Greater Tompkins County Municipal Health Insurance Consortium

Audit and Finance Committee

March 21, 2017
Old Jail Conference Room

1. Call to Order (3:30) — S. Thayer

2. Approve Minutes of February 28, 2016 Meeting (3:32)

3. Executive Director's Report (3:35) — D. Barber

4. Financial Update (3:40) — R. Snyder & S. Locey

5. Medical Claims Audit (4:00) — D. Barber
   a. **<u>Resolution</u>:** Acceptance of Medical Claims Audit Report

6. **<u>Resolution:</u>** Adoption of Administrative Procedures for RFP's (4:15)

7. Pharmaceutical Claims Audit (4:20) — D. Barber

8. **<u>Resolution:</u>** Implementation of a Process to Allow for Reimbursement of Prescription Maintenance Medication Purchase Voluntarily and Independently by Covered Individuals through CanaRx (4:25)

9. **<u>Resolution:</u>** Authorization for Chair to Sign Contract – CSEA Dental/Vision (4:35)

10. Invoice Payment Process (4:45)

11. Next Agenda Items (4:50)
    a. Draft plan to set parameters for the number of plans a partner can offer

12. Adjourn (4:50)

Next Meeting: April 25, 2017

Audit and Finance Committee
Minutes - Draft
February 28, 2017
Old Jail Conference Room

Present: Steve Thayer, Chuck Rankin, Mack Cook, Rordan Hart, Laura Shawley, Bud Shattuck, Genevieve Suits (arrived at 3:57 p.m.)
Absent: Phil VanWormer, Peter Salton
Guests: Judy Drake, Board of Directors Chair; Don Barber, Executive Director; Rick Snyder, Treasurer; Steve Locey, Consultant; Ann Rider, Town of Enfield; Carolyn Guard, BMI (via conference call); Ed McDermott, BMI; Beth Miller, Mary Stubley, Excellus

Call to Order

Mr. Thayer, Chair, called the meeting to order at 3:32 p.m.

Changes to the Agenda

There were no changes to the agenda.

Approval of January 24, 2017 Minutes

It was MOVED by Mr. Cook, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present, to approve the minutes of January 25, 2017 as corrected. MINUTES APPROVED.

Executive Director's Report

CanaRx

Mr. Barber said the Committee has been provided a draft copy of a resolution to move forward with CanaRx and noted the Consortium's attorney has reviewed the document. Mr. Cook said as a Board member he continues to have concerns with taking action that is counter to the attorney's opinion. He questioned whether the Consortium would be at risk by entering into an agreement even though it may be in the best interest of employees. He stated that it may be in the short-term interest of the Consortium but may put it at risk in the long-term.

When asked what the Department of Financial Services has said about this Mr. Locey said DFS has only advised it is not in violation of New York State Insurance Law and suggested the Consortium look at other municipal and education laws in New York State. He said Mr. Powers pointed out there could be some potential issues in federal law. Mr. Locey reviewed possible but unlikely scenarios that could happen: DFS could pull the Consortium's Certificate of Authority or could issue a Cease and Desist order. Mr. Barber noted the Consortium has reached out to the Department; therefore, it isn't a situation where they haven't been informed. Mr. Shattuck asked how easily the Consortium could get out of this arrangement if ordered to do so; Mr. Locey said use of CanaRx could stop immediately. It was noted that the Consortium would not have a contract with CanaRx, it would be a voluntary arrangement between a member and CanaRx.

Mr. Locey suggested bringing labor groups into the process and making them fully aware of the possibility of having to revert back to the current situation if the Consortium was ordered to stop the program.

Suggestions were made and will be incorporated in the draft resolution that will be presented at the next meeting in March.

Prescription Drug Tier 4 Discussion

Mr. Barber said as Mr. Locey and his staff have been looking into adding a fourth prescription drug tier to Consortium benefit plans they have found within New York State Insurance Law the Consortium cannot have a different copay for a tier 4 than it has for tier 3. Although ProAct is looking into what other options exist with specialty medications, moving forward with a fourth prescription drug tier is now on hold.

BMI Medical Audit

Mr. Barber introduced Ed McDermott of BMI to provide a report on the recent medical claims audit. Mr. McDermott said this was the third audit BMI has conducted for the Consortium and they have used the same process. BMI has a proprietary health benefit auditing software, Audit IQ, which is essentially a relational database that is built on a sequel server framework. It is extremely robust technology that brings in all the rules of accurate claims administration. They built into the program all plan exclusions, limitations, and parameters, therefore, there will be a different implementation of Audit IQ for each of the plans. They then bring in eligibility data followed by claims data. The claims data is run against the parameters set within the database and generally a large list is returned. Once a list is generated BMI auditors sort and go through each of the claims and particularly pays attention to the episode of care to identify patterns.

Mr. McDermott explained how they look at each claim and identify a list of claims they would like to further review on-site. For the Consortium, however, they were able to receive data electronically from Excellus. After gathering and evaluating this data, they took another look to make sure that claims being submitted as errors were indeed errors. They turned over a list of errors to the administrator (Excellus) and asked them to tell whether they agree with BMI and if they do not agree, why they paid the claim. That verbatim explanation is included in the audit report presented. This brings them to the point where they are now of working with the post audit support coordinator. He introduced Ms. Guard and explained how her experience and wealth of knowledge brings the technology, clinical knowledge, and insurance knowledge to the process.

Ms. Guard said based on the items that continue to be outstanding issues she has compiled a project management spreadsheet that she has also provided to Excellus. It contains information that will be needed from Excellus by March 10th to follow-up to ensure the Consortium's claims have been processed according to plan intent. She said Excellus has confirmed receipt of the information and will be complying with the deadline and expects to be able to report back to the Committee by its next meeting. She said they have broken the claims out into four categories: plan-related, coding-related, fraud and abuse, financial impact to the plan and timely filing of claims, and other party liability.

Mr. McDermott commented about the process timeline and said they are at the point where the first report has been published and they are entering the period of further investigation. He hopes after receiving further information from Excellus that they will be able to provide further clarity on the remaining issues.

Mr. McDermott said based on the past audit and the work that BMI did on behalf of the Consortium Ms. Guard had some concerns about the responsiveness of Excellus. While she stated she had a good relationship with the one individual she worked with for the audit project, overall the responses they have received from Excellus could not be characterized as cooperative. He said any conversation that could take place between the Consortium and

Excellus to facilitate the information being exchanged would make the post audit part of the process more effective.

