REPORT ON EXAMINATION

OF THE

GREATER TOMPKINS COUNTY MUNICIPAL

HEALTH INSURANCE CONSORTIUM

AS OF

DECEMBER 31, 2015

DATE OF REPORT **APRIL 18, 2018**

EXAMINER **CHARLES J. McBURNIE**

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April 18, 2018

Honorable Maria T. Vullo
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 31505, dated July 7, 2016, attached hereto, I have made an examination into the condition and affairs of Greater Tompkins County Municipal Health Insurance Consortium, a municipal cooperative health benefit plan certified pursuant to the provisions of Article 47 of the New York Insurance Law, as of December 31, 2015, and respectfully submit the following report thereon.

The examination was conducted at the administrative office of Greater Tompkins County Municipal Health Insurance Consortium located at 125 East Court Street, Ithaca, New York.

Wherever the designations the "Plan" or "GTCMHIC" appear herein, without qualification, they should be understood to indicate the Greater Tompkins County Municipal Health Insurance 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 was conducted as of December 31, 2011. This examination of the Plan was a combined (financial and market conduct) examination and covered the four-year period from January 1, 2012 through December 31, 2015. 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, 2016 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 December 31, 2015 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis, 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 evaluation 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 identify prospective risks that may threaten the future solvency of GTCMHIC.

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 determined management's compliance with the Department's statutes and guidelines, generally accepted accounting principles, and annual statement instructions.

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 examination also evaluated the Plan's critical risk categories in accordance with the NAIC's ten critical risk categories. These categories are as follows:

- Valuation/Impairment of Complex or Subjectively Valued Invested Assets
- Liquidity Considerations
- Appropriateness of Investment Portfolio and Strategy
- Appropriateness/Adequacy of Reinsurance Program
- Reinsurance Reporting and Collectability
- Underwriting and Pricing Strategy/Quality
- Reserve Data
- Reserve Adequacy
- Related Party/Holding Company Considerations
- Capital Management

GTCMHIC was audited annually, for fiscal years 2012 through 2015, by the accounting firm Insero & Co. CPAs, LLP (formerly Ciaschi, Dietershagen, Little, Mickelson & Company, LLP). The Plan received an unmodified opinion in each of those years. Certain audit work papers of Insero & Co. CPAs, LLP, were reviewed and relied upon 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 require explanation or description.

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item No. 6 of this report.

2. DESCRIPTION OF THE PLAN

GTCMHIC is a New York Insurance Law Article 47 municipal cooperative health benefit plan that began its operations in 2011 with thirteen participating municipalities. With the addition of the City of Cortland, the Town of Lansing, the Town of Willet, and the Village of Homer between 2013 and 2015, the Plan had seventeen participating municipalities as of December 31, 2015. As a subsequent event to the examination, on May 13, 2016, the Department was notified of three new participants to the Plan: the towns of Marathon, Truxton and Virgil. These three participants were first reported in the Plan's Quarterly Statement as of March 31, 2016.

On October 1, 2010, the Plan was issued a certificate of authority by the Superintendent under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority and in accordance with the Municipal Cooperative Agreement, each of the participants have agreed to share the costs and assume the liabilities for hospital, surgical, prescription drug, and major medical benefits provided to covered employees (and retirees) and their dependents under the Plan.

As of December 31, 2015, the seventeen participating municipalities were as follows:

City of Cortland	Town of Ithaca
City of Ithaca	Town of Ulysses
County of Tompkins	Town of Willet
Town of Caroline	Village of Cayuga Heights
Town of Danby	Village of Dryden
Town of Dryden	Village of Groton
Town of Enfield	Village of Homer
Town of Groton	Village of Trumansburg
Town of Lansing	

A. Corporate Governance

Pursuant to the Municipal Cooperative Agreement, management of the Plan is to be vested in a governing board, comprised of one representative from each participating municipality. The governing board of the Plan as of December 31, 2015 was as follows:

Name and Residence	Principal Affiliation
Mack Cook Cortland, NY	Director of Finance, City of Cortland
Alvin Doty, Jr. Marathon, NY	Town Supervisor, Town of Willet
Judy Drake Lansing, NY	Human Resources Director, Town of Ithaca
John Fracchia Brooktondale, NY	Town Board Member, Town of Caroline
Amy Guererri Geneva, NY	Commissioner of Personnel, County of Tompkins
Rordan Hart Trumansburg, NY	Village Trustee, Village of Trumansburg
Herb Masser Ithaca, NY	Town Board Member, Town of Enfield

