Greater Tompkins County Municipal Health Insurance Consortium

Audit and Finance Committee

March 22, 2016

3:30 p.m.

Old Jail Conference Room

1. Call to Order (3:30) — Thayer

2. Approve Minutes of February 23, 2016 Meeting (3:32)

3. Executive Director's Report (3:35) — Barber
   a. Newsletter & retreat
   b. **RESOLUTION:** AUTHORIZATION TO SIGN MEMORANDUM OF AGREEMENT WITH BOCES FOR NEWSLETTER PRINTING
   c. Recertification
   d. **RESOLUTION:** DIRECTING EXECUTIVE DIRECTOR TO COMMUNICATE WITH EMPLOYERS- DEPENDENT RECERTIFICATION PROCESS

4. JURAT Update (3:55) — Snyder

5. Report on Actuarial Opinion (4:00) — Locey

6. 2016 Financial Update (4:05) — Locey

7. Medical Claims Audit (4:15)
   a. Update on Medical Claims Audit Action Plan — Locey
   b. **RESOLUTION:** ADOPTION OF RETROSPECTIVE CLAIM TERMINATION POLICY

8. Discussion of Medicare Advantage Plan and Risk Assessment (4:30) — Locey
   a. Review Memorandum concerning Medicare Advantage Plan and Risk Assessment Fee

9. Process for establishing Guidelines on Members Changing Plans (4:45)
   a. **RESOLUTION:** GUIDELINES FOR MEMBERS CHANGING PLANS and OPEN ENROLLMENT

10. PBM RFP- process discussion (4:50)

11. Next Agenda Items (4:55)

12. Adjournment (5:00)

Next Meeting: April 26, 2016

Minutes - draft
Audit and Finance Committee
February 23, 2016
2:00 p.m.
Old Jail Conference Room

Present: Steve Thayer, Chuck Rankin, Laura Shawley
Absent: Peter Salton, Phil Vanwormer, Mack Cook
Guests: Rick Snyder, Steve Locey, Don Barber, Lisa Christian

Call to Order

Mr. Thayer called the meeting to order at 2:34 p.m. Mr. Snyder commented that he no longer has a conflict with a meeting on this date and could meet later if it would be more convenient to members. The Committee will be polled on this to see if a later start time would be more accommodating to members.

Approval of Minutes of January 26, 2016

It was MOVED by Mr. Rankin, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present, to approve the minutes of January 26, 2016 as submitted. MINUTES APPROVED.

Executive Director's Report

Mr. Barber reported he has been working on the newsletter and the first one should be ready for distribution during the first week in March. He asked members to share comments and provide him with feedback. He reported two new director orientation sessions were held and were attended by eight new directors. The next educational retreat date has been scheduled for May 10th at 9 a.m.

At the last Board meeting he raised the subject of the aggregate stop loss waiver that was requested from the State. He said the Department has not responded to the Consortium's response concerning the conditions surrounding the approval not making sense. He will be reaching out to Dan Sheridan at the Department and will report back at the next meeting.

He provided a revised draft resolution concerning the Code of Ethics. He spoke of previous discussion the Consortium had with Haylor, Freyer, and Coon and the question that was raised as to whether labor directors are covered by the Consortium's Directors and Officers Policy and said he was informed they are covered.

Mr. Barber reported a meeting was held with Tompkins Cortland Community College representatives to discussion billing and other issues and provided a brief overview of concerns that were raised. TC3, the third largest employer in the Consortium, is looking to have a voice within the Consortium. There was discussion of Article 47 not allowing them to have a Director's role on the Board. However, he said through the Municipal Cooperative Agreement the Consortium may be able to provide that. Mr. Snyder thanked Mr. Barber for facilitating the meeting and said it was very helpful and he felt progress had been made.

Mr. Barberported there was also discussion at the meeting of the County and the TC3 having issues with completing the dependent recertification and some suggestions were made to resolve those issues. He will continue to check-in with those municipalities to see the process is progressing. Ms. Drake, Chair of the Board, was also in attendance and said she would like the process to be complete by the end of March. He said he has not heard back

from the City of Ithaca; Mr. Thayer said he will follow-up with Schelley Michell Nunn and ask that she send Mr. Barber an update.

The other issues that were raised at the meeting was census data coming from Excellus and the tremendous amount of work it is requiring of benefit clerks. Mr. Barber said he and Mr. Locey met with Beth Miller of Excellus and told her the problem needs to be resolved and accurate census data has to be provided to the benefit clerks. Ms. Miller is working on it and said Excellus recognizes that this is an issue. He will continue to follow-up on this until a resolution is found. There was also discussion of the Blue4U benefit that is attached to metal level plans and a decision was made to stop the roll-out in Tompkins County, primarily because at the present time there is no location in Tompkins County for a blood draw. Excellus has reached out to Cayuga Medical Center to try to rectify the situation. The program has continued to roll-out in Cortland County.

RESOLUTION NO. 2015 - AMENDMENT TO GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM CODE OF ETHICS POLICY AND DESIGNATING COMMUNITY DISPUTE RESOLUTION CENTER AS NEUTRAL THIRD PARTY

MOVED by Mr. Thayer, seconded by Mrs. Shawley.

Mr. Barber noted that Mack Cook, member of the Board of Directors who has gone through this, is comfortable with the proposed resolution. He also said this allows the mediation process to take place.

The resolution was unanimously approved by members present.

WHEREAS, Section 15 of the GTCMHIC Board of Directors Resolution 001-2014 regarding adoption of Code of Ethics reads as follows:

"Reporting of Ethics Violations. When becoming aware of a possible violation of the Consortium's Code of Ethics, employees, Board of Directors, employees of members, and the public may report the matter to the Consortium Attorney-in-fact, John Powers, Esq.. In reporting the matter, members may choose to go on record as the complainant or report the matter on a confidential basis."

WHEREAS, the Code of Ethics Policy is silent on the process for resolving if any violation has occurred and the possible remedy, and

WHEREAS, the Consortium's Attorney-In-Fact has opined that the process for resolving a Code of Ethic's violation necessarily falls within ambit of the alternative dispute resolution process codified at Article V of the Municipal Cooperative Agreement (MCA), and

WHEREAS the 2015 Amended Municipal Cooperative Agreement amended the original Article V to add "Board Member" and "Committee Person" as additional parties, in addition to any "Participant," that would also be subject to the alternative dispute resolution process, and

WHEREAS, the Audit and Finance Committee has determined that disputes arising as a result of reported Code of Ethics violations could also involve persons who are not subject to MCA Article V and that with such persons, as well as Board Members and Committee Persons, mediation would provide a productive intermediate step to resolution prior to a formal finding

and/or Board of Directors determination as part of the alternative dispute resolution process, and

WHEREAS, a neutral third party is desired to mediate and, if needed, conduct the review process, and make a recommendation for resolution to the Executive Committee as stated in 2015 Amended MCA Article V.3.a.(i), and

WHEREAS, the Community Dispute and Resolution Center of Tompkins County provides such services and is willing to serve in the neutral third party role for any Greater Tompkins County Municipal Health Insurance Company reported ethics violations, now therefore be it

RESOLVED, That the Audit and Finance Committee of the GTCMHIC Board of Directors hereby recommends that section 15 of the adopted Code of Ethics be amended to read:

> "15. Reporting of Ethics Violations. When becoming aware of a possible violation of the Consortium's Code of Ethics, employees, Board of Directors, employees of members, and the public may report the matter to the Consortium Attorney-in-fact, John Powers, Esq.. In reporting the matter, members may choose to go on record as the complainant or report the matter on a confidential basis. Resolution of the reported violation shall occur according to the alternative dispute resolution (ADR) process set forth in Article V of the 2015 Amended MCA, except as follows. In lieu of the ADR step set forth at MCA Article V.3.a.(i), the Attorney-In-Fact will collect all information presented regarding the matter and send that information to a neutral third party designated by the Board of Directors who shall attempt to resolve the matter informally through mediation. If unsuccessful, the mediator shall make a recommendation with respect to resolution of the dispute in writing to the Executive Committee, which shall present the recommendation to the Board as provided for in 2015 Amended MCA Article V.3.a.(i). The remainder of Article V shall remain in effect",

RESOLVED, further, That the Community Dispute and Resolution Center of Tompkins County is designated as the neutral third party in the event of requested ethics review.

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RESOLUTION NO. - 2016 – AMENDMENT TO RESOLUTION NO. 04-2016 - AUTHORIZING CONTRACT FOR ACTUARIAL SERVICES - ARMORY ASSOCIATES – 2015 and 2016

MOVED by Mr. Rankin, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present.