Mr. McDermott read the final statement by Excellus in the audit summary response: "Overall, the audit performed by BMI was for medical appropriateness through the use of BMI's software to review medical procedures and diagnosis. The claims were reviewed judgmentally without the review of actual medical record documentation. In several cases conclusions were made based solely upon the CPT code or on diagnosis for determination of the appropriate payment of the claim benefit. There are many other components that are integrated into the claim processing system. For example, clinical edits, software, Excellus medical policies, and internal claim pends or suspends though one dimensional aspect of the audit software does not always merge easily with the complexities of a claim processing system". He said this statement is inaccurate and unwarranted in BMI's view.

He said the statement is inaccurate because BMI was performing the audit for medical appropriateness and that is a small part of what the audit was staged around. It was not only for medical appropriateness but for accuracy, administrative-correctness, and everything that goes into whether a claim should be paid and judged the way that it is. He commented the claims being reviewed "judgmentally" has a specific meaning to BMI. In this type of auditing there is a very focused audit which there is some methodology for selecting the claims that are going to be the subject for the audit. In a judgmental audit, which is specific to BMI, they build the case "from the ground up" rather than using assumptions and use evidence to make judgements about what claims are accurate and what claims are not accurate. The statement that "claims were reviewed without actual medical documentation" is incorrect because they had actual medical documentation that BMI was assisted in getting from the Excellus system by the Excellus employee who worked with BMI on the audit.

Mr. McDermott further stated that decisions were not based "solely upon the CPT code or on diagnosis for determination of the appropriate payment of the claim benefit". Also, BMI is very well-aware of the complexity of claims payments systems and although audit software does not always merge easily with the complexities of a claim processing system, the system used by BMI goes well-beyond a one-dimensional software-based system alone.

Mr. Barber said when the report was initially received from BMI there were 114 items that needed further work and that list has now been consolidated down to 37 items. Out of that list 14 are considered to have been resolved due to work done in past audits. He said six items require the Board of Directors to make decisions and they will come back to the next Committee meeting. The remaining 17 are issues that continue to be worked on with Excellus.

Mr. Locey said due to reoccurring findings, a goal from this audit will be that whenever items are identified that Excellus needs to fix that there be follow-up to mandate Excellus to fix them. Also, in cases where Excellus did not comply with national coding guidelines, they need to comply with those guidelines or bring forward their reasoning to the Board of Directors.

Ms. Guard expects to be able to report back to the Consortium on the status of the audit by March 14th. The Committee will include this on its agenda for the March 21st meeting.

Approval of Invoice

There was a brief discussion concerning the approving payment of the final invoice for BMI while the process has not yet been completed. Mr. McDermott commented that the delay is due to the amount of time BMI has had to wait to receive information from Excellus and

suggested that in the future BMI move to an interim payment system to avoid impacting the Company's accounts receivables.

On motion and duly seconded, and unanimously adopted by voice vote by members present, the final invoice dated January 4, 2017 was approved. MOTION CARRIED.

Discussion of Addition to Excellus Administrative Services Contract

Mr. Barber said there is new language within the Excellus Administrative Services Contract (Section 6.7) relating to provider quality improvement programs. It specifically states that "BlueCross BlueShield may from time-to-time enter into arrangements with participating providers that are designed to drive improvements to the cost and quality of health care delivery within the service area and such arrangements may include risk-sharing programs whereby participating providers are paid compensation and other remuneration for achieving certain performance targets as well as other programs that may result in associated vendor fees and provider receiving compensation for providing quality infrastructure and meeting certain quality operational goals. The payments described in this section may be included as a claims expense or as a separate amount charged by Excellus to the employer. In any event these payments exceed actual program costs Excellus may apply such funds to future quality improvement programs."

Mr. Barber recalled when the Consortium was approached by CAPA (Cayuga Area Physicians Alliance) with a request for $300,000 to implement their Clinical Integration program; however, the Consortium asked for further information before making a commitment to the program. At some point CAPA stopped communicating. Although it was known that CAPA was approaching insurance companies to fund Clinical Integration, we were surprised to find language incorporated into the Consortium's contract with Excellus that appears to put the Consortium on the hook for funding Clinical Integration without any input to the dollar amount or outcomes data sharing of savings.

Ms. Stubley spoke of the changes that have taken place since she reported to the Consortium a couple of years ago and said there have been many changes in the industry. Medicare and Medicaid are incentivizing providers around cost and quality. They are driving changes in the payment system and trying to move away from fee for service payment and provide for more upfront payments with goals in place. This is the first year under Medicare that providers are being measured on a composite score of quality and efficiency. They are being measured this year but their payments in 2019 can be increased or decreased based on that score.

Ms. Stubley said the Excellus ACQA (Accountable Cost and Quality Arrangement) Program is aligned with what they are seeing from the State and Federal governments. They are working to be aligned with all of those changes and why providers are looking to Excellus as an insurance company to collaborate on these cost and quality goals and to find efficiencies. She said the contract language is very general; it allows Excellus to handle the quality and incentive programs that it develops as part of the rate negotiation process. She said rate negotiations are very complex and include a lot of variables and performance in cost and quality programs is one of those areas. They identify cost and quality goals for a population and set cost and quality charges for those patients. If they hit those goals they receive a different reimbursement rate for the following year and if they miss the goals they will receive a lower reimbursement rate. She said they are seeing better performance and better quality outcomes than the non-ACQA population but it is hard to measure the return on investment as it is still evolving.

Mr. Locey asked why it is included in the contract if it is built into the reimbursement to the provider and whether there are additional monies going to the claim provider as part of the system. Ms. Stubley said there are additional monies going to the provider outside of the claim payment; however, they are seeing some rate changes in the market. The language was intended to be general because they do not know what will be coming from the State and Federal governments. Mr. Locey asked if the fees will be separated and identifiable in the bills received from Excellus to be able to gauge its effectiveness. Ms. Stubley said Excellus is not pulling it out separately, it is part of the claim payments as it is hypothetical.

