Greater Tompkins County Municipal Health Insurance Consortium

Joint Meeting

Audit and Finance Committees

Thursday, April 18, 2013 - 3 p.m.

Ithaca Town Hall

Agenda

1. Call to Order of Joint Meeting
2. Approve Minutes of March 21, 2013 meeting (Audit Committee)
3. Approve Minutes of March 27, 2013 meeting (Finance Committee)
4. Overview of work completed by the Bonadio Group including a review of 2012 financials
5. Adjournment of Finance Committee
6. Audit Committee: Approve Whistleblower/Fraud Policy
7. Next Agenda Items

   Review external audit report (May)
   Review 1st quarter 2013 report (May)
   Review results of State Audit (May)
   Oversee development of Code of Ethics and Conflict of Interest Policy
   Develop Request for Proposals for audit services
   Reports to Board of Directors

8. Adjournment

Draft 4-1-2013

Minutes
Greater Tompkins County Municipal Health insurance Consortium
Audit Committee
March 21, 2013 - 3:00 p.m.

Attendees: Steve Thayer, Judy Drake, Chuck Rankin, Laura Shawley (arrived at 3:25 p.m.), Chantalise DeMarco, Michelle Pottorff; Don Barber, Jerry Mickelson, Steve Locey (via conference call)

Call to Order

Mr. Thayer called the meeting to order at 3:05 p.m.

Acceptance of Minutes

The minutes of the February 21, 2013 meeting were approved as submitted.

Overview of Work Performed by Consultant, Locey and Cahill

Mr. Locey said Locey and Cahill was charged with developing all of the plan documents. On an ongoing basis they continually review and update those documents to ensure they are compliant with Federal and New York State mandate changes and the Affordable Care Act. Once changes are made those documents are filed with the New York State Department of Financial Services.

Since the beginning of the Consortium they have been charged with putting together the benefit plans that are offered by the Consortium in terms of prescription drug copays, PPO copays, and different types of indemnity plans, etc. From a cost perspective they are charged with putting together the premium equivalent rates for the various plan options and making sure they are rated from an equitable perspective and seeing that the variance in the rate is commensurate with the benefit. In addition, they are charged with putting together the budget on an ongoing and annual basis. They collect financial data from the Consortium and paid claims data from the Prescription Benefits Manager and Excellus and analyze that on an ongoing basis. They look at claim trends, the difference between what was budgeted and actually paid out, and all the different cost variables within the Consortium to make sure it is meeting all of the expectations. They also put together claims lag reports, looking at paid and incurred data and are look at claims development models to make sure projections are still being done correctly based on what is happening in the market.

Mr. Locey said they also respond to daily questions in terms of eligibility and provide support to all of the Consortium's committees and the Board of Directors. They have also been involved in meetings with Cayuga Medical Center and Excellus concerning the Clinical Integration initiative. Locey and Cahill has also been working to provide necessary information to the Bonadio Group, Aquarius Capital, the external auditors, and the New York State Department of Financial Services for the State audit.

There was a discussion of the pharmacy expenses and Mr. Locey was asked if there is integration of the claims into the Stop Loss coverage. Mr. Locey said yes; when a person is

identified as being close to the Stop Loss deductible level at Excellus they get reporting from the PBM as well to make sure the Stop Loss carrier is getting all of the claims data related to that person.

Mr. Thayer asked how much Locey and Cahill looks at the actual paid claims activity at Excellus. Mr. Locey said right now they just look at data. For many of their other clients they provide a service called a Quality Assurance Audit where they will review a random statistically valid sampling of claims. They also do a catastrophic claim or large loss review at the same time. The focus for this is to: 1) make sure that claims are being processed in accordance with the plan document, normal business practices from a claims and insurance operations perspective, ensure compliance with state and federal mandates; and 2) look at how catastrophic claims are managed. This is something they are not currently contracted to do for the Consortium and he noted this is something that was mentioned in the 2011 independent auditor's report that should be done.

From a claims perspective what they are currently looking at is aggregate claims data for prescription drug and medical and are doing analysis through the data cube at Excellus based on catastrophic loss, trends, and anything that will help them better manage the Consortium from a financial perspective. They are not looking at the accuracy of claims payment. Mr. Locey said this is something most consortiums do and they recommend the Audit Committee consider making a recommendation to the full Board on this at some point in the future. Most consortiums focus primarily on the medical side and not on the prescription drug side; however, if prescription drug claims begin to veer from expectations it may trigger a need to audit the PBM to see what is going on.

