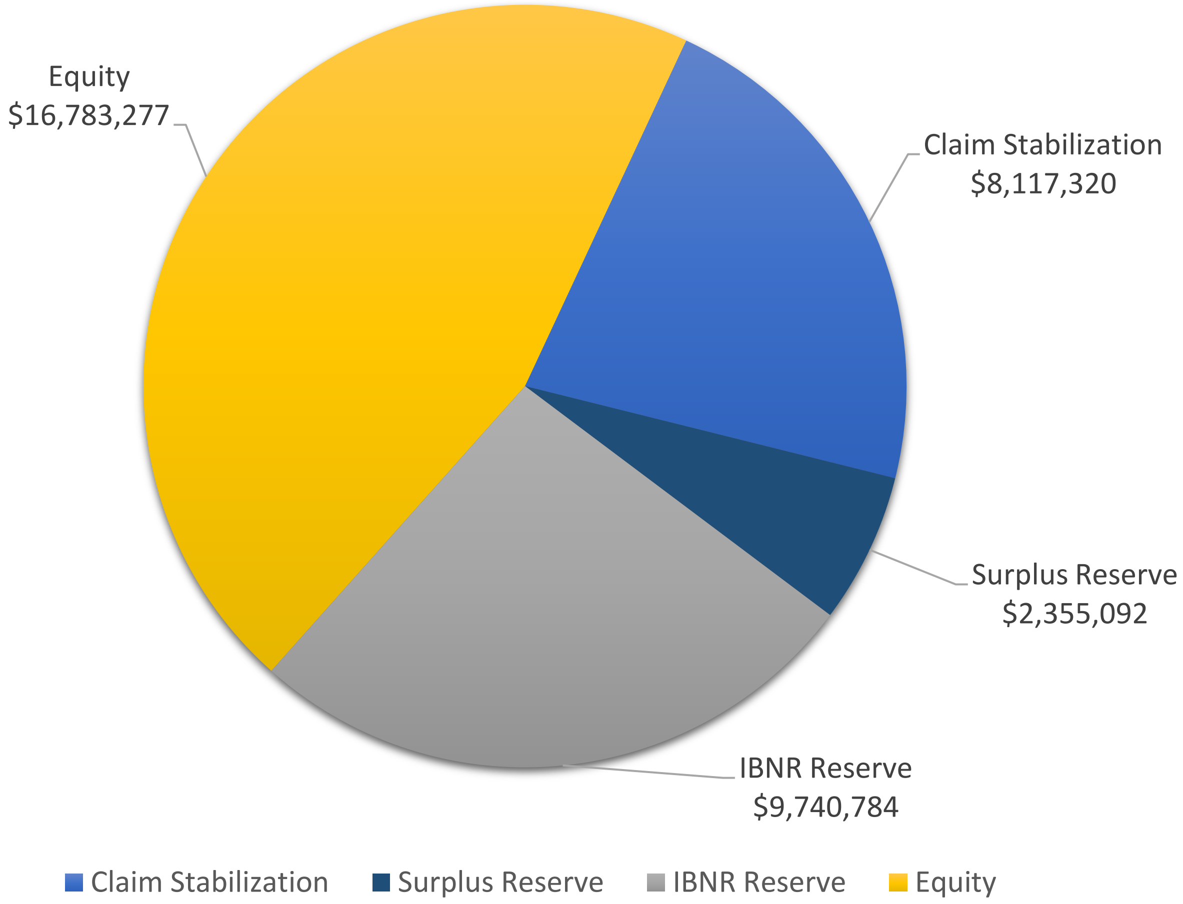
# FRANKLIN-ESSEX-HAMILTON SCHOOL DISTRICTS

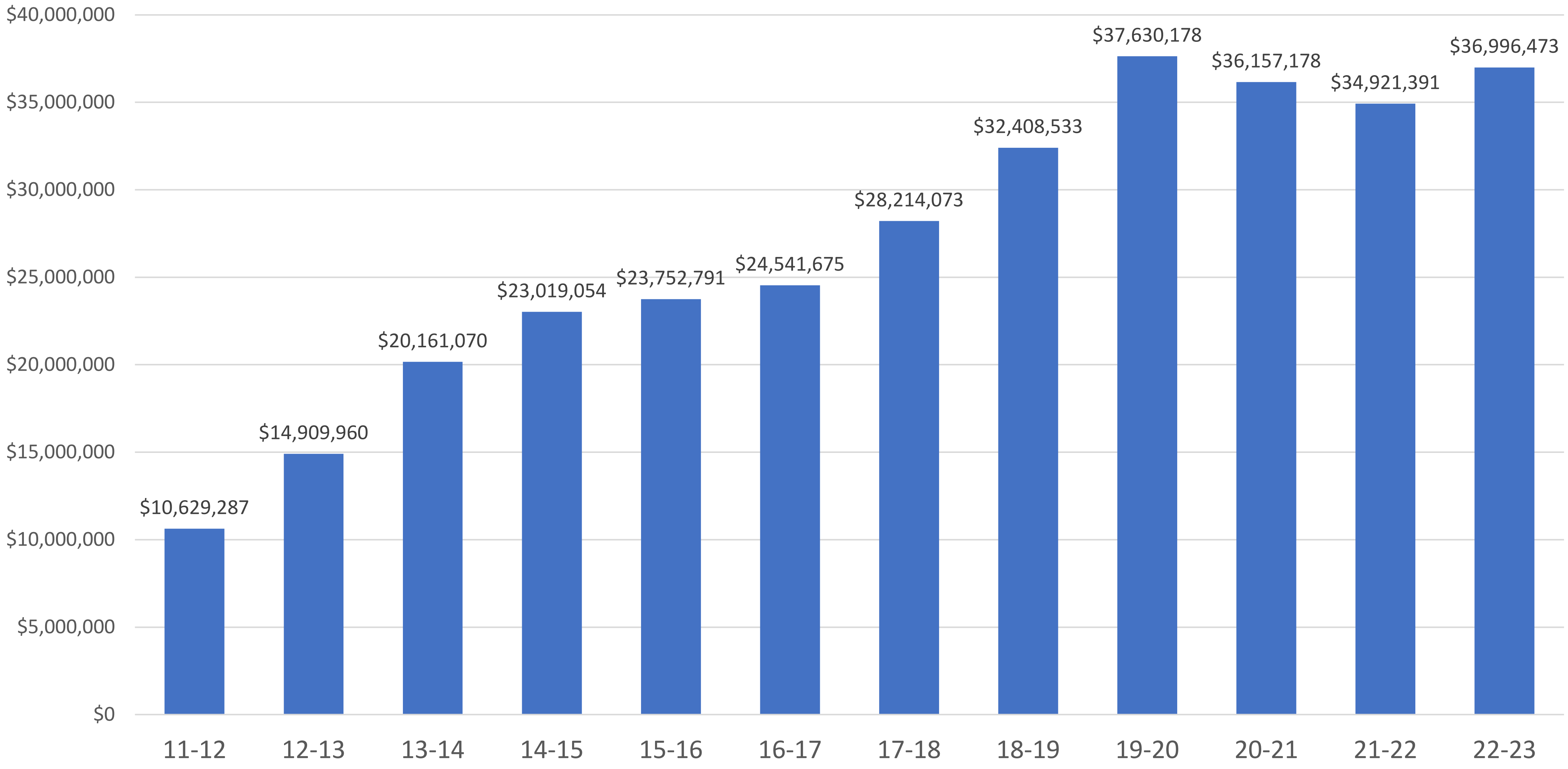
## HEALTH INSURANCE CONSORTIUM

# A HISTORY OF COOPERATION

# 2022/23 Fund Balance = $36,996,473



# ENDING FUND BALANCE



# 1981
# LEAVING THE STATEWIDE SYSTEM

In the late 1970's the problem was that all schools in the statewide plan were in the same rating pool and those in rural areas such as us were paying for the higher costs of health care in downstate urban areas.

Prior to taking any action, all bargaining groups were involved in the discussions.  Contract addenda “sign offs” were obtained from bargaining units with certain stipulations:

- It was agreed that the Plan Administrators for an alternately funded health care plan would be Blue Cross & Blue Shield of Utica-Watertown, Inc.  However, the parties agreed that the Governing Body of the plan, with the consent of the Associations in the group, could change the Plan Administrator.

- **It was also agreed that benefit levels in place at the time of the agreement would remain in place.**

# 1991
# FORMING A COOPERATIVE UNDER GENERAL MUNICIPAL LAW

Section 5 of the General Municipal Law allows school districts to join together to provide collectively those services they are allowed to provide individually.

On July 1, 1991, the BOCES and nine component school districts formed a consortium under general municipal law which was called the **Franklin-Essex-Hamilton School Districts Health Insurance Consortium** and adopted an alternative funding arrangement to take advantage of specific cost containment opportunities.

Employee groups allowed this organizational change since all health benefits remained the same as they had been in 1981 as well as the Drug Co-Pays and Major Medical Deductibles as follows:

Drug Co-Pay - $.50 Generic / $1.00 Brand Name

Major Medical Deductible - $75.00 Single / $225.00 Family

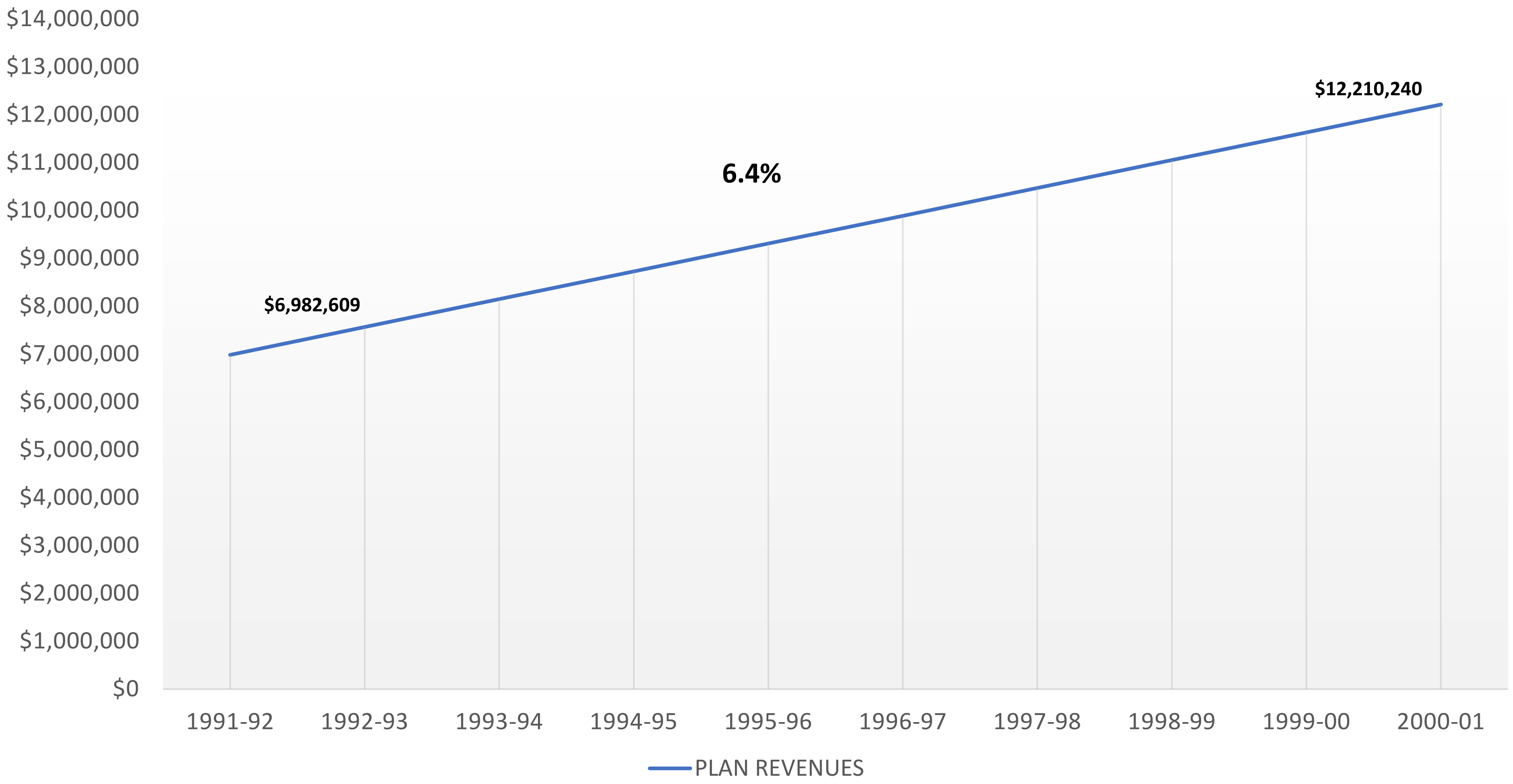
# 1995
# FORMING THE JOINT GOVERNING BOARD

With health care costs rising faster than general inflation and at a rate above most wage agreements, districts became more aggressive in seeking partial payment of premiums at the local bargaining tables.  Employees resisted these efforts and negotiations often became quite heated.

