GREATER TOMPKINS COUNTY MUNICIPAL

Health Insurance Consortium

www.healthconsortium.net

Orientation Manual

Don Barber, Executive Director

(edConsortium@tompkins-co.org)

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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.

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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

"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

Welcome to the Greater Tompkins County Municipal Health Insurance Consortium!!

Welcome to the Greater Tompkins County Municipal Health Insurance Consortium!!

The Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC) received its Certificate of Authority to conduct operations in October 2010 and began providing health insurance for 2000 employees and retirees of thirteen municipalities within Tompkins County on January 1, 2011. GTCMHIC is an insurance company that creates benefit plans, collects premiums, and pays medical and pharmaceutical claims for its cover members. But the Consortium is different from other insurance companies because individually and collectively we invest in realizing high quality, affordable, dependable Health Insurance.

Currently the employees and retirees of the thirty-one (31) municipalities of the towns of Aurelius, Caroline, Cincinnatus, Danby, Dryden, Enfield, Groton, Homer, Ithaca, Lansing, Marathon, Montezuma, Moravia, Newfield, Owasco, Preble, Scipio, Springport, Truxton, Ulysses, Virgil, and Willet; the villages of Cayuga Heights, Dryden, Groton, Homer, Trumansburg, and Union Springs the cities of Cortland and Ithaca and Tompkins County are covered by Consortium's approved benefit plan(s) for medical and pharmaceutical claims.

The Consortium's mission is to be an efficient inter-municipal cooperative that provides high-quality, cost-stable health insurance for members and their employees and retirees.

The GTCMHIC is currently covering over 5,200 employees/retirees and eligible dependents. 2017 premiums totaled $40.8 Million. Premiums represent 98% of all revenues. The other 2% is from miscellaneous sources like interest on funds and premiums for ancillary benefits. The Consortium's expenses were $38.7 million. 93% of the expenses paid claims in 2017. This 93% efficiency is an extremely efficient model by industry standards and has resulted in very competitive premiums. The most recent Annual report is found elsewhere in this manual.

The GTCMHIC vision is to provide 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.

You can learn much more about the GTCMHIC and Health Insurance in general by watching the 9/15/14 "Introduction to Consortium and Health Insurance" Education Retreat, "Building a Benefit Plan" Retreat of 6/12/15, "Developing Health Insurance Premiums" 5/10/16, and "Subscriber Choices and Impact" 5/10/17. All are available at the Consortium's website.

Welcome and thank you for your interest!

Municipal Cooperative Agreement:

Municipal Cooperative Agreement Summary and Responsibilities of Participants, Board of Directors, and Organized Labor

The Municipal Cooperative Agreement (MCA) is the foundational document for the GTCMHIC that has been approved by the State Insurance Department, now Department of Financial Services, resulting in the Certificate of Authority. The MCA is the agreement between the participating municipalities that describes their responsibility to each other and the structure of this Health Insurance Consortium. The MCA creates the Board of Directors (BoD); giving the BoD sole responsibility for directing and protecting the operation and financial security of GTCMHIC.

The MCA is organized as follows:

Sections A&B:	describe Participants and their responsibilities
Sections C-H:	describe the Board of Directors, their operating procedures, and responsibilities
Section I:	describes the Plan Administrator
Section J:	describes the function of the Chief Financial Officer
Section K:	describes the Joint Committee on Plan Structure and Design
Sections L-N:	describe Premiums
Sections O-X:	describe processes for Participants to work with each other for items like changes to MCA, joining, leaving, dissolution, and disputes, etc.

Summary of Participant Responsibilities (MCA section):

1. All eligible employees and retirees of participants must be covered by Consortium health Plan unless Board approval (A.3.)
2. Joining the Consortium is a minimum of three (3) year commitment (A.4.)
3. Costs and liabilities of the Consortium are assumed by the Participants on a pro-rata based on premiums paid (B.1.&3.)
4. Each Participant appoints one Director and Alternate Director and delegate to Joint Committee on Benefit Plan Design (C.1.)
5. Premium payments are due by 1st of month and penalty if late (L.3.)
6. Withdrawal can only occur on last day of plan year (P.1.) However, notice of intent to withdraw is required by October 3rd (P.2.)
7. Description of withdrawing member's pro-rata share of liabilities or assets (P.3.)
8. Participants acknowledge that all Directors are responsible for attending all scheduled meetings. Non-attendance at any scheduled meeting is deemed acquiescence by the absent Participant. However, a Participant that was absent from a meeting will not be presumed to have acquiesced in a particular action taken at the meeting if, within fifteen (15) calendar days after learning of such action, the Participant delivers written notice to the Chairperson that it dissents from such action. (R.5)
9. Requirement to review MCA every 5 years (Q.2.)
10. Disputes are subject to "Alternate Dispute Resolution" (V.)
11. Legislative Approval is required in writing to state ratification of the MCA (X.1-3)

Summary of Directors responsibility:

1. No remuneration (C3)
2. Can only represent one municipality (C4)
3. Must comply with the Conflict of Interest Policy (C5)
4. BoD actions require a majority of entire Board (C6)
5. Alternate Director can vote in place of Director (C7)
6. Quorum of majority of Directors required to conduct business (C8)
7. Special meetings can be called (C9)
8. Process when Special meetings are impractical (C10)
9. Creation and responsibilities of Executive Committee (F)
10. Responsibilities of Officers (G, H, J)
11. All Directors are responsible for attending all scheduled meetings. Non-attendance at any scheduled meeting is deemed acquiescence by the absent Participant. However, a Participant that was absent from a meeting will not be presumed to have acquiesced in a particular action taken at the meeting if, within fifteen (15) calendar days after learning of such action, the Participant delivers written notice to the Chairperson that it dissents from such action.

Summary of Organized Labor Responsibility:

1. A labor representative is chosen to be the Chairperson of the Joint Committee on Benefit Plan Design and that person is also a Consortium Director (C.11)
2. Each bargaining unit has a seat on the Joint Committee on Benefit Plan Design (K.1)
3. At least one and possibly more labor delegates are elected Consortium Directors (K.5)

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2015 AMENDMENT TO THE

MUNICIPAL COOPERATION AGREEMENT

(Final 10-06-2015)

THIS AGREEMENT (the "Agreement") made effective as of the 1st day of October 2010 (the "Effective Date"), and as amended herein, by and among each of the signatory municipal corporations hereto (collectively, the "Participants").

W H E R E A S:

1. Article 5-G of the New York General Municipal Law (the "General Municipal Law") authorizes municipal corporations to enter into cooperative agreements for the performance of those functions or activities in which they could engage individually;

2. Sections 92-a and 119-o of the General Municipal Law authorize municipalities to purchase a single health insurance policy, enter into group health plans, and establish a joint body to administer a health plan;

3. Article 47 of the New York Insurance Law (the "Insurance Law" or "N.Y. Ins. Law"), and the rules and regulations of the New York State Superintendent of Financial Services (the "Superintendent") set forth certain requirements for governing self-insured municipal cooperative health insurance plans;

4. Section 4702(f) of the Insurance Law defines the term "municipal corporation" to include a county, city, town, village, school district, board of cooperative educational services, public library (as defined in Section 253 of the New York State Education Law) and district (as defined in Section 119-n of the General Municipal Law); and

5. The Participants have determined to their individual satisfaction that furnishing the health benefits (including, but not limited to, medical, surgical, hospital, prescription drug, dental, and/or vision) for their eligible officers, eligible employees (as defined by the Internal Revenue Code of 1986, as amended, and the Internal Revenue Service rules and regulations), eligible retirees, and the eligible dependents of eligible officers, employees and retirees (collectively, the "Enrollees") (such definition does not include independent contractors and/or consultants) through a municipal cooperative is in their best interests as it is more cost- effective and efficient. Eligibility requirements shall be determined by each Participant's collective bargaining agreements and/or their personnel policies and procedures.

NOW, THEREFORE, the parties agree as follows:

A. PARTICIPANTS.

1. The Participants hereby designate themselves under this Agreement as the Greater Tompkins County Municipal Health Insurance Consortium (the "Consortium") for the purpose of providing health benefits (medical, surgical, hospital, prescription drug, dental, and/or vision) to those Enrollees that each Participant individually elects to include in the Greater Tompkins County Municipal Health Insurance Consortium Medical Plan(s) (the "Plan(s)").

2. The following Participants shall comprise the current membership of the Consortium (a) County of Tompkins; (b) City of Ithaca; (c) Town of Enfield; (d) Town of Caroline; (e) Town of Ithaca; (f) Town of Danby; (g) Town of Dryden; (h) Town of Ulysses; (i) Village of Cayuga Heights; (j) Village of Groton; (k) Village of Dryden; (l) Village of Trumansburg; (m) Town of Groton; (n) Town of Lansing: (o) City of Cortland; (p) Village of Homer; (q) Town of Willet. Membership in the Consortium may be offered to any municipal corporation within the geographical boundaries of the Counties of Tompkins, Cayuga, Chemung, Cortland, Tioga, Schuyler, and Seneca, provided however that, in the sole discretion of the Board (as defined below), the applicant provides satisfactory proof of its financial responsibility and is of the same type of municipal corporation as the initial Participants. Notwithstanding anything to contrary set forth in this Agreement, admission of new Participants shall not require amendment of this Section A(2). Membership shall be subject to the terms and conditions set forth in this Agreement, any amendments hereto and applicable law.

3. Participation in the Plan(s) by some, but not all, collective bargaining units or employee groups of a Participant is not encouraged and shall not be permitted absent prior Board approval. Further, after obtaining approval, any Participant which negotiates an alternative health insurance plan offering other than the plan offerings of the Consortium with a collective bargaining unit or employee group may be subject to a risk charge as determined by the Board.

4. Initial membership of additional participants shall become effective as soon as practical but preferably on the first day of the Plan Year following the adoption by the Board of the resolution to accept a municipal corporation as a Participant. Such municipal corporation must agree to continue as a Participant for a minimum of three (3) years upon entry.

5. The Board, by a two-thirds (2/3) vote of the entire Board, may elect to permit additional municipal corporations located within the geographical boundaries set forth in Paragraph A(2) to become Participants subject to satisfactory proof, as determined by the Board, of such municipal corporation's financial responsibility. Such municipal corporations must agree to continue as a Participant for a minimum of three (3) years upon entry.

6. A municipal corporation that was previously a Participant, but is no longer a Participant, and which is otherwise eligible for membership in the Consortium, may apply for re-entry after a minimum of three (3) years has passed since it was last a Participant. Such re-entry shall be subject to the approval of two-thirds (2/3) of the entire Board. This re-entry waiting period may be waived by the approval of two-thirds (2/3) of the entire Board. In order to re-enter the Consortium, a municipal corporation employer must have satisfied in full all of its outstanding financial obligations to the Consortium. A municipal corporation must agree to continue as a Participant for a minimum of three (3) years upon re-entry.

B. PARTICIPANT LIABILITY.

1. The Participants shall share in the costs of, and assume the liabilities for benefits (including medical, surgical, and hospital) provided under the Plan(s) to covered officers, employees, retirees, and their dependents. Each Participant shall pay on demand such Participant's share of any assessment or additional contribution ordered by the governing Board of the municipal cooperative health benefit plan, as set forth in Section L(4) of this Agreement or as ordered by the Superintendent or under Article 74 (seventy four) of the New York State Insurance Law. The pro rata share shall be based on the Participant's relative "premium" contribution to the Plan(s) as a percentage of the aggregate "premium" contribution to the Plan(s), as is appropriate based on the nature of the assessment or contribution.

2. New Participants (each a "New Participant") who enter the Consortium may, at the discretion of the Board of Directors, be assessed a fee for additional financial costs above and beyond the premium contributions to the Plan(s). Any such additional financial obligations and any related terms and conditions associated with membership in the Consortium shall be determined by the Board, and shall be disclosed to the New Participant prior to its admission.

3. Each Participant shall be liable, on a pro rata basis, for any additional assessment required in the event the Consortium funding falls below those levels required by the Insurance law as follows:

a. In the event the Consortium does not have admitted assets (as defined in Insurance Law § 107) at least equal to the aggregate of its liabilities, reserves and minimum surplus required by the Insurance Law, the Board shall, within thirty (30) days, order an assessment (an "Assessment Order") for the amount that will provide sufficient funds to remove such impairment and collect from each Participant a pro-rata share of such assessed amount.

b. Each Participant that participated in the Consortium at any time during the two (2) year period prior to the issuing of an Assessment Order by the Board shall, if notified of such Assessment Order, pay its pro rata share of such assessment within ninety (90) days after the issuance of such Assessment Order. This provision shall survive termination of the Agreement of withdrawal of a Participant.

c. For purposes of this Section B(3), a Participant's pro-rata share of any assessment shall be determined by applying the ratio of the total assessment to the total contributions or premium equivalents earned during the period covered by the assessment on all Participants subject to the assessment to the contribution or premium equivalent earned during such period attributable to such Participant.

C. BOARD OF DIRECTORS.

1. The governing board of the Consortium, responsible for management, control and administration of the Consortium and the Plan(s), shall be referred to as the "Board of Directors" (the "Board"). The voting members of the Board shall be composed of one representative of each Participant and representatives of the Joint Committee on Plan Structure and Design (as set forth in Section C(11)), who shall have the authority to vote on any official action taken by the Board (each a "Director"). Each Director, except the representatives of the Joint Committee on Plan Structure and Design, shall be designated in writing by the governing body of the Participant.

2. If a Director designated by a Participant cannot fulfill his/her obligations, for any reason, as set forth herein, and the Participant desires to designate a new Director, it must notify the Consortium's Chairperson in writing of its selection of a new designee to represent the Participant as a Director.

3. Directors shall receive no remuneration from the Consortium for their service and shall serve a term from January 1 through December 31 (the "Plan Year").

4. No Director may represent more than one Participant.

5. No Director, or any member of a Director's immediate family shall be an owner, officer, director, partner, or employee of any contractor or agency retained by the Consortium, including any third party contract administrator.

6. Except as otherwise provided in Section D of the Agreement, each Director shall be entitled to one vote. A majority of the entire Board, not simply those present, is required for the Board to take any official action, unless otherwise specified in this Agreement. The "entire Board", as used herein and elsewhere in this Agreement, shall mean the total number of Directors when there are no vacancies.

While physical presence is strongly encouraged, Directors who cannot be physically present at any meeting may attend remotely utilizing appropriate technology that allows for real time audio and visual participation and voting in the meeting upon confirmation that communication is with all participants as it progresses.

7. Each Participant may designate in writing an alternate Director to attend the Board's meeting when its Director cannot attend. The alternate Director may participate in the discussions at the Board meeting and will, if so designated in writing by the Participant, be authorized to exercise the Participant's voting authority. Only alternate Directors with voting authority shall be counted toward a quorum. The Joint Committee on Plan Structure and Design may designate alternate Directors as set forth in Section C(11).

8. A majority of the Directors of the Board shall constitute a quorum. A quorum is a simple majority (more than half) of the entire Board. A quorum is required for the Board to conduct any business. This quorum requirement is independent of the voting requirements set forth in Section C(6). The Board shall meet on a regular basis, but not less than on a quarterly basis at a time and place within the State of New York determined by a vote of the Board. The Board shall hold an annual meeting (the "Annual Meeting") between October 3rd and October 15th of each Plan Year.