Ms. Drake asked what committee would be reviewing the claims data and identifying where high claims are. Mr. Locey said up to this point they have been looking at that information internally and have not been charged with reporting it out to any one source. He noted that when looking at claims data it is important from a management perspective to get a handle on where expenses are going in terms of budgeting and planning for the future; however, he expressed caution in getting caught up too much in the data as there is not a lot you can do about some things but some data can be important from a wellness or disease management perspective. Items that are important to look at are the generic fill rate, mail order versus retail use, and treatable types of conditions such as high blood pressure, high cholesterol, and diabetes. Demographic analysis is also important. Mr. Locey said they can provide this information to the committee that would be looking at and evaluating this information.

Excellus provides a year-end utilization report and the PBM will provide a separate report. The information is also available through the Blues' data cube. Liz Karns has been provided with access to that data.

Ms. Shawley arrived at this time.

Ms. Drake asked how Locey and Cahill receive the financial information. Mr. Locey said they receive information from a number of sources. They receive information on a monthly

basis from David Squires in terms of receipts, revenues, and expenses. He also provides any accounts receivable, accounts payable information, and billing information. In addition, they have direct access into the Blues' data system and receive monthly reports from the PBM on claims data, and incurred and paid claims data from both Excellus and the PBM.

Mr. Thayer spoke of the changes that are coming from the federal level and asked how they will impact the Consortium. Mr. Locey said the Affordable Care Act has three taxes that will be implemented on January 1, 2014: 1) Health Insurance Fees that will be charged to health insurance companies (because the Consortium is self-insured this will not apply); 2) Transitional Reinsurance Program Tax (this will cost about $5 per contract per month with the money paid to the federal government to fund a pool of money that will be used to help the State-run health insurance exchanges offset some of the bad risk they believe will come into the program during the first couple years of operation. This will be a temporary tax and should not run past 2016.; 3) Patients Outcome Research Trust Fund Tax. There is a not-for-profit being set up to analyze medical treatment protocols, devices, drug therapies, products, etc. They are supposed to report to the medical community on what they believe is effective in terms of treatment and cost to help treat illnesses and injuries more effectively. This tax will be $1 per covered life per year for the first year, $2 in the second year and after that will increase by an inflationary escalator. This should amount to less than $5,000 of impact to the Consortium for the first year).

Update on New York State Department of Financial Services Audit

Mr. Squires reported he received a second bill in the amount of $3,500; the expected total cost of the audit is $10,000. Mr. Barber said the State will submit a draft report in April and a final meeting will be held prior to the release of the final report. At a meeting prior to the auditors leaving it was communicated that one concern they had was the lack of quorum at meetings of the Joint Committee on Plan Structure and Design. With regard the capitalization payments, he said the State now views this as an assessment and have asked that the Consortium inform the State when those funds are intended to pay back. He reported the Bonadio Group will be meeting in the next week with the Department of Financial Services to review the draft JURAT filing and he expects the filing to go smoothly. He said he would like this Committee to become familiar with enterprise risk management and then go through the process with the Board of Directors. He will be bringing information he receives at the NYMIR retreat over the summer.

Mr. Mickelson asked that the Bonadio Group be authorized to provide him with a copy of the preliminary draft. Mr. Barber will take care of this.

Ms. Drake asked for an update on the question concerning the 2,000 covered lives. Mr. Barber said the State was informed the Consortium had 24,012 covered lives for the entire year. When divided by 12 months it met the 2,000 per month covered life requirement and the State accepted this. He said the number of contracts is not an issue now that the City of Cortland and Town of Lansing have joined.

Ms. Drake asked if this Committee or the Board of Directors will be looking at bills being paid. Mr. Barber said the Board will be presented with an invoice at the Bonadio Group at its meeting next week. He will be asking that a process be developed as well for future invoices. Mr. Squires said he could submit the disbursement register on a regular basis; Mr. Barber suggested that be presented to the Finance Committee.

Review of Draft Charter

After review, the Committee approved the Charter below and will include a copy in the Board of Directors agenda packet. Ms. Shawley will provide the Committee's report as Mr. Thayer is unable to attend the Board meeting.

