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."

Board of Directors Meeting
June 25, 2020 – 6:00 pm – Zoom Meeting

https://zoom.us/j/97236585210?pwd=MmZ0SGRlNDFiaEEvU3ljeER4WEZjUT09
Meeting ID: 972 3658 5210; Password: 840688
1(646)558-8656

1. Call to Order and Recognition of New Members

2. Approval of May 14, 2020 Minutes **(VOTE)** (6:00)

3. Changes to the Agenda

4. Chair's Report: (6:05) — J. Drake
   a. Welcome Christopher Wagner, Seneca County
   b. Appointment to Operations Committee to replace Greg Pelicano

5. Report from Executive Committee: (6:10) — J. Drake
   a. **RESOLUTION:** Ratify Action by Executive Committee to Extend Expanded Coverage to Allow Paid-in-Full Benefits for any COVID-Related Treatment

6. Executive Director (6:20) — E. Dowd
   a. Second Quarter Report
   b. Update on Premium Relief
   c. Utilization Report Review
      1. Excellus Medical Claims Utilization
      2. ProAct – Prescription Drug Claims Utilization

7. Financial Report (6:40)
   a. Financial Report — S. Locey
   b. Treasurers Report — R. Snyder

8. Report from Operations Committee (6:50) — L. Holmes
   a. **RESOLUTION**: Authorizing Extension of Office Lease Agreement with the Town of Ithaca
   b. **RESOLUTION:** Amendment of Resolution No. 003-2014 – Adoption of Consortium Procurement Policy and Request for Proposal Guidelines.

9. Report from Audit and Finance Committee (7:00) — M. Cook
   a. **RESOLUTION:** Authorize Extension of Contract for Medical Claims Auditing Services BMI Medical Claims Auditing Services
   b. **RESOLUTION:** Adoption of Catastrophic Claims Reserve
   c. **RESOLUTION:** Adoption of Policy Defining Purpose of Rate Stabilization Reserve

10. Report from Governance Structure Committee (7:30) C. Rankin
    a. **MOTION:** Delegate Authority to Governance Structure Committee to Make Final Changes and send Draft 2020 Municipal Cooperative Agreement to Municipalities for Approval

11. Report from Joint Committee (7:40) J. Bower
    a. Resolutions:
        1. **Resolution:** Authorization by the Board of Directors to Remove Benefit Plans from the Consortium's Benefit Plan Offerings
        2. **Resolution:** Approval of Adjustments to the Bronze, Silver, and Gold Metal Level Plans
        3. **Resolution:** Approval of Amendment to Out of Network Subscriber Costs
        4. **Resolution:** Approval of Adding Eyewear and Hearing Aid Benefit to all Metal Level Plans and the Medicare Supplement Plan

12. Report from Owning Your Own Health Committee (7:50) K. Servoss

13. New Business (7:55)

14. Adjournment (8:00)

Next Meeting: August 27, 2020

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Special Meeting
Board of Directors – DRAFT
May 14, 2020 – 6:00 p.m.
Remote by Zoom

Municipal Representatives: 35

Steve Thayer, City of Ithaca
Mack Cook, City of Cortland
Greg Pelicano, Seneca County
Lisa Holmes, Tompkins County
Ed Fairbrother, Town of Big Flats
Mark Witmer, Town of Caroline
Luann King, Town of Cincinnatus
Laura Shawley, Town of Danby
Ellen Woods, Town of Enfield (arrived at 6:20 pm)
Miles McCarty/Nathan Nagel, Village of Freeville
Chuck Rankin, Town of Groton
Kevin Williams, Town of Homer
Donald Fischer, Town of Horseheads
Judy Drake, Town of Ithaca
Charmagne Rumgay, Town of Lansing
Terrance Baxter, Town of Moravia
Christine Laughlin, Town of Newfield (exc. at 7 pm)
Joan Jayne, Town of Niles
Jim Doring, Town of Preble
Gary Mutchler, Town of Scipio
Tom Gray, Town of Sennett
Ray Bunce, Town of Spencer
David Schenck, Town of Springport
Tom Brown, Town of Truxton
Rich Goldman, Town of Ulysses
Peter Salton, Village of Cayuga Heights
Michael Murphy, Village of Dryden
Nancy Niswender, Village of Groton
Donna Dawson, Village of Horseheads
Tanya DiGennaro, Village of Homer
Ronny Hardaway, Village of Lansing
Rordan Hart, Village of Trumansburg
Bud Shattuck, Village of Union Springs
Lonnie Childs, Village of Watkins Glen
John Malenick, Town of Montezuma (arrived at 6:38 pm)

Labor Representatives: 4

Jim Bower, 2nd Labor Representative and Joint Comm. on Plan Structure & Design Chair
Zack Nelson, 3rd Labor Representative
Tim Farrell, 5th Labor Representative
Jeanne Grace, Labor Representative Alternate

Excused: 3

Alex Patterson, Town of Aurelius
Kathrin Servoss, Town of Dryden
Eric Snow, Town of Virgil

Absent: 7

Jason Cole, Lansing Community Library
Tom Adams,Town of Marathon
Richard Nielens, Town of Mentz
Ed Wagner, Town of Owasco
Alvin Doty, Town of Willet
Doug Perine, 4th Labor Representative
Carol Sosnowski 6th Labor Representative

Others in attendance:

Elin Dowd, Executive Director
Rick Snyder, Tompkins County Finance
Steve Locey, Robert Spenard, Locey & Cahill
Corey Prashaw, ProAct
Don Barber, Consultant
Michelle Cocco, Clerk of the Board
Debra Meeker, Admin./Computer Assistant
Beth Miller, Excellus

Call to Order

Ms. Drake, Chair, called the meeting to order at 6:05 p.m. and welcomed new Directors.

Approval of Minutes – December 19, 2019

It was MOVED by Ms. King, seconded by Ms. Jayne, and unanimously adopted by voice vote by members present by video or teleconference, to approve the minutes of December 19, 2019 as submitted. MINUTES APPROVED.

Changes to the Agenda

A resolution entitled Adoption of Policy Regarding Mid-Year Plan Changes was added to the agenda.

Chair's Report

Ms. Drake said there are still outstanding Code of Ethics Conflict of Interest forms and reminded Directors to submit one if they have not yet done so.

Appointments to Claims and Appeals Committee

It was MOVED by Ms. Drake, seconded by Ms. King, and unanimously adopted by voice vote by members present by video or teleconference, to appoint Bud Shattuck, Tom Brown, and Donna Dawson, to the Claims and Appeals Committee with no set terms. MOTION CARRIED.

Appointment to Audit and Finance Committee

It was MOVED by Ms. Drake, seconded by Ms. Niswender, and unanimously adopted by voice vote by members present by video or teleconference, to appoint Jon Munson the Audit and Finance Committee as a Labor representative for a term expiring December 31, 2021. MOTION CARRIED.

