REPORT ON EXAMINATION

OF

PUTNAM/NORTHERN WESTCHESTER

HEALTH BENEFITS CONSORTIUM

AS OF JUNE 30, 2018

EXAMINER: **HUSSEIN AGOUDA, CFE**
EDOUARD MEDINA

DATE OF REPORT: **FEBRUARY 15, 2024**

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February 15, 2024

Honorable Adrienne A. Harris
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 31838, dated December 13, 2018, 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, 2018, 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, 2013. This examination of the Plan was a combined (financial and market conduct) examination and covered the five-year period July 1, 2013, through June 30, 2018. 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, 2019 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, 2018, 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 utilizes 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 (9) branded risk categories.

These categories are as follows:

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

The Plan was audited for the fiscal years 2014 through 2018 by the accounting firm of UHY LLP ("UHY"). The Consortium received an unmodfied opinion in each of those years. Certain audit workpapers of UHY, in connection with its audit of the Plan's 2018 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 regarding the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item No. 7 of this report.

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 of thirteen (13) 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 thirteen (13) participating members consisted of the following local school districts located throughout the Putnam and Northern Westchester counties and Putnam Northern Westchester BOCES, as of June 30, 2018:

- 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

(i). Board of Trustees and Joint Governance Board

Pursuant to the Consortium's existing Municipal Cooperation Agreement ("MC Agreement"), which was last approved by the Department effective on March 1, 2017, management of the Plan is vested in a Board of Trustees ("Trustees") consisting of five (5) individuals/employees from the various member school districts and Putnam Northern Westchester BOCES. The Trustees are selected each fiscal year by a majority of the Plan's members for a term of one year unless removed earlier from office within such term. Furthermore, the MC Agreement also calls for the Trustees to be assisted by a Joint Governance Board in the governance of the Plan. The Joint Governance Board consists of twelve (12) voting members plus four (4) alternates and includes the group representatives of active managerial or other employee or retiree individuals that are selected by the Plan Members or bargaining units, as applicable.

The following individuals were members of the Plan's Board of Trustees as of June 30, 2018:

Name and Residence	Principal Business Affiliation
Diane Chaissan Newburgh, NY	Director of Finance and Administrative Services, Croton-Harmon Union Free School District
John Chow White Plains, NY	Business Administrator, Chappaqua Central School District
Victor Karlsson Hopewell Junction, NY	Superintendent, Brewster Central School District Assistant Superintendent,

Name and Residence	Principal Business Affiliation
John McCarthy Hopewell Junction, NY	Putnam Northern Westchester BOCES
George Stone White Plains, NY	Superintendent, Lakeland Central School District

The following individuals were officers of the Plan as of June 30, 2018:

Name	Position
Diane Chaissan	President
Todd Currie	Chief Financial Officer
John McCarthy	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 Cooperative Agreement. The Board meetings were generally well attended by the Trustees with each Trustee attending at least one-half of all the total meetings in which they were eligible to attend.

The following sixteen (16) members, including the four (4) alternates, served on the Joint Governance Board of the Plan as of the June 30, 2018:

Name and address	Principal Affiliation
Douglas Andreotti Poughkeepsie, NY	Teacher, Putnam Northern Westchester BOCES
Diane Chaissan Newburg, NY	Assistant Superintendent for Business, Croton-Harmon Union Free School District
Chow John White Plains, NY	Business Administrator, Chappaqua Central School District
Elaine Colagiovanni Danbury, CT	Secretary to School Administrator, Lakeland Central School District
Alphonse Cotoia Rhinebeck, NY	Teacher, Putnam Northern Westchester BOCES

