Greater Tompkins County Municipal Health Insurance Consortium

Audit and Finance Committee

December 22, 2015
2:30 p.m.
Old Jail Conference Room

1. Call to Order (2:30) — Thayer

2. Approve Minutes of October 27, 2015 Meeting (2:32)

3. Executive Director's Report (2:35) — Barber
   a. Aggregate Stop-Loss Waiver update
   b. Mission/Vision Statement
   c. Dependent Certification update
   d. Update of Prescription Drug Audit

4. Financial Update (2:45) — Locey
   a. Stop Loss Policy

5. Actuary RFP (3:05) — Barber

6. Update on Medical Claims Audit Action Plan (3:10) — Locey

7. Interfacing premium invoice data between Excellus and Treasurer (3:25) — Locey

8. 2016 Meeting Schedule (3:35)

9. Next Agenda Items (3:40)

10. Adjournment (3:45)

Next meeting: January ??

Minutes - draft
Audit and Finance Committee
October 27, 2015
2:30 p.m.
Old Jail Conference Room

Present: Steve Thayer, Kathy Miller (arrived at 3:10 p.m.), Mack Cook, Chuck Rankin, Phil Vanwormer, Laura Shawley
Absent: Peter Salton
Guests: Rick Snyder, Steve Locey, Judy Drake, Don Barber

Call to Order

Mr. Thayer called the meeting to order at 2:35 p.m.

Approval of Minutes of September 22, 2015

It was MOVED by Mr. Cook, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present, to approve the minutes of September 22, 2015 as corrected. MINUTES APPROVED.

Executive Director's Report

Ms. Miller arrived at this time.

RESOLUTION NO. - ACCEPTANCE OF APPLICATION BY THE TOWN OF TRUXTON TO BECOME A PARTICIPANT IN THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

MOVED by Ms. Shawley, seconded by Mr. Cook, and unanimously adopted by voice vote by members present. Mr. Barber said the Town will be bringing four families into the Platinum Plan.

WHEREAS, by Resolution No. 005 of 2012 and amended by Resolution No. 27 of 2014 the Consortium Board of Directors adopted a policy outlining a process of applying for membership to the Consortium, and

WHEREAS, the Town of Truxton has submitted an official resolution authorizing the Town of Truxton to join the Consortium in accordance with the terms and conditions outlined in the Municipal Cooperative Agreement, and

WHEREAS, the Town of Virgil has complied with membership process outlined in Resolution No. 005 of 2012 and amended by Resolution No. 027 of 2014 and has submitted copies of financial reports which are being reviewed[1] by the Consortium's Treasurer, Chief Financial Officer and/or the Consortium's Auditor, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Greater Tompkins County Municipal Health Insurance Consortium, accepts and welcomes the Town of Truxton as the 19th municipal participant, with health insurance coverage beginning January 1, 2016, pending a successful review and verification of the financial records of the Town of Truxton by the CFO and Treasurer,

[1] Language added by Audit and Finance Committee will be removed when presented to the Board of Directors as the financial review will be complete at that time.

RESOLVED, further, That the Board of Directors waives the requirement of payment of 5% of premium to the Surplus Reserve Account,

RESOLVED, further, That the Board of Directors determines that the terms of assessing the pro rata share of any surplus or deficit to the applicant shall at the time the applicant leaves the Consortium or upon dissolution of the Consortium shall be based on their share of any deficit or being paid their share of any surplus that was generated during their years of participation. The Board of Directors would identify the surplus or deficit which exists on the date of entry and again on the date of withdrawal or dissolution and bill or pay the applicant accordingly.

* * * * * * *

Mr. Barber said he has been advising municipalities that 60 days notice is needed from for groups wishing to join the Consortium and asked for guidance from the Committee on a timeline to give the Town of Homer in terms of joining the Consortium by January 1st. He was advised that the Committee and Board could take action at the November meetings but the Town should be informed there may be a delay in receiving identification cards.

Meeting with Large Employers on Metal Level Plans

Mr. Barber said Mr. Locey has noted that other consortiums are adopting guidelines for using metal level plans because the actuarial value changes premiums and the possibility of people moving between plans creates some issues with trying to keep track of things such as deductibles. A meeting will be held on October 30th with large employers to frame the issue so employers can be aware there are impacts to employees, employers, and the Consortium. Based on this, information will be brought forward to the Committee and Board. Mr. Locey said he would like to hear from the larger employers what the long-term goal is. If they would like to eventually wean employee off the older plans continuing to allow people to move back and forth from plans will prevent that from happening.

