GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM

Municipalities building a
stable insurance future.

125 E. Court Street
Ithaca, NY 14850
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AGENDA
Joint Committee on Plan Structure and Design
December 4, 2014 - 1:30 P.M.

Rice Conference Room, Tompkins County Health Department

55 Brown Road, Ithaca, New York

1. Welcome

2. Vice Chair's Report (1:30) — Laura Shawley

3. Approval of August 7, September 4, and November 6, 2014 minutes (1:35)
   a. Set 2015 Meeting Schedule

4. Report from Board of Directors Chair (1:40) — Judy Drake

5. Executive Director Report (1:45) — Don Barber

6. Review First Draft of Bronze Plan (1:50) — Steve Locey

7. Report out from Audit and Finance Committee (2:05) — Don Barber
   a. 2-Person Category for Benefit Plans
   b. New members and acceptance process

8. Discussion about role of Joint Committee in Relation to the Consortium Board of Directors: benefit plan review, selection of labor Directors, other (2:15)

9. Next Meeting Agenda (2:30)

10. Adjournment

Next Meeting: TBD

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MINUTES
Greater Tompkins County Municipal Health Insurance Consortium
Joint Committee on Plan Structure and Design
November 6, 2014 – 1:30 p.m.
Rice Conference Room, Health Department

draft

Present:
Municipal Representatives: 9 members
Judy Drake, Town of Ithaca; Brooke Jobin, Tompkins County; Jennifer Case (excused at 2:30 p.m.); Joan Mangione, Village of Cayuga Heights; Mack Cook, City of Cortland; Schelley Michell Nunn, City of Ithaca (arrived at 1:46 p.m.); Michael Murphy, Village of Dryden; Cindy Whitaker, Town of Caroline; Sharon Bowman, Town of Lansing

Municipal Representative via Proxy: 0

Union Representatives: 7 members
Scott Weatherby, TC3 Staff Unit CSEA Vice President; Tim Logue, City of Ithaca Executive Unit; Tim Arnold, Town of Dryden Teamsters; Olivia Hersey, TC3 Professional Admin. Assoc. Unit; Jon Munson, Town of Ithaca Teamsters; Melissa Schmidt, TC3 Staff Unit; Doug Perine, Tompkins County White Collar

Union Representatives via Proxy: 2
James Bower, IUOE Local 158, District 832 Bolton Point (S. Weatherby); Wilma VanDee (D. Reynolds)

Others in attendance:
Don Barber, Executive Director; Steve Locey, Locey & Cahill; Sharon Dovi, TC3; Margaret Gannon, CSEA Health Benefits Department; Beth Miller, Excellus

Call to Order

Mr. Weatherby, Chair, called the meeting to order at 1:35 p.m.

Approval of Minutes of August 7 and September 4, 2014

The minutes of August 7 and September 4, 2014 were deferred due to lack of quorum. MINUTES DEFERRED.

Chair's Report

Mr. Weatherby, Chair, had no report.

Report from the Board of Directors

Ms. Drake, Board Chair, reported the final Municipal Cooperative Agreement has been signed by all members and is now available on the Consortium website. The 2015 Budget was approved and included a premium rate increase of 5%. The 2011 Audit by the New York State Department of Financial Services was finalized and is also available on the website.

Executive Director

Mr. Barber reported the last flu clinic was held and according to ProAct they were very successful; a full report will be presented to the Owning Your Own Health Committee.

He reported the roll-out of the recertification process is underway and he and Beth Miller held 12 meetings with City and County employees during the last week and a half. He said Cortland has hired an outside firm to perform the recertification process. He said if anyone did not attend the Retreat they are encouraged to view the presentation along with the PowerPoint presentation that is available on the Consortium website.

Ms. Jobin said she would like information on how many spaces were made available and filled at each flu clinic location. She is interested in knowing if there was successful outreach to fill those spaces by location.

2-Person Category for Benefit Plans

Mr. Barber said the Audit and Finance Committee has been asked to consider a two-person premium. He referred to a memorandum prepared by Locey and Cahill dated September 25, 2014 containing detailed information.

Mr. Barber said the Consortium does not pay Excellus a certain amount to execute the claims. He said although it makes sense if someone is from the same age group and has only two people as opposed to having more people you would expect to pay less in claims because there are fewer people. However, the medical and prescription costs increase by age; if there is a disproportionate number of the population that are older who are two-person it may not be the same if they were equal parts of the population paying a two-person rate. He said prior to the Consortium the majority of health insurance plans did not have a two-person rate; this is why it was not included as an option and would need to be approved by both labor and management.

He said since 93% of the Consortium's premium pays for actual claims, adding a two-person tier does not change the covered population or the resulting claims so the amount that has to be raised to pay claims remains the same. If the two-person rate were an intermediate premium between single and family then to receive enough premium to pay those claims the other two rates would need to be adjusted.

Mr. Barber said that since the rates are negotiated and a part of the collective bargaining process this Committee should discuss a process to move forward as the Consortium could only offer it if there was across-the-board change for single and family rates. He said Mr. Locey had offered to work with an individual municipality to adjust rates if the Consortium didn't move forward with a two-person rate and an individual municipality wished to move forward.

Ms. Nunn arrived at this time.

Ms. Miller clarified a two-person rate would apply to the subscriber and one other person; it would not have to a spouse. She also said it should be assumed that anyone eligible to have a two-person rate would take advantage of it because it would be a lower rate.

Mr. Barber said the Audit and Finance Committee looked at this to do an analysis to determine what the impacts would be but has referred it to this Committee for discussion.

During a discussion of the estimated savings it was stated that a 2-person family would receive a $138 decrease in their rate while all other family plans would experience a $102 increase in their monthly rate. Mr. Murphy noted employees generally only pay a portion of the premium; therefore, there would not be a major savings or cost increase to the employee. Ms. Drake said the one population that this would benefit would be the retirees because they are typically paying 50% of the premium or more. When the Consortium was formed the Town of Ithaca moved from a three-tier rate to a two-tier rate.

Mr. Locey said from a Consortium perspective it doesn't matter whether there are two or three rates because in the end the same amount of money would be collected in rate. He thinks one reason this has been brought forward is that there are plans available on the open market that have multiple rate choices. He said there needs to be a look taken at whether it makes sense to give a price break to a particular group.

Mr. Weatherby said he thinks this would be difficult to get support from a bargaining unit for this.

Based on the lack of interest Mr. Cook suggested the Audit and Finance Committee table this indefinitely. If at some point in the future there is interest expressed in pursuing it further it can be brought back for further discussion and consideration.

Ms. Nunn said when this was suggested previously at the City of Ithaca there was concern about the financial impact it would have on families and doesn't think the City's position has changed. She asked if it makes sense to move in this direction if it would also make sense to move to a two-tiered system in terms of new hires. Mr. Locey said he thinks this would be difficult because of complexity and fairness issues as a result of employees who would be paying different sets of rates. He also noted the billing process is already very complicated.

Mr. Barber summarized the discussion and said this Committee is not interested in pursuing a two-person rate at this time. If a group would like to have a three-tier rate they could contact Mr. Locey and establish that internally.

Recertification Process

Mr. Cook said several municipalities have received an e-mail from CSEA asking that they cease and desist the Recertification process and asked for direction on this.

