Greater Tompkins County Municipal Health Insurance Consortium
Joint Meeting
Audit Committees
Thursday, May 16, 2013 - 3 p.m.

Ithaca Town Hall

Agenda

1. Call to Order
2. Approve Minutes of April 18, 2013 meeting
3. Approve Whistleblower/Fraud Policy
4. Review Recommendation from NYS Department of Financial Services
5. Review external audit report
6. Other Items
7. Adjournment

Future Agenda Items:
Review 1st quarter 2013 report (June)
Review results of State Audit (June)
Oversee development of Code of Ethics and Conflict of Interest Policy
Develop Request for Proposals for audit services
Become familiar with Enterprise Risk Model (Don Barber requested)
Reports to Board of Directors

Draft 4-21-2013

Minutes
Greater Tompkins County Municipal Health insurance Consortium
Joint Meeting of Audit and Finance Committees
April 18, 2013 - 3:00 p.m.

Attendees: Steve Thayer, Judy Drake, Chuck Rankin, Laura Shawley, Chantalise DeMarco (arrived at 3:10 p.m.), Mack Cook, Liz Karns, Mimi Theusen, David Squires, Joe Mareane, Steve Locey, Randy Shepard

Call to Order

Ms. Karns called the meeting to order at 3:05 p.m.

Acceptance of Minutes

It was MOVED by Ms. Shawley, seconded by Ms. Drake, and unanimously adopted by voice vote by members present, to approve the minutes of the March 21, 2013 Audit Committee meeting.

It was MOVED by Mr. Cook, seconded by Ms. Karns, and unanimously adopted by voice vote by members present, to approve the minutes of the March 27, 2013 Finance Committee meeting.

Mr. Squires reported that invoices received to date for the State Audit total $15,000.

Ms. DeMarco arrived at this time.

Overview JURAT Report by the Bonadio Group

Mr. Shepard distributed a memorandum outlining a meeting he had with the New York State Department of Financial Services to review the draft 2012 Annual report (JURAT). He reported the meeting was attended by Warren Youngs, Daniel Sheridan, Charmaine Menga, Gail Ross, and himself. It went very well and said the questions raised centered around gaining a better understanding of what was being reported on the various lines of the report because of the State's unfamiliarity with the Consortium. He commented that the members of the Department of Financial Services were very helpful and appreciative. He believes most of the questions raised were able to be addressed and his sense of their questions was that they are trying to understand how the Consortium works.

At this time Mr. Shephard walked members through the questions that were posed by the Department and responses to the DFS by Mr. Shepard; comments from those present have been added.

NY1
Question – Indicated that the "Name of Administrator" should be the plan administrator, as in who is responsible at the plan level.

Response – This field will be changed to Don Barber as the Chairperson, unless otherwise directed by the Board.

NY2

Question – Line 3 – DFS would like an explanation as to why there are no premiums receivable to the plan at year-end.

Response – Mr. Shepard indicated that the billing cycles of the Consortium are such that premiums are due on the first of the month, and therefore a receivable is unlikely, although not impossible. His recommendation is to provide a narrative of the billing process as part of the overflow pages.

Ms. Karns said she would like to see narratives be a standing item whenever these reports are filed, as they will help new members better understand these kinds of items. Mr. Shepard did not see a problem with this.

Question – Details for Item 5 – DFS requested including the words "receivable" for line 0501 and 0502.

Response – The changes will be made accordingly.

Question – Line 0801 – DFS did not understand what the amounts on hand with Excellus represented and would like more details in the overflow area.
Response – Additional information will be provided in the overflow area to describe what this asset represents.

Mr. Shepard said the State didn't understand the prepaid claims and whose money that was; he tried to explain what this represented and asked Mr. Locey to review this and see that the wording is correct.

Question – Line 0802 – DFS was unsure what this amount represented and wanted to have details about the bank name where this money was held. Furthermore, they indicated that if this was intended to represent the stabilization reserve than the amount in the account should equal the calculated required reserve prior to year-end.

Response – Information such as the Bank Name, Account Type, and balance will be reported on NY15 in the overflow area. Since the annualized earned premium amount can be reasonably determined prior to year-end because of the billing cycle, this amount can be known and transferred prior to year-end accordingly. To be discussed with Board for 2013 filing.

Mr. Shepard said on the first draft JURAT he provided the amount reported for the surplus was different than the value on the restricted cash line and the State expressed concern over this. They said whatever is in reserve should be in the bank account and if it was not they wanted to know where it was held so they put the information in the overflow page and put a reconciliation between the amount in the surplus and the amount in the bank account. He noted it is a lot closer than it initially was. He said they also want moving forward that the transfer of cash be done before year-end so the account has exactly what the reserve says it should have. And because it is based on premium and that is known at the beginning of the month the amount will be known by year-end.

Mr. Locey said the reason it was established the way it was is because that account represented all of the assessments that were paid in upfront. He asked if there was a recommendation as to where that has to be in a separate account because he has never seen that in Article 47. Mr. Shepard said he also doesn't think this is in Article 47 and believes the State just

wants it in a segregated account but doesn't say where. Mr. Locey noted this account will go away when municipalities are paid back.

NY3
Question – Line 1 – DFS would like an explanation as to why there are no accounts payable at year-end and would like an explanation of the various contracts and terms thereon. They suggest including information in the overflow area of NY15.

Response – Provide a narrative on NY15 to discuss why there is no accounts payable at year-end, but contract terms will not be discussed. If desired by DFS, that can be provided under separate cover and not part of the filing.

Mr. Shepard explained that the plan is still new and there are no accounts payable as expenses were known and included in the budget.

Mr. Shepard noted that premium payments are due by the first of each month.

Question – Line 4 – DFS did not understand why there were no unearned premiums at yearend.
Response – See response to NY2 – Line 3 question for approach to address concern.

NY4
Question – Line 6 and 9 – DFS requested that the gross amounts, less the reductions for rebates and reductions, be show in the overflow area of NY15.

Response – Information will be provided as requested.

Question – Lines 13-16 – DFS requested that the Consortium explain why there are no amounts on these lines.

Response – Information will be provided as requested.

Question – Line 0303 – DFS would like the detail described and not included as miscellaneous.
Response – Additional information will be provided accordingly.

Ms. Theusen said they have proposed adjustments for Stop-loss and drug rebates and will provide to Mr. Shepard for inclusion in the report.

Question – Line 0301 – DFS would like an explanation in the overflow area of NY15 as to what these ancillary benefits (revenue and expense) represent.

Response – A narrative explanation will be provided as requested. The Bonadio Group requests that language be provided by the Consortium.

Question – Line 1703 – DFS requested a change in the language used for this line and was unsure what this represented. Their concern was that amounts for specialists and other medical claim related professional services was being provided.

Response – Line will be renamed to "Consulting fees" per request of DFS.

NY6
Question – Question 3 – DFS would like the Consortium to establish a policy related to conflict of interest disclosures.

Response – The Consortium Board needs to consider and take appropriate action. Mr. Thayer said the Audit Committee intends to take action on this.

Question – Question 7 – DFS believes this should be answered in the affirmative, with the explanation in line 7b that none were owned at year-end.

Response – Change will be made accordingly.

Question – Question 11 – DFS wondered where the general liability insurance for the Consortium was covered. There needs to be an explanation and information accordingly.

Response – I responded that I thought this was being covered by Tompkins County, but that I would clarify with the Consortium directly. Bonadio requests clarification from the Consortium.

Mr. Locey said each of the members have their own general liability policy so each entity is covered. He said the Consortium is not really an entity by itself as it is a number of entities. Mr. Shepard said the DFS may want to see each of the policies*. Following a brief discussion, it was agreed that Mr. Shepard would be provided with a statement regarding the general liability coverage being maintained by each member independently.*

NY11

Question – The main concern from DFS on this schedule related to the amount reported in Section III, Column D. Their concern is that it is unlikely that this amount would be zero at year-end based on their experience with other insurers and municipal cooperatives.

Response – Mr. Shepard indicated that his information was obtained from the third-party consultant hired by the Consortium who stated that no amounts were unpaid at year-end related to a prior period. He has requested additional information from Locey & Cahill via email on April 15, 2013.

Mr. Locey agreed to contact Excellus to ascertain whether there were any unpaid claims related to 2011. And to be complete, Mr. Shepard recommended the same question should be posed to Medco on the Drug side. Once known the Bonadio Group will either break that detail out, or the Consortium will need to draft a statement regarding why that column will be reported as zero.

Mr. Shepard also asked that the Actuary report be attached to the final filing.

NY15

Question – DFS noted that amounts in the 2011 columns varied from what was submitted in the Amendment filed February 2013.

Response – Mr. Shepard informed them of the changes made to conform to the current year presentation and they requested that this be noted in the overflow page.

Additional Concerns Raised

Mr. Shepard reported that under Section L(3) all payments are due by the 1st day of the month, subject to a penalty for late filing. Mr. Shepard said this not occurring at all, in fact the majority, if not all payments did not come in until mid-month. The calculated loss to the Consortium was $267,515.33 for 2012. This is taking into account that every participant's first late month was waived in accordance with the agreement. These premiums should always be collected in advance and the Consortium should not be advancing the money.

Mr. Locey responded that every consortium Locey & Cahill works with has this clause in their agreement, however, he doesn't know anyone that enforces it. If there is a cash flow problem a concern would typically be addressed at a Board meeting.

Ms. Karns said she is uncomfortable having things in a contract that are not enforced and asked if this language needed to be included. Mr. Locey said there should be some language in the agreement so that it could be enforced if needed.

It was suggested that the language in the Municipal Cooperative Agreement could be changed from "must be" paid by… It was agreed that this could be considered with other possible changes to the MCA. It was suggested by Mr. Cook that the Finance Committee look at this.

He further stated that the Consortium should not be running a $25m organization using excel schedules and worksheets and that the information needs to be converted to a formal accounting system and tracked accordingly. He recommended either utilizing the system from Tompkins County, or consideration of a Quick Books webhosted environment which allows for access through the internet.

Ms. Karns asked who would be the "keeper" of this; Mr. Locey recommended it would be the Consortium's Treasurer.

The Committee had no further questions and the Finance Committee adjourned at 3:50 p.m.

Review of Draft Fraud Policy

The proposed changes presented were accepted and the changes noted below were added. It was agreed the suggested changes would be incorporated and a final policy would be presented at the next meeting and once approved by this Committee it will be presented to the full Board for approval.

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

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

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

[1] Municipal Cooperative Agreement; Section E. Board of Directors (18)

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

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

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

Ms. Theusen commented on the good work done by Mr. Shepard and the Bonadio Group and expects the next filing to go well.

Adjournment

The meeting adjourned at 4:08 p.m.

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*Draft #2 (incorporates 4-18-2013 changes)

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March 1, 2013

Ms. Gail A. Ross
Examiner in Charge
New York State Department of Financial Services
Health Bureau
25 Beaver Street
New York, NY 10004

Dear Ms. Ross:

This letter is in response to the questions raised relative to the audit being performed on the Greater Tompkins County Municipal Health Insurance Consortium by the New York State Department of Financial Services. Specifically, this letter deals with those questions raised in your memo entitled Examination Request #6 which was dated February 6, 2013.

We have restated your question below with our response on behalf of the Consortium immediately following each question.

1. ***Has the board ever requested certification from independent CPA that the responsible parties have implemented the procedures adopted by the board? If yes, provide.***

   The Greater Tompkins County Municipal Health Insurance Consortium does not adjudicate. The Consortium has hired Excellus BCBS to adjudicate hospital, medical, and surgical claims. As a licensed Article 43 insurance company they are audited by the New York State Department of Financial Services which would include detailed information regarding their claims adjudication processes. As a result, the GTCMHIC Board of Directors does not have any procedures in place relative to claims adjudication. In addition to the Department's oversight of Excellus BCBS as a licensed insurer, Excellus has several layers of internal and external audits which are conducted to ensure claims are adjudicated in accordance with applicable State and Federal mandates, industry standards, medical provider and facility contracts, and appropriate fee schedules. Excellus BCBS conducts these external reviews through the following resources:

   a. Connolly- primary comprehensive data mining vendor, contracted with Excellus BCBS since 2011. This vendor is a National Recovery Audit Contractor for CMS.

   b. Accent- secondary comprehensive data mining vendor, contracted with Excellus BCBS since 2009.

   c. AfterMath Claim Science- data mining vendor specifically focused on retro-termination member eligibility.

   d. CDR Associates- negative credit balance and voluntary provider submission.

   e. Trover- Subrogation and Other Payor Liability

As a result of the above information, the Board of Directors has not requested certification from an independent CPA regarding the Board's claims adjudication procedures as the Board of Directors has no direct claims adjudication procedures in place.

With the above being said, it is the intent of the Board of Directors of the GTCMHIC to conduct periodic audits of a statistically valid sampling of claims to ensure Excellus BCBS is adjudicating claims as they are contracted to do so. These audits will be conducted by an independent third party and any findings will be shared with the Board of Directors who will determine what, if any, corrective actions are required.

2. ***Has the board ever requested from the Plan's attorney a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations? If yes provide.***

Again, as stated above, the GTCMHIC does not have any claims adjudication processes in place. Therefore, there has not been a need to have the Plan's attorney provide a statement as described in the question. Excellus BlueCross BlueShield may possess such a document which they may have already shared with the Department as a licensed insurance carrier. Please let us know if you require this documentation to be provided by Excellus BCBS and we will work to facilitate this and submit as required.

We hope this information is helpful in addressing this matter as it relates to the audit being conducted by yourself and the New York State Department of Financial Services. As always, please let us know if you have any questions or if we can be of any further assistance.

Sincerely,

Stephen P. Locey
President, CEO

SPL:cvg

E-mail from auditor dated April 23, 2013.

I have reviewed the response dated March 1, 2013 by Locey & Cahill's; the following are my comments:

Although the consortium does not adjudicate claims, the ultimate responsibility remains with the Consortium to verify that responsible parties have implemented the procedures adopted by the board. As such, the Consortium should have procedures in place that would require the board to have internal audit or CPA and general counsel provide a statement that responsible officers have implemented procedures adopted by the board.

Again, although Excellus process claims on behave of the consortium, it is the responsibility of the Consortium to verify that claims manual utilized by TPA is in accordance with plan documents. Therefore, procedures should be in place that require the board to verify compliance with applicable statues, rules and regulations. Excellus did provide claims manual used to process claims on CAPS. ICPS, and LRSP systems and it will be used in audit of claims adjudicated in 2011.

Please be aware that it is the Consortium's ultimate responsibility to make sure that it is in compliance with applicable Department statutes, rules and regulations. Therefore, we will make the following recommendations: The board adopt written procedures that would require the board to obtain annual certification, either from an internal auditor or the Consortium’s independent CPA firm and the Consortium’s general counsel, that the Consortium’s responsible officers have implemented procedures adopted by the board and that the Consortium’s current claims adjudication procedures, including those set forth in current claims manuals, are in accordance with applicable Department statutes, rules and regulations.

The board obtain annual certifications from its third party claims administrators that claims are being processed in accordance with the Plan Document and applicable Department statutes, rules and regulations.