Ms. Drake said she has concerns but is unable to attend the meeting; Mr. Locey offered to share her concerns at the meeting.

Code of Ethics

Mr. Barber reported the Broker, Haylor, Freyer, and Coon, will be present at the November 19th Board meeting to provide an overview of what the Directors and Officers policy covers and will be able to answer questions relating to Code of Ethics issues that have been raised.

Recertification Process Update

Mr. Barber reported employers are close to finishing the process of gathering information. At this time there are approximately 310 contracts evaluated that have dependents and 12 cases where someone was removed (4%). He hopes to have a report for the Committee and the Board at the November meetings on the financial impact of this process.

Aggregate Stop Loss Waiver

Mr. Barber reported the Department of Financial Services has been reviewing the spreadsheet and has been asking specific questions such as why the Consortium's net income is dropping each year. He said this was a good opportunity to explain the Consortium's

strategies and desire to have a fund balance that is protective of the Consortium. Information will be sent back to the Department and he hopes to have a report by the next Board meeting.

Mrs. Shawley asked why the Town of Newfield would not be joining. Mr. Barber explained that the issue was bringing the employees on board. Mr. Locey explained that most of the small employers have the Silver or Bronze metal plans. The Blues have approximately 15 different styles of each of these plans and the Consortium has only one of each; therefore, there are some differences. He said it can be difficult for groups to understand that on an overall basis the benefit is the same. Another issue is when they buy coverage on the open market they are getting a rating system that has individual, individual employee plus one, and family coverage and the Consortium has only individual or family coverage. If the savings is 3% in aggregate in terms of the overall premium being charged, when the adjustment is made on the rates internally someone will ultimately not be happy.

Mr. Locey spoke of the amount of time he and Mr. Barber have taken to meet with the interested municipalities and prepare information. It was suggested that meetings could be set up in areas where multiple municipalities could attend.

Financial Update

Mr. Locey said he believes the only issue remaining on the Stop Loss waiver request is information being submitted to the State and said he believes the questions relate to the Catastrophic Claims Reserve and the Rate Stabilization Reserve information and thinks this will be resolved soon. He agreed with Mr. Barber's explanation with regard to decreasing net income and said the Board will be vigilant in overseeing this and making prudent decisions when setting the budget. This will be looked at annually with the understanding that the Consortium's goal is to maintain an unencumbered balance that is at least 18% of premium revenue.

Mr. Locey distributed an updated financial report and said medical claims continue to be very low. He communicates with Excellus on a regular basis and said he asked that they go back to Provider Relations to double-check there was not something missing or a system issue that would result in an adjustment to the results later and was assured there is nothing outstanding that could account for the claims being 19% ($3.7 million) below budget. On the drug side, claims are slightly above budget (3%); however, he noted last month was a five-payment month and may have skewed those numbers. In aggregate, the Consortium is 14% below budget on claims and on revenue the Consortium is very close to budget (.23% over budget). Instead of having a net income of $2 million there is a net income of well over $5 million. Again, he said he is very comfortable with the rate increase of 3% that was approved by the Board of Directors.

Mr. Locey reviewed the various graphs and charts he prepared and noted prescription drug rebates are slightly up and the Consortium is paying $.93 of each dollar for claims, which shows the Consortium is a very efficient operation.

He reviewed the cumulative monthly budget versus actual from January, 2011 to September 30, 2015 and said the cumulative variance has been 3.7% below budget historically. This is what has allowed the Consortium to keep the rate increase lower than what the trend in claims has been.

Update on Medical Claims Audit

Mr. Locey reported on conversations he has had with BMI and said there have been some communication issues. He distributed a spreadsheet showing the items identified during the BMI audit and explained there were some items that were plan document issues that are still in the process of being corrected. He explained highlighted areas of the spreadsheet that identified items that Excellus agreed to correct but he hasn't receive final information on whether those have been resolved.

The next area of items highlighted showed items where there are outstanding questions on. He explained how claims are adjudicated and said there are standard practices that all administrators use; however, there are cases where insurance companies have their own internal processes which may differ from the normal practice across the board. There are instances where an insurance company may not put a particular code on a file because it may cost them more money to review and investigate the claim rather than if they did pay something erroneously by paying a bad claim. This is done in some cases as a business decision which may not be a proper decision from a claims adjudication perspective but they are doing it for other reasons. This is some of the things they are noticing in what BMI is reporting as a potential recovery and what Excellus is saying was properly paid based on their adjudication process.