9. Special meetings of the Board may be called at any time by the Chairperson or by any two (2) Directors. Whenever practicable, the person or persons calling such special meeting shall give at least three (3) days notice to all of the other Directors. Such notice shall set forth the time and place of the special meeting as well as a detailed agenda of the matters proposed to be acted upon. In the event three (3) days notice cannot be given, each Director shall be given such notice as is practicable under the circumstances.

10. In the event that a special meeting is impractical due to the nature and/or urgency of any action which, in the opinion of the Chairperson, is necessary or advisable to be taken on behalf of the Consortium, the Chairperson may send resolutions regarding said actions via electronic communication to each and all of the Directors. The Directors may then electronically communicate their approval or disapproval of said resolution via signed document to the Chairperson. In accordance with NY Business Corporation Law Section 708(b), unanimous consent is required for the Chairperson to act on behalf of the Board in reliance upon such approvals. Any actions taken by the Chairperson pursuant to this paragraph shall be ratified at the next scheduled meeting of the Board

11. The Chair of the Joint Committee on Plan Structure and Design and any At-Large Labor Representatives (as defined in Section K) (collectively the "Labor Representatives") shall serve as Directors and shall have the same rights and obligations as all other Directors. The Joint Committee on Plan Structure and Design may designate in writing alternate Directors to attend the Board's meetings when the Labor Representatives cannot attend. The alternate Director may, if designated in writing, be authorized to exercise the Labor Representatives' voting authority.

D. WEIGHTED VOTING.

1. Except as otherwise provided in this Agreement, any two or more Directors, acting jointly, may require a weighted vote on any matter that may come before the Board. In such event, the voting procedure set forth in this Section D shall apply in lieu of any other voting procedures set forth in this Agreement. Such weighted voting procedures shall apply solely with respect to the matter then before the Board.

2. For purposes of this Section D, each Director shall receive votes as follows:

a. each Director representing a Participant with five hundred (500) or fewer Enrollees shall be entitled to one (1) vote.

b. each Director representing a Participant with more than five hundred (500) Enrollees shall be entitled to a number of votes equaling the total number of votes assigned under subsection 2(a) above minus the number of Labor Representative votes, divided evenly by the number of Participants eligible under this subsection 2(b) and rounded down to the nearest whole number.

c. the Labor Representatives shall be entitled to one (1) vote each.

3. Attached as Addendum "A" to this Agreement is an example of the application of the voting formula contained in subparagraph "2" of this Section.

4. Notwithstanding anything to the contrary contained in this Agreement, any action taken pursuant to this Section D shall require the approval of two-thirds (2/3) of the total number of votes, if all votes had been cast.

E. ACTIONS BY THE BOARD

1. Subject to the voting and quorum requirements set forth in this Agreement, the Board is required, in accordance with NY Insurance Law Article 4705, to take action on the following matters:

a. In accordance with N.Y. Ins. Law § 4705(d)(5), to approve an annual budget for the Consortium, which shall be prepared and approved prior to October 15th of each year, and determine the annual premium equivalent rates to be paid by each Participant for each Enrollee classification in the Plan on the basis of a community rating methodology in accordance with N.Y. Ins. Law § 4705(d)(5)(B) and filed with and approved by the Superintendent.

b. To audit receipts and disbursements of the Consortium and provide for independent audits, and periodic financial and operational reports to Participants in accordance with N.Y. Ins. Law § 4705(e)(1).

c. To establish a joint fund or funds to finance all Consortium expenditures, including claims, reserves, surplus, administration, stop-loss insurance and other expenses in accordance with N.Y. Ins. Law § 4705(d)(4).

d. To select and approve the benefits provided by the Plan(s) including the plan document(s), insurance certificate(s), and/or summary plan description(s) in accordance with N.Y. Ins. Law § 4709, a copy of the Plan(s) effective on the date of this Agreement is incorporated by reference into this Agreement.

e. In accordance with N.Y. Ins. Law § 4705(d)(2), may contract with third parties, if appropriate, which may include one or more Participants, for the furnishing of all goods and services reasonably needed in the efficient operation and administration of the Consortium, including, without limitation, accounting services, legal counsel, contract administration services, consulting services, purchase of insurances and actuarial services. Provided, however (a) the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts, as required in Section 92-a(6) of the General Municipal Law; (b) payment for contracted services shall be made only after such services are rendered; (c) no Director or any member of such Director's immediate family shall be an owner, officer, director, partner or employee of any contract administrator retained by the Consortium; and (d) all such agreements shall otherwise comply with the requirements of Section 92-a(6) of the General Municipal Law.

f. To purchase stop-loss insurance on behalf of the Consortium and determine each year the insurance carrier or carriers who are to provide the stop- loss insurance coverage during the next Plan Year, as required by N.Y. Ins. Law §§ 4707 and 4705(d)(3).

g. To designate one governing Board member to retain custody of all reports, statements, and other documents of the Consortium, in accordance with N.Y. Ins. Law § 4705(c)(2), and who shall also take minutes of each Board meeting which, if appropriate, shall be acted upon by the Board in a subsequent meeting.

h. In accordance with N.Y. Ins. Law § 4705(e)(1), to choose the certified public accountant and the actuary to provide the reports required by this Agreement and any applicable law.

i. To designate an attorney-in-fact to receive summons or other legal process in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Consortium. The Board designates John G. Powers, Esq. as the Consortium's initial attorney-in-fact.

2. Subject to the voting and quorum requirements set forth in this Agreement, the Board is authorized to take action on the following matters:

a. To fill any vacancy in any of the officers of the Consortium.

b. To fix the frequency, time and place of regular Board meetings.

c. To have a plan consultant (the "Plan Consultant") contract in place for the upcoming Plan Year, prior to October 1st of each year.

d. To review, consider and act on any recommendations made by the Plan Consultant.

e. To establish administrative guidelines for the efficient operation of the Plan.

f. To establish financial regulations for the entry of new Participants into the Consortium consistent with all applicable legal requirements and this Agreement.

g. To determine and notify each Participant prior to October 15th of each Plan Year of the monthly premium equivalent for each enrollee classification during the next Plan Year commencing the following January 1st.

h. To designate the banks or trust companies in which joint funds, including reserve funds, are to be deposited and which shall be located in this state, duly chartered under federal law or the laws of this state and insured by the Federal Deposit Insurance Corporation, or any successor thereto.

i. To designate annually a treasurer (the "Treasurer") who may or may not be a Director and who shall be the treasurer, or equivalent financial officer, for one of the Participants. The Treasurer's duties shall be determined by the Chief Fiscal Officer to whom he/she will report.

j. To take all necessary action to ensure that the Consortium obtains and maintains a Certificate of Authority in accordance with the Insurance Law.

k. To take all necessary action to ensure the Consortium is operated and administered in accordance with the laws of the State of New York.

l. To take any other action authorized by law and deemed necessary to accomplish the purposes of this Agreement.

F. EXECUTIVE COMMITTEE.

1. The Executive Committee of the Consortium shall consist of the Chairperson, the Vice-Chairperson, the Secretary, and the Chief Fiscal Officer of the Consortium. The Secretary shall be the governing board member who holds all records in accordance with Article E, Section 1(g).

2. The Executive Committee may meet at any time between meetings of the Board, at the discretion of the Chairperson. The Executive Committee shall make recommendations to the Board.

3. The Executive Committee shall manage the Consortium between meetings of the Board, subject to such approval by the Board as may be required by this Agreement.

G. OFFICERS.

1. At the Annual Meeting, the Board shall elect from its Directors a Chairperson, Vice Chairperson, Chief Fiscal Officer, and Secretary, who shall serve for a term of one (1) year or until their successors are elected and qualified. Any vacancy in an officer's position shall be filled at the next meeting of the Board.

2. Officers of the Consortium and employees of any third party vendor, including without limitation the officers and employees of any Participant, who assist or participate in the operation of the Consortium, shall not be deemed employees of the Consortium. Each third party vendor shall provide for all necessary services and materials pursuant to annual contracts with the Consortium. The officers of the Consortium shall serve without compensation from the Consortium, but may be reimbursed for reasonable out-of-pocket expenses incurred in connection with the performance of such officers' duties.

3. Officers shall serve at the pleasure of the Board and may be removed or replaced upon a two-thirds (2/3) vote of the entire Board. This provision shall not be subject to the weighted voting alternative set forth in Section D.

H. CHAIRPERSON; VICE CHAIRPERSON; SECRETARY.

1. The Chairperson shall be the chief executive officer of the Consortium.

2. The Chairperson, or in the absence of the Chairperson, the Vice Chairperson, shall preside at all meetings of the Board.

3. In the absence of the Chairperson, the Vice Chairperson shall perform all duties related to that office.

4. The Secretary shall retain custody of all reports, statements, and other documents of the Consortium and ensure that minutes of each Board meeting are taken and transcribed which shall be acted on by the Board at a subsequent meeting, as appropriate.

I. PLAN ADMINISTRATOR.

The Board, by a two-thirds (2/3) vote of the entire Board, may annually designate an administrator and/or insurance company of the Plan (the "Plan Administrator") and the other provider(s) who are deemed by the Board to be qualified to receive, investigate, and recommend or make payment of claims, provided that the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services and/or insurance contracts and payment for such contracted services shall be made only after such services are rendered or are reasonably expected to be rendered. All such contracts shall conform to the requirements of Section 92-a(6) of the General Municipal Law.

J. CHIEF FISCAL OFFICER.

1. The Chief Fiscal Officer shall act as the chief financial administrator of the Consortium and disbursing agent for all payments made by the Consortium, and shall have custody of all monies either received or expended by the Consortium. The Chief Fiscal Officer shall be a fiscal officer of a Participant. The Chief Fiscal Officer shall receive no remuneration from the Consortium. The Plan shall reimburse the Participant that employs the Chief Fiscal Officer for reasonable and necessary out-of-pocket expenses incurred by the Chief Fiscal Officer in connection with the performance of his or her duties that relate to the Consortium.

2. All monies collected by the Chief Fiscal Officer relating to the Consortium, shall be maintained and administered as a common fund. The Chief Fiscal Officer shall, notwithstanding the provisions of the General Municipal Law, make payment in accordance with procedures developed by the Board and as deemed acceptable to the Superintendent.

3. The Chief Fiscal Officer shall be bonded for all monies received from the Participants. The amount of such bond shall be established annually by the Consortium in such monies and principal amount as may be required by the Superintendent.

4. All monies collected from the Participants by the Chief Fiscal Officer in connection with the Consortium shall be deposited in accordance with the policies of the Participant which regularly employs the Chief Fiscal Officer and shall be subject to the provisions of law governing the deposit of municipal funds.

5. The Chief Fiscal Officer may invest moneys not required for immediate expenditure in the types of investments specified in the General Municipal Law for temporary investments or as otherwise expressly permitted by the Superintendent.

6. The Chief Fiscal Officer shall account for the Consortium's reserve funds separate and apart from all other funds of the Consortium, and such accounting shall show:

a. the purpose, source, date and amount of each sum paid into the fund;

b. the interest earned by such funds;

c. capital gains or losses resulting from the sale of investments of the Plan's reserve funds;

d. the order, purpose, date and amount of each payment from the reserve fund; and

e. the assets of the fund, indicating cash balance and schedule of investments.

7. The Chief Fiscal Officer shall cause to be prepared and shall furnish to the Board, to participating municipal corporations, to unions which are the exclusive bargaining representatives of Enrollees, the Board's consultants, and to the Superintendent:

a. an annual audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the municipal cooperative health benefit plan;

b. an annual report and quarterly reports describing the Consortium's current financial status; and

c. an annual independent actuarial opinion on the financial soundness of the Consortium, including the actuarial soundness of contribution or premium equivalent rates and reserves, both as paid in the current Plan Year and projected for the next Plan Year.

8. Within ninety (90) days after the end of each Plan Year, the Chief Fiscal Officer shall furnish to the Board a detailed report of the operations and condition of the Consortium's reserve funds.

K. JOINT COMMITTEE ON PLAN STRUCTURE AND DESIGN.

1. There shall be a Joint Committee on Plan Structure and Design (the "Joint Committee"), which shall consist of (a) a representative of each collective bargaining unit that is the exclusive collective bargaining representative of any Enrollee or group of Enrollees covered by the Plan(s) (the "Union Members"); and (b) a representative of each Participant (the "Management Members"). Management Members may, but are not required to be, Directors.

2. The Joint Committee shall review all prospective Board actions in connection with the benefit structure and design of the Plan(s), and shall develop findings and recommendations with respect to such matters. The Chair of the Joint Committee shall report such findings and recommendations to the Board at any regular or special meeting of the Board.

3. The Joint Committee shall select (a) from among the Union Members, an individual who shall serve as Chair of the Joint Committee; and (b) from among the Management Members, an individual who shall serve as Vice Chair of the Joint Committee. The Joint Committee shall establish its own parliamentary rules and procedures.

4. Each eligible union shall establish such procedures by which its representative to the Joint Committee is chosen and such representative shall be designated in writing to the Chairperson of the Board and the Chair of the Joint Committee.

5. The Union Members on the Joint Committee on Plan Structure and Design shall select from among the Union Members an individual to serve as an additional at-large voting Labor Member on the Board of Directors of the Consortium. If the number of municipal members on the Consortium rises to seventeen (17), the union members of the Joint Committee on Plan Structure and Design shall select from among the Union Members an additional at-large voting Labor Member on the Board of Directors of the Consortium. The at-large voting Labor Member(s) along with the Joint Committee Chair shall collectively be the "Labor Representatives" as defined in Section C(11) of this Agreement. If the number of municipal members on the Consortium rises to twenty-three (23), the Union Members may select from among their members a third At-Large Labor Representative to serve as a Director. Thereafter, for every increase of five (5) additional municipal members added to the Consortium Union Members may select from among their members one (1) At-large Labor Representative to serve as Director. Attached hereto as Addendum "B" is a table illustrating the addition of At-Large Labor Representatives as set forth in this Section. Any At-Large Labor Representative designated according to this section shall have the same rights and obligations as all other Directors.

L. PREMIUM CALCULATIONS/PAYMENT.

1. The annual premium equivalent rates shall be established and approved by a majority of the entire Board. The method used for the development of the premium equivalent rates may be changed from time to time by the approval of two-thirds (2/3) of the entire Board, subject to review and approval by the Superintendent. The premium equivalent rates shall consist of such rates and categories of benefits as is set forth in the Plan[s] that is determined and approved by the Board consistent with New York law.

2. In accordance with N.Y. Ins. Law § 4706, the Consortium shall maintain reserves and stop-loss insurance to the level and extent required by the Insurance Law and as directed by the Superintendent.

3. Each Participant's monthly premium equivalent, by enrollee classification, shall be paid by the first day of each calendar month during the Plan Year. A late payment charge of one percent (1%) of the monthly installment then due will be charged by the Board for any payment not received by the first of each month, or the next business day when the first falls on a Saturday, Sunday, legal holiday or day observed as a legal holiday by the Participants.

The Consortium may waive the first penalty once per Plan Year for each Participant, but will strictly enforce the penalty thereafter. A repeated failure to make timely payments, including any applicable penalties, may be used by the Board as an adequate justification for the expulsion of the Participant from the Consortium.

4. The Board shall assess Participants for additional contributions, if actual and anticipated losses due to benefits paid out, administrative expenses, and reserve and surplus requirements exceed the amount in the joint funds, as set forth in Section B(3) above.

5. The Board, in its sole discretion, may refund amounts in excess of reserves and surplus, or retain such excess amounts and apply these amounts as an offset to amounts projected to be paid under the next Plan Year's budget.