Mr. Barber said the Consortium would be making a payment for a program but has no idea of what the program's objectives or accomplishments are, therefore, there is no accountability from the Consortium's standpoint. He asked if the Consortium would know if Excellus decides to make an assessment at some point in the future. She said the program doesn't currently have an assessment but is willing to report annually on the status of what they are looking and present the quality results. Mr. Locey said if there is no additional fee currently being charged he doesn't see a need to include language in the contract that authorizes Excellus to charge a fee that is currently not being charged but may be charged in the future.

Mr. Hart said he would like to know if Excellus would sign the next contract if this language was removed. He said although the Consortium is getting bigger the premiums are from taxpayer dollars and having the Consortium being subject to an open-ended cost without knowledge of what it is would be a problem. Ms. Miller said the language is intentionally vague to allow things to change if needed and may also be related to Blue Card fees; she will check with the legal department at Excellus and get an answer to Mr. Hart's question.

Ms. Stubley provided information on quality results that are being seen through the ACQA program. Slightly less than half of the Consortium's members are in an ACQA, most being in a Cayuga Area Plan. She also noted that they are seeing more of a willingness by providers to share data. Mr. Locey stated one of the big gaps that exists within the system is physicians having access to real-time information about pharmaceuticals that includes costs and effectiveness. Ms. Stubley said there is a pharmacist dedicated to ACQA and they will be adding another because the experience has been so positive; the pharmacist is looking at utilization and identifying drugs that have a lower cost alternative. Mr. Locey suggested it would be helpful if physicians had easy access to a database that included medications and pricing when issuing a prescription.

Financial Update

Mr. Locey reviewed the Treasurer's report through January 31, 2017. He noted the Consortium's contract count is up by 2.3% over 2016 and up 2.14% in covered lives. This has resulted in revenue being slightly higher 1.5% over where it was projected to be; medical claims is 47% below budget; however, results are based on only one month. Prescription drug claims are 2.9% above budget. He also called attention to the Consortium being at 5,200 covered lives and 2,400 contracts. This is an 18% increase in covered lives and 20% increase in contracts with an increase from 13 to 28 entities since the Consortium first started operations. Mr. Locey reported all incurred and paid data has been sent to the Actuary as well as updated demographic information through January, 2017.

Mr. Snyder reported on the year-end closing and said the JURAT will be provided to Bonadio within a week for review. A final JURAT should be ready at the end of March for submittal to the State by April 15th.

Process to Pay Invoices

This item was deferred to the next agenda.

Administrative Procedures for Request for Proposals

This item was deferred to the next agenda.

Invoice Approval

The Committee was presented with invoices from Hancock and Estabrook and the Department of Financial Services were presented for the Committee's information.

Mr. Locey will include a line item in the budget for the DFS Audit.

Next Agenda Items

The following items will be included on the next agenda:

Adoption of Administrative Procedures for Requests for Proposals;
CanaRx Resolution;
Invoice payment process; and
BMI Audit update

Adjournment

The meeting adjourned at 5:20 p.m.

Greater Tompkins County Municipal Health Insurance Consortium

125 East Court Street • Ithaca, New York 14850 • (607)274-5590
www.tompkinscountyny.gov/hconsortium • consortium@tompkins-co.org

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RESOLUTION NO. - 2017 – ACCEPTANCE OF MEDICAL CLAIMS AUDIT REPORT

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

WHEREAS, by Resolution No. 014 of 2016 the Board of Directors authorized a contract with BMI Audit Services to perform a medical claims audit to ensure medical claims are paid by Excellus are in accordance with benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices, 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 2016 Medical Claims.

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RESOLUTION NO. - 2017 – ADOPTION OF ADMINISTRATIVE PROCEDURES FOR HANDLING REQUESTS FOR PROPOSALS

WHEREAS, a need has been identified to establish administrative procedures relating to the manner by which requests for proposals are handled administratively by the Consortium, and

WHEREAS, this process is intended to ensure continuity in the process used for issuing proposals through to execution of a contract, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, that the following Administrative Procedures for Handling Requests for Proposals is hereby adopted:

- The Executive Director will monitor expirations dates of contracts and notify the Audit and Finance Committee of upcoming RFP's that need to be issued or the need to issue an RFP for new services (*see Consortium Procurement Policy)*.
- The Executive Director will work with the Consultant to develop a draft RFP and present to the appropriate Consortium committee for approval to issue the RFP. The Board of Directors shall approve the issuance of RFPs for Medical Claims Administrator, Pharmacy Drug Manager, Consultant, Executive Director, any other RFP for services being provided for the first-time. RFPs for routine services (auditing, actuary) may be issued upon approval of the appropriate Consortium committee. The committee recommending the issuance of an RFP will consider and make a recommendation on the creation and membership of a special committee to review responses.
- The Administrative Clerk will distribute final RFPs electronically to companies that have responded previously and any others suggested by the Executive Director, Consultant, or Treasurer. The document will be posted on both the Consortium website and the New York State Purchasing website.
- RFP's will be submitted to the attention of the Administrative Clerk.
- As responses are received they will be forwarded by the Administrative Clerk to the Consortium's Executive Director and Consultant.
- Any questions submitted will be forwarded to the Executive Director and Consultant upon receipt. If an addendum is warranted it will be developed as quickly as possible and provided to the Administrative Clerk. The Administrative Clerk will distribute it electronically to the initial distribution list and post on the Consortium and New York State Purchasing websites.
- If an addendum is issued less than four calendar days prior to the due date the response due date shall be extended by four days from the date the addendum was issued.
- If a committee has been established to review responses, the Administrative Clerk will set meetings and provide the membership with all responses.

- The Executive Director and the Consultant will present the Audit and Finance Committee with a report on the responses and a recommendation or the recommendation of the review committee. The Audit and Finance Committee shall make a recommendation to the Board of Directors. *Per the Consortium's Procurement Policy written evaluations of each response must be provided and the Board of Directors shall authorize the award and contract for the requested service(s).*
- Upon approval of a contract the Administrative Clerk will work with the Executive Director to secure a contract. The County's Contracts Coordinator will review contracts prior signing by a Consortium representative.
- The Administrative Clerk will see that a contract is signed by all parties to the agreement, return a copy of the agreement to all parties, and file a copy in the Consortium's records and with the Consortium Treasurer.