Mr. Locey distributed a document from Excellus in response to the audit that included agreed-to findings and which they blamed the errors on either a human error or s problem with the old software system. With regard to disputed claims situations where Excellus paid the claim according to their medical policy criteria and the way they have always done things; BMI has identified some of these things as not being medically necessary and these are the kinds of things that need further discussion. He will continue to have conversations with Excellus and BMI and Mr. Barber has agreed to assist in the effort to remove items from the list. There is a possibility that if there are items that cannot be resolved this Committee may need to meet with Excellus and BMI to allow each to present their case so the Committee can make a recommendation on how to resolve those items.

Prescription Drug Claims Audit

Mr. Locey reported he had a conversation with BMI about the rebate portion of the audit and said they will be auditing five drugs for rebates to make sure the Consortium received back all money it should have from ProAct. He said ProAct does not negotiate its own rebate deals; the use a third party, Optum, and BMI has stated they cannot audit Optum in terms of their direct contract with the drug manufacturer. All they can audit is whatever Optum is paying ProAct that ProAct is ultimately paying to the Consortium. He said BMI has experience auditing Optum and they said they are very good and will include that statement of this in their audit. BMI will be checking to see if ProAct is auditing Optum and if so Mr. Locey asked that there be a statement concerning the outcome of that audit to show they are performing within the terms of their contract.

Hancock Estabrook Invoice

The Committee reviewed an invoice dated October 14, 2015 and no objection was raised to processing payment. Mr. Locey said much of the work performed during the period related to the Excellus cyberattack. One of the suggestions by John Powers was that the Consortium be provided a list of everyone Excellus contacted as a result of information being compromised. He said Excellus has provided this in addition to all of the information that was sent to members.

November Meeting

Due to the next meeting being scheduled after the Board of Directors meeting members agreed to cancel the November 24 meeting. The Committee will meet immediately prior to the Board meeting if necessary.

Next Agenda

Items for the next agenda include an update on the medical and prescription drug claims audits, recertification process update, resolution to accept new members, report on the Aggregate Stop Loss waiver request, and an update on the Code of Ethics.

Contracts

Mr. Barber said there are various contracts that need to be renewed and the Committee provided the following direction:

Audit Services – Members were pleased with the service provide and recommended the Consortium continue with CDLM in 2016;
Financial Reporting – Mr. Snyder recommended the assistance provided by the Bonadio Group in preparing with financial statements continue in 2016;
Actuary – Mr. Mack suggested moving towards having one firm do all of the municipal actuarial statements. Mr. Barber was asked to develop a request for proposals for this service.

Mr. Snyder said he has received a series of e-mails forwarded to him concerning reporting requirements for the Affordable Care Act. He said the e-mails were from the Public Library and TC3 and contained questions and requests for training. Mr. Barber will send information on the Affordable Care Act reporting requirements. Mr. Locey said Mr. Snyder could direct anyone with questions to contact him; he also offered to hold an informational meeting.

Adjournment

The meeting adjourned at 3:50 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk

Municipalities building a
stable insurance future.

125 East Court Street
Ithaca, NY 14850
604-274-5590
INFO: consortium@twcny.rr.com
www.tompkins-co.org/healthconsortium

Actuarial Services

for the

Greater Tompkins County Municipal Health Insurance Consortium

Issue Date: January 4, 2016

Due date: January 18, 2016

Responses shall be submitted no later than 4:30 p.m. Friday January 18, 2016, delivered via email to: Consortium@twcny.rr.com .

All questions regarding the Request for Proposals shall be accepted via email no later than January 15, 2016.

Background

The **Greater Tompkins County Municipal Health Insurance Consortium** (Consortium) is an entity of municipalities created by the Tompkins County Council of Governments (TCCOG). The mission of the Consortium is to provide high-quality, cost-stable health insurance for members and their employees and retirees.

In 2010, 13 of the County's 17 municipalities have joined the Consortium and received its Certificate of Authority from the New York State Insurance Department. Currently, the Consortium has 20 municipal participants.

The bylaws of the Consortium are outlined by a municipal cooperative agreement and the Board of Directors governs the Consortium. Details are available for download at www.Tompkins-co.org/healthconsortium.

SCOPE OF SERVICES

1.00 Provide an evaluation of the actuarial soundness of the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC).

1.01 Prepare a certified opinion statement of the Consortium's claim relating to loss reserves, provision for experience rating refunds, and any other actuarial items, as per the attached Exhibit 1.