M. EMPLOYEE CONTRIBUTIONS.

If any Participant requires an Enrollee's contribution for benefits provided by the Consortium, the Participant shall collect such contributions at such time and in such amounts as it requires. However, the failure of a Participant to receive the Enrollee contribution on time shall not diminish or delay the payment of the Participant's monthly premium equivalent to the Consortium, as set forth in this Agreement.

N. ADDITIONAL BENEFITS.

Any Participant choosing to provide more benefits, coverages, or enrollment eligibility other than that provided under the Plan(s), will do so at its sole expense. This Agreement shall not be deemed to diminish such Participant's benefits, coverages or enrollment eligibility, the additional benefits and the payment for such additional benefits, shall not be part of the Plan(s) and shall be administered solely by and at the expense of the Participant.

O. REPORTING.

The Board, through its officers, agents, or delegates, shall ensure that the following reports are prepared and submitted:

1. Annually after the close of the Plan Year, not later than one-hundred twenty (120) days after the close of the Plan Year, the Board shall file a report with the Superintendent showing the financial condition and affairs of the Consortium, including an annual independent financial audit statement and independent actuarial opinion, as of the end of the preceding plan year.

2. Annually after the close of the Plan Year, the Board shall have prepared a statement and independent actuarial opinion on the financial soundness of the Plan, including the contribution or premium equivalent rates and reserves, both as paid in the current Plan Year and projected for the next Plan Year.

3. The Board shall file reports with the Superintendent describing the Consortium's then current financial status within forty-five (45) days of the end of each quarter during the Plan year.

4. The Board shall provide the annual report to all Participants and all unions, which are the exclusive collective bargaining representatives of Enrollees, which shall be made available for review to all Enrollees.

5. The Board shall submit to the Superintendent a report describing any material changes in any information originally provided in the Certificate of Authority. Such reports, in addition to the reports described above, shall be in such form, and containing such additional content, as may be required by the Superintendent.

P. WITHDRAWAL OF PARTICIPANT.

1. Withdrawal of a Participant from the Consortium shall be effective only once annually on the last day of the Plan Year.

2. Notice of intention of a Participant to withdraw must be given in writing to the Chairperson prior to October 3rd of each Plan Year. Failure to give such notice shall automatically extend the Participant's membership and obligations under the Agreement for another Plan Year, unless the Board shall consent to an earlier withdrawal by a two-thirds (2/3) vote.

3. Any withdrawing Participant shall be responsible for its pro rata share of any Plan deficit that exists on the date of the withdrawal, subject to the provisions of subsection "4" of this Section. The withdrawing Participant shall be entitled to any pro rata share of surplus that exists on the date of the withdrawal, subject to the provisions of subsection "4" of this Section. The Consortium surplus or deficit shall be based on the sum of actual expenses and the estimated liability of the Consortium as determined by the Board. These expenses and liabilities will be determined one (1) year after the end of the Plan Year in which the Participant last participated.

4. The surplus or deficit shall include recognition and offset of any claims, expenses, assets and/or penalties incurred at the time of withdrawal, but not yet paid. Such pro rata share shall be based on the Participant's relative premium contribution to the Consortium as a percentage of the aggregate premium contributions to the Consortium during the period of participation. This percentage amount may then be applied to the surplus or deficit which existed on the date of the Participant's withdrawal from the Consortium. Any pro rata surplus amount due the Participant shall be paid to the Participant one year after the effective date of the withdrawal. Any pro rata deficit amount shall be billed to the Participant by the Consortium one year after the effective date of the withdrawal and shall be due and payable within thirty (30) days after the date of such bill.

Q. DISSOLUTION; RENEWAL; EXPULSION.

1. The Board at any time, by a two-thirds (2/3) vote of the entire Board, may determine that the Consortium shall be dissolved and terminated. If such determination is made, the Consortium shall be dissolved ninety (90) days after written notice to the Participants.

a. Upon determination to dissolve the Consortium, the Board shall provide notice of its determination to the Superintendent. The Board shall develop and submit to the Superintendent for approval a plan for winding-up the Consortium's affairs in an orderly manner designed to result in timely payment of all benefits.

b. Upon termination of this Agreement, or the Consortium, each Participant shall be responsible for its pro rata share of any deficit or shall be entitled to any pro rata share of surplus that exists, after the affairs of the Consortium are closed. No part of any funds of the Consortium shall be subject to the claims of general creditors of any Participant until all Consortium benefits and other Consortium obligations have been satisfied. The Consortium's surplus or deficit shall be based on actual expenses. These expenses will be determined one year after the end of the Plan Year in which this Agreement or the Consortium terminates.

c. Any surplus or deficit shall include recognition of any claims/expenses incurred at the time of termination, but not yet paid. Such pro rata share shall be based on each Participant's relative premium contribution to the Plan as a percentage of the aggregate premium contributions to the Plan during the period of participation. This percentage amount would then be applied to the surplus or deficit which exists at the time of termination.

2. The continuation of the Consortium under the terms and conditions of the Agreement, or any amendments or restatements thereto, shall be subject to Board review on the fifth (5^{th}) anniversary of the Effective Date and on each fifth (5^{th}) anniversary date thereafter (each a "Review Date").

a. At the annual meeting a year prior to the Review Date, the Board shall include as an agenda item a reminder of the Participants' coming obligation to review the

terms and conditions of the Agreement.

b. During the calendar year preceding the Review Date, each Participant shall be responsible for independently conducting a review of the terms and conditions of the Agreement and submitting to the Board of Directors a written resolution containing any objection to the existing terms and conditions or any proposed modification or amendment to the existing Agreement, such written resolution shall be submitted to the Board on or before March 1st preceding the Review Date. Failure to submit any such resolution shall be deemed as each Participant's agreement and authorization to the continuation of the Consortium until the next Review Date under the existing terms and conditions of the Agreement.

c. As soon as practicable after March 1st, the Board shall circulate to all Participants copies of all resolutions submitted by the Participants. Subject to Section S hereof, any resolutions relating to the modification, amendment, or objection to the Agreement submitted prior to each Review Date shall be considered and voted on by the Participants at a special meeting called for such purpose. Such special meeting shall be held on or before July 1st preceding the Review Date.

d. Notwithstanding the foregoing or Section T hereof, if at the Annual Meeting following any scheduled Review Date the Board votes on and approves the budget and annual assessment for the next year, the Participants shall be deemed to have approved the continuation of the Consortium under the existing Agreement until the next Review Date.

3. The Participants acknowledge that it may be necessary in certain extraordinary circumstances to expel a Participant from the Consortium. In the event the Board determines that:

a. a Participant has acted inconsistently with the provisions of the Agreement in a way that threatens the financial well-being or legal validity of the Consortium; or

b. a Participant has acted fraudulently or has otherwise acted in bad faith with regards to the Consortium, or toward any individual Participant concerning matters relating to the Consortium, the Board may vote to conditionally terminate said Participant's membership in the Consortium. Upon such a finding by the affirmative vote of seventy-five percent (75%) of the Participants, the offending Participant shall be given sixty (60) days to correct or cure the alleged wrongdoing to the satisfaction of the Board. Upon the expiration of said sixty (60) day period, and an absent satisfactory cure, the Board may expel the Participant by an affirmative vote of seventy-five percent (75%) of the Participants (exclusive of the Participant under consideration). This section shall not be subject to the weighted voting provision provided in Section D. Any liabilities associated with the Participant's departure from the Consortium under this provision shall be determined by the procedures set forth in Section P of this Agreement.

R. REPRESENTATIONS AND WARRANTIES OF PARTICIPANTS.

Each Participant by its approval of the terms and conditions of this Agreement hereby represents and warrants to each of the other Participants as follows:

1. The Participant understands and acknowledges that its participation in the Consortium under the terms and conditions of this Agreement is strictly voluntary and may be terminated as set forth herein, at the discretion of the Participant.

2. The Participant understands and acknowledges that the duly authorized decisions of the Board constitute the collective will of each of the Participants as to those matters within the scope of the Agreement.

3. The Participant understands and acknowledges that the decisions of the Board made in the best interests of the Consortium may on occasion temporarily disadvantage one or more of the individual Participants.

4. The Participant represents and warrants that its designated Director or authorized representative understands the terms and conditions of this Agreement and is suitably experienced to understand the principles upon which this Consortium operates.

5. The Participant understands and acknowledges that all Directors, or their authorized representatives, are responsible for attending all scheduled meetings. Provided that the quorum rules are satisfied, non-attendance at any scheduled meeting is deemed acquiescence by the absent Participant to any duly authorized Board-approved action at the meeting. However, a Participant that was absent from a meeting will not be presumed to have acquiesced in a particular action taken at the meeting if, within fifteen (15) calendar days after learning of such action, the Participant delivers written notice to the Chairperson that it dissents from such action. The Participant shall also notify the other members of the Board of such dissent. The Chairperson shall direct the Secretary to file the notice with the minutes of the Board.

6. The Participant understands and acknowledges that, absent bad faith or fraud, any Participant's vote approving any Board action renders that Board action immune from later challenge by that Participant.

S. RECORDS

The Board shall have the custody of all records and documents, including financial records, associated with the operation of the Consortium. Each Participant may request records and documents relative to their participation in the Consortium by providing a written request to the Chairperson and Chief Fiscal Officer. The Consortium shall respond to each request no later than thirty (30) days after its receipt thereof, and shall include all information which can be provided under applicable law.

T. CHANGES TO AGREEMENT.

Any change or amendment to this Agreement shall require the unanimous approval of the Participants, as authorized by their respective legislative bodies.

U. CONFIDENTIALITY.

Nothing contained in this Agreement shall be construed to waive any right that a covered person possesses under the Plan with respect to the confidentiality of medical records and that such rights will only be waived upon the written consent of such covered person.

V. ALTERNATIVE DISPUTE RESOLUTION ("ADR").

1. General. The Participants acknowledge and agree that given their budgeting and

fiscal constraints, it is imperative that any disputes arising out of the operation of the Consortium be limited and that any disputes which may arise be addressed as quickly as possible. Accordingly, the Participants agree that the procedures set forth in this Section V are intended to be the exclusive means through which disputes shall be resolved. The Participants also acknowledge and agree that by executing this Agreement each Participant is limiting its right to seek redress for certain types of disputes as hereinafter provided.

2. Disputes subject to ADR. Any dispute by any Participant, Board Member, or Committee Person arising out of or relating to a contention that:

a. the Board, the Board's designated agents, a Committee person, or any Participant has failed to adhere to the terms and conditions of this Agreement or any duly-passed resolution of the Board;

b. the Board, the Board's designated agents, a Committee person, or any Participant has acted in bad faith or fraudulently in undertaking any duty or action under the Agreement; or

c. any other dispute otherwise arising out of or relating to: (i) the terms or conditions of this Agreement; (ii) any duly-passed decision, resolution, or policy by the Board of Directors; or (iii) otherwise requiring the interpretation of this Agreement shall be resolved exclusively through the ADR procedure set forth in paragraph (3) below.

3. ADR Procedure. Any dispute subject to ADR, as described in subparagraph (2), shall be resolved exclusively by the following procedure:

a. Board Consideration: Within ninety (90) days of the occurrence of any dispute, the objecting party (the "Claimant") shall submit a written notice of the dispute to the Chairperson specifying in detail the nature of the dispute, the parties claimed to have been involved, the specific conduct claimed, the basis under the Agreement for the Participant's objection, the specific injury or damages claimed to have been caused by the objectionable conduct to the extent then ascertainable, and the requested action or resolution of the dispute. A dispute shall be deemed to have occurred on the date the objecting party knew or reasonably should have known of the basis for the dispute.

i. Within sixty (60) days of the submission of the written notice, the Executive Committee shall, as necessary, request further information from the Claimant, collect such other information from any other interested party or source, form a recommendation as to whether the Claimant has a valid objection or claim, and if so, recommend a fair resolution of said claim. During such period, each party shall provide the other with any reasonably requested information within such party's control. The Executive Committee shall present its recommendation to the Board in writing, including any underlying facts, conclusions or support upon which it is based, within such sixty (60) day period.

ii. Within sixty (60) days of the submission of the Executive Committee's recommended resolution of the dispute, the Board shall convene in a special meeting to consider the dispute and the recommended resolution. The Claimant and the Executive Committee shall each be entitled to present any argument or material it deems pertinent to the matter before the Board. The Board shall hold discussion and/or debate as appropriate on the dispute and may question the Claimant and/or the Executive Committee on their respective submissions. Pursuant to its regular procedures, the Board shall vote on whether

the Claimant has a valid claim, and if so, what the fair resolution should be. The weighted voting procedure set forth in Section D shall not apply to this provision. The Board's determination shall be deemed final subject to the Claimant's right to arbitrate as set forth below.

b. Arbitration. The Claimant may challenge any Board decision under subparagraph (V)(3)(a)(ii) by filing a demand for arbitration with the American Arbitration Association within thirty (30) days of the Board's vote (a "Demand"). In the event a Claimant shall fail to file a Demand within thirty (30) days, the Board's decision shall automatically be deemed final and conclusive. In the event the Participant files a timely Demand, the arbitrator or arbitration panel may consider the claim:

provided however;

i. in no event may the arbitrator review any action taken by the Board that occurred three (3) or more years prior to when the Chairperson received notice of the claim; and

ii. in no event may the arbitrator award damages for any period that precedes the date the Chairperson received notice of the claim by more than twenty-four (24) months.

c. The Participants agree that the procedure set forth in this Section V shall constitute their exclusive remedy for disputes within the scope of this Section.

W. MISCELLANEOUS PROVISIONS.

1. This instrument constitutes the entire Agreement of the Participants with respect to the subject matter hereof, and contains the sole statement of the operating rules of the Consortium. This instrument supersedes any previous Agreement, whether oral or written.

2. Each Participant will perform all other acts and execute and deliver all other documents as may be necessary or appropriate to carry out the intended purposes of this Agreement.

3. If any article, section, subdivision, paragraph, sentence, clause, phrase, provision or portion of this Agreement shall for any reason be held or adjudged to be invalid or illegal or unenforceable by any court of competent jurisdiction, such article, section, subdivision, paragraph, sentence, clause, phrase, provision or portion so adjudged invalid, illegal or unenforceable shall be deemed separate, distinct and independent and the remainder of this Agreement shall be and remain in full force and effect and shall not be invalidated or rendered illegal or unenforceable or otherwise affected by such holding or adjudication.

4. This Agreement shall be governed by and construed in accordance with the laws of the State of New York. Any claims made under Section V(3)(b) except to the extent otherwise limited therein, shall be governed by New York substantive law.

5. All notices to any party hereunder shall be in writing, signed by the party giving it, shall be sufficiently given or served if sent by registered or certified mail, return receipt requested, hand delivery, or overnight courier service addressed to the parties at the address designated by each party in writing. Notice shall be deemed given when transmitted.

6. This Agreement may be executed in two or more counterparts each of which shall be deemed to be an original but all of which shall constitute the same Agreement and shall become

binding upon the undersigned upon delivery to the Chairperson of an executed copy of this Agreement together with a certified copy of the resolution of the legislative body approving this Agreement and authorizing its execution.

7. The provisions of Section V shall survive termination of this Agreement, withdrawal or expulsion of a Participant, and/or dissolution of the Consortium.

8. Article and section headings in this Agreement are included for reference only and shall not constitute part of this Agreement.

9. No findings or recommendations made by the Joint Committee on Plan Structure and Design or by the Chair of the Joint Committee shall be considered a waiver of any bargaining rights under any contract, law, rule, statute, or regulation.