Name and address	Principal Affiliation
Ken Crowley Poughkeepsie, NY	Assistant Superintendent for Business, Sommers Central School District
Barbara Dellon Yorktown Heights, NY	Teacher, Lakeland Central School District
Jill Figarella Wappingers Fall, NY	Treasurer, Putnam Valley Central School District
Nathan Heltzel Ridgewood, NJ	Guidance Counselor, Lakeland Central School District
Victor Karlsson Hopewell Junction, NY	Superintendent, Brewster Central School District
John McCarthy Hopewell Junction, NY	Assistant Superintendent, Putnam Northern Westchester BOCES
Jennifer Murphy Amawalk, NY	Retired Teacher, Briarcliff Unified Free School District
Linda Peters Greenwich, CT	Assistant Superintendent for Business, Briarcliff Unified Free School District
John Roden Carmel, NY	Retired Teacher, Yorktown Central School District
George Stone White Plains, NY	Superintendent, Lakeland Central School District
Elizabeth Weiden-Philipbar Poughkeepsie, NY	Teacher, Yorktown Central School District

The four (4) alternate members include Alphonse Cotoia, Nathan Heltzel, Ken Crowley, and Linda Peters.

(ii). Finance Committee Function / Activities

In Article I of the Consortium's Municipal Cooperation Agreement, it states that the Consortium's Finance Committee which is a sub-committee of the Joint Governance Board ("Joint Board"), shall provide assistance and advice to the Trustees. However, the Finance Committee does not currently have a charter in place detailing the Committee's specific role(s) and responsibilities. During the course of the examination and the onsite management interviews, the examiner ascertained (from the Consortium's officials interviewed) the Finance Committee's seemingly heavy involvement in performing many functions (i.e., evaluating and assessing the Consortium's funding, deciding the Consortium's premium rates, selection of the independent CPA, etc.).

Given the many functions the Finance Committee is tasked with, it is recommended as a best business practice that the Consortium consider adopting a Finance Committee charter.

(iii). Audit Committee Meetings

The Consortium's Audit Committee's ("AC") charter indicates that the AC should have a minimum of two semi-annual meetings. However, it was noted that the AC held only two meetings from its inception to June 30, 2018.

It is recommended that the Consortium's AC comply with its charter by holding the requisite number of meetings in accordance with its established AC charter.

(iv). Board's Conflict of Interest and Code of Conduct and Ethics

ARTICLE VI, SERVICE PROVIDERS, paragraph (3)(b) of the MC Agreement, states, in part:

> "…No Plan Trustee or Governance Board member, or any individual of his / her immediate family shall be an owner, officer, director, partner or employee of any service provider contracted by the Plan."

During the examination period, it should be noted that the Consortium did not have a formal written conflict of interest and code of conduct and ethics policy in place. This observation was corroborated by statements made by Consortium's officials throughout the course of the examiners' C-Level interviews wherein the interviewees indicated that the Plan did not have any code of conduct and ethics policies/procedures while simultaneously referencing adherence to the policies/guidelines of their employing school districts and Putnam Northern Westchester BOCES.

It is recommended as a best practice that the Consortium establish a formal written conflict of interest, code of conduct and ethics policy for its Trustees and Joint Governance Board members.

It is also recommended as a best practice that the Consortium include the Attorney-in-Fact / Risk Manager in its formal written conflict of interest and code of conduct ethics policy due to the importance of the position to the Consortium.

B. Third-Party Administrators

The Consortium had administrative service agreements with various third-party administrators, including but not limited to the following parties, as of June 30, 2018:

i. PFM Asset Management LLC ("Advisor") - Investment Advisory Management Agreement

The captioned agreement dated June 22, 2012, requires that PFM provide the Consortium with investment advisory services related to the evaluation, sale, and

reinvestment of the Plan's assets assigned and available to PFM under the Plan's custodial investments account.

ii. U.S. National Bank Custodial Agreement ("Custodian")

The captioned agreement effective June 22, 2012, requires that the bank provide custody and other services in connection with securities, cash and other property delivered to the Custodian by the Plan. The agreement also includes a clause that subjects the agreement to be governed by the laws of the State of Minnesota instead of the laws of the State of New York.

iii. JPMorgan Chase Bank ("JPM Chase") Pledged Assignment and Custodial Agreement

The captioned agreement, effective March 9, 2017, is for custodial/safekeeping purposes of the Consortium's ("Local Government") public funds deemed as eligible securities, pursuant to Section 10 of the New York State General Municipal Law, and for safekeeping services of such other Consortium pledged securities account held by JPM Chase.

iv. Aetna Life Insurance Company ("Aetna")

The captioned agreement, effective January 1, 2010, requires that Aetna provide the Plan and the Plan's provider network with various administrative services, including claims administration, member services, patient management (e.g., prospective, concurrent and retrospective utilization reviews).

v. Navitus Health Solutions, LLC ("Navitus") Pharmacy Benefits Management Agreement

The pharmacy benefits management ("PBM") agreement between the Consortium and Navitus, effective January 1, 2018, superseded the Plan's prior PBM agreement with CVS / Caremark. The Navitus agreement requires Navitus to administer the Consortium's pharmacy benefits program. The prior CVS / Caremark agreement, which covered the period, January 1, 2015, to December 31, 2017), was terminated, effective December 31, 2017.

vi. Innovative Software Solutions, Inc.("ISSI") Software License and Consolidated

Systems Operating Environment Agreement

The captioned agreement effective May 31, 2013, provides the Consortium with the rights to ISSI's Licensed Software, including; (1) ongoing support and maintenance services, as described in the Agreement's Exhibit A (i.e., employers / members / dependents enrollment tracking, billing and processing); and (2) systems configuration services, as described in the agreement's Exhibit B (i.e., to address participants; members; dependents; and employers processing, employer contributions and remittance processing, enrollment and recordkeeping, benefit eligibility processing module and data feeds to Aetna, Express Scripts, and Medicare.)

vii. Willis Towers Watson Consulting Agreement

The Consortium entered into the captioned Agreement effective on November 14, 2016, and subsequently renewed effective on May 1, 2019, to April 30, 2022, with Willis Towers Watson, a multinational risk management, insurance brokerage and advisory company. The examiner provides more details below on the Agreement.

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

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

The examiner noted the following deficiencies relating to the above-mentioned agreements:

- *Under the "State Governing Law" sections of the Plan's respective; (1) PFM Asset Management LLC Agreement, (2) U.S. National Bank Custodial Agreement, and (3) Innovative Software Solutions, Inc. Agreement, the governing laws of other states, instead of the laws of the State of New York, were to be followed.*

It is recommended that the Consortium revise the State Governing Law sections of all of its Agreements to require that New York State's laws govern said agreements.

A similar recommendation relative, to its U.S. National Bank Agreement, appears in the prior report on examination.

It is also recommended that the Consortium submit all revised Agreements to the Department.

- *On the signature page of the Plan's JP Morgan Chase Custodial Agreement, it was noted that the signature of a Putnam Northern Westchester BOCES' official appeared on the page instead of a Consortium Officer such as the Chief Financial Officer ("CFO"), President or Secretary's. It is incumbent upon the Consortium to ensure that the signing and binding of the Plan to various agreements is limited solely to appointed Officers (i.e., Chief Fiscal Officer, President or Secretary). The examiner noted that the signature of a Consortium Officer was also a requirement of the Agreement.*

It is recommended that the Consortium refrain from authorizing any employees of the Consortium's participating Putnam Northern Westchester County school districts and Putnam Northern Westchester BOCES membership from signing any of the Consortium's binding agreements. It is incumbent upon the Consortium to ensure that only the Plan's officers (i.e., CFO, President and Secretary) sign the Consortium agreements.

- *In the Consortium's Willis Towers Watson Consulting Agreements dated November 14, 2016, and as subsequently renewed effective on May 1, 2019 to April 30, 2022, such agreements do not indicate the specific consulting services that are being performed by the consultant under the duties and responsibilities section of the agreement. The examiner noted that the agreements refer to an Appendix A which is to set forth the specific consulting services being or to be provided. However, the referenced appendix was not included with either agreement. In addition, the examiner noted that this current agreement was never signed by Willis Tower Watson.*

It is recommended that the Consortium ensure that the scope / description of the consulting services being provided to the Plan by Willis Tower Watson are fully disclosed in the parties' agreement.

It is recommended that the Consortium, relative to its current Willis Towers Watson Consulting Agreement, obtain the requisite Appendix A attachment, complete with the detailed scope / description of the consulting services that Willis Towers Watson is providing to the Consortium.

It is also recommended, relative to the Consortium's current in-force Willis Towers Watson's Consulting Agreement, that the Consortium have an officer / representative sign the agreement.

It is further recommended that the Consortium upon implementing the requisite updates noted in the above-mentioned agreements, submit such agreements to the Department.

C. Territory and Plan of Operation

As of June 30, 2018, the Plan held a certificate of authority to operate as 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 Section 4706(a)(5) of the New York Insurance Law, the Plan is required to maintain a surplus reserve account equal to five percent of the annualized earned premium. The Plan reported its total surplus reserve in the amount of $5,662,711, as of June 30, 2018. The Plan annually met this requirement throughout the examination period.

Membership of the Plan was stable during the examination period, with a moderate increase from 7,858 members at June 30, 2014 to 8,197 members as of June 30, 2018. The Plan's members were all enrolled at the local school districts level and PNW BOCES.

D. Summary Plan Document

Section 4703(b)(4) of the New York Insurance Law ("NYIL") states:

> "(b) The governing board shall file an application for a certificate of authority on such form as the superintendent may prescribe, and shall provide to the satisfaction of the superintendent the following:
>
> (4) a copy of all documents, including the summary plan description, furnished to the participating municipal corporations and their employees or retirees describing plan benefits;"

Section 4710(a)(1) of the NYIL states the following:

> "(a) The governing board of the municipal cooperative health benefit plan shall:
>
> (1) file for approval with the superintendent a description of material changes in any information provided in the application for certificate of authority in the form and manner prescribed by the superintendent;"

The Plan's covered members received health care coverage based on the defined benefits provided in the Consortium's Summary Plan Document ("SPD"), 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 updated its SPD during the years 2015, 2016 and 2017 however the Consortium's SPD in use during the examination period was last approved by the Department effective April 22, 2010.

Regarding the Plan's submission of the SPD updates to the Department for approval, the Consortium stated all the annual update proposals were submitted to the Department for approval. However, it should be noted that the Plan was unable to substantiate its 2015 and 2016 SPD update filings with the Department. According to the Consortium, the Department never responded to either of the Summary Plan Document proposals, and thus, the Consortium proceeded with using

each year's updated benefit and making the unapproved SPDs available online on its website.

The examiner noted that on March 31, 2017, correspondence from the Department was sent to the Consortium in response its 2017 SPD submission. The correspondence included a list of thirty-four (34) Department follow up comments for the Consortium to address however, the Consortium never responded to the Department's correspondence.

It is recommended that the Consortium obtain the Department's approval for all changes made to its Summary Plan Document in compliance with Section 4710(a)(1) of the New York Insurance Law.

Furthermore, it was noted that the Consortium used the Department's old address, in its SPD instead of DFS' current address.

It is further recommended that the Consortium update its SPD to include the Department's current New York City address.

The Consortium reported the following net written premiums and membership for the years 2014 through 2018:

Plan Year	Net Premiums Written	Membership
2018	$113,254,224	8,197
2017	104,792,005	8,095
2016	101,988,133	7,969
2015	99,963,853	7,847
2014	99,814,800	7,858
Total	$519,813,015	

The underwriting ratios presented below are on an earned-incurred basis and encompass the five-year period covered by this examination:

	Amounts	Ratios
Claims	$503,863,724	96.93%
General administrative expenses	13,813,495	2.66%
Net underwriting gain	2,135,796	0.41%
Premiums	$519,813,015	100.00%

The above claims to premium ratio amount of 96.93% shows that the Plan met the Medical Loss Ratio requirements per Section 3231 of the New York Insurance Law and Insurance Circular Letter No. 15 (2011).

E. Stop-Loss Insurance

Section 4707(a)(1) of the New York Insurance Law states, in part:

> "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: (1) 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…"

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

The Consortium's policy with Nationwide Life Insurance Company, a New York authorized insurer, which renews annually, included the following coverage / policy liability limits, as of June 30, 2018:

Coverage	Policy Liability Limits
Specific stop-loss coverage Maximum benefit for aggregate losses	$1 million deductible per person and 100% in excess of deductible for a maximum of $2 million per contract year per person.
Aggregate stop-loss coverage Maximum benefit for specific losses	100% excess of attachment point, $1 million per policy year per covered person.
Nationwide Life Insurance Company's Minimum aggregate attachment point	$141,944,547

The following calculation reflects the required attachment point:

Aggregate attachment point per Nationwide Life Insurance Company stop-loss policy		$141,944,547
Plan's total expected incurred claims for fiscal year 2017 / 2018	$104,725,000	
NY statutory attachment point percent	125%	
Less: Statutory annual aggregate attachment point		130,906,250
Difference		$ 11,038,297

As determined by the above calculation, the Nationwide Life Insurance Company's aggregate attachment point of $141,944,547 exceeded the New York Insurance Law Section 4707(a) statutory maximum limitation.

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.

A similar recommendation appeared in the prior report on examination.

F. Service Organization Control reports "SOC"

The "SOC 2 - SOC for Service Organizations: Trust Services Criteria, Report on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, or Privacy (January 1, 2018)", as defined by The American Institute of Certified Public Accountants ("AICPA") provides the following:

> "These reports are intended to meet the needs of a broad range of users that need detailed information and assurance about the controls at a service organization relevant to security, availability, and processing integrity of the systems the service organization uses to process users' data and the confidentiality and privacy of the information processed by these systems…"

A review of the Consortium's operations risks, and controls processes relative to its outsourcing services, revealed that third-party administrators' SOC reports are not being requested by management for review.

It is recommended as a best business practice that the Consortium implement additional control processes by requesting its third-party administrators' SOC reports on a regular basis.

3. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, and net worth as of June 30, 2018, as reported in the Plan's 2017-2018 filed fiscal-year end statement, and condensed summary of operations and a reconciliation of the surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial conditions as presented in its June 30, 2018, filed annual statement.

Independent Accountants

The CPA firm of UHY, LLP ("UHY") was retained by the Plan to audit the Plan's combined GAAP basis financial statements of financial position and related statements of operations, surplus and cash flows for each fiscal year within the examination period.

UHY concluded 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.

A. Balance Sheet

Assets	
Bonds	$27,957,791
Cash and cash equivalents	40,519,084
Premiums receivable	5,021,110
Other invested assets	31,896
Total assets	$73,529,881
Liabilities	
Unpaid claims	$9,587,367
Additional reserve for IBNR	9,611,534
Accounts payable	1,635,281
Claim stabilization reserve	10,900,000
Total liabilities	$31,734,182
Surplus	
Aggregate write-ins for special surplus funds	2,972,000
Aggregate write-ins for current liability	(1)
Unassigned fund (surplus)	33,160,989
Surplus per Section 4706(a)(5)	5,662,711
Total surplus	$41,795,699
Total liabilities and surplus	$73,529,881

B. Statement of Revenue, and Expenses, and Changes in Surplus

Surplus increased $4,919,657 during the five-year examination period, July 1, 2013, through June 30, 2018, detailed as follows:

Revenue		
Premiums and related revenue	$519,813,015	
Prescription drug rebates	38,431,178	
Aggregate write-ins for other than health care related revenues	7,389,675	
Aggregate write ins for other income or expense	364,125	
Non-health revenue	1,373,923	
Investment income	14,479	
Total revenue		$ 567,386,395
Expenses		
Hospital / medical benefits	363,225,242	
Prescription drugs	179,069,660	
General administrative expenses	13,813,495	
Total underwriting deductions		556,108,397
Net income		$ 11,277,998