WHEREAS, the Greater Tompkins County Health Insurance Consortium authorized a contract with Armory Associate of Syracuse, New York to perform actuarial services for the Consortium for the years 2015 and 2016 with an option to extend the contract for the years 2017 and 2018, and

WHEREAS, the quote received from Armory Associates was for five years which would be a two-year contract for fiscal years ending 12/31/2015 and 12/31/2016 with the option to extend for three additional years (for fiscal years ending 12/31/2017, 12/31/2018, and 12/3120/19), and

WHEREAS, it is recommended by the Consortium Treasurer that the contract line-up with the end of the biennial periods for Tompkins County, City of Ithaca, and the City of Cortland, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the option to extend the contract with Amory Associates to perform actuarial services be amended to include 2019.

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Mr. Barber provided an update on the prescription drug audit and said it is moving forward and a report should be ready to be presented to the Committee next month.

He reported on the medical claims audit and said the Board of Directors at its last meeting passed a resolution that referred to national coding guidelines. Discussions that took place after that meeting led to a conversation today that was arranged by Beth Miller and individuals from the audit department at Excellus. They provided an explanation as to what happened and said they have changed software and said they do follow national coding guidelines. Mr. Barber said he and will continue to work on this and plans to have it resolved prior to the next Board meeting.

Financial Update

To provide some explanation to respond to questions that have been raised as to why the Consortium did better financially in 2015 than in past years Mr. Locey distributed a spreadsheet showing the Stop Loss history from 2011 to 2015. The number of members with claims over $200,000 has gone from three and four in all years to only one in 2015. Total claims expenses over deductible in 2012 was over $1 million but since then the number has been relatively low. Mr. Locey pointed out that the number of insured has grown and although there were more claimants with claims that exceeded $100,000 none were of a catastrophic level.

Mr. Locey distributed data from Excellus showing claims incurred from October 1, 2014 and September 20, 2015 that were paid through December 31, 2015. Items highlighted included the plan cost which was down by $1.8 million from last year (8%) and inpatient plan cost per member per month was down by 28%. The number of claimants with plan cost of greater than $100,000 was down by 39% and the plan cost for those claimants was also down by 39%. The number of admissions was down from 407 to 308 (24%) and there was a 9% reduction in emergency room visits.

He distributed year-to-date budget versus actual expenses for January 2016. For the first month of 2016 total income was up by .28% over the adopted budget and expenses were 28.45% below budget. He noted that there are fees that have not yet been paid and accounts for part of the variance in expenses. Mr. Locey said an analysis was done for the IBNR (Incurred But Not Reported) and it was less than it has been historically. In the IBNR report it was noted that since BlueCross BlueShield changed its claims operating system they have sped up their claims payment quite a bit and instead of seeing 25% of claims being paid in the month that were incurred they are now seeing 40-50% of claims being paid in the month they were incurred. He will prepare data to show the trends and how claims are being paid faster are decreasing the Consortium's liability. He said he is seeing numbers well below the current 12% level and as low as 7%. Mr. Barber said he would like to share that information with the Department of Financial Services.

Prescription Drug Audit

Mr. Locey distributed a timeline for the prescription drug audit. Mr. Barber asked Mr. Locey to communicate with BMI and request that they attend the next meeting to present the report on the prescription drug audit.

Retrospective Terminations

Mr. Locey said the Affordable Care Act requires there to be procedures in place to concerning retrospective termination and the proposed resolution is modeled after the Excellus Group Administrator Guide. The Consortium now needs to have a uniform policy that addresses the retroactive payment of premium. When asked how far back premium is reimbursed Ms. Christian explained that if there was a clerical error on the part of the person who was entering the information or they forgot to enter the information they are only supposed to go back three months, however, she has seen it go back much further.

The Committee provided input on the following items that will be incorporated into the resolution:

How far to go back for retrospective termination. 60 days retro-premium for actives and 90-day retro-premium for retirees unless there is extenuating circumstances. In those cases it would go to an appeals process.

Appeals process. It was the consensus that appeals would be decided upon by the Audit and Finance Committee and reported to the Board of Directors.

Mr. Locey will incorporate this information into the resolution for the Committee's consideration at the next meeting.

Recommending Municipalities Adopt Policy Restricting Members Changing Plans

Mr. Barber explained that the metal level and Medicare Supplement plans have different actuarial value calculations and moving within those plans can have impacts if it is done too frequently. Mr. Locey has advised that three years would be enough time to get enough premium to cover the exposure. Municipalities could extend the time period beyond three years but this resolution recommends a minimum of three years. Mr. Locey explained that a member who expects to incur a large increase in expenses could change plans to cover expenses and then elect to go to a less expensive plan when expenses decline. If this were to happen he said the Consortium would never have enough of a stable premium base to cover expenses and this could result in elevated costs for all members. Setting a minimum number of years for a participant to be enrolled in a plan will make them be more careful when electing to change plans and will help the Consortium to avoid adverse risk selection. Mr. Locey said this proposal is an attempt to reach a middle-ground where employers are not restricted in their ability to set up plans but also protects the Consortium's financial stability. There are additional decisions such as limiting which plans employees could select but it was noted that although there could be discussions, these are employer and not Consortium decisions.

There was consensus that members also be encouraged to conclude an open enrollment period by November 30th; this will be incorporated into a resolution. Mr. Locey and Mr. Barber will prepare for consideration at the next meeting.

Medicare Advantage Plan and Risk Assessment

Mr. Locey said at the last meeting there was discussion of the Medicare Advantage Plan and some of the issues that it poses from a competitive perspective for the Consortium. He believes there are a couple of Consortium members that are currently offering a Medicare Advantage Plan. He distributed information from the Kaiser Foundation in which it was stated that "Medicare payment to plans for Medicare Part A and Part B services are projected to total $172 billion in 2015, accounting for 27% of total Medicare spending". This is the amount of money Medicare is giving to Medicare Advantage plans to cover the equivalent of benefits that Medicare gives out in Parts A and B. This year that was approximately $9,000 per member. The enrollment in Medicare Advantage has greatly increased, primarily because employer plans have increased in cost and as people are looking for alternatives to Medicare these are all-inclusive plans that include prescription drug coverage.

When this first began prior to 1997 Medicare paid plans 95% of the average traditional Medicare costs in each county; however, some of the changes that have occurred are resulting in a decrease in reimbursement. This will cause companies that cannot make a profit and remain competitive to withdraw from the market. Mr. Locey said at the present time they are a viable alternative to what the Consortium offers because the Consortium cannot offer the subsidies. There has been discussion of having a risk assessment charge for any municipality that wanted to offer a Medicare Advantage program and at the last meeting it was suggested that the Consortium consider a risk assessment charge of three percent if a municipality wanted to pull their Medicare-age retirees out and put them in a separate Medicare Advantage program.

Mr. Locey addressed the question of what the financial impact would be and said an analysis of the Medicare-aged population in Locey and Cahill's largest data pool showed a difference of slightly under 3% on the average claims cost per covered life. He said although it has not been done to date, the Municipal Cooperative Agreement includes a provision to impose a risk assessment charge. Mr. Barber suggested he and Mr. Locey develop a memo for the Board of Directors with some bullet points to introduce this and allow time for discussion at the next Board meeting.

Invoice Review

The Committee had no questions concerning the Hancock Estabrook invoice dated February 5, 2016.

Next Agenda

The following suggestions were made for future agenda items:

Prescription Drug Claims Audit Report
Medical Claims Audit Report
Resolution – Retrospective Claim Termination Policy
Resolution – Establishing Guidelines for Members Changing Plans
Memorandum concerning Medicare Advantage plan and Risk Assessment Fee
Report on actuarial opinion by Armory Associates
Report on response from State on Stop Loss waiver communication

Adjournment

The meeting adjourned at 3:46 p.m.

GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM

Municipalities building a
stable insurance future.

125 E. Court Street
Ithaca, New York 14850
607-274-5590
Consortium@tompkins-co.org
www.tompkinscountyny.gov/hconsortium

RESOLUTION NO. 2016 - AUTHORIZATION TO SIGN MEMORANDUM OF AGREEMENT WITH BOCES FOR NEWSLETTER PRINTING

WHEREAS, the Executive Committee directed the Consortium's Executive Director to develop a quarterly newsletter to be circulated through a combination of an electronic and paper format to members of Consortium, and

WHEREAS, the expense for printing the newsletter was not included in the Consortium's 2016 annual budget, and

WHEREAS, the Consortium has received a quote from BOCES to print the Consortium's Newsletter at a cost no greater than $250 per issue that is contingent upon approval by both the Consortium Board of Directors and the BOCES Board of Directors, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors hereby authorizes the Chair of the Board of Directors to sign a Memorandum of Agreement with BOCES to provide printing services for the newsletter on an on-going basis at a cost not to exceed $250 per issue.

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RESOLUTION NO. 2016 – DIRECTING EXECUTIVE DIRECTOR TO COMMUNICATE WITH EMPLOYERS - DEPENDENT RECERTIFICATION PROCESS

WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC) adopted Resolution No. 018-2014 entitled: "APPROVAL OF THE 2014/2015 RECERTIFICATION PLAN INCLUDING FORMS AND GUIDELINES FOR VERIFICATION OF SPOUSE AND/OR DEPENDENT STATUS FOR ALL CONTRACTS, ACTIVE AND RETIRED, OF THE CONSORTIUM" in September 2014 and then adopted Resolutions No. 001-2015, 004- 2015, and 005-2015 – Amending Recertification Process Completion Time Line in 2015, and

WHEREAS, the latest deadline, of Resolution No. 005-2015 extended the Dependent Certification process to December 31, 2015, has now passed, and

WHEREAS, the Consortium Board of Directors have set clear criteria for information that will demonstrate dependency as stated in our benefit plans; and stated a process for shifting responsibility to Excellus Fraud Unit for getting dependent verification information for any members that refuse to voluntarily supply this information to their employer human resource staff, and

WHEREAS, the Consortium employers have essentially completed the dependent verification process and have documented that 4% of the pre-certification contracts with dependents were in error, and

WHEREAS the City of Ithaca has __ family contracts with unconfirmed dependents, Tompkins County has approximately 40 family contracts with unconfirmed dependents, and TC3 has 5 family contracts with unconfirmed dependents, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors directs the Executive Director to communicate with the City of Ithaca, Tompkins County, and Tompkins Cortland Community College to make a determination of dependent eligibility for those members that have supplied inadequate or conflicting dependent verification information within 30 days,

RESOLVED, further, That the Audit and Finance Committee recommends that the Board of Directors direct the Executive Director to communicate with the City of Ithaca, Tompkins County, and Tompkins Cortland Community College that for those members that have not supplied dependent information, that the employer notify Excellus Fraud Unit of the suspicion of fraud and request their services to investigate within 30 days,

RESOLVED, further, That should any of these employers not comply with this request and complete the dependent verification process with 30 days that the Consortium will assess an additional premium equal to the average cost of claims for one person per month per unresolved contract.

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GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

Actuarial Attestations

Pursuant to Article 47 of the

New York State Insurance Law

Prepared by:

ARMORY ASSOCIATES, LLC
Actuarial Consulting Group

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SUMMARY OF PLAN OPERATIONS

History

The Greater Tompkins County Municipal Health Insurance Consortium was established on October 1, 2010 when the New York State Department of Financial Services (formerly known as the State of New York Insurance Department) issued the Consortium a Certificate of Authority pursuant to Article 47 of the New York State Insurance Law. The Consortium's actual operations, both administrative and financial, began on January 1, 2011 when it began providing health insurance coverage to more than 2,000 employees and retirees associated with the thirteen (13) founding participating municipalities:

City of Ithaca	Town of Ithaca
County of Tompkins	Town of Ulysses
Town of Caroline	Village of Cayuga Heights
Town of Danby	Village of Dryden
Town of Dryden	Village of Groton
Town of Enfield	Village of Trumansburg
Town of Groton	

Since its inception, the Consortium has operated and been managed based on sound financial principles which have allowed the Consortium to impose modest rate increases while creating more than adequate cash assets to cover the liabilities of the Consortium and to provide adequate protections and cash flow for the Consortium's operations.

As of December 31, 2015, the Consortium consisted of a total of sixteen (16) participating municipalities with the addition of the City of Cortland on January 1, 2013, the Town of Lansing on January 1, 2013, and the Village of Homer on January 1, 2015.

In addition, the Consortium is adding four (4) new municipal partners as of January 1, 2016 with the addition of the Town of Marathon, the Town of Truxton, the Town of Virgil, and the Town of Willet, bringing the number of participating municipalities up to twenty (20).

Mission and Vision Statement

Belief:
Individually and collectively we invest in realizing high quality, affordable, dependable Health Insurance

Mission Statement:
The Greater Tompkins County Municipal Health Insurance Consortium is an efficient inter-municipal cooperative that provides high-quality, cost-stable health insurance for members and their employees and retirees.

Vision Statement:
The Greater Tompkins County Municipal Health Insurance Consortium provides its municipal partners in Tompkins County and the six contiguous counties, a menu of health insurance plans to the benefit of the employees, retirees, and their families.

- The Consortium administers operations by collaborating with claims administrators, providers, and employee representatives in an effort to manage its costs, efficiencies, and success.

- The Consortium strives to provide a trust-worthy, responsive, and efficient vehicle that enables access to its quality products, models a new health insurance paradigm, and educates its members to become more directly involved in their own personal health.

- The Consortium promotes a culture of preventative health care for the well-being of its members.

Consortium Goal

The consortium, as we understand it, was formed based on the principle that by having the municipalities pool their resources in a shared funding self-insured health insurance plan that the participating municipalities would be able to provide their employees, retirees, and all covered members with benefit plans consistent with those guaranteed by their collective bargaining agreements, personnel policies, and/or legislative policies in a more financial efficient manner.

Governance and Internal Administration

The Greater Tompkins County Municipal Health Insurance Consortium is managed and overseen by a Board of Directors which consists of one representative from each of the participating municipalities and three (3) union representatives. The Board of Directors is responsible for all plan operations, including, but not limited to, managing the finances of the Consortium. The Consortium receives support services through a combination of internal personnel primarily provided by the County of Tompkins and a number of professional firms. These municipal employers and private firms collectively contract with the Consortium to provide services relative to general consulting advice and guidance, financial audit, legal, accounting, claims audit, and actuarial services.

Medical Plan Claims Administration

The Greater Tompkins County Municipal Health Insurance Consortium is a self-insured plan which currently contracts with Excellus BlueCross BlueShield for the services related to the hospital, medical, and surgical plan. The Consortium contracts with Excellus via an Administrative Services Contract (ASC) for the provision of services by Excellus which includes, but may not be limited to, membership, billing, provider network development and management, claims adjudication, customer service and support, and the overall management of the various benefit plans. In terms of medical plans, the Consortium's benefit plan menu currently offers an array of options including indemnity plans, PPO Plans, Comprehensive Benefit Plans, PPACA Metal Level Plans, and Medicare Supplement Plans. Most of these plans offer prescription drug coverage as a separate copay plan structure which we will summarize later on in this report.

Indemnity Plans

The reference to indemnity plans is a fairly old description of a medical benefits plan which is structured to provide paid-in-full basic hospital, medical, and surgical care coverage. These plans typically have a "major medical" component which is subject to a deductible, coinsurance, and an out-of-pocket maximum. These plans are usually coupled with a prescription drug card program or have the prescription drugs embedded in the "major medical" as a way to provide the covered members with a complete benefit plan to treat their illnesses and/or injuries. The Consortium currently offers the following Indemnity Plans:

Plan Code	*Medical Plan Benefit Description*
MM1	GTCMHIC Indemnity Medical Plan 1 ($50/ $150 Deductible and $400/$1,200 OOP Max.)
MM2	GTCMHIC Indemnity Medical Plan 2 ($100 / $200 Deductible and $400/$800 OOP Max.)
MM3	GTCMHIC Indemnity Medical Plan 3 ($100 / $200 Deductible and $750/$2,250 OOP Max.)
MM4	GTCMHIC Indemnity Medical Plan 4 ($100 / $250 Deductible and $400/$1,200 OOP Max.)
MM5	GTCMHIC Indemnity Medical Plan 5 ($100 / $300 Deductible and $400/$1,200 OOP Max.)
MM6	GTCMHIC Indemnity Medical Plan 6 (Comprehensive Value Plan)
MM7	GTCMHIC Indemnity Medical Plan 7 (Rx Embedded in MM)

PPO Plans

A Preferred Provider Organization (PPO) Plan is a more modern plan design which requires the covered members to pay a modest copayment for certain in-network medical services.

However, as with indemnity plans, many of the in-network basic hospital, medical, and surgical services are "paid-in-full" in the Consortium's PPO Plans. This type of plan also provides benefits for out-of-network services which are usually subject to a deductible, coinsurance, and out-of-pocket maximum. These plans are typically coupled with a prescription drug card program to provide the covered members with a complete benefit plan to treat their illnesses and/or injuries. The Consortium currently offers the following PPO Plans:

Plan Code	*Medical Plan Benefit Description*
PPO1	$10.00 GTCMHIC PPO Plan
PPO2	$15.00 GTCMHIC PPO Plan
PPO3	$20.00 GTCMHIC PPO Plan
PPOT	$10.00 GTCMHIC "Teamsters Look Alike" PPO Plan

Medicare Supplement Plan
Currently the Consortium does offer a medical supplemental plan for retirees who are Medicare-eligible which is designed to provide benefits to compliment the Federal Medicare Program Parts A and B. This Medicare Secondary Plan can be offered as a medical only plan or it can be coupled with a three-tier prescription drug card program.

