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, JANUARY 11, 2018 - 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:

Vivian H. Gray, Vice Chair
Alan Bernstein

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of December 14, 2017

II. PUBLIC COMMENT

III. FOR INFORMATION

A. Single-Payer Healthcare Update
Barry W. Lew, Legislative Affairs Officer

B. Engagement Report for December 2017
Barry W. Lew, Legislative Affairs Officer

C. Staff Activities Report for December 2017
Cassandra Smith, Director, Retiree Healthcare

D. LACERA Claims Experience
Stephen Murphy, Segal Consulting

E. Federal Legislation
Stephen Murphy, Segal Consulting

(for discussion purposes)

IV. REPORT ON STAFF ACTION ITEMS

V. GOOD OF THE ORDER

(For information purposes only)

VI. 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.

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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, DECEMBER 14, 2017, 4:05 P.M. – 4:10 P.M.

COMMITTEE MEMBERS

PRESENT: Vivian H. Gray, Vice Chair
David L. Muir, Alternate

ABSENT: William de la Garza, Chair
Alan Bernstein
Ronald Okum

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Marvin Adams
Shawn R. Kehoe
Keith Knox (Chief Deputy to Joseph Kelly)
Herman B. Santos

STAFF, ADVISORS, PARTICIPANTS

Cassandra Smith
Barry Lew

Segal Consulting

Stephen Murphy

Due to the absence of Messrs. de la Garza, Bernstein, and Okum, Board of Retirement Chair Shawn Kehoe appointed Mr. Adams as a voting member of the Committee. Mr. Kehoe also announced that Mr. Muir, as the alternate, would be a voting member of the Committee.

The meeting was called to order by Chair Gray at 4:05 p.m.

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of November 9, 2017

Mr. Adams made a motion, Ms. Gray seconded, to approve the minutes of the regular meeting of November 9, 2017. The motion passed unanimously.

II. PUBLIC COMMENT

III. FOR INFORMATION

A. Engagement Report for November 2017
Barry W. Lew, Legislative Affairs Officer

The engagement report was discussed.

B. Staff Activities Report for November 2017
Cassandra Smith, Director, Retiree Healthcare

The staff activities report was discussed.

C. LACERA Claims Experience
Stephen Murphy, Segal Consulting

The LACERA Claims Experience reports through October 2017 were discussed.

D. Federal Legislation
Stephen Murphy, Segal Consulting

(for discussion purposes)

Segal Consulting gave an update on federal legislation.

IV. REPORT ON STAFF ACTION ITEMS

There was nothing to report on for staff action items.

V. GOOD OF THE ORDER

(For information purposes only)

VI. ADJOURNMENT

The meeting adjourned at 4:10 p.m.

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LACERA

January 3, 2018

FOR INFORMATION ONLY

TO: Insurance, Benefits and Legislative Committee

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: January 11, 2017 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Single-Payer Healthcare Update**

This memo highlights recent developments related to Senate Bill 562, which would enact the Healthy California Act and establish a universal single-payer health care system in California.

BACKGROUND

SB 562, which would enact the Healthy California Act, was introduced on February 17, 2017 and passed by the Senate on June 1, 2017. When the bill moved to the Assembly, Speaker Anthony Rendon indicated that there were flaws in the bill that needed to be addressed. He made the decision to have the bill remain in the Assembly Rules Committee until further notice and thus have the bill carry over into the 2018 legislative year. He later announced that during the legislative interim, the Assembly Select Committee on Health Care Delivery Systems and Universal Coverage will hold hearings to develop plans for achieving universal health care in California. The first hearings were held on October 23 and October 24, 2017 and focused on healthcare delivery systems in California and other countries.

ASSEMBLY SELECT COMMITTEE ON HCDS&UC HEARINGS

On December 11, 2017, the Assembly Select Committee held its second informational hearing on universal coverage and cost containment efforts in the United States. The speakers included representatives from the Woodrow Wilson School at Princeton University, Tufts University School of Medicine, Manatt Health, UC Berkeley Center for Labor Research and Education, Kaiser Family Foundation, and Mathematica Policy Research. Former Governor of Vermont, Peter Shumlin, also appeared on the panel. The hearing was held locally in Los Angeles. Joe Ackler, LACERA's legislative advocate, was unable to monitor the hearing from Sacramento since it was not livestreamed. However, LACERA staff was able to attend the hearing in person.

UNIVERSAL COVERAGE SYSTEMS IN OTHER STATES AND CITIES

Overview

Heather Howard, Director of the Robert Wood Johnson Foundation's State Health and Values Strategies Program and a lecturer at Princeton University's Woodrow Wilson School of Public and International Affairs, provided an overview of universal coverage

efforts over the years beginning with the establishment of Medicare and Medicaid in 1965; various state efforts in Hawaii, Minnesota, and Massachusetts; the Children's Health Insurance Program (CHIP); the establishment of the Affordable Care Act (ACA) in 2010; and post-ACA state efforts in Vermont, New York, Minnesota, California, and Nevada.

Two key concepts were highlighted in this overview: the critical role of state actions and decisions on universal coverage and the need for federal partnership and cooperation in state efforts to achieve universal coverage. For example, Medicaid participation was decided on a state-by-state basis between 1966 and 1982. States have regulatory authority on the group and individual market. Under the ACA, states had the option of establishing their own insurance exchanges, and such states that also expanded Medicaid generally had higher coverage rates than states with federal exchanges; states that did not expand Medicaid tend to have lower coverage rates. For states that have made efforts toward extending coverage, federal partnership and cooperation is necessary in terms of financial resources and policy flexibility. Chief among these is the federal government providing waiver authority to the states to achieve coverage expansion. However, there is also uncertainty regarding federal resources due to potential entitlement reforms with respect to Medicare and Medicaid that may hamper states' efforts to expand coverage.

Vermont

Former Governor of Vermont Peter Shumlin discussed his experience with the challenges of trying to enact single-payer health care in Vermont. Although the Governor ran on a campaign platform of single-payer health care, the initiative ultimately failed to be enacted. There were three challenges outlined by the Governor. First, he pointed out that one of the main challenges that emerged was the rising costs of health care. Despite the fact that there were one-time savings from the absence of insurance companies in a single-payer system and other ongoing administrative savings, his administration found that no model—whether single-payer or the current system—would work unless costs were contained. Rising costs would lead to rising annual premiums and ultimately to annual tax increases, which would not be politically feasible.

Second, the Governor also stressed the need for a transparent and open dialogue about health care costs in the current system paid for by insurance. Since people do not know the true costs of the health care services they currently receive, they are unable to comprehend and accept the amount of payroll and income taxes that would be necessary to finance a single-payer system.

Lastly, the Governor noted poor timing in his efforts in trying to establish a single-payer system concurrently as Vermont was also in the middle of implementing the ACA. Most notably, Vermont experienced a disastrous launch of its health insurance exchange website that led to a loss of public confidence in his administration.

The Governor recommended that California's single-payer health care legislation contain conditions that must be met before public financing can occur such as a federal administration that would be cooperative in providing waiver authority and a cost containment plan that shifts away from a fee-for-service model to an outcomes-based payment system in order to achieve savings. He also cautioned that the potential loss of the state and local tax deduction under the federal tax reform bill could present challenges to raising taxes to fund single-payer health care.

Massachusetts

Paul Hattis, Associate Professor of Public Health and Community Medicine at Tufts University School of Medicine, discussed efforts in Massachusetts to move towards universal coverage. During the 1990's, the state introduced consumer protections such as prohibiting denial of coverage due to preexisting conditions and community rating rules. In 2006, the state enacted Chapter 58 of the Laws of 2006 (also known as "Romneycare"). It introduced concepts familiar in the ACA such as creating health insurance exchanges for people without employer-provided health insurance, merging individual and small group markets, providing subsidies based on income levels, and establishing an individual mandate.

After the enactment of the ACA, Massachusetts found that the ACA's subsidies were not as generous as the existing subsidies provided by Massachusetts, especially for those who were under 300 percent of the federal poverty level. The state had to apply for a Medicaid Section 1115 waiver to enable the state affordability schedule to exceed the federal affordability schedule.

The trend of uninsurance rates for non-elderly adults age 18-64 based on various surveys ranged from 8 to 10 percent in 2006 (when Romneycare was enacted) to 3 to 5 percent in 2015. According to the 2015 Massachusetts Health Insurance Survey, health coverage status at the time of the survey is 96 percent insured. As of 2017, Massachusetts has 4.1 million insured under private commercial enrollment, 1.1 million insured under Medicare, and 1.9 million insured under MassHealth, the state's universal coverage program. The state's Health Safety Net (HSN) Trust Fund is available to uninsured and underinsured residents whose family income is under a certain percentage of the federal poverty level. The HSN acts as a secondary payer for eligible individuals enrolled in the aforementioned plans.

Hawaii

Heather Howard, Director of the Robert Wood Johnson Foundation's State Health and Values Strategies Program and a lecturer at Princeton University's Woodrow Wilson School of Public and International Affairs, discussed Hawaii's efforts at universal coverage under its Prepaid Health Care Act (PHCA). The PHCA was enacted in 1974, the same year that the Employee Retirement Income Security Act of 1974 (ERISA) was enacted. ERISA sets minimum standards for pension and health plans and generally

preempts state law. In 1983, Hawaii was successful in obtaining a waiver that exempts the state from ERISA preemption and is the only state to have done so. However, the waiver only applied to the PHCA as it was in effect in 1983 and thus has prevented Hawaii from making any substantive changes to the PHCA in order to retain the exemption.

The PHCA has three components: an employer mandate, employee's share of premiums, and plan standardization. The employer mandate applies to employers of all sizes (include sole proprietorships) and requires them to offer coverage to any employee working 20 or more hours per week. However, there are exemptions from the mandate for certain commission-based and seasonal agricultural workers. The waiting period before coverage is offered is four weeks of employment. Although there are nominal penalties for not complying with the employer mandate, noncompliant employers may be held liable for the medical costs of an eligible employee. The employee's share of the premiums is the lesser of one-half of the premium cost or 1.5 percent of the employee's monthly wages. The coverage plans under the PHCA can be fully insured by an insurance company or self-insured by an employer. The plans are then approved by the state and designated based on plan design and the level of benefits offered. Hawaii also received an ACA Section 1332 waiver that allowed the PHCA to continue operating. The Section 1332 waiver allows states to implement innovate ways to provide health care that is at least as comprehensive and affordable without the waiver.

The result of the PHCA having been in effect for over 40 years has been Hawaii having one of the lowest uninsured rates in the country, especially among service workers and employees of small businesses. Studies have also found that wages have not been depressed as a result of the employer mandate. However, Hawaii is not necessarily a model for other states to adopt. For example, Hawaii's plans are not high-deductible plans and do not have increasing out-of-pocket costs. Moreover, attempts by a state to regulate employer plans may cause ERISA preemption issues, from which Hawaii is exempt.

Medicaid Buy-In

Cindy Mann, a partner at Manatt Health, discussed two approaches for states depending on the state's goals in promoting universal coverage, ensuring marketplace access and affordability, and ensuring continuity and alignment among different health care delivery systems.

Both approaches are based on the existing Medicaid infrastructure (known as Medi-Cal in California). The Public Option approach leverages Medicaid to offer a public product in the marketplace to improve consumer choice or affordability. The Medicaid Buy-In approach leverages Medicaid to offer a public product to expand access for people not eligible for Medicaid.

The Public Option would involve California promoting access and competition in the marketplace by offering a new product in the marketplace that is available to all parts of the state. The product would be created by the state using the existing Medicaid infrastructure of benefit design, claims payment, and oversight management and would be offered on Covered California. The state would contract with Medicaid managed care organizations to deliver care. Qualified enrollees would receive tax credit subsidies. Essentially, the Public Option is a government-sponsored health insurance plan that would compete with private insurers in a health insurance exchange.

The Medicaid Buy-In would provide access to people not otherwise eligible for Medicaid or subsidies by allowing them to enroll in a Medicaid product. California would create the product using the existing Medicaid infrastructure of benefit design, claims payment, and oversight management. However, the product would not be offered in the marketplace through Covered California, and the product is subsidized with state funds only and not federal funds. This would be similar in concept to California's Health4AllKids program that covers health care for undocumented children who are not otherwise eligible for Medicaid.

City and County of San Francisco

San Francisco's universal healthcare model includes the Healthy San Francisco (HSF) program and an employer mandate. The HSF program covers people not covered by an employer-provided health insurance or a public program. The employer mandate prescribes minimum standards for healthcare spending by employers on employees. San Francisco's model is a shared responsibility system that involves individuals, employers, the public, and providers.

HSF provides comprehensive health services and access to health care for those who do not have another source of coverage. It provides access, not insurance, so enrollees are covered only within San Francisco and not out of network. It provides a network of medical homes for primary and preventive services and designated sites for specialty care and emergency services. The medical home network is composed of 60 percent in the public health network, about a third in a community clinic consortium, and the remainder with Kaiser or other providers. Specialty care is provided by nonprofit hospitals as part of their charity care.

HSF's eligibility requirements are that an uninsured San Francisco resident is not eligible for other sources of coverage. It's open to families with incomes under 500 percent of the federal poverty level ($60,300 for single individuals and $102,000 for a family of three).

The cost of the HSF program in 2016 was $75 million ($44 million from San Francisco Department of Public Health and the remaining $30 million from charity care by providers). The financing of HSF is based on quarterly fees charged to individuals on a sliding scale ($0 for up to 100 percent of the federal poverty level to $150 for up to

500% of the federal poverty level). Public financing comes from San Francisco's general fund and enrollment of individual in Medi-Cal, which provides state and federal funding. The employer mandate for funding applies to employers with employees working 8 hours or more a week. The cost for large firms, which have over 100 employees, is 75 percent of the average employer health plan and is equal to $2.83 per hour per employee for a 40-hour workweek. For firms with 20-99 employees, the cost is 50 percent of the average employer health plan and is equal to $1.89 per hour per employee for a 40-hour workweek. By mandating a spending requirement but not plan standards, HSF avoids ERISA preemption issues.

The passage of the ACA resulted in 108,000 enrolling in ACA coverage with the uninsured rate dropping 63 percent from 2013 to 2016. However, there is still a need for HSF for those not covered under the ACA since HSF enrollment before the ACA was 65,650 and 13,209 after the ACA.

COST CONTAINMENT EFFORTS IN OTHER STATES

Overview

Larry Levitt, Senior Vice-President of the Kaiser Family Foundation, provided an overview of the drivers of growth in health care costs and potential solutions. The following is a list of notable statistics:

- On average, other wealthy countries spend about half as much per person on health as the U.S. (U.S.: $9,451, comparable countries: $4,908).
- The gap between the U.S. and comparable countries health spending as a percentage of GDP has widened (U.S.: 17 percent, comparable countries: 11 percent)
- Mortality rates have fallen steadily in U.S. and comparable countries, although U.S. mortality are still higher than comparable countries (U.S.: 826 per 100,000 population, comparable countries; 723 per 100,000 population)
- The U.S. has the lowest insured rate of comparable countries (U.S.: 90.9 percent, comparable countries: 99.9 percent)
- U.S. lead comparable countries in MRI use (U.S.: 107 per 1,000 population, comparable countries: 64 per 1,000 population)
- Average price of MRI in U.S. is significantly higher than other comparable countries (U.S.: $1,145, Netherlands: $461, Australia: $350, Switzerland: $138)
- Average price of angioplasty in U.S. is significantly higher than other comparable countries (U.S.: $27,907, Switzerland: $10,897, Australia: $8,477, Netherlands: $5,295)

- Average price of bypass surgery in U.S. is significantly higher than other comparable countries (U.S.: 75,345, Australia: $42,130, Switzerland: $36,509, Netherlands: $15,742)
- Average price of drugs in U.S. is higher than other countries (U.S.: $2,225, Canada: $1,646, Netherlands: $1,509, England: $1,117, Switzerland: $1,017)
- Wages in the U.S. have grown 64 percent since 1999. However, family premiums and worker contributions have grown 224 percent and 270 percent, respectively.
- Wages in the U.S. have grown 31 percent since 2005. However, deductibles and co-insurance have grown 229 percent and 89 percent, respectively.
- Across the population, the top 1 percent of health spenders contribute to over 20 percent of expenditures; the top 20 percent of health spenders contribute to 83 percent of expenditures. The top 50 percent contribute to 97 percent of expenditures, whereas the bottom 50 percent contribute to 3 percent of expenditures.

The potential opportunities for driving down healthcare costs include providing more transparency on prices, simplifying administration of payments, encouraging a shift toward paying for value, taking antitrust actions to address consolidation and pricing power, regulating prices and spending, creating a public option insurance plan or Medicaid buy-in, and creating a single payer system. Mr. Levitt noted that although there are many benefits to containing healthcare costs, there are challenges as well. For example, cost containment is difficult and can be a zero-sum game where gains may have to be balanced by losses. Moreover, the role of Medicare in cost containment would require federal cooperation.

Maryland

Sule Gerovich, Senior Researcher at Mathematica Policy Research, discussed Maryland's global budgeting system. Ms. Gerovich noted that high-deductible plans are not the solution to cost containment since there is generally a lack of patient engagement with the provider with respect to prices. She stressed that the key to cost containment is how payments to providers are structured.

Since the late 1970's, Maryland established an all-payer system in which the state sets the hospital rates for all public and private payers; all payers, including Medicare, Medicaid, private, and the uninsured are charged the same rate for each of the hospital's services. The rates differ for each hospital and are updated annually on a prospective basis; however, higher cost hospitals such as academic medical centers have higher rates. Claims processing and benefit coverage are determined by each payer.

The state's Health Services Cost Review (HSCR) Commission oversees hospital rate regulation for all payers. It is an independent quasi-public commission. Its seven commissioners consist of stakeholder representatives appointed by the Governor. It has authority over inpatient and outpatient hospital services (but not physician services) provided by 47 acute care hospitals with total revenues of $15 billion.

Maryland was able to establish an all-payer system through obtaining a federal waiver under Section 1814(b) of the Social Security Act that allowed for Medicare and Medicaid to pay for 94 percent of the state's regulated rates with a 6-percent discount. A requirement by the federal government for Maryland to maintain the waiver was that the state must meet a performance test: Maryland's growth rate of inpatient discharge must be under the national trend. Although there was price control in Maryland, cost control could not be achieved unless utilization rates were also controlled since higher utilization increases revenue, given that prices were fixed.

Maryland's approach to controlling utilization was providing global budgets for hospitals, made possible by a Section 1115 federal waiver. The HSCR Commission provides a budget with a prospective adjustment to hospitals. Hospitals in turn use their budget to determine service improvements. Their profitability would depend on reviewing avoidable utilizations such as reducing readmission rates, reducing infection rates, or improving chronic care, so that patients do not end up frequently using higher cost services such as emergency care. This approach shifts away from fee-for-service to value based on quality scores and efficiency.

To avoid the issue of health care rationing, the HSCR Commission must make appropriate adjustments to the global budgets. Adjustments are made for medical inflation (market-basket inflation rate and special circumstances beyond hospital's control such as drug prices), utilization growth (population growth estimates and aging), and other factors (coverage expansions from ACA, flu epidemic, and specialized services such as cancer care or transplants). At the same time, policies are developed to avoid unintended consequences of budget incentives such as increasing transfers between hospitals and constraining access.

In general, Maryland's global budget system saved money for its payers, including Medicare, kept healthy profit levels for hospitals, and improved quality.

Massachusetts

Paul Hattis, Associate Professor of Public Health and Community Medicine at Tufts University School of Medicine, discussed the reasons that Massachusetts' cost containment law that was passed in 2012. In 2006, when Romneycare was passed, the purpose of the law was to increase health care access and coverage; stakeholders avoided policy discussions on cost and quality of care. Massachusetts had for many years been the most expensive state for health care on a per capita basis. There were

also several health care mergers and acquisitions that exacerbated the higher pricing of health care.

The 2012 law created two new independent state agencies to provide oversight and guidance on the state's efforts on cost containment. The Center for Health Information and Analysis (CHIA) was created as a data hub to maintain an all-payer claims database, collect a wide variety of provider and health data, examine trends in the commercial health care market (non-Medicare), and develop a consumer-facing cost transparency website. The Health Policy Commission (HPC) is a policy hub that uses the CHIA data to set statewide benchmarks on the growth of health care costs, hold hearings on cost trends, produce an annual report on cost trends, enforce benchmarks on performance, conduct cost and market impact reviews, and support investments in community hospitals and innovate health care models.

The approach by Massachusetts to contain costs consists of three components. One is the shift toward global payments that moves away from fee-for-service (volume) to value. Two is to increase provider price transparency, perform cost and market impact reviews, and require performance improvement plans. Three is establishing spending growth targets for all medical care.

NEXT HEARING
The next hearing in early 2018 will examine various proposals as well as legal and other challenges that must be addressed.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

cc: Robert Hill
James Brekk
JJ Popowich
Bernie Buenaflor
Steven P. Rice
Cassandra Smith
Leilani Ignacio
Joe Ackler, Ackler & Associates

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
DECEMBER 2017
FOR INFORMATION ONLY

Wall Street Editorial on Governor Jerry Brown

A Wall Street Journal editorial recently discussed Governor Brown's intervention in a state Supreme Court case involving the purchase of "airtime," which was prohibited by his 2012 pension reforms. The Governor's office filed a brief arguing that the expansion of the scope of the vested rights doctrine at issue in the case "would introduce an inflexible hardening of the traditional formula for public employee pension modifications, rendering pension systems incapable of adapting to changed fiscal or factual circumstances." The WSJ noted that if lawmakers are legally barred from reducing government pensions, then they may have no choice but to raise taxes to pay for them. However, there would be a tension between the need to raise taxes and the elimination of state and local tax deductions in the federal tax reform plan that would make raising taxes in high-tax states politically difficult. (Source)

> Staff Note: At the time the editorial was written, the federal tax reform plan had not yet passed. The final tax reform plan signed into law eliminates state and local tax deductions except for a limit of $10,000 for real property tax deductions.

State of Oregon PERS UAL Task Force

Oregon Governor Kate Brown convened a task force to identify opportunities to pay for an additional $5 billion of the Oregon Public Employee Retirement System's (PERS) unfunded actuarial liability (UAL) over the next five years. Oregon PERS currently has an unfunded actuarial liability of $25.3 billion in 2016, which increased from $21.8 billion in 2015. Factors contributing to the increase include a lowered investment return assumption from 7.5 percent to 7.2 percent and employers underfunding the system each biennium.

The approach of the Task Force was to be comprehensive and creative in identifying potential revenue sources and to leave "no idea unexamined or no rock unturned;" however, the Task Force was directed not to consider changes to benefit levels, rates of return, or specific investments. The Task Force focused on options that are most applicable to the state and large PERS employers but may also be considered by other PERS employers to accelerate payment of their own UAL. The following is a list of the options and their funding opportunities that are estimated to yield $4.2 - $6.4 billion available to reduce the UAL:

- Reduce excess risk capital across state-controlled entities by state-level pooling risk capital ($750 million - $1.5 billion)

- Create new PERS investment fund for non-state employers to provide higher returns to credit against these employers' PERS liability (Unknown funding opportunity)
- Redirect surplus capital from the State Accident Insurance Fund (workers' compensation system) to PERS under various methods to address UAL ($500 million plus)
- Harvest one-time "windfall" income from various sources: Oregon capital gains taxes, Oregon estate taxes, lawsuit settlements, school district state funding rebalance, increased debt collections, foreclosed properties ($1.2 billion plus)
- Convert ownership of unclaimed property after 10 years from the Common School Fund to the state to allow state to dedicate earnings to reduce PERS UAL for Oregon schools ($200 million plus)
- Sweep excess agency reserve funds into PERS (Unknown funding opportunity)
- Increase state alcohol revenues and dedicate incremental funds to PERS and increase excise beer and wine taxes ($453 million plus)
- Privatize public universities ($250 million - $1.5 billion)
- Maximize financial value of state's real property assets by selling property no longer in use or property that have high operating expenses ($128 million plus)
- Natural resources: undertake approved timber harvests on federal land, increase cap on private landowners' share of fire suppression costs, levy one-time fees on granting of water rights ($330 - $530 million plus)
- Increase lottery revenue by expanding gaming options ($175 million plus)
- Divert a portion of projected contributions from Rainy Day Funds to PERS ($200 million)
- PERS Resolution Program to provide incentives such as matching funds from the state for employers to develop and implement UAL reduction plans that reflect local priorities ($2 billion plus)

The Task Force issued its final report on November 1, 2017 to the Governor and noted that the various policy options are funding opportunities that do not include implementation costs, collateral financial impacts, or political constraints that all require significant additional analysis. (Source) (Source) (Source)

Staff Note: The idea that seems to have the most traction with the Governor is the establishment of a matching fund to provide incentives to local government agencies to develop their own plans to address the UAL. The philosophy of the Governor in establishing a task force to identify funding opportunities shares similarities with the "shared responsibility plan" advocated by educators in

Kentucky (as noted in the November 2017 Engagement Report) that assumes additional revenue can be generated by a more modernized state tax system to address the funding gap in Kentucky's teachers' retirement system. In both cases, the approach was to identify new potential revenue sources to reduce the unfunded actuarial liability rather than implement changes to benefit structures.

U.S. Life Expectancy Drops for Second Year in a Row

According to a report by the National Center for Health Statistics (part of the Centers for Disease Control and Prevention), life expectancy in 2016 for the total U.S. population was 78.6, a statistically significant drop of 0.1 year from the 2015 life expectancy of 78.7, the second time in a row life expectancy has declined. One trend of concern has been an increase in drug overdose deaths based on provisional data for 2017. For example, the age-adjusted rate of drug overdose deaths in 2016 (19.8 per 100,000) was 21 percent higher than the rate in 2015 (16.3 per 100,000); the 2016 rate is also more than three times the rate in 1999.
(Source) (Source) (Source)

Staff Note: As noted in the September 2017 Engagement Report, declines in life expectancy have caused large companies to reduce the longevity assumptions in their actuarial valuations, which in turn reduces estimated pension obligations. Mortality trends affect not just private sector pension plans but also the financial outlook for Social Security benefits since they are reflected in the baseline mortality tables issued by the Society of Actuaries; the Society is working on updates for public sector pension plans. Whether this decline in life expectancy is a blip or a more permanent trend remains to be seen. Note that in LACERA's 2016 actuarial valuation, the mortality assumptions include a projection for expected future mortality improvement.

A Preview of the U.S. Without Pensions

A recent article in The Washington Post profiles the financial struggles of older workers who lost their pension benefits as major U.S. companies shifted away from traditional pensions during the past three decades. As the private sector shifted away from pensions, individual retirement accounts were intended to supplement Social Security in providing for retirement security. The article notes that the average Social Security benefit is about $14,000 per year. According to the Federal Reserve's 2016 Survey of Consumer Finances, the median retirement account balance among workers at the median income level is about $25,000. The article also notes that the issue of retirement security was the subject of a report by the Government Accountability Office (GAO) that examined the shift away from traditional pensions to retirement savings accounts. The GAO report describes the challenges to retirement security for individuals; the

inadequacies in the three-legged stool of retirement security: Social Security, private employer-sponsored plans, and individual savings; and the need to re-evaluate the nation's approach to financing retirement. To that end, the GAO recommends that Congress consider establishing an independent commission to examine the U.S. retirement system and make recommendations on policy goals and improvements in retirement security. The commission should include representatives from government agencies, employers, financial services industry, unions, participant advocates, and researchers to help inform policymakers. (Source) (Source) (Source)

> Staff Note: House Speaker Paul Ryan has signaled that entitlement reform may be next after the passage of tax reform legislation. However, reforms on Social Security are unlikely to employ the same strategy used for tax reform since Senate rules forbid changes to the Social Security program through the budget reconciliation process that enables the Senate to pass legislation with only 50 votes.

American Legislative Exchange Council Publication:
Unaccountable and Unaffordable 2017

The American Legislative Exchange Council published a report entitled "Unaccountable and Unaffordable 2017." The report examines the unfunded liabilities of over 280 state-administered pension plans by outlining the valuation and reporting standards of state pension plans, providing an alternative calculation of unfunded liabilities by using a risk-free rate of return, exploring how discount rates function, examining systems that adjusted their discount rates in 2015 and 2016, explaining the mathematics and financial economics behind the calculation of unfunded liabilities, examining the levels of transparency in financial reporting of pension plans among various states, and reviewing states that have taken substantive steps to reform pension policy.

In its ranking of states with the lowest to highest unfunded liabilities in 2017 based on a *risk-free rate of return assumption*, the report lists Vermont as number one with $9.5 billion and California as number fifty with $987 billion. California is ranked number 39 in terms of unfunded labilities per capita at $25,166, whereas Tennessee is ranked number one with $7,601. The report also contrasts California's funding ratio of 70 percent using an assumed rate of return versus 33 percent using a risk-free rate of return. (The discussion of California would pertain to the California Public Employees' Retirement System.)

The report also assesses the level of transparency in financial reporting of pension plans by various states. Kentucky was provided as a notable example of a state that provided up-to-date, easily-found comprehensive financial reporting. Other states that the report positively noted include Montana, Nebraska, and North Carolina. The states

the report considers the least transparent include Alabama, California, Georgia, and Louisiana. (Source)

Staff Note: According to its website, the American Legislative Exchange Council (ALEC) is a nonpartisan, voluntary membership organization of state legislators dedicated to the principles of limited government, free markets, and federalism. Its membership includes nearly one-quarter of the country's state legislators. As examined in a 2013 Brookings article, ALEC provides model legislation that is disseminated to state legislators for introduction at state legislatures. Although ALEC does list various official ALEC policies on its website, it is not a complete list since its list of policies are continuously updated with additions and removals. The Brookings article found that in 2011-2012, 132 bills based on ALEC model legislation were introduced. Democrats sponsored 10 percent of those bills, whereas Republicans sponsored 90 percent. About 57 percent of legislators who sponsored ALEC model legislation can be explicitly connected to ALEC. Of the 34 states in which ALEC model legislation was introduced, the most common states were West Virginia, Oklahoma, and Mississippi. California does not appear to have had any ALEC model legislation introduced. (Source)

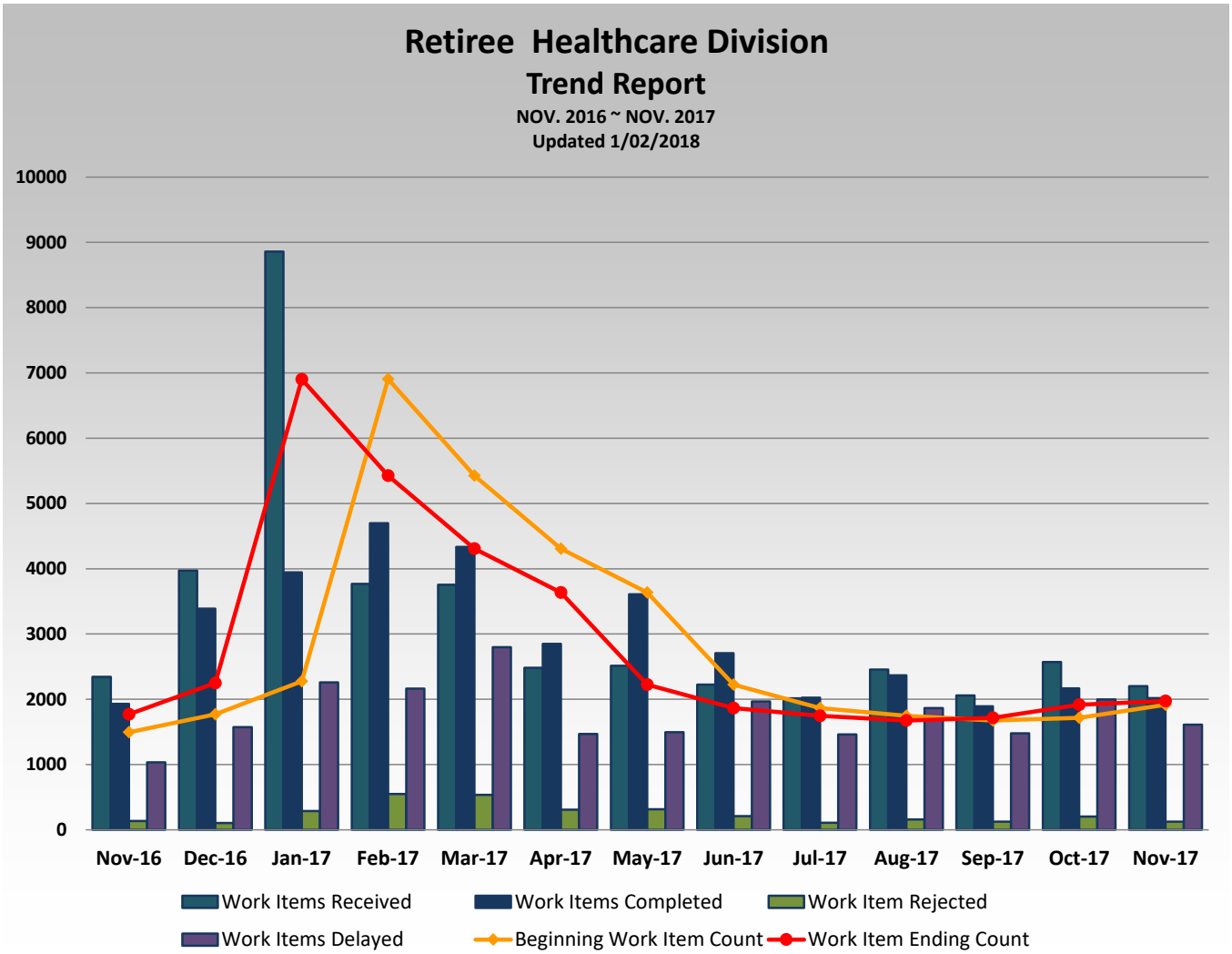
INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
DECEMBER 2017
FOR INFORMATION ONLY

2018 Medicare Part B Premium Reimbursement Program

As staff informed your Board, the Centers for Medicare & Medicaid Services (CMS) announced the 2018 Medicare Part B premiums/deductibles in November. The standard monthly premium for Medicare Part B will be $134.00. However, most people who receive Social Security benefits pay less than this amount ($130 on average).

Staff was advised this item will be placed on the Board of Supervisors' agenda for their January 16, 2018 Board meeting.

We are finalizing the 2018 Part B notice and a mass mailing is scheduled to be conducted to our retirees after the Board of Supervisors approve continuing the Medicare Part B Premium Reimbursement Program in 2018. In addition, we are working with Systems staff to update the 2018 Medicare Part B premium amounts in the system.

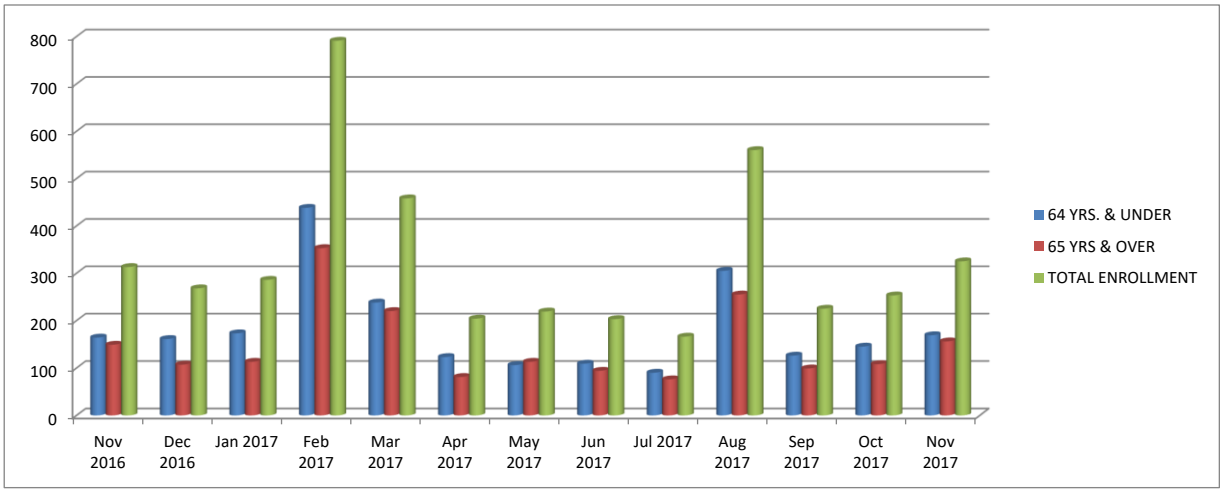


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Nov-16	1494	2342	1929	135	1034	1772
Dec-16	1772	3970	3387	105	1572	2250
Jan-17	2276	8859	3944	288	2260	6903
Feb-17	6906	3767	4698	549	2164	5426
Mar-17	5426	3753	4334	537	2798	4308
Apr-17	4308	2484	2848	308	1467	3636
May-17	3636	2513	3609	314	1495	2226
Jun-17	2226	2225	2706	211	1966	1864
Jul-17	1864	2016	2026	108	1460	1746
Aug-17	1746	2457	2368	160	1865	1675
Sep-17	1675	2059	1893	125	1480	1716
Oct-17	1716	2571	2167	205	1999	1915
Nov-17	1915	2202	2018	126	1611	1973

Retirees Monthly Age Breakdown
NOV. 2016 ~ NOV. 2017

Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
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
Jun 2017	109	94	203
Jul 2017	90	76	166
Aug 2017	305	255	560
Sep 2017	126	99	225
Oct 2017	145	108	253
Nov 2017	169	156	325



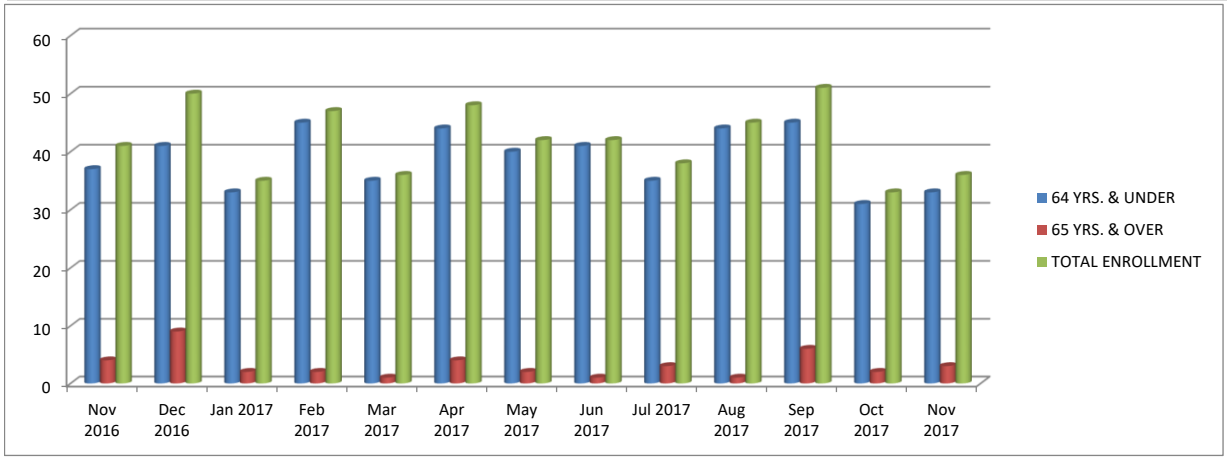
PLEASE NOTE:

- **December's data (12/2017) is not yet available as data is provided on a <u>full month basis</u>.**
- **Next Report will include the following dates: December 1, 2016 through December 31, 2017.**

Retirees Monthly Age Breakdown
NOV. 2016 ~ NOV. 2017

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
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
Jun 2017	41	1	42
Jul 2017	35	3	38
Aug 2017	44	1	45
Sep 2017	45	6	51
Oct 2017	31	2	33
Nov 2017	33	3	36



PLEASE NOTE:

- **December's data (12/2017) is not yet available as data is provided on a full month basis.**
- **Next Report will include the following dates: December 1, 2016 throught December 31, 2017.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
202	1	-$104.90	0	$0.00
222	1	$238.90	0	$0.00
240	6469	$715,454.40	8	$246.50
241	156	$16,950.20	0	$0.00
242	850	$98,290.90	0	$0.00
243	3744	$828,354.20	6	$473.50
244	21	$2,355.40	0	$0.00
245	52	$6,350.60	0	$0.00
246	18	$1,989.40	0	$0.00
247	100	$11,779.10	0	$0.00
248	11	$2,406.50	1	$36.50
249	46	$10,792.80	0	$0.00
250	15	$3,333.20	0	$0.00
Plan Total:	**11,484**	**$1,698,190.70**	**15**	**$756.50**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	31	$2,811.30	0	$0.00
322	9	$1,032.50	0	$0.00
324	13	$2,759.90	0	$0.00
327	2	$238.90	0	$0.00
329	2	$440.70	0	$0.00
Plan Total:	**57**	**$7,283.30**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
403	10201	$1,135,300.40	7	$206.50
413	1651	$192,473.60	0	$0.00
418	5196	$1,147,031.80	3	$175.30
419	272	$29,338.40	0	$0.00
426	215	$23,908.10	0	$0.00
427	165	$17,977.10	0	$0.00
445	2	$210.90	0	$0.00
451	33	$3,730.10	0	$0.00
455	1	$134.00	0	$0.00
457	11	$1,892.50	0	$0.00
458	1	$134.00	0	$0.00
462	52	$5,647.80	0	$0.00
465	10	$1,087.40	0	$0.00
466	30	$6,554.00	0	$0.00
467	1	$134.00	0	$0.00
472	33	$3,556.20	0	$0.00
476	4	$465.60	0	$0.00
478	13	$2,884.30	0	$0.00
482	81	$8,857.40	0	$0.00
486	10	$1,153.00	0	$0.00
488	43	$9,626.20	0	$0.00
491	2	$209.80	0	$0.00
492	1	$104.90	0	$0.00
494	1	$226.70	0	$0.00
Plan Total:	**18,029**	**$2,592,638.20**	**10**	**$381.80**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	300	$33,786.30	0	$0.00
613	104	$22,821.50	0	$0.00
Plan Total:	**404**	**$56,607.80**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1593	$179,237.20	1	$36.50
702	324	$38,348.60	0	$0.00
703	912	$202,847.10	1	$0.00
704	68	$8,148.20	$0.00	$0.00
705	29	$6,723.30	0	$0.00
Plan Total:	**2,926**	**$435,304.40**	**2**	**$36.50**
Grand Total:	**32,900**	**$4,790,024.40**	**27**	**$1,174.80**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
202	1	-$104.90	0	$0.00
222	1	$238.90	0	$0.00
240	6469	$715,454.40	8	$246.50
241	156	$16,950.20	0	$0.00
242	850	$98,290.90	0	$0.00
243	3744	$828,354.20	6	$473.50
244	21	$2,355.40	0	$0.00
245	52	$6,350.60	0	$0.00
246	18	$1,989.40	0	$0.00
247	100	$11,779.10	0	$0.00
248	11	$2,406.50	1	$36.50
249	46	$10,792.80	0	$0.00
250	15	$3,333.20	0	$0.00
Plan Total:	**11,484**	**$1,698,190.70**	**15**	**$756.50**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	31	$2,811.30	0	$0.00
322	9	$1,032.50	0	$0.00
324	13	$2,759.90	0	$0.00
327	2	$238.90	0	$0.00
329	2	$440.70	0	$0.00
Plan Total:	**57**	**$7,283.30**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
403	10201	$1,135,300.40	7	$206.50
413	1651	$192,473.60	0	$0.00
418	5196	$1,147,031.80	3	$175.30
419	272	$29,338.40	0	$0.00
426	215	$23,908.10	0	$0.00
427	165	$17,977.10	0	$0.00
445	2	$210.90	0	$0.00
451	33	$3,730.10	0	$0.00
455	1	$134.00	0	$0.00
457	11	$1,892.50	0	$0.00
458	1	$134.00	0	$0.00
462	52	$5,647.80	0	$0.00
465	10	$1,087.40	0	$0.00
466	30	$6,554.00	0	$0.00
467	1	$134.00	0	$0.00
472	33	$3,556.20	0	$0.00
476	4	$465.60	0	$0.00
478	13	$2,884.30	0	$0.00
482	81	$8,857.40	0	$0.00
486	10	$1,153.00	0	$0.00
488	43	$9,626.20	0	$0.00
491	2	$209.80	0	$0.00
492	1	$104.90	0	$0.00
494	1	$226.70	0	$0.00
Plan Total:	**18,029**	**$2,592,638.20**	**10**	**$381.80**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2017

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	300	$33,786.30	0	$0.00
613	104	$22,821.50	0	$0.00
Plan Total:	**404**	**$56,607.80**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1593	$179,237.20	1	$36.50
702	324	$38,348.60	0	$0.00
703	912	$202,847.10	1	$0.00
704	68	$8,148.20	$0.00	$0.00
705	29	$6,723.30	0	$0.00
Plan Total:	**2,926**	**$435,304.40**	**2**	**$36.50**
LOCAL 1014				
804	170	$26,287.90	0	$0.00
805	168	$24,437.30	0	$0.00
806	575	$160,828.90	0	$0.00
807	36	$5,359.50	0	$0.00
808	12	$3,754.50	0	$0.00
812	225	$31,448.70	0	$0.00
Plan Total:	**1,186**	**$252,116.80**	**0**	**$0.00**
Grand Total:	**34,086**	**$5,042,141.20**	**27**	**$1,174.80**

Medical and Dental Vision Insurance Premiums
January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	677	$587,724.30	$97,655.00	$503,709.00	$601,364.00	($4,334.25)	$597,029.75
202	367	$628,857.18	$54,270.55	$534,139.35	$588,409.90	$0.00	$588,409.90
203	94	$182,697.35	$45,347.31	$125,811.26	$171,158.57	$0.00	$171,158.57
204	33	$36,753.42	$14,322.73	$26,885.65	$41,208.38	$0.00	$41,208.38
205	1	$237.47	$9.50	$227.97	$237.47	$0.00	$237.47
SUBTOTAL	**1,172**	**$1,436,269.72**	**$211,605.09**	**$1,190,773.23**	**$1,402,378.32**	**($4,334.25)**	**$1,398,044.07**
Anthem Blue Cross I							
211	853	$937,217.28	$60,174.96	$887,845.67	$948,020.63	($9,824.83)	$938,195.80
212	300	$595,673.86	$32,426.69	$531,951.19	$564,377.88	($1,972.43)	$562,405.45
213	56	$130,273.36	$17,866.02	$112,407.34	$130,273.36	$0.00	$130,273.36
214	19	$27,512.38	$4,807.43	$22,704.95	$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	**1,232**	**$1,692,133.04**	**$115,486.24**	**$1,556,154.17**	**$1,671,640.41**	**($11,797.26)**	**$1,659,843.15**
Anthem Blue Cross II							
221	2,119	$2,322,240.48	$144,261.97	$2,194,256.26	$2,338,518.23	($7,664.36)	$2,330,853.87
222	1,866	$3,692,388.96	$93,887.58	$3,545,245.77	$3,639,133.35	$1,972.43	$3,641,105.78
223	605	$1,412,070.17	$61,414.46	$1,306,828.12	$1,368,242.58	$2,326.31	$1,370,568.89
224	145	$211,410.92	$19,664.10	$191,746.82	$211,410.92	$0.00	$211,410.92
225	3	$1,092.12	$182.02	$910.10	$1,092.12	$0.00	$1,092.12
SUBTOTAL	**4,738**	**$7,639,202.65**	**$319,410.13**	**$7,238,987.07**	**$7,558,397.20**	**($3,365.62)**	**$7,555,031.58**

Medical and Dental Vision Insurance Premiums
January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	6,488	$2,878,228.20	$445,077.55	$2,440,699.60	$2,885,777.15	($9,287.05)	$2,876,490.10
241	155	$220,456.08	$25,182.85	$193,860.05	$219,042.90	$0.00	$219,042.90
242	858	$1,213,921.62	$85,582.24	$1,111,381.22	$1,196,963.46	$0.00	$1,196,963.46
243	3,751	$3,311,522.89	$382,151.47	$2,893,390.49	$3,275,541.96	($6,104.31)	$3,269,437.65
244	21	$16,638.72	$3,438.68	$13,200.04	$16,638.72	$0.00	$16,638.72
245	53	$41,992.96	$5,070.84	$38,506.76	$43,577.60	$0.00	$43,577.60
246	18	$31,716.90	$1,762.05	$29,954.85	$31,716.90	$0.00	$31,716.90
247	101	$177,967.05	$7,929.23	$170,037.82	$177,967.05	$0.00	$177,967.05
248	11	$13,522.08	$1,966.85	$11,555.23	$13,522.08	$0.00	$13,522.08
249	47	$57,776.16	$5,162.97	$52,613.19	$57,776.16	$0.00	$57,776.16
250	15	$20,661.30	$991.74	$19,669.56	$20,661.30	$0.00	$20,661.30
SUBTOTAL	**11,518**	**$7,984,403.96**	**$964,316.47**	**$6,974,868.81**	**$7,939,185.28**	**($15,391.36)**	**$7,923,793.92**
CIGNA Network Model Plan							
301	340	$482,769.40	$129,035.67	$353,733.73	$482,769.40	$0.00	$482,769.40
302	147	$376,663.98	$91,886.33	$282,215.31	$374,101.64	$0.00	$374,101.64
303	17	$51,434.18	$14,443.17	$30,939.93	$45,383.10	$0.00	$45,383.10
304	24	$45,208.56	$17,348.66	$27,859.90	$45,208.56	$0.00	$45,208.56
SUBTOTAL	**528**	**$956,076.12**	**$252,713.83**	**$694,748.87**	**$947,462.70**	**$0.00**	**$947,462.70**

Medical and Dental Vision Insurance Premiums

January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
CIGNA Healthspring Pref w/ Rx - Phoenix, AZ							
321	30	$11,919.19	$1,115.01	$8,497.24	$9,612.25	$0.00	$9,612.25
322	10	$15,262.40	$488.40	$13,247.76	$13,736.16	$0.00	$13,736.16
324	13	$9,892.74	$1,293.67	$8,599.07	$9,892.74	($760.98)	$9,131.76
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	**57**	**$43,645.97**	**$3,294.69**	**$36,518.10**	**$39,812.79**	**($760.98)**	**$39,051.81**

Medical and Dental Vision Insurance Premiums
January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,538	$1,447,700.72	$136,354.27	$1,316,894.39	$1,453,248.66	$0.00	$1,453,248.66
403	10,280	$2,639,593.32	$276,534.98	$2,376,789.64	$2,653,324.62	($4,047.79)	$2,649,276.83
404	534	$554,072.75	$17,813.16	$537,295.24	$555,108.40	$4,142.60	$559,251.00
405	949	$931,722.00	$19,732.71	$912,970.05	$932,702.76	($1,961.52)	$930,741.24
406	48	$83,764.80	$33,063.38	$47,211.22	$80,274.60	$0.00	$80,274.60
411	1,773	$3,316,253.76	$176,418.24	$3,119,295.66	$3,295,713.90	$1,867.26	$3,297,581.16
413	1,657	$1,976,292.50	$92,432.46	$1,849,657.29	$1,942,089.75	$0.00	$1,942,089.75
414	134	$263,347.52	$3,851.93	$259,495.59	$263,347.52	($1,965.28)	$261,382.24
418	5,181	$2,626,742.76	$207,777.03	$2,397,352.57	$2,605,129.60	($2,020.96)	$2,603,108.64
419	269	$350,605.71	$6,061.71	$335,554.11	$341,615.82	($1,284.27)	$340,331.55
420	133	$274,418.90	$1,485.57	$274,996.63	$276,482.20	$0.00	$276,482.20
421	9	$8,438.67	$750.11	$7,688.56	$8,438.67	$0.00	$8,438.67
422	224	$429,837.75	$1,681.16	$422,425.42	$424,106.58	$0.00	$424,106.58
423	19	$50,819.87	$8,760.18	$42,059.69	$50,819.87	$0.00	$50,819.87
426	215	$264,316.70	$3,663.58	$260,653.12	$264,316.70	$0.00	$264,316.70
427	166	$330,957.52	$3,668.47	$327,289.05	$330,957.52	$0.00	$330,957.52
428	56	$112,470.96	$1,124.70	$111,346.26	$112,470.96	$0.00	$112,470.96
429	12	$36,045.75	$4,910.84	$25,589.41	$30,500.25	$0.00	$30,500.25
430	131	$255,911.12	$3,477.25	$252,433.87	$255,911.12	$0.00	$255,911.12
431	11	$29,896.46	$4,307.05	$25,589.41	$29,896.46	$0.00	$29,896.46
432	5	$17,411.00	$5,779.45	$11,631.55	$17,411.00	$0.00	$17,411.00
SUBTOTAL	**23,344**	**$16,000,620.54**	**$1,009,648.23**	**$14,914,218.73**	**$15,923,866.96**	**($5,269.96)**	**$15,918,597.00**

Medical and Dental Vision Insurance Premiums

January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Colorado							
450	6	$6,029.22	$1,406.82	$4,622.40	$6,029.22	$0.00	$6,029.22
451	33	$12,098.46	$1,305.15	$11,159.93	$12,465.08	$0.00	$12,465.08
453	1	$2,221.15	$248.72	$1,972.43	$2,221.15	$0.00	$2,221.15
455	1	$1,363.49	$0.00	$1,363.49	$1,363.49	$0.00	$1,363.49
457	10	$7,977.64	$1,392.46	$5,134.70	$6,527.16	$0.00	$6,527.16
458	1	$2,302.38	$0.00	$2,302.38	$2,302.38	$0.00	$2,302.38
SUBTOTAL	**52**	**$31,992.34**	**$4,353.15**	**$26,555.33**	**$30,908.48**	**$0.00**	**$30,908.48**
Kaiser - Georgia							
441	3	$3,493.23	$208.59	$3,284.64	$3,493.23	$0.00	$3,493.23
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	54	$22,046.04	$2,947.62	$19,098.42	$22,046.04	$0.00	$22,046.04
463	3	$6,962.49	$2,031.41	$4,931.08	$6,962.49	$0.00	$6,962.49
465	10	$15,646.70	$938.80	$14,707.90	$15,646.70	$0.00	$15,646.70
466	30	$24,255.60	$1,649.38	$22,606.22	$24,255.60	$0.00	$24,255.60
467	1	$2,721.09	$394.78	$2,326.31	$2,721.09	$0.00	$2,721.09
SUBTOTAL	**120**	**$98,049.46**	**$10,553.12**	**$86,331.93**	**$96,885.05**	**$0.00**	**$96,885.05**

Medical and Dental Vision Insurance Premiums
January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Hawaii							
471	6	$6,019.20	$561.79	$5,457.41	$6,019.20	$0.00	$6,019.20
472	33	$14,173.83	$2,336.51	$11,837.32	$14,173.83	$0.00	$14,173.83
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	4	$5,698.84	$2,678.45	$3,020.39	$5,698.84	$0.00	$5,698.84
478	13	$11,050.26	$782.02	$10,268.24	$11,050.26	$0.00	$11,050.26
SUBTOTAL	**60**	**$44,484.43**	**$6,888.90**	**$37,595.53**	**$44,484.43**	**$0.00**	**$44,484.43**
Kaiser - Oregon							
481	8	$8,701.04	$1,892.47	$6,808.57	$8,701.04	$0.00	$8,701.04
482	81	$30,557.25	$4,798.60	$25,758.65	$30,557.25	($754.50)	$29,802.75
484	2	$4,334.54	$547.47	$3,787.07	$4,334.54	$0.00	$4,334.54
485	1	$3,246.90	$920.59	$2,326.31	$3,246.90	$0.00	$3,246.90
486	10	$14,568.80	$2,156.18	$12,412.62	$14,568.80	$0.00	$14,568.80
488	43	$32,099.50	$3,911.66	$28,187.84	$32,099.50	$0.00	$32,099.50
491	2	$2,759.82	$0.00	$2,759.82	$2,759.82	$0.00	$2,759.82
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	**151**	**$104,325.58**	**$15,277.77**	**$89,047.81**	**$104,325.58**	**($754.50)**	**$103,571.08**
SCAN Health Plan							
611	302	$89,996.00	$18,893.20	$71,996.80	$90,890.00	($894.00)	$89,996.00
613	104	$61,152.00	$9,843.12	$51,308.88	$61,152.00	$0.00	$61,152.00
SUBTOTAL	**406**	**$151,148.00**	**$28,736.32**	**$123,305.68**	**$152,042.00**	**($894.00)**	**$151,148.00**

Medical and Dental Vision Insurance Premiums
January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
UHC Medicare Adv.							
701	1,593	$541,494.79	$67,922.54	$475,945.74	$543,868.28	($1,695.35)	$542,172.93
702	327	$459,000.09	$28,578.65	$426,210.43	$454,789.08	$1,403.67	$456,192.75
703	910	$611,837.82	$64,856.16	$538,939.98	$603,796.14	($670.14)	$603,126.00
704	70	$111,095.60	$6,221.36	$103,287.16	$109,508.52	$0.00	$109,508.52
705	29	$24,752.95	$785.27	$23,967.68	$24,752.95	$0.00	$24,752.95
706	1	$307.71	$12.31	$295.40	$307.71	$0.00	$307.71
SUBTOTAL	**2,930**	**$1,748,488.96**	**$168,376.29**	**$1,568,646.39**	**$1,737,022.68**	**($961.82)**	**$1,736,060.86**
United Healthcare							
707	427	$460,145.40	$44,276.92	$407,287.68	$451,564.60	$1,072.60	$452,637.20
708	374	$736,001.20	$32,253.26	$699,352.20	$731,605.46	$1,957.45	$733,562.91
709	287	$666,012.20	$33,648.68	$632,363.52	$666,012.20	$0.00	$666,012.20
SUBTOTAL	**1,088**	**$1,862,158.80**	**$110,178.86**	**$1,739,003.40**	**$1,849,182.26**	**$3,030.05**	**$1,852,212.31**

Medical and Dental Vision Insurance Premiums
January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	52	$56,063.80	$1,725.03	$54,338.77	$56,063.80	$0.00	$56,063.80
802	277	$538,485.23	$12,985.88	$529,387.33	$542,373.21	$0.00	$542,373.21
803	247	$566,398.17	$18,620.01	$554,308.37	$572,928.38	$2,293.11	$575,221.49
804	170	$183,285.50	$8,991.74	$174,293.76	$183,285.50	($26,287.90)	$156,997.60
805	168	$326,590.32	$10,419.79	$316,170.53	$326,590.32	($24,437.30)	$302,153.02
806	576	$1,119,738.24	$33,708.79	$1,083,219.62	$1,116,928.41	($163,744.89)	$953,183.52
807	36	$82,551.96	$1,651.04	$80,900.92	$82,551.96	($5,359.50)	$77,192.46
808	12	$27,517.32	$183.45	$27,333.87	$27,517.32	($3,754.50)	$23,762.82
809	21	$22,641.15	$3,126.62	$19,514.53	$22,641.15	$0.00	$22,641.15
810	8	$15,551.92	$1,905.11	$13,646.81	$15,551.92	$0.00	$15,551.92
811	5	$11,465.55	$825.52	$10,640.03	$11,465.55	$0.00	$11,465.55
812	225	$242,583.75	$21,045.42	$222,077.40	$243,122.82	($33,605.00)	$209,517.82
SUBTOTAL	**1,797**	**$3,192,872.91**	**$115,188.40**	**$3,085,831.94**	**$3,201,020.34**	**($254,895.98)**	**$2,946,124.36**
Medical Plan Total	**49,193**	**$42,985,872.48**	**$3,336,027.49**	**$39,362,586.99**	**$42,698,614.48**	**($295,395.68)**	**$42,403,218.80**

Medical and Dental Vision Insurance Premiums
January 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	23,302	$1,215,640.96	$141,143.20	$1,083,334.06	$1,224,477.26	($3,222.43)	$1,221,254.83
502	21,459	$2,333,705.40	$185,357.91	$2,136,455.92	$2,321,813.83	($1,307.01)	$2,320,506.82
503	15	$962.25	$150.11	$812.14	$962.25	$0.00	$962.25
SUBTOTAL	**44,776**	**$3,550,308.61**	**$326,651.22**	**$3,220,602.12**	**$3,547,253.34**	**($4,529.44)**	**$3,542,723.90**
CIGNA Dental HMO/Vision							
901	3,251	$150,163.69	$19,520.69	$131,151.09	$150,671.78	($54.02)	$150,617.76
902	2,278	$215,789.16	$19,406.56	$195,342.88	$214,749.44	($283.56)	$214,465.88
903	4	$187.12	$5.61	$181.51	$187.12	$0.00	$187.12
SUBTOTAL	**5,533**	**$366,139.97**	**$38,932.86**	**$326,675.48**	**$365,608.34**	**($337.58)**	**$365,270.76**
Dental/Vision Plan Total	**50,309**	**$3,916,448.58**	**$365,584.08**	**$3,547,277.60**	**$3,912,861.68**	**($4,867.02)**	**$3,907,994.66**
GRAND TOTALS	**99,502**	**$46,902,321.06**	**$3,701,611.57**	**$42,909,864.59**	**$46,611,476.16**	**($300,262.70)**	**$46,311,213.46**

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

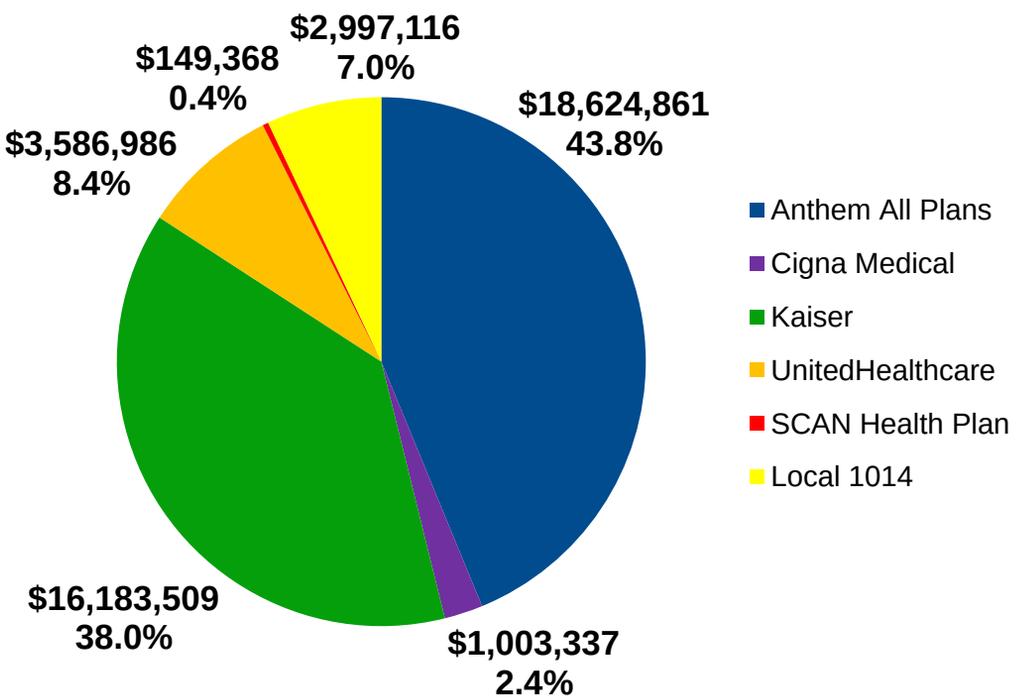
Premium & Enrollment

Coverage Month November 2017

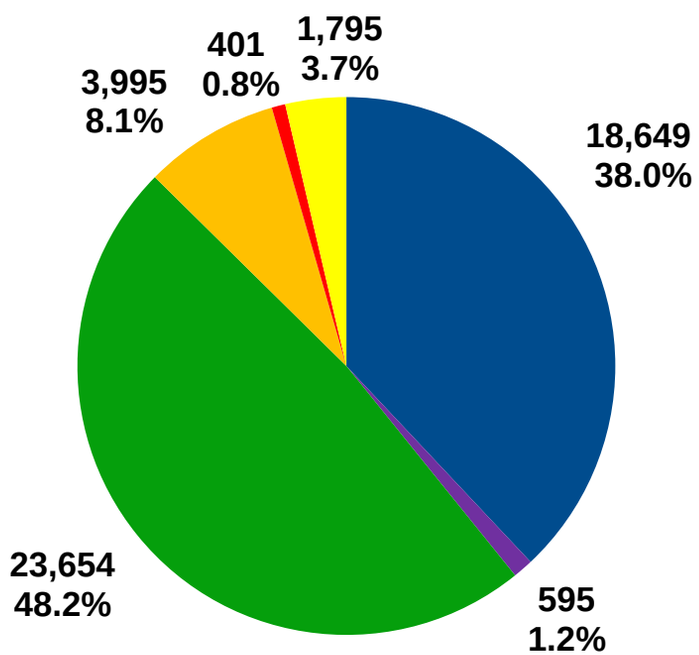
Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$18,624,861	43.8%	18,649	38.0%
Cigna Medical	$1,003,337	2.4%	595	1.2%
Kaiser	$16,183,509	38.0%	23,654	48.2%
UnitedHealthcare	$3,586,986	8.4%	3,995	8.1%
SCAN Health Plan	$149,368	0.4%	401	0.8%
Local 1014	$2,997,116	7.0%	1,795	3.7%
Combined Medical	**$42,545,177**	**100.0%**	**49,089**	**100.0%**

Cigna Dental & Vision (PPO and HMO)	**$3,902,964**	**50,197**

Monthly Premium



Retirees



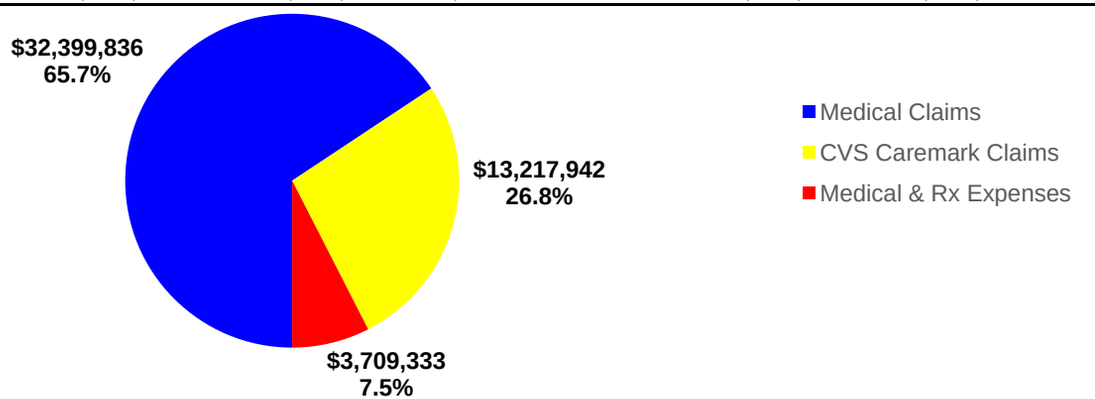
Los Angeles County Employees Retirement Association

Anthem Plans I & II

Coverage Month November 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-17	6,003	$9,296,857	$5,371,906	$2,613,705	$7,985,611	$1,330.27	85.9%	$742,630	$8,728,240	93.9%
Aug-17	6,007	$9,314,660	$8,829,894	$2,744,147	$11,574,041	$1,926.76	124.3%	$743,259	$12,317,300	132.2%
Sep-17	5,994	$9,275,562	$5,646,555	$2,506,725	$8,153,280	$1,360.24	87.9%	$741,988	$8,895,268	95.9%
Oct-17	5,984	$9,267,345	$6,588,991	$2,773,387	$9,362,378	$1,564.57	101.0%	$740,846	$10,103,224	109.0%
Nov-17	5,982	$9,270,299	$5,962,491	$2,579,978	$8,542,469	$1,428.03	92.1%	$740,610	$9,283,079	100.1%
Dec-17										
Jan-18										
Feb-18										
Mar-18										
Apr-18										
May-18										
Jun-18										
YTD Plan Year	29,970	$46,424,723	$32,399,836	$13,217,942	$45,617,779	$1,522.11	98.3%	$3,709,333	$49,327,112	106.3%
12 Month Rollup	72,086	$109,771,230	$77,150,107	$30,740,273	$107,890,380	$1,496.69	98.3%	$11,961,262	$119,851,642	109.2%

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



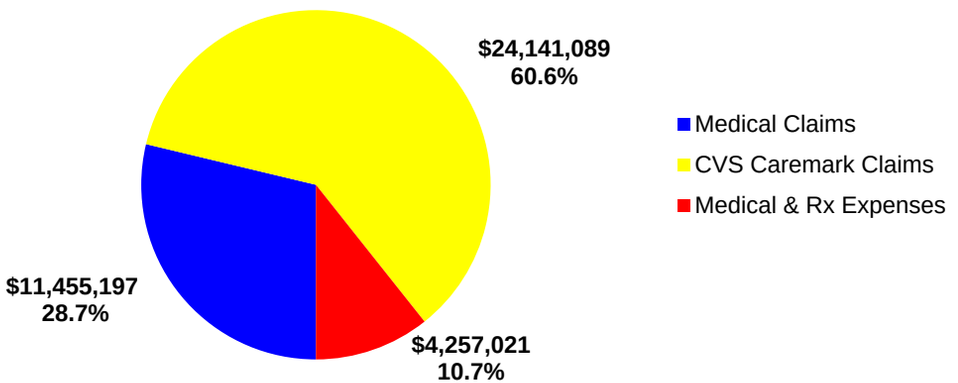
Los Angeles County Employees Retirement Association

Anthem Plan III

Coverage Month November 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-17	11,381	$7,802,939	$1,930,103	$4,624,278	$6,554,380	$575.91	84.0%	$847,547	$7,401,927	94.9%
Aug-17	11,406	$7,865,983	$2,678,326	$4,777,074	$7,455,401	$653.64	94.8%	$849,408	$8,304,809	105.6%
Sep-17	11,443	$7,867,942	$2,286,704	$4,713,992	$7,000,696	$611.79	89.0%	$852,164	$7,852,860	99.8%
Oct-17	11,460	$7,880,228	$2,253,007	$5,010,897	$7,263,904	$633.85	92.2%	$853,430	$8,117,334	103.0%
Nov-17	11,474	$7,906,791	$2,307,058	$5,014,847	$7,321,905	$638.13	92.6%	$854,472	$8,176,378	103.4%
Dec-17										
Jan-18										
Feb-18										
Mar-18										
Apr-18										
May-18										
Jun-18										
YTD Plan Year	57,164	$39,323,884	$11,455,197	$24,141,089	$35,596,286	$622.70	90.5%	$4,257,021	$39,853,307	101.3%
12 Month Rollup	135,791	$91,997,668	$29,255,549	$56,903,831	$86,159,380	$634.50	93.7%	$10,238,963	$96,398,343	104.8%

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



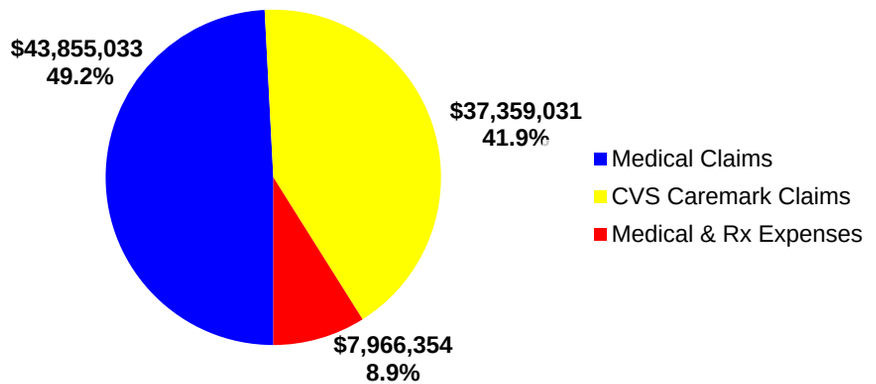
Los Angeles County Employees Retirement Association

Anthem Plans I, II, & III

Coverage Month November 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-17	17,384	$17,099,797	$7,302,008	$7,237,983	$14,539,991	$836.40	85.0%	$1,590,176	$16,130,167	94.3%
Aug-17	17,413	$17,180,643	$11,508,220	$7,521,222	$19,029,442	$1,092.83	110.8%	$1,592,667	$20,622,109	120.0%
Sep-17	17,437	$17,143,504	$7,933,258	$7,220,717	$15,153,976	$869.07	88.4%	$1,594,152	$16,748,127	97.7%
Oct-17	17,444	$17,147,574	$8,841,997	$7,784,284	$16,626,282	$953.12	97.0%	$1,594,276	$18,220,558	106.3%
Nov-17	17,456	$17,177,089	$8,269,549	$7,594,825	$15,864,374	$908.82	92.4%	$1,595,083	$17,459,457	101.6%
Dec-17										
Jan-18										
Feb-18										
Mar-18										
Apr-18										
May-18										
Jun-18										
YTD Plan Year	87,134	$85,748,607	$43,855,033	$37,359,031	$81,214,065	$932.06	94.7%	$7,966,354	$89,180,419	104.0%
12 Month Rollup	207,877	$201,768,898	$106,405,656	$87,644,104	$194,049,760	$933.48	96.2%	$22,200,225	$216,249,985	107.2%

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



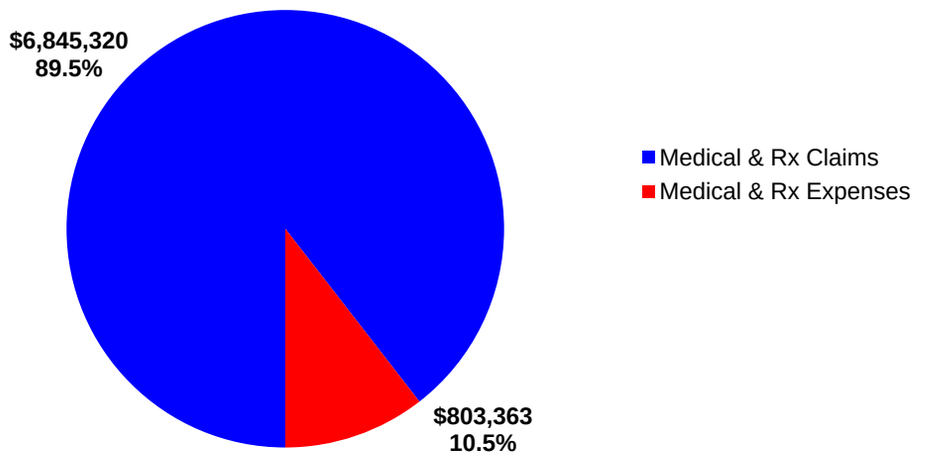
Los Angeles County Employees Retirement Association

Anthem Prudent Buyer

Coverage Month November 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-17	1,232	$1,492,151	$1,099,832	$892.72	73.7%	$163,756	$1,263,589	84.7%
Aug-17	1,217	$1,479,494	$1,531,310	$1,258.27	103.5%	$161,763	$1,693,072	114.4%
Sep-17	1,205	$1,465,281	$1,195,213	$991.88	81.6%	$160,168	$1,355,380	92.5%
Oct-17	1,197	$1,455,738	$1,697,487	$1,418.12	116.6%	$159,104	$1,856,591	127.5%
Nov-17	1,193	$1,447,772	$1,321,479	$1,107.69	91.3%	$158,573	$1,480,051	102.2%
Dec-17								
Jan-18								
Feb-18								
Mar-18								
Apr-18								
May-18								
Jun-18								
YTD Plan Year	6,044	$7,340,436	$6,845,320	$1,132.58	93.3%	$803,363	$7,648,684	104.2%
12 Month Rollup	14,927	$17,827,621	$15,393,774	$1,031.27	86.3%	$2,246,495	$17,640,270	98.9%

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

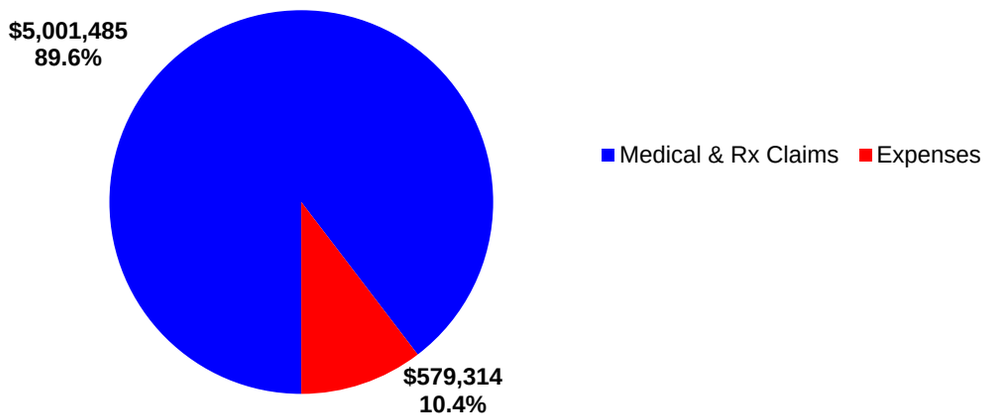
Cigna HMO [1]

Coverage Month November 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-17	553	$975,087	$966,449	$1,747.65	99.1%	$116,133	$1,082,582	111.0%
Aug-17	551	$983,796	$873,851	$1,585.94	88.8%	$117,170	$991,021	100.7%
Sep-17	549	$984,764	$939,360	$1,711.04	95.4%	$117,285	$1,056,645	107.3%
Oct-17	539	$960,763	$1,273,588	$2,362.87	132.6%	$114,427	$1,388,015	144.5%
Nov-17	536	$959,687	$948,237	$1,769.10	98.8%	$114,299	$1,062,535	110.7%
Dec-17								
Jan-18								
Feb-18								
Mar-18								
Apr-18								
May-18								
Jun-18								
YTD Plan Year	2,728	$4,864,097	$5,001,485	$1,833.39	102.8%	$579,314	$5,580,799	114.7%
12 Month Rollup	6,744	$11,673,310	$11,441,129	$1,696.49	98.0%	$1,395,735	$12,836,864	110.0%

[1] Excludes Cigna's HealthSpring Preferred Plan.

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

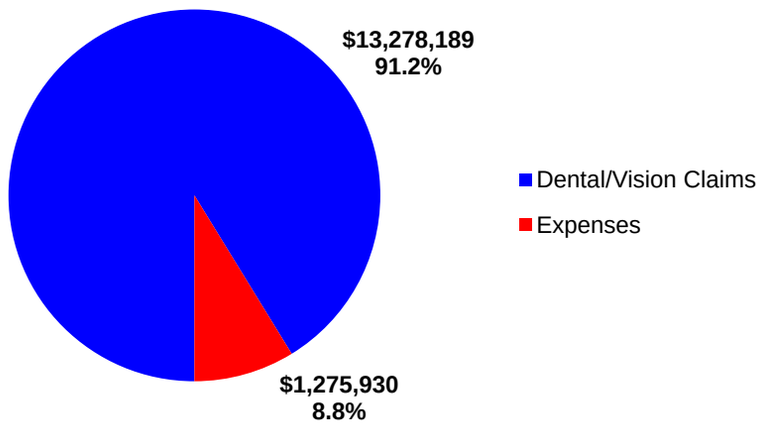
Cigna Dental PPO + Vision

Coverage Month November 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-17	44,382	$3,514,433	$2,517,042	56.8%	$56.71	71.6%	$254,699	$2,771,742	78.9%
Aug-17	44,439	$3,509,103	$2,968,943	56.5%	$66.81	84.6%	$254,313	$3,223,256	91.9%
Sep-17	44,537	$3,521,546	$2,618,579	54.8%	$58.80	74.4%	$255,215	$2,873,794	81.6%
Oct-17	44,600	$3,524,019	$2,729,264	57.1%	$61.19	77.4%	$255,394	$2,984,659	84.7%
Nov-17	44,669	$3,536,624	$2,444,360	57.3%	$54.72	69.1%	$256,308	$2,700,668	76.4%
Dec-17									
Jan-18									
Feb-18									
Mar-18									
Apr-18									
May-18									
Jun-18									
YTD Plan Year	222,627	$17,605,725	$13,278,189	56.5%	$59.64	75.4%	$1,275,930	$14,554,119	82.7%
12 Month Rollup	529,513	$41,392,585	$33,708,631	55.7%	$63.66	81.4%	$2,978,177	$36,686,808	88.6%

Expenses: Cigna Admin Costs and Premium Taxes

Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month November 2017

- Kaiser insures approximately 24,000 LACERA retirees, with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in Southern California.

Category	Current Period 8/1/2016 - 7/31/2017	Prior Period 8/1/2015 - 7/31/2016	Change
Average Members	**8,744**	**8,713**	**0.36%**
Inpatient Claims PMPM	$196.05	$201.41	-2.66%
Outpatient Claims PMPM	$270.17	$252.72	6.90%
Pharmacy	$90.64	$94.09	-3.67%
Other	$107.63	$109.97	-2.13%
Total Claims PMPM	**$664.49**	**$658.19**	**0.96%**
Total Paid Claims	**$69,722,919**	**$68,817,726**	**1.32%**
Large Claims over $400,000 Pooling Point			
Number of Claims over Pooling Point	8	5	
Amount over Pooling Point	$872,808	$1,667,107	-47.65%
% of Total Paid Claims	**1.25%**	**2.42%**	
Inpatient Days / 1000	280.5	348.0	-19.40%
Inpatient Admits / 1000	58.6	73.6	-20.38%
Outpatient Visits / 1000	11,904.8	12,353.0	-3.63%
Pharmacy Scripts PMPY	10.9	11.4	-4.39%