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, APRIL 12, 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:

Les Robbins, Chair
Shawn R. Kehoe, Vice Chair
Herman B. Santos
Gina Zapanta-Murphy
Thomas Walsh, Alternate

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of March 15, 2018

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 Assembly Bill 2004, which would enact the Big Bear Fire Agencies Pension Consolidation Act of 2018. (Memorandum dated March 28, 2018)

B. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement adopt an "Oppose" position on Senate Bill 1031, which would prohibit the payment of cost-of-living adjustments. (Memorandum dated April 2, 2018)

IV. FOR INFORMATION

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

B. Engagement Report for March 2018
Barry W. Lew, Legislative Affairs Officer

C. Staff Activities Report for March 2018
Cassandra Smith, Director, Retiree Healthcare

D. Medical and Dental Claims Audit Findings
MaryAnne Watson, Segal Consulting

- Anthem Medical Plan Audit
- Cigna Dental Plan Audit

E. LACERA Claims Experience
Stephen Murphy, Segal Consulting

F. Federal Legislation
Stephen Murphy, Segal Consulting

(for discussion purposes)

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, MARCH 15, 2018, 10:40 A.M. – 11:10 A.M.

COMMITTEE MEMBERS

PRESENT: Les Robbins, Chair
Herman B. Santos
Gina Zapanta-Murphy
Thomas Walsh, Alternate

ABSENT: Shawn R. Kehoe, Vice Chair

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Marvin Adams
Alan Bernstein
Keith Knox (Chief Deputy to Joseph Kelly)
William Pryor

STAFF, ADVISORS, PARTICIPANTS

Cassandra Smith Barry Lew
Steven Rice

Segal Consulting

Stephen Murphy

The meeting was called to order by Chair Robbins at 10:40 a.m. Due to the absence of Mr. Kehoe, the Chair announced that Mr. Walsh, 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 February 15, 2018

Mr. Santos made a motion, Mr. Walsh seconded, to approve the minutes of the regular meeting of February 15, 2018. The motion passed unanimously.

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:

1. Approve a visit with Congress by Board members and staff during the week of May 21, 2018 in Washington D.C.;
2. Approve the attached "LACERA Overview and Priorities"; and
3. Approve reimbursement of all travel costs incurred in accordance with LACERA's Education and Travel Policy.

(Memorandum dated March 7, 2018)

The recommendation to be amended that, in the event of more than two Board members wishing to attend, the Board Chair would designate which two members would be attending.

Mr. Santos made a motion, Mr. Walsh seconded, to approve the recommendation as amended. The motion passed unanimously.

B. 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 1270, which relates to the appointment of assistant administrators and chief investment officers. (Memorandum dated March 1, 2018)

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

IV. FOR INFORMATION

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

Mr. Lew provided a summary of the final informational hearings related to Senate Bill 562, which would enact the Healthy California Act and establish a universal single-payer health care system in California.

B. Engagement Report for February 2018
Barry W. Lew, Legislative Affairs Officer

The engagement report was discussed.

C. Staff Activities Report for February 2018
Cassandra Smith, Director, Retiree Healthcare

The staff activities report was discussed.

D. LACERA Claims Experience
Stephen Murphy, Segal Consulting

The LACERA Claims Experience reports through January 2018 were discussed.

E. Federal Legislation
Stephen Murphy, Segal Consulting

(for discussion purposes)

Segal Consulting gave an update on federal legislation.

V. REPORT ON STAFF ACTION ITEMS

There was nothing to report on for staff action items.

VI. GOOD OF THE ORDER

(For information purposes only)

VII. ADJOURNMENT

The meeting adjourned at 11:10 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

March 28, 2018

TO: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Shawn R. Kehoe, Vice Chair
Herman B. Santos
Gina Zapanta-Murphy
Thomas Walsh, Alternate

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: April 12, 2018 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Assembly Bill 2004—Big Bear Fire Agencies Pension Consolidation Act of 2018**

Author: *Obernolte [R]*
Sponsor: *Author-sponsored*
Introduced: *February 1, 2018*
Status: *In SENATE. Read first time. (03/22/2018)*

Staff Recommendation: *Watch*

RECOMMENDATION
That the Insurance, Benefits and Legislative Committee recommend that the Board of Retirement adopt a "Watch" position on Assembly Bill 2004, which would enact the Big Bear Fire Agencies Pension Consolidation Act of 2018.

LEGISLATIVE POLICY/ENGAGEMENT POLICY STANDARD
A "Watch" position indicate that the legislative 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 (CERL). AB 2004 would add provisions to CERL that apply only to the San Bernardino County Employees' Retirement Association.

SUMMARY
AB 2004 would enact the Big Bear Fire Agencies Pension Consolidation Act of 2018, which would authorize the Board of Retirement of the San Bernardino County Employees' Retirement Association (SBCERA) to consent to membership of the Big Bear Fire Authority in the retirement association.

ANALYSIS

Existing Law

CERL authorizes the boards of retirement of the counties of Los Angeles, Orange, San Bernardino, and Kern to enter into agreements with the California Public Employees' Retirement System (CalPERS) for termination of a contracting agency's participation in CalPERS and transfer into the county retirement system of safety members of the contracting agency. The agreements provide for the transfer of members' service credit and contributions from CalPERS to the county retirement system.

From 1995 to 2002, LACERA has received transfers of certain CalPERS safety members whose contracting agencies' firefighting and law enforcement functions were assumed by the County of Los Angeles. Examples of these agencies include Azusa, Bell, Claremont, Glendora, Pomona, Hawthorne, Covina, El Monte, Gardena, and Inglewood.

This Bill

The Big Bear Fire Authority is a joint powers authority established by the Big Bear City Community Services District and the Big Bear Lake Fire Protection District in order to consolidate fire department administration and jurisdictions. The Big Bear Fire Authority would be a participating district in SBCERA upon adoption of a resolution by SBCERA's Board of Retirement.

Employees of the Big Bear Lake Fire Protection District are members of CalPERS for whom existing law provides for the transfer of membership from CalPERS to SBCERA.

The Big Bear Lake Fire Protection District is a subsidiary district of the City of Big Bear Lake, which is currently a participating district in SBCERA. AB 2004 would enable safety employees currently employed by the Big Bear Lake Fire Protection District (and who are members of SBCERA) to be deemed employees of the Big Bear Fire Authority. The status of the safety employees with respect to membership in SBCERA would be as if the employees remained members of SBCERA without any break in service or change of employer.

The Big Bear Fire Authority would be deemed to be a district under CERL and would assume all of the rights, obligations, and status of the city safety plan, which is the portion of the City of Big Bear Lake's retirement plan that covers the safety employees of the Fire Protection District. AB 2004 would provide that the termination of the city safety plan would not trigger a withdrawal liability since the Fire Authority would assume the prior obligations of the city safety plan as if no change in the participating employer had occurred.

The Fire Authority would also assume the rights, duties, and obligations of the city safety plan's replacement benefit plan. AB 2004 would provide that the rights of

members in the retirement system to participate in the replacement benefits plan would be as if there had been no change to the status of the employer. The Fire Authority's assumption of the replacement benefits plan would not be deemed to be the creation or offering of a new replacement benefits plan, which is prohibited under the California Public Employees' Pension Reform Act of 2013.

AB 2004 would facilitate the transfer of employment of SBCERA members from the Big Bear Lake Fire Protection District to the Big Bear Fire Authority.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE recommend that the Board of Retirement adopt a "Watch" position on Assembly Bill 2004, which would enact the Big Bear Fire Agencies Pension Consolidation Act of 2018.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachments
Attachment 1—Board Positions Adopted on Related Legislation
Attachment 2—Support And Opposition
AB 2004 as introduced on February 1, 2018

BOARD POSITIONS ADOPTED ON RELATED LEGISLATION

AB 868 (Chapter 86, Statutes of 2015) authorized the San Bernardino County Employees' Retirement Association to accept transfers of safety members from the California Public Employees' Retirement System. The Board of Retirement adopted a "Watch" position.

AB 2819 (Chapter 419, Statutes of 1990) authorized LACERA to accept transfers of safety members from the California Public Employees' Retirement System. AB 2819 was sponsored by LACERA.

SUPPORT
None

OPPOSITION
None

ASSEMBLY BILL No. 2004

Introduced by Assembly Member Obernolte

February 1, 2018

An act to add Article 4.5 (commencing with Section 31570) to Chapter 3 of Part 3 of Division 4 of Title 3 of the Government Code, relating to public employee retirement, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 2004, as introduced, Obernolte. Big Bear Fire Agencies Pension Consolidation Act of 2018.

The County Employees Retirement Law of 1937 authorizes a county to establish a retirement system, as specified, in order to provide pension benefits to county, city, and district employees. Under that law, all officers and employees of a district become members of the county's retirement association on the first day of the calendar month after adoption, by specified vote thresholds, of a resolution by the governing body of the district providing for inclusion of the district in the retirement association and, if the county board of supervisors is not the governing body of the district, the board of retirement consents by majority vote.

This bill would enact the Big Bear Fire Agencies Pension Consolidation Act of 2018, which, on and after the effective date of a resolution of the Board of Retirement of the San Bernardino County Employees' Retirement Association consenting to membership by employees of the Big Bear Fire Authority as described above, would provide that all safety employees currently employed by the Big Bear Lake Fire Protection District as of that date would be deemed to be

employees of the authority and that all duties and obligations of the fire protection district in the employment relationship would be assumed by the authority. The bill would specify that the authority is a "district" for purposes of the County Employees Retirement Law of 1937. The bill would provide that the authority would assume the rights, obligations, and status previously occupied by the City of Big Bear Lake with regard to the portion of the city safety plan, which is that portion of the city's retirement plan that covers safety employees of the fire protection district, and to the replacement benefits program. The bill would also provide that termination of the city safety plan would not trigger withdrawal liability. The bill would state that its provisions are severable.

This bill would make legislative findings and declarations as to the necessity of a special statute for the County of San Bernardino.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $^2/_3$. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. Article 4.5 (commencing with Section 31570) is added to Chapter 3 of Part 3 of Division 4 of Title 3 of the Government Code, to read:

Article 4.5. Big Bear Fire Agencies Pension Consolidation Act of 2018

31570. It is the intent of the Legislature that this article authorize the Big Bear Fire Authority to assume all of the revenues, debts, obligations, and liabilities of the City of Big Bear Lake's safety plan, which covers the employees of the Big Bear Lake Fire Protection District.

31571. This article shall be known, and may be cited, as the Big Bear Fire Agencies Pension Consolidation Act of 2018.

31572. For purposes of this article, the following definitions apply:

(a) "Authority" means the Big Bear Fire Authority, which is a joint powers authority established by the Big Bear City Community Services District and the Big Bear Lake Fire Protection District

pursuant to the Joint Exercise of Powers Act (Chapter 5 (commencing with Section 6500) of Division 7 of Title 1) in 2012.

(b) "City" means the City of Big Bear Lake.

(c) "City safety plan" means that portion of the city's retirement plan through the San Bernardino County Employees' Retirement Association that covers the safety employees of the fire protection district.

(d) "Fire protection district" means the Big Bear Lake Fire Protection District.

31573. (a) On and after the effective date of a resolution of the Board of Retirement of the San Bernardino County Employees' Retirement Association consenting to membership of the authority's employees pursuant to subdivision (b) of Section 31557, all safety employees currently employed by the fire protection district as of that date shall be deemed to be employees of the authority, and all duties and obligations of the fire protection district in the employment relationship shall be assumed by the authority. The status of each employee deemed to be an employee of the authority pursuant to this section, with respect to membership in the retirement system, shall, in all respects, be as if the employee had remained a member of the retirement system without any break in service or change of employer. The authority shall be deemed to be a "district," as defined in this chapter, and shall, in all respects, assume all of the rights, obligations, and status previously occupied by the city, with regard to the city safety plan, as a participating district in the retirement system, including, but not limited to, all of the following: the payment of employer contributions, the payment of unfunded actuarial liability, the withholding of employee contributions, the reporting of compensation earnable and pensionable compensation, record retention and audit compliance, the enrollment of eligible employees as members of the retirement system, compliance with restrictions on the employment of retired persons, and the pickup of employee contributions pursuant to Section 414(h)(2) of the Internal Revenue Code and any agreement or resolution implementing that section.

(b) The termination of the city safety plan shall not trigger withdrawal liability pursuant to Section 31564.2. The authority shall assume the prior obligations of the city safety plan for the payment of unfunded actuarial liability, which shall continue to

be included in contribution rates calculated and approved pursuant to this chapter, including, but not limited to, Sections 31453, 31453.5, 31454, 31581, and 31585, as if no change in the participating employer had occurred.

(c) The authority shall succeed to the rights, duties, and obligations of the city safety plan with respect to its replacement benefits program pursuant to Chapter 3.9 (commencing with Section 31899). The rights of each member of the retirement system to participate in the replacement benefits program, as those rights exist at the time of the transfer of rights, duties, and obligations to the authority pursuant to this section, whether the member is actively employed, deferred, or retired, shall continue as if there had been no change in the status of the employer. The transfer of rights, duties, and responsibilities shall not be deemed to be the creation of a new replacement benefit program and the continuation of employees' rights pursuant to this section shall not be deemed the offering of a new plan to any employee for purposes of Section 7522.43 or subdivision (c) of Section 31899.

SEC. 2. 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. 3. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances regarding pension and employment obligations relating to fire protection services for the City of Big Bear Lake in the County of San Bernardino.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to facilitate the transfer of employment from the Big Bear Lake Fire Protection District to the Big Bear Fire Authority in a timely and expeditious manner, it is necessary that this act take effect immediately.

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LACERA

April 2, 2018

TO: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Shawn R. Kehoe, Vice Chair
Herman B. Santos
Gina Zapanta-Murphy
Thomas Walsh, Alternate

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: April 12, 2018 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Senate Bill 1031—Cost-of-Living Adjustments**
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Author: *Moorlach [R]*
Sponsor: *Author-sponsored*
Introduced: *February 8, 2018*
Status: *To SENATE Committee on PUBLIC EMPLOYMENT & RETIREMENT (02/22/2018)*

Staff Recommendation: *Oppose*

RECOMMENDATION
That the Insurance, Benefits and Legislative Committee recommend that the Board of Retirement adopt an "Oppose" position on Senate Bill 1031, which would prohibit the payment of cost-of-living adjustments.

LEGISLATIVE POLICY STANDARD
The Board of Retirement's legislative policy standard is to oppose proposals that infringe on the Board's plenary authority or fiduciary responsibility. The Board also opposes proposals that deprive members of vested benefits (Legislative Policy, page 6).

SUMMARY
SB 1031, as introduced on February 8, 2018, would prohibit a public retirement system from making a cost-of-living adjustment to any allowance if the unfunded actuarial liability of the system is greater than 20 percent.

ANALYSIS
Existing Law
Plan A members are entitled to a maximum cost-of-living adjustment (COLA) of 3 percent each year for their retirement allowances payable April 1. Plan B, C, D, and G members are entitled to a maximum COLA of 2 percent each year. Plan E members are entitled to a maximum COLA of 2 percent each year, prorated for service credit earned

on and after June 4, 2002. The COLAs are cumulative and compounded by future increases.

The Board of Retirement determines before April 1 each year whether there has been an increase or decrease in the cost of living based on the Bureau of Labor Statistics Consumer Price Index (CPI) for All Urban Consumers for the Los Angeles-Long Beach-Anaheim, California area. If the change in the CPI exceeds the maximum COLA payable, the increase is accumulated for payment in future years in which the change in CPI is below the maximum COLA payable.

If the COLA accumulation percentage equals or exceeds 20 percent (i.e., the member has lost 20 percent or more of purchasing power), the Board of Retirement may provide a supplemental COLA known as the Supplemental Target Adjustment for Retirees (STAR COLA). From 1990 to 2000, a STAR COLA was paid to members whose retirement allowances lost 25 percent or more of purchasing power and thus restored the allowance to 75 percent of its purchasing power. During this period, the STAR COLA was an ad hoc benefit that was paid for that calendar year only and was not a permanent benefit that was added to the member's base allowance that would be subject to compounding by future COLAs. Beginning in 2001, the STAR COLA benefit was increased to restore 80 percent of purchasing power, and each STAR COLA benefit was a permanent benefit subject to compounding by future COLAs.

This Bill
SB 1031 would prohibit a COLA payment to any retirement allowance for any year beginning on or after January 1, 2019 in which the unfunded actuarial liability of the system is greater than 20 percent. The determination of the unfunded actuarial liability is based on the plan actuary's calculations as presented in the actuarial valuation report and then reported in the Comprehensive Annual Financial Report (CAFR). If a retirement system's unfunded liability is greater than 20 percent (i.e., the funded ratio is below 80%), then the prohibition on the payment of the COLA would apply to the calendar year following the fiscal year of the CAFR in which the unfunded actuarial liability is reported.

SB 1031's method of applying the unfunded actuarial liability to determine the retirement system's ability to provide benefits lacks precision and is ambiguous. Generally, the unfunded actuarial liability is expressed as a dollar amount rather than a percentage. The actuarial value of assets compared to the actuarial accrued liability results in a funded ratio that expresses the funding adequacy of the plan as a percentage. For example, if the actuarial value of assets covers 85 percent of the actuarial accrued liability, then a plan's funded ratio at that point in time is 85 percent. Moreover, this convention of expressing a plan's funded ratio (rather than an unfunded ratio of 15 percent) is consistent with how that information is prepared by the actuary and presented in the CAFR. Although plan experience impacts the funded ratio

calculation, the plan's actual investment returns can be a significant factor determining the funded ratio, which is independent of COLA awards. SB 1031's use of an unfunded ratio may lead to confusion by stakeholders of a plan's funded status.

If enacted, SB 1031 would apply to all existing retirees, not just employees who become new members on or after January 1, 2019 (the effective date of SB 1031), and raise the issue of vested rights as a result of prohibiting the payment of COLAs for those who became members before January 1, 2019 and were funding their COLA benefit throughout their careers. More specifically, a portion of each contributory member's contribution every pay period is designated to fund a basic benefit and a COLA benefit.

The vested rights issue in SB 1031's prohibition on paying COLAs is particularly problematic for Plan E members. The COLA for Plan E members is prorated based on service credit earned on and after June 4, 2002. Since Plan E is a noncontributory plan and its members do not pay normal contributions, the Plan E retirement allowance and COLA is funded by employer contributions only. However, Plan E members may purchase an Elective COLA for service credit earned before June 4, 2002 by paying an actuarially equivalent cost for the benefit such that no Elective COLA liability is borne by the plan sponsor and results in no diminution of the retirement system's funded ratio. Thus, a Plan E member who purchases an Elective COLA has paid an actuarially equivalent amount to fully fund his or her COLA for service credit earned before June 4, 2002. SB 1031 would prohibit the payment of the Elective COLA and deny Plan E members their Elective COLA benefit based on the funded ratio of the plan as a whole, despite the fact that the cost of the Elective COLA paid for by the member included an assumption that it would not diminish the retirement system's funded ratio.

SB 1031 would also have the effect of increasing the COLA accumulation percentage at a faster rate than under existing law, assuming COLAs are prohibited from being paid. Any increases in the CPI would not result in a COLA payment and would instead be accumulated. Moreover, any decreases in the CPI below the maximum COLA percentage would not result in a decrease in the COLA accumulation to enable payment of the maximum COLA. Although the prohibition on paying COLAs may have the effect of improving the plan's funded ratio, it would also have the effect of accelerating the erosion of the retirees' purchasing power and shift the burden of maintaining the purchasing power of retirees from the normal COLA to the STAR COLA, which was intended to supplement the normal COLA by maintaining purchasing power of 80 percent. The increased funding pressure on the STAR COLA may in turn cause a reduction in the percentage of purchasing power that the STAR COLA is able to fund.

Although SB 1031 does not reduce the *amount* of a member's base retirement benefit, it has the effect of reducing the *value* of that benefit by prohibiting the replacement of that benefit's purchasing power. Thus, not only does the bill raise vested rights issues, it also infringes on the Board of Retirement's plenary authority and fiduciary responsibility

in effectuating the purpose of CERL (pursuant to Government Code Section 31541), which is to recognize a public obligation to county employees who become incapacitated by age or long service by providing retirement security and to provide a means by which incapacitated employees may be replaced by more capable employees to the betterment of public service without prejudice and without inflicting hardship upon the employees removed.

SB 1031 does not apply to the retirement systems created by the University of California, charter counties, or charter cities. The charter counties with retirement systems under CERL include Alameda, Fresno, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, and San Mateo. However, these charter counties (as well as the University of California and charter cities) may elect to make SB 1031 applicable.

The County of Los Angeles became a charter county on June 2, 1913 and established LACERA on January 1, 1938. Although LACERA is not subject to SB 1031 unless the County of Los Angeles elects to make it applicable, SB 1031 has the potential to deprive members of vested benefits and infringe on the Board of Retirement's plenary authority and fiduciary responsibility.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE recommend that the Board of Retirement adopt an "Oppose" position on Senate Bill 1031, which would prohibit the payment of cost-of-living adjustments.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachments
Attachment 1—Board Positions Adopted on Related Legislation
Attachment 2—Support And Opposition
SB 1031 (Moorlach) as introduced on February 8, 2018

cc: Robert Hill
James Brekk
John Popowich
Bernie Buenaflor
Steven P. Rice
Beulah Auten
Ted Granger
Joe Ackler, Ackler & Associates

BOARD POSITIONS ADOPTED ON RELATED LEGISLATION

SB 32 (2017, died) would have enacted the California Public Employees' Pension Reform Act of 2018. Among other provisions, the bill would have prohibited a public retirement system from making a cost-of-living adjustment to any allowance payable to a member or beneficiary on or after January 1, 2018 if the unfunded actuarial liability of the California Public Employees' Retirement System or the California State Teachers' Retirement System was greater than zero. The Board of Retirement adopted a "Watch" position. (Note: The Insurance, Benefits and Legislative Committee recommended an "Oppose unless amended" position, but SB 32 failed passage in the Senate Committee on Public Employment and Retirement before the Board of Retirement's regularly scheduled meeting.)

SUPPORT
None

OPPOSITION
California State Teachers' Retirement System

(Note: SB 1031 has been referred to the Senate Committee on Public Employment and Retirement. However, the Committee has not yet released a bill analysis indicating officially registered support or opposition from interested parties. CalSTRS considered SB 1031 at its meeting on March 29, 2018 and adopted an "Oppose" position.)

SENATE BILL No. 1031

Introduced by Senator Moorlach

February 8, 2018

An act to add Section 7522.45 to the Government Code, relating to public employees' retirement.

LEGISLATIVE COUNSEL'S DIGEST

SB 1031, as introduced, Moorlach. Public employees' retirement: cost-of-living adjustments: prohibitions.

The Public Employees' Retirement Law establishes the Public Employees' Retirement System and the Teachers' Retirement Law establishes the State Teachers' Retirement System for the purpose of providing pension benefits to specified public employees and teachers. Existing law establishes the Judges' Retirement System II, which provides pension benefits to elected judges, and the Legislators' Retirement System, which provides pension benefits to elective officers of the state other than judges and to legislative statutory officers. The County Employees Retirement Law of 1937 authorizes counties to establish retirement systems pursuant to its provisions in order to provide pension benefits to county, city, and district employees. Existing law provides for the application of cost-of-living adjustments to allowances paid to persons retired under, or survivors or beneficiaries of persons retired under, various public retirement systems. The California Public Employees' Pension Reform Act of 2013, on and after January 1, 2013, requires a public retirement system, as defined, to modify its plan or plans to comply with the act and, for its purposes, defines pensionable compensation, establishes limits on benefits, and requires the sharing of normal costs between members and employers for the pension systems to which it applies.

The bill would prohibit a public retirement system, as defined, from making a cost-of-living adjustment to any allowance payable to, or on behalf of, a person retired under the system, or to any survivor or beneficiary of a member or person retired under the system, for any year beginning on or after January 1, 2019, in which the unfunded actuarial liability of that system is greater than 20%. The bill would require that the determination of unfunded actuarial liability be based on a specified financial report and would apply the prohibition on cost-of-living adjustments, if any, to the calendar year following the fiscal year upon which the report is based.

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

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

SECTION 1. Section 7522.45 is added to the Government Code, to read:

7522.45. (a) For purposes of this section:

(1) "Public retirement system" means the Public Employees' Retirement System, the State Teachers' Retirement System, the Legislators' Retirement System, the Judges' Retirement System, the Judges' Retirement System II, county and district retirement systems created pursuant to the County Employees Retirement Law of 1937 (Chapter 3 (commencing with Section 31450) of Part 3 of Division 4 of Title 3), independent public retirement systems, and individual retirement plans offered by public employers.

(2) Notwithstanding paragraph (1), "public retirement system" does not include a retirement system created by an entity described in Section 9 of Article IX of, or Section 4 or 5 of Article XI of, the California Constitution, except to the extent that the entity elects to make this section applicable to the entity.

(b) (1) Notwithstanding any other law, except as otherwise required by Section 9 of Article I of the California Constitution, a public retirement system shall not make a cost-of-living adjustment to any allowance payable to, or on behalf of, a person retired under the system, or to any survivor or beneficiary of a member or person retired under the system, for any year beginning on or after January 1, 2019, in which the unfunded actuarial liability of the system is greater than 20 percent. If a system is found to have an unfunded liability of greater than 20 percent

pursuant to the comprehensive annual financial report described in paragraph (2), the prohibition on cost-of-living adjustments shall apply to the calendar year following the fiscal year upon which the report is based.

(2) For purposes of paragraph (1), the determination of unfunded actuarial liability shall be based upon the comprehensive annual financial report that Section 7503 requires each state or local public retirement system to create.

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LACERA

April 2, 2018

FOR INFORMATION ONLY

TO: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Shawn R. Kehoe, Vice-Chair
Herman Santos
Gina Zapanta-Murphy
Thomas Walsh, Alternate

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: April 12, 2018 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Single-Payer Healthcare Update**

This memo provides information regarding the report issued by the Assembly Select Committee on Health Care Delivery Systems and Universal Coverage entitled "A Path to Universal Coverage and Unified Health Care Financing in California." Staff provides this memo for informational purposes only and not for action. No inference should be drawn as to the impact on LACERA's retiree health care program. The Retiree Healthcare Division will separately, at the appropriate time and as necessary, provide information to the Board on the impact of this legislation on LACERA.

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. Although SB 562 discusses accommodation of employer retiree health benefits, the implications on LACERA are unclear with regard to out-of-state retirees, alignment of benefits between SB 562 and the retiree healthcare program, and funding from public sector sponsors of retiree healthcare plans. The Board of Retirement adopted a "Watch" position on SB 562.

The Select Committee held a series of hearings from October 2017 to February 2018 and contracted with the University of California San Francisco to provide a report to the Select Committee summarizing the hearings, including any findings and potential options.

A PATH TO UNIVERSAL COVERAGE AND UNIFIED HEALTH CARE FINANCING IN CALIFORNIA

The report recognizes that the transition to a publicly financed universal health care system would be substantially more disruptive than building upon the foundations of the current system. Even if California were to embark on the transition, it would take years to fulfill state and federal requirements necessary for a publicly financed system. The report examines the short-term steps and a roadmap for future steps California can take in this process.

SHORT-TERM STEPS TO IMPROVE COVERAGE, AFFORDABILITY, ACCESS, FRAGMENTATION AND TRANSPARENCY

Improve Coverage

Medi-Cal covers low-income undocumented children and could be expanded to income-eligible undocumented adults. This would target the largest group of individuals who remain uninsured in California and who would potentially be included in a universal coverage system.

The Covered California premium tax credit assistance could be extended to undocumented individuals using state funds. This would target the portion of the undocumented uninsured population whose income is too high to qualify for Medi-Cal but who would be eligible for federal insurance subsidies but for their immigration status.

Improve Affordability

There are approximately 1 million uninsured in California who are citizens or legal residents. More than two-thirds are eligible for Medi-Cal or federal subsidies under Covered California, and these numbers are expected to grow in 2019 with the repeal of the tax penalty under the individual mandate. California could take steps such as increasing outreach to individuals who are eligible for Medi-Cal or federal subsidies to purchase insurance, enhancing coordination between Medi-Cal and Covered California to mitigate churn, using state funds to further reduce financial barriers for those who are above 400 percent of the federal poverty limits for federal subsidies, and implementing a state individual mandate with a tax penalty to incentivize participation.

Another proposal is limiting out-of-network prices for hospitals to a specified ratio of the price that would be paid by Medicare for similar services. The theory is that limiting out-of-network prices would result in a reduction of in-network prices for those hospitals that have negotiated prices above the specified ratio.

Improve Access

The implementation of the Affordable Care Act resulted in an expansion of the Medi-Cal program, but the number of available physicians has not kept pace with the expansion. Physicians indicate low reimbursement rates as a reason they do not participate in the

program. Increasing Medi-Cal payment rates may help increase physician capacity and consequently access to care for Medi-Cal enrollees.

Most areas of California have healthy plan competition in the individual market, and there are no areas in which there is not at least one option. Exploring a Medicaid Public Option in the individual market could protect against erosion of coverage if insurers were to leave any regional market.

Simplify the Consumer Choice Process
Requiring each fully-insured product in the large group market to be either a bronze, silver, gold, or platinum plan as defined by Covered California could bring greater uniformity that would focus competition among insurers on price and quality. However, greater uniformity may also eliminate opportunities for employers to experiment with innovation in coverage options and payment structures. ERISA preemption would likely exempt self-insured employers from this requirement.

Increase Transparency
Requiring hospitals and larger medical groups to post information on average prices received from people covered by employer-sponsored insurance, Covered California, Medicare, and Medi-Cal would result in greater transparency in prices that may lead to lower prices.

The establishment of an All-Payer Claims Database would be useful in monitoring and improving cost and quality of care and would facilitate management of a system of unified public financing. ERISA preemption issues would arise with respect to obtaining claims data from self-insured plans.

A ROADMAP FOR A BROADER TRANSFORMATION OF CALIFORNIA'S HEALTH CARE SYSTEM
If the California Legislature were to embrace the goal of universal coverage, the report recommends that the Legislature establish a planning commission responsible for advancing progress toward universal coverage. The planning commission would engage in the following activities:

1. Convene a stakeholder engagement process to design coverage and benefit packages, eligibility rules, provider payment rules, and quality assurance and improvement. The process would also examine the role of local governments and whether there should be devolution of decision-making authority from the state to local governments.

2. Establish data collection and reporting efforts to support management, evaluation, transparency, and public accountability. For example, an All-Payer Claims Database can be used to support monitoring and decision-making.

3. Model state budgetary implications and assess options for raising and managing revenues as well as consideration of costs based on different plan designs.

4. Make recommendations to the Legislature on plan design and coordinate with the Legislature on enabling legislation and necessary ballot propositions.

5. Prepare the state to seek federal waivers and statutory changes by preparing waiver requests and proposing changes to federal law.

6. Develop the scope and budget for an information technology system to administer the universal health care system and for a financial management system to manage an annual health care budget of $300 to $400 billion.

7. Coordinate and partner with nongovernmental entities such as foundations, nonprofits, consumer advocacy organizations, and University of California faculty to educate the public about cost, access, and quality of care under the current system and opportunities for improvement under a universal coverage system.

The report notes that even if federal statutory changes and waiver approvals are currently in place, it would take at least two years, and more likely three or four years, to implement a system of universal coverage through public financing. The roadmap provides a structure for overseeing the many tasks that must be completed to establish a universal coverage system in California.

CONCLUSION
The Assembly Select Committee is a fact-finding committee and held its series of hearings for the purpose of exploring strategies for universal coverage in California. The Select Committee is not a policy committee and does not have the authority to pass SB 562 to the full Assembly. SB 562 is currently held in the Assembly Rules Committee, pending assignment to a policy committee. The legislative deadline for SB 562 to pass out of a policy committee is April 27, 2018. Staff will continue to monitor SB 562.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

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

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
MARCH 2018
FOR INFORMATION ONLY

Millennials and Retirement: Already Falling Short

A report by the National Institute on Retirement Security examines the retirement outlook for the Millennial generation (those born between 1981 and 1991), which numbers 83.2 million. It is the largest, best educated, and most diverse generation in U.S. history. The generation is expected to live longer than the Baby Boomers and GenX and is challenged with having a lower income replacement from Social Security and a lower likelihood of having a defined benefit pension.

The report examines the challenges posed by the current retirement system in the U.S. for working Millennials between the ages of 21 to 32. The key findings of the report are as follows:

1. Two-thirds of working Millennials have nothing saved for retirement.
2. Only five percent of working Millennials are saving adequately for retirement.
3. Although two-thirds of Millennials have access to an employer-sponsored retirement plan, only about one-third participate in an employer plan.
4. A significant gap exists between Millennial Latinos and other racial/ethnic groups in participation in employer-sponsored retirement plans.
5. Four out of ten Millennials cite eligibility requirements as a reason for not participating in a retirement plan.
6. Across all racial/ethnic groups, more than nine out of ten Millennials actually participate in employer-sponsored retirement plans, when they're eligible to participate.

Some of the policy options that may be of benefit include:

1. Expanding defined contribution plan eligibility for part-time workers.
2. Reducing waiting periods for workers to become eligible to participate.
3. Increasing auto-enrollment into plans.
4. Increasing employer matches and default contribution rates.
5. Providing education increasing awareness of benefits of the employer match.
6. Promoting and educating Millennials about the Savers Credit (non-refundable income tax credit).
7. Protecting and strengthening Social Security. (Source)

Plan Sponsor Council of America Study on Automatic Features
The PSCA released its 60th Annual Survey of Profit Sharing and 401(k) Plans. About 60 percent of plans have an automatic enrollment feature in 2016 compared to 35 percent in 2007. Automatic enrollment is most common in large plans: 70 percent of plans with 5,000 or more participants compared with 34 percent of plans with less than 50 participants. Three-fourths of plans with automatic enrollment also have automatic escalation of default deferral rates over time. (Source)

Kentucky Pension Reform
A pension reform bill on teachers' pensions in Kentucky was passed after its provisions were included in another bill that was gutted and amended during the remaining three days of the legislative session. Certain stakeholders objected that the bill did not include an actuarial analysis, fiscal impact statement, or opportunities for hearings and testimony. The bill did not include certain provisions that teachers found objectionable in previous versions of the bill such as reduction of cost-of-living adjustments for retired teachers and changing the service requirement for full retirement benefits.

Instead, the new bill will move future teachers from the current defined benefit plan into a new "hybrid" cash balance plan that includes features of defined benefits and 401(k)-style savings plans. The bill will also limit the number of sick days that can be counted toward retirement. Another significant provision in the new bill lowered the amount of pension income that can be excluded from state income tax from $41,110 to $31,110, which is projected to raise $12 million annual revenue. However, another bill was gutted and amended to delete that reduction.(Source) (Source) (Source)

Colorado State Pension Reform
The Colorado state pension system currently has a $32 billion unfunded liability. A pension reform bill in Colorado is advancing without bipartisan support and has been marked by a partisan divide. The bill proposes to reduce with the unfunded liability by increasing employee contributions by 3 percent, lowering annual cost-of-living adjustments, and raising the retirement age for new employees. The bill also changes the annual salary calculation from the highest three-year average to the highest seven-year average and also offers employees the opportunity to enroll in a 401(k)-style defined contribution plan rather than a defined benefit plan. One change that was removed involved raising the retirement age for current workers younger than 46 since it would have created lawsuits. (Source) (Source)

Wisconsin Pension Payments

The nearly 200,000 retirees in the Wisconsin will see an increase in their pension checks beginning May 1. Payments from the Core Trust Fund (which had a return in 2016 of 8.6 percent) will rise 2 percent; the fund has a diversified portfolio with a five-year smoothing for gains and losses. For the average retiree receiving $24,700 per year, the Core Fund increase will add $494 a year to their benefit. The Variable Fund is an all-stock fund with voluntary participation and is more volatile. It had a return in 2016 of 10.6 percent, and payments from that fund will rise 4 percent. Wisconsin's pension system is generally considered fully funded and has a unique "shared risk" model that provides for automatic adjustments to benefits that can rise above a minimum level and also fall back down. (Source) (Source)

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
MARCH 2018
FOR INFORMATION ONLY

CVS Annual Review Meeting

On March 16, 2018, staff, representatives from CVS, and Segal attended the CVS Annual Review Meeting held at LACERA. The following topics were discussed:

- January – December 2017 Rx Utilization Review
- Potential Plan Opportunities/Recommendations
- Administrative Items

Centers for Medicare and Medicaid Services (CMS) Medicare Part D Retiree Drug Subsidy (RDS) Applications for Plan Year 7/1/2018 – 6/30/2019

We are pleased to inform your Board that staff, carriers, and Segal completed the CMS Retiree Drug Subsidy program application process for the new 2018/2019 RDS Applications by the CMS deadline for the following plans:

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

As a background, The Retiree Drug Subsidy (RDS) program was authorized by Medicare Part D of the Medicare Modernization Act, and permits employers and unions with qualifying prescription drug plans to receive retiree drug subsidy payments from the federal government.

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

Retiree Wellness Program - Staying Healthy Together
Spring Half-Day Workshop

The spring workshop will be held in April. The presentation topic is titled "Move More for Diabetes Control" and will be presented by Kristie E. Holt, Health Education and Disease Management Specialist, sponsored by UnitedHealthcare. In addition, Dr. Cary Sun of Cigna will give a presentation on "Diabetes and Oral Health". Below are the workshop details:

Date: Tuesday, April 17, 2018
Time: 9:00 a.m. – 1:00 p.m.
Place: Carson Event Center, 801 E. Carson Street, Carson, CA

We hope that you can join us! The event sponsors are our carriers: Anthem Blue Cross, CVS/Caremark, Cigna, Kaiser, UnitedHealthcare, and SCAN.

AHIP National Health Policy conference

Staff attended the AHIP National Health Policy conference in Washington, - DC held on March 7- 8, 2018. At this years' conference much of the discussions were centered on:

- Navigating What's Next for Health Care
- Tackling the Nation's Opioid Crisis
- Taking Back Health Care: Real-World Consumer Perspectives
- Single-Payer Health Care: Is it the Right Approach for the U.S.?
- Accelerating Speed to Value: How Data is Driving the Transition to Value-Based Care

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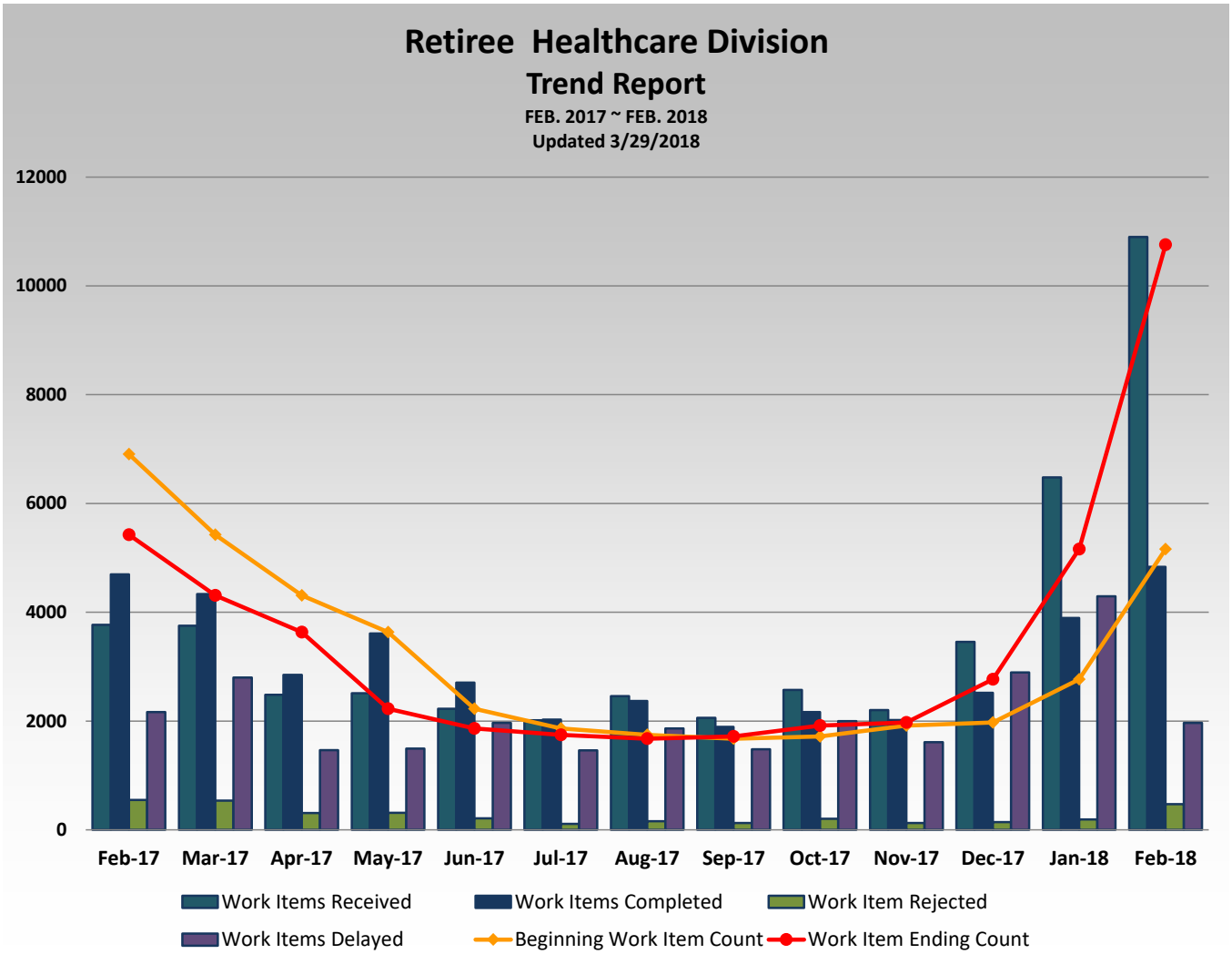
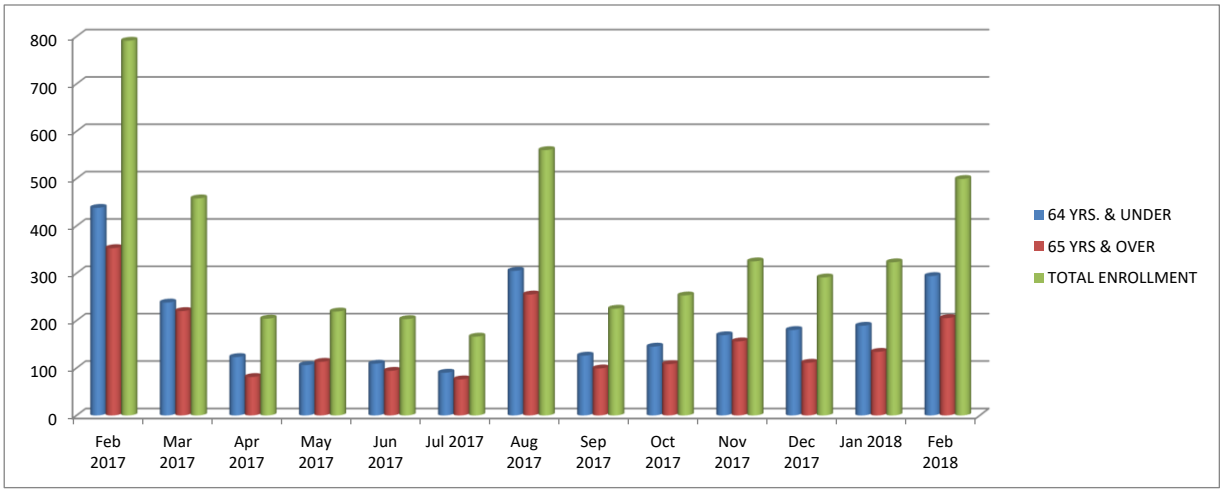


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Feb-17	6906	3767	4698	549	2164	5426
Mar-17	5426	3753	4334	537	2798	4308
Apr-17	4308	2484	2848	308	1467	3636
May-17	3636	2513	3609	314	1495	2226
Jun-17	2226	2225	2706	211	1966	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
Dec-17	1973	3457	2521	143	2892	2766
Jan-18	2766	6478	3895	190	4293	5159
Feb-18	5159	10900	4834	470	1965	10755

Retirees Monthly Age Breakdown
FEB. 2017 ~ FEB. 2018

Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
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
Dec 2017	180	111	291
Jan 2018	189	134	323
Feb 2018	294	205	499



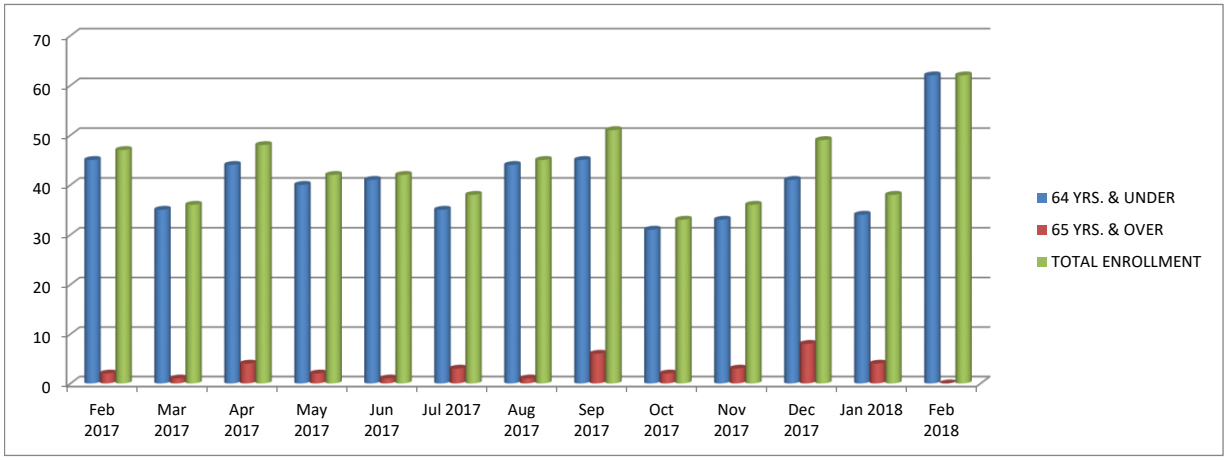
PLEASE NOTE:

- **March's data (3/2018) is not yet available as data is provided on a <u>full month basis</u>.**
- **Next Report will include the following dates: March 1, 2017 through March 31, 2018.**

Retirees Monthly Age Breakdown
FEB. 2017 ~ FEB. 2018

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
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
Dec 2017	41	8	49
Jan 2018	34	4	38
Feb 2018	62	0	62



PLEASE NOTE:

- **March's data (3/2018) is not yet available as data is provided on a full month basis.**
- **Next Report will include the following dates: March 1, 2017 throught March 31, 2018.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 1/31/2018

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	6,467	$718,591.70	8	$246.50
241	151	$16,415.10	0	$0.00
242	858	$100,916.10	0	$0.00
243	3,746	$827,680.30	5	$449.10
244	20	$2,385.90	0	$0.00
245	53	$6,111.70	0	$0.00
246	20	$2,281.40	0	$0.00
247	101	$12,073.30	0	$0.00
248	10	$2,167.60	1	$36.50
249	45	$10,345.00	0	$0.00
250	15	$3,173.60	0	$0.00
Plan Total:	**11,486**	**$1,702,141.70**	**14**	**$732.10**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	30	$3,360.20	0	$0.00
322	9	$1,032.50	0	$0.00
324	14	$2,973.90	0	$0.00
327	2	$238.90	0	$0.00
329	1	$226.70	0	$0.00
Plan Total:	**56**	**$7,832.20**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
401	1	-$104.90	0	$0.00
403	10,198	$1,136,836.40	7	$206.50
404	1	-$104.90	0	$0.00
413	1,644	$193,076.40	0	$0.00
418	5,198	$1,154,583.50	3	$175.30
419	275	$29,639.30	0	$0.00
426	215	$23,643.60	0	$0.00
427	164	$17,843.10	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	10	$1,699.60	0	$0.00
458	1	$134.00	0	$0.00
462	52	$5,747.80	0	$0.00
465	10	$1,087.40	0	$0.00
466	29	$6,327.30	0	$0.00
467	1	$134.00	0	$0.00
472	33	$3,614.40	0	$0.00
476	4	$465.60	0	$0.00
478	13	$3,000.70	0	$0.00
482	80	$8,778.60	0	$0.00
486	10	$1,180.00	0	$0.00
488	43	$9,646.20	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:	**18,022**	**$2,601,844.50**	**10**	**$381.80**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 1/31/2018

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	300	$33,801.90	0	$0.00
613	104	$22,226.70	0	$0.00
Plan Total:	**404**	**$56,028.60**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1,594	$178,536.70	1	$36.50
702	330	$39,065.00	0	$0.00
703	909	$203,347.50	0	$0.00
704	69	$8,805.70	0	$0.00
705	28	$6,482.30	0	$0.00
Plan Total:	**2,930**	**$436,237.20**	**1**	**$36.50**
Grand Total:	**32,898**	**$4,804,084.20**	**25**	**$1,150.40**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 3/31/2018