PPACA Metal Level Plans
To stay competitive with benefit plan offerings available in the health insurance marketplace and through private market insurance companies, the Consortium recently approved the inclusion of the GTCMHIC Standard Platinum, Gold, Silver, and Bronze Plans. The PPACA Metal Level Plans are designed to maintain an Actuarial Value (AV) of 90%, 80%, 70%, and 60%, respectfully.

The Actuarial Value is the percentage of the average person's medical care costs which will be paid by the plan each year. As a result, the GTCMHIC Standard Platinum, Gold, Silver, and Bronze Plans' benefits are subject to possible alteration each year to ensure the AV of each plan is maintained. It should be noted that unlike the other medical benefit plans offered by the Consortium, these plans do not have any options available to choose from in terms of varying levels of deductibles, copayments, coinsurance amounts, or out-of-pocket maximums on the medical or prescription drug side of the plan.

The Consortium will calculate the Actuarial Value of the Metal Level Plans each year using the AV Calculator developed by the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) which was implemented in accordance with the Patient Protection and Affordable Care Act (ACA). If such calculator is no longer available or in use, an independent Actuary will develop the AV of the health insurance plans on an annual basis.

In either case, it is the intent that the result will represent an empirical estimate of the AV calculated in a manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population and that said AV will be equal to 90% for the Platinum Plan, 80% for the Gold Plan, 70% for the Silver Plan, and 60% for the Bronze Plan within an acceptable deviation of + or – 2% for these specific plan designs.

Prescription Drug Claims Administration

In addition to Excellus BlueCross BlueShield, the Consortium also engages the services of a Prescription Benefit Manager (PBM) to administer the various prescription drug plans offered by the Consortium. Currently, the PBM utilized by the Consortium is ProAct, Inc. which has been the acting PBM since January 1, 2013. Prior to that the Consortium engaged the services of Express Scripts who was the PBM from January 1, 2011 to December 31, 2012.

The Consortium offers both two-tier and three-tier copayment structure prescription drug plans. The overwhelming majority of the covered members are enrolled in the three-tier prescription drug programs which is a formulary based product that charges a different copayment based on the tier classification of the medication being purchased. The following are the current two-tier and three-tier prescription drug options available:

Two-Tier Plans

Plan Code	*Retail Pharmacy*		*Mail-Order Pharmacy*	
	Generic	*Brand Name*	*Generic*	*Brand Name*
2T1	$1.00	$1.00	$0.00	$0.00
2T2	$2.00	$5.00	$0.00	$0.00
2T3	$2.00	$10.00	$0.00	$0.00
2T4	$0.00	$15.00	$0.00	$30.00
2T5	$5.00	$15.00	$10.00	$30.00
2T6	$5.00	$20.00	$10.00	$40.00

Three-Tier Plans

Plan Code	**Retail Pharmacy**			**Mail-Order Pharmacy**		
	Tier 1	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**
	Generic	**Preferred Brand**	**Non-Preferred Brand**	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
3T1	$0.00	$5.00	$20.00	$0.00	$10.00	$40.00
3T2	$5.00	$10.00	$25.00	$5.00	$10.00	$25.00
3T3	$5.00	$10.00	$25.00	$10.00	$20.00	$50.00
3T4	$5.00	$10.00	$25.00	$15.00	$30.00	$75.00
3T5	$5.00	$15.00	$25.00	$5.00	$15.00	$25.00
3T5a	$5.00	$15.00	$30.00	$5.00	$15.00	$30.00
3T6	$5.00	$15.00	$30.00	$10.00	$30.00	$60.00
3T7	$5.00	$20.00	$35.00	$10.00	$40.00	$70.00
3T8	$10.00	$20.00	$35.00	$20.00	$40.00	$70.00
3T9	$10.00	$25.00	$40.00	$20.00	$50.00	$80.00
3T10	$15.00	$30.00	$45.00	$30.00	$60.00	$90.00
3T11	20%	20%	40%	15%	15%	40%
3T12	20%	30%	45%	20%	30%	45%
3T13	20%	30%	50%	20%	30%	50%

It should be noted that the plan designs shaded grey above are no longer available for additional members to join. The particular plan designs are for the current enrolled members only.

Scope of Work

In terms of the specifics of this engagement, Amory Associates, LLC, a consulting actuarial firm has been retained by the Greater Tompkins County Municipal Health Insurance Consortium to provide an analysis and actuarial attestation relative to the adequacy of the Consortium's "reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported" as of December 31, 2015. This reserve has been set at a level of 12% of the incurred claims associated with the Consortium for the 2015 Fiscal Year. We have been advised that this is the reserve level which was authorized by the New York State Department of Financial Services upon the approval of the Consortium's Article 47 Application and issuance of its Certificate of Authority on October 1, 2010.

As stated earlier in this document, the Greater Tompkins County Municipal Health Insurance Consortium is operating pursuant to a Certificate of Authority which was issued by the New York State Department of Financial Services (formerly the State of New York Insurance Department). This particular law required the Consortium to submit an application which included two exhibits which mandated that the Consortium submit an Actuarial Attestation relative to the surplus of the plan (Exhibit B1) and an Actuarial Attestation associated with the Soundness of the Premium Equivalent Rates (Exhibit B2).

Exhibit B1 of the Application is related to New York State Insurance Law, Section 4706, which summarizes the reserve requirements of a municipal cooperative health benefit plan, as follows (formatting and emphasis added):

§4706. Reserve and Surplus Requirements.

(a) Notwithstanding any provision of law, the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan's chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:

(1) a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the superintendent's satisfaction that a lesser amount will be adequate;

(2) a reserve for unearned premium equivalents;

(3) a claim stabilization reserve;

(4) a reserve for other obligations of the municipal cooperative health benefit plan; and

(5) a surplus account, established and maintained for the sole purpose of satisfying unexpected obligations of the municipal cooperative health benefit plan in the event of termination or abandonment of the plan, which shall not be less than:

A ***five percent of the annualized earned premium equivalents during the current fiscal year of a municipal cooperative health benefit plan which consists of five or more participating municipal corporations and covers two thousand or more employees and retirees; or***

As part of the ongoing oversight of the Consortium by the New York State Department of Financial Services, the Consortium is required to complete and submit an Annual Report each year to the Superintendent of the Department within 120-days of the close of the fiscal year in accordance with Section 4710 of the New York State Insurance Law, as follows (emphasis and formatting added):

§4710. Additional Filing Requirements and Annual Report.

(a) The governing board of the municipal cooperative health benefit plan shall:

(1) file for approval with the superintendent a description of material changes in any information provided in the application for certificate of authority in the form and manner prescribed by the superintendent;

(2) annually, not later than one hundred twenty days after the close of the plan year, file a report with the superintendent showing the financial condition and affairs of the plan (including an annual independent financial audit statement and independent actuarial opinion) as of the end of the preceding plan year, in such form and providing such other information as the superintendent may prescribe and in compliance with section three hundred seven of this chapter;

The Annual Report includes N.Y. Schedule F – Claims Payable Analysis, Page NY11 which is the summary of the unpaid claims reserve which Armory Associates, LLC is attesting to in this report.

Limited Use of Work Product and Data Sources

Limited Use of Work Product

Armory Associates, LLC's report and related work product are intended for the internal use of the Greater Tompkins County Municipal Health Insurance Consortium. These collective works are for use by the Consortium's consultant Locey & Cahill, LLC and the Consortium's financial auditors Ciaschi, Dietershagen, Little, Mickelson & Company and the Bonadio Group in connection with the completion of the year-end financial audit. In addition, the Consortium, its internal personnel, and its advisors may utilize this information contained in this report for the completion of the Consortium's Annual Report (JURAT) to the New York State Department of Financial Services (NYS-DFS) as required.

This report, including its attachments and related work-product may include proprietary information and, as such, should be considered a confidential document and not distributed to any other external parties without first obtaining the written consent of Armory Associates, LLC. If such consent is granted, Armory Associates, LLC insists that the distribution of this report and work-product be done in its entirety along with a statement advising the receiver of such information that this information should be reviewed by a qualified actuary to ensure the information and any conclusions are interpreted and reviewed in accordance with actuarial standards of practice.

Please note that the information contained in this report has been developed specifically for the Consortium based on its need to satisfy the requirements of Article 47 of the New York State Insurance Law and the requirements set forth by the New York State Department of Financial Services relative to the annual filing of information by Article 47 Municipal Cooperative Health Benefit Plans. As such, the information, assumptions, and conclusions found in this report may not be appropriate to use for other purposes. Armory Associates, LLC does not intend to benefit from the overall results of the report and we assume no duty, liability or obligation to parties that use this work for other reasons other than its stated intention.

