IN PERSON & VIRTUAL BOARD MEETING

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

TO VIEW VIA WEB

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, SEPTEMBER 4, 2024

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 Sections 54953(f).

Any person may view the meeting in person at LACERA's offices or online at [https://LACERA.com/leadership/board-meetings.](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
David Ryu, 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 August 7, 2024

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 August 2024**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

B. **Staff Activities Report for August 2024**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

C. **LACERA-Administered Retiree Healthcare (RHC) Benefits Program and Medicare Basics Video Presentation**
Cassandra Smith, Director, Retiree Healthcare
Cynthia Martinez, Chief, Communications
(Video Presentation) (Memo dated August 26, 2024)

V. REPORTS (Continued)

D. **Annual Anthem Blue Cross and Cigna Audits**
Cassandra Smith, Director, Retiree Healthcare
Amber Turner, Segal Consulting
Felicia Zhang, Segal Consulting
(Presentation) (Memo dated August 22, 2024

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

F. **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.)

VII. 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

8:30 A.M. – 8:57 A.M., WEDNESDAY, AUGUST 7, 2024

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

COMMITTEE TRUSTEES

PRESENT: Les Robbins, Chair

Vivian H. Gray, Vice Chair

Ronald Okum, Trustee

ABSENT: Shawn R. Kehoe, Trustee

David Ryu, Alternate Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

Wayne Moore, Trustee

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Santos H. Kreimann, Chief Executive Officer

STAFF, ADVISORS AND PARTICIPANTS (Continued)

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

I. CALL TO ORDER

This meeting was called to order by Chair Robbins at 8:30 a.m.

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

There were no requests received.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of July 3, 2024

Trustee Okum made a motion, Trustee Gray seconded, to approve the minutes of the regular meeting of July 3, 2024. The motion passed by the following roll call vote:

Yes: Gray, Okum, Robbins

No: None

Absent: Kehoe

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. NON-CONSENT ITEMS

A. **H.R. 5241 – Governmental Plans**
Recommendation as submitted by Barry W. Lew, Legislative Affairs Officer: That the Committee recommend the Board of Retirement adopt an "Oppose" position on H.R. 5241, which would enable full-time first responders employed by nonprofit public safety agencies to participate in governmental pension plans.
(Memo dated July 22, 2024)

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

Yes: Okum, Robbins

No: Gray

Absent: Kehoe

VI. REPORTS

A. **Engagement Report for July 2024**
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 July 2024**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

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

VI. REPORTS (Continued)

C. **LACERA Claims Experience**
Stephen Murphy, Segal Consulting
(Presentation)

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

D. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Information Only)

Segal Consulting gave an update on federal legislation. This item was received and filed.

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.)

Santos Kreimann, CEO, requested additional information be added to page 6 (Anthem Lifetime Max Accumulation Status By Plan) of the LACERA Claims Experience report presented by Segal.

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 8:57 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
AUGUST 2024
FOR INFORMATION ONLY

Auto-Enrollment Significantly Drives Equity in Retirement Savings

New research by Vanguard highlights the impact of automatic enrollment in workplace retirement plans on savings equity among different racial and ethnic groups. The study analyzed 14 large defined contribution plans and found that automatic enrollment significantly boosts participation rates, especially for lower-paid Black and Hispanic employees, whose participation was 2.5 times higher than in voluntary enrollment plans. Participation rates across racial groups were more consistent in auto-enrollment plans, with minimal differences between Black and white employees. In contrast, voluntary plans showed significant racial disparities.

The research also showed that employees across all racial and ethnic groups earning $75,000 or less in auto-enrollment plans had higher savings rates, with Hispanic employees saving 8.3% compared to 4.9% in voluntary plans. However, participants in auto-enrollment plans were more likely to take hardship withdrawals, which Vanguard attributes to the higher participation of lower-compensated workers in automatic enrollment plans.

The study suggests that modern plan features like automatic enrollment and professionally managed allocations improve equity in retirement savings. Vanguard's findings encourage plan sponsors to adopt these features, as they lead to better and more equitable outcomes for all employees. (Source)

A National Retirement Savings Plan

Experts agree that expanding access to 401(k) plans is essential for improving retirement savings in the U.S., where only about half of private-sector workers are covered by employer-sponsored plans. This lack of coverage leaves many people, especially lower-income workers and people of color, with little or no retirement savings, relying solely on Social Security, whereas the 401(k) has worked well for higher-income workers who are able to contribute and enjoy tax-deferral benefits.

To address this, three proposals for universal retirement savings plans have been put forward.

One proposal is a national "auto-IRA" plan, which would automatically enroll workers without access to workplace savings plans. Seventeen states have already enacted auto-IRA legislation, and early results are promising, though a federal version has not yet advanced. The Automatic IRA Act of 2024, for instance, would require employers with more than 10 employees to enroll workers automatically, with a default contribution rate and a modest tax credit for employers. Despite concerns that such plans could reduce

private 401(k) offerings, evidence suggests they may actually encourage more employers to offer their own plans.

A second proposal is a national 401(k) plan with government matching contributions, similar to the federal Thrift Savings Plan. The national 401(k) would feature automatic enrollment and eligibility with an initial contribution rate of 3%. It would also make low- and moderate-income workers eligible for up to 5% in matching contributions through a refundable federal tax credit.

A third proposal is the promotion of Multiple-Employer Plans (MEPs) and Pooled-Employer Plans (PEPs), designed to help small businesses offer retirement plans by lowering administrative burdens. However, their growth has been slow due to marketing challenges and high costs.

Experts argue that implementing these proposals could significantly increase retirement savings, especially for low- and moderate-income workers, helping to reduce reliance on Social Security and improve overall retirement security in the U.S. (Source)

State 401(k) Mandates May Cause "Crowd-In" Effect: Boosting Private Plans
A recent paper by the National Bureau of Economic Research (NBER) suggests that state-mandated retirement plans, specifically state-facilitated auto-IRAs, may be driving more small employers to offer private 401(k) plans. By analyzing tax data from four states—Oregon, Illinois, California, and Connecticut—researchers found that at least 30,000 small businesses were prompted to establish employer-sponsored retirement plans (ESRPs) due to these mandates. This effect, termed the "crowd-in" effect, indicates that rather than crowding out private plans, state mandates are encouraging their adoption.

The study revealed that these 30,000 firms represent about one-sixth of all small companies affected by the mandates and account for a significant portion (27-45%) of the increase in employer retirement plan coverage. The researchers also noted that the cost and perceived administrative burden of state programs might be driving some employers to opt for private plans instead. This research adds to the ongoing debate on the impact of state auto-IRAs on the private retirement plan market, with evidence suggesting that these mandates could enhance overall retirement savings plan coverage rather than diminish it. (Source)

San Francisco Ballot Measure Reduces Eligible Retirement Age
In November, San Francisco voters will decide whether firefighters can retire with full pensions at age 55, instead of the current age of 58 for most. The measure, known unofficially as the Fire Department Service Retirement Pension, would retroactively apply to firefighters hired after 2012, aligning them with those hired before 2012 who can

already retire at 55. The proposal is supported by the firefighters' union, the entire Board of Supervisors, and mayoral candidates Daniel Lurie and Mark Farrell.

The push for this change is fueled by recent studies revealing significantly higher cancer risks among firefighters compared to other city workers and the general population. Notably, research from the National Institute for Occupational Safety and Health and the International Agency for Research on Cancer has shown elevated death rates from various cancers, including mesothelioma, lung cancer, and leukemia, among firefighters in San Francisco, Chicago, and Philadelphia. Additionally, studies from the National Institute of Standards and Technology have identified carcinogenic chemicals, known as PFAS or "forever chemicals," in firefighters' protective gear, with concentrations increasing over time.

Locally, data from the Firefighters Cancer Prevention Foundation show that 207 active and retired San Francisco firefighters have been diagnosed with cancer in the past six years, with 300 deaths since 2006. These cases have resulted in $12.3 million in increased workers' compensation costs. The proposed pension amendment seeks to account for these health risks by allowing firefighters to retire earlier, with adjusted pension benefits that consider their increased cancer risk. (Source)

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
AUGUST 2024
FOR INFORMATION ONLY

LACERA Retiree Healthcare Wellness Program Called Staying Healthy Together – Fall Workshop

The next retiree wellness workshop event will be held next month. This event will feature a variety of activities designed to encourage healthy habits, reduce stress, reconnecting with fellow retirees, and attending informative wellness presentations.

Event Details:

Date: Tuesday, September 24, 2024
Time: 8:30 a.m. – 1:00 p.m.
Location: Carson Event Center, 801 E. Carson St., Carson, CA

Activities Include:

- Yoga demonstration
- Health screenings
- Massage chairs
- Interactive wellness booths
- Raffle prizes
- Photo booth
- Healthy snacks

By popular demand, Dr. Wendy Hileman (sponsored by UnitedHealthcare) will be back to give an educational presentation on Alzheimer's and Dementia. Additionally, Caroline Guitierrez from Kaiser will be talking about Taking Care of YourSELF.

We invite you to join us and our retirees in this special event.

We thank our carriers (Anthem Blue Cross, Accordant, Cigna, CVS Caremark, Kaiser Permanente, SCAN Health Plan, UnitedHealthcare), the Segal team, and staff for their support in making this a successful event for our retired members.

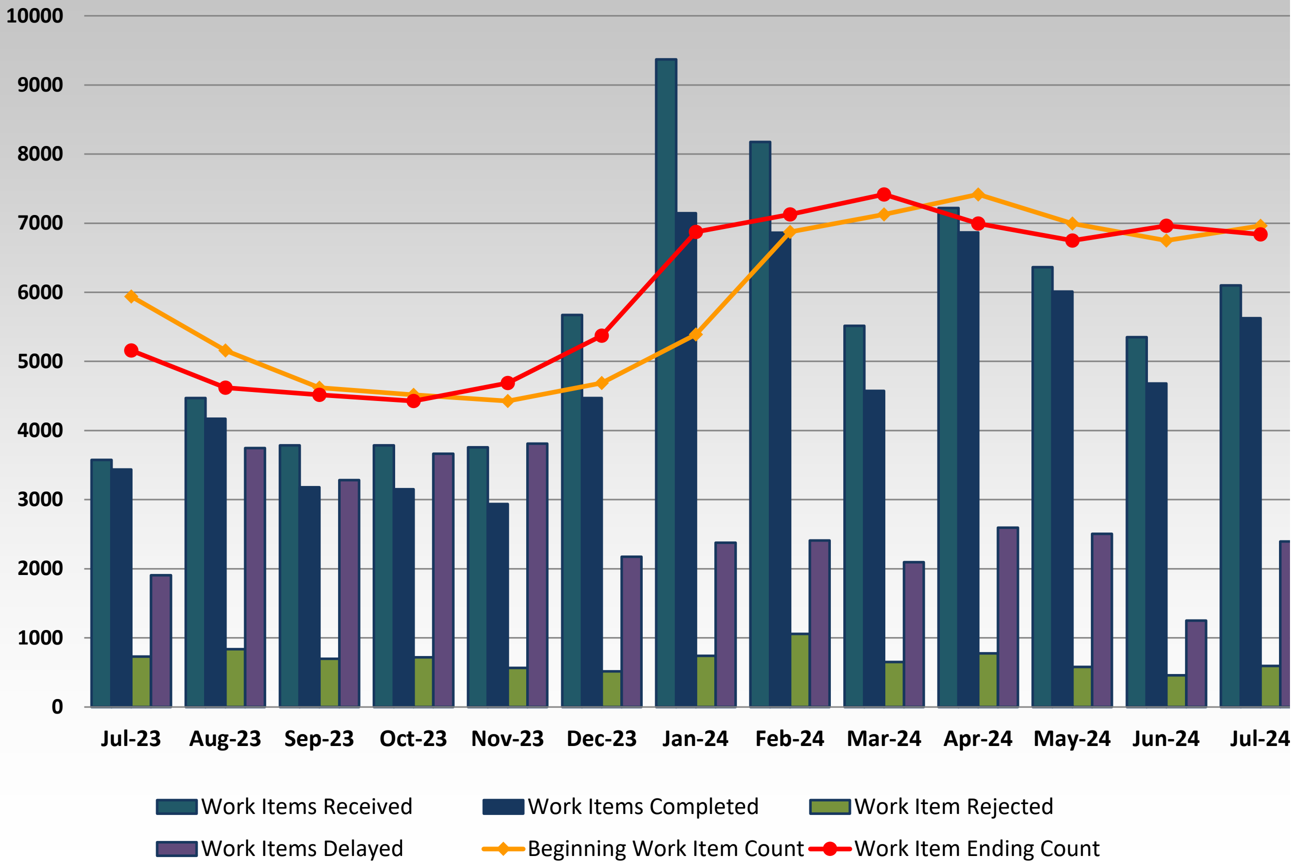
2024 CMS National Training Program Workshop

Staff attended a 2024 CMS National Training Program Workshop conducted in Woodbridge New Jersey on August 13-15, 2024. This training was the first one in 5 years. In addition to the topic presenters, subject matter experts were in attendance and on hand to assist with clarifying questions asked from the audience.

Sessions staff attended included:

- Medicare Basics
- Medicare Basics: Medicare Advantage
- Medicare Part D
- Common Mistakes People with Medicare Make
- Coordination of Benefits: Who Pays First
- Medicare.gov

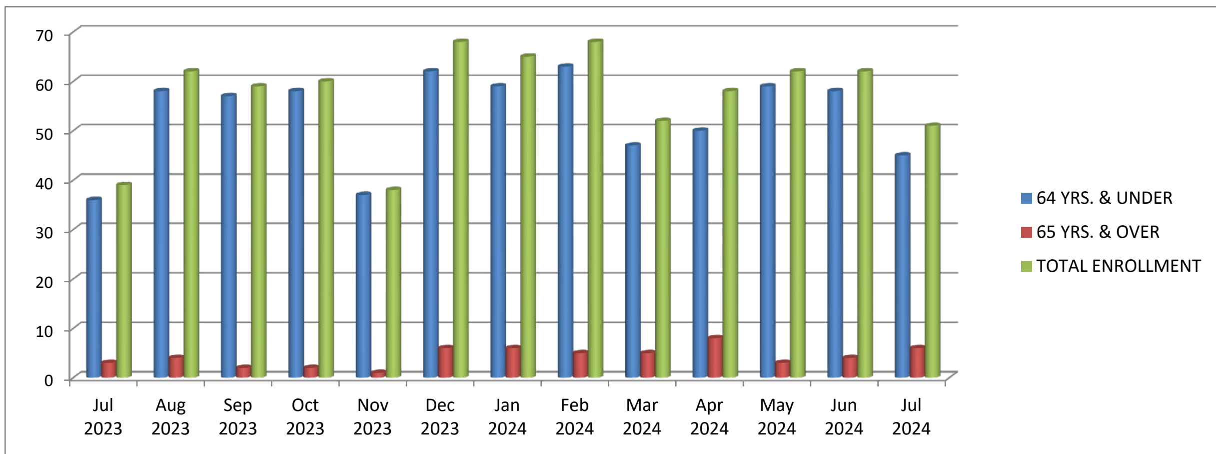
There were many educational topics on the agenda that will be shared with staff. In addition, we are looking to include much of this training information in the Retiree Healthcare Core Training Program.