X. APPROVAL, RATIFICATION, AND EXECUTION.

1. As a condition precedent to execution of this Municipal Cooperative Agreement and membership in the Consortium, each eligible municipal corporation desiring to be a Participant shall obtain legislative approval of the terms and conditions of this Agreement by the municipality's governing body.

2. Prior to execution of this Agreement by a Participant, the Participant shall provide the Chairperson with the resolution approving the municipality's participation in this Consortium and expressly approving the terms and conditions of this Municipal Cooperative Agreement. Each presented resolution shall be maintained on file with the Consortium.

3. By executing this Agreement, each signatory warrants that he/she has complied with the approval and ratification requirements herein and is otherwise properly authorized to bind the participating municipal corporation to the terms and conditions of this Agreement.

Addendum "A"

Example of Weighted Voting Formula under Section D(2)

If 11 Participants have 500 or fewer enrollees each and 2 Participants have more than 500 enrollees each, under subparagraph "a" the 11 each get 1 vote. Under subparagraph "b" the 2 large Participants get 4 votes each, which is calculated by taking the total number of votes under subparagraph "a" [11] subtracting the number of Labor Representative votes [2], dividing by the number of eligible Participants under subsection "b" [2], and rounding the result [4.5] down to the nearest whole number [4]. The Labor Representative shall have 1 vote, irrespective of the votes available to the Participants.

Addendum "B"

Illustration of At-Large Labor Representative Calculation

Total Number of Participants	Total Number of At-Large Labor Representatives
< 17	1
17-22	2
23-27	3
28-32	4
33-37	5
38-42	6

Organization:

As agreed in the Municipal Cooperative Agreement (MCA) the Board of Directors (BoD) has sole responsibility for directing the operation of and protecting the viability of the GTCMHIC.

All of the functions below report to the BoD as shown in the subsequent graphic.

The Executive Director and Plan Consultant report to and support the BoD in providing information and executing BoD decisions.

Executive Director: The Executive Director (currently Don Barber) is contracted to plan, coordinate, direct and evaluate all programs and operations to ensure that services are performed efficiently and effectively and in accordance with the Board's direction. The Executive Director is a contractor that works at the pleasure of the BoD.

Plan Consultant: The Plan Consultant (currently Locey and Cahill, LLC.) is contracted to provide technical review and professional opinion regarding benefit plan design, financial matters, and on any matters before the BoD. The Plan Consultant is the primary intermediary between the BoD and the third party administrators and Insurance providers. The Plan Consultant provides monthly financial updates and premium and reserve recommendations. The Plan Consultant is a contractor that works at the pleasure of the BoD.

CLAIMS ADMINISTRATION

Medical Claims Administrator: Excellus provides medical claims administration for GTCMHIC. Each municipality's Benefit Clerk has an operations manual which describes the medical and prescription claims process as well as enrollment and removing of covered lives. Excellus also offers customized information for each covered employees, wellness support, monthly health topic, and much more through this web portal:
https://www.excellusbcbs.com/wps/portal/xl/cwp/greatertompkins

Prescription Claims Administrator: Pro-Act provides pharmaceutical claims administration for GTCMHIC. Pro-Act also offers customized information for each covered employees, wellness support, quarterly newsletters, and much more through this web portal: https://secure.proactrx.com/

COMMITTEES

Serving in an advisory role are the Joint Committee on Plan Structure and Design, Appeals, OYOH, and the Audit and Finance Committees, which are led by Directors and provide the first line of deliberative review of items that will come before the BoD.

PROFESSIONAL SUPPORT SERVICES

Also advising and providing oversight functions are a number of professional support services for: Legal, Claims and Financial Third party Auditing, Actuary, Article 47 Accounting.

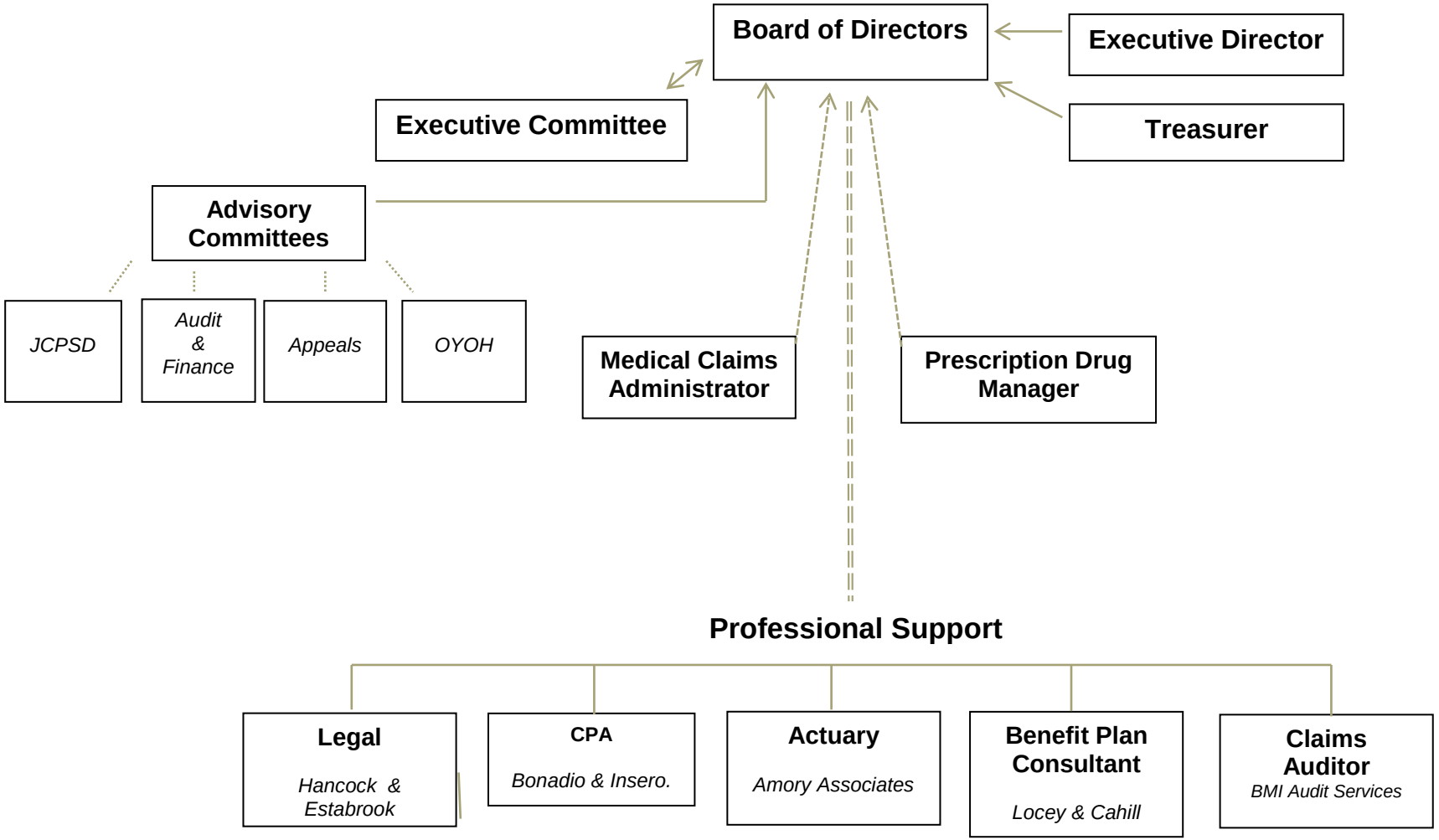
Appeals procedure: The Claims Appeal procedure is described in detail on the Consortium Website. The process begins with initial contact with Excellus or Pro-Act. The appeal can be made by the patient, patient representative, or service provider. If the internal appeal process is not satisfactory, a covered person is not satisfied with an appeal determination regarding a claim that does not relate to a medical necessity or experimental/investigational services denial, the covered person may request a claim review by the GTCMHIC Appeals Committee by filing a written request for a review. (Also see page 46)

AUDIT

Financial and claims operations are audited annually by third party auditing firms. Their results are reported to Board of Directors and to the Department of Financial Services (DFS).

For the years 2011 and the first 6 months of 2012, the GTCMHIC was audited by DFS. The audit has been completed. The final report has been made available to the public through the DFS website. DFS is currently auditing year 2012 through 2015. Draft recommendations have not been received as of the writing of this page.

Greater Tompkins County Municipal Health Insurance Consortium



Contact Information:

Greater Tompkins County Municipal Health Insurance Consortium
125 E. Court Street, Ithaca, NY 14850
Administrative Clerk: Michelle Pottorff (Consortium@tompkins-co.org)
Executive Director: Don Barber (EDConsortium@tompkins-co.org)

Membership and Billing Inquiry Unit: Phone: 1-800-724-5032
Excellus BlueCross BlueShield
P.O. Box 22999. Rochester, NY 14692

Membership & Billing professionals are available: M-Th 8 a.m. – 5 p.m., Fri. 9 a.m. - 5 p.m.

Customer Care Department (Claims and Benefits) Phone: 1-800-499-1275
Excellus BlueCross BlueShield
P.O. Box 22999, Rochester, NY 14692
Customer Care professionals are available: M-Th. 8 a.m.- 7 p.m.; Fri. 9 a.m.-7 p.m.; Sat. 9 a.m. - 1 p.m.

Prescription Drugs: Phone: 1-877-635-9545
ProAct Pharmacy Benefits
1230 Route 11, Gouverneur, NY 13624
The ProAct Help Desk Customer Service Team is available: M-F 7 a.m. – 10 p.m./Sat. 8:30 a.m. – 5 p.m.

Municipal Health Insurance Benefit Clerks:

Village of Cayuga Heights – Joan Mangione - jmangione@cayuga-heights.ny.us	257-1238
Village of Dryden – Debra Marrotte - villageclerk@dryden-ny.org	844-8122
Village of Groton – Nancy Niswender - niswender@gmail.com	898-3966
Village of Homer – Don Ferris - dferris@homerny.com	749-3322
Village of Trumansburg – Tammy Morse – clerk@trumansburg-ny.gov	387-6501
Village of Union Springs – Joanne Fleming - usclerk@verizon.net	315-889-7341
Town of Aurelius – Deborah Pinkney - aurclerk@rochester.rr.com	315-255-1894
Town of Caroline – Ciindy Whittaker - cwhitt9127@aol.com	539-6400
Town of Cincinnatus – LuuAnn King - thesyrupking@gmail.com	863-4018
Town of Danby – Laura Shawley - danbyhwy@yahoo.com	277-4788
Town of Dryden – Jenn Case - Bookkeeper@dryden.ny.us	844-8888
Town of Enfield – Beth McGee - supervisor@townofenfield.com	273-8256
Town of Groton – Chuck Rankin - crankingroton@gmail.com	898-4177
Town of Homer – Anita Jebbett – townofhomer@yahoo.com	749-4581
Town of Ithaca – Judy Drake Jdrake@town.ithaca.ny.us	273-1721
Town of Lansing – Charmagne Rumgay - charrum@twcny.rr.com	533-8819
Town of Marathon – Thomas Adams - thomasd@frontiernet.net	849-3455
Towns of Montezuma – June Smith - montezumaclerk@tds.net	315-776-9943
Town of Moravia – Vikki Price - moraviatown@scccinternet.com	315-497-1972
Town of Newfield – Nadine Bennett – nadinebennett@cornell.edu	564-0654
Town of Owasco – Darcelle Foster – bookkeeper@owascony.gov	315-253-9021
Town of Preble – James Doring - jdoring@twcny.rr.com	749-3199
Town of Scipio – Gary Mutchler garymutchler@juno.com	315-364-5740 or 315-730-3638
Town of Springport – Dave Schenck d77ma@aol.com	315-889-7717
Town of Truxton – Kimberly Reakes – townoftruxton@frontiernet.net	842-6984
Town of Ulysses - Carissa Parlato clerk@ulysses.ny.us	387-5767
Towns of Virgil and Willett – Gina Nourse - Virgilbookkeeper@frontiernet.net	835-6174
Tompkins County – Sarah Thomas – sthomas@tompkins-co.org	274-5526
TC3 – Sharon Dovi dovis@tc3.edu	844-8211
City of Ithaca – Denise Malone dmalone@cityofithaca.org	274-6539
City of Cortland – Mack Cook mcook@cortland.org	756-7312
Julie Maddren – payroll@cortland.org	758-8373

2018 Board of Directors

1.	Judith Drake, Chair	Town of Ithaca
2.	Rordan Hart, Vice Chair	Village of Trumansburg
3.	Steven Thayer, Chief Fiscal Officer	City of Ithaca
4.	Charles Rankin, Secretary	Town of Groton
5.	Amy Guererri	Tompkins County
6.	Mack Cook	City of Cortland
7.	Alex Patterson	Town of Aurelius
8.	John Fracchia	Town of Caroline
9.	LuAnn King	Town of Cincinnatus
10.	Laura Shawley	Town of Danby
11.	Kathy Servoss	Town of Dryden
12.	Ann Rider	Town of Enfield
13.	Kevin Williams	Town of Homer
14.	Charmagne Rumgay	Town of Lansing
15.	Thomas Adams	Town of Marathon
16.	John Malenick	Town of Montezuma
17.	Terrence Baxter	Town of Moravia
18.	Christine Laughlin	Town of Newfield
19.	Ed Wagner	Town of Owasco
20.	Jim Doring	Town of Preble
21.	Gary Mutchler	Town of Scipio
22.	David Schenck	Town of Springport
23.	Tom Brown	Town of Truxton
24.	Richard Goldman	Town of Ulysses
25.	Eric Snow	Town of Virgil
26.	Alvin Doty, Jr.	Town of Willet
27.	Peter Salton	Village of Cayuga Heights
28.	Michael Murphy	Village of Dryden
29.	Nancy Niswender	Village of Groton
30.	Kristen Case	Village of Homer
31.	Bud Shattuck	Village of Union Springs
32.	Olivia Hersey	Chair, Joint Comm. on Plan Structure and Design
33.	Jim Bower	2nd Labor Representative
34.	Zack Nelson	3rd Labor Representative
35.	Doug Perine	4th Labor Representative
36.	Tim Farrell	4th Labor Representative

Consortium website: www.healthconsortium.net
Executive Director: Don Barber – edconsortium@tompkins-co.org
Consortium e-mail: consortium@tompkins-co.org

Respectfully submitted:

Judy Drake
Chair of Board of Directors

Don Barber
Executive Director

Greater Tompkins County Municipal Health Insurance Consortium
Policy for Disclosing Possible Wrongful Conduct (Whistleblower Policy)

Overview

The Greater Tompkins County Municipal Health Insurance Consortium was established to provide cost effective health and other related insurance benefits for the employees and retirees of member municipalities and their dependents. The aggregate cost of the program affects the future benefits of all members. Ultimately, the true payers of these benefits are the taxpayers of the municipalities in which these employers are located. It is, therefore, incumbent upon everyone involved to ensure that any wrongful acts, such as theft, fraud, waste or abuse are properly reported.

Disclosure Policy

It is the policy of the Consortium that all individuals involved in the administration of the plan, as well as all members who receive benefits provided by the plan abide by the plan documents and all applicable state and federal laws and regulations. Any expected acts of theft, fraud, waste or abuse should be reported to the Consortium's Audit Committee or directly to the Attorney-in-fact[1] (John G. Powers of Hancock Estabrook LLP) for further investigation. Such investigation shall be commenced within 30 days. A written report of findings shall be submitted to the Board of Directors within 60 days.