Information and Data Reliance

Armory Associates, LLC relied upon the paid claims, census, and other related data as provided by the Consortium's consultant Locey & Cahill, LLC, its medical benefits administrator Excellus BlueCross BlueShield, and its prescription drug benefits administrator ProAct, Inc. Armory Associates, LLC relied upon the accuracy of this data in the development of its work-product, opinions, and conclusions. Armory Associates, LLC did not audit or verify the accuracy of the paid claims data, census data, or any other information received in connection with his analysis. It should be further noted that the paid claims data received included claims related expenses associated with the Excellus BlueCross BlueShield BlueCard Network and the New York State Health Care Reform Act (HCRA) surcharge. If the underlying data or information is flawed, inaccurate, or incomplete, the results of our analysis may likewise be flawed, inaccurate, or incomplete.

Armory Associate's Summary of Findings

Article 47 of the New York State Insurance Law

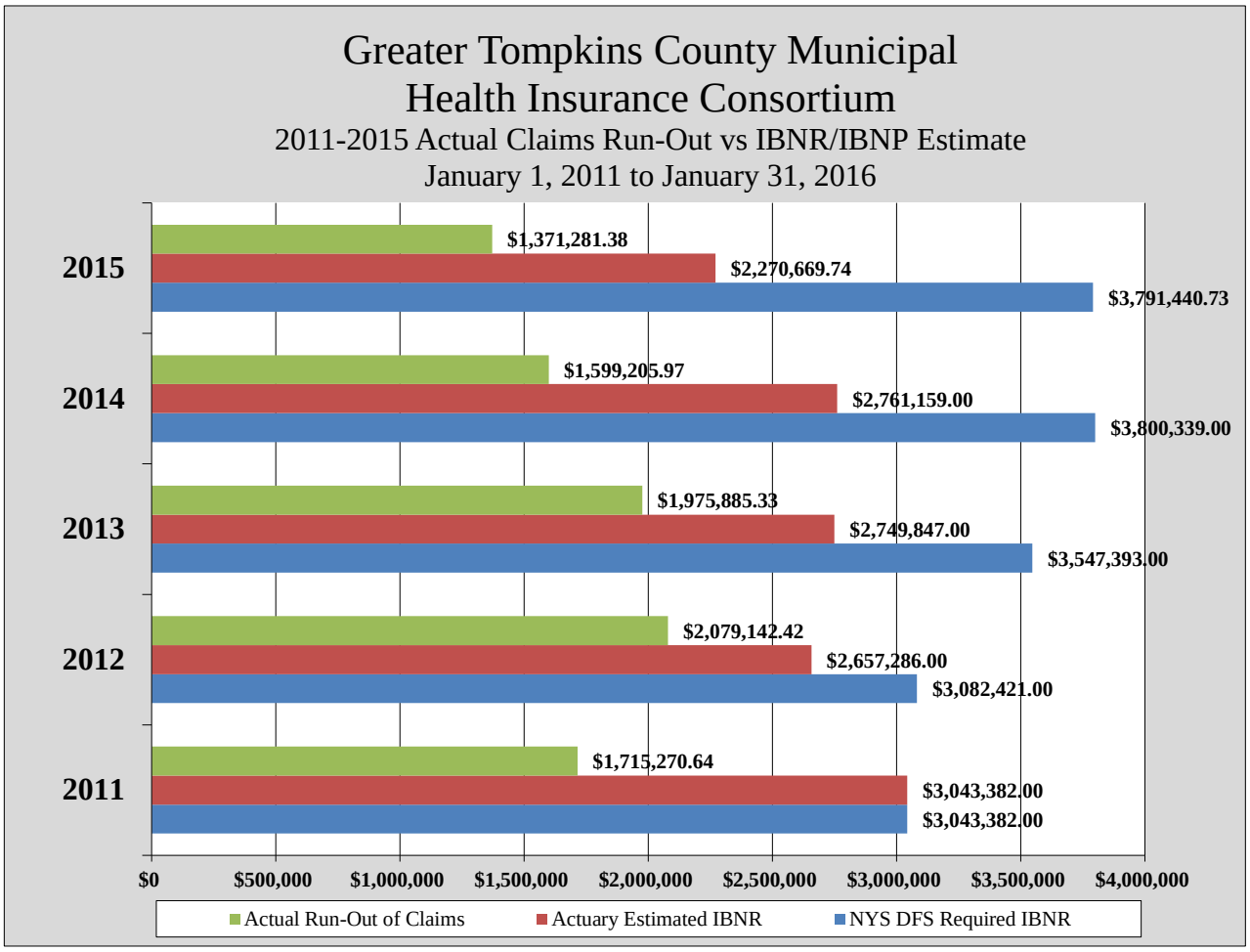
As of December 31, 2015, the Greater Tompkins County Municipal Health Insurance Consortium established a reserve in the amount of $3,786,231 which represents the incurred but not reported (IBNR) and incurred but not paid (IBNP) claims reserve liability. This process was completed in accordance with Section 4706(a)(1) of Article 47 of the New York State Insurance Law which reads as follows (emphasis added):

> ***a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the superintendent's satisfaction that a lesser amount will be adequate;***

It should be noted that Armory Associates, LLC was advised by the Consortium that the New York State Department of Financial Services has approved the use of a factor of 12% of incurred medical (hospital, surgical, and medical) and prescription drug claims. It is the opinion of Armory Associates, LLC that this factor is a conservative factor based on the actual claims experience of the Consortium. Please refer to the table below which summarizes the estimates which are also contained in Attachment A at the end of this report and in NY11 of the Consortium's Annual Report.

Description	As Estimated by Armory Associates, LLC			GTCMHIC NYS Article 47 Required IBNP/IBNR
	Medical	Rx	Totals	
1. IBNR/IBNP - Calculated Using Completion Factor Method (Attachment B and C)	$2,020,307	$7,077	$2,027,384	
2. Standard Adverse Deviation Set at 10% (Row 1 x 0.1000)	$202,031	$708	$202,738	
3. Claims Run-Out Administrative Expense Estimate (Row 1 x 0.0200)	$40,406	$142	$40,548	
4. Total Claims Liability as of 12/31/2015 (Row 1+ Row 2+Row 3)	$2,262,744	$7,926	$2,270,670	$3,631,888
5. 2015 Incurred Claims (Attachment D)	$20,405,771	$8,498,749	$28,904,520	$30,265,738
6. Total Liability as a % of Incurred Claims (Row 4 ÷ Row 6)			7.86%	12.00%

It is the opinion of Armory Associates, LLC that the reserve fund established by the Greater Tompkins County Municipal Health Insurance Consortium at the close of the 2015 Fiscal Year is sufficient to meet the Consortium's outstanding obligations and are in compliance with the terms and conditions of the Consortium's Certificate of Authority issued by the New York State Department of Financial Services in accordance with Article 47 of the New York State Insurance Law. As proof of this opinion, Armory Associates, LLC reviewed prior years to see how the actual claims run-out performed in comparison to the estimates provided by the previous actuaries and the requirements set forth by the New York State Department of Financial Services as of January 31, 2016. Please refer to the following exhibit for a summary of this information:



All actuarial computations included in this analysis and report were prepared in accordance with generally accepted actuarial principles and practices with reliance on the accuracy and completeness of the information provided by Excellus BlueCross BlueShield, ProAct, Inc., Locey & Cahill, LLC, and the Consortium for this purpose.

The financial solvency of a plan and the adequacy of plan's reserves are proven as time passes. No one can predict with absolute accuracy the increases in medical costs and/or the rate at which claims will be reported or paid. However, an estimate of the true cost can be provided through actuarial estimates. As actual experience emerges, we will evaluate the techniques and assumptions utilized in this analysis, making modifications as deemed necessary.

Armory Associate's Methodology

The most significant financial liability associated with any self-insured medical plan is the "incurred but not reported" (IBNR) and the "incurred but not paid" (IBNP) claims liability. The IBRN/IBNP liability represents the estimate of the dollar amount which will be paid on or after today for claims that were incurred on or before today (i.e., for which services have been rendered) prior to the measurement date of December 31, 2015, but for which payment will not be made until after the measurement date. This liability includes claims that have been incurred but not reported plus claims that have been reported but not paid.

The Department of Financial Services recommends that Municipal Cooperative Health Benefit Plans determine their IBNR/IBNP claim reserves separately for hospital, medical, and surgical claims and pharmacy claims. A recent study conducted by the New York State Department of Financial Service suggested that the IBNR/IBNP reserve should be set at an amount reflecting application of actuarial methods and principals including a ten-percent (10%) margin for claim fluctuations. However, the factor for medical claims reserves should be not less than seventeen-percent (17%) of incurred hospital, medical, and surgical claims and related expenses. The Department further noted that for prescription drug claims, the IBNR/IBNP reserve should be set at an amount reflecting application of the same actuarial methods and principals including a ten-percent (10%) margin for claim fluctuations for medical claims with the acceptable factor being no lower than five-percent (5%) of incurred pharmacy claims and related expenses.

With the above being said, Article 47 of the New York State Insurance Law has not been amended from its original requirement setting the IBNR/IBNP factor at 25% of incurred claims and expenses thereon. This particular requirement is in place unless "a qualified actuary has demonstrated to the Superintendent that a lesser amount will be adequate." We have been advised that the Consortium during its application process did in fact demonstrate to the Superintendent's satisfaction that utilizing a 12% IBNR/IBNP factor was prudent and reasonable. As a result, the Superintendent of the Department of Financial Services has agreed to allow the Consortium to establish its reserves for its IBNR/IBNP liability in an amount equal to or greater than twelve-percent (12%) of the expected hospital, medical, surgical, and pharmacy incurred claims. The balance of this section summarizes the approach used by Armory Associates, LLC to determine the adequacy of the IBNR/IBNP reserve held by the Consortium as of December 31, 2015 in the amount of $3,786,231.

While the ultimate amount of claims that will be paid out cannot be determined until history unfolds, a reasonable approximation can be provided through actuarial estimates, based on past claims payment patterns. Monthly paid claims for medical and pharmacy data segregated by the month incurred as developed by Excellus BlueCross BlueShield, Express Scripts/Medco, and ProAct, Inc. was provided by the Consortium's consultant Locey & Cahill, LLC for ***dates of service*** between January 1, 2011 through December 31, 2015 and ***paid dates*** between January 1, 2011 through December 31, 2015.

Estimates of the December 31, 2015 unpaid claims liabilities were obtained through the use Armory Associates' Development Method Model (Completion Factor Model). This model utilizes the provided monthly claims triangle to develop monthly completion factors by determining the ratio of successive month lags (cumulative paid amounts) using a straight average of nine (9) months of lag development. Prior to determining the successive month lags, the monthly paid claims data was adjusted to reflect the current membership basis. These completion factors represent the percentage of claims incurred in a given month that are paid in that month, the following month, etc. These factors are then applied to the cumulative claims paid for each month of incurred claims data to estimate the total incurred claims in the month. Unique completion factors were developed for medical claims and prescription drug claims separately as these two services complete with significantly differing patterns due primarily to the point of sale systems utilized by pharmacies which transmit claims on a more real time basis as compared to medical claims.

The final set of completion factors are used to calculate ultimate incurred claim estimates for each month of incurred claims from January 2013 through December 2015. The IBNR/IBNP reserve estimates for each month of incurred claims are calculated as the difference between ultimate incurred claims and claims incurred and paid for the month as of the valuation date. Also, based on Armory Associates analysis, it was assumed that the medical historical completion factor for the first month (December 2015)was to be "non-credible" and the total final expected claims for this month was determined using a 5% trend factor. Attachments B and C contain the detail of this calculation for medical and pharmacy incurred claim cost estimates.

Because the calculation of incurred but unpaid claim liabilities described above provides a "best estimate" of the true liabilities that will emerge, a margin for conservatism to account for volatility and fluctuations in the claims activity is appropriate. These margins vary in practice and are, in part, discretionary. It should be noted that the Armory Associates, LLC estimates include a ten-percent (10%) margin or Provision for Adverse Deviation (PAD). While the exact amount of the margin is subject to judgment, it is recommended that these margins be consistent from year to year.

A provision for claim settlement expenses is also typically appropriate. This amount represents the expense attributable to payment of incurred but unpaid claims. The estimates provided in this report included a 2% assumption for administration costs associated with paying reserve claims applied to the IBNR/IBNP. Attachment A provides a summary of the Armory Associates, LLC calculated IBNP components for both medical claims and pharmacy claims along with a comparison to the Consortium's "booked" IBNR/IBNP based on twelve-percent (12%) of medical and pharmacy incurred claims as reported by the Consortium's Treasurer.

Based on the results of Armory Associate's reserve calculations using actuarial development methods, the total IBNP, including margins described above, as of December 31, 2015 represents approximately 7.86% of annual incurred medical and pharmacy claims for 2015. In light of these results, the reserves held by the Consortium for claims that have been incurred but unpaid as of December 31, 2015 are sufficient to satisfy the Consortium's obligations.

Attachment A

Please refer to the following for a summary of the incurred and paid claims data for the past several fiscal years:

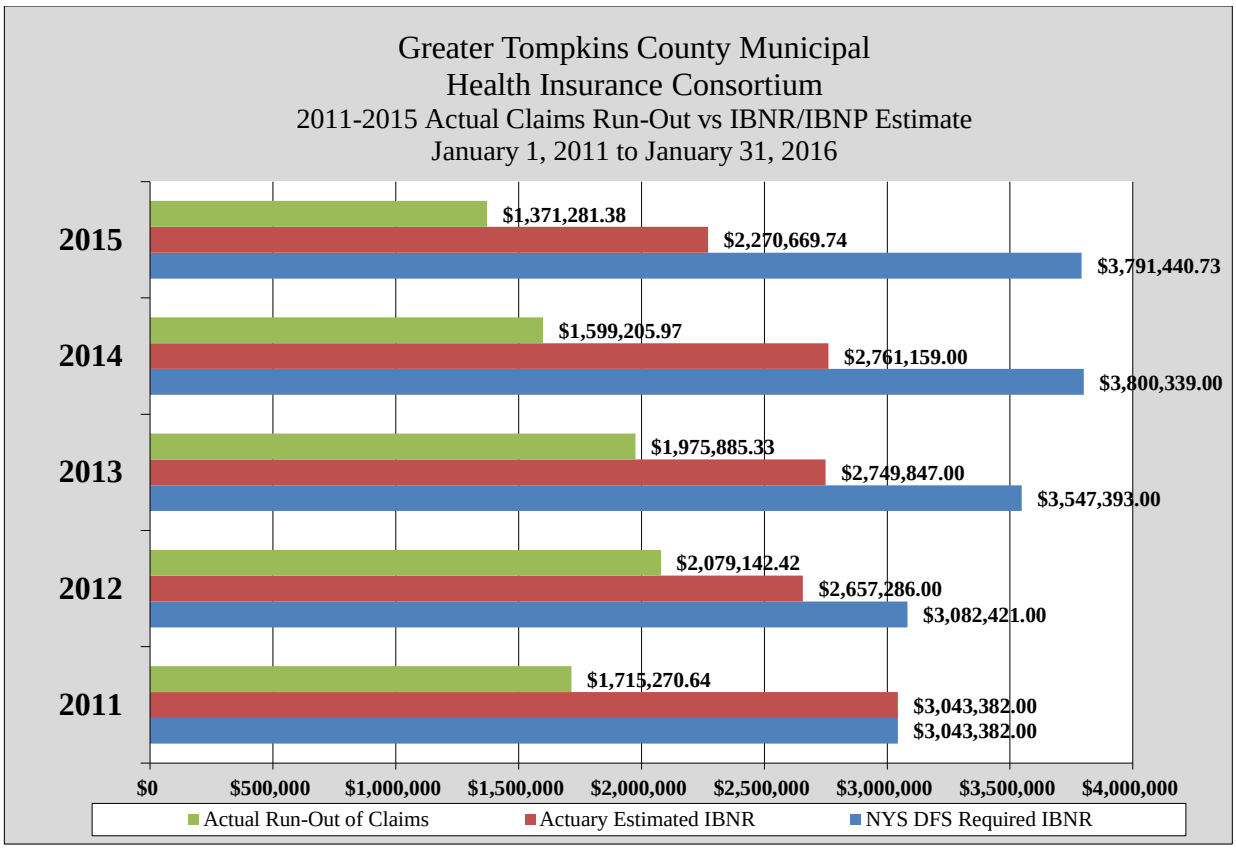
	Incurred 2011 Paid 2011	*Incurred 2011 Paid 2012*	*Incurred 2011 Paid 2013*	*Incurred 2011 Paid 2014*	*Incurred 2011 Paid 2015*	*Total Incurred 2011*	*Total Paid 2011*
Hospital/Medical	$15,750,814.63	$1,587,467.53	-$14,621.39	$305.82	$717.68	$17,324,684.27	$15,750,814.63
Prescription Drug	$6,465,217.00	$141,401.00	$0.00	$0.00	$0.00	$6,606,618.00	$6,465,217.00
Total	$22,216,031.63	$1,728,868.53	-$14,621.39	$305.82	$717.68	$23,931,302.27	$22,216,031.63
Percent of Total Incurred	92.83%	7.22%	-0.06%	0.00%	0.00%		

	Incurred 2012 Paid 2012	*Incurred 2012 Paid 2013*	*Incurred 2012 Paid 2014*	*Incurred 2012 Paid 2015*	*Incurred 2012 Paid 2016*	*Total Incurred 2012*	*Total Paid 2012*
Hospital/Medical	$16,435,539.13	$1,906,175.60	$31,460.83	$451.99	$0.00	$18,373,627.55	$18,023,006.66
Prescription Drug	$6,987,849.00	$141,054.00	$0.00	$0.00	$0.00	$7,128,903.00	$7,129,250.00
Total	$23,423,388.13	$2,047,229.60	$31,460.83	$451.99	$0.00	$25,502,530.55	$25,152,256.66
Percent of Total Incurred	91.85%	8.03%	0.12%	0.00%	0.00%		

	Incurred 2013 Paid 2013	*Incurred 2013 Paid 2014*	*Incurred 2013 Paid 2015*	*Incurred 2013 Paid 2016*	*Total Incurred 2013*	*Total Paid 2013*
Hospital/Medical	$19,829,032.74	$1,957,209.22	$24,099.11	-$1,097.96	$21,810,341.07	$21,720,586.95
Prescription Drug	$7,017,431.00	-$5,712.00	$289.00	$0.00	$7,012,008.00	$7,158,485.00
Total	$26,846,463.74	$1,951,497.22	$24,388.11	-$1,097.96	$28,822,349.07	$28,879,071.95
Percent of Total Incurred	93.14%	6.77%	0.08%	0.00%		

	Incurred 2014 Paid 2014	*Incurred 2014 Paid 2015*	*Incurred 2014 Paid 2016*	*Total Incurred 2014*	*Total Paid 2014*
Hospital/Medical	$20,616,174.23	$1,581,484.34	-$4,552.37	$22,193,106.20	$22,605,150.10
Prescription Drug	$7,746,659.00	$22,274.00	$0.00	$7,768,933.00	$7,740,947.00
Total	$28,362,833.23	$1,603,758.34	-$4,552.37	$29,962,039.20	$30,346,097.10
Percent of Total Incurred	94.66%	5.35%	-0.02%		

As clearly noted above, the 12% required claims liability factor mandated by the New York State Department of Financial Services is, in our professional opinion, a very conservative estimate as historically, the run-out of claims has not exceeded 8.25% of the incurred claims for a fiscal year.



Below is the summary of the 2015 analysis conducted by Armory Associates, LLC

Description	As Estimated by Armory Associates, LLC			GTCMHIC NYS Article 47 Required IBNP/IBNR
	Medical	Rx	Totals	
1. IBNR/IBNP - Calculated Using Completion Factor Method (Attachment B and C)	$2,020,307	$7,077	$2,027,384	
2. Standard Adverse Deviation Set at 10% (Row 1 x 0.1000)	$202,031	$708	$202,738	
3. Claims Run-Out Administrative Expense Estimate (Row 1 x 0.0200)	$40,406	$142	$40,548	
4. Total Claims Liability as of 12/31/2015 (Row 1+ Row 2+Row 3	$2,262,744	$7,926	$2,270,670	$3,631,888
5. 2015 Incurred Claims (Attachment D)	$20,405,771	$8,498,749	$28,904,520	$30,265,738
6. Total Liability as a % of Incurred Claims (Row 4 ÷ Row 6)			7.86%	12.00%

Attachment B

	Month	Completion Factor	Total Paid Claims to Date	Membership	Projected Final Claims	Reserve Before Subjective Adjs
Dec-15	1	39.98%	$629,225	5,016	**$1,573,966**	**$1,418,628**
Nov-15	2	84.43%	$1,564,467	5,023	**$1,852,983**	**$288,516**
Oct-15	3	93.29%	$2,016,532	5,007	**$2,161,564**	**$145,032**
Sep-15	4	96.27%	$1,610,246	5,036	**$1,672,609**	**$62,363**
Aug-15	5	97.74%	$1,595,831	5,029	**$1,632,671**	**$36,840**
Jul-15	6	99.05%	$1,511,390	5,036	**$1,525,899**	**$14,510**
Jun-15	7	99.24%	$1,801,546	5,025	**$1,815,387**	**$13,841**
May-15	8	99.25%	$1,536,843	5,030	**$1,548,412**	**$11,568**
Apr-15	9	99.49%	$1,660,217	5,025	**$1,668,665**	**$8,448**
Mar-15	10	100.01%	$1,896,154	5,027	**$1,895,884**	**($269)**
Feb-15	11	99.98%	$1,624,620	5,046	**$1,624,946**	**$326**
Jan-15	12	99.94%	$1,827,717	5,035	**$1,828,798**	**$1,081**
Dec-14	13	100.05%	$1,941,652	4,991	**$1,940,615**	**($1,037)**
Nov-14	14	100.03%	$1,829,349	5,003	**$1,828,814**	**($536)**
Oct-14	15	99.99%	$1,759,379	5,007	**$1,759,594**	**$215**
Sep-14	16	100.05%	$1,847,939	5,002	**$1,847,085**	**($854)**
Aug-14	17	99.87%	$1,607,356	5,005	**$1,609,458**	**$2,102**
Jul-14	18	99.88%	$1,675,617	5,010	**$1,677,635**	**$2,019**
Jun-14	19	99.84%	$1,935,550	5,008	**$1,938,645**	**$3,095**
May-14	20	99.82%	$1,761,311	5,014	**$1,764,503**	**$3,192**
Apr-14	21	99.84%	$1,984,314	5,022	**$1,987,554**	**$3,240**
Mar-14	22	99.91%	$2,030,457	5,026	**$2,032,249**	**$1,792**
Feb-14	23	99.93%	$1,757,567	5,042	**$1,758,726**	**$1,159**
Jan-14	24	99.93%	$2,067,166	5,044	**$2,068,617**	**$1,450**
Dec-13	25	99.92%	$1,767,220	5,060	**$1,768,586**	**$1,366**
Nov-13	26	99.94%	$1,867,627	5,066	**$1,868,663**	**$1,036**
Oct-13	27	99.97%	$2,163,098	5,056	**$2,163,706**	**$608**
Sep-13	28	99.97%	$1,857,141	5,066	**$1,857,635**	**$495**
Aug-13	29	100.00%	$1,746,041	5,062	**$1,746,121**	**$81**
Jul-13	30	100.00%	$1,963,738	5,080	**$1,963,742**	**$4**

Medical Claims Development Model

Based on Armory Associates analysis, it was assumed that the medical historical completion factor for the first month (December 2015)was to be "non-credible" and the total final expected claims for this month was determined using a 5% trend factor.

Attachment C

	Month	Completion Factor	Total Paid Claims to Date	Membership	Projected Final Claims	Reserve Before Subjective Adjs
Dec-15	1	99.60%	$875,446	5,016	**$878,955**	**$3,509**
Nov-15	2	99.60%	$747,537	5,023	**$750,533**	**$2,996**
Oct-15	3	99.99%	$717,078	5,007	**$717,180**	**$102**
Sep-15	4	100.02%	$669,680	5,036	**$669,553**	**($127)**
Aug-15	5	99.98%	$687,433	5,029	**$687,543**	**$110**
Jul-15	6	99.99%	$743,880	5,036	**$743,991**	**$111**
Jun-15	7	99.99%	$732,028	5,025	**$732,129**	**$101**
May-15	8	99.99%	$677,897	5,030	**$677,988**	**$91**
Apr-15	9	99.99%	$667,003	5,025	**$667,079**	**$76**
Mar-15	10	99.99%	$671,615	5,027	**$671,662**	**$47**
Feb-15	11	100.00%	$614,158	5,046	**$614,176**	**$18**
Jan-15	12	100.00%	$687,152	5,035	**$687,171**	**$19**
Dec-14	13	100.00%	$740,317	4,991	**$740,331**	**$14**
Nov-14	14	100.00%	$614,141	5,003	**$614,149**	**$8**
Oct-14	15	100.00%	$619,057	5,007	**$619,060**	**$3**
Sep-14	16	100.00%	$670,778	5,002	**$670,778**	**$0**
Aug-14	17	100.00%	$694,983	5,005	**$694,983**	**$0**
Jul-14	18	100.00%	$665,023	5,010	**$665,023**	**$0**

Prescription Drug Claims Development Model

Attachment D

STATEMENT AS OF December 31, 2015 (Year Ending) OF THE Greater Tompkins County Municipal Health Insurance Consortium (Name)