1.02 Contractor must follow HIPAA guidelines and be willing to sign Business Associate Agreement with the GTCMHIC.

1.03 Describe the forecasting methodology to be used to complete the tasks. Justify the chosen actuarial methods to be used in written narrative form.

1.04 Perform the service of conducting Actuarial Review of Outstanding Claim Liabilities as of December 31, 201X actuary valuation of municipal participants, required to file this report, to comply with GASB 45 Other Post-employment Benefits (OPEB).

Instructions to Proposers:

2.01 The GTCMHIC will receive proposals for actuarial services up until the date and time specified in the RFP Schedule.

Proposals must be submitted via e-mail to: consortium@twcny.rr.com. All proposals must be received prior to the opening date and time specified in the RFP.

The proposal shall be signed by a representative who is authorized to contractually bind the Contractor.

Requirements of the Proposal:

2.02 All proposals shall be submitted as specified on the proposal pages included in the RFP document. Any attachments must be clearly identified. To be considered, the proposal must respond to all parts of the RFP.

2.03 Any other information thought to be relevant, but not applicable to the enumerated categories, should be provided as an appendix to the proposal. If publications are

supplied by a proposer to respond to a requirement, the response should include reference to the document number and page number. This will provide a quick reference for the evaluators. Proposals not providing this reference will be considered to have no reference material included in the additional documents.

Proposals shall include:

A. Actuary Qualifications & Experience:
   a. Qualifications: The NYS Department of Financial services requires that a "Qualified Actuary" is a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation, or a person who otherwise has demonstrated his competency in such actuarial evaluation to the satisfaction of the commissioner.
   b. Experience: Proposer must be an actuary. Documentation must be submitted to support experience with self-funded Health programs of New York governmental entities. The Actuarial firm's personnel assigned to this project must have first hand experience in preparing Actuarial Certification and State exhibits required by the New York State Office of Financial Services (rate sufficiency certification and the evaluation and assessment of the reserving practices of governmental entities of similar size. Resumes should be included.

B. Other relevant experience with non-governmental clients who may demonstrate the scope of services and resources available from the actuarial firm.

C. Staff Qualifications: The qualifications of the person(s) who will have primary responsibility for completion of this assignment, must be included; supporting documentation for experience in accounting principles as promulgated in **Exhibit 1.**

PROPOSAL PAGES ARE AS FOLLOWS:

Proposal Summary Pages, including Signature Page

-Financial Proposal

-Technical Proposal

-Questionnaire   Attachments to your Proposal

CONSIDERATION FOR AWARD/AWARD PROCEDURES

The award of the contract will be based on certain objective and subjective considerations listed below:

EVALUATION CRITERIA ASSIGNED POINTS

1. Understanding of the overall needs of the GTCMHIC as presented in the narrative technical proposal. Evaluation of responses to specific points identified in Scope of work. Methodology proposed, assets committed to complete tasks, personnel assigned to project, and ability to prepare the actuary analysis of 2015 data by March 30, 2016. Points available are 0-30. 30

2. Contractor capabilities and experience. To include: qualifications of the proposer and staff to be assigned to the GTCMHIC's contract (resumes required); time in business; financial stability; experience in rate sufficiency certification; and experience in analysis of employee benefit plans. Includes client references. Points available are 0-40. 40

3. Proposed pricing schedule and estimated cost to the GTCMHIC.

Points available are 0-30. 30

MAXIMUM TOTAL POINTS: 100 points.

Evaluation of proposals will be conducted by an evaluation committee of qualified GTCMHIC Staff, or other persons selected by the GTCMHIC. The committee will evaluate all responsive proposals based upon the information and references contained in the proposals as submitted. The committee will score and rank all responsive proposals, and determine a minimum of three (3), if more than three (3) proposals are responsive, to be finalists for further consideration. In the event there are less than three (3) responsive proposals, the committee will give further consideration to all responsive proposals received. The committee may determine the need to conduct oral interviews, for clarification purposes only, with the finalists and re-score and re-rank the finalists proposals. The first ranked proposer resulting from this process will be recommended to the GTCMHIC Board of Directors for award.

Information and references submitted will be considered in the award.

The GTCMHIC may require additional information and Proposers agree to furnish such information. The GTCMHIC reserves the right to award the contract to that Proposer who will best serve the interest of the GTCMHIC. The GTCMHIC reserves the right, based upon its deliberations and in its opinion, to accept or reject any or all proposals. The GTCMHIC also reserves the right to waive minor irregularities or variations to the specifications and in the bidding process.

PROPOSAL SUMMARY PAGES - SIGNATURE PAGE

TO: The GTCMHIC

The below signed hereby agrees to furnish the services at the price(s) and terms stated subject to all instructions, conditions, specifications addenda, legal advertisement, and conditions contained in the RFP. I have read all attachments including the specifications and fully understand what is required. By submitting this signed proposal I will accept a contract if approved by the GTCMHIC and such acceptance covers all terms, conditions, and specifications of this proposal. I have not divulged to, discussed with, or compared this proposal with any other proposer(s) and have not colluded with any other proposer(s) or parties to this RFP. I certify I am authorized to contractually bind the Proposing firm:

Proposal submitted by:

Principal Contact
(printed):____

Title: ____

Company Name:____
(Legally Registered)

Address:____

NAME OF ACTUARY:____

Principal Contact Name:____ (If different from above firm)

Address:____

City:_____________________ State:_______________ Zip:________

Telephone:____________________ FAX:____________________

E-Mail:____

ADDENDUM ACKNOWLEDGEMENT - Proposer acknowledges that the following addenda have been received and are included in his proposal:

VARIANCES: State any variations to specifications, terms and conditions in the space provided below or reference in the space provided below all variances contained on other pages of RFP, attachments or proposal pages. No variations or exceptions by the Proposer will be deemed to be part of the proposal submitted unless such variation or exception is listed and contained within the proposal documents and referenced in the

space provided below. If no statement is contained in the below space, it is hereby implied that your proposal complies with the full scope of this RFP.

Variances:

PROPOSAL SUMMARY PAGES - FINANCIAL PROPOSAL

ITEM DETAIL COSTS: FIRM, FIXED HOURLY RATE: $__________

X

ESTIMATED NUMBER OF HOURS:__________ = $______________

ESTIMATED

ANNUAL TOTAL Expenses: Provide a detailed breakdown of all anticipated expenses, number of trips and all associated additional costs, if applicable:

Hotel: $_________

Travel: $_________

Meals: $_________

Misc: $_________

Total Estimated Annual Expenses: = $ ________ TOTAL ESTIMATED ANNUAL

COST TO THE GTCMHIC = $____________

OR: GUARANTEED ANNUAL MAXIMUM COST TO THE GTCMHIC NOT TO

EXCEED: $_________ PROPOSAL SUMMARY PAGE - TECHNICAL PROPOSAL

The following issues should be fully responded to in your proposal in concise narrative form. Additional sheets should be used, but they should reference each issue and be presented in the same order.

I. Understanding of the GTCMHIC's needs for actuarial services for the GTCMHIC's self-insured Health Plans and your overall approach to those needs. Provide a copy of an actuarial analysis of a health benefit program and Actuarial Certification and State Exhibits required by New York State Office of Financial Services that your firm prepared for a public sector client with at least 2,000 employees. If proprietary information must be protected, a redacted version would be acceptable.

II. Approach and concept for the ACTUARIAL SERVICES:

III. How many calendar days from final execution of the contract would you need prior to the initial meeting with the GTCMHIC?

__________ Days

How many calendar days would you estimate that you would need after the initial meeting with the GTCMHIC until you would have your preliminary outline available for GTCMHIC review?

__________ Days

Prior Experience: Number of years experience the proposer has had in providing similar services: years List below those persons who will have a management or senior position working with the GTCMHIC, if you are awarded the contract. List name, title or position, and project duties. A resume or summary of experience and qualifications must accompany your proposal.

List all government agency clients for whom you have provided similar services in the last three years. Provide agency name, address, telephone number, contact person, and date service was provided. If services provided differs from the one presented in your proposal, please delineate such differences

List other non-government client references for whom you have performed these services within the past three (3) years:

List those GTCMHIC agencies with which the proposer has had contracts or agreements during the past three (3) years:

Lawsuits (any) pending or completed involving the corporation, partnership or individuals with more than ten percent (10%) interest:

a. List all pending lawsuits, which are concerned directly with the staff or part of your organization proposed for the contract:

b. List all judgments from lawsuits in the last 5 years, which are concerned directly with the staff or part of your organization proposed for the contract.

The proposer understands that the information contained in these Proposal Pages is to be relied upon by the GTCMHIC in awarding the proposed Agreement, and such information is warranted by the proposer to be true. The proposer agrees to furnish such additional information, prior to acceptance of any proposal, relating to the qualifications of the proposer, as may be required by the GTCMHIC.

PROPOSER PLEASE INSURE THAT YOU HAVE SIGNED THE SIGNATURE PAGE OF THESE PROPOSAL PAGES. OMISSION OF A SIGNATURE ON THAT PAGE MAY RESULT IN REJECTION OF YOUR PROPOSAL

COMPLETE AND RETURN THE REQUIRED NUMBER OF **PROPOSAL PAGES AND ATTACHMENTS.**

EXHIBIT 1

MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN — NEW YORK DATA REQUIREMENTS — ANNUAL

GENERAL INFORMATION AND INSTRUCTIONS

For Filing The New York Data Requirements For MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN:

GENERAL

1. Date of Filing: The supplemental report is required to be filed in duplicate with the Department of Insurance — Statistical Unit no later than 120 days after fiscal year end.
2. Unanswered questions and blank lines or schedules will not be accepted as meaning anything. If no answers or entries are to be made, write "None", "Not Applicable (N/A)", or "-0-" in the space provided.
3. Any item which cannot be readily classified under one of the printed items should be entered as a special item and adequately described.
4. If additional supporting statements or schedules are added in connection with answering interrogatories or providing information on the financial statement, the additions should be properly keyed to the item being answered (Example — "Interrogatories, 24") and indicate the reporting date and the name of the MCHBP.
5. The jurist (Page 1) of all filed statements, including reproduced copies, must be manually signed by the appropriate corporate officers, have the corporate seal affixed thereon where appropriate and be properly notarized.
6. If this report does not contain the information asked for in the blanks or is not prepared in accordance with

these instructions, it will not be accepted.

7. **Actuary Statement.**

(1) There is to be included on or attached to Page 1 of the annual statement, the statement of a qualified actuary setting forth his or her opinion relating to loss reserves, provision for experience rating refunds, and any other actuarial items. "Qualified actuary," as used herein means a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation, or a person who otherwise has demonstrated his competency in such actuarial evaluation to the satisfaction of the commissioner.

(2) Such a statement of opinion must consist of a paragraph identifying the actuary; a scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the actuary's work (see sections 5-7 below); and an opinion paragraph expressing his or her opinion with respect to such subjects (see sections 8-10 below). One or more additional paragraphs may be needed in individual cases if the actuary considers it necessary to state a qualification of his or her opinion or to explain some aspect of the annual statement which is not already sufficiently explained in the annual statement.

(3) The opening paragraph should generally indicate the actuary's relationship to the organization.

For an actuary who is an employee of the organization the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title of actuary), am an officer (employee) of (named organization) and a member of the American Academy of Actuaries,"

For a consulting actuary, the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) with regard to loss reserves, actuarial liabilities and related items."

For a person other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title), am an officer (employee) of (name of organization) and I [have competency in actuarial valuations for organizations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind]

I, (name and title of consultant), am associated with the firm of (name of firm). I [have competency in actuarial valuations for organizations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind] and have been retained by the (name of organization) with regard to such valuation."

(4) The following are examples, for illustrative purposes, of language which in typical circumstances would be included in the remainder of the statement of opinion. The illustrative language should be modified as needed to meet the circumstances of a particular case, and the actuary should in any case, use language which clearly expresses his or her professional judgment.

(5) The scope paragraph should contain a sentence such as the following:

> "I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31 20__.

The paragraph should list those items and amounts with respect to which the actuary is expressing an opinion. The list should include but not necessarily be limited to:

(i) Claims Unpaid (Reported and Unreported)

(ii) Provision for deferred maternity benefits, if any

(iii) Other actuarial liabilities

(iv) Dues items, such as receivables, due and unpaid, unearned, and paid in advance as they may relate to actuarial items.

(6) If the actuary has examined the underlying records and/or summaries, the scope paragraph should also include a sentence such as the following:

> "My examination included such review of the assumptions and methods used and of the underlying basic records and/or summaries and such tests and calculations as I considered necessary."

(7) If the actuary has not examined the underlying records and/or summaries, but has relied upon those prepared by the organization, the scope paragraph should include a sentence such as one of the following:

(i) "I relied upon underlying records and/or summaries prepared by the responsible officers or employees of the organization. In other respects, my examination included such review of the assumptions and methods used and such tests of the calculations as I considered necessary."

(ii) "I relied upon (name of firm) for the actuary of the underlying records and/or summaries. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary."

(8) The opinion paragraph should include a sentence which covers at least the points listed in the following illustration:

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

(i) are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

(ii) are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Statement was prepared,

(iii) meet the requirements of the laws of (state of domicile),

(iv) make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements,

(v) are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end,

(vi) include appropriate provision for all actuarial items which ought to be established."

(9) If there has been any material change in the assumptions and/or methods from those previously employed, that change should be described in the statement of opinion by inserting a phrase such as:

"A material change in assumptions (and/or methods) was made during the past year but such change accords with accepted actuarial standards." A brief description of the change should follow.

The adoption of new coverages requiring underlying assumptions which differ from assumptions used for prior coverages is not a change in assumption within the meaning of this paragraph.

(10) If the actuary is unable to form an opinion, he or she should refuse to issue a statement of opinion. If the opinion is adverse or qualified, the actuary should issue an adverse or qualified opinion explicitly stating the reason(s) for such opinion.

(11) If the actuary does not express an opinion as to the accuracy and completeness of underlying listings or summaries used in his evaluation, there should be included on or attached to Page 1 of the statement blank the statement of an organization officer or accounting firm who prepared such underlying data similar to the following:

"I (name of officer of organization), (title of officer), of (name of organization and address of organization), (or accounting firm), hereby affirm that the listings and summaries of data prepared for and submitted to (name of actuary) were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete

EXHIBIT 2

ANTI-DISCRIMINATION CLAUSE

During the performance of this contract, (the contractor) hereby agrees as follows:

(a) The contractor will not discriminate against any employee or applicant for employment because of race, creed, color or national origin, and will take affirmative action to insure that they are afforded equal employment opportunities without discrimination because of race, color, creed, ethnicity, Vietnam-era veteran status, disabled veteran, marital status, disability, national origin, or status as an ex-offender. Such action shall be taken with reference, but not be limited, to: recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff or termination, rates of pay or other forms of compensation, and selection for training or retraining, including apprenticeship and on-the-job training.

(b) The contractor will send to each labor union or representative of workers with which he has or is bound by a collective bargaining or other agreement or understanding, a notice, to be provided by the State Commissioner for Human Rights, advising such labor union or representative of the contractor's agreement under clauses (a) through (f) hereinafter called "non-discrimination clauses". If the contractor was directed to do so by the contracting agency as part of the bid or negotiation of this contract, the contractor shall request such labor union or representative to furnish him with as written statement that such labor union or representative either will affirmatively cooperate, within the limits of its legal and contractual authority, in the implementation of the policy and provisions of these non-discrimination clauses or that it consents and agrees that recruitment, employment and the terms and conditions of employment under this contract shall be in accordance with the purposes and provisions of these non-discrimination clauses. If such labor union or representative fails or refuses to comply with such a request that it furnish such a statement, the contractor shall promptly notify the State Commission for Human Rights of such failure or refusal.

(c) The contractor will post and keep posted in conspicuous places, available to employees and applicants for employment, notices to be provided by the State Commission for Human Rights setting forth the substance of the provisions of clauses (a) and (b) and such provisions of the State's and local Tompkins County Laws against discrimination as the State Commission for Human Rights shall determine.

(d) The contractor will state, in all solicitations or advertisements for employees placed by or on behalf of the contractor, that all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color or national origin.

(e) The contractor will comply with the provisions of Sections 291-299 of the Executive Law and the Civil Rights Law, will furnish all information and reports deemed necessary by the State Commission for Human Rights under these non-discrimination clauses and such sections of the Executive Law, and will permit access to his books, records and accounts by the State Commission for Human Rights, the Attorney General and the Industrial Commissioner for purposes of investigation to ascertain compliance with these non-discrimination clauses and such sections of the Executive Law and Civil Rights Law.

(f) This contract may be forthwith cancelled, terminated or suspended, in whole or in part, by the contracting agency upon the basis of a finding made by the State Commission for Human Rights that the Contractor may be declared ineligible for future contracts made by or on behalf of the State or a public authority or agency of the State, until he satisfies the State Commission for Human Rights that he has established and is carrying out a program in conformity with the provisions of these non-discrimination clauses. Such finding shall be made by the State Commission for Human Rights after conciliation efforts by the Commission have failed to achieve compliance with these non-discrimination clauses and after a verified complaint has been filed with the Commission, notice thereof has been given to the Contractor and opportunity has been afforded him to be heard publicly before three members of the Commission. Such sanctions may be imposed and remedies invoked independently of or in addition to sanctions and remedies otherwise provided by law. The Contractor will include the provisions of clauses (a) through (f) in every subcontract or purchase order in such a manner that such provisions be performed within the State of New York. The Contractor will take such action in enforcing such provisions of such subcontract or purchase order as the contracting agency may direct, including sanctions or remedies for non-compliance. If the Contractor becomes involved in or is threatened with litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the Contractor shall promptly so notify the Attorney General, requesting him to intervene and protect the interests of the State of New York.