Anti-Discrimination Policy

Any employee who discloses an alleged act of theft, fraud, waste or abuse shall not be discriminated or retaliated against by his/her employer or by any representative of the Consortium. In fact, all disclosures or complaints shall be kept confidential to the maximum extent possible. Disclosures or complaints submitted anonymously shall receive the same treatment as those submitted with identification. Any acts of discrimination or retaliation due to an individual's disclosure of theft, fraud, waste or abuse shall be reported to the Consortium's Audit Committee or directly to the Attorney-in-fact. Reports of discrimination shall be investigated within 30 days. A written report of findings shall be submitted to the Board of Directors within 60 days.

Distribution

This policy shall initially be distributed to each member municipality, each member of the Board of Directors, and the Joint Committee on Plan Structure and Design. A copy shall also be posted in a conspicuous location at each member municipality facility, and on the Consortium's website.

Review

This policy shall be reviewed by the Board of Directors at least once every three (3) years.

Greater Tompkins County Municipal Health Insurance Consortium
Code of Ethics and Conflict of Interest Policy

(Adopted 2-27-2014; amended by Res. No. 008-2016)

Employees and the Board of Directors of the **Greater Tompkins County Municipal Health Insurance Consortium** shall:

1. Be dedicated to the concepts of an effective Consortium and believe that professional general management is essential to the achievement of this objective.

2. Shall affirm the dignity and work of the services rendered by the Consortium and maintain a constructive, creative, and practical attitude toward Consortium affairs and a deep sense of responsibility as a trusted public servant.

3. Be dedicated to the highest ideals of honor and integrity in all public and personal relationships in order that the member may merit the respect and confidence of the elected officials, of other officials and employees, and of the public.

4. Conduct themselves so as to maintain public confidence in their profession, the Consortium, and in their performance of the public trust.

5. Conduct their official and personal affairs in such a manner as to give the clear impression that they cannot be improperly influenced in the performance of their official duties.

6. Recognize that the chief function of the Consortium at all times is to serve the interests of all members.

7. Shall not disclose **Confidential Information** to others or use to further their personal interest, confidential information acquired by them in the course of their official duties.

8. Shall not, except pursuant to such reasonable exceptions as are provided by regulation, solicit or accept any gift or other item of monetary value from any person or entity seeking official action from, doing business with, or conducting activities regulated by the employee's agency, or whose interests may be substantially affected by the performance or nonperformance of the employee's duties.

9. Make no unauthorized commitment or promises of any kind purporting to bind the Consortium.

10. Shall act impartially and not give preferential treatment to any private organization or individual.

11. Shall not engage in outside employment or activities, including seeking or negotiating for employment, that conflict with official Consortium duties and responsibilities.

12. Shall endeavor to avoid any actions creating the appearance that they are violating the law or the ethical standards promulgated pursuant to this order.

13. Shall adhere to all laws and regulations that provide equal opportunity for all Americans regardless of race, color, religion, sex, national origin, age, or disability.

14. Shall not invest or hold any investment, directly or indirectly, in any financial business, commercial, or other private transaction that creates a conflict with their official duties.

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

16. Employees and the Board of Directors should not discuss or divulge information with anyone about pending or completed ethics cases except as authorized by the Board of Directors.

Notice of Privacy Practices

(Approved by Board of Directors 12/19/2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY.

We understand that personal and health information about you is personal. We are committed to safeguarding your personal and protected health information (PHI.) PHI is any information that can identify you as an individual and your past, present or future physical or mental health condition.

This policy supports your health plans need to collect information and the right of the individual to privacy. It ensures that the health plan can collect personal and health information necessary for its functions, while recognizing the right of the individuals to have their information handled in ways that they would reasonably expect and in ways that protect the privacy of their personal and health information. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Use and Disclosures- Personal and health information is collected and used for the following purposes:
We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.

Treatment: Your health information may be used by Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC) or disclosed to other organizations for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all organizations who may provide treatment or who may be consulted by GTCMHIC representatives.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of GTCMHIC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates: Your personal and health information may be disclosed to business associates independent of our business with which we contract. However, we will only make such disclosures if we have received satisfactory assurances that the business associate will properly safeguard your privacy and the confidentiality of your PHI. For example, we may contract with a company to consult to us regarding the health plan.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

***Other uses and disclosures require your authorization*:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Information about treatments*:* Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request-restrictions-on-the-use and-disclosure-of-your-protected-health-information.
- The right to receive confidential communication's concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

GTCMHIC: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Privacy Official.**

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the Privacy Official. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. **You will not be penalized or otherwise retaliated against for filing a complaint.**

Contact Person: You can receive further information concerning our privacy practices by contacting:

Privacy Official
e-mail: consortium@tompkins-co.org
GTCMHIC
125 East Court Street
Ithaca, NY 14850
607-274-5590
607-274-5558 (fax)

This Notice is effective on or after January 1, 2014.

Greater Tompkins County Municipal Health Insurance Consortium Procurement Policy

All procurements made by the Greater Tompkins County Municipal Health Insurance Consortium involving the expenditure of the Consortium funds will be made in accordance with the following procurement standards.

Purchases will be reviewed by the Consortium Treasurer to prevent duplication and to ensure that costs are reasonable.

I. METHODS FOR PROCUREMENT

Procurements shall be made using one of the following methods:

A. Verbal or Written Quotations

Purchases which cost between $1.00 and $499.99 may be made by authorized purchasers using the purchaser's best discretion with expense(s) to be directly paid or reimbursed by the Consortium upon receipt of a valid proof of purchase (i.e. receipt or invoice). Efforts will be made to get the lowest and best price, but written documentation is not required.

Purchases which cost between $500.00 and $2,999.99 require three verbal (telephone) quotes. A memorandum shall be prepared detailing the date of contact, company name, contact person, pricing, and delivery terms. Purchaser shall make every attempt to ensure fair and competitive pricing.

Purchases of supplies, equipment, and professional services between $3,000.00 and $20,000.00 require written quotations. Reasonable attempts shall be made to obtain a minimum of three responses. Documentation detailing such attempts shall be prepared and filed with the paid bill file.

B. Bids or Request for Proposals

Bids will be sought for purchases of goods or equipment that exceed $20,000. Detailed specifications will be developed for approval by the Consortium prior to posting on the appropriate website(s). Bids shall be awarded to the lowest responsible bidder(s) meeting all specifications with acceptable deviations. Bids shall be awarded by the Board of Directors.

Request for Proposals shall be sought when the cost for services is expected to exceed $20,000. Specifications shall be developed and approved by the Consortium prior to posting on the appropriate website(s). As a general rule, Request for Proposals shall be posted on the appropriate website(s) for a minimum of twenty-one days. The Board of Directors shall authorize the award and contract for the requested service(s).

Request for Proposal specifications shall detail the following:

- Scope of Services
- Evaluation Criteria
- Project Schedule
- Contract Term

Contract shall be awarded to the offerer that submits the proposal determined to be in the best interest of the Consortium once proposals have been reviewed and, if needed, negotiated. Written evaluations of each response must be provided.

The Consortium reserves the right to reject all proposals, to negotiate with an offerer, and to solicit new Request for Proposals if determined to be in the best interest of the Consortium.

II. CONTRACTS

Generally, all procurement involving services will require a written description of the service or, when applicable, a written contract.

A contract for professional services shall be for up to three years with the option to renew for an additional two years.

All contracts shall contain a cancelation clause which allows the Consortium to cancel any contract for cause. All contracts shall contain a cancellation clause which allows the Consortium to cancel any contract without cause with either a 30 or 60 day notice.

All contracts shall contain indemnification and hold harmless language and shall state required insurance coverage as deemed sufficient and appropriate by the Board of Directors.

III. DOCUMENTATION

Supporting documentation for purchases that do not require bidding or seeking proposals shall be retained and filed by the Consortium Treasurer or designee.

All bid and proposal responses shall be filed and maintained in accordance with the New York State Records Retention laws, in the Tompkins County Finance Department, Purchasing Division.

IV. ADDITIONAL GUIDELINES FOR RFP DEVELOPMENT (SEE ATTACHED)

Please see the following page for additional guidelines for writing an RFP.

GUIDELINES FOR WRITING AN RFP

Include Rules for Submitting a Proposal – The rules for submitting a proposal (instructions) must be included in the specifications. Respondents will need to know who, where, and how (format) to submit their response.

Make it a Performance Specification – Describe the performance desired rather than specifying the exact goods or services that are required. For example, a janitorial contract for providing a "clean work environment" should outline the program goals and ask for the qualifications of the Respondent's personnel rather than telling them the number of people needed to perform the work, their required qualifications, or the number of times they must perform certain tasks.

- *Keep it Non*-Proprietary – Do not specify the service so narrowly that it fits only one provider.
- *Disclose the Contract Term* – In the Statement of Work explain the term of the contract.
- *Disclose Award Criteria & Weights* – Disclose the criteria that will be used to evaluate the proposals and the weight that will be given to each criterion. This lets the Respondents know what is important and how their proposals will be judged.
- *Require Only What Will be Evaluated* – Do not ask for information that will not be considered in making the award and that will contain a cost to the Respondent to provide (such as financial statements). The Respondents will pass along that cost to you in their proposals so ultimately you would pay for something you did not intend to use.
- *Do Not Over Specify* – Do not ask for services that are not necessary. If you are not willing to pay for additional services, do not include them in the specifications unless you include them as "options". To avoid the appearance of an arbitrary award, identify the priority of options that will be selected if funds are available. For example: "within budgetary limits, options will be awarded in the following priority: A, B, C, and F."
- *Hold a Pre-Solicitation Conference if Necessary* – A pre-solicitation conference may be necessary to give Respondents a chance to clarify the specifications and propose changes or corrections to them.

Checklist for Developing RFPs

- Meet and discuss the end-user's needs before and during development of the RFP.
- Establish the award criteria and include it in the RFP.
- Explain award criteria and how to evaluate the proposals that are received.
- Set up the scoring method and evaluation team before mailing the RFP.
- Determine if you will hold a Pre-Solicitation Conference.
- Determine the contract term and any options for extension.
- Establish a timeline for the RFP to include, at a minimum, the following:

    - Release Date
    - Ending Date for Questions
    - Pre-Solicitation Conference Date, Location and Time
    - Due Date
    - Award Date
    - Contract Commencement

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

RESOLUTION NO. 003-2013 - ESTABLISHMENT OF POLICY FOR PRIVATE ADVERTISING ON CONSORTIUM MATERIALS

MOVED by Mr. Barber, seconded by Ms. Tyler, and unanimously adopted by voice vote by members present.

WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC) is a consortium of public entities that contracts with private entities such as Third Party Administrators and consultants for technical services, and

WHEREAS, contracting firms are not restricted by the GTCMHIC from autonomous decisions, actions, and communications with enrollees and GTCMHIC members, now therefore be it

RESOLVED, That the Board of Directors of the GTCMHIC establishes the Private Advertising on Consortium Materials Policy to be that all communications with enrollees must state who they are, the relationship to the GTCMHIC, the purpose of this particular piece of communication, and the necessary content to accomplish the stated purpose,

RESOLVED, further, That information contracting firms want to send to enrollees must first be approved by a majority of the Executive Committee of the GTCMHIC prior to its release,

RESOLVED, further, That this policy is not intended to delay the distribution of materials from vendors to members that may be informative and beneficial in nature.

* * * * * * * * *

Committees:

Advisory committees perform most of the research and deliberation on policy, financial condition and premium rates, planning and operations. The Committees share their work with the BoD. Committee work is volunteer and is the key to keeping Consortium costs low. Directors, municipal officials (elected and appointed), and employees covered by a Consortium benefit plans are all encouraged to share their wisdom and experiences to guide the Consortium.

Joint Committee on Plan Structure and Design

This is a special Committee of the GTCMHIC. It is comprised of a delegate from each municipality and a delegate from each bargaining group. The Chair of the Joint Committee on Plan Structure and Design (JC) is elected from the committee members and must be a labor delegate. The Vice Chair is also elected from the committee members and must be a management delegate. The JC adopts by-laws consistent with the MCA. The most recent adopted by-laws are attached.

The JC has been meeting monthly on the first Thursday at 1:30 PM. If a delegate cannot attend, the by-laws allow them to send in a proxy to an attending delegate.

The JC, like all other GTCMHIC committees, are advisory to the BoD which has ultimate responsibility to take action.

In addition to serving on the Joint Committee on Plan Structure and Design, employees can be elected to be a Director, and serve on the Own Your Own Health Committee and by appointment the Audit and Finance Committee.

Appeals Committee

The Appeals process can be found on the “Employee Information” page of the website. The role of the Consortium’s Appeals Committee is to ensure that the Appeals process stays current with regulation and legal decisions and decide on appeals that have not been resolved through the Claims Administrator’s appeals process and a neutral third party’s appeal process.

Appeals procedure: The Claims Appeal procedure is described in detail on the Consortium Website. The process begins with initial contact with Excellus or Pro-Act. The appeal can be made by the patient, patient representative, or service provider. If the internal appeal process through the benefit plan administrator is not satisfactory, a covered person is not satisfied with an appeal determination regarding a claim that does not relate to a medical necessity or experimental/investigational services denial, the covered person may request a claim review by the GTCMHIC Appeals Committee by filing a written request for a review.

Audit and Finance Committee

Appointing membership to Audit and Finance Committee is the responsibility of the Board of Directors. Current membership can be found on the “Special Committee” website page. The Committee has been charged with these responsibilities:

- recommend a budget
- recommend premium rates
- review financial reports and filings including JURAT reports
- recommend reinsurance, retention, and reserving policies
- audit policies and procedures to ensure compliance with Article 47 and the Certificate of Authority
- review medical claims audit reports
- establish a list of all reports due to the Board and regulators and the process and time line to insure accurate and timely reporting

Executive Committee

From the MCA: The Executive Committee of the Consortium shall consist of the Chairperson, the Vice-Chairperson, Secretary and the Chief Fiscal Officer of the Consortium.

The Executive Committee may meet at any time between meetings of the Board at the discretion of the Chairperson. The Executive Committee shall make recommendations to the Board.

The Executive Committee shall manage the Consortium between meetings of the Board, subject to such approval by the Board as may be required by the Agreement.

Owning Your Own Health Committee

Owning Your Own Health Committee would be typically called Wellness in other organizations but is called OYOH for the Consortium because it speaks to the culture change that is needed to improve each of our lives and retain more of our labor's value in our pockets. The OYOH Committee has the potential to be strategic planning arm of the Consortium. It current membership includes community professionals in health care and health policy, human resource professionals, municipal and labor representatives.

The cost of health care in our region has been increasing at a rate of 8.5% per year. At this rate and over ten (10) years, the cost on health care more than doubles (2.25 times greater). The current municipal government climate is limiting resources to two (2) percent increase per year which means 1.22 greater after ten years.

The PPACA requires employers to provide health insurance coverage. When taking wages and health insurance cost as a compensation unit, one concludes that without a change in health care costs, all of an employees increased value will be translated into maintenance of health insurance premium for a similar benefit plan.

The GTCMHIC Health Insurance Forum of September 15, 2014 can be found on the website. It provides the background as to why health care and health insurance are increasing much faster than inflation. The main external reasons are rapid changes in care technology and mandated coverage. The main internal reason is life style choices including exercise and diet. The OYOH committee is cognizant that the key to improving our health and comfort is through becoming more aware of the effect our daily choices have on our health. Hence the term "Own Your Own".

The value of the Health Consortium described in the introduction can be multiplied many times by successful wellness strategies. We have individual needs and triggers to become healthier. Your participation in wellness programs and developing wellness strategies will have profound impact on our individual and collective quality of life.

Bylaws
Joint Committee on Plan Structure and Design
updated 9-1-2016

1. The Joint Committee will consist of one representative from each bargaining unit with enrollees covered by the Consortium plans and one representative from each of the participating municipalities.

2. The purpose of the Joint Committee will review all prospective Board actions in connection with the benefit structure and design of the plans offered by the consortium in order to develop findings and shall make recommendations to the Board with regard to such actions.

3. The Joint Committee has the authority to: be involved in reviewing benefits; investigate creative program designs for optimal use of resources; receive (quarterly) reports regarding use of benefits, UCR changes, and potential cost increases; compare benefits and costs about any carrier change; gather information about benefits, service levels, and related program costs.

4. The Joint Committee's findings and recommendations with respect to benefit structure and design issues are presented to the Consortium Board of Directors through the Committee Chair who is a Director.

5. All Joint Committee actions shall be by a majority vote of a quorum which is defined as one-quarter of the municipal membership and one-quarter of the union membership. This requirement shall be reviewed annually.

6. Members who are unable to attend meetings may submit a completed proxy form by paper copy, fax, or email to the Consortium's Administrative Clerk prior to the meeting. The designated proxy must meet the eligibility as outlined in Section K.1 of the Municipal Cooperative Agreement. The proxy designation must include: 1) the date of the meeting they will not be attending, 2) the individual to whom they are designating as the proxy, and 3) If the person is not currently a member of the Committee, identify the labor group or municipality for which the individual would be eligible for Committee membership.

7. Each January the Joint Committee Chairperson will be elected by a majority of a duly convened quorum of the Joint Committee and must be a union representative on the Joint Committee. The Vice-Chairperson of the Committee will also be elected by the Joint Committee and must be a representative from one of the participating municipalities.

8. The Joint Committee Chairperson will serve as a voting Director on the Consortium Board of Directors, representing Labor. The Labor representatives, only, of the Joint Committee will elect from among the Labor representatives at-large voting Labor Member to the Board of the Consortium to represent Labor. If the number of participating municipalities in the Consortium increases to 17, the Labor representatives, only, of the Joint Committee will elect from among the Labor representatives a second at-large voting Labor Member to the Board of the Consortium to represent Labor.

9. If any point in the year, the Joint Committee Chairperson or Vice-Chairperson, or the at-large voting Labor Member to the Board of the Consortium resign, retire or are otherwise are not eligible to continue, elections will be held at the next Joint Committee meeting to fill the vacant position.

10. Bargaining unit representatives will be the president of each bargaining unit or that persons' designee from the unit. Management representatives will be appointed by the respective elected leader of each participating municipality. (The term of appointments will vary according to the pleasure of the appointing authority).

11. The Joint Committee meetings will be scheduled at dates, times and location agreed upon by consensus for future meetings. The meeting agenda will be made available 1 week prior to each meeting. There should be a good faith effort by management and labor for all to attend and participate.

12. Consortium's Administrative Assistant will be responsible for distributing agendas and handouts, scheduling meetings, taking notes, creating draft minutes and posting materials on the GTCMHIC website.

13. The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Joint Committee in all cases to which they are applicable and in which they are not inconsistent with these bylaws and any special rules of order the Joint Committee may adopt.

Wellness Policy Resolution Sample

Whereas, physical health or wellness is a personal asset that frees one to concentrate on work, family and relationships, and hobbies, and

Whereas, wellness is a dynamic process of learning new life skills and becoming aware of and making conscious choices toward a balanced and healthy lifestyle, and

Whereas, wellness cannot be guaranteed by any set of actions, yet wellness can be improved and increased by personal choices, and

Whereas, workplace environment, policies, and incentives can support and provide awareness for wellness choices, and

Whereas, Article 47 of NYS Insurance Law requires and envisions a partnerships between employer and employees in directing their health insurance, and

Whereas, employer and employees are collaborating to fund Health Insurance, and

Whereas, the cost of health insurance and time loss due to illness and injury are both directly reduced when its members are in good health,

Now therefore be it resolved that the (municipality) seeks to become an active partner with staff in raising healthy choice awareness, promoting healthy behaviors by providing information and opportunities, and facilitating wellness action steps

Be it further resolved that the (municipality) creates a Wellness Advisory Committee charged promoting health and wellness of staff and their family through education and program initiatives that:

- Encourage habits of wellness
- Increase awareness of factors and resources contributing to well-being
- Inspire and empower individuals to take responsibility for their own health
- Recommend action steps to create a workplace culture that encourages environmental and social support for healthy lifestyle choices

Be It Further Resolved that the (municipality) appoints: _____ to the Wellness Committee and directs the committee to report back to the (municipality) the status of their deliberations by _____.

Benefit Plan Menu:

The Consortium's benefit plan menu currently offers medical plans (Metal Level, PPO and indemnity) with prescription drug benefits through a copay card, medical plans with the prescription drug benefits embedded in the "major medical" portion of the plan, a Medicare Supplement plan, and PPACA Metal Level plans.

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 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. 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 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 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.

Prescription Drug Plans

The Consortium currently 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.

Adding New Plan Designs

The process for development and review of a new plan requires a participating employer, a committee, or a Director to make a request to the Consortium Board of Directors to add a new benefit plan. Most commonly, this request would come from the Joint Committee on Plan Structure and Design. The Board of Directors would ask the Benefit Plan Consultant to develop a proposal based on certain criteria. The Benefit Plan Consultant would then bring forward a draft plan for review by the Joint Committee. Once the plan specifics are firmed up, the Benefit Plan Consultant would develop the premium equivalent rates which are presented to the Audit and Finance Committee. The Audit & Finance Committee would the financial impact of adding such a plan. At any time after the new benefit plan has been brought before Joint Committee on Plan Structure and Design and the Audit & Finance Committee, a Director may bring a resolution forward to the Board of Directors for consideration regardless of the degree of support by the Consortium's advisory committees.

Benefit Plan Summaries

The Benefit Plan summaries for each municipality may be found on the "Employee/Retiree Information" page of the Consortium's website. A listing of the currently offered plans is attached for your reference and review. For more detailed information or questions please start with your Municipal Health Insurance Clerk whose contact information can be found on "Resource and other Information" page of the Consortium website. The next stop for information is Excellus BlueCross BlueShield and their contact information is found on the "Employee/Retiree Information" page of the website.

If you need to make changes with you plan's coverage, contact your Municipal Health Insurance Clerk (contact information is attached).

Ancillary Benefit Offerings

In addition to the traditional medical and prescription drug plan offerings, the Consortium also has several fully-insured ancillary benefit plans which are made available to the participating municipalities to be used at their discretion. These ancillary benefits include the following:

- CSEA Employee Benefit Fund Dutchess Dental Plan
- CSEA Employee Benefit Fund Platinum 12 Vision Plan
- Upstate Union Health and Welfare Fund Legal Benefit Plan
- Lincoln Financial Group Life Insurance
- Lincoln Financial Group Accidental Death & Dismemberment Insurance
- Lincoln Financial Group Disability Insurance

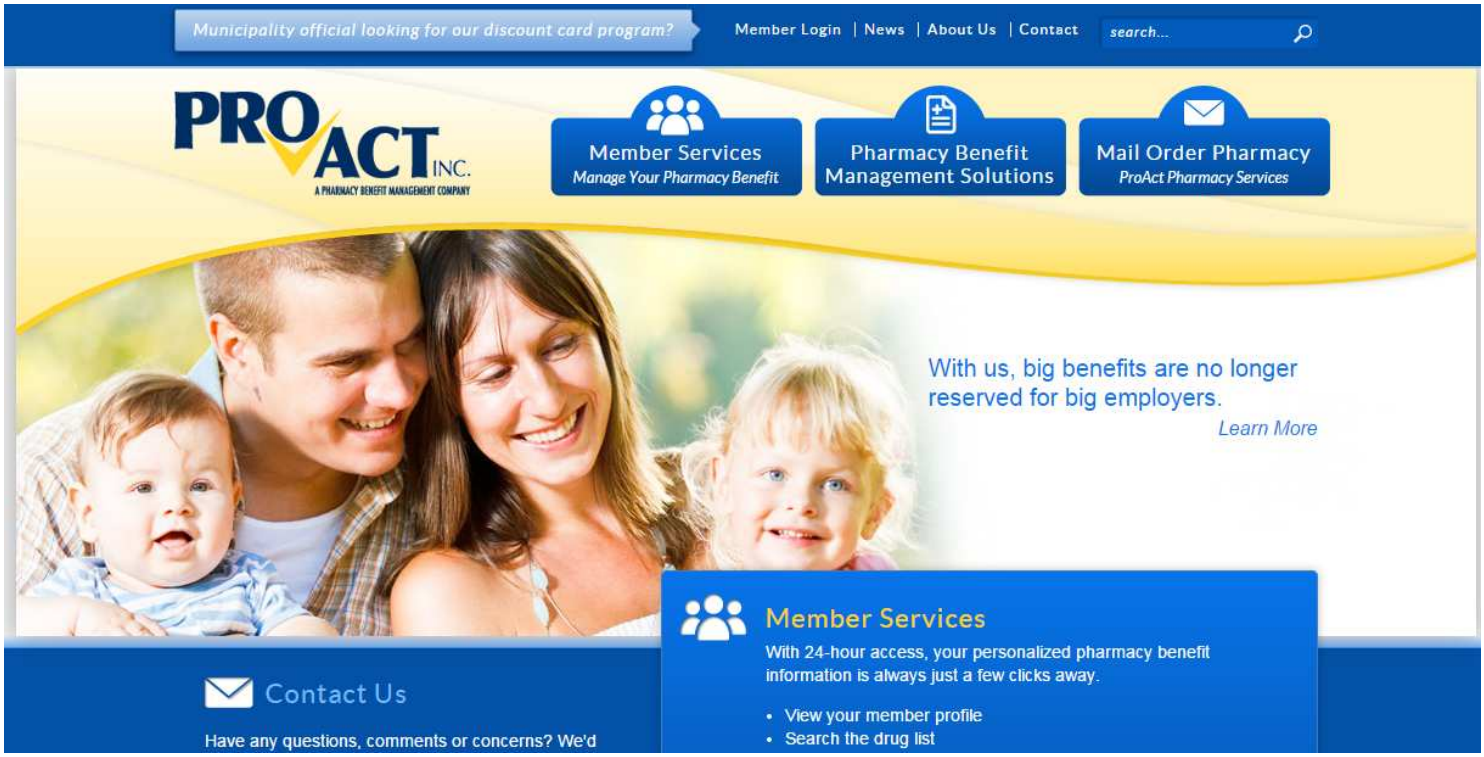
If your municipality is interested in adding one or more of the above ancillary benefit packages, please contact the Consortium's Executive Director who will assist you with this process.

Benefit Plan Administration Partners:

Medical Plan Administrator: Excellus:
https://www.excellusbcbs.com/wps/portal/xl/cwp/greatertompkins

Prescription Drug Manager: ProAct

https://secure.proactrx.com/



Claims Appeals Process:

For Claims Other Than Medical Necessity or Experimental/Investigational Services:

If a claim is denied in whole or in part, the covered person will receive notification of a claim denial via an explanation of benefits (EOB) form. The EOB form will be provided by the plan administrator. The EOB will show the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for the consideration of the claim, the plan administrator will request it.

If a covered person does not agree with the denial of a claim, the covered person may call the claims clerk on the toll-free number (1-800-499-1275). If the claim is not resolved to the covered person's satisfaction, the covered person should then speak to the manager of the plan administration office. At that point, a final determination will be made by the plan administrator. The covered person will be notified in writing of the plan administrator's determination. A review by the Appeals Committee of the Plan and/or arbitration may be available; see the Sections titled "Review By the Appeals Committee" and "Arbitration" below.

Review by the Appeals Committee

If a covered person is not satisfied with an appeal determination regarding a claim, the covered person may request a claim review by the Plan's Appeals Committee by filing a written request for a review with the plan administrator. Upon receipt of a written request, copies of all pertinent information will be gathered and presented to the Appeals Committee. The covered person may also submit written opinions and/or any comments regarding the claim to the plan administrator, who will include the information with the materials that are presented to the Appeals Committee.
Requests for review by the Appeals Committee should be filed promptly; however, requests may be filed at any time within 120 days of the final adverse determination by the plan administrator.
The Appeals Committee will render its decision within 60 days of the receipt of the written request for review, unless specific circumstances warrant an extension. The decision of the Appeals Committee pertaining to the review will be delivered in writing to the covered person, stating the specific reasons for the decision and the specific reference to the pertinent plan provisions upon which the decision is based.

Arbitration

If the covered person and/or the covered person's labor organization is not satisfied with the decision of the Appeals Committee; and if the labor organization determines that the claim is meritorious and further appeal is in the best interests of the labor organization, the labor organization may submit the claim to arbitration, the outcome of which will be binding on all parties.

A request for arbitration must be submitted, in writing, to the plan administrator within 30 days of receipt of the written decision of the Appeals Committee.

Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure

Appeals concerning medical necessity or experimental/investigational services will not be heard through the Consortium's Appeal Committee. See the website for complete details of this appeals procedure and timelines. This process can start pre-admission.

Summary of Educational Retreat of GTCMHIC of September 15, 2014:

Basics of Health Care, Health Insurance and the Consortium Operations

Health Care

Health care is the diagnosis, treatment, and prevention of disease, illness, injury, or impairments.

Health care is delivered by practitioners and professionals (physicians, nurses, pharmacists, psychologists, etc.).

Health care is private sector business that sells services and products, that in 2013 amounted to $3 trillion; and is growing as a percentage of spending much faster than other major purchases.

Patient Choices: If you want service, which type of service, and where to receive service.

Prescription Drugs

Tier 1: Generic- average cost = $18
Tier 2: Brand Name – average cost = $246
Tier 3: Specialty – average cost = $2,205

Health Insurance

Health Insurance is an agreement between the patient, who pays premiums to an insurance company, which pays for agreed medical services and Rx formularies.

Health Insurance is a premium/risk pool from persons of varying age and health conditions that cooperatively cover each other's cost of health care within agreed parameters. 20% of the risk pool accumulate 80% of the claims cost.

We need health insurance because time of health care need is unpredictable and cost can be exorbitant.

Premiums

Actuaries use statistical science to predict for a population claims expense based on specific benefit plan(s).

Premiums are then calculated to raise enough revenue to cover predicted claims cost plus other operational cost- including insurance for the rare large expense treatments.

Benefit Plans

Benefit Plans are a contract between a person and the health insurance company to cover specified services and prescription formularies. Health Insurance Companies contract with "in-network" providers for specific costs for services.

Benefit plans must provide Federal and State mandated benefits.

GTCMHIC has a menu of medical and Rx plans that were necessary to meet pre-existing labor contracts and now PP&ACA metal plan requirements.
GTCMHIC has a process to change, delete, and add benefit plans.

Benefit Plans have member cost sharing such as deductibles, co-insurance, and Co-payments.

Although the Consortium Board has not made chances to existing benefit plans, benefits are expanding due to federal and state mandates, new medical procedures, and new pharmaceuticals.

Advancements in Medical Technology Reasons for Hyper-inflation of Health Insurance

Advancement in Pharmaceuticals
Federal and State Mandated benefits

GTCMHIC-Beginning

Tompkins County Council of Governments was granted a Shared Service Incentive grant for $250,000 to establish the first Article 47 Insurance Consortium since the law for their creation was passed in 1993.

Article 47 allows large and small employers to form a consortium and provides a meaningful role for labor.

Consortium was issued its Certificate of Authority in October 2010 and started operating 1/1/11. It started with 13 municipalities, 2000 contracts, covering 4360 total lives.

The Municipal Cooperating Agreement is the agreement between partners and foundation for operations.

GTCMHIC Financial Model

Self-Insured pooling of risks and premiums for Tompkins County and adjacent county municipal governments.

Board of Directors are volunteers.

Claims are 93% of operational cost – which is exceptionally efficient compared to Non-Profits. Pooling risks of a large number increases buying power and stabilizes claims predictions- which stabilizes premiums.

Premiums are established by October 15th ahead of municipal budget adoption

GTCMHIC Growing Stronger

Consortium now has 16 municipal partners with over 2,300 contracts and 5,100 covered lives. In 2014, $37.8 million was the anticipated revenue.

Anticipated claims for 2014 are 93% of premium.

Over the four year history, claims have been within 1% of actuary prediction.

The premium increases for 2012, 2013, 2014, and 2015 were 9%, 9%, 8% and 5% respectively. Since 2011, average annual Consortium premiums increase is 4% less than competition.

Opportunities and Challenges

Medical care inflation
Advancements in medical technology
Advancements in pharmaceuticals
Regulatory mandates
State and Federal taxes and fees

Website (www.healthconsortium.net):

The GTCMHIC website is not only an archive but also contains working documents and is the depository for information that is designed to be useful to Board and committee members, employees and retirees, municipal staff, and others seeking to learn more about GTCMHIC. Below is a summary of the information that is continually updated and accessible through the main tabs on the website:

Board of Directors:
- Membership
- Meeting Schedule
- Actions and Resolutions
- Agendas & Minutes
- Policies

Newsletter
- Current and Past Issues of the Consortium Connection

Employee and Retiree Information:
- Appeals Information
- Link to Medical Claims Administrator and Health Plans
- Link to Prescription Drug Benefit Manager and Formulary Chart
- Premium Equivalent Rates

Financials:
- Quarterly and Annual Financial Filings
- Fiscal Year Results
- Audit Reports
- Budget Information

Health Plan Information
- Plan Summaries and Rate Information

Joint Committee on Plan Structure and Design:
- Agendas & Minutes
- Meeting Schedule
- Bylaws
- Proxy Form
- Membership

Special Committees:
- Agendas & Minutes
- Meeting Schedule
- Membership

History:
- Archived Consortium Information

News:
- News Articles and Announcements

Resources and Other Information:
- Resources for Employers
- Reports

Wellness:
- Links to Wellness Information and Programs

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

"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

Greater Tompkins County Municipal Health Insurance Consortium 2016 Annual Report

May 2017

For the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC), 2016 was highlighted by a collaborative process to change benefit levels for all metal level plans (Platinum, Gold, Silver, and Bronze) to maintain actuarial value, we formally adopted our mission and vision statements, welcomed eight (8) new members, and conducted an extensive search for the best Prescription Benefits Manager going forward. This search resulted in the Consortium remaining with ProAct. 2016 net income was $1.85 million and marked the completion of the Greater Tompkins County Municipal Health Insurance Consortium's sixth financially successful year. While the result was positive, the net income was $525 thousand less than budgeted due to a sharp increase in pharmacy claim costs. The main factor was not an increase in usage but rather exponential growth in the cost of Specialty medicines.

GTCMHIC is an Article 47 municipal cooperative health benefits plan that creates hospital, medical, surgical, and prescription drug plans, collects premiums, and pays medical and pharmaceutical claims for its covered members. The Consortium began its operations in 2011 with thirteen municipal partners. With the 2016 addition of the Cortland Towns of Preble and Cincinnatus and Cayuga County towns of Moravia, Aurelius, Montezuma, Scipio, Springport, and Village of Union Springs, the Consortium now has twenty-eight (28) municipal partners and five labor Directors; covering approximately 2,350 employee and retiree contracts and more than 5,000 covered lives.

The Consortium is also responsible for establishing adequate reserves to provide security for members and municipal partners for the foreseeable future. The Consortium has statutory Surplus and Incurred But Not Reported Reserves of $1,925,998 and $4,430,732 respectively. The Consortium also has elective Catastrophic Claims ($1.05M) and Rate Stabilization ($1.76M) Reserves.

Operations Highlights:

- In 2016, the Consortium received $38.5 million in premiums with total expenses of $37.4 million.
- The Board used some of that net income and fund balance to moderate medical inflation of roughly 8% in approving a 5% premium rate increase for 2017; except for metal plans which had lower increases and in some cases, decreases due to benefit changes to remain within their actuarial value (see below).
- The Consortium continues to operate very efficiently with 93.58% of its expenses going to pay claims.
- Two Cortland County towns and six Cayuga County municipalities joined the Consortium in 2016.
- All four metal level plans Platinum, Gold, Silver, and Bronze had grown outside their actuarial value limits. Through a collaborative process carried out by the Joint Committee on Plan Structure and Design, the plan benefits were changed to bring them back. Rather than the 5% premium increase of the other plans, these plans had premium increases of Platinum 3.5%, Gold 0.3%, Silver -3.5%, and Bronze -1.7%.
- For the third year, the Consortium offered flu clinics. In 2016, they were conducted in six locations to 245 members. Additionally, 218 members received flu vaccines at their pharmacy and 838 received flu vaccines at other locations like their doctor's office. In total 26% of our members received flu vaccines.

- The Consortium participants completed certifying dependents as eligible. The process netted an annual savings of approximately $280,000.

- A Consortium-wide educational retreat on Developing Premiums was conducted on May 10, 2016. It is available on the website.

- The Consortium created and distributed a quarterly newsletter to the employees of the participating municipalities in the Consortium.

- The Consortium continued auditing third party claim administration processes to ensure their practice meets our benefit plan description.

Committees:

The Greater Tompkins Consortium Board is supported by several special committees that perform the in-depth research and deliberation to propose policies, products, and process improvements to benefit the operation of the Consortium.

- In 2016, the Audit and Finance Committee, chaired by CFO Steve Thayer, in addition to its annual task of developing the next year's budget and premium rates, completed the prescription claims audit process of ProAct and began the medical claims audit of Excellus. The Audit and Finance Committee collaborates closely with Steve Locey, the Consultant, and Rick Snyder, Treasurer, to monitor the budget and spending trends while maintaining a strong reserving policy.

- The Owning Your Own Health (OYOH) Committee, chaired by Ted Schiele, monitored the Excellus Blue4U program to fill the wellness component of our benefit plans that require it, they provide valuable input for the quarterly newsletter, and they coordinated Flu Clinics with ProAct.

- The Joint Committee on Plan Structure and Design, chaired by Director Phil VanWormer, reviewed and recommended changes to the metal plans that were out of range for actuarial value. In addition, they deliberated on the concept of using CanaRx as a pharmacy for 90 brand name maintenance medicines and recommended the Consortium agree to use this pharmacy.

Financial Highlights:

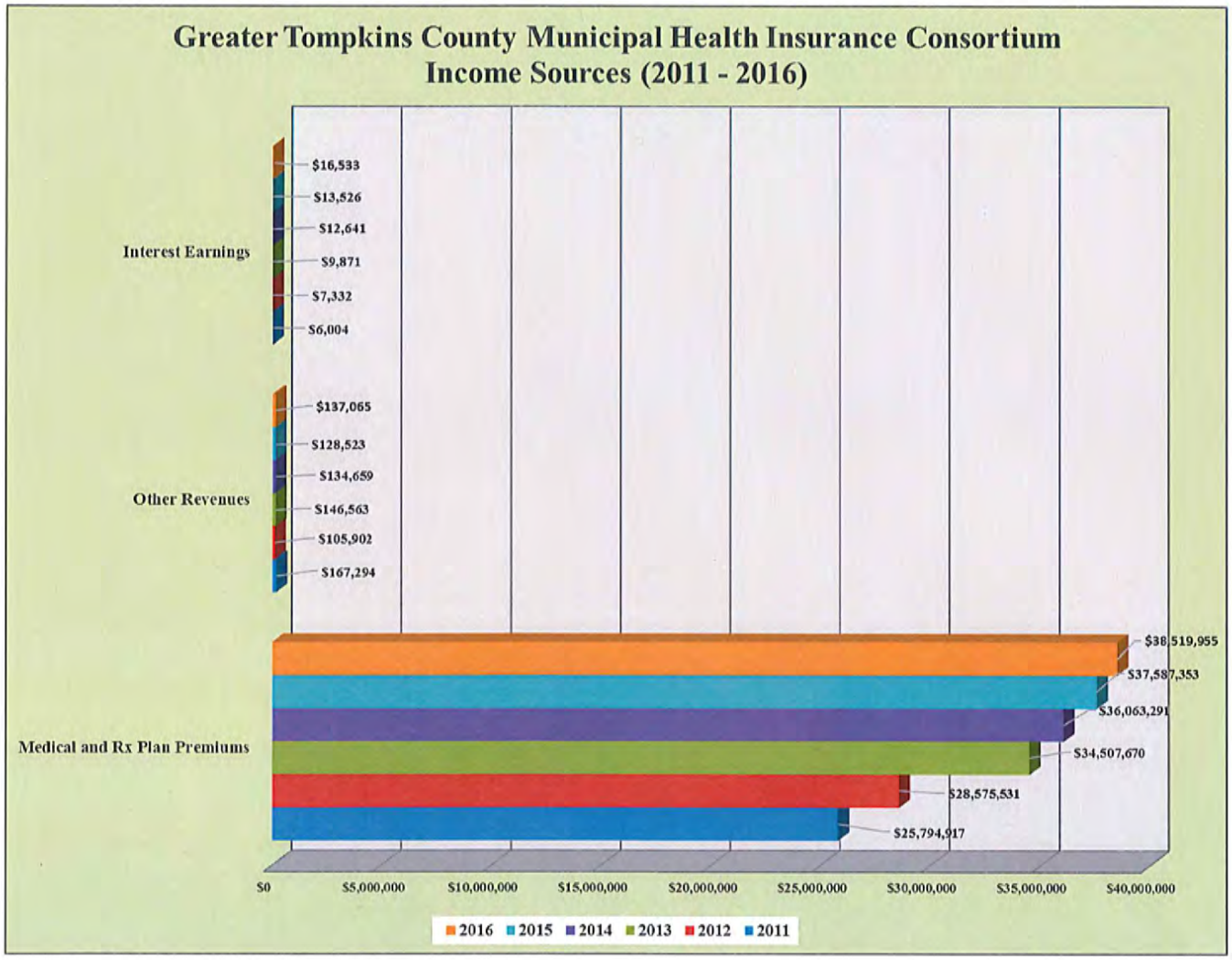
Net position:

For the year ending December 31, 2016, the Plan's net position has increased by $1,173,320 to a new total of $19,001,285. The GTCMHIC Board of Directors has been consciously building reserves starting in year one (2011) when required to post the Incurred But Not Reported Reserve (IBNR) of $3.0 million and Surplus reserve of $1.3 million. In subsequent years, additional reserves were created to protect the Consortium against any abnormal claims activity which is a statistical possibility. For instance, the "Catastrophic Claims Reserve" is established to protect the Consortium with the retention of the first $400,000 of a specific claim. This larger claim retention reduced the Stop-Loss Insurance premium. The Board of Directors, with this 2016 posting of net position, determined that fund balance could be used to offset premiums which resulted in a 5% increase in premiums when compared to the industry average medical inflation of roughly 8%.

Statements of Revenues and Expenses - The Statements of Revenues, Expenses, and Changes in Net Position present the results of operations of the Plan for the years ending December 31:

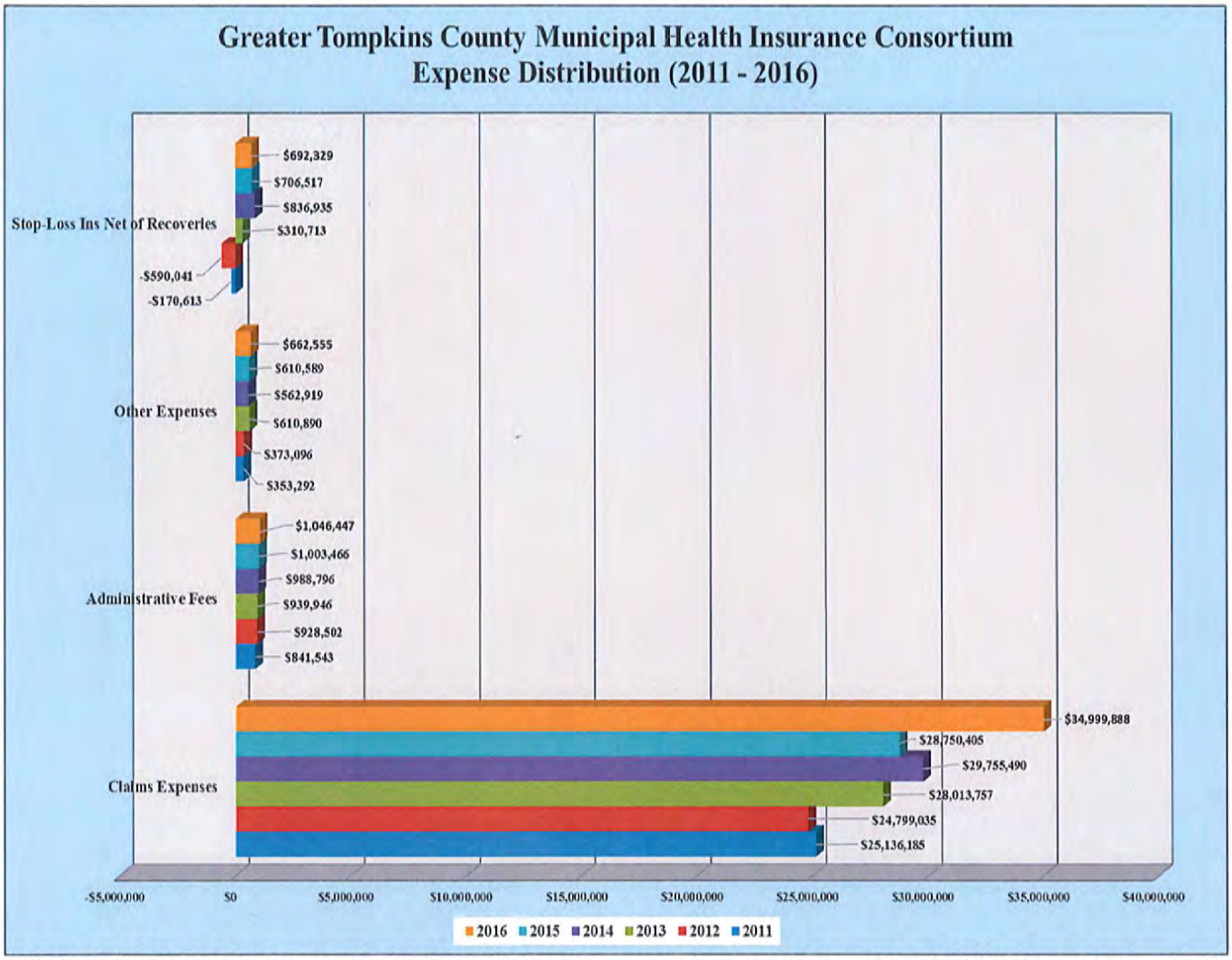
Revenue Overview

	2016	2015	2014
Premiums	$ 38,519,955	$ 37,587,353	$ 36,036,291
Aggregate write-ins for other revenues	137,065	128,523	134,659
Interest earnings	16,533	13,526	12,641
Total Revenues	$ 38,673,553	$ 37,729,402	$ 36,210,591



Expense Overview - The following table summarizes expenses by function for the years ending December 31:

	2016	2015	2014
Claims expense	$ 34,999,888	$ 28,750,405	$ 29,755,490
Administrative fees (3rd party administrators)	1,046,447	1,003,466	988,796
Other expenses	662,555	610,589	562,919
Reinsurance expenses, net of recoveries	692,329	706,517	836,935
Total Expenses	$ 37,401,219	$ 31,070,977	$ 32,144,140

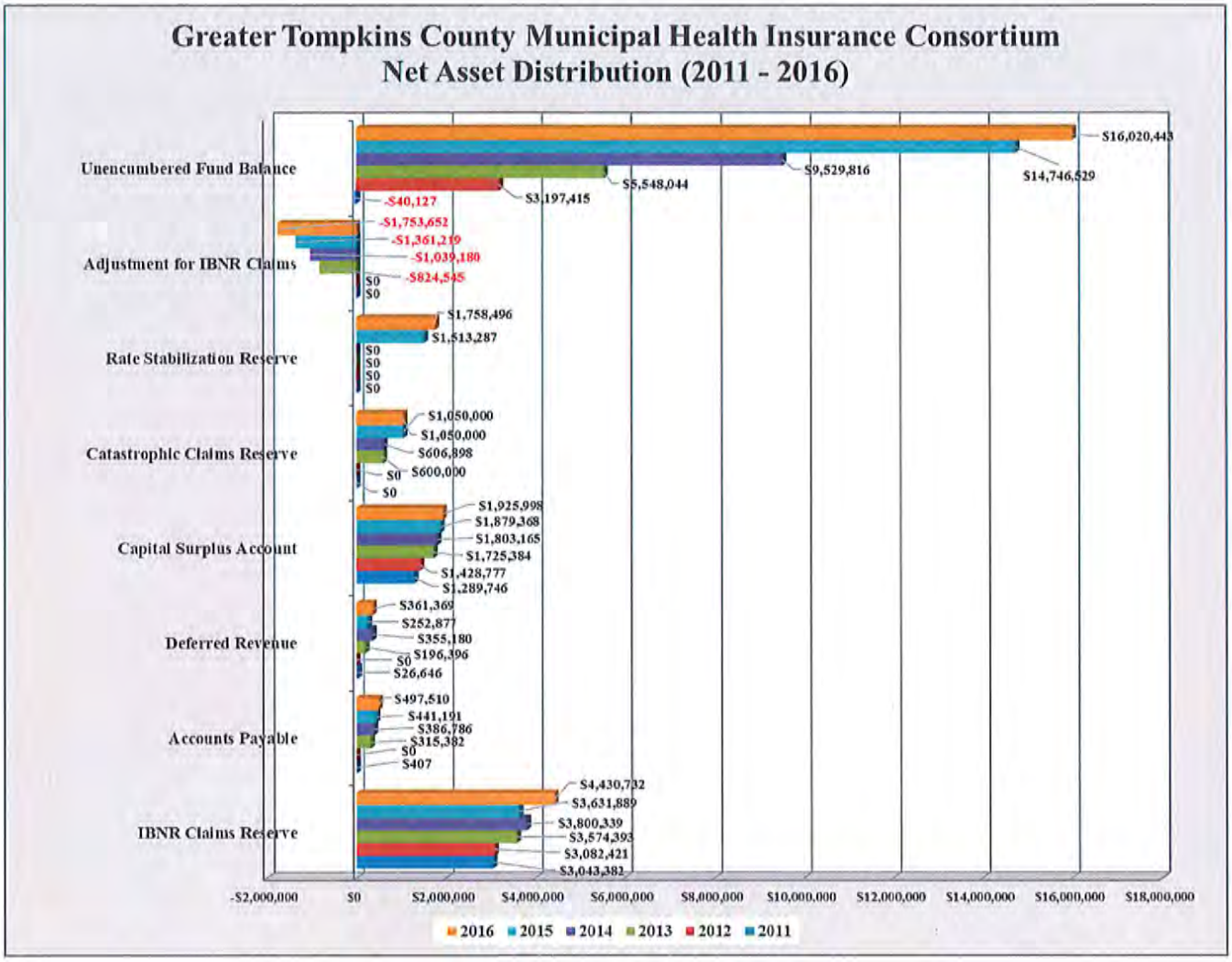


Please note the expense summation above shows a very efficient structure with >93.6% of expenses going to pay claims in 2016.

Reserving for the Future:
Article 47 of the New York State Insurance Law requires its certificate holders to maintain a Surplus Reserve equal to 5% of premiums each year. In addition, this legislation requires municipal cooperative health benefit plans to maintain an Incurred But Not Reported Claims (IBNR) Reserve of 12% of the expected paid claims each year.

To add more protection and stability to the Consortium's financial position, in 2013 the Board of Directors established a "Catastrophic Claims Reserve" which equaled $1,050,000 in 2015. This reserve was established to provide resources for the risk of the specific stop-loss insurance deductible at $400,000 per covered life for the contract period (claims incurred annually from January to December and paid from January to March of the next year).

As a result of the positive financial position the Consortium has developed over the last several years, the Board of Directors looked to further strengthen the Consortium's long-range financial position by establishing a rate stabilization reserve set at 5% of the expected claims cost for the year. This reserve is available to be used to off-set those times when the paid claims exceed the expected result and provide the Consortium with time to build a financial plan to recover from unexpected losses.



Economic Factors Affecting the Future:

- Prior to the start of the 2016 Fiscal Year, the Consortium renewed its specific stop-loss insurance maintaining the $400,000 deductible level which was initiated prior to the 2015 Fiscal Year. This increase in deductible was done in an effort to keep the premium increase at a reasonable level. The increased deductible does create an additional level of risk associated with the Consortium's operations. However, the Consortium experienced fewer catastrophic losses during the 2013 through 2016 Fiscal Years. This contributed to the better than expected paid claims result which allowed the Consortium Board of Directors to establish and maintain a Catastrophic Claims Reserve to help off-set the increased risk associated with the higher deductible. The Catastrophic Claims Reserve was initially established during the 2014 Fiscal Year at approximately $600,000 to create financial resources when the stop-loss risk retention (deductible) was increased from $250,000 to $300,000. During the 2015 budget development process, the Board again agreed to increase the specific stop-loss insurance deductible to its current level of $400,000. This resulted in an additional increase in exposure and lower premium expense. To help protect the Consortium's financial position, the Board of Directors voted to increase the Catastrophic Claims Reserve to $1,050,000 for the 2015 Fiscal Year. During deliberations of the Audit and Finance Committee regarding the stop-loss insurance deductible amount for 2017, the Committee reviewed the complete history of large loss claims (over $100,000) and determined that increasing the deductible to $450,000 was an acceptable risk. This will result in lower premium for 2017 than budgeted. The Audit and Finance Committee further determined the Catastrophic Claims Reserve of $1,050,000 was adequate for 2017. This is an area which will be reviewed by the Board of Directors on an annual basis to ensure a tolerable balance is achieved between risk and the cost of stop-loss insurance.

- With better than expected paid claims and expense results in the initial years of operation of the Consortium, the Board of Directors made the decision, during the 2015 Fiscal Year, to establish a Claims/Rate Stabilization Reserve to further protect the Consortium's cash flow and provide additional financial stability. The level of this reserve was set at 5% of the expected/paid claims expense for the year. These funds will be used to mitigate premium rate increases if claim projections are exceeded. The Consortium's goal is to maintain reasonable, prudent, and modest premium increases for the foreseeable future. This reserve grows each year with the growth in total premiums earned.

- The Affordable Care Act's (ACA's) ongoing implementation since its inception in 2010 has resulted in increased costs to the Consortium, including the Patient Centered Outcomes Research Institute (PCORI) Fee. This fee which was $4,448.00 in 2013 more than doubled in cost for the 2014 Fiscal year, with the $10,252 payment made in July 2014. In 2015, this fee rose to $2.08 per covered life and in 2016 this fee was $2.17 per covered life. Starting with the 2017 Fiscal Year, the PCORI fee will continue to increase each year by an inflationary escalator as determined by the United States Internal Revenue Service until 2019.

  In addition to the ACA PCORI Fee, the Consortium was subject to the ACA Transitional Reinsurance Program Fee which required the Consortium to pay $316,764 during the 2014 Fiscal Year, $221,100 during the 2015 Fiscal Year, and $138,188 during the 2016 Fiscal Year. This particular fee has now sunset and will not impact the Consortium's financial performance going forward.

- The Board of Directors is also keeping a close eye on the effects of potential dismantling of some or all of the Patient Protection Affordable Care Act. Fees and taxes are at 0.8% of the total expenses. Should fees and taxes be altered by either increase of decrease, they can be managed in future budgets with little impact on premium equivalent rates.

- Another area which has drawn the attention of the Consortium's Board of Directors is the significant increase in the cost of prescription medications on a per fill basis. The cost per fill for 2016 was 17% greater than 2015. These increases are being seen across all tiers of medications with significant growth in specialty pharmaceuticals purchased by covered members. The cost per fill of Specialty medications increased 29% between 2015 and 2016. The Board was informed that much of this increase were claims for hepatitis medicines which can only be given once and will not be recurring. The Board of Directors will continue to work with ProAct, Inc. and its other advisors to mitigate the rate of growth in this area.

- The Consortium continues to see a decrease in Incurred But Not Reported (IBNR) actuarial findings. For 2011, the Consortium's calculated IBNR was 10.15% of paid claims. The IBNR calculation for 2016 is 7.45%. While this does not affect the mandated 12% of actual paid claims reserve required by the NYS Department of Financial Services, it does provide sound data that the 12% IBNR will not be increased in the foreseeable future.

- The Town of Marathon, the Town of Virgil, and the Town of Truxton joined the Plan on January 1, 2016. In addition, on January 1, 2017, the Town of Aurelius, Town of Cincinnatus, Town of Montezuma, Town of Moravia, Town of Preble, Town of Scipio, Town of Springport, and Village of Union Springs joined the Consortium. The Consortium continues to gain interest from neighboring municipalities.

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

"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

Statement of Position

Greater Tompkins County Municipal Health Insurance Consortium
Statements of Net Position - December 31,

	2016	2015
ASSETS		
Current Assets:		
Cash and cash equivalents	$17,270,389	$15,353,516
Accounts receivable - stop loss and drug rebates	166,253	13,034
Premiums receivable	45,226	46,866
Prepaid expenses	64,491	-0-
Total Current Assets	17,546,359	15,413,416
OTHER ASSETS		
Noncurrent Assets:		
Premium claims deposit	527,500	527,500
Restricted cash and cash equivalents	6,217,037	6,213,006
Total Other Assets	6,744,537	6,740,506
Total Assets	24,290,896	22,153,922
LIABILITIES		
Current Liabilities:		
Incurred claims liability	4,430,732	3,631,889
Accounts payable	497,510	441,191
Unearned revenues	361,369	252,877
Total Current Liabilities	5,289,611	4,325,957
Total Liabilities	5,289,611	4,325,957
NET POSITION		
Restricted		
Restricted for contingency reserve - Section 4706(a)(5)	1,925,998	1,879,368
Adjustment for incurred but not reported claims	(1,753,652)	(1,361,219)
Subtotal	172,346	568,149
Board Designated		
Catastrophic claims reserve	1,050,000	1,050,000
Rate Stabilization Reserve	1,758,496	1,513,287
Subtotal	2,808,496	2,563,287
Unrestricted	16,020,443	14,746,52
Net Position	19,001,285	17,827,965

Statements of Revenues, Expenses, and Changes in Net Position

For the Years Ended December 31,

	2016	2015
Operating Revenues:		
Premiums	$38,519,955	$37,587,353
Aggregate write-ins for other revenues	137,065	128,523
Total Operating Revenues	38,657,020	37,715,876
Operating Expenses:		
Claims expense	34,999,888	28,750,405
Reinsurance expenses, net	692,329	706,517
Administrative fees	1,046,447	1,003,466
Aggregate write-ins for other expenses	662,555	610,589
Total Operating Expenses	37,401,219	31,070,977
Excess of Operating Revenues Before Non-Operating Revenue (Expense)	1,255,801	6,644,899
Non-operating Revenue (Expense):		
Interest earnings	16,533	13,526
Change in Net Position	1,272,334	6,658,425
Net Position, January 1,	17,827,965	10,900,699
Adjustment for incurred but not reported claims	(99,014)	268,841
Net Position, December 31,	$19,001,285	$17,827,965

Accomplished Goals for 2016:

- Produced quarterly newsletters
- Completed Dependent Verification Process
- Produce and delivered 3rd annual training entitled "Establishing Premium Rates"
- Develop benefit changes for all four "Metal level plans" to maintain Actuarial Value
- Transition eight new municipal partners into Consortium
- Requested proposals for Prescription Benefits Manager and decided to remain with ProAct
- Identified and investigated two strategies to manage Prescription claims cost: Approving CanaRx for certain brand name maintenance medicines and Copay Assistance for Specialty Medicines

Goals for 2017:

Complete claims audit of both medical and prescriptions claims administration

- Respond to recommendations from the Department of Financial Services second audit
- Consortium-wide awareness of CanaRx pharmacy benefits to subscribers
- Produce and deliver 4th annual training entitled "Role of Subscribers in Managing Health Care Costs"
- Develop and implement an enrollment process that defines responsibilities and timeline for the Consortium and its third-party administrators

2017 Board of Directors

1.	Judith Drake, Chair	Town of Ithaca
2.	Rordan Hart, Vice Chair	Village of Trumansburg
3.	Steven Thayer, Chief Fiscal Officer	City of Ithaca
4.	Charles Rankin, Secretary	Village of Groton
5.	Amy Guererri	Tompkins County
6.	Mack Cook	City of Cortland
7.	John Fracchia	Town of Caroline
8.	LuAnn King	Town of Cincinnatus
9.	Laura Shawley	Town of Danby
10.	Kathrin Servoss	Town of Dryden
11.	Herb Masser	Town of Enfield
12.	Don Scheffler	Town of Groton
13.	Charmagne Rumgay	Town of Lansing
14.	Thomas Adams	Town of Marathon
15.	Vacancy	Town of Montezuma
16.	Gary Hatfield	Town of Moravia
17.	Jim Doring	Town of Preble
18.	Gary Mutchler	Town of Scipio
19.	David Schenck	Town of Springport
20.	Tom Brown	Town of Truxton
21.	Richard Goldman	Town of Ulysses
22.	Eric Snow	Town of Virgil
23.	Alvin Doty, Jr.	Town of Willet
24.	Peter Salton	Village of Cayuga Heights
25.	Michael Murphy	Village of Dryden
26.	Vacancy	Village of Homer
27.	Bud Shattuck	Village of Union Springs
28.	Phil VanWormer	Chair, Joint Comm. on Plan Structure and Design
29.	Jim Bower	2nd Labor Representative
30.	Olivia Hersey	3rd Labor Representative
31.	Doug Perine	4th Labor Representative
32.	Tim Farrell	5th Labor Representative

Consortium website: www.tompkinscountyny.gov/hconsortium
Executive Director: Don Barber – edconsortium@tompkins-co.org
Consortium e-mail: consortium@tompkins-co.org

Respectfully submitted:

Judy Drake
Chair of Board of Directors

Don Barber
Executive Director