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A&F Committee Action Not Being Requested Will be included on 3/23/2017 Board of Directors Agenda

RESOLUTION NO. - 2017 – IMPLEMENTATION OF A PROCESS TO ALLOW FOR REIMBURSEMENT OF PRESCRIPTION MAINTENANCE MEDICATION PURCHASED VOLUNTARILY AND INDEPENDENTLY BY COVERED INDIVIDUALS THROUGH CANARX

WHEREAS, CanaRx Services, Inc. ("CanaRx") is a Canadian Corporation, incorporated in 2002 that holds itself as providing safe, affordable brand name maintenance medications at a uniform reduced cost to American residents, and

WHEREAS, CanaRx contracts with government-licensed pharmacies in Canada, the United Kingdom, Austrailia, and New Zealand to supply government-certified Name Brand 90- day maintenance medications (approximately 300 medications) packaged and sealed by the original manufacturer, for direct delivery to participants, and

WHEREAS, CanaRx purports to be fully HIPAA compliant, fully-licensed, fully-regulated, and compliant with the laws of the dispensing jurisdiction, and

WHEREAS, CanaRx offers the purchase of its medications via voluntary participation for personal use, and CanaRx has represented that its importation of FDA-approved prescription medicine made by FDA-regulated manufacturers, rigorously conforms with the standards set forth by the United States Food and Drug Administration, is fully legal under the laws of the United States, and poses no additional risk the public's health and safety, and

WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium (the "Consortium") has relied on these representations, warranties, and assurances, and

WHEREAS, the Consortium will not enter into any direct contractual arrangement with CanaRx in order to pay the prescription medication claims incurred by covered individuals within the Consortium who voluntarily and independently choose CanaRx to fill those prescriptions, and

WHEREAS, the Consortium's current health benefit plans offer mail order copays of $10-$30 for 2 tier plans, and $20 to $140 in 3 tier plans, and

WHEREAS, the CanaRx formulary has a $0 copay for all medications, which saves members in 3-tier plans between $80 and $560 per year, and

WHEREAS, a study by ProAct, Inc. ("ProAct"), of the Consortium's 2015 drug utilization performance predicted that utilization of CanaRx medications would cost on average 65% less than the same medications purchased through ProAct, and using the 2015 drug utilization performance that study further predicted that had all 5,392 claims for medications available from the CanaRx formulary been purchased from CanaRx, the Consortium's medication claim spend would have been decreased by more than $1.6 million representing a significant reduction of the cost of covered medications, and

RESOLUTION NO. - 2017 – IMPLEMENTATION OF A PROCESS TO ALLOW FOR REIMBURSEMENT OF PRESCRIPTION MAINTENANCE MEDICATION PURCHASED VOLUNTARILY AND INDEPENDENTLY BY COVERED INDIVIDUALS THROUGH CANARX

WHEREAS, the Owning Your Own Health and Joint Committee on Plan Structure and Design have adopted resolutions urging the Consortium to take advantage of this opportunity for its members, and

WHEREAS, Tompkins County has been permitting its covered employees and retirees to use CanaRx to fill their Brand Name maintenance medications since 2007, now therefore be it

RESOLVED, on recommendation of the Owning Your Own Health Committee and the Joint Committee on Plan Structure and Design, That the GTCMHIC Board of Directors hereby directs the Executive Director to give notice to its current Prescription Benefits Manager, ProAct, to implement a process with CanaRx to allow for reimbursement of the cost of prescription maintenance medication purchased voluntarily and independently by covered individuals through the CanaRx formulary, and

RESOLVED, further, That the GTCMHIC Board of Directors hereby agrees that the Consortium may implement such processes as are necessary to provide for such reimbursement directly to CanaRx on behalf of covered individuals choosing to purchase prescription maintenance medication through the CanaRx formulary, including those employees of Tompkins County with pre-existing CanaRx contracts.

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RESOLUTION NO. - 2017 - AUTHORIZATION FOR CHAIR TO SIGN CONTRACT - CSEA DENTAL/VISION PLAN

WHEREAS, members of the GTCMHIC have access to dental and vision coverage through CSEA, and

WHEREASE, this benefit is not a Consortium product, so the premium costs are a straight pass through with those members protected by this benefit paying all of the premium cost, and

WHEREAS, the members using this benefit from CSEA are very happy with the cost and benefit coverage, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the GTCMHIC Board of Directors authorizes the Chairperson to sign a three contract for this benefit package with CSEA Employee Benefit Fund for the period July 1, 2017 thru June 30, 2020.

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GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

Actuarial Attestations

Pursuant to Article 47 of the

New York State Insurance Law

Prepared by:

Ph: 315-752-0060
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History

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

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

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

As of December 31, 2016, the Consortium consisted of a total of twenty (20) participating municipalities with the addition of the City of Cortland on January 1, 2013, the Town of Lansing on January 1, 2013, the Village of Homer on January 1, 2015, the Town of Willet on May 1, 2015, the Town of Marathon on January 1, 2016, the Town of Truxton on January 1, 2016, and the Town of Virgil on January 1, 2016.

Mission and Vision Statement

Belief:

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

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

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

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

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

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

Consortium Goal

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

Governance and Internal Administration

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

Medical Plan Claims Administration

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

Indemnity Plans

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

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

PPO Plans

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

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

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

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

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

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

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

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

Prescription Drug Claims Administration

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

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

Two-Tier Plans

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

Three-Tier Plans

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

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

Scope of Work

In terms of the specifics of this engagement, Amory Associates, LLC, a consulting actuarial firm has been retained by the Greater Tompkins County Municipal Health Insurance Consortium to provide an analysis and actuarial attestation relative to the adequacy of the Consortium's "reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported" as of December 31, 2016. This reserve has been set at a level of 12% of the incurred claims associated with the Consortium for the 2016 Fiscal Year. We have been advised that this is the reserve level which was authorized by the New York State Department of Financial Services upon the approval of the Consortium's Article 47 Application and issuance of its Certificate of Authority on October 1, 2010.

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

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

§4706. Reserve and Surplus Requirements.

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

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

(2) a reserve for unearned premium equivalents;

(3) a claim stabilization reserve;

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

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

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

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

§4710. Additional Filing Requirements and Annual Report.