GENERAL CONDITIONS ACCEPTED BY:

Firm: ____

By: ____

Date: ____

Title: ____

EXHIBIT 2

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

GENERAL CONDITIONS

NON-COLLUSION CERTIFICATE

NON-COLLUSIVE CERTIFICATION:

(a) By submission of this bid/proposal, each bidder/proposer and each person signing on behalf of any bidder/proposer certifies, and in the case of a joint bid/proposal each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his/her/their knowledge and belief:

1. The prices in this bid/proposal have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2. Unless otherwise required by law, the prices that have been quoted in this package have not been knowingly disclosed by the bidder/proposer prior to opening, directly or indirectly, to any other bidder/proposer or to any competitor; and

3. No attempt has been made or will be made by the bidder/proposer to induce any other person, partnership, or corporation to submit or not to submit a bid/proposal for the purpose of restricting competition.

____

Name of Bidder/Proposer

____

Signature and Title of Signer

____

Date

NOTE:

A bid/proposal shall not be considered for award nor shall any award be made where (a) 1, 2 and 3 above have not been complied with; provided, however, that if in any case the bidder/proposer cannot make the foregoing certification, the bidder/proposer shall so state and shall furnish with the bid/proposal a signed statement that sets forth in detail the

reason(s) therefore. Where (a) 1, 2, and 3 above have not been complied with, the bid/proposal shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the political subdivision, public department, agency or official thereof to which the bid/proposal is made, or his designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder/proposer (a) has published price lists, rates or tariffs covering items being procured, (b) has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or (c) has sold the same items to other customers at the same prices being bid/proposed, does not constitute, without more, a disclosure within the meaning of subparagraph (a) 1.

EXHIBIT 2

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

INSURANCE AND INDEMNIFICATION

The Successful Responder Shall Maintain and Agree to the Following:

Responder shall indemnify, hold harmless and defend the Consortium its officers, employees, agents and elected officials from and against any and all claims and actions brought against the Consortium and its officers, employees, agents and elected officials for injury or death to any person or persons or damage to property arising out of the performance of this contract by the Consortium, its employees, subcontractors or agents except all actions and claims arising out of the negligence of Consortium. The Responder shall maintain the following minimum limits of insurance or as required by law, whichever is greater.

A.) **Workers' Compensation and New York Disability** - Statutory Coverage Employer's Liability - Unlimited.

B.) **Commercial General Liability** including, contractual, independent contractors, products/completed operations - Occurrence Form required.

*	Each Occurrence	$1,000,000
*	General Aggregate	2,000,000
*	Products/Completed Operations Aggregate	2,000,000
*	Personal and Advertising Injury	1,000,000
*	Fire Damage Legal	50,000
*	Medical Expense	5,000

All insurance shall be written with insurance carriers licensed by the State of New York Insurance Department and have a

Best's rating of A XI or better. The accord Certificate of Insurance or insurance company certificate may be used for proof of Workers' Compensation and Disability. All Certificates shall contain a sixty (60) day notice of cancellation, non-renewal or material change to Tompkins County. All Certificates must be signed by a licensed agent or authorized representative of the insurance company. Broker signature is not acceptable. Certificates of Insurance shall be submitted with the RFP response.

The Greater Tompkins County Health Insurance Consortium

Mission Statement DRAFT

The GTCHIC provides its products and services to the benefit primarily of Tompkins County Municipalities (and secondarily the six contiguous counties surrounding Tompkins County) and their employees / employee families, in all their diversity, both current and future. The Consortium also benefits the municipal citizenry through reduced tax burdens and healthier public servants, community members. In time, the GTCHIC may seek to serve a larger regional constituency.

The GTCHIC works to promote and maintain the health and well-being of its members by providing a trust-worthy, responsive, and efficient vehicle by which members are enabled to access quality, affordable health insurance products and protection.

The GTCHIC does this in three ways:

- Administration: Collaboratively works to identify and maintain quality, affordable products and services through efficient plan application and management.
- Advocacy: Works with healthcare providers to identify innovative opportunities for improved prevention, timely treatment, broad service-provider access, and effective self-management of long-term health conditions.
- Education: Models a new health care and insurance paradigm, where members, equipped with education, information, and resources, become more directly involved in their own personal health and well-being.