Greater Tompkins County
Municipal Health Insurance Consortium
Audit Committee Charter

On behalf of the Board of Directors of Directors, the Audit Committee is charged with:

- Reviewing financial reports and filings;
- Audit policies and procedures to be sure they are in compliance with Article 47 and the Certificate of Authority;
- Reviewing medical claims audit reports;
- Establishing a list of all reports due to the Board and regulators and the process and time line to insure accurate and timely reporting

The Audit Committee shall review with the external and internal auditors the financial statements, the financial reporting process, the system of internal controls, the audit process, and the Consortium's monitoring of compliance with laws and regulations. The Audit Committee shall report this information to the Board of Directors.

In addition, the Audit Committee shall provide its recommendations for action to be taken by the Board of Directors and management in order to strengthen the Consortium's controls, compliance procedures and financial reporting process.

The Audit Committee shall monitor management's progress in responding to the internal and external auditors' findings.

The Audit Committee shall be composed of no fewer than three and no more than five Board of Directors members. No member of the Audit Committee shall be an officer or employee of, or receive any compensation from, the Consortium. The Board of Directors treasurer may not serve on the Audit Committee. The Chair of the Board of Directors shall be an ex officio non-voting member of the Audit Committee. At least one member shall serve as the financial expert, defined as an individual professionally knowledgeable in business management and financial reporting. Ideally, the financial expert shall have specific experience with a similar Consortium.

Internal control

- Assuring that management is setting the appropriate tone in communicating the importance of internal controls and in establishing policies and procedures to mitigate risk;
- Determining whether internal control recommendations made by internal and external auditors have been implemented by management;
- Making certain that the internal and external auditors keep the Audit Committee informed about fraud, illegal acts, deficiencies in internal control and other audit-related matters;
- Determining which aspects of internal control and compliance procedures are being tested annually by the internal and external auditors; and
- Understanding the nature of significant deficiencies and material weaknesses reported with the financial statements and reportable findings under *Government Auditing Standards*

General

- Reviewing significant accounting and reporting issues, including recent professional and
- regulatory pronouncements, and understanding their impact on the Consortium's financial statements; and
- Reviewing significant risks and exposures and the plans to minimize them

Annual financial statements

- Reviewing the annual financial statements and related footnotes and assessing whether they reflect appropriate accounting principles;
- Reviewing the Management Discussion and Analysis (**MD&A)** disclosures and concluding as to their reasonableness based on the Audit Committee's knowledge of the Consortium;
- Reviewing the management letter and monitoring the Consortium's compliance with its recommendations;
- Ascertaining whether the internal and external auditors have communicated issues and concerns to each other for appropriate follow-up and action;
- Verifying that the external auditors communicate all matters to the Audit Committee as required by their professional standards; and
- Review, as necessary, other monthly or quarterly financial statements for accuracy and timeliness

Compliance with laws and regulations

- Reviewing the effectiveness of the Consortium's system for monitoring compliance with laws and regulations; and
- Satisfying itself that all regulatory compliance matters have been considered in the preparation of the financial statements; and
- Reviewing the findings of any significant examinations by regulatory agencies; and
- Reviewing any state funding and reports filed

Internal audit

- Ascertaining that the organization has the appropriated structure and staffing levels to carry out its internal audit; and
- Confirming that health insurance claims are audited, internally as needed

External audit

- Selecting and retaining the Consortium's external auditors; and
- Approving the external auditors' fees; and
- Reviewing and approving the external auditors' proposed audit scope and approach; and
- Reviewing the performance of the external auditors and recommending their retention or discharge; and
- Reviewing and confirming the external auditors' assertion of their independence in accordance with professional standards; and
- Reviewing and approving the engagement of the external auditors to perform services, including consulting services, unrelated to the audit

Reporting responsibilities

- Reporting to the Board of Directors at least annually with appropriate recommendations regarding the Audit Committee's activities and any key external audit issues

Other responsibilities

- Meeting with the external auditors, internal auditors and management in separate executive sessions at least annually;
- Confirming that significant findings and recommendations made by the internal and external auditors are received, discussed, and acted upon appropriately and promptly;
- Reviewing and updating the Audit Committee Charter; and

- Reviewing and approving the Consortium's conflict-of-interest, code-of-ethics and whistleblower policies

Next Agenda Items (April 18, 2013)

The following items will be included on the next meeting agendas:

Overview of work completed by the Bonadio Group (April)
Approve Whistleblower/Fraud Policy
Review external audit report (May)
Review 1st quarter 2013 report (May)
Review results of State Audit (May)
Oversee development of Code of Ethics and Conflict of Interest Policy
Develop Request for Proposals for audit services
Reports to Board of Directors

Review of Whistleblower/Fraud Policy Samples

The Committee reviewed draft sample polices and accepted the Putnam/Northern Westchester Health Benefits Consortium's Fraud Policy as a sample template. Ms. Drake and Ms. Shawley agreed to work on this document and will have an updated draft included on the next agenda.

