Greater Tompkins County Municipal Health Insurance Consortium

Audit and Finance Committee

Agenda

July 24, 2018 – 3:30 p.m.

Old Jail Conference Room

1. Call to Order (3:30) — M. Cook

2. Changes to Agenda (3:30)

3. Approve Minutes of June 24, 2018 (3:32)

4. Executive Director's Report (3:35) — D. Barber
   a. DFS Communications
   b. Other Committees Activities – Operations Audit
   c. Investment Management Services Review Committee status report
   d. Potential members
      1. **Resolution No.** – Acceptance of Application by the Town of Big Flats to Become a Participant in the Greater Tompkins County Municipal Health Insurance Consortium
      2. **Resolution No.** – Acceptance of Application by the Village of Freeville to Become a Participant in the Greater Tompkins County Municipal Health Insurance Consortium
   e. Captive Layer for Stop-Loss

5. Financial Update (4:00) — S. Locey
   a. 2019 Budget

6. REVISIT: **RESOLUTION:** Approval of Amendment to Conflict of Interest Policy (4:10) — D. Barber

7. Analysis of claims costs by demographics and the impact of exclusion of a population from the Consortium (4:15) — S. Locey

8. Discussion of potential smaller size applicants- number of plans (4:35) — D. Barber

9. Next Agenda Items: (4:55)

10. Adjourn (5:00)

Next Meeting: August 28, 2018

Audit and Finance Committee
June 26, 2018 – 3:30 p.m. - draft
Old Jail Conference Room

Present: Mack Cook, Steve Thayer, Peter Salton, Bud Shattuck, Laura Shawley (arrived at 3:35 p.m.), Chuck Rankin, Rordan Hart, Olivia Hersey
Excused: Ann Rider,
Guests: Judy Drake, Board of Directors Chair; Don Barber, Executive Director; Judy Taber, Locey & Cahill (via conference call); Rick Snyder, Treasurer

Call to Order

Mr. Cook, Chair, called the meeting to order at 3:30 p.m.

Changes to the Agenda

The following resolutions were added to the agenda:

- Authorizing Chairperson of the Board to Sign the Municipal Health Financing Cooperative Intermunicipal Agreement
- Authorizing Acceptance of Application by the Village of Horseheads to Become a Participant in the Greater Tompkins County Municipal Health Insurance Consortium

Approval of Minutes of May 22, 2018

It was MOVED by Mr. Shattuck, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present with Mr. Salton abstaining, to approve the minutes of May 22, 2018 as corrected. MINUTES APPROVED.

Executive Director's Report

Department of Financial Services Communication (DFS)

Mr. Barber said he hasn't heard from DFS this month; however, there are two items outstanding. The first relates to the Conflict of Interest Policy and the other is acknowledgement by the Board of Directors that they have received the Audit Examination report.

Other Committees

He reported the Online Enrollment e-mail has gone out to all employers requesting them to respond whether they or the Consortium will do their online enrollment.

Mrs. Shawley arrived at this time.

He reported on the Investment Management RFP status and said 19 firms inquired about it and six submitted responses. He provided a spreadsheet containing an overview of each responder. The Review Committee will meet in a few weeks and will be discussing a variety of options.

Potential Members

Mr. Barber reported on the status of potential members:

Village of Horseheads – ready to be accepted (30 covered lives)
Town of Big Flats – very interested and has submitted all documents (30 covered lives)
Village of Freeville – very interested and has submitted all documents (30 covered lives)
Village of Lansing – very interested and likely to adopt a resolution this month
Town of Sennet - plan comparisons have been sent
Town of Horseheads – plan comparisons have been sent

Seneca County – Mr. Barber has met with them and they are very interested; more information will be known after a meeting they are having with three unions

Currently, there is a total of 31 municipalities in the Consortium.

New York State Legislation

Mr. Barber reported on Legislation being proposed by State to change the definition of the groups that can join the Consortium. In the proposed legislation the term "District" in an Article 47 would include Urban Renewal agencies, public libraries, and other quasi government agencies receiving at least 50% of funding from a general purpose local government. The Legislation passed the NYS Senate but has not been considered by the Assembly.

Mr. Barber said the Stop-Loss carrier underwrites each partner as if they were not in MHFC (Municipal Healthcare Financing Cooperative) to determine annual Stop-Loss premium. Under the terms of the Stop-Loss agreements, a portion (~65%) of the Stop-Loss premiums collected is ceded to a Captive Manager. The ceded premium then varies by underwriting factors, including deductible and claims experience. Any partners' subscriber claim invoice, which exceed the partner's specific deductible, would be sent to the Stop-Loss carrier by its Claims Administrator who would send an invoice to the Captive Manager for claims expense in that captive layer. This proceeds until the end of the year (July of following year to allow IBNR to run-out). At that point, any excess funds held by the Captive Manager would be returned to the partners on a pro-rata share of premiums paid.

As a condition to having access to the return of premium, the partners are each required to post in a letter of credit equal to 20% of the annual premium. For the Consortium's instance this would be roughly $100,000 against its Catastrophic Claims Reserve which is currently $2,000,000. Should total claims expense of that year, from all partners, in the Captive layer exceed total ceded premium, there will be a call by the Captive Manager for each partner, on a pro-rata basis, for all or a portion of their collateral. (In the event of a call, the collateral will need to be fully funded for the next annual cycle.) Should captive claims expense exceed premiums and posted collateral, the Stop-Loss carrier pays 100% of all claims expense going forward in that year.

Mr. Barber said a resolution from each municipal partner that intends to join has been requested which will allow them to move forward with getting a structure in place. He noted signing the Intermunicipal Agreement does not commit the Consortium to anything other than attending meetings and helping to direct how the HFC is constructed. The Consortium would have to take another action in the Fall and every year thereafter to participate.

Resolution No. - Authorizing Chairperson of the Board to sign the Municipal Healthcare Financing Cooperative Inter-Municipal Agreement

MOVED by Mr. Salton, seconded by Ms. Hersey, and unanimously adopted by voice vote by members present.

WHEREAS, since inception the Consortium has paid $4.2 million in Stop-Loss premium which has paid $2.1 million of claims expense above the Consortium deductible, and

WHEREAS, $1.1 million of the Stop-Loss claims spend was in 2012, which demonstrates why Stop-Loss insurance is critical, and the other six years total $1 million of Stop-Loss claims expense, and

WHEREAS, creating a self-funded captive layer above the specific deductible will allow the Consortium recoup premium expense in years of low Stop-Loss claims expense, and

WHEREAS, the New York State Association of Counties (NYSAC) has identified four to seven self-funded consortiums and counties that are willing to pursue the captive layer model for 2019, and

WHEREAS, this group of interested partners need to know, by Board resolution authorizing the signing of the Inter-Municipal Agreement (IMA), which municipalities are willing to commit to the process of sharing data, developing bylaws, and agreements with a Stop-Loss carrier, consultant, and Captive Manager to create a Municipal Healthcare Financing Cooperative (MHFC), and

WHEREAS, there are no anticipated costs for forming MHFC, and
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WHEREAS, the act of signing the IMA is a commitment to be a partner in the creation of the MHFC and is not a commitment to enter into the captive, now therefore be it

RESOLVED, That the Audit and Finance Committee recommends That the Board of Directors authorize its Chairperson to sign the attached Inter-Municipal Agreement.

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Invoices

The following invoices were presented for information only:

Photography (Michael Grace-Martin) – June 7, 2018	$ 250
Hancock Estabrook – June 8, 2018	$2,532.50

It was MOVED by Mr. Cook, seconded by Mr. Shattuck, and unanimously adopted by voice vote to approve payment of an invoice for Bonadio & Co., LLP dated May 31, 2018 in the amount of $4,316.25. MOTION CARRED.

Mr, Barber said at a recent NYSAC meeting he learned that Green Mountain has been taken out and Berkley will be managing the captive layer. There previously was discussion about the protected cell model where each partner would have their own protected cell and although purchasing insurance through the captive layer collectively, they would keep their own accountant. The new model has a segregated account with all partners separated out but treated as one community. He said three contracts will be coming forward: Stop Loss policy with Berkley, a reinsurance agreement between Berkley and the captive, and an intermunicipal agreement between partners. When those are received he will forward them to Mr. Locey, Mr. Powers, and the Committee.

Ms. Rider arrived at this time.

Financial Report

Ms. Taber reviewed items contained in a financial update Mr. Locey provided to the Committee and said the budget is in relatively good shape. Claims costs for the month of May were slightly higher than expected; however, at this point it doesn't cause alarm because there is a trend for claims being higher in the month of May.

Mr. Barber referred to assumptions contained at the bottom of the budget projection spreadsheet showing the medical paid claims trend now being 5.5% and prescription drug at 8.5%; last year the numbers were 7.5% for medical and 9.5% for prescription drug. He asked

what the reason is for the drop in these numbers. He also noted Aggregate Stop Loss can be removed from the spreadsheet.

Mr. Barber noted the report now reflects drug rebates in the amount of almost $500,000 that have come in since the last meeting. He said Mr. Locey provided a large loss report showing to date in 2018 there have been seven claimants with claims above $100,000.

In response to a question by Ms. Drake as to whether the budget includes BMI audit fees and the Wellness Consultant, Mr. Snyder said BMI is included in the audit line. Mr. Locey will be asked to elaborate on assumptions 4 (claims trends) and 8 (Aggregate Stop Loss), and the makeup of the auditing and consulting fees.

RESOLUTION NO. - 2018 – AUTHORIZE EXTENSION OF CONTRACT FOR MEDICAL CLAIMS AUDITING SERVICES – BMI MEDICAL CLAIMS AUDITING SERVICES

MOVED by Ms. Hersey, seconded by Mr. Thayer.

Mr. Barber said Mr. Locey is recommending the resolution contain a "not to exceed" amount and that BMI increase the number of claims audited increase from 200 that were done in the last audit; Mr. Barber suggested 250 and also noted the last contract with BMI for the claims audit was $46,500. Ms. Taber said since this would be the third audit BMI will do of medical claims Mr. Locey thinks it will require far less time to conduct the audit and the process. Changes to the last Resolved and an additional Resolved were accepted as friendly amendments to the resolution based on these recommendations.

The resolution was unanimously adopted by voice vote by members present.

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. 014-2014 a 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. 014-2014 authorized an extension of the contract for 2018 Fiscal Year, and

WHEREAS, the Executive Director and Consultant have recommended the contract be extended for the purpose of performing an audit of 2016-2017 medical claims, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That a contract for 2016-2017 medical claims auditing services with a minimum sampling size of 250 be awarded to BMI for the 2018 Fiscal Year for an amount not to exceed $42,500,

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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RESOLUTION NO. – 2018 – APPROVAL OF ADJUSTMENTS TO THE SILVER METAL LEVEL PLAN

MOVED by Mr. Salton, seconded by Mrs. Shawley.

Ms. Hersey explained this resolution approves changes in deductible levels for the Silver Metal Level Plan to bring it in-line with the required actuarial value range. The Joint Committee on Plan Structure and Design spend a good amount of time discussing this and coming up with a recommendation that would not require the plan to be changed next year. She said they also received feedback from the municipalities that offer this plan.

The resolution was unanimously adopted by voice vote by members present.

WHEREAS, data entered into the federal actuarial calculator indicates the Consortium's Silver Plan's actuarial value for 2019 will be 72.64% which exceeds the Plan's limit of 72%, and

WHEREAS, the three Participating Consortium employers enrolled in the Silver Metal Level Plan have been participating in the deliberations of benefit changes to their Plan, and

WHEREAS, Silver Metal Level Plan benefit plan adjustment to increase the in-network deductible for single from $1,800 to $2,200 and family coverage from $3,600 to $4,400 has a 2019 actuarial value of 71.11%, now therefore be it

RESOLVED, on recommendation of the Joint Committee on Plan Structure and Design and the Audit and Finance Committee, That the Board of Directors approves an adjustment to the Silver Metal Level Plan to increase the in-network deductible for single from $1,800 to $2,200 and family coverage from $3,600 to $4,400 and to increase the Out-of-Network deductible for single from $3,600 to $4,400 and family coverage from $7,200 to $8,800, effective January 1, 2019.

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RESOLUTION NO. – 2018 – RESOLUTION OF THE BOARD OF DIRECTORS OF THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM – AMENDMENT TO CONFLICT OF INTEREST POLICY

Mr. Barber said this resolution came up as a result of the Examination Report from DFS. It adds new language that requires Directors and Officers to annually complete a Conflict of Interest Disclosure. During discussion of the resolution concerns were raised over several sections of the resolution and form. Questions were raised as to:

- How someone could be required to complete the form Prior to an election, appointment or employment to serve on the Board;

- The question on the form “Are you, or to your knowledge is any relative, a member of the Board of Directors, an officer, key employee, or consultant to, or have any other interest in any other business entity other than the Consortium?”
- Who will review completed forms.

It was stated that although the proposed form is similar to the County’s there are differences. Ms. Drake said she believes the form proposed originated with John Powers, the Consortium’s legal counsel. Mr. Barber said he would look into where the proposed form originated.

It was MOVED by Mr. Salton, seconded by Ms. Hersey, and unanimously adopted by voice vote by members present, to Table the resolution to the next meeting. MOTION TO TABLE CARRIED. Mr. Cook will request the resolution be withdrawn at the June 28, 2018 Board of Directors meeting.

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 Audit and Finance 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 "17" and appended Exhibit “A”:

"17. Prior to the election, appointment or employment of individuals to serve as an officer, director or key employee of the Consortium, and each successive year thereafter, such officer, director and key employee shall complete and execute a Disclosure and Acknowledgment Form, substantially consistent to the form attached hereto as Exhibit "A" or as modified from time to time thereafter. Such completed forms shall be kept as organizational records of the Consortium. For purposes of this policy, (i) the terms "officer" and "director" shall have the same meaning as set forth in the Municipal Cooperative Agreement, dated October 1, 2010; and (ii) the term "key employee" shall mean any employee of the Consortium with executive or managerial capacity."