Mr. Barber said the Board of Directors authorized the recertification process and there was full transparency. If an employer decides to respond to the letter from CSEA it is a collective bargaining issue and not a Consortium issue. Until the Board of Directors stops the process it is continuing to move forward. Mr. Cook asked if municipalities fulfill their responsibility as instructed by the Board if the Consortium would hold them harmless for any monetary damages that are rendered if they don't honor the order to cease and desist. Mr. Barber said the Board would have to make a decision on this and they will meet again in December and this is timely enough to provide an opportunity if something needs to be

changed. He cautioned that this Committee is not to be discussing collective bargaining issues. He said if a municipality decides not to continue it should bring this to the Board.

Mr. Weatherby read the following statement:

"In CSEA's case the issue has been referred to our CSEA attorneys and respective labor relations specialists. It is a mandatory subject of bargaining for the individual CSEA units and that has already been established by PERB (Public Employee Relations Board". He said there have been two court cases on this already of which one was in Cortland County.

Mr. Cook asked if it is CSEA's position that it only impacts their bargaining units and for those municipalities that have several different bargaining units does it apply. Ms. Hersey said her bargaining unit, NYSID, has also said the same thing as CSEA. She thinks most of the bargaining units will have the same perspective that it is a mandatory subject of bargaining. Mr. Barber said if the labor Directors on the Board want to ask that the Board take a different path there is a process for that to happen.

Mr. Weatherby said CSEA doesn't oppose ensuring that all of the right people are being insured but there are impacts of which one could be the cost associated with obtaining a document such as a marriage license.

Ms. Gannon suggested that anyone represented by CSEA reach out to their labor relation specialist who handles that municipality. She said she thinks an audit is important and if there are fraudulent claims being made they need to be caught and stopped; however, there are also concerns with personal information being provided. Ms. Hersey said one of her members is not in possession of their marriage license and has to wait 14 to 16 weeks to obtain a copy which would prohibit them from completing the process in the timeline.

Mr. Barber asked that Mr. Weatherby take the issue of what this Committee is back to CSEA. The Consortium is an Article 47 and the Committee was created to have a venue for labor and management to sit down together to run the Consortium. This problem he said shows it is not being done well since being this far into the process and having the process stopped. He said there needs to be an understanding of how both sides are going to work together smoothly.

Mr. Perine asked why the Consortium didn't come to the unions when this process was being decided upon and request that they check with their legal department and members to see if there were any problems. Mr. Barber said every bargaining unit gets a copy of the information discussed by this Committee and this has been discussed at least twice in the past. He said if there is a better way to communicate he is open to hearing suggestions.

Mr. Barber said this process was brought forward as a result of the audit performed by the New York State Department of Financial Services. Late last year the Board was introduced to the process that would start on new hires that began on January of 2014. There have been discussions along the way of doing a full recertification and that date was established in the Spring of 2014 with the rollout set to take place in the Fall. He also said he reported on two different occasions what the roll-out plan was to this Committee. Mr. Barber said employers and employees have a stake in the outcome of the Consortium and there needs to be a way to communicate among everyone that will work better.

Mr. Locey said Locey and Cahill has been involved in two similar audits but each used outside firms to perform the audits. Both involved NYSID and CSEA and no one objected to the

process so this process was built with similar safeguards and he even thought it was better protected because an outside firm was not being used. He said they thought that by having employees sharing information with their employer it would be better than sending to a stranger, an amnesty period was built in, nothing was built in with regard to any punitive action to an employee although there was discussion about punitive action about fraudulent claims, and there was discussion about an appeals process. There was not any discussion built in about the reimbursement of the costs to secure documentation because they had not seen this as being an issue with the other audits. Mr. Locey said the Consortium has an attorney, Hancock and Estabrook, and if anyone would like something reviewed it can be referred to them upon approval by the Board of Directors for analysis and opinion.

Basics of Benefit Plan Design

Mr. Locey distributed a detailed memorandum dated November 6, 2014 regarding "Building a Medical and Prescription Drug Benefits Plan". He explained the Consortium is self-insured and the State has deemed that Article 47 Municipal Cooperative Health Benefit Plans have to operate under the same rules as an Article 43 Not-for-Profit insurance company in terms of benefits. There are also many other rules and regulations the Consortium must comply with. Mr. Locey pointed out highlights contained in the lengthy document that provided an overview of how a medical and prescription drug benefit plan is developed in New York State. Due to the comprehensive nature of the document and usefulness in future discussions it is included as an addendum to these minutes.

Mr. Barber thanked Mr. Locey for putting together the document and said it will be very useful during the Committee's discussion of developing plans.

New Business

There was no new business.

Old Business

There was no old business.

Next Meeting Agenda

Discussion of the role of the Joint Committee in relation to the Consortium Board of Directors and review of a draft Bronze Plan was deferred to the next meeting. The Committee will also establish a2015 meeting schedule and appoint an alternate to the Board of Directors to replace John Licitra.

Adjournment

The meeting adjourned at 2:48 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk

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MEMORANDUM

DATE: NOVEMBER 6, 2014

FROM: LOCEY & CAHILL, LLC

TO: GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM JOINT COMMITTEE ON PLAN STRUCTURE AND DESIGN

RE: BUILDING A MEDICAL AND PRESCRIPTION DRUG BENEFITS PLAN

The Greater Tompkins County Municipal Health Insurance Consortium Joint Committee on Plan Structure and Design is a very diverse group of individuals with Committee Members coming from a wide variety of backgrounds and health insurance knowledge. As a result, we collectively thought it would be a good idea to provide an overview of health insurance, specifically dealing with how a medical and prescription drug benefit plan is developed in New York State.

To initiate this discussion, it is important to understand the type of insurance companies that generally provide health insurance in New York State and the variety of funding mechanisms utilized for the provision of health insurance. The reason this is important is due to the fact that there are variances in the way different health insurance plans have to comply with State and Federal Mandates, Laws, and Regulations.

The main types of insurance companies operating in New York State are:

1. **New York State Insurance Law Article 32 Commercial Insurance Companies**

2. **New York State Insurance Law Article 43 Not-for Profit Insurance Companies**

3. **New York State Public Health Law Article 44 Health Maintenance Organizations**

The funding mechanisms utilized by various health insurance plans, both fully-insured and self-inured, include, but may not be limited to, the following:

1. **Fully-Insured Plans**

    a. Prospective Rating – premium rates are guaranteed for the contract period.

        i. Experience Rating – premiums are based on the actual paid claims experience of the group, benefit plans provided, and insurance company overhead costs which may include administrative fees, profit margins, and contributions to reserves. As a result, premiums will vary based on the risk factors associated with the population.

ii. Community Rating – premiums are based on the carrier's entire book of business for all covered members utilizing the same benefit plan. There is no variance in premium rate based on the risk factors of a single employer group or population.

b. Retrospective Rating – premium rates are not guaranteed for the year. At the beginning of the year, the premium rates are developed along with paid claims expectations. If the employer-sponsored health insurance plan's experience is below a pre-determined paid claims threshold, no additional premium is due to the insurance carrier. If the paid claims estimate is exceeded then the employer would owe the insurance carrier additional premiums not to exceed a pre-determined ceiling. This type of arrangement combines some of the principles of self-funded while capping the maximum amount to be paid.

c. Minimum Premium – with this insurance model, the employer-sponsored plan has the ability to set their own premium equivalent rates and hold all reserve funds. The employer or contract holder is required to pay the insurance company an administrative fee and reimburse the carrier on a dollar-for-dollar basis for all paid claims. This type of funding mechanism operates from a risk perspective like a self-insured plan, but is still technically considered insured according to the Laws, Rules, and Regulations in New York State.