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

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

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

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

Limited Use of Work Product and Data Sources

Limited Use of Work Product

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

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

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

Information and Data Reliance

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

Armory Associate's Summary of Findings

Article 47 of the New York State Insurance Law

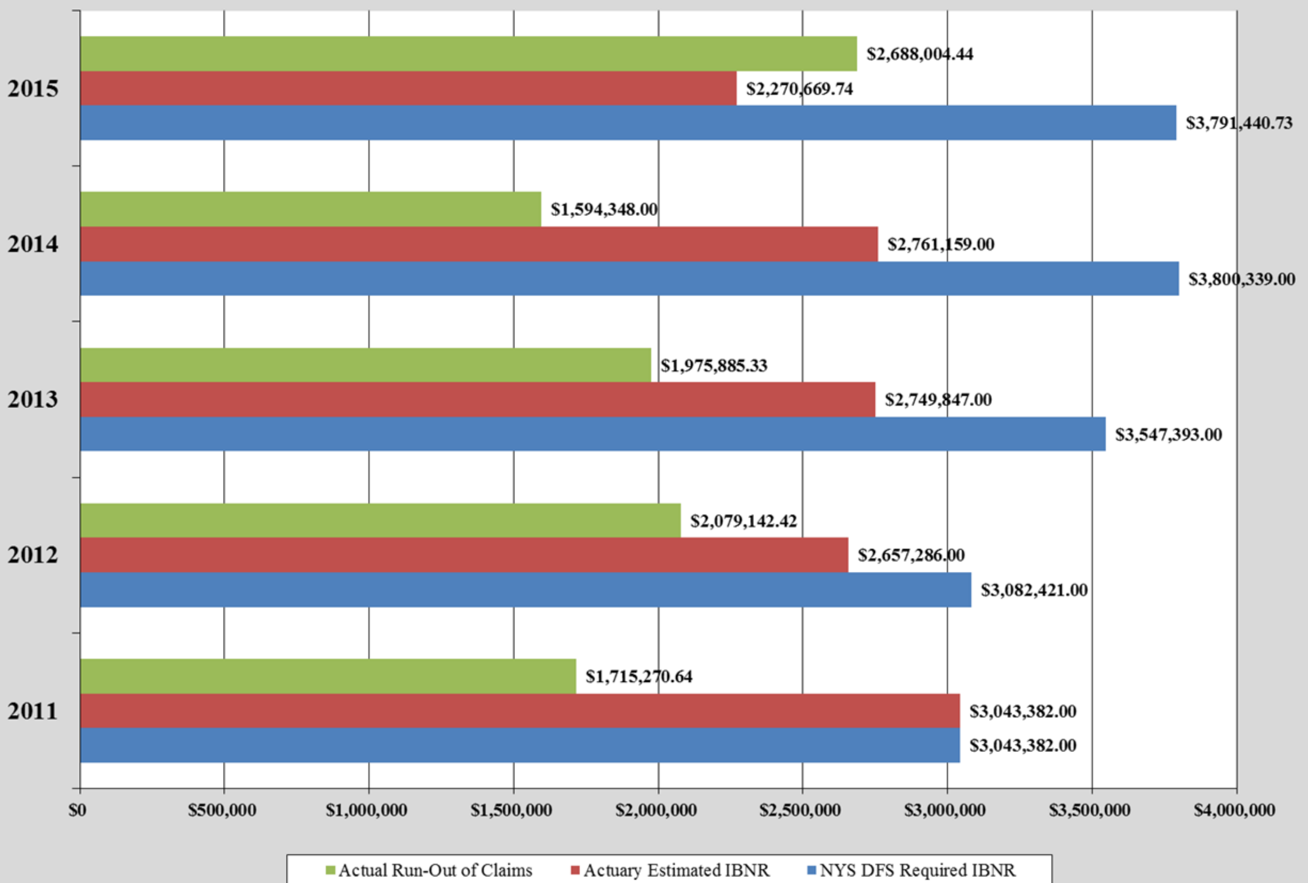
As of December 31, 2016, the Greater Tompkins County Municipal Health Insurance Consortium established a reserve in the amount of $4,430,732 which represents the incurred but not reported (IBNR) and incurred but not paid (IBNP) claims reserve liability. This process was completed in accordance with Section 4706(a)(1) of Article 47 of the New York State Insurance Law which reads as follows (emphasis added):

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

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

Description	As Estimated by Armory Associates, LLC			GTCMHIC NYS Article 47 Required IBNP/IBNR
	Medical	Rx	Totals	
1. IBNR/IBNP - Calculated Using Completion Factor Method (Attachment B and C)	$2,385,789	$4,461	$2,390,250	
2. Standard Adverse Deviation Set at 10% (Row 1 x 0.1000)	$238,579	$446	$239,025	
3. Claims Run-Out Administrative Expense Estimate (Row 1 x 0.0200)	$47,716	$89	$47,805	
4. Total Claims Liability as of 12/31/2016 (Row 1+ Row 2+Row 3)	$2,672,084	$4,996	$2,677,080	$4,430,732
5. 2016 Incurred Claims (Attachment D)	$25,243,422	$9,925,694	$35,169,116	$36,922,768
6. Total Liability as a % of Incurred Claims (Row 4 ÷ Row 5)			7.61%	12.00%

It is the opinion of Armory Associates, LLC that the reserve fund established by the Greater Tompkins County Municipal Health Insurance Consortium at the close of the 2016 Fiscal Year is sufficient to meet the Consortium's outstanding obligations and are in compliance with the terms and conditions of the Consortium's Certificate of Authority issued by the New York State Department of Financial Services in accordance with Article 47 of the New York State Insurance Law. As proof of this opinion, Armory Associates, LLC reviewed prior years to see how the actual claims run-out performed in comparison to the estimates provided by the previous actuaries and the requirements set forth by the New York State Department of Financial Services as of January 31, 2017. The only year of which the actual run-out exceeded the IBNR estimate was 2015 and this was a result of one high claimant that received treatment (starting in July 2015) out of State that caused a delay in the claim being received in May 2016. Even with this one-time anomaly the total run-out of claims for 2015 was still significantly lower than the NYS DFS Required IBNR. Please refer to the following exhibit for a summary of this information:



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

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

Armory Associate's Methodology

The most significant financial liability associated with any self-insured medical plan is the "incurred but not reported" (IBNR) and the "incurred but not paid" (IBNP) claims liability. The IBRN/IBNP liability represents the estimate of the dollar amount which will be paid on or after today for claims that were incurred on or before today (i.e., for which services have been rendered) prior to the measurement date of December 31, 2016, but for which payment will not be made until after the measurement date. This liability includes claims that have been incurred but not reported plus claims that have been reported but not paid.