**In the fall of 1995, a group of district representatives and employee representatives met to explore alternative approaches.**

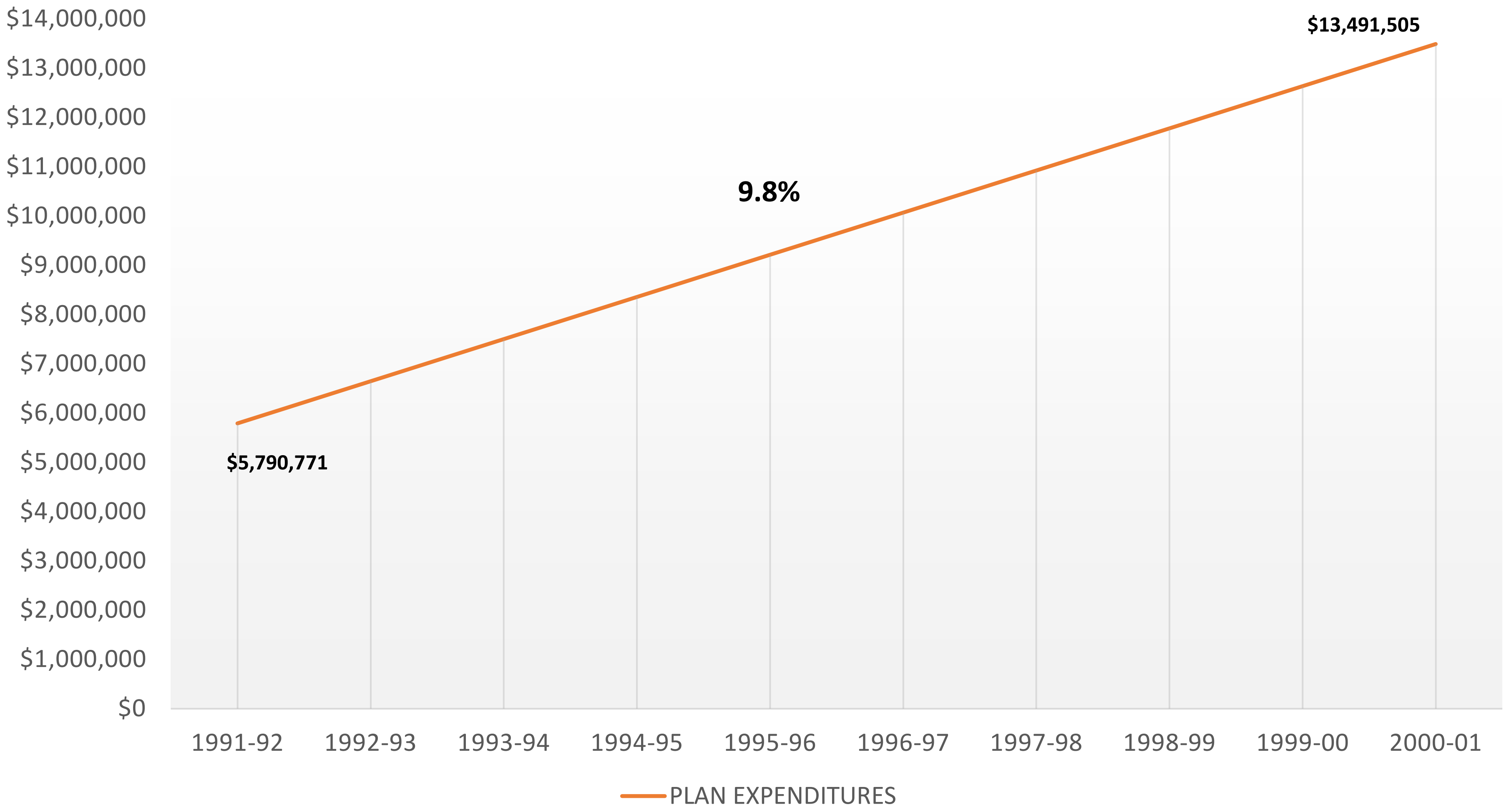
# Projected Annual Revenues vs. Expenditures Trend Line

## Prepared October 1996



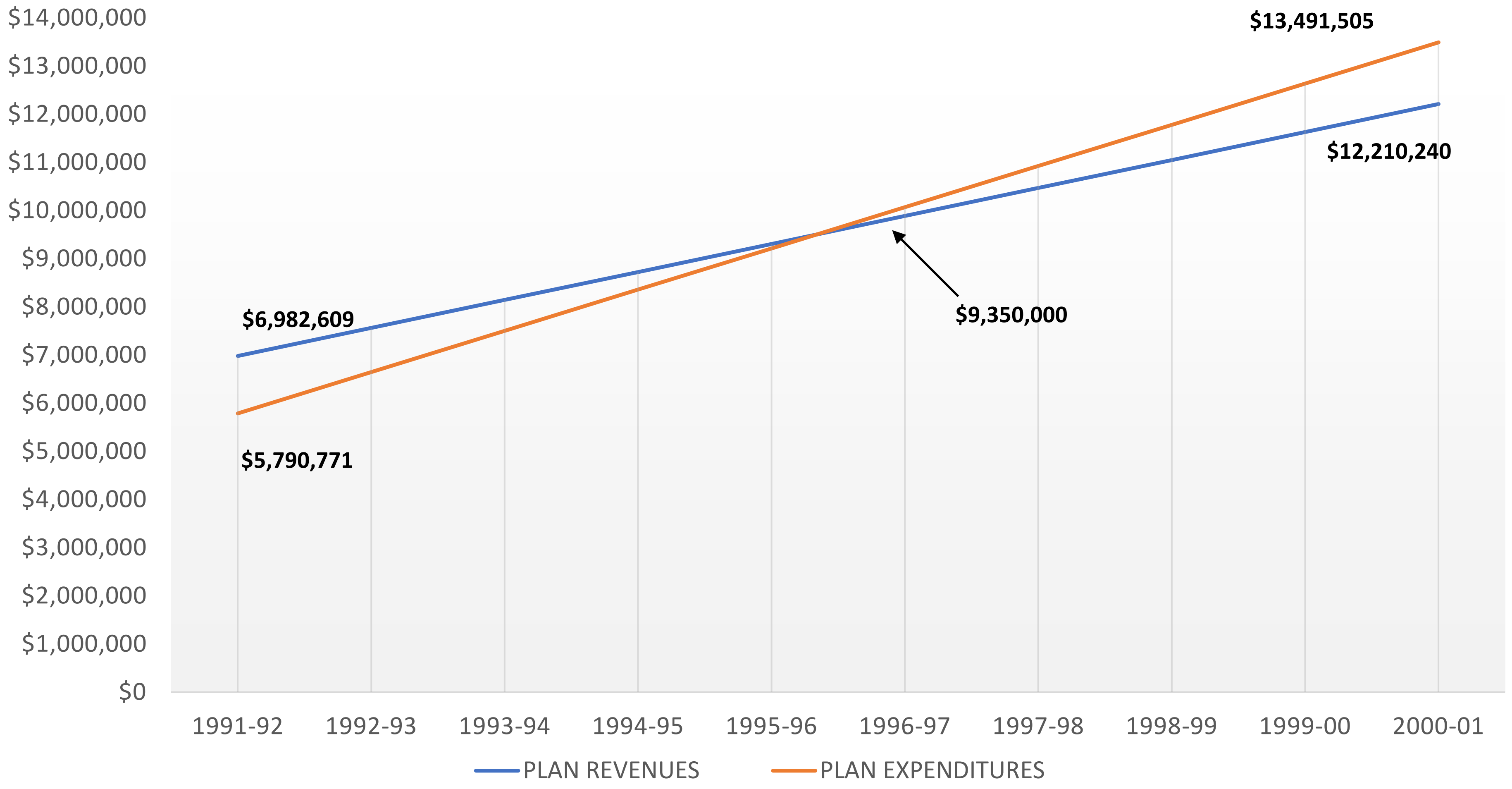
# Projected Annual Revenues vs. Expenditures Trend Line

## Prepared October 1996



# Projected Annual Revenues vs. Expenditures Trend Line

## Prepared October 1996



# Regional Health Insurance Discussions

## District Goals:

- Immediate cost savings
- Long range cost control
- Elimination of dual coverage within consortium
- Shared ownership/employee cost sharing

## Employee Goals:

- Joint governance structure
- Preservation of existing benefits
- Moratorium on health insurance bargaining at the local table

# Summary of Agreement

- **Establishment of a joint governance board to make decisions about all aspects of the health insurance plan within carefully defined parameters.**

- **An immediate increase in the drug co-pay and major medical deductibles.**

- **Modification of dual coverage within the Consortium to provide the same level of benefit to eligible employees while sharing costs equally between the affected school districts.**

# Summary of Agreement (cont'd.)

- A moratorium on health insurance bargaining expiring July 1, 2002.
- Establishment of an IRS Section 125 Plan (Flex Spending).
- Provision for a "triggering event" which would necessitate the Joint Governing Board to act.

# Memorandum of Understanding

1. The parties are currently investigating the proper legal vehicle which must be established to effect the intended governance structure. Once that is determined, it is the intent of the parties to take any and all necessary actions to put this joint governance structure in place. Meanwhile, a joint board will be created as defined above. **Any decisions made by this joint board will come before the current Board of Directors with the understanding that said decisions shall be approved.**

# Memorandum of Understanding (cont'd.)

2. **Reserves and surpluses during the initial period commencing July 1, 1996 and further referenced in item 14 will be maintained as follows:**

   **A. Reserves – equal to 25% of Projected Annual Claims**

   **B. Unencumbered Surplus – 7% of Projected Premiums**

The governing board of the consortium specified in item 1 above shall determine the allocation and use of funds in excess of reserves and/or unencumbered surplus amounts/percentages. It is agreed and understood that no new benefits will be added to the plan prior to July 1, 1999 except as mandated by law.

# Memorandum of Understanding (cont'd.)

5. **The "triggering event" which would necessitate the governing board to act by March 1, 1999 effective on July 1, 1999 for the 1999-2000 school year and on March 1, for any school year thereafter would be a projected diminishment of reserves and surpluses below the agreed upon levels as specified in item 2** above determined by the Plan's Consultant and subject to independent verification should a majority vote of the governing body demand such, after a premium increase equivalent to the Bureau of Labor Statistics for Northeastern United States Medical CPI for the latest 12 month period available as of March 1 in any given year has been applied in any applicable plan year (school fiscal year).

# Memorandum of Understanding (cont'd.)

7. **Parties ratifying this Memorandum of Understanding as outlined in item 15 hereby agree to simultaneously incorporate this Memorandum of Understanding into their respective Collective Bargaining Agreements.**

8. **Any "other" agreements entered into by the respective parties that are in conflict with the terms or intents of the agreement reached in this negotiation shall be amended to incorporate the terms and/or intent of said agreement as necessary and/or appropriate.**

# MEMORANDUM OF UNDERSTANDING DETAILS

**November 1996**

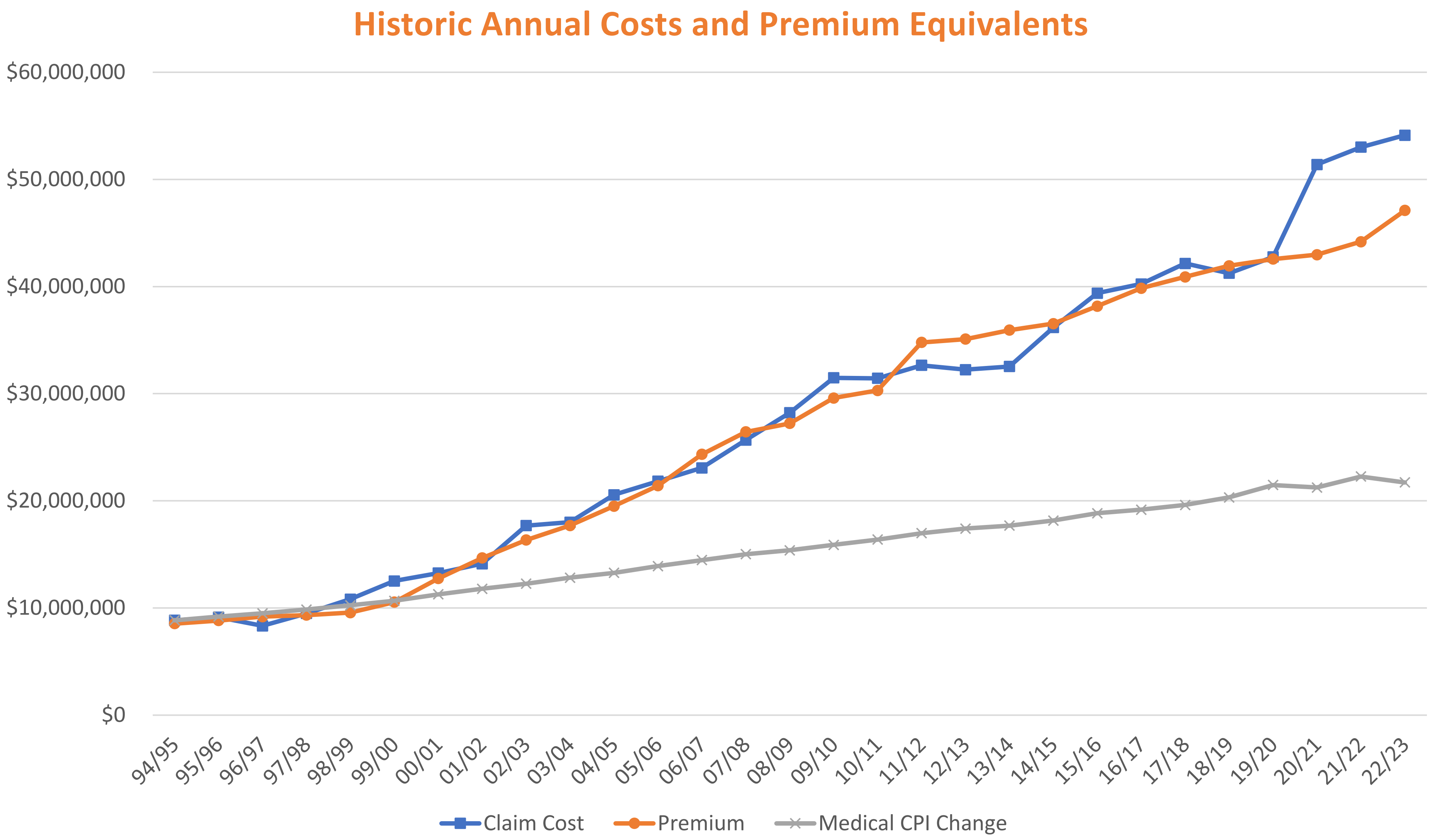
Seven-year moratorium on health insurance bargaining at the local district level
The premium equivalents for 96-97 were increased 4% over 95-96 rates and those rates frozen for 97-98 and 98-99.

Major medical deductibles increased from $75/individual & $225/family to $150/$450.

Drug co-pays increased from $.50 generic & $1.00 brand to $3.00 & $5.00

Drugs available by mail with no co-pay

Total Annual Value $1,000,000

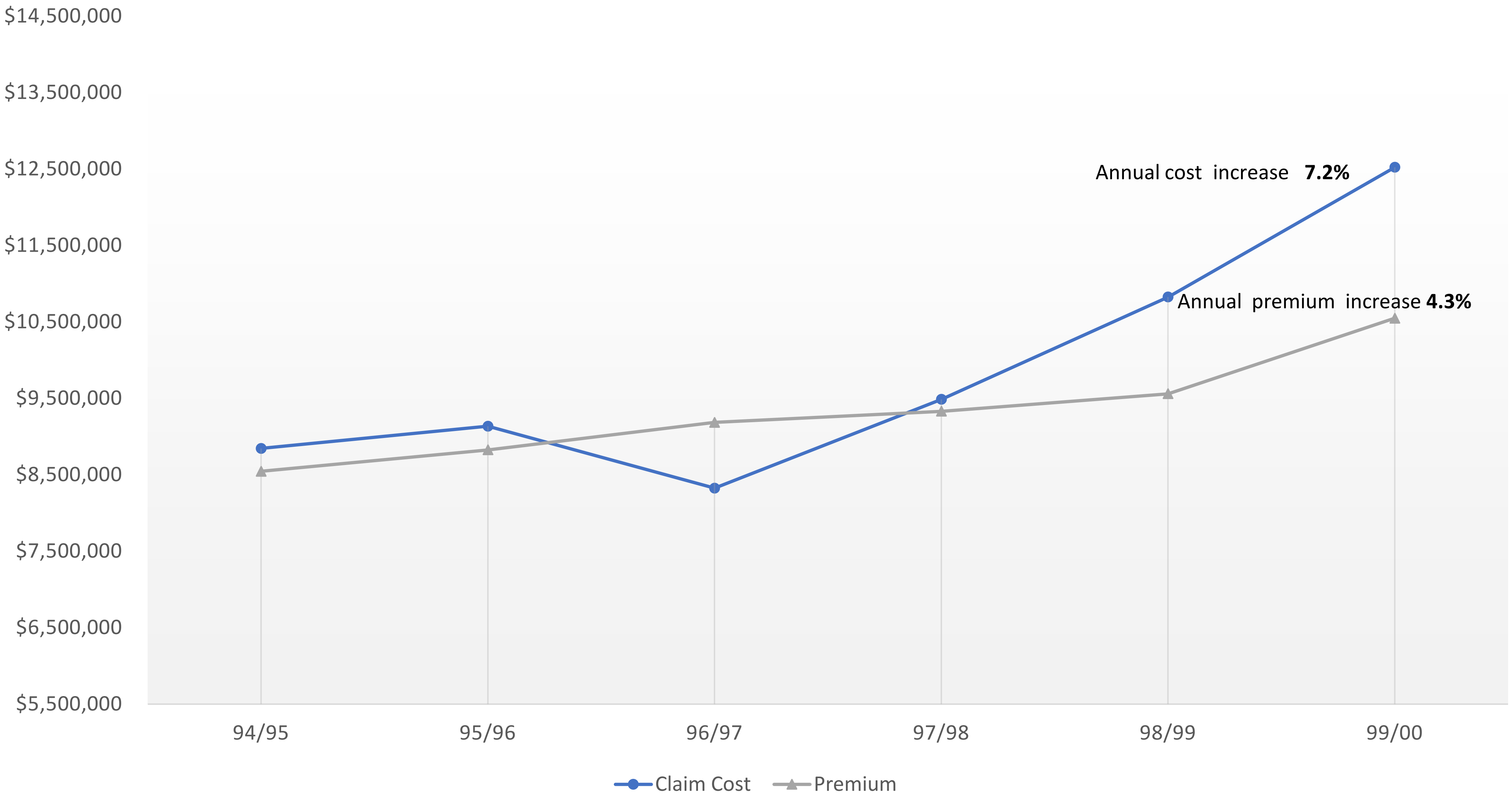

Historic Annual Costs and Premium Equivalents
$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$0
94/95
95/96
96/97
97/98
98/99
99/00
00/01
01/02
02/03
03/04
04/05
05/06
06/07
07/08
08/09
09/10
10/11
11/12
12/13
13/14
14/15
15/16
16/17
17/18
18/19
19/20
20/21
21/22
22/23
Claim Cost
Premium
Medical CPI Change