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RESOLUTION NO. - 2018 - ACCEPTANCE OF APPLICATION BY THE VILLAGE OF HORSEHEADS TO BECOME A PARTICIPANT IN THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

MOVED by Mr. Rankin, seconded by Ms. Hersey, and unanimously adopted by voice vote by members present. It was noted that

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

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

WHEREAS, the Village of Horseheads has complied with membership process outlined in Resolution No. 005 of 2012 and amended by Resolution No. 027 of 2014 and has submitted copies of financial reports which have been reviewed and found acceptable by the Consortium's Treasurer, Chief Financial Officer and/or the Consortium's Auditor, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee of the Greater Tompkins County Municipal Health Insurance Consortium, That the Board of Directors hereby accepts and welcomes the Village of Horseheads as the 32nd municipal participant, with health insurance coverage beginning January 1, 2019.

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Non-compliance with MCA Requirement of all Contracts

Ms. Taber said the Municipal Cooperative Agreement states that participation in plans by some but not the whole of the bargaining units or employee groups of a Participant is not encouraged and shall not be permitted absent prior Board approval. As more and more groups are seeking to consider the Consortium as the option for their health insurance this becomes an important issue to the Consortium in that the Consortium doesn't want to have groups providing it with adverse risk. She said Mr. Locey provided the Committee with a report showing the average costs based on different age bands for the purpose of showing how it is possible for a group to offer incentives to certain groups not to participate in the overall Consortium because they are low risk and might benefit from cheaper premiums elsewhere, leaving the Consortium with the risk that could add additional costs to premiums for everyone.

Ms. Taber said there are groups that might take their Medicare-age population and offer them a Medicare Advantage plan rather than join the Consortium and participate in one of its plans. Mr. Cook said if the Consortium moves forward with a policy it is important to remember that the 65 or older employees whether working or not are very important to the Consortium's financial make-up because of the subsidy. He said the Consortium should be very cautious about groups that do not want to bring retirees in with them.

Mr. Cook asked for comments from the Committee on whether a policy on this should be established. It was noted that there currently are a few groups that were not brought in and there would need to be a discussion of how to address those. Ms. Drake suggested the Consortium follow the MCA and referred to the resolution accepting the Town of Owasco that specifically stated they did not have to bring their retirees. She said this should either be done when they are accepted, or the Consortium could accept a municipality but make an assessment for the employees who are brought on because they did not bring their retirees or a bargaining unit.

Mr. Snyder said he would like to know if Mr. Locey is aware of any other groups imposing a risk assessment charge. Mr. Salton said he would like to see information on the different types of groups (collective bargaining groups, etc.) this could apply to and demographics,

Mr. Barber said Mr. Locey has suggested that all municipal partners be asked to provide information on what contracts they have they are not covered by the Consortium.

It was the consensus of the Committee that this should be explored further. Ms. Drake said it is important that this be addressed soon as there are many groups looking at the Consortium of which some are counties. She added that if a decision is made to assess a fee there will also need to be time spent developing what that fee would be. Mr. Cook noted that the Consortium has a limited number of lives but a large number of employers and one major new participant has the ability of moving the risk profile.

The Committee felt it would be helpful to do a survey of existing municipalities in the Consortium to find out what groups they have and what their health insurance cost arrangement is with employees and retirees. Mr. Barber was asked to develop a survey. This will continue to be discussed at the next meeting.

Unfinished Business

There was no unfinished business.

Next Agenda Items

The following items will be included on the next agenda:

- Conflict of Interest Resolution
- Analysis of claims and costs by demographic groups and exclusion of a population from the Consortium;
- Resolutions to accept new members;
- 2019 Budget;
- The number of plans an employer can offer;
- Update on the Investment Management Services contract
- 1094 and 1095 (September agenda)

Adjournment

The meeting adjourned a 5:24 p.m.

Segal Consulting

333 West 34th Street New York, NY 10001-2402
T 212.251.5000 www.segalco.com

MEMORANDUM

To: Don Barber, Executive Director – Greater Tompkins Health Insurance Consortium

From: Lawrence Singer
Miriann Yoo

Date: May 11, 2018

Re: Administrative Review Proposal - Project Outline

We are pleased to submit a proposal to perform an administrative review of the Greater Tompkins Health Insurance Consortium's operations, and the various roles and responsibilities of its contracted Plan administrators.

An administrative review is a high level review of the Plan designed to provide the Plan's Board of Directors a sense of the Plan's current state. The review will evaluate the Plan's major processes and operating procedures as compared to industry standards. The review will also identify any service gaps or redundancies between the Plan, the Plan's service providers, and participating employers.

The review's objective is to determine the efficiency of operations and the ability of the Consortium, in its current state, to effectively deliver benefit services. Our specific evaluation will focus on what we consider the two primary areas of benefit plan administration:

> Business processes – The current work processes and procedures required to administer the Plan's benefits on a day to day basis.
>
> Technology – The technology infrastructure, including computer applications and other online tools used for data collection, retention and reporting, as well as electronic data and email security.

We understand that the Consortium utilizes the following vendors to administer the Plan:

Excellus Blue Cross & Blue Shield – medical claims administration and eligibility, enrollment and billing services.

Pro-Act – pharmacy benefits manager.

Scope

For this project, our Administration and Technology Consulting (ATC) practice will perform the following:

1) **Contract Review:** A review of the administrative services agreement (ASA) with Excellus, to:

   a) Identify all contracted services, responsibilities, and key operational tasks to ensure that roles and responsibilities are expressly identified and defined, and most importantly carried out by the responsible party;

   b) Determine how well is Excellus delivering these services and performing their responsibilities;

   c) Identify performance standards and guarantees, and how the vendor is measuring and reporting on their actual performance;

   d) Analyze Excellus reporting:
      - type of management reports available
      - level of review conducted
      - reports submitted to the Consortium; and

   e) Provide the Consortium with observations and recommendations for improvements.

   This study will not include a review of the Plan's PBM (Pro-Act) pricing terms or clinical and care management programs, which is being addressed in a separate project outline led by our Pharmacy Benefits Consulting Team or a review of the Plan's stop-loss arrangement which is being addressed in a separate project outline led by our Stop-Loss Consulting Team. Nor will this study include a review of the Plan's rate development and financial situation or its Compliance status, both of which can be addressed in separate studies id desired by the Board of Directors.

2) **Review of Roles and Interactions between the Executive Director, Vendors and Participating Employers:**

   a) Review how Excellus and Pro-Act relate to each other and their data transfer system/arrangement

   b) Review how the Executive Director and Plan Benefit Consultant relate to participating employers;

   c) Provide the Consortium with our observations and recommendations for improvements.

3) **Internal Operations:** Review the Consortium's internal administrative operations to evaluate:

   a) Data handling efficiency and security

   b) Reporting procedures and Data Analysis

   c) Current us of technology

   d) Financial Operating Ratios Review

e) Provide the Consortium with observations and recommendations for improvements.

Process and Deliverables:

Our process will generally include the following activities:

Segal will request and review copies of all existing vendor agreements. Other items to be reviewed would include:

A current copy of the Plan Document (and/or similar document(s) describing the Plan's benefits); we will access the Plan's website (http://healthconsortium.net/) for available documents first.

List of all Plan professionals (other than the administrative vendors listed above), and other vendors/subcontractors that are involved in the management of the Plan, their roles and responsibilities; for example, any specialized care management firms or sub-networks as well as Plan legal counsel to the extent they are involved in the appeals process.

Upon receipt of this information, Segal will review all provisions and contact the Executive Director and vendors directly as necessary to seek clarifications and understand how each vendor carries out their job functions and responsibilities, and interact with one another.

In-person meetings and site visits may be required in order to catalog and inventory all responsibilities and provide more meaningful and attainable recommendations for improvements.

A summary of findings and recommendations would be provided as the final deliverable, which will identify and discuss any areas of overlap/duplication or gaps in service, and recommendations for improvements, if any.

Timeline:

This project takes about 6 weeks to complete once the above noted information is received. Should in-person meetings and site visits be required, the process may take longer depending on availability and scheduling.

Estimated Fee:

Our fees for a comprehensive contract review and analysis are based on actual time charges and are estimated between $25,000 to $35,000, including interview times and discussion with the Executive Director and Board (as appropriate). Out of pocket travel expenses are not included in the estimate.

We look forward to working with you on this important project. Please call us if you have any questions about our proposal or require additional information.

Segal Consulting

333 West 34th Street New York, NY 10001-2402
T 212.251.5000 www.segalco.com

MEMORANDUM

To: Don Barber, Executive Director – Greater Tompkins Health Insurance Consortium

From: Lawrence Singer

Date: May 11, 2018

Re: Proposed Segal Service Sets

Here are three updated proposals. These proposals are based on our discussion in March and your May 8th e-mail in which you defined an expanded scope of work the Board of the Greater Tompkins Health Consortium is seeking. We understand the Board of Directors is looking for an experienced, independent benefits consulting firm to analyze the Consortium's current operations and provide recommendations based on the Consortium's current size and, going forward, expected increased size.

The defined scope of work basically addresses operational issues. As consultant to more multiemployer and multiple employer health plans than any other firm, we agree that a fully functioning multiple employer health plan needs to be assured that best achievable practices are being followed. Sub-optimal performance, whether due to a contractual requirement (or absence of a requirement) or performance, will have an impact on plan costs as well as services to participating employers and plan members. Most important, sub-optimal performance will have an effect on the economic security offered to plan members and ultimately on plan members' health. Clearly, sub-optimal performance will inhibit the Consortium's growth objectives.

While Segal has a broad portfolio of expertise to help benefit plan sponsors, based on the objectives articulated in your May 8th e-mail, we have suggested three areas of analysis that will likely provide the most helpful information to meet the Board's objectives as well as give the Board information on the cost that should be associated with desired services. By cost, we mean stop-loss premium, ProAct prescription drug assessed costs, rebates and any other fees, administrative fees paid to Excellus, as well as any health care claims costs that might be different if Excellus employed alternatives we have seen used by other health plans similar to the Consortium.

Indeed, the proposals' objectives are ones we have helped many other public sector clients address. We are confident that as we apply our skills and experience to perform the services discussed in these proposals, the Board will be fully educated on all relevant issues to implement the improvements that our analysis will suggest.

We have expanded the scope of services we will provide to address the objectives in your May 8th e-mail but we have maintained the objective of providing analyses of the cost elements that were included in our original project outlines. We strongly feel that your Board should see our benchmarks on the cost elements to be used as the basis for discussions with ProAct, Excellus and the stop-loss carrier.

Your Board may not be familiar with us. Please direct them to our website: www.segalco.com and share the following key characteristics of our firm:

Objectivity

Founded in 1939, we have extensive experience in providing consulting and actuarial services to public employee benefit programs. Segal is totally employee owned and independent of any financial, insurance, administrative or investment entity.

We were the first major fee-based employee benefits consulting firm. Currently, about 95% of our compensation is fee-based. The balance is insurance commissions paid at the client's request, typically as an offset to a defined fee for a defined set of services. In all situations, it is our policy to disclose all compensation.

Experience

Our core health consulting team is supported by top specialists in various aspects of employee benefits such as collective bargaining, communications, compliance and administration and technology consulting, as well as health actuaries and health benefits analysts with underwriting and clinical expertise. Segal has developed many of the practices that are generally employed by benefits consultants, including competitive bidding for group benefits and network valuation techniques.

Segal has about 2,800 clients, including about 400 in the public sector. We are consultants to more multiemployer and multiple employer benefit plans than any other consulting firm. We have worked with eight of the 27 New York public sector multiple employer health plans as well as two New York counties who have engaged us to consider the merits of establishing a multiple employer health plan.

We are familiar with the Consortium's providers and do not expect any problems in obtaining needed data.

Consulting Approach

Rather than just supply data, we work closely with our clients and their other professionals and services providers to develop strategic solutions to current challenges and to identify future directions.

Quality and Service

We maintain a process of full peer review of consulting advice and recommendations. Our internal quality control standards require a three-stage production and review process of actuarial work. In addition, Howard Goldsmith, a Senior Vice President, serves as the Region's Public Sector Business Leader. In this capacity, he is responsible for the oversight of all services

delivered to the region's Public Sector clients as well as the measurement of client satisfaction. He regularly visits clients to obtain client input and assess the firm's performance.

Sensitivity to Collective Bargaining

At Segal, we understand that employee benefits in the public sector in New York are almost always subject to collective bargaining. We are both expert in and sensitive to this dynamic, thus increasing the likelihood of successful solutions. We have a national practice that focuses on services in this area managed by an economist with extensive experience in all aspects of the collective bargaining process.

Public Sector Leadership

Our professionals are frequent speakers, authors, and advisors to organizations including the State and Local Government Benefits Association, the National Association of State Retirement Administrators, the National Conference on Public Employee Retirement Systems and the International Foundation of Employee Benefits Plans.

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Segal Consulting

333 West 34th Street New York, NY 10001-2402
T 212.251.5000 www.segalco.com

MEMORANDUM

To: Don Barber, Executive Director – Greater Tompkins Health Insurance Consortium

From: Lawrence Singer
Stephen Wolff, PharmD, ASA, MAAA

Date: May 11, 2018

Re: Pharmacy Benefit Manager Review - Project Outline

We are pleased to submit a proposal to provide insight and expert resources to review the current Pharmacy Benefit Manager (PBM) contract and the PBM's performance.

A thorough review will help to ensure that the best overall value is delivered to the Consortium and its Plan members. We offer a broad scope of services to help ensure that the Board of Directors is getting the maximum value expected from the prescription drug benefit program and PBM. Through our National Pharmacy Benefits Practice, Segal employs technical and clinical expertise focused on the prescription benefit marketplace and knowledgeable about the latest trends and services of the various PBM vendors.

Scope

Because the PBM industry is continuously evolving, prescription drug agreements and contracts require diligent monitoring to ensure alignment with industry norms and trends. Segal's specialists in our National Pharmacy Benefit Consulting Practice will review the PBM contract in its entirety for providing comprehensive services and compare it to industry standards. We will perform an analysis to help ensure that the Consortium is getting the most from the prescription drug benefit program. Our analysis will likely provide the Board of Trustees with valuable findings and solutions to reduce health plan costs and improve the quality of the pharmacy benefit services provided to Plan members.

The service team will identify areas of concern within the contract that are unfavorable to the Consortium and provide recommendations that can be used for immediate consideration as the basis for contract negotiation or for future negotiations between the Consortium and ProAct, its PBM partner. Segal's wealth of experience in the PBM industry facilitates our ability to review and improve contractual terms and provisions ensuring Segal's clients receive optimal service performance and market competitive pricing.

Process and Deliverables

To begin, Segal requires the most recent master contract and amendments between the Consortium and the PBM. Segal will also request the latest plan performance summary from ProAct. After review of the documents is completed, Segal will prepare a detailed memo for the Consortium The memo will outline the specific areas within the contract where opportunities to improve terms or provisions exist and will provide recommendations to address the noted areas of concern.

Our analysis will review:

- Discounts;
- Dispensing fees;
- Administrative fees;
- Key contractual provisions;
- Plan performance & utilization patterns.

These items will be compared to benchmarks from peer groups and industry standards. This will give the Consortium insight into areas that may benefit from improvement and will help the Consortium to determine if they are getting the best value from the PBM. Segal has access to a wealth of prescription drug data. We have established a unique database of major health plans to use for benchmarking and other comparative analyses. Our database also includes a library of PBM contract terms and plan sponsor design features. In addition to our own proprietary database of Segal client prescription drug claim history and experience, we purchase AWP and other data from MediSpan.

Segal will also prepare a checklist for the Consortium, detailing contracted responsibilities that the PBM has to the Consortium (including payment timings, performance guarantee reporting, financial reconciliations, and other contractually stipulated arrangements). Performance guarantees stipulated in the contract will be reviewed, along with PBM reporting on performance guarantee performance. While the PBM's performance on certain guarantees fall under the scope of this project, a separate financial audit would be required to ensure that the PBM is meeting all of the financial guarantees.

Segal will also work with the Consortium and the PBM to develop a reporting package that is optimal for the needs of the Consortium.

Timeline

This project will take approximately six weeks to complete once acceptable documentation is received from the PBM. Be advised that we have a working relationship with ProAct and do not expect any delays in obtaining information when authorized by the Consortium. Throughout the process, the team will communicate urgent issues, project progress and status updates to the Consortium.

Estimated Fee

Our fees for a comprehensive contract review and analysis are based on actual time charges and are estimated between $10,000 to $12,000, including discussion with the Executive Director and Board (as appropriate). Out of pocket travel expenses are not included in the estimate.

We look forward to working with you on this important project. Please call us if you have any questions about our proposal or require additional information.

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Segal Consulting

333 West 34th Street New York, NY 10001-2402
T 212.251.5000 www.segalco.com

M E M O R A N D U M

To: Don Barber, Executive Director – Greater Tompkins Health Insurance Consortium

From: Lawrence Singer
Michael Tesoriero

Date: May 11, 2018

Re: Stop-Loss Review - Project Outline

We are pleased to submit a proposal to perform review of the stop-loss contract maintained by the Greater Tompkins Health Insurance Consortium.

This engagement would take a high level review of the stop-loss arrangement in place and is designed to provide the Plan's Board of Directors a sense of the Plan's risk protection arrangement. Stop-loss coverage helps limit the Plan's exposure to catastrophic claims and protect the Plan's reserves, and therefore its participating employers, from catastrophic and unpredicted claim liabilities. The review will evaluate the effectiveness of the protection as it addresses contract terms and attachment points and efficiency as rates are compared to our database of current premiums for similar programs analyzed in our pricing formula.

Scope

For this project, our Stop-Loss Team will perform the following tasks:

- Prepare a data request to collect hospital, medical and prescription drug claims utilization data as well as individual claims data for the last three years to study the claims utilization pattern.
- Review the Plan Document and care management procedures in place to address 1) how they may impact the Plan's risk and 2) if they are properly reflected in the stop-loss contract.
- Review the current stop-loss contract. We will review all of the contract terms (*i.e.* appropriateness of stop loss level, claim basis, coverages, reimbursement limits, exclusions, etc.) to ensure that the basic requirements of the stop loss coverage are being provided in your current policy. We will also comment if there are certain additional provisions (*i.e.* no lasers, no new laser at renewal, rate cap, dividend eligible provision, etc.)

Process and Deliverables:

Our process will generally include the following activities:

- Upon receipt of this information, Segal will review all provisions and contact the Executive Director, as necessary, to understand any history that may warrant an exceptional term or pricing factor.
- A summary of findings and recommendations would be provided as the final report.

Timeline:

This project takes about two weeks to complete once the above noted information is received. Should in-person meetings and site visits be required, the process may take longer depending on availability and scheduling.

Estimated Fee:

Our fees for a comprehensive contract review and analysis are based on actual time charges and are estimated between $5,000 to $7,000, including discussion with the Executive Director and Board (as appropriate). Out of pocket travel expenses are not included in the estimate.

We look forward to working with you on this important project. Please call us if you have any questions about our proposal or require additional information.

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Greater Tompkins County Municipal Health Insurance Consortium

125 East Court Street • Ithaca, New York 14850 • (607)274-5590
www.healthconsortium.net • consortium@tompkins-co.org

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

RESOLUTION NO. - 2018 - ACCEPTANCE OF APPLICATION BY THE TOWN OF BIG FLATS TO BECOME A PARTICIPANT IN THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

WHEREAS, by Resolution No. 005 of 2012 and amended by Resolution No. 27 of 2014 and Resolution No. 7 of 2018 the Consortium Board of Directors adopted a policy outlining a process of applying for membership to the Consortium, and

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

WHEREAS, the Town of Big Flats has complied with membership process outlined in Resolution No. 005 of 2012 and amended by Resolution No. 027 of 2014 and Resolution No. 7 of 2018 and has submitted copies of financial reports which have been reviewed and found acceptable by the Consortium's Treasurer, Chief Financial Officer and/or the Consortium's Auditor, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee of the Greater Tompkins County Municipal Health Insurance Consortium, That the Board of Directors hereby accepts and welcomes the Town of Big Flats as the 33rd municipal participant, with health insurance coverage beginning January 1, 2019.

* * * * * * * *

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RESOLUTION NO. - 2018 - ACCEPTANCE OF APPLICATION BY THE VILLAGE OF FREEVILLE TO BECOME A PARTICIPANT IN THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

WHEREAS, by Resolution No. 005 of 2012 and amended by Resolution No. 27 of 2014 and Resolution No. 7 of 2018 the Consortium Board of Directors adopted a policy outlining a process of applying for membership to the Consortium, and

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

WHEREAS, the Village of Freeville has complied with membership process outlined in Resolution No. 005 of 2012 and amended by Resolution No. 027 of 2014 and Resolution No. 7 of 2018 and has submitted copies of financial reports which have been reviewed and found acceptable by the Consortium's Treasurer, Chief Financial Officer and/or the Consortium's Auditor, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee of the Greater Tompkins County Municipal Health Insurance Consortium, That the Board of Directors hereby accepts and welcomes the Village of Freeville as the 34th municipal participant, with health insurance coverage beginning January 1, 2019.

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RESOLUTION NO. – 2018 – RESOLUTION OF THE BOARD OF DIRECTORS OF THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM – AMENDMENT TO CONFLICT OF INTEREST POLICY

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 Audit and Finance 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 "17" and appended Exhibit "A":

"17. No later than April 15th, and each successive year thereafter, individuals serving as an ~~Prior to the election, appointment or employment of individuals to serve as an officer, director or key employee of the Consortium, and each successive year thereafter, such~~ officer, director and key employee shall certify they have read and agree to the terms stated within the Greater Tompkins County Municipal Health Insurance Consortium's Conflict of Interest and Code of Ethics Policy. The Board of Directors shall be made aware of any outstanding agreements at its next regularly scheduled meeting after the April 15 deadline. Should a successor be appointed to fill a position mid-year they shall be asked to sign the agreement at that time.

~~complete and execute a *Disclosure and Acknowledgment Form*, substantially consistent to the form attached hereto as Exhibit "A" or as modified from time to time thereafter. Such completed forms shall be kept as organizational records of the Consortium.~~

For purposes of this policy, (i) the terms "officer" and "director" shall have the same meaning as set forth in the Municipal Cooperative Agreement, dated October 1, 2010; and (ii) the term "key employee" shall mean any employee of the Consortium with executive or managerial capacity." These positions include:

- All Directors and Alternates designated by a Participant to have voting authority;
- Executive Director or Assistant Executive Director;
- Treasurer;
- Wellness Consultant;
- Plan Consultant;
- Administrative Clerk

* * * * * * * *

Greater Tompkins County Municipal Health Insurance Consortium
Code of Ethics and Conflict of Interest Policy
(Adopted 2-27-2014; amended by Res. No. 008-2016)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CODE OF ETHICS AND CONFLICT OF INTEREST AGREEMENT

To be signed and submitted to the Consortium no later than **April 15th** of each year.

I have read and agree to the terms stated within the Greater Tompkins County Municipal Health Insurance Consortium's Conflict of Interest and Code of Ethics.

_____	_____
Signature	*Print Name*
_____	_____
Consortium Title/ Municipality	*Date*