N.Y. SCHEDULE F — CLAIMS PAYABLE ANALYSIS (ON A FISCAL YEAR BASIS)

Calculation of Unpaid Claims Reserves at Year End

Unpaid claims reserve = [(percent approved by the department expressed as a decimal)*(Paid claims CY - Unpaid claims PY)]/(1-percent approved by the department expressed as a decimal)

Reserve requirement	12%	As Approved by the Department of Financial Services (Formally the Insurance Department)
Paid claims CY	$ 29,395,009	From Section I, Col B, Line 4 below
Unpaid claims PY	$ 2,761,159	From Section I, Col C, Line 4 below. Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Result	$ 3,631,889	
Total Claim Payable Per Actuary - Hospital and Medical Claims	$ 2,262,744	Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Total Claims Payable Per Actuary - Drug Claims	7926	Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Total Claims Payable Per Actuary - Other	0	Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Total Claims Payable Per Actuary	$ 2,270,670	To be reported on page NY 3 Line 1.1
Total Additional Amount Requirered by Section 4706(a)(1)	$ 1,361,219	To be reported on Page NY 3 Line 1.2
Total Claims Payable	$ 3,631,889	To be reported on Page NY 3 line 1.3

SECTION I — CLAIMS INCURRED

A Description of Claims	B Paid During Year	C Unpaid Prior Year	D Unpaid Current Year	E Incurred This Year* (B - C + D)
1. Hospital & Medical Claims - Per Actuary	20,881,539	2,738,512	2,262,744	20,405,771
2. Drug Claims - Per Actuary	8,513,470	22,647	7,926	8,498,749
3. Other - Per Actuary	-	-	-	-
4. Total	29,395,009	2,761,159	2,270,670	28,904,520

*Must equal hospital and medical expenses accrued and unpaid which are reported on Report #2, page NY4, Line18.

SECTION II — ANALYSIS OF UNPAID CLAIMS — CURRENT FISCAL YEAR

A Description of Claims	B Reported Claims in Process of Adjustment	C Estimated Incurred but Unreported	D Total—Claims Payable* (Columns B + C)
1. Hospital & Medical Claims - Per Actuary	380,684	1,882,060	2,262,744
2. Drug Claims - Per Actuary	-	7,926	7,926
3. Other - Per Actuary	-	-	-
4. Total	380,684	1,889,986	2,270,670

* Must equal Section 1, Col. D.

SECTION III — ANALYSIS OF UNPAID CLAIMS — PREVIOUS FISCAL YEAR

A	Claims Paid During the Year*		Claims Unpaid at End of Current Year Viz: Estimated Liability at End of Current Year		F Total Claims Paid During the Year and Claims Unpaid at End of Current Year on Claims Incurred in Prior Years (B + D)	G** Estimated Liability of Unpaid Claims at End of Previous Year	H Amount Unpaid Claims is Over or (Under) Reserved
Description of Claims	B On Claims Incurred Prior to Current Year	C On Claims Incurred During the Year	D On Claims Unpaid at End of Previous Year	E On Claims Incurred During the Year			
1. Hospital & Medical Claims	1,606,753	19,274,786	21,755	2,240,989	1,628,508	2,738,512	1,110,004
2. Drug Claims	22,563	8,490,907	-	7,926	22,563	22,647	84
3. Other	-	-	-	-	-	-	-
4. TOTAL	1,629,316	27,765,693	21,755	2,248,915	1,651,071	2,761,159	1,110,088

* Must equal Section 1, Col. B.

** Must equal Section 1, Col. C.

NOTE: The sum of the amounts reported on Line 4, Column D+E must equal the amount reported on Schedule F, Section II, Line 4, Column D

NOTE: All three sections must be reported on a fiscal year basis.

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Attachment E

Statement of Actuarial Opinion
Greater Tompkins County Municipal Health Insurance Consortium
Annual Statement as of December 31, 2015

Table of Key Indicators

This Opinion is	☒ Unqualified	☐ Qualified	☐ Adverse	☐ Inconclusive
Identification Section	☒ Prescribed Wording Only	☐ Prescribed Wording with Additional Wording		☐ Revised Wording
Scope Section	☒ Prescribed Wording Only	☐ Prescribed Wording with Additional Wording		☐ Revised Wording
Reliance Section	☒ Prescribed Wording Only	☐ Prescribed Wording with Additional Wording		☐ Revised Wording
Opinion Section	☐ Prescribed Wording Only	☒ Prescribed Wording with Additional Wording		☐ Revised Wording
Relevant Comments				☒ Revised Wording
☐ The Actuarial Memorandum includes "Deviation from Standard" wording regarding conformity with an Actuarial Standard of Practice				

Identification

I, Damon R. Hacker, ASA, MAAA, Managing Partner and Actuary, am an employee of Armory Associates, LLC. I am a member of the American Academy of Actuaries and recognized as qualified to perform actuarial valuations for organizations of this kind and have been retained by the Greater Tompkins County Municipal Health Insurance Consortium with regard to loss reserves, actuarial liabilities and related items. I was appointed on February 16th, 2016 in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.

Scope

I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the financial statements of the Greater Tompkins County Municipal Health Insurance Consortium as of December 31, 2015:

A. Claims unpaid (Page 3, Line 1.1); **$2,270,670**

B. Additional amounts required by Section 4706(a)(1) (Page 3, Line 1.2); **$1,361,219**

C. Total Claims Payable (Page 3, Line 1.3); **$3,631,889**

D. Surplus per Section 4706(a)(5) (Page 3, 21); **$1,879,368**

E. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement; **NOT APPLICABLE**

F. Specified actuarial items presented as assets in the annual statement; **NOT APPLICABLE**

Reliance

My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic liability records as such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic liability records to Schedule F, Section III.

Opinion

In my opinion, the amounts carried in the balance sheet on account of the items identified above:

A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principals;

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;

C. Meet the requirements of the Insurance Laws and regulations of the State of New York and are at least as great as the minimum aggregate amounts required by New York and are in compliance with the terms of the Consortium's Certificate of Authority as determined by the Superintendent of Financial Services (i.e., 12% of annual medical and pharmacy incurred claims);

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements;

E. Are computed on the basis of assumptions and methods consistent with those used in computing the corresponding items in the annual statement as of the preceding year-end; and

F. Include appropriate provision for all actuarial items which ought to be established.

Schedule F, Section III was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

RELEVANT COMMENTS

The amount carried on the balance sheet for contingency (termination) reserves (i.e., the surplus account, page NY3, line 21) was not calculated using actuarial methods. Instead, it was determined using the methodologies described in Article 47, Section 4706(a)(5) of 5% of annualized earned premium equivalents.

Please note that the prior actuarial review of the outstanding claim liabilities was completed by a different actuarial firm. Based on the information provided in the previous report, it is our opinion that there was not a material change in the actuarial methods and assumptions.

Damon R. Hacker, ASA, FCA, MAAA
Managing Partner and Actuary
120 Walton Street, Suite 501
Syracuse, NY 13202
Tel: (315) 752-0060 x328
Date: March 15, 2015

GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM

Municipalities building a
stable insurance future.

125 E. Court Street
Ithaca, New York 14850
607-274-5590
Consortium@tompkins-co.org
www.tompkinscountyny.gov/hconsortium

RESOLUTION NO. 2016 – APPROVAL OF GUIDELINES FOR MEMBERS CHANGING PLANS

WHEREAS, the Consortium has over 100 plan combination options that any of our partners can by resolution add to their list of plans available to their employees, and

WHEREAS, the recently adopted “metal level” plans (platinum, Gold, silver, and bronze) as well as Medical Supplement have different actuarial conditions for setting premiums than the other Consortium plan offerings, and

WHEREAS, employees frequently changing between these five plans or between any of these five plans and another Consortium plan can have adverse consequences with not enough premium being raised to cover claims, and

WHEREAS, employees staying with their selection of one of these five plans for a period of at least three years will allow for adequate capture of premium for claims, and

WHEREAS, the Consortium does not want to interfere with municipal partners offerings and employees ability to choose, and

WHEREAS, the qualifying events that allow changes in benefit plans at the time of the event are: marriage, divorce, legal separation, annulment, birth, change in legal custody status, dependent ages off, adoption, death, start of or loss of employment, start of or loss of eligibility for Medicare or Medicaid coverage, change in residency, and

WHEREAS, the Consortium Benefit Plans are administered on a calendar year basis, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors recommends to our municipal partners that they each adopt a policy that will restrict changing from the platinum, gold, silver, bronze, and medical supplement plans to another plan for three years after coverage begins,

RESOLVED, further, That the Audit and Finance Committee recommends that the Board of Directors adopts the policy that all non-qualifying event benefit changes are submitted to the medical plan administrator by December 1 for implementation on January 1.

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