LIVE VIRTUAL COMMITTEE MEETING

OCTOBER 15, 2020 AT 9:00 AM*

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE MEETING

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

TO VIEW VIA WEB

https://members.lacera.com/lmpublic/live_stream.xhtml

TO PROVIDE PUBLIC COMMENT

You may submit a request to speak during Public Comment or provide a written comment by emailing PublicComment@lacera.com. If you are requesting to speak, please include your contact information, agenda item, and meeting date in your request.

Attention: Public comment requests must be submitted via email to PublicComment@lacera.com no later than 5:00 p.m. the day before the scheduled meeting.

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

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, OCTOBER 15, 2020 - 9:00 A.M.**

This meeting will be conducted by the Insurance, Benefits and Legislative Committee by teleconference under the Governor's Executive Order N-29-20.

Any person may view the meeting online at
https://members.lacera.com/lmpublic/live_stream.xhtml

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

COMMITTEE MEMBERS:

Les Robbins, Chair
Vivian H. Gray, Vice Chair
Wayne Moore
Ronald A. Okum
Shawn R. Kehoe, Alternate

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of August 13, 2020

II. PUBLIC COMMENT

(You may submit written public comments by email to PublicComment@lacera.com. Please include the agenda number and meeting date in your correspondence. Correspondence will be made part of the official record of the meeting. Please submit your written public comments or documentation as soon as possible and up to the close of the meeting.

You may also request to address the Boards. A request to speak must be submitted via email to PublicComment@lacera.com no later than 5:00 p.m. the day before the scheduled meeting. Please include your contact information, agenda item, and meeting date so that we may contact you with information and instructions as to how to access the Board meeting as a speaker.)

III. ACTION ITEMS

A. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement direct its voting delegate to vote YES on sponsorship by the State Association of County Retirement Systems (SACRS) of "COVID-19 Disability Retirement Presumption" for the SACRS 2021 legislative platform. (Memorandum dated October 1, 2020)

IV. FOR INFORMATION

A. Engagement Report for September 2020
Barry W. Lew, Legislative Affairs Officer

B. Staff Activities Report for September 2020
Cassandra Smith, Director, Retiree Healthcare

C. LACERA Anthem 2020-2021 Lifetime Maximum
Paul Sadro, Segal Consulting

D. Medical and Dental Claims Audit Findings
Amber Turner, 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. ITEMS FOR STAFF REVIEW

VI. GOOD OF THE ORDER

(For information purposes only)

VII. ADJOURNMENT

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

****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.

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

MINUTES OF THE MEETING OF THE

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

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

THURSDAY, AUGUST 13, 2020, 10:17 A.M. – 11:02 A.M.

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

COMMITTEE MEMBERS

PRESENT: Les Robbins, Chair
Vivian H. Gray, Vice Chair
Wayne Moore
Ronald Okum
Shawn R. Kehoe, Alternate

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Herman B. Santos *(left at 10:40 a.m.)*

STAFF, ADVISORS, PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare
Santos H. Kreimann, Chief Executive Officer
Barry W. Lew, Legislative Affairs Officer

Stephen Murphy, Vice President
Segal Consulting

Paul Sadro, Senior Actuary
Segal Consulting

Joseph Ackler, State Legislative Advocate
Ackler & Associates

Naomi Padron, State Legislative Advocate
McHugh Koepke & Associates

The meeting was called to order by Chair Robbins at 10:17 a.m.

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of June 11, 2020

Mr. Moore made a motion, Mr. Robbins seconded, to approve the minutes of the regular meeting of June 11, 2020. The motion passed unanimously.

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee consider whether to recommend that the Board of Retirement propose an amendment to the County Employees Retirement Law of 1937 to provide for a COVID-19 presumption for disability retirement. (Memorandum dated August 4, 2020)

Ms. Gray made a motion, Mr. Moore seconded, to recommend that the Board of Retirement approve submission of a legislative proposal for inclusion in the SACRS 2021 Legislative Platform to amend the County Employees Retirement Law of 1937 to provide for a COVID-19 presumption for disability retirement. The motion passed unanimously.

B. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement approve submission of a legislative proposal for inclusion in the SACRS 2021 Legislative Platform that would enable benefit option changes for members retired for service who subsequently apply for and are granted disability retirement. (Memorandum dated July 31, 2020)

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

III. ACTION ITEMS (Continued)

C. Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement approve submission of a legislative proposal for inclusion in the SACRS 2021 Legislative Platform regarding clarifying and technical amendments to the County Employees Retirement Law of 1937. (Memorandum dated July 31, 2020)

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

IV. FOR INFORMATION

A. Engagement Report for July 2020
Barry W. Lew, Legislative Affairs Officer

The engagement report was discussed.

B. Staff Activities Report for July 2020
Cassandra Smith, Director, Retiree Healthcare

The staff activities report was discussed.

C. LACERA Claims Experience
Stephen Murphy, Segal Consulting

The LACERA Claims Experience reports through June 2020 were discussed.

D. Federal Legislation
Stephen Murphy, Segal Consulting

(for discussion purposes)

Segal Consulting gave an update on federal legislation.

V. ITEMS FOR STAFF REVIEW

There was nothing to report.

VI. GOOD OF THE ORDER

(For information purposes only)

VII. ADJOURNMENT

The meeting adjourned at 11:02 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

October 1, 2020

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

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: October 15, 2020 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **PROVIDE VOTING DIRECTIONS ON SACRS 2021 LEGISLATIVE PROPOSALS**

RECOMMENDATION
That the Insurance, Benefits and Legislative Committee recommend that the Board of Retirement direct its voting delegate to vote YES on sponsorship by the State Association of County Retirement Systems (SACRS) of "COVID-19 Disability Retirement Presumption" for the SACRS 2021 legislative platform.

DISCUSSION
Each year, the 20 retirement systems operating under the County Employees Retirement Law of 1937 (CERL) are asked to submit proposals to the SACRS Legislative Committee for sponsorship in the annual SACRS legislative platform. The items submitted should have application to all CERL systems rather than an individual system; they should not propose new benefits that will be paid for by the plan sponsor; and they should not create major issues, such as conflicts with Proposition 162 or with any of the 19 other CERL retirement systems.

The SACRS Legislative Committee received three proposals for inclusion in the SACRS 2021 legislative platform, which were all submitted by LACERA, and discussed the proposals at its meeting of September 18, 2020.

COVID-19 Disability Retirement Presumption (LACERA)
- *SACRS Legislative Committee Recommendation:* ***Decline to Sponsor.***
- *Staff Recommendation:* ***Vote YES to Sponsor.***

This proposal was approved for submission to SACRS by the Board of Retirement at its meeting of September 2, 2020. Attached is the board memo for that meeting that discusses the background, issue, and proposed solution for a disability retirement presumption for COVID-19.

The SACRS Legislative Committee recommended that SACRS decline to sponsor the proposal for "COVID-19 Disability Retirement Presumption." The recommendation by the SACRS Legislative Committee is an advisory recommendation. Regardless of the recommendation, the proposal will be presented to the full SACRS membership for a vote by each system's voting delegate at the Business Meeting of the SACRS 2020 Fall Conference on November 13, 2020.

Disability Retirement Option Change & Clarifying and Technical Amendments

The SACRS Legislative Committee considered the other two proposals submitted by LACERA to be technical proposals that were noncontroversial and recommended that they be included in an omnibus housekeeping bill that the committee intends to formulate for every two-year legislative cycle. These proposals will be incorporated into a list of other clarifying and technical amendments currently being developed for the 2021-22 legislative cycle that the committee intends to present to the SACRS membership for approval at the Business Meeting of the SACRS 2021 Fall Conference. Therefore, directions for LACERA's voting delegate are not necessary at this time for these two proposals.

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE recommend that the Board of Retirement direct its voting delegate to vote YES on sponsorship by the State Association of County Retirement Systems (SACRS) of "COVID-19 Disability Retirement Presumption" for the SACRS 2021 legislative platform.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachments

Disability Retirement Presumption: COVID-19 (Memo dated August 24, 2020)
SACRS 2021 Legislative Platform Worksheet: Disability Retirement Option Change
SACRS 2021 Legislative Platform Worksheet: Clarifying and Technical Amendments

cc: Santos H. Kreimann
JJ Popowich
Steven P. Rice
Ricki Contreras
Frank Boyd
Vincent Lim
Joe Ackler, Ackler & Associates

LACERA

August 24, 2020

TO: Each Member
Board of Retirement

FROM: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Vivian H. Gray, Vice Chair
Wayne Moore
Ronald A. Okum
Shawn R. Kehoe, Alternate

FOR: September 2, 2020 Board of Retirement Meeting

SUBJECT: **Disability Retirement Presumption: COVID-19**

RECOMMENDATION
That the Board of Retirement approve submission of a legislative proposal for inclusion in the SACRS 2021 Legislative Platform to amend the County Employees Retirement Law of 1937 to provide for a COVID-19 presumption for disability retirement.

LEGISLATIVE POLICY STANDARD
LACERA's Legislative Policy does not contain a legislative policy standard related to creating an additional presumption for disability retirement. Therefore, whether the BOR should propose an additional presumption in the County Employees Retirement Law of 1937 (CERL) for disability retirement is subject to determination by the BOR.

BACKGROUND
At the Board of Retirement's (BOR) meeting of June 3, 2020, LACERA's state legislative advocates, Joe Ackler (Ackler & Associates) and Naomi Padron (McHugh Koepke & Associates) provided an update on recent developments in the California Legislature and Office of the Governor regarding the pandemic and the state budget. The update included discussions of current legislation related to COVID-19 presumptions under workers' compensation. The BOR requested that staff work with the state legislative advocates on the possibility of including frontline workers in a COVID-19 presumption for disability retirement that would apply to retirement systems operating under CERL.

At the Insurance, Benefits and Legislative Committee's (IBLC) meeting of August 13, 2020, the IBLC discussed staff's memo on whether the IBLC should recommend that the BOR propose an additional presumption in CERL for disability retirement. The IBLC directed staff to formulate a proposal for inclusion in the State Association of County Retirement Systems (SACRS) 2021 Legislative Platform that would provide for a COVID-19 presumption in CERL.

Each year, the 20 retirement systems operating under CERL are asked to submit proposals to the SACRS Legislative Committee for sponsorship in the SACRS Legislative Platform. The items submitted should have applicability to all CERL systems rather than

an individual system; they should not propose new benefits that will be paid for by the plan sponsor; and they should not create major issues, such as conflicts with Proposition 162 or with any of the 19 other CERL retirement systems.

CURRENT LAW

Government Code Section 31720.5 provides a rebuttable presumption related to heart trouble for disability retirement. The presumption applies to safety members, fireman members, and members in active law enforcement.

Government Code Section 31720.6 provides a disputable presumption related to cancer for disability retirement. The presumption applies to safety members, firefighters, or members in active law enforcement.

Government Code Section 31720.7 provides a rebuttable presumption related to blood-borne infectious disease or a methicillin-resistant Staphylococcus aureus skin infection for disability retirement. The presumption applies to safety members, firefighters, county probation officers, and members in active law enforcement.

Government Code Section 31720.9 provides a rebuttable presumption related to exposure to biochemical substances for disability retirement. The presumption applies to peace officer members and firefighter members.

ISSUE

A member who applies for service-connected disability retirement generally has the burden of proving that his or her permanent incapacity was the result of injury or disease arising out of and in the course of employment and that the employment contributed substantially to the incapacity.

However, for certain diseases and injuries, presumptions exist under the rationale that those diseases and injuries appear to be service-connected but would be difficult for a member to prove as being service-connected.

Given the challenges of contact tracing[1] due to the increasingly widespread nature[2] of the COVID-19 pandemic, there may be cases where members contracted COVID-19 and became permanently incapacitated but have difficulty proving that the disease arose out of and in the course of employment.

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[1] Steinhauer, J., & Goodnough, A. (2020, July 31). Contact Tracing Is Failing in Many States. Here's Why. *New York Times*. https://www.nytimes.com/2020/07/31/health/covid-contact-tracing-tests.html; Petersen, M. (2020, July 31). L.A. County's Tracing Team Repeatedly Failed to Detect Coronavirus Outbreaks at Workplaces. *Los Angeles Times*. https://www.latimes.com/california/story/2020-07-31/la-contact-tracers-struggle-to-keep-up-with-coronavirus-cases

[2] The Johns Hopkins Center for Health Security. (2020, July 29). *Resetting Our Response: Changes Needed in the US Approach to COVID-19*. https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/200729-resetting-our-response.pdf

PROPOSED SOLUTION

A rebuttable presumption related to a service-connected permanent incapacity due to COVID-19 would provide that members are presumed to have contracted COVID-19 arising out of and in the course of employment, unless the presumption is controverted by other evidence.

Although an award of workers' compensation benefits does not necessarily mean that a member also qualifies for disability retirement benefits under CERL, courts have found that the two types of benefits are related in subject matter and harmonious in purpose.

There are currently three workers' compensation bills (AB 196, AB 664, and SB 1159) in the California Legislature that provide a disputable presumption for COVID-19-related injuries that can assist us in the formulation of a new disability retirement presumption. Each bill uses different approaches as noted in the staff memo dated August 4, 2020 to the IBLC. However, SB 1159 appears to be the most comprehensive of the three bills in that it codifies Governor Newsom's Executive Order N-62-20, which provided a COVID-19 presumption for workers' compensation benefits for a specified period of time that has since expired for essential workers, and provides a presumption after that period for employees who are safety members and health care workers whose jobs cannot be done remotely and require contact with members of the public and who may be at higher risk of contracting COVID-19.

Therefore, the proposed COVID-19 presumption for disability retirement in CERL is modeled after the provisions of SB 1159 and CERL's existing disability retirement presumption that deals with other infectious diseases. The proposed presumption would apply to members in county service during the period of March 19, 2020—July 5, 2020 who are considered essential workers and were unable to shelter in place by working remotely.

Beginning July 6, 2020, the workers' compensation presumption expired. However, SB 1159 extends the presumption on and after this date for safety members and certain health care workers whose jobs require contact with members of the public potentially infected with the coronavirus. The proposed disability retirement presumption follows this rationale by designating county workers whose jobs cannot be done remotely but require contact with the public and who may be at higher risk of contracting COVID-19.

If this proposal is enacted in the 2021 legislative year, it will be effective January 1, 2022. However, there may be disability retirement applications for COVID-19-related illnesses that are filed before the effective date of the presumption. The proposal would provide that the presumption applies to new and pending applications as of the effective date and that the board may reconsider COVID-19-related applications that were denied before the effective date.

CONSIDERATIONS

- Establishing a disability retirement presumption is a plan design issue since it establishes eligibility criteria for a benefit. Plan design changes have generally been proposed by either the plan sponsor or employee organizations.
- COVID-19 is a new infectious disease for which there are currently no drugs or other therapeutics approved by the U.S. Food and Drug Administration.[3] There are treatment guidelines that exist for clinical management, but they continue to evolve as more data and research on the disease become available.[4] Thus, the extent to which COVID-19 causes permanent incapacity also continues to evolve.
- The disability retirement presumptions in CERL have historically been sponsored by safety member organizations. LACERA's state legislative advocate indicates that employee organizations are considering this issue and may sponsor a proposal for a disability retirement presumption on COVID-19 in the 2021 legislative year.
- Absent a presumption, demonstrating work-related causation for infectious disease requires showing that the risk of contracting the disease on the job is greater than the risk to which members of the general community are exposed.
- The County of Los Angeles' state legislative agenda is to oppose legislation that creates new presumptions related to service-connected disability retirement and to oppose legislation eliminating requirements to demonstrate on-the-job exposure in order to qualify for service-connected disability retirement benefits.

IT IS THEREFORE RECOMMENDED THAT THE BOARD approve submission of a legislative proposal for inclusion in the SACRS 2021 Legislative Platform to amend the County Employees Retirement Law of 1937 to provide for a COVID-19 presumption for disability retirement.

ATTACHMENTS

SACRS 2021 Legislative Platform Worksheet
IBLC memo dated August 4, 2020

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[3] Centers for Disease Control and Prevention. (2020, April 25). Information for Clinicians on Investigational Therapeutics for Patients with COVID-19. Retrieved August 21, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html

[4] National Institutes of Health. (2020, July 17). COVID-19 Treatment Guidelines. Retrieved August 21 2020 from https://www.covid19treatmentguidelines.nih.gov/introduction/

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

TO: SACRS ADMINISTRATORS AND RETIREMENT BOARD CHAIRS

FROM: Mike Robson and Trent Smith on behalf of SACRS Legislative Committee

SUBJECT: **SACRS 2021 LEGISLATIVE TIMELINES**

If you intend to propose legislation to be sponsored by SACRS, please return your request, EXPLAINED ON THE ATTACHED WORKSHEET, before August 30, 2020 to:

Mike Robson & Trent Smith
Edelstein, Gilbert, Robson & Smith LLC
1127 11th Street, Suite 1030
Sacramento, CA 95814

Email to both:
Mike@EGRSlobby.com
Trent@EGRSlobby.com

SACRS also encourages the use of the Legislative Proposal survey found on the SACRS website. https://www.surveymonkey.com/r/sacrslegislativeproposals

Below is the SACRS Legislative Committee calendar for soliciting legislative proposals from SACRS retirement associations for consideration in the 2021 Legislative Session:

July 3, 2020
Emailing of Committee request that retirement associations submit proposals for inclusion in the SACRS 2021 Legislative Platform.

August 30, 2020
Deadline for requests to be received by Edelstein, Gilbert, Robson & Smith LLC.

September 18, 2020
Date of Legislative Committee meeting at which requests will be discussed.

October 16, 2020
Legislative Committee will submit proposals, (both those that the Legislative Committee recommends by inclusion in SACRS Legislative Platform, and other proposals received) to all retirement associations for consideration.

November 13, 2020
Those legislative proposals recommended by the Legislative Committee, as well as other proposals, will be discussed at the SACRS Fall Conference.

2021 SACRS LEGISLATIVE PLATFORM WORKSHEET
PLEASE COMPLETE AND RETURN BY AUGUST 30, 2020

Title of Issue: COVID-19 Disability Retirement Presumption

Association: LACERA

Contact Person: Barry Lew

Phone #: 626-564-2370

Fax #: N/A

Please answer the following questions as fully as possible:

1. Description of issue.

   A member who applies for service-connected disability retirement generally has the burden of proving that his or her permanent incapacity was the result of injury or disease arising out of and in the course of employment and that the employment contributed substantially to the incapacity.

   However, for certain diseases and injuries, presumptions exist under the rationale that those diseases and injuries appear to be service-connected but would be difficult for a member to prove as being service-connected.

   Given the challenges of contact tracing[1] due to the increasingly widespread nature[2] of the COVID-19 pandemic, there may be cases where members contracted COVID-19 and became permanently incapacitated but have difficulty proving that the disease arose out of and in the course of employment.

2. Recommended solution.

   A rebuttable presumption related to a service-connected permanent incapacity due to COVID-19 would provide that members are presumed to have contracted COVID-19 arising out of and in the course of employment, unless the presumption is controverted by other evidence.

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[1] Steinhauer, J., & Goodnough, A. (2020, July 31). Contact Tracing Is Failing in Many States. Here's Why. *New York Times*. https://www.nytimes.com/2020/07/31/health/covid-contact-tracing-tests.html; Petersen, M. (2020, July 31). L.A. County's Tracing Team Repeatedly Failed to Detect Coronavirus Outbreaks at Workplaces. *Los Angeles Times*. https://www.latimes.com/california/story/2020-07-31/la-contact-tracers-struggle-to-keep-up-with-coronavirus-cases

[2] The Johns Hopkins Center for Health Security. (2020, July 29). *Resetting Our Response: Changes Needed in the US Approach to COVID-19*. https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/200729-resetting-our-response.pdf

Although an award of workers' compensation benefits does not necessarily mean that a member also qualifies for disability retirement benefits under CERL, courts have found that the two types of benefits are related in subject matter and harmonious in purpose.

There are currently three workers' compensation bills (AB 196, AB 664, and SB 1159) in the California Legislature that provide a disputable presumption for COVID-19-related injuries that can assist us in the formulation of a new disability retirement presumption. Each bill uses different approaches as noted in the staff memo dated August 4, 2020 to the IBLC. However, SB 1159 appears to be the most comprehensive of the three bills in that it codifies Governor Newsom's Executive Order N-62-20, which provided a COVID-19 presumption for workers' compensation benefits for a specified period of time that has since expired for essential workers, and provides a presumption after that period for employees who are safety members and health care workers whose jobs cannot be done remotely and require contact with members of the public and who may be at higher risk of contracting COVID-19.

Therefore, the proposed COVID-19 presumption for disability retirement in CERL is modeled after the provisions of SB 1159 and CERL's existing disability retirement presumption that deals with other infectious diseases. The proposed presumption would apply to members in county service during the period of March 19, 2020—July 5, 2020 who are considered essential workers and were unable to shelter in place by working remotely.

Beginning July 6, 2020, the workers' compensation presumption expired. However, SB 1159 extends the presumption on and after this date for safety members and certain health care workers whose jobs require contact with members of the public potentially infected with the coronavirus. The proposed disability retirement presumption follows this rationale by designating county workers whose jobs cannot be done remotely but require contact with the public and who may be at higher risk of contracting COVID-19.

If this proposal is enacted in the 2021 legislative year, it will be effective January 1, 2022. However, there may be disability retirement applications for COVID-19-related illnesses that are filed before the effective date of the presumption. The proposal would provide that the presumption applies to new and pending applications as of the effective date and that the board may reconsider COVID-19-related applications that were denied before the effective date.

3. Specific language that you would like changed in, or added to, '37 Act Law, and suggested code section numbers.

   Add a new Section 31720.10:
   (a) If a member becomes ill or dies due to a COVID-19-related illness, the illness so developing or manifesting itself in those cases shall be presumed to arise out of, and in the course of, employment. The illness so developing or manifesting itself in those cases shall in no case be attributed to any illness

existing prior to that development or manifestation.

(b) Any member described in subdivision (a) permanently incapacitated for the performance of duty as a result of a COVID-19-related illness shall receive a service-connected disability retirement.

(c) The presumption described in subdivision (a) is rebuttable by other evidence. Unless so rebutted, the board is bound to find in accordance with the presumption. The presumption shall be extended to a member following termination of service for a period of 14 days.

(d) "COVID-19" means the coronavirus disease 2019 caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

(e) "Member" means a person—
(1) (A) in county service on or after March 19, 2020, and on or before July 5, 2020, who was designated by the State Public Health Officer in a list of essential critical infrastructure workers in accordance with the Governor's Executive Order of March 19, 2020 (Executive Order N-33-20); and

(B) who is diagnosed with COVID-19 within 14 days after a day on or after March 19, 2020, and on or before July 5, 2020 that the person performed labor or services at the person's place of employment at the employer's direction. For the purpose of this subdivision, "person's place of employment" does not include a person's home or residence.