# THE FIRST YEARS
# 1996-2000

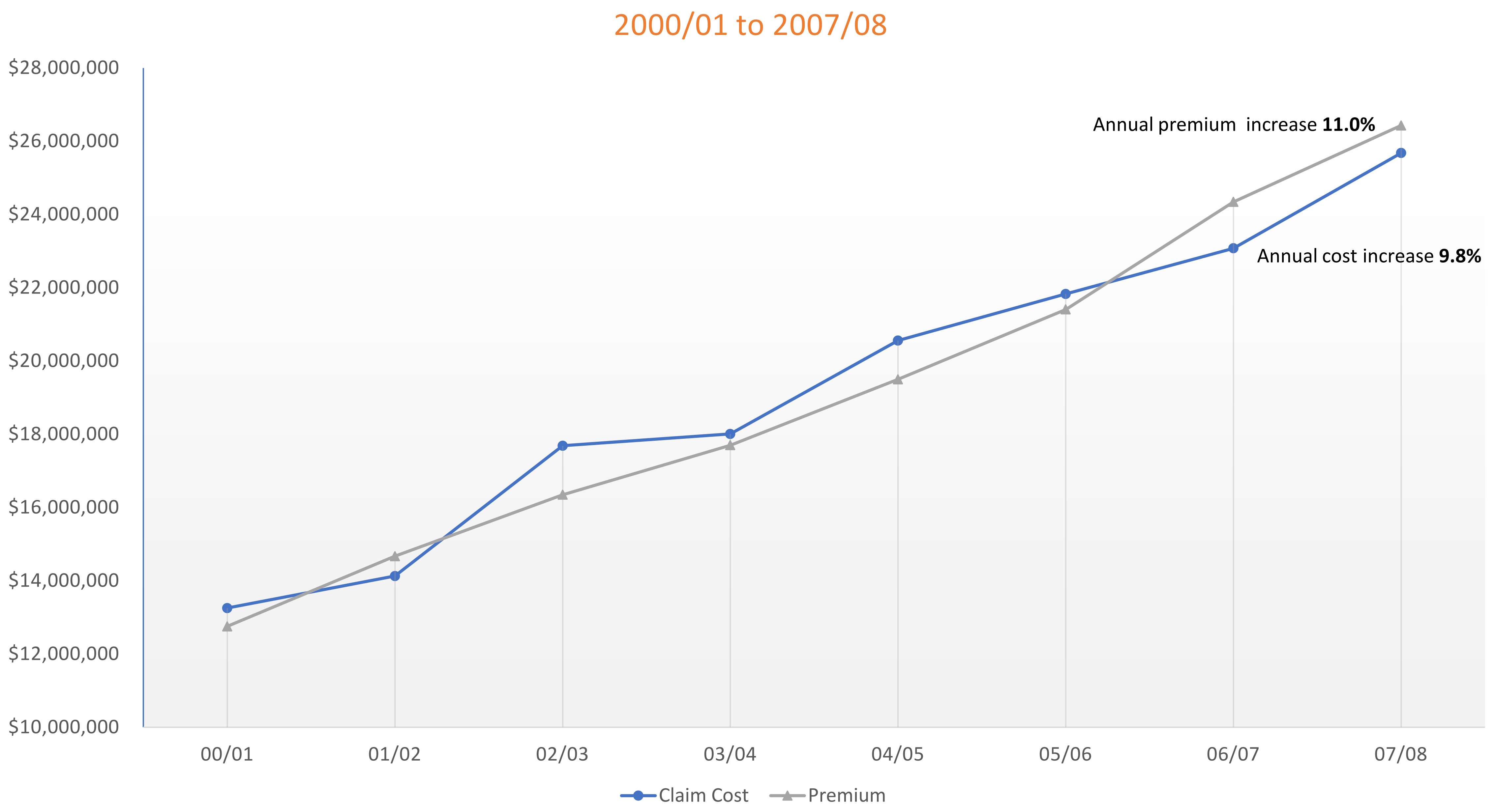
## May 1999

Medical rate of inflation is 4.8% and an increase in district contributions matching that keeps reserves at the required levels.

## 1994/1995 to 1999/2000



# WILL IT WORK LONG TERM? 2000-2008


2000/01 to 2007/08
$28,000,000
$26,000,000
$24,000,000
$22,000,000
$20,000,000
$18,000,000
$16,000,000
$14,000,000
$12,000,000
$10,000,000
00/01
01/02
02/03
03/04
04/05
05/06
06/07
07/08
Annual premium increase **11.0%**
Annual cost increase **9.8%**
Claim Cost
Premium

# 2000
# THE FIRST REAL TEST FOR THE JOINT GOVERNING BOARD

Medical inflation rate is 3.9% and an increase in district contributions of that amount leaves us far short of required reserves-$1,800,000 on a one-year basis.  After an independent auditor verifies the figures, employers and employees agree that an arbitrator is needed to determine the meaning of the triggering event language.

# Arbitration Decision

## Dennis J. Campagna, Esq. March 16, 2000

1. Pursuant to the ratified Memorandum of Understanding governing the operation of the Franklin-Essex-Hamilton Health Insurance Consortium, and beginning with the 1999-2000 school (fiscal) year, the participating districts are **not** limited, in their contribution for premium increases, to the Medical CPI under those circumstances where, the Governing Board, acting as a result of the existence of a “triggering event”, **has determined that additional contributions by participating school districts are required, necessary and proper, for the continued well being of the Consortium, and the efficient delivery of services to its constituents.**

2. **Pursuant to the ratified Memorandum of Understanding, the MOU vests the Governing Board with full authority to take whatever action(s) it deems necessary, legal and proper, as fiduciaries of the Fund, to insure the continued existence of the Consortium, and the efficient delivery of benefits to its constituents, during those times when it is required to act as a result of the existence of a “triggering event”.** Such action may not include a unilateral action by the Governing Board to dissolve the Consortium, without the mutual agreement by and between the parties to the MOU, and the required ratification by constituent members.

# RECORD OF DECISIONS

**October 2000**

Not settled until four months into the new fiscal year and then by a 15-3 vote

Introduced three tier drug co-pay structure and deductible for drugs

Drug deductible $25/individual
Drug co-pay at retail increased to $8.00/$15.00/$30.00
Drug co-pay at mail initiated at $5.00/$10.00/$20.00

Acknowledged the right of the Board of Directors to set premiums if the JGB fails to do so by March 1st

Total Annual Value $800,000

Premium equivalents increased 18% for 00-01 and 10% for 01-02

This was intended to be a four-year deal, but that required an extension of the moratorium which we could not accomplish at this time. There seemed to be a mutual agreement that multiple year deals involving plan design changes were better than annual changes in benefits.

# Arbitration Decision

## James R. Markowitz – January 23, 2001

Because I find that item 9 clearly contemplates that the Joint Board may change health insurance benefits, I need not reach the issues raised by either party regarding the Weisman Award or the Compagna Award. For the same reason I need not analyze the bargaining history leading to the execution of the MOU or the negotiations preceding the Joint Board's resolution of October 26, 2000. **Suffice it to say that through item 9 of Appendix G, the collective bargaining agreement contains authority for the Joint Board to alter health insurance benefits. Because of this the District's decision to abide by the Board's resolution did not violate the parties' contract.** The grievance is, therefore, denied.

# RECORD OF DECISIONS

**February 2002**

Moratorium extended until June 30, 2004

Annual maximum out of pocket for drug spend introduced at $1,000

Ambulance coverage increased from flat $50 to be paid as major medical claim, that is subject to the deductible and co-insurance features of our plan. Air ambulance service also covered but at the ground ambulance amounts.

Cardiac rehabilitation Phase II coverage added - also subject to deductible and co-insurance.

Total Annual Cost Est. $100,000

Premium equivalents for 02-03 and 03-04 increased by 7.6%

# 2004
# WAS THE 2000 DEAL A ONE TIME ACHIEVEMENT OR COULD WE BUILD ON IT?

The increase in the Medical CPI required the districts to raise their contributions by $775,000, but this still left a huge deficit-$2,400,000 on a one-year basis. A multiple year approach seemed to be the way to go.

# RECORD OF DECISIONS (cont'd.)

**January 2004**

Moratorium extended another three years to June 30, 2007

Mail order drug co-pays increased to $16/$30/$60

Hospital in-patient deductible of $50 introduced

Total Annual Value $480,000

Premium equivalents of 04-05, 05-06, and 06-07 increased by 9.7%

Without actually stating it, the "split the employee split the difference" philosophy of 2000 transitioned to one of 'keep the employee cost share the same" as costs increased

# 2005
# EVENT #6
# SERIOUS SHORTFALL IN REVENUE DUE TO FAULTY ASSUMPTONS ON CENSUS

The plan put in place in January of 2004 turned out to be severely inadequate.  Revised revenue figures show a large decrease in reserves, such that they would fall below the required amount.

# RECORD OF DECISIONS (cont'd.)

**February 2006**

Districts assess themselves $1,000,000 to make up revenue shortfall

Presidents of 22 bargaining units and their advisors meet and agree on a first step to bring Medicare rates closer to what they should be on a paid claims basis by allowing a 15% increase in those rates.

# RECORD OF INDECISIONS

**December 2006**

Concept of 10% employee cost share through deductible and co-pays collapses under magnitude of cost – in excess of $2,000,000 over three years

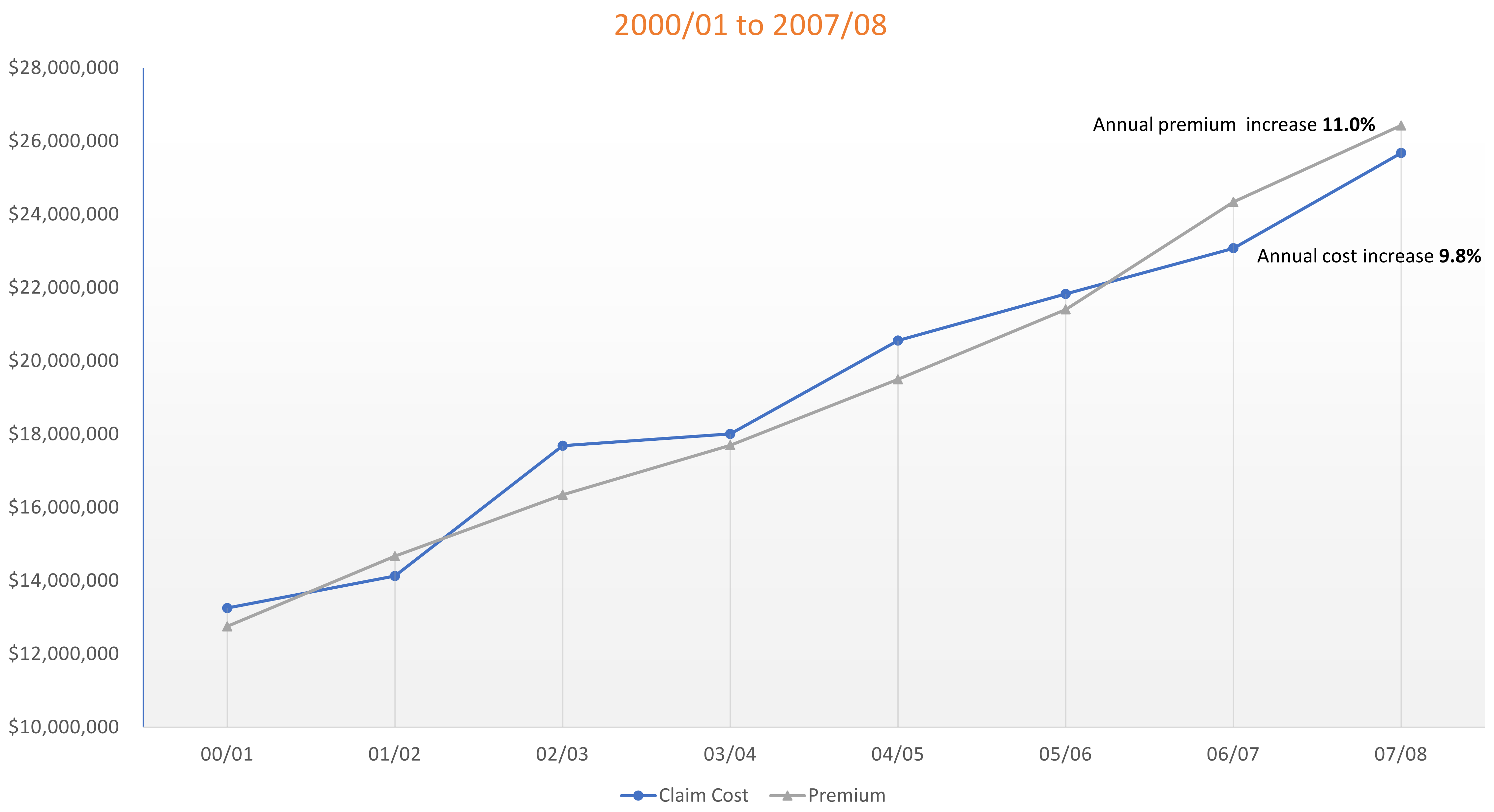
(Over $3,000,000 for years 4-6)

**February 2007**

During the course of negotiations  some districts were insisting on employee premium share. Employees were insisting they could not legally approve such an arrangement at the JGB level; it would have to be discussed in local negotiations.

Negotiations broke down with districts looking for $900,000 and employees willing to agree to $300,000 in plan design changes.

Both sides recognized it meant the end of the moratorium.  Many members feared it also meant the end of a functioning joint governing board.



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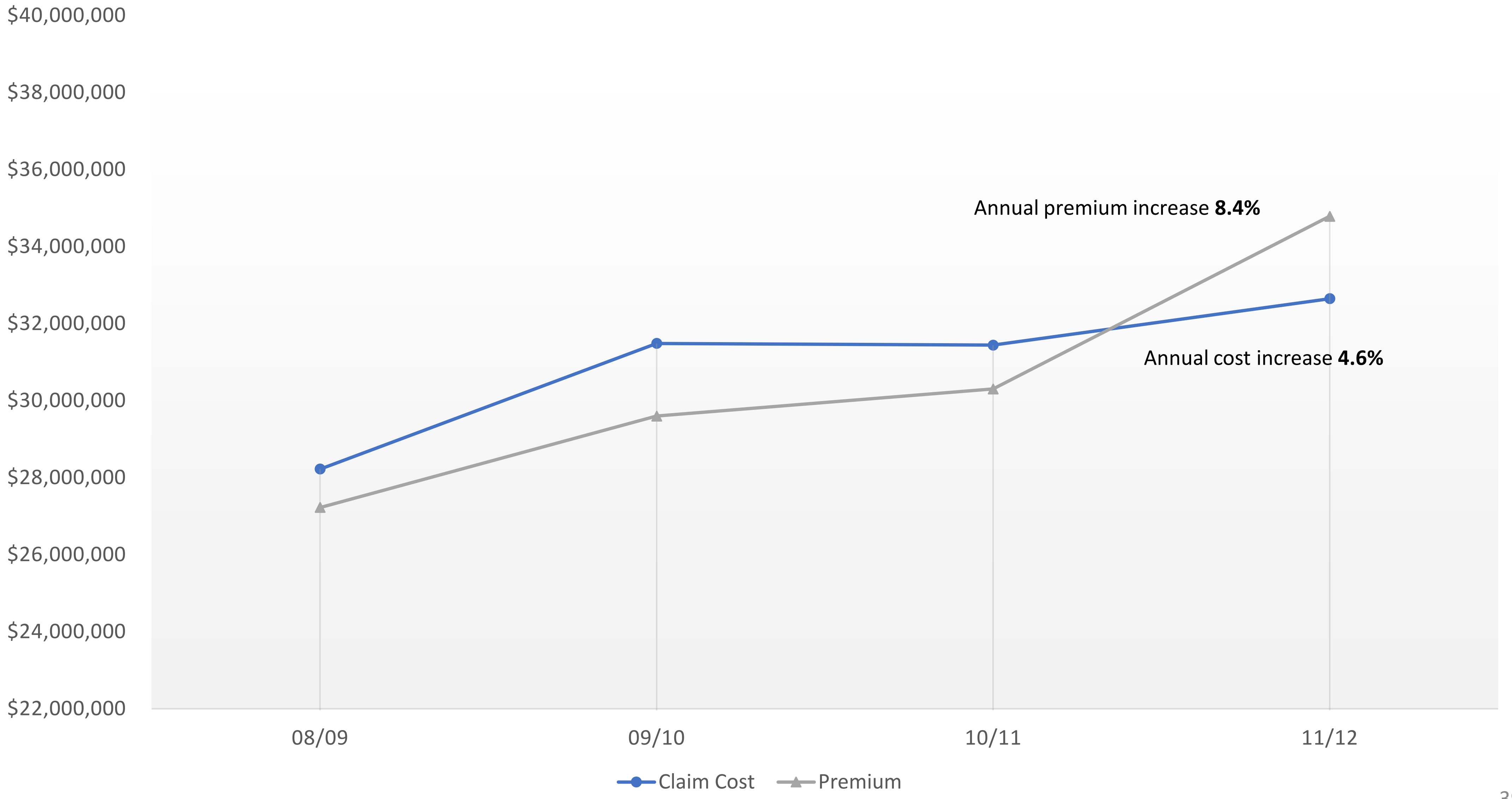
$14,000,000
$12,000,000
$10,000,000
Annual premium increase 11.0%
Annual cost increase 9.8%
00/01
01/02
02/03
03/04
04/05
05/06
06/07
07/08
Claim Cost
Premium

# TOUGH TIMES AND SCARY PROJECTIONS 2008-2012

# 2008/09 to 2011/12



# 2010
# THE FORCED MOVE TO CLASSIC BLUE

It became clear to the JGB that this change provided significant additional benefits to subscribers and therefore increased district claims costs.  After agreeing upon a value of $400,000 for those improved benefits a plan was developed to, essentially, split the cost between employees and employers.

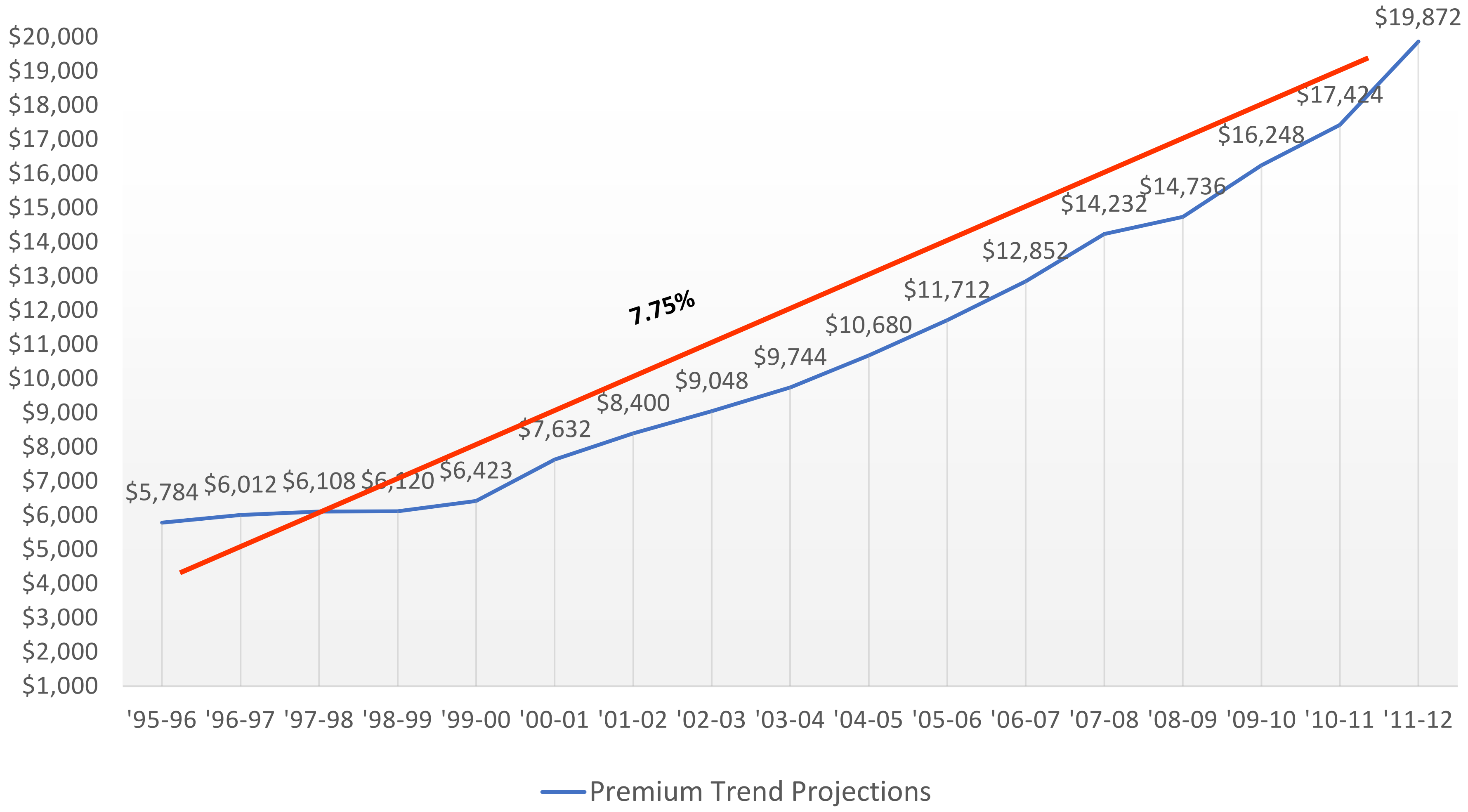
Note: The move was announced in 2010, effective 1/1/12.

# These plan design changes were approved

- Deductible from $150/$450 to $200/$600
- MOOP from $400/$400 to $200/$600
- Hospital inpatient co-pay from $50 to $200
- Retail formulary $15 to $17
- Retail non-formulary $30 to $32
- Mail formulary $30 to $34
- Mail non-formulary $60 to $64
- Generic co-pay incentive program
- Evidence based plan design for diabetes

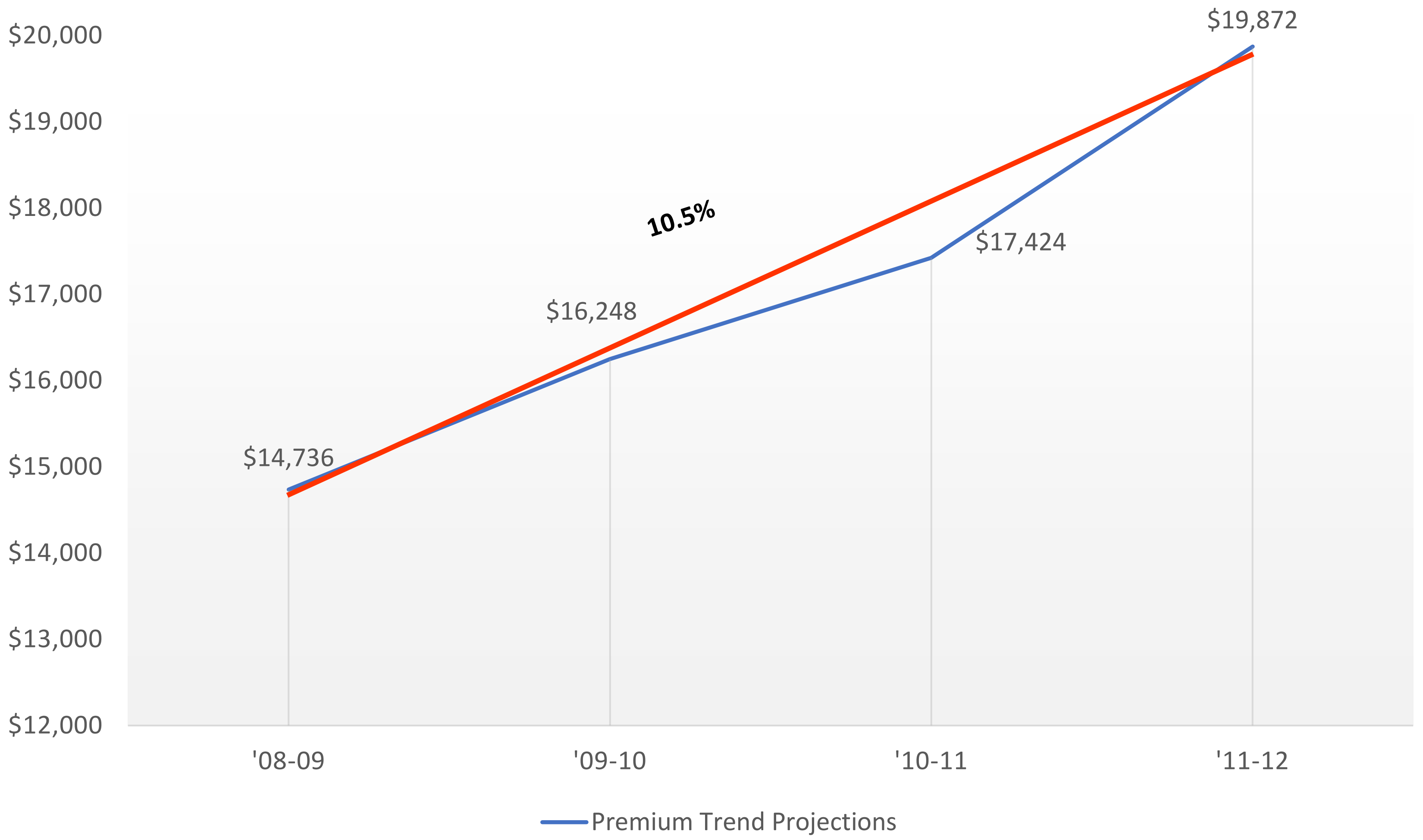
# Premium Trend Projections

## Annual Family Premium

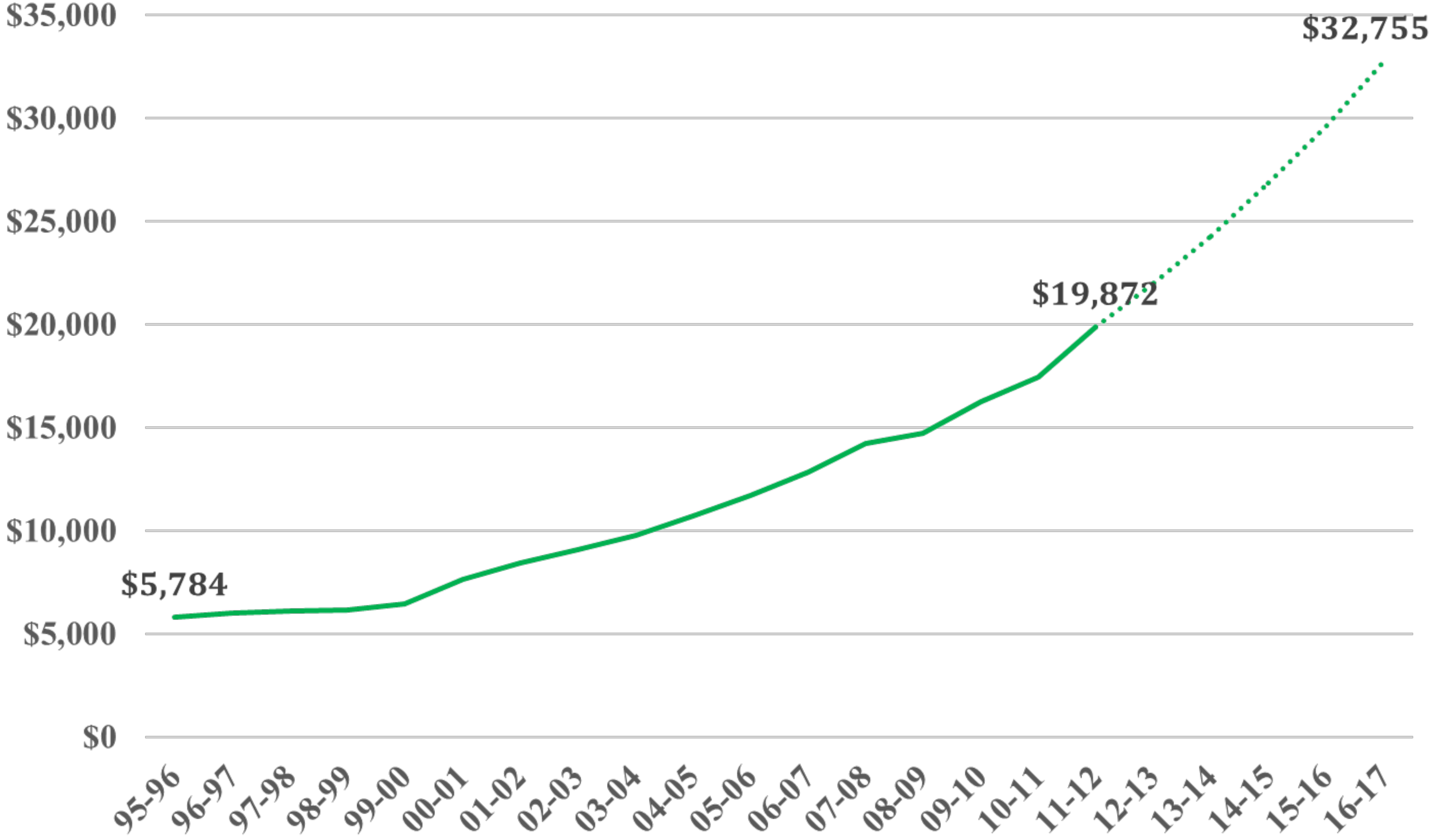


# Premium Trend Projections

## Annual Family Premium

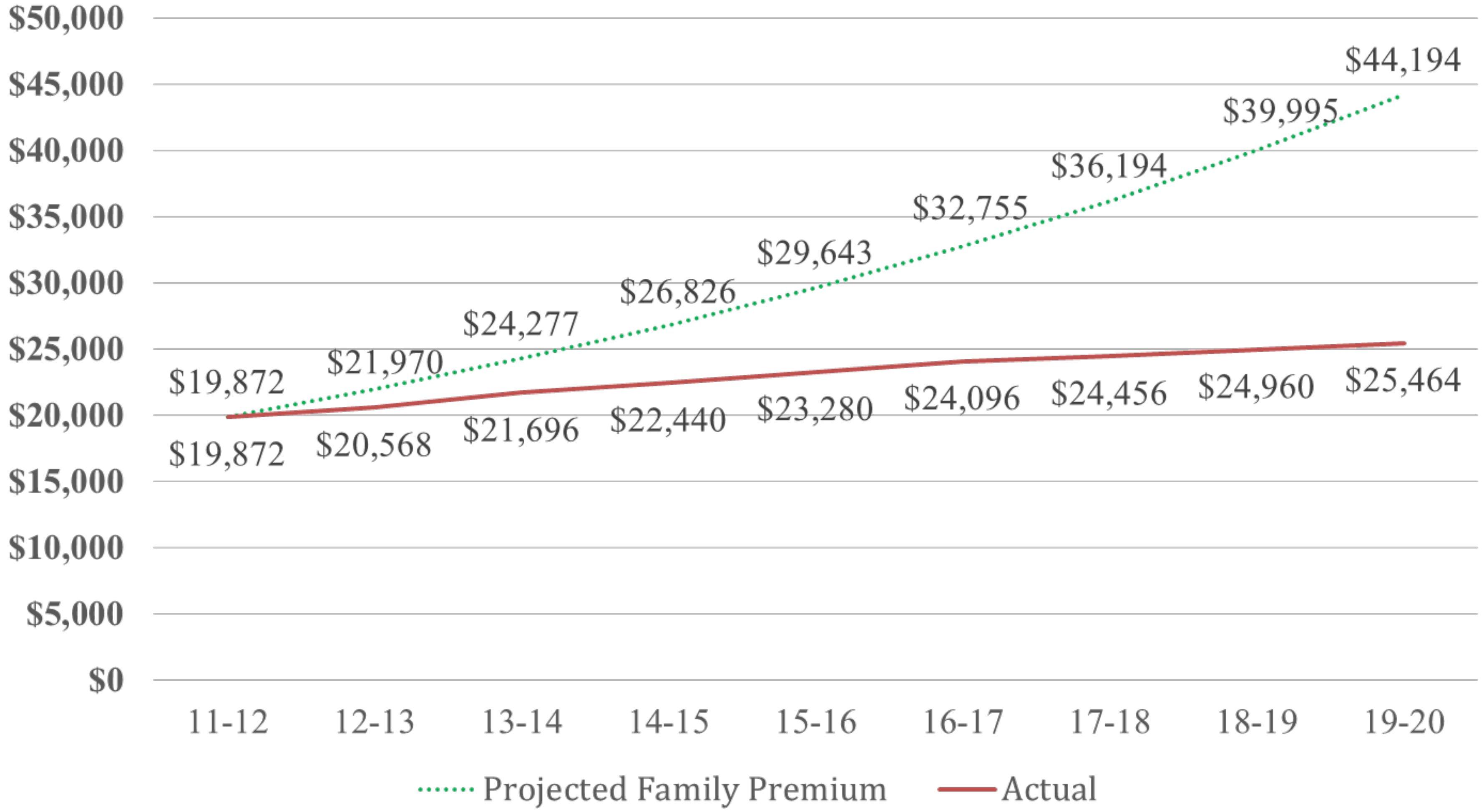


# Premium Trend History and Projections



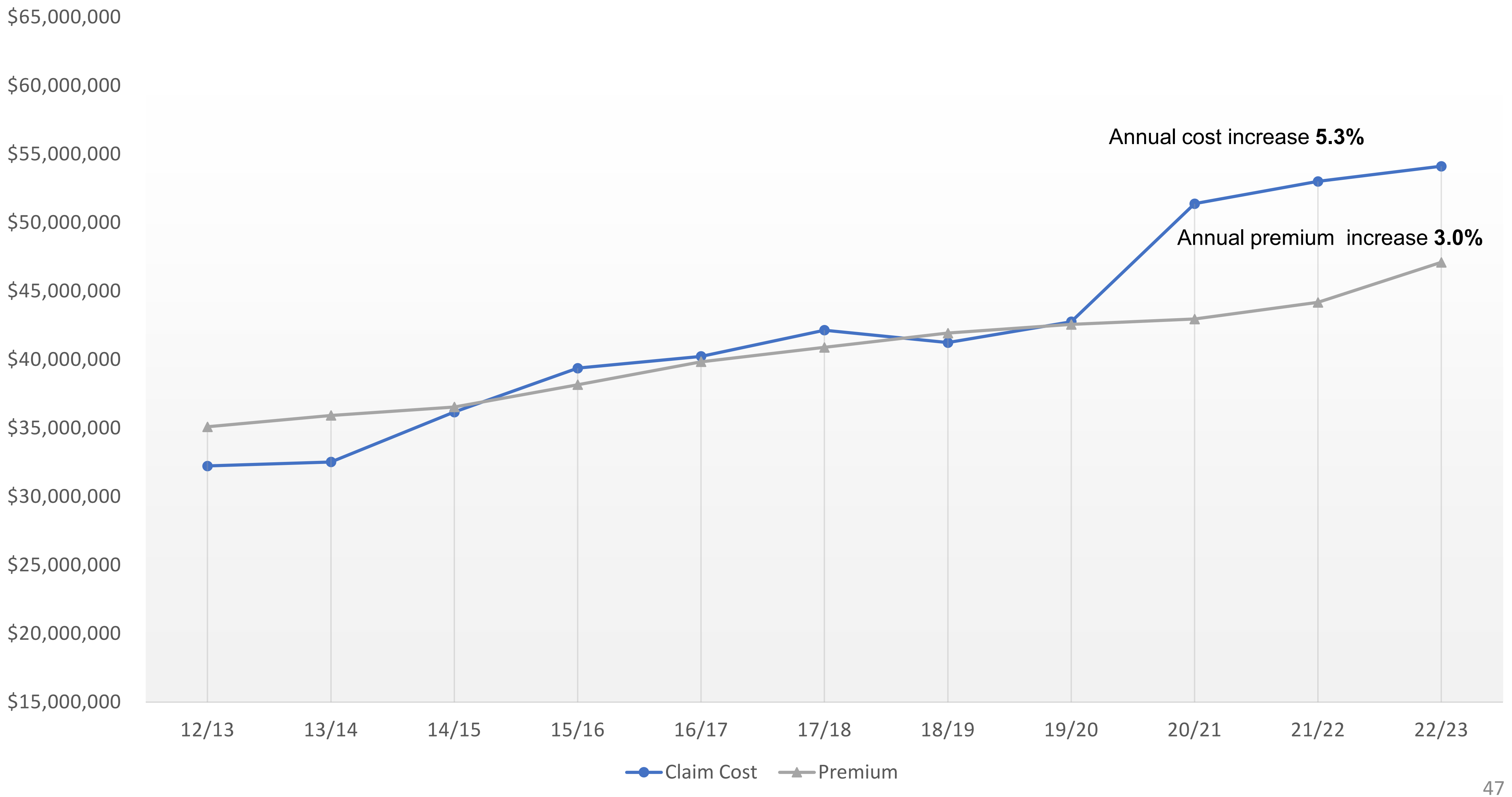
# Family Premiums 2011-2020

## Projections versus Actual



# A DECADE OF SUCCESS 2012-2023

# 2012/13 to 2022/23



# WHAT HAPPENED?

- Claims costs were lower than projected for three reasons
  - Good decisions by the Joint Governing Body
  - The move to Classic Blue and the adoption of EGWP
  - COVID-19
- Stop-loss insurance results deviated significantly from market norms
- Drug rebates and subsidies increased rapidly

# JGB DECISIONS 2010-11

- Apply for Early Retiree Drug Subsidy-estimated value $950,000

- Add Caremark Pharmacy Advisory Program-estimated value $17,000

- Add Enhanced Safety Monitoring Investigations

# JGB DECISIONS 2011-2012

- Approve move from ERDS to EGWP-estimated value $500,000

- Approve Specialty Drug Step Therapy (RA)

# JGB DECISIONS 2012-2013

- Add Generic Incentive Program-Nexium and Crestor-estimated value $3,000

- Add Infertility and MS to Specialty Drug Step Therapy

# JGB DECISIONS 2013-2014

- Approve Generic Step Therapy Program-estimated value $170,217
- Approve BUDCO to do Dependent Eligibility Audit-est. value $1,137,853
- Defeat Mandatory Mail (13-4-1)-estimated value to Consortium $55,000, to members $129,000

# JGB DECISIONS 2014-2015

- Approve Prior Authorization for compounds in excess of $500
  - Estimated value $35,000
- Again defeat Mandatory Mail (12-5-1)
  - Estimated values as before
- Defeat diabetic supplies at zero copay (8-9-1)
- Approve Excellus Case Management Program

# JGB DECISIONS 2015-2016

- Approve Keenan/Express Scripts as PBM
- Approve Smart 90 Program-estimated value $188,185
- Approve ESI Inflation Protection Program
- Approve Oncology Care Value Program

# JGB DECISONS 2016-2017

- Approve Excellus Telemedicine Program
- Approve ESI Inflammatory Conditions Care Value Program-estimated value $30,000
- Approve ESI Market Events Protection Plan
- Approve ESI Limited Advanced Utilization Management (AUM) Plan-estimated value $275,000
- Approve KPCM Pharmacy Care Management Preferred-value range stated at $249,707 to  $306,229
- Approve Generic Diabetic meds at zero co-pay-estimated cost $28,452

# JGB DECISIONS 2017-2018

- Approve ESI MS Care Value Program
- Approve ESI Hepatitis-C Care Value Program

# JGB DECISIONS 2018-2019

- Defeat extending Smart 90 to the EGWP population-estimated cost $27,000

- Approve ESI AUM Preferred Program-estimated value $475,696

- Approve SaveOn Specialty Program-estimated value $331,000

# JGB DECISIONS 2022-2023

- Move to AUM Advantage Plus-value $140,341
- Adopt Screen Rx-value
  - $63,311 on commercial side
  - $117,333 on EGWP side

# UNEXPECTED CLAIMS EXPENSES

| | Projected Expenses | Actual Expenses | Difference |
|---|---|---|---|
| 2012-2013 | $36,985,722 | $32,241,366 | $4,744,356 |
| 2013-2014 | $37,021 | $32,532,017 | $4,489,646 |
| 2019-2020 | $48,813,777 | $42,765,835 | $6,047,942 |
| Combined Other Years | | | $1,163,026 |
| | | | |
| **TOTAL** | | | **$16,444,968** |

# STOP LOSS HISTORY

| | | Premium | | Recovery Actual | | Difference |
|---|---|---|---|---|---|---|
| 2011/12 | | $671,046 | | $565,448 | | ($105,598) |
| 2012/13 | | $725,007 | | $998,384 | | $273,377 |
| 2013/14 | | $796,973 | | $509,529 | | ($287,444) |
| 2014/15 | | $774,297 | | $1,566,834 | | $792,537 |
| 2015/16 | | $898,911 | | $702,192 | | ($196,719) |
| 2016/17 | | $992,060 | | $1,339,648 | | $347,588 |
| 2017/18 | | $982,178 | | $1,173,293 | | $191,115 |
| 2018/19 | | $1,260,091 | | $1,869,229 | | $609,138 |
| 2019/20 | | $1,345,708 | | $1,318,680 | | ($27,028) |
| 2020/21 | | $1,519,671 | | $1,071,961 | | ($447,710) |
| 2021/22 | | $1,789,438 | | $1,492,315 | | ($297,123) |
| 2022/23 | | $1,888,623 | | $1,373,860 | | ($514,763) |
| | | | | | | |
| **Total** | | **$13,644,003** | | **$13,981,373** | | **$337,370** |

# STOP LOSS HISTORY

| | | Recovery Projected | | Recovery Actual | | Difference |
|---|---|---|---|---|---|---|
| 2011/12 | | $0 | | $586,556 | | $586,556 |
| 2012/13 | | $0 | | $998,384 | | $998,384 |
| 2013/14 | | $0 | | $509,529 | | $509,529 |
| 2014/15 | | $0 | | $1,566,834 | | $1,566,834 |
| 2015/16 | | $0 | | $702,192 | | $702,192 |
| 2016/17 | | $0 | | $1,339,648 | | $1,339,648 |
| 2017/18 | | $300,000 | | $1,173,293 | | $873,293 |
| 2018/19 | | $300,000 | | $1,869,229 | | $1,569,229 |
| 2019/20 | | $500,000 | | $1,318,680 | | $818,680 |
| 2020/21 | | $500,000 | | $1,071,961 | | $571,961 |
| 2021/22 | | $500,000 | | $1,492,315 | | $992,315 |
| 2022/23 | | $500,000 | | $1,373,860 | | $873,860 |
| **TOTAL** | | **$2,600,000** | | **$14,002,487** | | **$11,400,487** |

# STOP-LOSS INSURANCE ANALYSIS FOR 23-24

| DEDUCTIBLE (with lasers) | | PREMIUM | | EXPECTED RECOVERY |
|---|---|---|---|---|
| | | | | |
| $300,000 | | $1,969,779 | | $1,214,427 |
| | | | | |
| $500,000 | | $941,314 | | $571,240 |
| | | | | |
| Difference: | | $1,028,465 | | $643,187 |
| | | | | |
| Net advantage: | | | | $385,278 |

NOTE: Expected recoveries calculated by 5-year average of reimbursements received. At 62% and 61% respectively they are very near the industry standard of 60%.

# DRUG REBATES AND SUBSIDIES

| | Projected | | Actual | | Difference |
|---|---|---|---|---|---|
| 11/12 | $250,000 | | $565,448 | | $315,448 |
| 12/13 | $250,000 | | $714,087 | | $464,087 |
| 13/14 | $250,000 | | $1,023,959 | | $773,959 |
| 14/15 | $500,000 | | $872,609 | | $372,609 |
| 15/16 | $500,000 | | $1,188,670 | | $688,670 |
| 16/17 | $900,000 | | $241,539 | | ($658,461) |
| 17/18 | $1,000,000 | | $4,886,866 | | $3,886,866 |
| 18/19 | $2,600,000 | | $3,755,084 | | $1,155,084 |
| 19/20 | $2,700,000 | | $4,879,717 | | $2,179,717 |
| 20/21 | $3,700,000 | | $5,796,863 | | $2,096,863 |
| 21/22 | $5,100,000 | | $5,471,356 | | $371,356 |
| 22/23 | $5,200,000 | | $6,721,471 | | $1,521,471 |
| | | | | | |
| **TOTAL** | **$22,950,000** | | **$36,117,669** | | **$13,167,669** |

# DRUG REBATES AND SUBSIDIES

| | Projected | | Actual | | Difference |
|---|---|---|---|---|---|
| 11/12 | $250,000 | | $565,448 | | $315,448 |
| 12/13 | $250,000 | | $714,087 | | $464,087 |
| 13/14 | $250,000 | | $1,023,959 | | $773,959 |
| 14/15 | $500,000 | | $872,609 | | $372,609 |
| 15/16 | $500,000 | | $1,188,670 | | $688,670 |
| 16/17 | $900,000 | | $241,539 | | ($658,461) |
| 17/18 | $1,000,000 | | $4,886,866 | | $3,886,866 |
| 18/19 | $2,600,000 | | $3,755,084 | | $1,155,084 |
| 19/20 | $2,700,000 | | $4,879,717 | | $2,179,717 |
| 20/21 | $3,700,000 | | $5,796,863 | | $2,096,863 |
| 21/22 | $5,100,000 | | $5,471,356 | | $371,356 |
| 22/23 | $5,200,000 | | $6,721,471 | | $1,521,471 |
| | | | | | |
| **TOTAL** | **$22,950,000** | | **$36,117,669** | | **$13,167,669** |

# SUMMARY OF BUDGET PERFORMANCE DIFFERENCES

| | | |
|---|---|---|
| **Claims lower than projected** | | $16,444,968 |
| **Stop-loss recoveries higher than projected** | | $11,402,487 |
| **Growth of drug rebates and subsidies** | | $13,167,669 |
| **Premiums** | | $1,235,408 |
| **Liability changes** | | $1,828,297 |
| **Interest** | | $334,139 |
| **TOTAL** | | **$44,412,968** |

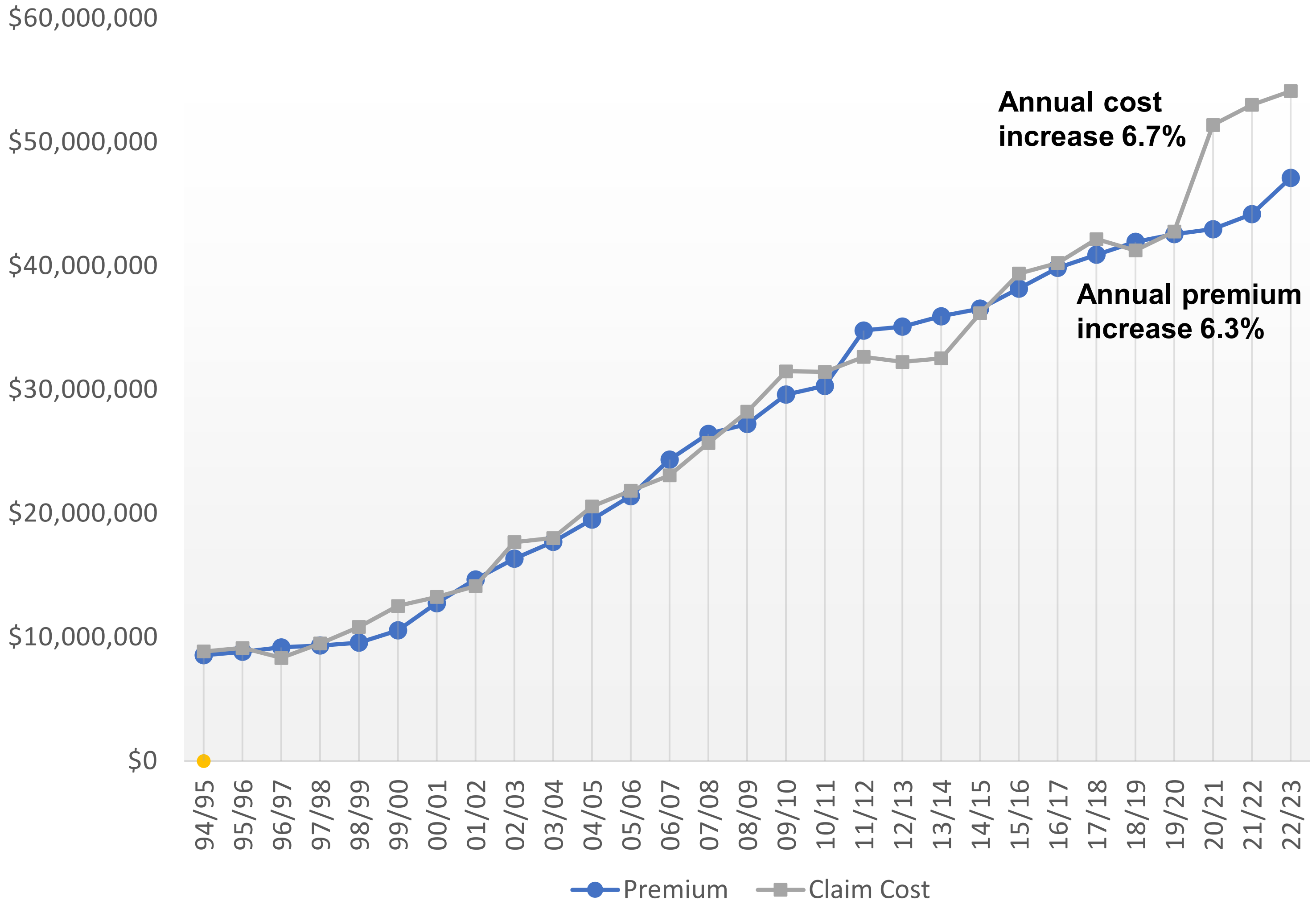
# SUMMARY OF REASONS FOR FUND BALANCE GROWTH

| | <u>**Total Budget Performance**</u> |
|---|---|
| | |
| Projected | ($14,159,072 |
| | |
| Actual | $44,412,968 |
| | |
| Difference | $30,253,896 |

# ADVANTAGES OF A SIGNIFICANT FUND BALANCE

- Avoids the need for a bond for IBNR liability with Excellus
  - Approx. $65,000
- Provides basis for substantial interest income
  - $1,1103,285 in 23-24 budget
- Provides flexibility to deal with stop loss
- Provides flexibility to deal with tough budget situations

# Historic Annual Costs and Premium Equivalents



# Memorandum of Understanding (cont'd.)

**2.** **Reserves and surpluses during the initial period commencing July 1, 1996 and further referenced in item 14 will be maintained as follows:**

**A. Reserves – equal to 25% of Projected Annual Claims**

**B. Unencumbered Surplus – 7% of Projected Premiums**

The governing board of the consortium specified in item 1 above shall determine the allocation and use of funds in excess of reserves and/or unencumbered surplus amounts/percentages. It is agreed and understood that no new benefits will be added to the plan prior to July 1, 1999 except as mandated by law.

# FEH Health Insurance Consortium

# *Health Insurance Reserve Analysis*

*Prepared by:*

***KBM Management, Inc.***



*November 2023*

# General Municipal Law § 6-n

Insurance reserve fund. 1. a. "Municipal corporation," as used in this section, shall mean a municipal corporation, as defined in section two of this chapter, school district, except a school district in a city with a population of one hundred twenty-five thousand or more, board of cooperative educational services, fire district, a district corporation and a special improvement district governed by a separate board of commissioners.

2. (a) The governing board of any municipal corporation may establish a reserve fund to be known as the insurance reserve fund. Upon the creation of the fund, the municipality may make expenditures from the fund for any loss, claim, action or judgment for which the municipal corporation is authorized or required to purchase or maintain insurance…

# Article 47 of the Insurance Laws

4701. Legislative Findings. (a) Cooperative health risk-sharing agreements allow public entities to: share, in whole or part, the costs of self-funding employee health benefit plans; provide municipal corporations, school districts and other public employers with an alternative approach to stabilize health claim costs; lower per unit administration costs; and enhance negotiating power with health providers by spreading such costs among a larger pool of risks.

(b) Appropriate safeguards are necessary to help keep self-funded municipal cooperative health benefits plans from exposing municipalities and their taxpayers to unpredictable and potentially catastrophic liabilities. Minimum standards regarding benefits and participation can better assure that self-funded municipal cooperative health benefit plans will continue to act responsibly and provide coverage for high-cost conditions and high-cost individuals.

# § 4706: Reserve and Surplus Requirements

(1) a reserve for payment of claims and expenses thereon reported but not yet paid, and claims and expenses thereon incurred but not yet reported which shall not be less than an amount equal to twenty-five percent of expected incurred claims and expenses thereon for the current plan year, unless a qualified actuary has demonstrated to the superintendent's satisfaction that a lesser amount will be adequate;

(3) a claim stabilization reserve;

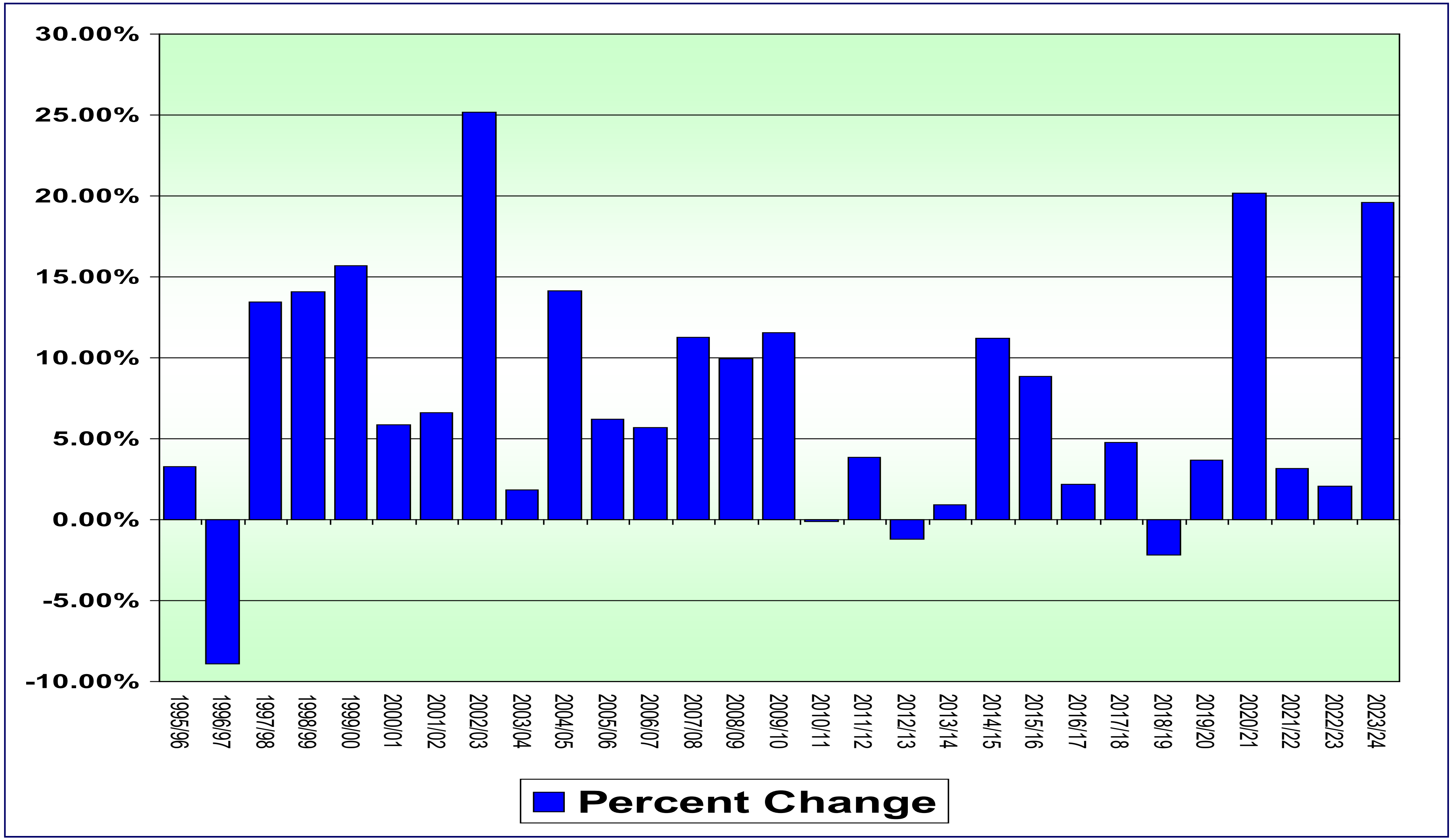
(5) a surplus account, established and maintained for the sole purpose of satisfying unexpected obligations of the municipal cooperative health benefit plan in the event of termination or abandonment of the plan, which shall not be less than:

(A) five percent of the annualized earned premium equivalents during the current fiscal year of the municipal cooperative health benefit plan which consists of five or more participating municipal corporations and covers two thousand or more employees and retirees

# Budget Projection

| Health Insurance Budget - By Category of Health Costs | 2022-23 | 2023-24 |
|---|---|---|
| | (Actual) | (Projected) |
| **Overall Health Insurance Budget (Claims and Administrative Costs)** | | |
| Medical Claims | $34,690,881 | $35,497,816 |
| Prescription Drug Claims | $15,180,243 | $15,369,023 |
| Medical Administrative Cost | $ 3,750,857 | $ 3,535,556 |
| Prescription Drug Administrative Cost | $ 314,499 | $ 355,428 |
| Other Costs | $ 278,985 | $ 150,000 |
| Total Health Ins. Budget (Claims & Other Costs) | $54,215,465 | $54,907,823 |
| | | |
| **District Health Insurance Costs (Claims & Administrative Costs)** | **$54,215,465** | **$54,907,823** |
| **Premium Equivalent (Includes Premium Conrtribution)** | **$47,101,843** | **$47,770,680** |

# Annual Health Insurance Cost Change

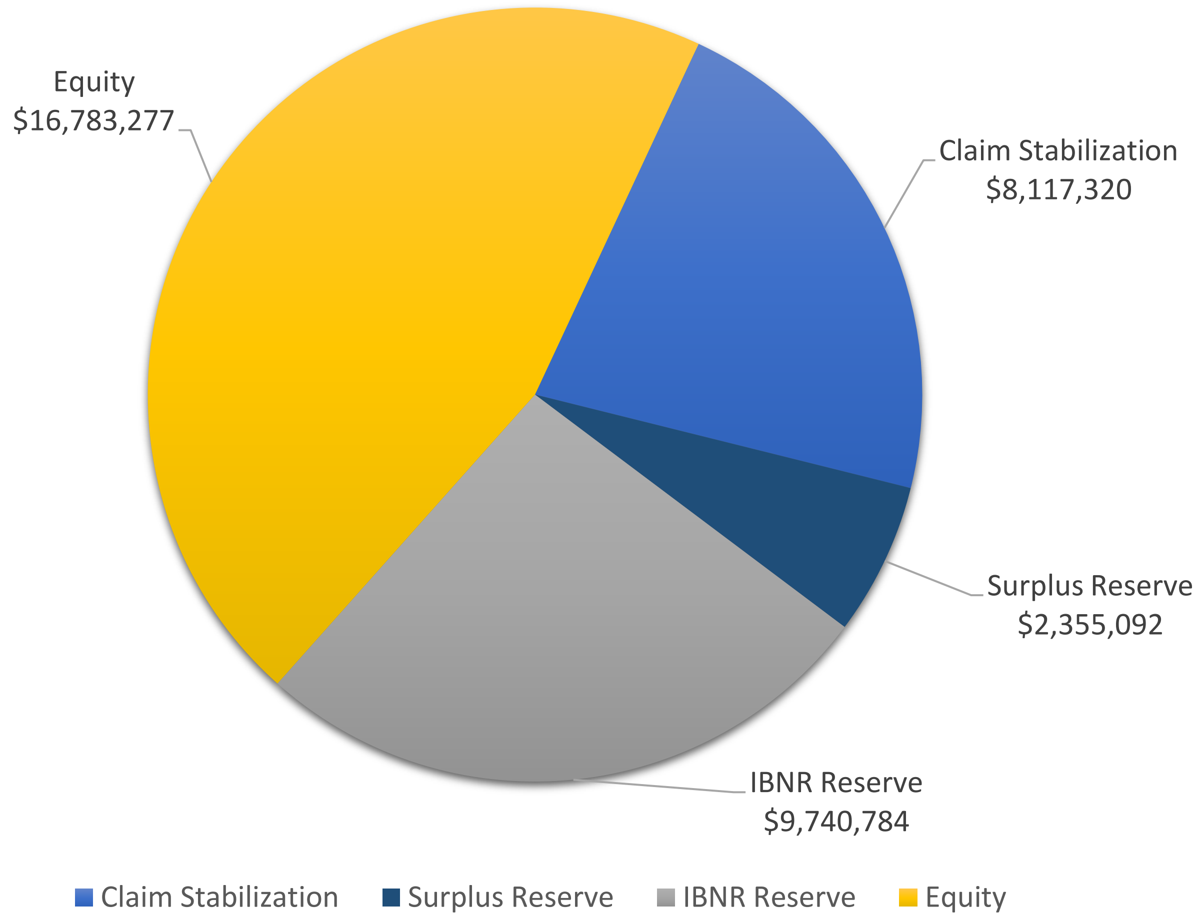


# Reserve Recommendation

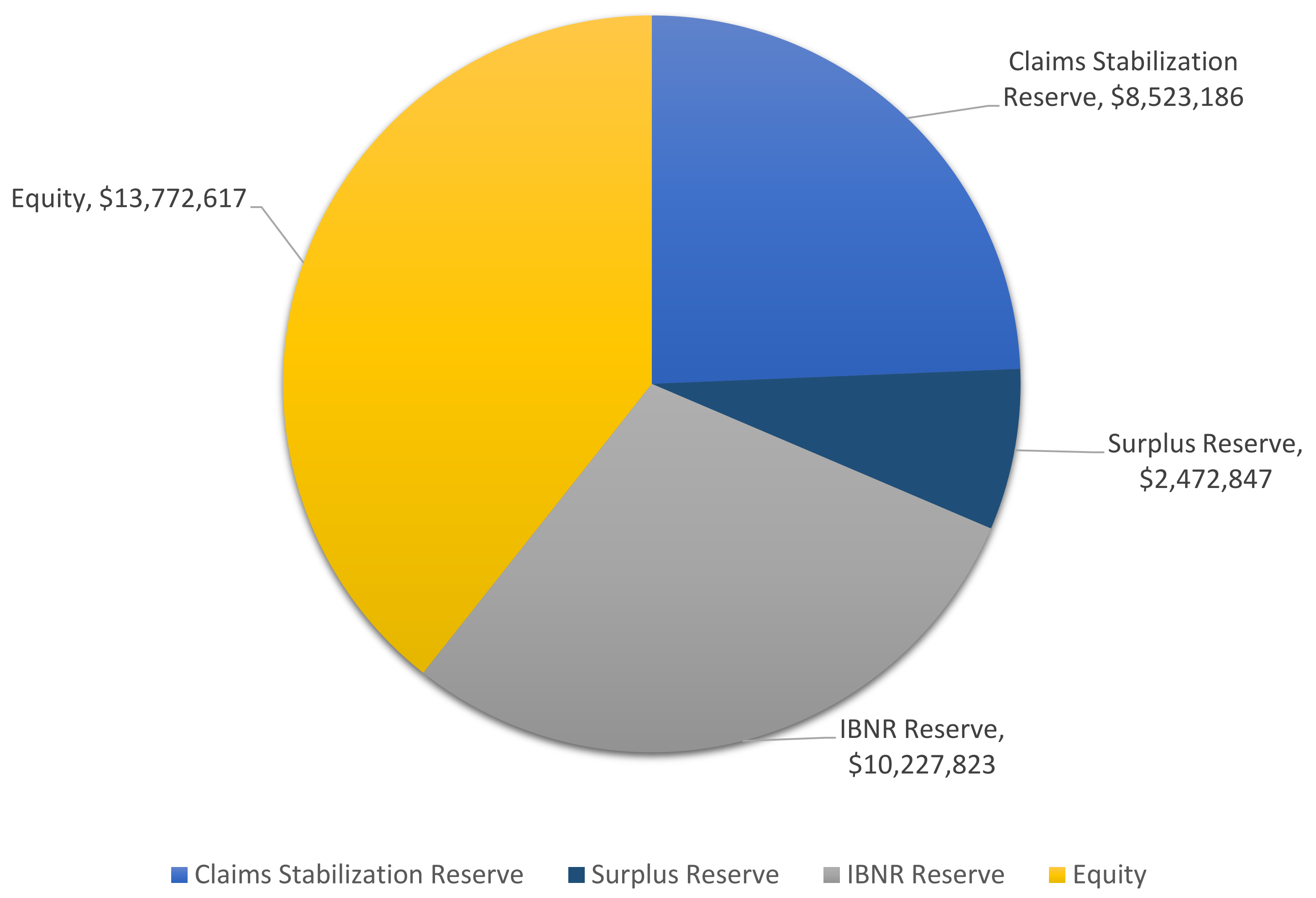
| | 2022/23 | 2023/24 |
|---|---|---|
| **4706 (1) - Accrual (IBNR) Calculation** | **Actual** | **Projected** |
| 18%^ of Projected Claims and Expenses | $9,740,784 | $9,883,408 |
| | | |
| **4706 (3) - Claim Stabilization Reserve** | | |
| (A) 25%* of Maximum Cost Change | $13,528,866 | $13,726,956 |
| (B) 7%* of Average Cost Change | $3,788,083 | $3,843,548 |
| (C) 15% of Projected Claims and Expenses | $8,117,320 | $8,186,095 |
| | | |
| **4706 (5) - Surplus Account** | | |
| 5%^ of Annualized Projected Premium Equivalents | $2,355,092 | $2,388,534 |
| | | |
| **(A) Maximum Reserve** | **$25,624,742** | **$25,998,898** |
| **(B) Minimum Reserve** | **$15,883,959** | **$16,115,490** |
| **(C) Recommended Reserve** | **$20,213,196** | **$20,458,037** |

^ Previously Approved by JGB
* Based on Historic Changes in Costs

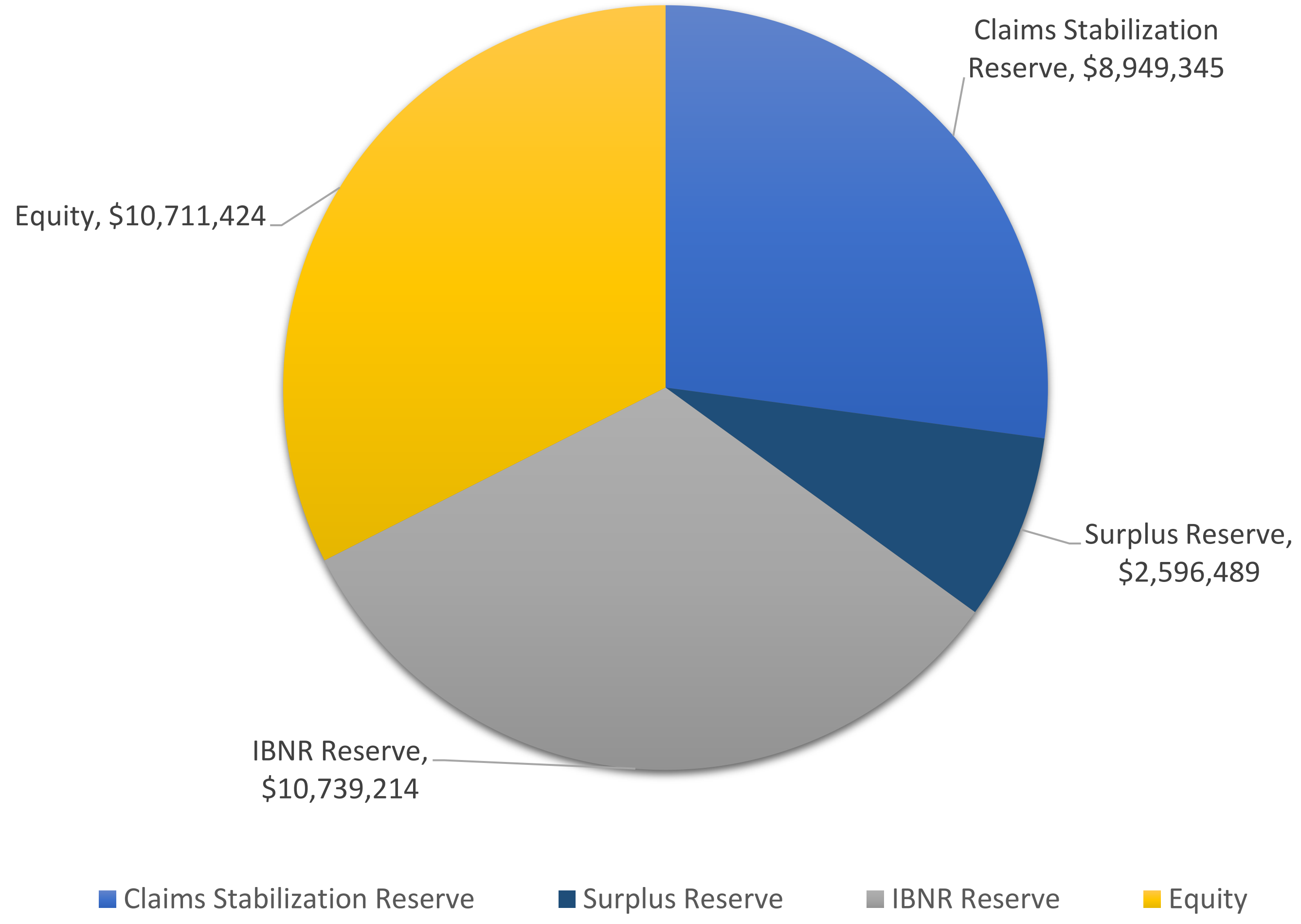
# 2022/23 Fund Balance = $36,996,473



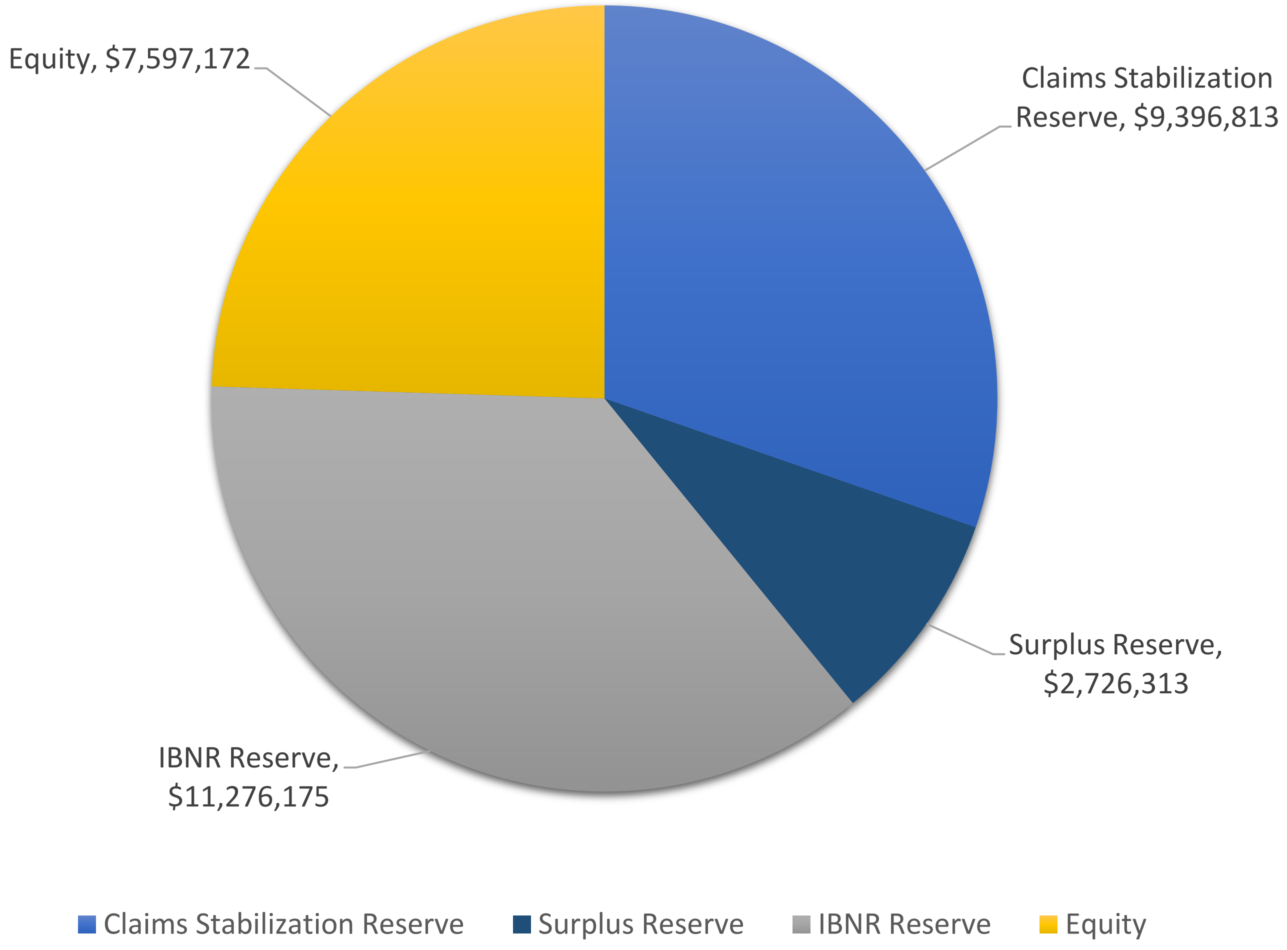
# 2023/24 Fund Balance = $34,996,473



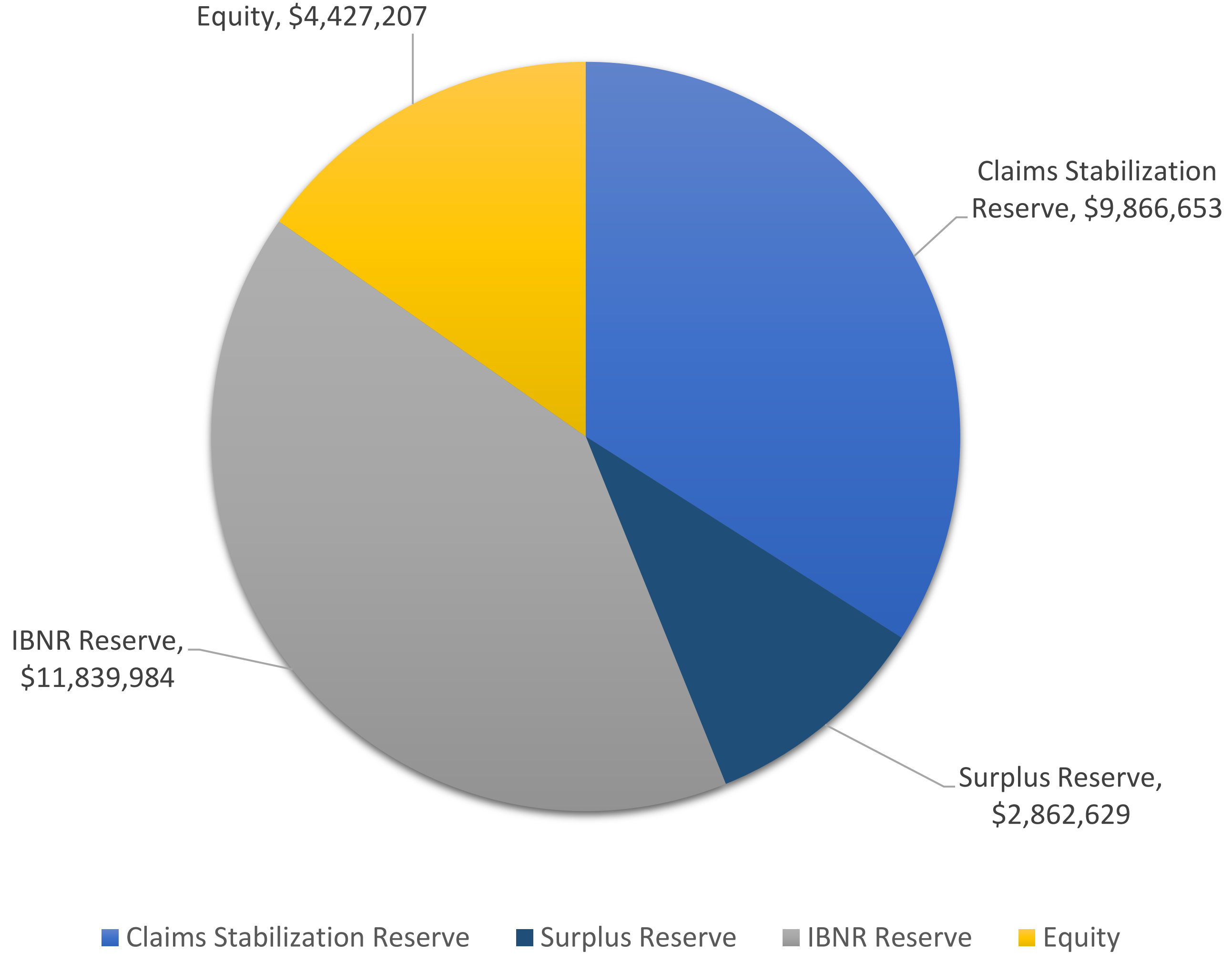
# 2024/25 Fund Balance = $32,996,473



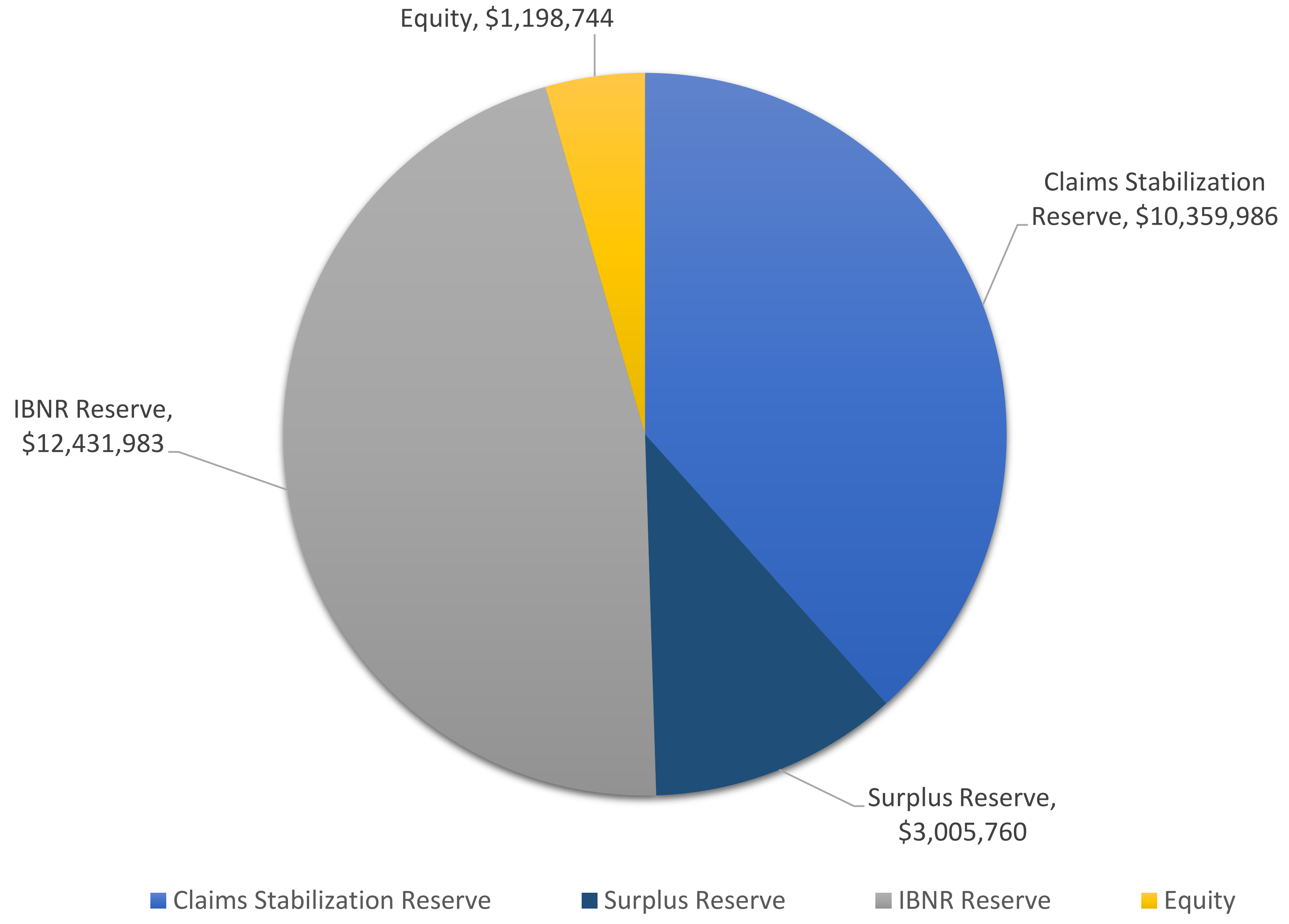
# 2025/26 Fund Balance = $30,996,473

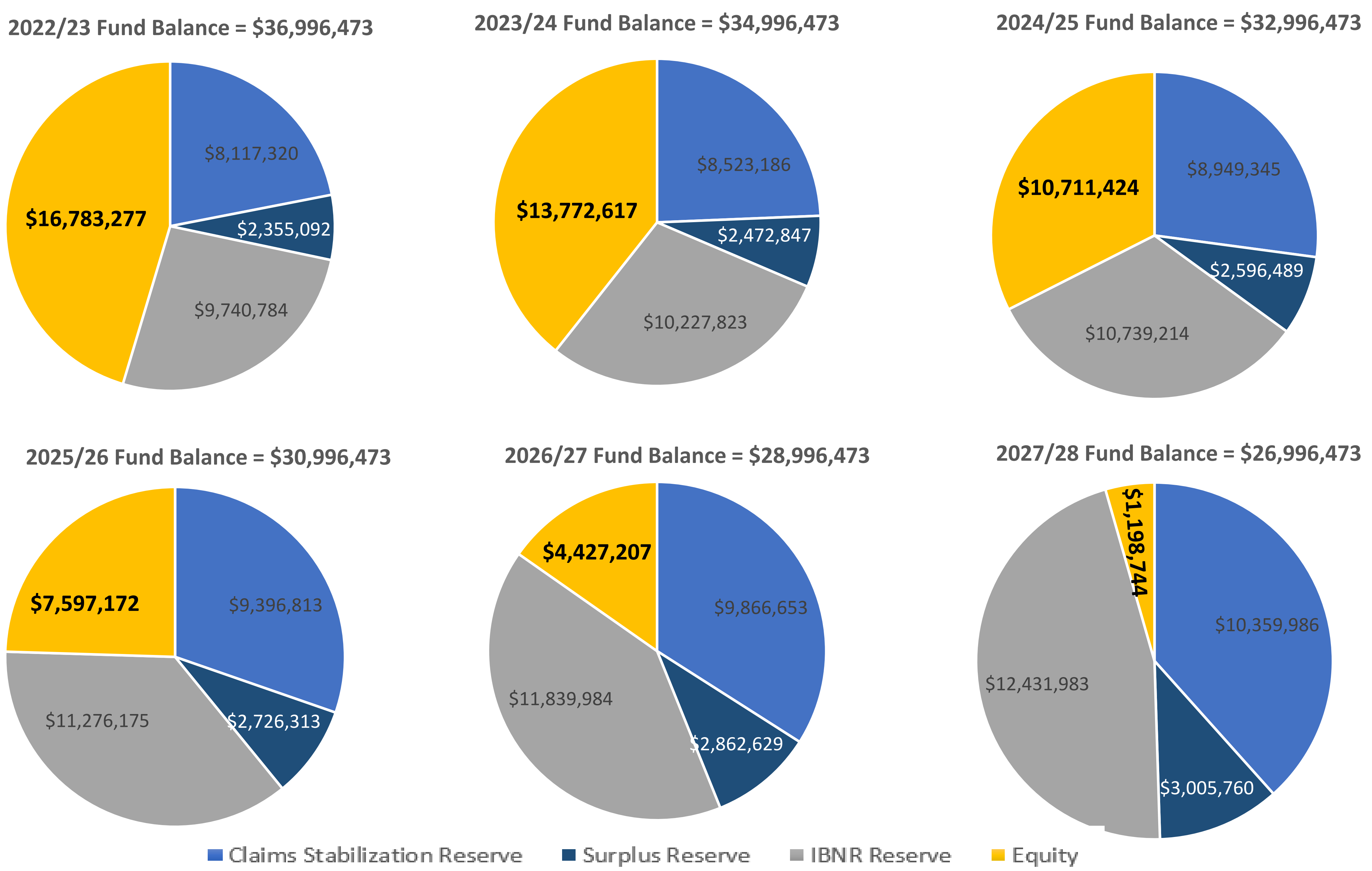


# 2026/27 Fund Balance = $28,996,473



# 2027/28 Fund Balance = $26,996,473




2022/23 Fund Balance = $36,996,473
$8,117,320
$2,355,092
$9,740,784
$16,783,277
2023/24 Fund Balance = $34,996,473
$8,523,186
$2,472,847
$10,227,823
$13,772,617
2024/25 Fund Balance = $32,996,473
$8,949,345
$2,596,489
$10,739,214
$10,711,424
2025/26 Fund Balance = $30,996,473
$9,396,813
$2,726,313
$11,276,175
$7,597,172
2026/27 Fund Balance = $28,996,473
$9,866,653
$2,862,629
$11,839,984
$4,427,207
2027/28 Fund Balance = $26,996,473
$10,359,986
$3,005,760
$12,431,983
$1,198,744
Claims Stabilization Reserve
Surplus Reserve
IBNR Reserve
Equity

# SUMMARY

- Plan design changes such as minor  increases in deductibles and co-pays no longer sufficient to deal with serious budget shortfalls
- Positive budget performance due to stop-loss estimates no longer likely
- Positive budget performance from drug rebates and subsidies less likely to be significant
- Events like the move to Classic Blue or EGWP or an epidemic like COVID-19 cannot be expected

# SUMMARY

- Use plan equity carefully, keeping in mind the long-range financial integrity of the consortium
- Programs that offer some measure of utilization management or improve subscriber compliance with treatment plans should carefully consider when proposed by Excellus or Express Scripts
-

# CLOSING REMARKS

- TODAY’S MEETING IS A STATE OF THE CONSORTIUM MEETING. AS YOU HAVE SEEN THE CURRENT STATE OF THE CONSORTIUM IS STRONG. AS MR. CALNON ALSO DISCUSSED THERE IS A CONVERGENCE OF FACTORS THAT MAY COME INTO PLAY IN THE FUTURE

# CLOSING REMARKS

- IN THE FUTURE, THE CONSORTIUM AND JOINT GOVERNING BOARD WILL MOST LIKELY FACE ISSUES THAT NEED TO BE RESOLVED THROUGH NEGOTIATIONS. THE PARTIES IN THIS ROOM HAVE SUCCESSFULLY NEGOTIATED BEFORE AND I HAVE EVERY CONFIDENCE THAT THEY WILL AGAIN.

# CLOSING REMARKS

- AS THE CONSORTIUM AND JOINT GOVERNING BOARD FACE THE OPPORTUNITIES AND CHALLENGES THAT LIE AHEAD, THEY WILL RELY ON THE CONTINUED SUPPORT OF ALL THE PARTIES PRESENT TODAY. WORKING TOGETHER WE HAVE ALL MADE THIS CONSORTIUM WORK FOR ALMOST THIRTY YEARS, LET'S SET OUR GOAL TO MAKE IT WORK FOR ANOTHER THIRTY.