Changes in surplus

	Gains in Surplus	Losses in Surplus	Total
Total surplus, per report on examination, as of June 30, 2013			$ 36,876,043
Net income	$ 11,277,998		
Change in IBNR		$ 4,679,316	
Change in claim stabilization reserve		2,000,000	
Change in contingency reserve		462,711	
Change in other expenses reserves		542,000	
Adjustment to Section 4708(a)(5) surplus account	903,165		
Statutory adjustment to net surplus	422,521		
	12,603,684	7,684,027	
Net increase in surplus			4,919,657
Total surplus per report on examination, as of June 30, 2018			$ 41,795,700

4. UNPAID CLAIMS (INCLUDING CLAIMS STABILIZATION RESERVE)

The examination's liabilities for Claims Payable as of June 30, 2018, in the amount of $19,198,901, comprising of Unpaid Claims and Additional Reserve for IBNR of $9,587,367 and $9,611,534 respectively, were deemed adequate. Furthermore, the Plan also reported additional New York Insurance Law Article 47 Reserves in an amount totaling $13,400,000, which included the Plan's Claims Stabilization Reserve in the amount of $10,900,000, and $2,500,000 for Reserves for other obligations. These Reserve amounts were deemed reasonable.

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 would 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.

5. SUBSEQUENT EVENTS

Stop-Loss Reinsurance Waiver

Subsequent to the June 30, examination date, the Consortium notified the department on July 11, 2019, a request to waive both its specific and aggregate stop loss requirement. Such request was made following a June 12, 2019, meeting of the Consortium's Joint Governance Board where the Board unanimously approved the request to the NYSDFS. In requesting the waiver, the Consortium indicated that the policy cost the Plan approximately $250,000 annually over the last eight years ($2 millions) while collecting a total of $140,222 in reimbursement due to two large claims (i-in 2010 for $139,645 and a second in 2016 for 577).

On August 1, 2019, the Department granted Putnam's request to waive both the specific and aggregate stop-loss insurance requirements, but only for Fiscal Year 2019/2020 (July 1, 2019, through June 30, 2020) based on the following:

A. Putnam's total reserves and surplus, on March 31, 2019, is greater than 150% of the total reserves required by Section 4706(a)(1) of the NYIL claims and expenses reported but not yet paid, and claims and expenses incurred but not yet reported and Section 4706(a)(5) NYIL unexpected obligations in the event of termination or abandonment of the plan;

B. Putnam does not expect any new participants enrolling in Fiscal Year 2019/2020; unchanged / stable exposure (in terms of underlying lives covered) is expected; and

C. Putnam satisfying the provision described in Section 4707(b)(1) of the NYIL (i.e., maintaining total reserves and surplus of at least 150% of the total reserves required by Sections 4706(a)(1) and 4706(a)(5)) of the NYIL.

Should the Plan decide to seek a waiver for the next fiscal year (July 1, 2020, through June 30, 2021), it is required to submit another application requesting a waiver of the stop-loss insurance requirements.

6. MARKET CONDUCT ACTIVITIES

During 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 medical and hospital claims management, grievances, utilization review and enrollment management. Navitus administers the Consortium's pharmacy benefits program, as of January 1, 2018 (previously managed by CVS/Caremark from January 1, 2015, to December 31, 2017); Claim Technologies Incorporated ("CTI") provides medical claims audit; Stonebridge Associates provides pharmacy claims audit, and Innovative Software Solutions, Inc. develops and maintains enrollment system.

While Aetna and Navitus are relied upon by the Plan, relative to these management functions, the Plan has full responsibility and ultimate decision-making authority over these functions.

This general review focused on the Plan's practices in the following major areas:

A. Operational
B. Prompt payment of claims
C. ACA compliance - Preventive care no cost share services
D. Complaints and grievances
E. Utilization review and appeals

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 Claim Technologies Incorporated ("CTI"), to conduct an audit of Aetna's claims processing and payment procedures. CTI's audit objectives included quantifying the dollar amounts associated with the claims that Aetna did not pay accurately; determining whether the terms of the agreement for the administrative services between the Consortium and Aetna were being followed; determining whether claims were paid according to the provisions of the SPD; determining whether members were eligible and covered by the Consortium's medical plan at the time a service cost was incurred and paid by Aetna; determining whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement; determining the Consortium's operational compliance with New York Insurance Law and regulations, Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act ("HIPAA") and the applicable industry standards, including but not limited to prevailing fee schedule. The audit above also encompassed CTI's review of the Consortium's prompt payment claims results based upon the requirements of the U.S. Department of Labor, which require 100% compliance within 30 calendar days.

It should be noted that in CTI's audit of Aetna's adjudication of the Plan's paid claims, for six out of a total 110 claims sampled, Aetna took longer than 45 days to pay such claims.an error rate of 5.54%.

B. Prompt Payment of Claims

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within 30 days of receipt for a claim that is transmitted via the internet or electronic mail or within 45 days of receipt for a claim submitted by other means, such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

A review of the Consortium's compliance with Section 3224-a, was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, no material issues were noted by the examiner.

C. Preventive Care / No Cost Share Member Benefit

The Affordable Care Act ("ACA") and applicable sections of the New York Insurance Law require health plans to pay for certain preventive services, including contraceptives, as a preventive service at no cost.

The examiner obtained the Plan's 2018 pharmacy claims data from Navitus and CVS, to review for compliance with the ACA and New York Insurance Law no cost share provisions.

Based on the examiner's analysis of the Plan's preventive care pharmacy claims, there were no cost-share issues noted.

The examiner's initial review of the medical and hospital claims processed by Aetna revealed that there were 4,945 applicable claims that had a cost share applied by the Consortium.

A further review of these claims revealed that there was a total of 5,718 lines within the 4,945 claims and 112 claim lines out of the 5,718 claim lines had cost share applied in violation of the above-mentioned New York no cost-share statutes.

The examiner determined that the number of medical and hospital claims that were not in compliance with the no cost-sharing provisions on preventive service claims appeared to be immaterial when compared to the claims' population. However, Aetna's implementation of additional internal controls can further reduce the number of claims processing errors related to cost sharing on preventive service claims.

It is recommended that the Consortium implement additional internal controls that would eliminate claims processing errors related to cost sharing on medical and hospital preventive service claims.

D. Appeals/Grievances/Complaints Procedures

During the review of the Plan Summary Document (SPD) it was noted on page 79 that an incorrect address was indicated for members to file their appeals, grievance, and complaints to the Department of Financial Services. The address provided was the Department's old address at Beaver Street in New York City.

It is recommended that the Consortium update its Summary Plan Document to include the correct address of the Department's Consumer Assistance Unit.

E. Utilization Review and Appeals

(i) First Adverse Determinations

Section 4903(b)(1) of the New York Insurance Law states, in part:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information..."

The examiner obtained the Plan's 2018 Concurrent, Prospective and Retrospective utilization appeals review cases. Based upon a total population of 233 cases, a random sample of ten (10) cases consisting of five (5) Prospective, three (3) Concurrent and two (2) Retrospective cases was selected and reviewed.

It was noted that out of the five (5) Prospective cases reviewed whereby the Consortium was required to respond both by telephone and in writing to the insured or insured's designee and insured's health care provider of a request for services, that a written response / notice for one (1) case was not provided within three (3) business days of receipt of the necessary information, in addition to the telephonic notice.

It is recommended that the Plan comply with Section 4903(b)(1) of the New York Insurance Law by providing both telephonic and written responses to the insured or insured's designee and the insured's health care provider within the requisite three business days timeframe relative to members' requests for Prospective healthcare services.

