REPORT ON EXAMINATION

OF

PUTNAM/NORTHERN WESTCHESTER

HEALTH BENEFITS CONSORTIUM

AS OF

JUNE 30, 2013

DATE OF REPORT **MARCH 17, 2016**

EXAMINER **KENNETH I. MERRITT**

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March 17, 2016

Honorable Maria T. Vullo
Acting Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 31189, dated June 5, 2014, attached hereto, I have made an examination into the condition and affairs of the Putnam/Northern Westchester Health Benefits Consortium, which is authorized to operate as a municipal cooperative health benefit plan pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2013, and respectfully submit the following report thereon.

The examination was conducted at the home office of Putnam/Northern Westchester Health Benefits Consortium, located at 200 Boces Drive, Yorktown Heights, New York.

Wherever the designations the "Plan" or "Consortium" appear herein, without qualification, they should be understood to indicate the Putnam/Northern Westchester Health Benefits Consortium.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

The previous examination of the Plan was conducted as of June 30, 2010. This examination of the Plan was a combined (financial and market conduct) examination and covered the three-year period from July 1, 2010, through June 30, 2013. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2014 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook, and where deemed appropriate by the examiner, transactions occurring subsequent to June 30, 2013 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilized that assessment in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as to identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and a determination of management's compliance with the Department's statutes and guidelines, and the applicable statutes of the New York State General Municipal Law.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited for fiscal year 2011 by the accounting firm of Sickler, Torchia, Allen and Churchill, CPAs, PC. During fiscal years 2012 and 2013, the Plan was audited by the accounting firm of UHY LLP ("UHY"). The Consortium received an unqualified opinion in each of those years. Certain audit workpapers of UHY, in connection with its audit of the Plan's 2013 fiscal year-end financial statements, were reviewed and relied upon by the examiner in conjunction with this examination.

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

A review was also made to ascertain what actions were taken by the Plan with regard to the recommendations contained in the prior report on examination.

2. DESCRIPTION OF THE PLAN

Putnam/Northern Westchester Health Benefits Consortium was organized in 1987 pursuant to Article 5-G of the New York General Municipal Law for the purpose of providing health insurance benefits to participating county and city school districts and Putnam Northern Westchester Board of Cooperative Educational Services ("Putnam Northern Westchester BOCES"). The Plan received a certificate of authority from the Department, effective November 1, 1999 under Article 47 of the New York Insurance Law to continue operating as a self-funded municipal cooperative health benefit plan. The Consortium comprises thirteen school districts and Putnam Northern Westchester BOCES, whose objective is to collectively administer a low-cost, self-funded health insurance program that provides hospital, medical and prescription drug benefits to the active employees, retirees and their dependents from each of the school districts and Putnam Northern Westchester BOCES.

The Consortium's participating members consisted of the following local school districts located throughout Putnam and Northern Westchester counties and Putnam Northern Westchester BOCES, as of June 30, 2013:

- Brewster Central School District
- Briarcliff Manor Union Free School District
- Chappaqua Central School District
- Croton-Harmon Union Free School District
- Garrison Union Free School District
- Haldane Central School District
- Hendrick Hudson Central School District
- Lakeland Central School District
- Mahopac Central School District
- Peekskill City School District
- Putnam Valley Central School District
- Putnam Northern Westchester BOCES
- Somers Central School District
- Yorktown Central School District

School districts applying for membership into the Plan may do so on the basis of an approval of a majority of the Consortium's Board of Trustees.

A. Corporate Governance

Pursuant to the Consortium's Municipal Cooperation Agreement, which was last approved by the Department effective June 1, 2000, management of the Consortium is to be vested in a Board of Trustees (the "Board") consisting of five members. Individuals serving on the Board are elected by a majority of the Plan's participating member school districts and Putnam Northern Westchester BOCES. Each Trustee may serve on the Board for an indefinite period or until either their voluntary resignation or removal from office by a majority vote of the Consortium's members.

