Greater Tompkins County Municipal Health Insurance Consortium

Audit and Finance Committee

June 23, 2015
3:00 p.m.
Old Jail Conference Room

Agenda

1. Call to Order (3:00) — Thayer

2. Approve Minutes of May 26, 2015 Meeting (3:05)

3. Executive Director's Report (3:07) — Barber
    a. MCA Update
    b. Other municipal interest
    c. Code of Ethics

4. Financial Update 2015 (3:15) — Locey
    a. Preliminary Discussion of 2016 Budget

5. Work Plan: BMI Audit Recommendations (3:30) — Locey

6. Walk through process for determining Actuarial Value and Amending Benefit Plan (3:50) — Locey

7. Discussion of Fund Balance target (4:00)

8. Prescription Drug Claims Audit (4:20) — Locey

9. Next Agenda Items (4:30)

10. Adjournment (4:35)

*Hancock Estabrook invoices included for information only

Next meeting: July 28, 2015 – 3 p.m.

**Tuesday following Board meeting*

Minutes - draft
Audit and Finance Committee
May 26, 2015
3 p.m.
Old Jail Conference Room

Present: Steve Thayer, Kathy Miller, Mack Cook, Chuck Rankin
Excused: Peter Salton, Laura Shawley
Absent: S. Weatherby
Guests: Don Barber, Steve Locey, Rick Snyder, Ed McDermott, Carolyn Guard, BMI (via conference phone; Judy Drake (arrived at 4:07 p.m.)

Call to Order

Mr. Thayer called the meeting to order at 3:05 p.m.

Approval of Minutes of April 28, 2015

It was MOVED by Mr. Cook, seconded by Mr. Rankin. Mr. Cook commented at the last meeting there were comments made on the payment status of the TC3. Mr. Snyder said his staff is still working with staff at the College and although it is still outstanding he expects the matter to resolved soon. The minutes of the April 28, 2015 meeting were unanimously adopted by voice vote by members present as corrected. MINUTES APPROVED.

Executive Director's Report

Mr. Barber reported the Municipal Cooperative Agreement will be coming to the Board at this week's meeting. He highlighted the five primary areas that are proposed as changes:

- The definition of the potential area for the Consortium to accept members will now specify that it include municipalities with the six counties that are adjacent to Tompkins County;
- Allow for Skype-type participation by members at meetings;
- Creates the Secretary position as required by the Department of Financial Services;
- The Dispute section will include Directors and Committee members in addition to participants; and
- Removal of the clause that said every municipal resolution accepting the agreement shall be attached to the agreement.

Mr. Barber reported the Owning Your Own Health Committee will be bringing forward a resolution requesting funding to assist the Committee in development a mission and vision statement and branding for a wellness program. The Bronze Plan will also be brought forward to the Board for approval. Interest in joining the Consortium has been expressed by the Town of Virgil and the City of Elmira. Niagara County has been working towards forming a Consortium of its own but has been having difficulty getting all parties to work together.

Mr. Barber reported the County is not able to be the Consortium's Ethics review board; therefore, the Consortium will need to develop a process for this. The Executive Committee has asked that the Ethics Policy be reviewed to be more objective and measurable. Lastly, he said the Board needs to formally accept the audit performed by CDLM and a resolution will need to be added to the agenda at this week's meeting. He announced the retreat is scheduled for June 12th at 9 a.m.

RESOLUTION NO. **- AMENDMENT TO RESOLUTION NO. 018-2014, RESOLUTION NO. 001-2015, AND RESOLUTION NO. 004-2015 – AMENDING RECERTIFICATION PROCESS TIMELINE**
(Changes to Resolution No. 1 of 2015 are in bold)

MOVED by Mr. Rankin, seconded by Mr. Cook.

Mr. Barber explained that with one exception labor and management have come to an agreement on process. The resolution changes the end date for the process from May 1st to November 1st with the appeals process to run through the end of the year.

Mr. Thayer said the City of Ithaca has been working hard with the two units there were issues with. He believes the City is close to an agreement with the police and believes the fire units will follow. Ms. Miller asked how often the recertification process would take place. Mr. Barber said it will be up to the Board but believes every five years would be appropriate. Once the initial recertification process is complete the years following will be much easier. Mr. Locey said the Affordable Care Act requires reports submitted by employers larger than 100 to include the social security number for every person covered under the health insurance plan. Mr. Cook asked that this be communicated to all bargaining units. Mr. Locey will provide a write-up and copy of the IRS forms. He will be sharing a report with the Committee that reviews the employer shared responsibility requirements and reporting.

The resolution was approved unanimously by voice vote by members present.

RESOLVED, on recommendation of the Finance and Audit Committee, the Board of Directors hereby approves 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,

RESOLVED, further, That the municipal partners will be instructed and expected to execute the same verification process for consistency of results and will report such results to the Consortium,

RESOLVED, further, That the verification process will begin on November 1, 2014 with an amnesty period until February 28, 2015 for those participants without the additional collective bargaining step for the removal of any ineligible spouse and/or dependents without penalty and therefore eligible for COBRA,

RESOLVED, further, That for those participants and contracts with the additional collective bargaining step, the amnesty period for those contracts covered by the impact bargaining process, the amnesty period will continue until two (2) months after the collective bargaining process on dependent certification has been ratified, and

RESOLVED, further That any ineligible covered lives discovered after February 28, 2015, or two months after impact bargaining ratification for those affected contracts may be subject to reimbursement of premium paid by the employer since the change in status or January 1, 2011 whichever is later and the ineligible person will not be eligible for COBRA,

RESOLVED, further, That any dependent of an employee or retiree for which no verification information has been submitted will be terminated on **November** 1, 2015 and the

member will be invoiced for that coverage since January 1, 2011 and the employee/retiree and their spouse and/or dependents will not be eligible for COBRA,

RESOLVED, further, That the Recertification Plan provides an appeals process from May 1 through **December 31**, 2015 that will be administered by the Appeals Committee."

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Introduction of Gold and Silver Plans

Mr. Locey said a summary of the plans was included in the agenda packet; the only change to that document is in the Silver Plan the deductible is higher and is $1,300 for an individual and $2,600 for a family and the out-of-pocket maximums changed slightly. The reason for the change was after meeting with municipalities that were looking to join last year who had silver plans it was discovered that all Silver plans that existed had health savings accounts attached to them. In order to have a health savings account attached there needs to be a certain level of deductible and a minimum out-of-pocket maximum to qualify as a high deductible health plan. Mr. Locey reviewed the plans and stated they have been presented to the Joint Committee on Plan Structure and Design. He said there have been municipalities that have expressed interest in joining the Consortium but there weren't compatible plans in place so it will be good for the Consortium to adopt all of the metal plans.

Financial Update

Mr. Locey distributed a financial update through April 30, 2015. He said revenue is within .44% of budget. Rebates on prescription drugs are higher than expected, premiums are slightly lower than expected (likely due to plan design changes and census changes). The one area that is significantly lower is in the medical claims area. As of April there was $8.3 million budgeted and there have been claims in the amount of $6.6 million which is 21% below budget. Prescription drug claims were budgeted for $2.665 million and they are currently at $2.663 million. Net income was budgeted for $.5 million to this point and to date the Consortium is at $2.9 million.

First Quarter JURAT

Mr. Snyder provided a brief update on the first quarter financial filing. Highlights included the following through March: Total assets were $17.2 million compared to $15.4 in 2014; total liabilities were $12.512 million compared to $10.9 million last year (14.8% increase); total revenue was $9.424 million compared to $9.203 million last year. He called attention to the increase in expenses from $4,341,451 to $7,779,990 last year and said there was a lag in billing at this time last year from Excellus that did not catch up until the second quarter. There was $1.6 million in net income compared to $4.8 million last year which was also because of not paying any premiums in those months.

Medical Claims Audit Report

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Mr. McDermott distributed a summary of the medical claims audit report and a project worksheet. He commented on the process and said in the course of staging the audit BMI read the summary plan descriptions, took an eligibility file and customized their technology to analyze claims. They customized that environment not only for the eligibility of the dates of coverage and termination of employees, but for all of the exclusions, limitations, and parameters for the specific plan options. Once that was customized they brought in 100% of claims and evaluated

all of the claims against those criteria as well as the generally accepted rules of claims payment accuracy.

The auditors manually sifted through all of the potential errors to put aside the errors that were false positives. The auditors then reconstructed the episodes of care to make sure that when selections were made of claims that they were the most productive and effective for them to review on-site. The selection process was to compose an audit sample that is sent back to the Administrator and claim files were reviewed for elements that couldn't be included in a medical file such as doctor notes, operative notes, and prior authorizations to make sure that they were there and that the claims payer made a good decision based on the information they had available to them and that they had all of the information they needed to pay the claim. As a result of that they found that some of the potential errors were paid correctly and some were paid incorrectly. Those they believe were paid incorrectly were turned back over to Excellus on an electronic spreadsheet to indicate if they were in agreement and to tell why they paid the claim the way they did. Excellus required an opportunity to review the draft report before it was released. This provided them an opportunity to bring forward all of the information so the post audit conversations can be as productive as possible. After that the draft review the report was released. Mr. McDermott noted BMI uses a term "related claims" which are additional claims for the same claimant for the same episode of care.

Ms. Guard reviewed the summary of findings contained in the audit and explained all of the issues that were identified in the project management spreadsheet. Information contained on the spreadsheet included total financial liability incurred by the plan based on the error in processing. She noted there was a high instance of claims where members are going to the emergency room and urgent care for dental-related services.

Ms. Guard spoke of an issue relating to the coordination of benefits and said Excellus had indicated in its audit response they would review a member's claims that should have been coordinated with Medicare but to date no response has been received. She said this raises a question of whether it was a processing error and that one claim slipped through or whether it is a systemic issue and questioned how they investigate for coordination of benefits.