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

With the above being said, Article 47 of the New York State Insurance Law has not been amended from its original requirement setting the IBNR/IBNP factor at 25% of incurred claims and expenses thereon. This particular requirement is in place unless "a qualified actuary has demonstrated to the Superintendent that a lesser amount will be adequate." We have been advised that the Consortium during its application process did in fact demonstrate to the Superintendent's satisfaction that utilizing a 12% IBNR/IBNP factor was prudent and reasonable. As a result, the Superintendent of the Department of Financial Services has agreed to allow the Consortium to establish its reserves for its IBNR/IBNP liability in an amount equal to or greater than twelve-percent (12%) of the expected hospital, medical, surgical, and pharmacy incurred claims. The balance of this section summarizes the approach used by Armory Associates, LLC to determine the adequacy of the IBNR/IBNP reserve held by the Consortium as of December 31, 2016 in the amount of $4,430,732.

While the ultimate amount of claims that will be paid out cannot be determined until history unfolds, a reasonable approximation can be provided through actuarial estimates, based on past claims payment patterns. Monthly paid claims for medical and pharmacy data segregated by the month incurred as developed by Excellus BlueCross BlueShield, Express Scripts/Medco, and ProAct, Inc. was provided by the Consortium's consultant Locey & Cahill, LLC for ***dates of service*** between January 1, 2011 through December 31, 2016 and ***paid dates*** between January 1, 2011 through December 31, 2016.

Estimates of the December 31, 2016 unpaid claims liabilities were obtained through the use Armory Associates' Development Method Model (Completion Factor Model). This model utilizes the provided monthly claims triangle to develop monthly completion factors by determining the ratio of successive month lags (cumulative paid amounts) using a straight average of nine (9) months of lag development. Prior to determining the successive month lags, the monthly paid claims data was adjusted to reflect the current membership basis. These completion factors represent the percentage of claims incurred in a given month that are paid in that month, the following month, etc. These factors are then applied to the cumulative claims paid for each month of incurred claims data to estimate the total incurred claims in the month. Unique completion factors were developed for medical claims and prescription drug claims separately as these two services complete with significantly differing patterns due primarily to the point of sale systems utilized by pharmacies which transmit claims on a more real time basis as compared to medical claims.

The final set of completion factors are used to calculate ultimate incurred claim estimates for each month of incurred claims from January 2014 through December 2016. The IBNR/IBNP reserve estimates for each month of incurred claims are calculated as the difference between ultimate incurred claims and claims incurred and paid for the month as of the valuation date. Also, based on Armory Associates analysis, it was assumed that the medical historical completion factor for the first month (December 2016)was to be "non-credible" and the total final expected claims for this month was determined using a 5% trend factor. Attachments B and C contain the detail of this calculation for medical and pharmacy incurred claim cost estimates.

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

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

Based on the results of Armory Associate's reserve calculations using actuarial development methods, the total IBNP, including margins described above, as of December 31, 2016 represents approximately 7.61% of annual incurred medical and pharmacy claims for 2016. In light of these results, the reserves held by the Consortium for claims that have been incurred but unpaid as of December 31, 2016 are sufficient to satisfy the Consortium's obligations.

Attachment A

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

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

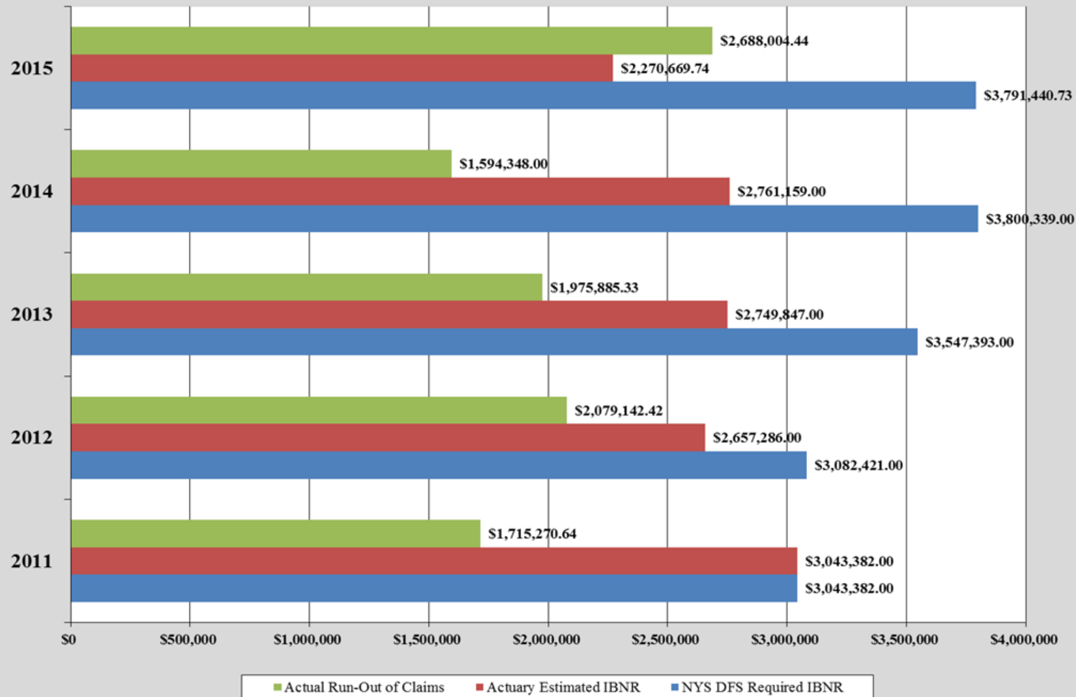
	Incurred 2012 Paid 2012	Incurred 2012 Paid 2013	Incurred 2012 Paid 2014	Incurred 2012 Paid 2015	Incurred 2012 Paid 2016	Total Incurred 2012	Total Paid 2012
Hospital/Medical	$16,435,539.13	$1,906,175.60	$31,460.83	$451.99	$0.00	$18,373,627.55	$18,023,006.66
Prescription Drug	$6,987,849.00	$141,054.00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