(2) (A) in county service on or after July 6, 2020, who is a safety member, firefighter, member active in law enforcement, county probation officer, nurse or physician who provides direct patient care at a health facility, or a custodial employee in contact with COVID-19 patients at a health facility; and

(B) who is diagnosed with COVID-19 within 14 days on or after July 6, 2020 that the person performed labor or services at the person's place of employment at the employer's direction. For the purpose of this subdivision, "person's place of employment" does not include a person's home or residence.

(f) This section applies to new and pending applications for disability retirement. This section also applies to applications for disability retirement due to COVID-19 that the board denied prior to the effective date of this section but in its discretion may reconsider after the effective date of this section.

4. Why should the proposed legislation be sponsored by SACRS rather than by your individual retirement association?

   The current disability retirement presumptions apply to all SACRS systems and not just to any individual retirement system. The proposed presumption would also apply to all SACRS systems.

5. Do you anticipate that the proposed legislation would create any major problems such as conflicting with Proposition 162 or create a problem with any of the other 19 SACRS retirement associations?

   The proposed legislation should not cause any conflicts with Proposition 162 or any administrative issues with the other SACRS retirement associations.

6. Who will support or oppose this proposed change in the law?

   Support: labor organizations. Opposition: plan sponsors and plan sponsor organizations such as the California State Association of Counties, Urban Counties of California, and Rural County Representatives of California.

7. Who will be available from your association to testify before the Legislature?

   Barry Lew and Joe Ackler.

Email or mail your legislative proposals to:

Mike Robson and Trent Smith
Edelstein, Gilbert, Robson, & Smith LLC
1127 11th Street, Suite 1030
Sacramento, CA 95814

Email to both:
Mike@EGRSlobby.com
Trent@EGRSlobby.com

LACERA

August 4, 2020

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

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: August 13, 2020 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Disability Retirement Presumption: COVID-19**

RECOMMENDATION
That the Insurance, Benefits and Legislative Committee consider whether to recommend that the Board of Retirement propose an amendment to the County Employees Retirement Law of 1937 to provide for a COVID-19 presumption for disability retirement.

BACKGROUND
At the Board of Retirement's (BOR) meeting of June 3, 2020, LACERA's state legislative advocates, Joe Ackler (Ackler & Associates) and Naomi Padron (McHugh Koepke & Associates) provided an update on recent developments in the California Legislature and Office of the Governor regarding the pandemic and the state budget. The update included discussions of current legislation related to COVID-19 presumptions under workers' compensation. The BOR requested that staff work with the state legislative advocates on the possibility of including frontline workers in a COVID-19 presumption for disability retirement that would apply to retirement systems operating under the County Employees Retirement Law of 1937 (CERL).

Although LACERA members may be granted disability retirement due to permanent incapacity from COVID-19, the issue is whether the burden of proof for permanent incapacity should be presumed and whether the presumption should be rebuttable. This memo is a discussion of various issues and factors that need to be considered if staff is directed to formulate a legislative proposal.

LEGISLATIVE POLICY STANDARD
LACERA's Legislative Policy does not contain a legislative policy standard related to creating an additional presumption for disability retirement. Therefore, whether the BOR should propose an additional presumption in CERL for disability retirement is subject to determination by the BOR.

CURRENT LAW

Government Code Section 31720.5 provides a rebuttable presumption related to heart trouble for disability retirement. The presumption applies to safety members, fireman members, and members in active law enforcement.

Government Code Section 31720.6 provides a disputable presumption related to cancer for disability retirement. The presumption applies to safety members, firefighters, or members in active law enforcement.

Government Code Section 31720.7 provides a rebuttable presumption related to blood-borne infectious disease or a methicillin-resistant Staphylococcus aureus skin infection for disability retirement. The presumption applies to safety members, firefighters, county probation officers, and members in active law enforcement.

Government Code Section 31720.9 provides a rebuttable presumption related to exposure to biochemical substances for disability retirement. The presumption applies to peace officer members and firefighter members.

DISCUSSION

Sponsorship

The current disability retirement presumptions[1] related to cancer, blood-borne disease, and biochemical substances were sponsored by safety member organizations. The legislative proposals were primarily supported by safety member organizations. Opposition came from plan sponsor organizations. Proposing another disability retirement presumption would be a plan design and benefit structure issue that this Committee and the BOR should consider as to whether it falls within LACERA's purview as a plan administrator.

Staff inquired with LACERA's state legislative advocates, County of Los Angeles staff for compensation matters, and staff at an employee organization and did not receive indications that any employee organizations are currently sponsoring legislation on a new disability retirement presumption.

At its meeting in April 17, 2020, the State Association of County Retirement Systems (SACRS) Legislative Committee discussed the issue of sponsoring a disability retirement presumption for COVID-19. Some committee members noted that this may be considered a benefit enhancement that is not appropriate for SACRS to sponsor. However, the committee chair noted that SACRS member systems may submit any proposals for consideration by the committee and to be voted on by the member systems.

Members Covered

Frontline workers, essential workers, critical workers, public safety officers…who should be covered? The simple answer may be all members. However, if LACERA's potential

[1] The heart presumption was originally enacted in 1951, and its original legislative history was not available online.

proposal does not cover all members and compromises may need to be made due to opposition, LACERA may be in a sensitive position of proposing and advocating benefits for only certain slices of its membership.

Governor Newsom's Executive Order N-62-20 was issued on May 6, 2020 and created a presumption related to COVID-19 for workers' compensation benefits. The order applied to dates of injury occurring through 60 days of the order. The order applied to employees who reported to work locations and are on a list of "Essential Critical Infrastructure Workers" designated by the State Public Health Officer pursuant to Executive Order N-33-20.

The Governor's Executive Order has since expired on July 5, 2020. There are no indications that he will extend the order, and currently workers' compensation presumptions related to COVID-19 have been proposed in state and federal legislation. However, the legislation is not consistent with respect to who should be entitled to the presumption as listed below. LACERA would need to decide whether any potential proposal would cover all members or a defined subset of members.

BILL	**EMPLOYEES COVERED**
AB 196 (Gonzalez)	Employees deemed essential in Executive Order N-33-20. However, the bill does not apply to firefighters, peace officers, certain health care employees, and fire and rescue services coordinators.
AB 664 (Cooper, Bonta, Gonzalez)	Firefighters, peace officers, certain health care employees, and fire and rescue services coordinators.
SB 893 (Caballero)	Hospital employees.
SB 1159 (Hill)	Any employee with a COVID-19-related illness (provision in effect until 1/1/2024); state and local firefighting members including certain firefighters on federal locations, peace officers engaged in active law enforcement, fire and rescue services coordinators, nurses, physicians, emergency medical technicians (provision in effect until 7/1/2024); employers with five or more employees not within the previous categories (provision in effect until 7/1/2024).
S 3607 (Grassley)	Public safety officers.

Coverage Window and Conclusiveness

The current state and federal legislative proposals also differ in terms of who is covered based on when labor or services were performed resulting in an injury that would qualify for coverage as well as the conclusiveness of the presumption. LACERA would need to

decide whether any potential proposal should specify a period in which an injury occurred that would qualify for coverage and whether the presumption is rebuttable.

BILL	INJURY PERIOD	PRESUMPTION TYPE
AB 196 (Gonzalez)	On or after March 1, 2020	Conclusive
AB 664 (Cooper, Bonta, Gonzalez)	On or after January 1, 2020	Rebuttable
SB 893 (Caballero)	No specified date or period	Rebuttable
SB 1159 (Hill)	March 19, 2020 to July 5, 2020 (provision in effect until 1/1/2024); on or after July 6, 2020 (provision in effect until 7/1/2024)	Rebuttable
S 3607 (Grassley)	January 1, 2020 to December 31, 2021	Not specified

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE consider whether to recommend that the Board of Retirement propose an amendment to the County Employees Retirement Law of 1937 (CERL) to provide for a COVID-19 presumption for disability retirement.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

cc: Santos H. Kreimann
JJ Popowich
Steven P. Rice
Frank Boyd
Ricki Contreras
Joe Ackler, Ackler & Associates
Naomi Padron, McHugh Koepke & Associates

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

TO: SACRS ADMINISTRATORS AND RETIREMENT BOARD CHAIRS

FROM: Mike Robson and Trent Smith on behalf of SACRS Legislative Committee

SUBJECT: **SACRS 2021 LEGISLATIVE TIMELINES**

If you intend to propose legislation to be sponsored by SACRS, please return your request, EXPLAINED ON THE ATTACHED WORKSHEET, before August 30, 2020 to:

Mike Robson & Trent Smith
Edelstein, Gilbert, Robson & Smith LLC
1127 11th Street, Suite 1030
Sacramento, CA 95814

Email to both:
Mike@EGRSlobby.com
Trent@EGRSlobby.com

SACRS also encourages the use of the Legislative Proposal survey found on the SACRS website. https://www.surveymonkey.com/r/sacrslegislativeproposals

Below is the SACRS Legislative Committee calendar for soliciting legislative proposals from SACRS retirement associations for consideration in the 2021 Legislative Session:

July 3, 2020
Emailing of Committee request that retirement associations submit proposals for inclusion in the SACRS 2021 Legislative Platform.

August 30, 2020
Deadline for requests to be received by Edelstein, Gilbert, Robson & Smith LLC.

September 18, 2020
Date of Legislative Committee meeting at which requests will be discussed.

October 16, 2020
Legislative Committee will submit proposals, (both those that the Legislative Committee recommends by inclusion in SACRS Legislative Platform, and other proposals received) to all retirement associations for consideration.

November 13, 2020
Those legislative proposals recommended by the Legislative Committee, as well as other proposals, will be discussed at the SACRS Fall Conference.

2021 SACRS LEGISLATIVE PLATFORM WORKSHEET
PLEASE COMPLETE AND RETURN BY AUGUST 30, 2020

Title of Issue: Disability Retirement Option Change

Association: LACERA

Contact Person: Barry Lew

Phone #: 626-564-2370

Fax #: N/A

Please answer the following questions as fully as possible:

1. Description of issue.

   SB 2137 was enacted in 1998 and amended Section 31725.7. It was sponsored by SACRS and included among other provisions the ability of a member who applied for disability retirement and then retired for service to change his or her benefit option if granted disability retirement; the survivor was provided this ability if the member died prior to the disability retirement determination.

   AB 992 was enacted in 2015 and amended Section 31760. It was sponsored by SACRS and clarified that although a member generally has until the first payment of a retirement allowance to change a benefit option, he or she may change the option elected at the time a service retirement was granted pending determination of disability retirement, if he or she is subsequently granted disability retirement.

   Section 31722 allows a member to file a disability retirement application while the member is in service, within four months after discontinuance of service, within four months after the expiration of any period during which a presumption is extended beyond his or her discontinuance of service, or while, from the date of discontinuance of service to the time of the application, he or she is continuously physically or mentally incapacitated to perform his or her duties.

   If a member retires for service and thereby discontinues service by ceasing to work for a salary from which deductions are made, he or she may still be eligible for disability retirement by filing a disability retirement application that meets a specified filing period under Section 31722. Members retired for service are not precluded from filing a disability retirement application.

   If such a member who retired for service is found to be eligible for disability retirement, appropriate adjustments are also made retroactive to the effective date of disability retirement. However, the member is not eligible to change the option that was chosen when he or she retired for service to apply to the disability retirement benefit, even though the member's disability retirement benefit may begin on or

before the service retirement date due to the fact that the member may be eligible for an earlier effective date of disability retirement.

Section 31725.7 only allows a benefit option change for members who retired for service after filing a disability retirement application but does not provide the same ability for those who retired for service before filing an application, even though both members may subsequently be granted a disability retirement.

2. Recommended solution.

In order for members and survivors to change their service retirement benefit option upon the granting of a disability retirement, Section 31725.7 must be amended to provide for that ability. Section 31760 must also be amended to account for this exception to the general rule of allowing benefit option changes until the first payment of a retirement allowance.

Section 31725.7 was originally enacted to lessen the financial burden on members who apply for disability retirement but whose applications may require an extended period of time to adjudicate by allowing them to retire for service in the meantime. It was later amended to provide flexibility for these members who were granted disability retirement to change their retirement option. Since the amount of a service retirement allowance and continuance may be different from a disability retirement allowance and continuance, members consider the benefit option that best meets their financial situation based on their retirement status.

However, Section 31725.7 does not account for the fact that members may also be able to file a disability retirement application after retiring for service. Such members also experience a change in retirement status by being granted disability retirement but are not afforded the same opportunity to change the benefit option. The member is not treated equally as of the effective date of disability retirement in being able to change the benefit option.

The proposed amendments would enable the member to receive the highest possible benefit as of the effective date of disability retirement, regardless when the disability application was actually filed. It would treat members equally due to a change in their retirement status as a result of being granted a disability retirement. It would replace the service retirement benefit with a disability retirement benefit as of the disability effective date since members cannot receive both types of benefits for the same period of time; however, any service retirement benefits received before the disability effective date would not be adjusted.

3. Specific language that you would like changed in, or added to, ’37 Act Law, and suggested code section numbers.

31725.7.
(a) At any time after filing an application for disability retirement with the board, the member may, if eligible, apply for, and the board in its discretion may grant, a service retirement allowance pending the determination of his or

her entitlement to disability retirement. If he or she is found to be eligible for disability retirement, appropriate adjustments shall be made in his or her retirement allowance retroactive to the effective date of his or her disability retirement as provided in Section 31724.

(b) Notwithstanding subdivision (a), this section shall also apply to a member retired for service who subsequently files an application for disability retirement with the board. If he or she is found to be eligible for disability retirement, appropriate adjustments shall be made in his or her retirement allowance retroactive to the effective date of his or her disability retirement as provided in Section 31724. This subdivision shall only apply to members whose effective date of disability retirement is on or after January 1, 2022.

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

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

~~(d)~~(e) Notwithstanding subdivision ~~(c),~~(d), if the retired member should die before a final determination is made concerning entitlement to disability retirement, the rights of the beneficiary may be as selected by the member at the time of retirement for service, or as if the member had selected an unmodified allowance. The optional or unmodified type of allowance selected by the member at the time of retirement for service shall not be binding as to the type of allowance the member receives if the member is awarded a disability retirement. A change to the optional or unmodified type of allowance shall be made only at the time a member is awarded a disability retirement and the change shall be retroactive to the service retirement date and benefits previously paid shall be adjusted. If a change to the optional or unmodified type of allowance is not made, the benefit shall be adjusted to reflect the differences in retirement benefits previously received. This paragraph shall only apply to members who retire on or after January 1, 1999.

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

accordance with one of the optional settlements specified in this article.

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

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

4. Why should the proposed legislation be sponsored by SACRS rather than by your individual retirement association?

   The proposed legislation applies to all SACRS member systems, and SACRS in the past has sponsored legislation dealing with issues of disability retirement and option changes.

5. Do you anticipate that the proposed legislation would create any major problems such as conflicting with Proposition 162 or create a problem with any of the other 19 SACRS retirement associations?

   No. The amendments should be considered technical changes similar to the changes proposed by SB 2137 (1998) and AB 992 (2015) providing clarification with respect to benefit options.

6. Who will support or oppose this proposed change in the law?

   SACRS member systems that desire clarification in the law would support. SB 2137, which was the predecessor legislation providing the ability to make option changes, had support from safety member organizations and no opposition.

7. Who will be available from your association to testify before the Legislature?

   Barry Lew and Joe Ackler.

Email or mail your legislative proposals to:

Mike Robson and Trent Smith
Edelstein, Gilbert, Robson, & Smith LLC
1127 11th Street, Suite 1030
Sacramento, CA 95814

Email to both:
Mike@EGRSlobby.com
Trent@EGRSlobby.com

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

TO: SACRS ADMINISTRATORS AND RETIREMENT BOARD CHAIRS

FROM: Mike Robson and Trent Smith on behalf of SACRS Legislative Committee

SUBJECT: SACRS 2021 LEGISLATIVE TIMELINES

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2021 SACRS LEGISLATIVE PLATFORM WORKSHEET
PLEASE COMPLETE AND RETURN BY AUGUST 30, 2020

Title of Issue: Clarifying and Technical Amendments

Association: LACERA

Contact Person: Barry Lew

Phone #: 626-564-2370

Fax #: N/A

Please answer the following questions as fully as possible:

1. Description of issue.

   Various sections of CERL require technical and clarifying amendments that would facilitate plan administration.

2. Recommended solution.

   Post-Retirement Employment
   Description
   Section 31680.2 provides that retired members may be reemployed without reinstatement to membership in a position requiring special skills or knowledge for a period of time not to exceed 90 working days or 720 hours in one fiscal year of any other 12-month period. Section 31680.3 provides that the period of time not exceed 120 working days or 960 hours.

   Proposed Amendments
   The current statutes are missing the phrase "a period of time," which should be inserted between "for" and "not" in the first sentence of each. Section 31680.6 provides context for this correction in that it extends "…the period of time provided for in Section 31680.2…."

   Government Code Sections Affected
   31680.2 and 31680.3.

   County Health Officer as Board's Medical Advisor
   Description
   CERL requires the county health officer to advise the board on medical matters and, if requested by the board, shall attend its meetings. In practice, medical matters generally arise in the adjudication of disability retirement applications, and the various retirement systems operating under CERL usually do not have the actual county health officer perform this function. The county health officer's deputy or other representative may be performing this function, or the retirement systems may

be engaging physicians in private practice.

Proposed Amendments
Clarify that the county health officer, either directly or through a duly authorized representative, shall advise the board on medical matters. Also clarify that the board may contract with a physician in private practice under its existing authority to secure the necessary medical service and advice in carrying out its adjudication of disability retirement applications.

Government Code Sections Affected
31530 and 31732.

Installment Payments
Description
Members who elect to make additional contributions to purchase service credit may elect to make the contributions either on a pretax or after-tax basis. If members make pretax contributions, federal tax law prohibits them from changing or stopping the contributions before termination of service.

Section 31641.8 was enacted in 1955 and provides that a member who has elected to make contributions by installment payments may, at any time prior to the effective date of retirement, complete payment by lump sum. This section does not conform with federal tax law with respect to pretax contributions.

Proposed Amendments
Section 31641.8 should be deleted as being obsolete. The payment terms related to pretax and after-tax contributions in conformity with federal tax law are generally specified in the contracts that members sign when they elect to make additional contributions. Moreover, members have up to 120 days after the effective date of retirement to complete the payment of contributions.

Government Code Sections Affected
31641.8.

3. Specific language that you would like changed in, or added to, '37 Act Law, and suggested code section numbers.

Post-Retirement Employment
31680.2.
(a) Any person who has retired may be employed in a position requiring special skills or knowledge, as determined by the county or district employing him or her, for a period of time not to exceed 90 working days or 720 hours, whichever is greater, in any one fiscal year or any other 12-month period designated by the board of supervisors and may be paid for that employment. That employment shall not operate to reinstate the person as a member of this system or to terminate or suspend his or her retirement allowance, and no deductions shall be made from his or her salary as contributions to this system.

(b) (1) This section shall not apply to any retired person who is otherwise

eligible for employment under this section if, during the 12-month period prior to an appointment described in this section, that retired person receives unemployment insurance compensation arising out of prior employment subject to this section with the same employer.

(2) A retired person who accepts an appointment after receiving unemployment insurance compensation as described in this subdivision shall terminate that employment on the last day of the current pay period and shall not be eligible for reappointment subject to this section for a period of 12 months following the last day of employment.

(3) Beginning January 1, 2013, if any provision of this section conflicts with the California Public Employees' Pension Reform Act of 2013, the provisions of that act shall prevail, except that the limit on postretirement employment provided in subdivision (a) to the greater of 90 working days or 720 hours shall remain effective.

31680.3.
(a) Notwithstanding Section 31680.2, any member who has been covered under the provisions of Section 31751 and has retired may be reemployed in a position requiring special skills or knowledge, as determined by the county or district employing the member, for a period of time not to exceed 120 working days or 960 hours, whichever is greater, in any one fiscal year and may be paid for that employment. That employment shall not operate to reinstate the person as a member of this system or to terminate or suspend the person's retirement allowance, and no deductions shall be made from the person's salary as contributions to this system.

(b) (1) This section shall not apply to any retired member who is otherwise eligible for reemployment under this section if, during the 12-month period prior to an appointment described in this section, that retired person receives unemployment insurance compensation arising out of prior employment subject to this section with the same employer.

(2) A retired person who accepts an appointment after receiving unemployment insurance compensation as described in this subdivision shall terminate that employment on the last day of the current pay period and shall not be eligible for reappointment subject to this section for a period of 12 months following the last day of employment.

(c) Beginning January 1, 2013, if any provision of this section conflicts with the California Public Employees' Pension Reform Act of 2013, the provisions of that act shall prevail.

County Health Officer as Board's Medical Advisor
31530.
The county health officer, either directly or through a duly authorized representative, shall advise the board on medical matters and, if requested by the board, shall attend its meetings.

31732.
The board shall secure such medical, investigatory and other service and advice as is necessary to carry out the purpose of this article. Notwithstanding Section 31529, the board may contract with an attorney in private practice for the legal services and advice necessary to carry out the purpose of this article. Notwithstanding Section 31530, the board may contract with a physician in private practice for the medical advice necessary to carry out the purpose of this article. It shall pay for such services and advice such compensation as it deems reasonable.

Installment Payments
~~31641.8~~
~~Any member who has elected to make contributions pursuant to this chapter by installment payments may, at any time prior to the effective date of his retirement, complete payment thereof by lump sum.~~

4. Why should the proposed legislation be sponsored by SACRS rather than by your individual retirement association?

   The proposed changes are applicable to all SACRS member systems.

5. Do you anticipate that the proposed legislation would create any major problems such as conflicting with Proposition 162 or create a problem with any of the other 19 SACRS retirement associations?

   No. These are technical and clarifying changes.

6. Who will support or oppose this proposed change in the law?

   SACRS member systems should support the changes as they will facilitate plan administration. There should not be any opposition since the changes do not affect CERL's benefit structure.

7. Who will be available from your association to testify before the Legislature?

   Barry W. Lew and Joe Ackler.

Email or mail your legislative proposals to:

Mike Robson and Trent Smith
Edelstein, Gilbert, Robson, & Smith LLC
1127 11th Street, Suite 1030
Sacramento, CA 95814

Email to both:
Mike@EGRSlobby.com
Trent@EGRSlobby.com

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
SEPTEMBER 2020
FOR INFORMATION ONLY

Biden Overhaul of 401(k) Plans

Presidential candidate Joe Biden's tax plan would equalize the tax benefits of retirement plans. Contributions to 401(k) plans are currently made on a pretax basis. The benefits skew toward higher-income employees since they are in higher tax brackets. Lower-income employees in lower tax brackets do not receive the same tax savings and generally have lower participation rates in retirement savings plans. The Biden tax plan would eliminate the pretax basis of the contributions and provide savers a tax credit of up to 26 percent. This would limit but not eliminate the tax benefits for the highest earners and shift more tax benefits to the lowest earners. Moreover, since the contributions would be made on an after-tax basis, high-income employees may start to put more savings into Roth accounts instead of 401(k)'s. It remains to be seen whether the tax credit should be refundable or nonrefundable. (Source) (Source)

Remote Work in the Public Sector

The National Association of State Retirement Systems (NASRA) conducted a survey of 29 retirement systems in 24 different states regarding work from home policies and practices. The survey is mostly qualitative, so responses among systems vary widely and are difficult to generalize. Some of the highlights include the following:

- Twenty-one systems have a written policy governing remote work, and 8 do not.
- Fourteen systems had developed a policy before the pandemic, and 7 developed it in response to the pandemic.
- Employees required to work remotely include field representatives, those under quarantine, and those deemed "at risk."
- Employees ineligible to work remote include call center staff, IT personnel, front desk, mailroom staff, and those whose resources are located in the office.
- Employer-provided supplies and equipment provided for remote work include computers hardware, headsets, monitors, cellphones, and ergonomic workstations.
- Cybersecurity systems for remote workers include virtual desktop infrastructure, virtual private networks, and multifactor authentication.

The pandemic has also sparked conversations about whether remote recruiting should be expanded for government IT positions. For some employers, since remote work has resulted in greater effectiveness and efficiency, remote recruiting of candidates whose physical presence is not required in an office broadens the talent pool to even workers living out of state. (Source) (Source)

Ohio State Spending Data
The Ohio Checkbook is the state's searchable online database of state and local financial and transactional information that includes revenues and expenditures. Launched in June 2020, it combines two websites previously operated by the State Treasurer's office and the Office of Budget and Management

Financial information is provided in multiple formats and allows users to drill down from summary data to individual transactions. The database includes 5 of Ohio's public retirement systems. The Ohio Public Employees Retirement System has been the only system to have salary information displayed on the website. The 2019 salary information now includes the School Employees Retirement System of Ohio and the Ohio State Highway Patrol Retirement System. The database contains administrative expenditures of the systems but not retired member payee information. (Source) (Source)

> Staff Note: The County of Los Angeles maintains an Open Data portal that provides public access to a wide variety of county data.

State of Wisconsin Investment Board Podcast
The Wisconsin Retirement System is one of the few fully funded pension plans in the U.S. The State of Wisconsin Investment Board has launched "The SWIB Podcast: Wisconsin Retirement System Insights," a monthly podcast about the board's investment strategies to fund the Wisconsin Retirement System. The podcasts are produced in partnership with Milwaukee-based Podcamp Media and available on most major podcast platforms.
(Source) (Source)

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
SEPTEMBER 2020
FOR INFORMATION ONLY

Retiree Wellness Program – Fall Staying Healthy Together Half-Day Workshop-Update

Due to the COVID-19 public health emergency, staff had to cancel the Retiree Fall Staying Healthy Together workshop. Staff is looking into alternative ways to host a virtual workshop for our members for safe and healthy activities that they can access while we continue to be impacted by the COVID-19 pandemic. We will provide more information as they become available.

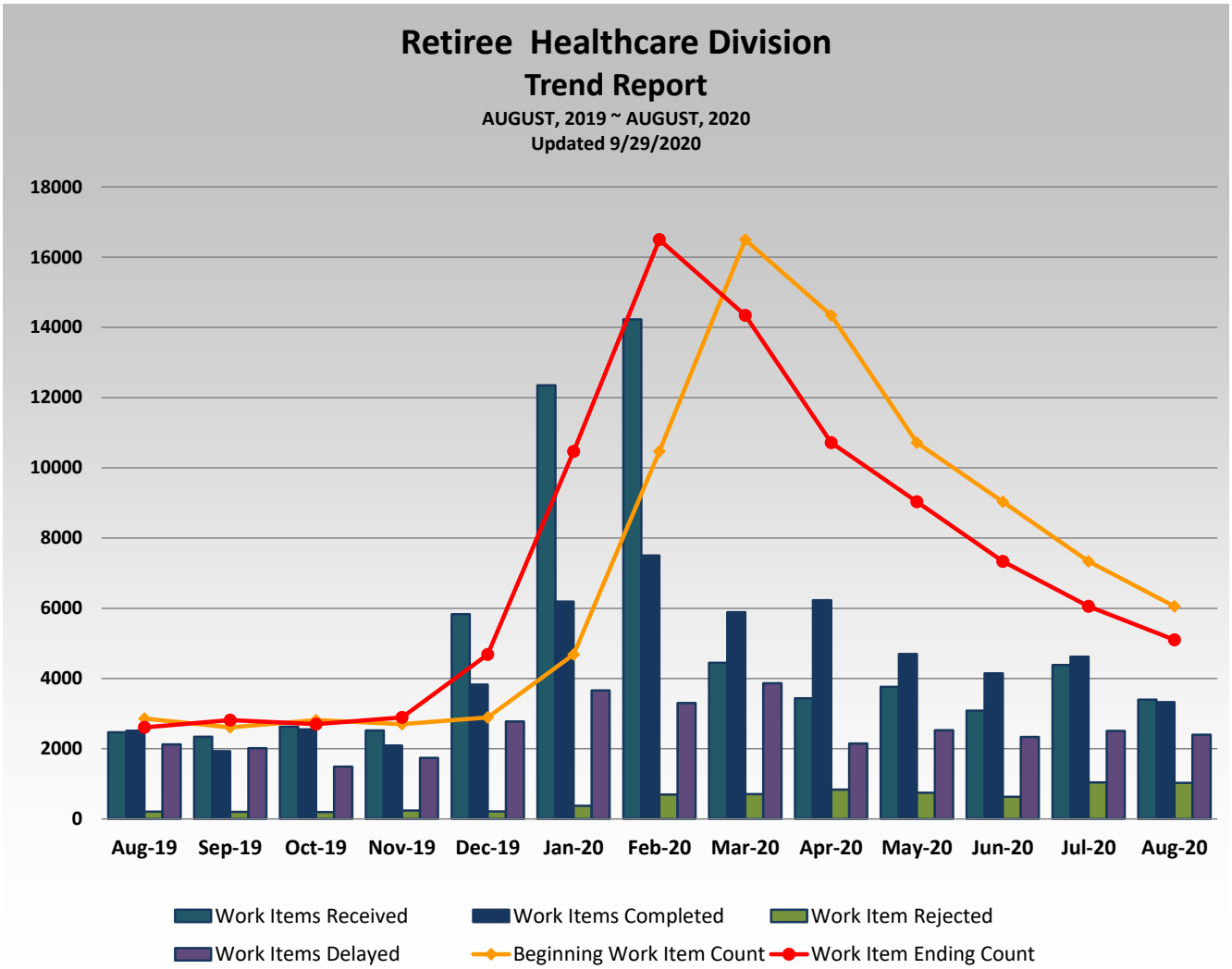
Centers for Medicare and Medicaid Services (CMS) Medicare Part D Retiree Drug Subsidy (RDS) Applications: Plan Year 7/1/2018 – 6/30/2019 – Subsidy Payments

Staff and carriers completed the RDS subsidy payment requests and submitted them to CMS/RDS for the following plans: Anthem Blue Cross, Cigna, Kaiser, and LACFF Local 1014.

We received approval from CMS/RDS that all payment requests submitted were approved. On September 3, 2020, a total of $12 Million subsidy payments were received and below is a breakdown per plan:

Plan	Total RDS Subsidy Payment Amount Approved
Anthem Blue Cross	$10,251,707
Cigna HMO	$282,745
Kaiser	$384,234
LACFF Local 1014	$949,353
TOTAL:	**$11,868,039**

As a background, CMS Medicare Part D RDS Program was enacted in December 2003, as part of the Medicare Modernization Act, to reimburse Plan Sponsors for a portion of their Qualifying Covered Retirees' costs for prescription drugs otherwise covered by Medicare Part D. To qualify for the subsidy, a Plan Sponsor must show that its coverage is "actuarially equivalent" to, or at least as generous as, the defined standard Medicare Part D coverage. Subsidy payments equal 28 percent of each qualifying retiree's allowable prescription drug costs between the applicable cost threshold and cost limit.

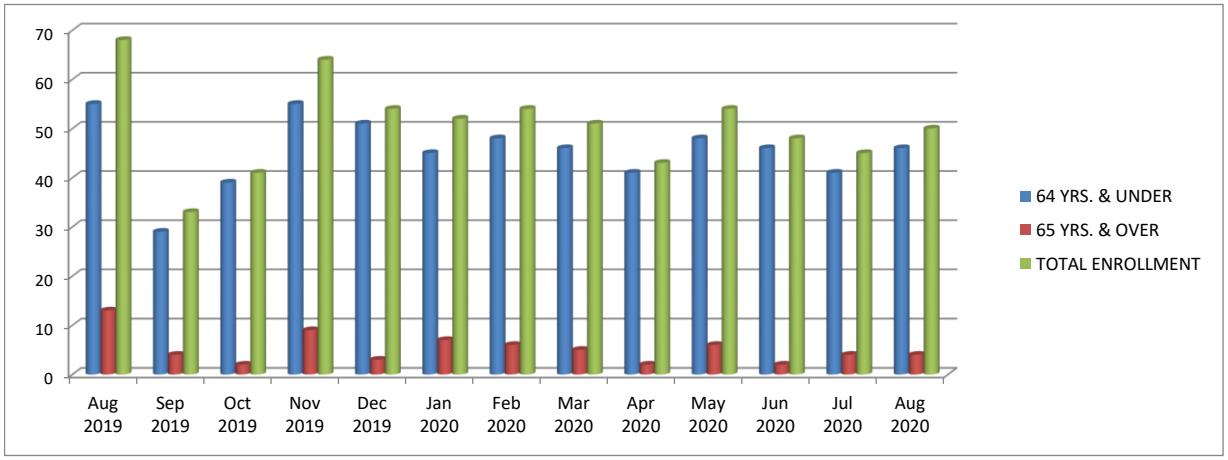


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Aug-19	2861	2471	2516	208	2121	2608
Sep-19	2608	2344	1933	205	2016	2814
Oct-19	2814	2631	2553	194	1488	2698
Nov-19	2698	2522	2088	242	1737	2890
Dec-19	2890	5834	3827	214	2774	4683
Jan-20	4683	12350	6189	374	3663	10470
Feb-20	10470	14225	7504	694	3301	16497
Mar-20	16497	4445	5888	709	3864	14345
Apr-20	14345	3434	6228	836	2147	10715
May-20	10715	3764	4697	748	2526	9034
Jun-20	9034	3084	4150	633	2334	7335
Jul-20	7335	4382	4623	1038	2510	6056
Aug-20	6056	3397	3324	1027	2400	5102

Retirees Monthly Age Breakdown
AUGUST, 2019 ~ AUGUST, 2020

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
Aug 2019	55	13	68
Sep 2019	29	4	33
Oct 2019	39	2	41
Nov 2019	55	9	64
Dec 2019	51	3	54
Jan 2020	45	7	52
Feb 2020	48	6	54
Mar 2020	46	5	51
Apr 2020	41	2	43
May 2020	48	6	54
Jun 2020	46	2	48
Jul 2020	41	4	45
Aug 2020	46	4	50



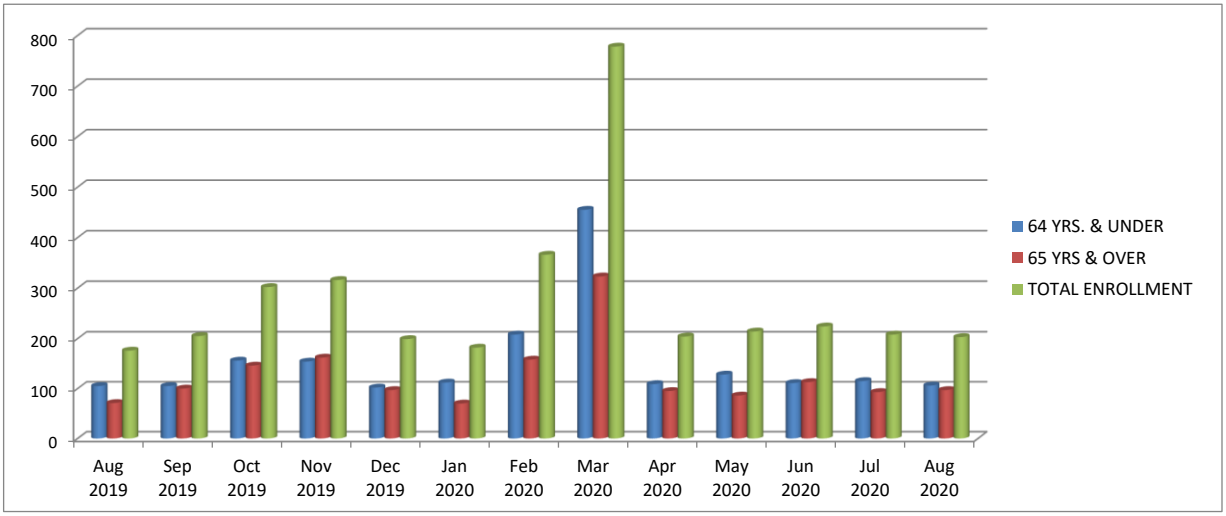
PLEASE NOTE:

- **Next Report will include the following dates: September 1, 2019 throught September 30, 2020.**

Retirees Monthly Age Breakdown
AUGUST, 2019 ~ AUGUST, 2020

Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
Aug 2019	105	71	176
Sep 2019	105	100	205
Oct 2019	156	146	302
Nov 2019	154	162	316
Dec 2019	102	97	199
Jan 2020	112	70	182
Feb 2020	208	158	366
Mar 2020	455	323	778
Apr 2020	109	95	204
May 2020	128	86	214
Jun 2020	111	113	224
Jul 2020	115	93	208
Aug 2020	106	97	203



PLEASE NOTE:

- **Next Report will include the following dates: September 1, 2019 through September 30, 2020.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 9/30/2020

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	6935	$908,031.50	2	$148.30
241	147	$19,276.20	0	$0.00
242	880	$118,157.60	0	$0.00
243	4095	$1,090,447.05	1	$54.20
244	15	$1,911.20	0	$0.00
245	56	$7,291.40	0	$0.00
246	19	$1,778.30	0	$0.00
247	126	$17,678.20	0	$0.00
248	11	$1,554.00	1	$43.00
249	54	$14,565.10	0	$0.00
250	16	$4,196.50	0	$0.00
Plan Total:	**12,354**	**$2,184,887.05**	**4**	**$245.50**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	29	$3,704.30	0	$0.00
322	6	$764.60	0	$0.00
324	19	$5,081.00	0	$0.00
327	3	$385.00	0	$0.00
329	1	$226.70	0	$0.00
Plan Total:	**58**	**$10,161.60**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	7	$983.20	0	$0.00
397	4	$567.30	0	$0.00
398	3	$849.40	0	$0.00
403	11100	$1,438,760.00	4	$59.30
406	2	($480.80)	0	$0.00
413	1611	$215,397.70	0	$0.00
418	5698	$1,513,053.95	1	$163.70
419	271	$33,430.80	0	$0.00
426	216	$29,084.70	0	$0.00
427	175	$21,209.50	0	$0.00
445	4	$531.70	0	$0.00
446	2	$248.10	0	$0.00
451	33	$4,412.30	0	$0.00
455	2	$289.20	0	$0.00
457	8	$2,065.00	0	$0.00
458	2	$278.60	0	$0.00
462	60	$7,691.00	0	$0.00
465	7	$971.50	0	$0.00
466	27	$6,676.70	0	$0.00
467	1	$144.60	0	$0.00
472	32	$4,208.70	0	$0.00
476	5	$393.00	0	$0.00
478	16	$4,577.70	0	$0.00
479	2	$289.20	0	$0.00
482	75	$10,009.10	0	$0.00
486	6	$808.20	0	$0.00
488	43	$12,035.20	0	$0.00
Plan Total:	**19,412**	**$3,308,485.55**	**5**	**$223.00**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 9/30/2020

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	313	$41,549.60	0	$0.00
613	98	$23,012.10	0	$0.00
Plan Total:	**411**	**$64,561.70**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1788	$236,364.90	1	$36.50
702	377	$52,566.60	0	$0.00
703	1119	$298,443.90	0	$0.00
704	92	$12,612.80	0	$0.00
705	34	$9,142.90	0	$0.00
Plan Total:	**3,410**	**$609,131.10**	**1**	**$36.50**
Grand Total:	**35,645**	**$6,177,227.00**	**10**	**$505.00**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 9/30/2020

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	6935	$908,031.50	2	$148.30
241	147	$19,276.20	0	$0.00
242	880	$118,157.60	0	$0.00
243	4095	$1,090,447.05	1	$54.20
244	15	$1,911.20	0	$0.00
245	56	$7,291.40	0	$0.00
246	19	$1,778.30	0	$0.00
247	126	$17,678.20	0	$0.00
248	11	$1,554.00	1	$43.00
249	54	$14,565.10	0	$0.00
250	16	$4,196.50	0	$0.00
Plan Total:	**12,354**	**$2,184,887.05**	**4**	**$245.50**
CIGNA-HEALTHSPRING PREFERRED with RX				
321	29	$3,704.30	0	$0.00
322	6	$764.60	0	$0.00
324	19	$5,081.00	0	$0.00
327	3	$385.00	0	$0.00
329	1	$226.70	0	$0.00
Plan Total:	**58**	**$10,161.60**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	7	$983.20	0	$0.00
397	4	$567.30	0	$0.00
398	3	$849.40	0	$0.00
403	11100	$1,438,760.00	4	$59.30
406	2	($480.80)	0	$0.00
413	1611	$215,397.70	0	$0.00
418	5698	$1,513,053.95	1	$163.70
419	271	$33,430.80	0	$0.00
426	216	$29,084.70	0	$0.00
427	175	$21,209.50	0	$0.00
445	4	$531.70	0	$0.00
446	2	$248.10	0	$0.00
451	33	$4,412.30	0	$0.00
455	2	$289.20	0	$0.00
457	8	$2,065.00	0	$0.00
458	2	$278.60	0	$0.00
462	60	$7,691.00	0	$0.00
465	7	$971.50	0	$0.00
466	27	$6,676.70	0	$0.00
467	1	$144.60	0	$0.00
472	32	$4,208.70	0	$0.00
476	5	$393.00	0	$0.00
478	16	$4,577.70	0	$0.00
479	2	$289.20	0	$0.00
482	75	$10,009.10	0	$0.00
486	6	$808.20	0	$0.00
488	43	$12,035.20	0	$0.00
Plan Total:	**19,412**	**$3,308,485.55**	**5**	**$223.00**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 9/30/2020

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	313	$41,549.60	0	$0.00
613	98	$23,012.10	0	$0.00
Plan Total:	**411**	**$64,561.70**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1788	$236,364.90	1	$36.50
702	377	$52,566.60	0	$0.00
703	1119	$298,443.90	0	$0.00
704	92	$12,612.80	0	$0.00
705	34	$9,142.90	0	$0.00
Plan Total:	**3,410**	**$609,131.10**	**1**	**$36.50**
LOCAL 1014				
804	181	$31,907.90	0	$0.00
805	181	$29,237.90	0	$0.00
806	619	$195,295.90	0	$0.00
807	42	$7,519.00	0	$0.00
808	12	$3,470.40	0	$0.00
812	238	$37,742.10	0	$0.00
813	1	$144.60	0	$0.00
Plan Total:	**1,274**	**$305,317.80**	**0**	**$0.00**
Grand Total:	**36,919**	**$6,482,544.80**	**10**	**$505.00**

Medical and Dental Vision Insurance Premiums
October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	559	$563,171.07	$85,368.54	$476,811.27	$562,179.81	($2,007.74)	$560,172.07
202	291	$580,600.02	$53,004.35	$515,746.69	$568,751.04	$0.00	$568,751.04
203	72	$160,464.24	$36,371.81	$121,863.76	$158,235.57	$0.00	$158,235.57
204	31	$41,284.80	$14,810.86	$23,893.64	$38,704.50	$0.00	$38,704.50
SUBTOTAL	**953**	**$1,345,520.13**	**$189,555.56**	**$1,138,315.36**	**$1,327,870.92**	**($2,007.74)**	**$1,325,863.18**
Anthem Blue Cross I							
211	692	$860,624.88	$56,781.30	$796,424.40	$853,205.70	($7,419.18)	$845,786.52
212	256	$570,483.20	$35,566.04	$532,688.71	$568,254.75	$0.00	$568,254.75
213	56	$147,193.20	$17,452.88	$129,740.32	$147,193.20	$0.00	$147,193.20
214	19	$31,078.30	$4,023.83	$27,054.47	$31,078.30	($1,635.70)	$29,442.60
215	2	$837.14	$33.48	$803.66	$837.14	$0.00	$837.14
SUBTOTAL	**1,025**	**$1,610,216.72**	**$113,857.53**	**$1,486,711.56**	**$1,600,569.09**	**($9,054.88)**	**$1,591,514.21**
Anthem Blue Cross II							
221	2,205	$2,732,731.30	$159,560.73	$2,609,206.47	$2,768,767.20	($8,655.71)	$2,760,111.49
222	1,938	$4,343,249.05	$112,670.49	$4,168,062.22	$4,280,732.71	($2,228.45)	$4,278,504.26
223	793	$2,094,874.65	$80,430.53	$1,960,235.84	$2,040,666.37	$0.00	$2,040,666.37
224	173	$286,247.50	$30,064.19	$251,276.21	$281,340.40	$3,271.40	$284,611.80
225	1	$418.57	$209.28	$209.29	$418.57	$0.00	$418.57
SUBTOTAL	**5,110**	**$9,457,521.07**	**$382,935.22**	**$8,988,990.03**	**$9,371,925.25**	**($7,612.76)**	**$9,364,312.49**

Medical and Dental Vision Insurance Premiums
October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	6,963	$3,512,187.54	$505,296.06	$3,039,763.92	$3,545,059.98	($14,116.92)	$3,530,943.06
241	146	$238,217.84	$23,918.38	$217,345.88	$241,264.26	$0.00	$241,264.26
242	881	$1,435,745.36	$87,465.47	$1,300,855.64	$1,388,321.11	($3,219.16)	$1,385,101.95
243	4,104	$4,127,004.31	$457,854.73	$3,633,383.88	$4,091,238.61	($11,761.01)	$4,079,477.60
244	15	$13,529.10	$2,417.21	$15,525.17	$17,942.38	($901.94)	$17,040.44
245	55	$50,508.64	$5,123.02	$46,287.56	$51,410.58	$0.00	$51,410.58
246	18	$38,136.80	$3,251.66	$27,071.96	$30,323.62	$0.00	$30,323.62
247	130	$260,936.00	$17,101.31	$239,820.29	$256,921.60	$0.00	$256,921.60
248	9	$15,399.67	$391.99	$3,958.04	$4,350.03	$0.00	$4,350.03
249	55	$78,398.32	$5,711.88	$68,486.53	$74,198.41	$0.00	$74,198.41
250	16	$25,101.12	$815.79	$24,285.33	$25,101.12	$0.00	$25,101.12
SUBTOTAL	**12,392**	**$9,795,164.70**	**$1,109,347.50**	**$8,616,784.20**	**$9,726,131.70**	**($29,999.03)**	**$9,696,132.67**
CIGNA Network Model Plan							
301	262	$430,085.04	$115,043.21	$308,539.94	$423,583.15	$0.00	$423,583.15
302	88	$258,789.52	$67,766.80	$191,022.72	$258,789.52	($2,940.77)	$255,848.75
303	10	$34,724.50	$9,012.46	$18,767.14	$27,779.60	$0.00	$27,779.60
304	14	$30,260.44	$13,903.43	$16,357.01	$30,260.44	($2,161.46)	$28,098.98
SUBTOTAL	**374**	**$753,859.50**	**$205,725.90**	**$534,686.81**	**$740,412.71**	**($5,102.23)**	**$735,310.48**

