IN PERSON & VIRTUAL BOARD MEETING

APRIL 5, 2023 AT 8:00 AM

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE MEETING

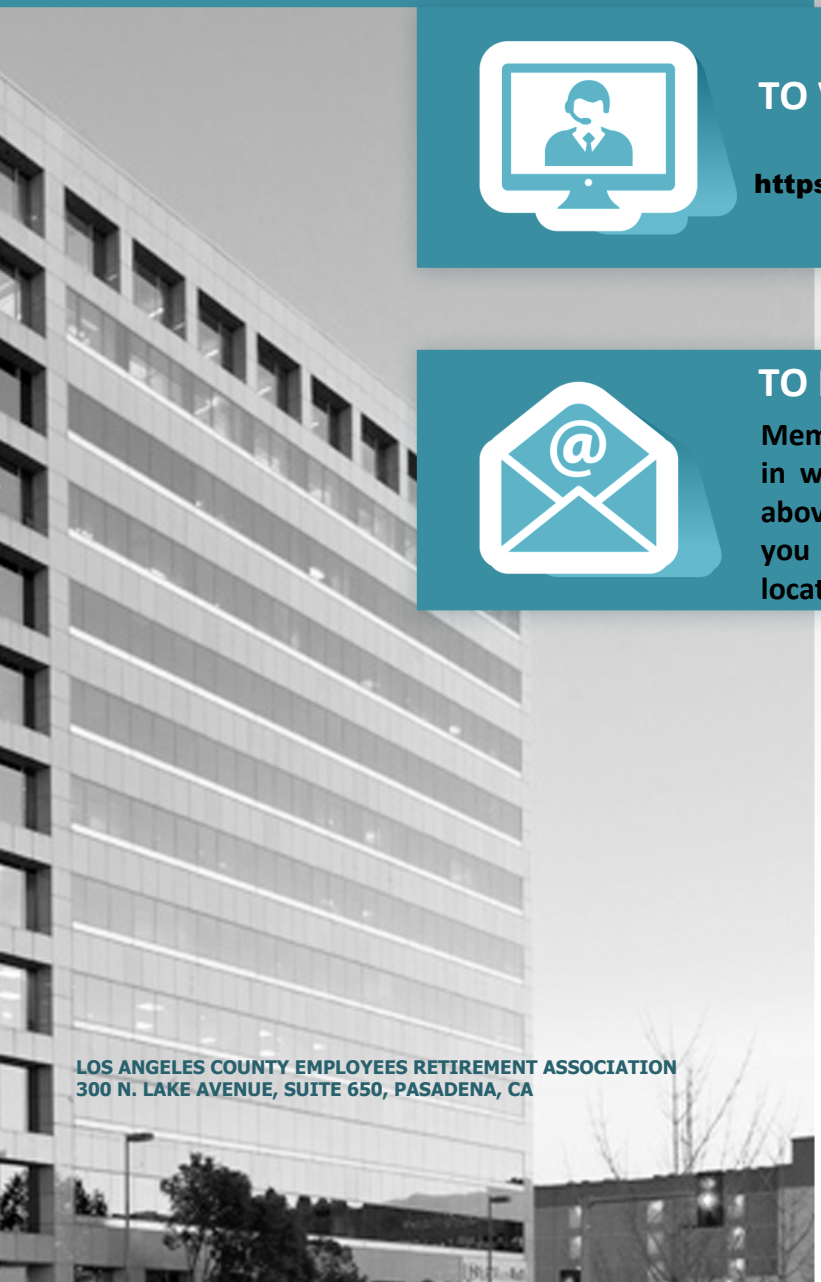
TO VIEW VIA WEB

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

TO PROVIDE PUBLIC COMMENT

Members of the public may address the Committee orally and in writing. To provide Public Comment, you should visit the above link and complete the request form by selecting whether you will provide oral or written comment from the options located under Options next to the Committee meeting.

Attention: If you have any questions, you may email PublicComment@lacera.com. If you would like to make a public comment during the committee meeting, review the Public Comment instructions.



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

AGENDA

A REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE

COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

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

8:00 A.M., WEDNESDAY, APRIL 5, 2023

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

Any person may view the meeting in person at LACERA's offices or online at https://LACERA.com/leadership/board-meetings.

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

COMMITTEE TRUSTEES:

Les Robbins, Chair
Vivian H. Gray, Vice Chair
Shawn R. Kehoe, Trustee
Ronald Okum, Trustee
JP Harris, Alternate Trustee

I. CALL TO ORDER

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

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

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of March 1, 2023

IV. PUBLIC COMMENT

(Members of the public may address the Committee orally and in writing. To provide Public Comment, you should visit https://LACERA.com/leadership/board-meetings and complete the request form by selecting whether you will provide oral or written comment from the options located under Options next to the Committee meeting.

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

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

V. REPORTS

A. **Engagement Report for March 2023**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

B. **Staff Activities Report for March 2023**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

C. **Group Dental and Medical Benefits – Audit Results**
Amber Turner, Segal Consulting
(Presentation)

- Cigna Dental Plan Audit
- Anthem (d.b.a. Elevance) Medical Plan Audit

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

V. REPORTS (Continued)

E. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Discussion Purposes)

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

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

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

IX. ADJOURNMENT

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

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

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

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

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

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

8:35 A.M. – 8:50 A.M., WEDNESDAY, MARCH 1, 2023

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

COMMITTEE TRUSTEES

PRESENT:

Vivian H. Gray, Vice Chair (In-Person)

Shawn R. Kehoe, Trustee (In-Person)

JP Harris, Alternate Trustee (In-Person)

ABSENT: Les Robbins, Chair

Ronald Okum, Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

Alan Bernstein, Trustee (In-Person)

Keith Knox, Trustee (In-Person)

Antonio Sanchez, Trustee (In-Person)

Herman B. Santos, Trustee (Teleconference)

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Santos H. Kreimann, Chief Executive Officer

Luis Lugo, Deputy Chief Executive Officer

JJ Popowich, Assistant Executive Officer

Laura Guglielmo, Assistant Executive Officer

Steven P. Rice, Chief Counsel

Barry W. Lew, Legislative Affairs Officer

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

Tony Roda, Williams & Jensen

McHugh Koepke & Associates
Shari McHugh
Naomi Padron

I. CALL TO ORDER

This meeting was called to order by Vice Chair Gray at 8:35 a.m. In the absence of Trustees Robbins and Okum, the Vice Chair announced that Trustee Harris, as the alternate, would be a voting member of the Committee.

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

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

(Memo dated February 23, 2023)

There were no requests received.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of February 1, 2023

Trustee Kehoe made a motion, Trustee Gray seconded, to approve the minutes of the regular meeting of February 1, 2023. The motion passed by the following roll call vote:

Yes: Kehoe, Harris, Gray

No: None

Absent: Robbins, Okum

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. NON-CONSENT ITEMS

A. **Selection of Federal and State Legislative Advocates**
Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement 1) Approve the engagement of Williams & Jensen and Doucet Consulting Solutions as LACERA's federal legislative advocates; and 2) Approve the engagement of McHugh Koepke & Associates as LACERA's state legislative advocate. (Memo dated February 15, 2023)

Trustee Kehoe made a motion, Trustee Harris seconded, to approve staff recommendation. The motion passed by the following roll call vote:

Yes: Kehoe, Harris, Gray

No: None

Absent: Robbins, Okum

VI. REPORTS

A. **Engagement Report for February 2023**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

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

B. **Staff Activities Report for February 2023**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

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

C. **LACERA Claims Experience**
Michael Szeto, Segal Consulting
(For Information Only)

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

D. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Discussion Purposes)

Segal Consulting gave an update on federal legislation.

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

There was nothing to report.

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

There was nothing to report.

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

There was nothing to report.

X. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 8:50 a.m.

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

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
MARCH 2023
FOR INFORMATION ONLY

Are Defined Benefit Pension Funds Still Useful Recruiting, Retention Tools

According to the founder of a firm that assists with evaluations of RFPs for benefit plan service providers, a pension plan is probably the most underappreciated employee benefit. However, it may be a forgotten benefit for most workers in the private sector.

The current private sector industries that continue to provide pension benefits include energy procurement, big banks, and biotechnology. The 10 largest private pension providers by market capitalization include notable names such as Berkshire Hathaway, JPMorgan Chase, Johnson & Johnson, Exxon Mobil, Proctor & Gamble, Pfizer, and Bank of America. In 1960, corporate pension funds covered 23 million people with pension assets of $57 billion. Currently, there are $3.7 trillion in private sector pension assets. About 86% of corporate plans are healthy and will achieve full funding in three years.

How employees of different generations value pension benefits varies since the ability to view and quantify defined contribution account balances makes them more tangible and perceived as more valuable than the abstract idea of a pension fund. However, corporate pension plans are no longer a selling point given that companies nowadays take less of a paternalistic approach to their employees who fail to reconcile the value of the pension. In contrast, the public sector continues to use pension benefits to attract and retain qualified employees. (Source)

Alaska Lawmakers Propose Pension Plan for State Workers

Alaska is the only state where all new public employees have only a defined contribution plan. Since 2006, when the state moved from a pension plan to a 401(k)-style plan, it has had difficulties recruiting state workers. An analysis by the state's Division of Retirement and Benefits indicates that the 401(k)-style plan for new employees is providing significantly smaller benefits than the pension system that was discontinued in 2006.

A bipartisan coalition in the Alaska Senate outlined a plan to overhaul the state's public retirement system. The proposal would create a new pension tier and allow workers in the current defined contribution plan to switch over. Although the new tier does not include retiree health insurance, workers can contribute to a health reimbursement account that can cover health care premiums until they are eligible for Medicare. Employee contribution rates would be tied to stock market performance, and cost-of-living adjustments can be withheld if the plan is less than 90-percent funded. (Source) (Source)

North Dakota's Competing Pension Plan Bills
The North Dakota state legislature recently advanced two competing bills related to the state public employee pension plan, which has a $1.9 billion shortfall. The bills diverge on whether to preserve the defined benefit plan or transition to a defined contribution plan for future employees. The competing bills will most likely end up in a conference committee at the end of the session.

The Senate bill seeks to preserve the pension plan with a $250 million infusion from the general fund and state contributions over the next 30 years. It would increase employee and employer contributions. The bill would also expand the option of enrolling in the defined contribution plan to all new employees.

The House bill would take effect in 2025 and put all new hires in the defined contribution plan. It would also allow employees in the pension plan hired within the last five years to switch to the defined contribution plan, which includes a $10,000 incentive to make the switch if they stay an additional three years. (Source)

The Pandemic Economic Impact After the End of California's COVID Emergency
On February 27, 2023, the final day of California's COVID emergency, the Public Policy Institute of California (PPIC) looked back over the past three years on how the state's economic challenges and responses evolved and on Californian's economic circumstances today.

- At the beginning of the pandemic, Californians were very worried about their health and economic well-being, in particular those with incomes under $40,000.
- In May 2020, strong majorities approved of Governor Newsom's handling of both the outbreak (69%) and the jobs and the economy (59%). Although approval declined over the pandemic's first year, it did not dip below 50% in surveys through February 2022.
- The share of Californians expecting bad economic times went from 43% in January 2020 to 79% in April 2020. Economic optimism dwindled in 2022, and PPIC's February 2023 survey found that 66% are expecting bad economic times.
- About 2.8 million jobs were lost in the first two months of the pandemic. However, by October 2022, 2.8 million jobs had been gained but not necessarily in the sectors or occupations that experienced the greatest losses.
    - The sectors farthest behind their pre-pandemic levels are accommodations and food service, arts and entertainment, and other services. Other large sectors of the California economy such as government, retail trade, and manufacturing are slightly below pre-pandemic levels.

  - Surge in demand for goods are evident in the transportation and warehouse sectors, which are up 16%.

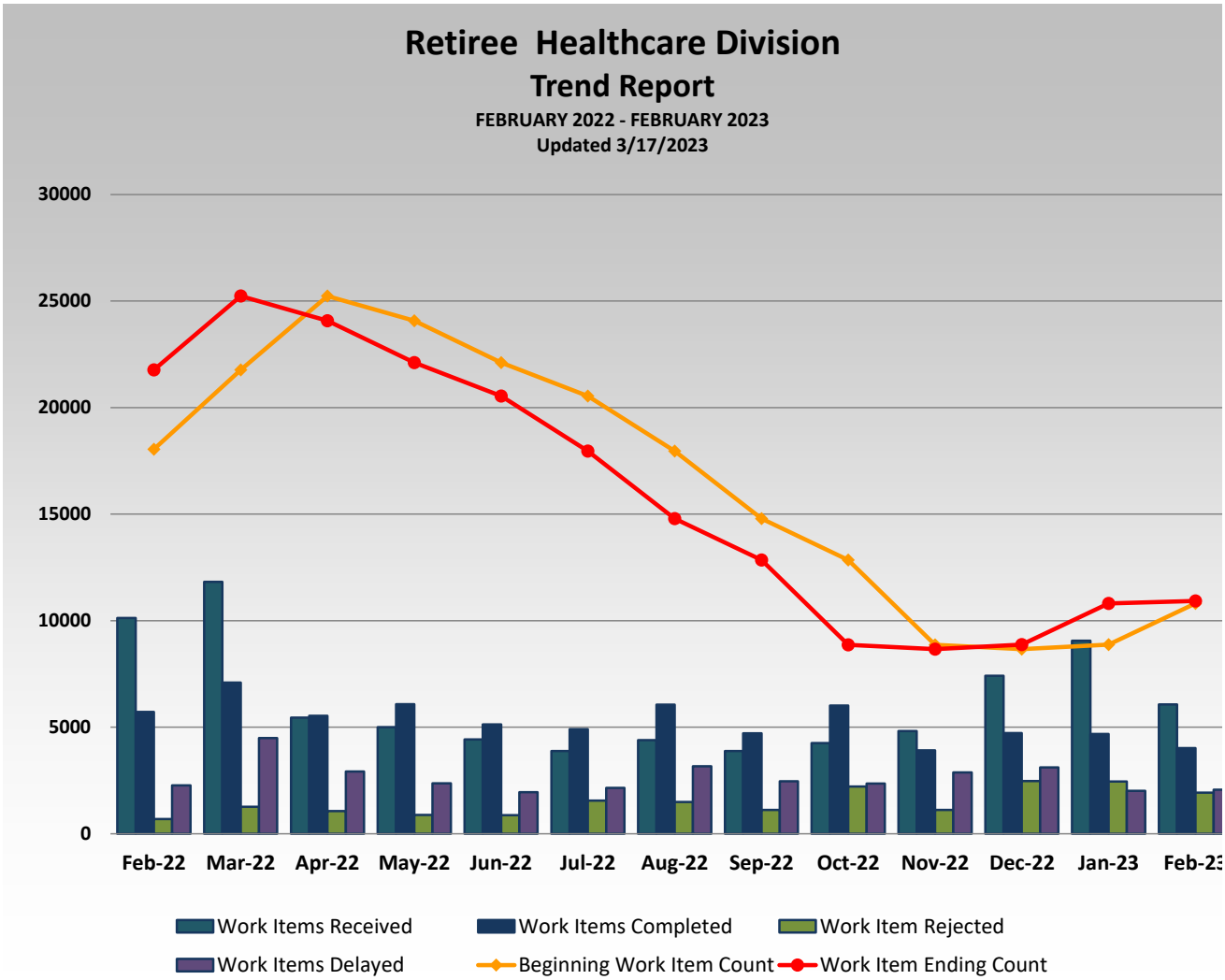
- About $100 billion in unemployment insurance, federal stimulus payments, California's Golden State stimulus, and the expanded Child Tax Credit helped stabilize household resources.
  - In May 2020, 30% of Californians said they were financially worse off (compared to the 53% who reported so during the Great Recession). By November 2021, only 18% reported being worse off. However, by November 2022, 29% reported being worse off, about the same as they were at the onset of the pandemic. (Source)

Californians' Views on Governor Newsom and the State of the State
The Public Policy Institute of California (PPIC) surveyed Californians' views of Governor Newsom with the following findings:

- A majority of California adults (58%) and likely voters (57%) approve of the Governor's handling of his job.
- He also receives positive ratings for handling other key challenges facing the state:
  - Jobs and the economy: 57% of adults and 56% of likely voters.
  - State budget and taxes: 52% of adults and 53% of likely voters.
  - Environment: 59% of adults and 59% of likely voters.
  - Education issues: 60% of adults and 57% of likely voters.
- There is a partisan divide in support for the Governor: 83% of Democrats approve of the job he is doing, compared to 55% of independents and 12% of Republicans.
- The three issues that are foremost of concern to Californians include the economy, homelessness and housing affordability, and climate change.
- Californians are also optimistic (61% yes versus 37% no) that the Governor and the Legislature can work together to get things done. (Source)

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
MARCH 2023
FOR INFORMATION ONLY

There is nothing to report this month.

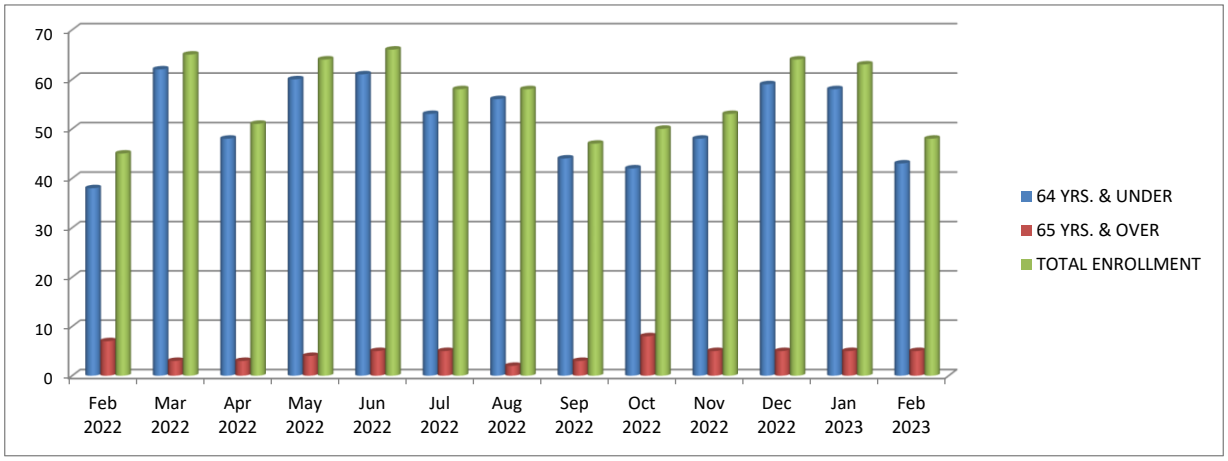


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Feb-22	18050	10131	5715	691	2272	21775
Mar-22	21775	11821	7090	1271	4489	25235
Apr-22	25235	5451	5542	1067	2922	24077
May-22	24077	4999	6078	883	2364	22115
Jun-22	22115	4423	5128	870	1950	20540
Jul-22	20540	3880	4911	1552	2154	17957
Aug-22	17957	4394	6060	1496	3171	14795
Sep-22	14795	3885	4712	1121	2464	12847
Oct-22	12847	4252	6013	2218	2361	8868
Nov-22	8868	4822	3911	1114	2884	8665
Dec-22	8665	7418	4728	2476	3116	8879
Jan-23	8879	9057	4680	2448	2010	10808
Feb-23	10808	6067	4019	1934	2070	10922

Retirees Monthly Age Breakdown
FEBRUARY 2022 - FEBRUARY 2023

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
Feb 2022	38	7	45
Mar 2022	62	3	65
Apr 2022	48	3	51
May 2022	60	4	64
Jun 2022	61	5	66
Jul 2022	53	5	58
Aug 2022	56	2	58
Sep 2022	44	3	47
Oct 2022	42	8	50
Nov 2022	48	5	53
Dec 2022	59	5	64
Jan 2023	58	5	63
Feb 2023	43	5	48



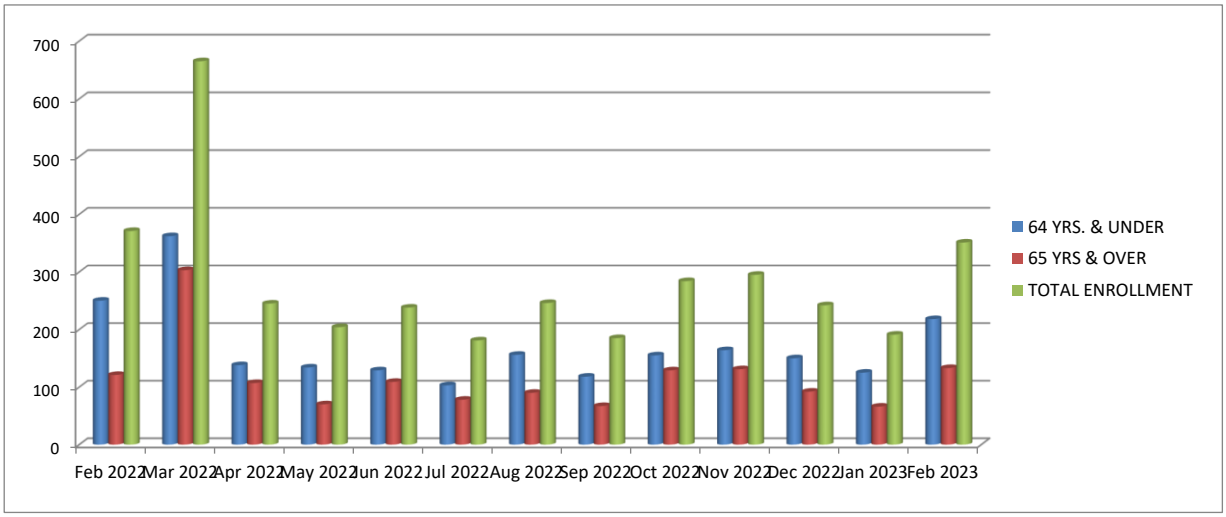
PLEASE NOTE:

- **Next Report will include the following dates: March 1, 2022, throught March 31, 2023.**

Retirees Monthly Age Breakdown
FEBRUARY 2022 - FEBRUARY 2023

Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
Feb 2022	250	121	371
Mar 2022	362	303	665
Apr 2022	138	107	245
May 2022	134	70	204
Jun 2022	129	109	238
Jul 2022	103	78	181
Aug 2022	156	90	246
Sep 2022	118	67	185
Oct 2022	155	129	284
Nov 2022	164	131	295
Dec 2022	150	92	242
Jan 2023	125	66	191
Feb 2023	218	133	351



PLEASE NOTE:

- **Next Report will include the following dates: March 1, 2022, through March 31, 2023.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 3/31/2023

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	7336	$1,106,801.45	2	$129.57
241	141	$21,867.30	0	$0.00
242	916	$143,329.40	0	$0.00
243	4387	$1,356,499.77	0	$0.00
244	18	$2,917.00	0	$0.00
245	52	$8,323.90	0	$0.00
246	16	$2,310.90	0	$0.00
247	142	$22,462.60	0	$0.00
248	11	$5,006.40	1	$43.00
249	71	$25,005.00	0	$0.00
250	15	$4,592.50	0	$0.00
Plan Total:	**13,105**	**$2,699,116.22**	**3**	**$172.57**
CIGNA - PREFERRED with RX				
321	34	$4,796.10	0	$0.00
322	7	$997.60	0	$0.00
324	23	$7,105.70	0	$0.00
327	1	$104.90	0	$0.00
Plan Total:	**65**	**$13,004.30**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	17	$2,670.50	0	$0.00
397	5	$804.20	0	$0.00
398	7	$2,205.80	0	$0.00
403	11738	$1,751,943.80	1	$17.00
413	1562	$246,202.30	0	$0.00
418	6153	$1,885,607.14	0	$0.00
419	236	$34,016.00	0	$0.00
426	251	$37,301.10	0	$0.00
427	21	$2,140.30	0	$0.00
445	2	$329.80	0	$0.00
446	1	$145.10	0	$0.00
451	35	$5,376.00	0	$0.00
455	4	$1,154.30	0	$0.00
457	12	$3,752.50	0	$0.00
459	2	$659.60	0	$0.00
462	86	$13,024.10	0	$0.00
465	4	$659.60	0	$0.00
466	29	$9,230.10	0	$0.00
472	29	$4,422.50	0	$0.00
476	3	$393.00	0	$0.00
478	15	$4,816.80	0	$0.00
479	1	$144.60	0	$0.00
482	81	$12,179.00	0	$0.00
486	1	$164.90	0	$0.00
488	43	$12,118.10	0	$0.00
491	1	$148.50	0	$0.00
Plan Total:	**20,339**	**$4,031,609.64**	**1**	**$17.00**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 3/31/2023

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	279	$42,551.40	0	$0.00
613	80	$24,294.20	0	$0.00
620	1	$164.90	0	$0.00
622	5	$821.70	0	$0.00
623	2	$539.60	0	$0.00
Plan Total:	**359**	**$66,845.60**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1972	$300,754.70	1	$36.50
702	380	$59,667.90	0	$0.00
703	1297	$404,486.40	0	$0.00
704	93	$14,520.30	0	$0.00
705	44	$13,103.80	0	$0.00
Plan Total:	**3,786**	**$792,533.10**	**1**	**$36.50**
Grand Total:	**37,654**	**$7,603,108.86**	**5**	**$226.07**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 3/31/2023

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245	52	$8,323.90	0	$0.00
246	16	$2,310.90	0	$0.00
247	142	$22,462.60	0	$0.00
248	11	$5,006.40	1	$43.00
249	71	$25,005.00	0	$0.00
250	15	$4,592.50	0	$0.00
Plan Total:	**13,105**	**$2,699,116.22**	**3**	**$172.57**
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451	35	$5,376.00	0	$0.00
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Plan Total:	**20,339**	**$4,031,609.64**	**1**	**$17.00**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 3/31/2023

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622	5	$821.70	0	$0.00
623	2	$539.60	0	$0.00
Plan Total:	**359**	**$66,845.60**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	1972	$300,754.70	1	$36.50
702	380	$59,667.90	0	$0.00
703	1297	$404,486.40	0	$0.00
704	93	$14,520.30	0	$0.00
705	44	$13,103.80	0	$0.00
Plan Total:	**3,786**	**$792,533.10**	**1**	**$36.50**
LOCAL 1014				
804	176	$37,559.60	0	$0.00
805	215	$40,562.40	0	$0.00
806	685	$254,621.60	0	$0.00
807	36	$7,123.00	0	$0.00
808	17	$5,606.60	0	$0.00
812	254	$45,642.20	0	$0.00
813	2	$329.80	0	$0.00
Plan Total:	**1,385**	**$391,445.20**	**0**	**$0.00**
Grand Total:	**39,039**	**$7,994,554.06**	**5**	**$226.07**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	475	$429,623.32	$66,627.48	$364,800.98	$431,428.46	($2,727.21)	$428,701.25
202	247	$441,432.18	$38,824.79	$404,380.21	$443,205.00	($1,772.82)	$441,432.18
203	75	$152,025.08	$27,404.50	$102,657.98	$130,062.48	($2,000.33)	$128,062.15
204	27	$31,297.32	$9,667.41	$25,107.39	$34,774.80	$0.00	$34,774.80
SUBTOTAL	**824**	**$1,054,377.90**	**$142,524.18**	**$896,946.56**	**$1,039,470.74**	**($6,500.36)**	**$1,032,970.38**
Anthem Blue Cross I							
211	588	$751,204.71	$47,979.38	$715,977.23	$763,956.61	($1,275.39)	$762,681.22
212	236	$551,294.40	$26,599.90	$508,614.54	$535,214.44	($2,297.06)	$532,917.38
213	74	$211,306.68	$23,202.03	$167,786.70	$190,988.73	$0.00	$190,988.73
214	22	$40,476.72	$3,777.80	$35,012.39	$38,790.19	$0.00	$38,790.19
215	1	$432.89	$17.32	$415.57	$432.89	$0.00	$432.89
SUBTOTAL	**921**	**$1,554,715.40**	**$101,576.43**	**$1,427,806.43**	**$1,529,382.86**	**($3,572.45)**	**$1,525,810.41**
Anthem Blue Cross II							
221	2,333	$2,988,238.77	$168,555.47	$2,830,596.64	$2,999,152.11	($0.77)	$2,999,151.34
222	2,009	$4,665,328.86	$105,526.68	$4,421,988.58	$4,527,515.26	$2,297.06	$4,529,812.32
223	906	$2,478,789.90	$100,722.72	$2,284,620.61	$2,385,343.33	$0.00	$2,385,343.33
224	214	$365,977.01	$36,159.11	$378,711.27	$414,870.38	$0.00	$414,870.38
SUBTOTAL	**5,462**	**$10,498,334.54**	**$410,963.98**	**$9,915,917.10**	**$10,326,881.08**	**$2,296.29**	**$10,329,177.37**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	7,361	$3,842,443.92	$516,592.19	$3,356,591.49	$3,873,183.68	($18,236.32)	$3,854,947.36
241	141	$235,667.46	$19,882.37	$217,444.72	$237,327.09	($1,659.63)	$235,667.46
242	912	$1,528,519.23	$93,138.56	$1,430,405.78	$1,523,544.34	$0.00	$1,523,544.34
243	4,378	$4,557,983.82	$487,735.38	$4,004,069.80	$4,491,805.18	($3,711.12)	$4,488,094.06
244	18	$16,753.68	$1,917.35	$15,767.09	$17,684.44	$0.00	$17,684.44
245	53	$49,330.28	$4,635.16	$46,556.64	$51,191.80	$0.00	$51,191.80
246	16	$33,106.88	$3,103.77	$30,003.11	$33,106.88	$0.00	$33,106.88
247	141	$300,031.10	$19,739.96	$269,945.24	$289,685.20	$0.00	$289,685.20
248	11	$15,881.03	$1,126.11	$14,754.92	$15,881.03	$0.00	$15,881.03
249	73	$105,392.29	$5,601.68	$108,452.99	$114,054.67	($1,443.73)	$112,610.94
250	15	$24,264.60	$841.17	$23,423.43	$24,264.60	($1,617.64)	$22,646.96
SUBTOTAL	**13,119**	**$10,709,374.29**	**$1,154,313.70**	**$9,517,415.21**	**$10,671,728.91**	**($26,668.44)**	**$10,645,060.47**
CIGNA Network Model Plan							
301	244	$406,163.45	$104,814.49	$299,689.15	$404,503.64	($1,657.81)	$402,845.83
302	62	$188,439.30	$45,643.84	$136,814.90	$182,458.74	($2,991.10)	$179,467.64
303	8	$28,251.92	$7,870.08	$16,850.35	$24,720.43	$0.00	$24,720.43
304	14	$30,784.88	$13,346.14	$17,438.74	$30,784.88	$0.00	$30,784.88
SUBTOTAL	**328**	**$653,639.55**	**$171,674.55**	**$470,793.14**	**$642,467.69**	**($4,648.91)**	**$637,818.78**
CIGNA Preferred w/ Rx - Phoenix, AZ							
321	34	$13,140.66	$1,731.48	$11,409.18	$13,140.66	$0.00	$13,140.66
322	7	$12,038.46	$687.91	$11,350.55	$12,038.46	$0.00	$12,038.46
324	23	$17,548.54	$1,831.16	$15,717.38	$17,548.54	$0.00	$17,548.54
327	1	$2,260.85	$452.17	$1,808.68	$2,260.85	$0.00	$2,260.85
SUBTOTAL	**65**	**$44,988.51**	**$4,702.72**	**$40,285.79**	**$44,988.51**	**$0.00**	**$44,988.51**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,478	$1,709,637.15	$134,506.45	$1,573,829.13	$1,708,335.58	($2,023.95)	$1,706,311.63
403	11,734	$3,105,777.45	$284,301.71	$2,799,627.67	$3,083,929.38	($9,735.58)	$3,074,193.80
404	499	$590,663.97	$11,459.64	$601,596.76	$613,056.40	($5,894.85)	$607,161.55
405	1,325	$1,523,634.86	$18,692.41	$1,503,794.27	$1,522,486.68	($5,740.90)	$1,516,745.78
411	1,861	$4,283,300.34	$193,999.98	$4,144,356.64	$4,338,356.62	$0.00	$4,338,356.62
413	1,555	$2,194,152.86	$103,401.52	$2,064,710.95	$2,168,112.47	($2,793.32)	$2,165,319.15
414	61	$141,064.94	$1,387.52	$139,677.42	$141,064.94	$0.00	$141,064.94
418	6,109	$3,182,249.70	$226,596.64	$2,886,546.21	$3,113,142.85	($4,645.12)	$3,108,497.73
419	237	$340,830.28	$4,582.56	$320,498.46	$325,081.02	$0.00	$325,081.02
420	111	$262,969.28	$1,127.02	$236,017.32	$237,144.34	($15,210.21)	$221,934.13
421	8	$9,148.56	$1,097.83	$8,050.73	$9,148.56	$0.00	$9,148.56
422	257	$593,255.00	$2,373.02	$600,008.98	$602,382.00	$0.00	$602,382.00
423	2	$4,625.08	$0.00	$4,625.08	$4,625.08	$0.00	$4,625.08
426	248	$351,718.77	$2,970.69	$344,544.27	$347,514.96	($1,401.27)	$346,113.69
427	18	$30,073.26	$916.51	$20,564.39	$21,480.90	$0.00	$21,480.90
428	47	$108,906.05	$463.43	$110,759.77	$111,223.20	$0.00	$111,223.20
429	1	$2,347.94	$0.00	$2,347.94	$2,347.94	$0.00	$2,347.94
430	144	$329,235.84	$3,338.06	$328,184.14	$331,522.20	$0.00	$331,522.20
431	1	$4,634.30	$0.00	$0.00	$0.00	$0.00	$0.00
SUBTOTAL	**25,696**	**$18,768,225.63**	**$991,214.99**	**$17,689,740.13**	**$18,680,955.12**	**($47,445.20)**	**$18,633,509.92**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Colorado							
450	2	$2,122.66	$424.53	$1,698.13	$2,122.66	$0.00	$2,122.66
451	35	$10,496.50	$1,319.54	$9,176.96	$10,496.50	$0.00	$10,496.50
453	11	$28,128.72	$517.00	$25,267.66	$25,784.66	$0.00	$25,784.66
454	0	$6,328.18	($1,365.09)	($8,127.18)	($9,492.27)	$0.00	($9,492.27)
455	4	$5,404.92	$0.00	$9,458.61	$9,458.61	$0.00	$9,458.61
457	12	$7,077.60	$1,238.58	$5,839.02	$7,077.60	$0.00	$7,077.60
459	2	$3,282.26	$65.65	$3,216.61	$3,282.26	$0.00	$3,282.26
SUBTOTAL	**66**	**$62,840.84**	**$2,200.21**	**$46,529.81**	**$48,730.02**	**$0.00**	**$48,730.02**
Kaiser - Georgia							
441	4	$4,660.96	$0.00	$4,660.96	$4,660.96	$0.00	$4,660.96
442	7	$8,156.68	$0.00	$8,156.68	$8,156.68	$0.00	$8,156.68
445	2	$3,161.42	$0.00	$3,161.42	$3,161.42	$0.00	$3,161.42
446	1	$1,580.71	$0.00	$1,580.71	$1,580.71	$0.00	$1,580.71
461	13	$15,148.12	$2,656.75	$11,326.13	$13,982.88	$0.00	$13,982.88
462	86	$36,590.42	$5,037.55	$31,552.87	$36,590.42	$0.00	$36,590.42
463	3	$6,961.47	$1,218.82	$5,742.65	$6,961.47	$0.00	$6,961.47
465	4	$6,322.84	$0.00	$6,322.84	$6,322.84	$0.00	$6,322.84
466	29	$24,387.26	$1,765.97	$22,621.29	$24,387.26	$0.00	$24,387.26
SUBTOTAL	**149**	**$106,969.88**	**$10,679.09**	**$95,125.55**	**$105,804.64**	**$0.00**	**$105,804.64**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Hawaii							
471	7	$6,450.71	$258.03	$6,192.68	$6,450.71	$0.00	$6,450.71
472	29	$13,033.47	$2,013.44	$11,020.03	$13,033.47	$0.00	$13,033.47
473	1	$1,852.78	$577.39	$1,275.39	$1,852.78	$0.00	$1,852.78
474	4	$7,332.20	$0.00	$7,332.20	$7,332.20	$0.00	$7,332.20
475	2	$5,489.16	$71.04	$5,418.12	$5,489.16	$0.00	$5,489.16
476	3	$4,082.88	$1,878.12	$2,204.76	$4,082.88	$0.00	$4,082.88
477	1	$2,764.31	$467.25	$2,297.06	$2,764.31	$0.00	$2,764.31
478	15	$13,332.90	$1,919.93	$11,412.97	$13,332.90	$0.00	$13,332.90
479	1	$2,292.21	$0.00	$2,292.21	$2,292.21	$0.00	$2,292.21
SUBTOTAL	**63**	**$56,630.62**	**$7,185.20**	**$49,445.42**	**$56,630.62**	**$0.00**	**$56,630.62**
Kaiser - Oregon							
481	3	$3,393.54	$565.59	$2,827.95	$3,393.54	$0.00	$3,393.54
482	81	$39,035.52	$6,409.51	$32,626.01	$39,035.52	$0.00	$39,035.52
483	2	$2,766.24	$521.55	$2,244.69	$2,766.24	$0.00	$2,766.24
484	5	$13,514.16	($90.09)	$9,099.53	$9,009.44	$0.00	$9,009.44
486	1	$1,603.10	$0.00	$1,603.10	$1,603.10	$0.00	$1,603.10
488	42	$41,015.12	$3,681.82	$33,517.94	$37,199.76	$0.00	$37,199.76
491	1	$1,604.54	$0.00	$1,604.54	$1,604.54	$0.00	$1,604.54
498	2	$5,008.60	$414.48	$4,594.12	$5,008.60	$0.00	$5,008.60
SUBTOTAL	**137**	**$107,940.82**	**$11,502.86**	**$88,117.88**	**$99,620.74**	**$0.00**	**$99,620.74**
SCAN Health Plan							
611	277	$79,682.40	$17,187.50	$63,066.10	$80,253.60	($1,142.40)	$79,111.20
613	80	$44,896.00	$8,956.79	$35,939.21	$44,896.00	$0.00	$44,896.00
SUBTOTAL	**357**	**$124,578.40**	**$26,144.29**	**$99,005.31**	**$125,149.60**	**($1,142.40)**	**$124,007.20**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
SCAN Health Plan, AZ							
620	1	$285.60	$0.00	$285.60	$285.60	$0.00	$285.60
SUBTOTAL	**1**	**$285.60**	**$0.00**	**$285.60**	**$285.60**	**$0.00**	**$285.60**
SCAN Health Plan, NV							
622	5	$1,428.00	$0.00	$1,428.00	$1,428.00	$0.00	$1,428.00
623	2	$1,122.40	$0.00	$1,122.40	$1,122.40	$0.00	$1,122.40
SUBTOTAL	**7**	**$2,550.40**	**$0.00**	**$2,550.40**	**$2,550.40**	**$0.00**	**$2,550.40**
UHC Medicare Adv.							
701	1,966	$669,115.65	$76,234.46	$587,190.86	$663,425.32	($722.72)	$662,702.60
702	375	$625,282.35	$28,312.62	$579,104.52	$607,417.14	$0.00	$607,417.14
703	1,290	$870,304.50	$82,776.94	$764,864.96	$847,641.90	$0.00	$847,641.90
704	96	$182,712.42	$10,925.83	$160,713.11	$171,638.94	$0.00	$171,638.94
705	43	$39,088.28	$2,700.62	$33,722.55	$36,423.17	$0.00	$36,423.17
706	2	$744.26	$44.66	$699.60	$744.26	$0.00	$744.26
SUBTOTAL	**3,772**	**$2,387,247.46**	**$200,995.13**	**$2,126,295.60**	**$2,327,290.73**	**($722.72)**	**$2,326,568.01**
United Healthcare							
707	507	$668,560.56	$61,331.37	$600,345.25	$661,676.62	$0.00	$661,676.62
708	462	$1,108,828.56	$72,112.09	$1,015,438.41	$1,087,550.50	$0.00	$1,087,550.50
709	374	$1,051,046.25	$84,267.73	$992,003.63	$1,076,271.36	$0.00	$1,076,271.36
SUBTOTAL	**1,343**	**$2,828,435.37**	**$217,711.19**	**$2,607,787.29**	**$2,825,498.48**	**$0.00**	**$2,825,498.48**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	81	$102,020.31	$4,030.40	$97,989.91	$102,020.31	$0.00	$102,020.31
802	327	$742,610.46	$22,800.64	$719,083.11	$741,883.75	$0.00	$741,883.75
803	350	$937,594.00	$26,841.99	$909,787.63	$936,629.62	$2,678.84	$939,308.46
804	180	$226,711.80	$6,574.59	$220,137.21	$226,711.80	($38,819.11)	$187,892.69
805	216	$490,531.68	$12,853.76	$477,677.92	$490,531.68	($40,562.40)	$449,969.28
806	687	$1,560,163.26	$35,245.63	$1,524,917.63	$1,560,163.26	($254,621.60)	$1,305,541.66
807	38	$101,795.92	$1,071.53	$100,724.39	$101,795.92	($7,123.00)	$94,672.92
808	17	$45,540.28	$214.31	$45,325.97	$45,540.28	($5,606.60)	$39,933.68
809	18	$22,671.18	$3,677.74	$18,993.44	$22,671.18	$0.00	$22,671.18
810	9	$20,438.82	$2,679.76	$17,759.06	$20,438.82	$0.00	$20,438.82
811	3	$8,036.52	$1,928.77	$6,107.75	$8,036.52	$0.00	$8,036.52
812	254	$319,915.54	$22,847.33	$298,327.72	$321,175.05	($45,642.20)	$275,532.85
813	2	$4,541.96	$0.00	$4,541.96	$4,541.96	($329.80)	$4,212.16
SUBTOTAL	**2,182**	**$4,582,571.73**	**$140,766.45**	**$4,441,373.70**	**$4,582,140.15**	**($390,025.87)**	**$4,192,114.28**
Kaiser - Washington							
393	6	$8,576.94	$1,077.61	$4,238.49	$5,316.10	$0.00	$5,316.10
394	17	$7,640.82	$1,357.38	$6,283.44	$7,640.82	$0.00	$7,640.82
395	3	$7,982.25	$1,091.07	$6,891.18	$7,982.25	$0.00	$7,982.25
397	5	$8,403.60	$605.06	$7,798.54	$8,403.60	$0.00	$8,403.60
398	7	$6,222.44	$1,031.15	$5,191.29	$6,222.44	$0.00	$6,222.44
SUBTOTAL	**38**	**$38,826.05**	**$5,162.27**	**$30,402.94**	**$35,565.21**	**$0.00**	**$35,565.21**
Medical Plan Total	**54,530**	**$53,582,532.99**	**$3,599,317.24**	**$49,545,823.86**	**$53,145,141.10**	**($478,430.06)**	**$52,666,711.04**

Medical and Dental Vision Insurance Premiums
April 2023

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	25,762	$1,325,247.66	$140,098.55	$1,200,938.12	$1,341,036.67	($4,274.07)	$1,336,762.60
502	23,826	$2,491,713.39	$189,172.77	$2,301,786.45	$2,490,959.22	($3,110.70)	$2,487,848.52
503	9	$564.03	$37.61	$526.42	$564.03	$0.00	$564.03
SUBTOTAL	**49,597**	**$3,817,525.08**	**$329,308.93**	**$3,503,250.99**	**$3,832,559.92**	**($7,384.77)**	**$3,825,175.15**
CIGNA Dental HMO/Vision							
901	3,854	$187,181.95	$20,920.01	$166,396.93	$187,316.94	($678.02)	$186,638.92
902	2,918	$284,667.88	$22,913.00	$260,993.34	$283,906.34	$0.00	$283,906.34
903	2	$97.98	$25.48	$72.50	$97.98	$0.00	$97.98
SUBTOTAL	**6,774**	**$471,947.81**	**$43,858.49**	**$427,462.77**	**$471,321.26**	**($678.02)**	**$470,643.24**
Dental/Vision Plan Total	**56,371**	**$4,289,472.89**	**$373,167.42**	**$3,930,713.76**	**$4,303,881.18**	**($8,062.79)**	**$4,295,818.39**
GRAND TOTALS	**110,901**	**$57,872,005.88**	**$3,972,484.66**	**$53,476,537.62**	**$57,449,022.28**	**($486,492.85)**	**$56,962,529.43**

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

***Benchmark premiums are bolded.**

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

***Benchmark premiums are bolded.**

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

***Benchmark premiums are bolded.**

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

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

Kaiser Oregon (continued)

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

Kaiser Rate Category Definitions

"Basic" - includes those who are under age 65

Medicare Cost ("Supplement")

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

"Senior Advantage"

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

"Excess I"

-Is for participants who have Medicare Part A only.

"Excess II"

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

"Excess III"

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

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

SCAN Health Plan

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

United Healthcare Medicare Advantage (UHCMA)

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

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

United Healthcare (UHC)

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

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

Local 1014 Firefighters

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

***Benchmark premiums are bolded.**

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

***Benchmark premiums are bolded.**

Los Angeles County Employees Retirement Association

Group Dental and Medical Benefits - Audit Results

Audit Period: July 1, 2021 through June 30, 2022

April 5, 2023/ Amber M. Turner, MBA, PMP

Segal

Agenda

Dental Claims Audit

- **Results**
- **Findings**

Medical Claims Audit

- **Results**
- **Findings**

Next Steps

Cigna Dental Audit - Results

Cigna provided data files for all dental claims processed and paid during the 12-month audit period of July 1, 2021 through June 30, 2022, representing $35,174,022.98 in benefit payments. The review of the statistical sample of 225 claims did not identify any errors.

Cigna surpassed the performance guarantee standards for the categories of Financial, Payment, Procedural, and Overall Accuracy.

Cigna fell below the performance guarantee for Time-to-Process.

Category	Statistical Achievement	Performance Guarantees	Industry Standard
Financial Accuracy (dollar value)	100.00%	99.00%	**99.00%**
Payment Accuracy (free from financial error)	100.00%	95.00%	**95.00%**
Procedural Accuracy (free from processing error)	100.00%	N/A	**97.00%**
Overall Processing Accuracy (free from error)	100.00%	97.00%	**95.00%**
Time-to-Process[1] (within 10 business days)	**90.38%**	**93.00%**	**95.00%**

Cigna Dental Audit – Key Findings

The Key Findings for the Cigna Dental Audit are as follows:

- Segal confirms that the issue from last year's audit regarding code D1999 for personal protective gear applying coinsurance has been corrected.
- Segal calculated the time-to-process performance guarantee achievement for 10 business days at 90.38%.
  - *Cigna's self-reported performance guarantee indicated 91.5%.*
- Both Segal's and Cigna's performance guarantee calculations are below the performance guarantee of 93.00% of claims processed within 10 business days.
  - *Cigna noted that this delay was due to receiving higher than expected claims volume and new workflow technology. Due to the delays in processing, Cigna has increased its staff by 36% and implemented systematic updates to balance the incoming claims. Cigna noted that these changes should be reflected in the 3rd quarter of 2022.*
  - Cigna has initiated the penalty process for failing to meet the performance guarantee.

Elevance Medical Audit- Results

Anthem (d.b.a. Elevance) provided data files for all medical claims processed and paid during the 12-month audit period of July 1, 2021, through June 30, 2022, representing $139,134,201.98 in benefit payments. The review of the statistical sample of 220 medical claims in the audit period identified seven (7) in-sample errors: Four (4) overpayments and Three (3) underpayments.

Elevance surpassed the performance guarantee standard in the Time-to-Process, Financial Accuracy, and Procedural Accuracy categories.

Category	Statistical Achievement	Performance Guarantee	Industry Standards
Financial Accuracy (dollar value)	99.64%	99.00%	**99.00%**
Payment Accuracy (free from financial error)	98.17%	N/A	**97.00%**
Procedural Accuracy (free from processing error)	100.00%	97.00%	**95.00%**
Overall Processing Accuracy (free from error)	98.17%	N/A	**95.00%**
Time-to-Process* (within 14 calendar days)	**99.02%**	**90.00%**	**95.00%**
(within 30 calendar days)	**99.19%**	**N/A**	**100.00%**

Please note that the Accuracy Results do not include OOS or target claims.

In addition to the in-sample errors, sixteen (16) out-of-sample (OOS) errors were identified. The sixteen errors included one (1) overpayment and fifteen (15) underpayments. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

The review of the target sample of 35 medical claims identified an additional twenty-two (22) in-sample overpayment errors and two (2) OOS underpayments.

Elevance Medical Audit – Overall Results

The Following Chart represents both target and statistical findings within the audit.

	Audit Findings	
Issue	**Financial Impact**	**# of claims**
Plan Limit Exceeded Maximum*	$20,889.46	1
Hearing Aids Limit*	$12,692.71	7
Duplicate Claim Payment*	$4,176.77	6
Foot Orthotics Exclusion	$1,247.33	3
Precertification Deductible	$800.00	4
Acupuncture Over $30.00*	$388.76	5
OON Preventive Overpaid*	$156.80	1
Total Overpaid	**$40,351.83**	**27**

	Audit Findings	
Issue	Financial Impact	# of claims
Deductible Overapplied*	-$923.69	11
OP Surgery Copayment*	-$229.93	1
OOP Overapplied*	-$112.50	6
Medicare coordination	-$8.05	1
Preventive Applied Deductible*	-$1.80	1
Total Underpaid	**-$1,275.97**	**20**

* Represents errors agreed to by Elevance in the Audit

Next Steps Following the Audits

The following are next step recommendations for LACERA:

- Cigna
  - Segal recommends that LACERA confirm with Cigna when the penalty amount of $25,000 will be disbursed to LACERA.
- Elevance
  - Segal recommends that LACERA discuss with Elevance the action plan that is put forward to address all claim categories in error and ensure amounts owed to the member were refunded or credited.

Los Angeles County Employees Retirement Association

Analysis of Cigna Health and Life Insurance Company Dental Claims Processing and Payment Procedures

Audit Period: July 1, 2021, through June 30, 2022
Final Report

March 24, 2023 / Amber M. Turner, MBA, PMP

Segal

Cigna Dental Claims Audit – Final Report

Section I – Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Cigna Health and Life Insurance Company (Cigna) in its administration of the Los Angeles County Employees Retirement Association (LACERA) group dental benefits. Amber Turner and Jennifer Lagua of Segal's Benefit Audit Solutions Practice conducted the remote audit during the week of September 26, 2022 via system access through Cigna's Dentacom claims adjudication system. The audit encompassed a total sample of 225 claims for the 12-month audit period of July 1, 2021, through June 30, 2022.

Scope of Services

Cigna provided data files for all dental claims processed and paid during the 12-month audit period of July 1, 2021, through June 30, 2022, representing $35,174,022.98 in benefit payments. The review objective was to ensure claims were paid in accordance with LACERA's plan provisions, including the following components:

- A stratified sample of 225 random claims providing statistical validity in processing accuracy levels with comparison to performance guarantees and industry standards;
- Time-to-Process achievement was measured from the date a claim is first received to the initial date processed for payment or denial for all claims during the audit period; and,
- An Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures.

The auditors completed an electronic form for each sampled claim; this worksheet served as the primary documentation on which the report is based. 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 alphabetic 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 in order to identify any variances in procedures and benefit determination.

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 multiemployer plan benefits.

During the 12-month audit period of July 1, 2021, through June 30, 2022 dental benefit payments for 153,024 claims totaled $35,174,022.98 in the file. Sampled benefit payments for 225 random, stratified claims totaled $85,312.89 (0.24% of total payments for the review period).

The stratified, statistical audit sample was selected through analyses performed by our 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.