Name and Residence	Principal Affiliation
Kathy Miller Lansing, NY	Town Supervisor, Town of Lansing
Michael Murphy Dryden, NY	Village Trustee, Village of Dryden
Charles Rankin Groton, NY	Village Clerk, Village of Groton
Peter Salton Ithaca, NY	Village Trustee, Village of Cayuga Heights
Don Scheffler Groton, NY	Town Supervisor, Town of Groton
Laura Shawley Candor, NY	Bookkeeper, Town of Danby
Genevieve Suits Homer, NY	Village Mayor, Village of Homer
Mary Ann Summer Dryden, NY	Town Supervisor, Town of Dryden
Steven Thayer Ithaca, NY	City Comptroller, City of Ithaca
Nancy Zahler. Trumansburg, NY	Town Board Member, Town of Ulysses

The board of directors met no more frequently than on a quarterly basis during each year of the examination period. The board of directors held an annual meeting between October 3rd and October 15th of each year within the period of examination.

The minutes of all meetings of the board were reviewed. Such meetings were generally well attended; however, it was noted that three board members failed to attend at least one-half of such board meetings they were eligible to attend.

Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that board members attend meetings consistently and set forth their views on relevant matters so that appropriate decisions may be reached by the board.

It is recommended that the board members who are unable or unwilling to consistently attend meetings resign or be replaced.

Section 4709 of the New York Insurance Law states in part:

> "(a) The governing board of the municipal cooperative health benefit plan shall deliver or cause to be delivered the plan document to all participating municipal corporations and to unions which are the exclusive collective bargaining representatives of employees covered by the plan and the summary plan description to every employee or retiree of participating municipal corporations covered by the plan…"
>
> "(c) Conspicuously printed on the first page of the plan document and summary plan description, in at least ten point bold-face type, shall be the following statement: …
>
> This municipal cooperative health benefit plan is not a licensed insurer. It operates under a more limited certificate of authority granted by the superintendent of financial services. Municipal corporations participating in the municipal cooperative health benefit plan are subject to contingent assessment liability."

A review of the plan document and summary plan description, "(GTCMHIC) Senior Plan GTC SP – 001," indicated that said plan did not contain the wording required by Section 4709(c) of the New York Insurance Law.

It is recommended that the Plan comply with Section 4709(c) of the New York Insurance Law by including the required wording within its Plan Document and Summary Plan Description.

Section 4709(a) of the New York Insurance Law, cited above, establishes the requirement that GTCMHIC distribute an approved Plan Document and Summary Plan Description that is unique for each available benefit plan to members covered by such benefit plans. During the

examination, it was noted that such documents were available for retirees only. No such document was available for employees.

It is recommended that the Plan comply with Section 4709(a) of the New York Insurance Law by preparing and having approved unique plan documents and summary plan descriptions for all eligible members, to include both retirees and employees.

The principal officers of the Plan as of December 31, 2015 were as follows:

Officers	**Title**
Judy Drake	Chairperson
Rordan Hart	Vice Chairperson
Donald Barber	Executive Director
Steve Thayer	Chief Financial Officer
Rick Snyder	Treasurer
Chuck Rankin	Secretary

The board of directors of the Plan designated John G. Powers, Esq. as the Attorney in-Fact, and authorized him to receive service on a summons or other legal paper in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Plan.

B. Territory and Plan of Operation

The Plan provides hospital, medical and pharmacy benefits to eligible members and retirees of the participating municipalities in Tompkins County within New York State. Effective July 2015, service was also made available within the following six counties: Cayuga, Cortland, Tioga, Chemung, Schuyler, and Seneca.

The Plan reported annual written premiums of $37,587,353 for the calendar year ending December 31, 2015. The Plan's enrollment, as of December 31, 2015, was 2,294.

C. Stop-loss Coverage

As required by Section 4707 of the New York Insurance Law, the Plan maintains both aggregate stop-loss coverage and specific stop-loss coverage. The issuer of such stop-loss coverage, HM Life Insurance Company of New York, is authorized in New York State. The following is a summary of the Plan's stop-loss coverage program as of December 31, 2015:

Type	Limits
Excess-of-loss (one layer)	100% of excess of $400,000 per member, per contract year.
Aggregate excess-of-loss	$1,000,000 excess of the annual aggregate attachment point (125% of incurred claims expenses), for the current contract period.