	Incurred 2013 Paid 2013	Incurred 2013 Paid 2014	Incurred 2013 Paid 2015	Incurred 2013 Paid 2016	Total Incurred 2013	Total Paid 2013
Hospital/Medical	$19,829,032.74	$1,957,209.22	$24,099.11	-$946.74	$21,810,341.07	$21,720,586.95
Prescription Drug	$7,017,431.00	-$5,712.00	$289.00	$98.00	$7,012,008.00	$7,158,485.00
Total	$26,846,463.74	$1,951,497.22	$24,388.11	-$848.74	$28,822,349.07	$28,879,071.95
Percent of Total	93.14%	6.77%	0.08%	0.00%		

	Incurred 2014 Paid 2014	Incurred 2014 Paid 2015	Incurred 2014 Paid 2016	Incurred 2014 Paid 2017	Total Incurred 2014	Total Paid 2014
Hospital/Medical	$20,616,174.23	$1,581,484.34	-$10,009.73	$192.39	$22,187,841.23	$22,605,150.10
Prescription Drug	$7,746,659.00	$22,274.00	$407.00	$0.00	$7,769,340.00	$7,740,947.00
Total	$28,362,833.23	$1,603,758.34	-$9,602.73	$192.39	$29,957,181.23	$30,346,097.10
Percent of Total	94.68%	5.35%	-0.03%	0.00%		

	Incurred 2015 Paid 2015	Incurred 2015 Paid 2016	Incurred 2015 Paid 2017	Total Incurred 2015	Total Paid 2015
Hospital/Medical	$19,274,786.06	$2,661,013.57	$29,204.87	$21,965,004.50	$20,881,539.18
Prescription Drug	$8,490,907.00	-$2,214.00	$0.00	$8,488,693.00	$8,513,470.00
Total	$27,765,693.06	$2,658,799.57	$29,204.87	$30,453,697.50	$29,395,009.18
Percent of Total	91.17%	8.73%	0.10%		

As clearly noted above, the 12% required claims liability factor mandated by the New York State Department of Financial Services is, in our professional opinion, a conservative estimate.



Below is the summary of the 2016 analysis conducted by Armory Associates, LLC

Description	As Estimated by Armory Associates, LLC			GTCMHIC NYS Article 47 Required IBNP/IBNR
	Medical	Rx	Totals	
1. IBNR/IBNP - Calculated Using Completion Factor Method (Attachment B and C)	$2,385,789	$4,461	$2,390,250	
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3. Claims Run-Out Administrative Expense Estimate (Row 1 x 0.0200)	$47,716	$89	$47,805	
4. Total Claims Liability as of 12/31/2016 (Row 1+ Row 2+Row 3)	$2,672,084	$4,996	$2,677,080	$4,430,732
5. 2016 Incurred Claims (Attachment D)	$25,243,422	$9,925,694	$35,169,116	$36,922,768
6. Total Liability as a % of Incurred Claims (Row 4 ÷ Row 6)			7.61%	12.00%

Attachment B

Medical Claims Development Model

	Month	Completion Factor	Total Paid Claims to Date	Membership	Projected Final Claims	Reserve
Dec-16	1	40.66%	$1,142,375	5,090	**$2,522,495**	**$1,380,120**
Nov-16	2	84.64%	$2,030,092	5,082	**$2,398,600**	**$368,508**
Oct-16	3	92.02%	$1,977,361	5,074	**$2,148,886**	**$171,525**
Sep-16	4	93.48%	$2,032,073	5,070	**$2,173,888**	**$141,816**
Aug-16	5	94.77%	$1,808,214	5,067	**$1,908,086**	**$99,873**
Jul-16	6	96.09%	$1,970,623	5,046	**$2,050,814**	**$80,191**
Jun-16	7	96.87%	$2,076,333	5,043	**$2,143,377**	**$67,044**
May-16	8	97.55%	$2,200,098	5,058	**$2,255,316**	**$55,218**
Apr-16	9	97.80%	$1,733,525	5,059	**$1,772,585**	**$39,059**
Mar-16	10	99.27%	$1,852,540	5,059	**$1,866,227**	**$13,686**
Feb-16	11	100.46%	$1,711,012	5,051	**$1,703,137**	**($7,875)**
Jan-16	12	100.47%	$1,845,021	5,059	**$1,836,343**	**($8,679)**
Dec-15	13	100.47%	$1,955,031	5,014	**$1,945,970**	**($9,061)**
Nov-15	14	100.30%	$1,985,999	5,023	**$1,979,990**	**($6,008)**
Oct-15	15	100.08%	$2,490,267	5,007	**$2,488,204**	**($2,063)**
Sep-15	16	100.04%	$1,769,987	5,031	**$1,769,308**	**($679)**
Aug-15	17	99.95%	$1,772,004	5,024	**$1,772,894**	**$889**
Jul-15	18	99.95%	$1,658,904	5,031	**$1,659,743**	**$840**
Jun-15	19	99.95%	$1,765,356	5,020	**$1,766,319**	**$963**
May-15	20	99.96%	$1,536,022	5,030	**$1,536,640**	**$618**
Apr-15	21	99.99%	$1,657,946	5,025	**$1,658,085**	**$139**
Mar-15	22	99.99%	$1,888,717	5,027	**$1,888,863**	**$146**
Feb-15	23	100.00%	$1,625,787	5,046	**$1,625,767**	**($20)**
Jan-15	24	100.01%	$1,829,779	5,035	**$1,829,602**	**($177)**
Dec-14	25	100.01%	$1,937,929	4,991	**$1,937,774**	**($155)**
Nov-14	26	100.00%	$1,829,425	5,003	**$1,829,339**	**($86)**
Oct-14	27	100.00%	$1,760,397	5,007	**$1,760,370**	**($26)**
Sep-14	28	100.00%	$1,846,875	5,002	**$1,846,858**	**($17)**
Aug-14	29	100.00%	$1,608,564	5,005	**$1,608,566**	**$1**
Jul-14	30	100.00%	$1,675,780	5,010	**$1,675,780**	**$0**

Based on Armory Associates analysis, it was assumed that the medical historical completion factor for the first month (December 2016)was to be "non-credible" and the total final expected claims for this month was determined using a 5% trend factor.