Standard Utilization Review Appeals

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

> "A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination…"

Section 410.9(e)(9) of Insurance Regulation No. 166 (NYCRR Part 410.9) states, in part:

> "Each notice of a final adverse determination of an expedited or standard utilization review appeal under section 4904 of the Insurance Law shall be in writing, dated and include the following:
> (9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal."

The examiner obtained the Plan's 2018 log of 115 utilization review appeals cases consisting of 112 level one appeals and three (3) level two appeals. A sample of ten (10) cases was randomly selected and reviewed. A review of the Plan's level one appeal cases, revealed that the written statement included in the notices and applicable to the 45-day time frame for the insureds to request external appeals, did not appear in bolded text as required by the Regulation.

It is recommended that the Plan comply with Section 410.9(e)(9) of Insurance Regulation No. 166 in the issuance of the Consortium's final adverse determination notices to the insureds by ensuring that the written statement applicable to the 45-day timeframe for the insureds to request external appeals is written in bolded text.

Section 410.9(h)(1) of Insurance Regulation No. 166 (11 NYCRR 410.9) states, in part:

> "Health care plans shall facilitate the prompt completion of external appeal requests, including but not limited to, the following:
> (1) health care plans shall provide the insured with a copy of the standard description of the external appeal process as developed jointly by the superintendent and commissioner, including a form and instructions for requesting an external appeal along with a description of the fee, if any, charged to insureds for an external appeal, criteria for determining eligibility for a waiver of such fees based on financial hardship, and the process for requesting a waiver of such fees based on financial hardship".

The examiner noted in one (1) instance that the external appeal form and instructions for requesting an external appeal was not included in the appeal decision notice sent to the member.

It is recommended that the Plan comply with Insurance Regulation No. 166 by including the requisite external appeal form and instructions for requesting an external appeal along with all the Consortium's appeal decision notices sent to the members.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior market conduct report contained thirteen (13) comments and recommendations (page numbers refer to the prior market conduct report):

ITEM NO.		PAGE NO.
	Investment Policy	
1.	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.	6
	The Plan has complied with this recommendation.	
	Joint Governance Board Agreement	
2.	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.	8
	The Plan has complied with this recommendation.	
	Municipal Cooperation Agreement	
3.	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.	10
	The Plan has complied with this recommendation.	
	Custodian Agreement	
4.	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.	11
	The Plan has complied with this recommendation.	

ITEM NO.		PAGE NO.
	Custodian Agreement	
5.	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. *The Plan has complied with this recommendation.*	12
	Stop-loss Insurance Policy	
6.	It is recommended that the Consortium comply with Section 4707(a) 15 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. *The Plan has not complied with this recommendation. A similar recommendation is included in this report.*	15
	Financial Statements	
7.	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. *The Plan has complied with this recommendation.*	17
	Claims Unpaid	
8.	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. *The Plan has complied with this recommendation.*	22
9.	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. *The Plan has complied with this recommendation.*	22

ITEM NO.		PAGE NO.
	Operational	
10.	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. *The Plan has complied with this recommendation.*	24
	Prompt Payment of Claims	
11.	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. *The Plan has complied with this recommendation.*	26
12.	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. *The Plan has complied with this recommendation.*	26
13.	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. *The Plan has not complied with this recommendation. The Plan has not complied with this recommendation. A similar recommendation is included in this report.*	26

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____
Hussein Agouda, CFE
Financial Services Examiner

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

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

_____
Hussein Agouda, CFE

Respectfully submitted,

Edouard Medina
Financial Services Manager 1

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

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

Edouard Medina

Subscribed and sworn to before me
This_____ day of_____2024

APPOINTMENT NO. **31838**

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:*

Hussein Agouda*

as a proper person to examine the affairs of the

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 13th day of December, 2018

MARIA T. VULLO
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau

*Retired as of July 2024 and the examination was completed by Edouard Medina