Adjournment

The meeting adjourned at 4:08 p.m.

Minutes
Greater Tompkins County Municipal Health insurance Consortium
Finance Committee
March 27, 2013 – 1 p.m.

Draft 4-3-2013

Present: Don Barber, Liz Karns, Mack Cook, Jared Pittman
Excused: Glen Morey
Staff and guests: David Squires, Jerry Mickelson, Joe Mareane, Michelle Pottorff

Call to Order

Mr. Barber called the meeting to order at 1:04 p.m.

Approval of Minutes of February 22, 2013

It was MOVED by Ms. Karns, seconded by Mr. Cook, and unanimously adopted by voice vote by members present, to approve the minutes of February 22, 2013 as submitted with Mr. Pittman abstaining.

Draft JURAT

Mr. Barber reported Randy Shepherd of the Bonadio Group has provided a copy of the draft JURAT report and has asked that comments be submitted prior to April 1st. He will be meeting with the Department of Financial Services prior to the filing to make sure it is in proper order. Mr. Locey spoke to the way the form was developed and said this report has nothing to do with a municipal cooperative benefit plan; it is designed for an insurance company. He said the State treats the Consortium like it is an insurance company and many of the same factors do not apply.

Other Business

Mr. Squires announced the person in the Finance Office who handles the billing for the Consortium will be retiring at the end of April and he will be taking over those responsibilities until a permanent replacement is found. He also reported that the Board will be receiving information tomorrow that will show that the income for the Consortium that has been reported is substantially below budget. This is because there has been a problem with the billing process through the County. Because of delay in posting a payment the Consortium's cash position for February is about $3 million below where it should be. He said although there is still an issue with the TC3 payment, the County's payment issue has been resolved. Mr. Locey said a meeting will take place after this meeting to resolve the issue so that each entity can directly get a bill and be provided with its specific enrollment information.

Budget Preparation Overview

Mr. Barber said in the very near future the Committee should be looking at the budget and looking at what things are assumed, what is known, data estimates, and premium equivalent rates.

Mr. Locey distributed several documents. He said everything associated with the Consortium from a financial standpoint starts with the budget, including the development of the premium equivalent rates. First, there needs to be an understanding of what the Consortium's

liabilities and expenses are and how much revenue needs to be generated in a given year. Once this information is developed it dictates the premium. In terms of the premium from the Consortium's perspective the rates are a way for the Consortium to gather its revenue. The premium equivalent rates are created and billed to the entities so that they can charge their employees and retirees. Mr. Locey provided a line item comparison from 2011 to 2012 of the line item budget items. The document may be expanded to include new taxes associated with the Affordable Care Act and a break-out of revenue items.

There are a number of revenue sources, the premium revenue being the largest portion. On an annual average basis the premium accounts for approximately 95% of the total revenue. The ancillary benefit premiums are only a pass-through. Mr. Squires reiterated his previous recommendation that the Consortium no longer handle these. *Mr. Barber said he doesn't think this would be a big issue and suggested Mr. Squires offer the Board of Directors a recommendation.* Mr. Squires said he would suggest setting up a different bank account and handling these outside of the Consortium's finances. This would also eliminate the requirement to report this information to the New York State Department of Financial Services. Mr. Locey said the original capitalization investment and the associated interest is also recorded as interest income on reserve funds. Included in "other" are prescription drug rebates and Stop Loss insurance recoveries.

On the expense side, medical and prescription drug claims are "hard" numbers, however, there is an expected deviation due to different illness patterns, different people covered, and different mandates. The Admin. Fees, NYS Graduate Medical Expense, and Stop Loss Insurance are fairly predictable. The legal fees is a soft number built in just to have funds to cover a lawsuit, claim appeal, or something that comes up concerning a plan document where a legal opinion is needed. The remaining fees, such as consultant fees, audit fees, insurances, internal coordination, and surety bond fee/loan interest collectively total less than ¼ of a percent of the Consortium's expenses. The Advance Deposit to Excellus was a large one-time payment that is incrementally increased each year. The total balance is to equal two weeks worth of paid claims; therefore, the increase from year-to-year is the difference and is based on the value of claims. Mr. Locey said the money is sent out as if it were an expense but it sits at the Blues in an account; therefore, it should be considered as an asset of the Consortium. Mr. Barber said the Bonadio Group is working this out with the Department of Financial Services.