Attachment C

Prescription Drug Claims Development Model

	Month	Completion Factor	Total Paid Claims to Date	Membership	Projected Final Claims	Reserve
Dec-16	1	99.73%	$914,914	5,090	**$917,380**	**$2,466**
Nov-16	2	99.73%	$849,854	5,082	**$852,145**	**$2,291**
Oct-16	3	99.97%	$855,220	5,074	**$855,497**	**$277**
Sep-16	4	100.03%	$859,225	5,070	**$858,942**	**($283)**
Aug-16	5	100.03%	$910,253	5,067	**$909,969**	**($284)**
Jul-16	6	100.01%	$858,246	5,046	**$858,167**	**($79)**
Jun-16	7	100.00%	$650,010	5,043	**$649,986**	**($24)**
May-16	8	100.00%	$894,734	5,058	**$894,764**	**$30**
Apr-16	9	100.00%	$895,508	5,059	**$895,537**	**$29**
Mar-16	10	100.00%	$926,718	5,059	**$926,739**	**$21**
Feb-16	11	100.00%	$931,030	5,051	**$931,039**	**$9**
Jan-16	12	100.00%	$801,980	5,059	**$801,987**	**$7**
Dec-15	13	100.00%	$871,338	5,014	**$871,338**	**$0**
Nov-15	14	100.00%	$747,942	5,023	**$747,942**	**$0**
Oct-15	15	100.00%	$717,454	5,007	**$717,454**	**$0**
Sep-15	16	100.00%	$669,804	5,031	**$669,804**	**$0**
Aug-15	17	100.00%	$688,140	5,024	**$688,140**	**$0**
Jul-15	18	100.00%	$743,987	5,031	**$743,987**	**$0**

STATEMENT AS OF December 31, 2016 (Year Ending) OF THE Greater Tompkins County Municipal Health Insurance Consortium (Name)

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

Calculation of Unpaid Claims Reserves at Year End

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

Reserve requirement	12%	As Approved by the Department of Financial Services (Formally the Insurance Department)
Paid claims CY	$ 34,898,595	From Section I, Col B, Line 4 below
Unpaid claims PY	$ 2,406,559	From Section I, Col C, Line 4 below. Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Result	$ 4,430,732	
Total Claim Payable **Per Actuary** - Hospital and Medical Claims	$ 2,672,084	Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Total Claims Payable **Per Actuary** - Drug Claims	4996	Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Total Claims Payable **Per Actuary** - Other	0	Includes expenses on claims reported and not yet paid, and expenses on claims incurred but not yet reported
Total Claims Payable **Per Actuary**	$ 2,677,080	To be reported on page NY 3 Line 1.1
Total Additional Amount Requirered by Section 4706(a)(1)	$ 1,753,652	To be reported on Page NY 3 Line 1.2
Total Claims Payable	$ 4,430,732	To be reported on Page NY 3 line 1.3

SECTION I — CLAIMS INCURRED

A Description of Claims	B Paid During Year	C Unpaid Prior Year	D Unpaid Current Year	E Incurred This Year* (B - C + D)
1. Hospital & Medical Claims - **Per Actuary**	24,969,971	2,398,633	2,672,084	25,243,422
2. Drug Claims - **Per Actuary**	9,928,624	7,926	4,996	9,925,694
3. Other - **Per Actuary**			-	-
4. Total	34,898,595	2,406,559	2,677,080	35,169,116

*Must equal hospital and medical expenses accrued and unpaid which are reported on Report #2, page NY4, Line 17

SECTION II — ANALYSIS OF UNPAID CLAIMS — CURRENT FISCAL YEAR

A Description of Claims	B Reported Claims in Process of Adjustment	C Estimated Incurred but Unreported	D Total—Claims Payable* (Columns B + C)
1. Hospital & Medical Claims - **Per Actuary**	1,080,512	1,591,572	2,672,084
2. Drug Claims - **Per Actuary**		4,996	4,996
3. Other - **Per Actuary**			-
4. Total	1,080,512	1,596,568	2,677,080

* Must equal Section 1, Col. D.

SECTION III — ANALYSIS OF UNPAID CLAIMS — PREVIOUS FISCAL YEAR

A	Claims Paid During the Year*		Claims Unpaid at End of Current Year Viz: Estimated Liability at End of Current Year		F	G**	H
Description of Claims	B On Claims Incurred Prior to Current Year	C On Claims Incurred During the Year	D On Claims Unpaid at End of Previous Year	E On Claims Incurred During the Year	Total Claims Paid During the Year and Claims Unpaid at End of Current Year on Claims Incurred in Prior Years (B + D)	Estimated Liability of Unpaid Claims at End of Previous Year	Amount Unpaid Claims is Over or (Under) Reserved
1. Hospital & Medical Claims	2,650,057	22,319,914	(16,461)	2,688,545	2,633,596	2,398,633	(234,963)
2. Drug Claims	(1,709)	9,930,333	-	4,996	(1,709)	7,926	9,635
3. Other	-	-	-	-	-	-	-
4. TOTAL	2,648,348	32,250,247	(16,461)	2,693,541	2,631,887	2,406,559	(225,328)

* Must equal Section 1, Col. B.

** Must equal Section 1, Col. C.

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

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

Attachment E

Statement of Actuarial Opinion
Greater Tompkins County Municipal Health Insurance Consortium
Annual Statement as of December 31, 2016

Table of Key Indicators

This Opinion is	☒ Unqualified	☐ Qualified	☐ Adverse	☐ Inconclusive

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

Identification

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

Scope

I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the financial statements of the Greater Tompkins County Municipal Health Insurance Consortium as of December 31, 2016:

A. Claims unpaid (Page 3, Line 1.1); **$2,677,080**

B. Additional amounts required by Section 4706(a)(1) (Page 3, Line 1.2); **$1,753,652**

C. Total Claims Payable (Page 3, Line 1.3); **$4,430,732**

D. Surplus per Section 4706(a)(5) (Page 3, 21); **$1,925,998**

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

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

Reliance

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

Opinion

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

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

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

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

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

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

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

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

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

RELEVANT COMMENTS

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

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Date: March 14, 2017