The following individuals were members of the Plan's board of trustees as of June 30, 2013:

Name and Residence	Principal Business Affiliation
Diane Chaissan Newburgh, NY	Director of Finance and Administrative Services, Croton-Harmon Union Free School District
Tim Conway Brewster, NY	Interim Superintendent, Brewster Central School District
Starr Dinio Wappingers Falls, NY	Business Administrator, Mahopac Central School District
John McCarthy Hopewell Junction, NY	Assistant Superintendent, Putnam Northern Westchester BOCES
Raymond Morningstar Mohegan, NY	Assistant Superintendent, Lakeland Central School District

The following individuals were appointed as officers of the Plan as of June 30, 2013:

Name	Position
Diane Chaissan	President
Todd Currie	Chief Financial Officer
Raymond Morningstar	Secretary

The Board of Trustees met at least twice during each of the fiscal years under examination, as required by Article IV of the Plan's Municipal Cooperation Agreement. Board meetings were generally well attended by the Trustees with each Trustee attending at least one-half of all the total meetings they were eligible to attend during the examination period.

Article 3, Section 39 of the New York State General Municipal Law states the following, in part:

> "Investment policies for local governments. 1. Each local government, which for purposes of this section shall include…school districts including boards of cooperative educational services and district corporations… shall by resolution adopt a comprehensive investment policy which details the local government's operative policy and instructions to officers and staff regarding the investing, monitoring and reporting of funds of the local government."

The Consortium currently does not have in place any formal written investment policies, in contravention of Article 3, Section 39 of the New York State General Municipal Law.

It is recommended that the Plan comply with Article 3, Section 39 of the New York General Municipal Law and establish a comprehensive written investment policy.

In accordance with the Plan's Municipal Cooperation Agreement, in addition to the above mentioned Board of Trustees, the Plan maintains a twelve member Joint Governance Board ("JGB") that consists of the same five individuals that serve on the Plan's Board of Trustees, plus other school districts administrators and employees' union labor representatives. The JGB provides a broader and more inclusive governance of the Plan due to the varied

backgrounds of the members. The JGB operates according to a Joint Governance Agreement (the "JGB Agreement") that was established by the Plan, effective on July 1, 1992. The JGB Agreement calls for the JGB to provide support and assistance to the Board of Trustees and to act principally on matters affecting the administration of the Plan. The Agreement requires the JGB to meet at least two times during each calendar year.

The Plan's existing Joint Governance Board Agreement, Item B, states the following:

> "There shall be a Joint Governance Board (Board) established which shall replace the management Finance Committee and the employee Governance Board. Such Board shall not exceed twelve (12) members in size and will be equally represented by representatives and alternates chosen by the participating employers and by the unions representing the employees of the participating employers."

The following thirteen (13) members served on the JGB of the Plan as of June 30, 2013:

Name and Residence	Principal Affiliation
Douglas Andreotti Poughkeepsie, NY	Teacher, Putnam Northern Westchester BOCES
George Benack Millwood, NY	Teacher, Chappaqua Central School District
Diane Chaissan Newburgh, NY	Director of Finance and Administrative Services, Croton-Harmon Union Free School District
Gloria Colucci Hopewell Junction, NY	Superintendent, Garrison Union Free School District
Starr Dinio Wappinger Falls, NY	Business Administrator, Mahopac Central School District
Edward Furman, Jr. Stony Point, NY	Superintendent, Croton-Harmon Union Free School District
John McCarthy Hopewell, NY	Assistant Superintendent, Putnam Northern Westchester BOCES

Name and Residence	Principal Affiliation
Winnie McCarthy Poughkeepsie, NY	Retired, Putnam Northern Westchester BOCES
Raymond Morningstar Mohegan Lake, NY	Assistant Superintendent for Business, Lakeland Central School District
John Roden Carmel, NY	Retired, Yorktown Central School District
Stuart Sabshin Cornwall on Hudson, NY	Retired, Peekskill City School District
Mary Uhle Patterson, NY	Superintendent, Putnam Valley Central School District
Elizabeth Weiden-Philipbar Poughkeepsie, NY	Teacher, Peekskill City School District

The JGB membership of thirteen individuals exceeded the allowable maximum of twelve members pursuant to the JGB Agreement. When asked why there were more than twelve members, the Plan indicated that one member is an alternate and that the alternate only votes when another member is absent. It was noted during the review of the minutes that in many instances, the thirteenth member did vote regardless of whether or not another member was absent. This practice of having a thirteenth member, even as an alternate, is not permitted under the JGB Agreement in that the requirement for twelve members stipulates that alternates be included as part of the total.

It is recommended that the Plan comply with its Joint Governance Board Agreement by having no more than twelve total members serving on the Consortium's Joint Governance Board.

The minutes to the meetings held by the Joint Governance Board during the examination period revealed that the meetings were generally well attended, with all of the members having attended at least 50% of the all of the meetings in which they were required to attend.

B. Municipal Cooperation Agreement

The Consortium has an existing Municipal Cooperation Agreement which was signed at various dates in June 2000 by each of the Plan's participating school districts and Putnam Northern Westchester BOCES. The Agreement is subject to the statutory requirements specified under Section 4705 of the New York Insurance Law and sets forth the matter and conditions under which the Plan is to be managed and operated by the Consortium's respective Board of Trustees and Joint Governance Board. While the Agreement was approved by the Department effective June 1, 2000, the examiner's review of the Agreement revealed that the document as currently written is not fully compliant with Section 4705 of the New York Insurance Law.

Following are some examples of statutes under Section 4705 of the New York Insurance Law that were found to be deficient in the Agreement:

Section 4705(a) of the New York Insurance Law states in part the following:

> "The municipal cooperation agreement under which the municipal cooperative health benefit plan is established and maintained, and any amendment thereto, shall be approved by each participating municipal corporation by majority vote of each such corporation's governing body…"

Section 4705(a)(2) of the New York Insurance Law states in part the following:

> "…all participating municipal corporations agree to share the costs of and assume the liabilities for medical, surgical and hospital benefits provided under the municipal cooperative health benefit plan to the covered employees (including retirees) and their dependents of all participating municipal corporations;"

Section 4705(d)(2)(A) of the New York Insurance Law states the following:

> "The charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts as required in subdivision six of section ninety-two-a of the general municipal law;"

It is recommended that the Consortium submit an amended Municipal Cooperation Agreement which complies with all of the requirements of Section 4705 of the New York Insurance Law to the Department for approval.

C. Third Party Administrators

The Plan maintained contractual arrangements with the following outside service providers as of June 30, 2013:

1. Administrative Services Agreement

   The captioned agreement, effective January 1, 2010 between the Consortium and Aetna Life Insurance Company ("Aetna"), calls for Aetna to provide the Plan with various administrative services including but not limited to the following functions: (a) claims administration, (b) member services, (c) patient management (e.g., prospective, concurrent and retrospective utilization reviews), (d) provider network, and (e) preparation of monthly, quarterly and annual/bank financial/accounting reports (e.g., paid benefits, claims analysis, claims/bank account reconciliation, etc.).

2. Express Scripts, Inc. ("ESI") Pharmacy Benefit Management

   The Agreement with Express Scripts, Inc. ("ESI") calls for ESI to administer the Consortium's pharmacy benefits program by providing the Plan with various services including, but not limited to the following functions: (a) implementation and establishment of members' eligibility files, (b) provide a network of participating pharmacies, mail pharmacy service, specialty products services, etc., (c) claims processing, (d) drug utilization reviews, (e) formulary support and rebate management, (f) claims data retention, and (g) preparation of management and

financial reports available through ESI's on-line standard management information reporting applications.

3. PFM Asset Management LLC ("PFM") Investment Advisory Agreement

   PFM provides the Consortium with advisory services related to the evaluation, sale, and reinvestment of Plan assets assigned and available to PFM under the Plan's custodial investments account.

4. Bank Custodial Agreement

   The captioned Agreement, which was entered effective June 22, 2012 between Putnam Northern Westchester BOCES Health Consortium {sic} and U.S. Bank National Association, is utilized for safekeeping of the Plan's invested assets.

   The examiner's review of the above mentioned Custodial Agreement and the related U.S. Bank National Association account statements received by the Plan revealed the following deficiencies:

   a) Both the Consortium's Custody Agreement and its monthly custody statements received from U.S. Bank National Association are in the name of Putnam Northern Westchester BOCES instead of Putnam/Northern Westchester Health Benefit Consortium.

   b) Section 17.8 of the Custody Agreement entitled "Governing Law" indicates the State of Minnesota laws apply to the Agreement, rather than New York State's laws.

It is recommended that the Consortium amend the name listed in its Custodial Agreement with U.S. Bank National Association ("U.S. Bank") as well as the name included on U.S. Bank's monthly bank statements to Putnam/Northern Westchester Health Benefits Consortium.

It is recommended that the Consortium revise Section 17.8 of its Custody Agreement to indicate that New York State's laws apply to the Agreement.

5. Aquarius Capital Solutions Group LLC ("Aquarius")

The Consortium and Aquarius have a longstanding contract for Aquarius to provide the Consortium with annual actuarial reserving and premium rates services.

D. Territory and Plan of Operation

As of June 30, 2013, the Plan held a certificate of authority to operate a municipal cooperative health benefit plan, as authorized by Section 4704 of the New York Insurance Law, in the counties of Putnam and Westchester. Pursuant to the requirements of Section 4706 of the New York Insurance Law, the Plan is required to maintain a surplus account reserve equal to five percent of the annualized earned premium. The Plan met this requirement throughout the examination period.

As of June 30, 2013, the Plan provided coverage to 7,869 members. Membership was stable during the examination period. Plan members were enrolled at the local school district level.

The Plan's covered members receive health care coverage based on the defined benefits provided in the Consortium's Plan Document, which is the group contract issued by a municipal cooperative health benefit plan to participating municipal corporations describing the terms and conditions of coverage. The Consortium's Plan Document that was in effect during the examination period was approved by the Department on April 22, 2010. This Document was in compliance with the Affordable Care Act due to the Plan's status as a Grandfathered Plan until

January 2016. A new Plan Document, in consideration of the Plan's changed status, has been submitted to the Department for approval and is under consideration.

The Consortium reported the following net written premiums and membership amounts for the years 2011 through 2013:

Plan Year	Net Premiums Written	Membership
2013	$103,145,297	7,869
2012	$101,692,636	7,912
2011	$99,709,466	8,036

The Plan's premium rates are established by its Finance Committee and such rates were developed in compliance with New York Insurance Law Section 4705(d)(5)(B).

In January 2013, the Consortium began offering Medicare Advantage PPO ("MA") coverage to its eligible members under a group policy issued by Aetna Life Insurance Company. Under the Consortium's group policy, the participating school districts and Putnam Northern Westchester BOCES pay their MA premiums to the Plan and the Plan in turn remits the payments to Aetna in exchange for healthcare benefits for the Plan's covered members. As of the Plan's June 30, 2013 fiscal year end reporting date, the Plan reported total MA premiums in the amount of $2,238,665 and total MA enrollment, including covered dependents, of 3,519.

E. Stop-Loss Insurance

The Plan is required to maintain both specific and aggregate stop-loss insurance pursuant to Section 4707 of the New York Insurance Law in order to limit its exposure to medical and prescription drug expense losses.

The policy, which renews annually, included the following coverage/policy liability limits, as of June 30, 2013:

Coverage	Policy Liability Limits
Specific excess of loss coverage Maximum benefit for aggregate losses	100% of $2 million excess of the Plan's $1 million deductible, per policy year per covered person.
Aggregate coverage Maximum benefit for specific losses	100% of $1 million per policy year per covered person.
U.S. Fire's minimum aggregate attachment point	$132,485,126

Section 4707(a)(i) of the New York Insurance Law states in part the following:

> "The governing board of a municipal cooperative health benefit plan shall obtain and maintain on behalf of the plan a stop-loss insurance policy or policies delivered in this state and issued by a licensed insurer, providing:
>
> (i) Aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty-five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year; and …"

The following calculation reflects the required attachment point:

Aggregate attachment point per U.S. Fire stop-loss policy		$132,485,126
Plan's total expected incurred claims for FY 2012/2013, per Actuary	$103,000,000	
NY Statutory Attachment Point Percent	125%	
Statutory annual aggregate attachment point		128,750,000
Difference		$ 3,735,126

The examiner noted that U.S. Fire's aggregate attachment point of $132,485,126 exceeded the New York Insurance Law Section 4707(a) statutory maximum limitation, as determined in the above calculation.

It is recommended that the Consortium comply with Section 4707(a) of the New York Insurance Law by maintaining aggregate stop-loss coverage with an annual aggregate retention amount or attachment point that does not exceed the statutory maximum limitations.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities and net worth as of June 30, 2013, as reported in the Plan's 2012-2013 filed fiscal-year end statement, a condensed summary of operations and a reconciliation of the net worth account for each of the years under review. While there were some adjustments made to reclassify certain of the Plan's reserve and surplus accounts, the examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in the June 30, 2013 filed fiscal year statement.

Independent Accountants:

During the period covered by this examination, the Consortium retained for the audit of its combined GAAP basis statement of financial positions and related statements of operations, net worth and cash flows, the CPA firm of Sickler, Torchia, Allen & Churchill ("STAC"), as of the June 30, 2011 fiscal year reporting date. For the reporting dates June 30, 2012 and 2013 respectively, the firm of UHY LLP was retained by the Plan to audit the Consortium's combined

GAAP basis statement of financial position and the related statements of operations, net worth, and cash flows for the fiscal years then ended.

STAC and UHY concluded respectively that the GAAP basis financial statements presented fairly, in all material respects, the financial position of the Plan at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

Part 89.5(e)(1) of Insurance Regulation No. 118 (11 NYCRR 89) states in part the following:

> "A company may not utilize for any purpose of this Part any work performed or prepared by a CPA if that CPA also contemporaneously provides any of the following non-audit services … :
>
> (i) bookkeeping or other services related to the accounting records or financial statements of the company; …"

During the course of the examiner's review of the Consortium's records, including those generated by its CPA, the examiner noted that for fiscal years 2012 and 2013, the Consortium's CPA, UHY, assisted the Plan with the preparation of certain financial records, including the Trial Balance Report and the fiscal year-end financial statements at the same time that the firm was performing an independent audit engagement on the Consortium's financial statements. Based on the aforementioned Regulation, the Consortium should not be accepting assistance with the preparation of the Plan's financial statements and the independent audit of the Plan's financial statements from the same CPA firm.

It is recommended that the Plan comply with Part 89.5 of Insurance Regulation No. 118 (11 NYCRR 89) and refrain from receiving assistance with the preparation of its financial statements from the same CPA firm that is simultaneously auditing the Consortium's financial statements for external filing purposes.

A. Balance Sheet

Assets	Examination	Plan	Surplus Increase/ (Decrease)
Bonds	$27,021,687	$27,021,687	
Cash and cash equivalents	36,504,769	36,504,769	
Premiums receivable	5,082,424	5,082,424	
Total assets	$68,608,880	$68,608,880	
Liabilities			
Unpaid claims	$12,567,782	$12,567,782	
Additional reserve for IBNR	4,932,220	5,137,675	$ 205,455
Accounts Payable	2,902,835	2,902,835	
Claim stabilization reserve	8,900,000	8,900,000	
Section 4706(a)(4) other obligations reserve	2,000,000	0	(2,000,000)
Unearned premium reserve	430,000	0	(430,000)
Total liabilities	$31,732,837	$29,508,292	$ 2,224,545
Total Surplus			
Gross paid in and contributed surplus	$ 0	$ 2,267,280	(2,267,280)
Contingency reserve	5,200,000	5,157,265	42,735
Unassigned surplus	$31,676,043	$31,676,043	0
Total Surplus	$36,876,043	$39,100,588	$(2,224,545)
Total liabilities and surplus	$68,608,880	$68,608,880	

The above examination changes reflect the examiner's re-classification of various account balances reported by the Plan as of June 30, 2013, as a result of the Plan having to subsequently re-file its initial June 30, 2013 financial statement filing with the Department on the basis of an updated financial statement format. Subsequent to the Consortium filing its June 30, 2013 financial statement with the Department, the Department directed the Plan to resubmit an

amended statement under a revised financial statement format currently used by other Article 47 municipal cooperative health insurance plans. A distinguishing aspect of the updated statement format versus the previous version is that the latter included the GAAP basis net assets account which reflects the difference between total assets and total liabilities. Under the updated format, the net assets account or retained earnings account was replaced with the surplus account and such other additional surplus account line items that were similar and more consistent with the NAIC statutory basis accounting reporting. In following the Department's instruction to re-file the statement under the revised format, the examiner noted that the Consortium improperly reported certain of its Article 47 statutory reserves (liabilities), including the unearned premiums and other obligations reserves into the gross contributed and paid surplus account. The examiner noted that the Plan reported a gross contributed and paid in surplus amount in an amount totaling $2,267,280 in its re-filed June 30, 2013 fiscal year end financial statement. The examiner's review of this account revealed that the balance comprised the Plan's unearned premiums and other obligations reserve in the amounts of $267,280 and $2,000,000 respectively. The examiner also noted that the Consortium's Unearned Premiums account balance of $267,280 should have been reported in the amount of $430,000.

The reduction to the "Additional Reserve for Incurred But Not Reported" ("IBNR") account in the amount of $205,455 was made to adjust the Consortium's Statutory Reserve at the 2013 fiscal year-end to reflect a total account balance of $17,500,000 or 17% of the Plan's total expected incurred losses for the current year. Putnam's 17% statutory maximum reserve requirement was previously approved by the Department, effective April 17, 2007.

The $42,735 increase to the residual account "Contingency Reserve, represents a rounding adjustment.

B. Statement of Revenue, Expenses, and Surplus

Net surplus increased $20,310,737 during the three-year examination period, July 1, 2011 through June 30, 2013, detailed as follows:

Revenue		
Premiums and related revenue	$304,547,399	
Prescription drug rebates	13,507,617	
Aggregate write-ins for other than healthcare related revenues	2,912,342	
Investment income	457,448	
Total revenue		$321,424,806
Expenses		
Hospital/medical benefits	200,971,766	
Prescription drugs	86,492,950	
Aggregate write-ins for other expenses	2,680,687	
General administrative expenses	10,937,916	
Total underwriting deductions		301,083,319
Net income		$ 20,341,487

Total surplus, per report on examination, as of June 30, 2010			$16,565,306
	Gains in Surplus	Losses in Surplus	
Net income	$20,341,487		
Change in IBNR	1,499,250		
Change in Claims Stabilization Reserve		$1,500,000	
Change in Unearned Premium Reserve		30,000	
Change in Other Expenses Reserve		1,000,000	
Change in Stop-loss Insurance	1,000,000		
Net increase in surplus			20,310,737
Total surplus per report on examination, as of June 30, 2013			$ 36,876,043

4. CLAIMS PAYABLE (INCLUDING CLAIMS STABILIZATION RESERVE)

The examination liabilities for Claims Payable in the amount of $17,500,000 comprises Unpaid Claims and Additional Reserve for IBNR of $12,567,782 and $4,932,330 respectively. The Plan also reported additional New York Insurance Law Article 47 Reserves in an amount totaling $11,330,000, which included the Plan's Claims Stabilization Reserve in the amount of $8,900,000. These are the same amounts as reported by the Plan as of June 30, 2013.

Section 4706(a)(1) of the New York Insurance Law requires that the governing board of a municipal cooperative health benefit plan establish a reserve fund, including a reserve for the payment of claims and expenses reported but not yet paid, and claims and expenses incurred but not yet reported. This reserve fund is required to be not less than an amount equal to twenty-five percent (25%) of expected incurred claims and expenses for the current plan year, unless a

qualified actuary has demonstrated to the Superintendent's satisfaction that a lesser amount will be adequate. The Plan was granted approval by the Department on April 11, 2007, to reduce its reserves for claims and related expenses required by Section 4706(a)(1) of the New York Insurance Law, from the statutorily mandated 25%, to 17% of the Plan's current year's expected incurred claims and expenses.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred on or prior to June 30, 2013.

The examiner's review of supporting documentation for the Incurred Claims account balance reported as of June 30, 2013, revealed a discrepancy between the account balance as reported by the Plan in its filed financial statement and the same account as reported by the Consortium's outside consulting actuary in that firm's actuarial opinion report. Specifically, where the Plan's statement included a total claims incurred balance in the amount of $99,012,072, the Plan's actuary reported a balance of $97,256,490 in the firm's actuarial report, a difference of $1,755,582. The examiner noted further that the total pharmacy claims payments of $31,251,450 reported in the Plan's 2013 fiscal year-end filed statement did not reconcile to the corresponding paid pharmacy claims total of $27,765,772, as reported in the Plan's lag triangle report. Based on the difference of $3,485,678 in pharmacy payments between the Plan's filed

statement and its lag triangle report, the Plan supplied the examiner with copies of additional paid invoice documents that the Plan made to Express Scripts, Inc. in the amount of $2,933,132. The Plan never recorded such paid invoices into the lag triangle report and when added to the lag triangle report's pharmacy payments, the aforementioned discrepancy in the pharmacy claims payments were significantly reduced to a much smaller variance of $552,546.

In a follow-up to the above mentioned discrepancies, the examiner utilized the Consortium's CPA workpapers as an additional source of information to verify the reasonableness of the claims account reporting.

It is recommended that the Plan ensure that its fiscal year-end incurred claims balance, as reported in the Plan's filed financial statement, reconciles with the report issued by the Plan's outside actuary.

It is recommended that the Plan exercise due care and vigilance when preparing the Consortium's claims lag triangle reports. The Plan should also be vigilant to ensure that the information that is being recorded in the reports is complete and reliable.

5. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct investigation.

Aetna Life Insurance Company ("Aetna") is the third-party administrator ("TPA") for the Plan's claims management, grievances, and utilization review processes per an Administrative Services Agreement between the parties. Under this agreement, which covers the Consortium's medical and hospital claims, Aetna manages all claims services, including members' enrollment verifications, claim payments and check issuance, and issuance of the explanation of benefits statements and other member services. Express Scripts, Inc. administers the processing and adjudication of the Plan's prescription drug claims. While Aetna and Express Scripts, Inc. are relied upon by the Consortium relative to these management functions, the Plan has full responsibility and ultimate decision-making authority for these functions.

The review of claims adjudication was directed at practices of the Plan in the following major areas:

A. Operational
B. Utilization review
C. Explanation of benefits statements
D. Prompt payment of claims

The following is a summary of the examiner's review of the above Plan activities for the examination period that required comments and/or recommendations.

A. Operational

During the examination period, the Plan utilized The Segal Company ("Segal Consulting"), an independent third-party administration and technology consulting firm, to conduct an analysis of Aetna's claims processing and payment procedures. The analysis

included, but was not limited to, an evaluation of the claims processing and payment procedures utilized by Aetna in their administration of the Consortium's group health plan benefits. The analysis also encompassed Segal Consulting's review of the Consortium's prompt payment of claims results based on the requirements of the U.S. Department of Labor, which require 100% compliance within 30 calendar days, rather than on the requirements of New York Insurance Law.

The examiner reviewed Segal Consulting's "turnaround time analysis" which tested 100% of all adjudicated claims based on the received and processed dates provided in the claim file. The file contained an overall population of 245,023 medical claims processed during the twelve-month period January 1, 2012 through December 31, 2012. The results of Segal Consulting's analysis revealed that Aetna processed 97.13% of all claims within 14 calendar days of receipt and 98.84% of all claims within 30 calendar days of receipt. The process and benefits gained by the Plan retaining Segal Consulting to review the claims processing practices of Aetna will be further enhanced by the Consortium requiring Segal Consulting to expand the scope and review of its analysis to include the New York Insurance Law prompt pay statutes. Currently the contract with Segal does not specify any particular requirements regarding which statutory requirements to enforce.

It is recommended that the Plan ensure that its independent third-party administrator, Segal Consulting, includes New York's statutory requirements and compliance as part of the scope of its audits of the Plan's claims processing TPA, Aetna Life Insurance Company. A similar recommendation was made in the prior report on examination.

B. Prompt Payment of Claims

A review was made of Aetna's claims processing procedures and internal controls to measure its compliance with Section 3224-a of the New York Insurance Law which provides the standards for prompt, fair and equitable settlement of claims for health care and payments for health care services.

Section 3224-a(c)(1) of the New York Insurance Law states in part the following:

> "…any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. Where the amount of interest due on such a claim is less than two dollars, and insurer, organization or corporation shall not be required to pay interest on such claim."

The examiner's sampling of the Plan's 2014 calendar year paid claims data file did not reveal any issues with regard to the Plan's compliance with Sections 3224-a (a) and (b) of the New York Insurance Law. Therefore, additional testing procedures were not performed for those sections of law.

The examiner did perform a review of Section 3224-a(c)(1), cited above, for purposes of evaluating Aetna's internal control procedures relating to the proper calculation and payment of interest on claims that were deemed to be late. The review included a non-statistical sample of twenty-five (25) claims that were paid late during 2014. The sample of the twenty-five claims revealed that twenty-one (21) of the claims that were paid late in violation of Section 3224-a of

the New York Insurance Law properly included applicable interest payments as required by New York Insurance Law Section 3224-a(c). The remaining four out of the sample of twenty-five claims or 16% that were paid late did not include the requisite additional delinquent interest payments.

It is the responsibility of the Consortium to proactively monitor and ensure Aetna's timely processing and adjudication of the Plan's claim payments in accordance with the above mentioned New York Prompt Pay Law.

It is recommended that the Consortium institute controls to ensure that Aetna processes the Plan's claims in a manner that is in full compliance with Section 3224-a of the New York Insurance Law. A similar recommendation was made in the prior report on examination.

It is also recommended that the Consortium institute audits of Aetna's claim-adjudicating practices to ensure that the Plan is in full compliance with New York Insurance Law Section 3224-a. A similar recommendation was made in the prior report on examination.

It is recommended that the Plan, through its TPA Aetna, ensure that claims affected by Aetna's internal control deficiencies be corrected, including reimbursing all claimants who never received additional interest for the late payment of claims as required by New York Insurance Law Section 3224-a(c). A similar recommendation was made in the prior report on examination.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on organization included eight (8) recommendations detailed as follows (page numbers refer to the report on examination):

PAGE NO.		ITEM NO.
	Operational	
1.	It is recommended that the Plan ensures that its independent third-party auditor, Thomson Reuters, include statutory compliance as part of the scope of its audits of the Plan's TPA, Aetna Life Insurance Company. *The Plan has not complied with this recommendation.*	16
	Claims Processing	
2.	It is recommended that the Plan ensures its TPA, Aetna Life Insurance Company, is processing and paying claims accurately. *The Plan has not complied with this recommendation.*	17
	Utilization Review	
3.	It is recommended that the Plan ensures its contracted claims processor, Aetna Life Insurance Company complies with New York Insurance Law Sections 4903(c), 4904(e), and Department Regulation No. 166. *The Plan has complied with this recommendation.*	19

ITEM NO. **PAGE NO.**

Explanation of Benefits statements

4. Although ALIC, pursuant to its contractual agreement with the Plan, is responsible for sending EOBs on behalf of the Plan to the Plan's members and providers, the management of PNW retains the ultimate responsibility for compliance with applicable provisions of the New York Insurance Law and related regulations. Therefore, the Plan's management must be diligent in its oversight of its market conduct activities, including the dissemination of EOBs. In this regard, although ALIC is regulated by the State of Connecticut, it is incumbent upon ALIC to be aware of and comply with pertinent New York Insurance Laws and regulations when processing the Plan's claims and in providing appropriate documents, including EOBs to the Plan's members and providers on the Plan's behalf. 21

The Plan has complied with this recommendation.

5. It is recommended that the Plan ensures its claim processing TPA, Aetna, comply with New York Insurance Law Section 3234 and provide its members with explanation of benefits statements that are complete, clear, accurate, and otherwise comply with all aspects of that Law. 21

The Plan has complied with this recommendation.

Prompt Payment of Claims

6. It is recommended that Aetna institute controls to ensure that it is in full compliance with Section 3224-a of the New York Insurance Law. 24

The Plan has not complied with this recommendation.

7. It is also recommended that the Plan institute audits of its claim-adjudicating TPA, Aetna, to ensure that it maintains full compliance with all aspects of Section 3224-a of the New York Insurance Law. 24

The Plan has not complied with this recommendation.

ITEM NO.		PAGE NO.
8.	It is recommended that the Plan, through its TPA Aetna, ensures that claims affected by the aforementioned areas of compliance, occurring during and subsequent to the examination period be corrected. The Plan or its designee should ensure that such remediation is performed. *The Plan has not complied with this recommendation*.	24

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
iii.	It is recommended that the Plan, through its TPA Aetna, ensure that claims affected by Aetna's internal control deficiencies be corrected, including reimbursing all claimants who never received additional interest for the late payment of claims as required by New York Insurance Law Section 3224-a(c). A similar recommendation was made in the prior report on examination.	26

Respectfully submitted,

_____/S/_____
Kenneth Merritt
Associate Insurance Examiner

STATE OF NEW YORK)
) SS
)
COUNTY OF NEW YORK)

Kenneth Merritt, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____/S/_____
Kenneth Merritt

Subscribed and sworn to before me
this _____ day of_____2016.

APPOINTMENT NO. 31189

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Kenneth Merritt

as a proper person to examine the affairs of

Putnam/Northern Westchester Health Benefits Consortium

and to make a report to me in writing of the condition of said

Municipal Cooperative Health Benefit Plan

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed my name and affixed the official Seal of the Department at the City of New York

this 5th day of June, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau