by the Director of Finance and the board that the action does all of the following:

(A) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(B) Will not diminish any individual's access to any health care service or right the individual would otherwise have.

(C) Is in the interest of the program.

(D) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(3) Actions under this subdivision shall not apply to eligibility for payment for long-term care.

(g) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, the board may require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(h) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(i) The program shall provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan under Section 1860D of Title XVIII of the *federal* Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(j) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the *federal* Social Security Act (42 U.S.C. Sec. 1395w-114), the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member's eligibility for that subsidy; however, the board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

(k) The program shall make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member's coverage under the program may be terminated. Information provided by members to the board for the purposes of this section shall not be used for any other purpose.

(*l*) The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

Article 2. The Healthy California Trust Fund

100655. (a) The Healthy California Trust Fund is hereby created in the State Treasury for the purposes of this title. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

(c) The board shall establish and maintain a prudent reserve in the fund.

(d) The board or staff of the board shall not utilize any funds intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) The fund shall consist of all of the following:

(1) All moneys obtained pursuant to legislation enacted as proposed under Section 100657.

(2) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established under Medicare, any federally matched public health program, or the Affordable Care Act.

(3) The amounts paid by the State Department of Health Care Services that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally matched public health program, or the Affordable Care Act for health

benefits that are equivalent to health benefits covered under Healthy California.

(4) Federal and state funds for purposes of the provision of services authorized under Title XX of the *federal* Social Security Act (42 U.S.C. Sec. 1397 et seq.) that would otherwise be covered under Healthy California.

(5) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care services for services and benefits covered under Healthy California. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this title.

(g) All federal moneys shall be placed into the Healthy California Federal Funds Account, which is hereby created within the Healthy California Trust Fund.

(h) Moneys in the fund shall only be used for the purposes established in this title.

Article 3. Healthy California Financing

100657. (a) It is the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the program. In developing the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

(b) It is the intent of the Legislature to enact legislation that would require all state revenues from the program to be deposited in an account within the Healthy California Trust Fund to be established and known as the Healthy California Trust Fund Account.

Chapter 8. Collective Negotiation by Health Care Providers with Healthy California

Article 1. Definitions

100660. For purposes of this chapter, the following definitions apply:

(a) (1) "Health care provider" means a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code and who is any of the following:

(A) An individual who practices that profession as a health care provider or as an independent contractor.

(B) An owner, officer, shareholder, or proprietor of a health care provider.

(C) An entity that employs or utilizes health care providers to provide health care services, including, but not limited to, a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) A health care provider under Division 2 (commencing with Section 500) of the Business and Professions Code who practices as an employee of a health care provider is not a health care provider for purposes of this chapter.

(b) "Health care providers' representative" means a third party that is authorized by health care providers to negotiate on their behalf with Healthy California over terms and conditions affecting those health care providers.

(c) "Healthy California" or "HC" means the Healthy California program established in Section 100601.

Article 2. Collective Negotiation Authorized

100662. (a) Health care providers may meet and communicate for the purpose of collectively negotiating with Healthy California on any matter relating to Healthy California, including, but not limited to, rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies.

(b) This chapter shall not be construed to allow or authorize an alteration of the terms of the internal and external review procedures set forth in law.

(c) This chapter shall not be construed to allow a strike of Healthy California by health care providers related to the collective negotiations.

(d) This chapter shall not be construed to allow or authorize terms or conditions that would impede the ability of Healthy

California to obtain or retain accreditation by the National Committee for Quality Assurance or a similar body, or to comply with applicable state or federal law.

Article 3. Collective Negotiation Requirements

100664. (a) Collective negotiation rights granted by this chapter shall meet all of the following requirements:

(1) Health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with HC.

(2) Health care providers may communicate with health care providers' representatives.

(3) A health care providers' representative is the only party authorized to negotiate with HC on behalf of the health care providers as a group.

(4) A health care provider can be bound by the terms and conditions negotiated by the health care providers' representatives.

(5) In communicating or negotiating with the health care providers' representative, HC is entitled to offer and provide different terms and conditions to individual competing health care providers.

(b) This chapter does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

(c) This chapter does not affect or limit collective action or collective bargaining on the part of a health care provider with his or her employer or any other lawful collective action or collective bargaining.

100666. (a) Before engaging in collective negotiations with HC on behalf of health care providers, a health care providers' representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this chapter.

(b) Each person who acts as the representative of negotiating parties under this chapter shall pay a fee to the board to act as a representative. The board, by regulation, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board in administering this chapter.

Article 4. Prohibited Collective Action

100668. (a) This chapter does not authorize competing health care providers to act in concert in response to a health care providers' representative's discussions or negotiations with HC, except as authorized by other law.

(b) A health care providers' representative shall not negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

Chapter 9. Operative Date

100670. (a) Notwithstanding any other law, this title shall not become operative until the date the Secretary of California Health and Human Services notifies the Secretary of the Senate and the Chief Clerk of the Assembly in writing that he or she has determined that the Healthy California Trust Fund has the revenues to fund the costs of implementing this title.

(b) The California Health and Human Services Agency shall publish a copy of the notice on its Internet Web site.

SEC. 3. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. The Legislature finds and declares that Section 2 of this act, which adds Sections 100610 and 100617 to the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect private, confidential, and proprietary information, it is necessary for that information to remain confidential.

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LACERA

FOR INFORMATION ONLY

July 5, 2017

TO: Insurance, Benefits & Legislative Committee
William de la Garza, Chair
Vivian H. Gray, Vice Chair
Ronald Okum
Alan Bernstein
David Muir, Alternate

FROM: Steven P. Rice SPR
Chief Counsel

FOR: July 13, 2017 Board of Retirement Meeting

SUBJECT: **STATUS OF REQUESTS FOR PROPOSALS FOR STATE AND FEDERAL LEGISLATIVE ADVOCACY SERVICES CONCERNING HEALTH, BENEFIT, AND PLAN ADMINISTRATION ISSUES**

On May 11, 2017, the Board of Retirement approved issuance of Requests for Proposals (RFPs) for state and federal legislative advocacy services. The RFPs were issued on May 22, 2017 and responses were received by June 23, 2017, both as scheduled. The status of the RFPs is as follows:

State RFP

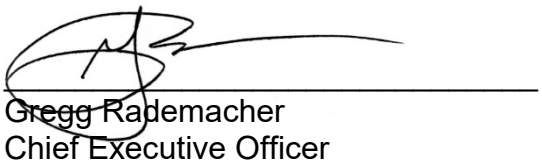
Two responses were received to the California state RFP, one from the incumbent provider and one from another party. Staff concluded that two responses are insufficient to provide the Committee and the Board with meaningful alternatives. Accordingly, staff will extend the RFP response period until August 11, 2017, with the goal of bringing qualified candidates to the Committee for interviews at the September 6, 2017 or October 12, 2017 meeting. If a sufficient number of additional qualified responses is not received by August 11, staff will discuss the matter with the Committee at the September 6 meeting. Staff understands that parties may be discouraged from responding to the RFP because LACERA has an existing provider.

Federal RFP

Seven responses were received to the federal RFP. The responses were reviewed and scored by an evaluation committee consisting of representatives of the Retiree Healthcare, Benefits, Member Services, and Legal Divisions. Three finalists were selected to be interviewed by the Committee. The original RFP schedule called for Committee interviews to be conducted on July 13, 2017. However, due to the summer

schedules of the responding parties' representatives (all of whom must travel from Washington, D.C. to Los Angeles), it is necessary to postpone the interviews. Arrangements are still being finalized. However, staff currently intends to present the candidates for interviews at the Committee's September 6, 2017 or October 12, 2017 meeting.

Reviewed and Approved.



Gregg Rademacher
Chief Executive Officer

c. Gregg Rademacher
Robert Hill
John J. Popowich
Cassandra Smith
Leilani Ignacio
Barry Lew

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
JUNE 2017
FOR INFORMATION ONLY

July 1, 2017 – June 30, 2018 - Insurance Premium Rate Table Update

Staff completed the insurance premium rate tables update for the June 30, 2017 Pay Period, for coverage effective July 1, 2017. In addition, the insurance rate table update for the Los Angeles County Firefighters Local 1014 medical plan was also completed.

We would like to thank Systems staff for their continued support with this annual project.

Retiree Healthcare Communications

The updates of the Retiree Healthcare communications for the July 1, 2017 – June 30, 2018, plan year was completed by staff. The following communication pieces were updated and uploaded to the LACERA website:

- Premium Rate Booklet, Effective July 1, 2017
- Out-of-State Premium Rate Booklet, Effective July 1, 2017
- Comparison Chart, Effective July 1, 2017
- Comparison Chart, with Medicare, Effective July 1, 2017
- Comparison Chart, Out-of-Area, Effective July 1, 2017
- Dental/Vision Chart, Effective July 1, 2017

Kudos to the Aon team, RHC team, and Communications team for their assistance with this annual project.

2017 Out-of-State Rate Booklet Mass Mailing

Staff completed the mass mailing of the 2017 Out-of-State Rate Booklet and Comparison Chart to 400+ members.

The rate booklet includes the new rates for the out-of-state medical plans, namely: Kaiser – Colorado, Kaiser Georgia, Kaiser Hawaii, Kaiser Oregon, and Cigna HealthSpring Preferred Rx (available in Maricopa County and Apache Junction, Pinal County, AZ only).

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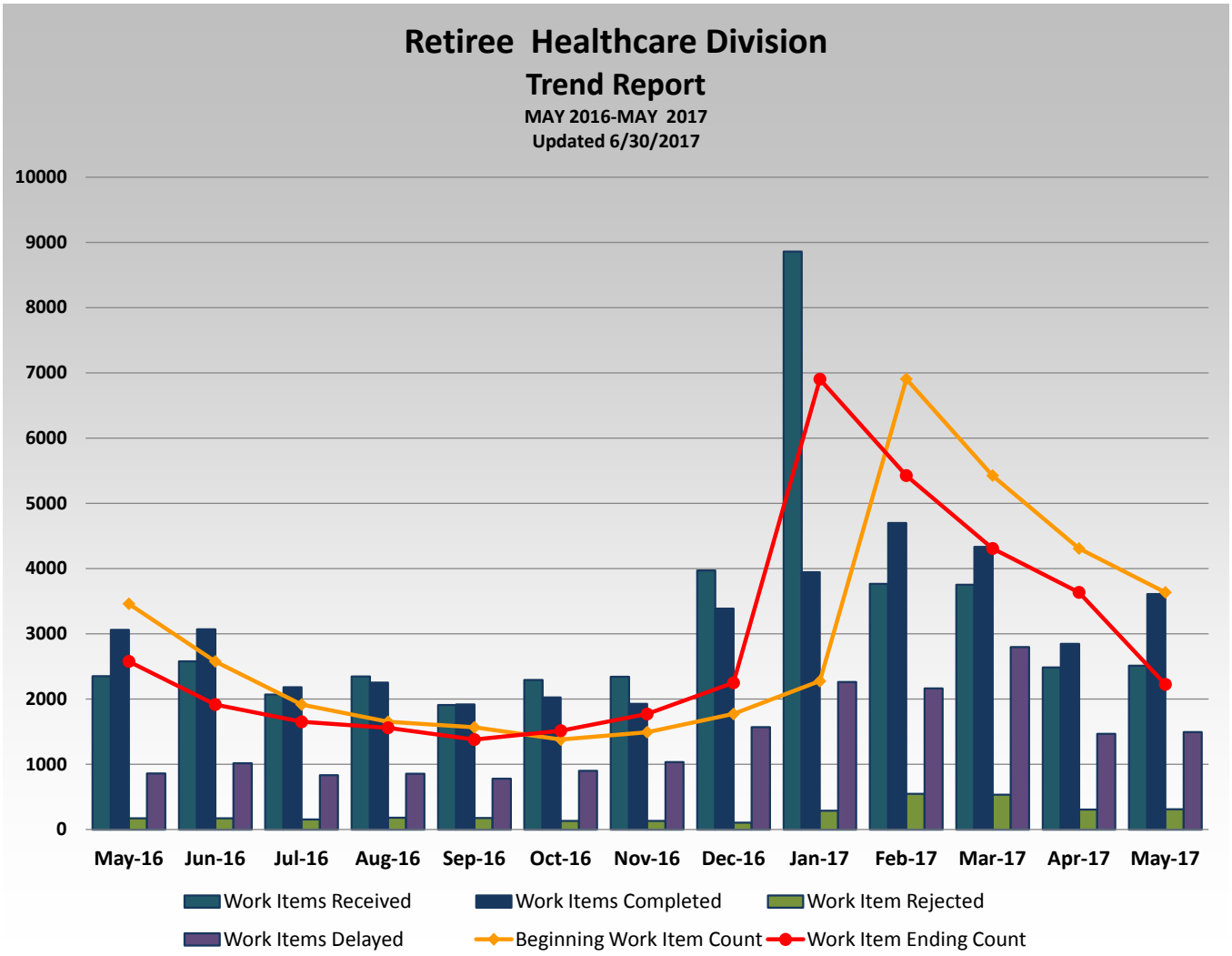
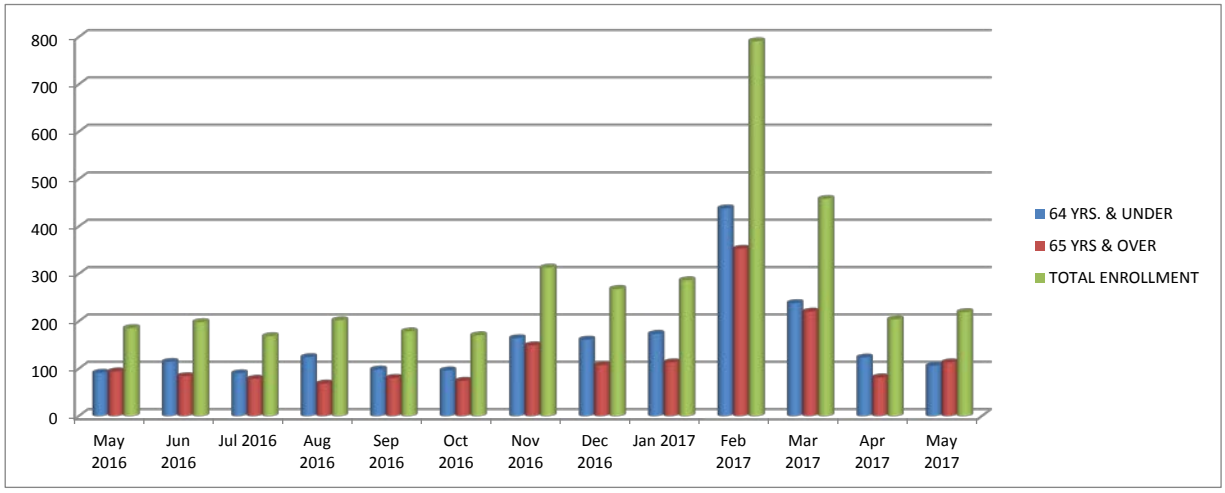


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
May-16	3461	2350	3059	174	860	2578
Jun-16	2578	2579	3068	172	1015	1917
Jul-16	1917	2072	2183	154	836	1652
Aug-16	1652	2347	2255	183	855	1561
Sep-16	1568	1910	1920	178	780	1380
Oct-16	1380	2295	2027	132	899	1516
Nov-16	1494	2342	1929	135	1034	1772
Dec-16	1772	3970	3387	105	1572	2250
Jan-17	2276	8859	3944	288	2260	6903
Feb-17	6906	3767	4698	549	2164	5426
Mar-17	5426	3753	4334	537	2798	4308
Apr-17	4308	2484	2848	308	1467	3636
May-17	3636	2513	3609	314	1495	2226

Retirees Monthly Age Breakdown
MAY 2016 ~ MAY 2017

Service Retirement			
MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
May 2016	91	94	185
Jun 2016	114	84	198
Jul 2016	90	78	168
Aug 2016	124	68	202
Sep 2016	98	80	178
Oct 2016	96	74	170
Nov 2016	164	149	313
Dec 2016	161	107	268
Jan 2017	173	113	286
Feb 2017	438	353	791
Mar 2017	238	220	458
Apr 2017	123	81	204
May 2017	106	113	219



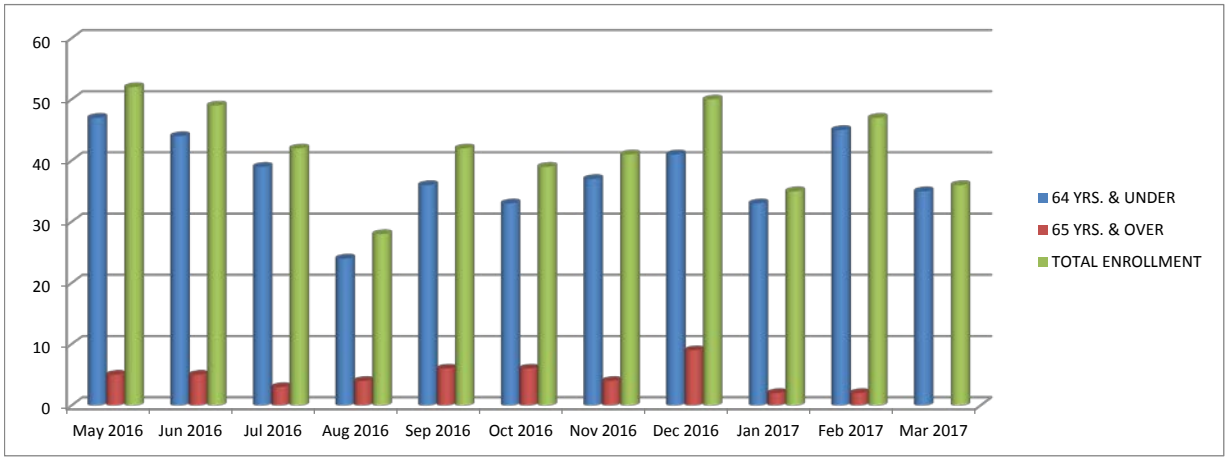
PLEASE NOTE:

- **June's data (6/2017) is not yet available as data is provided on a full month basis.**
- **Next Report will include the following dates: June 1, 2016 through June 30, 2017.**

Retirees Monthly Age Breakdown
MAY 2016 ~ MAY 2017

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
May 2016	47	5	52
Jun 2016	44	5	49
Jul 2016	39	3	42
Aug 2016	24	4	28
Sep 2016	36	6	42
Oct 2016	33	6	39
Nov 2016	37	4	41
Dec 2016	41	9	50
Jan 2017	33	2	35
Feb 2017	45	2	47
Mar 2017	35	1	36
Apr 2017	44	4	48
May 2017	40	2	42



PLEASE NOTE:

- **June's data (6/2017) is not yet available as data is provided on a full month basis.**
- **Next Report will include the following dates: June 1, 2016 throught June 30, 2017.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 6/30/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	6,419	$707,618.30	9	$270.90
241	160	$17,670.90	0	$0.00
242	840	$94,891.90	0	$0.00
243	3,675	$806,786.30	6	$473.50
244	19	$2,087.40	0	$0.00
245	51	$6,053.50	0	$0.00
246	19	$2,108.10	0	$0.00
247	101	$12,226.10	0	$0.00
248	11	$2,406.50	1	$36.50
249	45	$10,273.70	0	$0.00
250	14	$3,120.80	0	$0.00
Plan Total:	**11,354**	**$1,665,243.50**	**16**	**$780.90**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	30	$3,277.60	0	$0.00
322	9	$1,032.50	0	$0.00
324	14	$2,969.70	0	$0.00
327	2	$238.90	0	$0.00
329	2	$440.70	0	$0.00
Plan Total:	**57**	**$7,959.40**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
403	9,998	$1,109,448.02	7	$206.50
405	1	($104.90)	0	$0.00
413	1,674	$191,937.40	0	$0.00
418	5,059	$1,113,131.30	4	$217.30
419	271	$29,665.20	0	$0.00
426	208	$22,704.80	0	$0.00
427	159	$17,043.60	0	$0.00
445	2	$210.90	0	$0.00
451	32	$3,491.40	0	$0.00
457	12	$3,235.80	0	$0.00
458	1	$134.00	0	$0.00
462	50	$4,392.10	0	$0.00
465	11	$432.90	0	$0.00
466	27	$5,837.30	0	$0.00
472	33	$3,528.10	0	$0.00
476	6	$733.60	0	$0.00
478	11	$2,348.30	0	$0.00
482	82	$8,933.20	0	$0.00
486	11	$1,257.90	0	$0.00
488	41	$9,170.30	0	$0.00
492	1	$104.90	0	$0.00
494	1	$226.70	0	$0.00
Plan Total:	**17,691**	**$2,527,862.82**	**11**	**$423.80**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 6/30/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	294	$33,047.50	0	$0.00
613	105	$22,657.40	0	$0.00
Plan Total:	**399**	**$55,704.90**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1,562	$173,817.70	1	$36.50
702	342	$39,504.70	0	$0.00
703	868	$190,623.30	1	$10.50
704	76	$8,630.40	0	$0.00
705	27	$6,199.50	0	$0.00
Plan Total:	**2,875**	**$418,775.60**	**2**	**$47.00**
Grand Total:	**32,376**	**$4,675,546.22**	**29**	**$1,251.70**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 6/30/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	6,419	$707,618.30	9	$270.90
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242	840	$94,891.90	0	$0.00
243	3,675	$806,786.30	6	$473.50
244	19	$2,087.40	0	$0.00
245	51	$6,053.50	0	$0.00
246	19	$2,108.10	0	$0.00
247	101	$12,226.10	0	$0.00
248	11	$2,406.50	1	$36.50
249	45	$10,273.70	0	$0.00
250	14	$3,120.80	0	$0.00
Plan Total:	**11,354**	**$1,665,243.50**	**16**	**$780.90**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	30	$3,277.60	0	$0.00
322	9	$1,032.50	0	$0.00
324	14	$2,969.70	0	$0.00
327	2	$238.90	0	$0.00
329	2	$440.70	0	$0.00
Plan Total:	**57**	**$7,959.40**	**0**	**$0.00**
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405	1	($104.90)	0	$0.00
413	1,674	$191,937.40	0	$0.00
418	5,059	$1,113,131.30	4	$217.30
419	271	$29,665.20	0	$0.00
426	208	$22,704.80	0	$0.00
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465	11	$432.90	0	$0.00
466	27	$5,837.30	0	$0.00
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476	6	$733.60	0	$0.00
478	11	$2,348.30	0	$0.00
482	82	$8,933.20	0	$0.00
486	11	$1,257.90	0	$0.00
488	41	$9,170.30	0	$0.00
492	1	$104.90	0	$0.00
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Plan Total:	**17,691**	**$2,527,862.82**	**11**	**$423.80**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 6/30/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
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613	105	$22,657.40	0	$0.00
Plan Total:	**399**	**$55,704.90**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1,562	$173,817.70	1	$36.50
702	342	$39,504.70	0	$0.00
703	868	$190,623.30	1	$10.50
704	76	$8,630.40	0	$0.00
705	27	$6,199.50	0	$0.00
Plan Total:	**2,875**	**$418,775.60**	**2**	**$47.00**
LOCAL 1014				
804	164	$23,113.20	0	$0.00
805	176	$24,261.10	0	$0.00
806	554	$133,188.16	0	$0.00
807	37	$5,811.20	0	$0.00
808	10	$2,280.00	0	$0.00
812	220	$25,513.40	0	$0.00
Plan Total:	**1,161**	**$214,167.06**	**0**	**$0.00**
Grand Total:	**33,537**	**$4,889,713.28**	**29**	**$1,251.70**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	707	$613,729.80	$101,109.78	$511,661.21	$612,770.99	($3,375.44)	$609,395.55
202	389	$664,645.80	$68,782.40	$590,841.54	$659,623.94	$0.00	$659,623.94
203	99	$192,313.00	$44,385.75	$138,414.12	$182,799.87	$0.00	$182,799.87
204	36	$40,094.64	$15,347.38	$24,747.26	$40,094.64	$0.00	$40,094.64
205	1	$237.47	$9.50	$227.97	$237.47	$0.00	$237.47
SUBTOTAL	**1,232**	**$1,511,020.71**	**$229,634.81**	**$1,265,892.10**	**$1,495,526.91**	**($3,375.44)**	**$1,492,151.47**
Anthem Blue Cross I							
211	887	$971,158.56	$62,123.84	$929,284.73	$991,408.57	($9,592.11)	$981,816.46
212	314	$621,315.45	$35,543.13	$558,789.26	$594,332.39	($3,839.70)	$590,492.69
213	53	$125,620.74	$16,942.93	$104,087.24	$121,030.17	$0.00	$121,030.17
214	19	$27,512.38	$5,415.60	$22,096.78	$27,512.38	$0.00	$27,512.38
215	4	$1,456.16	$211.14	$1,245.02	$1,456.16	$0.00	$1,456.16
SUBTOTAL	**1,277**	**$1,747,063.29**	**$120,236.64**	**$1,615,503.03**	**$1,735,739.67**	**($13,431.81)**	**$1,722,307.86**
Anthem Blue Cross II							
221	2,105	$2,305,817.28	$142,004.90	$2,180,603.21	$2,322,608.11	($4,263.16)	$2,318,344.95
222	1,879	$3,714,085.69	$98,395.76	$3,561,145.43	$3,659,541.19	$5,759.55	$3,665,300.74
223	601	$1,400,438.62	$56,289.13	$1,334,471.95	$1,390,761.08	$2,264.26	$1,393,025.34
224	139	$202,722.80	$15,425.55	$181,724.95	$197,150.50	$0.00	$197,150.50
225	2	$728.08	$182.02	$546.06	$728.08	$0.00	$728.08
SUBTOTAL	**4,726**	**$7,623,792.47**	**$312,297.36**	**$7,258,491.60**	**$7,570,788.96**	**$3,760.65**	**$7,574,549.61**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	6,440	$2,856,504.05	$446,876.85	$2,417,234.70	$2,864,111.55	($9,929.10)	$2,854,182.45
241	159	$228,935.16	$25,736.93	$200,852.69	$226,589.62	($1,375.57)	$225,214.05
242	840	$1,196,963.46	$75,408.83	$1,087,730.14	$1,163,138.97	$1,375.57	$1,164,514.54
243	3,679	$3,252,530.06	$375,499.51	$2,827,762.59	$3,203,262.10	($4,285.70)	$3,198,976.40
244	19	$15,054.08	$3,375.29	$11,678.79	$15,054.08	$0.00	$15,054.08
245	52	$41,200.64	$5,562.08	$36,388.90	$41,950.98	$0.00	$41,950.98
246	19	$33,478.95	$2,889.76	$30,589.19	$33,478.95	$0.00	$33,478.95
247	102	$179,729.10	$9,761.76	$175,112.64	$184,874.40	($3,430.10)	$181,444.30
248	11	$13,522.08	$1,966.85	$11,555.23	$13,522.08	$0.00	$13,522.08
249	46	$56,546.88	$5,015.45	$50,302.15	$55,317.60	$0.00	$55,317.60
250	14	$19,283.88	$991.74	$18,292.14	$19,283.88	$0.00	$19,283.88
SUBTOTAL	**11,381**	**$7,893,748.34**	**$953,085.05**	**$6,867,499.16**	**$7,820,584.21**	**($17,644.90)**	**$7,802,939.31**
CIGNA Network Model Plan							
301	356	$505,487.96	$134,761.69	$370,726.27	$505,487.96	($1,332.53)	$504,155.43
302	153	$394,600.36	$94,075.86	$282,538.82	$376,614.68	$0.00	$376,614.68
303	20	$63,536.34	$7,453.20	$32,816.52	$40,269.72	$0.00	$40,269.72
304	24	$45,208.56	$23,531.97	$30,514.79	$54,046.76	$0.00	$54,046.76
SUBTOTAL	**553**	**$1,008,833.22**	**$259,822.72**	**$716,596.40**	**$976,419.12**	**($1,332.53)**	**$975,086.59**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
CIGNA Healthspring Pref w/ Rx - Phoenix, AZ							
321	30	$11,534.70	$1,776.35	$9,758.35	$11,534.70	$0.00	$11,534.70
322	10	$15,262.40	$488.40	$13,247.76	$13,736.16	$0.00	$13,736.16
324	14	$10,653.72	$1,293.67	$9,360.05	$10,653.72	$0.00	$10,653.72
327	2	$3,976.10	$397.61	$3,578.49	$3,976.10	$0.00	$3,976.10
329	2	$2,595.54	$0.00	$2,595.54	$2,595.54	$0.00	$2,595.54
SUBTOTAL	**58**	**$44,022.46**	**$3,956.03**	**$38,540.19**	**$42,496.22**	**$0.00**	**$42,496.22**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,595	$1,504,896.15	$134,659.53	$1,364,302.68	$1,498,962.21	$4,559.75	$1,503,521.96
403	10,079	$2,588,269.32	$274,752.87	$2,330,628.89	$2,605,381.76	($4,852.00)	$2,600,529.76
404	522	$540,609.30	$19,718.74	$524,772.44	$544,491.18	$990.72	$545,481.90
405	920	$903,279.96	$20,312.08	$895,320.86	$915,632.94	$1,904.82	$917,537.76
406	43	$80,274.60	$25,098.43	$36,283.67	$61,382.10	$15,250.50	$76,632.60
411	1,824	$3,415,218.54	$183,452.17	$3,248,846.81	$3,432,298.98	$0.00	$3,432,298.98
413	1,680	$2,003,576.25	$86,554.54	$1,905,988.16	$1,992,542.70	$3,439.65	$1,995,982.35
414	145	$286,930.88	$5,533.38	$281,326.89	$286,860.27	($1,894.67)	$284,965.60
418	5,047	$2,558,030.12	$206,310.16	$2,340,287.64	$2,546,597.80	($3,340.40)	$2,543,257.40
419	273	$351,889.98	$7,177.72	$344,653.31	$351,831.03	($1,225.32)	$350,605.71
420	123	$255,849.20	$1,403.04	$250,409.42	$251,812.46	$0.00	$251,812.46
421	9	$8,438.67	$525.08	$7,913.59	$8,438.67	$0.00	$8,438.67
422	223	$426,016.97	$1,681.16	$424,335.81	$426,016.97	$0.00	$426,016.97
423	18	$53,494.60	$6,647.76	$28,505.13	$35,152.89	($2,598.45)	$32,554.44
426	207	$255,711.04	$3,417.70	$251,063.96	$254,481.66	($2,374.02)	$252,107.64
427	159	$318,995.20	$3,588.71	$311,483.67	$315,072.38	($1,929.10)	$313,143.28
428	54	$108,454.14	$1,124.70	$107,329.44	$108,454.14	$0.00	$108,454.14
429	16	$44,364.00	$7,143.04	$37,220.96	$44,364.00	$0.00	$44,364.00
430	130	$255,911.12	$3,477.25	$240,996.25	$244,473.50	$0.00	$244,473.50
431	10	$27,178.60	$3,915.50	$23,263.10	$27,178.60	$0.00	$27,178.60
432	7	$24,375.40	$8,091.23	$16,284.17	$24,375.40	($37,191.00)	($12,815.60)
SUBTOTAL	**23,084**	**$16,011,764.04**	**$1,004,584.79**	**$14,971,216.85**	**$15,975,801.64**	**($29,259.52)**	**$15,946,542.12**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Colorado							
450	5	$5,024.35	$1,004.87	$4,019.48	$5,024.35	$0.00	$5,024.35
451	32	$11,731.84	$1,488.46	$10,243.38	$11,731.84	$0.00	$11,731.84
453	2	$4,442.30	$497.44	$3,944.86	$4,442.30	$0.00	$4,442.30
457	12	$8,702.88	$1,392.46	$9,345.38	$10,737.84	$0.00	$10,737.84
458	1	$2,302.38	$0.00	$2,302.38	$2,302.38	$0.00	$2,302.38
SUBTOTAL	**52**	**$32,203.75**	**$4,383.23**	**$29,855.48**	**$34,238.71**	**$0.00**	**$34,238.71**
Kaiser - Georgia							
441	2	$2,328.82	$139.06	$2,189.76	$2,328.82	$0.00	$2,328.82
442	4	$4,657.64	$278.12	$4,379.52	$4,657.64	$0.00	$4,657.64
445	2	$3,129.34	$0.00	$3,129.34	$3,129.34	$0.00	$3,129.34
461	13	$15,137.33	$2,104.42	$11,868.50	$13,972.92	$0.00	$13,972.92
462	51	$21,229.52	$3,225.24	$13,921.68	$17,146.92	($408.26)	$16,738.66
463	3	$6,962.49	$2,031.41	$4,931.08	$6,962.49	$0.00	$6,962.49
465	10	$17,211.37	$938.80	$5,319.88	$6,258.68	$0.00	$6,258.68
466	27	$21,830.04	$1,552.36	$20,277.68	$21,830.04	$0.00	$21,830.04
SUBTOTAL	**112**	**$92,486.55**	**$10,269.41**	**$66,017.44**	**$76,286.85**	**($408.26)**	**$75,878.59**
Kaiser - Hawaii							
471	7	$7,022.40	$1,123.58	$5,898.82	$7,022.40	$0.00	$7,022.40
472	33	$14,173.83	$2,027.26	$12,146.57	$14,173.83	($4,538.64)	$9,635.19
473	1	$1,547.10	$452.22	$1,094.88	$1,547.10	$0.00	$1,547.10
474	3	$5,995.20	$77.91	$5,917.29	$5,995.20	$0.00	$5,995.20
476	6	$8,548.26	$3,362.31	$5,185.95	$8,548.26	$0.00	$8,548.26
478	11	$9,350.22	$374.01	$8,976.21	$9,350.22	$0.00	$9,350.22
SUBTOTAL	**61**	**$46,637.01**	**$7,417.29**	**$39,219.72**	**$46,637.01**	**($4,538.64)**	**$42,098.37**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Oregon							
481	7	$7,613.41	$1,892.47	$5,720.94	$7,613.41	$0.00	$7,613.41
482	82	$30,934.50	$4,723.15	$26,211.35	$30,934.50	$0.00	$30,934.50
484	2	$4,334.54	$547.47	$3,787.07	$4,334.54	$0.00	$4,334.54
486	11	$16,025.68	$2,156.18	$13,869.50	$16,025.68	$0.00	$16,025.68
488	41	$30,606.50	$3,433.90	$27,172.60	$30,606.50	$0.00	$30,606.50
489	1	$1,010.66	$0.00	$1,010.66	$1,010.66	$0.00	$1,010.66
492	1	$1,544.92	$308.98	$1,235.94	$1,544.92	$0.00	$1,544.92
494	1	$1,826.13	$0.00	$1,826.13	$1,826.13	$0.00	$1,826.13
495	2	$4,686.68	$741.82	$3,944.86	$4,686.68	$0.00	$4,686.68
SUBTOTAL	**148**	**$98,583.02**	**$13,803.97**	**$84,779.05**	**$98,583.02**	**$0.00**	**$98,583.02**
SCAN Health Plan							
611	295	$87,910.00	$18,999.92	$69,831.08	$88,831.00	($307.00)	$88,524.00
613	105	$61,740.00	$10,337.04	$51,402.96	$61,740.00	($606.00)	$61,134.00
SUBTOTAL	**400**	**$149,650.00**	**$29,336.96**	**$121,234.04**	**$150,571.00**	**($913.00)**	**$149,658.00**
UHC Medicare Adv.							
701	1,563	$531,661.76	$64,437.69	$467,251.68	$531,689.37	($997.74)	$530,691.63
702	339	$484,266.15	$31,309.76	$428,408.23	$459,717.99	$1,331.52	$461,049.51
703	863	$582,351.66	$59,295.31	$507,363.25	$566,658.56	($2,628.64)	$564,029.92
704	75	$122,205.16	$5,629.98	$110,310.32	$115,940.30	($1,503.62)	$114,436.68
705	27	$23,045.85	$1,212.04	$21,833.81	$23,045.85	$0.00	$23,045.85
SUBTOTAL	**2,867**	**$1,743,530.58**	**$161,884.78**	**$1,535,167.29**	**$1,697,052.07**	**($3,798.48)**	**$1,693,253.59**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
United Healthcare							
707	431	$466,581.00	$48,907.50	$416,141.28	$465,048.78	$0.10	$465,048.88
708	360	$706,639.45	$30,238.13	$686,943.92	$717,182.05	$3,674.48	$720,856.53
709	292	$682,256.40	$34,298.44	$656,242.09	$690,540.53	$4,355.98	$694,896.51
SUBTOTAL	**1,083**	**$1,855,476.85**	**$113,444.07**	**$1,759,327.29**	**$1,872,771.36**	**$8,030.56**	**$1,880,801.92**
Local 1014 Firefighters							
801	50	$53,907.50	$1,530.97	$56,264.37	$57,795.34	$0.00	$57,795.34
802	277	$538,485.23	$15,240.90	$574,326.87	$589,567.77	$0.00	$589,567.77
803	254	$582,449.94	$18,757.60	$691,332.63	$710,090.23	$4,492.31	$714,582.54
804	165	$177,894.75	$8,905.49	$168,989.26	$177,894.75	($23,981.76)	$153,912.99
805	178	$346,030.22	$11,314.02	$331,941.83	$343,255.85	($24,261.10)	$318,994.75
806	555	$1,078,914.45	$33,125.60	$1,043,014.48	$1,076,140.08	($136,320.32)	$939,819.76
807	38	$87,138.18	$1,880.35	$85,257.83	$87,138.18	($5,811.20)	$81,326.98
808	10	$22,931.10	$183.45	$22,747.65	$22,931.10	($2,280.00)	$20,651.10
809	24	$25,875.60	$3,299.12	$22,576.48	$25,875.60	$0.00	$25,875.60
810	7	$13,607.93	$1,594.07	$13,047.86	$14,641.93	$0.00	$14,641.93
811	5	$11,465.55	$825.52	$10,640.03	$11,465.55	$0.00	$11,465.55
812	221	$238,271.15	$21,153.24	$220,923.03	$242,076.27	($23,401.25)	$218,675.02
SUBTOTAL	**1,784**	**$3,176,971.60**	**$117,810.33**	**$3,241,062.32**	**$3,358,872.65**	**($211,563.32)**	**$3,147,309.33**
Medical Plan Total	**48,818**	**$43,035,783.89**	**$3,341,967.44**	**$39,610,401.96**	**$42,952,369.40**	**($274,474.69)**	**$42,677,894.71**

Medical and Dental Vision Insurance Premiums

July 2017

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	23,061	$1,203,331.20	$140,844.74	$1,070,912.61	$1,211,757.35	($2,861.23)	$1,208,896.12
502	21,310	$2,319,696.00	$183,039.48	$2,123,385.38	$2,306,424.86	($1,593.60)	$2,304,831.26
503	11	$705.65	$132.14	$573.51	$705.65	$0.00	$705.65
SUBTOTAL	**44,382**	**$3,523,732.85**	**$324,016.36**	**$3,194,871.50**	**$3,518,887.86**	**($4,454.83)**	**$3,514,433.03**
CIGNA Dental HMO/Vision							
901	3,223	$148,962.75	$19,302.77	$130,260.15	$149,562.92	($230.85)	$149,332.07
902	2,284	$216,545.32	$19,922.49	$194,061.27	$213,983.76	($376.00)	$213,607.76
903	4	$187.12	$5.61	$181.51	$187.12	$0.00	$187.12
SUBTOTAL	**5,511**	**$365,695.19**	**$39,230.87**	**$324,502.93**	**$363,733.80**	**($606.85)**	**$363,126.95**
Dental/Vision Plan Total	**49,893**	**$3,889,428.04**	**$363,247.23**	**$3,519,374.43**	**$3,882,621.66**	**($5,061.68)**	**$3,877,559.98**
GRAND TOTALS	**98,711**	**$46,925,211.93**	**$3,705,214.67**	**$43,129,776.39**	**$46,834,991.06**	**($279,536.37)**	**$46,555,454.69**

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

***Benchmark premiums are bolded.**

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

***Benchmark premiums are bolded.**

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

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser Georgia (continued)		
$1,689.48	463	Retiree and Family (Two family members are "Basic")
$2,531.72	464	Retiree and Family (Three or more family members are "Basic)
$1,203.35	465	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$717.22	466	Retiree and Family (Two family members are "Senior Advantage")
$2,045.59	467	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$1,559.46	468	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
$1,915.57	469	Retiree and Family (Three or more family members are "Senior Advantage"; one is "Basic")
$2,045.59	470	Retiree and Family (Three or more family members are "Basic"; one is "Senior Advantage"
Kaiser Hawaii		
$795.16	471	Retiree Only ("Basic" under age 65)
$346.45	472	Retiree Only ("Senior Advantage")
$1,381.42	473	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$1,585.31	474	Retiree and Family (Two family members are "Basic")
$2,375.47	475	Retiree and Family (Three or more family members are "Basic")
$1,136.61	476	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$2,171.58	477	Retiree and Family (One family member is "Basic" under age 65; one is over age 65 without Medicare Part A or Medicare Part B)
$687.90	478	Retiree and Family (Two family members are "Senior Advantage"
$1,722.87	479	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)
Kaiser Oregon		
$806.67	481	Retiree Only ("Basic" under age 65)
$465.92	482	Retiree Only ("Senior Advantage")
$1,205.27	483	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$1,608.34	484	Retiree and Family (Two family members are "Basic")
$2,410.01	485	Retiree and Family (Three or more family members are "Basic")
$1,267.59	486	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
N/A	487	Retiree Only (Medicare Cost "Supplement" program)
$926.84	488	Retiree and Family (Two family members are "Senior Advantage")
$1,110.84	489	Retiree Only (Over age 65 with Medicare Part A only)
$1,205.27	490	Retiree Only (Over age 65 with Medicare Part B only)

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

Kaiser Oregon (continued)

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

Kaiser Rate Category Definitions

"Basic" - includes those who are under age 65

Medicare Cost ("Supplement")

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

"Senior Advantage"

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

"Excess I"

-Is for participants who have Medicare Part A only.

"Excess II"

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

"Excess III"

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

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

SCAN Health Plan

$304.00	611	Retiree Only with SCAN
$603.00	613	Retiree and 1 Dependent - Both with SCAN (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child. Both Retiree and Dependent must have Medicare.)

United Healthcare Medicare Advantage (UHCMA)

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

$293.62	701	Retiree Only with Secure Horizons
$1,203.81	702	Retiree and 1 Dependent - One with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$582.24	703	Retiree and 1 Dependent - Both with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$1,360.59	704	Retiree and 2 or More Dependents - One with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
$739.02	705	Retiree and 2 or More Dependents - Two with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
$261.24	706	Survivor Children Only Rates

United Healthcare (UHC)

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

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

Local 1014 Firefighters

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

***Benchmark premiums are bolded.**

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

***Benchmark premiums are bolded.**

Los Angeles County Employees Retirement Association

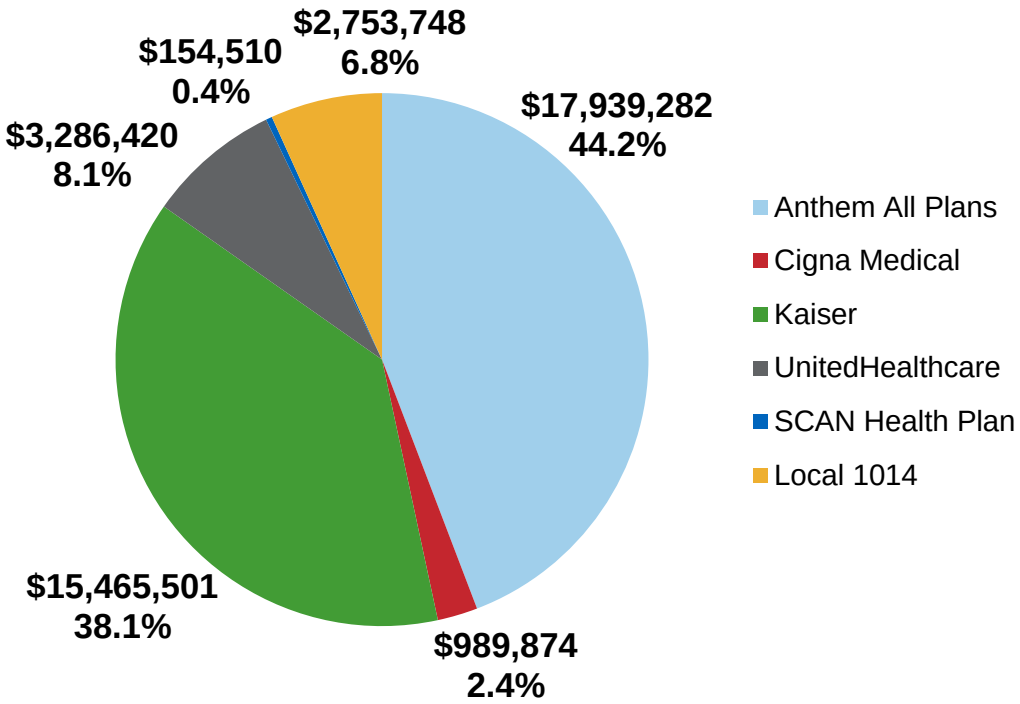
Premium & Enrollment

Coverage Month May 2017

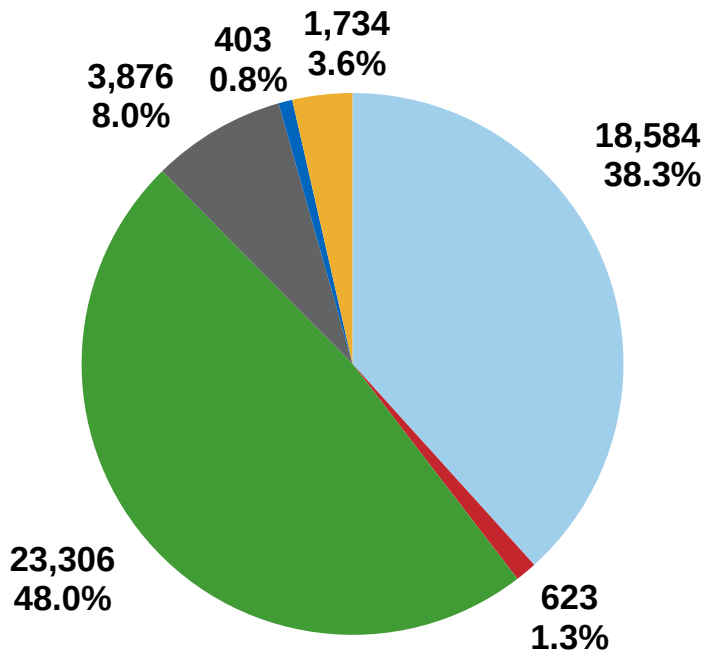
Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$17,939,282	44.2%	18,584	38.3%
Cigna Medical	$989,874	2.4%	623	1.3%
Kaiser	$15,465,501	38.1%	23,306	48.0%
UnitedHealthcare	$3,286,420	8.1%	3,876	8.0%
SCAN Health Plan	$154,510	0.4%	403	0.8%
Local 1014	$2,753,748	6.8%	1,734	3.6%
Combined Medical	**$40,589,336**	**100.0%**	**48,526**	**100.0%**

Cigna Dental & Vision (PPO and HMO)	**$3,750,732**		**49,595**

Monthly Premium



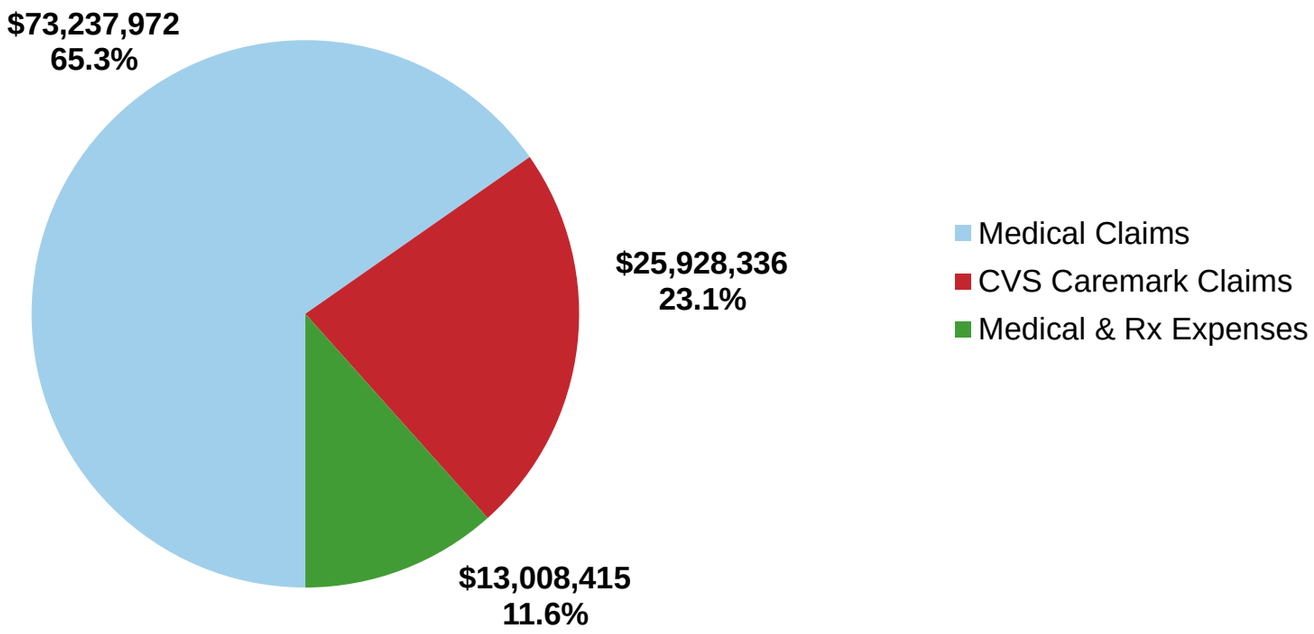
Retirees



Los Angeles County Employees Retirement Association
Anthem Plans I & II
Coverage Month May 2017

Month	Monthly Enrollment	Monthly Premium	Medical Claims	CVS Caremark Claims	Medical & Rx Claims	Claims Per Retiree Per Month	Paid Loss Ratio	Medical & Rx Expenses	Total Paid Claims & Expenses	Expense Ratio
Jul-16	6,088	$9,121,640	$6,534,411	$2,101,899	$8,636,310	$1,418.58	94.7%	$1,191,231	$9,827,541	107.7%
Aug-16	6,078	$9,135,046	$7,874,179	$2,364,260	$10,238,438	$1,684.51	112.1%	$1,200,737	$11,439,175	125.2%
Sep-16	6,065	$9,111,569	$6,408,946	$1,939,840	$8,348,785	$1,376.55	91.6%	$1,186,724	$9,535,509	104.7%
Oct-16	6,043	$9,086,383	$6,521,156	$2,190,072	$8,711,228	$1,441.54	95.9%	$1,182,770	$9,893,998	108.9%
Nov-16	6,025	$9,041,462	$7,818,475	$2,310,711	$10,129,186	$1,681.19	112.0%	$1,179,437	$11,308,623	125.1%
Dec-16	6,016	$9,027,477	$7,044,987	$2,176,658	$9,221,645	$1,532.85	102.2%	$1,178,090	$10,399,735	115.2%
Jan-17	6,010	$9,029,340	$5,286,698	$2,412,010	$7,698,708	$1,280.98	85.3%	$1,176,968	$8,875,676	98.3%
Feb-17	6,005	$9,030,218	$5,749,803	$2,564,515	$8,314,318	$1,384.57	92.1%	$1,176,066	$9,490,384	105.1%
Mar-17	6,010	$9,063,902	$7,007,080	$2,606,369	$9,613,449	$1,599.58	106.1%	$1,177,464	$10,790,913	119.1%
Apr-17	6,006	$9,057,867	$6,533,587	$2,479,009	$9,012,596	$1,500.60	99.5%	$1,176,875	$10,189,472	112.5%
May-17	6,029	$8,942,714	$6,458,651	$2,782,994	$9,241,645	$1,532.87	103.3%	$1,182,053	$10,423,698	116.6%
Jun-17										
YTD Plan Year	66,375	$99,647,618	$73,237,972	$25,928,336	$99,166,308	$1,494.03	99.5%	$13,008,415	$112,174,723	112.6%
11 Month Average	6,034	$9,058,874	$6,657,997	$2,357,121	$9,015,119	$1,494.03	99.5%	$1,182,583	$10,197,702	112.6%
12 Month Rollup	72,481	$108,780,546	$79,408,267	$27,878,910	$107,287,178	$1,480.21	98.6%	$13,996,369	$121,283,546	111.5%

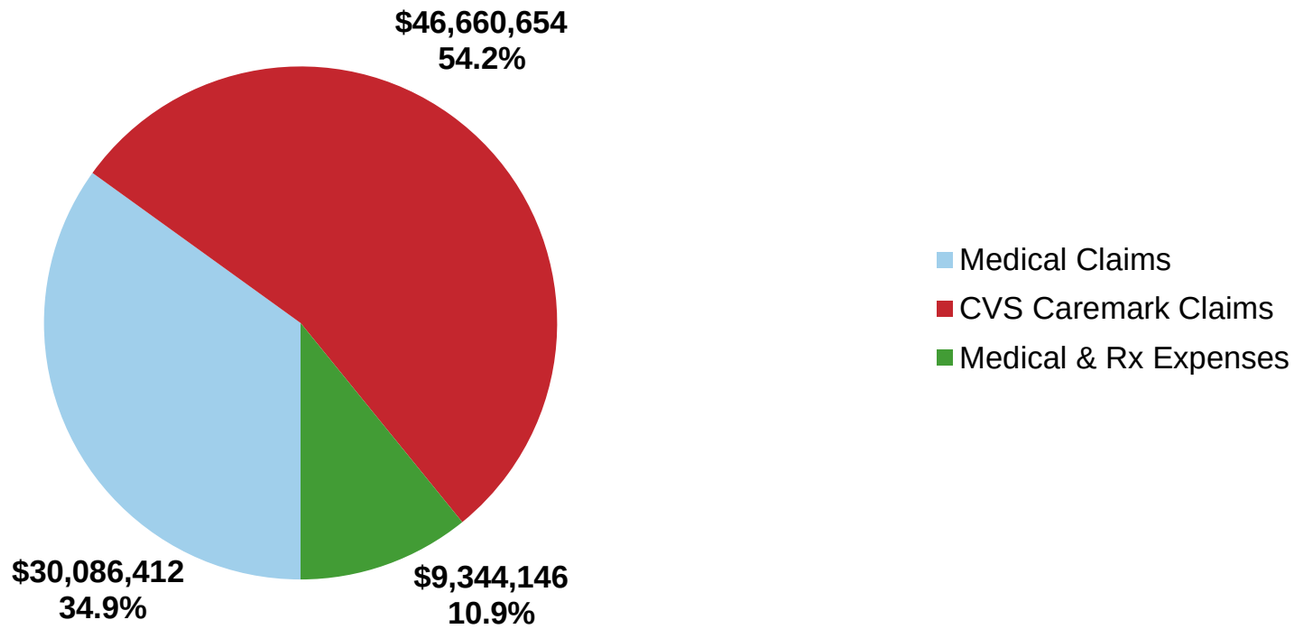
Medical Claims reported by Anthem
CVS Caremark Claims reported by CVS
Expenses: Anthem Admin, Stop Loss, and Premium Taxes
Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association
Anthem Plan III
Coverage Month May 2017

Month	Monthly Enrollment	Monthly Premium	Medical Claims	CVS Caremark Claims	Medical & Rx Claims	Claims Per Retiree Per Month	Paid Loss Ratio	Medical & Rx Expenses	Total Paid Claims & Expenses	Expense Ratio
Jul-16	11,065	$7,446,109	$2,789,671	$3,515,111	$6,304,782	$569.80	84.7%	$841,825	$7,146,608	96.0%
Aug-16	11,083	$7,427,254	$2,960,288	$3,940,053	$6,900,341	$622.61	92.9%	$843,195	$7,743,536	104.3%
Sep-16	11,112	$7,458,876	$2,956,685	$3,631,303	$6,587,988	$592.87	88.3%	$845,401	$7,433,389	99.7%
Oct-16	11,131	$7,449,421	$3,010,763	$3,770,776	$6,781,539	$609.25	91.0%	$846,846	$7,628,386	102.4%
Nov-16	11,150	$7,412,057	$2,933,086	$3,773,422	$6,706,508	$601.48	90.5%	$848,292	$7,554,800	101.9%
Dec-16	11,160	$7,479,004	$2,734,313	$3,895,819	$6,630,133	$594.10	88.6%	$849,053	$7,479,186	100.0%
Jan-17	11,185	$7,479,338	$2,556,474	$4,879,204	$7,435,678	$664.79	99.4%	$850,955	$8,286,633	110.8%
Feb-17	11,195	$7,494,130	$2,794,741	$4,476,666	$7,271,407	$649.52	97.0%	$851,716	$8,123,123	108.4%
Mar-17	11,207	$7,509,780	$2,703,079	$5,155,011	$7,858,091	$701.18	104.6%	$852,629	$8,710,719	116.0%
Apr-17	11,233	$7,523,877	$2,270,751	$4,671,412	$6,942,163	$618.02	92.3%	$854,607	$7,796,769	103.6%
May-17	11,299	$7,543,280	$2,376,560	$4,951,877	$7,328,437	$648.59	97.2%	$859,628	$8,188,065	108.5%
Jun-17										
YTD Plan Year	122,820	$82,223,126	$30,086,412	$46,660,654	$76,747,066	$624.87	93.3%	$9,344,146	$86,091,212	104.7%
11 Month Average	11,165	$7,474,830	$2,735,128	$4,241,878	$6,977,006	$624.87	93.3%	$849,468	$7,826,474	104.7%
12 Month Rollup	133,838	$89,630,437	$33,044,423	$50,251,801	$83,296,224	$622.37	92.9%	$10,109,673	$93,405,897	104.2%

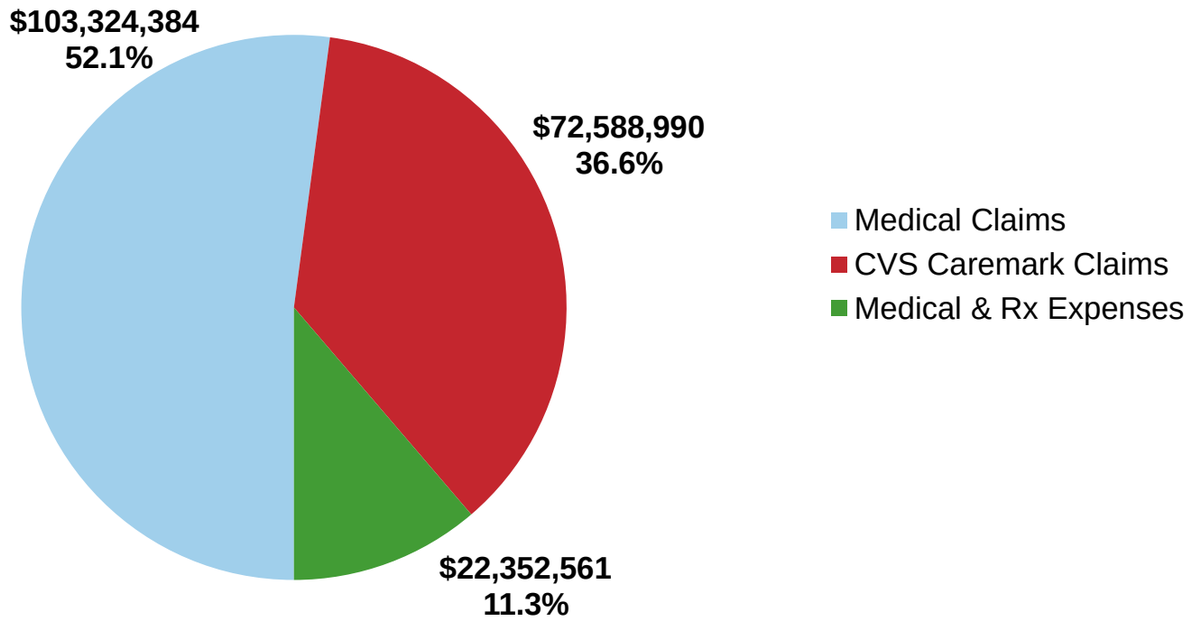
Medical Claims reported by Anthem
CVS Caremark Claims reported by CVS
Expenses: Anthem Admin, Stop Loss, and Premium Taxes
Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association
Anthem Plans I, II, & III
Coverage Month May 2017

Month	Monthly Enrollment	Monthly Premium	Medical Claims	CVS Caremark Claims	Medical & Rx Claims	Claims Per Retiree Per Month	Paid Loss Ratio	Medical & Rx Expenses	Total Paid Claims & Expenses	Expense Ratio
Jul-16	17,153	$16,567,749	$9,324,082	$5,617,010	$14,941,092	$871.05	90.2%	$2,033,056	$16,974,148	102.5%
Aug-16	17,161	$16,562,300	$10,834,467	$6,304,312	$17,138,779	$998.71	103.5%	$2,043,932	$19,182,711	115.8%
Sep-16	17,177	$16,570,445	$9,365,631	$5,571,142	$14,936,773	$869.58	90.1%	$2,032,125	$16,968,898	102.4%
Oct-16	17,174	$16,535,804	$9,531,919	$5,960,848	$15,492,768	$902.11	93.7%	$2,029,616	$17,522,384	106.0%
Nov-16	17,175	$16,453,519	$10,751,561	$6,084,132	$16,835,694	$980.24	102.3%	$2,027,729	$18,863,423	114.6%
Dec-16	17,176	$16,506,481	$9,779,300	$6,072,477	$15,851,777	$922.90	96.0%	$2,027,143	$17,878,920	108.3%
Jan-17	17,195	$16,508,678	$7,843,172	$7,291,214	$15,134,386	$880.16	91.7%	$2,027,923	$17,162,309	104.0%
Feb-17	17,200	$16,524,347	$8,544,544	$7,041,181	$15,585,725	$906.15	94.3%	$2,027,782	$17,613,506	106.6%
Mar-17	17,217	$16,573,683	$9,710,160	$7,761,380	$17,471,540	$1,014.78	105.4%	$2,030,092	$19,501,632	117.7%
Apr-17	17,239	$16,581,744	$8,804,338	$7,150,421	$15,954,759	$925.50	96.2%	$2,031,482	$17,986,241	108.5%
May-17	17,328	$16,485,995	$8,835,211	$7,734,871	$16,570,081	$956.26	100.5%	$2,041,681	$18,611,762	112.9%
Jun-17										
YTD Plan Year	189,195	$181,870,744	$103,324,384	$72,588,990	$175,913,374	$929.80	96.7%	$22,352,561	$198,265,935	109.0%
11 Month Average	17,200	$16,533,704	$9,393,126	$6,598,999	$15,992,125	$929.80	96.7%	$2,032,051	$18,024,176	109.0%
12 Month Rollup	206,319	$198,410,984	$112,452,690	$78,130,712	$190,583,402	$923.73	96.1%	$24,106,042	$214,689,444	108.2%

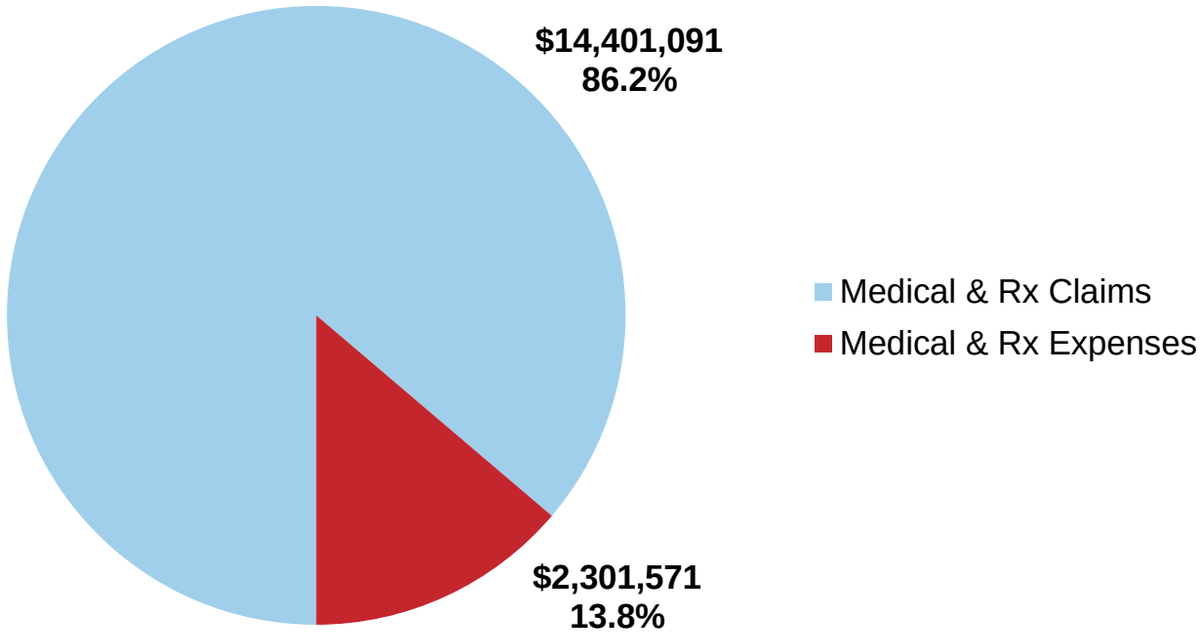
Medical Claims reported by Anthem
CVS Caremark Claims reported by CVS
Expenses: Anthem Admin, Stop Loss, and Premium Taxes
Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association
Anthem Prudent Buyer
Coverage Month May 2017

Month	Monthly Enrollment	Monthly Premium	Medical & Rx Claims	Claims Per Retiree Per Month	Paid Loss Ratio	Medical & Rx Expenses	Total Paid Claims & Expenses	Expense Ratio
Jul-16	1,321	$1,562,451	$1,318,391	$998.03	84.4%	$214,610	$1,533,001	98.1%
Aug-16	1,312	$1,564,102	$1,376,003	$1,048.78	88.0%	$213,148	$1,589,151	101.6%
Sep-16	1,302	$1,546,234	$1,512,698	$1,161.83	97.8%	$211,523	$1,724,221	111.5%
Oct-16	1,298	$1,529,406	$1,442,196	$1,111.09	94.3%	$210,873	$1,653,069	108.1%
Nov-16	1,297	$1,519,166	$1,313,575	$1,012.78	86.5%	$210,711	$1,524,285	100.3%
Dec-16	1,296	$1,534,396	$1,226,492	$946.37	79.9%	$210,548	$1,437,040	93.7%
Jan-17	1,281	$1,511,991	$1,081,781	$844.48	71.5%	$208,111	$1,289,892	85.3%
Feb-17	1,278	$1,515,171	$1,240,390	$970.57	81.9%	$207,624	$1,448,014	95.6%
Mar-17	1,267	$1,500,630	$1,309,228	$1,033.33	87.2%	$205,837	$1,515,065	101.0%
Apr-17	1,259	$1,492,207	$1,096,604	$871.01	73.5%	$204,537	$1,301,141	87.2%
May-17	1,256	$1,453,288	$1,483,733	$1,181.32	102.1%	$204,050	$1,687,782	116.1%
Jun-17								
YTD Plan Year	14,167	$16,729,041	$14,401,091	$1,016.52	86.1%	$2,301,571	$16,702,661	99.8%
11 Month Average	1,288	$1,520,822	$1,309,190	$1,016.52	86.1%	$209,234	$1,518,424	99.8%
12 Month Rollup	15,497	$18,301,399	$15,630,457	$1,008.61	85.4%	$2,480,738	$18,111,195	99.0%

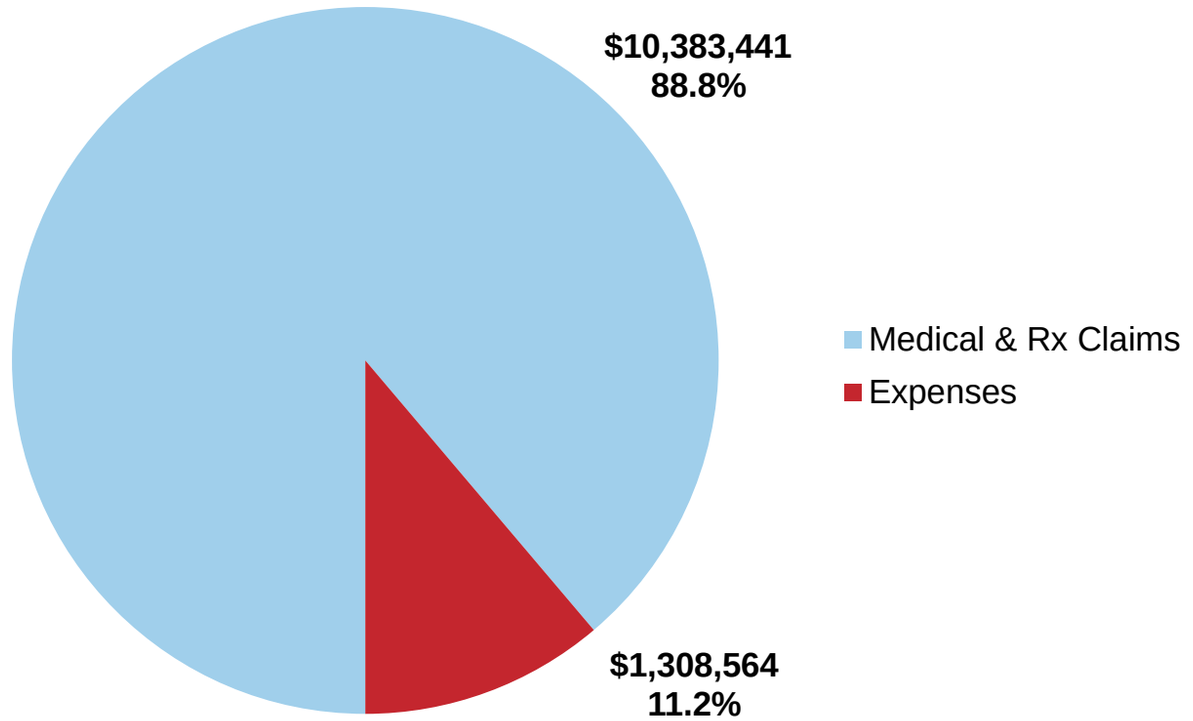
Medical Claims reported by Anthem
CVS Caremark Claims reported by CVS
Expenses: Anthem Admin, Stop Loss, and Premium Taxes
Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association
Cigna HMO
Coverage Month May 2017

Month	Monthly Enrollment	Monthly Premium	Medical & Rx Claims	Claims Per Retiree Per Month	Paid Loss Ratio	Expenses	Total Paid Claims & Expenses	Expense Ratio
Jul-16	600	$1,024,268	$1,053,209	$1,755.35	102.8%	$122,809	$1,176,018	114.8%
Aug-16	598	$1,023,919	$898,265	$1,502.11	87.7%	$122,767	$1,021,032	99.7%
Sep-16	594	$1,014,533	$1,055,166	$1,776.37	104.0%	$121,642	$1,176,808	116.0%
Oct-16	591	$1,003,760	$915,797	$1,549.57	91.2%	$120,350	$1,036,147	103.2%
Nov-16	586	$997,382	$910,226	$1,553.29	91.3%	$119,586	$1,029,812	103.3%
Dec-16	586	$994,079	$916,156	$1,563.41	92.2%	$119,190	$1,035,346	104.2%
Jan-17	582	$986,897	$850,611	$1,461.53	86.2%	$118,328	$968,939	98.2%
Feb-17	576	$977,802	$833,174	$1,446.48	85.2%	$117,238	$950,412	97.2%
Mar-17	577	$980,844	$902,355	$1,563.87	92.0%	$117,603	$1,019,957	104.0%
Apr-17	570	$959,495	$1,062,781	$1,864.53	110.8%	$115,043	$1,177,824	122.8%
May-17	564	$950,862	$985,701	$1,747.70	103.7%	$114,008	$1,099,709	115.7%
Jun-17								
YTD Plan Year	6,424	$10,913,840	$10,383,441	$1,616.35	95.1%	$1,308,564	$11,692,005	107.1%
11 Month Average	584	$992,167	$943,949	$1,616.35	95.1%	$118,960	$1,062,910	107.1%
12 Month Rollup	7,026	$11,917,547	$11,293,060	$1,607.32	94.8%	$1,414,961	$12,708,020	106.6%

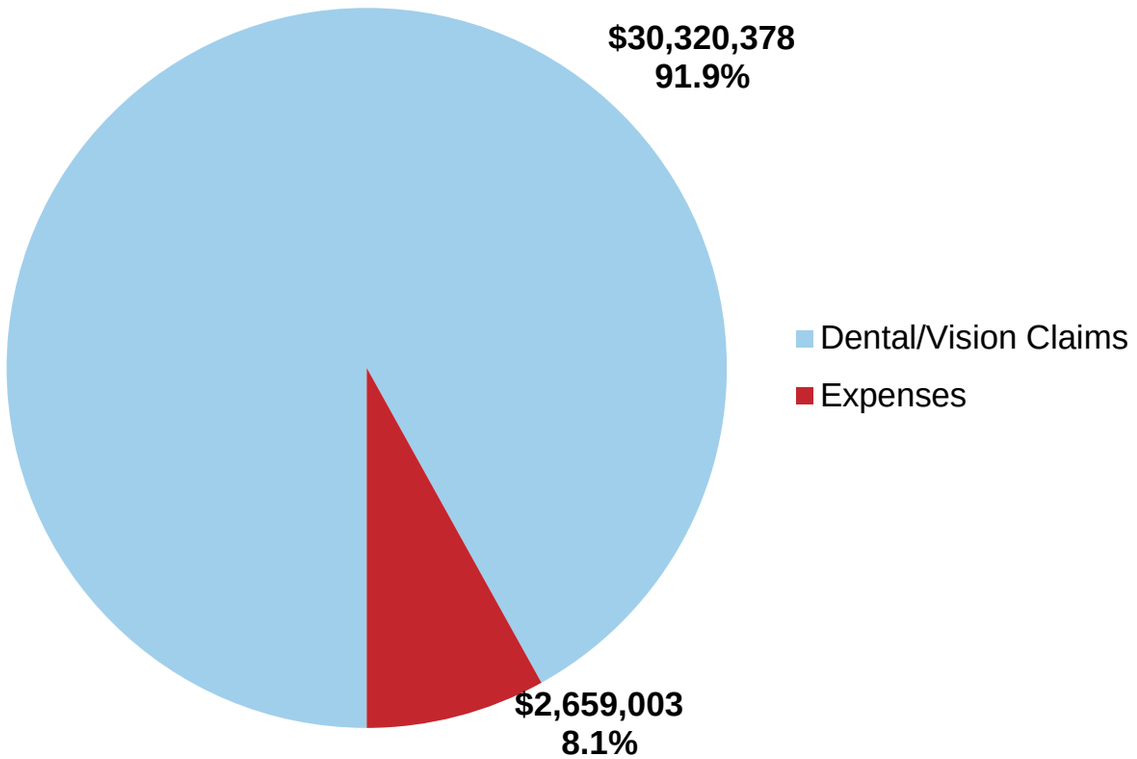
Monthly Enrollment and Premium Data as reported by LACERA
Medical Claims reported by Cigna
Expenses: Cigna Admin Costs and Premium Taxes
Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association
Cigna Dental PPO + Vision
Coverage Month May 2017

Month	Monthly Enrollment	Monthly Premium	Dental/Vision Claims	In-Network Dental Claims %	Claims Per Retiree Per Month	Paid Loss Ratio	Expenses	Total Paid Claims & Expenses	Expense Ratio
Jul-16	43,276	$3,364,467	$2,534,298	54.5%	$58.56	75.3%	$240,770	$2,775,067	82.5%
Aug-16	43,353	$3,367,060	$2,730,885	57.7%	$62.99	81.1%	$240,955	$2,971,841	88.3%
Sep-16	43,417	$3,364,087	$2,602,511	56.8%	$59.94	77.4%	$240,743	$2,843,254	84.5%
Oct-16	43,475	$3,370,847	$2,457,048	58.3%	$56.52	72.9%	$241,226	$2,698,274	80.0%
Nov-16	43,509	$3,368,847	$2,492,934	58.3%	$57.30	74.0%	$241,083	$2,734,017	81.2%
Dec-16	43,572	$3,379,536	$2,489,459	56.2%	$57.13	73.7%	$241,848	$2,731,307	80.8%
Jan-17	43,639	$3,386,797	$2,807,693	55.3%	$64.34	82.9%	$242,368	$3,050,061	90.1%
Feb-17	43,678	$3,388,192	$3,098,119	54.3%	$70.93	91.4%	$242,468	$3,340,586	98.6%
Mar-17	43,758	$3,393,355	$3,514,158	54.4%	$80.31	103.6%	$242,837	$3,756,995	110.7%
Apr-17	43,810	$3,384,485	$2,527,910	55.1%	$57.70	74.7%	$242,202	$2,770,112	81.8%
May-17	44,100	$3,388,694	$3,065,363	55.4%	$69.51	90.5%	$242,503	$3,307,866	97.6%
Jun-17									
YTD Plan Year	479,587	$37,156,368	$30,320,378	55.9%	$63.22	81.6%	$2,659,003	$32,979,381	88.8%
11 Month Average	43,599	$3,377,852	$2,756,398	55.9%	$63.22	81.6%	$241,728	$2,998,126	88.8%
12 Month Rollup	522,769	$40,393,686	$33,102,214	56.1%	$63.32	81.9%	$2,937,764	$36,039,978	89.2%

Expenses: Cigna Admin Costs and Premium Taxes
Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month May 2017

- Kaiser insures approximately 23,000 LACERA members, with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in Southern California.

Category	Current Period 1/1/2016 - 12/31/2016	Prior Period 1/1/2015 - 12/31/2015	Change
Average Members	**8,746**	**8,576**	**1.98%**
Inpatient Claims PMPM	$211.37	$200.41	5.47%
Outpatient Claims PMPM	$257.56	$231.51	11.25%
Pharmacy	$90.42	$101.49	-10.91%
Other	$110.25	$109.44	0.74%
Total Claims PMPM	**$669.61**	**$642.85**	**4.16%**
Total Paid Claims	**$70,276,909**	**$66,156,979**	**6.23%**
# of Large Claims over $400,000 Pooling Point	9	4	
Large Claims $ over $400,000 Pooling Point	$4,550,160	$2,865,036	58.82%
Large Claims as a % of all claims	**6.47%**	**4.33%**	
Inpatient Days / 1000	359.1	379.3	-5.33%
Inpatient Admits / 1000	69.5	78.1	-11.01%
Outpatient Visits / 1000	12,180.8	12,287.8	-0.87%
Pharmacy Scripts PMPY	11.3	11.7	-3.42%

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Health Care Reform

Employer-Sponsored Group Health Plans and Affordable Care Act Repeal Efforts

This chart compares the Affordable Care Act to provisions of both the House-passed American Health Care Act and the Senate Discussion Draft, called the Better Care Reconciliation Act. This chart is current as of June 26, 2017.

Affordable Care Act (Current Law)	American Health Care Act (House-Passed Bill)	Better Care Reconciliation Act (Version of the Senate Discussion Draft Released June 26, 2017)
Individual shared responsibility penalty for not having health coverage is the greater of $695 (indexed) or 2.5 percent of income.	Individual shared responsibility penalty would be reduced to zero, retroactive to January 1, 2016. Effective in 2018 for mid-year enrollments and open enrollments in 2019, a continuous-coverage requirement would require individuals to pay a 30 percent premium surcharge for individual market coverage if they have a coverage gap of more than 63 days during a 12-month look-back period. The surcharge would last for the entire plan year. States could apply for a waiver from the continuous-coverage surcharge under certain circumstances.	Same approach to individual shared responsibility penalty as House bill Effective in 2019, individuals with a coverage gap of more than 63 days in a 12-month look-back period would have to wait 6 months for individual market coverage to take effect.
Employer shared responsibility penalty imposes $2,000 (indexed) penalty under Internal Revenue Code Section 4980H(a) or a $3,000 (indexed) penalty under Section 4980H(b).	Penalty would be reduced to zero, retroactive to January 1, 2016. If the penalty were to be repealed, the rules related to it would also be rendered obsolete, including the 30-hour rule for defining full-time employees.	Same as House bill

Affordable Care Act (Current Law)	American Health Care Act (House-Passed Bill)	Better Care Reconciliation Act (Version of the Senate Discussion Draft Released June 26, 2017)
40 percent excise tax on certain high-cost health plans ("Cadillac tax"); applies to amount over thresholds ($10,200 for single coverage, $27,500 for other coverage tiers); effective in 2020	This tax would be delayed until 2026.	Same as House bill
Health Flexible Spending Arrangements (FSAs) — statutory salary reduction limitation ($2,600 in 2017)	No statutory limit on FSA salary reduction for tax years starting in 2017.	Same as House bill, but effective in 2018
Health Savings Accounts (HSAs) Maximum HSA contribution $3,400 single/ $6,750 family in 2017 20 percent penalty on non-qualified distributions	Maximum HSA contribution would be increased to the out-of-pocket limit (in 2018, $6,650 for single coverage and $13,300 for family coverage), effective in 2018. The penalty would be reduced to 10 percent in 2017. Additional administrative changes	Same as House bill
Over-the-counter (OTC) medications not payable without a prescription	Effective in 2017, OTC could be paid without a prescription.	Same as House bill
Health insurance provider tax (suspended for 2017)	Repealed	Same as House bill
Medicare Part D retiree drug subsidy expenses not deductible	Expenses would be deductible beginning in 2017.	Same as House bill

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Affordable Care Act (Current Law)	American Health Care Act (House-Passed Bill)	Better Care Reconciliation Act (Version of the Senate Discussion Draft Released June 26, 2017)
Medical device tax (suspended for 2016 and 2017) Fee on branded prescription drugs Medicare tax on investment income Tanning tax $500,000 limit on deduction of remuneration to health insurance executives	Repealed in 2017	Same as House bill, but two taxes (medical device tax and fee on branded prescription drugs) repealed in 2018
Medicare payroll tax for certain high-income individuals (0.9 percent)	Repealed effective 2023	Same as House bill
Threshold for deducting medical expenses on personal income tax return (10 percent of adjusted gross income)	5.8 percent of adjusted gross income beginning in 2017	7.5 percent of adjusted gross income beginning in 2017
W-2 reporting of health coverage	W-2 requirement retained, and new rule added requiring employers to indicate the months in which an employee was eligible for group health coverage	Unchanged from Affordable Care Act
Form 1094 and 1095 reporting	Unchanged from Affordable Care Act	Unchanged from Affordable Care Act
Comparative Effectiveness Research Fees – paid annually to fund Patient-Centered Outcomes Research Institute (PCORI) through 2019	Unchanged from Affordable Care Act	Unchanged from Affordable Care Act
Rules applicable to Medicare Part D and Medicare Advantage employer group waiver plans (EGWPs)	No provisions in American Health Care Act	No provisions in Better Care Reconciliation Act

Affordable Care Act (Current Law)	American Health Care Act (House-Passed Bill)	Better Care Reconciliation Act (Version of the Senate Discussion Draft Released June 26, 2017)
Essential health benefits (EHBs) must be provided by individual and small group plans. Group health plans cannot place an annual or lifetime maximum on EHBs.	States could apply for waiver from EHB requirements. Group health plans could probably use a waiver state's EHB benchmark and place maximums on non-EHB benefits.	Expands Affordable Care Act Section 1332 waiver authority. States could obtain from the Health and Human Services Department a waiver of EHB requirements, cost-sharing limits, and actuarial value level requirements without demonstrating that coverage would be as comprehensive or as affordable, or that a comparable number of people would have coverage. Only requirement would be that the State's plan not increase the federal deficit. The impact on group health plans is uncertain.
Plans in Exchanges must meet "metal" levels (bronze, silver, gold, platinum) based on their actuarial value	Metal levels would be eliminated effective in 2020.	A waiver under Section 1332 could include a waiver of these requirements.

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Affordable Care Act (Current Law)	American Health Care Act (House-Passed Bill)	Better Care Reconciliation Act (Version of the Senate Discussion Draft Released June 26, 2017)
Federal Marketplace and State Exchanges provide premium subsidies (premium assistance tax credits) to individuals between 100 and 400 percent of Federal Poverty Level (FPL) on sliding scale. Tax credits are sufficient to purchase second-lowest-cost silver plan.	Repeals premium assistance tax credits in 2020. For 2018 and 2019, tax credits would be modified slightly (*e.g.*, individual's required contribution would be based on income and age). Effective 2020, bill would create a new age-based tax credit that could be used to purchase insurance in the individual market or an exchange. Credits would be capped at $14,000/family and phased out at higher incomes. Credits are not designed to ensure purchase of a silver plan. Individuals would be ineligible for credit if they are eligible for coverage in employer-sponsored plan. Age — Annual Credit Amount Under Age 30 — $2,000 Age 30–39 — $2,500 Age 40–49 — $3,000 Age 50–59 — $3,500 Age 60 or Older — $4,000 Individuals would be required to pay back all excess subsidies received in error in 2018 and 2019.	Keeps premium assistance tax credits through 2019 and then changes them effective 2020. (No lower income limit, but upper income limit reduced from 400 percent FPL to 350 percent FPL; individual's required contribution for coverage would be based on income and age; would ensure purchase of 58 percent actuarial value plan only, instead of current 70 percent silver plan) Individuals would be required to pay back all excess subsidies received in error starting in 2018.
Cost-sharing subsidies provided to those with incomes below 250 percent of the FPL	Cost-sharing subsidies eliminated in 2020. Bill does not fund cost-sharing subsidies through 2019.	Funds the cost-sharing subsidies through 2019 and then repeals them
Age rating in the individual and small-group market is limited to 3:1 (*i.e.*, the premium for an adult who is age 64 cannot be more than three times the premium for a 21-year-old)	Age rating would be 5:1 effective in 2018. States could apply for waiver to set a different ratio.	Age rating would be 5:1 effective in 2019. States could choose a different ratio.

Affordable Care Act (Current Law)	American Health Care Act (House-Passed Bill)	Better Care Reconciliation Act (Version of the Senate Discussion Draft Released June 26, 2017)
Individual-market plans are prohibited from charging higher premiums based on medical status.	States could apply for a waiver that would permit medical underwriting for people who do not maintain continuous coverage. This would be in lieu of the continuous-coverage surcharge discussed above.	Unchanged from Affordable Care Act
Medical Loss Ratios (MLRs) are 85 percent for large groups and 80 percent for small groups.	Unchanged from Affordable Care Act	Permits states to set MLR ratios starting in 2019.
Medicaid	Changes ability of states to expand Medicaid eligibility and would cut the amount of federal payments to states for the expansion program. Medicaid would convert from an entitlement program to one with a federal cap beginning with fiscal year 2020 (which begins October 1, 2019). Under the new per-capita-cap structure, the federal government would provide a certain amount of funding per eligible beneficiary, and the states would have to work within that cap or provide additional funding of their own.	Same as House bill, however, slightly delayed phase out of expansion. Also indexes per capita payment amount in future years to basic inflation, resulting in greater funding cut than House bill.
Small business tax credit	Repealed in 2020	Same as House bill
Provision not in the Affordable Care Act	Creates a Patient and State Stability Fund to be used for various purposes, such as a high-risk pool and federal "invisible" risk-sharing program	Creates a similar program called the State Stability and Innovation Program
Group health plan coverage mandates (*e.g.*, dependents to age 26, no annual or lifetime limits)	Unchanged from Affordable Care Act for group health plans	Unchanged from Affordable Care Act for group health plans

Affordable Care Act (Current Law)	American Health Care Act (House-Passed Bill)	Better Care Reconciliation Act (Version of the Senate Discussion Draft Released June 26, 2017)
Rules for non-grandfathered group health plans (*e.g.*, coverage of preventive services, out-of-pocket maximum, external appeals)	Unchanged from Affordable Care Act	Unchanged from Affordable Care Act
Summary of Benefits and Coverage	Unchanged from Affordable Care Act	Unchanged from Affordable Care Act
Section 1557 nondiscrimination rules	Unchanged from Affordable Care Act	Unchanged from Affordable Care Act
Provision not in the Affordable Care Act	Provision not in the American Health Care Act	Would create fully insured "Small Business Health Plans" (small business risk-sharing pools), similar to "association health plans" in previous bills, which could be offered by associations pursuant to a certification by the Secretary of Labor

For more information about the American Health Care Act and/or the Better Care Reconciliation Act, contact your Segal consultant.

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Segal Consulting is a member of The Segal Group.

Healthy California Act (SB 562)

SB 562 proposed the establishment of a government-run universal healthcare system to serve California's nearly 40 million residents.

- Covered individuals would include people who receive coverage through work, Medi-Cal, and Medicare
- SB 562's funding requirements were estimated between $331 and $400 billion
  - California's current general fund budget is $124 billion

Suggested Funding Sources

- $225 billion transfer of existing governmental healthcare funding (i.e., Medicare, Medi-Cal, ACA insurance premium subsidies, etc.)
- 15% increase in state payroll tax
- 2.3 percent gross tax on businesses revenue above $2 million
- 2.3 percent general sales tax on everything except housing, utilities, groceries and other necessities

On June 23, 2017, Assembly Speaker Anthony Rendon chose not to advance SB 562 to a policy hearing during the first year of this two-year legislative session.

Speaker Rendon encouraged the Senate to continue working on developing legislation that addresses "financing, delivery of care, and cost control."