Mr. Barber said two critical numbers on the document are the paid medical and paid prescription drug claims and asked for an explanation of how these numbers are determined. Mr. Squires said medical claims are electronically paid bi-weekly to Excellus. He said the claims fluctuate depending on whether there are four or five weeks in a month. The prescription drug billing is bi-weekly and one of those cycles includes an administrative charge; this can also fluctuate as there are three cycles in some months as opposed to two.

Mr. Locey said expenses are benefit-driven as claims are approximately 95% of the budget. He provided information showing the relationship of medical claims versus prescription drug claims and noted a couple of items relative to the trend of both. Historically prescription drug claims have been trending faster than medical claims; however it has slowed over the past year, mostly due to there being a lot of highly utilized drugs that are now available in a generic

form and also because drug claims are much more predictable from month to month as they are mostly maintenance-type drugs being used.

Mr. Locey provided information on how Locey and Cahill analyzes and trend paid claims data in terms of the budget. He reviewed how claims are analyzed and said the medical claims tend to fluctuate much more and has to do with timing of payment and severity of claims. The medical claims make up approximately 72.4% of the total and the prescription drug claims make up about 27.6 percent of the total aggregate expense. In addition, Locey and Cahill is looking at the data to analyze trend information, noting the Consortium is still fairly immature and there have been some big changes in terms of census since it first started. He said the trend of growth (without the City of Cortland and Town of Lansing) from April, 2011 to December 32, 2012 was showing at 3.19%. This is slightly lower than what they are seeing with other municipal groups they work with which is about 6%. The information for those groups is also based on around six years of experience, whereas the Consortium's information is based on a much shorter time. He said this has to be estimated realistically, yet conservatively. In terms of contract count, approximately 200 family and 100 individual contracts were added by the addition of the City of Cortland and the Town of Lansing.

Mr. Locey said once a budget is finalized they begin to develop premium equivalent rates and provided information on indemnity plans versus PPO plans showing the monthly paid claims by covered life for plan type. He explained the difference between the two plans, stating an indemnity plan is an older style health insurance plan that includes paid-in-full medical, hospital, surgical and everything that falls into the major medical category and subject to a deductible co-insurance. With most indemnity plans the major medical claims account for less than 15% of the total claims. A PPO plan is different in that instead of a deductible and co-insurance, a co-pay is paid when a person goes to a physician's office; all of the other elements are fairly similar in terms of the underlying benefit. The variance between an indemnity plan and a PPO in the public sector is nominal.

Once the budget is done the premium equivalent rates are developed. They include two segments: medical broken out between PPO and Indemnity, and drug. By separating these it provides an understanding of the financial impact when negotiating. Looking at the population that is covered they come up with a base which is an average cost per covered life for all the expenses of the Consortium. From there they begin applying variables, such as going from individual to family, variances in benefit and different copay levels. Once the variances are set they go back and look at them periodically but they do not look at them regularly. In a community rated environment they cannot charge one group more than another based on risk, charges have to be based on benefits covered under a plan. Mr. Locey said the factor for the Consortium in determining covered lives for family rates is 2.4 times.

Mr. Barber summarized the process, stating that Mr. Locey builds the budget and then looks at the number of covered lives and this sets the base rate. Benefits factors and variables are then applied. *Mr. Barber said it would be helpful if after Mr. Locey went through the process of determining premium equivalent rates if he could explain what went into the process.*

Medicare Supplement

Mr. Locey distributed additional information and stated they looked at data relative to the Medicare-age population. He noted that although they are working on this, the information provided is not broken out between Medicare-age retirees and Medicare-age actives. He said the breakout of the drug data is not relevant because Medicare does not cover drug expenses. On the medical side, however, there is a big difference. The information broken out demographically in different age bands and Mr. Locey noted that the age 45 to 64 age group is predominantly the most expensive age group. The other group that is very expensive is the age 0 to 1 because of premature births, at-risk births, etc.

With the over age 65 population the bulk of the expenses are for prescription drugs. In 2012, however, there must have been an over age 65 active who had significant claims as the medical expenses appear very high. When this has been done in the past and the Medicare age population has been separated into retired versus active they typically have found their drug expenses to be approximately $4,000 per covered life and their medical expenses less than $1,000. In aggregate they are in the $4,500 to $5,000 range which is comparable to the overall average.

Mr. Locey stated the complexity in trying to come up with different rates, such as a Medicare supplement or a two-person rate is that if premiums change for one group and expenses stay the same the revenue has to be made up somewhere else. He said another complexity is that there are many different plans and many different contribution rates and trying to come up with one global solution is be very complicated.

Mr. Barber said his interpretation from the information presented is that the costs for the over age 65 population is close to what the cost is for the average population; therefore, the retirees are not subsidizing the plan. Mr. Locey said that is correct and what they are finding in most of the analysis they are doing. He stated there is a huge drop off in the medical costs for this population when Medicare becomes primary but they are only dropping down to the costs of the average age population because the drug costs are significantly higher. Mr. Barber asked how the private sector is providing a Medicare supplement and if they are providing prescription drug coverage. Mr. Locey said many private sector employers do not provide coverage to retirees, they do not provide prescription drug coverage, or they receive the Retiree Drug Subsidy to offset some of the retiree costs. The Medicare Advantage program receives money from the federal government to subsidize the plan they are providing because it is in lieu of Medicare. Mr. Locey said it has been rumored that part of balancing the State Budget is going to include a sharp decrease in the amount of funding for Medicare which is going to impact Medicare Advantage plans and will ultimately raise premiums and lower benefits.

Stop Loss and Reserving

Mr. Locey distributed information on the Annual Aggregate Stop Loss Insurance. The first document displayed information on what Locey and Cahill evaluated in 2013 for Stop Loss insurance. There are two types of Stop Loss insurance, one is Specific and covers individuals and Aggregate covers the entire population. Under Specific, if an individual exceeds the

deductible level the claims are paid and submitted to the Stop Loss carrier for reimbursement to the Plan. On the Aggregate side the insurance company sets the expected claim cost for the entire population and there is an attachment point. For the Consortium it is 125% of expenses above claims costs; if the Consortium reached that number it would reimburse the Consortium for everything above that. Most of the Consortiums they work with do not purchase Aggregate; the Consortium purchases it only because it is mandated to. He said this costs the Consortium approximately $40,000 and will likely never be used as it would mean the budget would have been off by 25% in a given year. Also, the coverage is minimal as it only provides $1 million once the operation goes beyond the attachment point.

Mr. Locey also distributed a history of what Stop Loss insurance has been purchased for 2011-2013 that showed three members had claims that exceeded $200,000 in 2011 and 5 in 2012. Total eligible reimbursements in 2011 were $146,000 and $976,000 in 2012.

Mr. Locey said in terms of integrating the drug reporting with the medical reporting, Excellus is taking in the data from the drug company for anyone who exceeds $10,000 in drug expenses for the year.

Next Meeting

Mr. Baber said the Bonadio Group will be meeting with the Audit Committee on April 18th and recommended that this Committee join them as it will be a good time to go through the 2012 financials. He suggested the Committee also discuss the 2014 budget and a process to pay back the Capitalization Reserve. Mr. Barber also noted that the Department of Financial Services views the Consortium's reserves at being at the very minimum level and there should be discussion of what the Consortium's goal is for those levels.

Adjournment

The meeting adjourned at 2:31 p.m.

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

Overview

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

Disclosure Policy

It is the policy of the Consortium that all individuals involved in the administration of the plan, as well as all members who receive benefits provided by the plan abide by the plan documents and all applicable state and federal laws and regulations. Any expected acts of theft, fraud, waste or abuse should be reported to the Consortium's Audit Committee or directly to the Chair of the Consortium's Board of Directors, for further investigation. Such investigation shall be commenced within 30 days. A written report of findings shall be submitted to the Board of Directors ~~Joint Governance Board~~ within 60 days.

Anti-Discrimination Policy

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

Distribution

This policy shall initially be distributed to each member municipality ~~District Benefits Representative~~, each member of the Board of Directors and Joint Committee ~~Office of Risk Management~~, ~~each member of the PNW BOCES Business Office, each Chief School Administrator and each School Business Administrator~~, . A copy shall also be posted in a conspicuous location at each member municipality~~each employer's Business Office and Personnel Office and within the Consortium's Office of Risk Management~~.

Review

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