She reviewed an issue that arose relating to diagnostic scans and Mr. Locey responded that all of the contracts are dictated by collective bargaining agreements. When the Consortium was formed everyone had fully insured coverage through the Blues and that coverage had to be mirrored with the Consortium when it was formed. He said they need to go back and confirm that was the way it was prior and the plan document will be amended going forward. Ms. Guard said BMI identified claims in which there was a large amount paid. They provided the precertification and although they provided a specific date range she questioned whether case management was performed throughout those dates to ensure that the level of care was supported and/or the medical necessity or length of stay was supported. Mr. Locey will follow-up on this with Excellus.

Ms. Drake arrived at this time.

Ms. Drake asked about the plan design analysis. Ms. Guard said she looks at the summary plan language and identifies areas where there are limits and exclusions. The plan design analysis offers potential savings to the Consortium by making a few modest changes to the current plan language. It was noted that changes have to be negotiated with labor. Mr. Locey said there needs to be a review of the suggestions contained in the report that pertain to plan design analysis to identify which things are achievable and realistic.

Mr. Barber will send the report to the New York State Department of Financial Services. He and Mr. Locey will work with Excellus to develop an action plan for resolving issues that were identified within the report and will provide the Committee with an update on the progress. Mr. McDermott and Ms. Guard extended an offer from BMI to assist if needed.

Resolution No. – Acceptance of Medical Claims Audit Report

MOVED by Ms. Miller, seconded by Mr. Cook, and unanimously adopted by voice vote by members present.

WHEREAS, the New York State Department of Financial Services, during its most recent audit recommended that the Consortium conduct periodic medical claims audits, and

WHEREAS, by Resolution No. 004 of 2014 the Board of Directors charged the Audit Committee with making a recommendation to select a qualified professional firm to perform a medical claims audit as part of their fiduciary responsibility to conduct periodic medical claims audits to ensure the medical claims are paid by Excellus are in accordance with the benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices, and

WHEREAS, after a review of responses to a Request for Proposals the Audit Committee engaged the firm of BMI to perform an audit of the Consortium's medical claims, and

WHEREAS, BMI has completed the medical claims audit and presented the final report to the Audit and Finance Committee, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors accepts the final audit report presented by BMI on 2014 Medical Claims.

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Process to Establish Fund Balance Targets

Mr. Barber said there was a previous discussion of what the appropriate fund balance target should be. He will ask Mr. Locey to update his January 17, 2014 memorandum to prepare the Committee for discussion at the next meeting. It was suggested that the Consortium look at standards that exist elsewhere, including Excellus.

Next Agenda Items

The following items were suggested for inclusion on the next agenda:

Discussion of process to establish Fund Balance target;
Preliminary discussion of 2016 budget;
Update on BMI Audit recommendations;
Define process for determining actuarial value;
Prescription drug auditing process;

Adjournment

The meeting adjourned at 4:37 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

Audit Period: 1/1/2012 - 12/31/2013

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
2	Abortion (Disputed)	Excellus Greater Tompkins	Discussion/Clarification Impact Report	Documentation provided to BMI for purpose of audit indicated "elective termination of a pregnancy, including abortion and related expenses" are excluded. Conflict in administration as Excellus indicates these services are covered under the plan. Discussion should occur to clarify plan intent. If it is determined elective abortions are not covered reimbursement should occur without member liability. Also, documentation should then be provided by Excellus the claim payment system is set up to deny as well as an impact report be provided to determine additional payment error.	$8,5760.89 plus amount determined through impact report			
3								
4	Acupuncture (Disputed)	Excellus Greater Tompkins	Discussion/Clarification Impact Report Documentation	Documentation provided to BMI for the purpose of this audit do not address acupuncture benefits. Excellus states acupuncture is subject to a 50% benefit payment for in-network services with a 10 visit/year limitation - no deductible. Discussion should occur between Excellus and Greater Tompkins to clarify plan intent. If it is determined there is no visit limitation for this service Excellus should reimburse the plan as well as provide an impact report to determine if additional benefits were paid in error. Reimbursement request based on discussion and clarification.	TBD			
5								
6	Add-on Codes (Agreed)	Excellus	Documentation Impact Report Discussion/Reimbursement to plan	Excellus currently does not have a clinical edit to identify add-on codes which have been submitted with the required primary procedure code and agreed to incorrect processing of audit samples for benefits. Greater Tompkins requests documentation be provided regarding why it was determined to not review for this incorrect coding practice. Discussion should occur between Greater Tompkins and Excellus as to if claims submitted for their members can be reviewed for incorrect add-on code submission. Greater Tompkins requests reimbursement for the agreed to audit sample error amounts which should result in no member liability due to physician incorrect coding.	934.66 plus amount determined through impact report			
7								

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

Audit Period: 1/1/2012 - 12/31/2013

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
8	Age Indicator (Disputed)	Excellus	Documentation Impact Report Discussion Reimbursement to plan	Excellus currently does not have a clinical edit to identify when age specific codes have been submitted which are in conflict with the members age at the time of service. As indicated by Excellus this error resulted in a higher reimbursement and/or a lower reimbursement if coded correctly. Greater Tompkins requests documentation be provided regarding why it was determined to not review for this incorrect coding practice. Discussion should occur between Greater Tompkins and Excellus as to if claims submitted for their members can be reviewed for conflict between age specific procedure codes and members age. Greater Tompkins requests reimbursement for the agreed to audit sample error amounts which resulted in a higher reimbursement than warranted without member liability. A request for an impact report is also made to determine additional benefit payment in error related to this situation with subsequent reimbursement if found.	$221.56 plus amount determined through impact report results			
9								
10	Anesthesia Indicator (Disputed)	Excellus Greater Tompkins	Discussion Impact Report Documentation	Sedation during colonoscopy and/or upper GI provided by anesthesiologist. Excellus states medical necessity for anesthesia is "based on Excellus medical policy criteria". Greater Tompkins requests Excellus provide documentation of this medical policy as well as how claims are reviewed to determine if they meet the criteria for allowance of benefits. Discussion should occur between Excellus and Greater Tompkins based on the documentation provided and determination made if Greater Tompkins agrees with administration of this benefit. Greater Tompkins requests Excellus provide an impact report regarding the number of claims and total dollar amount paid for services of anesthesiologists services related to colonoscopy and/or upper GI procedures to determine total financial impact to the plan.	TBD			
11								
12	Coordination of Benefits (Agreed/Unresolved)	Excellus	Documentation Reimbursement	Greater Tompkins request documentation regarding how Excellus confirms if the member has other insurance as well as how often this information is updated, if letter are sent and if so how often, etc. Excellus indicated they were reviewing the member's history to determine if other claims were processed in error without taking other insurance payment into consideration. Greater Tomkins requests a report indicating the result of this review. Greater Tompkins requests reimbursement for the over payment related to the audit sample claim as well as for any other amounts determined through Excellus review of members history.	$24.97 plus amount determined through member history review			
13								

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

Audit Period: 1/1/2012 - 12/31/2013

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
14	Copay (Agreed/Unresolved)	Excellus	Documentation Reimbursement Impact Report	Excellus agreed to not applying the plan's required $25 copayment for urgent care facility claims as well as the $35 copayment for emergency room services was not applied. Greater Tompkins requests an impact report be run to determine the total financial impact of this omission and reimbursement made to the plan for the agreed to amount as well as amount determined through the report without member liability. Greater Tompkins requests documentation confirming the claim processing system is correctly programmed to apply the copayment going forward.	$200 plus amount determined through impact report			
15								
16	Copayment (Unresolved)	Excellus Greater Tompkins	Documentation Impact Report Discussion Reimbursement	(1) No copay applied to claim submitted for allergy shots. Based on information provided to BMI a $10 copayment should apply. Per Excellus they disagree. Documentation should be provided by Excellus to support administration. Discussion should occur to ensure plan intent. (2) Copayment was not applied to office visit for member aged 6. Excellus states no copayment applies for members age 0-19. Information provided to BMI does not concur. Documentation should be provided by Excellus to support administration. Discussion should occur to ensure plan intent.	TBD			
17								
18	Copay (Disputed)	Excellus	Documentation Reimbursement Impact Report	Several issues exist under the disputed copay category: (1) Submission of office visit same day as acupuncture service rendered - Unless documentation supports a separate service unrelated to the acupuncture was rendered benefits should not be paid and application of modifier '25' is not supported. Greater Tompkins request documentation as to how Excellus evaluates services submitted with a '25' modifier. Has editing system been modified to allow bypass of review with this modifier? (2) Documentation provided to BMI indicates for this plan services should be paid at 100% for emergency room services without application of copayment. $10 copayment was applied and Excellus states a $35 copayment should have. Conflict in language and administration. Discussion should occur to ensure plan intent and claim payment system corrected documented if applicable. (3) Clarification if speech therapy performed in the home should be included in the plan's limitation is needed as well as if a copay should be applied. Discussion should occur between Excellus and Greater Tompkins to confirm plan intent. Subsequent claim system updates may be needed as a result and/or impact reports to determine total financial impact if benefits paid in error.	TBD			
19								

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
20	Cosmetic (Disputed)	Excellus Greater Tompkins	Documentation	Claims were identified during the audit which were paid for potential cosmetic procedures with documentation of medical necessity. These claims were for diagnoses of skin tags, benign lesions, and keloid. Greater Tompkins requests Excellus provide documentation of their policy regarding potential cosmetic procedures as well as how claims are reviewed for medical necessity as well as list of procedures which they state have been determined to not require review and reason why. Discussion should occur between Excellus and Greater Tompkins to determine if they are agreeable with current administration of this benefit.	TBD			
21								
22	Dental (Agreed)	Excellus	Documentation Reimbursement Impact Report	services and well as related services (facility and/or anesthesia) which are not covered under the plan. Greater Tompkins requests reimbursement occur to the plan without member liability.	$300 plus amount determined through impact report			
23								
24	Dental (Unresolved)	Excellus	Discussion Documentation Impact Report	Claims identified where services were rendered in an urgent care and/or emergency room setting for diagnosis of dental caries. Discussion should occur regarding plan intent. Appears based on number of claims members could be utilizing this setting rather than going to a dentist for treatment - Greater Tompkins requests impact report to determine frequency of this type of situation and cost to the plan. BMI identified a claim where benefits were paid under the medical plan or a mandibular orthopedic repositioning device - diagnosis submitted did not support. Greater Tompkins requests Excellus provide documentation of review for medical necessity under the plan.	TBD			
25								
26	Diagnostic Scans (Disputed)	Excellus	Documentation Impact Report Discussion	BMI identified where a $10 copayment was applied to diagnostic services. Based on information provided to BMI for the purpose of this audit no copayment should be applied. Greater Tompkins requests Excellus provide documentation supporting administration of this benefit. If determined a copayment should not have been applied Greater Tompkins request Excellus provide a impact report to determine total financial liability to the member with subsequent reimbursement.	TBD			
27								
28	Durable Medical Equipment (Agreed)	Excellus	Documentation Reimbursement Impact Report	certification before processing a durable medical equipment claim for benefits. Greater Tompkins requests reimbursement to the plan without member liability. Greater Tompkins requests documentation be provided to	$167.79 plus amount determined through impact report			
29								

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
30	Genetic Testing (Disputed)	Excellus	Documentation Impact Report	BMI identified numerous claims submitted for genetic testing where diagnosis did not support medical necessity. Greater Tompkins requests Excellus provide documentation regarding their guidelines for coverage of genetic testing and how review occurs to determine benefit payment is allowed. Greater Tompkins requests an impact report to show genetic tests processed for benefits, amount paid, and submitted diagnoses.				
31								
32	Global Days (Disputed)	Excellus	Documentation	BMI identified claims where benefits were paid for services (office visits) which are not allowed separate reimbursement due to the fact they are included in the global surgical package. Greater Tompkins request Excellus provide documentation if Claim Check Software has been modifier to allow claims to bypass if submitted with modifier '24'. Excellus also indicates an additional auditing system was implemented in 2014 - provide documentation as to if updates related to identification of global day services.	TBD			
33								
34	Immunizations (Disputed)	Excellus	Impact Report Discussion	Benefits were paid for excluded related to immunizations which only would be given if traveling outside the United States. Discussion should occur regarding plan intent and if determined these should be excluded an impact report is requested to be provided by Excellus to determine total financial liability to the plan. Reimbursement is requested also without member liability.	TBD			
35								
36	Infertility (Unresolved)	Excellus	Documentation Discussion	Based on Excellus response there appears to be conflict between administration of this benefit and the information provided to BMI for the purpose of this audit. Discussion should occur to clarify intent as well as Excellus provide documentation upon what they are basing adjudication of claims	TBD			
37								
38	Injectable Medications (Agreed)	Excellus	Documentation Reimbursement Impact Report	Excellus agreed to processing in error a claim submitted for unclassified drugs without description of what was being provided. Greater Tompkins requests reimbursement to the plan without member liability. Greater Tompkins request documentation of Excellus policy/procedure related to when an unclassified drug code is submitted. Are the claims pended for manual review, etc.? Greater Tompkins requests an impact report be run to determine if additional claim were processed without documentation to provide a description of the drug dispensed.	$800.00 plus amount determined through impact report			
39								

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
40	Injectable Medications (Disagreed)	Excellus	Documentation Impact Report Reimbursement	Claims were submitted with a unlisted injection code; however, documentation was provided the drug administered was Avastin. This drug is only approved for use by the FDA for treatment of various types of cancer but not approved for the submitted diagnosis of diabetic macular edema. Greater Tompkins requests Excellus provide documentation of how they based benefits were available under the plan as well as impact report regarding the number of claims submitted for this drug and benefit paid for Avastin. Charges were also identified for drugs used during anesthesia and submitted for reimbursement by the anesthesiologist. This is not normal practice and these drugs should be billed by the facility. Greater Tompkins requests documentation be provided by Excellus as to policy/procedure related to payment of benefits in this particular situation. Greater Tompkins also requests an impact report be run regarding this situation with total dollar incurred by the plan.				
41								
42	Large Claim (Unresolved)	Excellus	Documentation Discussion	Length of stay for identified large claims were provided by Excellus; however, documentation of case management, medical necessity, etc. was not provided as requested. Discussion should occur between Excellus and Greater Tompkins regarding the review of large claims as well as management for continued medical necessity for the length of stay.	TBD			
43								
44	Medical Necessity (Agreed)	Excellus	Documentation Reimbursement Impact Report	Excellus agreed to benefits processed in error regarding the submission of unlisted codes without documentation to support what services were provided. Greater Tompkins requests reimbursement to the plan without member liability. Greater Tompkins requests documentation as to Excellus policy/procedure regarding the submission of claims with unlisted procedure codes. Greater Tompkins requests an impact report from Excellus to determine if additional claims submitted with unlisted procedure codes were processed without documentation to indicate what services were provided.	$4,039.62 plus amount determined through impact report			
45								
46	Orthoptics (Agreed)	Excellus	Documentation Reimbursement Impact Report	Excellus agreed to processing in error claims submitted for plan excluded orthoptic training. Excellus indicates claim processing system is correctly programmed and these errors were result of manual processing. Greater Tompkins requests documentation as to why these claim were processed manually vs. auto-adjudication resulting in benefit payment error. Greater Tompkins requests reimbursement without member liability. Greater Tompkins requests an impact report be provided by Excellus to determine if additional claims were processed in error.	$1,663.86 plus amount determined through impact report			
47								

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
48	Paid After Termination (Unresolved)	Excellus	Discussion	Claims were identified as processed after a retro-termination. Discussion should occur between Excellus and Greater Tompkins regarding the process of termination as well as recovery of claim processed after that date.	TBD			
49								
50	Potential Other Party Liability (Unresolved/Disputed)	Excellus	Documentation	Claims were identified where investigation is continuing without resolution at this time for services related to potential other party liability. Greater Tompkins requests documentation is provided regarding the current status and if recovery has been made in what amount and on what date. Claims with diagnoses indicating potential other party liability were identified where Excellus states investigation was "rejected" for investigation. Greater Tompkins requests Excellus provide documentation providing explanation for rejection.	TBD			
51								
52	Short Term Therapy (Disputed/Unresolved)	Excellus	Documentation	Claim submitted for therapy provided for member under age of 3 and benefits paid over the plan's stated visit limitation. This claim was not submitted to indicate the therapy was part of early intervention program and therefor subject to different benefits. Greater Tompkins requests Excellus provided documentation as to their policy/procedure regarding identification of services subject to the early intervention program. Claim identified as processed over the plan's visit limitation. Greater Tompkins requests Excellus provide documentation of payment history as related to the audit sample. Also, requests Excellus provide documentation of how system is programmed to provide accurate accumulation of claims for services subject to visit limits. Claims were identified where therapy was provided in the home setting. Greater Tompkins requests Excellus provide documentation of review for appropriateness of setting. Conflict in administration with Excellus not applying copayment and information provided to BMI indicating a copayment applies to outpatient services. Discussion should occur to confirm plan intent.	TBD			
53								
54	Timely Filing (Agreed)	Excellus	Documentation Reimbursement	plan's timely filing limitation. Greater Tompkins requests reimbursement to the plan without member liability. Greater Tompkins requests documentation from Excellus as to how claim system identifies claims submitted beyond the	$216.35			
55								
56	Unbundling (Disputed)	Excellus	Documentation	Greater Tompkins requests Excellus provide documentation regarding the modification of their Claim Check software: (1) upon what is the modification based; (2) how often is the software updated; (3) does the system allow bypass for claims submitted with the modifier '59'.	TBD			
57								

Value Forward Recommendations for Greater Tompkins

(Administrator: Excellus)

	A	B	C	D	E	F	G	H
1	**Audit Category**	**Responsible Party**	**Activity**	**Action Required**	**Financial Impact**	**Target Date**	**Completion Date**	**Notes**
58	Upcoding (Disputed)	Excellus	Documentation Impact Report	BMI identified claims submitted for chiropractic services where the diagnosis did not support the level of service billed. Greater Tompkins requests Excellus provide documentation as to how the claim payment system review for level of service support. Greater Tompkins also requests an impact report be provided related to the common codes submitted and subject to upcoding: 98941; 98943 and 98942. BMI also identified claims where a office visit was billed for the same date as chiropractic services. Submitted with '25' modifier; however, diagnosis submitted did not support reimbursement. Greater Tompkins requests Excellus provide documentation as to if their system evaluates for this scenario. Also, is their editing program set up to allow bypass of review with submission of '25' modifier.	TBD			
59								
60	Vision (Agreed)	Excellus	Documentation Impact Report Reimbursement	Excellus agreed to processing a claim for vision screening in error at 80% versus 100% for preventive care. Documentation should be provided Excellus has correct claim payment system to reflect preventive benefit co-insurance amount. Greater Tompkins requests Excellus run an impact report to determine if additional claims were processed in error. Reimbursement should occur to the provider based on incorrect lower payment than due.	TBD			

GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM
Municipalities building a stable insurance future.

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RESOLUTION NO. 008-2015 - RESOLUTION TO ADOPT THE "BRONZE PLAN"

MOVED by Mrs. Shawley, seconded by Ms. Sumner. A voice vote resulted as follows: Ayes – 19, Noes – 1 (Hersey). RESOLUTION ADOPTED.

WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium (Consortium) is a self-insured municipal cooperative health benefit plan operating pursuant to a Certificate of Authority issued on October 1, 2010 in accordance with the provisions of Article 47 of the New York State Health Insurance Law, and

WHEREAS, the Consortium's consultant, Locey and Cahill, LLC and medical claims administrator, Excellus BlueCross BlueShield, have collaboratively developed the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" which is consistent with and meets the standards for Bronze level benefit plans as defined by the Patient Protection and Affordable Care Act, and

WHEREAS the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" will have an Actuarial Value as defined by the Patient Protection and Affordable Care Act equal to an overall plan benefit for the average participant of 60%, and

WHEREAS, the Joint Committee on Plan Structure and Design and the Audit and Finance Committee have reviewed the details of the "GTCMHIC Standard Bronze Plan" and supports the addition of this Plan to the Consortiums menu of plan offerings, and

WHEREAS, the addition of this Plan or other metal level Plans of coverage will not diminish, alter, or eliminate any current medical or prescription drug plans offered by the Consortium, and

WHEREAS, comparable benefit plans are available to the Consortium's Participating Municipalities either through the Patient Protection and Affordable Care Act Health Insurance Exchange or the private health insurance marketplace, and

WHEREAS, several Participating Municipalities in the Consortium are seeking plan designs consistent with the metal levels of coverage as defined by the Patient Protection and Affordable Care Act, now therefore be it

RESOLVED, on recommendation of the Joint Committee on Plan Structure and Design and the Audit and Finance Committees, That the Greater Tompkins County Municipal Health Insurance Consortium Board of Directors adopts the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" for inclusion in the Greater Tompkins County Municipal Health Insurance Consortium's available benefit plan menu to be effective as soon as practicable,

RESOLVED, further, the Consortium Board of Directors requires that Said Actuarial Value be calculated annually by the rating and underwriting department at Excellus BlueCross BlueShield or an independent actuarial firm using the Actuarial Value 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. If such calculator is no longer available or in use, the Consortium will have an independent Actuary develop the Actuarial Value of the health insurance plan on an annual basis. In either case, it is the intent that the result will represent an empirical estimate of the Actuarial Value 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 Actuarial Value will be equal to 60% within an acceptable deviation of + or – 2%,

RESOLVED, further, That the Greater Tompkins County Municipal Health Insurance Consortium Board of Directors directs the Executive Director to coordinate the development of procedures necessary to coordinate the logistics of making changes to the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" which will occur no more frequently than once annually on January 1st of the year in question and that those procedures will become effective when approved by the Consortium Board of Directors.

* * * * * * * * *

LOCEY & CAHILL, LLC

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MEMORANDUM

DATE: JULY 17, 2014

FROM: LOCEY & CAHILL, LLC

TO: THE AUDIT AND FINANCE COMMITTEE OF THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

RE: GTCMHIC LIABILITIES AND RESERVES

As the Greater Tompkins County Municipal Health Insurance Consortium continues to mature and grow one of the questions being raised has to do with the level of net cash assets being held by the Consortium. As a result, we feel it is prudent to review the current financial position, to review the statutory requirements associated with reserve funds, and to have discussions with the GTCMHIC Audit & Finance Committee regarding the target amount of unencumbered funds the Consortium should maintain on a regular basis.

In addition to the above, we feel it is important for the Audit & Finance Committee to have dialogue about the way excess premiums may be credited back to the Participating Municipalities from time to time by either mitigating future premium increases or by returning excess funds directly to the Participating Municipalities. In the following, we have provided some detailed information about the liabilities and reserves of the Consortium to assist the Committee in your deliberations about this most important financial planning process.

LIABILITIES

The liabilities associated with the Consortium's operations are associated with covered medical and prescription drug benefits that are incurred by covered members which have yet to be received or paid by the insurance company or plan administrator. For example, if the Consortium were to end its operations on any given December 31st there are going to be covered medical services received by covered members on or before December 31st which will not be paid until sometime after December 31st. This is commonly referred to in the industry as the Incurred but Not Reported (IBNR) and Incurred but Not Paid (IBNP) Claims Liability.

In recent years, with the increases in technology associated with the billing and payment of medical and prescription drug benefit claims and with the substantive increase in the volume of prescription drug claims which are inherently electronic in nature, the overall value of this liability has decreased as a percentage of expected/paid claims. In fact, twenty years ago, this liability equaled approximately the value of three months (24%) of annual expected incurred or paid claims. Today, this value is closer to less than two months of expected incurred or paid claims.

The New York State Department of Financial Services has allowed the Greater Tompkins County Municipal Health Insurance Consortium to utilize a factor of 12.0% of expected incurred claims as the estimate of this liability since the inception of the Consortium. To substantiate this factor, each year the Consortium is required to have an independent actuarial firm evaluate the Incurred but Not Reported (IBNR) and Incurred but Not Paid (IBNP) Claims Liability. For the past three years, the actuaries have determined that the current required factor of 12.0% of the expected incurred claims for the year is a prudent, reasonable, and conservative estimate of the actual IBNR/IBNP liability.

It should be noted that the GTCMHIC is the only Consortium to receive the authority to use an IBNR/IBNP factor of 12% of expected incurred claims. We have been advised by the Department that all other Article 47 Municipal Cooperative Health Benefit Plans have been required to utilize a factor of no less than 17.0% in their budget computations. As a point of reference, a 5% increase in the value of this liability calculation would require the Consortium to set aside approximately $1,500,000 in additional funds into the reserve associated with this liability during the 2014 Fiscal Year.

It is our professional opinion and the professional opinion of the Consortium actuarial firm that the IBNR/IBNP factor being utilized by the Consortium is appropriate. We believe our position is further substantiated by a report conducted by the New York State Department of Financial Services in 2011, copy attached for your reference and review. This particular study suggests that the IBNR/IBNP should be factored separately for medical and prescription drug claims. The report concludes that the medical claims liability should be determined by using a factor of no less than 17% of expected incurred claims and that the prescription drug claims liability should be determined by using a factor of no less than 5% of expected incurred claims. We believe these amounts are still extremely conservative, but closer to the current methodology utilized by the Greater Tompkins County Municipal Health Insurance Consortium.

In the following, we will review the current reserve categories utilized by the Consortium.

RESERVES

The reserves held by the Consortium are the cash assets which have been assigned to cover a direct liability or to assist the Consortium with cash flow and provide protection during times when paid claim projections are exceeded. These cash assets have also been a great source of revenue to the Consortium which has allowed the Consortium to hold premium increases down over the years. Currently, the Consortium has two reserve accounts as mandated by Article 47 of the New York State Insurance Law and a third reserve category for catastrophic claims as approved by the GTCMHIC Board of Directors to be utilized during the 2014 Fiscal Year.

In terms of the statutory requirements, please refer to the following excerpt from Article 47 of the New York State Insurance Law:

NYS Insurance Law §4706

(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

In recognition of the above requirements and in consideration of the cash asset position of the Consortium at the time the 2014 Fiscal Year Budget was adopted, the Consortium's Board of Directors approved the following reserves to be utilized by the Greater Tompkins County Municipal Health Insurance Consortium during the 2014 Fiscal Year:

Incurred but Not Reported (IBNR) Claims Reserve

The IBNR Claims Reserve had been set at an amount equal to 12.0% of expected/paid claims consistent with the requirements of §4706(a)(1) and the direction provided to the Consortium by the New York State Department of Financial Services. As stated earlier, it is our professional opinion that this is a conservative estimate of the liability, but the New York State Department of Financial Services has always acted based on a very conservative approach regarding this statutory requirement.

In addition, it has been the position of the Board of Directors and it is our recommendation that the Consortium maintain this level of reserve as we collectively never want any Municipality to be "locked-in" to the Consortium. If this reserve was established at an amount not sufficient to cover the liability, a Participating Municipality could find itself owing a significant amount of money if they chose to leave the Consortium. We feel that a Municipality's decision to leave or stay in the Consortium should not be affected by the Consortium's lack of adequate reserve balances and this is a philosophy we would encourage the Consortium's Board of Directors to continue to embrace, even during tough economic times. At the close of the 2013 Fiscal Year, this reserve equaled $3,412,531.04 and it is projected to be $3,613,497.29 for the 2014 Fiscal Year (12.0% of actual paid claims totaling $30,112,477.38).

Surplus Account

This particular reserve is a statutory requirement of Article 47, §4706(a)(5), and this reserve was established by the Consortium Board of Directors as required. The intent of this particular reserve is to protect the Consortium from the ill effects associated with those times when the actual paid claims exceed the projections. This reserve is required to be maintained each year at a value equal to 5% of the annualized premium for that particular fiscal year. The Surplus Account for the 2014 Fiscal Year is estimated at a value of $1,871,059.68 (5% of expected premiums equaling $37,421,193.52).

Catastrophic Claims Reserve

This particular reserve was established by the Consortium's Board of Directors to protect the financial integrity of the Consortium from the negative effects of individual large losses. The recommendation to establish this reserve category was made last year in response to the decision of the Board of Directors to increase the Specific Stop-Loss Insurance Deductible in an effort to keep the insurance affordable.

Currently, the Specific Stop-Loss Insurance Deductible is set at $300,000 per covered member per policy period. This presents a sizeable exposure to the Plan as the deductible is equal to approximately 1% of our expected annual paid claims estimate for the 2014 Fiscal Year. This particular reserve was initially set at 2% of the expected health insurance paid claims expense for the 2014 Fiscal Year.

In addition to the above information regarding the current reserve categories, we advised the Board of Directors that the Finance Committee would continue to review the overall financial results of the Consortium and make additional recommendations to the Board of Directors relative to reserve and cash management protocols.

One item which we advised the Board of Directors the Committee would consider is the possible addition of a Rate Stabilization Reserve which would be used to protect the cash flow position of the Consortium and allow the Board of Directors to develop a long-term financial strategy to protect the financial integrity of the Consortium when projected expenses are exceeded. A possible outcome may be the establishment of a Rate Stabilization Reserve at a level not to exceed 5% of the expected premium income of the Consortium for a given fiscal year.

CONCLUSIONS/RECOMMENDATIONS:

Locey & Cahill, LLC recommends a multi-faceted financial plan which will utilize unencumbered funds of the Consortium to minimize the future increase in premiums paid by the Participating Municipalities and their covered members. We believe this is the best way to handle the use of cash assets which are deemed in excess of what is needed. The other alternatives would require either issuing checks back to or crediting premiums bills of the Participating Municipalities. The difficulty with that approach is that the excess funds were not all contributed by the Municipalities as some of the funds come from employee and retiree contributions. As a result, it is almost impossible to equitably return excess premiums in a manner which would be considered fair and appropriate.

We caution the Audit & Finance Committee and the Board of Directors to stay disciplined in your approach as we do not want to create a situation where we are forced to drastically raise premiums in the future to meet expenses and maintain the Consortium's financial stability. If the Consortium mitigates premium increases at an excessive level, you could compound your financial problems as you will have a situation where expenses are exceeding premium revenues, inflation continues to increase those expenses, you have potentially lost the interest income revenue source, and you may need to replenish reserve accounts to satisfy the statutory requirements of Article 47 of the New York State Insurance Law. This could result in premium increases exceeding 10% in a given year.

This approach may be viewed as conservative by some. However, it is our professional opinion that a long-term planned use of budgeting strategies designed to minimize premium increases is in the best interest of the Consortium, the Participating Municipalities, the covered members, and the tax payers. As a result, we offer the following considerations to the Audit & Finance Committee and to the Board of Directors:

1. Maintain the Surplus Account at 5% of the annual premium of the Consortium in compliance with §4706(a)(5) of the New York State Insurance Law. The value of this reserve, as projected for the 2014 Fiscal Year, is $1,871,059.68. This will maintain the financial stability of the Consortium, protect the Municipalities from the possibility of a mid-year assessment if paid claims projections are exceeded, and satisfy a statutory requirement.

2. Maintain the IBNR Claims Liability Reserve as required by §4706(a)(1) of the New York State Insurance Law at a value in line with the expected cost of "run-out" claims. We are recommending that this reserve continue to be funded at 12.0% of expected incurred claims consistent with the direction received by the Consortium from the New York State Department of Financial Services. This particular reserve is estimated to equal approximately $3,613,497.29 for the 2014 Fiscal Year.

3. Continue to evaluate the stop-loss insurance policy, possibly increasing the deductible again in future years, and increase the Catastrophic Claims Reserve to an amount equal to 5.0% of the expected medical and prescription drug claims cost for the year. We have estimated this reserve for the 2014 Fiscal Year would equal approximately $1,500,000, if increased to this level. The current factor used for the Catastrophic Claims Reserve is 2% of expected medical and prescription drug paid claims which equals approximately $600,000 for the 2014 Fiscal Year. This reserve is specifically designed to protect the cash flow of the Consortium from the effects of a significant increase in the overall paid claims due to high dollar claimants and to help mitigate the amount of premium dollars spent on stop-loss insurance each year.

4. Establish a Claim or Rate Stabilization Reserve in an amount equal to 5% of the expected paid premium income of the Consortium. This reserve would be considered a "place holder" for funds as the Consortium utilizes portions of the unencumbered fund balance to mitigate future rate increases. The value of this reserve for the 2014 Fiscal Year based on current projections would be approximately $1,725,000. This would leave approximately $7,000,000 in unencumbered funds to be used in the next several fiscal years to mitigate premium rate increases.

5. Establish an investment strategy consistent with the laws, rules, and regulations of the State of New York designed to maximize the interest income earned, maintain the flexibility in cash assets necessary for the prudent financial management of the Consortium, and protect the tax payer funds used to finance this Consortium and its operations.

We have attached the 2014 Fiscal Year Budget Worksheet to this memorandum for your review and reference.

In conclusion, the final thought that we offer to the Audit & Finance Committee and the Board of Directors of the Greater Tompkins County Municipal Health Insurance Consortium at this time is to consider the views, opinions, and recommendations expressed above and consider establishing a target level of unencumbered fund balance to be maintained by the Consortium for cash flow purposes. This policy should provide some guidance as to how any excess funds would be used to mitigate future premium increases.

We thank you for your time and consideration of this most important information. As always, should you have any questions or concerns, regarding this information or any other issues facing the Greater Tompkins County Municipal Health Insurance Consortium, please feel free to contact our offices at 315-425-1424.

New York State Department of Financial Services

Report on Municipal Cooperative Health Benefit Plans: Impact of Claim Reserve Requirements Under Section 4706 of the Insurance Law

Executive Summary

Article 47 of the New York State Insurance Law allows municipalities to join together to form municipal cooperative health benefit plans to provide health benefits for their employees. Article 47 sets forth the minimum standards for establishing a municipal cooperative health benefit plan, including minimum claims reserve requirements. These statutory reserve requirements, however, have been seen by some municipalities as an impediment to forming a municipal cooperative health benefit plan. Chapter 494 of the Laws of 2009 requires the Superintendent of Insurance (the Superintendent of Financial Services as of October 3, 2011) to conduct a study of the impact of the current municipal cooperative health benefit plan reserve requirements and make recommendations for changes.

The Department of Financial Services analyzed and compared to two sets of claims data: (1) data for each of the ten existing municipal cooperative health benefit plans and (2) data for selected commercial insurance carriers doing business in New York State.

The Department recommends that claim reserves should be determined separately for (1) all hospital and medical care claims (other than prescription drugs) and (2) for prescription drugs. For hospital and medical care claims, the claim reserves should be set at an amount reflecting application of actuarial principles, based on prevailing conditions including a 10.0% margin for claim fluctuations, but no lower than 17.0% of incurred hospital and medical claims and related expenses. For prescription drug claims, the claim reserves should be set at an amount reflecting application of actuarial principles, based on prevailing conditions, and including a 10.0% margin for claim fluctuations, but no lower than 5.0% of incurred prescription drug claims.

These recommendations would preserve the current standards generally applied by the Department for most municipal cooperative health benefit plans on hospital and medical care claims, but would significantly decrease the current standards for prescription drug claims, from 17.0% to 5.0%, upon review and approval by the Superintendent. This flexibility would enhance the ability of municipalities to form municipal cooperative health benefit plans under Article 47 of the New York State Insurance Law.

Introduction

Chapter 494 of the Laws of 2009, also known as the mandate relief bill, was signed into law by Governor David Paterson on November 12, 2009. The legislation amended the Insurance Law, the Public Health Law, the General Municipal Law, the Public Authorities Law, the Local Finance Law, the Civil Practice and Rules Law, the General Obligations Law, and repealed certain provisions of the Civil Practice Law.

The memorandum in support of the bill indicates that, among other things, the law would encourage efficiencies and provide local governments savings that ultimately benefit local property taxpayers by making it easier for municipal governments to form municipal cooperative health benefit plans (MCHBPs) for their employees, which will reduce overall health insurance costs. Section five (5) of the bill requires the Superintendent of Financial Services to conduct a study of the impact of the current MCHBP plan reserve requirements and make recommendation for changes.

The legislation ordered a study of existing requirements to determine obstacles that impede municipalities pooling resources to provide employees welfare benefits at reduced cost, and requested that the Superintendent make recommendations for change based on such study.

This report addresses the impact of claim reserve requirements under Section 4706 of the Insurance Law. It provides an actuarial analysis of the reserve requirements and offers recommendation for changes in the reserve requirement for MCHBPs.

Publication of this report was delayed while the Department of Financial Services reviewed the application of the Greater Tompkins County Municipal Health Insurance Consortium to form an MCHBP. The Department worked extensively with Consortium to help them meet their reserve requirements. That application was approved in October 2010.

Background and History

Municipal cooperatives were first authorized in 1994 under Chapter 689 of the Laws of 1994, signed into law by Governor Mario Cuomo on August 8, 1994. The original purpose of the law was to protect the financial stability and solvency of municipalities. The statement in support of the legislation states:

> This bill provides safeguards necessary to keep municipal cooperatives that provide health benefits to employees of participating municipal corporations on a shared-funding basis from exposing municipalities and their taxpayers to unpredictable and potentially catastrophic liabilities. It establishes minimum reserve and surplus requirements, stop-loss (reinsurance) requirements to allow for reductions in these reserves, and filing and reporting requirements to ensure that municipal cooperative health benefit plans are operated on an actuarially sound basis.
>
> These financial safeguards should promote the stability and solvency of existing municipal cooperatives, and prevent inadequately funded or incompetently managed programs from commencing operations in this state.

The memorandum in support of the bill also explained the requirement that the Insurance Department work closely with municipal cooperatives already in existence to facilitate compliance with the reserve and other requirements of Article 47 over the next five years.

Section 4714 of the Insurance Law sets forth requirements for municipal cooperatives that provided medical, surgical or hospital service on or before January 1, 1993 pursuant to a municipal cooperation agreement authorized under Article 5-G of the general municipal law. Under the terms of these agreements, municipal corporations agree to join together to share the risks associated with health care costs, thereby spreading costs in a larger pool of risks. Such arrangements allow participating corporations to stabilize their health care costs and to lower administrative expenses. Existing municipal cooperatives were grandfathered and given five years to bring reserve and surplus requirements to the levels required by Section 4706 of the Insurance Law.

Although the law was passed in 1994, the first municipal cooperative became certified in 1999. Others needed more than the five years to become compliant. The Insurance Department exercised regulatory forbearance allowing additional time for entities to meet the reserve requirements.

There are currently eleven certified MCHBPs in New York State (See Table I below). All were formed by school districts and certified as municipal cooperatives under the grandfather provisions in Section 4714. The most recent MCHBP, the Greater Tompkins County Municipal Health Insurance Consortium, is the first to be certified since 2003.