D. Administrative Services Agreements

The Plan entered into contractual agreements with the following vendors that provided various administrative services to the Plan:

Medco Health Solutions, Inc.

Effective January 1, 2011, Medco Health Solutions, Inc. ("Medco") provided prescription drug benefits programs and, in connection therewith, established networks of participating retail pharmacies to service the Plan's members. In addition, it operated a system for the processing, fulfillment and payment of claims for prescription drugs furnished by such pharmacies. Medco adjudicated the Plan's claims for prescription drug benefits in accordance with the applicable plan design.

ProAct, Inc.

Effective January 1, 2013, the Plan contracted with ProAct, Inc., a New York corporation with offices located at 6333 Route 298, East Syracuse, NY to replace Express Scripts/Medco as the Pharmacy Benefit Manager for the Plan. ProAct processes claims received from Participating Pharmacies and Plan Participants, determines whether such claims qualify for reimbursement in accordance with the terms of the applicable benefit plan and payment.

Excellus Health Plan, Inc.

Effective January 1, 2011, Excellus Health Plan, Inc., provided the following services to assist the Plan in the administration of medical and hospital claims under the benefit plans: claims processing and administrative services, the preparation and delivery of reports required under the agreement, medical review, managed care services (if applicable), use of its provider network, and arranging for the provision of benefits to participants who require covered services outside of the service area.

Excellus Health Plan, Inc., prepared and provided to the Plan, as part of the service agreement, a monthly report of funds requested and received for payment of benefits under the benefit plan, annual claims utilization reports, annual accounting reports for the benefit plan, including an accounting of claims experience and reports containing information necessary to enable the Plan to comply with its ERISA and Internal Revenue Code ("Code") reporting and disclosure requirements.

Armory Associates, LLC ("Armory")

Effective February 16, 2016, GTCMHIC contracted with Armory Associates, LLC to provide the Plan with an annual demographic analysis of the Plan's current covered employees, retirees, and their dependents, and a review of incurred and paid claims for medical and prescription drug claims to determine the appropriate level of reserve funds necessary to fund GTCMHIC claims liabilities.

Armory Associates, LLC, also provides GTCMHIC with an annual Actuarial Certification Statement that includes a statement of opinion regarding whether GTCMHIC's balance sheet, which includes provisions for an IBNR Reserve and Surplus Account, is in accordance

with accepted actuarial standards consistently applied, is fairly stated in accordance with sound actuarial principles, and meets the requirements of the Laws of the State of New York.

E. Consultants

Locey & Cahill Consulting Services, LLC ("Locey & Cahill, LLC")

Effective April 28, 2011, the Plan contracted with Locey & Cahill Consulting Services, LLC ("Locey & Cahill, LLC") to ensure that the Plan is in compliance with all applicable Federal and State Laws and Regulations, including the work associated with compliance with the Patient Protection and Affordable Care Act.

Locey & Cahill, LLC also tracks all vendor contracts associated with the Greater Tompkins County Municipal Health Insurance Consortium's operations.

Donald Barber, Executive Director ("Consultant")

Effective July 1, 2016, the Plan entered into a consulting agreement with Donald Barber, the Plan's Executive Director.

Mr. Barber coordinates, directs and evaluates the Plan's programs and operations to ensure that all services are performed efficiently and effectively. He also assures that the provisions of the Municipal Cooperative Agreement and New York Insurance Law Article 47, regarding the operation of the Consortium are observed and enforced. He attends board and committee meetings and reports any business interactions that take place with the Plan's providers.

F. Conflict of Interest

A review of the Plan's conflict of interest/code of ethics policies determined that the Plan's board of directors, officers and key employees did not sign the existing conflict of interest forms.

For such policies to be effective, it is a good business practice to have board members and senior officers sign the conflict of interest/code of ethics disclosure form at least annually.

It is recommended that, as a good business practice, the Plan's board members, officers and key employees sign the established conflict of interest/code of ethics forms annually.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities and surplus as of December 31, 2015, as contained in the Plan's 2015 filed annual statement, a condensed summary of operations, and a reconciliation of the surplus account for each of the years under examination. The examiner's review of a sample of transactions did not uncover differences which would materially affect the Plan's financial reporting at December 31, 2015.

The firm of Insero & Co. CPAs, LLP (formerly Ciaschi, Dietershagen, Little, Mickelson & Company, LLP) was retained by the Plan to audit the Plan's combined statements of financial position as of December 31, 2015, and the related statements of operations and surplus for the year then ended.

Insero & Co., CPAs, LLP concluded that the statutory 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.

A. Balance Sheet

Assets	
Cash and cash equivalents	$15,353,516
Premium receivable	46,866
Amounts recoverable from reinsurers	13,035
Restrictive cash	6,213,006
Excellus BCBS prepaid claims	527,500
Total assets	$22,153,923
Liabilities	
Claims payable	$ 3,631,889
Accounts payable	441,191
Premiums received in advance	243,894
Prepaid ancillary benefits premiums	8,983
Total liabilities	$ 4,325,957
Surplus	
Assigned for Catastrophic Claims	1,050,000
Rate stabilization reserve	1,513,287
Unassigned funds (Surplus)	13,385,311
Surplus per Section 4706(a)(5)	1,879,368
Total surplus	$17,827,966
Total liabilities and surplus	$22,153,923

B. Statement of Revenue and Expenses and Surplus

Surplus increased $16,578,347 during the four-year examination period, January 1, 2012 through December 31, 2015, detailed as follows:

Revenue		
Premiums	$119,743,718	
Prescription drugs*	16,990,128	
Investment income	43,370	
Non-health revenues	515,647	
Total revenue		$ 137,292,863
Expenses		
Hospital and medical claims	$ 83,256,451	
Prescription drug claims	28,062,235	
Aggregate write-ins for other expenses:	1,497,310	
Claims subtotal	$112,815,996	
Stop-loss recoveries	1,652,006	
Net claims incurred	111,163,990	
Administrative expenses	7,042,268	
Aggregate write-ins for other expenses	514,183	
Total expenses		118, 720,441
Net income		$ 18,572,422

* Prescription drug coverage as reported in the statement is reflective of calendar years 2014 and 2015 only. Prior to those periods, the prescription drug premiums were included with medical and hospital premiums.

	Gain in Surplus	Loss in Surplus	
Surplus, per report on examination, as of December 31, 2011			$1,249,619
Net income	$18,572,422		
Change in other surplus items		$1,994,075	
Net increase in surplus			16,578,347
Surplus, per report on examination, as of December 31, 2015			$17,827,966

4. CLAIMS PAYABLE

The examination analysis of the claims unpaid 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.

Section 4706(a)(1) of the New York Insurance Law states:

> "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 less amount will be adequate."

As such, the Plan is required to establish a reserve for payment of claims and expenses that are reported and not yet paid and incurred but not yet reported. The amount of this reserve can be reduced with the approval of the Superintendent of Financial Services. The Consortium has been

given approval to estimate this reserve at twelve percent (12%) of the expected incurred claims (combined medical and prescription drugs) and expenses of the current plan year.

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 subscribers and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The general review was directed at practices of the Plan in the following areas:

A. Claims processing
B. Utilization review
C. Record retention

A. Claims Processing

Prompt Pay Law

Section 3224-a(a) of the New York Insurance Law states:

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

The examiner performed a review to test for compliance with the requirements of Section 3224-a of the New York Insurance Law ("Prompt Pay Law") by using a statistical sampling methodology covering medical and hospital claims submitted to the Plan during the period January 1, 2015 through December 31, 2015. The review did not reveal any problem areas.

B. Utilization Review ("UR")

ProAct, Inc. has been designated as one of the Plan's utilization review agents. It was determined that ProAct, Inc. has not filed its utilization review plan with the Department, in violation of New York Insurance Law Sections 4901(a) and (b).

Section 4901(a) of the New York Insurance Law states:

> "Every utilization review agent shall biennially report to the superintendent of financial services, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section."

It is recommended the Plan ensure that all utilization review agents that perform medical necessity reviews for its claimants comply with the filing requirements of Sections 4901(a) and (b) of the New York Insurance Law.