Ms. Drake reported a lot of work has taken place in recent months that included several communications with the Department of Financial Services (DFS) on things such as the Municipal Cooperative Agreement, financial filings, changes to LIBOR which relates to investment regulation changes, and preparation of a response to the Business Continuity Plan during the Pandemic.

Ms. Drake reported a communication was received last week from DFS stating they would not continue review of the proposed Municipal Cooperative Agreement because the Consortium's Certificate of Authority says that it can only operate within Tompkins County. She said this was surprising since the Consortium has been operating outside of Tompkins County since 2013 and has submitted financial filings as well revised the 2015 MCA to DFS. The Department was a part of the review of these documents and this has never been raised as an issue until now. She said work is being undertaken at this time to get the Certificate of Authority updated and said the Governance Structure Committee may be reconvened to consider additional language in the MCA that would match the Certificate of Authority.

Mr. Salton said he wasn't aware of the existence of the Certificate of Authority and would like it to be made accessible to Directors. Ms. Dowd clarified that the original Certificate of Authority is a one-page document that states the Consortium has authority to operate in Tompkins County. Mr. Locey said when the original MCA was filed it was clear in the Agreement that the Board had the authority to allow municipalities outside of Tompkins County to join. He believes when the Certificate of Authority was received everyone was under the assumption that it was stipulating that the Consortium was certified and that the base of operations for the Consortium was Tompkins County.

It was never thought that the Consortium was restricted to the borders of Tompkins County because they approved the Municipal Cooperative Agreement that allowed municipalities from outside of Tompkins County to be Participants. Ms. Drake said this will be discussed at both the Executive and Governance Structure Committees.

Executive Committee

RESOLUTION NO. 001-2020 – RATIFYING ACTION OF THE EXECUTIVE COMMITTEE TO WAIVE COST SHARING FOR THE TREATMENT OF COVID-19

Ms. Dowd noted that all mandates have been extended thru the end of July; however, what isn't covered is the cost of treatment. Excellus asked the Consortium to join them and to go beyond the mandate in eliminating any barriers to individuals having to pay. This ratifies what was put into place and the Consortium will continue to respond to mandates. She noted this is only for the member cost share and is only for coverage of treatment after testing and diagnosis.

It was MOVED by Mr. Baxter, seconded by Ms. Loughlin, and unanimously adopted by voice vote by members present by video or teleconference. RESOLUTION ADOPTED.

WHEREAS, On Thursday, April 2nd, the BlueCross BlueShield Association announced that independent and locally operated BlueCross BlueShield plans across the country decided to waive member cost-sharing for the treatment of COVID-19 through May 31, 2020, and

WHEREAS, this waives the member's copayment or cost share for testing, diagnosis and treatment, even if that treatment is delivered in the hospital, and

WHEREAS, it was recommended that it was in the best interest of Consortium to implement these measures effective April 10th to ensure that all members had access to the medical care needed without incurring any out of pocket expense will be helpful in slowing the spread of the virus, and

WHEREAS, due to the urgency in implementation of this waiver was unanimously approved by an electronic poll of the Executive Committee on May 8, 2020, now therefore be it

RESOLVED, That the Board of Directors hereby retroactively ratifies the action of the Executive Committee and approves the retroactive waiving of the member cost-sharing for the treatment of COVID-19 through May 31, 2020.

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Ms. Drake reported the Executive Committee met on May 5th and had discussion of options of lessening the cost burden of members due to COVID-19 and noted many municipalities are furloughing employees. Suggestions include having a premium holiday to looking at the 2021 premium rate increase. No recommendation has been made at this time; both the Executive and Audit and Finance Committees will continue to discuss this at upcoming meetings. Directors were encouraged to submit comments or ideas about this to Ms. Dowd. Ms. Drake reported the Committee also discussed plan design changes that will be presented at the next meeting of the Joint Committee on Plan Structure and Design.

Executive Director's Report

Ms. Dowd welcomed Ms. Cocco back from a medical leave and welcomed Debra Meeker who was recently hired to replace Brittni Griep in the position of Administrative/Computer Assistant. She thanked Tompkins County for allowing Brittni to assist with during the transition. Ms. Dowd provided the Board with a PowerPoint presentation with the following highlights:

- ❑ Waived all copay or co-insurance related fees to COVID-19 care (testing, diagnoses, treatment, etc.) through May 31st, 2020.
- ❑ Waived restrictions on prescription renewal limitations.
- ❑ Waived co-pays on any Telemedicine visits, regardless of diagnosis, through May 31st, 2020.
- ❑ Members with high deductible health plans will not be responsible for copayments, coinsurance and deductibles for COVID-19 related testing even if the deductible has not been met, under guidance from the Internal Revenue Service. This also means that an individual with an HDHP (High Deductible Health Plan) that covers these costs may continue to contribute to a health savings account (HSA).
- ❑ As of the end of April the total spend was $8,200; the average costs per member related to testing was $202.
- ❑ There have been many conversations with municipalities on areas including furloughs and layoffs, mid-year plan changes, 2021 plan movement, and requests for budget relief.
- ❑ 2019 Year-end reporting included: 18% growth in enrollment, $50.7M in revenue - $456,000 in interest income, 93.46% of total expenses to cover claims costs; net income $4.4 million; the Consortium received a clean audit from Insero & Co., and the year-end JURAT was filed.
- ❑ Presentations for municipalities interested in joining are being held by webinar.
- ❑ The ProAct and Excellus Utilization reports will be presented at the June Board meeting

Report from the Operations Committee

Ms. Holmes reported the Committee has three times since the last Board meeting. At those meetings the Committee adopted the Consortium's Cyber Security audit, discussed the Request for Proposals and procurement process and will continue to work on these in addition to developing a crisis management plan, a business continuity plan, and a disaster recovery plan.

RESOLUTION NO. 002-2020 – AMENDMENT TO THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM CODE OF ETHICS AND CONFLICT OF INTEREST POLICY (AMENDS RESOLUTION NOS. 001 OF 2014, 008 OF 2016, AND 016 OF 2018)

MOVED by Mr. Salton, seconded by Ms. King, and unanimously adopted by voice vote by members present by video or teleconference. RESOLUTION ADOPTED.

WHEREAS, on February 27, 2014, the Board of Directors of the Greater Tompkins County Municipal Health Insurance Consortium ("GTCMHIC" or "Consortium") adopted a *Code of Ethics and Conflict of Interest Policy (Resolution No. 001 of 2014),* and

WHEREAS, the New York State Department of Financial Services has recommended that the Consortium implement, as a good business practice, a process whereby board directors, officers, and key employees review and execute annual conflict of interest disclosure and acknowledgement forms, now therefore be it

RESOLVED, on recommendation of the Operations Committee, That the Consortium's *Code of Ethics and Conflict of Interest Policy* dated February 27, 2014 is amended to include the following additional paragraph:

14b. "Any Director or employee who has, will have, or later acquires an interest in any actual or proposed contract, purchase agreement, lease agreement or other agreement, including oral agreements, with the Consortium which he or she is an officer or employee, shall publicly disclose the nature and extent of such interest in writing to the Board Chair and to the governing body thereof

as soon as he or she has knowledge of such actual or prospective interest, including prior to abstaining from a Board vote due to such conflict. Such written disclosure shall be made part of and set forth in the official record of the proceedings of such body."

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RESOLUTION NO. 003-2020 - ADOPTION OF POLICY REGARDING MID-YEAR PLAN CHANGES

MOVED by Ms. Holmes, seconded by Mr. Schenck. Mr. Hart referred to the third Resolved and said while he supports this resolution he believes the technology exists and that the Consortium should be pushing Excellus to port patient information and deductibles over. Since most of the new municipalities coming into the Consortium will be small with very few contracts he thinks Excellus should be able to overcome any technical obstacles that prevent this from happening. Ms. Dowd responded that she will continue to work with Excellus to be able to move deductibles for mid-year plan changes. She said purpose of the resolution is to make sure members are aware that this is a hurdle and are informed of the consequences when moving plans.

In response to Mr. Williams, Ms. Dowd said mid-year changes are being allowed because of negotiated contracts, some village budgets being effective in June, and due to exposure related to COVID-19 a lot of municipalities needed to look at enrollment due to those being laid off or furloughed. She said mid-year plan changes are strongly discouraged; however, there are situations where there are good reasons to do so.

In response to concerns expressed it was MOVED by Mr. Salton, seconded by Mr. Baxter, and unanimously adopted by voice vote by members present, to approve the following amendment: "RESOLVED, further, That the Consortium will negotiate with the Medical Claims Administrator, Excellus, and the Prescription Benefit Manager, ProAct, to be able to migrate specific patient information mid-year." AMENDMENT CARRIED.

The resolution as amended was unanimously adopted by voice vote by members present by video or teleconference. RESOLUTION ADOPTED.

WHEREAS, it has been brought to the attention of the Greater Tompkins County Municipal Health Insurance Consortium ("Consortium") Board of Directors that the Consortium's policies require updating regarding mid-year plan changes which are the result of collective bargaining, municipal board policy, personnel policy, or an individual qualifying for a plan change consistent with IRS 26 CFR §1.125-4 – Permitted Election Changes, and

WHEREAS, the Consortium offers several health insurance benefit plan options which include various Indemnity Plans, various Preferred Provider Organization (PPO) Plans, a Comprehensive Value Plan, and several High Deductible Health Plans (HDHPs), and

WHEREAS, these various health insurance benefit plan choices include a number of different deductible options, out-of-pocket maximum options, and other benefit limit options that are all managed on a calendar year basis, and

WHEREAS, allowing mid-year changes to benefit plans by a Participating Municipality for a collective bargaining group, employee group, and/or retiree group could cause administrative and financial issues for the covered member and/or the Consortium, and

WHEREAS, the Consortium needs to establish a policy and procedure to ensure any plan changes occur in a timely fashion with the least amount of administrative and financial disruption to the Consortium and to the covered member as possible, now therefore be it

RESOLVED, on recommendation of the Operations Committee, That the GTCMHIC hereby adopts a policy requiring all Participating Municipalities in the Consortium to notify the Consortium's Executive Director on or before October 31st each year of any benefit plan changes being made by said Consortium Participant with an effective date of January 1st of the next plan year,

RESOLVED, further, That the Policy also requires GTCMHIC Participants seeking to make mid-year benefit and/or plan changes must provide notice to the Consortium's Executive Director no later than 90-days preceding the effective date of said change or changes,

RESOLVED, further, That due to the complexities associated with migrating specific patient information regarding the covered member's satisfaction of their deductible, out-of-pocket maximum, and/or any specific benefit limitations, the Consortium will not be populating the new benefit plan with any of this data or information,

RESOLVED, further, That the GTCMHIC Board of Directors strongly discourages Participating Municipalities in the Consortium from making mid-year changes involving a group of employees or retirees who are either already in a High Deductible Health Plan (HDHP) or would be moving into a High Deductible Health Plan (HDHP).

RESOLVED, further, That the Consortium will negotiate with the Medical Claims Administrator, Excellus, and the Prescription Benefit Manager, ProAct, to be able to migrate specific patient information mid-year.

RESOLVED, further, That the Consortium Board of Directors strongly recommends that a municipality that migrates to a lessor benefit remain with that decision for two full plan years."

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Financial Report

Mr. Locey reviewed 2019 financial results and noted interest income was well-above budget. Prescription drug rebates were slightly under budget as was premium revenue. Premium revenue was down due to members moving to lower-cost plans and this should be offset by lower claims costs. He said 95.8% of the Consortium's revenue came from premium and approximately 3% of revenue comes from prescription drug rebates. In 2019 claims were significantly below budget which was the result of lower claims cost due to members moving to lower-cost plans, the movement of new municipalities into the Consortium and not having mature claims when they first joined, and there being fewer high cost claims.

Mr. Locey said only 6.5% of the Consortium's budget went towards the payment of all costs to operate the program; this is a very low number for a health insurance plan of this size and demonstrates that the Consortium is operating very efficiently. He said the Consortium had a very good year, approved a very modest increase for 2020, had excess revenue, and is now having discussion of what to do going forward to help take pressure off of municipalities.

Mr. Locey reviewed financial results through March 31st and said the Consortium is close to budget on revenue. In terms of expense the Consortium was already well below budget on both medical and prescription drug claims expense which is largely due to the number of high deductible health plans and members paying deductibles early in the year. He presented information related to the impact of COVID-19 from a claims perspective and stated claims went from averaging $2 million per month to $1.6 million in April; this is due to the number of minor or elective procedures being postponed. Those procedures will be resuming soon, therefore, he expects claims to return to the normal level. This is an area that will be monitored closely. He noted he doesn't expect there to be

a large impact from a claims perspective because many of those impacted by COVID-19 are the elderly population and Medicare A and B is picking up a large part of the expense.

Treasurer's Report

Mr. Snyder reviewed the 2019 annual financial filing (JURAT) and explained how information contained in the filing corresponds to the external audit report. He noted the following: total assets were up 18.5% to $32 million and liabilities were up $1.3 million or 24.6% over 2018. The Consortium's net position increased by $3.5 million to $25,328,000 which shows a healthy growth in the organization. He called attention to a new line being required to be reported of the net investment income in the amount of $348,000 which is the net interest income after paying for the Investment Manager. He commented that due to DFS reporting requirements the total net income was adjusted downward; however, the Consortium's true net income is $4.4 million that is in the audit. Mr. Snyder called attention to the increase in the Consortium's net position being $3,684,253.

Mr. Snyder reviewed the results of the 2019 external audit report prepared by Insero & Co., highlighting the Consortium's growth in reserves and the increase in net position.

Report from the Audit and Finance Committee

RESOLUTION NO. 004-2020 – AMENDMENT TO ADMINISTRATIVE SERVICES AGREEMENT – EXCELLUS BLUE CROSS BLUE SHIELD

MOVED by Mrs. Shawley, seconded by Ms. King. Mr. Cook said this resolution addresses billing and will not have a significant impact on Consortium operations or revenue. It amounts to less than one percent of the budget on an annual basis. The resolution was unanimously adopted by voice vote by members present by video or teleconference. RESOLUTION ADOPTED.

WHEREAS, the Greater Tompkins County Municipal Health Consortium Board of Directors executed an Administrative Services Agreement with Excellus BlueCross BlueShield effective January 1, 2018, and

WHEREAS, the Agreement has been revised with updated and clearer language from the BlueCross BlueShield Association (BCBSA) to better describe the program, and

Whereas, the following outlines modifications to the Agreement:

- a better description of the manner in which Host BlueCard claims are handled;
- a revised description of BlueCard Fees including the Access Fees;
- additional language around Value-Base Payment Programs at Host Plans; and
- a description of what is now called "Global Care", which is the new name for the BCBSA Worldwide program;
- the addition of new language protecting the confidentiality of Home and Host Blue Plan claim pricing information; this requirement also included a new paragraph that the group notify the Consortium if they get acquired by another organization. The purpose of these changes is to protect Blue Plan data due to the recognition of the increasing importance of data to the health care industry; the BCBSA wants to protect confidential and proprietary Blue Plan negotiated rates from inappropriate disclosure, including to competitors;
- new language describing the fact that Excellus may employ new clinical editing-type programs and that any savings associated with the programs will be credited back to the Consortium net of its administrative expenses associated with the program.

WHEREAS, by a majority of affirmative votes received through an electronic poll, the Board of Directors authorized the Chair to sign the amended agreement pending formal approval by the full Board at its next regular meeting, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors affirms the results of an electronic poll authorizing the Chair of the Board to sign the revised Administrative Services Agreement with Excellus BlueCross BlueShield retroactive to January 1, 2020.

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Mr. Cook, Chair, had no further report.

Report from the Governance Structure/MCA Review Committee

Mr. Rankin, Chair, reported the Committee met on January 8th and February 5th and although the Committee finalized the draft MCA there were developments as explained by Ms. Drake earlier in the meeting. A meeting will be scheduled once further information is received from the Department of Financial Services.

Report from the Joint Committee on Plan Structure and Design

Mr. Bower, Chair, reported Committee has been seeking interest in a member to fill the Labor Director seat vacated by Olivia Hersey's retirement. He said one of his goals as the new Committee Chair is to increase labor participation and attendance at meetings and will be updating the contact list for bargaining units. Suggestions being explored include increasing both physical and remote attendance. At the next meeting there will be discussion and a recommendation of adjustments to the Metal Level Plans and adjustments to its bylaws to reflect updated practices and the MCA.

The Committee also received a presentation on the Excellus Utilization Report comparing claims for 2018 to 2019. Highlights from that report included utilization being up by 11% but driven by an increase in enrollment. Total costs increased by 9%; costs per member month went down by 8%, and high claimant costs decreased. Some of the same past trends continued including members utilizing an Emergency Room for low acuity conditions as well as high number of diabetes-related costs. Mr. Bower reported the Committee will be working jointly with the Owning Your Own Health Committee to target a number of issues.

Report from the Owning Your Own Health Committee

Mr. Bower reported on behalf of Kathy Servoss, Chair, and said the Committee has been developing a wellness calendar. They have been working with Excellus to promote specific focus areas for each month such as diabetes awareness, cancer awareness, finding a primary care provider, when to use urgent care versus an emergency department, benefits of flu shots, etc. He reported on participation in the Blue4You clinics that were held in late February through March; one clinic was canceled due to COVID-19 and will be rescheduled.

New Business

There was no new business.

Adjournment

The meeting adjourned at 7:50 p.m.

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RESOLUTION NO. - 2020 – EXTENSION OF EXPANDED COVERAGE TO ALLOW PAID-IN-FULL BENEFITS FOR ANY COVID-RELATED TREATMENT

WHEREAS, at its May 14, 2020 the Consortium expanded coverage to allow paid in full benefits for any COVID-related treatment, for otherwise-covered services, through May 31, 2020, and

WHEREAS, this coverage waived co-pays for inpatient admissions, observation care, skilled nursing, ambulance, home care or any claim for otherwise-covered service that were filed with a diagnosis of confirmed COVID-19, and

WHEREAS, Excellus BCBS has decided to extend this benefit through September 7, 2020 and believes it is in the best interests of our community to implement these measures for their minimum premium, self-funded and Article 47 customers, and

WHEREAS, it is expected that utilization should continue to be low as the care has to be related to COVID-19; therefore, it would be with minimal risk to continue to provide this benefit to make sure all our subscribers have no barriers to care or access to treatment to help slow or stop the pandemic, and

WHEREAS, to the best of our knowledge, there are no New York State or Federal Mandates that obligate the Greater Tompkins County Municipal Health Insurance Consortium to provide these enhanced benefits, and

WHEREAS, the Consortium recognizes that the impending financial crisis is impacting all municipalities in the Consortium and that extending benefits beyond those that have been agreed to and/or collectively bargained but also recognizes Consortium Directors want their subscribers to have the care they need without any barriers for this unusual virus, now therefore be it

RESOLVED, on recommendation of the Executive Committee, That the Board of Directors hereby ratifies the action approved by an electronic poll of the Executive Committee to extend expanded coverage to allow paid in full benefits for any COVID-related treatment, for otherwise-covered services through September 7, 2020.

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RESOLUTION NO. - 2020 – AUTHORIZING EXTENSION OF OFFICE SPACE LEASE AGREEMENT WITH THE TOWN OF ITHACA

WHEREAS, in 2019 the Executive Committee negotiated a lease agreement with The Town of Ithaca for office space, and

WHEREAS, the Consortium's legal counsel reviewed and approved the language contained in the lease agreement, and

WHEREAS, the term of the lease is for one year with the ability to extend annually with all utilities being the responsibility of the landlord, now therefore be it

RESOLVED, on recommendation of the Operations Committee, That the Board of Directors authorizes the Vice Chair to sign said lease agreement with the Town of Ithaca for office space for the period April 1, 2020 thru March 31, 2021.

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RESOLUTION NO. - 2020 – AMENDMENT OF RESOLUTION NO. 003-2014 - ADOPTION OF CONSORTIUM PROCUREMENT POLICY AND REQUEST FOR PROPOSAL GUIDELINES

WHEREAS, in response to a recommendation of the New York State Department of Financial Services the Consortium developed and adopted a policy on April 24, 2014 for the purpose of establishing guidelines for the procurement of goods and services by the Consortium involving an expenditure of funds, and

WHEREAS, the Consortium's Executive Director has reviewed and identified a need to update this policy that addresses the procurement of goods and services with additional guidelines for the development of requests for proposals, now therefore be it

RESOLVED, on recommendation of the Operations Committee, That the Board of Directors hereby amends Resolution No. 003-2014 and adopts the attached amended Greater Tompkins County Municipal Health Insurance Consortium's Procurement Policy and Request for Proposal Guidelines,

RESOLVED, further, That the Policy shall become effective immediately upon adoption by the Board of Directors.

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GTCMHIC Procurement Policy

Adopted _____

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

The Executive Director shall have responsibility for all Consortium purchasing and bidding.

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

It is the policy of the Consortium to provide equal opportunity to all qualified suppliers. The principle of public purchasing is to obtain goods and services equitably through open competition at the least cost to the taxpayer while serving the interest of the Consortium.

Consortium procurement shall operate in full view of all members.

I. METHODS FOR PROCUREMENT

Procurements shall be made according to the parameters set forth in Tables A and B using one of the following methods:

A. Verbal or Written Quotations

Purchases costing up to $3,000 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 $3,000.00 and $9,999.99 require at least two written 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 $10,000.00 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 Executive Committee unless specifically required to be awarded by 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 Executive Committee shall authorize the award and contract for the requested service(s).

The Consortium reserves the right to postpone bid openings for its own convenience and to make changes to the specifications.

Per NYS General Municipal, State and Local laws, the Consortium may award a Bid to a vendor and/or contractor offering the "Best Value" to the Consortium. "Best Value" allows the Consortium to participate in bids let by National Cooperatives and other government agencies that have awarded contracts through this method if it proves to be in the best interest of the Consortium and member taxpayers.

Request for Proposal specifications shall detail the following:

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

Contract shall be awarded to the offeror 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 offeror, 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 cancellation 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 Executive Committee.

III. DOCUMENTATION

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

All bid and proposal responses shall be filed and maintained in accordance with the New York State Records Retention laws.

IV. *GUIDELINES FOR WRITING A REQUEST FOR PROPOSAL ("RFP")*

These guidelines shall be followed with securing a bid through the RFP Process:

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, how (format) and when 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.

V. EMERGENCY PROCUREMENT

In the case of a public emergency, as declared by the Federal, State or Local authorities, and affirmed by the Consortium Executive Committee, goods and services exceeding the bid limits may be procured without competitive bidding.

The Executive Director is hereby authorized to award bids during such a declaration of emergency. Notification of such awards shall be provided in writing to the Executive Committee.

In cases where an emergency exists and a part, repair person and/or services are needed to make equipment operational and can be obtained immediately, the Executive Director or designee(s) should do the vendor research, locate the part or service needed and place the order.

VI. BEST VALUE

All awards may be made to a vendor and/or contractor offering the “Best Value” to the Consortium.

The Executive Committee or their designee will have the final approval when using “Best Value” and determine when its use would be appropriate and which criteria to use.

Award Criteria:

In determining the “Best Value” for the Consortium, the purchase price and whether the goods or services meet specifications are the most important considerations. However, the Executive Director or their designee may consider other relevant factors, including but not limited to:

- Installation costs;
- Life cycle costs;
- Quality and reliability;
- Delivery terms;
- Cost of employee training associated with a purchase;
- Effect of a purchase on productivity;
- Indicators of probable supplier performance under the contract such as past supplier performance, the supplier's financial resources and ability to perform, the supplier's experience or demonstrated capability and responsibility;
- Ability to provide reliable maintenance agreements and support;
- Ability to comply with state, federal, or other requirements linked to funding sources for specific projects including but not limited to MWBE participation, Section 3, Davis-Bacon, previous violation of federal or state labor standards, conflicts of interest, and equal employment opportunity.
- Business Enterprise status (e.g. DBE, MWBE, SDVBE);
- Other factors relevant to determining the best value for the Consortium in the context of a particular purchase, including the status of the vendor as a The Greater Tompkins County Health Insurance Consortium based business.

VII. SOLE SOURCE

Sole Source is an item or service that is available from only ONE source and there is no substantial equivalent or comparable item (s) in existence. An item cannot be created as a Sole Source by developing restrictive specifications. The product/service must have differentiation that makes it unique. The uniqueness must be demonstrably of real importance and benefit in the way the end item/ service is to be used.

In determining the “Sole Source” product/service for the Consortium, a memorandum of support will be created by the Executive Director and kept on file that details each of the following:

- Explain in detail why this product/service is the only one on the market that can satisfy the needs of the Consortium
- Explain why there are no alternatives, or the alternatives are not acceptable.
- Explain why the manufacturer/supplier or goods/service provider are the only available source to obtain the product or service, describing what research has been done to make sure this is truly a sole source.
- Explain why the price for this product/service is considered reasonable.

Table A

Purchasing Policy and Procedure for Procurement of Materials and Supplies	
Purchase Amount	**Purchasing Procedure**
Under $3,000.00 per single item	Executive Director should obtain one (1) to two (2) verbal quotations, but not required. Quotes shall be kept on file.
Between $3,000.00 to $9,999.00 per single item	Executive Director shall obtain at least two (2) written quotations inclusive of all charges. Audit and Finance Committee to review all purchases at regular monthly meetings.
Between $10,000.00 to $19.999.00 per single item	Executive Director shall obtain three (3) written quotations inclusive of all charges.; Copies to be submitted to the Audit and Finance Committee. Audit and Finance Committee to recommend purchase through resolution to Executive Committee.
Over $20,000.00	Competitive sealed bids are required by NYS law for all purchases of any single item costing over $20,000.00 or aggregate purchases over $20,000.00 of any single item or type of items made within the twelve (12) - month period commencing on the date of purchase. The Executive Committee may establish an ad hoc Committee to review RFP specifications and all bids against set criteria. The Executive Director will develop the bid document and solicit bids according to legal requirements. Bid awards to be made by the Audit and Finance Committee or their designee through resolution to be presented at the next Executive Committee or Board of Directors meeting. Emergency purchases and sole source requests must be made in writing to Executive Committee. *Note:* If time allows, two (2) quotes will be obtained for emergency purchases over $10,000.

Table B

Purchasing Policy and Procedure for Procurement of Professional Services (RFP's)	
Purchase Amount	**Purchasing Procedure**
Under $10,000.00 per occurrence annually.	Executive Director shall obtain one (1) to two (2) proposals. Contract is required. Proposals should accompany the contract.
Between $10,000.00 and $19,999.00 per occurrence or annually.	Executive Director shall obtain two (2) proposals. A contract is required. Copies to be submitted to the Audit and Finance Committee. Audit and Finance Committee to recommend purchase through resolution to Executive Committee.
$20,000+ per occurrence or annually	Executive Director shall obtain three (3) written quotations inclusive of all charges. Copies to be submitted to the Audit and Finance Committee. The Executive Committee may establish an ad hoc Committee to review RFP specifications and all bids against set criteria. The Executive Director will develop the bid document and solicit bids according to legal requirements. Bid awards to be made by the Audit and Finance Committee or their designee through resolution to be presented at the next Board of Directors meeting.

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RESOLUTION NO. - 2020 – AUTHORIZE FOR MEDICAL CLAIMS AUDITING SERVICES – BMI MEDICAL CLAIMS AUDITING SERVICES – 2018-2019 CLAIMS

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

WHEREAS, being a self-insured medical plan the Consortium is responsible for the payment of claims as adjudicated by the Third Party Administrator, currently Excellus Blue Cross Blue Shield, and

WHEREAS the Board of Directors believes that it is part of their fiduciary responsibility to conduct periodic medical claims audits to ensure the medical claims are paid by Excellus are in accordance with the benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices, and

WHEREAS, a Request for Proposals for Medical Claims Auditing Services was issued on May 6, 2016 and by Resolution No. 006-2018 contract was awarded to BMI Auditing Services to perform medical claims auditing services for the Consortium for the 2016 Fiscal Year, and

WHEREAS, upon satisfactory completion of the terms of the contract, Resolution No. 006-2018 authorized an extension of the contract, and

WHEREAS, due to the COVID-19 Pandemic, the Executive Director and Consultant have recommended the contract be extended for the purpose of performing an audit of 2018-2019 medical claims, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That a contract for 2018-2019 medical claims auditing services be awarded to BMI for the 2020 Fiscal Year for an amount not to exceed $41,500,

RESOLVED, further, That the Chair of the Board of Directors, Benefit Plan Consultant, and the Executive Director are authorized to finalize terms of the agreement.

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Pending Action by the Audit and Finance Committee 6-23-2020

RESOLUTION NO. - 2020 – ADOPTION OF CATASTROPHIC CLAIMS RESERVE POLICY

WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium ("GTCMHIC") has been issued a Certificate of Authority to operate as a New York State Insurance Law Article 47 Municipal Cooperative Health Benefit Plan, and

WHEREAS, Section 4707(a)(2) of the New York State Insurance Law requires the GTCMHIC to purchase "specific stop-loss coverage with a specific retention amount or attachment point not greater than four percent of the amount certified by a qualified actuary to represent the plan`s expected claims for the current fiscal year", and

WHEREAS, 4% of the GTCMHIC's expected claims for the 2020 Fiscal Year equals approximately $2,048,000 ($51,200,0000 in expected claims x .04), and

WHEREAS, the GTCMHIC Board of Directors issued a Request for Quote (RFQ) to licensed, reputable insurance carriers seeking quotes for specific stop-loss insurance at various deductible levels and with certain required coverage parameters, and

WHEREAS, the GTCMHIC Board of Directors has agreed to purchase specific stop-loss insurance from Excellus BlueCross BlueShield ("Excellus") with a policy period deductible of $1,000,000 for all covered insured members with the exception of one member who has a separate deductible of $1,200,000, and

WHEREAS, the GTCMHIC Board of Directors recognizes the purchasing of specific stop-loss insurance at a $1,000,000 deductible level increases the amount of risk that the Consortium retains as a primarily self-insuring entity, and

WHEREAS, the GTCMHIC maintains a Catastrophic Claims Reserve of $4,500,000 to help cover large dollar claimant expenses, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the GTCMHIC Board of Directors hereby adopts the following policies with respect to the Catastrophic Claims Reserve for the 2020 Fiscal Year:

1. Interest income earned on funds held in the Catastrophic Claims Reserve shall be retained within same, as they are earned.

2. The GTCMHIC Treasurer is directed to, on a quarterly basis and within 60 days of the end of said quarter, transfer from the Catastrophic Claims Reserve to the general

operating fund of the GTCMHIC a dollar amount equal to any claims paid in excess of $500,000 but less than $1,000,000 per member, excepting:

a. The one member identified by Excellus as having a separate deductible of $1,200,000. For this member, funds will be transferred from the Catastrophic Claims Reserve to the general operating fund for any claims incurred above $500,000 but less than $1,200,000.

3. The foregoing provisions apply only to claims incurred between January 1, 2020 and December 31, 2020 and paid between January 1, 2020 and March 31, 2021.

4. This policy shall be reviewed and amended as necessary, on an annual basis in coordination with the GTCMHIC budget process and the purchase of specific stop-loss insurance coverage as required by statute.

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Pending Action by the Audit and Finance Committee 6-23-2020

RESOLUTION NO. -2020 - ADOPTION OF POLICY DEFINING PURPOSE OF RATE STABILIZATION RESERVE

WHEREAS, Resolution No. 019-2014 adopted the 2015 Budget and established a Rate Stabilization Reserve at $1.64 million "to protect the cash flow position of the Consortium should there be a year when claims cost exceed the prediction", and

WHEREAS, Resolution No. 034-2019 increased the funding level for the Rate Stabilization Reserve to 7.5% of expected claims, and

WHEREAS, financial pressures placed on municipalities as a result of the COVID-19 pandemic has resulted in several discussions and a need to adopt a formal policy of the Board defining the purpose of the Rate Stabilization Reserve, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors hereby adopts a policy defining the purpose of the Rate Stabilization Reserve to be to mitigate premium increases.

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RESOLUTION NO. – AUTHORIZATION BY THE BOARD OF DIRECTORS TO REMOVE BENEFIT PLANS FROM THE CONSORTIUM'S MENU BENEFIT PLAN OFFERINGS

WHEREAS, to achieve administrative efficiencies the Consortium wishes to consolidate and streamline its menu of benefit plan offerings, and

WHEREAS, although included in the menu of benefit plan offerings, there are medical and prescription drug plans that are not being utilized by Consortium Participants and have no enrolled Participants, and

WHEREAS, the removal of these plans from the Consortium's menu of benefit plans would create administrative efficiencies and has been recommended by the Consortium's Consultants, now therefore be it

RESOLVED, on recommendation of the Executive Committee and the Joint Committee on Plan Structure and Design, That the following benefit plans be removed from the Consortium's Menu of Benefit Plan Offerings effective January 1, 2021:

1. **Indemnity Plan MM3**
   Plan Description:
   MM3 – Basic Benefits with "Major Medical" $100/$200 Deductible & $750/$2,250 Out-of-Pocket Maximum

2. **Medicare Supplement Plans MS1. MS2. MS5, and MS6**
   Plan Descriptions:
   MS1 - Medicare Supplement Plans with No Prescription Drug Coverage
   MS2 - Medicare Supplement Plans with $5/$15/$30 Rx Copay Plan
   MS5 - Medicare Supplement Plans with 20%/20%/40% Rx Copay Plan
   MS6 - Medicare Supplement Plans with 20%/30%/50% Rx Copay Plan

RESOLVED to restrict the following plans from any new members utilizing them,

1. **Indemnity Plans MM1, MM2, MM5, and MM7**
   Plan Descriptions:
   MM1 – Basic Benefits with "Major Medical" $50/$100 Deductible & $400/$1,200 Out-of-Pocket Maximum
   MM2 – Basic Benefits with "Major Medical" $100/$200 Deductible & $200/$400 Out-of-Pocket Maximum
   MM5 – Basic Benefits with "Major Medical" $100/$300 Deductible & $400/$1,200 Out-of-Pocket Maximum
   MM7 – Basic Benefits with "Major Medical" $50/$150 Deductible & $400/$1,200 Out-of-Pocket Maximum

2. **PPO Plans PPO1, PPO2, PPO3, and PPOT**
   PPO1 - $10 PPO with $1,000/$3,000 Out-of-Pocket Maximum and $250/$750 Out-of-Network Deductible
   PPO2 - $15 PPO with $1,500/$4,500 Out-of-Pocket Maximum and $500/$1,500 Out-of-Network Deductible
   PPO3 - $20 PPO with $2,000/$6,000 Out-of-Pocket Maximum and $750/$2,250 Out-of-Network Deductible
   PPOT - $10 PPO with $1,000/$3,000 Out-of-Pocket Maximum ("Teamsters Lookalike Plan")

3. **Comprehensive Value Plan MM6**
   MM6 – Comprehensive Plan with $500/$1,500 Deductible & $2,500/$7,500 Out-of-Pocket Maximum

4. **2-Tier Rx Plans 2T1, 2T2, and 2T3**
   2T1 – 2-Tier Rx Plan with $1/$1 generic/brand retail copays and $0/$0 generic/brand mail-order copays
   2T1 – 2-Tier Rx Plan with $2/$5 generic/brand retail copays and $0/$0 generic/brand mail-order copays
   2T1 – 2-Tier Rx Plan with $2/$10 generic/brand retail copays and $0/$0 generic/brand mail-order copays

5. **3-Tier Rx Plans 3T3, 3T5a, 3T6, 3T7, 3T9, 3T10, 3T11, and 3T13**
   3T3 – 3-Tier Rx Plan with $5/$10/$25 Tier 1/2/3 retail copays and mail-order copays at 2x retail
   3T5a – 3-Tier Rx Plan with $5/$15/$30 Tier 1/2/3 retail copays and mail-order copays at 1x retail
   3T6 – 3-Tier Rx Plan with $5/$15/$30 Tier 1/2/3 retail copays and mail-order copays at 2x retail
   3T7 – 3-Tier Rx Plan with $5/$20/$35 Tier 1/2/3 retail copays and mail-order copays at 2x retail
   3T9 – 3-Tier Rx Plan with $10/$25/$40 Tier 1/2/3 retail copays and mail-order copays at 2x retail
   3T10 – 3-Tier Rx Plan with $15/$30/$45 Tier 1/2/3 retail copays and mail-order copays at 2x retail
   3T11 – 3-Tier Rx Plan with 20%/20%/40% Tier 1/2/3 retail and 15%/15%/40% mail-order copays
   3T13 – 3-Tier Rx Plan with 20%/30%/50% Tier 1/2/3 retail and 20%/30%/50% mail-order copays

RESOLVED, further, That the Board of Directors shall take action to consider eliminating any of these plans from its menu of offerings once the membership drops to zero (0) enrollment and the plan is no longer being offered to active employees or retirees.

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RESOLUTION NO. – APPROVAL OF ADJUSTMENTS TO THE BRONZE, SILVER, AND GOLD METAL LEVEL PLANS

WHEREAS, the Consortium must annually review the actuarial values for its Metal Level Plans to ensure they each fall within the established ranges set by the Centers for Medicare and Medicaid Services (CMS), and

WHEREAS, upon entering data into the federal actuarial calculator for 2021 it has been determined that adjustments need to be made to the Bronze, Silver, and Gold Metal Level Plans, now therefore be it

RESOLVED, on recommendation of the Executive Committee and the Joint Committee on Plan Structure and Design, That effective January 1, 2021 a benefit plan adjustment to the Minimum Deductible/Out-of-Pocket Maximum will be made to the Consortium's Bronze, Silver, and Gold Metal Level Plans as follows:

Gold	**From** In-Network	To In-Network	**From** Out-of-Network	**To** Out-of-Network
Deductible Single/Family	$1400/$2800	$1500/$3000	$2800/$5600	$3000/$6000
Out-of-Pocket Single/Family	$3000/$6000	$3500/$7000	$6000/$12,000	$7000/$14,000
Actuarial Value	82.95%	81.77%		
Silver				
Deductible Single/Family	$2200/$4400	$2500/$5000	$4400/$8800	$5000/$10,000
Out-of-Pocket Single/Family	$6000/$12,000	$6000/$12000	$12,000/$24,000	$12,000/$24,000
Actuarial Value	72.69%	71.75%		
Bronze				
Deductible Single/Family	$6550/$13,100	$7000/$14,000	$13,100/$26,200	$14,000/$28,000
Out-of-Pocket Single/Family	$6550/$13,100	$7000/$14,000	$13,100/$26,200	$14,000/$28,000
Actuarial Value	65.64%	64.6%		

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RESOLUTION NO. – ADJUSTMENTS TO THE OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS ASSOCIATED WITH THE CONSORTIUM'S PLATINUM PPO PLAN, GOLD HDHP, SILVER HDHP, AND BRONZE HDHP

WHEREAS, the Consortium's Metal Plans (Platinum Preferred Provider Organization ("PPO") Plan, Gold High Deductible Health Plan ("HDHP"), Silver HDHP, and Bronze HDHP) all include various levels of member cost sharing in the form of deductibles, copayments, and/or coinsurance amounts, and

WHEREAS, these plans currently utilize a network of medical care providers, facilities, and pharmacies who have agreements in place with Excellus BlueCross BlueShield, other BlueCross BlueShield Plans, and ProAct, Inc. to provide services to the Consortium's covered members on an "in-network" basis at a discounted allowable amount, and

WHEREAS, the Consortium's Metal Plans each include an out-of-pocket maximum or cap on the collective amount of deductibles, copayments, and/or coinsurance amounts a covered member and/or a family of covered members would have to pay for claims incurred in a given plan year, and

WHEREAS, the Consortium's Metal Plans currently have separate and distinct deductible and out-of-pocket maximum amounts for services rendered by "in-network" and "out-of-network" medical care providers, facilities, and pharmacies, and

WHEREAS, the current (2020 Plan Year) deductibles and out-of-pocket maximums associated with the Consortium's Metal Level Plans for services rendered by non-network or "out-of-network" medical care providers, facilities, and/or pharmacies is twice as much as the applicable deductibles associated with the Consortium's GOLD HDHP, Silver HDHP, and Bronze HDHP and out-of-pocket maximums associated with the Consortium's Platinum PPO Plan, Gold HDHP, Silver HDHP, and Bronze HDHP (see below), and

GTCMHIC Metal Level Plan Name		Deductible		Out-of-Pocket Maximum	
		Individual	Family	Individual	Family
Platinum PPO Plan	In-Network (Medical and Rx)	n/a	n/a	$2,000.00	$6,000.00
	Out-of-Network (Medical Only)	$500.00	$1,500.00	$4,000.00	$12,000.00
Gold HDHP	In-Network (Medical and Rx)	$1,400.00	$2,800.00	$3,000.00	$6,000.00
	Out-of-Network (Medical Only)	$2,800.00	$5,600.00	$6,000.00	$12,000.00
Silver HDHP	In-Network (Medical and Rx)	$2,200.00	$4,400.00	$6,000.00	$12,000.00
	Out-of-Network (Medical Only)	$4,400.00	$8,800.00	$12,000.00	$24,000.00
Bronze HDHP	In-Network (Medical and Rx)	$6,550.00	$13,100.00	$6,550.00	$13,100.00
	Out-of-Network (Medical Only)	$13,100.00	$26,200.00	$13,100.00	$26,200.00

RESOLUTION NO. – ADJUSTMENTS TO THE OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS ASSOCIATED WITH THE CONSORTIUM'S PLATINUM PPO PLAN, GOLD HDHP, SILVER HDHP, AND BRONZE HDHP

WHEREAS, the Consortium's Metal Plans benefit design which encourages the use of "in-network" medical care providers, facilities, and pharmacies by limiting the member's out-of-pocket costs has produced positive results with the 2019 Excellus Medical Claims Utilization Report showing the Consortium saved approximately $37.7 million through the use of "in-network" medical care providers and facilities and that the Consortium only paid out $897,396 in "out-of-network" medical care costs in 2019 which was a very modest 1.75% of the total medical claims paid during the year, and

WHEREAS, the typical reasons subscribers choose "out-of-network" medical care providers and/or facilities are the lack of choice in a given specialty area, hospitals having non-participating specialist scheduled during multi-discipline procedures, economics associated with covered members having to travel longer distances to find a participating provider (for example no dialysis provider in Tompkins County), and perceived quality and/or skill differences, especially mental health services, but also in newly developing specialized procedures, and

WHEREAS, that even with the above data demonstrating that Consortium covered members are using "in-network" medical care providers, facilities, and pharmacies for the vast majority of their medical care needs that the cost of using "out-of-network" medical care providers and facilities can add a significant financial burden to the member's out-of-pocket costs, and

WHEREAS, Excellus BlueCross BlueShield encourages the Consortium to use financial incentives to drive care to "in- network" medical care providers, facilities, and pharmacies through the use of a minimum 50% differential for "in-network" and "out-of-network" deductibles and out-of-pocket maximums to ensure the Consortium maintains substantive "in-network" provider discounts, now therefore be it

RESOLVED, the Joint Committee on Plan Structure and Design recommends the Board of Directors adopt the following 2021 deductible and out-of-pocket maximum schedule for the Consortium's Platinum PPO Plan, Gold HDHP, Silver HDHP, and Bronze HDHP:

GTCMHIC Metal Level Plan Name		Deductible		Out-of-Pocket Maximum	
		Individual	Family	Individual	Family
Platinum PPO Plan	In-Network (Medical and Rx)	n/a	n/a	$2,000.00	$6,000.00
	Out-of-Network (Medical Only)	$500.00	$1,500.00	$3,000.00	$9,000.00
Gold HDHP	In-Network (Medical and Rx)	$1,500.00	$3,000.00	$3,500.00	$7,000.00
	Out-of-Network (Medical Only)	$2,250.00	$4,500.00	$5,250.00	$10,500.00
Silver HDHP	In-Network (Medical and Rx)	$2,500.00	$5,000.00	$6,000.00	$12,000.00
	Out-of-Network (Medical Only)	$3,750.00	$7,500.00	$9,000.00	$18,000.00
Bronze HDHP	In-Network (Medical and Rx)	$7,000.00	$14,000.00	$7,000.00	$14,000.00
	Out-of-Network (Medical Only)	$10,500.00	$21,000.00	$10,500.00	$21,000.00

RESOLVED, further, That the Joint Committee on Plan Structure and Design directs our Executive Director to secure an underwriting analysis to show the impact of these changes on claims cost which the Board should consider in establishing 2021 premiums for the Platinum, Gold, Silver, and Bronze plans.

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RESOLUTION NO. – AMENDMENT OF ALL METAL LEVEL AND MEDICARE SUPPLEMENT CONSORTIUM PLANS TO INCLUDE VISION AND HEARING BENEFITS

WHEREAS, only the Consortium's old-style PPO plans have a vision benefit "$60 Reimbursement every year Includes Frames/Lenses or Contact Lenses", the other plans from the Consortium menu do not have an eyewear benefit, and

WHEREAS, none of the of the Consortium plans have a hearing aid benefit, and

WHEREAS, the average age of Consortium subscribers is 53.4 years old, and

WHEREAS, Excellus' PPO plans have a hearing aid benefit that reads; "In- network - covered at 50% for a single purchase once every 3 years, Out-of-network - covered at 50%, subject to the deductible for a single purchase once every 3 years", and

WHEREAS, the Consortium's Benefit Plan Consultant has reported that the additional premium cost for both eyewear and hearing aid benefit is $3 single and $7 family per member per month, now therefore be it

RESOLVED, on recommendation of the Joint Committee on Plan Structure and Design, That the Board of Directors includes the following benefit in the Bronze, Silver, Gold, and Platinum Metal Level Plans and the Medicare Supplement plan:

- Hearing Aids: "In- network - covered at 50% for a single purchase once every 3 years, Out-of-network - covered at 50%, subject to the deductible for a single purchase once every 3 years", and
- Eyewear: "Covered at $60 Reimbursement every year Includes Frames/Lenses or Contact Lenses"

RESOLVED, further, That Executive Director is directed to secure an underwriting analysis to show the impact of these changes on claims cost which the Board should consider in establishing 2021 premiums for the Platinum, Gold, Silver, Bronze and Medicare Supplement plans.

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