Table I - Certified Municipal Cooperatives

Municipal Cooperative Health Benefit Plan	**Date Certified**
Allegany-Cattaraugus Schools	11/01/2001
Catskills Area Schools Employee Benefits Plan	04/01/2001
Cayuga-Onondaga Area School	08/01/2001
Chautauqua County School District's Medical Health Plan	12/01/2001
Greater Tompkins County Municipal Health Insurance Consortium	10/1/2010
Jefferson-Lewis School Employee's Healthcare Plan	06/01/2001
Orange-Ulster School Districts Health Plan	11/01/2000
Putnam/Northern Westchester Health Benefits Consortium	11/01/1999
St. Lawrence-Lewis Counties School Districts Employees Medical Plan	10/06/2009
State-Wide Schools Cooperative Health Benefit Plan	10/01/2003
Steuben Area Schools Employees Benefit Plan	06/01/2001

Reserve Requirements

Section 4706 of the Insurance Law requires the governing board of a MCHBP to establish a reserve fund and pay into the fund the amounts necessary to satisfy all contractual obligations and liabilities of the fund. The reserve for payment of claims and related expenses reported to the MCHPB but not yet paid, and claims and related expenses incurred but not yet reported must be no less than 25% of expected incurred claims and expenses for the current plan year, unless a qualified actuary has demonstrated to the Superintendent that a lesser amount would be adequate.

Moneys supporting the reserve fund must be deposited in one or more banks or trust companies designated by the governing board in accordance with the required municipal agreement, and the chief financial officer must account for the reserve funds separate and apart from all other funds of the MCHBP. The MCHBPs must maintain a detailed record of the purpose, source, date and amount of payment from the fund, the assets of the funds, any capital gains and losses from investments, and have a plan for dissolution of the health benefit plan in the event a participating municipality withdraws from the cooperative, or under other circumstances acceptable to the Superintendent.

Claim Reserve Trends in the Mid-Eighties:

In the mid 1980's, it was customary for health insurers to establish their claim reserves at the end of each calendar year at approximately 25% of claims paid during the calendar year.

This factor of 25% of annualized claims was representative of the level of the claim reserves for services provided to insureds during a specified period of time ending on a given date, for which reimbursement had not yet been paid to the insured or provider of the service. This level of reserves was based on slower payment of claims resulting from the prevailing conditions at the time, including:

1. The plans of benefits at that time were mostly of the "pure indemnity" major medical type, where members were reimbursed for a given coinsurance percentage, typically 80%, after the satisfaction of a calendar year deductible, typically $100 or $200, of medical care charges for services rendered. Such charges incorporated all charges, including charges for prescription drugs. There were far fewer copay plans in place during this time frame.

2. It was customary for members to receive services and for providers to mail statements of charges to members, who would then seek reimbursements from their insurance carriers. There were few, if any, electronic submissions of claims by providers.

3. There were few financial arrangements between providers (hospitals and physicians) and insurance carriers to establish negotiated fees on charges by providers, and more specifically for periodic prepayments for services such as monthly capitation based on expected services to be rendered.

4. Prescription drug benefits were included within the major medical benefits and subject to the calendar year deductible applicable for all charges. Members would get their prescriptions filled at the pharmacy, pay the pharmacy the total costs and seek reimbursement from the insurance carriers. Frequently, members were not able to satisfy the deductible. Pharmacy benefits managers (PBMs) were only beginning in 1986, and the drug card structure was not generally prevailing until the later part of the 1980s.

Current Loss Reserve Trends

Changes were introduced starting late in the 1980s and throughout the 1990s, including:

1. Plans of benefits were gradually and significantly revised, through insurers' introduction of Health Maintenance Organization (HMO) plans and subsequently Preferred Provider Organizations (PPO). The Exclusive Provider Organization (EPO) was not introduced until much later in the 1990s. These types of plans incorporated the use of participating provider networks where the insured has limited liability other than a fixed copay, and significantly reduced the use of calendar year deductibles for services rendered by providers who were part of the network.

2. Electronic submission of claims by providers directly to the insurance carriers, particularly for physicians participating in the PPO network, was introduced and has since been expanded.

3. Financial arrangements and negotiated reimbursement rates such as case rates, capitation and other fixed payments between providers (mainly hospitals) and

insurance carriers were introduced, initially by HMOs and subsequently expanded by insurance carriers.

4. Prescription drug card programs were introduced, under which members were provided with a medical benefits card and could obtain their prescription drugs at participating pharmacies subject to a copay amount. PBMs became more prevalent and contracted with insurers and HMOs to expand the pharmacy networks. PBMs are paid fixed payments to administer the processing of claims between the insurance carriers and the pharmacies.

Such changes lead to a reduction in the prevailing level of the required claim reserves. While these changes had already impacted on the level of claim reserves when Article 47 was enacted in 1994, the claim reserve threshold in 1994 was based on conditions prevailing years earlier, when a 25% reserve factor was the norm.

Administrative Adjustment of Required Claim Reserves

Section 4706 of the Insurance Law calls for the establishment of a reserve at the end of each reporting year for payment of claims and expenses not yet paid on reported and unreported claims. Such reserves must be equal to 25% of estimated incurred claims and expenses for the current plan year.

Section 4706 of the Insurance Law includes a provision under which this 25% minimum level may be modified upon a demonstration by a qualified actuary that a lesser amount would be adequate, subject to the approval of the Superintendent.

Most MCHBPs submitted requests to the Insurance Department for adjustments in such reserve factors over the years. The Department did not acquiesce to any requests for a reduction made prior to calendar year 2002. Starting in 2003, the Department agreed to reduce the 25% factor, subject to a minimum level of no lower than 17.0% of expected incurred claims and related expenses. This reduction was approved based on an actuarial review of the claims information, especially the distribution of the claims by incurred months (month during which medical services were received) and following those incurred claims by the months when they were actually paid (month when benefits were paid to providers or members). This analysis takes the form of what are referred to as claim lag triangles, which are commonly used by actuaries in the calculation of claim reserves. Currently, all but two MCHBPs are using a reserve factor of 17.0%. The remaining entities have either not requested a reduction in the reserve requirement, or a request for reduction was denied by the Insurance Department.

Actuarial Report of Required Claim Reserves

This report incorporates the results of an analysis of the financial experience in the last few years on claims reserves developed using subsequent claim payments and remaining reserves for the original ten MCHBPs. This report also discusses considerations pertaining to the payment of claims. Furthermore, this report provides the

results of a similar analysis conducted on the level of claim reserves for selected insurance carriers for comparison purposes.

Two separate but comparative analyses were incorporated in the review of the required claim reserves on MCHBPs. The first type dealt with the claims experience data for each of the ten original MCHBPs. The second type of analysis was conducted on selected insurance carriers doing business in New York State, some operating as HMOs, and others operating as insurance companies, i.e., mostly PPO and EPO plans, but also including the more recently popular high deductible plans. This was done to determine if conclusions could be drawn from current reserve levels for HMOs and insurers and applied to the MCHBPs.

For the analysis covering the claims experience for the ten MCHBPs, separate analyses were conducted for prescription drug claims and for all hospital and medical care claims, (i.e. all claims for other than for prescription drug claims). Both analyses were based on available claims information, typically covering three to four years of claims experience for each MCHBP.

Results of the analyses are summarized below. This information illustrates that reserve factors fluctuate greatly by MCHBPs and insurance carriers, and also by calendar year. Some of the reasons for such fluctuations can be explained by the way services are rendered by providers to members and in the way claims are adjudicated, processed and paid by the MCHBP or its claims administrator.

The determination of necessary claim reserves can be visualized as a funnel where incurred claims for services provided are poured in at the top, whether such claims are reported or not reported, and paid claims are discharged at the bottom of the funnel for benefits paid. The claims inside the funnel are those where services have been provided to insureds, but payment has not yet been made. At any date the claims inside the funnel are the claims that must be provided for in a liability for claim reserves as of that date.

Many factors impact such claim reserves, including:

1. Number of working days within each month. The number of working days every month generally fluctuates from a low of 19 to a high of 23. The lower the number of working days, the higher the claim reserves, regardless of the impact of other factors since there is less opportunity to process and pay claims during that month so there is potential for greater accumulation of unpaid claims.

2. Changes in the membership. An increase in the membership, particularly towards the end of a calendar year or fiscal year would tend to increase the claim reserves. Increases in membership will generate more claims, and if the increase occurs later in the calendar year many of those claims will not be paid until subsequent the calendar year. Such changes in membership and claims could be exacerbated if claims submissions for other medical business handled by the administrator who is adjudicating the MCHBP also increases.

3. The impact of seasonality. Certain months of the year have lower utilization, particularly in November and December because of the holidays, where medical procedures may be postponed by the providers or the members. Certain groups, particularly school groups, may also be impacted by the behavior of their members during selected months of the year. Another form of seasonality may be a major snow storm or power outage in the geographical area where the administrators are located.

4. Plan benefits or changes in the benefit plans. The level of benefits or underlying cost sharing by the insured, as well as changes to these benefits or cost sharing may also influence the behavior of the members, either increasing or decreasing their utilization, which will subsequently have an impact on the claim reserves.

5. Large amount claims. Large amount claims, for example premature twins, would develop delays in the submissions of the claims information to the administrators, and would require more time for claim examiners to adjudicate and process, and could lead to increase in the claim reserves.

6. Changes in Administrators. A change in administrators would have a significant impact on the claim reserves due to inherent delays in routing claims to the new administrator.

7. Changes in Claims Systems. A change in the systems or software used to adjudicate and process claim submissions would also have a significant impact on claim reserves, increasing such reserves.

8. Claim Backlog. It is customary for administrators to maintain a reasonable level of claims in backlog to justify maintaining resources in case of a drop in the level of claim submissions. Administrators tend to delay the hiring of new claims examiners when the claim backlog increases significantly. There is usually a learning curve for new examiners to become proficient in claims adjudication. These factors impact the level of claim reserves.

Actuarial Analysis on Medical Care Claims for MCHBPs

The analysis on the ten original certified MCHBPs was conducted separately for the prescription drug claims and for all hospital and medical care claims (other than prescription drugs) as indicated above.

With respect to the hospital and medical care claims, the analysis was conducted based on a charting of information obtained from the various MCHBPs on the distribution of claims by (i) incurred month (month service was provided) and (ii) paid month (month of claims payment for those same services). These charts are referred to herein as “lag triangles”. The information used was generally available from financial reports provided by the various MCHBPs. Information was requested for incurred

months from January 2006 through December 2009; some MCHBPs were not able to provide all four years of data. However, all MCHBPs were able to provide at least three years of data.

As part of the analysis, the information in the lag triangles was "completed" for each calendar year where data has not fully matured (i.e. run out via subsequent claim payments). Incurred data for each month of 2006 and 2007 is considered to be matured via subsequent claims payments by year end 2009 (the evaluation date) and no further claims will be paid. Therefore, the actual claim reserves for each incurred month in those years are known as of December 31, 2009. However, data for incurred months in 2008 and especially 2009 has not fully matured meaning that the remaining claim payments for incurred months within those years needed to be estimated based on the run out pattern of the prior years, in order to set the actual claim reserve for the 2008 and 2009 calendar months.

For each MCHBP, for each incurred month, the information described below was derived. (To simplify the explanation of this process, the information below is expressed in terms of incurred months between July of 2007 and of June 2009):

(a) Incomplete incurred claims for 12 months through June 2008;

(b) Complete incurred claims for 12 months through June 2008, incorporating the "remaining" claims reserves derived by process explained above;

(c) Total of (1) all actual claims paid from July 2008 through the end of the experience period, with respect to incurred months of June 2008 and prior, plus (2) total remaining claim reserves estimated at the end of the experience period (June 2009) with respect to incurred months of June 2008 and prior. This item (c) is the claim reserve at June 30, 2008;

(d) Ratios of item (c) (claim reserve at June 30, 2008) to item (b) (complete incurred claims for a 12 month period from July 2007 through June 2008).

Table II, below summarizes the results on the average ratios of claim reserves to total incurred claims obtained for "completed" claims for the various MCHBPs, for the following measurement periods:

Period A representing 12 months from July 2007 through June 2008;
Period B representing 12 months from July 2008 through June 2009; and
Period C representing 24 months from July 2007 through June 2009.

Table II also illustrates for each MCHBP, the minimum and the maximum month ratio derived for each MCHBP in the 24 month "Period C" timeframe. These ratios should be compared to the existing 25% minimum standard contained in Section 4706 of the Insurance Law. Subtotals are illustrated for the averages for the three larger MCHBPs,

designated with an asterisk, for the seven smaller MCHBPs (no asterisk) and in total for all ten MCHBPs.

Table II - Medical Claims (Other Than Prescription Drugs) for MCHBPs

	Period A Average Reserve %	Period B Average Reserve %	Period C Average Reserve %		Period C Minimum	Period C Maximum
Allegany	12.34%	11.95%	12.17%		9.72%	15.74%
Catskills	13.98%	12.05%	12.79%		10.33%	16.36%
Cayuga	11.24%	10.58%	10.90%		9.28%	12.48%
Chautauqua	12.26%	12.96%	12.63%		7.74%	19.63%
Jefferson-Lewis	11.94%	12.68%	12.63%		11.94%	14.10%
* Orange-Ulster	17.95%	14.78%	16.28%		9.65%	22.91%
* Putnam/Northern	14.39%	13.01%	13.66%		11.96%	15.51%
St. Lawrence	9.49%	10.47%	9.99%		8.13%	12.17%
* State-Wide	18.30%	19.89%	19.18%		13.59%	23.02%
Steuben	13.07%	9.52%	11.36%		7.54%	15.46%
*** Larger [3]**	**17.06%**	**16.20%**	**16.62%**		**13.66%**	**19.71%**
Smaller [7]	**11.62%**	**11.66%**	**11.70%**		**9.92%**	**13.71%**
Total [10]	**14.85%**	**14.36%**	**14.62%**		**12.61%**	**17.61%**

As can be seen in the table above, there are variations in these ratios by MCHBP and by incurred month. A similar pattern also existed within both period A (7/07-6/08) and period B (7/08-6/09) but only the range for the combined 24 month period C.

Our analysis showed that the larger MCHBPs have higher claim reserve ratios than the smaller MCHBPs. The Department did not explore the underlying reasons for this.

Actuarial Analysis on Prescription Drugs for MCHBPs

The analysis of the claims for prescription drugs was conducted based on information obtained from the various MCHBPs regarding payment for the invoices received from PBMs.

Many MCHBPs and some insurance carriers describe the process of payment of claims on prescription drugs as "instantaneous," meaning that at any point in time there are no claim reserves required. This is not the case as illustrated by the process set in place by PBMs and described in the following paragraphs.

(1) Members go to the pharmacies and submit the prescription from the physicians, or renew their prescription drugs;

(2) Pharmacies collect the copays from members and submit to the PBMs their "claims" on these prescriptions, i.e. the negotiated price, which varies according to the copay level plus a dispensing fee, both agreed to in negotiations between the PBMs and the pharmacies;

(3) For each two week period, which vary by PBM (for example 12/06/2008 through 12/19/2008), the PBMs request payments including administration fees from the MCHBPs or insurance carriers for participating and non-participating pharmacies;

(4) The MCHBPs or the insurance carriers remit payments to the PBMs.

The claim reserves at 12/31/2008 in the example above would be the sum of all the invoices from the PBMs which have not been settled by 12/31/2008, plus an estimate of the amounts in the unreported invoices for the subsequent two week period (12/20/2008 through 01/02/2009), with respect to the days prior to 01/01/2009 only.

Table III below was populated using prescription drug paid claim information provided by the MCHBPs.

Table III - Prescription Drug Claims for MCHBPs

		Drugs	
		Average	
Allegany		3.93%	
Catskills		4.98%	
Cayuga		7.48%	
Chautauqua		4.80%	
Jefferson-Lewis		4.76%	
* Orange-Ulster		4.91%	
* Putnam/Northern		2.27%	
St. Lawrence		5.44%	
* State-Wide		4.86%	
Steuben		3.10%	
*** Larger [3]**		**3.77%**	
Smaller [7]		**4.82%**	
Total [10]		**4.22%**	

As with medical care coverage, there are fluctuations by MCHBPs, as illustrated above, and by period. The ratios for prescription drug coverage vary from a low of 2.27% to a high of 7.48%, with an average of 4.22%, corresponding to about 2.2 weeks' worth of claims, or about 15.4 days' worth of claims.

Results on Actuarial Analysis on Prescription Drugs and Medical Care for MCHBPs

Table IV, below, illustrates the ratios of claim reserves to incurred claims for (a) medical care coverage (per Table II, the Period C Average Ratio, above), (b) prescription drug coverage (per Table III, above) and (c) composite of medical and prescription drug coverage.

As expected, the claim reserves for prescription drug coverage expressed as a percentage of the incurred claims for prescription drug coverage are at a much lower level (4.22%), than for medical care coverage (14.62%).

The ratios of both medical care coverage and for prescription drug coverage are average ratios for the period from July 2007 through June 2009.

Table IV- Ratios of Medical Care and Prescription Drug by MCHBP

	Medical	Drugs	Composite
	Average	Average	Average
Allegany	12.17%	3.93%	6.41%
Catskills	12.79%	4.98%	10.25%
Cayuga	10.90%	7.48%	10.50%
Chautauqua	12.63%	4.80%	10.15%
Jefferson-Lewis	12.63%	4.76%	10.39%
* Orange-Ulster	16.28%	4.91%	13.32%
* Putnam/Northern	13.66%	2.27%	9.23%
St. Lawrence	9.99%	5.44%	8.52%
* State-Wide	19.18%	4.86%	15.56%
Steuben	11.36%	3.10%	7.91%
*** Larger [3]**	**16.62%**	**3.77%**	**12.77%**
Smaller [7]	**11.70%**	**4.82%**	**9.46%**
Total [10]	**14.62%**	**4.22%**	**11.39%**

The composite ratios for medical care coverage and for prescription drug coverage reflect the distribution of claims prevailing on each MCHBP and in aggregate for all MCHBPs, between medical care claims and prescription drug claims.

Actuarial Analysis of Prescription Drug and Medical Care Claims for Insurance Carriers

As discussed earlier in this report, an analysis was conducted on the claim reserves for six selected insurance carriers: four carriers doing business in the upstate regions of New York State and two carriers doing business in the downstate regions of

New York State. The analysis was conducted on the combined HMO and indemnity lines of business for these six carriers.

Plans of benefits for these insurance carriers covered the broad spectrum of the lines of business for these carriers, including both government programs such as Medicare and Medicaid, and commercial lines of business such as large groups, small groups, Direct Pay and Healthy NY plans.

In aggregate for all insurance carriers combined, the claims added up to about $19 billion per year, for both medical care coverage and prescription drug coverage combined.

The analysis was conducted on the claim reserves established at three specific dates at December 31, 2006, December 31, 2007 and December 31, 2008. Actual claim run outs on the claim reserves at these dates were monitored for a 12 month period following the selected dates.

The results were tabulated separately for each of the three dates and in aggregate for the three dates combined. The ratios of claim reserves to incurred claims were 11.60% at December 31, 2006, 11.35% at December 31, 2007 and 11.19% at December 31, 2008, for an overall ratio of 11.38% for all three dates combined. All these ratios are composite ratios for combined medical care coverage and prescription drug coverage.

While this last ratio of 11.38% is very similar to the ratio of 11.39% illustrated in Table IV, earlier herein for all ten MCHBPs, it should be kept in mind that the distribution of claims between medical care coverage and prescription drug coverage is very different for the MCHBPs, where prescription drugs account for about 31.06% of all claims, and for the insurance carriers where prescription drugs account for only about 11.97% of all claims.

For all MCHBPs, claims for prescription drug coverage represent about 31.06% of total claims for combined medical care and prescription drug coverage. This percentage of 31.06% is significantly above similar percentage for insurance carriers, where the percentage is about 11.97%.

Higher percentages of prescription drugs are due to the fact that MCHBPs cover mostly unionized workers. Union groups tend to have very low copays for prescription drugs compared to traditional large and small groups. Furthermore, insurers that offer Medicare Advantage plans exclude the Medicare Part D prescription drugs from claim reserves.

Table V, below compares the results of the analyses on the ten MCHBPs and on the insurance carriers.

Table V – Comparison of Prescription Drugs Ratios and Reserve Ratios for MCHBPs and Insurers

	Drug Percent	Reserve Ratios
MCHBPs	31.06%	11.39%
MCHBPs Alternate*	11.97% *	13.08%*
Ins. Carriers	11.97%	11.38%

* Alternate results illustrated for the MCHBPs, using the same lower distribution of prescription drug claims observed for the insurance carriers.

Adjustments for Explicit Margins for Fluctuations

Actuarial Standards of Practice (ASOP) requires that the claim reserves determined by actuaries should incorporate some adjustments for a margin for fluctuations in the claims.

Given the level of the annualized claims involved in the MCHBPs, and the potential for tax implications on the municipalities that result from adverse misestimation of the reserves, it is recommended that an explicit margin of 10.0% be added to the claim reserves.

The experienced factors illustrated in Table IV for average medical and average prescription drug ratios of claim reserves to incurred claims exclude any provision for such margins for fluctuations. Table VI illustrates the experienced factors as developed for Table IV, and the experienced factors adjusted for a 10.0% margin for claim fluctuations:

Table VI - Experience Factor Adjusted for a 10.0% Margin

	Medical	**Drugs**	**Composite**
No Margins	14.62%	4.22%	11.39%
Incl. 10% Margin	16.08%	4.65%	12.53%

Summary and Conclusion

Given the fluctuations by MCHBP in the experienced reserve factors at the end of a given calendar year or fiscal year, as a percentage of incurred claims for the calendar year or fiscal year, it is not feasible to recommend a unique factor to be applicable for all MCHBPs.

On the other hand, the MCHBPs often do not have the proper actuarial expertise to evaluate the prevailing conditions at the time the claim reserves are being established, particularly the smaller MCHBPs. Therefore it is not feasible for MCHBPs to establish their own claim reserves based on conditions prevailing at the time the claim reserves are being established.

Consequently, the Department of Financial Services recommends that the claim reserves be determined separately for medical care claims and for prescription drug claims. Based on its review of claims data from existing municipal cooperative health benefit plans and selected commercial insurers, the Department further recommends that, for medical care claims, the claim reserves would be set as an amount reflecting application of actuarial principles and percentage of incurred claims based on prevailing conditions including a 10.0% margin for claim fluctuations, but no less than 17.0% of incurred claims.

For prescription drug claims, the claim reserves would be set as an amount reflecting application of actuarial principles and based on prevailing conditions as determined by the Superintendent including a 10.0% margin for claim fluctuations but no less than 5.0% of incurred claims.

Increased flexibility in minimum claims reserve requirements, based on sound actuarial principles and analysis, would increase the ability of municipalities to establish MCHBPs.

Greater Tompkins County Municipal Health Insurance Consortium

2011-2013 Actual Results and 2014 - 2017 Fiscal Year Budget Projections (cash basis)

	Projected Budget 2014 Fiscal Year	*Revised Budget 2014 Fiscal Year*	*Projected Budget 2015 Fiscal Year*	*Projected Budget 2016 Fiscal Year*	*Projected Budget 2017 Fiscal Year*
Beginning Balance	***$10,432,477.52***	***$10,432,477.52***	***$15,366,517.14***	***$19,352,249.91***	***$19,176,115.32***
Income					
Medical Plan Premiums	$37,421,193.52	$36,435,154.35	$39,292,253.19	$38,256,912.07	$41,256,865.85
Ancillary Beneit Plan Premiums	$153,761.77	$139,132.29	$169,137.94	$186,051.74	$204,656.91
Interest	$5,000.00	$13,845.00	$5,000.00	$5,000.00	$5,000.00
Capitalization Investment	***$0.00***	***$0.00***	***$0.00***	***$0.00***	***$0.00***
Rx Rebates	$250,000.00	$250,000.00	$257,500.00	$265,225.00	$273,181.75
Stop-Loss Claim Reimbursements	$0.00	$100,000.00	$0.00	$0.00	$0.00
Other	$0.00	$1,000.00	$0.00	$0.00	$0.00
Total Income	$37,829,955.28	$36,939,131.64	$39,723,891.14	$38,713,188.80	$41,739,704.51
Expenses					
Medical Paid Claims	$22,817,790.22	$22,185,848.99	$24,837,164.65	$27,035,253.73	$29,427,873.68
Rx Paid Claims Rebate Credit	$250,000.00	$250,000.00	$257,500.00	$265,225.00	$273,181.75
Rx Paid Claims	$7,294,687.16	$6,841,572.16	$7,940,266.97	$8,642,980.60	$9,407,884.38
Medcial Admin Fees	$873,298.27	$878,762.70	$899,497.22	$926,482.14	$954,276.60
Rx Admin Fees	$79,353.60	$69,690.00	$81,734.21	$84,186.24	$86,711.82
NYS Graduate Medical Exp.	$246,178.28	$184,423.02	$258,487.19	$271,411.55	$284,982.13
ACA PCORI Fee	$10,260.00	$10,260.00	$10,773.00	$11,311.65	$11,877.23
ACA Trasitional Reins.Program Fee	$321,300.00	$318,402.00	$0.00	$0.00	$0.00
Stop-Loss Aggregate and Specific	$711,651.60	$711,651.60	$853,981.92	$1,024,778.30	$1,229,733.96
Advance Deposit / Pre-Paid Claims	$100,000.00	$100,000.00	$100,000.00	$100,000.00	$100,000.00
Legal Fees	$20,000.00	$20,000.00	$20,600.00	$21,218.00	$21,854.54
Consultant Fees	$65,379.44	$50,000.00	$51,500.00	$53,045.00	$54,636.35
Actuarial Fees	$0.00	$10,000.00	$10,300.00	$10,609.00	$10,927.27
Accounting Fees	$15,000.00	$15,000.00	$15,450.00	$15,913.50	$16,390.91
Audit Fees	$0.00	$60,000.00	$61,800.00	$63,654.00	$65,563.62
Executive Director	$0.00	$17,500.00	$35,000.00	$35,000.00	$36,050.00
Insurances (D&O / Prof. Liab.)	$24,432.10	$24,432.10	$26,875.31	$29,562.84	$32,519.13
Internal Coordination (Finance)	$67,750.67	$67,750.67	$69,783.19	$71,876.68	$74,032.99
Internal Coordination (Support)	$14,056.73	$14,056.73	$14,478.43	$14,912.78	$15,360.17
Surety Bond Fee / Loan Interest	$0.00	$0.00	n/a	n/a	n/a
Payment Refund	$0.00	$0.00	$0.00	$0.00	$0.00
Ancillary Benefit Premiums	$170,742.06	$170,742.06	$187,816.26	$206,597.89	$227,257.68
Capitalization Repayment	***$0.00***	***$0.00***	***n/a***	***n/a***	***n/a***
Other Expenses	$5,000.00	$5,000.00	$5,150.00	$5,304.50	$5,463.64
Total Expenses	$33,086,880.12	$32,005,092.02	$35,738,158.36	$38,889,323.40	$42,336,577.84
Net Income	***$4,743,075.16***	***$4,934,039.62***	***$3,985,732.78***	***-$176,134.60***	***-$596,873.32***
Ending Balance	***$15,175,552.68***	***$15,366,517.14***	***$19,352,249.91***	***$19,176,115.32***	***$18,579,241.99***
Liabilities and Reserves					
IBNR Reserve	$3,613,497.29	$3,483,290.54	$3,933,291.80	$4,281,388.12	$4,660,290.97
Surplus Account	$1,871,059.68	$1,821,757.72	$1,964,612.66	$1,912,845.60	$2,062,843.29
Catastrophic Claims Reserve	$602,249.55	$580,548.42	$655,548.63	$713,564.69	$776,715.16
Total Liabilities and Reserves	$6,086,806.51	$5,885,596.68	$6,553,453.09	$6,907,798.41	$7,499,849.42
Unencumbered Fund Balance	***$9,088,746.17***	***$9,480,920.46***	***$12,798,796.83***	***$12,268,316.91***	***$11,079,392.57***

Assumptions 2015 to 2017 Fiscal Years

1. Premium Revenue Increased by 5.0%
2. Interest Income = Last 2 Years Average
3. Prescription Drug Rebates = $250,000
4. Paid Claims Trend = 8.85%
5. Administrative Fees Per Agreement with Excellus BCBS then Increased by 3% Per Annum
6. NYS GME Increased by 5%
7. Specific Stop-Loss Insurance Increased by 20%
8. Aggregate Stop-Loss Insurance Increased by 5%
9. Surety Bond Fee / Loan Interest Estimated at 3% of Principle Balance
10. All other Fees Increased by 3%
11. Capitalizatin Repayment includes anuual interest of 3%
12. Beginning Balance and Ending Balance includes Advance Deposit held at Excellus BCBS as a pre-payment of claims ($798,600 as of 12-31-2012)