Medical and Dental Vision Insurance Premiums

October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
CIGNA Healthspring Pref w/ Rx - Phoenix, AZ							
321	30	$11,534.70	$1,614.87	$9,919.83	$11,534.70	$0.00	$11,534.70
322	7	$11,873.19	$678.47	$9,498.55	$10,177.02	$0.00	$10,177.02
324	19	$14,458.62	$1,795.92	$12,662.70	$14,458.62	$0.00	$14,458.62
327	3	$6,685.56	$445.70	$6,239.86	$6,685.56	$0.00	$6,685.56
329	1	$1,334.15	$0.00	$1,334.15	$1,334.15	$0.00	$1,334.15
SUBTOTAL	**60**	**$45,886.22**	**$4,534.96**	**$39,655.09**	**$44,190.05**	**$0.00**	**$44,190.05**

Medical and Dental Vision Insurance Premiums

October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,515	$1,674,201.15	$144,916.30	$1,515,271.27	$1,660,187.57	$4,351.40	$1,664,538.97
403	11,148	$3,218,282.56	$322,332.23	$2,912,044.75	$3,234,376.98	($4,319.55)	$3,230,057.43
404	580	$685,392.30	$14,540.12	$670,853.32	$685,393.44	($8,243.55)	$677,149.89
405	1,111	$1,259,693.55	$21,510.71	$1,232,533.99	$1,254,044.70	$2,259.54	$1,256,304.24
406	36	$77,054.88	$29,894.06	$41,077.54	$70,971.60	$0.00	$70,971.60
411	1,888	$4,127,300.80	$204,630.95	$3,834,127.57	$4,038,758.52	$0.00	$4,038,758.52
413	1,608	$2,231,240.62	$101,457.94	$2,073,756.00	$2,175,213.94	$0.00	$2,175,213.94
414	111	$250,582.50	$2,167.20	$248,415.30	$250,582.50	$0.00	$250,582.50
418	5,686	$3,241,243.02	$247,950.48	$2,989,366.38	$3,237,316.86	($3,978.38)	$3,233,338.48
419	270	$396,527.04	$4,256.83	$386,438.93	$390,695.76	$0.00	$390,695.76
420	132	$309,843.60	$1,126.70	$308,716.90	$309,843.60	$0.00	$309,843.60
421	7	$7,614.95	$1,000.82	$6,614.13	$7,614.95	$0.00	$7,614.95
422	251	$556,824.24	$2,209.60	$554,614.64	$556,824.24	$0.00	$556,824.24
423	20	$62,152.20	$11,685.96	$50,466.24	$62,152.20	$0.00	$62,152.20
426	216	$304,547.04	$2,876.29	$308,670.19	$311,546.48	$0.00	$311,546.48
427	176	$408,503.61	$7,477.70	$398,717.98	$406,195.68	$2,307.93	$408,503.61
428	60	$137,965.20	$827.78	$134,838.00	$135,665.78	$0.00	$135,665.78
429	8	$25,579.28	$4,551.68	$21,027.60	$25,579.28	$0.00	$25,579.28
430	141	$317,467.14	$3,737.54	$313,729.60	$317,467.14	($2,251.54)	$315,215.60
431	12	$37,794.36	$6,252.96	$31,541.40	$37,794.36	$0.00	$37,794.36
432	7	$28,332.64	$9,933.49	$18,399.15	$28,332.64	($4,047.52)	$24,285.12
SUBTOTAL	**24,983**	**$19,358,142.68**	**$1,145,337.34**	**$18,051,220.88**	**$19,196,558.22**	**($13,921.67)**	**$19,182,636.55**

Medical and Dental Vision Insurance Premiums

October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Colorado							
450	7	$7,349.51	$797.94	$6,551.57	$7,349.51	$0.00	$7,349.51
451	33	$11,518.98	$1,452.06	$10,415.98	$11,868.04	$0.00	$11,868.04
453	3	$6,963.54	$278.19	$6,685.35	$6,963.54	$0.00	$6,963.54
454	3	$9,401.67	$1,516.32	$7,885.35	$9,401.67	$0.00	$9,401.67
455	2	$2,781.98	$0.00	$2,781.98	$2,781.98	$0.00	$2,781.98
457	8	$5,520.96	$1,104.19	$4,416.77	$5,520.96	$0.00	$5,520.96
458	2	$4,744.64	$94.89	$4,649.75	$4,744.64	$0.00	$4,744.64
SUBTOTAL	**58**	**$48,281.28**	**$5,243.59**	**$43,386.75**	**$48,630.34**	**$0.00**	**$48,630.34**
Kaiser - Georgia							
441	4	$4,434.68	$0.00	$4,434.68	$4,434.68	$0.00	$4,434.68
442	4	$4,434.68	$0.00	$4,434.68	$4,434.68	$0.00	$4,434.68
445	4	$6,096.56	$0.00	$6,096.56	$6,096.56	$0.00	$6,096.56
446	2	$3,048.28	$0.00	$3,048.28	$3,048.28	$0.00	$3,048.28
461	16	$17,738.72	$3,237.31	$14,501.41	$17,738.72	$0.00	$17,738.72
462	61	$25,831.67	$3,404.69	$22,426.98	$25,831.67	$0.00	$25,831.67
463	2	$4,418.68	$1,104.67	$3,314.01	$4,418.68	$0.00	$4,418.68
465	7	$10,668.98	$914.48	$9,754.50	$10,668.98	$0.00	$10,668.98
466	26	$22,651.38	$872.50	$20,939.94	$21,812.44	($1,677.88)	$20,134.56
467	1	$2,624.81	$0.00	$2,624.81	$2,624.81	$0.00	$2,624.81
SUBTOTAL	**127**	**$101,948.44**	**$9,533.65**	**$91,575.85**	**$101,109.50**	**($1,677.88)**	**$99,431.62**

Medical and Dental Vision Insurance Premiums
October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Hawaii							
471	3	$2,972.25	$0.00	$3,963.00	$3,963.00	($990.75)	$2,972.25
472	32	$14,343.68	$2,375.68	$11,968.00	$14,343.68	$0.00	$14,343.68
473	1	$1,774.62	$538.09	$1,236.53	$1,774.62	$0.00	$1,774.62
474	3	$5,920.50	$0.00	$5,920.50	$5,920.50	$0.00	$5,920.50
476	4	$7,154.95	$2,547.17	$1,745.80	$4,292.97	$0.00	$4,292.97
478	16	$14,215.68	$1,563.72	$13,540.44	$15,104.16	$0.00	$15,104.16
479	2	$4,429.72	$0.00	$4,429.72	$4,429.72	$0.00	$4,429.72
SUBTOTAL	**61**	**$50,811.40**	**$7,024.66**	**$42,803.99**	**$49,828.65**	**($990.75)**	**$48,837.90**
Kaiser - Oregon							
481	7	$8,102.64	$2,060.38	$6,042.26	$8,102.64	$0.00	$8,102.64
482	75	$35,952.00	$6,442.58	$30,468.14	$36,910.72	$0.00	$36,910.72
484	4	$9,228.20	$581.82	$8,646.38	$9,228.20	$0.00	$9,228.20
486	6	$9,773.28	$1,303.10	$8,470.18	$9,773.28	$0.00	$9,773.28
488	43	$40,880.96	$5,799.41	$36,032.27	$41,831.68	$0.00	$41,831.68
489	2	$2,152.16	$0.00	$2,152.16	$2,152.16	$0.00	$2,152.16
495	2	$5,016.00	$559.10	$4,456.90	$5,016.00	$0.00	$5,016.00
498	1	$2,407.52	$179.07	$2,228.45	$2,407.52	$0.00	$2,407.52
SUBTOTAL	**140**	**$113,512.76**	**$16,925.46**	**$98,496.74**	**$115,422.20**	**$0.00**	**$115,422.20**
SCAN Health Plan							
611	311	$85,449.00	$18,907.98	$70,066.02	$88,974.00	($273.00)	$88,701.00
613	93	$52,724.00	$7,370.60	$39,435.40	$46,806.00	$0.00	$46,806.00
SUBTOTAL	**404**	**$138,173.00**	**$26,278.58**	**$109,501.42**	**$135,780.00**	**($273.00)**	**$135,507.00**

Medical and Dental Vision Insurance Premiums

October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
UHC Medicare Adv.							
701	1,787	$615,267.95	$75,081.15	$544,290.99	$619,372.14	($2,745.20)	$616,626.94
702	375	$594,393.28	$37,827.88	$556,565.40	$594,393.28	($3,136.64)	$591,256.64
703	1,114	$759,696.00	$75,766.01	$679,209.11	$754,975.12	$1,356.60	$756,331.72
704	94	$170,820.48	$8,683.43	$155,019.53	$163,702.96	$0.00	$163,702.96
705	33	$30,238.24	$2,490.21	$29,526.75	$32,016.96	$0.00	$32,016.96
706	1	$352.92	$14.12	$338.80	$352.92	$0.00	$352.92
SUBTOTAL	**3,404**	**$2,170,768.87**	**$199,862.80**	**$1,964,950.58**	**$2,164,813.38**	**($4,525.24)**	**$2,160,288.14**
United Healthcare							
707	438	$547,527.48	$51,338.88	$502,077.25	$553,416.13	$1,233.17	$554,649.30
708	426	$970,387.88	$46,869.13	$910,009.87	$956,879.00	$0.00	$956,879.00
709	366	$987,678.00	$60,476.89	$913,682.07	$974,158.96	$13,174.96	$987,333.92
SUBTOTAL	**1,230**	**$2,505,593.36**	**$158,684.90**	**$2,325,769.19**	**$2,484,454.09**	**$14,408.13**	**$2,498,862.22**

Medical and Dental Vision Insurance Premiums
October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	62	$74,987.76	$2,636.67	$71,141.61	$73,778.28	$0.00	$73,778.28
802	321	$700,023.96	$18,841.71	$681,182.25	$700,023.96	$0.00	$700,023.96
803	326	$838,608.92	$22,071.35	$811,701.42	$833,772.77	$0.00	$833,772.77
804	182	$220,125.36	$7,281.09	$214,053.75	$221,334.84	($34,269.70)	$187,065.14
805	181	$394,717.56	$13,956.83	$380,760.73	$394,717.56	($29,237.90)	$365,479.66
806	620	$1,352,071.20	$33,016.61	$1,314,693.07	$1,347,709.68	($195,295.90)	$1,152,413.78
807	42	$108,041.64	$2,675.31	$105,366.33	$108,041.64	($7,519.00)	$100,522.64
808	12	$30,869.04	$205.79	$30,663.25	$30,869.04	($3,470.40)	$27,398.64
809	23	$27,818.04	$3,144.64	$25,882.88	$29,027.52	$0.00	$29,027.52
810	6	$13,084.56	$2,137.14	$10,947.42	$13,084.56	$0.00	$13,084.56
811	3	$7,717.26	$1,028.97	$6,688.29	$7,717.26	$0.00	$7,717.26
812	238	$287,856.24	$21,988.35	$265,867.89	$287,856.24	($38,951.58)	$248,904.66
813	1	$2,180.76	$0.00	$2,180.76	$2,180.76	($144.60)	$2,036.16
SUBTOTAL	**2,017**	**$4,058,102.30**	**$128,984.46**	**$3,921,129.65**	**$4,050,114.11**	**($308,889.08)**	**$3,741,225.03**
Kaiser - Washington							
393	3	$3,486.33	$743.76	$3,904.68	$4,648.44	$0.00	$4,648.44
394	7	$3,055.64	$0.00	$3,055.64	$3,055.64	$0.00	$3,055.64
395	1	$2,163.21	$0.00	$2,163.21	$2,163.21	$0.00	$2,163.21
397	4	$5,750.48	$230.02	$5,520.46	$5,750.48	$0.00	$5,750.48
398	3	$2,595.12	$519.02	$2,076.10	$2,595.12	$0.00	$2,595.12
SUBTOTAL	**18**	**$17,050.78**	**$1,492.80**	**$16,720.09**	**$18,212.89**	**$0.00**	**$18,212.89**
Medical Plan Total	**52,356**	**$51,570,553.21**	**$3,705,324.91**	**$47,470,698.19**	**$51,176,023.10**	**($369,646.13)**	**$50,806,376.97**

Medical and Dental Vision Insurance Premiums
October 2020

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	24,814	$1,279,864.26	$141,836.43	$1,148,789.98	$1,290,626.41	($3,456.11)	$1,287,170.30
502	23,171	$2,489,165.25	$189,351.51	$2,293,241.79	$2,482,593.30	($1,718.05)	$2,480,875.25
503	9	$570.60	$67.21	$503.39	$570.60	$0.00	$570.60
SUBTOTAL	**47,994**	**$3,769,600.11**	**$331,255.15**	**$3,442,535.16**	**$3,773,790.31**	**($5,174.16)**	**$3,768,616.15**
CIGNA Dental HMO/Vision							
901	3,350	$155,855.01	$19,705.81	$138,193.46	$157,899.27	($325.57)	$157,573.70
902	2,386	$227,861.92	$19,873.08	$207,896.54	$227,769.62	($476.30)	$227,293.32
903	1	$47.09	$20.72	$26.37	$47.09	$0.00	$47.09
SUBTOTAL	**5,737**	**$383,764.02**	**$39,599.61**	**$346,116.37**	**$385,715.98**	**($801.87)**	**$384,914.11**
Dental/Vision Plan Total	**53,731**	**$4,153,364.13**	**$370,854.76**	**$3,788,651.53**	**$4,159,506.29**	**($5,976.03)**	**$4,153,530.26**
GRAND TOTALS	**106,087**	**$55,723,917.34**	**$4,076,179.67**	**$51,259,349.72**	**$55,335,529.39**	**($375,622.16)**	**$54,959,907.23**

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.**

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October 6, 2020

Cassandra Smith
Director, Retiree Health Care
LACERA
300 N. Lake Avenue, Suite 300
Pasadena, CA 91101

Re: LACERA Anthem 2020-2021 Lifetime Maximum

Dear Cassandra:

Segal has updated the estimated annual costs of eliminating the Lifetime Maximum Benefit ("LMB") from all Anthem Blue Cross plans. The LMB of $1 million is currently in effect for the Anthem I, II, and Prudent Buyer plans. Anthem Plan III, which is a Medicare Supplement plan, currently has an unlimited LMB. In addition to the cost estimate, we summarize key provisions of the 1982 agreement from materials presented by LACERA staff at the Board of Retirement Offsite Retreat on January 31, 2018, as well as the impact of the LMB on the Retiree Healthcare Benefits Program ("RHBP").

OVERVIEW

In April 1982, an agreement was negotiated between LACERA Boards and the County's Board of Supervisors ("1982 Agreement"). LACERA's Board of Retirement reduced the County's retirement contribution and relinquished control over the healthcare program to the County. In exchange, the County accepted responsibility for funding the retirees' premium subsidy for an amount up to the benchmark Anthem I, II premium.

Per the 1982 Agreement, the County is the plan sponsor with LACERA the administrator of the healthcare program for retirees hired prior to July 1, 2014. LACERA is prohibited from enhancing or decreasing the medical or dental/vision benefit levels unless mandated by law, the contracted plan, or negotiations with the County. Consequently, benefit levels in Anthem I, II have remained fixed at their original levels.

Upon the availability of Medicare Advantage plans, in 1992, the Medicare Part B Reimbursement Program was designed and approved by the Board of Retirement and the Board of Supervisors. The program offers Medicare Advantage Plans and Medicare Supplement Plans that are mutually beneficial to stakeholders, offering greater benefit levels to LACERA's retirees at a lower premium cost to the County. This program was designed outside of the 1982 Agreement and is consequently subject to annual approval. Approval occurs after the program's feasibility is evaluated with the release of Part B premiums levels.

County subsidies are divided into two tiers based on the retiree's date of hire. Current retirees are subsidized under Tier I. The Tier I subsidy is a service based percentage of the lesser of the elected plan premium and the Anthem I, II benchmark premium. Retirees electing a plan with a premium greater than Anthem I, II are required to contribute the excess premium amount. Employees hired after June 30, 2014, will retire into Tier II. The Tier II subsidy is limited to the single rate for the retiree or surviving spouse and Medicare enrollment is required at age 65.

The Tier II benchmark rate decreases from the single Anthem I, II premium to the single Anthem III Medicare Supplement premium upon attaining age 65.

HEALTH BENEFITS

The healthcare environment has evolved considerably since 1982. The Affordable Care Act ("ACA") of 2010 has mandated benefit requirements for active plans. However, ACA mandates do not apply to retiree plans. Consequently, the Anthem I, II, and Prudent Buyer benefits have remained unchanged under the inertia of the 1982 Agreement. The retiree plan exception allows the LMB to persist in Anthem I, II, and Prudent Buyer despite the ACA prohibiting benefit maximums. The ACA mandated the elimination of benefit maximums in order to ensure that individuals receive uninterrupted coverage as their healthcare needs increase.

LACERA's $1 million LMB was established on July, 1, 1992, when healthcare costs were significantly lower and few retirees incurred expenses approaching the LMB. Tables from the 2020 Medicare Trustees Report document the rise in healthcare costs from 1992 to 2020, with Hospital Insurance (i.e., Medicare Part A) premiums increasing 140% and Supplementary Medical Insurance (i.e., Medicare Part B) premiums increasing 350%. Using these increases as proxies for medical service inflation, LACERA's adjusted LMB would likely range between $2 and $3 million today. Even after an inflationary adjustment, LACERA's LMB would be less than the ACA mandated unlimited maximum provided to active County of LA employees. As a consequence, a growing number of current and future retirees will be negatively impacted by LACERA's current LMB.

Plan Year	Number of members exceeding $1 million LMB
2017 – 2018	8
2018 – 2019	1
2019 – 2020	6
2020 - 2021 YTD	1
Total	16

In addition to the individuals that have exceeded the LMB, there are 72 members with lifetime cumulative claims of $600,000 or greater.

Cumulative Claims	Number of members
$600,000 - $699,999	36
$700,000 - $799,999	15
$800,000 - $899,999	10
$900,000 or greater	11
Total	72

Members exceeding the LMB have three options for continued coverage:

- LACERA HMO Plans
- Anthem Plan III
- Plans not offered through the RHBP

The County subsidy is only available for plans offered through the RHBP. Of the 16 members that have exceeded the LMB since 2017/2018, seven (7) no longer receive medical coverage through the RHBP and nine (9) have either completed or have pending transfers to other RHBP plan options.

Current Status	Number of members exceeding $1 million LMB
Terminated	7*
LACERA HMO	4
Pending transfer	3
Anthem Plan III	2
Total	16

*The 7 terminated includes 3 deceased members

Members residing outside of the HMO service area who are ineligible for Medicare would not have feasible coverage options in the RHBP after exceeding the LMB. Anthem III requires enrollment in Medicare Parts A and B. Medicare is not considered feasible for ineligibles, as members are required to pay up to $458 per month, based on 2020 premiums, plus any required penalties for late enrollment. There are also citizenship and residency requirements.

Retirees under age 65 are not eligible for Medicare unless they are disabled. Moreover, a large proportion of LACERA's retirees over age 65 are ineligible for Medicare due to the County's withdrawal from Social Security in 1982/1983. In the current healthcare environment, the LMB exacerbates challenges faced by many retirees who are already experiencing difficult health conditions.

To illustrate the impact of the current LMB on participants' continuity of care, the following case examples were provided by LACERA staff.

Member #1 – This member is an 81-year old enrolled in the Anthem Blue Cross II plan who had an unfortunate bicycle accident which following several surgeries pushed them up to their lifetime maximum. Unfortunately, for Member #1, they were not eligible for Medicare and therefore ineligible to transfer into Anthem Blue Cross III. In addition, due to the extent of their injuries, was not able to travel the distance that would be required to utilize an alternate LACERA-administered plan nor would they be able to continue the level of care being provided throughout and the treatments needed following the required surgeries.

Fortunate for this member, they were financially able to afford paying approximately $2,000/month out of pocket for Medicare for both member and spouse. Most of our members are not able to afford this as an option.

Member and spouse upon purchasing Medicare out of pocket were able to transfer into the LACERA-administered Anthem Blue Cross III plan. Member has since been able to continue with the treatment plan under Anthem but is a long road to recovery.

Member #2 – This member is a 62-year old who gave 24+ years of service to the County of LA. Member was in the midst of treatment for a major health diagnosis that utilized in excess of $900, 000 toward their lifetime maximum.

Member's physician submitted written correspondence expressing concern in our lifetime maximum following the ACA removal of such limits. Per the member's physician, "the alternative health plan available does not cover my services. This means that if the member is forced to enroll in an alternate plan, the member would no longer be eligible to receive treatment at his current facility, where the member's health has made vast improvements."

In an effort to maintain a continuity of care, member requested to be allowed remain in Anthem for at least one more year as he believed given the success seen thus far, member felt their numbers would continue to drop and enabling remission to occur. However, there would be no coverage once the lifetime maximum was met.

Member #3- This member is a 68- year old, unmarried individual who began employment with the County of LA in 1984; with currently over 35 years of service. Due to County of LA pulling out of Social Security in January 1983, when the member began employment, there were no Social Security nor Medicare taxes withheld from new hires. As a result, this member will never be eligible for Social Security or Medicare.

Member has multiple health issues requiring tertiary care. The member is currently enrolled in the Anthem Blue Cross plan under County of LA Employee Benefits and still working out of fear of reaching the maximum shortly after retiring, should the member retire and enroll in Anthem under the LACERA group, in order to maintain their continuity of care.

Member has been in contact with staff multiple times in efforts to determine if that were to happen, what plans would be available to transfer into. Staff has even assisted the member in an effort to calm their concerns, only to learn 2-3 of the member's treating physicians would not be available through other health plan options after reaching the lifetime maximum benefit with Antehm Blue Cross.

Consequently, the member continues to work through pain while postponing retirement, hoping the lifetime maximum benefit will be increased to the unlimited benefit provided to active County of LA employees.

COST

The LMB reduces future claims cost by terminating medical and prescription drug coverage when a member's aggregate lifetime claims exceed $1 million. Elimination of these claims may contribute to lower Anthem I, II, and Prudent Buyer premiums, which mitigate the County subsidy by an amount greater than the Anthem premium savings, as retirees enrolled in high cost HMO plans must contribute any excess premium above the benchmark.

The tables below reflect Anthem's projected costs associated with increasing the LMB. Since premiums are based on claims and additional charges, we believe it is best to estimate the cost impact as a percent of premium. The projected annual premium impacts are based on the negotiated premiums of $165,013,000 for the Anthem I, II, and Prudent Buyer plans, from the 2020-2021 Renewal Evaluation Report updated for current enrollment.

Lifetime Maximum Benefit	% Increase in Premiums	2020-2021 Anthem Premiums*	Estimated Annualized Premium Increase
$1.5 Million	0.33%	$165,013,000	$550,000
$2.0 Million	0.66%	$165,013,000	$1,100,000
$2.5 Million or Greater	1.00%	$165,013,000	$1,650,000

*Premiums exclude Anthem Plan III and LACERA's $8.00 administrative fee.

Lifetime Maximum Benefit	2020-2021 County Subsidy**	Estimated Annualized Subsidy Increase
$1.5 Million	$523,418,000	$619,000
$2.0 Million	$523,418,000	$1,239,000
$2.5 Million or Greater	$523,418,000	$1,854,000

**County subsidy as reported in the July 2020 Staff and Activities Report, excluding Dental/Vision and Local 1014.

In addition to premium and subsidy levels, the LMB may have a modest impact on enrollment in the Medicare Advantage and Medicare Supplement plans. Medicare plans have lower premiums than Anthem I, II, and Prudent Buyer, making them less costly for the County to subsidize. Retirees also have an incentive to enroll in the Medicare plans due to their richer benefit provisions, which lower their cost sharing at point of service.

Medicare plans offer an unlimited lifetime benefit (no LMB). This benefit enhancement over Anthem I, II and Prudent Buyer can serve as an incentive to enroll in Medicare plans. If the LMB were eliminated, some members may find it advantageous to drop their Medicare plan in favor of Anthem I, II and Prudent Buyer. However, this would likely be limited to Medicare eligible retirees with high cumulative claims and a Part B premium exceeding the County's reimbursement threshold. Exceeding the reimbursement threshold results from income-related monthly adjustment amounts ("IRMAA") and late enrollment penalties. IRMAA are estimated to affect 7% of Medicare participants. Late enrollment penalties are only expected to impact LACERA retirees affected by IRMAA, as unaffected retirees incur no net monthly cost for standard Part B due to County reimbursement.

Benefit provisions for LACERA's Anthem plans, County active plans, and other comparable retiree plans are shown in Exhibits I – IV.

Please feel free to contact us at 818-956-6722 if you have any questions.

Sincerely,

Paul Sadro, ASA, MAAA
Senior Actuary

cc: Stephen Murphy
Richard Ward
Jessica Kuhlman

Segal

LACERA
Non-Medicare PPO Plan Benchmark Comparison Exhibit 1 - LACERA Plans

Plan Sponsor/ Administrator	**Los Angeles County Employees Retiree Association (LACERA)**		
Medical Carrier	**Anthem**	**Anthem**	**Anthem**
Plan Name	**Plan I**	**Plan II**	**Prudent Buyer**
Lifetime Maximum	$1,000,000	$1,000,000	$1,000,000
Deductible	Individual: $100 Family: $100	Individual: $500 Family: $1,500	Individual: $100 Family: $200
Out-of-Pocket Maximum	N/A	$2,500 including deductible	N/A
Preventive	In-Network: $25 copay Out-of-Network: Not Covered	In-Network: $25 copay Out-of-Network: Not Covered	In-Network: $25 copay Out-of-Network: Not Covered
Hospital Room & Board	$75 per day	In-Network: 90% Out-of-Network: 70%	In-Network: 80% Out-of-Network: 70%
Outpatient Services	80%	80%	In-Network: 80% Out-of-Network: 70%
Emergency Room	80%	80%	In-Network: 80% Out-of-Network: 70%
Office Visits	80%	80%	In-Network: 80% Out-of-Network: 70%
Pharmacy Retail - 30 days	**In-Network** 80% **Out-of-Network** 60%	**In-Network** 80% **Out-of-Network** 60%	**In-Network** 80% **Out-of-Network** Varies
Pharmacy Mail Order - 90 days	Generic: $10 copay Brand: $30 copay Non-Preferred Brand: $50 copay Specialty: $150 copay	Generic: $10 copay Brand: $30 copay Non-Preferred Brand: $50 copay Specialty: $150 copay	Generic: $10 copay Brand: $30 copay Non-Preferred Brand: $50 copay Specialty: $150 copay

LACERA
Non-Medicare PPO Plan Benchmark Comparison Exhibit 2 - County of Los Angeles (Active Plans)

Plan Sponsor/ Administrator	County of Los Angeles (Active Plans)			
Medical Carrier	**Cigna**	**UHC**	**Anthem**	**Anthem**
Plan Name	**POS (Choices)**	**Select Plus (Options)**	**POS (Megaflex & Flex)**	**PPO (Megaflex & Flex)**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Deductible	**In-Network** Individual: None Family: None **Out-of-Network** Individual: $500 Family: $1,000	**In-Network** Individual: $300 Family: $1,500 **Out-of-Network** Individual: $1,500 Family: $3,000	**In-Network (Tier 2)** Individual: None Family: None **Out-of-Network (Tier 3)** Individual: $400 Family: $800	**In-Network** Individual: $150 Family: $450 **Out-of-Network** Individual: $400 Family: $800
Out-of-Pocket Maximum	**In-Network** Individual: $1,000 Two-Party: $2,000 Family: $3,000 **Out-of-Network** Individual: Unlimited Family: Unlimited	**In-Network** Individual: $5,000 Family: $13,700 **Out-of-Network** Individual: $15,000 Family: $45,000	**In-Network & Out-of-Network Combined** Individual: $3,000 Family: $9,000 Note: Applies to Tier 2 & 3 only	**In-Network** Individual: $1,000 Family: $2,000 **Out-of-Network** Individual: $3,600 Family: $7,200
Preventive	In-Network: 100% Covered Out-of-Network: 60% of R&C After Deductible	In-Network: 100% Covered Out-of-Network: No charge for covered amount	Tier 2 & 3: 100 Covered	100% Covered
Hospital Room & Board	In-Network: $50/day; $200 copay annual max Out-of-Network: 60% of R&C after deductible and after $1,000 fee/admission	In-Network: 80% Out-of-Network: 50%	In-Network (Tier 2): 80% Out-of-Network (Tier 3): 70% plus $500 deductible/admission	In-Network: 90% Out-of-Network: 70% plus $500 deductible/admission
Outpatient Services	In-Network: $50 copay Out-of-Network: 60% of R&C after deductible	In-Network: 80% Out-of-Network: 50%	In-Network (Tier 2): 80% Out-of-Network (Tier 3): 70%	In-Network: 90% Out-of-Network: 70%
Emergency Room	$50 copay; waived if admitted	In-Network: 80% Out-of-Network: 80% (50% if admitted)	$50 copay; waived if admitted	$50 copay (waived if admitted) then 90%
Office Visits	In-Network: $10 copay Out-of-Network: 60% of R&C after Deductible	In-Network: 80%, no deductible Out-of-Network: 50%	In-Network (Tier 2): $25 copay Out-of-Network (Tier 3): 70%	In-Network: $15 copay Out-of-Network: 70%
Pharmacy Retail - 30 days	**In-Network** Generic: $5 copay Brand: $20 copay **Out-of-Network** 60% of R&C after deductible	**In-Network** Tier 1: $5 copay Tier 2: $20 copay Tier 3: $35 copay **Out-of-Network** Not Covered	**In-Network (Tier 2) & Out-of-Network (Tier 3)** Generic: $10 copay Brand: $20 copay	**In-Network & Out-of-Network** Generic: $10 copay Brand: $20 copay
Pharmacy Mail Order - 90 days	**In-Network** Generic: $10 copay Brand: $40 copay **Out-of-Network** Not Covered	**In-Network** Tier 1: $10 copay Tier 2: $40 copay Tier 3: $70 copay **Out-of-Network** Not Covered	N/A	N/A

LACERA
Non-Medicare PPO Plan Benchmark Comparison Exhibit 3 - Other Retiree Plans

Plan Sponsor/ Administrator	Alameda County Employee Retiree Association (ACERA)	California Public Employees' Retirement System (CalPERS)		
Medical Carrier	PPO Plan Not Offered	**Anthem**	**Anthem**	**Anthem**
Plan Name		**PERS Select**	**PERS Choice**	**PERSCare**
Lifetime Maximum		Unlimited	Unlimited	Unlimited
Deductible		Individual: $1,000 Family: $2,000 Note: Combined for In-Network & Out-of-Network	Individual: $500 Family: $1,000 Note: Combined for In-Network & Out-of-Network	Individual: $500 Family: $1,000 Note: Combined for In-Network & Out-of-Network
Out-of-Pocket Maximum		Individual: $3,000 Family: $6,000 Note: Combined for In-Network & Out-of-Network	Individual: $3,000 Family: $6,000 Note: Combined for In-Network & Out-of-Network	Individual: $2,000 Family: $4,000 Note: Combined for In-Network & Out-of-Network
Preventive		In-Network: 100% Covered Out-of-Network: 60%	In-Network: 100% Covered Out-of-Network: 60%	In-Network: 100% Covered Out-of-Network: 60%
Hospital Room & Board		In-Network: 80% Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 90% Out-of-Network: 60%
Outpatient Services		In-Network: 80% Out-of-Network: 60%	In-Network: 80% Out-of-Network: 60%	In-Network: 90% Out-of-Network: 60%
Emergency Room		$50 copay plus 80%	$50 copay plus 80%	$50 copay plus 90%
Office Visits		In-Network: $35 copay Out-of-Network: 60%	In-Network: $20 copay Out-of-Network: 60%	In-Network: $20 copay Out-of-Network: 60%
Pharmacy Retail - 30 days		Generic: $5 copay Brand: $20 copay Non-Preferred: $50 copay	Generic: $5 copay Brand: $20 copay Non-Preferred: $50 copay	Generic: $5 copay Brand: $20 copay Non-Preferred: $50 copay
Pharmacy Mail Order - 90 days		Generic: $5 copay Brand: $40 copay Non-Preferred: $100 copay	Generic: $5 copay Brand: $40 copay Non-Preferred: $100 copay	Generic: $5 copay Brand: $40 copay Non-Preferred: $100 copay

LACERA
Non-Medicare PPO Plan Benchmark Comparison Exhibit 4 - Other Retiree Plans

Plan Sponsor/ Administrator	Los Angeles City Employees Retirement System (LACERS)	Orange County (Retirees)		San Diego County Employee Retiree Association (SDCERA)	San Francisco Health Service System
Medical Carrier	**Anthem**	**Blue Shield**	**Blue Shield**	PPO Plan Not Offered	**UHC**
Plan Name	**PPO**	**PPO (Sharewell)**	**PPO (Wellwise)**		**PPO (City Plan)**
Lifetime Maximum	$2,000,000	Unlimited	Unlimited		Unlimited
Deductible	Individual: $750 Family: $1,500	$5,000 Combined In-Network & Out-of-Network	**In-Network** Individual: $500 Family: $1,000 **Out-of-Network** Individual: $750 Family: $1,500		**In-Network** Individual: $250 Two-Party: $500 Family: $750 **Out-of-Network** Individual: $500 Two-Party: $1,000 Family: $1,500
Out-of-Pocket Maximum	$5,000	**In-Network** Family: $6,000 **Out-of-Network** Family: $12,000	**In-Network** Individual: $2,500 Family: $5,000 **Out-of-Network** Individual: $5,000 Family: $10,000		**In-Network** Individual: $3,750 Family: $7,500 **Out-of-Network** Individual: $7,500 Family: N/A
Preventive	100% Covered	100% Covered	100% Covered		In-Network: 100% Covered; deductible does not apply Out-of-Network: 50% Covered after deductible
Hospital Room & Board	90%	In-Network: 90% Out-of-Network: 70%	In-Network: 90% Out-of-Network: 70%		In-Network: 85% after deductible Out-of-Network: 50% after deductible
Outpatient Services	90%	In-Network: 90% Out-of-Network: 70%	In-Network: 90% Out-of-Network: 70%		50% after deductible
Emergency Room	90%	In-Network: 90% Out-of-Network: 70%	In-Network: 90% Out-of-Network: 70%		85% after deductible
Office Visits	In-Network: $20 copay Out-of-Network: 70%	In-Network: 90% Out-of-Network: 70%	In-Network: 90% Out-of-Network: 70%		In-Network: 85% after deductible per visit Out-of-Network: 50% after deductible per visit
Pharmacy Retail - 30 days	Generic: $10 copay Brand: $30 copay Non-Formulary: $50 copay	80%	Generic: 80% Brand: 75% Non-Preferred: 70%		**In-Network** Tier 1: $10 copay Tier 2: $25 copay Tier 3: $50 copay **Out-of-Network (50% after copay)** Tier 1: $10 copay Tier 2: $25 copay Tier 3: $50 copay
Pharmacy Mail Order - 90 days	Generic: $20 copay Brand: $60 copay Non-Formulary: $100 copay	80%	Generic: 80% Brand: 75% Non-Preferred: 70%		**In-Network** Tier 1: $20 copay Tier 2: $50 copay Tier 3: $100 copay **Out-of-Network** Not Covered

LACERA
Plan Sponsor Comparison - Medical Premium Subsidy

	LACERA [1]	LACERS[2]	CalPERS [3]
Subsidy at 10 Years of Service	40%	40%	50%
Maximum Premium Subsidy	100%	100%	100%
Premium Subsidies	**Eligibility:** 10 years of service **Service Percent:** 4% for each year of service with max 100% at 25 years **Subsidy:** Service percent multiplied by tiered premium up to benchmark, which covers all tiers of Anthem Plans I & II. **Part B Reimbursement Program:** Standard premium for retirees and dependents	**Eligibility:** 10 years of service **Service Percent:** 4% for each year of service with max 100% at 25 years **Subsidy:** Service percent multiplied by tiered premium up to benchmark, which covers Kaiser HMO retiree and spouse. Retirees contribute the difference for higher priced Anthem PPO and HMO premiums. **Part B Reimbursement Program:** Standard premium for retiree only	**Eligibility:** 10 years of service **Service Percent:** 5% for each year of service with a maximum of 100% at 20 years for retirees hired after 1988; retirees hired earlier receive 100%. **Subsidy:** Service percent is multiplied tiered benchmark, which provides full coverage for the Kaiser HMO plan. Retirees contribute the difference for higher priced Anthem premiums. **Part B Reimbursement Program:** Standard premium available to retirees and dependents

(1) Based on Tier 1 contribution structure.

(2) LACERS Tier 1 includes retirees hired prior to February 21, 2016. Actives hired after June 30, 2011 are required to contribute 4 to 4.5% toward retiree coverage to receive the uncapped contribution structure shown in the table. No current actives and few inactives receive the capped contribution.

(3) Contributions are based on 10 year vesting for retirees with date of hire prior to 2016. Some business units have a service percent starting with 50% at 15 years and a maximum of 100% at 25 years.

Los Angeles County Employee Retirement Association

Anthem Blue Cross

Analysis of Medical Claims Processing and Payment Procedures

For the Period of July 1, 2018 through June 30, 2019

August 4, 2020 / Amber M. Turner, MBA, PMP

Segal

Anthem Blue Cross Medical Claims Audit – Final Report

Section I – Executive Summary

This report analyzes and evaluates the claims processing and payment procedures utilized by Anthem Blue Cross ("Anthem") in their administration of Los Angeles County Employees Retirement Association ("LACERA") group medical benefits. Amber Turner and Jennifer Lagua conducted the onsite review at Anthem's Rancho Cordova, California claims office during the week of November 18, 2019.

Scope of Services

Anthem provided an electronic data file of all medical claims processed and paid during the 12-month audit period of July 1, 2018 through June 30, 2019. The review objective was to ensure claims were paid in accordance with LACERA's plan provisions. Segal's audit included the following in-house and onsite review components:

1. An adjudication procedures review to assess day-to-day processing guidelines and claim control measures;

2. A random stratified sample of 220 claims to measure validity in the financial dollar value and incidence (number) accuracy of all benefit payments processed during the audit period; and,

3. A 35 target claim selection identified through a 100% claims electronic analyses 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 serving as the primary documentation on which our report is based. To maintain patient confidentiality, claims addressed within this report are referred to as "Worksheets". These worksheets (1–220) are further distinguished with an alphabet character (A-K) that identifies the respective payment tier in the statistical analysis. The auditors reviewed each claim from receipt to release for check disbursement to identify any variances in procedures and benefit determination.

Worksheets T1–T35, include a "T" to distinguish the "target" sampling of claims identified through electronic analyses. These claims were reviewed for the attribute selected for validation (i.e., duplicate payment, benefit provision, etc.). Due to the focused review and selection of these claims, they are excluded from the overall calculation of processing performance.

Statistical Results

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

During the 12-month period of July 1, 2018 through June 30, 2019 total benefit payments of $113,499,260.11 were issued for 675,974 claims. Benefits payment for 220 stratified claims totaled $3,769,809.66 (3.3% of total payments).

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

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

The sample of 220 claims identified five (5) overpayments totaling $840.54, 12 underpayments for $61.03, two (2) out-of-sample overpayments for $1,804.37, and 6 (six) out-of-sample underpayments for $265.34. As seen in the chart below, Anthem met each of their performance guarantees but fell below industry standards in overall processing and payment accuracy due to the number of errors identified within the sample in Section II of this report.

Category	Statistical Achievement	Performance Guarantee	Industry Standards
Financial Accuracy (dollar value)	99.33%	99.00%	99.00%
Payment Accuracy (free from financial error)	91.13%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (free from error)	91.13%	N/A	95.00%
Time-to-Process[1] (within 14 calendar days)	97.57%	90.00%	95.00%
(within 30 calendar days)	99.21%	N/A	100.00%

[1] Turnaround time achievement has been calculated on 100% of the claims population for the audit period.

Target Sample Results

Anthem supported an additional sample of 35 claims selected through a series of 100% claims electronic analyses to identify and confirm the accuracy of specific plan provisions and exclusions.

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

- Duplicate claims analysis;
- Reimbursement of Plan exclusions and limitations;
- Patient out-of-pocket expenses (deductible, copay and coinsurance); and,

- Plan variables not represented in the random selection.

The auditors manually reviewed the electronic results and the patient history for the sampled claims onsite to validate the processing event or identify the root cause of the error; as applicable. Of the 35 target claim samples, **13 overpayments totaling $23,479.25** were discovered. Further detail is provided in Section III of this report.

Key Findings and Recommendations

The following bullet points summarize the primary review findings identified by Segal's auditors during the individual claims review with recommendations, as indicated. Anthem was presented with a draft report on January 15th for their review and comment. Their written responses were delivered to Segal on February 10, 2020 and are paraphrased in italics throughout this report; their entire response is included in Section V of this report.

➢ Overpayment recovery efforts should be initiated for the errors identified within the statistical and target selections.

- Of the 35 target claim samples, **13 overpayments totaling $23,479.25** were discovered
- Of the 220 claims identified five (5) overpayments totaling $840.54, 12 underpayments for $61.03, two (2) out-of-sample overpayments for $1,804.37, and 6 (six) out-of-sample underpayments for $265.34.

Anthem stated all agreed upon financial errors meeting the adjustment guidelines have been placed into the adjustment and recovery process.

➢ The following errors were identified through the stratified and target claim samples:

- Out-of-pocket amount was over the limit for the calendar year due to medical and prescription amounts comingling. (2A, 96C, 118C, 130D, 142D, and 180G) Segal recommends Anthem initiate a standard practice/process to identify and adjust any underpayments.

  Anthem agreed to these errors and claims were adjusted as of January 23, 2020. Currently, they are working on system adjustments to capture over applied accumulators due to comingling.

- Incorrect claims payments lead to adjustments outside the audit period. (101C and T33)

  Anthem agreed to both of these errors. Sample T33 was adjusted as of January 23, 2020. Sample 101C is under the adjustment threshold. Anthem provided coaching to the processor due to these manual errors.

- Incorrect coordination with Medicare (3A, 8A, 12A, 20A, 34A, 59B, 62B, 78B, 108C, 117C and 132D)

  Anthem agreed to these errors and is working on system modifications to accommodate Medicare's new coding. Anthem anticipates the research of the systematic nature of these

errors to be completed by February 28, 2020. Anthem will review the volume, correct the errors and will make a determination on generating the financial impact report. Anthem will provide the results of the impact analysis to LACERA upon completion.

- Claim coordinated with other insurance incorrectly. (94C and T35)

  Anthem has requested additional time to research this claim. Anthem is anticipating the research to be complete by February 28, 2020. Once the research is completed, Anthem will provide its findings to LACERA.

- Adjustments not made post Medicare transition for retro claims. (104C and 110C)

  Anthem has requested additional time to research this claim. Anthem is anticipating the research to be complete by February 28, 2020. Once the research is completed, Anthem will provide its findings to LACERA.

- Non-certification deductible not applied. (166F, 198I, 204J, and 208J)

  Anthem disagreed with this error noting claims that are admissions through emergency and claims that are from participating providers do not require authorizations.

  Segal recommends LACERA discuss with Anthem the non-certification deductible criteria.

- Acupuncture over the $30 per visit limit. (T6, T7, T8, and T9)

  Anthem agreed to errors on sample T6, T7, and T9 and adjusted these claims as of January 23, 2020. Anthem disagreed on sample T8 noting although the benefit is for acupuncture the physician was not an acupuncturist.

  Segal recommends Anthem and LACERA discuss the application of this benefit with different physician types.

- Hearing aid exam paid when not covered under the policy. (T12 and T13)

  Anthem maintains that these exams do not relate to hearing aids. The claims processed correctly. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.

  Segal maintains the error due to the CPT code description and recommends LACERA discuss with Anthem this code scenario.

- Smoking cessation paid when not covered under the policy. (T15 and T16)

  Anthem disagrees with the assessed errors and maintains that these exams do not relate to smoking cessation; the diagnosis differs in relation to the procedure. The claims processed correctly. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.

  Segal recommends LACERA and Anthem discuss the adjudication of this code with different diagnosis types.

- Pharmacy prescription drugs paid for under the medical policy. (T24 and T25)

  Anthem agreed with the error assessed on sample T25 but is not moving forward with adjustments to the claim as it is under the recovery threshold. Anthem disagreed with the error on sample T24 noting per the CVS affiliation with LACERA at the time. CVS allowed Anthem to coordinate the benefits when LACERA was the secondary or tertiary carrier. Anthem was allowed to recoup the copays and / or fees. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.

- Duplicate claim payment. (T25)

  Anthem noted additional time is needed to research this claim. Anthem is anticipating the research to be complete by February 28, 2020. Anthem will provide the results of the research to LACERA upon completion.

➢ **Segal recommends financial impact reports should be generated for the following categories.**

- Claims coordinated with other insurance incorrectly
- Newly Medicare transition claim adjustments
- Non application of deductible for non-certification
- Non application of deductible for non-certification for emergency claims
- Acupuncture over $30 per visit
- Acupuncture over $30 per visit with a provider other than an acupuncturist
- Hearing aid exams
- Smoking cessation

Anthem stated Impact reports for the identified and agreed upon systemic issues will be generated and provided to LACERA.

➢ Anthem does not require approval to write-off non-recovery overpayments.

Segal recommends Anthem and LACERA discuss a write-off threshold.

Anthem noted their account management is available to discuss a write-off thresholds upon LACERA's request.

Segal recommends LACERA request a report for write-offs and claims that will not be recovered due to not meeting the overpayment threshold.

➢ **Segal recommends Anthem establish procedures regarding adjustments to Medicare transition claims.**

Anthem noted their account management is available to discuss adjustments to Medicare transition claims upon LACERA's request.

Section II – Statistical Claim Sample

Anthem provided a data file of all medical claims processed and paid during the 12-month audit period of July 1, 2018 through June 30, 2019, which was utilized for sampling purposes. Benefit payments for 675,974 claims totaled $113,499,260.11. Sampled benefit payments for 220 stratified claims totaled $3,769,809.66. Relevant claims processing information was verified through Anthem's responses to the adjudication questionnaire, onsite discussions, auditor's observations, and the individual claims review.

Stratification Table

The selection of 220 claims was stratified by dollar amount in order to provide large claims representation that is more valid in determining financial accuracy levels. The methodology of our stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allows a quantifiable degree of confidence, whereby results obtained in the audit sample are a true reflection of the way all claims were processed during the audit period.

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

Strata	Dollar Range of Strata		Number of Claims in		Dollar Amount in	
			Range	Selection	Selection	Strata
A	$0.00	$19.99	214,170	45	$529.53	$2,452,390.77
B	$20.00	$39.99	190,036	40	$1,051.80	$5,155,700.73
C	$40.00	$119.99	158,254	35	$2,366.62	$11,107,892.67
D	$120.00	$319.99	68,651	30	$5,843.68	$12,762,887.51
E	$320.00	$824.99	24,282	10	$5,387.66	$12,028,727.37
F	$825.00	$2,099.99	14,179	10	$12,686.33	$18,349,694.78
G	$2,100.00	$5,499.99	4,296	10	$29,876.29	$13,941,345.61
H	$5,500.00	$14,999.99	1,382	10	$97,785.67	$12,116,279.48
I	$15,000.00	$42,499.99	582	10	$240,973.11	$13,970,165.13
J	$42,500.00	$149,999.99	132	10	$808,244.97	$9,049,112.06
K	$150,000.00	$460,125.01	10	10	$2,565,064.00	$2,565,064.00
Total			**675,974**	**220**	**$3,769,809.66**	**$113,499,260.11**

Review Process

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

- Claims were paid only on behalf of eligible individuals based on records contained in the claims system.
- Documentation (i.e., provider bills, physician statements, utilization review decisions or penalty findings, surgical reports, etc.) was on file for claims paid and verified when necessary.
- Duplicate claims were properly denied.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Claims personnel properly referred claims for medical necessity when appropriate; however, we did not determine medical necessity.
- Benefits were paid under the proper classification, diagnostic, and procedure codes as an incorrect entry could affect payment accuracy or future benefit determinations.
- Coordination of benefits and subrogation provisions were enforced, when applicable.
- Appropriate benefit limitations, deductibles, copayments, coinsurance, and out-of-pocket maximums were applied.
- Proper medical necessity was investigated as defined by the Plan.
- Prior authorization was obtained when required.
- Claims system logic was reviewed for examiner edits and auto-adjudication capabilities.
- Arithmetic calculations were correct.
- Payment was made to the proper party (i.e., the provider of service if benefits were assigned or claimant received benefits if the provider was not assigned).
- Turnaround time for processing of claims was within industry standards or established performance guarantees.

All questions and potential errors were presented to Anthem's onsite representatives daily; additional supporting documentation was provided through January 8, 2020.

Statistical Error Table

The sample of 220 claims identified five (5) overpayments totaling $840.54, 12 underpayments for $61.03, two (2) out-of-sample overpayments for $1,804.37, and 6 (six) out-of-sample underpayments for $265.34. Anthem should initiate overpayment recovery efforts for claims identified in the following table and produce financial impact reports for auto-adjudicated claim types found in error.

Statistical Sample Errors		
Worksheet	**(Under)/ Overpayment**	**Explanation**
2A	Out-of-Sample ($38.07)	The out of pocket amount was over the limit for the calendar year. This is likely a result of comingling with the prescription drug accumulator. (Manual and Auto-adjudication) As reported in the 2018 audit, it is not unusual for these error to occur due to real-time prescription dispensing and delayed update to medical records; however, Anthem should have a standard practice in place to identify and adjust underpayments. Anthem agreed to the error assessed during the onsite audit. *Anthem stated they are working to develop a report to capture all over applied accumulators that resulted from the comingling with the prescription plan. The underpayment errors were adjusted on January 23, 2020. Anthem's Account Management is available to discuss this issue with LACERA upon request.*
96C	Out-of-Sample ($1.28)	
118C	Out-of-Sample ($199.64)	
130D	Out-of-Sample ($9.81)	
142D	Out-of-Sample ($9.00)	
180G	Out-of-Sample ($7.54)	
101C	($0.33)	Member call regarding an incorrect claim payment which lead to a claim adjustment. (Manual adjudication) Anthem agreed to the error assessed during the onsite audit. *Anthem noted the manager will meet with the processor to review and discuss the error. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing LACERA claims.*
3A	($4.63)	The Medicare patient responsibility was not applied correctly. This seems to be a repeat error item from the 2018 audit. (Auto-adjudication) Anthem is currently researching the systematic nature of these errors and will report back to LACERA when their assessment is complete.
8A	($27.72)	
12A	($0.22)	
20A	($0.13)	
34A	($6.89)	
59B	($0.19)	
62B	($0.18)	

Statistical Sample Errors		
Worksheet	**(Under)/ Overpayment**	**Explanation**
78B	($14.10)	**Segal request Anthem provide the final results to LACERA within 10 business days from the release of the draft report**. *Anthem is working on system modifications to accommodate Medicare's new coding. Anthem agrees to the identified underpayments totaling $61.03. Anthem anticipates the research of the systematic nature of these errors to be completed by February 28, 2020. Anthem will review the volume, correct the errors and will make a determination on generating the financial impact report. Anthem will provide the results of the impact analysis to LACERA upon completion.*
108C	($0.80)	
117C	($1.86)	
132D	($3.98)	
94C	$40.54	Claim coordinated with the other insurance incorrectly. Zero patient responsibility existed. (Auto-adjudication) Onsite Anthem noted they require more time to research these claims. **Segal request a financial impact report be provided for this instance.** *Anthem stated they need additional time to research this claim. Anthem is anticipating the research to be complete by February 28, 2020. Once the research is completed, Anthem will provide its findings to LACERA.*
104C	Out-of-Sample $1,684.85	For each member, Medicare was transitioned to primary in 2019. Claims on file did not adjust to coordinate with Medicare. (Auto-adjudication) Anthem noted they require more time to research these claims. **Segal recommends Anthem establish procedures regarding adjustments to Medicare transition claims.** *Anthem has requested additional time to research these claims. Anthem is anticipating the research to be complete by February 28, 2020. Once the research is completed, Anthem will provide its findings to LACERA.*
110C	Out-of-Sample $119.52	
166F	$200.00	Non-certification deductible was not applied to the claim. (Auto-adjudication)
198I	$200.00	

Statistical Sample Errors		
Worksheet	**(Under)/ Overpayment**	**Explanation**
		Anthem agreed to disagree and noted authorization does not apply to participating providers. Segal disagrees Anthem's assessments and notes page 69 of the Plan document does not restrict to only nonparticipating providers. Segal request a financial impact report be provided for this instance. *Anthem disagrees with the assessed errors. Anthem maintains that authorization does not apply to participating providers. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.* **Segal recommends Anthem and LACERA discuss the non-certification deductible as it applies to participating providers**.
204J	$200.00	Non-certification deductible was not applied to the claim. (Auto-adjudication)
208J	$200.00	Anthem noted due to the emergency nature of the claim the authorization process was waived. **Segal disagrees with the waiver of the non-certification deductible noting on page 69 of the Plan document, authorization for emergency must be completed within 24 hours of an emergency admission. Segal request a financial impact report be provided for this instance.** *Anthem disagrees with the assessed errors. Anthem maintains that due to the emergency nature of the services rendered; the authorization process was waived. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.* **Segal recommends Anthem and LACERA discuss the non-certification deductible as it applies to emergency admissions.**
Total	**5 overpayments**	**$ 840.54**
	2 out-of-sample overpayments	**$1,804.37**
	12 underpayment	**$ 61.03**
	6 out-of-sample underpayments	**$ 265.34**

Turnaround Time Achievement

Turnaround time is measured from the date a claim is first received to the initial date processed for payment or denial; subsequent adjustments were measured from receipt of the new information to the benefit determination date with processing measured as the longest interval.

Measurements for turnaround time include routing delays due to internal review (i.e., review, quality audit). Industry standards indicate 95% of all claims should be processed within 14 calendar days. Best practice, which follows Department of Labor regulations, requires 100% within 30 calendar days. However, electronic calculations often do not allow for distinction of multiple processing events.

From our electronic analysis, we can conclude **there were no concerns with turnaround time on the claims.** Results from our electronic analysis of all claims processed during the audit period revealed Anthem processed 97.57% of the claims within 14 calendar days (10 business days) and 99.21% within 30 calendar days. The 14 calendar day (10 business days) metric exceeded the performance guarantee of 95.00%, which was agreed upon with LACERA.

Section III – Target Claims

Segal performed an electronic review of all claims (100%) processed and paid during the audit period (July 1, 2018 through June 30, 2019). Our electronic review was designed to identify potential deficiencies in the benefit delivery system; however, our analysis was not expected to identify data entry errors (i.e., incorrect patient, date of service, or provider) or creative billing practices of the provider.

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

- Potential duplicate payments.
- Reimbursement of Plan exclusions, limitations, and prior authorizations.
- Patient out-of-pocket expenses (deductible, copay and coinsurance).

The respective Summary Plan Document ("SPD") and Summary Benefit Coverage ("SBC") served as our reference for the electronic analyses. Electronic reports provided a list of suspected errors that required the auditor's manual review to refine the analysis and identify any patterns of concern; a selection of claims was chosen to confirm suspected errors and identify appropriate query revisions.

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

Of the 35 claims targeted through electronic analyses, 22 were supported by claim documentation, confirmation of Plan intent, and/or explanation of established administrative procedures.

Target Error Table

The sample of 35 claims identified **13 overpayments totaling $23,479.25**. Anthem should initiate overpayment recovery efforts for claims identified in the following table as well as initiate financial impact reports for the requested claims below. Audit findings are detailed in the following table.

Target Sample Errors		
Worksheet	**Overpayment**	**Explanation**
T6	$150.00	Acupuncture was over the $30.00 per visit allowance. (Manual and Auto- adjudication)
T7	$259.00	
T9	$120.00	Anthem agreed onsite with this assessment. Segal recommends Anthem generate a financial impact report. *Anthem agrees to the errors assessed during the onsite audit. The root cause was manual processing. The manager will meet with the processor to review and discuss the errors. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing claims for LACERA. The overpayments were adjusted and recovered on January 23, 2020.*
T8	$350.00	Acupuncture was over the $30.00 per visit allowance. (Manual and Auto- adjudication) Anthem disagrees with this assessment and stated because the doctor's specialty is not acupuncture the benefit should not be limited to the $30.00 allowance. Segal disagrees with this assessment and recommends Anthem generate a financial impact report for acupuncture claims over $30.00 with a physician other than an acupuncturist. *Anthem disagrees with the assessed error. The doctor's specialty is not acupuncture; therefore, the benefit should not be limited to the $30.00 allowance. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.* Segal holds this claim as an error and recommends Anthem and LACERA discuss the application of this benefit with different physician types.
T12	$760.64	Per the Plan document, hearing aids and exams are not covered. A benefit for CPT code 92591, which is described as hearing aid exam for both ears was paid. (Manual and Auto-adjudication) Anthem stated this exam does not have to do with hearing aids. **Segal maintains the error due to the CPT code description.**
T13	$246.43	

Target Sample Errors		
Worksheet	**Overpayment**	**Explanation**
		Anthem maintains that these exams do not relate to hearing aids. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request. **Segal maintains the error due to the CPT code description and recommends LACERA discuss with Anthem this code scenario.**
T15	$12.03	Per the Plan document, smoking cessation is not covered. A benefit for CPT code 99406, which is described as smoking and tobacco cessation counseling visit was paid. (Manual and Auto- adjudication) Anthem stated this exams does not have to do with smoking cessation as the diagnosis differs in relation to the procedure. **Segal maintains the error due to the CPT code description.** *Anthem disagrees with the assessed errors and maintains that these exams do not relate to smoking cessation; the diagnosis differs in relation to the procedure. The claims processed correctly. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.* **Segal recommends LACERA and Anthem discuss the adjudication of this code with different diagnosis types.**
T16	$12.25	
T24	$24.00	Prescription drugs are not covered under this policy. (Manual adjudication) Anthem disagreed with this assessment noting since the primary insurance paid they paid as secondary. **Segal disagrees with Anthems assessment noting the claim should have been processed through the prescription drug program.** *Anthem disagrees with the assessed error. Anthem maintains that the claim processed correctly per the CVS affiliation with LACERA at the time. CVS allowed Anthem to coordinate the benefits when LACERA was the secondary or tertiary carrier. Anthem was allowed to recoup the copays and/or fees. Anthem's Account Management is available to*

Target Sample Errors		
Worksheet	**Overpayment**	**Explanation**
		discuss this benefit in further detail with LACERA upon request. **Segal recommends LACERA and Anthem discuss this benefit in further detail.**
T25	$25.76	Prescription drugs are not covered under this policy. (Manual adjudication) Anthem agreed onsite with this assessment. *Anthem stated the root cause of this error is manual processing. The manager will meet with the processor to review and discuss the error. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing claims for LACERA. The overpayment will not be perused as it is under the threshold for recovery.*
T32	$26.53	Duplicate claim payment. (Manual adjudication) Anthem agreed onsite with this assessment. *Anthem stated the root cause of this error is manual processing. The manager will meet with the processor to review and discuss the error. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing LACERA claims. The overpayment will not be perused as it is under the threshold for recovery.*
T33	$1,864.34	An incorrect amount was paid for the claim. The claim was adjusted outside of the audit period. (Manual adjudication) Anthem agreed onsite with this assessment. *Anthem stated the root cause was manual processing. The manager will meet with the processor to review and discuss the error. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing claims for LACERA. Anthem completed a recovery adjustment on January 23, 2020.*
T35	$19,646.27	The member has Medicare and the claim was not coordinated to incorporate Medicare's payment. (Manual adjudication) Anthem noted more research into this claim is necessary.

Target Sample Errors		
Worksheet	**Overpayment**	**Explanation**
		Anthem stated additional time is needed to research this claim. Anthem is anticipating the research to be complete by February 28, 2020. Anthem will provide the results of the research to LACERA upon completion.
Total	**13 overpayments**	**$23,479.25**

Section IV – Claim Control Measures

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

- Anthem receives on average 77,000 claims per day for LACERA.
  - 93% of claims are received electronically company wide.
  - 83% of claims are auto-adjudicated company wide.
  - 88% were auto-adjudicated for LACERA.
- Anthems system can automatically detect potential COB or TPL claims that may require further manual review.
  - COB questionnaires are sent out once per a year for LACERA members.
  - Investigations are also conducted based on claim submission information and data match programing.
- The minimum amount to initiate subrogation is $750.00 using the pay and pursue subrogation method.
- Additional information requests and correspondence is sent out through the following system generated methods:
  - Explanation of benefits (EOB)
  - Letter of other insurance
  - Provider remittance
  - COB questionnaires
- Customer service also non-system generated correspondence to members and providers as a response to a phone or written inquiry.

Claims billed over $19,000.00 are routed to a special unit for processing.

A high-dollar claims auditor reviews all claims over $300,000.00.

Manually adjudicated high-dollar claims for more than $40,000.00.

Any refund over the $30.00 threshold is pursued.

Section V – Anthem's Formal Response

Internal Audit Assurance Services
21215 Burbank Blvd., 3rd Floor
Woodland Hills, CA 91367

February 10, 2020

Amber M. Turner, MBA
The Segal Group, Inc.
Associate Consultant
Benefit Audit Solutions
330 N. Brand Blvd., Ste. 1100
Glendale, California 91203-2337

Re: Los Angeles County Employees Retirement Association Medical Plan Audit Draft Report

Dear Ms. Turner:

Anthem Blue Cross of California (Anthem) reviewed the audit report prepared by Segal Consulting on behalf of Los Angeles County Employees Retirement Association (LACERA). The audit consisted of 220 random stratified sample and 35 targeted claims processed and paid during the 12-month audit period of July 1, 2018 through June 30, 2019. The on-site review took place the week of November 18, 2019 at our Rancho Cordova facility.

Anthem's responses to the Key Findings and Recommendations are presented below:

Claims Audit Results

Statistical Error Table

The following errors were identified through the stratified and target claims samples.

Based on the sample of 220 claims, Segal identified five (5) overpayments totaling $840.54, twelve (12) underpayments for $61.03, two (2) out-of-sample overpayments for $1,804.37, and six (6) out-of-sample underpayments for $265.34.

Five in-sample overpayments totaling $840.54

- Sample 94C – This error resulted in a total overpayment of $40.54. The claim coordinated with the other insurance incorrectly. Zero patient responsibility existed (auto adjudication). Segal requests a financial impact report be provided for this instance.

  Anthem Response: *Anthem has requested additional time to research this claim. Anthem is anticipating the research to be complete by February 28, 2020. Once the research is completed, Anthem will provide its findings to LACERA.*

- Samples 166F, 198I – These errors resulted in a total overpayment of $400.00. Non-certification deductible was not applied to the claim (auto adjudication). Segal disagrees with Anthem's assessments and notes page 69 of the Plan document does not restrict to only nonparticipating providers. Segal requests a financial impact report for this instance.

  Anthem Response: *Anthem disagrees with the assessed errors. Anthem maintains that authorization does not apply to participating providers. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.*

- Samples 204J, 208J – These errors resulted in a total overpayment of $400.00. Non-certification deductible was not applied to the claim (auto adjudication). Segal disagrees with the waiver of the non-certification deductible noting on page 69 of the Plan document, authorization for emergency must be completed within 24 hours of an emergency admission... Segal requests a financial impact report for this instance.

  Anthem Response: *Anthem disagrees with the assessed errors. Anthem maintains that due to the emergency nature of the services rendered; the authorization process was waived. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.*

2 Out-of-Sample overpayments totaling $1,804.37

- Samples 104C and 110C – These errors resulted in a total overpayment of $1,804.37. For each member, Medicare was transitioned to primary in 2019. Claims on file did not adjust to coordinate with Medicare (auto-adjudication). Segal recommends Anthem establish procedures regarding adjustments to Medicare transition claims.

  Anthem Response: *Anthem has requested additional time to research these claims. Anthem is anticipating the research to be complete by February 28, 2020. Once the research is completed, Anthem will provide its findings to LACERA.*

12 Underpayment errors resulting in a total underpayments of $61.03

- Samples 3A, 8A, 12A, 20A, 34A, 59B, 62B, 78B, 108C, 117C and 132D – These errors resulted in a total underpayments of $61.03. The Medicare patient responsibility was not applied correctly. This seems to be a repeat error item from the 2018 audit (auto adjudication). Segal requests Anthem to provide the results of their review to LACERA within 10 business days from the release of the draft report.

  Anthem Response: *Anthem is working on system modifications to accommodate Medicare's new coding. Anthem agrees to the identified underpayments totaling $61.03. Anthem anticipates the research of the systematic nature of these errors to be completed*

by February 28, 2020. Anthem will review the volume, correct the errors and will make a determination on generating the financial impact report. Anthem will provide the results of the impact analysis to LACERA upon completion. .

- Sample 101C – Member call regarding an incorrect claim payment, which lead to a claim adjustment. (Manual adjudication)

  Anthem Response: *Anthem agrees to the error assessed during the onsite audit. The manager will meet with the processor to review and discuss the error. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing LACERA claims.*

6 Out-of-Sample errors

- Samples 2A, 96C, 118C, 130D, 142D and 180G – These errors resulted in total underpayments of $265.34. The out of pocket amount was over the limit for the calendar year. This is likely a result of comingling with the prescription drug accumulator (manual and auto-adjudication). As reported in the 2018 audit, it is not unusual for these errors to occur due to real time prescription dispensing and delayed update to medical records; however, Anthem should have a standard practice in place to identify and adjust underpayments.

  Anthem Response: *Anthem agrees to the errors assessed. Anthem is working to develop a report to capture all over applied accumulators that resulted from the comingling with the prescription plan. The underpayment errors were adjusted on 01/23/2020. Anthem Account Management is available to discuss this issue with LACERA upon request.*

Target Error Table Summary

The sample of 35 claims identified 13 overpayments totaling $23,479.25. Anthem should initiate overpayment recovery efforts for claims identified in the audit as well as initiate financial impact reports for the requested claims.

- Samples T6, T7 and T9 – These errors resulted in a total overpayment of $529.00 – Acupuncture was over the $30.00 per visit allowance (Manual and Auto-adjudication). Segal recommends Anthem generate a financial impact report.

  Anthem Response*: Anthem agrees to the errors assessed during the onsite audit. The root cause was manual processing. The manager will meet with the processor to review and discuss the errors. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing claims for LACERA. The overpayments were adjusted and recovered on 01/23/2020.*

- Sample T8 – This error resulted in a total overpayment of $350.00 – Acupuncture was over the $30.00 per visit allowance (Manual and Auto-adjudication). Segal disagrees with Anthem assessment and recommends that Anthem generate a financial impact report for acupuncture claims over $30.00 with a physician other than an acupuncturist.

Anthem Response: *Anthem disagrees with the assessed error. The doctor's specialty is not acupuncture; therefore, the benefit should not be limited to the $30.00 allowance. The claim processed correctly. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.*

- Samples T12 and T13- These errors resulted in a total overpayment of $1,007.07 – Per Plan document, hearing aids and exams are not covered. A benefit for CPT code 92591, which is described as hearing aid exam for both ears was paid (Manual and Auto-adjudication). Segal maintains the error due to the CPT code description.

  Anthem Response: *Anthem maintains that these exams do not relate to hearing aids. The claims processed correctly. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.*

- Samples T15 and T16 – These errors resulted in a total overpayment of $24.28. Per the Plan document, smoking cessation is not covered benefit. A benefit for CPT code 99406, which is described as smoking and tobacco cessation counseling visit, was paid (Manual and Auto-adjudication). Segal maintains the error is due to the CPT code description.

  Anthem Response: *Anthem disagrees with the assessed errors. Anthem maintains that these exams do not relate to smoking cessation; the diagnosis differs in relation to the procedure. The claims processed correctly. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.*

- Sample T24 –This error resulted in a total overpayment of $24.00 – Prescription drugs are not covered under this policy (Manual adjudication). Segal states that the claim should have been processed through the prescription drug program.

  Anthem Response: *Anthem disagrees with the assessed error. Anthem maintains that the claim processed correctly per the CVS affiliation with LACERA at the time. CVS allowed Anthem to coordinate the benefits when LACERA was the secondary or tertiary carrier. Anthem was allowed to recoup the copays and / or fees. Anthem's Account Management is available to discuss this benefit in further detail with LACERA upon request.*

- Sample T25 – This error resulted in a total overpayment of $25.76 - Prescription drugs are not covered under this policy (Manual adjudication).

  Anthem Response: *Anthem agrees to the error assessed. The root cause was manual processing. The manager will meet with the processor to review and discuss the error. The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing claims for LACERA. The overpayment is under the threshold for recovery.*

- Samples T32 – This error resulted in a total overpayment of $26.53 – Duplicate claim payment (Manual adjudication).

  Anthem Response: *Anthem agrees to the error. The root cause was manual processing. The manager will meet with the processor to review and discuss the error. The Employer*

Service Representative and Unit Lead will provide coaching to the entire designated staff processing LACERA claims. *The overpayment is under the recovery threshold.*

- Sample T33 –This error resulted in a total overpayment of $1,864.34 – An incorrect amount was paid for this claim. The claim was adjusted outside of the audit period (Manual adjudication).

  Anthem Response: *Anthem agrees to the error assessed. The root cause was manual processing. The manager will meet with the processor to review and discuss the error. . The Employer Service Representative and Unit Lead will provide coaching to the entire designated staff processing claims for LACERA. A recovery adjustment was completed on 01/23/2020.*

- Sample T35 – This error resulted in a total overpayment of $19,646.27 – The member has Medicare and the claim was not coordinated to incorporate Medicare's payment (Manual adjudication).

  Anthem Response: *Additional time is needed to research this claim. Anthem is anticipating the research to be complete by February 28, 2020. Anthem will provide the results of the research to LACERA upon completion.*

Recommendations

- Overpayment recovery efforts should be initiated for errors identified within the statistical and target selections.

  Anthem Response: *All agreed upon financial errors meeting the adjustment guidelines have been placed into the adjustment and recovery process.*

- Adjustments should be performed on the identified underpayments.

  Anthem Response: *All agreed upon financial errors meeting the adjustment guidelines have been placed into the adjustment and recovery process.*

- Segal recommends financial impact reports should be generated for the identified categories.

  Anthem Response: *Impact reports will be generated for the identified and agreed upon systemic issues.*

- Segal recommends Anthem and LACERA Discuss a write-off threshold.

  Anthem Response: *Anthem's Account Management is available to discuss this recommendation with LACERA upon request.*

- Segal recommends Anthem establish procedures regarding adjustments to Medicare transition claims.

  Anthem Response: *Anthem's Account Management is available to discuss this recommendation with LACERA upon request.*

Anthem Blue Cross appreciates the opportunity to respond to the report and representatives are available to discuss this audit, the findings and our response with both Segal Consulting and LACERA upon request. If you have any questions, please do not hesitate to call me at (818) 234-3276 or if you prefer, my email address is george.garcia@anthem.com.

Sincerely,

George R. Garcia
External Audit Manager Senior
Customer Audit Services

cc: Lisa Adams, Anthem
Ivan Ashby, Anthem
Marijane Gadbury, Anthem
Tina Griffin, Anthem
Michael Saavedra, Anthem
Kristine Walsh, Anthem

Los Angeles County Employee Retirement Association

Cigna Health and Life Insurance Company

Analysis of Dental Claims Processing and Payment Procedures

For the Period of July 1, 2018 through June 30, 2019

August 4, 2020 / Amber M. Turner, MBA, PMP

Segal

Cigna Dental Claims Audit – Final Report

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. Amber Turner and Jennifer Lagua conducted the October 29-31, 2019 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 of July 1, 2018 through June 30, 2019, representing $33,473,358.17 in benefit payments. Our review to ensure claims were paid in accordance with LACERA's plan provisions included the following components:

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

The auditor completed an electronic 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". These worksheets (1–225) 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 and benefit determination.

Statistical Results

During the 12-month audit period July 1, 2018 through June 31, 2019, total benefit payments of $33,473,358.17 were issued for 149,921 claims. Benefit payments for the 225 stratified claims sample totaled $99,597.65 (0.297% of total payments).

The sample of 225 claims identified one (1) in sample underpayment for $38.60, one (1) in sample overpayment totaling $38.40, one (1) out of sample underpayment for $62.60, and three (3) other out of scope underpayments processed in the prior audit period. All claims found in error were manually processed.

As seen in the chart below, Cigna met each of their performance guarantees. The errors assessed are detailed in Section II of this report.

Performance Measurements			
Category	**Statistical Achieveme**	**Performance Guarantee**	**Industry Standards**
Financial Accuracy (dollar value)	99.81%	99.00%	99.00%
Overall Processing Accuracy (free from error)	98.88%	95.00%	95.00%
Payment Accuracy (free from financial error)	98.88%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Time-to-Process (within 10 business days)*	95.58%*	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. These standards include acceptable performance levels for administration of fully-insured, self-insured, corporate, public, and multi-employer plan benefits.

Key Findings and Recommendations

The following bullet points summarize the primary review findings identified by Segal's auditors during the individual claims review with recommendations, as indicated. Cigna was presented with a draft report on November 6, 2019 for their review and comment. Their written responses were delivered to Segal on November 22, 2019 and are paraphrased in italics throughout this report; their entire response is included in Section 5.

- Cigna should adjust the payment errors identified in this review:

  - $101.20 additional payment for underpayments processed during the audit period. Cigna indicated they will not adjust an additional $145.80 for claims processed in the prior audit period. (Worksheet 22A)

    Cigna noted all claims found in error for this member were adjusted as of November 5, 2019. On November 1, 2019 coaching and additional education was provided to the team members regarding processing procedures and coordination of benefits.

    Segal agrees the proper actions were followed to remedy this error.

  - $38.40 overpayment recovery effort should be initiated. (Worksheet 52B)

    Cigna noted the claim found in error was adjusted as of November 5, 2019. On November 1, 2019 coaching and additional education was provided to the team

members regarding processing procedures and specifically processing of codes D4210 through D4999.

Segal agrees the proper actions were followed to remedy this error.

- LACERA should review Cigna's practice of reducing undocumented periodontal maintenance services to a lower routine cleaning benefit. No action is required unless the policy does not meet the Plan's intent. (Worksheet 52B; Additional Observation)

  Cigna noted their procedures for periodontal maintenance is consistent with the American Dental Association's administration of this benefit. Cigna is open to discussing the administration of this benefit with LACERA.

  Segal does not disagree with the administrative policy, but recommends confirmation that it meets LACERA's intent for administration of their plan of benefit.

All findings from the prior audit period were resolved prior to report distribution. Segal appreciates Cigna's ongoing support in resolving questions posed during this review period.

Section II – Statistical Claim Review

Cigna provided a data file of all dental claims processed and paid during the 12-month audit period of July 1, 2018 through June 30, 2019, which was utilized for sampling purposes. Benefit payments for 149,921 claims totaled $33,473,358.17. Sampled benefit payments for 225 stratified claims totaled $99,597.65. Relevant claims processing information was verified through Cigna's responses to the adjudication questionnaire, onsite discussions, auditor's observations, and the individual claims review.

Stratification Table

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		Dollar Amount in	
			Range	Selection	Selection	Strata
A	$0.01	$79.99	40,435	50	$2,979.78	$2,243,827.79
B	$80.00	$119.99	34,586	40	$3,901.44	$3,384,750.15
C	$120.00	$189.99	30,652	30	$4,468.80	$4,571,207.03
D	$190.00	$309.99	17,190	25	$5,882.84	$4,096,829.19
E	$310.00	$499.99	9,859	20	$7,764.40	$3,876,521.84
F	$500.00	$749.99	7,129	15	$9,157.30	$4,358,820.01
G	$750.00	$999.99	4,370	10	$8,865.15	$3,795,952.59
H	$1,000.00	$1,499.99	4,889	10	$12,493.14	$5,922,281.17
I	$1,500.00	$1,599.99	801	15	$22,500.00	$1,201,583.60
J	$1,600.00	$3,000.00	10	10	$21,584.80	$21,584.80
Total			**149,921**	**225**	**$99,597.65**	**$33,473,358.17**

Review Process

Cigna provided a copy of the sampled claim submissions and access to their claims system for the auditor's 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 sampled patients' claims history was reviewed to confirm proper application of deductibles and calendar year maximums.

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

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

Statistical Error Table

The sample of 225 claims identified one (1) in sample underpayment for $38.60, one (1) in sample overpayment totaling $38.40, one (1) out of sample underpayment for $62.60, and three (3) other out of scope underpayments processed during the prior audit period. All claims found in error were manually processed.

Cigna should initiate overpayment recovery efforts for claims found in error within the audit period. However, Cigna informed Segal that errors processed in a prior audit period will not be adjusted.

Statistical Sample Errors		
Worksheet	**(Under)/ Overpayment**	**Explanation**
22A	($38.60)	Claims for a spouse were processed as primary prior to 2017; Cigna had the earlier retiree effective date (2005) and therefore is primary to the spouse's retiree plan (2015). Manually processed claims were later paid inconsistently as primary and secondary. (Manual adjudication) *Cigna responded noting that all claims for this account found in error were adjusted as of November 5, 2019. Cigna moved forward with providing reinforcement coaching and education to the individual processor as well as a claim team huddle on November 1, 2019 which included the coaching topics of:* • *Review of the sample claim* • *Review of the dental claim processing checklist standard operating procedure ("SOP")* • *Review of coordination of benefits dental DentaCom SOP* **Segal agrees the proper actions were followed to remedy this error.**
	($62.60) out of sample	
	3 out of scope underpayments	Three additional claims processed prior to July 1, 2018 were underpaid $145.80. (Manual adjudication) *Please see the above Cigna response.*
52B	$38.40	Claims were previously denied as periodontal maintenance is only covered for patients with periodontal disease. The sample claim paid for periodontal maintenance. (Manual adjudication) *Cigna responded noting that all claims for this account found in error were adjusted as of November 5, 2019. Cigna moved forward with providing reinforcement coaching and education to the individual processor as well as a claim team huddle on November 1, 2019 which included the coaching topics of:* • *Review of the sample claim* • *Review of the dental claim processing checklist standard operating procedure ("SOP")* • *Review of 2019 procedure codes D4210 through D4999 through Dental Advisory Guide*

Statistical Sample Errors		
Worksheet	**(Under)/ Overpayment**	**Explanation**
		Segal agrees the proper actions were followed to remedy this error.
Total	**1 underpayment**	**$ 38.60**
	1 overpayment	**$ 38.40**
	1 out of sample underpayment	**$ 62.60**
	3 out of scope underpayments	**$145.80**

Additional Observation

Currently, it is Cigna's policy to process periodontal maintenance services as a preventative cleaning benefit when "scaling and root planning" has not been documented.

The American Academy of Periodontology recommends dentists offer deep cleanings when x-rays show bone loss and a full-mouth exam reveals one or more gum pockets greater than 4 millimeters deep; treatment should be limited to the affected teeth or mouth quadrant. Therefore, Cigna's policy serves as a claim control measure to ensure benefits are reimbursed at the most appropriate level and allowance.

Segal recommends LACERA discuss this policy with Cigna if it does not meet the Plan's intent.

Cigna noted their procedures for periodontal maintenance is consistent with the American Dental Association's administration of this benefit. Cigna is open to discussing the administration of this benefit with LACERA.

Segal does not disagree with the administrative policy, but recommends confirmation that it meets LACERA's intent for administration of their plan of benefit.

Turnaround Time Analysis

No concerns were identified.

Turnaround time for all claims (100%) processed from July 1, 2018 through June 30, 2019 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 of 93.00% with 95.58% achieved within 14 calendar (10 business) 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 (DOL) 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.

Section III – Claim Control Measures

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

- Cigna has 13 claim processors dedicated to LACERA dental claims with 85% working from home.
  - For remote workers the following is provided.
    - Remote access connection via two factor authentication with software in place on remote users desktops that force policy check prior to connecting to the network.
    - A "clean desk" policy must be adhered in a remote location just as it is required in an office location.
    - All Cigna workstations and laptops are encrypted with Digital Guardian software.
    - If external communication is required, the use of “Secure Message” must be used when sending an email outside Cigna’s network.
- On average Cigna receives approximately 14,000 claims per month.
  - 81.69% of claims are submitted electronically.
  - 78.67% of claims are auto adjudicated.
- Cigna has a special investigation unit (SIU), which provides antifraud detection and investigation, prepayment savings, and post-payment recovery services.
- There is no dollar threshold for requesting overpayment refunds.
- Performance guarantee claim quality audits are completed on a monthly basis.
- Cigna performs coordination of benefits investigation every 12 months.
  - Eligibility information is received via paper, mail, and phone calls.
  - Information is documented in the claims system and was witnessed in the onsite audit.
- Currently, there is no backlog of claims for LACERA.

Section IV – 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. Our independent audit results identified one (1) overpayment and one (1) underpayment; statistical measurements are presented below for comparison to Cigna's Performance Guarantee goals.

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.	99.00%	Met; 99.81%
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.	95.00%	Met; 98.88%
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	93.00%	Met; 95.58%
Claims processed within 20 Business Days	98.00%	Met*

* The electronic analysis for all claims reports 97.29% 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 V – Cigna's Formal Response

Steven P. Fallgren
Senior Account Manager
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November 13, 2019

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, 2018 through June 30, 2019)

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 28th, 2019 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 dental 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
Gina Hohbein, Cigna

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

SEGAL CONSULTING EVALUATION OF CIGNA

Executive Summary

Segal Consulting conducted a dental claims audit in Cigna's Denison Texas office October 29 – 31, 2019 of Los Angeles County Employees Retirement Association (LACERA) claims processed by Cigna. The sample consisted of 225 random dental claims processed and paid during the 12 month audit period of July 01, 2018 through June 30, 2019. Total benefit payments of $33,473,358.17 were paid on behalf of eligible employees and their dependents. Segal's sample and analysis represents benefit payments in the amount of $99,597.65.

The objectives of the audit included the following components:

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

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

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

Audit Overview

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

Sample Summary:

Platform	Scope Period	Total Volume of Paid Claims	Total Volume of Claim Payments	Audit Type	Audit Claim Sample Volume	Audit Sample Claim Payments
Dental	07/01/2018 - 06/30/2019	149,921	$33,473,358.17	*Random stratified Dental*	225	$99,597.65

Performance Measurements

Quality Metric	Segal Consulting Recognized Audit Results	Cigna Recognized Audit Results	Performance Guarantee	Recognized Industry Standard
Financial Accuracy	99.81%	99.81%	99.0%	99.0%
Payment Accuracy	98.88%	98.88%	n/a	97.0%
Procedural Accuracy	100.00%	100.00%	95.0%	95.0%

*Segal recognized Industry Standard

Audit Results

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

- Two (2) In-sample errors
  - Overpayment of $38.40
  - Underpayment of $38.60
- One (1) Out-of-sample error and Three (3) Out-of-scope errors (dates prior to scope of audit)
  - Underpayment of $208.40

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

Manual Processing Errors:

Error Detail	Cigna Remediation
Sample: 22 **Coordination of Benefits (COB) Application** (Claims for spouse were processed as primary prior to 2017; Cigna had the earlier retiree effective date (2005) and therefore is primary to the spouse's retiree plan (2015). In-Sample Underpayment: $38.60 Out-of-Sample Underpayments: $62.60 Out-of-Scope Underpayments: $145.80 Total Underpayments: $247.00	1. The sample claim (and related OOS claims) were adjusted as of November 5, 2019. 2. Reinforcement coaching and education provided to individual processor and also review with claim team during quality huddles on November 01, 2019. Coaching included the following: - Review of sample claim - Review of Dental Claim Processing Checklist SOP - Review of Coordination of Benefits Dental DentaCom SOP
Sample: 52 **Reimbursement: incorrectly allowed at full benefit** (Claims previously denied as periodontal maintenance - only covered for patients with periodontal disease. The sample claim paid for periodontal maintenance). Overpayment: $38.40	1) Refund request forwarded to Accent on November 5, 2019 and is currently pending recovery. 2) Reinforcement coaching and education provided to individual processor and also review with claim team during quality huddles on November 01, 2019. Coaching included the following: - Review of sample claim - Review of Dental Claim Processing Checklist SOP - Review CDT2019 D4210 through D4999 Dental Advisory DIPPO Dental Guide

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

SEGAL CONSULTING EVALUATION OF CIGNA

Client Intent:

Segal Consulting Turnaround Time Analysis	Cigna Response
LACERA should review Cigna's practice of reducing undocumented periodontal maintenance services to a lower routine cleaning benefit. No action is required unless the policy does not meet the Plan's intent.	Cigna's administration of periodontal maintenance (D4910) is consistent with the ADA CPT Code. The D4910 Periodontal Maintenance procedure is a "recall or re-care" type procedure that is completed following periodontal therapy and continues at varying intervals, determined by the clinical evaluation by the dentist, for the life of the dentition or any implant replacements. Cigna is happy to discuss the administration of this benefit with LACERA.

Time to Process:

Segal Consulting Turnaround Time Analysis	Cigna Response
Turnaround time for all claims (100%) processed from July 1, 2018 through June 30, 2019 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 of 93.00% with 95.58% achieved within 14 calendar (10 business) 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 (DOL) 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.

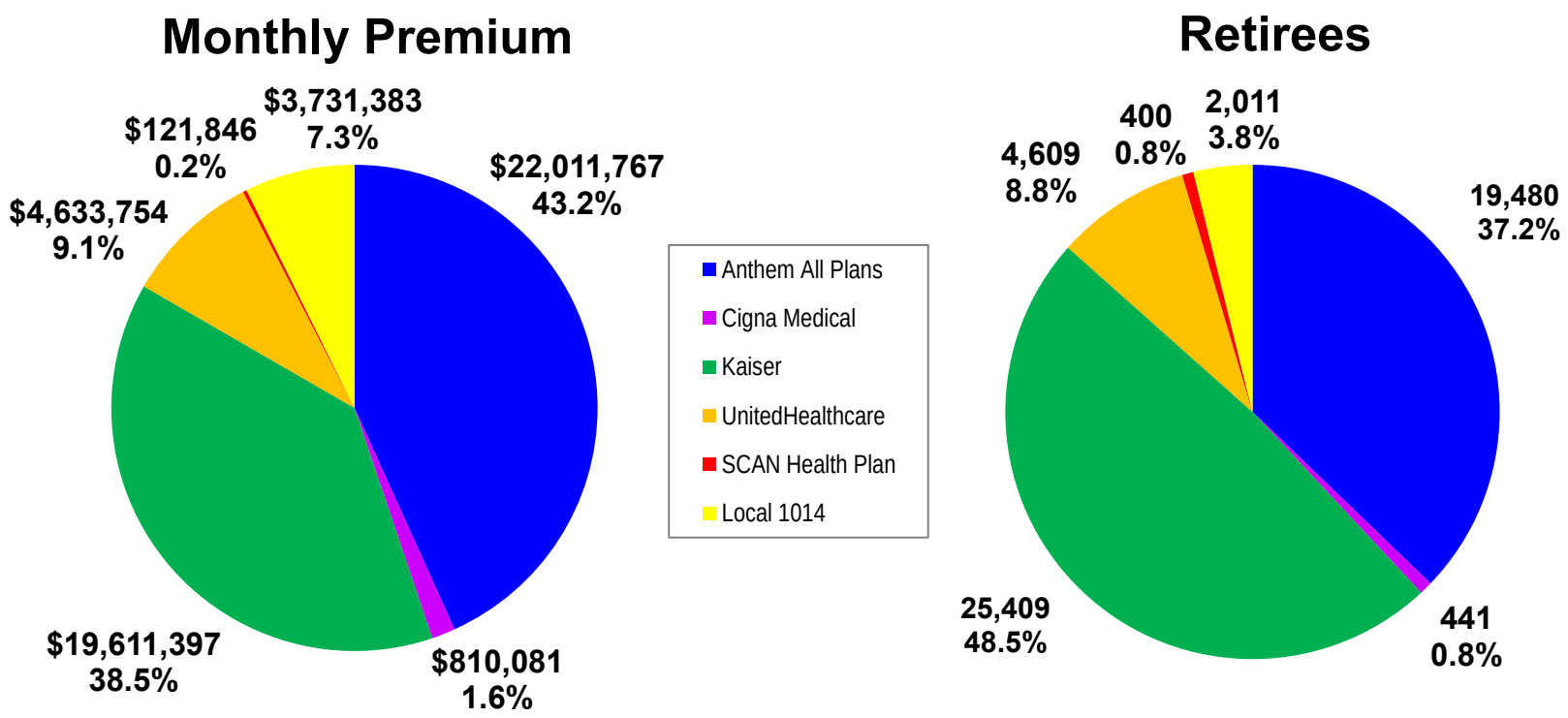
Time to Process Metric	2018 Contract Year Cigna Reported Result	Performance Guarantee Goal
10 business days	97.9%	93.00%

Los Angeles County Employees Retirement Association

Premium & Enrollment

Coverage Month Ending August 2020

Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$22,011,767	43.2%	19,480	37.2%
Cigna Medical	$810,081	1.6%	441	0.8%
Kaiser	$19,611,397	38.5%	25,409	48.5%
UnitedHealthcare	$4,633,754	9.1%	4,609	8.8%
SCAN Health Plan	$121,846	0.2%	400	0.8%
Local 1014	$3,731,383	7.3%	2,011	3.8%
Combined Medical	**$50,920,228**	**100.0%**	**52,350**	**100.0%**
Cigna Dental & Vision (PPO and HMO)	**$4,148,896**		**53,710**	

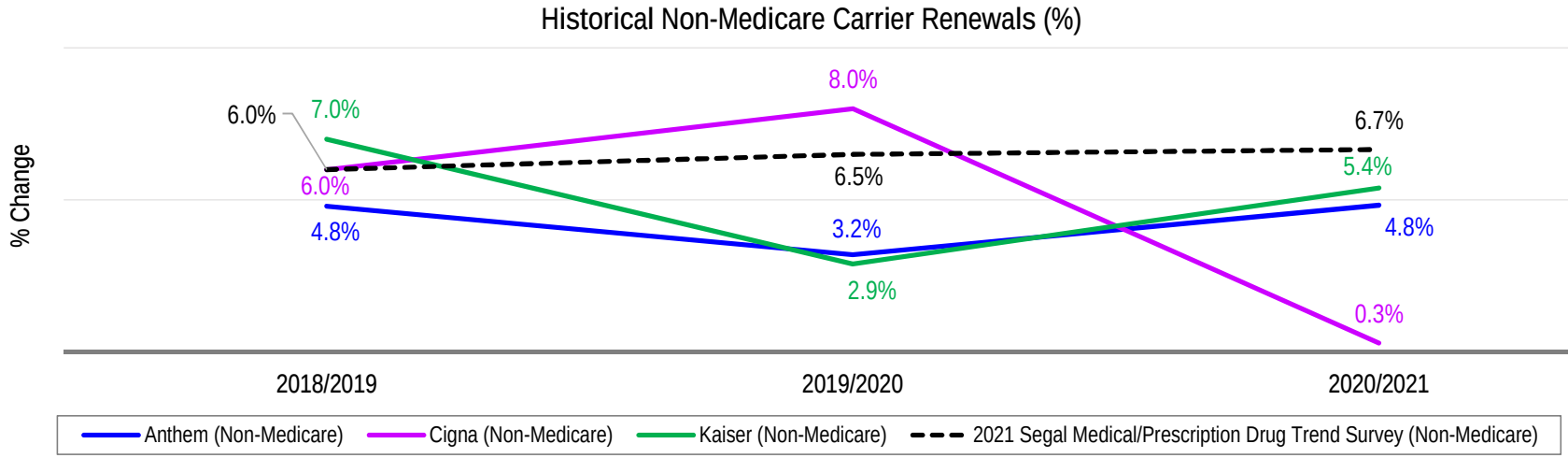


Note: Premiums **include** LACERA's Administrative Fee of $8.00 per member, per plan, per month.

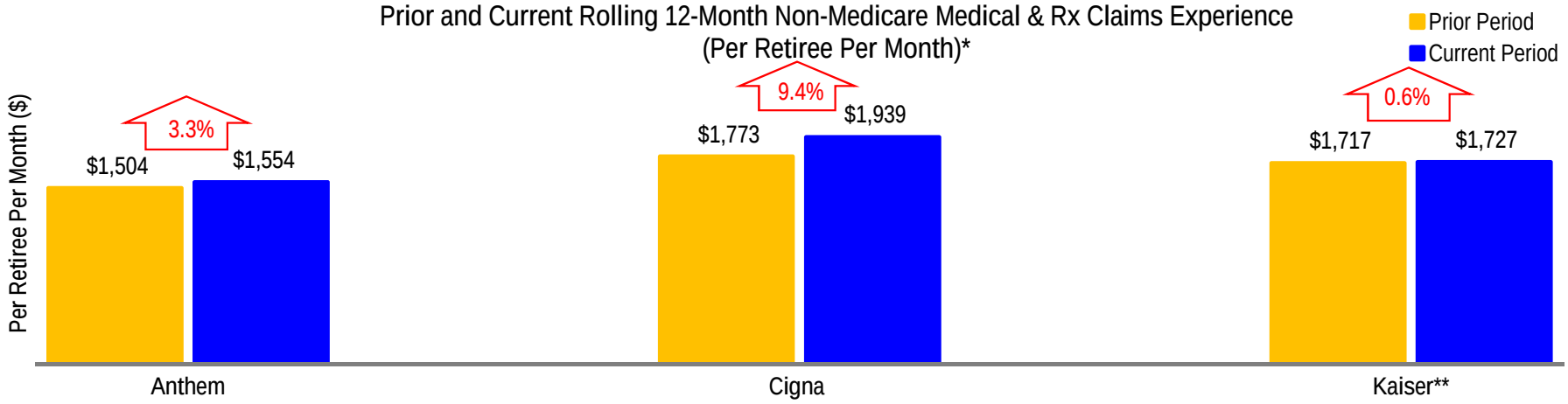
Los Angeles County Employees Retirement Association

Claims Experience by Carrier

Coverage Month Ending August 2020



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



*Based on Most Recent 12 months of Claims Experience through Coverage Month.

**Kaiser Claims Experience through April 2020.

Note: Figures above include gross claims only, and do not include rebates or pooling credits.

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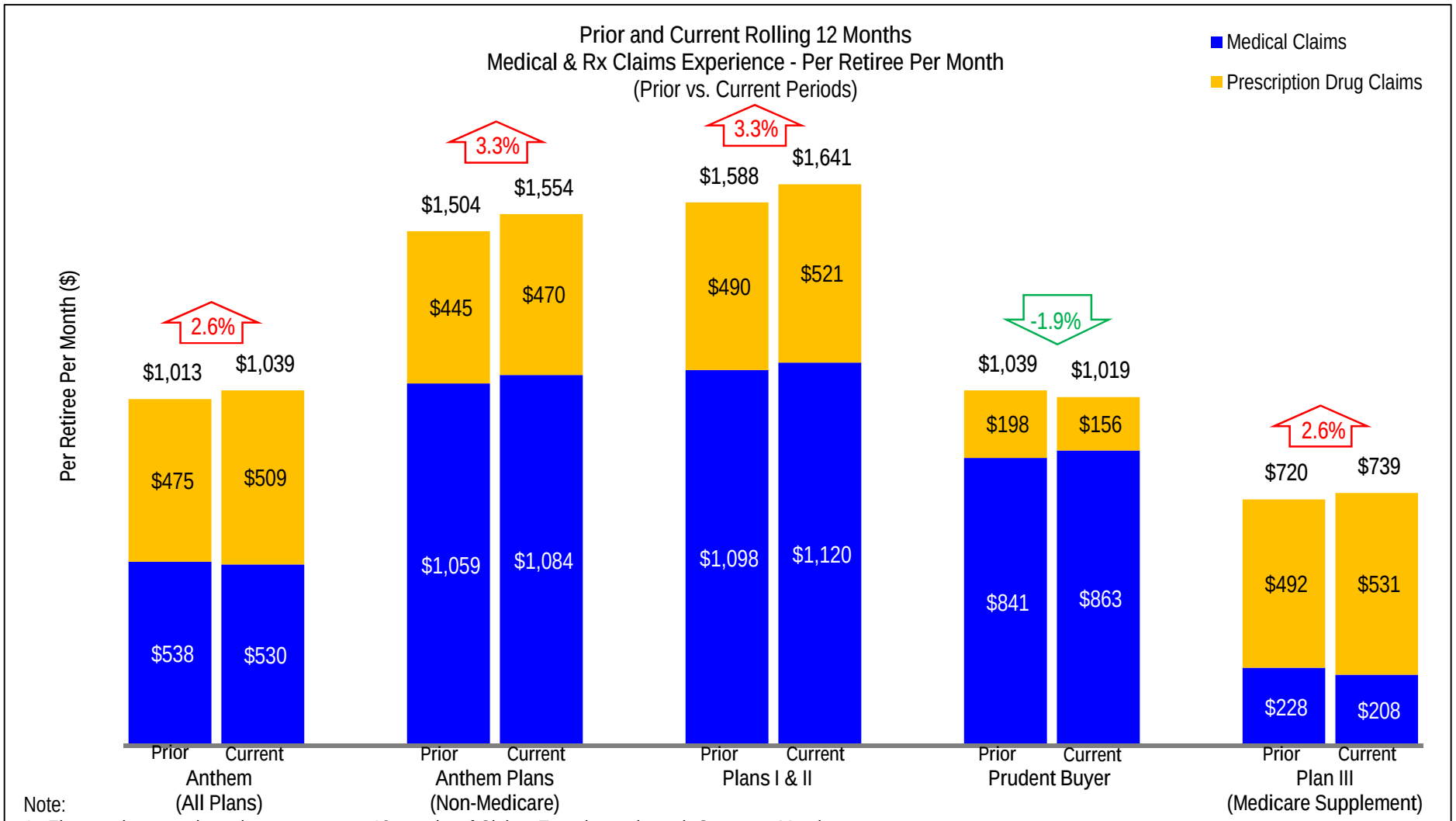
Anthem Claims Experience By Plan

Coverage Month Ending August 2020



Note:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Figures above include gross claims only, and do not include rebates, pooling credits, or ITS surcharges.
3. Prudent Buyer pharmacy claims are retroactively updated due to the timing of Anthem PBM's receipt of recorded claims.
4. Prudent Buyer pharmacy claims for the most recent month are adjusted by a factor of 1.37 to account for unreported clams.
5. Anthem applies ITS surcharges for Plans I-III, and Prudent Buyer, which add an estimated 0.5% and 1.0% to claims, respectively.

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Kaiser Utilization

Coverage Month Ending August 2020

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

Category	Current Period 5/1/2019 - 4/30/2020	Prior Period 5/1/2018 - 4/30/2019	Change
Average Contract Size	**2.38**	**2.35**	**1.28%**
Average Members	**8,825**	**8,723**	**1.17%**
Inpatient Claims Per Member Per Month	$157.79	$215.56	-26.80%
Outpatient Claims Per Member Per Month	$347.46	$306.25	13.46%
Pharmacy Per Member Per Month	$105.58	$96.43	9.49%
Other Per Member Per Month	$114.43	$112.27	1.92%
Total Claims Per Member Per Month	**$725.26**	**$730.51**	**-0.72%**
Total Paid Claims	**$76,802,561**	**$76,468,389**	**0.44%**
Large Claims over $450,000 Pooling Point			
Number of Claims over Pooling Point	6	4	
Amount over Pooling Point	$1,308,662	$1,301,748	0.53%
% of Total Paid Claims	**1.70%**	**1.70%**	
Inpatient Days / 1000	318.2	403.9	-21.22%
Inpatient Admits / 1000	48.5	59.3	-18.21%
Outpatient Visits / 1000	12,474.6	12,680.8	-1.63%
Pharmacy Scripts Per Member Per Year	10.6	10.6	0.00%

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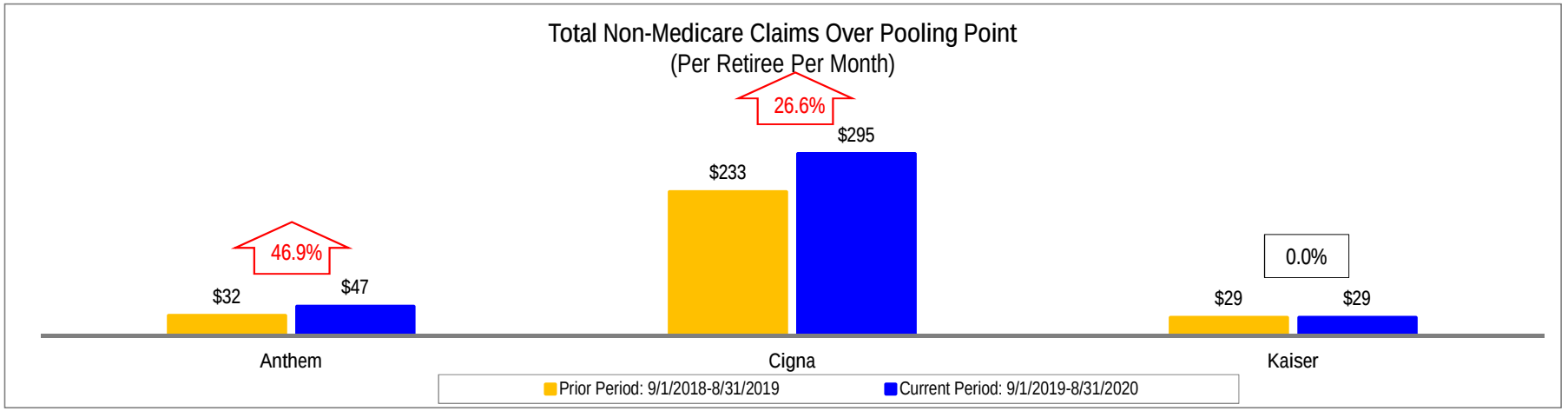
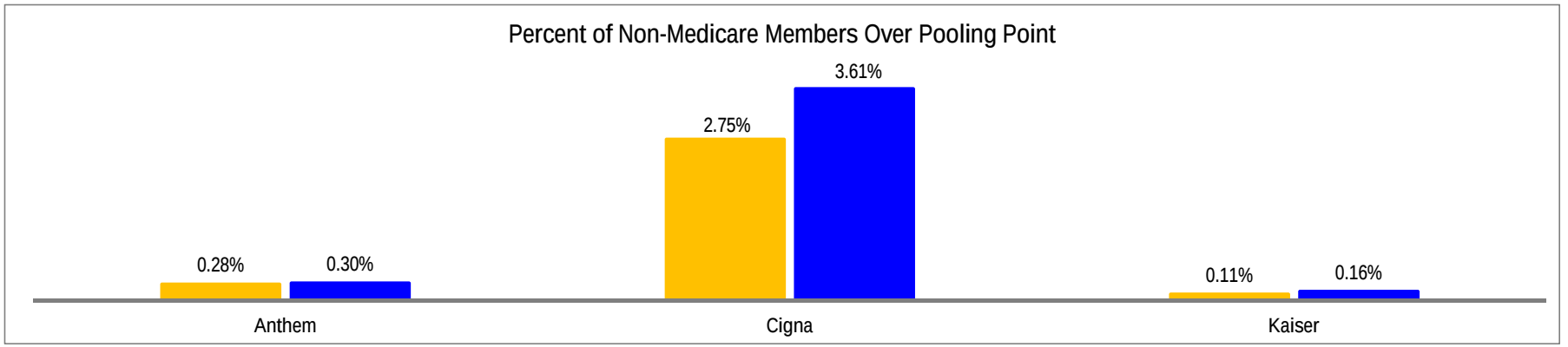
High Cost Claimants (Anthem, Cigna, & Kaiser)

Coverage Month Ending August 2020





Stop-Loss & Pooling Points Overview:

Plan sponsors mitigate the financial risk associated with individual large claimants through reinsurance. Claims exceeding the specified individual pooling threshold are deducted from the carrier's renewal calculation. The pooling credit is offset by the carrier's pooling expense, which is applied to all policyholders.

Anthem and Cigna's figures are based on most recent 12 months of Claims Experience through Coverage Month. Kaiser's figures are based on claims experience period between May through April.

Pooling Points by Carrier:

1. Anthem's pooling points are $300,000 for Plans I & II, and $250,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $450,000.

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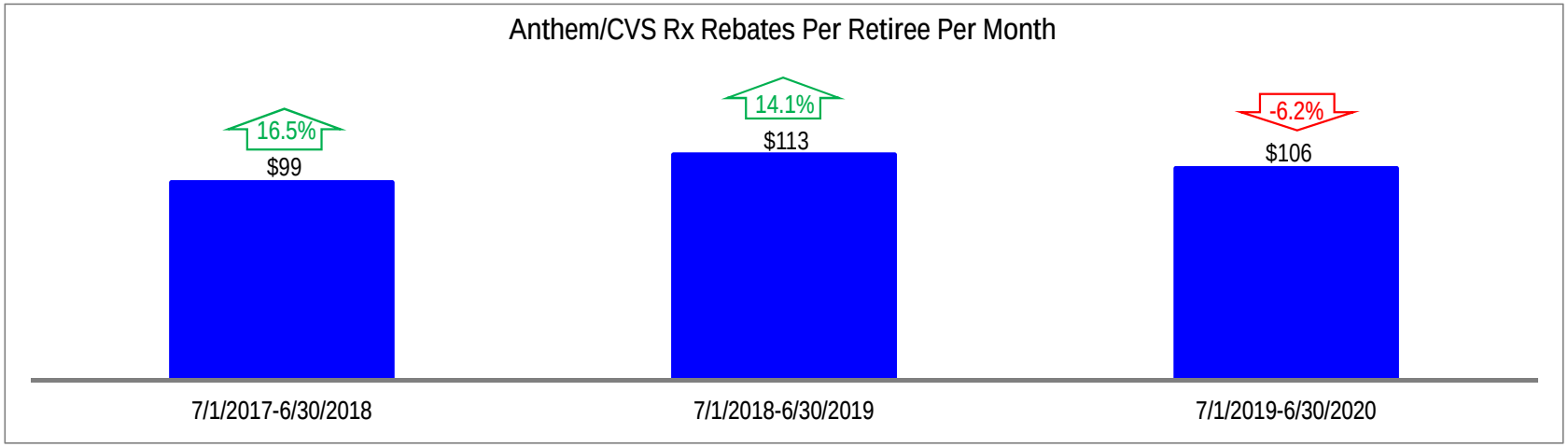
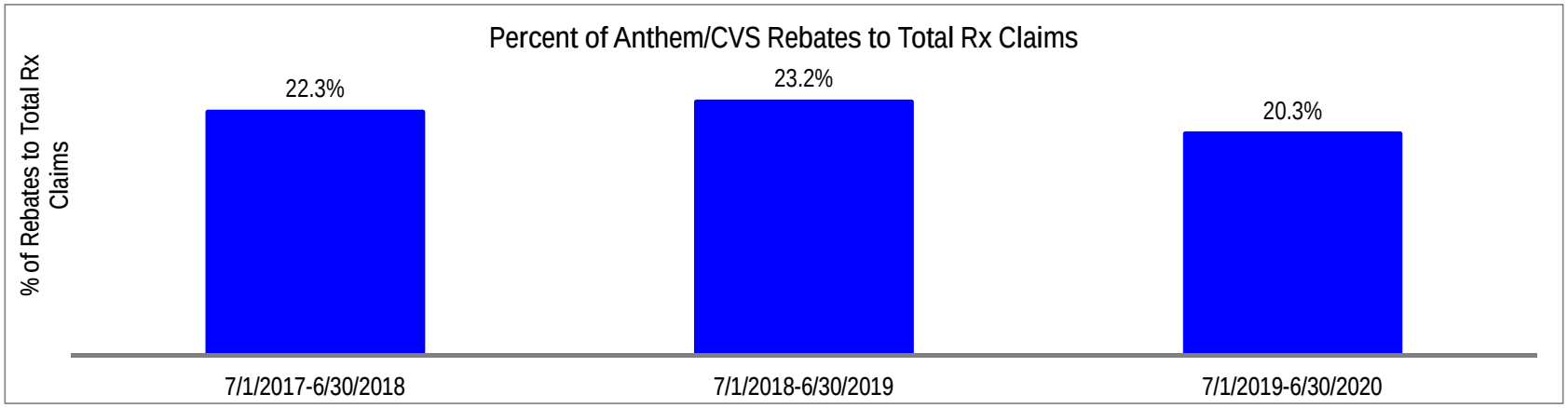
Prescription Drug Rebates (Anthem)

Coverage Month Ending August 2020





Rebates Overview:

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

Note:

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

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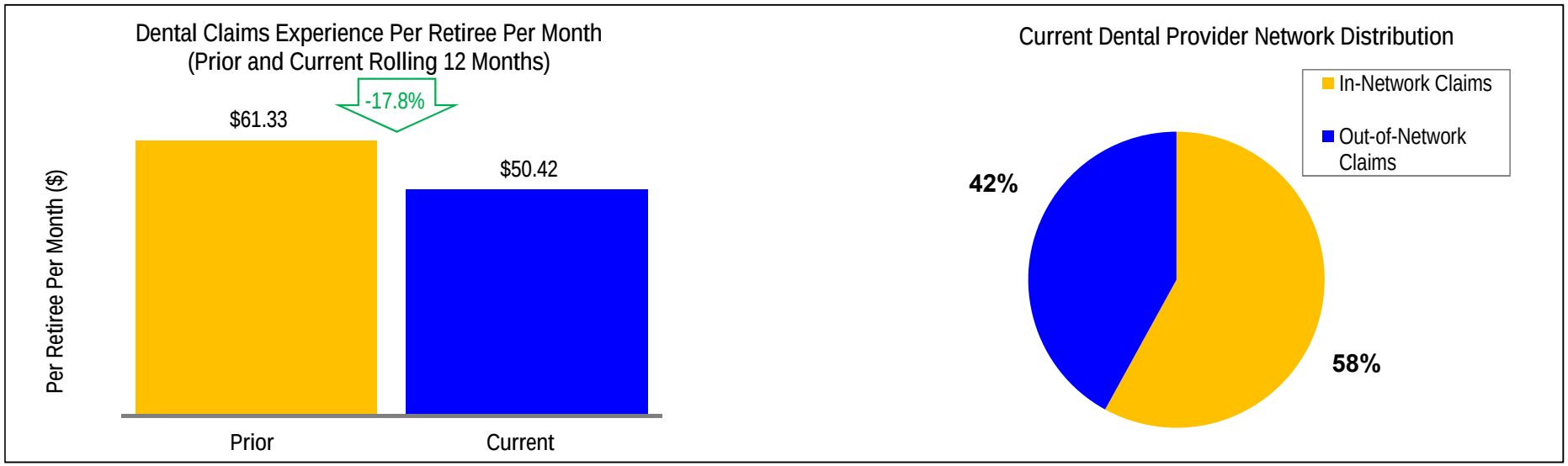
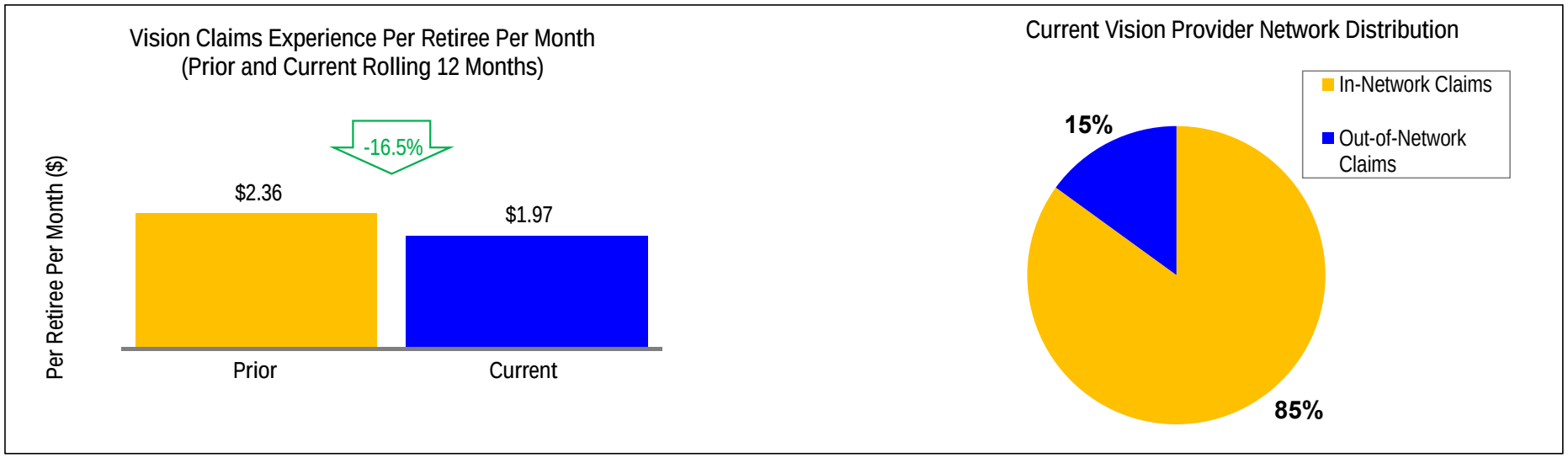
Cigna Dental & Vision Claims Experience

Coverage Month Ending August 2020





Notes:

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