	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Jul-23	5939	3576	3438	730	1908	5157
Aug-23	5157	4471	4172	836	3746	4620
Sep-23	4620	3787	3181	698	3282	4515
Oct-23	4515	3784	3151	721	3665	4427
Nov-23	4427	3757	2936	565	3812	4689
Dec-23	4689	5672	4471	516	2175	5374
Jan-24	5390	9371	7145	742	2377	6874
Feb-24	6874	8174	6862	1059	2411	7127
Mar-24	7127	5516	4573	653	2097	7417
Apr-24	7417	7221	6865	775	2593	6994
May-24	6994	6363	6012	579	2504	6749
Jun-24	6749	5351	4681	458	1252	6961
Jul-24	6961	6098	5624	596	2396	6839

Retirees Monthly Age Breakdown
JULY 2023 - JULY 2024

Disability Retirement			
MONTH	**64 YRS. & UNDER**	**65 YRS. & OVER**	**TOTAL ENROLLMENT**
Jul 2023	36	3	39
Aug 2023	58	4	62
Sep 2023	57	2	59
Oct 2023	58	2	60
Nov 2023	37	1	38
Dec 2023	62	6	68
Jan 2024	59	6	65
Feb 2024	63	5	68
Mar 2024	47	5	52
Apr 2024	50	8	58
May 2024	59	3	62
Jun 2024	58	4	62
Jul 2024	45	6	51

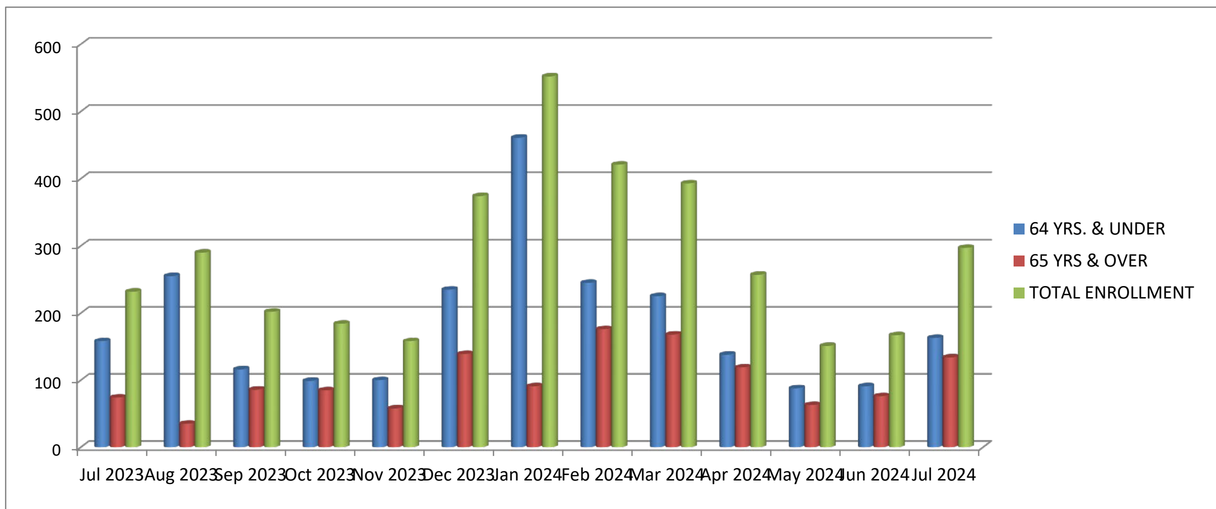


PLEASE NOTE:

- **Next Report will include the following dates: August 1, 2023 - August 31, 2024**

Retirees Monthly Age Breakdown
JULY 2023 - JULY 2024

Service Retirement			
MONTH	**64 YRS. & UNDER**	**65 YRS & OVER**	**TOTAL ENROLLMENT**
Jul 2023	158	74	232
Aug 2023	255	35	290
Sep 2023	116	86	202
Oct 2023	99	85	184
Nov 2023	100	58	158
Dec 2023	235	139	374
Jan 2024	461	91	552
Feb 2024	245	176	421
Mar 2024	225	168	393
Apr 2024	138	119	257
May 2024	88	63	151
Jun 2024	91	76	167
Jul 2024	163	134	297



PLEASE NOTE:

- **Next Report will include the following dates: August 1, 2023, through August 31, 2024.**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 8/31/2024

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	7648	$1,228,478.80	0	$0.00
241	133	$20,327.00	0	$0.00
242	953	$158,848.80	0	$0.00
243	4565	$1,495,308.36	0	$0.00
244	13	$2,022.40	0	$0.00
245	58	$10,178.50	0	$0.00
246	17	$2,894.90	0	$0.00
247	168	$29,076.90	0	$0.00
248	14	$4,227.40	0	$0.00
249	71	$25,489.00	0	$0.00
250	17	$5,487.30	0	$0.00
Plan Total:	**13,657**	**$2,982,339.36**	**0**	**$0.00**
CIGNA - PREFERRED with RX				
321	36	$5,309.80	0	$0.00
322	7	$1,027.00	0	$0.00
324	19	$6,031.50	0	$0.00
327	1	$104.90	0	$0.00
Plan Total:	**63**	**$12,473.20**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	21	$2,381.90	0	$0.00
397	3	$668.70	0	$0.00
398	9	$3,144.60	0	$0.00
403	12115	$1,911,516.38	0	$0.00
413	1543	$251,112.54	0	$0.00
418	6363	$2,071,917.85	0	$0.00
419	211	$32,026.20	0	$0.00
426	254	$41,669.30	0	$0.00
445	2	$349.40	0	$0.00
446	1	$145.10	0	$0.00
451	36	$5,699.00	0	$0.00
455	8	$1,572.30	0	$0.00
457	16	$5,411.20	0	$0.00
459	1	$349.40	0	$0.00
462	84	$13,785.40	0	$0.00
465	3	$494.00	0	$0.00
466	29	$10,148.40	0	$0.00
472	26	$4,236.80	0	$0.00
476	3	$433.70	0	$0.00
478	15	$4,985.10	0	$0.00
479	1	$144.60	0	$0.00
482	83	$14,410.40	0	$0.00
486	3	$803.70	0	$0.00
488	35	$11,714.20	0	$0.00
491	1	$148.50	0	$0.00
492	1	$174.70	0	$0.00
Plan Total:	**20,867**	**$4,389,443.37**	**0**	**$0.00**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 8/31/2024

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	282	$45,873.60	0	$0.00
613	99	$32,913.30	0	$0.00
620	7	$1,151.10	0	$0.00
622	13	$2,413.60	0	$0.00
623	2	$559.20	0	$0.00
Plan Total:	**403**	**$82,910.80**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	2133	$347,510.60	0	$0.00
702	399	$66,287.80	0	$0.00
703	1371	$456,606.40	0	$0.00
704	98	$16,172.00	0	$0.00
705	52	$17,799.90	0	$0.00
Plan Total:	**4,053**	**$904,376.70**	**0**	**$0.00**
Grand Total:	**39,043**	**$8,371,543.43**	**0**	**$0.00**

Medicare Part B Reimbursement and Penalty Report
PAY PERIOD 8/31/2024

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	7648	$1,228,478.80	0	$0.00
241	133	$20,327.00	0	$0.00
242	953	$158,848.80	0	$0.00
243	4565	$1,495,308.36	0	$0.00
244	13	$2,022.40	0	$0.00
245	58	$10,178.50	0	$0.00
246	17	$2,894.90	0	$0.00
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248	14	$4,227.40	0	$0.00
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Plan Total:	**13,657**	**$2,982,339.36**	**0**	**$0.00**
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321	36	$5,309.80	0	$0.00
322	7	$1,027.00	0	$0.00
324	19	$6,031.50	0	$0.00
327	1	$104.90	0	$0.00
Plan Total:	**63**	**$12,473.20**	**0**	**$0.00**
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Plan Total:	**20,867**	**$4,389,443.37**	**0**	**$0.00**

Medicare Part B Reimbursement and Penalty Report
PAY PERIOD 8/31/2024

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	282	$45,873.60	0	$0.00
613	99	$32,913.30	0	$0.00
620	7	$1,151.10	0	$0.00
622	13	$2,413.60	0	$0.00
623	2	$559.20	0	$0.00
Plan Total:	**403**	**82,911**	**0**	**0**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	2133	$347,510.60	0	$0.00
702	399	$66,287.80	0	$0.00
703	1371	$456,606.40	0	$0.00
704	98	$16,172.00	0	$0.00
705	52	$17,799.90	0	$0.00
Plan Total:	**4,053**	**$904,376.70**	**0**	**$0.00**
LOCAL 1014				
804	198	$44,548.00	0	$0.00
805	236	$46,330.50	0	$0.00
806	724	$278,472.20	0	$0.00
807	55	$10,761.50	0	$0.00
808	19	$8,036.10	0	$0.00
812	252	$48,531.60	0	$0.00
813	1	$174.70	0	$0.00
Plan Total:	**1,485**	**$436,854.60**	**0**	**$0.00**
Grand Total:	**40,528**	**$8,808,398.03**	**0**	**$0.00**

Medical and Dental Vision Insurance Premiums

September 2024

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	442	$494,795.56	$73,940.00	$423,876.00	$497,816.00	($7,488.12)	$490,327.88
202	223	$494,572.50	$41,544.13	$431,699.73	$473,243.86	($4,396.20)	$468,847.66
203	80	$200,941.56	$30,612.51	$172,809.81	$203,422.32	$0.00	$203,422.32
204	27	$38,764.17	$9,963.81	$27,364.65	$37,328.46	$0.00	$37,328.46
SUBTOTAL	**772**	**$1,229,073.79**	**$156,060.45**	**$1,055,750.19**	**$1,211,810.64**	**($11,884.32)**	**$1,199,926.32**
Anthem Blue Cross I							
211	530	$790,259.20	$52,860.14	$738,671.18	$791,531.32	$17,110.44	$808,641.76
212	227	$609,888.83	$28,976.26	$543,001.27	$571,977.53	$0.00	$571,977.53
213	73	$232,478.40	$25,823.94	$238,807.24	$264,631.18	$0.00	$264,631.18
214	20	$39,089.00	$3,518.00	$35,571.00	$39,089.00	$0.00	$39,089.00
215	1	$498.97	$139.71	$359.26	$498.97	$0.00	$498.97
SUBTOTAL	**851**	**$1,672,214.40**	**$111,318.05**	**$1,556,409.95**	**$1,667,728.00**	**$17,110.44**	**$1,684,838.44**
Anthem Blue Cross II							
221	2,390	$3,543,610.88	$183,723.52	$3,359,374.86	$3,543,098.38	$1,477.12	$3,544,575.50
222	2,056	$5,526,285.25	$134,189.09	$5,313,564.58	$5,447,753.67	$10,653.08	$5,458,406.75
223	941	$2,968,812.00	$103,782.05	$2,791,817.75	$2,895,599.80	$3,141.60	$2,898,741.40
224	239	$469,068.00	$44,092.37	$424,975.63	$469,068.00	$3,908.90	$472,976.90
SUBTOTAL	**5,626**	**$12,507,776.13**	**$465,787.03**	**$11,889,732.82**	**$12,355,519.85**	**$19,180.70**	**$12,374,700.55**

Medical and Dental Vision Insurance Premiums

September 2024

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	7,689	$4,628,744.89	$598,886.74	$4,071,561.82	$4,670,448.56	($14,861.25)	$4,655,587.31
241	132	$257,711.48	$23,452.77	$229,164.45	$252,617.22	$0.00	$252,617.22
242	948	$1,850,137.64	$108,008.20	$1,724,686.84	$1,832,695.04	($5,368.80)	$1,827,326.24
243	4,572	$5,498,601.81	$563,816.01	$4,844,346.08	$5,408,162.09	($11,074.11)	$5,397,087.98
244	13	$14,001.00	$1,787.82	$12,213.18	$14,001.00	$0.00	$14,001.00
245	59	$63,543.00	$7,151.28	$60,699.72	$67,851.00	$0.00	$67,851.00
246	17	$40,777.90	$3,358.18	$39,818.42	$43,176.60	$0.00	$43,176.60
247	170	$417,373.80	$21,540.33	$372,180.05	$393,720.38	$0.00	$393,720.38
248	14	$23,415.84	$2,140.87	$21,274.97	$23,415.84	$0.00	$23,415.84
249	71	$120,424.32	$6,188.50	$120,693.80	$126,882.30	$0.00	$126,882.30
250	17	$31,865.99	$2,436.81	$29,429.18	$31,865.99	$0.00	$31,865.99
SUBTOTAL	**13,702**	**$12,946,597.67**	**$1,338,767.51**	**$11,526,068.51**	**$12,864,836.02**	**($31,304.16)**	**$12,833,531.86**
CIGNA Network Model Plan							
301	225	$428,118.58	$105,212.88	$319,117.04	$424,329.92	($3,788.66)	$420,541.26
302	55	$188,133.55	$45,009.41	$143,124.14	$188,133.55	$0.00	$188,133.55
303	7	$32,312.64	$4,469.57	$11,686.75	$16,156.32	$0.00	$16,156.32
304	14	$35,191.38	$13,704.39	$24,000.66	$37,705.05	$0.00	$37,705.05
SUBTOTAL	**301**	**$683,756.15**	**$168,396.25**	**$497,928.59**	**$666,324.84**	**($3,788.66)**	**$662,536.18**
CIGNA Preferred w/ Rx - Phoenix, AZ							
321	36	$12,486.96	$1,595.57	$10,891.39	$12,486.96	$0.00	$12,486.96
322	7	$13,111.98	$749.25	$12,362.73	$13,111.98	$0.00	$13,111.98
324	19	$13,028.68	$1,398.88	$11,629.80	$13,028.68	$0.00	$13,028.68
327	1	$2,492.31	$498.46	$1,993.85	$2,492.31	$0.00	$2,492.31
SUBTOTAL	**63**	**$41,119.93**	**$4,242.16**	**$36,877.77**	**$41,119.93**	**$0.00**	**$41,119.93**

Medical and Dental Vision Insurance Premiums

September 2024

Kaiser/Senior Advantage

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
401	1,573	$2,172,649.20	$157,020.09	$1,982,931.20	$2,139,951.29	$4,138.79	$2,144,090.08
403	12,138	$3,443,303.20	$303,121.98	$3,120,565.42	$3,423,687.40	($5,140.76)	$3,418,546.64
404	460	$596,339.40	$9,385.90	$588,249.89	$597,635.79	($3,889.17)	$593,746.62
405	1,423	$1,930,989.38	$17,874.62	$1,922,422.29	$1,940,296.91	$2,708.26	$1,943,005.17
411	1,936	$5,270,050.80	$225,539.41	$5,000,207.83	$5,225,747.24	$13,471.50	$5,239,218.74
413	1,516	$2,527,730.25	$112,975.59	$2,326,876.39	$2,439,851.98	$11,026.47	$2,450,878.45
414	47	$129,337.46	$844.65	$115,295.11	$116,139.76	$0.00	$116,139.76
418	6,326	$3,546,816.00	$251,381.38	$3,276,974.46	$3,528,355.84	($2,784.00)	$3,525,571.84
419	213	$337,719.85	$3,832.70	$332,316.36	$336,149.06	$0.00	$336,149.06
420	100	$258,478.00	$1,240.69	$257,237.31	$258,478.00	$0.00	$258,478.00
421	7	$9,458.05	$1,026.87	$8,431.18	$9,458.05	$0.00	$9,458.05
422	269	$730,962.88	$2,265.71	$717,908.05	$720,173.76	$0.00	$720,173.76
426	256	$416,903.68	$3,713.03	$414,819.18	$418,532.21	$0.00	$418,532.21
428	42	$110,985.84	$528.50	$110,457.34	$110,985.84	($2,642.52)	$108,343.32
430	145	$394,237.96	$3,618.34	$385,219.10	$388,837.44	($5,400.52)	$383,436.92
SUBTOTAL	**26,451**	**$21,875,961.95**	**$1,094,369.46**	**$20,559,911.11**	**$21,654,280.57**	**$11,488.05**	**$21,665,768.62**

Medical and Dental Vision Insurance Premiums
September 2024

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Colorado							
450	3	$3,943.05	$525.74	$3,417.31	$3,943.05	$0.00	$3,943.05
451	36	$11,022.30	$1,412.04	$9,312.36	$10,724.40	$0.00	$10,724.40
453	8	$23,265.76	$1,959.60	$21,306.16	$23,265.76	$0.00	$23,265.76
454	1	$3,927.17	$1,162.56	$2,764.61	$3,927.17	$0.00	$3,927.17
455	8	$12,834.00	$1,668.41	$12,769.84	$14,438.25	$0.00	$14,438.25
457	17	$9,992.60	$1,058.04	$8,934.56	$9,992.60	$0.00	$9,992.60
459	1	$1,894.15	$75.77	$1,818.38	$1,894.15	$0.00	$1,894.15
SUBTOTAL	**74**	**$66,879.03**	**$7,862.16**	**$60,323.22**	**$68,185.38**	**$0.00**	**$68,185.38**
Kaiser - Georgia							
441	4	$6,242.08	$333.60	$5,908.48	$6,242.08	$0.00	$6,242.08
442	8	$12,484.16	$667.20	$11,816.96	$12,484.16	$0.00	$12,484.16
445	2	$3,924.74	$0.00	$3,924.74	$3,924.74	$0.00	$3,924.74
446	1	$1,962.37	$0.00	$1,962.37	$1,962.37	$0.00	$1,962.37
461	13	$20,286.76	$3,240.79	$17,045.97	$20,286.76	$0.00	$20,286.76
462	85	$34,837.25	$5,057.53	$30,189.57	$35,247.10	($409.85)	$34,837.25
463	3	$9,339.12	$2,680.94	$6,658.18	$9,339.12	$0.00	$9,339.12
465	3	$5,887.11	$313.98	$5,573.13	$5,887.11	$0.00	$5,887.11
466	29	$23,539.30	$1,704.57	$23,458.13	$25,162.70	$0.00	$25,162.70
SUBTOTAL	**148**	**$118,502.89**	**$13,998.61**	**$106,537.53**	**$120,536.14**	**($409.85)**	**$120,126.29**

Medical and Dental Vision Insurance Premiums

September 2024

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Hawaii							
471	5	$4,773.20	$267.30	$4,505.90	$4,773.20	$0.00	$4,773.20
472	26	$11,620.44	$1,591.11	$10,029.33	$11,620.44	$0.00	$11,620.44
473	1	$2,147.75	$670.63	$1,477.12	$2,147.75	$0.00	$2,147.75
474	4	$7,605.12	$0.00	$7,605.12	$7,605.12	$0.00	$7,605.12
475	3	$8,543.76	$0.00	$8,543.76	$8,543.76	$0.00	$8,543.76
476	3	$4,180.74	$1,226.36	$2,954.38	$4,180.74	$0.00	$4,180.74
478	15	$13,288.20	$1,488.28	$11,799.92	$13,288.20	$0.00	$13,288.20
479	1	$2,586.69	$0.00	$2,586.69	$2,586.69	$0.00	$2,586.69
SUBTOTAL	**58**	**$54,745.90**	**$5,243.68**	**$49,502.22**	**$54,745.90**	**$0.00**	**$54,745.90**
Kaiser - Oregon							
481	2	$2,613.30	$653.32	$1,959.98	$2,613.30	$0.00	$2,613.30
482	83	$45,521.35	$7,319.23	$41,839.39	$49,158.62	($497.98)	$48,660.64
483	3	$4,907.10	$830.25	$4,076.85	$4,907.10	$0.00	$4,907.10
484	6	$18,237.10	$0.00	$10,421.20	$10,421.20	$0.00	$10,421.20
486	3	$5,541.30	$0.00	$11,082.60	$11,082.60	$0.00	$11,082.60
488	35	$38,111.50	$5,858.27	$32,253.23	$38,111.50	$0.00	$38,111.50
491	1	$1,848.38	$0.00	$1,848.38	$1,848.38	$0.00	$1,848.38
492	1	$2,176.15	$0.00	$2,176.15	$2,176.15	$0.00	$2,176.15
SUBTOTAL	**134**	**$118,956.18**	**$14,661.07**	**$105,657.78**	**$120,318.85**	**($497.98)**	**$119,820.87**
SCAN Health Plan							
611	281	$75,828.00	$14,948.87	$61,146.13	$76,095.00	$0.00	$76,095.00
613	99	$52,074.00	$11,203.80	$41,922.20	$53,126.00	$0.00	$53,126.00
SUBTOTAL	**380**	**$127,902.00**	**$26,152.67**	**$103,068.33**	**$129,221.00**	**$0.00**	**$129,221.00**

Medical and Dental Vision Insurance Premiums
September 2024

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
SCAN Health Plan, AZ							
620	7	$1,869.00	$485.94	$1,383.06	$1,869.00	$0.00	$1,869.00
SUBTOTAL	**7**	**$1,869.00**	**$485.94**	**$1,383.06**	**$1,869.00**	**$0.00**	**$1,869.00**
SCAN Health Plan, NV							
622	14	$3,738.00	$501.96	$3,503.04	$4,005.00	($267.00)	$3,738.00
623	2	$1,052.00	$0.00	$1,052.00	$1,052.00	$0.00	$1,052.00
SUBTOTAL	**16**	**$4,790.00**	**$501.96**	**$4,555.04**	**$5,057.00**	**($267.00)**	**$4,790.00**
UHC Medicare Adv.							
701	2,127	$744,637.65	$83,399.25	$663,056.07	$746,455.32	($695.76)	$745,759.56
702	396	$742,982.89	$42,698.56	$683,398.02	$726,096.58	$3,687.26	$729,783.84
703	1,371	$945,859.70	$88,541.54	$858,895.96	$947,437.50	($528.81)	$946,908.69
704	99	$212,220.19	$11,892.71	$189,821.53	$201,714.24	$0.00	$201,714.24
705	52	$49,215.92	$2,309.37	$47,853.01	$50,162.38	$0.00	$50,162.38
706	1	$429.15	$17.17	$411.98	$429.15	$0.00	$429.15
SUBTOTAL	**4,046**	**$2,695,345.50**	**$228,858.60**	**$2,443,436.57**	**$2,672,295.17**	**$2,462.69**	**$2,674,757.86**
United Healthcare							
707	574	$874,850.76	$84,061.92	$779,929.49	$863,991.41	$0.00	$863,991.41
708	482	$1,356,474.60	$80,447.89	$1,216,285.34	$1,296,733.23	$0.00	$1,296,733.23
709	397	$1,305,623.92	$100,785.38	$1,178,791.18	$1,279,576.56	$0.00	$1,279,576.56
SUBTOTAL	**1,453**	**$3,536,949.28**	**$265,295.19**	**$3,175,006.01**	**$3,440,301.20**	**$0.00**	**$3,440,301.20**

Medical and Dental Vision Insurance Premiums

September 2024

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	81	$114,056.91	$3,520.26	$111,871.35	$115,391.61	$0.00	$115,391.61
802	340	$863,232.80	$28,943.68	$836,874.47	$865,818.15	$0.00	$865,818.15
803	396	$1,185,980.40	$36,358.10	$1,161,149.96	$1,197,508.06	$2,994.90	$1,200,502.96
804	202	$284,438.22	$9,293.49	$276,552.84	$285,846.33	$0.00	$285,846.33
805	239	$606,801.88	$16,710.06	$587,552.90	$604,262.96	$0.00	$604,262.96
806	725	$1,840,717.00	$40,216.46	$1,795,422.70	$1,835,639.16	$0.00	$1,835,639.16
807	56	$167,714.40	$5,450.73	$162,263.67	$167,714.40	$0.00	$167,714.40
808	20	$59,898.00	$239.59	$59,658.41	$59,898.00	$0.00	$59,898.00
809	16	$22,529.76	$2,365.62	$20,164.14	$22,529.76	$0.00	$22,529.76
810	10	$25,389.20	$2,995.92	$22,393.28	$25,389.20	$0.00	$25,389.20
811	4	$11,979.60	$2,755.31	$9,224.29	$11,979.60	$11,511.21	$23,490.81
812	254	$357,659.94	$22,557.85	$350,077.43	$372,635.28	$5,485.62	$378,120.90
813	1	$2,538.92	$0.00	$2,538.92	$2,538.92	$0.00	$2,538.92
SUBTOTAL	**2,344**	**$5,542,937.03**	**$171,407.07**	**$5,395,744.36**	**$5,567,151.43**	**$19,991.73**	**$5,587,143.16**
Kaiser - Washington							
393	6	$11,031.72	$2,169.00	$8,862.72	$11,031.72	$0.00	$11,031.72
394	20	$9,245.25	$1,099.46	$5,510.43	$6,609.89	$0.00	$6,609.89
395	2	$10,279.47	$763.22	$2,663.27	$3,426.49	$0.00	$3,426.49
397	3	$6,084.36	$0.00	$8,112.48	$8,112.48	$0.00	$8,112.48
398	9	$7,852.50	$1,256.40	$6,596.10	$7,852.50	$0.00	$7,852.50
SUBTOTAL	**40**	**$44,493.30**	**$5,288.08**	**$31,745.00**	**$37,033.08**	**$0.00**	**$37,033.08**
Medical Plan Total	**56,466**	**$63,269,870.13**	**$4,078,695.94**	**$58,599,638.06**	**$62,678,334.00**	**$22,081.64**	**$62,700,415.64**

Medical and Dental Vision Insurance Premiums

September 2024

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	26,689	$1,444,791.11	$147,544.85	$1,310,478.67	$1,458,023.52	($2,035.37)	$1,455,988.15
502	24,595	$2,785,572.28	$207,662.62	$2,571,122.50	$2,778,785.12	$350.92	$2,779,136.04
503	7	$466.41	$23.99	$442.42	$466.41	$0.00	$466.41
SUBTOTAL	**51,291**	**$4,230,829.80**	**$355,231.46**	**$3,882,043.59**	**$4,237,275.05**	**($1,684.45)**	**$4,235,590.60**
CIGNA Dental HMO/Vision							
901	4,220	$196,547.00	$21,065.52	$178,040.08	$199,105.60	$93.04	$199,198.64
902	3,137	$300,227.28	$21,476.86	$277,641.40	$299,118.26	$95.28	$299,213.54
903	2	$94.22	$33.92	$60.30	$94.22	$0.00	$94.22
SUBTOTAL	**7,359**	**$496,868.50**	**$42,576.30**	**$455,741.78**	**$498,318.08**	**$188.32**	**$498,506.40**
Dental/Vision Plan Total	**58,650**	**$4,727,698.30**	**$397,807.76**	**$4,337,785.37**	**$4,735,593.13**	**($1,496.13)**	**$4,734,097.00**
GRAND TOTALS	**115,116**	**$67,997,568.43**	**$4,476,503.70**	**$62,937,423.43**	**$67,413,927.13**	**$20,585.51**	**$67,434,512.64**

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)

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
$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.**

FOR INFORMATION ONLY

August 26, 2024

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

FROM: Cassandra Smith
Director, Retiree Healthcare Division

Cynthia Martinez,
Chief, Communications

FOR: September 4, 2024, Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **LACERA-ADMINISTERED RETIREE HEALTHCARE (RHC) BENEFITS PROGRAM AND MEDICARE BASICS VIDEO PRESENTATION**

BACKGROUND

In the past year, RHC and Communications collaborated to fulfill one of RHC's most important goals and objectives: create a comprehensive, educational video to help our members make informed decisions in choosing healthcare plan(s) for themselves and their eligible dependents and, if applicable, enrolling in Medicare. We have completed this project and are now ready to preview this video to the Board.

This initiative supports the Strategic Priority Goal of Superior Member Experience — innovate and continuously improve the member experience.

OVERVIEW

We designed this 20-minute video, *LACERA-Administered Retiree Healthcare Benefits Program and Medicare Basics*, to provide members with a clear and straightforward overview of retiree healthcare benefits. It consists of the following main sections:

- Retiree Healthcare Basics
- Healthcare Plans
- Importance of Medicare
- Different Parts of Medicare
- How to Enroll in Medicare

We understand that to a new retiree, transitioning to the LACERA-administered health plans can be daunting. This video will show members the key features of the offered non-Medicare, Medicare HMO, and dental/vision plans, and provide clear direction on how and when to enroll, determine premium amounts, and other guidance for selecting the right healthcare plan for themselves and their eligible dependents.

The *LACERA-Administered Retiree Healthcare Benefits Program and Medicare Basics* video will reside on lacera.com. Members can preview the video in its entirety or, due to the length of this video, we've applied helpful tools to assist with viewing specific sections. The 20-minute version will include bookmarks that can be easily navigated by a scroll bar toward the bottom. Alternatively, members can choose from our shorter segmented videos, each approximately 3–5 minutes long, listed by the sections provided above.

CONCLUSION

Retiree Healthcare and Member Services staff received training on how to assist members when viewing the video and provided positive feedback.

Communications has included a "Coming Soon" mention in the September issue of *Pathways*, the active member newsletter. Once the video has been published to lacera.com, Communications will send an email blast to active members with a link to the new video landing page, which will include the full-length RHC video and segments, as well as other educational videos for members.

To continue our efforts in providing additional retiree healthcare resources to members, RHC and Communications are currently completing a series of "how-to" videos. These videos will guide members through filling out their new enrollment, change, or cancellation healthcare forms.

REVIEWED AND APPROVED:

Luis Lugo
Deputy Chief Executive Officer

CS:CM:LI:EH:SS

LACERA

August 22, 2024

TO: Each Trustee,
Insurance, Benefits & Legislative Committee
Les Robbins, Chair
Vivian H. Gray, Vice Chair
Shawn R. Kehoe
Ronald Okum
David Ryu, Alternate

FROM: Cassandra Smith, Director
Retiree Healthcare Division

SUBJECT: **ANNUAL ANTHEM BLUE CROSS AND CIGNA AUDITS**

As part of LACERA's administration of LACERA's Retiree Healthcare Benefits Program (RHCBP), our fiduciary duty is to ensure that our health plans are processing incurred claims in accordance with the group benefits. To ensure compliance of the contractual agreement by the health plans, we conduct an annual audit of claims in order to identify any discrepancies or inaccuracies in billing and payments made for group participants by out vendor partners.

LACERA has historically included within our Healthcare Consultants contract, as part of their Statement of Work, an annual claims audit of the LACERA-administered Indemnity Medical and Dental plans. Our indemnity plans are Anthem Blue Cross (I, II, III, and Prudent Buyer) medical and Cigna dental PPO plans. Anthem Blue Cross and Cigna dental plans are the only identified plans due to the way claims are submitted and paid; via paper/electronic claim submissions for payment. HMO medical plans such as Kaiser Permanente, SCAN, and United Health billings are handled very differently, in that there are no paper claim submissions.

LACERA's healthcare consultant typically begins the annual audit process in late June. The auditor conducts a random selection of claims incurred during the identified period to be audited which assists LACERA with monitoring benefit compliance and to identify any discrepancies or inaccuracies in billing and payments made on claims for payment that assist with fulfilling LACERA's duty of administering the healthcare program and cost.

Staff would like to express our appreciation to the Segal team for their collaboration and continued guidance in LACERA's maintaining retiree healthcare cost and the program management.

Reviewed and approved:

Luis A. Lugo
Deputy Chief Executive Office

Attachments

Los Angeles County Employees Retirement Association

Analysis of Anthem Blue Cross Medical Claims Processing and Payment Procedures

Audit Period: July 1, 2022, through June 30, 2023

Final Report

May 24, 2024/ Amber M. Turner, MBA, PMP

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May 24, 2024

Cassandra Smith
Director, Retiree Healthcare Program
Retiree Healthcare Division
Los Angeles County Employees Retirement Association

Re: Medical Claims Audit - July 2022 - June 2023

Dear Cassandra:

On behalf of the Los Angeles County Employees Retirement Association, Segal's Benefit Audit Solutions Practice (Segal) completed a review of the medical health benefit plan administered by the Anthem Blue Cross (Anthem), for the period of July 1, 2022 through June 30, 2023. The audit includes an assessment of Anthem adjudication procedures, a random sampling of stratified statistical claims, and a targeted claim selection.

The following report presents the details and results of the review process.

Once you have reviewed this report, please let us know if you have any questions.

Sincerely,

Amber M. Turner

Amber M. Turner, MBA, PMP
Senior Consultant, Audits

cc: Stephen Murphy
Michael Szeto

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Section 1 — Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Anthem Blue Cross (Anthem), in its administration of the Los Angeles County Employees Retirement Association group medical benefits. Amber Turner and Jennifer Lagua of Segal's Benefit Audit Solutions (BAS) Practice conducted the remote audit during the week of December 4, 2023.

The audit encompassed a total sample of 255 claims consisting of 220 Stratified and 35 Target samples for the audit period of July 1, 2022 through June 30, 2023. The 255 sample claims equaling $6,476,904.22; or 4.26% by cost, of the $152,045,164.70 total claims for the audit period.

- $6,210,714.55 for the random, stratified statistical claim sample (220) statistical claims; and,
- $266,189.67 for the target claim sample(35) claims.

Overall, Segal identified $30,464.07 in Overpayments and -$2,013.45 in Underpayments, which are outlined under Key Findings and Recommendation section.

Segal's audit included the following review components.

- A random, stratified sample of 220 statistical medical claims to measure validity in the financial dollar value and incidence; and,
- A 35-target claim selection identified through electronic analysis of all claims designed to explore potential duplicate payments and/or sample various benefit applications (i.e., deductibles, employee cost-share, limitations, and exclusions).
- A measurement of the time to process claims from receipt of claim to the initial date processed for payment or denial.
- An adjudication procedure review to assess day-to-day processing guidelines and claim control measures.

Statistical achievement categories

As illustrated in the chart below, Anthem met the performance guarantees for financial, procedural, and time-to-process accuracy but fell below industry standard for payment and overall accuracy. The audit period Accuracy Results do not include target and/or out-of-sample claims.

Performance Guarantees Table

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	99.85%	99.00%	99.00%
Payment Accuracy (Free from financial error)	92.30%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (Free from error)	92.30%	N/A	95.00%
Time-to-Process			
(within 10 business days)	98.70%	90.00%	95.00%
(within 20 business days)	99.01%	N/A	100.00%

Note: Time-to-Process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.

NA = not applicable

Key findings and recommendations

The following issue numbers summarize the primary findings identified by Segal's auditors during the claims review. Anthem's responses to the findings from the remote review are summarized and italicized throughout the report. Anthem was presented with a draft report on February 5, 2024 for its review and comment. Anthem provided its formal response to the audit report on February 29, 2024, which can be found in Section 7 of this report.

Statistical and Target Audit Findings Summary Chart

Medical Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Number of Sample Claims
Issue 1: Incorrect Coordination of Benefits (COB)	$5.34	-$22.40	9
Issue 2: Deductible/Out-of-Pocket Overapplied	$0.00	-$1,869.41	18
Issue 3 Surgery Applied Cost Sharing	$0.00	-$121.64	1
Issue 4: Paid Over Plan Maximum	$2,320.35	-$0.00	1
Issue 5: Incorrect Pricing	$1,098.85	-$0.00	1
Issue 6: Acupuncture Over $30/ Visits Over 50/ Incorrect Cost Sharing	$937.40 & 2 Procedural Errors	-$0.00	6 Financial Errors and 2 Procedural Errors
Issue 7: Hearing Aids Over $300.00	$16,656.06 & 1 Procedural Error	-$0.00	5 Financial Errors and 1 Procedural Error
Issue 8: Foot Orthotics - Exclusion	$1,964.29	-$0.00	4
Issue 9: Preventive Care Over Age 17	$418.10	-$0.00	2
Issue 10: Duplicate Claim Payment	$7,063.68	-$0.00	2
Total	$30,464.07	-$2,013.45	52

Details regarding the identified deviations can be found in the claim sample error tables in Section 3 and Section 4 of this report.

Recommendations

Based upon the review, Segal recommends:

- **Issue 1: Incorrect Coordination of Benefits (COB)** – Anthem disagreed with Segal during the remote review and noted that Anthem provided 20% payment for the supplemental plan. Segal disagrees with Anthem and notes that Page 5 of the plan document states that LACERA 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. Segal recommends that LACERA discuss this issue with Anthem.
- **Issue 2: Deductible/Out-of-Pocket Overapplied** – Anthem agreed to these errors and have identified pharmacy comingling as the determining factor of the overage. Starting March of 2024, Anthem implemented a new reporting process to better streamline adjustments. Segal recommends that LACERA monitor this issue as it is a reoccurring issue from previous audits as well as confirm that Anthem has reimbursed the members that were impacted for this issue.
- **Issue 4: Paid Over Plan Maximum** – As this issue is due to the pharmacy comingling, Segal recommends that LACERA monitor this issue as Anthem noted a new process was implemented in March 2024.
- **Issue 6: Acupuncture Over $30/ Visits Over 50/ Incorrect Cost Sharing** – Anthem agreed to this issue and noted that starting in April 2024, Anthem will run quarterly reporting to review trends and identify opportunities, as needed. Annually, Anthem will determine if ongoing reporting is necessary. Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.
- **Issue 7: Hearing Aids Over $300.00** — Anthem agreed to this issue and noted that starting in April 2024, Anthem will run quarterly reporting to review trends and identify opportunities, as needed. Annually, Anthem will determine if ongoing reporting is necessary. Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.
- **Issue 8: Foot Orthotics - Exclusion** – Anthem disagreed with this issue during the remote review and noted that coverage for this benefit is extended beyond a diabetic diagnosis. Segal recommends that LACERA discuss this benefit with Anthem and determine if a plan document update is necessary.
- **Issue 9: Preventive Care Over Age 17** – Anthem agreed with these errors during the remote review but noted that if an adjustment is made potential impact to the member can occur. Segal recommends that LACERA discuss with Anthem to decide if adjustments are necessary.
- **Issue 3 Surgery Applied Cost Sharing, Issue 5: Incorrect Pricing, Issue 10: Duplicate Claim Payment** – No further intervention is necessary on these claim issues.

Section 2 — Audit Details

Anthem provided an electronic data file of all medical claims processed and paid during the 12-month period of July 1, 2022 through June 30, 2023. The objective of the review was to ensure that claims were paid in accordance with LACERA's plan provision.

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-M) 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.

Review process

Anthem provided a copy of the sampled claim submissions and access through its Claim System. 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 (COB) and subrogation provisions were enforced, where applicable.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Proper medical authorization is on file, as applicable.
- 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 stop-loss notifications were filed timely, as applicable.
- 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).
- Time-to-process for processing of claims was within industry standards or established performance guarantees.

The July 2021 and July 2022 Summary Plan Descriptions (SPDs) served as references for the statistical and electronic analyses, please note that a full list of resources documents has been added to the appendix. For the target claims selection, reports from the electronic analysis provided a list of suspected errors that required the auditors' manual review to refine the analysis and identify and patterns of concern, a selection of claims was chosen to confirm suspected errors and identify appropriate query revisions.

All questions and potential errors were presented to Anthem's representatives; outstanding responses post-audit were provided through January 31, 2024.

Section 3 — Statistical Review

The selection of 220 random claims for plan year July 1, 2022 through June 30, 2023 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

Below is the stratification table utilized for the audit.

Strata	Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar-Amount in Selection	Dollar-Amount in Strata
A	$0.01–$19.99	236,301	35	$443.98	$2,642,886.13
B	$20.00–$39.99	236,513	30	$834.45	$6,605,110.24
C	$40.00–$109.99	174,474	25	$1,792.50	$11,830,931.74
D	$110.00–$289.99	98,246	25	$4,435.31	$16,959,129.78
E	$290.00–$624.99	31,614	20	$7,697.65	$13,024,603.45
F	$625.00–$1,499.99	15,350	15	$14,986.69	$14,539,805.39
G	$1,500.00–$2,999.99	10,307	10	$21,201.03	$19,517,594.95
H	$3,000.00–$6,249.99	3,028	10	$41,638.51	$13,115,787.24
I	$6,250.00–$14,999.99	1,460	10	$83,243.22	$13,774,947.09
J	$15,000.00–$29,999.99	565	10	$225,261.74	$11,904,442.90
K	$30,000.00–$64,999.99	265	10	$402,888.55	$11,242,463.86
L	$65,000.00–$209,999.99	121	10	$1,055,023.75	$12,536,194.76
M	$210,000.00–$804,532.72	10	10	$4,351,267.17	$4,351,267.17

Strata	Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar-Amount in Selection	Dollar-Amount in Strata
Total		**808,254**	**220**	**$6,210,714.55**	**$152,045,164.70**

Statistical claim sample error table

The review of 220 statistical sample claims for the audit period of July 1, 2022 through June 30, 2023 identified eleven (11) in-sample errors:

- Three (3) overpayments totaling $1,104.19; and,
- Eight (8) underpayments totaling -$144.04.

In addition to the above errors, fifteen (15) out-of-sample (OOS) errors were identified. The fifteen (15) errors included one (1) overpayment for $2,320.35 and fourteen (14) underpayments totaling -$598.39. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

Segal recommended that Anthem initiate recovery and adjustment for claims identified in the following table and provide financial impact reports when noted below under Segal Final Comment. Anthem's responses are summarized and italicized with formal response found in Section 7 of this report.

Statistical Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
Issue 1: Incorrect COB					
3A	-$0.13	**Auto**	Claims incorrectly coordinated benefits with the other insurance. *Anthem disagreed with this error during the remote review and noted that it will only pay 20%.* Segal disagreed with Anthem and noted that Page 5 of the plan document states that LACERA will pay 100% of the difference between Medicare's Allowable Charge(s) and the amount Medicare pays for medically necessary Part B services	*Anthem disagrees. Following supplemental processing guidelines, Anthem provided 100% payment of 20% of the amount permitted by Medicare.*	**Segal recommends that LACERA discuss this issue with Anthem.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
			and supplies. As such, Anthem should pay the full patient responsible as noted by Medicare. Segal recommended that Anthem review this page of the plan document and determine if a financial impact report should be generated to assess financial impact for the member on this claim issue.		
7A	$5.30	**Auto**	The sample claim incorrectly coordinated benefits with the other insurance. *Anthem agreed to this error during the remote review.* As this claim was auto adjudicated, Segal recommended that Anthem review this claim and determine if there is financial impact for the member on this claim error issue.	*Anthem recognizes an overpayment of $5.33. The sample claim was auto adjudicated as a result of the manual entry of claim details. The examiner erroneously doubled the member's obligation of $5.33, creating a total payment of $10.66 upon auto adjudication. This does not affect the member, as the claim was processed as secondary in full. The payment made is below the recovery threshold of $30; hence, the recovery process will not be initiated.*	See sample 3A for explanation.
9A	-$0.06	**Auto**	See sample 3A for explanation.	See sample 3A for explanation.	See sample 3A for explanation.
11A	-$1.40	**Auto**	See sample 3A for explanation.	See sample 3A for explanation.	See sample 3A for explanation.
16A	-$0.56	**Auto**	See sample 3A for explanation.	See sample 3A for explanation.	See sample 3A for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
21A	-$1.80	**Auto**	See sample 3A for explanation.	See sample 3A for explanation.	See sample 3A for explanation.
22A	-$2.44	**Auto**	See sample 3A for explanation.	See sample 3A for explanation.	See sample 3A for explanation.
23A	-$16.01	**Auto**	See sample 3A for explanation.	See sample 3A for explanation.	See sample 3A for explanation.
38B	$0.04	**Auto**	See sample 3A for explanation.	See sample 3A for explanation.	See sample 3A for explanation.
Issue 2: Deductible/Out-of-Pocket Overapplied					
72C OOS	OOS: -$6.15	**Auto**	The annual deductible was overapplied for this member. *Anthem agreed to this error during the remote review.* As this is a reoccurring error and corrective action was provided in years previous, Segal recommended that Anthem provide the reason as to why corrective action steps were not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal recommended that Anthem provide financial impact reporting for this issue and adjust the claims and refund the members.	*Anthem agrees to overpayments in the of $673.55 for the above noted OOS claims. This plan has pharmacy integration. Pharmacy claims are posted as history claims based on transmission of data between Anthem and pharmacy vendor. During this process an overage in out-of-pocket may occur. There is a manual workflow in place to capture and correct overages. However, there may be times when the member's file is not adjusted timely. Anthem is aware this situation may occur and continues to review for enhancement opportunities. All identified samples are in review to correct the overages.*	**Segal recommends that LACERA monitor this issue as it is a reoccurring issue from previous audits as well as confirm that Anthem has reimbursed the members that were impacted by this issue.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
				Starting March 2024, Anthem will employ a new reporting process. This reporting process will allow Anthem to better streamline any adjustments that are needed. We will continue to monitor the volume of activity and any opportunities for improvement.	
74C OOS	OOS: -$25.31	**Auto**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
94D OOS	OOS: -$20.44	**Auto**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
95D OOS	OOS: -$128.59	**Auto**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
105D OOS	OOS: -$90.32	**Auto**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
108D OOS	OOS: -$11.67	**Auto**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
123E OOS	OOS: -$1.59	**Manual**	The annual out-of-pocket maximum was overapplied for this member. *Anthem agreed to this error during the remote review.* See Segal's recommendation for sample 72C OOS.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
137F OOS	OOS: -$15.87	**Manual**	The annual deductible and out-of-pocket maximum were over applied for this member.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
			Anthem agreed to this error during the remote review. See Segal's recommendation for sample 72C OOS.		
173I OOS	OOS: -$209.78	**Auto**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
185J OOS	OOS: -$20.80	**Auto**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
187J OOS	OOS: -$6.01	**Auto**	See sample 123E OOS for explanation.	See sample 123E OOS for explanation.	See sample 123E OOS for explanation.
194K OOS	OOS: -$6.33	**Manual**	See sample 123E OOS for explanation.	See sample 123E OOS for explanation.	See sample 123E OOS for explanation.
207L OOS	OOS: -$3.13	**Manual**	See sample 123E OOS for explanation.	See sample 123E OOS for explanation.	See sample 123E OOS for explanation.
214M OOS	OOS: -$52.40	**Manual**	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.	See sample 72C OOS for explanation.
Issue 3: Surgery Applied Cost Sharing					
163H	-$121.64	**Manual**	A benefit for surgery that should have been paid at 100% applied cost sharing. *Anthem agreed to this error during the remote review.* Segal recommended that Anthem adjust the claim and refund the member. Additionally, Segal recommended that Anthem provide coaching to its processor for this error.	*Anthem agrees. An examiner's error mistakenly led to the application of coinsurance resulting in an underpayment of $121.64. This claim is under review for correction. Additional training has been provided to the examiner responsible for the error.*	**No further intervention is necessary for this error.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
Issue 4: Paid Over Plan Maximum					
198K OOS	OOS: $2,320.35	**Manual**	Claims were paid beyond the plan lifetime maximum. *Anthem agreed to this error during the remote review and noted that it will be reviewing the member's file for additional information.* Segal recommended that Anthem provide the reasoning behind the plan paying over the maximum limit as well as provide the claims controls in place to prevent this type of payment overage.	*Anthem agrees. The member's lifetime maximum is over applied $2,320.35. Please see our response to OOS 72C for details on pharmacy and medical claims processing. The member's lifetime maximum is under review to correct the overage.*	
Issue 5: Incorrect Pricing					
215M	$1,098.85	**Manual**	Incorrect payment was applied to the claim. *Anthem agreed to this error during the remote review and noted that the claim was adjusted on November 16, 2023.* Segal noted that no further intervention is necessary for this error.	*Upon initial adjudication payment was made for services that fell outside of the authorization for the billed services. The claim was adjusted to retract $1,098.85 on 11/16/23, outside of the audit period. Therefore, Anthem agrees to a manual overpayment of $1,098.85 for the original adjudication.*	**No further intervention is necessary for this error.**

Summary of Statistical Sample Findings

Description	Amount
3 Overpayments	$1,104.19

Description	Amount
1 OOS Overpayment	$2,320.35
8 Underpayments	-$144.04
14 OOS Underpayments	-$589.39

Segal does not guarantee the accuracy of the claims adjudication of the medical benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Anthem's medical claims adjudication. The results in this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

Section 4 — Target Review

Segal performed an electronic review of all claims processed and paid during the audit period of July 1, 2022 through June 30, 2023. The electronic review was designed to identify potential deficiencies in the benefit delivery system.

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

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

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 sample error table

The review of 35 target sample claims for the audit period of July 1, 2022 through June 30, 2023 identified twenty-two (22) in- sample errors that affected nineteen (19) claims:

- Eighteen (18) overpayments totaling $26,829.53;
- One (1) underpayment of -$1,195.86; and,
- Three (3) procedural errors.

In addition to the above errors, four (4) out-of-sample (OOS) errors were identified. The four (4) errors included one (1) overpayment for $210.00 and three (3) underpayments totaling -$75.16. OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

Segal recommended that Anthem initiate recovery and adjustment for claims identified in the following table and provide financial impact reports when noted below under Segal's final comment. Anthem's responses are summarized and italicized with formal response found in Section 7 of this report.

Target Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
Issue 6:Acupuncture Over $30/ Visits Over 50/ Incorrect Cost Sharing					
T1	$72.50 OOS Overpaid: $210.00	**Manual**	Acupuncture was paid beyond the $30.00 limit. It was also identified that more than 50 visits were paid for this member. *Anthem agreed to this error during the remote review.* As this is a reoccurring error and corrective action was provided in years previous, Segal recommended that Anthem provide the reason as to why corrective action steps were not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal recommended that Anthem adjust the claims and refund the members.	*Anthem acknowledges overpayments totaling $727.40 for the aforementioned target samples. Additionally, the review of T5 identified a procedural error in which the examiner erroneously applied a $30 copayment.* *Acupuncture claims follow a 2-tier benefit structure, with a limit of $30 per visit and an annual maximum of 50 visits. Due to this, these claims are manually processed, which has been identified as the primary cause of these overpayments. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.* *Starting April 2024, Anthem will run a quarterly claim report to review trends and identify opportunities as needed. Anthem will assess*	**Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
				annually to determine if an ongoing report is needed.	
T2	$340.00	**Manual**	Acupuncture was paid beyond the $30.00 limit. *Anthem agreed to this error during the remote review.* See Segal's recommendation for sample T1.	See sample T2 for explanation.	See sample T2 for explanation.
T3	$161.94 & Procedural Error	**Manual**	Acupuncture was paid beyond the $30.00 limit and applied 20% coinsurance instead of 30% coinsurance. *Anthem agreed to this error during the remote review.* See Segal's recommendation for sample T1.	See sample T2 for explanation.	See sample T2 for explanation.
T4	$90.00	**Manual**	See sample T2 for explanation.	See sample T2 for explanation.	See sample T2 for explanation.
T5	$62.96 & Procedural Error	**Manual**	Acupuncture was paid beyond the $30.00 limit and applied a copayment instead of coinsurance. *Anthem agreed to this error during the remote review.* See Segal's recommendation for sample T1.	See sample T2 for explanation.	See sample T2 for explanation.
Issue 2: Deductible/Out-of-Pocket Overapplied					
T1 OOS	OOS: -$3.16	**Manual**	The annual deductible was overapplied for this member.	*Anthem agrees to overpayments in the of $673.55 for the above noted*	**Segal recommends that LACERA monitor this issue as it is a**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
			Anthem agreed to this error during the remote review. As this is a reoccurring error and corrective action was provided in years previous, Segal recommended that Anthem provide the reason as to why corrective action steps were not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal recommended that Anthem provide financial impact reporting for this issue and adjust the claims and refund the members.	*OOS claims. This plan has pharmacy integration. Pharmacy claims are posted as history claims based on transmission of data between Anthem and pharmacy vendor. During this process an overage in out-of-pocket may occur. There is a manual workflow in place to capture and correct overages. However, there may be times when the member's file is not adjusted timely. Anthem is aware this situation may occur and continues to review for enhancement opportunities. All identified samples are in review to correct the overages.* *Starting March 2024, Anthem will employ a new reporting process. This reporting process will allow Anthem to better streamline any adjustments that are needed. We will continue to monitor the volume of activity and any opportunities for improvement.*	**reoccurring issue from previous audits as well as confirm that Anthem has reimbursed the members that were impacted by this issue.**
T9 OOS	OOS: -$11.39	**Manual**	The annual out-of-pocket maximum was overapplied for this member. *Anthem agreed to this error during the remote review.*	See sample T1 OOS for explanation.	See sample T1 OOS for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
			See Segal's recommendation for sample T1 OOS.		
T10 OOS	-$60.61	**Manual**	The annual deductible and out-of-pocket maximum were over applied for this member. *Anthem agreed to this error during the remote review.* See Segal's recommendation for sample T1 OOS.	See sample T1 OOS for explanation.	See sample T1 OOS for explanation.
T25	-$1,195.86	**Manual**	The out-of-pocket overapplied on the sample claim. *Anthem agreed to this error during the remote review.* See Segal's recommendation for sample T1 OOS.	See sample T1 OOS for explanation.	See sample T1 OOS for explanation.
Issue 7: Hearing Aids Over $300.00					
T11	$4,690.00	**Manual**	Hearing aids paid over the $300.00 maximum lifetime limit. *Anthem agreed to this error during the remote review.* As this is a reoccurring error and corrective action was provided in years previous, Segal recommended that Anthem provide the reason as to why corrective action steps were not effective and the new corrective action	*Anthem acknowledges overpayments amounting to $16,656.06. The primary cause of these overpayments has been identified as the manual processing of hearing aid claims. Additionally, payment for the target sample T13 was retracted on September 26, 2023, and this claim is currently being reviewed for a*	**Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
			plan to prevent this discrepancy in the future. Additionally, Segal recommended that Anthem adjust the claims.	*potential repayment up to the lifetime maximum of $300. Except for sample T13, adjustments may have an impact on the member; hence, the respective claims will be adjusted only upon request.* *Starting April 2024, Anthem will run a quarterly claim report to review trends and identify opportunities as needed. Anthem will assess annually to determine if an ongoing report is needed.*	
T12	$2,758.50	**Manual**	See sample T11 for explanation.	See sample T11 for explanation.	See sample T11 for explanation.
T13	$3,812.00 & Procedural Error	**Manual**	Hearing aids paid over the $300.00 maximum lifetime limit. The claim was adjusted post audit (September 26, 2023) to zero. The claim should have paid $300.00. *Anthem agreed to this error during the remote review.* See Segal's recommendation for sample T11.	See sample T11 for explanation.	See sample T11 for explanation.
T14	$2,875.00	**Manual**	See sample T11 for explanation.	See sample T11 for explanation.	See sample T11 for explanation.
T15	$2,520.56	**Manual**	See sample T11 for explanation.	See sample T11 for explanation.	See sample T11 for explanation.
Issue 8: Foot Orthotics - Exclusion					

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
T16	$411.20	**Manual**	Foot orthotics, which are an exclusion were paid. *Anthem disagreed with these errors during the remote review and noted that coverage is not limited to a diabetic diagnosis.* Segal references page 56 of the plan document under what is not covered under the medical plan that notes Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes. The diagnosis for these claims did not contain a systematic illness.	*Anthem disagrees to the errors assessed for foot orthotics. The reported services for each target sample are covered under plan benefits. Further, coverage is not limited to a diabetic diagnosis. Therefore, the sample claims processed correctly per plan benefits.*	**Segal recommends that LACERA discuss this benefit with Anthem and determine if a plan document update is necessary.**
T17	$594.14	**Manual**	See sample T16 for explanation.	See sample T16 for explanation.	See sample T16 for explanation.
T18	$389.64	**Manual**	See sample T16 for explanation.	See sample T16 for explanation.	See sample T16 for explanation.
T19	$569.31	**Manual**	See sample T16 for explanation.	See sample T16 for explanation.	See sample T16 for explanation.
Issue 9: Preventive Care Over Age 17					
T30	$240.32	**Manual**	Preventive care services for a member over the age of 17 were paid. *Anthem agreed to this error during the remote review and noted that preventive care services are only*	*Anthem accepts overpayments totaling $418.10. In both cited instances, payment was manually extended for members who are above the age of 17. As the*	See sample T30 for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Anthem's Response	Segal's Final Comment
			covered under this plan through the age of 16. Segal recommended that Anthem coach its processor regarding benefits that are exclusions under this plan.	*adjustments could potentially impact the members, claims will only be revised upon request. Additional training has been provided to the examiner responsible for the error.*	
T32	$177.78	**Manual**	See sample T30 for explanation.	See sample T30 for explanation.	See sample T30 for explanation.
Issue 10: Duplicate Claim Payment					
T34	$6,236.00	**Manual**	Duplicate claim payment was made. *Anthem agreed to this error during the report review and noted that the claim was adjusted on July 7, 2023.* Due to the claim being adjusted post audit period the error is included within this review.	No further intervention is necessary on this claim.	No further intervention is necessary on this claim.
T35	$827.68	**Manual**	Duplicate claim payment was made. *Anthem agreed to this error during the report review and noted that the claim was adjusted on September 26, 2023.* Due to the claim being adjusted post audit period the error is included within this review.	No further intervention is necessary on this claim.	No further intervention is necessary on this claim.

Description	Amount
18 Overpayments	$26,829.53
1 OOS Overpayment	$210.00
1 Underpayment	-$1,195.86
3 OOS Underpayments	-$75.16
3 Procedural Errors	N/A

Segal does not guarantee the accuracy of the claims adjudication of the medical benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Anthem's medical claims adjudication. The results in this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

Section 5 — 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 medical claims processed during the audit period of July 1, 2022 through June 30, 2023 revealed Anthem processed 98.70% of the claims within fourteen (14) calendar days (ten business days) and 99.01% within thirty (30) calendar days (20 business days).

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial. Industry standards indicate 95% of all claims should be processed within fourteen (14) calendar days. Best practice, which follows U.S. Department of Labor, Employee Benefits Security Administration (EBSA), requires 100% within thirty (30) calendar days.*

Segal's electronic calculations of all claims processed within the audit period did not allow for distinction of multiple processing events, therefore, Segal can conclude there are no issues with the time to process.

* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits.pdf.

Section 6 — Adjudication Procedures Review

The objective of the review is to ensure that proper procedures are in place to ensure claims control measures. The processing guidelines were described in the Adjudications Procedures Review and evidenced within the 220 statistical and 35 target claim samples or confirmed through discussion with Anthem'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 Plan costs.

- Anthem has a unit dedicated to processing LACERA's claims.
  - Anthem's Member Service Representatives are trained to process and assist with claim adjustments.
  - If excess claims are submitted, designated staff who process claims regularly are able to provide assistance to the designated claim processors.
- On average, Anthem receives 77,876 claims monthly for LACERA.
  - 97.8% of Anthem's claims are submitted electronically.
  - 99.01% of Anthem's claims are auto adjudicated.
    - 91.61% of LACERA's claims are auto adjudicated.
- Eligibility information is submitted to Anthem by LACERA.
  - Anthem reconciles this information on a monthly basis.
- For possible third-party liability (TPL) claims, Anthem submits a questionnaire to the member based on diagnosis codes received on claims.
  - Anthem's claim system also has the capability to automatically identify possible TPL claims.
  - The minimum dollar amount to initiate TPL claim recoveries is $750.00.
- If additional information is necessary to adjudicate claims, Anthem's claim system has the capability to automate letters.
  - The following letters can be automatically generated:
    - Explanation of Benefits
    - Letter regarding other insurance
    - Provider remittance
    - Requests for medical records
- Claims that are paying more than $40,000 are sent for a high dollar claims review.
  - Claims paying higher than $300,000 undergo a secondary end-to-end audit completed by an audit lead or senior auditor.

- The following criteria may trigger a case management referral.
  - Inpatient admission of 10 days or greater
  - NICU admissions
  - High risk on readmission predictive model
  - Carelon’s oncology management triggers to help us identify and engage members with cancer sooner
  - An unplanned hospital admission by a member who was recently followed in care management (within the previous 30 days)
  - Catastrophic illnesses and injuries
  - High-dollar claims (greater than $75,000)
  - Potential transplant candidates
  - Specialty high-cost drugs
- The following subcontractor provides service to Anthem Blue Cross for LACERA’s claims:
  - Excela
    - Location: India, Philippines, Colorado, and Texas
    - Services: Mail pickup, batching and prepping imaging, and data entry

Section 7 — Anthem's Formal Response to the Draft Report

Anthem Blue Cross
Customer Audit Services
220 Virginia Avenue
Indianapolis, IN 46204

2/29/24

Via email only

Amber Turner, MBA, PMP
Senior Consultant, Audits
Segal
500 North Brand BLVD
Suite 1400
Glendale, CA 91203-3338

Re: Los Angeles County Employees Retirement Association Medical Claim Audit

Dear Ms. Turner,

Anthem BlueCross (Anthem) reviewed the audit report prepared by Segal on behalf of Los Angeles County Employees Retirement Association (LACERA). The audit was conducted remotely during the week of December 4th, 2023. The audit encompassed a total sample of 255 claims consisting of 220 Stratified and 35 Target samples for the audit period of July 1, 2022, through June 30, 2023.

Executive Summary

Segal has identified overpayments amounting to $30,604.07 and underpayments totaling -$2,013.45. During the audit, Out of Sample (OOS) errors were also uncovered. OOS claims refer to the claims that have not been selected as sample claims by Segal for the audit purpose but are identified through the claim history of a sampled member. These claims don't contribute to the financial accuracy aspect of the audit.

Anthem's response Segal's findings and recommendations are presented below.

Statistical Claim Sample

Issue 1: Incorrect COB

Sample 3A: Claims incorrectly coordinated benefits with the other insurance. Anthem disagreed with this error during the remote review and noted that it will only pay 20%. Segal disagrees with Anthem and notes that Page 5 of the plan document states that 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, Anthem should pay the full patient responsible as noted by Medicare. Segal recommends that Anthem review this page of the plan document and determine if a financial impact report should be generated to assess financial impact for the member on this claim issue.

Anthem's Response: Anthem disagrees. Following supplemental processing guidelines, Anthem provided 100% payment of 20% of the amount permitted by Medicare.

Sample 7A: The sample claim incorrectly coordinated benefits with the other insurance. Anthem agreed to this error during the remote review. As this claim was auto adjudicated, Segal recommends that Anthem review this claim and determine if there is financial impact for the member on this claim error issue.

Anthem's Response: Anthem recognizes an overpayment of $5.33. The sample claim was auto adjudicated as a result of the manual entry of claim details. The examiner erroneously doubled the member's obligation of $5.33, creating a total payment of $10.66 upon auto adjudication. This does not affect the member, as the claim was processed as secondary in full. The payment made is below the recovery threshold of $30; hence, the recovery process will not be initiated.

Samples 9A, 11A, 16A, 21A, 22A, 23A, 38B: See sample 3A for explanation.

Anthem's Response: See sample 3A for Anthem's response.

Issue 2: Deductible / Out-of- Pocket Overapplied

OOS 72C, 74C, 94D, 95D 105D, 108D, 123I, 137F, 173I, 185J, 187J, 194K, 207L, 214M, T1, T9, T10: The annual deductible was overapplied for this member. Anthem agreed to this error during the remote review. As this is a reoccurring error and corrective action was provided in years previous, Segal recommends that Anthem provide the reason as to why corrective action steps were not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal recommends that Anthem provide financial impact reporting for this issue and adjust the claims and refund the members.

Anthem's Response: Anthem agrees to overpayments in the of $673.55 for the above noted OOS claims. This plan has pharmacy integration. Pharmacy claims are posted as history claims based on transmission of data between Anthem and pharmacy vendor. During this process an overage in out-of-pocket may occur. There is a manual workflow in place to capture and correct overages. However, there may be times when the member's file is not adjusted timely. Anthem is aware this situation may occur and continues to review for enhancement opportunities. All identified samples are in review to correct the overages.

Starting March 2024, Anthem will employ a new reporting process. This reporting process will allow Anthem to better streamline any adjustments that are needed. We will continue to monitor the volume of activity and any opportunities for improvement.

Sample T25: The out-of-pocket overapplied on the sample claim.

Anthem's Response: Anthem agrees. Manual processing led to an underpayment error amounting to $1195.86. To rectify this underpayment, the sample claim was adjusted on December 6, 2023. Additional training has been provided to the examiner responsible for the error.

Issue 3: Surgery Applied Cost Sharing

Sample 163H: A benefit for surgery that should have been paid at 100% applied cost sharing. Anthem agreed to this error during the remote review. Segal recommends that Anthem adjust the claim and refund the member. Additionally, Segal recommends that Anthem provide coaching to its processor for this error.

Anthem's Response: Anthem agrees. An examiner's error mistakenly led to the application of coinsurance resulting in an underpayment of $121.64. This claim is under review for correction. Additional training has been provided to the examiner responsible for the error.

Issue 4: Paid Over Plan Maximum

OOS 198K: Claims were paid beyond the plan lifetime maximum. Anthem agreed to this error during the remote review and noted that it will be reviewing the member's file for additional information. Segal recommends that Anthem provide the reasoning behind the plan paying over the maximum limit as well as provide the claims controls in place to prevent this type of payment overage.

Anthem's Response: Anthem agrees. The member's lifetime maximum is over applied $2320.35. Please see our response to OOS 72C for details on pharmacy and medical claims processing. The member's lifetime maximum is under review to correct the overage.

Issue 5: Incorrect Pricing

Sample 215M: Incorrect payment was applied to the claim. Anthem agreed to this error during the remote review and noted that the claim was adjusted on November 16, 2023. Segal notes that no further intervention is necessary for this error.

Anthem's Response: Upon initial adjudication payment was made for services that fell outside of the authorization for the billed services. The claim was adjusted to retract $1,098.85 on 11/16/23, outside of the audit period. Therefore, Anthem agrees to a manual overpayment of $1,098.85 for the original adjudication.

Target Claim Sample

Issue 6: Acupuncture Over $30 / Visits Over 50 / Incorrect Cost Sharing

Samples T1, T2, T3, T4, T5: Acupuncture was paid beyond the $30.00 limit. It was also identified that more than 50 visits were paid for this member. Anthem agreed to this error during the remote review. As this is a reoccurring error and corrective action was provided in years previous, Segal recommends that Anthem provide the reason as to why corrective action steps were not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal recommended that Anthem adjust the claims and refund the members.

Anthem's Response: Anthem acknowledges overpayments totaling $727.40 for the aforementioned target samples. Additionally, the review of T5 identified a procedural error in which the examiner erroneously applied a $30 copayment.

Acupuncture claims follow a 2-tier benefit structure, with a limit of $30 per visit and an annual maximum of 50 visits. Due to this, these claims are manually processed, which has been identified as the primary cause of these overpayments. Adjustments may cause member impact; therefore, these claims will be adjusted upon request.

Starting April 2024, Anthem will run a quarterly claim report to review trends and identify opportunities as needed. Anthem will assess annually to determine if an ongoing report is needed.

Issue 7: Hearing Aids Over $300.00

Samples T11, T12, T13, T14, T15: Hearing aids paid over the $300.00 maximum lifetime limit. Anthem agreed to this error during the remote review. As this is a reoccurring error and corrective action was provided in years previous, Segal recommends that Anthem provide the reason as to why corrective action steps were not effective and the new corrective action plan to prevent this discrepancy in the future. Additionally, Segal recommended that Anthem adjust the claims and refund the members.

Anthem's Response: Anthem acknowledges overpayments amounting to $16,656.06. The primary cause of these overpayments has been identified as the manual processing of hearing aid claims. Additionally, payment for the target sample T13 was retracted on September 26, 2023, and this claim is currently being reviewed for a potential repayment up to the lifetime maximum of $300. Except for sample T13, adjustments may have an impact on the member; hence, the respective claims will be adjusted only upon request.

Starting April 2024, Anthem will run a quarterly claim report to review trends and identify opportunities as needed. Anthem will assess annually to determine if an ongoing report is needed.

Issue 8: Foot Orthotics – Exclusion

Samples T16, T17, T18, T19: Foot orthotics, which are an exclusion were paid. Anthem disagreed with these errors during the remote review and noted that coverage is not limited to a diabetic diagnosis. Segal references page 56 of the plan document under what is not covered under the medical plan that notes Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes. The diagnosis for these claims did not contain a systematic illness.

Anthem's Response: Anthem disagrees to the errors assessed for foot orthotics. The reported services for each target sample are covered under plan benefits. Further, coverage is not limited to a diabetic diagnosis. Therefore, the sample claims processed correctly per plan benefits.

Issue 9: Preventive Care Over Age 17

Sample T30, T32: Prevent services for a member over the age of 17 were paid. Anthem agreed to this error during the remote review and noted that preventive services are only covered under this plan up to the age of 16. Segal recommends that Anthem coach it's processor regarding benefits that are exclusions under this plan.

Anthem's Response: Anthem accepts overpayments totaling $418.10. In both cited instances, payment was manually extended for members who are above the age of 17. As the adjustments could potentially impact the members, claims will only be revised upon request. Additional training has been provided to the examiner responsible for the error.

Issue 10: Duplicate Claim Payment

Sample T34: Duplicate claim payment was made. Anthem agreed to this error during the report review and noted that the claim was adjusted on July 7, 2023. Due to the claim being adjusted post audit period the error is included within this review. No further intervention is necessary on this claim.

Anthem's Response: Anthem agrees. Manual processing led to a duplicate payment totaling $6,236. As noted by Segal, this duplicate payment was retracted on July 7, 2023.

Sample T35: Duplicate claim payment was made. Anthem agreed to this error during the report review and noted that the claim was adjusted on September 26, 2023. Due to the claim being adjusted post audit period the error is included within this review. No further intervention is necessary on this claim.

Anthem's Response: Anthem agrees. Manual processing resulted in a duplicate payment of $827.68. As noted by Segal, the duplicate payment was retracted September 26, 2023.

Anthem uses each audit as an opportunity for training and improvement. Our representatives are available to discuss the results of this audit upon request.

We look forward to working with Segal and LACERA in the future.

Sincerely,

Jen Masker

Jen Masker
External Audit Facilitator Sr, Customer Audit Services

cc: Karima Carr, Elevance Health
Marijane Gadbury, Elevance Health
Tina Griffin, Anthem
Nicole Harber, Anthem
LaTosha Harwell, Elevance Health

Appendix A

Source documentation

The information below is a list of all documentation used as part of the review process for the medical health benefit review.

- Summary Plan Description, effective July 1, 2022, for the following plans:
  - Plan I In State
  - Plan I Out-of-State
  - Plan II In State
  - Plan II Out-of-State
  - Plan III In State
  - Plan III Out-Of-State
  - Prudent Buyer
- Summary Plan Description, effective July 1, 2021, for the following plans:
  - Plan I In State
  - Plan I Out-of-State
  - Plan II In State
  - Plan II Out-of-State
  - Plan III In State
  - Plan III Out-Of-State
  - Prudent Buyer

Los Angeles County Employees Retirement Association

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

Audit Period: July 1, 2022, through June 30, 2023

Final Report

May 24, 2024 / Amber M. Turner, MBA, PMP

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Segal

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May 24, 2024

Cassandra Smith
Director, Retiree Healthcare Program
Retiree Healthcare Division
Los Angeles County Employees Retirement Association

Re: Dental Claims Audit- July 2022- June 2023

Dear Cassandra:

On behalf of the Los Angeles County Employees Retirement Association (LACERA), Segal's Benefit Audit Solutions Practice (Segal) completed a review of the dental benefit plan administered by the Cigna Healthcare (Cigna), for the period of July 1, 2022 through June 30, 2023. The audit includes an assessment of Cigna adjudication procedures and a random sampling of stratified statistical claims.

The following report presents the details and results of the review process.

Once you have reviewed this report, please let us know if you have any questions.

Sincerely,

Amber M. Turner

Amber M. Turner, MBA, PMP
Senior Consultant, Audits

cc: Stephen Murphy
Michael Szeto

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Section 1 — Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Cigna Healthcare (Cigna), in its administration of the Los Angeles County Employees Retirement Association group dental benefits. Amber Turner and Felicia Zhang of Segal's Benefit Audit Solutions (BAS) Practice conducted the remote audit during the week of October 23, 2023.

The audit encompassed a total sample of 225 stratified claims for the audit period of July 1, 2022 through June 30, 2023. The 225 sample claims equaling $93,355.43; or 0.26% by cost, of the $36,575,760.92 total claims for the audit period.

Overall, Segal identified one $73.60 Overpayment and one Procedural error, which are outlined under Key Findings and Recommendation section.

Segal's audit included the following review components.

- A random, stratified sample of 225 dental claims to measure statistical validity in the financial dollar value and incidence.
- A Measurement of the time to process claims from receipt of claim to the initial date processed for payment or denial.
- An adjudication procedure review to assess day-to-day processing guidelines and claim control measures.

Statistical achievement categories

As illustrated in the chart below, Cigna met the performance guarantees for Financial, Payment, and Overall Processing Accuracies but fell slightly below the 10-business day and 10- business days performance guarantee for Time-to-Process, per Segal's calculation.

Statistical Achievement Table

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	99.89%	99.00%	99.00%
Payment Accuracy (Free from financial error)	99.65%	95.00%	97.00%
Procedural Accuracy (free from processing error)	100.00%	N/A	95.00%
Overall Processing Accuracy (Free from error)	99.65%	97.00%	95.00%
Time-to-Process			
(within 10 business days)	92.23%	93.00%	95.00%
(within 20 business days)	94.81%	98.00%	100.00%

Note: Time-to-Process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.

N/A = Not Applicable

Segal recommended that Cigna review if a penalty needs to be assessed for failure to meet the performance guarantee as Segal's calculation did not include multiple processing events (i.e., adjustments).

Cigna confirmed with adjustments included, Cigna met 95.5% for 10 days and 98.0% for 20 days thus a penalty is not due to the turnaround time.

Key findings and recommendations

The following issue numbers summarize the primary findings identified by Segal's auditors during the claims review. Cigna's responses to the findings from the remote review are summarized and italicized throughout the report. Cigna was presented with a draft report on November 17, 2023 for its review and comment. Cigna provided its formal response to the audit report on December 18, 2023, which can be found in Section 6 of this report.

Statistical Audit Findings Summary Chart

Dental Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Number of Sample Claims
Issue 1: Crown Downgrade	$73.60	-$0.00	1
Issue 2: Incorrect Member	Procedural	-$0.00	1
Total	$73.60	-$0.00	**2**

Details regarding the identified deviations can be found in the statistical claim sample error table in Section 3 of this report.

Recommendations

Based upon the review, Segal recommends:

- Segal recommends that LACERA continue to audit the dental program on a yearly basis to ensure benefits are being adjudicated as per LACERA's intent. As of this report, both claims found in error provided coaching opportunities for Cigna to ensure that processors going forward do not repeat the same errors. Segal found this intervention was an appropriate course of action on Cigna's behalf.

Section 2 — Audit Details

Cigna provided an electronic data file of all dental claims processed and paid during the 12-month period of July 1, 2022 through June 30, 2023. The objective of the review was to ensure that claims were paid in accordance with LACERA's plan provisions.

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 (1-225) 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.

Review process

Cigna provided a copy of the sampled claim submissions and access through its Dentacom Claim System. 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 , frequency, review decisions, x-ray reports, etc.) is on file for claims paid and verified when necessary.
- Coordination of benefits (COB) provisions was enforced, where applicable.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Benefits were paid under the proper classification, diagnostic, and dental procedure codes as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, coinsurance, and annual limitation maximums were applied.
- 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 if benefits were not assigned).
- Time-to-process for processing of claims was within industry standards or established performance guarantees.

The 2022 and 2023 Dental Summary Plan Description (SPD) and Dental Certificate served as references for the statistical analysis; please note that a full list of resource documents has been added to the appendix.

All questions and potential errors were presented to Cigna's representatives; outstanding responses post-audit were provided through November 8, 2023.

Section 3 — Statistical Review

The selection of 225 random claims for plan year July 1, 2022 through June 30, 2023 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

Below is the stratification table utilized for the audit.

Strata	Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar-Amount in Selection	Dollar-Amount in Strata
A	$0.01–$69.99	27,026	40	$2,051.96	$1,340,735.59
B	$70.00–$99.99	26,799	35	$3,048.00	$2,269,956.39
C	$100.00–$139.99	28,023	30	$3,587.98	$3,286,990.02
D	$140.00–$219.99	28,828	25	$4,208.96	$5,001,767.45
E	$220.00–$339.99	16,573	20	$5,773.20	$4,485,179.87
F	$340.00–$499.99	8,954	20	$8,195.88	$3,667,694.20
G	$500.00–$774.99	7,724	15	$9,213.10	$4,811,460.27
H	$775.00–$1,099.99	5,389	10	$9,443.05	$4,993,582.68
I	$1,100.00–$1,499.99	4,148	10	$13,070.10	$5,240,146.65
J	$1,500.00–$1,619.99	972	10	$15,000.00	$1,458,484.60
K	$1,620.00–$2,388.00	10	10	$19,763.20	$19,763.20
Total		154,446	225	$93,335.43	$36,575,760.92

Statistical claim sample error table

The review of 225 statistical sample claims for the audit period of July 1, 2022 through June 30, 2023 identified two (2) in-sample errors:

- One (1) overpayment totaling $73.60; and,
- One (1) procedural error.

Cigna's responses are summarized and italicized with formal response found in Section 7 of this report.

Statistical Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Cigna's Response	Segal's Final Comment
Issue 1: Crown Downgrade					
190H	$73.60	Manual	A crown for a molar tooth did not downgrade the benefit from porcelain to metal. *Cigna agreed to this error during the remote review.* As this claim was manually adjudicated Segal recommended that Cigna provide coaching and additional education to its claim processor.	*Sample #190 was a manual claim processing error. This manual processing error has been reviewed with the individual claim processor for further coaching and training opportunities.* *Reinforcement coaching conducted in December 2023 included:* *• Reviewing the submitted claim form, all attachments, and claim history prior to finalization* *• Reviewing LACERA Account Specifics* *• Real time feedback during claim processing with individual claim processor* *Claim Correction Status*	**No further intervention is necessary.**

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent	Auto/ Manual	Initial Error	Cigna's Response	Segal's Final Comment
				Sample 190 ($73.60 OP) – Claim was sent for recovery November 2023.	
Issue 2: Incorrect Member					
222K	Procedural	**Manual**	A claim for a dependent processed under the member. *Cigna agreed to this error during the remote review.* As this claim was manually adjudicated and neither the member nor the dependent met the annual limitation, Segal recommended that Cigna provide coaching and additional education to its claim processor.	*Sample # 222 was a manual claim processing error. The claim processor is no longer with the company; however, the error has been reviewed with the claim teams for further coaching opportunities.* *Reinforcement coaching conducted in December 2023 included:* *• Reviewing the submitted claim form, all attachments, and claim history prior to finalization* *• Reviewing Dentacom checklist prior to finalization of the claim to ensure accuracy* *Claim Correction Status* *Sample 222 (non-financial) – Claim was corrected in December 2023.*	**No further intervention is necessary.**

Summary of Statistical Sample Findings

Description	Amount
1 Overpayment	$73.60
1 Procedural Errors	Not Applicable

Segal does not guarantee the accuracy of the claims adjudication of the dental benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Cigna's dental claims adjudication. The results in this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

Section 4 — Time-to-Process Achievement

Results from the electronic analysis of all dental claims processed during the audit period of July 1, 2022 through June 30, 2023 revealed Cigna processed 92.23% of the claims within fourteen (14) calendar days (10 business days), which fell slightly below the 10-business day performance guarantee of 93.00%, and 94.81% fell below the thirty (30) calendar days (20 business days).

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial. Industry standards indicate 95% of all claims should be processed within fourteen (14) calendar days. Best practice, which follows U.S. Department of Labor, Employee Benefits Security Administration (EBSA), requires 100% within thirty (30) calendar days.*

Segal's electronic calculations of all claims processed within the audit period did not allow for distinction of multiple processing events.

Segal recommended that Cigna review if a penalty needs to be assessed for failure to meet the performance guarantee as Segal's calculation did not include multiple processing events (i.e., adjustments).

Cigna confirmed with adjustments included, Cigna met 95.5% for 10 days and 98.0% for 20 days thus a penalty is not due to the turnaround time.

* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits.pdf.

Section 5 — Adjudication Procedures Review

The objective of the review is to ensure that proper procedures are in place to ensure claims control measures. The processing guidelines were described in the Adjudications Procedures Review and evidenced within the 225 statistical claim samples 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 Plan costs.

- LACERA's claims are adjudicated by a designated 43 member Cigna team located remotely across the United States.
  - Standards and routine monitoring are in place in order to address privacy needs and ensure data is protected.
- On average, during the audit period Cigna processed 15,107 LACERA claims per month.
- 72.25% of LACERA claims are auto-adjudicated by Cigna.
- 82.00% of claims are auto-adjudicated business wide through Cigna.
- Business wide, Cigna receives 88.10% 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. This process has not been adjusted since Segal started auditing.

- Pre-determinations are not required but are recommended for any services billed over $200.00.
- Members eligibility information is received via paper, email, and phone calls from LACERA.
  - Cigna's eligibility analyst review records to ensure that the records match the dental benefit option for each member.
- Cigna's system has the ability to automatically identify potential coordination of benefits (COB).
- COB investigations are triggered in the following instances:
  - If a claim is received for a dependent/spouse and other insurance investigation has not been updated within the past 12 months.
  - If a claim has an indication of other insurance.
  - Receipt of another insurance's explanation of benefits.
  - When a plan is changed.
    - If other insurance information is not received within 55 days, Cigna denies the claim (except in the case of North Carolina where members are allowed 90 days).
- Two external vendors are utilized for services related to LACERA's claims.
  - Firstsource is utilized for dental mail room and data entry.
  - Cotiviti (formerly HMS/Accent) is utilized for overpayment recoveries.

Section 6 — Cigna's Formal Response to the Draft Report

Los Angeles County Employees Retirement Association

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

December 2023

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Jason Auer
National Account Executive
National Accounts
CA License No. 0I40741

December 15th, 2023

26 Executive Park #200
Irvine, CA 92614
Tel 949.500.8018
Jason.Auer@CignaHealthcare.com

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, 2022, through June 30, 2023)

Dear Cassandra;

Thank you for the opportunity to respond to the findings of the final report from the dental plan audit of Cigna HealthCare's Claim Administration Services completed the week of October 27th, 2023, 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
National Account Executive

Cc Lisa Curley, Cigna
Susan Cabarloc, Cigna
Cindy Yanaga, Cigna

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Audit Overview

- Cigna has reviewed the report submitted by Segal. Cigna appreciates Segal's insights and recommendations on enhancement opportunities.
- Segal Consulting conducted an audit the week of October 23, 2023 of Los Angeles County Employees Retirement Association (LACERA) claims processed by Cigna.
- Scope details:
  > The sample consisted of 225 random dental claims processed from July 1, 2022 through June 30, 2023.

Audit Results	Segal Recognized Audit Results
Financial Accuracy	99.89%
Payment Accuracy	99.65%
Overall Accuracy	99.65%

•**Turnaround Time Statistics:**

Turnaround Metric	Segal's Findings	LACERA PY 2021 (7/1/2021 – 6/30/2022) Performance Guarantee Results (PG)	LACERA PY 2022 (7/1/2022 – 6/30/2023) Performance Guarantee Results (PG)	Performance Guarantee Goal (PY 2021 & PY 2022)
10 Days	**92.23%** (14 days**)**	**91.5%**	**95.5%**	93.00%
20 Days	**94.81%** (30 days**)**	**98.1%**	**98.0%**	98.00%

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Audit Summary

Claim Quality Audit

- **Error Summary:**
  - In Sample – 2 Errors
  - Out of Sample- 0 Errors
- **Financial Impact: Gross -**
  - Overpaid - $73.60
- **Recovery Status**
  - Recovered:$ 0.00
  - Outstanding: $73.60

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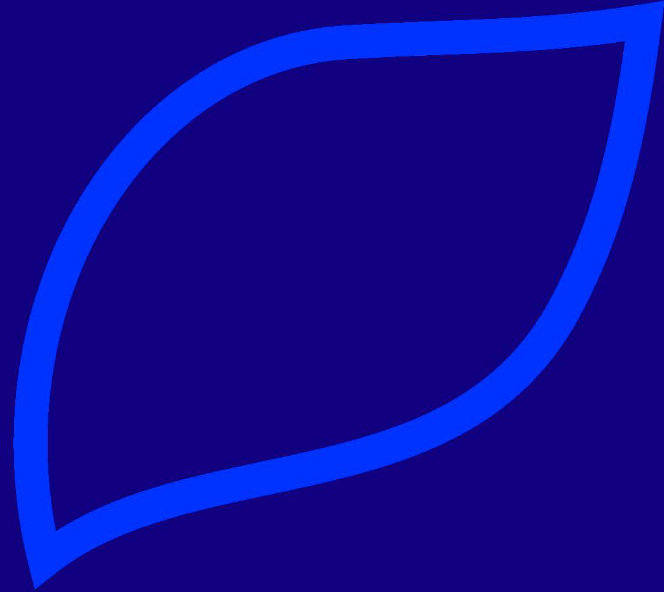
Random Sample



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Dental Audit Findings – Random Claim Sample

	Cigna Response
Crown Downgrade **Sample: 190** **Overpayment: $73.60** A crown for a molar tooth did not downgrade the benefit from porcelain to metal. As this claim was manually adjudicated Segal recommends that Cigna provide coaching and additional education to it's claim processor.	Cigna is in agreement with the audit findings for Sample #190. • Sample #190 was a manual claim processing error. This manual processing error has been reviewed with the individual claim processor for further coaching and training opportunities. Reinforcement coaching conducted in December 2023 included: • Reviewing the submitted claim form, all attachments, and claim history prior to finalization • Reviewing LACERA Account Specifics • Real time feedback during claim processing with individual claim processor Claim Correction Status Sample 190 ($73.60 OP) – Claim was sent for recovery November 2023

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Dental Audit Findings – Random Claim Sample

	Cigna Response
Incorrect Member **Sample: 222** A claim for a dependent processed under the member. As this claim was manually adjudicated and neither the member nor dependent met the annual limitation, Segal recommends that Cigna provide coaching and additional education to it's claim processor.	Cigna is in agreement with the audit findings for Sample #222. • Sample # 222 was a manual claim processing error. The claim processor is no longer with the company; however, the error has been reviewed with the claim teams for further coaching opportunities. Reinforcement coaching conducted in December 2023 included: • Reviewing the submitted claim form, all attachments, and claim history prior to finalization • Reviewing Dentacom checklist prior to finalization of the claim to ensure accuracy Claim Correction Status Sample 222 (non-financial) – Claim was corrected December 2023

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Dental Audit Findings – Time-to-Process Achievement

	Cigna Response
Time-to-Process Segal recommends that Cigna review if a penalty needs to be assessed for failure to meet the performance guarantee	Cigna is in agreement that we did not meet our time-to-process metric of 93% in 10 business days for the 7/1/2021 plan year (7/1/2021 – 6/30/2022). However, we did meet our time-to-process metric of 98% in 20 business days for the 7/1/2021 plan year as well as both metrics for the 7/1/2022 plan year (7/1/2022 – 6/30/2023) as referenced on slide 2. Cigna can confirm a missed metric penalty (for the 7/1/2021 plan year) was paid to the client on 11/29/2022. Cigna can also confirm we met both Turnaround Time metrics for the 7/1/2022 plan year, therefore a penalty payment was not due.

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Thank you for your partnership.

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Appendix A

Source documentation

The information below is a list of all documentation used as part of the review process for the dental benefit review.

- Dental Summary Plan Description and Texas (TX) , effective January 1, 2021 & 2022
- Dental Summary Plan Description and TX, effective January 1, 2021 & 2022
- Extraterritorial Legislation Rider, effective January 1, 2022
- TX Dental Certificate, effective January 1, 2021 & 2022
- Dental Certificate, effective January 1, 2021 & 2022

Los Angeles County Employees Retirement Association

Group Dental and Medical Benefits Audit Results

Audit Period: July 1, 2022 through June 30, 2023

September 4, 2024/ Amber M. Turner, MBA, PMP / Felicia Zhang

Segal

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Agenda

Dental Claims Audit

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

Medical Claims Audit

- **Results**
- **Key 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, 2022 through June 30, 2023, representing $36,575,790.92 in benefit payments. The review of the statistical sample of 225 claims identified one overpayment for $73.60 and one procedural error.

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 per Segal's assessment.

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	99.89%	99.00%	99.00%
Payment Accuracy (Free from financial error)	99.65%	95.00%	97.00%
Procedural Accuracy (free from processing error)	100.00%	N/A	95.00%
Overall Processing Accuracy (Free from error)	99.65%	97.00%	95.00%
Time-to-Process			
(within 10 business days)*	92.23%	93.00%	95.00%
(within 20 business days)	94.81%	98.00%	100.00%

Note: Time-to-Process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account. Cigna confirmed with adjustments included, Cigna met 95.5% for 10 days and 98.0% for 20 days thus a penalty is not due to the turnaround time.

Cigna Dental Audit – Key Findings

The following chart represents the issues identified within the dental audit.

Dental Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Number of Sample Claims
Issue 1: Crown Downgrade	$73.60	-$0.00	1
Issue 2: Incorrect Member	Procedural	-$0.00	1
Total	**$73.60**	**-$0.00**	**2**

Dental Next Steps

- As of this report, both claims found in error provided coaching opportunities for Cigna to ensure that processors going forward do not repeat the same errors. Segal found this intervention was an appropriate course of action on Cigna's behalf therefore no further intervention is necessary.

Anthem Medical Audit - Results

Anthem provided data files for all medical claims processed and paid during the 12-month audit period of July 1, 2022 through June 30, 2023, representing $152,045,164.70 in benefit payments. The review of 255 claims (220 Stratified and 35 Targeted) identified $30,464.07 in Overpayments and -$2,013.45 in Underpayments,.

Anthem met the performance guarantees for financial, procedural, and time-to-process accuracy but fell below industry standard for payment and overall accuracy. Targeted and out of sample claims are not included in the statistical accuracy.

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	99.85%	99.00%	99.00%
Payment Accuracy (Free from financial error)	92.30%	95.00%	97.00%
Procedural Accuracy (free from processing error)	100.00%	N/A	95.00%
Overall Processing Accuracy (Free from error)	92.30%	97.00%	95.00%
Time-to-Process			
(within 10 business days)*	98.70%	93.00%	95.00%
(within 20 business days)	99.01%	98.00%	100.00%

Anthem Medical Audit – Key Findings

The following chart represents the issues identified within the Medical audit.

Medical Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Number of Sample Claims	Recurring or New Issue
Issue 1: Incorrect Coordination of Benefits (COB)	$5.34	-$22.40	9	Recurring
Issue 2: Deductible/Out-of-Pocket Overapplied	$0.00	-$1,869.41	18	Recurring
Issue 3 Surgery Applied Cost Sharing	$0.00	-$121.64	1	Recurring
Issue 4: Paid Over Plan Maximum	$2,320.35	-$0.00	1	Recurring
Issue 5: Incorrect Pricing	$1,098.85	-$0.00	1	New
Issue 6: Acupuncture Over $30/ Visits Over 50/ Incorrect Cost Sharing	$937.40 & 2 Procedural Errors	-$0.00	6 Financial Errors and 2 Procedural Errors	Recurring
Issue 7: Hearing Aids Over $300.00	$16,656.06 & 1 Procedural Error	-$0.00	5 Financial Errors and 1 Procedural Error	Recurring
Issue 8: Foot Orthotics - Exclusion	$1,964.29	-$0.00	4	Recurring
Issue 9: Preventive Care Over Age 17	$418.10	-$0.00	2	New
Issue 10: Duplicate Claim Payment	$7,063.68	-$0.00	2	Recurring
Total	**$30,464.07**	**-$2,013.45**	**52**	

Medical Next Steps

- **Issue 1: Incorrect Coordination of Benefits (COB)** – Anthem disagreed with Segal during the remote review and noted that Anthem provided 20% payment for the supplemental plan. Segal disagrees with Anthem and notes that Page 5 of the plan document states that LACERA 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. Segal recommends that LACERA discuss this issue with Anthem.
- **Issue 2: Deductible/Out-of-Pocket Overapplied** – Anthem agreed to these errors and have identified pharmacy comingling as the determining factor of the overage. Starting March of 2024, Anthem implemented a new reporting process to better streamline adjustments. Segal recommends that LACERA monitor this issue as it is a reoccurring issue from previous audits as well as confirm that Anthem has reimbursed the members that were impacted for this issue.
- **Issue 4: Paid Over Plan Maximum** – As this issue is due to the pharmacy comingling, Segal recommends that LACERA monitor this issue as Anthem noted a new process was implemented in March 2024.
- **Issue 6: Acupuncture Over $30/ Visits Over 50/ Incorrect Cost Sharing** – Anthem agreed to this issue and noted that starting in April 2024, Anthem will run quarterly reporting to review trends and identify opportunities, as needed. Annually, Anthem will determine if ongoing reporting is necessary. Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.
- **Issue 7: Hearing Aids Over $300.00** –– Anthem agreed to this issue and noted that starting in April 2024, Anthem will run quarterly reporting to review trends and identify opportunities, as needed. Annually, Anthem will determine if ongoing reporting is necessary. Segal recommends that LACERA discuss ongoing reporting with Anthem as this is a reoccurring issue from previous audits.
- **Issue 8: Foot Orthotics - Exclusion** – Anthem disagreed with this issue during the remote review and noted that coverage for this benefit is extended beyond a diabetic diagnosis. Segal recommends that LACERA discuss this benefit with Anthem and determine if a plan document update is necessary.
- **Issue 9: Preventive Care Over Age 17** – Anthem agreed with these errors during the remote review but noted that if an adjustment is made potential impact to the member can occur. Segal recommends that LACERA discuss with Anthem to decide if adjustments are necessary.

- **Issue 3 Surgery Applied Cost Sharing, Issue 5: Incorrect Pricing, Issue 10: Duplicate Claim Payment** – No further intervention is necessary on these claim issues as they have since been resolved.

LACERA

Los Angeles County Employees Retirement Association

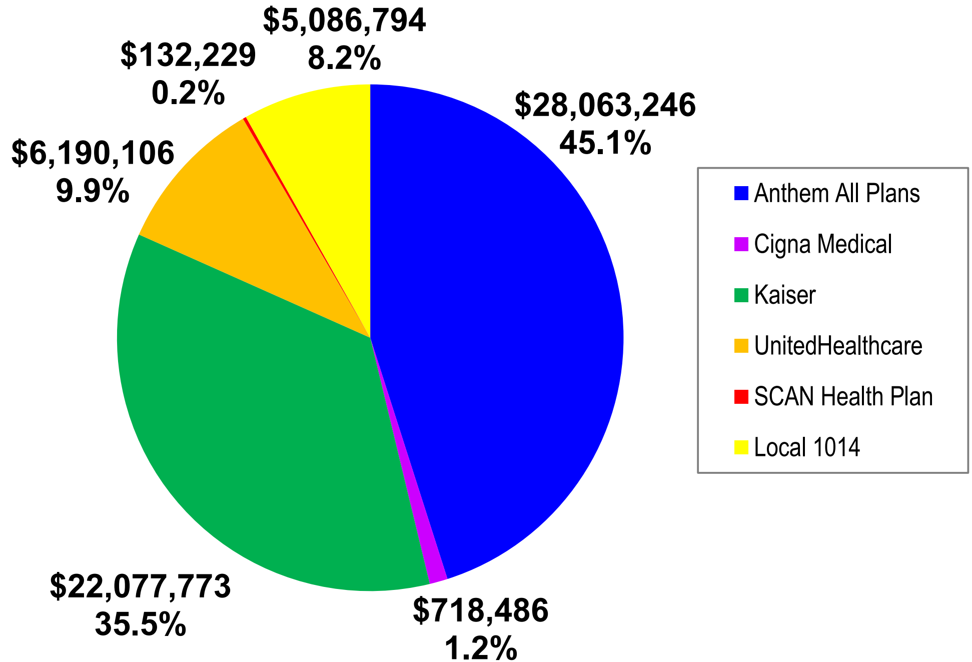
Premium & Enrollment

Coverage Month Ending July 2024

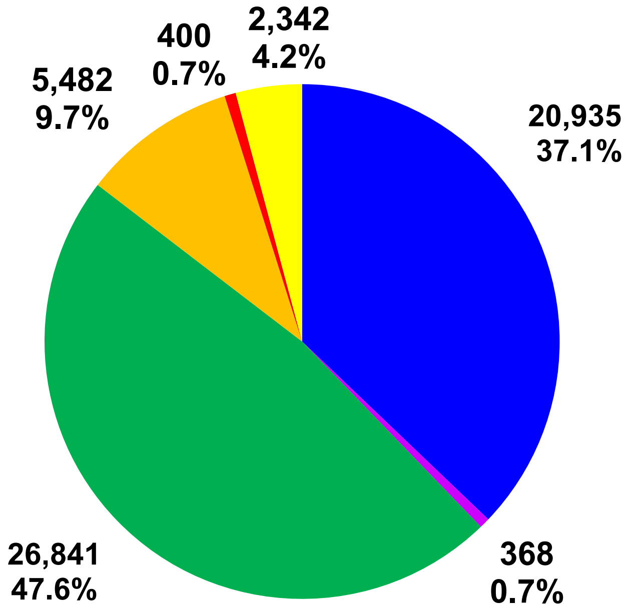
Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$28,063,246	45.0%	20,935	37.1%
Cigna Medical	$718,486	1.2%	368	0.7%
Kaiser	$22,077,773	35.5%	26,841	47.6%
UnitedHealthcare	$6,190,106	9.9%	5,482	9.7%
SCAN Health Plan	$132,229	0.2%	400	0.7%
Local 1014	$5,086,794	8.2%	2,342	4.2%
Combined Medical	**$62,268,633**	**100.0%**	**56,368**	**100.0%**

Cigna Dental & Vision (PPO and HMO)	Monthly Premium	Retirees
Cigna Dental & Vision (PPO and HMO)	**$4,728,003**	**58,524**

Monthly Premium



Retirees



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

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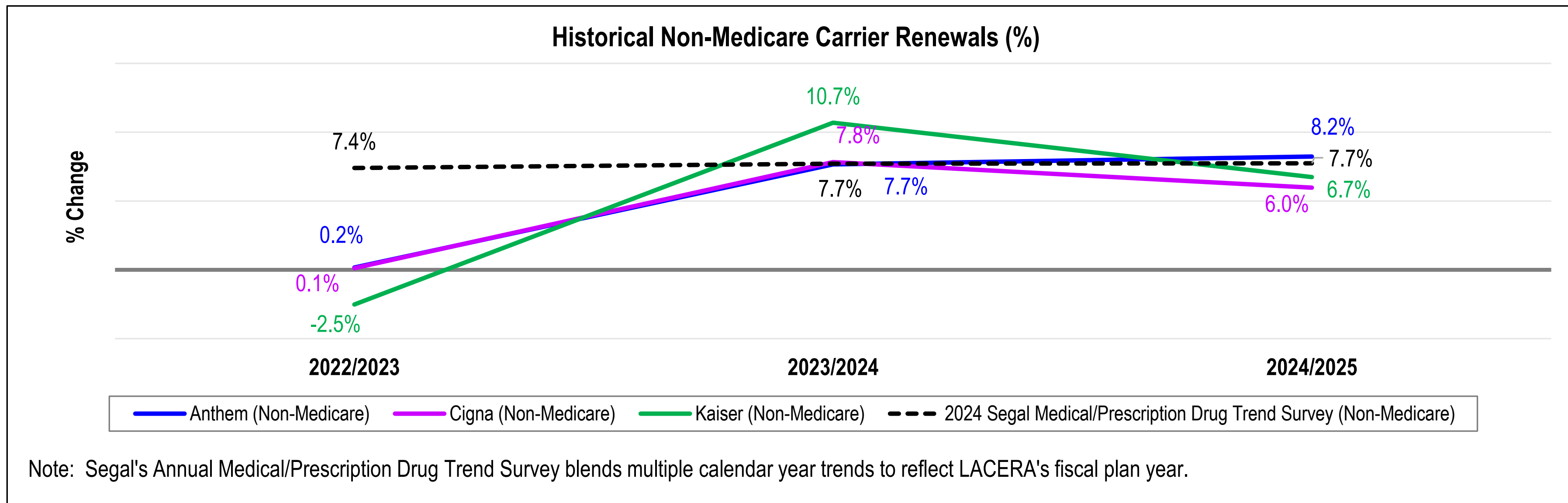
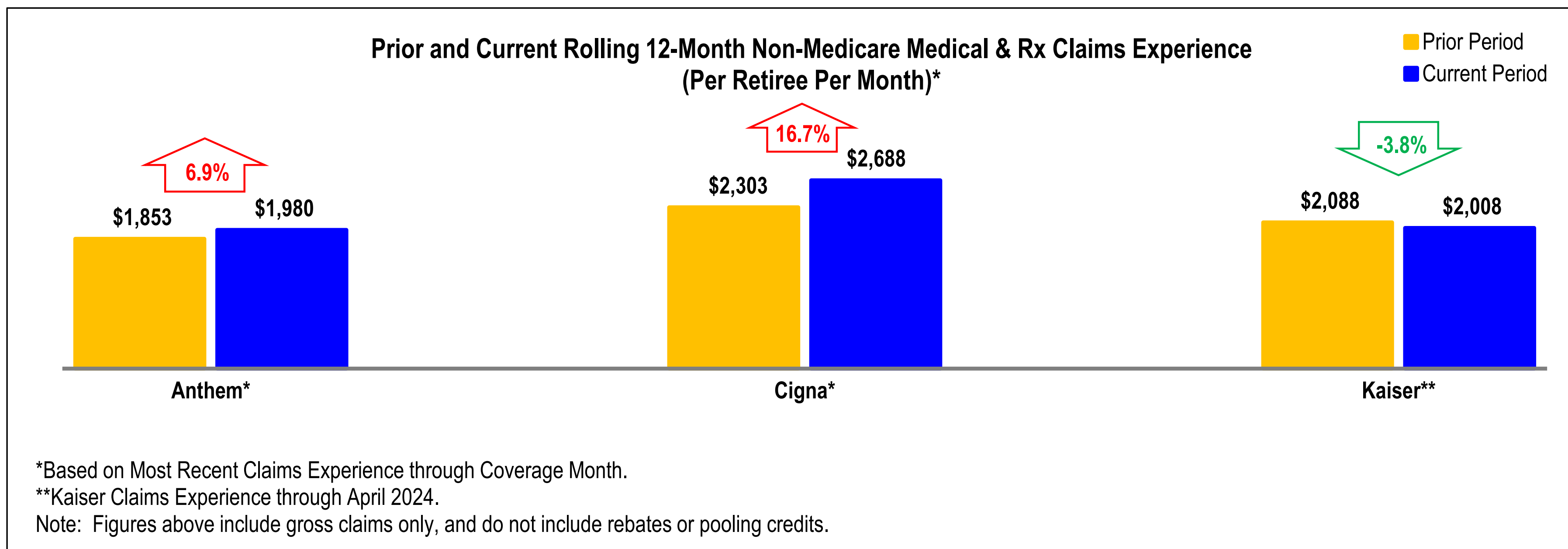
Los Angeles County Employees Retirement Association

Claims Experience by Carrier

Coverage Month Ending July 2024



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 April 2024.

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

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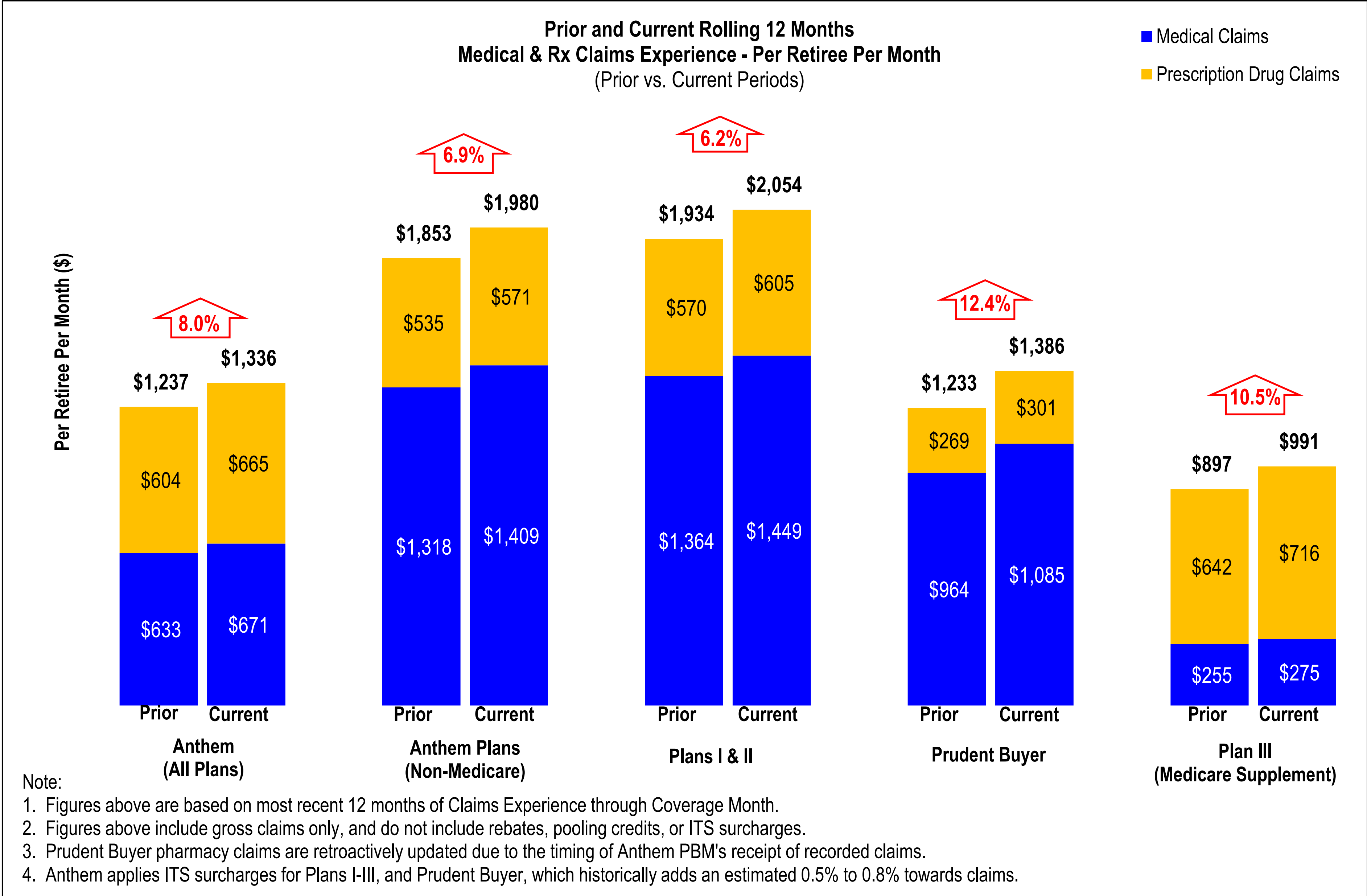
Anthem Claims Experience By Plan

Coverage Month Ending July 2024



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 0.8% towards claims.

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Kaiser Utilization

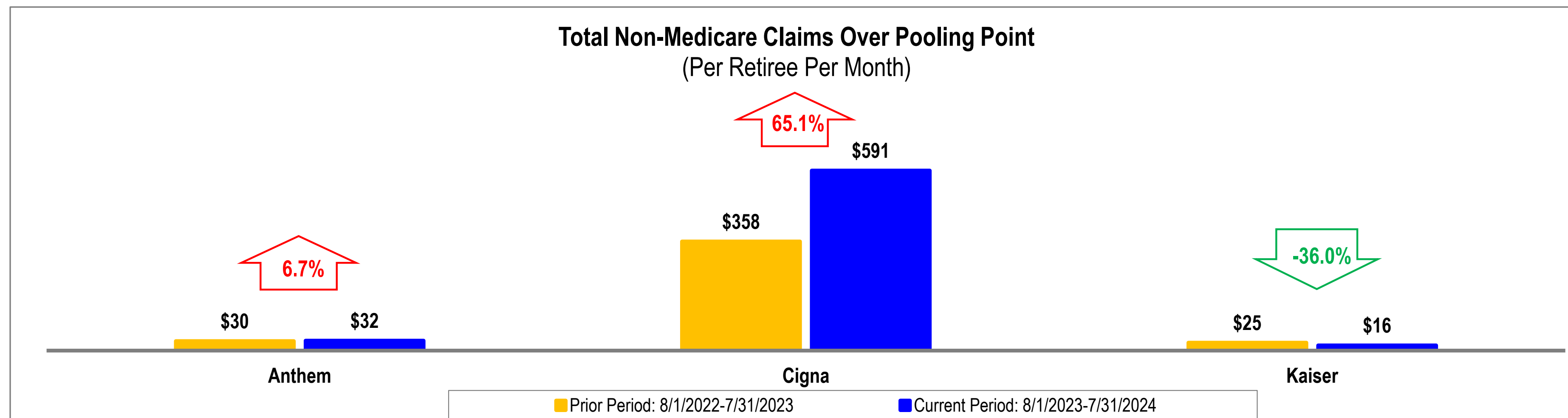
Coverage Month Ending July 2024

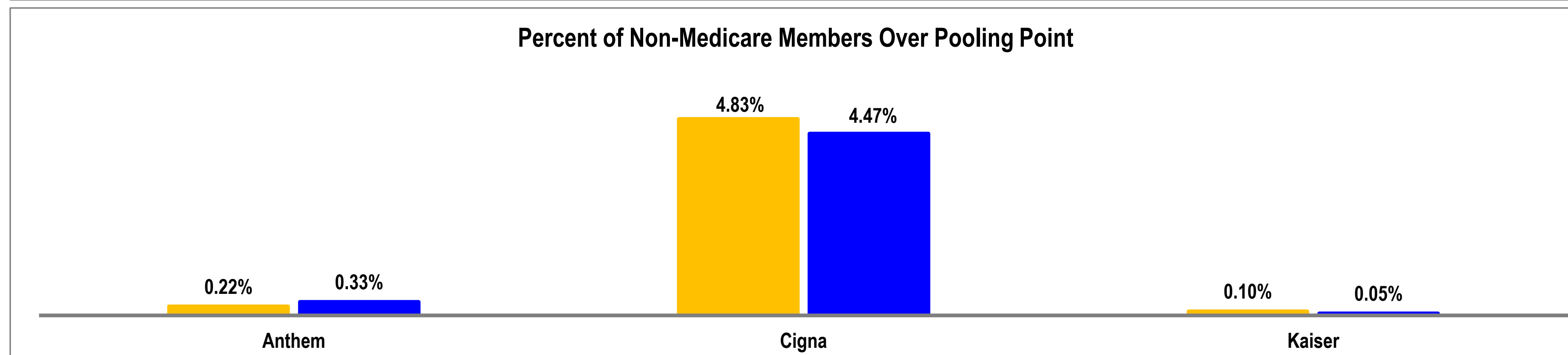
- Kaiser insures approximately 26,000 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in Southern California.

Category	Current Period 5/1/2023 - 4/30/2024	Prior Period 5/1/2022 - 4/30/2023	Change
Average Contract Size	**2.34**	**2.36**	**-0.85%**
Average Members	**8,864**	**8,980**	**-1.29%**
Inpatient Claims Per Member Per Month	$186.17	$270.66	-31.22%
Outpatient Claims Per Member Per Month	$394.07	$350.83	12.33%
Pharmacy Per Member Per Month	$141.92	$130.39	8.84%
Other Per Member Per Month	$139.35	$138.60	0.54%
Total Claims Per Member Per Month	**$861.51**	**$890.48**	**-3.25%**
Total Paid Claims	**$91,631,389**	**$95,957,865**	**-4.51%**
Large Claims over $550,000 Pooling Point [1]			
Number of Claims over Pooling Point	2	4	
Amount over Pooling Point	$723,562	$1,131,160	-36.03%
% of Total Paid Claims	**0.79%**	**1.18%**	
Inpatient Days / 1000	344.4	427.8	-19.50%
Inpatient Admits / 1000	51.8	54.5	-4.95%
Outpatient Visits / 1000	14,439.7	14,374.2	0.46%
Pharmacy Scripts Per Member Per Year	10.8	10.5	2.86%

[1] The pooling threshold is $525,000 for the plan year beginning 7/1/2023 through 6/30/2024 .

Los Angeles County Employees Retirement Association
High Cost Claimants (Anthem, Cigna, & Kaiser)
Coverage Month Ending July 2024





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 May through April.

Pooling Points by Carrier:

1. Anthem's pooling points are $400,000 for Plans I & II, and $300,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $550,000.

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Los Angeles County Employees Retirement Association

Anthem Lifetime Max Accumulation Status By Plan

Coverage Month Ending July 2024

Prior Month: June 2024 [1]			
Lifetime Claim Amount [2]	**Plans I & II**	**Prudent Buyer**	**Combined**
$900K-$999K	13	0	**13**
$800K-$899K	15	3	**18**
$700K-$799K	28	2	**30**
$600-$699K	46	1	**47**
$500-$599K	68	7	**75**
Total	**170**	**13**	**183**
Most Recent Month: July 2024 [3]			
Lifetime Claim Amount [2]	**Plans I & II**	**Prudent Buyer**	**Combined**
$900K-$999K	16	0	**16**
$800K-$899K	17	3	**20**
$700K-$799K	30	2	**32**
$600-$699K	46	2	**48**
$500-$599K	73	7	**80**
Total	**182**	**14**	**196**

[1] Based on data provided by Anthem on July 10, 2024.

[2] Members identified by Anthem as terminated were excluded from the counts above.

[3] Based on data provided by Anthem on August 8, 2024.

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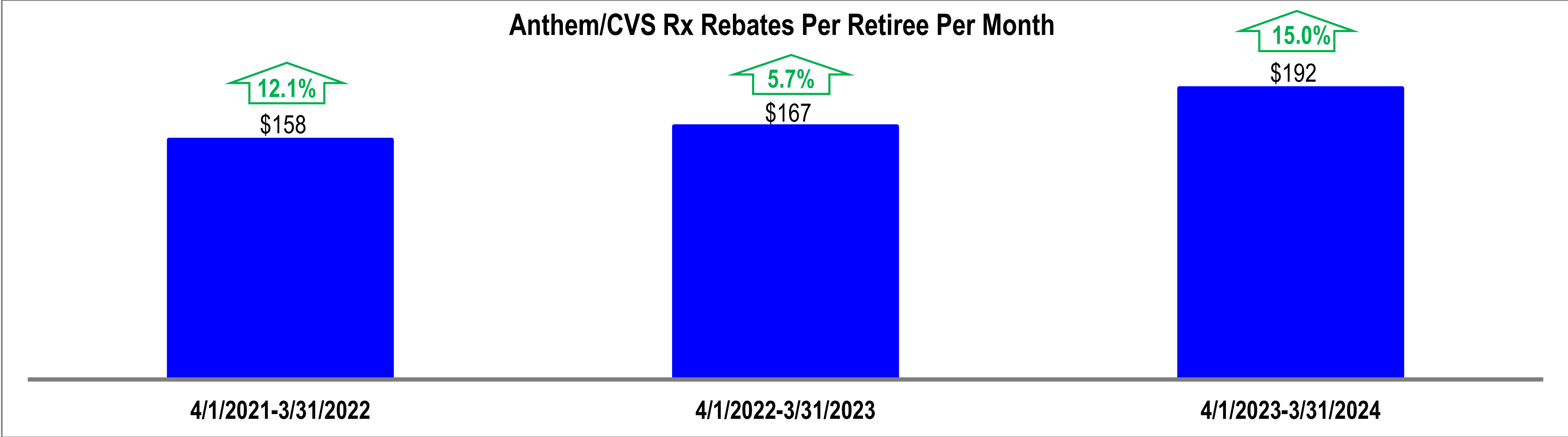
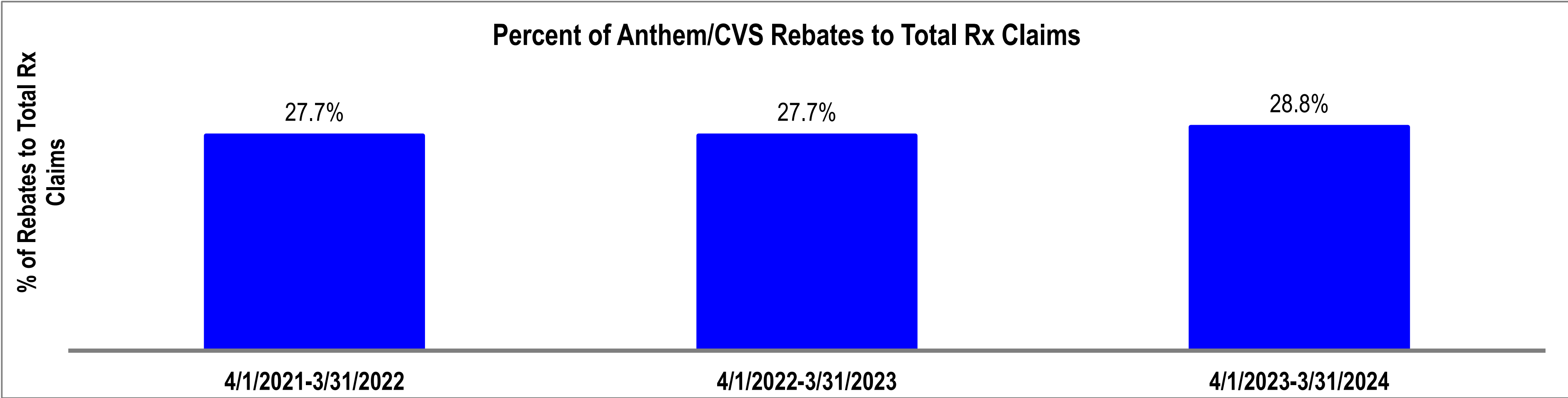
Los Angeles County Employees Retirement Association

Prescription Drug Rebates (Anthem)

Coverage Month Ending July 2024





Rebates Overview:

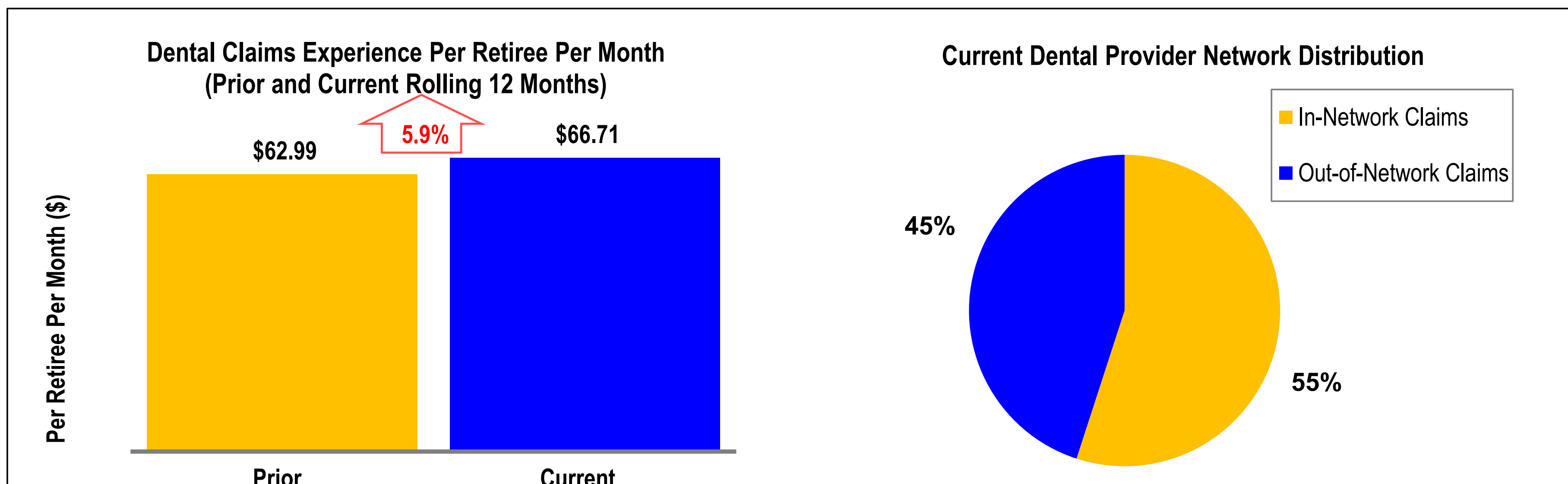
Pharmacy Benefit Managers negotiate volume-based rebates with drug manufacturers of brand medications. Manufacturer rebates are passed on to plan sponsors and are used to offset pharmaceutical claims expenses.

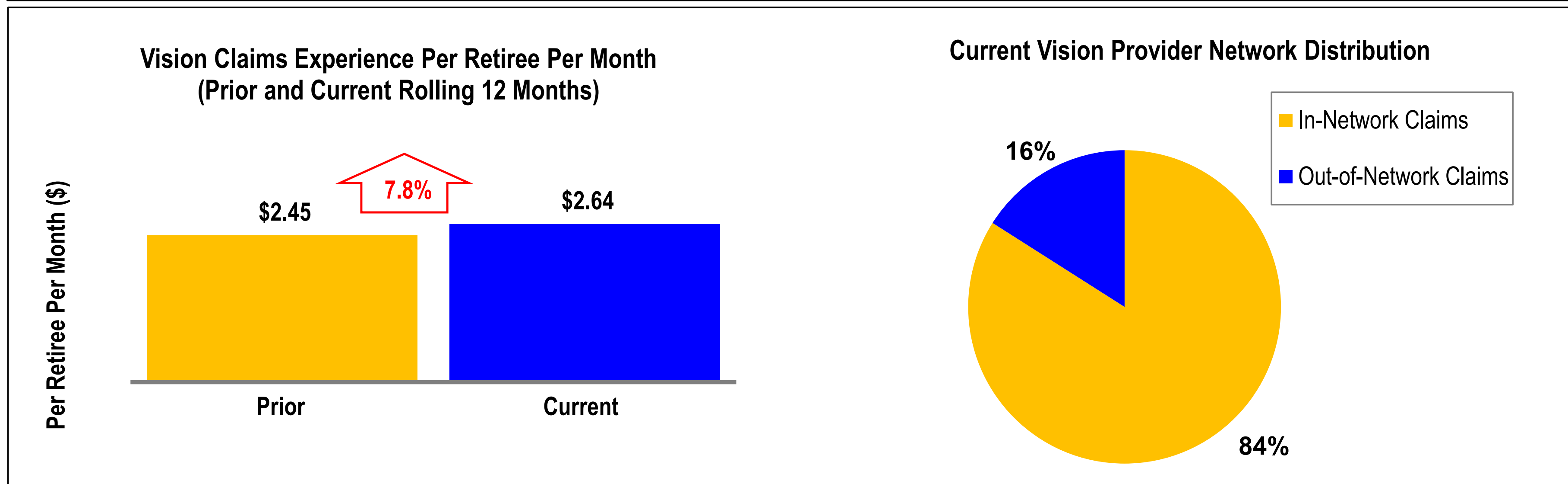
Note:

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.

LACERA

Los Angeles County Employees Retirement Association
Cigna Dental & Vision Claims Experience
Coverage Month Ending July 2024





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.