2. Self-Insured Plans

a. Single Employer Self-Insured Plans
This type of health insurance model has the employer assuming the role of the health insurance carrier and taking on the liability of all claim payments and benefit decisions. Private sector employers have to comply with ERISA (Employee Retirement Income Security Act of 1974) when operating such plans. Municipal employers are exempt from ERISA and therefore, are not subject to any Federal or State oversight.

b. Article 47 Municipal Cooperative Health Benefit Plans
These plans consist of two or more municipal corporations which pool their premiums, share risk, and jointly establish reserves associated with the operation of a health insurance plan. The New York State Department of Financial Services provides direct oversight over these plans which includes very stringent reporting requirements. In this model, every municipal corporation must be represented on the Board of Directors and with Consortiums newly formed after 1993, the Board must include union representatives as well.

c. Article 44 Employee Welfare Funds
Similar to an Article 47 Municipal Cooperative Health Benefits Plan, this type of health insurance plan consists of two or more municipal corporations which pool their premiums, share risk, and jointly establish reserves associated with the operation of a health insurance plan. There is oversight from the New York State Department of Financial Services which, in our professional opinion, are far less stringent than those associated with Article 47 plans. The biggest difference with this model for health insurance is that the governing body is made up of a number of Trustees half of which must represent management and half of which must represent labor. As a result, not every municipal employer or collective bargaining group has representation on the Board of Trustees.

The reason it was important to provide a base-line understanding of the various types of insurance companies and funding mechanisms that can be utilized is due to the fact that each model has a specific set of rules within which it must operate. In our case, the Greater Tompkins County Municipal Health Insurance Consortium is a Self-Insured Plan which operates pursuant to Article 47 of the New York State Insurance Laws.

As a result of the Consortium's designation as an Article 47 Municipal Cooperative Health Benefits Plan, all plan operations must be in accordance with the requirements of Article 47 of the New York State Insurance Law. This includes compliance with the New York State Department of Financial Services rules and regulations. In terms of the benefit plan design, the Department requires the Greater Tompkins County Municipal Health Insurance Consortium to operate pursuant to the laws, rules, and regulations associated with an Article 43 Not-for-Profit Insurance Company. This is the basis by which we will review the steps associated with building a benefit plan from the ground up.

ELIGIBILITY

To start the development of a medical and prescription drug benefits plan, the insurance carrier, which in our example is the Consortium and the various employers, must decide who is going to be covered by the health insurance plan. The options include the contract holder (employee or retiree), spouses, domestic partners, and/or dependent children.

1. Mandated Eligibility

a. Contract Holder
This would include active employees and retirees as defined by each employer's collective bargaining agreements, legislative actions, and/or personnel policies.

b. Dependent Children Under Age 26
Due to the Patient Protection and Affordable Care Act (ACA), a contract holder who elects family coverage may now include their natural born children, adopted children, and those children for whom they have been appointed legal guardian on their coverage until such time as that child reaches their 26th birthday.

2. Optional Eligibility

a. Legal Spouse
Coverage would be offered to either the opposite sex or same sex spouse of the employee or retiree, provided they were offered and elected family coverage and the marriage was affirmed by a legal jurisdiction recognized by the State of New York. This would include spouses upon legal separation, but who are not yet considered divorced spouses.

b. Domestic Partners
There are no current insurance laws or regulations in the State of New York which require employers to provide domestic partner coverage in their health insurance plans. In addition, if offered, domestic partner coverage could be limited to same-sex partners according to the Office of General Counsel Opinion dated November 29, 2007. As a result, an employer may elect whether or not to cover domestic partners as part of their health insurance plan. This is a standard option which has been included in the Consortium's benefit plans.

c. Dependent Children Under Age 30 (Young Adults)
In New York State there is a requirement that all insurance carriers "make available" a rider to cover dependent children up to their 30th birthday. This is an option which was not chosen by the Greater Tompkins County Municipal Health Insurance Consortium. To qualify for this coverage, the young adult must be unmarried, not eligible for their employer's health insurance plan, be under 29 years of age or less, and live, work, or reside in New York State or the insurance company's service area.

MINIMUM BENEFIT STANDARDS (NEW YORK CODES, RULES AND REGULATIONS, TITLE 11, PART 52)

In New York State, the New York State Department of Financial Services regulates health insurance plans to ensure the benefits provided are consistent with the Codes, Rules and Regulation of the State of New York (CCR-NY) for insurance products. In the following, we have provided the actual language as it currently appears in the CCR-NY which forms the ***basic requirements*** for all health insurance plans in New York State. Many of these provisions have been augmented through mandated benefit changes either on a Federal or State Level. However, this language should provide an understanding of how health insurance has improved over the years, many times without the need for collectively bargaining the changes.

1. **Basic Hospital Insurance (11 CRR-NY 52.5)**
Basic hospital insurance is an insurance policy which provides coverage subject to no deductible in excess of $500 for a period of not less than 60 days for any continuous hospital confinement of each covered person for services rendered while confined in a hospital (except as to subdivision [c] of this section) or, in the case of an article 43 corporation, for services rendered while confined in a member hospital, for necessary treatment because of sickness or injury for at least:

   (a) Daily room and board, consisting of bed and board, including general nursing care and special diets, in an amount not less than the lesser of:

      (1) 80 percent of the charges for semiprivate accommodations;

      (2) 100 percent of the charges for semiprivate accommodations for the first 20 days of confinement and at least 50 percent of such charges for the next 40 days; or

      (3) $240 per day; except that such $240 may be reduced to $165 for policies issued for delivery outside the metropolitan area.

   (b) Miscellaneous hospital services, during each period of continuous hospital confinement as an inpatient, in an amount not less than 80 percent of the charges incurred, up to at least $5,000 or 20 times the daily room and board rate if specified in dollar amounts for at least:

      (1) the use of operating, recovery and cystoscopic rooms and equipment;

      (2) the use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;

      (3) diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes for care in the hospital, and administration thereof, but not including those which are not commercially available for purchase and readily obtainable by the hospital;

(4) dressings and plaster casts;

(5) supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person;

(6) radiation therapy and chemotherapy; and

(7) any medical services and supplies which are customarily provided by hospitals, unless specifically excluded in the insurance or subscriber contract and the individual certificates issued in connection with group insurance.

(c) Outpatient services, consisting of:

(1) hospital services on the day surgery is performed;

(2) hospital services rendered within 24 hours after accidental injury, in an amount not less than the lesser of the reasonable charges incurred or the per-day amount provided for daily room and board if specified in dollar amounts under subdivision (a) of this section; and

(3) with respect to individual insurance written by insurers other than article 43 corporations, X-ray and laboratory tests performed in the outpatient department of a hospital, to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital.