Accuracy Results

Review of the statistical sample of 225 claims for the audit period of July 1, 2021, through June 30, 2022 did not identify any errors.

As seen in the following chart, Cigna surpassed the performance guarantee standards for the categories of Financial, Payment, Procedural, and Overall Accuracy. Cigna fell below the performance guarantee for Time-to-Process. Cigna's self-reported guarantee noted that Cigna achieved 91.5% within 10 business days, which is also below the 93% performance guarantee.

Category	Statistical Achievement	Performance Guarantees	Industry Standard
Financial Accuracy (dollar value)	100.00%	99.00%	99.00%
Payment Accuracy (free from financial error)	100.00%	95.00%	95.00%
Procedural Accuracy (free from processing error)	100.00%	N/A	97.00%
Overall Processing Accuracy (free from error)	100.00%	97.00%	95.00%
Time-to-Process[1] (within 10 business days)	**90.38%**	93.00%	95.00%

[1] Time-to-Process achievement was calculated on 100% of the claims population for the audit period and does not take adjustments into account.

Further details on the time-to-process achievement can be found in Section III of this report.

Key Finding

The following bullet point summarizes the primary finding identified by Segal's auditors during the claims review. Cigna was presented with a draft report on October 10, 2022, for its review and comment. Cigna's written responses were delivered to Segal on October 20, 2022, and are paraphrased in italics throughout this report; its entire response is included in Section V of the report.

- **Segal confirms that the issue from last year's audit regarding code D1999 for personal protective gear applying coinsurance has been corrected.**

- **Segal calculated the time-to-process performance guarantee achievement for 10 business days at 90.38%.**

  Cigna's self-reported performance guarantee indicated 91.5%.

  Both Segal's and Cigna's performance guarantee calculations are below the performance guarantee of 93.00% of claims processed within 10 business days.

  Cigna noted that this delay was due to receiving higher than expected claims volume and new workflow technology. Due to the delays in processing, Cigna has increased its staff by 36% and implemented systematic updates to balance the incoming claims. Cigna noted that these changes should be reflected in the 3rd quarter of 2022.

  Cigna has initiated the penalty process for failing to meet the performance guarantee. Segal recommends that LACERA confirm with Cigna when the penalty amount of $25,000 will be disbursed to LACERA.

Section II – Statistical Claims Sample

Cigna provided a data file of all dental claims processed and paid during the 12-month audit period of July 1, 2021, through June 30, 2022, which was utilized for sampling purposes.

Dental benefit payments for 153,024 dental claims totaled $35,174,022.98 in the file. Sampled benefit payments for 225 random, stratified claims totaled $85,312.89 (0.24% of total payments for the review period).

Relevant claims processing information was verified through Cigna's responses to the Adjudication Procedures questionnaire, remote review discussions, auditors' observations, and the individual claims review.

Stratification Table

The selection of 225 random claims for the audit period of July 1, 2021, through June 30, 2022 was stratified by dollar amount in order to provide large claims representation that is more valid in determining financial accuracy levels. The methodology of Segal's stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allows a quantifiable degree of confidence, whereby results obtained in the audit sample are a true reflection of the way all claims were processed during the audit period.

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

Stratification Table

Strata	Dollar Range of Strata	Number of Claims in		Dollar Amount in	
		Range	Selection	Selection	Strata
A	$0.01 - $79.99	38558	45	$2,665.39	$2,009,288.70
B	$80.00 - $109.99	27048	35	$3,312.77	$2,547,922.71
C	$110.00 - $149.99	23983	30	$3,801.72	$3,070,003.98
D	$150.00 - $199.99	17125	25	$4,338.97	$2,950,817.69
E	$200.00 - $279.99	14066	20	$4,650.70	$3,295,625.79
F	$280.00 - $424.99	11230	16	$5,564.80	$3,824,675.04
G	$425.00 - $699.99	9218	15	$8,221.50	$5,030,469.54
H	$700.00 - $924.99	4434	10	$8,203.40	$3,564,655.36
I	$925.00 - $1,199.99	3862	10	$11,012.84	$4,075,469.33
J	$1,200.00 - $1,799.99	3491	10	$13,567.00	$4,785,121.04
K	$1,800.00 - $3,000.00	9	9	$19,973.80	$19,973.80
Total		**153,024**	**225**	**$85,312.89**	**$35,174,022.98**

Review Process

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

Identification of potential financial and non-financial errors were documented and discussed with Cigna's representative daily. 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. Segal did not determine dental/clinical necessity; however, the auditors confirmed if 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 (COB) provisions were enforced, where applicable;
- Duplicate claims were properly denied; and,
- Time-to-process achievements for processing of claims was within established performance guarantees.

All questions and potential errors were presented to Cigna's representatives daily; additional supporting documentation was provided through October 4, 2022.

Statistical Claim Findings

The review of the statistical sample of 225 claims for the audit period of July 1, 2021, through June 30, 2022 did not identify any errors.

- Through the audit Segal was able to confirm that the issue from last year's audit regarding code D1999 for personal protective gear applying coinsurance has been corrected by Cigna.

Section III - Time-to-Process Achievement

Results from the electronic analysis of all dental claims processed during the audit period of July 1, 2021 through June 30, 2022 revealed that Cigna processed 90.38% of the claims within 14 calendar days (10 business days), which is slightly below the performance guarantee of 93.00% of claims within 10 business days. Cigna's self-reported guarantee noted that Cigna achieved 91.5% within 10 business days, which is also below the 93% performance guarantee.

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial; Electronic calculations do not allow for distinction of multiple processing events (i.e., adjustments).

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

Cigna noted that this delay was due to receiving higher than expected claims volume and new workflow technology. Due to the delays in processing, Cigna has increased its staff by 36% and implemented systematic updates to balance the incoming claims. Cigna noted that these changes should be reflected in the 3rd quarter of 2022.

Cigna has initiated the penalty process for failing to meet the performance guarantee. Segal recommends that LACERA confirm with Cigna when the penalty amount of $25,000 will be disbursed to LACERA.

Section IV – Adjudication Procedures Review

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

- LACERA's claims are adjudicated by a designated 30 member Cigna team located in Texas and Pennsylvania.
- On average, during the audit period Cigna processed 1,326 LACERA claims per week.
- 65.74% of LACERA claims are auto-adjudicated by Cigna.
  - 79.22% of claims are auto-adjudicated business wide through Cigna.
- Business wide, Cigna receives 86.72% of dental claims through electronic submission.
- Cigna's Special Investigations Unit (SIU) analytics team uses multiple approaches to monitor and identify suspect patterns of behavior and schemes (e.g., link analysis, trend analysis, outlier analysis, social analytics, geospatial analytics, predictive modeling). In addition to internal monitoring, Cigna also utilizes the following programs to identify suspected fraudulent claims.
  - Dedicated Data Mart (Healthcare Fraud Shield)
  - Geospatial Analytics (ArcGis)
  - Social Media Monitoring (Synthesio)
  - Link Analysis (i2)
  - P&R Dental Fraud and Abuse Detection
  - RatStats
  - Statistical Sampling Software
  - Multiple Control Models (SAS Miner, SAS Enterprise Guide, SQL)
  - Other Enabling Technologies (Teradata Studio, Toad, CA Workstation, Tableu, Cognos)
- Cigna reports suspicious fraudulent provider claims activity to law enforcement, leadership within NHCAA (National Health Care Anti-Fraud Association), Health Care Fraud Prevention Partnership, and other fraud focused organizations. If evidence of fraud is identified, a referral may be made to the state's Department of Insurance.

Section V – Cigna's Formal Response to the Draft Report

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October 20th, 2022

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, 2021 through June 30, 2022)

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 September 26th, 2022 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.

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,

Jason Auer
Senior Client Manager

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

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

SEGAL CONSULTING EVALUATION OF CIGNA

Executive Summary

Segal Consulting conducted a remote review September 26th 2022 – September 30th, 2022 via system access 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 1, 2021 through June 30, 2022. Total benefit payments of $35,174,022.98 were paid on behalf of eligible employees and their dependents. Segal's sample and analysis represents benefit payments in the amount of $85,312.89.

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.

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	07/01/2021 - 06/30/2022	153,024	$35,174,022.28	*Random stratified Dental*	225	$85,312.89

Performance Measurements

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

*Segal recognized Industry Standard

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

SEGAL CONSULTING EVALUATION OF CIGNA

Audit Results

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

- (Zero) 0 errors were identified

Key Finding 1:

Observation Detail	Cigna Response
D1999 PPE Segal confirms that the issue from last year's audit regarding code D1999 for personal protective gear applying coinsurance has been corrected.	1. Cigna is in agreement and appreciates Segal's observation related to code D1999.

Key Finding 2:

Observation Detail	Cigna Response
Performance Guarantee Time-to-Process Segal calculated the time-to-process performance guarantee achievement for 10 business days at 90.38%. Cigna's self-reported performance guarantee indicated 91.5%. Both Segal and Cigna's performance guarantee calculations are below the performance guarantee of 93.00% of claims processed within 10 business days.	1. Cigna respectfully maintains our previously self-reported performance guarantee result of 91.5%. Dental time to process is calculated by counting the number of business days from the day a claim is received by Cigna, to and including the day the claim is processed. The day that the claim is received is not included in the calculation and claim adjustments add another dimension to calculating turn-around time and can be the reason for the difference between the results reported by Cigna and Segal's analysis. In addition, Medicaid claims are not included in the time to process calculations. 2. Cigna recognizes that the 10 day time to process PG was not met for the July 2021 – June 2022 time period. Cigna began receiving higher than expected volume of receipts in Quarter 4 of 2021 which continued into Quarters 1 and 2 of 2022, that coupled with a productivity impact associated with newly implemented workflow technology contributed to higher than planned inventory levels. Cigna has enacted multiple measures including an increase in staffing by 36% as well as systemic updates to aid and support in balancing growth in inventory. Cigna continuously manages all inventory, new receipts and adjustments accordingly with appropriate focus and prioritization understanding customer and client concerns. Cigna has accomplished resolving new receipts inventory concerns mid-year 2022 with these measures which clients should see reflected throughout future time to process updates in Quarter 3.

Conclusion

Cigna recognizes LACERA as a valued client and Segal Consulting as a valued business partner. Cigna sincerely appreciates the ability to share the findings of this audit with LACERA.

Cigna **LACERA**

Together, all the way

Los Angeles County Employees Retirement Association

Analysis of Elevance Health Medical Claims Processing and Payment Procedures

Audit Period: July 1, 2021, through June 30, 2022
Final Report

March 24, 2023 / Amber M. Turner, MBA, PMP

Segal

Elevance Health Medical Claims Audit – Final Report

Section I – Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Anthem Blue Cross (Anthem) d.b.a. Elevance Health (Elevance) in its administration of the Los Angeles County Employees Retirement Association (LACERA) group medical benefits. Amber Turner and Jennifer Lagua of Segal's Benefit Audit Solutions Practice conducted the remote audit during the week of November 8, 2021. The audit was conducted via remote system access to Elevance's WGS system. The audit encompassed a review of a total of two hundred and fifty-five (255) sample claims (220 statistical claims and 35 target claims) for the audit period of July 1, 2021, through June 30, 2022. $3,773,641.41 ($3,591,093.33 for the random, statistical claim sample and $182,548.41 for the target claim sample), or 2.71% by cost, of the total $139,134,201.98 paid claims for the audit period were evaluated.

Scope of Services

Elevance provided an electronic data file of all medical claims processed and paid during the 12-month period of July 1, 2021, through June 30, 2022. The objective of the review was to ensure that claims that were paid in accordance with LACERA's plan provisions. Segal's audit included the following in-house and remote review components:

- An adjudication procedures review to assess day-to-day processing guidelines and claim control measures;
- A random, stratified sample of 220 statistical medical claims to measure validity in the financial dollar value and incidence (number) accuracy of all benefit payments processed during the audit period; and,
- A target sample of 35 claims identified through an electronic analyses of all claims designed to explore potential duplicate payments and/or sample various benefit applications (i.e., deductibles, employee cost-shares, limitations, and exclusions).
- Time-to-Process achievement was measured from the date a claim is first received to the initial date processed for payment or denial for all claims for the audit period of July 1, 2021, through June 30, 2022.

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

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

Random, Stratified 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 multiemployer plan benefits.

During the 12-month audit period of July 1, 2021, through June 30, 2022, medical benefit payments for 750,309 medical claims totaled $139,134,201.98 in the file. Sampled benefit payments for 220 random, stratified claims totaled $3,591,093.33 (2.58%).

The random, stratified statistical audit sample was selected through analyses performed by our 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.

Accuracy Results

Review of the statistical sample of 220 medical claims in the audit period of July 1, 2021, through June 30, 2022, identified seven (7) in-sample errors:

- **Four (4) overpayments totaling $800.00; and,**
- **Three (3) underpayments totaling -$239.78.**

In addition to the above errors, sixteen (16) out-of-sample (OOS) errors were identified. The sixteen errors included one (1) overpayment for $20,889.46, fifteen (15) underpayments totaling -$1,014.37. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

As seen in the following chart, Elevance surpassed the performance guarantee standard in the Time-to-Process, Financial Accuracy, and Procedural Accuracy categories through this audit.

Additionally, the 30-day Time-to-Process achievement is below the industry standard, however it may be explained by multiply processing events (i.e., claims that were processed within the correct timeframe but then later adjusted), which are not factored in the calculation.

Please note that the Accuracy Results do not include OOS or target claims.

Category	Statistical Achievement	Performance Guarantee	Industry Standards
Financial Accuracy (dollar value)	99.64%	99.00%	99.00%
Payment Accuracy (free from financial error)	98.17%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (free from error)	98.17%	N/A	95.00%
Time-to-Process* (within 14 calendar days)	99.02%	90.00%	95.00%
(within 30 calendar days)	99.19%	N/A	100.00%

* Time-to-process achievement has been calculated on 100% of the claims population for the audit period and does not take adjustments into account.

Target Sample Results

In addition to the random, statistical claim sample, Elevance supported a target sample of 35 claims. Target claims were selected through a series of electronic analyses to identify and confirm the accuracy of specific plan provisions and exclusions.

During the 12-month audit period of July 1, 2021, through June 30, 2022, medical benefit payments for 750,309 medical claims totaled $139,134,201.98 in the file. Sampled benefit payments for 35 targeted claims totaled $182,548.41 (0.13%).

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:

- Potential duplicate payments;
- Reimbursement of Plan exclusions, limitations, and prior authorizations;
- Patient out-of-pocket expenses (i.e., 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 via remote access on order to validate the processing event or identify the root cause of the error; as applicable.

Target Results

Review of the target sample of 35 medical claims in the 12-month audit period of July 1, 2021, through June 30, 2022, identified twenty-two (22) in-sample overpayment errors totaling $18,662.37.

In addition to the above errors, two (2) OOS underpayments identified totaling -$21.82.

Further information regarding these errors is provided in Section III of this report.

Key Findings and Recommendations

The following bullet points summarize the primary findings identified by Segal's auditors during the claims review. Segal recommended that Elevance adjust any payments identified in error. Elevance's responses to the findings from the remote review are summarized and italicized throughout the report. An asterisk is noted next to the issue if it is a reoccurring issue that was identified on prior audits. Elevance was presented with a draft report on January 31, 2023, for its review and comment. Elevance provided its formal response to Segal on February 21, 2023, which can be located in Section VI of the report.

- ***Medicare Coordination (Samples: 15A, Amount Underpaid: -$8.05)**

  The sample claim coordinated benefits incorrectly resulting in an underpayment.

  Elevance disagreed with this error during the remote review and noted that the payment is calculated from 20% of Medicare's allowable amount.

  Segal disagreed with Elevance and notes that per the plan document "We will pay 100% of the difference between Medicare's Allowable Charge(s) and the amount Medicare pays for medically necessary Part B services and supplies". As such, Segal noted that the amount for coinsurance and deductible that applies to the Medicare claims should be paid in full to the provider.

  Elevance's Final Response: Elevance Continues to disagree with Segal on this error.

  Segal's Final Response: Segal recommends that LACERA and Elevance discuss this issue regarding the Medicare coordination.

- ***Deductible Overapplied (Samples: 77C, 120D, 123D, 134D, 154E, 156E, 186H, 188H, 198I, 199I, and 214K, Amount Underpaid OOS: -$923.69)**

  The individual deductibles were over applied.

  Elevance agreed to these errors during the remote review and noted that a process was implemented to deter the overapplication, but these claims were missed.

  As this is a reoccurring error every year, Segal recommended that Elevance provide corrective action steps that will be in place to ensure no claims are "missed" in the future. Additionally, Segal recommended that Elevance adjust the claims and refund the members.

  Elevance's Final Response: Elevance noted that it has implemented a process to identify and correct this issue and will continue to monitor this situation.

Segal's Final Response: Segal recommends that LACERA continue to monitor this issue as it is reoccurring.

- **Preventive Applied Deductible (Sample: 88C, Amount Underpaid: -$1.80)**

  A claim for preventive care applied a deductible.

  Elevance agreed to this error during the remote review.

  Due to this claim being system adjudicated, Segal recommended that Elevance generate a financial impact report on all preventive claims that applied a deductible.

  Elevance's Final Response: Elevance noted it is currently working on a root cause analysis and financial impact reporting. Both will be released to LACERA upon completion.

  Segal's Final Response: Segal recommends that LACERA follow-up with Elevance for the results of the root cause analysis and financial impact reporting.

- **Outpatient (OP) Surgery Copayment (Sample: 145E, Amount Underpaid: -$229.93)**

  A claim for outpatient surgery applied coinsurance when outpatient surgery has no coinsurance application.

  Elevance agreed to this error during the remote review.

  Segal recommended that Elevance adjust the claim and refund the member for the amount overapplied to coinsurance.

  Elevance's Final Response: Elevance noted the claim was sent for adjustment and the processor received coaching on this issue.

  Segal's Final Response: No further intervention is necessary.

- ***Out-of-Pocket (OOP) Overapplied (Samples: 150E, 174G, 182H, 193I, T9, and T11, Amount Underpaid OOS: -$112.50)**

  The out-of-pocket maximums were overapplied.

  Elevance agreed to these errors during the remote review and noted that a process was implemented to deter the overapplication, but these claims were missed.

  As this is a reoccurring error every year Segal recommended that Elevance provide corrective action steps that will be in place to ensure no claims are "missed" in the future. Additionally, Segal recommended that Elevance adjust the claims and refund the members.

  Elevance's Final Response: Elevance noted that it has implemented a process to identify and correct this issue and will continue to monitor this situation.

  Segal's Final Response: Segal recommends that LACERA continue to monitor this issue as it is reoccurring.

- ***Precertification Deductible (Samples: 176G, 181H, 190H, and 200I, Amount Overpaid: $800.00)**

  Outpatient surgery did not obtain a pre-certification nor did a pre-certification penalty apply.

  Elevance disagreed to these errors during the remote review and noted that outpatient surgery pre-certification is not required.

Segal noted that the plan document notes that pre-certification applies to all surgeries, wherever performed.

Elevance's Final Response: Elevance noted that it continues to disagree with this error but its Account Management is open to discussing benefit modifications.

Segal's Final Response: Segal recommends that LACERA and Elevance discuss this issue regarding when and what outpatient surgeries require pre-certification.

- ***Plan Limit Exceeded Maximum (Sample: 218K, Amount Overpaid OOS: $20,889.46)**

  The plan maximum limit of $1,000,000 was exceeded.

  Elevance agreed to this error during the remote review and noted that this error was due to the pharmacy integration.

  Segal requested that Elevance review this error and provide an action plan for working with the pharmacy portion of the plan to ensure overapplications do not apply in the future.

  Elevance's Final Response: Elevance noted that this was due to pharmacy comingling. Elevance noted that it has implemented a process to identify and correct this issue and will continue to monitor this situation.

  Segal's Final Response: Segal recommends that LACERA continue to monitor this issue as it is reoccurring.

- ***Hearing Aids Limit (Samples: T1, T2. T3, T4, T5, T6, and T7, Amount Overpaid OOS: $12,692.71)**

  Hearing aids were paid over the $300.00 limit.

  Elevance agreed to these errors during the remote review

  Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.

  Elevance's Final Response: Elevance noted that this is a manual process and coaching was provided to the processors.

  Segal's Final Response: Segal recommends that LACERA continue to monitor this issue as it is reoccurring.

- ***Acupuncture Over $30.00 (Samples: T8, T10, T11, T12, and T13, Amount Overpaid: $388.76)**

  Acupuncture was paid over the $30.00 payment limit.

  Elevance agreed to these errors during the remote review.

  Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.

  Elevance's Final Response: Elevance noted that this is a manual process and coaching was provided to the processors.

  Segal's Final Response: Segal recommends that LACERA continue to monitor this issue as it is reoccurring.

- ***Foot Orthotics Exclusion (Samples: T15, T17, and T18, Amount Overpaid: $1,247.33)**

Orthotics were covered for diagnosis other than diabetes.

Elevance agreed to these errors during the remote review

Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.

Elevance's Final Response: Elevance continues to disagree and notes that pain in the foot as well as other diagnoses outside of diabetes are covered.

Segal's Final Response: Segal recommends that LACERA discuss this issue further with Elevance and provide guidance regarding what diagnoses should be covered for this benefit.

- **Out-of-Network (OON) Preventive (Sample: T21, Amount Overpaid: $156.80)**

  OON preventive care paid beyond the $20.00 limit.

  Elevance agreed to this error during the remote review.

  Segal recommended that Elevance provide the processor coaching regarding this processing error.

  Elevance's Final Response: Elevance noted that it provided refresher coaching to its claims processor.

  Segal's Final Response: No further intervention is necessary.

- ***Duplicate Claim Payment (Samples: T26, T27, T30, T31, T33, and T35, Amount Overpaid: $4,176.77)**

  Duplicate claim payments were made.

  Elevance agreed to these errors during the remote review.

  Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.

  Elevance's Final Response: Elevance noted that there errors were due to manual intervention and coaching to its claims processors in order to prevent future errors from reoccurring.

  Segal's Final Response: No further intervention is necessary.

July 1, 2021 – June 30, 2022 Audit Findings Summary Chart
(Statistical and Target Samples)

	Audit Findings	
Issue	**Financial Impact**	**# of claims**
Medicare coordination	-$8.05	1
Deductible Overapplied	-$923.69	11
Preventive Applied Deductible	-$1.80	1
OP Surgery Copayment	-$229.93	1
OOP Overapplied	-$112.50	6
Precertification Deductible	$800.00	4
Plan Limit Exceeded Maximum	$20,889.46	1
Hearing Aids Limit	$12,692.71	7
Acupuncture Over $30.00	$388.76	5
Foot Orthotics Exclusion	$1,247.33	3
OON Preventive	$156.80	1
Duplicate Claim Payment	$4,176.77	6
Total Overpaid	**$40,351.83**	**27**
Total Underpaid	**-$1,275.97**	**20**

Section II – Statistical Claims Sample

Elevance provided a data file of all medical claims processed and paid during the 12-month audit period of July 1, 2021, through June 30, 2022, which was utilized for sampling purposes.

During the 12-month audit period of July 1, 2021, through June 30, 2022, medical benefit payments for 750,309 medical claims totaled $139,134,201.98 in the file. Sampled benefit payments for 220 random, stratified claims totaled $3,591,093.33 (2.58%).

Relevant claims processing information was verified through Elevance's responses to the Adjudication Procedures questionnaire, remote review discussions, auditors' observations, and the individual claims review.

Stratification

The selection of 220 random claims for the 12-month audit period of July 1, 2021, through June 30, 2022, was stratified by dollar amount to provide large claims representation that is more valid in determining financial accuracy levels. The methodology of Segal's stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allows a quantifiable degree of confidence, whereby results obtained in the audit sample are a true reflection of the way all claims were processed during the audit period.

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

Stratification Table

Strata	Dollar Range of Strata	Number of Claims in		Dollar Amount in	
		Range	Selection	Selection	Strata
A	$0.01 - $19.99	211,079	35	$373.55	$2,324,950.67
B	$20.00 - $39.99	223,488	40	$1,104.52	$6,204,175.06
C	$40.00 - $139.99	198,696	35	$2,951.63	$15,215,007.27
D	$140.00 - $389.99	73,258	25	$5,655.05	$16,219,898.86
E	$390.00 - $1,199.99	26,015	20	$13,483.99	$16,744,627.73
F	$1,200.00 - $2,699.99	12,021	15	$27,234.59	$20,237,419.48
G	$2,700.00 - $6,249.99	3,543	10	$45,295.08	$14,164,711.96
H	$6,250.00 - $17,499.99	1,459	10	$91,541.31	$15,056,923.95
I	$17,500.00 - $49,999.99	572	10	$290,679.34	$16,395,666.82
J	$50,000.00 -$177,999.99	168	10	$742,607.95	$14,200,653.86
K	$178,000.00 -$364,047.64	10	10	$2,370,166.32	$2,370,166.32
Total		**750,309**	**220**	**$3,591,093.33**	**$139,134,201.98**

Review Process

Elevance provided a copy of the sampled claim submissions and access through its WGS claim system. The auditors recalculated and reviewed each claim manually from initial receipt to final benefit determination seeking evidence of compliance with established adjudication procedures and benefit provisions; 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.) is on file for claims paid and verified when necessary.
- Coordination of benefits and subrogation provisions were enforced, where applicable.
- Proper application of age, gender, and disease specific edits.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Proper medical necessity was investigated as defined by the Plan.
- Benefits were paid under the proper classification, diagnostic, and procedure codes as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, copayments, coinsurance, and out-of-pocket maximums were applied.
- As appropriate, high dollar claims were considered for care management and applicable stop-loss notifications were timely filed.

- Claims system logic for examiner edits and auto-adjudication capabilities.
- Arithmetic calculations were correct.
- Duplicate submissions were properly denied.
- Payment was made to the proper party (i.e., the provider of service if benefits were assigned; claimant is benefits were not assigned).
- Turnaround time for processing of claims was within industry standards or established performance guarantees.

All questions and potential errors were presented to Elevance's representatives daily; additional supporting documentation was provided through January 24, 2023.

Statistical Claim Findings Table

Review of the statistical sample of 220 medical claims in the audit period of July 1, 2021, through June 30, 2021, identified seven (7) in-sample errors:

- **Four (4) overpayments totaling $800.00; and,**
- **Three (3) underpayments totaling -$239.78.**

In addition to the above errors, sixteen (16) out-of-sample (OOS) errors were identified. The sixteen errors included one (1) overpayment for $20,889.46, fifteen (15) underpayments totaling -$1,014.37. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

Elevance should initiate claim adjustments for the claims identified in error on the following table.

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
Medicare Coordination				
15A	-$8.05	The sample claim coordinated benefits incorrectly resulting in an underpayment. (Auto Adjudication) *Elevance disagreed with this error during the remote review and noted that the payment is calculated from 20% of Medicare's allowable amount.* **Segal disagreed with Elevance and noted that per**	*Elevance Health continues to disagree to the assessed error on sample 15A. According to the member's Medicare coverage, physician home office visits are covered at 20% of Medicare's allowable charges for professional claims. The sample claim was paid at 20% of Medicare's allowed amount;*	**Segal recommends that LACERA and Elevance discuss this issue regarding the Medicare coordination.**

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
		the plan document "We will pay 100% of the difference between Medicare's Allowable Charge(s) and the amount Medicare pays for medically necessary Part B services and supplies". As such, Segal noted that the amount for coinsurance and deductible that applies to the Medicare claims should be paid in full to the provider.	*therefore, the claim processed correctly.*	
Deductible Overapplied				
77C	OOS: -$8.90	The individual deductibles were overapplied. (Auto and Manual Adjudication) *Elevance agreed to these errors during the remote review and noted that a process was implemented to deter the overapplication, but these claims were missed.* **As this is a reoccurring error every year, Segal recommended that Elevance provide corrective action**	*Elevance Health agrees to the out-of-sample underpayment errors assessed on samples 77C, 120D, 123D, 134D, 154E, 156E, 186H, 188H, 198I, 199I, and 214K, totaling $923.69. The member's deductible maximum was exceeded due to pharmacy co-mingling/integration. Due to the nature of the transmission of data between Elevance Health and the pharmacy vendor, overages to the deductible/out-of-pocket will occur. Since there*	**Segal recommends that LACERA continue to monitor this issue as it is reoccurring.**
120D	OOS: -$422.17			
123D	OOS: -$1.71			
134D	OOS: -$9.32			
154E	OOS: -$6.09			
156E	OOS:			

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
	-$33.92	**steps that will be in place to ensure no claims are "missed" in the future. Additionally, Segal recommended that Elevance adjust the claims and refund the members.**	*is no way to avoid these overages, Elevance Health has implemented a process to identify and correct them. Over-applied (exceeds) reports are system generated weekly and assigned to the accumulator team for review. Once assigned to the team, the team reviews the report and corrects the deductible/out-of-pocket accordingly. The accumulator team will adjust medical claims to correct the overages. If no medical claims are available, any remaining overages are sent to the pharmacy vendor so they can apply the appropriate refunds. Since this is a manual process, there may be times when overages are missed or not corrected immediately, which is what occurred with these sample claims. Elevance continues to review workflows in place for the opportunity to enhance and reduce our process for adjusting overages.*	
186H	OOS: -$55.31			
188H	OOS: -$332.53			
198I	OOS: -$17.85			
199I	OOS: -$6.08			
214K	OOS: -$29.81			

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
			The members' deductible/out-of-pocket overages identified in this audit are in the process of being resolved.	
Preventive Applied Deductible				
88C	-$1.80	A claim for preventive care applied a deductible. (Auto Adjudication) *Elevance agreed to this error during the remote review.* **Due to this claim being system adjudicated, Segal recommended that Elevance generate a financial impact report on all preventive claims that applied a deductible**.	*Elevance Health agrees to the underpayment error in the amount of $1.80 assessed on sample 88C. A preventive care service was applied to the medical deductible in error. The claim has been forwarded to Elevance Health's IT team to determine root cause. Once the details of the issue have been determined, Elevance Health will notify LACERA with the outcome and an impact report will be generated to capture all affected claims.*	**Segal recommends that LACERA follow-up with Elevance for the results of the root cause analysis and financial impact reporting.**
OP Surgery Copayment				
145E	-$229.93	A claim for outpatient surgery applied coinsurance when outpatient surgery has no coinsurance application. (Manual Adjudication)	*Elevance Health agrees to the $229.93 underpayment error on sample 145E. The issue was caused by a manual processing error as surgery services*	**No further intervention is necessary.**

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
		Elevance agreed to this error during the remote review. **Segal recommended that Elevance adjust the claim and refund the member for the amount overapplied to coinsurance.**	*performed by a participating provider should be reimbursed at 100%. The processor has been provided with coaching on the proper handling of such claims, and the claim has been placed in the adjustment process.*	
OOP Overapplied				
150E	OOS: -$3.86	The out-of-pocket maximums were overapplied. (Auto and Manual Adjudication) *Elevance agreed to these errors during the remote review and noted that a process was implemented to deter the overapplication, but these claims were missed.* **As this is a reoccurring error every year, Segal recommended that Elevance provide corrective action steps that will be in place to ensure no claims are "missed" in the future. Additionally, Segal**	*Elevance Health agrees to the out-of-sample underpayment errors assessed on samples 150E, 174G, 182H, 193I, T9, and T11, totaling $90.68. The member's out-of-pocket maximum was exceeded due to pharmacy co-mingling/integration. Due to the nature of the transmission of data between Elevance Health and the pharmacy vendor, overages to the deductible/out-of-pocket will occur. Since there is no way to avoid these overages, Elevance Health has implemented a process to identify and correct them. Over-*	**Segal recommends that LACERA continue to monitor this issue as it is reoccurring.**
174G	OOS: -$3.10			
182H	OOS: -$79.93			
193I	OOS: -$3.79			

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
		recommended that Elevance adjust the claims and refund the members.	*applied (exceeds) reports are system generated weekly and assigned to the accumulator team for review. Once assigned to the team, the team reviews the report and corrects the deductible/out-of-pocket accordingly. The accumulator team will adjust medical claims to correct the overages. If no medical claims are available, any remaining overages are sent to the pharmacy vendor so they can apply the appropriate refunds. Since this is a manual process, there may be times when overages are missed or not corrected immediately, which is what occurred with these sample claims. Elevance continues to review workflows in place for the opportunity to enhance and reduce our process for adjusting overages. The members' deductible/out-of-pocket overages identified in this audit are in the process of being resolved.*	

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
Precertification Deductible				
176G	$200.00	Outpatient surgery did not obtain a pre-certification nor did a pre-certification penalty apply. (Auto and Manual Adjudication) *Elevance disagreed to these errors during the remote review and noted that outpatient surgery pre-certification is not required.* **Segal noted that the plan document notes that pre-certification applies to all surgeries, wherever performed.**	*Elevance Health disagrees to the overpayment errors assessed on samples 176G, 181H, 190H, and 200I, totaling $800.00. The claims were processed correctly as pre-certification is not required for outpatient surgery. If this is not LACERA's intent, account management is available to discuss benefit modifications.*	**Segal recommends that LACERA and Elevance discuss this issue regarding when and what outpatient surgeries require pre-certification.**
181H	$200.00			
190H	$200.00			
200I	$200.00			
Plan Maximum Exceeded				
218K	OOS: $20,889.46	The plan maximum limit of $1,000,000 was exceeded. (Manual Adjudication) *Elevance agreed to this error during the remote review and noted that this error was due to the pharmacy integration.* **Segal requested that Elevance review this error**	*Elevance Health agrees to the out-of-sample error in the amount of $20,889.46. The member's lifetime maximum was exceeded due to pharmacy co-mingling/integration. Due to the nature of the transmission of data between Elevance Health and the pharmacy vendor,*	**Segal recommends that LACERA continue to monitor this issue as it is reoccurring.**

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
		and provide an action plan for working with the pharmacy portion of the plan to ensure overapplications do not apply in the future.	*overages to the deductible/out-of-pocket will occur. Since there is no way to avoid these overages, Elevance implemented a process to identify and correct them. Over-applied (exceeds) reports are system generated weekly and assigned to the accumulator team for review. Once assigned to the team, the team reviews the report and corrects the deductible/out-of-pocket accordingly. The accumulator team will adjust medical claims to correct the overages. If no medical claims are available, any remaining overages are sent to the pharmacy vendor so they can apply the appropriate refunds. Since this is a manual process, there may be times when overages are missed or not corrected immediately, which is what occurred with this sample claim. Elevance continues to review workflows in place for the opportunity to*	

Statistical Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
			enhance and reduce our process for adjusting overages. The members' deductible/out-of-pocket overages identified in this audit are in the process of being resolved.	
Total	**4 overpayments**			**$ 800.00**
	1 out-of-sample overpayment			**$20,889.46**
	3 underpayments			**-$ 239.78**
	15 out-of-sample underpayments			**-$ 1,014.37**

Section III – Target Claim Sample

Segal performed an electronic review of all medical claims processed and paid during the audit period of July 1, 2021, through June 30, 2022. The electronic review was designed to identify potential deficiencies in the benefit delivery system; however, the analysis was not intended to identify data entry errors (i.e., incorrect patient, date of service, or provider) or creative billing practices of the provider.

During the 12-month audit period of July 1, 2021, through June 30, 2022, medical benefit payments for 750,309 medical claims totaled $139,134,201.98 in the file. Sampled benefit payments for 35 targeted claims totaled $182,548.41 (0.13%).

The random nature of statistical sampling does not ensure every benefit provision or plan variation was identified in the selection. Therefore, the 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. Segal's query process was defined by the following categories:

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

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

Target Claim Findings Table

Review of the target sample of 35 medical claims in the 12-month audit period of July 1, 2021, through June 30, 2022, identified twenty-two (22) in-sample overpayment errors totaling $18,662.37.

In addition to the above errors, two (2) out-of-sample (OOS) underpayment identified totaling -$21.82.

Elevance should initiate claim adjustments for the claims identified in error on the following table.

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
Hearing Aids Limit				
T1	$550.00	Hearing aids were paid over the $300.00 limit. (Manual Adjudication) *Elevance agreed to these errors during the remote review* **Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.**	*Elevance Health agrees to the overpayment errors assessed on samples T1, T2. T3, T4, T5, T6, and T7, totaling $12,689.06 and not $12,692.71 as assessed by Segal. The issue was caused by manual processing errors and the processors have been provided with coaching and refresher training on the proper handling of such claims. These errors have also been shared with the entire team handling claims for LACERA during team meetings to prevent future errors from recurring. The claims have been*	**Segal recommends that LACERA continue to monitor this issue as it is reoccurring.**
T2	$4,200.00			
T3	$300.00			
T4	$190.00			
T5	$52.71			
T6	$3,200.00			
T7	$4,200.00			

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
			placed in the adjustment and recovery process.	
Acupuncture Over $30.00				
T8	$12.59	Acupuncture was paid over the $30.00 payment limit. (Manual Adjudication) *Elevance agreed to these errors during the remote review* **Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.**	*Elevance Health agrees to the overpayment errors assessed on samples T8, T10, T11, T12, and T13, totaling $338.76 and not $388.76 as assessed by Segal. The issue was caused by manual processing errors and the processors have been provided with coaching and refresher training on the proper handling of such claims. These errors have also been shared with the entire team handling claims for LACERA during team meetings to prevent future errors from recurring. The claims have been placed in the adjustment and recovery process.*	**Segal recommends that LACERA continue to monitor this recurring issue.**
T10	$12.59			
T11	$90.00			
T12	$30.00			
T13	$243.58			

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
OOP Overapplied				
T9	-$15.77	The out-of-pocket maximums were overapplied. (Auto and Manual Adjudication) *Elevance agreed to these errors during the remote review and noted that a process was implemented to deter the overapplication, but these claims were missed.* **As this is a reoccurring error every year, Segal recommended that Elevance provide corrective action steps that will be in place to ensure no claims are "missed" in the future. Additionally, Segal recommended that Elevance adjust the claims and refund the members.**	*Elevance Health agrees to the out-of-sample underpayment errors assessed on samples T9 and T11, totaling $21.82. The member's out-of-pocket maximum was exceeded due to pharmacy co-mingling/integration. Due to the nature of the transmission of data between Elevance Health and the pharmacy vendor, overages to the deductible/out-of-pocket will occur. Since there is no way to avoid these overages, Elevance Health has implemented a process to identify and correct them. Over-applied (exceeds) reports are system generated weekly and assigned to the accumulator team for review. Once assigned to the team, the team reviews the report and corrects the deductible/out-of-pocket accordingly. The accumulator team will adjust medical claims*	**Segal recommends that LACERA continue to monitor this recurring issue.**
T11	-$6.05			

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
			to correct the overages. If no medical claims are available, any remaining overages are sent to the pharmacy vendor so they can apply the appropriate refunds. Since this is a manual process, there may be times when overages are missed or not corrected immediately, which is what occurred with these sample claims. Elevance continues to review workflows in place for the opportunity to enhance and reduce our process for adjusting overages. The members' deductible/out-of-pocket overages identified in this audit are in the process of being resolved.	
Foot Orthotics Exclusion				
T15	$424.96	*Orthotics were covered for diagnosis other than diabetes. (Manual Adjudication)* *Elevance agreed to these errors during the remote review*	*After further review, we are retracting our original statement and disagree with assessed errors on samples T15, T17, and T18, totaling $1,247.33. Per the benefit plan design, the diagnosis codes M79671 (pain*	**Segal recommends that LACERA discuss this issue further with Elevance and provide guidance regarding what diagnoses should be covered for this benefit.**
T17	$278.02			
T18	$544.35			

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
		Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.	*in right foot) and M25571 (pain in right ankle and joints of right foot) are not listed as an exclusion. Foot orthotics are covered for diabetes but are not limited to the diabetes diagnosis. If this is not the benefit intent of LACERA, Elevance Health's account manager is available to discuss.*	
OON Preventive				
T21	$156.80	OON Preventive care paid beyond the $20.00 limit. (Manual Adjudication) *Elevance agreed to this error during the remote review.* **Segal recommended that Elevance provide the processor coaching regarding this processing error.**	*Elevance Health agrees to the $156.80 overpayment error assessed on sample T21. The issue was caused by a manual processing error and the processor has been provided with coaching and refresher training on the proper handling of such claims. The claim has been placed in the adjustment and recovery process.*	**No further intervention is necessary.**
Duplicate Claim Payment				
T26	$177.62	Duplicate claim payments were made. (Manual Adjudication)	*Elevance Health agrees to the overpayment errors assessed*	**No further intervention is necessary.**
T27	$660.00			

Target Sample Findings				
Worksheet	**Under/ Overpayment /Procedural**	**Initial Error**	**Elevance's Response**	**Segal's Final Comment**
T30	$1,150.00	*Elevance agreed to these errors during the remote review.* **Segal noted that this issue was identified in the prior audit. As such, Segal requested that Elevance provide an action plan in order to correct this issue.**	*on samples T26, T27, T30, T31, T33, and T35. The issue was caused by manual processing errors. The processors have been provided with coaching and refresher training on the proper handling of such claims. These errors have also been shared with the entire team handling claims for LACERA during team meetings to prevent future errors from recurring. The claims have been placed in the adjustment and recovery process.*	
T31	$1,200.00			
T33	$121.68			
T35	$867.47			
Total	**22 overpayments** **2 OOS underpayment**			**$18,662.37** **-$ 21.82**

Section IV - Time-to-Process Achievement

There were no concerns with the time-to-process measurement for non-adjusted claims. Results from the electronic analysis of all claims processed during the audit period (July 1, 2021, through June 30, 2022) revealed that Elevance processed 99.02% of the claims within 14 calendar days and 99.19% within 30 calendar days.

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial; subsequent adjustments were measured from receipt of the new information to the benefit determination date with processing measured as the longest interval. Measurements included routing delays due to internal review (i.e., documentation 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.

Section V – Adjudication Procedures Review

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

- LACERA claims are processed by a dedicated Elevance unit. Claims are systematically assigned to queues within the work unit and is managed by the claims managers.
- Elevance receives approximately 72,956 claims monthly for LACERA.
  - 97.2% of those claims received for LACERA are received electronically.
  - 91.97% of those claims for LACERA are auto adjudicated.
- On the job injuries are investigated by sending the member a questionnaire to complete. Query for these claims is based on diagnosis codes received through claim submissions.
- Elevance utilizes pay and pursue method for subrogation with a minimum threshold of $750.00.
- Coordination of benefits questionnaire is sent to members on an annual basis to inquire if other coverage exists.
- Elevance's system has the capability to automatically identify potential coordination of benefits and third-party liability claims.
- Fraud waste and Abuse is claims are identified by Elevance through mining its own claims data.
  - Elevance's Special Investigation Unit (SIU) is tasked with investigations into possible FWA by the member or provider.
- Claims paid more than $40,000 are routed to Elevance's high-dollar claims team for review.
- Claims paying more than $300,000 are reviewed by the high dollar claims team as well as a senior auditor or manager for review.
- Internal audits are conducted daily by Elevance and by Elevance's corporate office personnel monthly.
  - Audits are performed on a prepayment and post payment basis.
  - Audits are performed on a random stratified basis as well as on a random non statistical basis.

Section VI – Elevance's Formal Response to the Draft Report

February 21, 2023

Amber M. Turner
The Segal Company
330 North Brand Boulevard, Suite 1100
Glendale, CA 91203

Subject: Analysis of Anthem Blue Cross Medical Claims Processing and Payment Procedures, Los Angeles County Employee Retirement Association – Response to Draft Report

Dear Ms. Turner:

It has been a pleasure working with you throughout this process. We appreciate the opportunity to respond to the draft report and the time you took to summarize your findings.

Elevance Health the Anthem Blue Cross Blue Shield plan administrator has reviewed the Segal Company's (Segal) draft report prepared for the Los Angeles County Employee Retirement Association's claims processing audit. The audit review consisted of 220 random stratified statistical medical claims and 35 targeted samples processed by Elevance Health during the audit period of July 1, 2021, through June 30, 2022. This audit was conducted remotely during the week of December 19, 2022. Elevance Health's response to the findings and recommendations are presented below:

Random, Stratified Statistical Results
Segal's sample of 220 claims identified twenty-three (23) errors: four (4) in-sample overpayments totaling $800.00, three (3) in-sample underpayments totaling -$239.78, one (1) OOS overpayment for $20,889.46, and fifteen (15) OOS underpayments totaling -$1,014.37.

Elevance Health's Response: *Elevance Health disagrees with four (4) in-sample overpayment errors, totaling $800.00, and one (1) in-sample underpayment error, totaling $8.05. Elevance Health agrees with two (2) in-sample underpayment errors, totaling $231.73, one (1) OOS overpayment error, totaling $20,889.46, and fifteen (15) OOS underpayment errors, totaling $1,014.37.*

Target Sample Results

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The target sample of 35 claims identified twenty-four (24) errors: twenty-two (22) in-sample overpayment errors totaling $18,662.37 and two (2) OOS underpayment errors totaling -$21.82.

Elevance Health's Response: *Elevance Health disagrees with three (3) in-sample overpayment errors, totaling $1,247.33. Elevance Health agrees with nineteen (19) in-sample overpayments, totaling $17,361.39 and two (2) OOS underpayment errors, totaling $21.82.*

Statistical Sample Findings

Sample 15A: The sample claim coordinated benefits incorrectly resulting in an underpayment. (Amount Underpaid: -$8.05)

Segal notes that the amount for coinsurance and deductible that applies to the Medicare claims should be paid in full to the provider.

Elevance Health's Response: *Elevance Health continues to disagree to the assessed error on sample 15A. According to the member's Medicare coverage, physician home office visits are covered at 20% of Medicare's allowable charges for professional claims. The sample claim was paid at 20% of Medicare's allowed amount; therefore, the claim processed correctly.*

Samples 77C, 120D, 123D, 134D, 154E, 156E, 186H, 188H, 198I, 199I, and 214K: The individual deductibles were over applied. (Amount Underpaid OOS: -$923.69)

Segal recommends that Anthem provide corrective action steps that will be in place to ensure no claims are "missed" in the future. Additionally, Segal recommends that Anthem adjust the claims and refund the members.

Elevance Health's Response: *Elevance Health agrees to the out-of-sample underpayment errors assessed on samples 77C, 120D, 123D, 134D, 154E, 156E, 186H, 188H, 198I, 199I, and 214K, totaling $923.69. The member's deductible maximum was exceeded due to pharmacy co-mingling/integration. Due to the nature of the transmission of data between Elevance Health and the pharmacy vendor, overages to the deductible/out-of-pocket will occur. Since there is no way to avoid these overages, Elevance Health has implemented a process to identify and correct them. Over-applied (exceeds) reports are system generated weekly and assigned to the accumulator team for review. Once assigned to the team, the team reviews the report and corrects the deductible/out-of-pocket accordingly. The accumulator team will adjust medical claims to correct the overages. If no medical claims are*

available, any remaining overages are sent to the pharmacy vendor so they can apply the appropriate refunds. Since this is a manual process, there may be times when overages are missed or not corrected immediately, which is what occurred with these sample claims. Elevance continues to review workflows in place for the opportunity to enhance and reduce our process for adjusting overages. The members' deductible/out-of-pocket overages identified in this audit are in the process of being resolved.

Sample 88C: A claim for preventive care applied a deductible. (Amount Underpaid: -$1.80)

Due to this claim being system adjudicated, Segal recommends that Anthem generate a financial impact report on all preventive claims that applied a deductible.

Elevance Health's Response: *Elevance Health agrees to the underpayment error in the amount of $1.80 assessed on sample 88C. A preventive care service was applied to the medical deductible in error. The claim has been forwarded to Elevance Health's IT team to determine root cause. Once the details of the issue have been determined, Elevance Health will notify LACERA with the outcome and an impact report will be generated to capture all affected claims.*

Sample 145E: A claim for outpatient surgery applied coinsurance when outpatient surgery has no coinsurance application. (Amount Underpaid: -$229.93)

Segal recommends that Anthem adjust the claim and refund the member for the amount overapplied to coinsurance.

Elevance Health's Response: *Elevance Health agrees to the $229.93 underpayment error on sample 145E. The issue was caused by a manual processing error as surgery services performed by a participating provider should be reimbursed at 100%. The processor has been provided with coaching on the proper handling of such claims, and the claim has been placed in the adjustment process.*

Samples: 150E, 174G, 182H, 193I, T9, and T11: The out-of-pocket maximums were overapplied. (Amount Underpaid OOS: -$112.50)

Segal recommends that Anthem provide corrective action steps that will be in place to ensure no claims are "missed" in the future. Additionally, Segal recommends that Anthem adjust the claims and refund the members.

Elevance Health's Response: *Elevance Health agrees to the out-of-sample underpayment errors assessed on samples 150E, 174G, 182H, 193I, T9, and T11, totaling $112.50. The member's out-of-pocket maximum was exceeded due to pharmacy co-mingling/integration. Due to the nature of the transmission of data between Elevance Health and the pharmacy vendor, overages to the deductible/out-of-pocket will occur. Since there is no way to avoid these overages, Elevance Health has implemented a process to identify and correct them. Over-applied (exceeds) reports are system generated weekly and assigned to the accumulator team for review. Once assigned to the team, the team reviews the report and corrects the deductible/out-of-pocket accordingly. The accumulator team will adjust medical claims to correct the overages. If no medical claims are available, any remaining overages are sent to the pharmacy vendor so they can apply the appropriate refunds. Since this is a manual process, there may be times when overages are missed or not corrected immediately, which is what occurred with these sample claims. Elevance continues to review workflows in place for the opportunity to enhance and reduce our process for adjusting overages. The members' deductible/out-of-pocket overages identified in this audit are in the process of being resolved.*

Samples: 176G, 181H, 190H, and 200I: Outpatient surgery did not obtain a pre-certification nor did a pre-certification penalty apply. (Amount Overpaid: $800.00)

Segal notes that the plan document notes that pre-certification applies to all surgeries, wherever performed.

Elevance Health's Response: *Elevance Health disagrees to the overpayment errors assessed on samples 176G, 181H, 190H, and 200I, totaling $800.00. The claims were processed correctly as pre-certification is not required for outpatient surgery. If this is not LACERA's intent, account management is available to discuss benefit modifications.*

Sample 218K: The plan maximum limit of $1,000,000 was exceeded. (Amount Overpaid OOS: $20,889.46)

Segal Requests that Anthem review this error and provide an action plan for working with the pharmacy portion of the plan to ensure overapplications do not apply in the future.
Elevance Health's Response: *Elevance Health agrees to the out-of-sample error in the amount of $20,889.46. The member's lifetime maximum was exceeded due to pharmacy co-mingling/integration. Due to the nature of the transmission of data between Elevance Health and the*

pharmacy vendor, overages to the deductible/out-of-pocket will occur. Since there is no way to avoid these overages, Elevance implemented a process to identify and correct them. Over-applied (exceeds) reports are system generated weekly and assigned to the accumulator team for review. Once assigned to the team, the team reviews the report and corrects the deductible/out-of-pocket accordingly. The accumulator team will adjust medical claims to correct the overages. If no medical claims are available, any remaining overages are sent to the pharmacy vendor so they can apply the appropriate refunds. Since this is a manual process, there may be times when overages are missed or not corrected immediately, which is what occurred with this sample claim. Elevance continues to review workflows in place for the opportunity to enhance and reduce our process for adjusting overages. The members' deductible/out-of-pocket overages identified in this audit are in the process of being resolved.

Samples T1, T2. T3, T4, T5, T6, and T7: Hearing aids were paid over the $300.00 limit. (Amount Overpaid OOS: $12,692.71)

Segal notes that this issue was identified in the prior audit. As such, Segal requests that Anthem provide an action plan in order to correct this issue.

Elevance Health's Response: *Elevance Health agrees to the overpayment errors assessed on samples T1, T2. T3, T4, T5, T6, and T7, totaling $12,689.06 and not $12,692.71 as assessed by Segal. The issue was caused by manual processing errors and the processors have been provided with coaching and refresher training on the proper handling of such claims. These errors have also been shared with the entire team handling claims for LACERA during team meetings to prevent future errors from recurring. The claims have been placed in the adjustment and recovery process.*

Samples T8, T10, T11, T12, and T13: Acupuncture was paid over the $30.00 payment limit. (Amount Overpaid: $388.76)

Segal notes that this issue was identified in the prior audit. As such, Segal requests that Anthem provide an action plan in order to correct this issue.

Elevance Health's Response: *Elevance Health agrees to the overpayment errors assessed on samples T8, T10, T11, T12, and T13, totaling $338.76 and not $388.76 as assessed by Segal. The issue was caused by manual processing errors and the processors have been provided with coaching and refresher training on the proper handling of such claims. These errors have also been shared with the*

entire team handling claims for LACERA during team meetings to prevent future errors from recurring. The claims have been placed in the adjustment and recovery process.

Samples T15, T17, and T18: Orthotics were covered for diagnosis other than diabetes. (Amount Overpaid: $1,247.33)

Segal notes that this issue was identified in the prior audit. As such, Segal requests that Anthem provide an action plan in order to correct this issue.

Elevance Health's Response: *After further review, we are retracting our original statement and disagree with assessed errors on samples T15, T17, and T18, totaling $1,247.33. Per the benefit plan design, the diagnosis codes M79671 (pain in right foot) and M25571 (pain in right ankle and joints of right foot) are not listed as an exclusion. Foot orthotics are covered for diabetes but are not limited to the diabetes diagnosis. If this is not the benefit intent of LACERA, Elevance Health's account manager is available to discuss.*

Sample T21: Out-of-network preventive care paid beyond the $20.00 limit. (Amount Overpaid: $156.80)

Segal recommends that Anthem provide the processor coaching regarding this processing error.

Elevance Health's Response: *Elevance Health agrees to the $156.80 overpayment error assessed on sample T21. The issue was caused by a manual processing error and the processor has been provided with coaching and refresher training on the proper handling of such claims. The claim has been placed in the adjustment and recovery process.*

Samples T26, T27, T30, T31, T33, and T35: Duplicate claim payments were made. (Amount Overpaid: $4,176.77)

Segal notes that this issue was identified in the prior audit. As such, Segal requests that Anthem provide an action plan in order to correct this issue.

Elevance Health's Response: *Elevance Health agrees to the overpayment errors assessed on samples T26, T27, T30, T31, T33, and T35. The issue was caused by manual processing errors. The processors have been provided with coaching and refresher training on the proper handling of such claims. These*

errors have also been shared with the entire team handling claims for LACERA during team meetings to prevent future errors from recurring. The claims have been placed in the adjustment and recovery process.

Thank you for allowing Elevance Health the opportunity to respond to this draft report. Elevance Health representatives are available to discuss the results of this audit with Segal and LACERA upon request. We look forward to working with Segal and LACERA in the future.

Sincerely,

Sent via e-mail

Norma Huizar
External Audit Facilitator

cc: Karima Carr, Elevance Health
Frank Evangelista, Elevance Health
Marijane Gadbury, Elevance Health
Tina Griffin, Elevance Health
Nicole Harber, Elevance Health
LaTosha Harwell, Elevance Health
Norma Huizar, Elevance Health

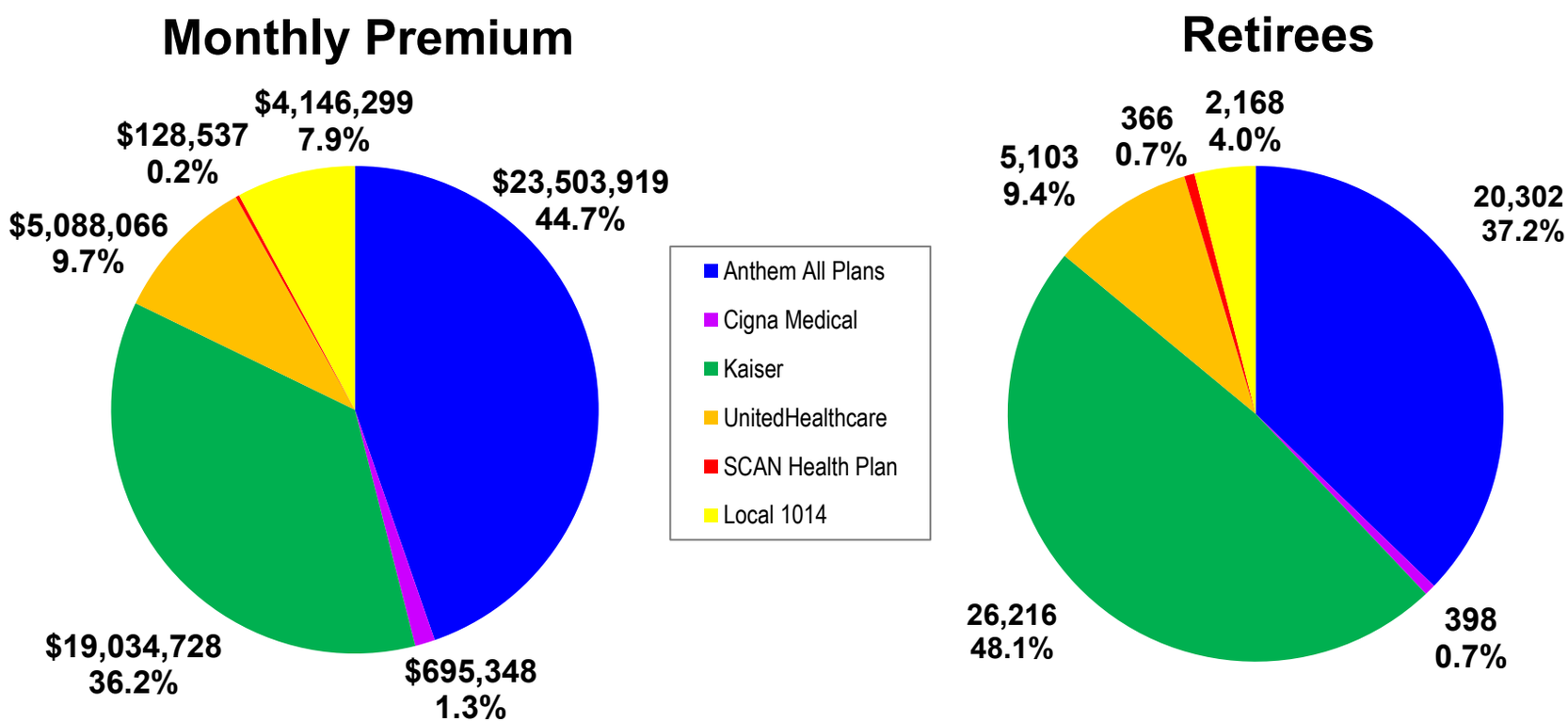
elevancehealth.com

Los Angeles County Employees Retirement Association

Premium & Enrollment

Coverage Month Ending February 2023

Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$23,503,919	44.7%	20,302	37.2%
Cigna Medical	$695,348	1.3%	398	0.7%
Kaiser	$19,034,728	36.2%	26,216	48.1%
UnitedHealthcare	$5,088,066	9.7%	5,103	9.4%
SCAN Health Plan	$128,537	0.2%	366	0.7%
Local 1014	$4,146,299	7.9%	2,168	4.0%
Combined Medical	**$52,596,896**	**100.0%**	**54,553**	**100.0%**
Cigna Dental & Vision (PPO and HMO)	**$4,279,848**		**56,333**	

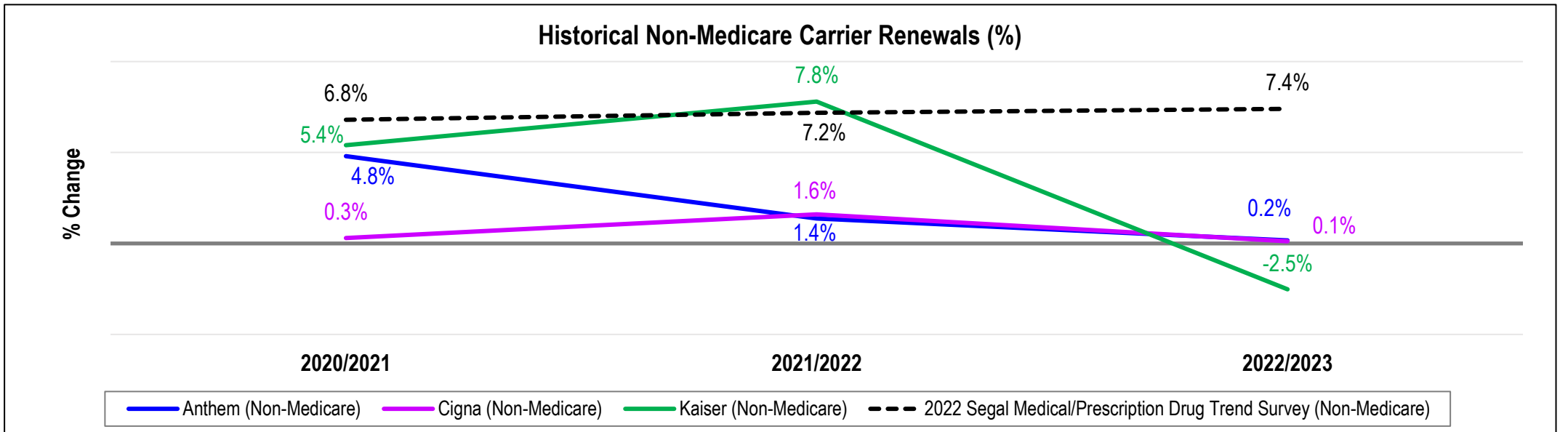


Note: Premiums **include** LACERA's Administrative Fee of $10.00 per member, per plan, per month.

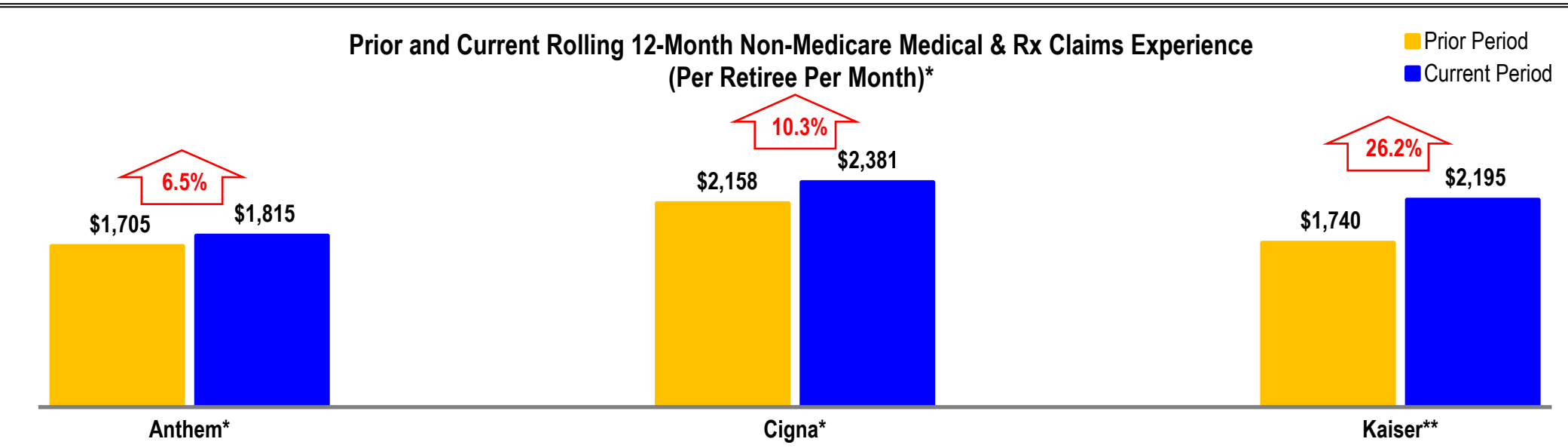
Los Angeles County Employees Retirement Association

Claims Experience by Carrier

Coverage Month Ending February 2023



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



*Based on Most Recent Claims Experience through Coverage Month.

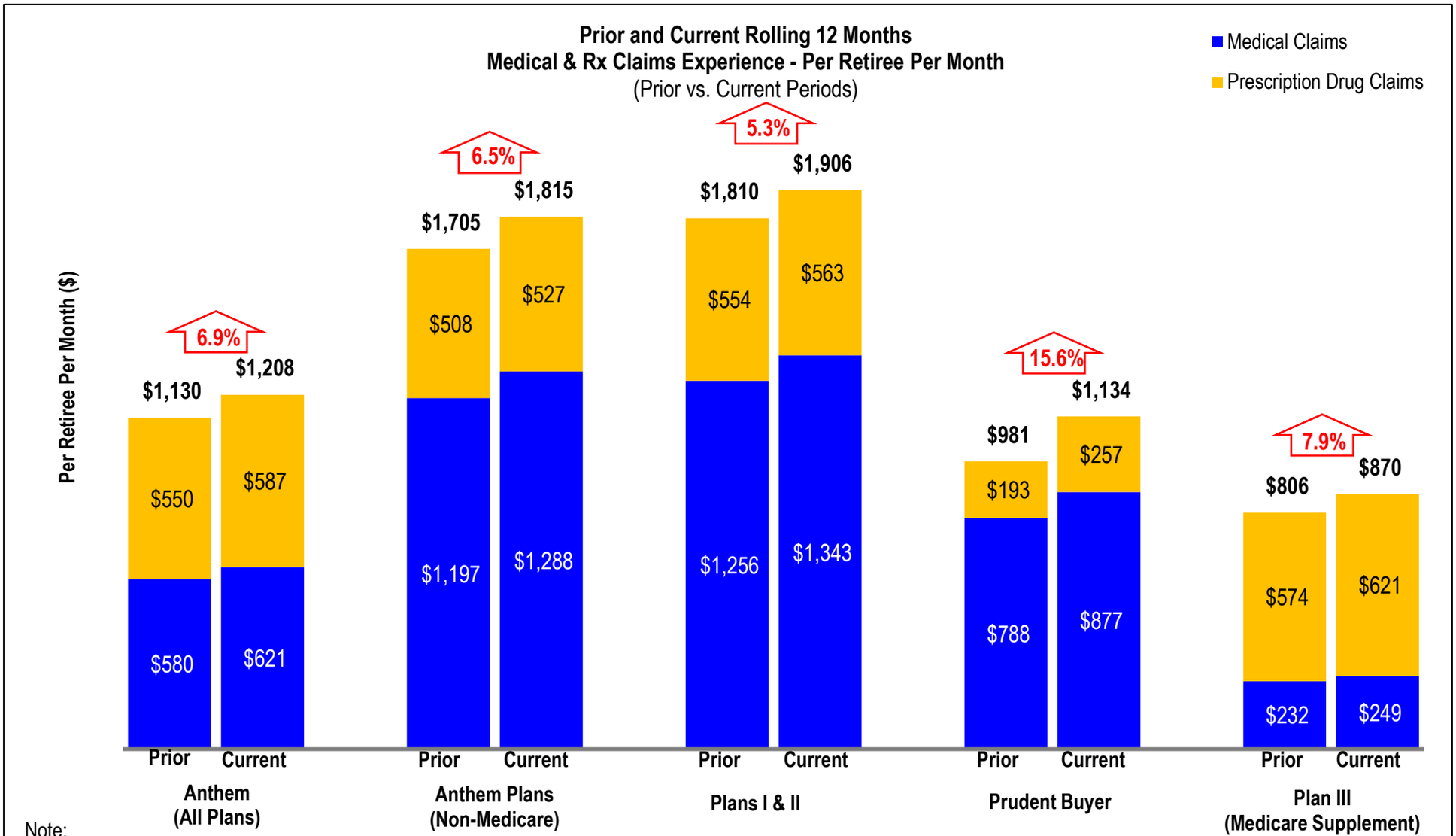
**Kaiser Claims Experience through August 2022.

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

Los Angeles County Employees Retirement Association

Anthem Claims Experience By Plan

Coverage Month Ending February 2023



Note:

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

Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month Ending February 2023

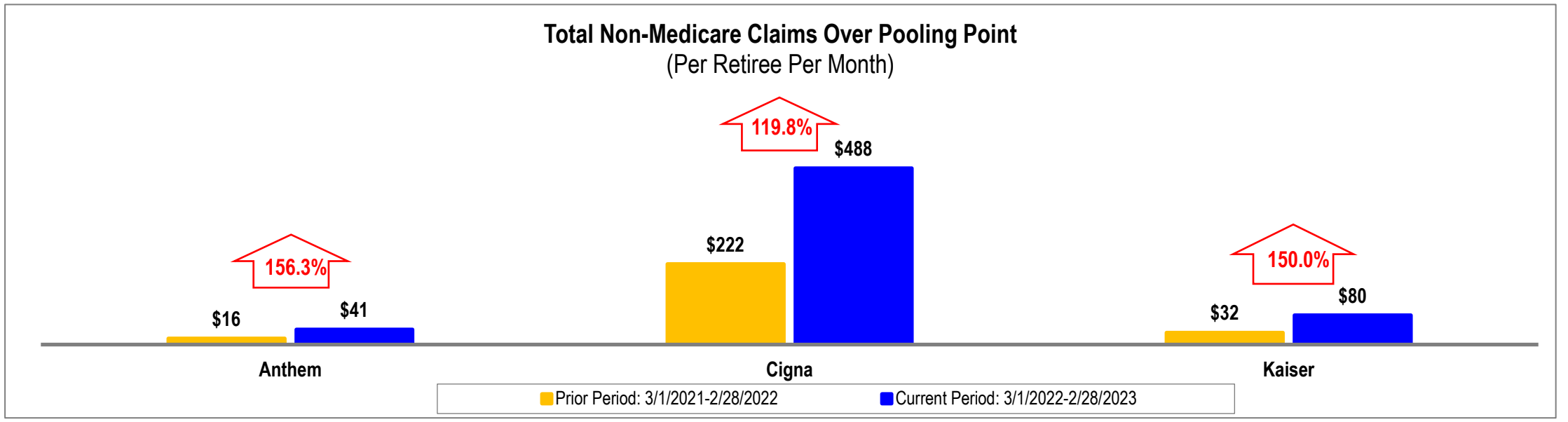
- Kaiser insures approximately 25,000 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in Southern California.

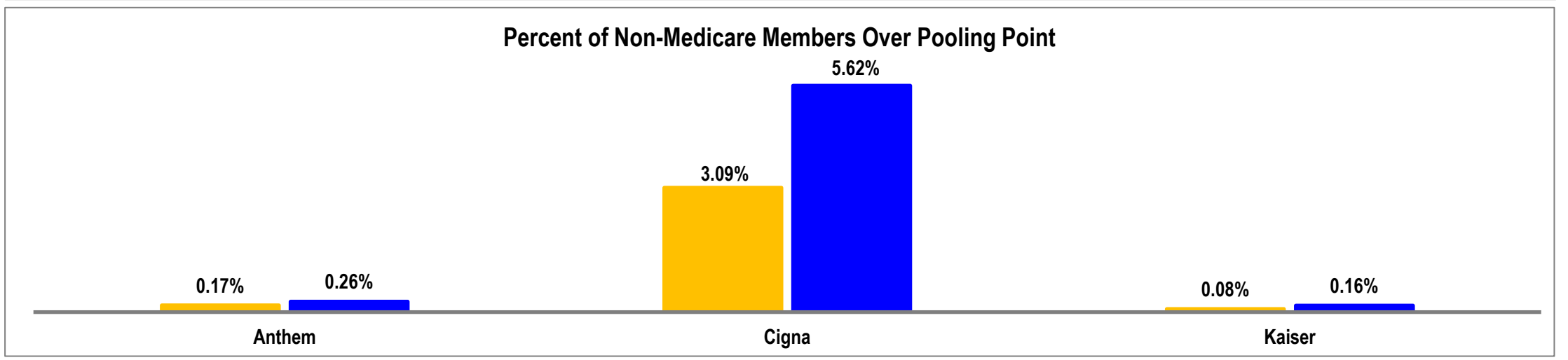
Category	Current Period 9/1/2021 - 8/31/2022	Prior Period 9/1/2020 - 8/31/2021	Change
Average Contract Size	**2.37**	**2.38**	**-0.42%**
Average Members	**8,917**	**8,796**	**1.38%**
Inpatient Claims Per Member Per Month	$297.45	$167.85	77.21%
Outpatient Claims Per Member Per Month	$367.71	$328.28	12.01%
Pharmacy Per Member Per Month	$119.85	$114.39	4.77%
Other Per Member Per Month	$140.55	$121.75	15.44%
Total Claims Per Member Per Month	**$925.56**	**$732.27**	**26.40%**
Total Paid Claims	**$99,036,150**	**$77,287,504**	**28.14%**
Large Claims over $500,000 Pooling Point			
Number of Claims over Pooling Point	6	3	
Amount over Pooling Point	$3,593,397	$1,437,611	149.96%
% of Total Paid Claims	**3.63%**	**1.86%**	
Inpatient Days / 1000	455.5	328.3	38.75%
Inpatient Admits / 1000	57.4	45.9	25.05%
Outpatient Visits / 1000	14,665.1	13,934.5	5.24%
Pharmacy Scripts Per Member Per Year	10.3	10.1	1.98%

Los Angeles County Employees Retirement Association

High Cost Claimants (Anthem, Cigna, & Kaiser)

Coverage Month Ending February 2023





Stop-Loss & Pooling Points Overview:

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

Anthem and Cigna figures are based on the most recent Claims Experience through Coverage Month. Kaiser's figures are based on Claims Experience period between September through August.

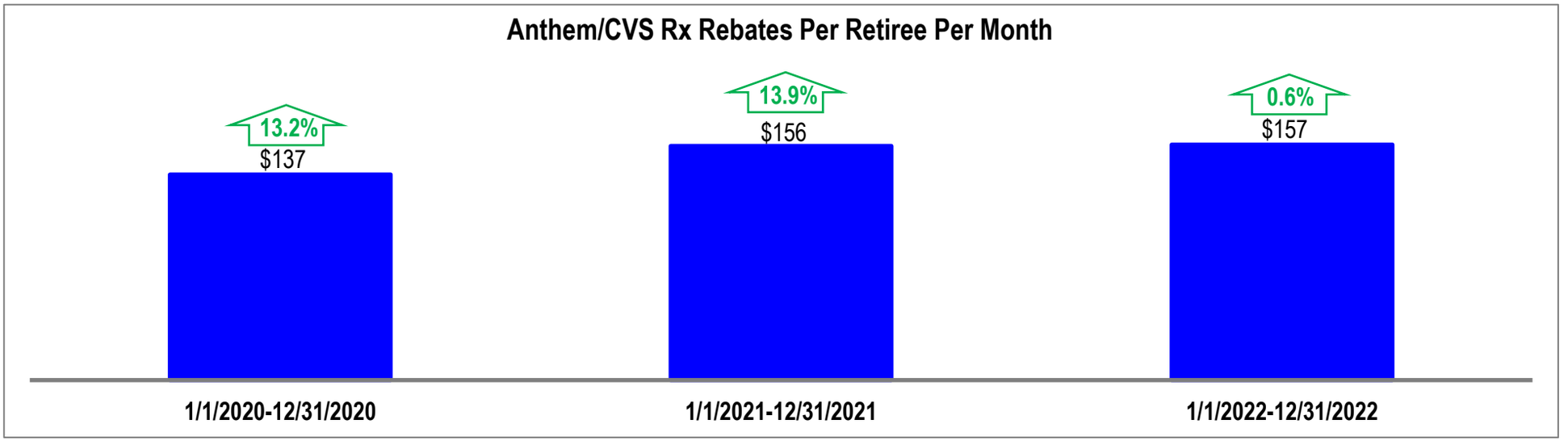
Pooling Points by Carrier:

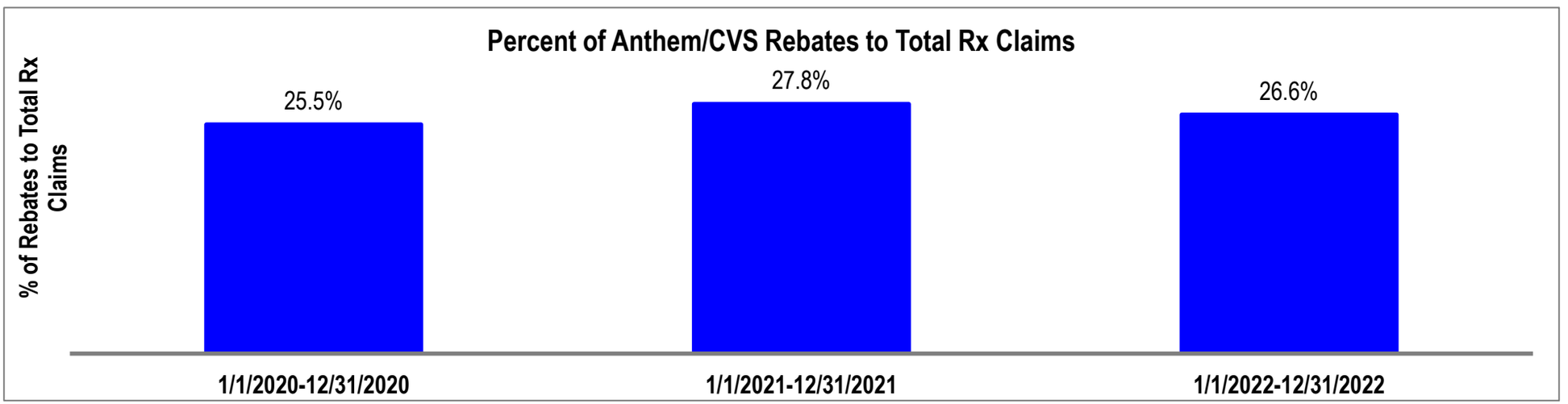
1. Anthem's pooling points are $350,000 for Plans I & II, and $300,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $525,000.

Los Angeles County Employees Retirement Association

Prescription Drug Rebates (Anthem)

Coverage Month Ending February 2023





Rebates Overview:

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

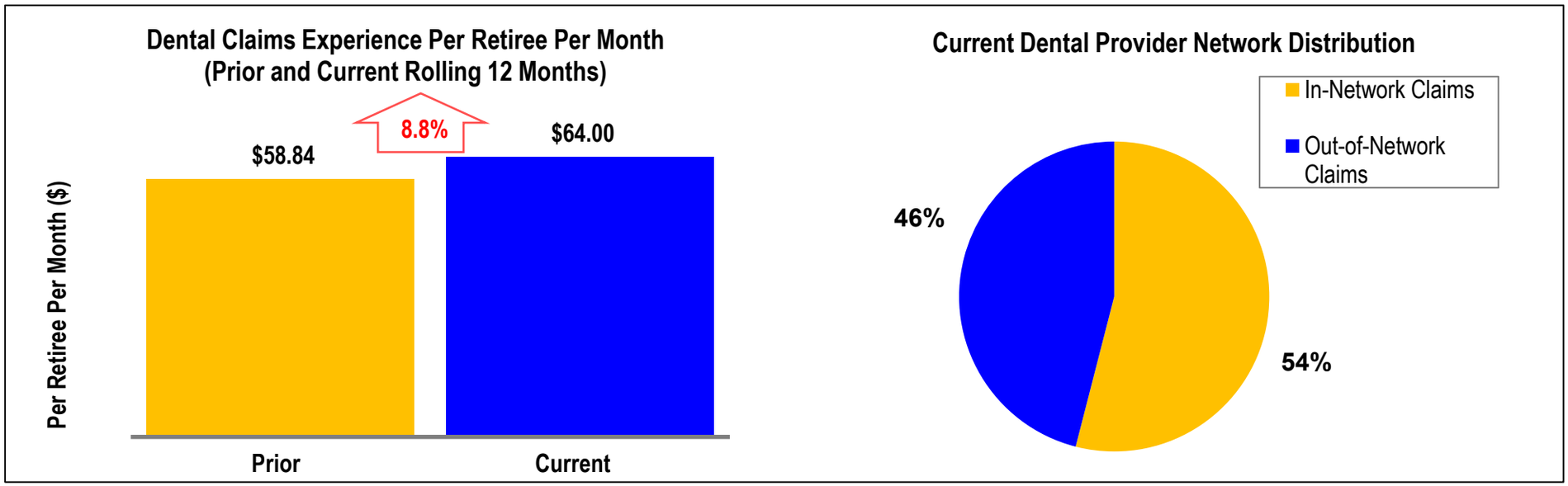
Note:

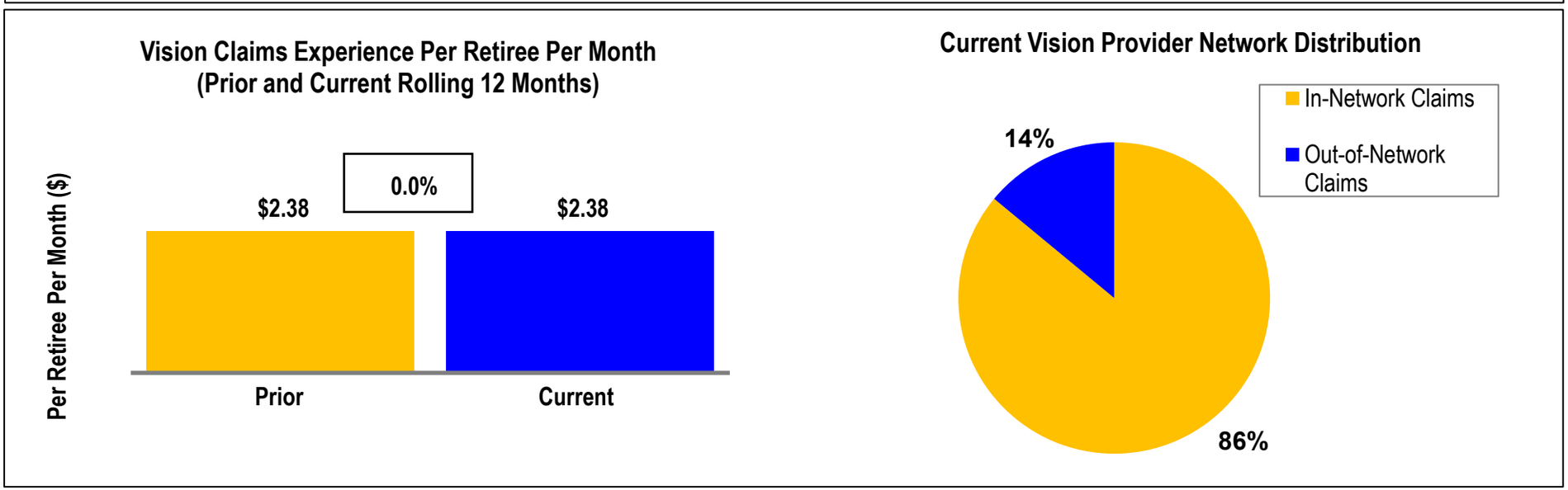
1. Prescription Claims and Rebates Data were provided by CVS.
2. Anthem Prudent Buyer prescription drugs are provided by CarelonRx and are not included in the charts above.

Los Angeles County Employees Retirement Association

Cigna Dental & Vision Claims Experience

Coverage Month Ending February 2023





Notes:

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

Segal

Compliance News | March 10, 2023

First "Gag Clause" Attestations Are Due by the End of 2023

The No Surprises Act (the Act) bans "gag clauses" that prevent disclosure of price or quality information in agreements between health plans and certain service providers. In addition, the Act requires plan sponsors to attest annually that they comply with this requirement.

The Departments of Labor, Health and Human Services and Treasury (collectively, the Departments) have released guidance concerning:

- What constitutes a gag clause
- How plan sponsors perform the attestation

Prohibition on gag clauses

The Act prohibits health plans and insurance issuers from entering into contracts with health care providers, provider networks, third-party administrators (TPAs) or other service providers that would restrict the plan from providing, accessing or sharing certain information. Specifically, contracts cannot restrict a plan from:

- Disclosing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants or beneficiaries, including providing, accessing or sharing the information or data
- Electronically accessing de-identified claims and encounter information or data for each participant, beneficiary or enrollee upon request and consistent with privacy rules under the Health Insurance Portability and Accountability Act (HIPAA), the Genetic Information Nondiscrimination Act and the Americans with Disabilities Act
- Sharing the information or data described above or directing such information to be shared with a business associate, consistent with HIPAA's privacy rules

Guidance on what constitutes a gag clause

Generally, a "gag clause" is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party.

In the new guidance, the Departments provide two examples of gag clauses prohibited by the No Surprises Act:

1. A contract between a TPA and a group health plan states that the plan will pay providers at rates designated as "point-of-service rates," but the TPA considers those rates proprietary and the contract states that the plan may not disclose the rates to participants.
2. A contract between a TPA and a plan provides that the plan's sponsor's access to provider-specific cost and quality of care information is only at the discretion of the TPA.

The guidance does **not** provide additional answers to common questions about gag clauses, such as whether a clause in a subcontractor agreement with a service provider would also be subject to the rule. Although the guidance does not give examples of specific contractual provisions that would violate the Act, it states that to the extent a term in a contract, either directly or indirectly, prevents a plan or issuer from providing, accessing or sharing the information or data, as provided for under the statute, that term in the contract violates the gag clause prohibitions and is prohibited. However, the guidance clarifies that health care providers, networks, TPAs and other service providers may place reasonable restrictions on the public disclosure of such information.

Annual gag clause attestation process

The Departments require the first gag clause attestation to be submitted by December 31, 2023, covering the period beginning December 27, 2020 (the effective date of the No Surprises Act's gag-clause prohibition), through the date of attestation. Subsequent attestations, covering the period since the last preceding attestation, are due by December 31 of each following year.

The Departments have created a website for submitting s attestations. The guidance contains instructions and a link to the Gag Clause Prohibition Compliance Attestation methodology for submitting an annual attestation of compliance with the gag clause prohibition. Attestations will be submitted at this link. Instructions and a system user manual for submitting attestations are available here.

Implications for plan sponsors

Plan sponsors should work with their legal counsel to ensure any contracts with TPAs or other network service providers do not contain gag clauses, as well as prepare to complete the attestation by December 31, 2023. Self-insured plans may enter into written agreements with service providers to complete the attestation on their behalf, but the plan remains legally responsible for compliance. Fully insured plans may provide the attestation on behalf of those plans. Plans that fail to comply may face a civil penalty of up to $100 per day, adjusted annually, for each individual affected by a violation.

The No Surprises Act has an extensive list of healthcare price transparency requirements for group health plans that we've summarized in a timeline.