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
201	1	$268.00	0	$0.00
202	1	$268.00	0	$0.00
221	1	-$104.90	0	$0.00
240	6491	$739,504.80	9	$198.50
241	149	$16,772.90	0	$0.00
242	872	$103,318.40	0	$0.00
243	3762	$860,396.80	5	$494.40
244	19	$2,212.80	0	$0.00
245	52	$6,023.00	0	$0.00
246	19	$2,159.60	0	$0.00
247	105	$13,164.00	0	$0.00
248	13	$3,096.40	1	$36.50
249	45	$10,591.80	0	$0.00
250	15	$3,394.00	0	$0.00
Plan Total:	**11,545**	**$1,761,065.60**	**15**	**$729.40**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	31	$3,285.40	0	$0.00
322	10	$1,166.50	0	$0.00
324	14	$3,147.90	0	$0.00
327	2	$238.90	0	$0.00
329	1	$226.70	0	$0.00
Plan Total:	**58**	**$8,065.40**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
401	1	-$104.90	0	$0.00
403	10241	$1,164,988.10	8	$221.20
413	1620	$192,984.00	0	$0.00
418	5216	$1,203,579.70	4	$163.30
419	279	$30,796.40	0	$0.00
426	215	$24,338.10	0	$0.00
427	166	$18,513.60	0	$0.00
445	3	$315.80	0	$0.00
451	33	$3,800.80	0	$0.00
455	1	$134.00	0	$0.00
457	7	$1,472.90	0	$0.00
458	1	$134.00	0	$0.00
462	56	$6,099.80	0	$0.00
465	10	$1,053.40	0	$0.00
466	28	$6,299.40	0	$0.00
467	1	$134.00	0	$0.00
472	32	$3,480.40	0	$0.00
476	4	$465.60	0	$0.00
478	13	$2,942.50	0	$0.00
482	77	$8,893.80	0	$0.00
486	12	$1,454.00	0	$0.00
488	43	$10,018.60	0	$0.00
491	2	$209.80	0	$0.00
492	1	$104.90	0	$0.00
Plan Total:	**18,062**	**$2,682,108.70**	**12**	**$384.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 3/31/2018

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	296	$34,436.60	0	$0.00
613	105	$22,443.30	0	$0.00
Plan Total:	**401**	**$56,879.90**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1614	$187,759.30	1	$36.50
702	324	$39,684.00	0	$0.00
703	915	$215,326.60	0	$0.00
704	69	$8,543.80	0	$0.00
705	28	$6,535.80	0	$0.00
Plan Total:	**2,950**	**$457,849.50**	**1**	**$36.50**
LOCAL 1014				
804	172	$27,825.30	0	$0.00
805	166	$24,571.00	0	$0.00
806	574	$163,156.30	0	$0.00
807	38	$5,895.30	0	$0.00
808	12	$3,754.50	0	$0.00
812	223	$31,196.20	0	$0.00
Plan Total:	**1,185**	**$256,398.60**	**0**	**$0.00**
Grand Total:	**34,201**	**$5,222,367.70**	**28**	**$1,150.40**

Medical and Dental Vision Insurance Premiums
April 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	665	$577,322.10	$93,099.32	$481,622.23	$574,721.55	($2,600.55)	$572,121.00
202	357	$608,406.54	$59,886.35	$548,520.19	$608,406.54	($1,704.22)	$606,702.32
203	92	$176,927.96	$41,539.53	$131,542.17	$173,081.70	$0.00	$173,081.70
204	34	$37,867.16	$15,391.93	$23,588.97	$38,980.90	$0.00	$38,980.90
205	1	$237.47	$9.50	$227.97	$237.47	$0.00	$237.47
SUBTOTAL	**1,149**	**$1,400,761.23**	**$209,926.63**	**$1,185,501.53**	**$1,395,428.16**	**($4,304.77)**	**$1,391,123.39**
Anthem Blue Cross I							
211	832	$912,035.04	$57,810.00	$853,130.16	$910,940.16	($9,843.92)	$901,096.24
212	292	$575,949.56	$32,308.36	$541,668.77	$573,977.13	($5,917.29)	$568,059.84
213	55	$127,947.05	$17,959.07	$109,987.98	$127,947.05	$0.00	$127,947.05
214	20	$28,960.40	$4,807.43	$24,152.97	$28,960.40	$0.00	$28,960.40
215	4	$1,456.16	$211.14	$1,245.02	$1,456.16	$0.00	$1,456.16
SUBTOTAL	**1,203**	**$1,646,348.21**	**$113,096.00**	**$1,530,184.90**	**$1,643,280.90**	**($15,761.21)**	**$1,627,519.69**
Anthem Blue Cross II							
221	2,116	$2,318,955.84	$143,692.63	$2,184,022.25	$2,327,714.88	($20,453.64)	$2,307,261.24
222	1,853	$3,668,719.80	$95,860.00	$3,525,521.48	$3,621,381.48	($5,917.29)	$3,615,464.19
223	616	$1,442,312.20	$58,157.63	$1,346,933.61	$1,405,091.24	$0.00	$1,405,091.24
224	149	$215,754.98	$20,156.43	$205,734.69	$225,891.12	$0.00	$225,891.12
225	2	$728.08	$182.02	$546.06	$728.08	$0.00	$728.08
SUBTOTAL	**4,736**	**$7,646,470.90**	**$318,048.71**	**$7,262,758.09**	**$7,580,806.80**	**($26,370.93)**	**$7,554,435.87**

Medical and Dental Vision Insurance Premiums
April 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	6,510	$2,887,981.90	$443,330.68	$2,464,123.66	$2,907,454.34	($3,546.80)	$2,903,907.54
241	149	$211,977.00	$23,345.71	$196,148.79	$219,494.50	$0.00	$219,494.50
242	876	$1,245,011.58	$87,051.94	$1,139,588.30	$1,226,640.24	$1,413.18	$1,228,053.42
243	3,764	$3,328,252.20	$380,783.75	$2,890,103.84	$3,270,887.59	($1,760.98)	$3,269,126.61
244	19	$15,054.08	$3,090.06	$11,964.02	$15,054.08	$0.00	$15,054.08
245	53	$41,992.96	$5,356.08	$35,844.56	$41,200.64	$0.00	$41,200.64
246	19	$33,478.95	$2,643.07	$30,835.88	$33,478.95	$0.00	$33,478.95
247	108	$190,301.40	$8,493.09	$181,808.31	$190,301.40	$0.00	$190,301.40
248	13	$15,980.64	$1,229.28	$14,751.36	$15,980.64	$0.00	$15,980.64
249	45	$55,317.60	$4,818.77	$50,498.83	$55,317.60	$0.00	$55,317.60
250	15	$20,661.30	$991.74	$19,669.56	$20,661.30	$0.00	$20,661.30
SUBTOTAL	**11,571**	**$8,046,009.61**	**$961,134.17**	**$7,035,337.11**	**$7,996,471.28**	**($3,894.60)**	**$7,992,576.68**
CIGNA Network Model Plan							
301	333	$474,249.94	$126,041.27	$345,368.85	$471,410.12	($1,419.91)	$469,990.21
302	144	$368,976.96	$91,138.63	$280,400.67	$371,539.30	$0.00	$371,539.30
303	17	$51,434.18	$14,443.17	$30,939.93	$45,383.10	$0.00	$45,383.10
304	23	$43,324.87	$16,739.23	$26,585.64	$43,324.87	$0.00	$43,324.87
SUBTOTAL	**517**	**$937,985.95**	**$248,362.30**	**$683,295.09**	**$931,657.39**	**($1,419.91)**	**$930,237.48**

Medical and Dental Vision Insurance Premiums

April 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	$1,730.21	$9,804.49	$11,534.70	$0.00	$11,534.70
322	11	$16,788.64	$854.70	$14,407.70	$15,262.40	$0.00	$15,262.40
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	1	$1,297.77	$0.00	$1,297.77	$1,297.77	$0.00	$1,297.77
SUBTOTAL	**58**	**$44,635.42**	**$4,276.19**	**$38,448.50**	**$42,724.69**	**$0.00**	**$42,724.69**

Medical and Dental Vision Insurance Premiums
April 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,519	$1,428,010.49	$136,837.63	$1,306,174.94	$1,443,012.57	($1,875.26)	$1,441,137.31
403	10,307	$2,649,601.50	$276,386.07	$2,372,860.36	$2,649,246.43	($5,132.40)	$2,644,114.03
404	551	$573,750.10	$15,510.17	$569,714.10	$585,224.27	$0.00	$585,224.27
405	960	$942,510.36	$19,536.56	$915,127.72	$934,664.28	$0.00	$934,664.28
406	52	$90,745.20	$36,752.43	$52,247.67	$89,000.10	$0.00	$89,000.10
411	1,788	$3,351,731.70	$173,318.58	$3,191,483.94	$3,364,802.52	($3,734.52)	$3,361,068.00
413	1,614	$1,932,401.25	$92,313.83	$1,832,811.12	$1,925,124.95	($1,186.25)	$1,923,938.70
414	142	$281,035.04	$4,677.35	$280,288.25	$284,965.60	$0.00	$284,965.60
418	5,209	$2,637,858.04	$208,363.13	$2,420,930.13	$2,629,293.26	($5,557.64)	$2,623,735.62
419	280	$362,164.14	$4,726.09	$363,859.46	$368,585.55	$0.00	$368,585.55
420	132	$272,355.60	$1,485.57	$270,870.03	$272,355.60	$0.00	$272,355.60
421	9	$8,438.67	$750.11	$7,688.56	$8,438.67	$0.00	$8,438.67
422	217	$414,554.63	$1,681.16	$414,783.86	$416,465.02	($1,910.39)	$414,554.63
423	25	$74,892.44	$8,293.86	$47,875.47	$56,169.33	$16,716.76	$72,886.09
426	213	$264,316.70	$3,270.18	$265,964.04	$269,234.22	$0.00	$269,234.22
427	167	$336,938.68	$3,668.47	$303,364.41	$307,032.88	($3,482.20)	$303,550.68
428	59	$118,496.19	$1,767.38	$122,754.04	$124,521.42	$0.00	$124,521.42
429	11	$30,500.25	$4,910.84	$25,589.41	$30,500.25	$0.00	$30,500.25
430	139	$271,539.28	$3,477.25	$273,922.59	$277,399.84	$0.00	$277,399.84
431	14	$43,485.76	$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	**23,413**	**$16,102,737.02**	**$1,007,813.16**	**$15,075,531.06**	**$16,083,344.22**	**($6,161.90)**	**$16,077,182.32**

Medical and Dental Vision Insurance Premiums
April 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Colorado							
450	6	$6,029.22	$884.29	$5,144.93	$6,029.22	$0.00	$6,029.22
451	33	$12,098.46	$1,305.15	$10,793.31	$12,098.46	$0.00	$12,098.46
453	2	$4,442.30	$655.23	$3,787.07	$4,442.30	$0.00	$4,442.30
455	1	$1,363.49	$0.00	$1,363.49	$1,363.49	$0.00	$1,363.49
457	7	$5,076.68	$1,160.38	$3,916.30	$5,076.68	$0.00	$5,076.68
458	1	$2,302.38	$0.00	$2,302.38	$2,302.38	$0.00	$2,302.38
SUBTOTAL	**50**	**$31,312.53**	**$4,005.05**	**$27,307.48**	**$31,312.53**	**$0.00**	**$31,312.53**
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	3	$4,694.01	$0.00	$4,694.01	$4,694.01	$0.00	$4,694.01
461	12	$13,972.92	$2,034.89	$10,773.62	$12,808.51	$0.00	$12,808.51
462	58	$23,679.08	$3,666.15	$20,421.19	$24,087.34	$0.00	$24,087.34
463	3	$6,962.49	$2,031.41	$4,931.08	$6,962.49	$0.00	$6,962.49
465	9	$15,646.70	$938.80	$13,143.23	$14,082.03	$0.00	$14,082.03
466	28	$22,638.56	$582.13	$22,056.43	$22,638.56	($808.52)	$21,830.04
467	1	$2,721.09	$394.78	$2,326.31	$2,721.09	$0.00	$2,721.09
SUBTOTAL	**121**	**$98,465.72**	**$10,134.87**	**$86,010.03**	**$96,144.90**	**($808.52)**	**$95,336.38**

Medical and Dental Vision Insurance Premiums
April 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	32	$13,744.32	$2,164.71	$11,579.61	$13,744.32	$0.00	$13,744.32
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	**59**	**$44,054.92**	**$6,717.10**	**$37,337.82**	**$44,054.92**	**$0.00**	**$44,054.92**
Kaiser - Oregon							
481	9	$9,788.67	$1,892.47	$7,896.20	$9,788.67	$0.00	$9,788.67
482	77	$29,048.25	$4,526.98	$24,521.27	$29,048.25	($1,886.25)	$27,162.00
484	1	$2,167.27	$352.63	$1,814.64	$2,167.27	$0.00	$2,167.27
486	12	$17,482.56	$2,156.18	$15,326.38	$17,482.56	$0.00	$17,482.56
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
495	2	$4,686.68	$741.82	$3,944.86	$4,686.68	$0.00	$4,686.68
SUBTOTAL	**147**	**$99,577.67**	**$13,890.72**	**$85,686.95**	**$99,577.67**	**($1,886.25)**	**$97,691.42**
SCAN Health Plan							
611	298	$88,804.00	$18,654.80	$70,447.20	$89,102.00	($894.00)	$88,208.00
613	103	$61,740.00	$9,960.72	$50,015.28	$59,976.00	$0.00	$59,976.00
SUBTOTAL	**401**	**$150,544.00**	**$28,615.52**	**$120,462.48**	**$149,078.00**	**($894.00)**	**$148,184.00**

Medical and Dental Vision Insurance Premiums
April 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
UHC Medicare Adv.							
701	1,618	$548,615.26	$68,234.50	$490,891.93	$559,126.43	($1,017.21)	$558,109.22
702	325	$459,000.09	$26,192.41	$430,000.34	$456,192.75	$0.00	$456,192.75
703	914	$613,848.24	$63,569.48	$552,289.18	$615,858.66	$0.80	$615,859.46
704	72	$114,269.76	$8,062.38	$104,620.30	$112,682.68	$0.00	$112,682.68
705	28	$23,899.40	$785.27	$23,114.13	$23,899.40	$0.00	$23,899.40
706	1	$307.71	$12.31	$295.40	$307.71	$0.00	$307.71
SUBTOTAL	**2,958**	**$1,759,940.46**	**$166,856.35**	**$1,601,211.28**	**$1,768,067.63**	**($1,016.41)**	**$1,767,051.22**
United Healthcare							
707	439	$471,944.00	$45,993.07	$429,168.73	$475,161.80	$1,072.60	$476,234.40
708	388	$767,320.40	$33,354.94	$728,093.11	$761,448.05	$0.00	$761,448.05
709	299	$698,500.60	$36,154.93	$660,025.07	$696,180.00	$0.00	$696,180.00
SUBTOTAL	**1,126**	**$1,937,765.00**	**$115,502.94**	**$1,817,286.91**	**$1,932,789.85**	**$1,072.60**	**$1,933,862.45**

Medical and Dental Vision Insurance Premiums
April 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	51	$54,985.65	$1,725.03	$53,260.62	$54,985.65	$0.00	$54,985.65
802	279	$542,373.21	$12,597.08	$535,608.10	$548,205.18	$0.00	$548,205.18
803	246	$564,105.06	$20,133.46	$550,850.93	$570,984.39	$2,293.11	$573,277.50
804	172	$185,441.80	$8,603.60	$176,838.20	$185,441.80	($27,825.30)	$157,616.50
805	166	$322,702.34	$11,002.98	$311,699.36	$322,702.34	($25,304.14)	$297,398.20
806	575	$1,117,794.25	$32,542.39	$1,082,442.03	$1,114,984.42	($164,400.45)	$950,583.97
807	38	$87,138.18	$1,651.04	$85,487.14	$87,138.18	($5,895.30)	$81,242.88
808	12	$27,517.32	$183.45	$27,333.87	$27,517.32	($3,754.50)	$23,762.82
809	23	$24,797.45	$3,126.62	$22,748.98	$25,875.60	$0.00	$25,875.60
810	9	$17,495.91	$1,905.11	$15,590.80	$17,495.91	$0.00	$17,495.91
811	5	$11,465.55	$825.52	$10,640.03	$11,465.55	$0.00	$11,465.55
812	223	$240,427.45	$20,549.47	$225,570.62	$246,120.09	($32,921.24)	$213,198.85
SUBTOTAL	**1,799**	**$3,196,244.17**	**$114,845.75**	**$3,098,070.68**	**$3,212,916.43**	**($257,807.82)**	**$2,955,108.61**
Medical Plan Total	**49,308**	**$43,142,852.81**	**$3,323,225.46**	**$39,684,429.91**	**$43,007,655.37**	**($319,253.72)**	**$42,688,401.65**

Medical and Dental Vision Insurance Premiums
April 2018

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	23,339	$1,217,466.56	$140,262.37	$1,084,138.38	$1,224,400.75	($3,847.48)	$1,220,553.27
502	21,550	$2,341,850.40	$185,567.19	$2,157,988.64	$2,343,555.83	($2,715.00)	$2,340,840.83
503	14	$898.10	$150.11	$747.99	$898.10	$0.00	$898.10
SUBTOTAL	**44,903**	**$3,560,215.06**	**$325,979.67**	**$3,242,875.01**	**$3,568,854.68**	**($6,562.48)**	**$3,562,292.20**
CIGNA Dental HMO/Vision							
901	3,258	$150,487.02	$19,474.53	$132,213.43	$151,687.96	($92.38)	$151,595.58
902	2,289	$216,828.88	$19,824.32	$196,531.96	$216,356.28	$566.08	$216,922.36
903	4	$187.12	$5.61	$181.51	$187.12	$0.00	$187.12
SUBTOTAL	**5,551**	**$367,503.02**	**$39,304.46**	**$328,926.90**	**$368,231.36**	**$473.70**	**$368,705.06**
Dental/Vision Plan Total	**50,454**	**$3,927,718.08**	**$365,284.13**	**$3,571,801.91**	**$3,937,086.04**	**($6,088.78)**	**$3,930,997.26**
GRAND TOTALS	**99,762**	**$47,070,570.89**	**$3,688,509.59**	**$43,256,231.82**	**$46,944,741.41**	**($325,342.50)**	**$46,619,398.91**

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.**

Segal Consulting

Los Angeles County Employees Retirement Association

Medical and Dental Claims Audit Findings

For the Period July 1, 2016 through June 30, 2017

April 12, 2018

Presented by:

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Audit Objectives

Audit Period
July 1, 2016 through June 30, 2017

Medical Benefits
Anthem
Fully-Insured

Dental Benefits
Cigna
Fully-Insured

- Fiduciary Oversight
- Independent Validation of Administrative Performance
  - Payments in compliance with Plan provisions
  - Administrative services as outlined in the administrator's contract
  - Comparison to Performance Guarantees and Industry Best Practices
- Early Detection of Any Deficiency or Need for Improvement
- Confidence in the Accuracy of Future Benefit Determinations

Project Approach

- Adjudication Procedures Review
  - Assessment of day-to-day processing guidelines and claim control measures
  - Compliance tested through onsite claims review
- Statistical Random Sample of Benefit Payments
  - Measures the accuracy of benefit determinations with focus on the dollar value
  - Accuracy tested through manual recalculation of benefits (using claims system)
- Target Claims Selection
  - Provides added confidence in payment accuracy levels
  - Potential payment concerns and benefit areas of interest
  - Review of benefit variables not included in the random sample
- Written Findings
  - Summarize onsite findings
  - Comparisons to industry best practice and performance guarantees
  - Recommendations for improvement
  - Includes the administrator's response

Statistical Sampling

- Statistical Confidence in Dollar Value and Number of Claims
  - 95% confidence and 3% precision within each stratum
  - Random selections within each stratified payment tier
  - Selection tested for minimal financial variance (less than 1%)
  - Error rates extrapolated to entire population for accuracy measurement
- Sampled Claims are Manually Reviewed from Receipt to Final Determination
  - Eligible for the date of service
  - Processed in strict accordance with Plan provisions
  - Supporting documentation was on file and verified when necessary
  - Pre-certification/authorization was obtained where required
  - Provider network status and applicable benefit reimbursement level
  - Proper benefit classification, diagnostic and procedure codes
  - Payment within the designated fee schedules and non-contracted allowances
  - Appropriate benefit limitations and deductibles were applied
  - Duplicate claims were properly denied

Medical Claims Administered by Anthem

- 668,181 claims resulted in benefit payments of $116,229,183.69
- 220 statistical selection reviewed payments totaling $4,462,522.02 (approximately 3.8% of total paid)

Strata	Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar Amount in Selection	Dollar Amount in Strata
A	$0.01 - $19.99	220,510	50	$613.45	$2,479,828.67
B	$20.00 - $49.99	213,462	50	$1,471.86	$6,421,524.27
C	$50.00 - $119.99	125,259	30	$2,266.98	$9,818,600.17
D	$120.00 - $424.99	75,235	25	$5,968.97	$15,672,013.90
E	$425.00 - $1,249.99	19,647	15	$10,552.12	$13,909,895.89
F	$1,250.00 - $3,499.99	10,473	10	$20,486.73	$18,344,277.45
G	$3,500.00 - $12,499.99	2,695	10	$64,572.06	$16,396,044.18
H	$12,500.00 - $44,999.99	722	10	$231,576.21	$16,513,721.31
I	$45,000.00 - $229,999.99	168	10	$857,693.36	$13,405,957.57
J	$230,000.00 - $577,444.01	10	10	$3,267,320.28	$3,267,320.28
Totals		668,181	220	$4,462,522.02	$116,229,183.69

- 35 claims were targeted to explore benefit variables not sampled
  - Potential duplicate payments (5)
  - Specific plan limitations and exclusions (30)
    - Hearing aids, hearing test
    - Smoking cessation
    - Nutritional counseling
    - Online physician, physician telephone services
    - Eyeglass lens and frames
    - Dental procedures
    - Potential subrogation

Anthem Medical Findings

- Anthem met or exceed their Performance Guarantees

Performance Measurements			
Category	**Statistical Achievement**	**Performance Guarantee**	**Industry Standards**
Financial Accuracy (dollar value)	99.92%	99.00%	99.00%
Overall Processing Accuracy (free from error)	95.91%	N/A	95.00%
Payment Accuracy (free from financial error)	96.57%	N/A	97.00%
Non-Financial Accuracy (without dollar error)	99.34%	97.00%	95.00%
Time-to-Process (within 14 calendar days)	96.48%	90.00%	95.00%

- Statistical sample identified 6 underpayments and 1 procedural error
  - Sequestration errors identified in prior audits were corrected in October 2016
  - An incorrect allowable expense calculation on lines containing a new Medicare reduction code resulted in a total underpayment of $20.38 (6 claims)
    - *Anthem is updating the coding in their processing system.*
    - *A financial impact report will be provided to LACERA upon completion of their review.*
  - The non-financial error was assessed for payment to an incorrect facility
    - *Anthem disagrees stating both providers utilize the same TAX ID number*
- Other Claim Matters were observed in the review of patient histories
  - 2 underpayments ($120.51 and $251.72) due to over application of individual deductibles upon receipt of prescription drug records
    - *Anthem should review safeguards to ensure timely identification and correction*
  - 1 underpayment caused by system migration from an old to new platform
    - *Anthem should review the timeliness of their reports and corrective actions*

Anthem Medical Findings – cont'd

- Target Sample of 35 Claims Found No Errors
- Claim Control Measures Meet Expectations
  - 93% of all claim submissions are received electronically; 88% are auto-adjudicated
  - Claims requiring manual review are directed to a dedicated claims unit
  - Eligibility processes are in place for timely update
    - Monthly reconciliation of eligibility lists received via paper (by email)
    - Retro-active terminations are reviewed for collection of ineligible payments
  - Other insurance information is documented once a year when no other coverage is noted in the system
    - Data match programs are used to identify possible Medicare and commercial coverages
  - Automated edits identify unbundling, mutually exclusive codes, duplicate charges, etc.
  - Allowances are automated based on the provider status, procedure(s) and date of service
  - Subrogation questionnaires are sent at 50-day intervals to determine whether a liable third-party exists
    - After three attempts, potential cases over $2,500 are sent to a third-party data base for investigation
  - Prepayment quality audit procedures were evidenced in the sample
    - High-dollar claims (i.e., $40,000) are systematically routed to security controlled audit queues
    - Claims paying greater than $300,000 undergo a secondary end-to-end audit
  - Overpayments in excess of $30 are pursued by Anthem's Financial Operations department

Dental Claims Administered by Cigna

- 142,565 claims resulted in benefit payments of $31,782,095.05
- 225 statistical selection reviewed payments totaling $91,886.29 (approximately .29% of total paid)

Strata	Dollar Range of Strata	Number of Claims in Range	Number in Audit Selection	Dollar Amount in Audit Selection	Total Dollar Amount in Strata
A	$0.01 - $49.99	13,035	25	$840.54	$438,257.56
B	$50.00 - $99.99	46,176	55	$4,296.00	$3,606,999.67
C	$100.00 - $149.99	30,522	35	$4,139.48	$3,609,863.10
D	$150.00 - $259.99	23,285	35	$6,845.98	$4,554,532.68
E	$260.00 - $474.99	12,386	25	$8,415.40	$4,169,325.78
F	$475.00 - $774.99	8,174	10	$6,528.39	$5,336,305.99
G	$775.00 - $1,199.99	5,924	10	$9,970.60	$5,906,583.44
H	$1,200.00 - $1,449.99	2,113	10	$12,937.60	$2,733,714.88
I	$1,450.00 - $1,999.99	937	10	$14,979.50	$1,403,579.15
J	$2,000.00 - $2,699.20	10	10	$22,932.80	$22,932.80
Totals		142,565	225	$91,886.29	$31,782,095.05

- Claims exceeding the calendar maximum of $1,500 were confirmed to include dates of services spanning two calendar years (e.g., October 2016 and January 2017 charges submitted and paid in June 2017).
- Cigna did not support our request for a target selection

Cigna Dental Findings

- Cigna exceeded their Performance Guarantees

Performance Measurements			
Category	**Statistical Achievement**	**Performance Guarantee**	**Industry Standards**
Financial Accuracy (dollar value)	100.00%	99.00%	99.00%
Overall Processing Accuracy (free from error)	99.53%	95.00%	95.00%
Payment Accuracy (free from financial error)	100.00%	N/A	97.00%
Time-to-Process (within 10 business days)	96.28%*	93.00%	95.00%

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

- One procedural error was identified for failure to transfer accumulators as a dependent under the retiree plan to the surviving spouse plan
  - *Cigna disagrees with the error stating they rely on eligibility information received from LACERA and were not notified of the change in plan status*
  - Segal recommends further discussion regarding automated reconciliation procedures that would include identification of account transfers and proper cross reference for prior accumulators
- An incorrect classification of bitewing x-rays in the 2017 certificate was identified
  - Cigna confirmed there has been no change in the system programming
  - Appropriate updates to the plan certificates have been made to ensure accurate coverage is indicated going forward

Cigna Dental Findings – cont'd

- Six examiners are dedicated to LACERA
  - One works in the office
  - Five work from home
- Claim Control Measures Meet Expectations
  - Electronic claims submission were 76.53%
  - Auto-adjudication rates were 66.93%
  - Eligibility is manually updated within four business days of receipt
    - Urgent communications are updated daily
  - Review of claims data for adequacy of information needed to process the claim
  - Cigna maintains established procedures for the denial and appeal process

Segal Consulting

Los Angeles County Employees Retirement Association

ANTHEM – MEDICAL PLAN AUDIT

Analysis of Claim Processing and Payment Procedures

For the Period
July 1, 2016 through June 30, 2017

Report Presented:

March 21, 2018

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Anthem Blue Cross
Medical Audit July 1, 2016 through June 30, 2017
March 21, 2018

Section I – Executive Summary

This report analyzes and evaluates the claims processing and payment procedures utilized by Anthem Blue Cross Life and Health Insurance Company (Anthem) in the administration of Los Angeles County Employees Retirement Association's (LACERA) group medical benefits. Jennifer Vasby, Connie Van Horn and MaryAnne Watson conducted the November 13-16, 2017 onsite review at Anthem's Indianapolis, Indiana claims office.

Scope of Services

Data files of all medical claims processed and paid during the 12-month audit period July 1, 2016 through June 30, 2017, representing $116,229,183.69 in benefit payments, was provided by Anthem for our audit purposes. Our onsite review included the following components:

- An Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures;
- A stratified sample of 220 claims was selected to provide statistical validity in the financial dollar value and incidence (number) accuracy of all benefit payments processed; and
- A 35 target claim selection identified through electronic analyses was designed to explore potential duplicate payments and/or sample various benefit applications (i.e., deductibles, employee cost-shares, limitations, and exclusions).

The auditors completed a form for each sampled claim. This worksheet was the primary documentation on which our report is based. Claims addressed within this report are referred to as "Worksheets". These worksheets (1-220) are further distinguished with an alphabet character (A-J) that identifies the respective payment tier in the statistical analysis. The auditors reviewed each claim from receipt to release for check disbursement to identify any variances in procedures or benefit determination.

Worksheets 221 through 255 include a "T" to distinguish the "target" sampling of claims identified through electronic analyses. These claims were reviewed for the attribute selected for validation (i.e., duplicate, benefit, etc.). Due to the focused review and selection of these claims, they are excluded from the overall calculation of processing performance.

Statistical Results

During the 12-month audit period July 1, 2016 through July 31, 2017, total benefit payments of $116,229,183.69 were issued for 668,181 claims. Benefits payments for 220 stratified claims totaled $4,462,522.02.

Our statistical sample was expected to identify less than a 3% error rate, which would then provide a 95% confidence level with ±3% precision. The audit results shown below are considered a valid reflection of how all claims were processed during the audit period. Our sample suggests Anthem met or exceeded each of their Performance Guarantees.

Performance Measurements			
Category	**Statistical Achievement**	**Performance Guarantee**	**Industry Standards**
Financial Accuracy (dollar value)	99.92%	99.00%	99.00%
Overall Processing Accuracy (free from error)	95.91%	N/A	95.00%
Payment Accuracy (free from financial error)	96.57%	N/A	97.00%
Non-Financial Accuracy (without dollar error)	99.34%	97.00%	95.00%
Time-to-Process (within 14 calendar days)	96.48%	90.00%	95.00%

For comparison to industry standards, processing errors are classified as "payment" or "procedural". Procedural errors do not involve a variance in payment; all errors in this review resulted in a payment error. Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third party administrators nationwide. Standards include acceptable performance for administration of fully-insured and self-insured corporate, public, and multi-employer plan benefits.

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

Target Sample Results

Anthem supported an additional sample of 35 claims selected through a series of electronic analyses to identify and confirm the accuracy of specific plan provisions and exclusions. Our onsite review included:

- 5 potential duplicate payments, and
- 30 specific plan provisions (hearing aids, hearing test, smoking cessation, nutritional counseling, online physician, physician telephone services, eyeglass frames, eyeglass lens, dental, potential subrogation).

No errors were identified during the onsite review of source documents and system notations.

Key Findings and Recommendations

The following bullet points summarize the primary review findings and recommendations identified by Segal's auditors. Anthem was presented with the draft report on December 19, 2017 for review and comment; additional information was subsequently provided to support proper claim adjudication for two claims. Anthem's responses are paraphrased in italics within our report; their complete response is presented in Section III.

- Six underpayments claims were due to an incorrect allowable expense calculation on lines containing a new Medicare reduction code. A financial impact report is required to identify similar underpayments throughout the audit period. (SAMPLES 17, 45, 68, 87, 93 &167; PAGE 6)

  Anthem agrees and is in the process of updating the coding in their processing system. A financial impact report will be provided to LACERA upon completion of their review.

  Receipt of Anthem's financial impact report will be placed in a follow-up status for review and discussion with LACERA.

- Segal recommends that Anthem review their safe guards in place to identify over application of deductibles and coinsurance levels due to prescription drug accumulator co-mingling; timely identification and correction to patient histories is required. (SAMPLES 153 & 199; PAGE 7)

  Anthem agrees and has these claims in queue for adjustment.

  Segal recommends Anthem load the PBM file feeds on a daily basis. Furthermore, a reconciliation report should be generated weekly with adjustments made to member accounts.

- Anthem identified an error in the calculation of patient accumulators due to the migration from one claims system to another. Financial impact reports were generated during 2017 and patient files adjusted; Anthem continues to monitor through weekly reports. (SAMPLE 216; PAGE 7)

  Anthem will provide reports outlining findings and results upon request.

  Receipt of Anthem's financial impact report will be placed in a follow-up status for review and discussion with LACERA.

* * * * * *

Section II – Claims Audit Review

Anthem provided a data file of all medical claims processed and paid from July 1, 2016 through June 30, 2017 for our sampling purposes. Relevant claims processing information was verified through Anthem's responses to the adjudication questionnaire, onsite discussions, auditors' observations, and the individual claims review.

Stratified Claims Review

Benefit payments for 668,181 claims during the 12-month audit period totaled $116,229,183.69. The 220 claim stratified selection represented benefits totaling $4,462,522.02. Prior history and benefit maximums were reviewed, as applicable, on each stratified claim. In addition to verifying the amount paid, audit samples were thoroughly reviewed to determine:

- Claims were paid only on behalf of eligible individuals, based on eligibility records maintained in Anthem's claims system;
- Claims were paid in strict accordance with Plan provisions;
- Pre-certification was obtained;
- Documentation (e.g., provider bills, physician statements, surgical reports, etc.) was on file for claims paid and verified when necessary;
- Amounts paid were within the designated fee schedules and non-contracted allowances;
- Benefits were paid under the proper benefit classification, diagnostic and procedure codes, as an incorrect entry may affect payment accuracy or future benefit determinations;
- Appropriate benefit limitations and deductibles were applied; and
- Duplicate claims were properly denied.

Claim Control Measures

Our audit sample review and responses to the questionnaire revealed Anthem utilizes the following claim control measures in the processing and payment of claims:

- Anthem receives 93% of all claim submissions electronically; LACERA averages 70,000 claims monthly of which 88% are auto-adjudicated (vs. company 83%).
- The system is programmed to direct claims requiring manual review to a dedicated claims unit with distribution to individuals possessing the required knowledge and skills.
- Automated edits identify unbundling, mutually exclusive codes, duplicate charges, etc.
- Fee allowances are automated based on the provider status, procedure(s) and date of service.

- An Anthem representative is assigned to translate eligibility lists received via paper (by email), into a spreadsheet by product suffix for monthly reconciliation. In the case of a retro-active termination, Anthem pursues collection of ineligible payments according to provisions and timeframes set forth in the client's contract and in accordance with State and Federal regulations and provider contracts.

- Anthem documents other insurance information once a year when there is no other coverage noted in the system; data match programs (i.e., CMS, CAQH) are used to identify possible Medicare and commercial coverages.

- Anthem's Subrogation Department sends questionnaires at 50-day intervals to determine whether a liable third-party exists. After three attempts, potential cases over $2,500 are sent to a third-party data base for investigation.

- Prior to payment, high-dollar claims (i.e., $40,000) are systematically routed to security controlled audit queues. All claims paying greater than $300,000 undergo a secondary end-to-end audit completed by the audit lead or senior auditor to confirm accuracy.

- Anthem's Financial Operations department pursues recovery of overpayments over $30.

Stratification Table

The selection of claims was stratified by dollar amount to give large claims more valid representation in the sample. The methodology of our stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allow a quantifiable degree of confidence, so the results obtained in the audit sample are a true reflection of the actual way all claims were processed during the audit period.

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

Strata	Dollar Range of Strata	Number of Claims in		Dollar Amount in	
		Range	Selection	Selection	Strata
A	$0.01 - $19.99	220,510	50	$613.45	$2,479,828.67
B	$20.00 - $49.99	213,462	50	$1,471.86	$6,421,524.27
C	$50.00 - $119.99	125,259	30	$2,266.98	$9,818,600.17
D	$120.00 - $424.99	75,235	25	$5,968.97	$15,672,013.90
E	$425.00 - $1,249.99	19,647	15	$10,552.12	$13,909,895.89
F	$1,250.00 - $3,499.99	10,473	10	$20,486.73	$18,344,277.45
G	$3,500.00 - $12,499.99	2,695	10	$64,572.06	$16,396,044.18
H	$12,500.00 - $44,999.99	722	10	$231,576.21	$16,513,721.31
I	$45,000.00 - $229,999.99	168	10	$857,693.36	$13,405,957.57
J	$230,000.00 - $577,444.01	10	10	$3,267,320.28	$3,267,320.28
Totals		668,181	220	$4,462,522.02	$116,229,183.69

Error Tables

Statistical Sample

Findings from the 220 stratified claims sample confirmed six underpayments totaling $20.38 and one procedural error. Three additional errors identified in the review of patient histories were reported as other claim matters, which are not measured in the statistical processing achievements.

Anthem has addressed the following system deficiencies identified in the claims sample. Segal recommends that Anthem review their internal procedures to ensure timely review of system updates that impact benefit determinations; patient files should be promptly adjusted.

- Updates to Medicare reduction codes will resolve the six underpayments. Financial impact reports will be presented to LACERA at conclusion of their system modification and analysis.
- Co-mingled medical and prescription drug accumulators can result in over application (underpayment) due to timing of receipt and update of the prescription drug files.

Worksheet	Over/(Under) Payment	Explanations
11A	Procedural	Payment was made to St. Joseph Heritage Health in error; the provider was St. Jude Hospital. *Anthem disagrees, stating both providers utilize the same TAX ID number.* Segal maintains the error. While the correct payment was issued, transfer to the proper facility may result in delayed updates to the patient's account.
17A 45A 68B 87B 93B 167E	($7.77) ($10.86) ($0.34) ($0.53) ($0.69) ($0.19)	Underpayments as secondary payer were due to an incorrect allowable expense calculation on lines containing a new Medicare reduction code. A financial impact report to identify similar underpayments is required after the system programming has been modified to acknowledge the new Medicare codes. *Anthem agrees and is in the process of updating the coding in their processing system. A financial impact report will be provided to LACERA.* Segal will review the financial impact report upon receipt and discuss any next steps with LACERA.

Worksheet	Over/(Under) Payment	Explanations
153D 199H	Other Claim Matter (Underpaid)	Patient individual deductibles were over applied due to subsequent co-mingling of prescription drug records. Deductibles were overstated $120.51 (Worksheet 153D) and $251.72 (Worksheet 199H). *Anthem agrees and has these claims in queue for adjustment.* Segal recommends that Anthem review their safe guards in place to identify over application of deductibles due to accumulator co-mingling to ensure timely identification and correction to patient underpayments.
216J	Other Claim Matter (Underpaid)	The patient's annual coinsurance has been over applied. *Anthem agrees and has routed the patient history for adjustment. They indicate this is a known issue caused by system migration (old claims platform to new), which is monitored through reporting.* Segal will review the financial impact report upon receipt and discuss any next steps with LACERA.
177F 217J	No Error or Comment	Anthem's response to the draft report provided the information required to remove the claim references.

Target Sample

An additional 35 claims, totaling $64,549.18 in payments, were chosen to ensure representation of variables in Plan benefits. Segal auditors focused on the following exclusions and limitations: hearing aids, hearing tests, smoking cessation, nutritional counseling, online physician services, physician telephone services, eyeglass frames, eyeglass lenses, dental claims, potential accidents and duplicate submissions.

No errors were identified.

Turnaround Time Achievement

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

Turnaround time is measured from the date a claim is first received to the initial date processed for payment or denial; subsequent adjustments are measured from receipt of the new information to the process date with processing measured as the longest interval. Measurements include routine delays due to internal review (i.e., medical review, quality audit); our calculations exclude delays for draft issuance.

Electronic calculations often do not allow for distinction of multiple processing events; accordingly, we compare electronic results to our sampled findings to determine if self-reported results are an accurate reflection of processing timeliness.

No concerns were identified in our review of claims processed during the period July 1, 2016 through June 30, 2017.

- Electronic analyses indicate a minimum 96.48% were processed in 14 calendar days; 98.21% was achieved at 30 calendar days.
- Stratified claims exceeding 30 days were the result of adjustments; Anthem handled each in a timely manner.

Section III – Performance Guarantees

The July 1, 2016 Performance Guarantee Agreement between Anthem and LACERA contained eight (8) service guarantees, each with 1% of their annual retention at risk in the form of a penalty for non-compliance.

Segal's statistical sampling places emphasis on the financial dollars paid during the audit period. Our statistical sample of 220 claims was structured to identify less than a 3% error rate, which provides a 95% confidence level with ±3% precision.

Performance Guarantee	Goal	Audit Result
Financial Accuracy represents the total dollars that should have been paid if all of the audited claims were paid correctly, minus the total dollars that were paid incorrectly, including both overpayments and underpayments, divided by the total dollars that should have been paid if all of the audited claims had been paid correctly.	99%	Met; 99.92%
Non-Financial Accuracy represents the total number of claim processing entries which do not have a financial impact on the claims processed, including but not limited to procedural and coding entries. The calculation will be the total number of claims audited minus the number of claims processed with one or more claims processing non-financial errors, divided by the number of claims audited.	97%	Met; 99.34%
Claim Time-to-Process (TTP) is calculated by counting the number of calendar days from the date all information required to complete processing is received by Anthem from parties outside the offices of Anthem, ending on the date such processing is completed.		
Claims processed within 14 Calendar Days	90%	Met; 96.48%
Claims processed within 30 Calendar Days	98%	Met; 98.21%

* Electronic calculations cannot carve-out delays pending additional information or multiple processing dates associated with adjustments; therefore, these calculations are likely understated.

Confirmation of the following guarantees was not included in the scope of this audit.

- Average Speed of Answer – 80% of calls answered within 20 seconds
- Abandonment Rate – Maximum of 3%
- First Call Resolution – 85% of calls answered
- Satisfaction of the Account Management - Exceeds or meets expectations

Section IV – Anthem's Report Response

Anthem Blue Cross
Internal Audit
220 Virginia Avenue
Indianapolis, IN 46204
Mailpoint: IN0203-C442

January 11, 2018

Jennifer Vasby
Segal Consulting
1230 W Washington St, Suite 501
Tempe, AZ 85281-1248

Re: Los Angeles County Employees Retirement Association

Dear Ms. Vasby:

Anthem Blue Cross (Anthem) reviewed the Segal Consulting (Segal) report of the claims audit conducted on behalf of Los Angeles County Employees Retirement Association (LACERA). This audit was conducted at Anthem's Indianapolis, IN facility the week of November 13, 2017. Anthem's response to each of these components is presented below.

Procedural Error

Sample 11A was identified as a procedural error. An inpatient physician charge; HCFA shows the provider as St. Jude Hospital; however, the payment was made to St. Joseph Heritage Health.

Anthem Response: *Anthem disagrees to this error and maintains that these two claims processed correctly per the reimbursement contract. Both providers are listed under the same payer tax identification number.*

Underpayments

Samples 17A, 45A, 68B 87B, 93B and 167E were underpaid office visit claims. All of the claims had Medicare as primary. The system is paying the incorrect allowable on some of the lines.

Anthem Response: *Anthem agrees to the underpayment findings. Medicare has implemented a new payment reduction code. Anthem is in the process of updating the coding in our processing system to accommodate Medicare's new coding. As part of our process, an impact report will be prepared to identify other possible underpayments due to this change.*

Samples 153D and 199H Inpatient Hospital, no error was noted on the claims; however, the member's individual deductible was over applied in the claims system.

Anthem Response: *Anthem agrees that the member's deductible was over applied due to pharmacy co-mingle. Anthem has safe guards in place to identify over applied member deductibles due to pharmacy co-mingling. The member's claim history is in queue for adjustment.*

Overpayment

Sample 177F an Outpatient Hospital claim, per the member's SPD cancer screening is covered at 80%. The member called to file an appeal and Anthem paid the additional 20% of the claim.

Anthem Response: *Anthem disagrees with this finding and maintains that the service paid correctly. The services were reviewed through the appeal process and approved for additional payment based on HCR preventive service guidelines. Anthem retains final decision authority for HCR related coverage decisions for fully-insured customers.*

Observations

Sample 216J Inpatient Hospital, the claim has no error; however, the member's coinsurance has been over applied.

Anthem Response: *Anthem agrees that the member's out of pocket was over applied due to the processing of out of sample medical claims. This is a known issue caused by system migration. Anthem continues to monitor the impact through reporting. The member's claim history has been routed and is in queue for adjustment.*

Sample 217J Inpatient Hospital the claim has no error; however, the claim was adjusted after the selection was provided to anthem.

Anthem Response: *The sample claim was identified prior to the audit and the adjustment occurred prior to the audit. This claim was identified as a Stop Loss claim. There are specific protocols in place within this facility provider's contract regarding the submission of Stop Loss claims. The facility did not follow the appropriate protocols causing the adjustment.*

Anthem appreciates the opportunity to respond to Segal's audit report. We look forward to discussing any of our responses with LACERA and Segal.

Sincerely,

Paul Zick
External Audit Manager
Customer Audit Services

cc: Jill Bromberg, Anthem
Michael Saavedra, Anthem
Marijane Gadbury, Anthem
Sheila Llewellyn, Anthem

Los Angeles County Employees Retirement Association

CIGNA – DENTAL PLAN AUDIT

Analysis of Claims Processing and Payment Procedures

For the audit period
July 1, 2016 through June 30, 2017

Report Presented:

March 21, 2018

SUBMITTED BY:
SEGAL CONSULTING
MARYANNE WATSON, SENIOR CONSULTANT
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Cigna Dental Plan Audit
Fiscal Year July 1, 2016 through June 30, 2017
Report Presented March 21, 2018

Section I - Executive Summary

This report analyzes and evaluates the claims processing and payment procedures utilized by Cigna Health and Life Insurance Company (Cigna) in the administration of the Los Angeles County Employees Retirement Association (LACERA) group dental benefits. Jennifer Vasby and MaryAnne Watson conducted the October 23-26, 2017 onsite review at Cigna's Denison, Texas claims office.

Scope of Services

Cigna provided data files for all dental claims processed and paid during the 12-month audit period July 1, 2016 through June 30, 2017 representing $31,335,529.30 in benefit payments. Our onsite claims review included the following components:

- An Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures; and
- A stratified sample of 225-claims processed from July 1, 2016 through June 30, 2017 to provide statistical validity in processing accuracy levels with comparison to performance guarantees and industry standards.

The auditors completed a form for each sampled claim; this worksheet was the primary documentation on which our report is based upon. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets".

Statistical Results

During the 12-month audit period July 1, 2016 through June 31, 2017, total benefit payments of $31,335,529.30 were issued for 142,565 claims. Benefit payments for the 225 stratified claims sample totaled $91,886.29.

Our onsite validation of 225-claims identified one procedural error; there were no variances in paid amounts. The audit results suggest that Cigna exceeded processing accuracy and timeliness goals during the audit period.

Performance Measurements			
Category	**Statistical Achievement**	**Performance Guarantee**	**Industry Standards**
Financial Accuracy (dollar value)	100.00%	99.00%	99.00%
Overall Processing Accuracy (free from error)	99.53%	95.00%	95.00%
Payment Accuracy (free from financial error)	100.00%	N/A	97.00%
Time-to-Process (within 10 business days)	96.28%*	93.00%	95.00%

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

The statistical sample was structured to identify less than a 3% error rate, which provides a 95% confidence level with ±3% precision. For comparison to performance guarantees and industry standards, processing errors are classified as "payment" or "procedural." Procedural errors do not involve a variance in payment.

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

Report Recommendations

All questions and comments regarding the statistical claim samples were reviewed with Cigna personnel. The following recommendation is offered for addressing a finding in this report. Cigna's written responses are paraphrased in italic within our report; the complete response is presented in Section IV.

- Our review identified a surviving spouse who transferred from the retiree plan to her own policy. Her accumulators were not reconciled resulting in application of a new deductible and calendar year benefit. Cigna indicated reconciliation of related patient accumulators requires specific identification from LACERA; no communication was received. A procedural error was assessed. (WORKSHEET 4)

  Cigna respectfully disagrees with Segal Consulting assessment of a Cigna error. Cigna processed and paid claims under the customer's file based on the eligibility information Cigna received from LACERA.

  Cigna can and will credit customer's files accordingly when notified of a surviving spouse which should have an ID move to occur. Cigna reviewed the customer's file and found no notification indicating the customer was a surviving spouse therefore had no insight or awareness to be able to credit the customer's file with the applicable deductible and out of pocket expenses.

  Cigna is currently in the process of reviewing the customer's file and crediting the accumulators. Cigna is in agreement there is no financial impact to the customer or LACERA.

  Segal recommends discussion between LACERA, Cigna, and Segal consultants regarding automated reconciliation procedures that would include identification of account transfers and proper cross reference of prior accumulators.

Section II – Dental Claims Audit Review

The following table identifies the payment tiers and respective number of claims and dollar value in the entire population and represented within our statistical claims sample. The methodology of our stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allow a quantifiable degree of confidence so the results obtained in the audit sample are a true reflection of the actual way all claims were processed during the audit period.

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

Strata	Dollar Range of Strata	Number of Claims in Range	Number in Audit Selection	Dollar Amount in Audit Selection	Total Dollar Amount in Strata
A	$0.01 - $49.99	13,035	25	$840.54	$438,257.56
B	$50.00 - $99.99	46,176	55	$4,296.00	$3,606,999.67
C	$100.00 - $149.99	30,522	35	$4,139.48	$3,609,863.10
D	$150.00 - $259.99	23,285	35	$6,845.98	$4,554,532.68
E	$260.00 - $474.99	12,386	25	$8,415.40	$4,169,325.78
F	$475.00 - $774.99	8,174	10	$6,528.39	$5,336,305.99
G	$775.00 - $1,199.99	5,924	10	$9,970.60	$5,906,583.44
H	$1,200.00 - $1,449.99	2,113	10	$12,937.60	$2,733,714.88
I	$1,450.00 - $1,999.99	937	10	$14,979.50	$1,403,579.15
J	$2,000.00 - $2,699.20	10	10	$22,932.80	$22,932.80
Totals		142,565	225	$91,886.29	$31,782,095.05

Claims exceeding the calendar maximum of $1,500 were confirmed to include dates of services spanning two calendar years (e.g., October 2016 and January 2017 charges submitted and paid in June 2017).

Stratified Dental Claims Review

Cigna provided a copy of the sampled claim submissions and access to their claims system for the auditors' reference as each claim was manually reprocessed from initial receipt to final benefit determination. Evidence of compliance with established adjudication procedures and plan provisions was explored for each claim; the patient's claims history was reviewed to confirm proper application of deductibles and calendar year maximums.

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

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

Cigna responses to our onsite findings were thoroughly reviewed and classified as no error where appropriate documentation and explanations supported the processing event; one non-financial issue was classified as a procedural error.

Claim Observations

The Cigna Dental Preferred Provider Insurance Certificate effective July 1, 2016, and printed in March 2017, was provided as the summary of benefits applicable to this audit period.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III, IX Combined Calendar Year Maximum	$1,500	
Calendar Year Deductible Individual Family Maximum	$25 per person Not Applicable to Class I $50 per family Not Applicable to Class I	
Class I Preventive Care	80%	80%
Class II Basic Restorative	80% after plan deductible	80% after plan deductible
Class III Major Restorative	50% after plan deductible	50% after plan deductible
Class IX Implants	80% after plan deductible	80% after plan deductible

Bitewing X-rays

Bitewing x-rays were described as a Class I Preventive Service payable at 100% but reimbursed under the Restorative Class II 80% benefit level. As such, eight (8) claims were submitted to Cigna as potential overpayments. Discussion during the onsite review confirmed the 2015 and 2016 certificates distinguished bitewing x-rays as a Class I benefit; however, the 2017 certificate reflected the Class II reimbursement level.

Understanding no changes in the benefit structure were approved for 2017, we asked Cigna to further review and advise the appropriate bitewing x-ray classification. Cigna reviewed the annual certificates dating back to 2012 and confirmed the 2014 through 2016 documents incorrectly classified bitewing x-rays as a Class I service. Review of their claim payment engine found no change in the programming of bitewing x-rays a Class II service subject to deductible and 80% reimbursement. Accordingly, the auditors reviewed and dismissed all payment errors.

Cigna confirmed the plan is administering bitewing X-rays per LACERA's intent. There are no required changes to the LACERA plan design or benefits.

During the audit the plan certificate was identified to have incorrect bitewing X-ray coverage indicated. Cigna has reviewed the plan certificates and made the appropriate updates to ensure the accurate coverage is indicated going forward.

Plan Transfers

One procedural error was assessed for failure to properly transfer accumulators when a retiree dependent transferred to a surviving spouse plan. Cigna explained that when a member moves between LACERA plans, they are not able to credit the member from one plan to the other without intervention and/or direction issued from the client. In this instance, no communication from LACERA was received.

Failure to combine patient files has the potential for application of a second deductible (resulting in an underpayment) and payment beyond the $1,500 calendar year maximum. The combined patient files were reviewed and confirmed to be free from payment error; the procedural error remains as a report finding.

Cigna respectfully disagrees with Segal Consulting assessment of Cigna error. Cigna processed and paid claims under the customer's file based on the eligibility information Cigna received from LACERA.

Cigna can and will credit customer's files accordingly when notified of a surviving spouse which should have an ID move to occur. Cigna reviewed the customer's file and found no notification indicating the customer was a surviving spouse therefore had no insight or awareness to be able to credit to the customer's file with the applicable deductible and out of pocket expenses.

Cigna is currently in the process of reviewing the customer's file and crediting the accumulators. Cigna is in agreement there is no financial impact to the customer or LACERA.

We recommend further discussion regarding identification of similar account transfers to ensure patients do not receive benefits exceeding the calendar year maximum.

Turnaround Time Analysis

Turnaround time for all claims (100%) processed from July 1, 2016 through June 30, 2017 was electronically calculated from the date a claim was first received to the date it was completed with payment or denial; delays for draft issuance were excluded. This electronic calculation measures calendar days.

The report supports that Cigna met their 10 business day "time-to-process" performance guarantee with 93% achieved within 5 calendar days. The claims system does not capture multiple events when a claim was pended for additional information or adjusted; consequently, our electronic review was expected to understate measurements beyond 10 business or 14 calendar days.

During the review of sampled claims, processing times exceeding 14 calendar days were reviewed for explanation with particular attention to those beyond the Department of Labor's 30-day requirement. Each claim was found to be processed in a timely manner; documentation supported proper delays for additional information and/or later adjustment to the claim.

Cigna is pleased with the Time to Process results.

Cigna is confident with the current staffing and with our self-reported Time to process metrics.

Cigna has several processes and key measures in place to ensure we are monitoring staffing levels across our service organization regularly. One key measure to validate appropriate staffing levels and timely claim processing is our "Time to Process" metric.

Cigna measures turn-around time from the date the claim is received until the date the claim is adjudicated. Claim adjustment(s) add another dimension to calculating turn-around time and can be a reason for the disparity between Cigna's self-reported results and Segal's analysis.

Cigna has and continues to exceed the Time to Process objectives for LACERA. Cigna is pleased with exceeding the Time to Process metric (99.10% during the 2016 Contract Year).

Claims Control Measures

Our review of sampled claims and onsite discussion revealed Cigna utilized the following claim control measures in the processing and payment of claims:

- Eligibility is manually updated within four business days of receipt; urgent communications are updated daily
- Electronic claims submission were 76.53%; auto-adjudication rates were 66.93%
- Six examiners are dedicated to LACERA; one works in the office and five work from home
- Review of claims data for adequacy of information needed to process the claim
- Cigna maintains established procedures for the denial and appeal process

- Cigna updates coordination of benefits (COB) information on a rolling 12-month basis
  - Requests for updated information are issued upon receipt of a claim for which the prior confirmation date extends beyond 12 months
  - Claims submitted without the primary plan's explanation of benefits (EOB) are pended with a request for the form; follow-ups are conducted every 30 days with denial at 90 days if the documentation has not been returned
- Should a potential accident be identified, Cigna processes the claim and then pursues additional information to determine if recovery opportunities exist through another party
- Automated calculation of fee allowance based on the provider's network status and the date(s) of service
- Internal audit procedures are established for quality control
- Overpayment recovery efforts are coordinated through a subcontracted vendor (Accent); the associated fee is included in Cigna's administrative fee

Section III – Performance Guarantees

The July 1, 2016 Performance Guarantee Agreement between Cigna and LACERA contained eight (8) service guarantees, each with a $25,000 penalty at risk. Processing Accuracy levels measured and reported by Cigna were determined from a statistically valid sample of claims paid during the Guarantee Period.

Segal's statistical sampling places emphasis on the financial dollars paid during the audit period. Our statistical sample of 225 claims was structured to identify less than a 3% error rate, which provides a 95% confidence level with ±3% precision. Only one procedural error was identified suggesting the confidence level is higher than 95%.

Performance Guarantee (Account Specific)	Goal	Audit Result
Financial Accuracy represents the sum of the absolute value of total dollars overpaid and the total dollars underpaid subtracted from the total dollars paid, divided by the total dollars paid, expressed as a percentage.	99%	Met; 100%
Claims Processing Accuracy (Overall Accuracy) represents the total number of claims/claims processed without any errors (both financial and non-financial errors) divided by the total claims/claims processed, expressed as a percentage.	95%	Met; 99.53%
Claim Time-to-Process (TTP) is calculated by counting the number of business days or calendar days (as appropriate as determined by Cigna) from the day that a claim is received by Cigna to and including the day the claim is processed. The day that the claim is received will not be included in this calculation.		
Claims processed within 10 Business Days	93%	Met; 95.43%
Claims processed within 20 Business Days	98%	Met *

* The electronic analysis for all claims reports 97.79% achievement within 28 calendar days and 98.00% within 30 calendar days. Electronic calculations cannot carve-out delays pending additional information or multiple processing dates associated with adjustments; therefore, these calculations are likely understated.

Confirmation of the following guarantees was not included in the scope of this audit.

- Average Speed of Answer – not to exceed 30 seconds, measured at the special account queue
- Call Abandonment Rate – less than 2% of calls received, measured at the special account queue
- CSA Quality – 95%, measured at Office level
- Account Management – 3.0 or better composite score from four quarterly assessments

Section IV – Cigna's Report Response

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December 26, 2017

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

RE: LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA)
Cigna Account Number: 3211348
Dental Plan Audit (Claims Paid July 1, 2016 through June 30, 2017)

Dear Cassandra;

Thank you for the opportunity to respond to the findings of the final report from the dental plan audit of Cigna HealthCare's Claim Administration Services completed the week of October 23rd, 2017 by Segal Consulting on behalf of LACERA. We reviewed the audit findings and want to share our commitment to resolve any outstanding issues or questions.

Attached please find Cigna HealthCare's response which identifies the steps that will be taken to improve quality based on the results and the recommendations identified through the audit of the medical program.

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

Sincerely,

Steven P. Fallgren
Senior Account Manager

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

Cigna's Response to the Executive Summary

Segal Consulting conducted an audit the week of October 23rd, 2017 of Los Angeles County Employees Retirement Association (LACERA) claims processed by Cigna. The sample consisted of 225 random medical claims processed from July 01, 2016 through June 30, 2017. Total benefit payments of $31,335,529 were paid on behalf of eligible employees and their dependents. Segal's analysis represents benefit payments in the amount of $91,886.

Random Sample:

Quality Metric	Segal Recognized Audit Results	Recognized Industry Standard	Cigna Recognized Audit Results
Financial Accuracy	100.00%	99.0%	100.00%
Payment Accuracy	100.00%	97.0%	100.00%
Processing Accuracy	99.53%	95.0%	100.00%

The objectives of the audit were to evaluate:

- The accuracy and timeliness of claims processing
- Cigna's internal controls and administrative procedures that ensure the accurate and timely processing of claims
- Cigna's interpretation of services and payment of claims, to ensure compliance with plan provisions and cost management controls
- Cigna's performance as compared to existing performance guarantees

Cigna has reviewed the report submitted by Segal.
Cigna appreciates Segal's insights and recommendations on enhancement opportunities.

Cigna is committed to a continuous quality improvement approach to ensure corrective actions are implemented. Segal's recommendations have been thoughtfully considered and Cigna's response is provided in the detailed information that follows.

LACERA as well as Segal are valued business partners and we look forward to reviewing the details of this audit with LACERA along with Segal. Cigna thanks Segal for their work and the opportunity to respond to this draft audit report.

Segal's Recommendation/ Observation	Cigna's Response
Recommendation 1: Surviving Spouse/ Plan Transfers *Our review identified a surviving spouse who transferred from the retiree plan to her own policy. Her accumulators were not reconciled resulting in application of a new deductible and calendar year benefit. Cigna indicated reconciliation of related patient accumulators requires specific identification from LACERA; no communication was received. A procedural error was assessed.* *Segal recommends discussion between LACERA, Cigna and Segal consultants regarding reconciliation procedures that would include identification of account transfers and proper cross reference of prior accumulators.* *One procedural error was assessed for failure to properly transfer accumulators when a retiree dependent transferred to a surviving spouse plan. Cigna explained that when a member moves between LACERA plans, they are not able to credit the member from one plan to the other without intervention and/or direction issued from the client. In this instance, no communication from LACERA was received.* *Failure to combine patient files has the potential for application of a second deductible (resulting in an underpayment) and payment beyond the $1,500 calendar year maximum. The combined patient files were reviewed and confirmed to be free from payment error; the procedural error remains as a report finding.*	Cigna respectfully disagrees with Segal Consulting assessment of a Cigna error. Cigna processed and paid claims under the customer's file based on the eligibility information Cigna received from LACERA. Cigna can and will credit customer's files accordingly when notified of a surviving spouse which should have an ID move to occur. Cigna reviewed the customer's file and found no notification indicating the customer was a surviving spouse therefore had no insight or awareness to be able to credit the customer's file with the applicable deductible and out of pocket expenses. Cigna is currently in the process of reviewing the customer's file and crediting the accumulators. Cigna is in agreement there is no financial impact to the customer or LACERA.

Recommendation 2: Bitewing X-rays

Bitewing x-rays were described as a Class I Preventive Service payable at 100% but reimbursed under the restorative Class II 80% benefit level. As such, eight (8) claims were submitted to Cigna as potential overpayments. Discussion during the onsite review confirmed the 2015 and 2016 certificates distinguished bitewing x-rays as a Class I benefit; however, the 2017 certificate reflected the Class II reimbursement level. Understanding no changes in the benefit structure were approved for 2017, we asked Cigna to further review and advise the appropriate bitewing x-ray classification. Cigna reviewed the annual certificates dating back to 2012 and confirmed the 2014 through 2016 documents incorrectly classified bitewing x-rays as a Class I service. Review of their claim payment engine found no change in the programming of bitewing x-rays a Class II service subject to deductible and 80% reimbursement. Accordingly, the auditors reviewed and dismissed all payment errors occurrence of similar errors in the future.

Cigna confirmed the plan is administering bitewing X-rays per LACERA's intent. There are no required changes to the LACERA plan design or benefits.

During the audit the plan certificate was identified to have incorrect bitewing X- ray coverage indicated. Cigna has reviewed the plan certificates and made the appropriate updates to ensure the accurate coverage is indicated going forward.

Observation: Time to Process

Turnaround time for all claims (100%) processed from July 1, 2016 through June 30, 2017 was electronically calculated from the date a claim was first received to the date it was completed with payment or denial; delays for draft issuance were excluded. This electronic calculation measures calendar days.

The report supports that Cigna met their 10 business day "time to process" performance guarantee with 93% achieved with in 5 calendar days. The claims system does not capture multiple events when a claim was pended for additional information or adjusted; consequently, our electronic review was expected to understate measurements beyond 10 business or 14 calendar days.

During the review of sampled claims, processing times exceeding 14 calendar days were reviewed for explanation with particular attention to those beyond the Department of Labor's 30-day requirement. Each claim was found to be processed in a timely manner; documentation supported proper delays for additional information and/or later adjustment to the claim.

Time to Process Metric	Segal's Analysis	Performance Guarantee Goal
10 business days	96.28%	93.00%

Cigna is pleased with the Time to Process results.

Cigna is confident with the current staffing and with our self-reported Time to process metrics.

Cigna has several processes and key measures in place to ensure we are monitoring staffing levels across our service organization regularly. One key measure to validate appropriate staffing levels and timely claim processing is our "Time to Process" metric.

Cigna measures turn-around time from the date the claim is received until the date the claim is adjudicated. Claim adjustment(s) add another dimension to calculating turn-around time and can be a reason for the disparity between Cigna's self-reported results and Segal's analysis.

Cigna has and continues to exceed the Time to Process objectives for LACERA. Cigna is pleased with exceeding the Time to Process metric..

Time to Process Metric	2016 Contract Year Cigna Reported Result	Performance Guarantee Goal
10 business days	99.10%	93.00%

Los Angeles County Employees Retirement Association

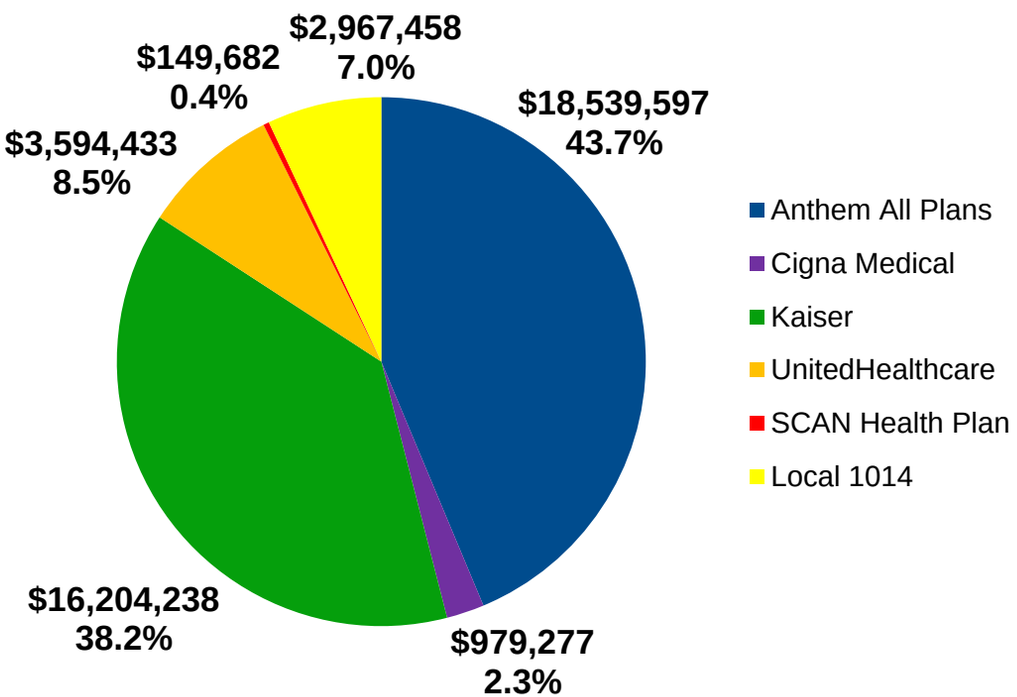
Premium & Enrollment

Coverage Month February 2018

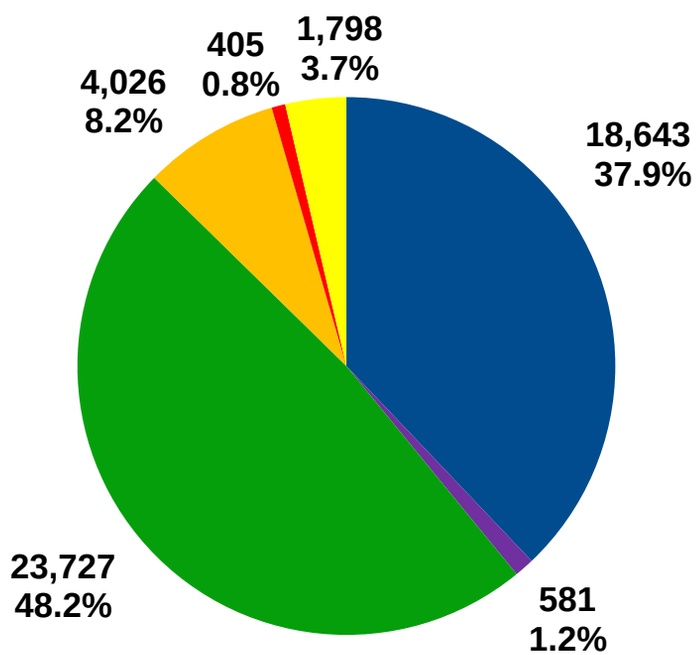
Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$18,539,597	43.7%	18,643	37.9%
Cigna Medical	$979,277	2.3%	581	1.2%
Kaiser	$16,204,238	38.2%	23,727	48.2%
UnitedHealthcare	$3,594,433	8.5%	4,026	8.2%
SCAN Health Plan	$149,682	0.4%	405	0.8%
Local 1014	$2,967,458	7.0%	1,798	3.7%
Combined Medical	**$42,434,686**	**100.0%**	**49,180**	**100.0%**

Cigna Dental & Vision (PPO and HMO)	**$3,907,876**	**50,322**

Monthly Premium



Retirees



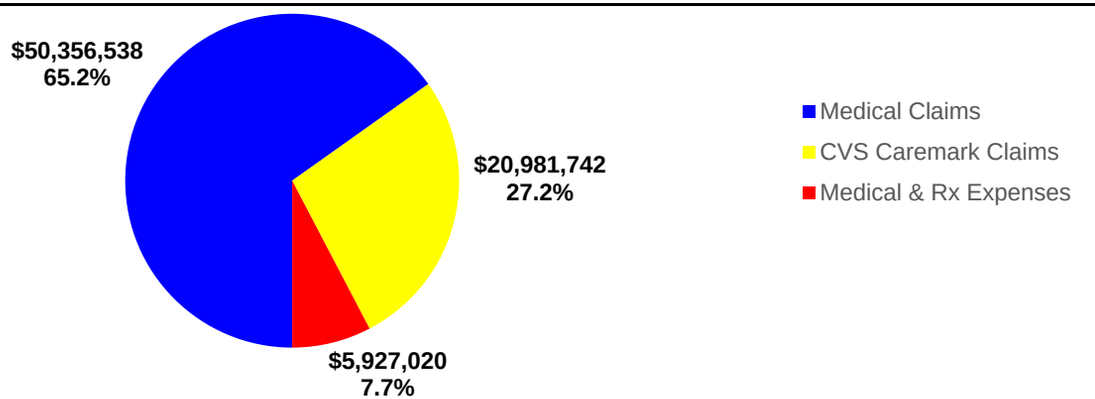
Los Angeles County Employees Retirement Association

Anthem Plans I & II

Coverage Month February 2018

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	5,975	$9,260,918	$6,208,427	$2,761,049	$8,969,476	$1,501.17	96.9%	$739,774	$9,709,250	104.8%
Jan-18	5,970	$9,214,875	$7,074,142	$2,593,312	$9,667,454	$1,619.34	104.9%	$739,291	$10,406,746	112.9%
Feb-18	5,964	$9,211,920	$4,674,133	$2,409,438	$7,083,571	$1,187.72	76.9%	$738,622	$7,822,193	84.9%
Mar-18										
Apr-18										
May-18										
Jun-18										
YTD Plan Year	47,879	$74,112,436	$50,356,538	$20,981,742	$71,338,279	$1,489.97	96.3%	$5,927,020	$77,265,300	104.3%
12 Month Rollup	71,964	$110,371,909	$77,025,320	$31,350,890	$108,376,210	$1,505.98	98.2%	$10,647,825	$119,024,035	107.8%

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



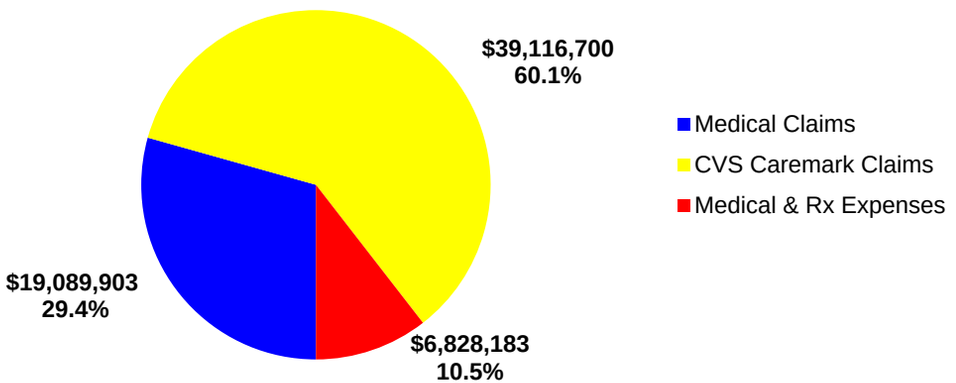
Los Angeles County Employees Retirement Association

Anthem Plan III

Coverage Month February 2018

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	11,490	$7,900,212	$2,102,584	$4,741,118	$6,843,702	$595.62	86.6%	$855,664	$7,699,366	97.5%
Jan-18	11,518	$7,923,794	$2,673,352	$5,471,633	$8,144,985	$707.15	102.8%	$857,749	$9,002,734	113.6%
Feb-18	11,518	$7,918,153	$2,858,770	$4,762,860	$7,621,629	$661.71	96.3%	$857,749	$8,479,378	107.1%
Mar-18										
Apr-18										
May-18										
Jun-18										
YTD Plan Year	91,690	$63,066,043	$19,089,903	$39,116,700	$58,206,602	$634.82	92.3%	$6,828,183	$65,034,785	103.1%
12 Month Rollup	136,777	$93,287,355	$28,804,727	$58,627,751	$87,432,478	$639.23	93.7%	$10,258,402	$97,690,880	104.7%

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



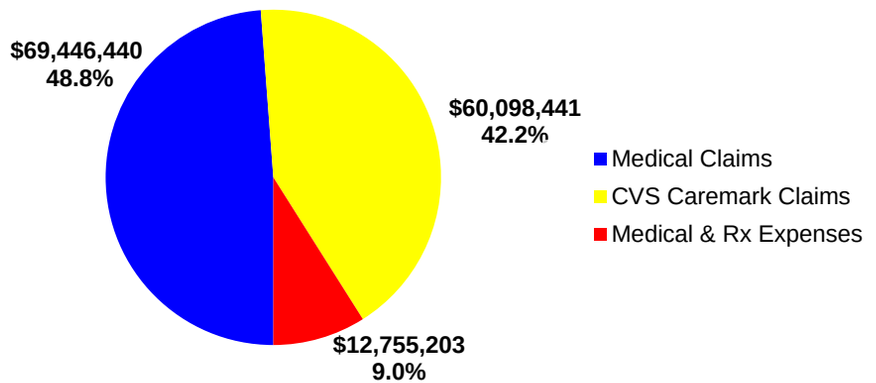
Los Angeles County Employees Retirement Association

Anthem Plans I, II, & III

Coverage Month February 2018

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	17,465	$17,161,130	$8,311,011	$7,502,167	$15,813,178	$905.42	92.1%	$1,595,438	$17,408,616	101.4%
Jan-18	17,488	$17,138,669	$9,747,494	$8,064,945	$17,812,439	$1,018.55	103.9%	$1,597,040	$19,409,479	113.2%
Feb-18	17,482	$17,130,074	$7,532,902	$7,172,298	$14,705,200	$841.16	85.8%	$1,596,371	$16,301,571	95.2%
Mar-18										
Apr-18										
May-18										
Jun-18										
YTD Plan Year	139,569	$137,178,479	$69,446,440	$60,098,441	$129,544,882	$928.18	94.4%	$12,755,203	$142,300,085	103.7%
12 Month Rollup	208,741	$203,659,264	$105,830,047	$89,978,641	$195,808,689	$938.05	96.1%	$20,906,227	$216,714,915	106.4%

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



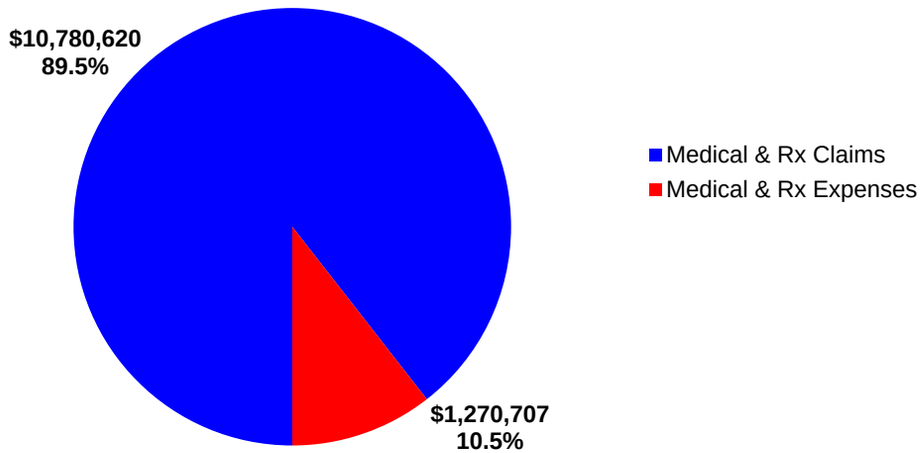
Los Angeles County Employees Retirement Association

Anthem Prudent Buyer

Coverage Month February 2018

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	1,183	$1,435,833	$1,535,133	$1,297.66	106.9%	$157,243	$1,692,377	117.9%
Jan-18	1,172	$1,398,044	$1,347,782	$1,149.98	96.4%	$155,781	$1,503,563	107.5%
Feb-18	1,161	$1,409,523	$1,052,384	$906.45	74.7%	$154,319	$1,206,703	85.6%
Mar-18								
Apr-18								
May-18								
Jun-18								
YTD Plan Year	9,560	$11,583,837	$10,780,620	$1,127.68	93.1%	$1,270,707	$12,051,327	104.0%
12 Month Rollup	14,588	$17,509,464	$15,780,411	$1,081.74	90.1%	$2,087,556	$17,867,967	102.0%

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

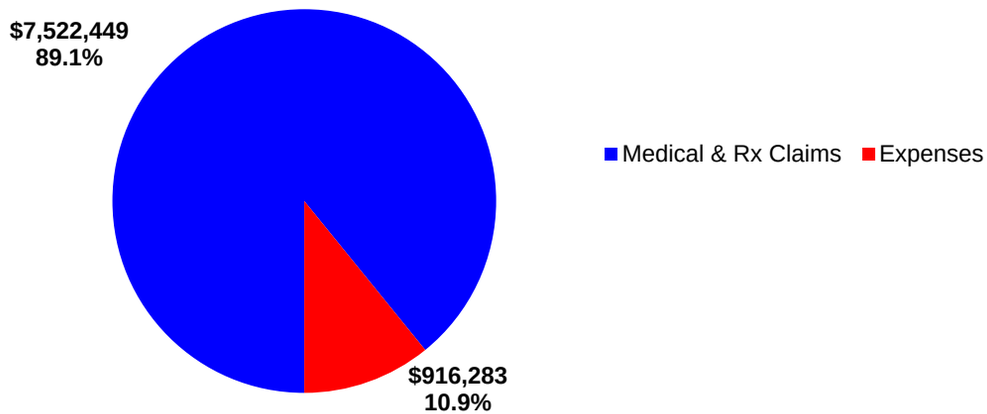
Cigna HMO [1]

Coverage Month February 2018

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	531	$943,758	$715,705	$1,347.84	75.8%	$112,402	$828,107	87.7%
Jan-18	528	$947,463	$876,131	$1,659.34	92.5%	$112,843	$988,974	104.4%
Feb-18	524	$938,078	$929,128	$1,773.14	99.0%	$111,725	$1,040,853	111.0%
Mar-18								
Apr-18								
May-18								
Jun-18								
YTD Plan Year	4,311	$7,693,396	$7,522,449	$1,744.94	97.8%	$916,283	$8,438,732	109.7%
12 Month Rollup	6,583	$11,543,832	$11,362,151	$1,725.98	98.4%	$1,377,949	$12,740,100	110.4%

[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

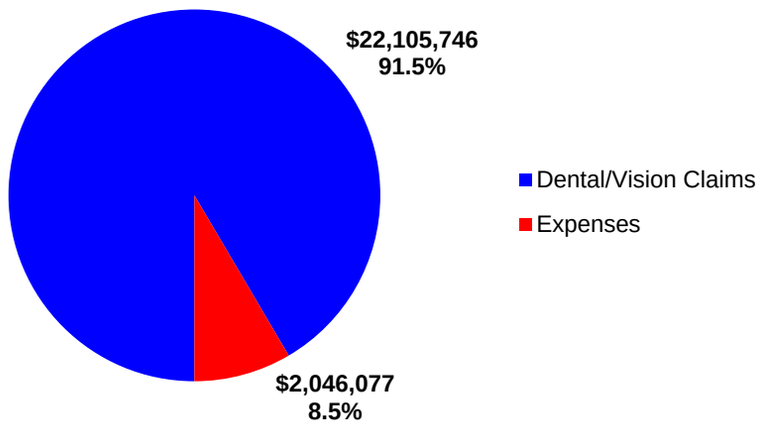
Cigna Dental PPO + Vision

Coverage Month February 2018

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	44,709	$3,539,802	$2,482,447	58.1%	$55.52	70.1%	$256,538	$2,738,985	77.4%
Jan-18	44,776	$3,542,724	$2,858,043	53.5%	$63.83	80.7%	$256,750	$3,114,793	87.9%
Feb-18	44,803	$3,544,236	$3,487,067	54.4%	$77.83	98.4%	$256,859	$3,743,926	105.6%
Mar-18									
Apr-18									
May-18									
Jun-18									
YTD Plan Year	356,915	$28,232,487	$22,105,746	55.9%	$61.94	78.3%	$2,046,077	$24,151,823	85.5%
12 Month Rollup	532,912	$41,864,821	$34,140,918	55.7%	$64.06	81.6%	$3,021,641	$37,162,559	88.8%

Expenses: Cigna Admin Costs and Premium Taxes

Enrollment and Premium Reported by LACERA



Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month February 2018

- 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 11/1/2016 - 10/31/2017	Prior Period 11/1/2015 - 10/31/2016	Change
Average Members	**8,745**	**8,738**	**0.08%**
Inpatient Claims PMPM	$188.88	$209.50	-9.84%
Outpatient Claims PMPM	$275.73	$257.21	7.20%
Pharmacy	$93.32	$94.17	-0.90%
Other	$106.21	$110.27	-3.68%
Total Claims PMPM	**$664.14**	**$671.15**	**-1.04%**
Total Paid Claims	**$69,698,162**	**$70,371,008**	**-0.96%**
Large Claims over $400,000 Pooling Point			
Number of Claims over Pooling Point	4	10	
Amount over Pooling Point	$871,694	$1,834,991	-52.50%
% of Total Paid Claims	**1.25%**	**2.61%**	
Inpatient Days / 1000	233.6	385.7	-39.43%
Inpatient Admits / 1000	53.3	72.6	-26.58%
Outpatient Visits / 1000	11,868.5	12,218.7	-2.87%
Pharmacy Scripts PMPY	10.9	11.4	-4.39%