2. Basic Medical Insurance (11 CRR-NY 52.6)

Basic medical insurance is an insurance policy which provides coverage for services rendered by a physician or, in the case of article 43 corporations, a participating physician, to each covered person for sickness or injury for:

(a) Surgical services, consisting of operating and cutting procedures for the treatment of a sickness or injury, and endoscopic procedures, including any pre- and post-operative care usually rendered in connection with such operation or procedure, in an amount:

(1) not less than 80 percent of the reasonable charges; or

(2) if specified in dollar amounts, a fee schedule providing amounts for any procedure at least equal to those provided for in a fee schedule with a maximum of $2,600 based on the relative values contained in the State of New York Certified Surgical Fee Schedule, or an equivalent fee schedule approved by the superintendent.

(b) Anesthetic services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician, other than the physician performing the surgical service or his assistant, in an amount not less than 80 percent of the reasonable charges or 15 percent of the benefit provided in paragraph (a)(2) of this section.

(c) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical or pregnancy care is required, in an amount not less than 80 percent of the reasonable charges or $25 per day for not less than 60 days.

3. Major Medical Insurance (11 CRR-NY 52.7)

Major medical insurance is an insurance policy which provides coverage for each covered person, to a maximum of not less than $100,000; copayment by the covered person not to exceed 25 percent; a deductible stated on a per-person, per-family, per-illness, per-benefit period, or per-year basis, or a combination of such bases, not to exceed five percent of the lowest overall maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance, in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for at least:

(a) daily room and board, as defined in section 52.5(a) of this Part;

(b) miscellaneous hospital services, as defined in section 52.5(b) of this Part; provided, however, that the maximum amount limitation shall not apply;

(c) surgical services, as defined in section 52.6(a) of this Part;

(d) anesthetic services, as defined in section 52.6(b) of this Part;

(e) in-hospital medical services, as defined in section 52.6(c) of this Part;

(f) mental health care consisting of coverage for diagnosis and treatment of mental illness for at least:

(1) 30 days per year of inpatient care in a hospital as defined by subdivision ten of section 1.03 of the Mental Hygiene Law;

(2) 30 outpatient visits per year at no less than $30 per visit and a yearly maximum of no less than $1,500 with reimbursement for early visits greater than or at least equal to reimbursement for subsequent visits in a facility issued an operating certificate by the Commissioner of Mental Health pursuant to the provisions of article 31 of the Mental Hygiene Law, or in a facility operated by the Office of Mental Health, or by a psychiatrist or psychologist licensed to practice in this State, or a professional corporation thereof; and

(3) outpatient crisis intervention services consisting of at least three psychiatric emergency visits per year. Upon certification, by a licensed mental health care provider whose services are covered under the policy, that a visit was the result of a psychiatric emergency (one where the person appears to have a mental illness for which immediate observation, care and treatment is appropriate and which is likely to result in serious harm to himself or others), benefits for such a visit shall be no less than $60 per visit. However, benefits provided under this paragraph may be used to reduce benefits otherwise payable under paragraph (1) or (2) of this subdivision;

(g) out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis, where coverage is not provided elsewhere in the policy, for diagnosis and treatment of sickness or injury, including the cost of drugs and medications available only on the prescription of a physician, and diagnostic X-ray, laboratory services, radiation therapy, chemotherapy and hemodialysis ordered by a physician; and

(h) prosthetic appliances, meaning artificial limbs or other prosthetic appliances (including replacements thereof which are functionally necessary), and rental or purchase (at insurer's option) of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement.

In order to be considered a qualified health insurance plan you must meet the above minimum requirements in terms of benefits provided to covered members. In addition, as new laws have been passed requiring certain services be included in health insurance plans, insurance carriers have to not only meet the basic requirements, they also have to include any Federal or State mandated benefits. In the following we will review these additional items which have been added to health insurance plans over the years.

NEW YORK STATE MANDATED BENEFITS

Over the years, many revisions have occurred in the New York State Insurance Laws which have enhanced the minimum standards associated with medical and prescription drug benefit plans. Below, we have listed the New York State Mandated Benefits which must be included in all Group Commercial and Article 43 Health Insurance Contracts (keep in mind the Consortium, as an Article 47 Municipal Cooperative Health Benefits Plan, is subject to the same requirements as an Article 43 Not-for-Profit Insurance Company and must include these benefits in all plans offered):

Benefit	Group Commercial	Article 43
Home health care	§3221(k)(1)	§4303(a)(3)
Preadmission testing	§3221(k)(2)	§4303(a)(1)
Second surgical opinion	§3221(k)(3)	§4303(b)
Emergency medical services See also: Circular Letter No. 1 (2002)	§3221(k)(4)	§4303(a)(2)
Maternity care	§3221(k)(5)	§4303(c)
Medical conditions leading to infertility	§3221(k)(6)	§4303(s)
Diabetic supplies, equipment, and self-management education	§3221(k)(7)	§4303(u)
Mastectomy care	§3221(k)(8)	§4303(v)
Second medical opinion for cancer diagnosis	§3221(k)(9)	§4303(w)
Post-mastectomy reconstruction	§3221(k)(10)	§4303(x)

Enteral Formulas	§3221(k)(11)	§4303(y)
Chiropractic care	§3221(k)(11)	§4303(y)
Experimental or investigational services recommended by an external appeal agent	§3221(k)(12)	§4303(z)
Chemical abuse and dependence (outpatient)	§3221(l)(7)	§4303(l)
Preventive and primary care	§3221(l)(8)	§4303(j)
Mammography screening	§3221(l)(11)	§4303(p)
Prostate cancer screening	§3221(l)(11-a)	§4303(z-1)
Cancer drugs	§3221(l)(12)	§4303(q)
Cervical cytology screening	§3221(l)(14)	§4303(t)
Pre-hospital emergency medical services	§3221(l)(15)	§4303(aa)
End of life care	§4805	§4805
Infertility coverage	§3321(k)(6)	§4303(s)
Bone density measurements, testing , drugs, and devices	§3221(k)(13)	§4303(bb)
Contraceptive drugs and devices	§3221(l)(16)	§4303 (cc)
Eating Disorders	§3221(k)(14)	§4303(dd)
Mental, nervous or emotional disorders or ailments	§3221(l)(5)	§4303(g) and (h)
Biologically based mental illness and serious emotional disturbances (large groups)	§3221(l)(5)	§4303(g) and (h)
Autism Spectrum* [Statutes change effective 11/1/2012]	§3221(l)(17)	§4303(ee)

It should be noted that all of the above changes to the New York State Insurance Law compelled employers to add benefits to their health insurance plans outside of the collective bargaining process.

NEW YORK STATE "MAKE AVAILABLE" BENEFITS

In addition to the required benefits listed above, New York State Insurance Laws include several benefit enhancements which must be made available for inclusion in an employer-sponsored medical and prescription drug benefits plan. Please refer to the following list for a summary of these benefits:

Benefit	Group Commercial	Article 43
Nursing home care	§3221(l)(2)	§4303(d) and (r)
Ambulatory care	§3221(l)(3)	§4303(e) and (f)
Social worker	§3221(l)(4)	§4303(i)

Biologically based mental illness and serious emotional disturbances (small groups)	§3221(l)(5)	§4303(g) and (h)
Inpatient treatment of alcoholism and substance abuse	§3221(l)(6)	§4303(k)
Registered nurse	§3221(l)(9)	§4303(m)
Hospice care	§3221(l)(10)	§4303(o)
Supplemental home care	§3221(l)(1)	§4303(a)(3)(D)

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) – ESSENTIAL HEALTH BENEFITS

In addition to compliance with the New York State Insurance Laws and the Codes, Rules and Regulations of the State of New York in developing a medical and prescription drug benefit plan, we now also have to comply with the requirements of the Patient Protection and Affordable Care Act (ACA). ACA required the Secretary of the United States Department of Health & Human Services to specify the "essential health benefits" (EHB) to be included in the "essential health benefits package." Starting in 2014, the EHB are required to be included in all Qualified Health Plans (QHPs). EHB is defined in Section 1302(b) of the Patient Protection and Affordable Care Act and includes at least the following general categories of benefit:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic disease management (details directly below)
- Pediatric services, including oral and vision care.

It should be noted that the preventive services for adults, women, and children include the following which have to be included in all health insurance plans with ***no out-of-pocket cost*** to the covered member:

Covered preventive services for adults include the following fifteen (15) services:

1. Abdominal Aortic Aneurysm (1x) screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Type 2 Diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk

11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Tobacco Use screening for all adults and cessation interventions for tobacco users
15. Syphilis screening for all adults at higher risk

Covered preventive services for women, including pregnant women, twenty-two (22) services:

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
5. Breast Cancer Chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
7. Cervical Cancer screening for sexually active women
8. Chlamydia Infection screening for younger women and other women at higher risk
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*
10. Domestic and interpersonal violence screening and counseling for all women*
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women*
16. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*
17. Osteoporosis screening for women over age 60 depending on risk factors
18. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling for sexually active women*
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services*

Covered preventive services for children include the following twenty-six (26) services:

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
4. Blood Pressure screening for children
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders

10. Fluoride Chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, and Pertussis. Haemophilus influenzae type b. Hepatitis A. Hepatitis B. Human Papillomavirus. Inactivated Poliovirus
    Influenza (Flu Shot). Measles, Mumps, Rubella. Meningococcal. Pneumococcal. Rotavirus. Varicella
18. Iron supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk of exposure
20. Medical History for all children throughout development
21. Obesity screening and counseling
22. Oral Health risk assessment for young children
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
25. Tuberculin testing for children at higher risk of tuberculosis
26. Vision screening for all children

In addition to the above Essential Health Benefits (EHB), the ACA also eliminated pre-existing condition clauses, shortened waiting periods to no greater than 90-days for new hires, and set limits on the amount of money paid by members toward their own medical care.

EXCLUSIONS

The following is the model language developed by the New York State Department of Financial Services relative to what can be included as exclusions in a health insurance plan in New York State. It should be noted that this list will vary on a State by State basis, but this is what we have to include in New York State as a minimum requirement.

No coverage is available under this [Certificate; Contract; Policy] for the following:

A. Aviation
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Cosmetic Services
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect.

We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this [Certificate; Contract; Policy]. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this [Certificate; Contract; Policy] unless medical information is submitted.

D. Coverage Outside of the United States, Canada or Mexico

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

E. Dental Services

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the Outpatient and Professional Services [and Pediatric Dental Care] section[s] of this [Certificate; Contract; Policy].
{Drafting Note: Include the bracketed language if pediatric dental benefits are covered.}

F. Experimental or Investigational Treatment

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this [Certificate; Contract; Policy], or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the [Certificate; Contract; Policy] for non-investigational treatments. See the Utilization Review and External Appeal sections of this [Certificate; Contract; Policy] for a further explanation of Your Appeal rights.

G. Felony Participation

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

H. Foot Care

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

I. Government Facility

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law [unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition].
{Drafting Note: The bracketed language above is optional.}

J. Medically Necessary
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this [Certificate; Contract; Policy].

K. Medicare or Other Governmental Program
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

L. Military Service
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

M. No-Fault Automobile Insurance
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

N. Services not Listed
We do not Cover services that are not listed in this [Certificate; Contract; Policy] as being Covered.

O. Services Provided by a Family Member
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

P. Services Separately Billed by Hospital Employees
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Q. Services with No Charge
We do not Cover services for which no charge is normally made.

R. Vision Services
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the [Pediatric] Vision Care section of this [Certificate; Contract; Policy].

S. War
We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

T. Workers' Compensation
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

It should be noted that the above exclusion list is not mandated as an insurance carrier could choose to not include one or more of the above exclusions and include the referenced service as a covered item.

MEDICAL AND PRESCRIPTION DRUG PLAN MODELS

There are basically five (5) plan design models available to Municipal Cooperative Health Benefit Plans operating pursuant to Article 47 of the New York State Insurance Law, Indemnity Plans, Preferred Provider Organization (PPO) Plans, Point-of-Service (POS) Plans, High Deductible Health Plans (HDHP), and plans modeled in accordance with the ACA Metal Level (Platinum, Gold, Silver, and Bronze) Plans. Please refer to the following for a brief description of each:

1. Indemnity Plans
   Historically, these were often referred to as "pay as you go" plans as the covered member could seek care from any medical facility or medical provider and the insurance plan would reimburse a set portion of the entire charges. As time went on, many insurance carriers started to develop preferred providers who would accept a reduced amount off of their normal charge which guaranteed the covered member would only have to pay any deductible or coinsurance amounts for care rendered by these "participating providers." The covered member was still able to seek care from any medical facility or provider, but if they were "not a participating provider," the covered member would be responsible for their deductible, coinsurance, and any charges which exceeded the insurance carrier's allowed amount for the related medical services.

2. Preferred Provider Organization (PPO) Plans
   These are probably the most common plan structures utilized by employers today. The PPO plan incorporates some of the principles of an indemnity plan in that covered members may seek care from any medical facility or medical provider. However, unlike the indemnity plan, the benefits will vary if the covered member seeks care from "participating providers" versus "non-participating providers." Typically, care rendered by "participating providers would be subject to a copayment (fixed fee) based on the type of service rendered (e.g., office visit, emergency room visit, surgery, etc.). If care is rendered by a "non-participating provider," the covered member typically has to satisfy an up-front deductible, pay a coinsurance amount, and possibly be subject to a balance bill from the provider for the difference between the provider's charge and the allowed amount. This type of plan still gives the freedom choice of provider, but has an economic incentive to seek care from "participating" or "in-network" providers.

3. Point of Services (POS) Plans
   This type of plan is similar to the PPO Plan in that care rendered by "participating providers would be subject to a copayment (fixed fee) based on the type of service rendered (e.g., office visit, emergency room visit, surgery, etc.). If care is rendered by a "non-participating provider," the covered member typically has to satisfy an up-front deductible, pay a coinsurance amount, and possibly be subject to a balance bill from the provider for the difference between the provider's charge and the allowed amount. However, this type of plan commonly restricts the freedom choice of provider as the plan may require the covered member to select a primary care physician who would have to refer the patient for services rendered by a specialist. This primary care physician is often called the "gatekeeper" and is used as a tool to manage the overall care of the patient and the cost of the care to the patient.

4. High Deductible Health Plans (HDHP)
   This type of plan design is very similar to an indemnity plan except there is a minimum deductible level which must be included in the plan for all covered medical services, except for those services required to be covered with no member cost sharing by Federal or State mandate. For the 2014 Calendar Year, a plan must have an individual deductible of at least $1,300 and a family deductible of at least $2,600 to qualify as a HDHP. These plans also must include an out-of-pocket maximum to include all deductibles, coinsurance amounts, and copayments not too exceed $6,350 for an individual or $12,700 for a family. In addition, covered members who are enrolled in a HDHP may also enroll in a Health Savings Account (HSA). This type of account allows covered members to pay for unreimbursed medical expenses on a pre-tax basis, but unused balances may be rolled over from year to year.

5. ACA Metal Level Plans
   The Affordable Care Act contains language which defines the Actuarial Value (AV) of a health insurance plan's coverage based on the percent of health care expenses covered by the plan for a typical population. Health Insurance plans designed for the "Health Insurance Marketplace" were based primarily on a PPO or an Indemnity plan model. These health insurance plans are placed into four categories based on their Actuarial Value (AV):

   a. Platinum Plan Models Actuarial Value (AV) = 90%

   b. Gold Plan Models Actuarial Value (AV) = 80%

   c. Silver Plan Models Actuarial Value (AV) = 70%

   d. Bronze Plan Models Actuarial Value (AV) = 60%

Once the style of plan is selected, the next step in the process is to determine the level of cost sharing from the covered members in terms of deductibles, coinsurance amounts, copayments, and out-of-pocket maximums.

MEMBER COST SHARING

The plan design model will dictate to some degree the type and amount of your covered member out-of-pocket expenses. As discussed earlier, historically, health insurance plans were referred to as indemnity plans which included a deductible, coinsurance amounts, and out-of-pocket maximums. Today, we have plan designs which still have some of the basic elements of the indemnity plans, but have incorporated fixed dollar costs (copayments) for services offered by medical facilities and medical providers who have agreed to a contracted rate with the insurance company or third party administrator.

The only limitation on out-of-pocket costs can be found in the ACA which now limits the covered members total cost of care for in-network and out-of-network services at $6,350 per individual and $12,700 per family. This limitation is an aggregate limit which includes any deductibles, coinsurance amounts, or copayments, but does not include any balance bill amounts for out-of-network providers. Once the out-of-pocket maximum is achieved, covered benefits are reimbursed at 100% of the allowed amount.

We have provided below a brief description of the various forms of out-of-pocket costs for your reference and review:

1. ***Deductibles***
   This is a fixed dollar amount which must be paid by the covered member for covered services prior to the benefit plan making any payments. In a traditional indemnity style plan, the deductible was typically located in the major medical portion of the benefits plan. In most cases, there is an individual deductible and a family deductible which must be satisfied. The Consortium currently has in-network deductibles as low as $50 to $100 for individuals in the standard indemnity plans and as high as $500 for members enrolled in the comprehensive plan. On the out-of-network benefits the deductibles range from $50 to $750 for an individual across all the various plan design models. It should be noted that annually less than 4% of all the covered benefits paid by the Consortium are related to out-of-network services.

2. ***Coinsurance Amounts***
   The coinsurance amount refers to the percentage split between the plan's payment and the amount that has to be paid by the covered member. Traditionally, for major medical services in an indemnity plan the coinsurance amount paid by the covered member equaled 20% of the allowed amount. Today, in PPO plans and other plan models which have in-network and out-of-network benefits, these coinsurance amounts can range from 10% to as much as 50% depending on the type of plan design chosen.

3. ***Copayments***
   The copayment amount refers to any fixed dollar amount costs associated with a health insurance plan. When PPO style benefit plans were first introduced, the copayment amounts were typically applied to office visits and prescription drugs. However, over the years as health insurance has become more and more expensive, plans have now started applying copayments to items such as inpatient hospital stays, surgical services, ambulance services, emergency room services, rehabilitative services, diagnostic radiology and laboratory services, and many more items in addition to the traditional office visit copayment and prescription drug copayments. One piece of good news from the continuing implementation of the ACA is that these copayments must now be included in the out-of-pocket maximums where historically, these copayments were not capped.

4. ***Out-of-Pocket Maximums***
   This is the maximum amount which the covered member will pay in deductibles, coinsurance amounts, and/or copayments prior to services being reimbursed at 100% of the allowed amount. Please keep in mind that the out-of-pocket maximum does not include amounts paid by the covered member for balance billings from out-of-network providers whose billed charges are in excess of the insurance company's or third party administrator's allowed amount.

The two primary reasons why cost sharing items like those described above are a "necessary evils" found in health insurance plans are as follows:

1. The amount of covered services paid by the member reduces the overall paid claims expense of the plan which ultimately keeps premiums lower for everyone. This is especially critical as we continue to head toward the implementation of the ACA "Cadillac Tax" which begins in 2018.

2. It has been proven in numerous studies over the years that when the covered member (patient) has a financial interest in the services being provided that they are a more involved consumer, ensuring services are necessary and priced at a reasonable level.

PROVIDER NETWORK

All of the items we have discussed up to this point describe what the benefit plan will or will not cover and the distribution of cost for said cover benefits between the Plan and the covered member. None of the items discussed above directly impact the number one cost driver associated with health insurance premiums which is the actual cost of care. In essence we are talking about the amount which will be allowed or paid by the insurance company or third party administrator to the hospitals, physicians, and other medical care providers for covered services they render to covered members.

Due to the high cost of care and the need for insurance companies and third party administrators to allow or pay reasonable rates for services rendered, most plans utilize a participating provider network. These networks consist of medical facilities and medical providers who have agreed, by contract, to be reimbursed a certain amount for covered services. If a member seeks care from an ***in-network*** medical facility or medical provider they should not be billed for any amounts above the insurance company's or third party administrator's allowed amount for covered services. However, the covered member will still be responsible for any deductibles, coinsurance amounts, or copayments as described in the health insurance plan.

Most health insurance carriers are regionally based. As a result, they may contract with medical facility and medical provider networks in other regions to provide members with access to medical care on a national basis. This is an important factor to consider when developing a health insurance plan as covered members who need to seek care on an ***out-of-network*** basis could be exposed to more out-of-pocket expenses due to medical facilities and/or medical providers "balance billing" for charges above and beyond the health insurance carrier's or third party administrator's allowed amount. This is especially a concern for employees when they are out of the insurance carrier's or third party administrator's service area (e.g., members who are traveling, students living out of the area, and retirees who have relocated).

There is always a delicate balance between having a large enough network of medical facilities and medical providers to provide as much access as possible with the level of reimbursement being allowed for covered services as low as possible. By having some exclusivity, insurance companies and third party administrators can drive costs lower. However, that may limit a person's ability to seek care from certain medical providers who would not agree to a lower reimbursement amount.

A few years ago, New York State filed law suits against several large health insurance companies involving their methodologies associated with the calculation of allowed amounts for out-of-network medical facilities and providers. These legal actions resulted in the following model language being created for health insurance plans to use in the description of their out-of-network provider reimbursement methodology:

1. Facilities [in Our Service Area].

For [insert type of Facility; Facilities] [in Our Service Area], the Allowed Amount will be XX% of:

a. the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount [unadjusted for geographic locality].

b. the Medicare amount [unadjusted for geographic locality].

c. an amount based on cost information from the Centers for Medicare and Medicaid Services.

d. the Fair Health rate.

e. the Viant (a national managed health care preferred provider organization)

f. the Facility's or Provider's charge.

g. a rate based on information provided by a third party vendor, which may reflect one or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.

h. an amount based on Our Participating Provider fee schedule or rate.

i. the average amounts paid by Us for comparable services to Our participating Hospitals/Facilities in the same county. If there are no like kind participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Us for comparable services in like kind participating Hospitals and/or Facilities in the contiguous county or counties.]

{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider facility charges. Include the type of facility in the first set of brackets if the plan uses different reimbursement methodologies for different types of facilities. If plans wish to use different reimbursement methodologies for different facilities, repeat the section above as appropriate for each facility type.}

If there is no amount as described above, the Allowed Amount will be XX% of:

a. the Facility's charge.

b. an amount based on Our Participating Provider fee schedule or rate.

2. Facilities Outside Our Service Area.

For [insert type of Facility; Facilities] outside Our Service Area, the Allowed Amount will be XX% of:

a. the Centers for Medicare and Medicaid Services Prospective Payment System amount [unadjusted for geographic locality].

b. the Medicare amount [unadjusted for geographic locality].

c. an amount based on cost information from the Centers for Medicare and Medicaid Services.

d. the Fair Health rate.

e. the Viant amount.

f. the Facility's charge.

g. a rate based on information provided by a third party vendor, which may reflect one or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.

h. an amount based on Our Participating Provider fee schedule or rate.

i. the average amounts paid by Us for comparable services to Our participating Hospitals/Facilities in the same county. If there are no like kind participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Us for comparable services in like kind participating Hospitals and/or Facilities in the contiguous county or counties.

{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider facility charges outside your service area if the methodology is different from the reimbursement methodology for non-participating provider facility charges inside your service area. Include the type of facility in the first set of brackets if the plan uses different reimbursement methodologies for different types of facilities. If plans wish to use different reimbursement methodologies for different facilities, repeat the section above as appropriate for each facility type.}

If there is no amount as described above, the Allowed Amount will be XX% of:

a. the Facility's charge.

b. an amount based on Our Participating Provider fee schedule or rate.

c. the average amounts paid by Us for comparable services to Our participating Hospitals/Facilities in the same county. If there are no like kind participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Us for comparable services in like kind participating Hospitals and/or Facilities in the contiguous county or counties.

3. For All Other Providers [in Our Service Area].

For all other Providers [in Our Service Area], the Allowed Amount will be XX% of:

a. the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].

b. the Medicare amount [unadjusted for geographic locality].

c. an amount based on cost information from the Centers for Medicare and Medicaid Services.

d. the Fair Health rate.

e. the Viant amount.

f. the Provider's charge.

g. a rate based on information provided by a third party vendor, which may reflect one or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.

h. an amount based on Our Participating Provider fee schedule or rate.

i. the average amounts paid by Us for comparable services to Our Participating Providers in the same county. If there are no like kind Participating Providers in the same county, then the average of amounts paid by Us for comparable services for like kind Participating Providers in the contiguous county or counties.

{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider charges.}

If there is no amount as described above, the Allowed Amount will be XX% of:

a. the Provider's charge.

b. an amount based on Our Participating Provider fee schedule or rate.

c. the average amounts paid by Us for comparable services to Our Participating Providers in the same county. If there are no like kind Participating Providers in the same county, then the average of amounts paid by Us for comparable services for like kind Participating Providers in the contiguous county or counties.

4. For All Other Providers Outside Our Service Area.

For all other Providers outside Our Service Area, the Allowed Amount will be XX% of:

a. [the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].

b. the Medicare amount [unadjusted for geographic locality].

c. an amount based on cost information from the Centers for Medicare and Medicaid Services.

d. the Fair Health rate.

e. the Viant amount.

f. the Provider's charge.

g. a rate based on information provided by a third party vendor, which may reflect one or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.

h. an amount based on Our Participating Provider fee schedule or rate.

i. the average amounts paid by Us for comparable services to Our Participating Providers in the same county. If there are no like kind Participating Providers in the same county, then the average of amounts paid by Us for comparable services for like kind Participating Providers in the contiguous county or counties.

{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider charges outside your service area if the methodology is different from the reimbursement methodology for non-participating provider charges inside your service area.}

If there is no amount as described above, the Allowed Amount will be XX% of:

a. the Provider's charge.

b. an amount based on Our Participating Provider fee schedule or rate.

c. the average amounts paid by Us for comparable services to Our Participating Providers in the same county. If there are no like kind Participating Providers in the same county, then the average of amounts paid by Us for comparable services for like kind Participating Providers in the contiguous county or counties.

In addition to developing an in-network and out-of-network pricing model for reimbursing medical facilities and medical providers for covered medical services, insurance carriers and self-insured health insurance plans must decide how they are going to reimburse claims related to foreign travel. This must be included in the Plan Document and the description must include what would be covered, how it would be paid, and how said services must be submitted as a claim (e.g., English translation, currency conversion, etc.).

CASE MANAGEMENT, UTILIZATION MANAGEMENT, AND DISEASE MANAGEMENT

Over the years as medical technology advanced, health insurance costs increased, and the covered member's proportionate share of the costs has diminished, health insurance plans have implemented several processes to assist members with their care, review the necessity of certain services, and work to ensure the most appropriate care is rendered in the most cost-effective environment. The most common examples of these programs are Case Management, Utilization Management, and Disease Management. The Utilization Review Accreditation Commission (URAC) defines each one of these programs as follows:

1. Case management is a collaborative process that helps consumers manage their comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. A health professional case manager assesses, plans, implements, coordinates, monitors, and evaluates options for consumers, their families, caregivers, and the health care team, including providers, to promote these outcomes.

2. Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called "utilization review."

3. Disease management has evolved from managed care and refers to the processes and people concerned with improving or maintaining health in large populations. It is concerned with common chronic illnesses, and the reduction of future complications associated with those diseases.

In order to effectively utilize these types of processes, it is critical that health insurers and third party administrators be made aware of cases which would meet the criteria for Case Management, Utilization Management, and/or Disease Management. To effectively achieve this goal, many health insurance plans have instituted pre-certification requirements which require the covered member or the covered member's medical care provider to contact the health insurance company or third party administrator to notify them of an inpatient stay or other medical treatment which meets the criteria for notice. Failing to provide notice may be subject to a penalty or reduced benefit being paid for that covered member. Any programs like these need to be clearly spelled out in the health insurance plan to ensure covered members are aware of the requirements and the potential penalties for non-compliance.

APPEALS PROCESSES

The last major component of a health insurance plan is the development of a claims appeals process. This process identifies the steps a covered member may take when they do not agree with the adjudication of a claim associated with their medical care. There are typically several steps to the process, which may include, but not be limited to, internal appeals, external appeals, and appeals committees. The Greater Tompkins Count Municipal Health Insurance Consortium includes a very detailed claims appeal process in every plan design as mandated by the New York State Department of Financial Services.

We hope the above provides you with a basic understanding of how a medical benefits plan is developed in New York State. This includes the basic requirements in New York State of hospital, medical/surgical, and major medical benefits. In addition, we have included information about the required benefits which must be included by virtue of Federal and State mandates. We also provided some summary information on allowable exclusions, the various types of plan models utilized by municipal employers, member cost sharing provisions, provider network development, managed care elements and appeals processes. All of this information is critical to the development of a medical benefits plan to ensure the covered member understand their rights, obligations, and protections as they relate to the payment of their medical and prescription drug services.

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

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MEMORANDUM

DATE: SEPTEMBER 25, 2014

FROM: LOCEY & CAHILL, LLC

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

RE: 2-PERSON RATE CATEGORY

This memorandum is in follow-up to recent Board discussions relative to the possibility of the Greater Tompkins County Municipal Health Insurance Consortium developing a new premium rate classification for two people. We have organized our thoughts relative to this issue in several categories for your ease of reference.

CONSORTIUM OVERVIEW

Prior to delving into the creation of a new premium rate classification, it is important to have a baseline understanding of the current financial arrangement the Consortium has with Excellus BlueCross and ProAct.

As you are aware, the Consortium self-insures its medical and prescription drug benefits plan through Excellus and ProAct utilizing an Administrative Services Only (ASO) Contract. This type of contract allows the Consortium to pay its claims on a dollar for dollar basis. In addition, the Consortium is allowed to retain all reserves associated with the Plan for investment and use as the Board of Directors sees fit. The Consortium, as part of these Agreements, is required to pay Excellus and ProAct an administrative fee and provide certain financial securities to protect Excellus' and ProAct's financial liability associated with the Plan.

A common misconception by those who are not familiar with this type of arrangement is that Excellus and/or ProAct is "charging a premium" to the Consortium. This, as you know, is not accurate. As you are aware, the Consortium has the ability to set its premium equivalent rates in any manner they see fit (provided the Consortium pays its bills including medical claims and retention). As a result, Excellus and ProAct are not involved in the premium equivalent rate setting process.

BUDGET AND RATE SETTING PROCESS

As a result of the above, the Consortium Board of Directors is charged with the development of the annual budget and the setting of the premium equivalent rates each year. In our role as Consultant to the Plan, we provide the necessary analysis and information for the Board of Directors so that they can make an informed and educated decision relative to the appropriate budget and rates.

Historically, this Consortium has developed its rates into two categories which include a Family Rate, and an Individual Rate. This has been the case since the inception of the Consortium. The Consortium Board of Directors has the ability to create any number of rating categories as they see fit for the proper and logical management of the Plan

FINANCIAL IMPACT ON THE CONSORTIUM

As a result of the financial relationship the Consortium has with Excellus and ProAct, the creation of an additional premium rate classification will have no direct impact on the cost of the Plan. As we mentioned earlier in this memorandum, the Consortium pays its expenses on a dollar for dollar basis with Excellus and ProAct and, as such, does not pay Excellus or ProAct a premium. The premiums are set by the Consortium Board of Directors and are established to cover the budgeted expenses of the Consortium for a given fiscal year. As a result, if the Consortium requires $38,295,774.27 to operate the Plan during the 2015 Fiscal Year, the structure of the premium equivalent rates will not change that fact. This is due to the fact that the Consortium will still be collectively covering the same people with no change in benefit level. As a result, whether the Consortium has two premium rate categories or ten premium rate categories, the bottom line is the Consortium still needs to generate approximately $38,295,774.27 in premium income to meet budget expectations.

In the following, we have provided an example of the impact of adding a two-person rate category. The first set of figures provides an analysis of the average overall premium rate for the Consortium based on current budget estimates for the 2015 Fiscal Year and the most recent census counts:

2015 Average Premium Rate Calculation | **2015 Budget = $38,295,774.27**

Fiscal Year	Average Number of Covered Lives Per Contract				
	Individual	2-Person	Family	Totals	
# of Contracts	923	0	1,407	2,330	
Current Rate Factor	1	2.17	2.17		
Covered Lives Factor	923	0	3,053	3,976	
Average Premium	$802.64	$1,741.74	$1,741.74		
Annual Revenue	$8,890,090.46	$0.00	$29,407,538.16	$38,297,628.62	0.0048%

As you will note, the above analysis produces the desired premium revenue figure for the 2015 Fiscal Year within a standard deviation of less than .005%. The one thing we do note about the structure of the Consortium's premium rates is the rather low factor used for the family premium rate category of 2.17. Typically, we see this factor set at closer to 2.4 times the individual premium rate. However, it should be noted that this premium rate ratio was carried forward from the premiums utilized by several of the municipalities prior to the formation of the Consortium.

We then utilized this same information to produce a two-person rate category using industry average premium rate factors for the two-person rate category. As you will note in the exhibit on the following page, we used a factor of two times the individual premium rate for the two-person rate category and 2.3 times the individual premium rate for the family rate category. This resulted in an overall premium income within $100 of the budgeted amount for the 2015 Fiscal Year. Please refer to the chart on the following page for the details associated with this aspect of the analysis:

2015 Two-Person Premium Rate Calculation | **2015 Budget = $38,295,774.27**

Fiscal Year	Average Number of Covered Lives Per Contract				
	Individual	2-Person	Family	Totals	
# of Contracts	923	597	810	2,330	
Current Rate Factor	1	2	2.3		
Covered Lives Factor	923	1,194	1,863	3,980	
Average Premium	$801.84	$1,603.68	$1,844.23		
Annual Revenue	$8,881,155.69	$11,488,763.52	$17,925,915.60	$38,295,834.81	0.0002%

We cannot stress enough the importance of keeping in mind that when we discuss the development of a new premium rate category, we are not doing anything to impact the expenses of the Consortium as we are still covering the same individuals at the same benefit level utilizing the same insurance company. As a result, the development of an additional rate category has no affect on the Consortium from a financial perspective. It should be noted that depending on an individual employer's demographic mix, it could have a positive or negative affect on each municipality's costs.

The real issue associated with the development of additional premium categories involves the affect it has on the other rating categories. If we decrease the amount of revenue being generated by a specific demographic group (in this case 2-Person Plans), we need to increase revenue from another demographic group to close the shortfall in the budget. In the example above, a 2-person family received a $138.06 decrease in their rate while all other family plans experienced a $102.49 increase in their monthly rate.

It should also be noted that the development of a two-person rate category would most likely result in the offering of a "price break" to a demographic group which is the most costly in terms of actual claim payments. It is our experience that the majority of two-person contracts are between the ages of 50 and 64. We are in the process of gathering age band claims data from Excellus BlueCross BlueShield and ProAct which would segregate the family contracts into two-person families and families with three or more covered members. We will report on our findings once all of the date is received and analyzed by our staff.

With the above being said, we acknowledge that there are many plans which offer a two-person rate in the marketplace (more for marketing purposes than sound actuarial purposes). The final decision of whether the Consortium is going to add a two-person rate category is for the Board of Directors to make as ultimately there is no financial impact to the Consortium. It should further be noted that if an individual municipality wanted to add a two-person rate category, this could be done internally provided the municipality reimburses the full premium billed amount each month. This would also be the case for any municipality who may be interested in joining the Consortium, but the lack of a two-person premium rate is making it difficult for them to become a member.

COLLECTIVE BARGAINING IMPACT

The last item we would like to bring up for discussion is the impact such a change would have on collectively bargained agreements at each of the municipalities and their respective unions. It has been our experience that when matters such as these have been discussed in the past that they have become very complex as the impact on an individual's cost could raise an issue relative to a change in the terms and conditions of employment. The example would be a person who has family coverage and pays 10% of the premium. If we lower the rate charged to the 2-person families and raise the rate charged to all other families, the Active Employee's cost is going to rise and this would most likely result in a grievance being filed, if we do not get approval in advance from the collective bargaining groups.

We hope that this discussion relative to the development of a "2-Person Rate" is helpful to the Greater Tompkins County Municipal Health Insurance Consortium Audit and Finance Committee. We are more than happy to provide any additional information or analysis relative to this topic as you may require.

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