Section 4904(c) of the New York Insurance Law states in part:

> "…The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal…"

Excellus Health Plan Inc., ("Excellus"), an entity licensed pursuant to Article 43 of the New York Insurance Law, was also designated as one of the Plan's utilization review agents. A review of appeals administered by Excellus Health Plan, Inc. on behalf of the Plan's members, indicated that, in seven out of 49 utilization determinations that were reviewed by the examiner,

Excellus did not provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing, in violation of Section 4904(c) of the New York Insurance Law.

It is recommended that the Plan ensure that all utilization review agents that perform medical necessity reviews for its claimants comply with the written acknowledgement of the appeal time frame requirement of Section 4904(c) of the New York Insurance Law.

C Record Retention

Part 243.2 (b)(2) of Insurance Regulation No. 152 states in part:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (2) An application where no policy or contract was issued for six calendar years or until after the filing of the report on examination in which the record was subject to review, whichever is longer."

It was determined that the Plan did not comply with Part 243.2(b)(2) of Insurance Regulation No. 152, by failing to maintain applications in instances when no policy or contract was issued, for six calendar years or until after the filing of the report on examination in which the record was subject to review.

It is recommended that the Plan comply with Part 243.2(b)(2) of Insurance Regulation No. 152 by maintaining all applications for coverage, regardless of whether a policy was actually issued. Such applications should be maintained for the greater of six calendar years or until after the filing of the report on examination in which the record was subject to review.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included nine recommendations detailed as follows (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Corporate Governance	
1.	It is recommended that, as a prudent business practice, the board of governors adopt written procedures that would require the board to obtain annual certification from either the Plan's internal auditor or its independent CPA firm to the effect that the Plan's responsible officers have implemented procedures adopted by the board.	7
	The Plan has complied with this recommendation.	
2.	It is recommended that, as a prudent business practice, the Plan's board of governors 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.	8
	The Plan has complied with this recommendation.	
3.	It is also recommended that the Plan's management and board of governors develop a plan for reviewing whether its TPA is paying its members claims in accordance with the Plan's contracts and the services Excellus is to provide.	8
	The Plan has complied with this recommendation.	
	Accounts and Records	
4.	It is recommended that the Plan maintain its contingency reserve in compliance with Section 4706(a)(5) of the New York Insurance Law.	11
	The Plan has complied with this recommendation.	

ITEM NO.		PAGE NO.
5.	It is recommended that the Plan take steps to complete its annual and quarterly statements in accordance with the annual and quarterly statements instructions and avoid the occasion to revise its filed statements. *The Plan has complied with this recommendation.*	11
6.	It is also recommended that when a revised annual or quarterly statement is submitted to the Department that the Plan complete the Jurat Page with the appropriate officers' signatures affixed and the amendment number included. *The Plan has complied with this recommendation.*	12
	Policy Forms/Benefits	
7.	It is recommended that the Plan file for approval its policy benefits forms with the Department in compliance with the requirements of Sections 4709(b) and 3201(b)(1) of the New York Insurance Law. Further, it is recommended that the Plan refrain from issuing any policy benefits forms that have not been approved by the Department. *The Plan has complied with these recommendations.*	19
	Complaints	
8.	It is recommended that the Plan, as a good business practice, maintain a complaint log in a manner consistent with Department (Insurance) Circular Letter No. 11 (1978). *The Plan has complied with this recommendation*	20
	Utilization Review	
9.	It is recommended that the Plan comply with Section 4916(b) of the New York Insurance Law and report the number of external appeals requested by its insureds and the outcomes of any such external appeals on an annual basis to the Superintendent. *The Plan has complied with this recommendation*	20

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM **PAGE NO.**

D. Record Retention

It is recommended that the Plan comply with Part 243.2(b)(2) of Insurance Regulation No. 152 and maintain all applications for coverage, regardless of whether a policy was actually issued. Such applications should be maintained for six calendar years or until after the filing of the report on examination in which the record was subject to review. 18

Respectfully submitted,

_____

Charles J. McBurnie
Insurance Examiner

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

Charles J. McBurnie**,** being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

_____

Charles J. McBurnie

Subscribed and sworn to before me
This _____ day of _____2018

APPOINTMENT NO. 31505

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***MARIA T. VULLO****, 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:*

Charles McBurnie

as a proper person to examine the affairs of

Greater Tompkins County Municipal Health Insurance Consortium

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

Consortium

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 7th day of July, 2016

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau