New York State Department of Financial Services

Report on Municipal Cooperative Health Benefit Plans: Impact of Claim Reserve Requirements Under Section 4706 of the Insurance Law

Executive Summary

Article 47 of the New York State Insurance Law allows municipalities to join together to form municipal cooperative health benefit plans to provide health benefits for their employees. Article 47 sets forth the minimum standards for establishing a municipal cooperative health benefit plan, including minimum claims reserve requirements. These statutory reserve requirements, however, have been seen by some municipalities as an impediment to forming a municipal cooperative health benefit plan. Chapter 494 of the Laws of 2009 requires the Superintendent of Insurance (the Superintendent of Financial Services as of October 3, 2011) to conduct a study of the impact of the current municipal cooperative health benefit plan reserve requirements and make recommendations for changes.

The Department of Financial Services analyzed and compared to two sets of claims data: (1) data for each of the ten existing municipal cooperative health benefit plans and (2) data for selected commercial insurance carriers doing business in New York State.

The Department recommends that claim reserves should be determined separately for (1) all hospital and medical care claims (other than prescription drugs) and (2) for prescription drugs. For hospital and medical care claims, the claim reserves should be set at an amount reflecting application of actuarial principles, based on prevailing conditions including a 10.0% margin for claim fluctuations, but no lower than 17.0% of incurred hospital and medical claims and related expenses. For prescription drug claims, the claim reserves should be set at an amount reflecting application of actuarial principles, based on prevailing conditions, and including a 10.0% margin for claim fluctuations, but no lower than 5.0% of incurred prescription drug claims.

These recommendations would preserve the current standards generally applied by the Department for most municipal cooperative health benefit plans on hospital and medical care claims, but would significantly decrease the current standards for prescription drug claims, from 17.0% to 5.0%, upon review and approval by the Superintendent. This flexibility would enhance the ability of municipalities to form municipal cooperative health benefit plans under Article 47 of the New York State Insurance Law.

Introduction

Chapter 494 of the Laws of 2009, also known as the mandate relief bill, was signed into law by Governor David Paterson on November 12, 2009. The legislation amended the Insurance Law, the Public Health Law, the General Municipal Law, the Public Authorities Law, the Local Finance Law, the Civil Practice and Rules Law, the General Obligations Law, and repealed certain provisions of the Civil Practice Law.

The memorandum in support of the bill indicates that, among other things, the law would encourage efficiencies and provide local governments savings that ultimately benefit local property taxpayers by making it easier for municipal governments to form municipal cooperative health benefit plans (MCHBPs) for their employees, which will reduce overall health insurance costs. Section five (5) of the bill requires the Superintendent of Financial Services to conduct a study of the impact of the current MCHBP plan reserve requirements and make recommendation for changes.

The legislation ordered a study of existing requirements to determine obstacles that impede municipalities pooling resources to provide employees welfare benefits at reduced cost, and requested that the Superintendent make recommendations for change based on such study.

This report addresses the impact of claim reserve requirements under Section 4706 of the Insurance Law. It provides an actuarial analysis of the reserve requirements and offers recommendation for changes in the reserve requirement for MCHBPs.

Publication of this report was delayed while the Department of Financial Services reviewed the application of the Greater Tompkins County Municipal Health Insurance Consortium to form an MCHBP. The Department worked extensively with Consortium to help them meet their reserve requirements. That application was approved in October 2010.

Background and History

Municipal cooperatives were first authorized in 1994 under Chapter 689 of the Laws of 1994, signed into law by Governor Mario Cuomo on August 8, 1994. The original purpose of the law was to protect the financial stability and solvency of municipalities. The statement in support of the legislation states:

> This bill provides safeguards necessary to keep municipal cooperatives that provide health benefits to employees of participating municipal corporations on a shared-funding basis from exposing municipalities and their taxpayers to unpredictable and potentially catastrophic liabilities. It establishes minimum reserve and surplus requirements, stop-loss (reinsurance) requirements to allow for reductions in these reserves, and filing and reporting requirements to ensure that municipal cooperative health benefit plans are operated on an actuarially sound basis.
>
> These financial safeguards should promote the stability and solvency of existing municipal cooperatives, and prevent inadequately funded or incompetently managed programs from commencing operations in this state.

The memorandum in support of the bill also explained the requirement that the Insurance Department work closely with municipal cooperatives already in existence to facilitate compliance with the reserve and other requirements of Article 47 over the next five years.

Section 4714 of the Insurance Law sets forth requirements for municipal cooperatives that provided medical, surgical or hospital service on or before January 1, 1993 pursuant to a municipal cooperation agreement authorized under Article 5-G of the general municipal law. Under the terms of these agreements, municipal corporations agree to join together to share the risks associated with health care costs, thereby spreading costs in a larger pool of risks. Such arrangements allow participating corporations to stabilize their health care costs and to lower administrative expenses. Existing municipal cooperatives were grandfathered and given five years to bring reserve and surplus requirements to the levels required by Section 4706 of the Insurance Law.

Although the law was passed in 1994, the first municipal cooperative became certified in 1999. Others needed more than the five years to become compliant. The Insurance Department exercised regulatory forbearance allowing additional time for entities to meet the reserve requirements.

There are currently eleven certified MCHBPs in New York State (See Table I below). All were formed by school districts and certified as municipal cooperatives under the grandfather provisions in Section 4714. The most recent MCHBP, the Greater Tompkins County Municipal Health Insurance Consortium, is the first to be certified since 2003.

Table I - Certified Municipal Cooperatives

Municipal Cooperative Health Benefit Plan	Date Certified
Allegany-Cattaraugus Schools	11/01/2001
Catskills Area Schools Employee Benefits Plan	04/01/2001
Cayuga-Onondaga Area School	08/01/2001
Chautauqua County School District's Medical Health Plan	12/01/2001
Greater Tompkins County Municipal Health Insurance Consortium	10/1/2010
Jefferson-Lewis School Employee's Healthcare Plan	06/01/2001
Orange-Ulster School Districts Health Plan	11/01/2000
Putnam/Northern Westchester Health Benefits Consortium	11/01/1999
St. Lawrence-Lewis Counties School Districts Employees Medical Plan	10/06/2009
State-Wide Schools Cooperative Health Benefit Plan	10/01/2003
Steuben Area Schools Employees Benefit Plan	06/01/2001

Reserve Requirements

Section 4706 of the Insurance Law requires the governing board of a MCHBP to establish a reserve fund and pay into the fund the amounts necessary to satisfy all contractual obligations and liabilities of the fund. The reserve for payment of claims and related expenses reported to the MCHPB but not yet paid, and claims and related expenses incurred but not yet reported must be no less than 25% of expected incurred claims and expenses for the current plan year, unless a qualified actuary has demonstrated to the Superintendent that a lesser amount would be adequate.

Moneys supporting the reserve fund must be deposited in one or more banks or trust companies designated by the governing board in accordance with the required municipal agreement, and the chief financial officer must account for the reserve funds separate and apart from all other funds of the MCHBP. The MCHBPs must maintain a detailed record of the purpose, source, date and amount of payment from the fund, the assets of the funds, any capital gains and losses from investments, and have a plan for dissolution of the health benefit plan in the event a participating municipality withdraws from the cooperative, or under other circumstances acceptable to the Superintendent.

Claim Reserve Trends in the Mid-Eighties:

In the mid 1980's, it was customary for health insurers to establish their claim reserves at the end of each calendar year at approximately 25% of claims paid during the calendar year.

This factor of 25% of annualized claims was representative of the level of the claim reserves for services provided to insureds during a specified period of time ending on a given date, for which reimbursement had not yet been paid to the insured or provider of the service. This level of reserves was based on slower payment of claims resulting from the prevailing conditions at the time, including:

1. The plans of benefits at that time were mostly of the "pure indemnity" major medical type, where members were reimbursed for a given coinsurance percentage, typically 80%, after the satisfaction of a calendar year deductible, typically $100 or $200, of medical care charges for services rendered. Such charges incorporated all charges, including charges for prescription drugs. There were far fewer copay plans in place during this time frame.

2. It was customary for members to receive services and for providers to mail statements of charges to members, who would then seek reimbursements from their insurance carriers. There were few, if any, electronic submissions of claims by providers.

3. There were few financial arrangements between providers (hospitals and physicians) and insurance carriers to establish negotiated fees on charges by providers, and more specifically for periodic prepayments for services such as monthly capitation based on expected services to be rendered.

4. Prescription drug benefits were included within the major medical benefits and subject to the calendar year deductible applicable for all charges. Members would get their prescriptions filled at the pharmacy, pay the pharmacy the total costs and seek reimbursement from the insurance carriers. Frequently, members were not able to satisfy the deductible. Pharmacy benefits managers (PBMs) were only beginning in 1986, and the drug card structure was not generally prevailing until the later part of the 1980s.

Current Loss Reserve Trends

Changes were introduced starting late in the 1980s and throughout the 1990s, including:

1. Plans of benefits were gradually and significantly revised, through insurers' introduction of Health Maintenance Organization (HMO) plans and subsequently Preferred Provider Organizations (PPO). The Exclusive Provider Organization (EPO) was not introduced until much later in the 1990s. These types of plans incorporated the use of participating provider networks where the insured has limited liability other than a fixed copay, and significantly reduced the use of calendar year deductibles for services rendered by providers who were part of the network.

2. Electronic submission of claims by providers directly to the insurance carriers, particularly for physicians participating in the PPO network, was introduced and has since been expanded.

3. Financial arrangements and negotiated reimbursement rates such as case rates, capitation and other fixed payments between providers (mainly hospitals) and

insurance carriers were introduced, initially by HMOs and subsequently expanded by insurance carriers.

4. Prescription drug card programs were introduced, under which members were provided with a medical benefits card and could obtain their prescription drugs at participating pharmacies subject to a copay amount. PBMs became more prevalent and contracted with insurers and HMOs to expand the pharmacy networks. PBMs are paid fixed payments to administer the processing of claims between the insurance carriers and the pharmacies.

Such changes lead to a reduction in the prevailing level of the required claim reserves. While these changes had already impacted on the level of claim reserves when Article 47 was enacted in 1994, the claim reserve threshold in 1994 was based on conditions prevailing years earlier, when a 25% reserve factor was the norm.

Administrative Adjustment of Required Claim Reserves

Section 4706 of the Insurance Law calls for the establishment of a reserve at the end of each reporting year for payment of claims and expenses not yet paid on reported and unreported claims. Such reserves must be equal to 25% of estimated incurred claims and expenses for the current plan year.

Section 4706 of the Insurance Law includes a provision under which this 25% minimum level may be modified upon a demonstration by a qualified actuary that a lesser amount would be adequate, subject to the approval of the Superintendent.

Most MCHBPs submitted requests to the Insurance Department for adjustments in such reserve factors over the years. The Department did not acquiesce to any requests for a reduction made prior to calendar year 2002. Starting in 2003, the Department agreed to reduce the 25% factor, subject to a minimum level of no lower than 17.0% of expected incurred claims and related expenses. This reduction was approved based on an actuarial review of the claims information, especially the distribution of the claims by incurred months (month during which medical services were received) and following those incurred claims by the months when they were actually paid (month when benefits were paid to providers or members). This analysis takes the form of what are referred to as claim lag triangles, which are commonly used by actuaries in the calculation of claim reserves. Currently, all but two MCHBPs are using a reserve factor of 17.0%. The remaining entities have either not requested a reduction in the reserve requirement, or a request for reduction was denied by the Insurance Department.

Actuarial Report of Required Claim Reserves

This report incorporates the results of an analysis of the financial experience in the last few years on claims reserves developed using subsequent claim payments and remaining reserves for the original ten MCHBPs. This report also discusses considerations pertaining to the payment of claims. Furthermore, this report provides the

results of a similar analysis conducted on the level of claim reserves for selected insurance carriers for comparison purposes.

Two separate but comparative analyses were incorporated in the review of the required claim reserves on MCHBPs. The first type dealt with the claims experience data for each of the ten original MCHBPs. The second type of analysis was conducted on selected insurance carriers doing business in New York State, some operating as HMOs, and others operating as insurance companies, i.e., mostly PPO and EPO plans, but also including the more recently popular high deductible plans. This was done to determine if conclusions could be drawn from current reserve levels for HMOs and insurers and applied to the MCHBPs.

For the analysis covering the claims experience for the ten MCHBPs, separate analyses were conducted for prescription drug claims and for all hospital and medical care claims, (i.e. all claims for other than for prescription drug claims). Both analyses were based on available claims information, typically covering three to four years of claims experience for each MCHBP.

Results of the analyses are summarized below. This information illustrates that reserve factors fluctuate greatly by MCHBPs and insurance carriers, and also by calendar year. Some of the reasons for such fluctuations can be explained by the way services are rendered by providers to members and in the way claims are adjudicated, processed and paid by the MCHBP or its claims administrator.

The determination of necessary claim reserves can be visualized as a funnel where incurred claims for services provided are poured in at the top, whether such claims are reported or not reported, and paid claims are discharged at the bottom of the funnel for benefits paid. The claims inside the funnel are those where services have been provided to insureds, but payment has not yet been made. At any date the claims inside the funnel are the claims that must be provided for in a liability for claim reserves as of that date.

Many factors impact such claim reserves, including:

1. Number of working days within each month. The number of working days every month generally fluctuates from a low of 19 to a high of 23. The lower the number of working days, the higher the claim reserves, regardless of the impact of other factors since there is less opportunity to process and pay claims during that month so there is potential for greater accumulation of unpaid claims.

2. Changes in the membership. An increase in the membership, particularly towards the end of a calendar year or fiscal year would tend to increase the claim reserves. Increases in membership will generate more claims, and if the increase occurs later in the calendar year many of those claims will not be paid until subsequent the calendar year. Such changes in membership and claims could be exacerbated if claims submissions for other medical business handled by the administrator who is adjudicating the MCHBP also increases.

3. The impact of seasonality. Certain months of the year have lower utilization, particularly in November and December because of the holidays, where medical procedures may be postponed by the providers or the members. Certain groups, particularly school groups, may also be impacted by the behavior of their members during selected months of the year. Another form of seasonality may be a major snow storm or power outage in the geographical area where the administrators are located.

4. Plan benefits or changes in the benefit plans. The level of benefits or underlying cost sharing by the insured, as well as changes to these benefits or cost sharing may also influence the behavior of the members, either increasing or decreasing their utilization, which will subsequently have an impact on the claim reserves.

5. Large amount claims. Large amount claims, for example premature twins, would develop delays in the submissions of the claims information to the administrators, and would require more time for claim examiners to adjudicate and process, and could lead to increase in the claim reserves.

6. Changes in Administrators. A change in administrators would have a significant impact on the claim reserves due to inherent delays in routing claims to the new administrator.

7. Changes in Claims Systems. A change in the systems or software used to adjudicate and process claim submissions would also have a significant impact on claim reserves, increasing such reserves.

8. Claim Backlog. It is customary for administrators to maintain a reasonable level of claims in backlog to justify maintaining resources in case of a drop in the level of claim submissions. Administrators tend to delay the hiring of new claims examiners when the claim backlog increases significantly. There is usually a learning curve for new examiners to become proficient in claims adjudication. These factors impact the level of claim reserves.

Actuarial Analysis on Medical Care Claims for MCHBPs

The analysis on the ten original certified MCHBPs was conducted separately for the prescription drug claims and for all hospital and medical care claims (other than prescription drugs) as indicated above.

With respect to the hospital and medical care claims, the analysis was conducted based on a charting of information obtained from the various MCHBPs on the distribution of claims by (i) incurred month (month service was provided) and (ii) paid month (month of claims payment for those same services). These charts are referred to herein as “lag triangles”. The information used was generally available from financial reports provided by the various MCHBPs. Information was requested for incurred

months from January 2006 through December 2009; some MCHBPs were not able to provide all four years of data. However, all MCHBPs were able to provide at least three years of data.

As part of the analysis, the information in the lag triangles was "completed" for each calendar year where data has not fully matured (i.e. run out via subsequent claim payments). Incurred data for each month of 2006 and 2007 is considered to be matured via subsequent claims payments by year end 2009 (the evaluation date) and no further claims will be paid. Therefore, the actual claim reserves for each incurred month in those years are known as of December 31, 2009. However, data for incurred months in 2008 and especially 2009 has not fully matured meaning that the remaining claim payments for incurred months within those years needed to be estimated based on the run out pattern of the prior years, in order to set the actual claim reserve for the 2008 and 2009 calendar months.

For each MCHBP, for each incurred month, the information described below was derived. (To simplify the explanation of this process, the information below is expressed in terms of incurred months between July of 2007 and of June 2009):

(a) Incomplete incurred claims for 12 months through June 2008;

(b) Complete incurred claims for 12 months through June 2008, incorporating the "remaining" claims reserves derived by process explained above;

(c) Total of (1) all actual claims paid from July 2008 through the end of the experience period, with respect to incurred months of June 2008 and prior, plus (2) total remaining claim reserves estimated at the end of the experience period (June 2009) with respect to incurred months of June 2008 and prior. This item (c) is the claim reserve at June 30, 2008;

(d) Ratios of item (c) (claim reserve at June 30, 2008) to item (b) (complete incurred claims for a 12 month period from July 2007 through June 2008).

Table II, below summarizes the results on the average ratios of claim reserves to total incurred claims obtained for "completed" claims for the various MCHBPs, for the following measurement periods:

Period A representing 12 months from July 2007 through June 2008;
Period B representing 12 months from July 2008 through June 2009; and
Period C representing 24 months from July 2007 through June 2009.

Table II also illustrates for each MCHBP, the minimum and the maximum month ratio derived for each MCHBP in the 24 month "Period C" timeframe. These ratios should be compared to the existing 25% minimum standard contained in Section 4706 of the Insurance Law. Subtotals are illustrated for the averages for the three larger MCHBPs,

designated with an asterisk, for the seven smaller MCHBPs (no asterisk) and in total for all ten MCHBPs.

Table II - Medical Claims (Other Than Prescription Drugs) for MCHBPs

	Period A	Period B	Period C		Period C	Period C
	Average Reserve %	Average Reserve %	Average Reserve %		Minimum	Maximum
Allegany	12.34%	11.95%	12.17%		9.72%	15.74%
Catskills	13.98%	12.05%	12.79%		10.33%	16.36%
Cayuga	11.24%	10.58%	10.90%		9.28%	12.48%
Chautauqua	12.26%	12.96%	12.63%		7.74%	19.63%
Jefferson-Lewis	11.94%	12.68%	12.63%		11.94%	14.10%
* Orange-Ulster	17.95%	14.78%	16.28%		9.65%	22.91%
* Putnam/Northern	14.39%	13.01%	13.66%		11.96%	15.51%
St. Lawrence	9.49%	10.47%	9.99%		8.13%	12.17%
* State-Wide	18.30%	19.89%	19.18%		13.59%	23.02%
Steuben	13.07%	9.52%	11.36%		7.54%	15.46%
*** Larger [3]**	**17.06%**	**16.20%**	**16.62%**		**13.66%**	**19.71%**
Smaller [7]	**11.62%**	**11.66%**	**11.70%**		**9.92%**	**13.71%**
Total [10]	**14.85%**	**14.36%**	**14.62%**		**12.61%**	**17.61%**

As can be seen in the table above, there are variations in these ratios by MCHBP and by incurred month. A similar pattern also existed within both period A (7/07-6/08) and period B (7/08-6/09) but only the range for the combined 24 month period C.

Our analysis showed that the larger MCHBPs have higher claim reserve ratios than the smaller MCHBPs. The Department did not explore the underlying reasons for this.

Actuarial Analysis on Prescription Drugs for MCHBPs

The analysis of the claims for prescription drugs was conducted based on information obtained from the various MCHBPs regarding payment for the invoices received from PBMs.

Many MCHBPs and some insurance carriers describe the process of payment of claims on prescription drugs as "instantaneous," meaning that at any point in time there are no claim reserves required. This is not the case as illustrated by the process set in place by PBMs and described in the following paragraphs.

(1) Members go to the pharmacies and submit the prescription from the physicians, or renew their prescription drugs;

(2) Pharmacies collect the copays from members and submit to the PBMs their "claims" on these prescriptions, i.e. the negotiated price, which varies according to the copay level plus a dispensing fee, both agreed to in negotiations between the PBMs and the pharmacies;

(3) For each two week period, which vary by PBM (for example 12/06/2008 through 12/19/2008), the PBMs request payments including administration fees from the MCHBPs or insurance carriers for participating and non-participating pharmacies;

(4) The MCHBPs or the insurance carriers remit payments to the PBMs.

The claim reserves at 12/31/2008 in the example above would be the sum of all the invoices from the PBMs which have not been settled by 12/31/2008, plus an estimate of the amounts in the unreported invoices for the subsequent two week period (12/20/2008 through 01/02/2009), with respect to the days prior to 01/01/2009 only.

Table III below was populated using prescription drug paid claim information provided by the MCHBPs.

Table III - Prescription Drug Claims for MCHBPs

		Drugs	
		Average	
Allegany		3.93%	
Catskills		4.98%	
Cayuga		7.48%	
Chautauqua		4.80%	
Jefferson-Lewis		4.76%	
* Orange-Ulster		4.91%	
* Putnam/Northern		2.27%	
St. Lawrence		5.44%	
* State-Wide		4.86%	
Steuben		3.10%	
*** Larger [3]**		**3.77%**	
Smaller [7]		**4.82%**	
Total [10]		**4.22%**	

As with medical care coverage, there are fluctuations by MCHBPs, as illustrated above, and by period. The ratios for prescription drug coverage vary from a low of 2.27% to a high of 7.48%, with an average of 4.22%, corresponding to about 2.2 weeks' worth of claims, or about 15.4 days' worth of claims.

Results on Actuarial Analysis on Prescription Drugs and Medical Care for MCHBPs

Table IV, below, illustrates the ratios of claim reserves to incurred claims for (a) medical care coverage (per Table II, the Period C Average Ratio, above), (b) prescription drug coverage (per Table III, above) and (c) composite of medical and prescription drug coverage.

As expected, the claim reserves for prescription drug coverage expressed as a percentage of the incurred claims for prescription drug coverage are at a much lower level (4.22%), than for medical care coverage (14.62%).

The ratios of both medical care coverage and for prescription drug coverage are average ratios for the period from July 2007 through June 2009.

Table IV- Ratios of Medical Care and Prescription Drug by MCHBP

	Medical	Drugs	Composite
	Average	Average	Average
Allegany	12.17%	3.93%	6.41%
Catskills	12.79%	4.98%	10.25%
Cayuga	10.90%	7.48%	10.50%
Chautauqua	12.63%	4.80%	10.15%
Jefferson-Lewis	12.63%	4.76%	10.39%
* Orange-Ulster	16.28%	4.91%	13.32%
* Putnam/Northern	13.66%	2.27%	9.23%
St. Lawrence	9.99%	5.44%	8.52%
* State-Wide	19.18%	4.86%	15.56%
Steuben	11.36%	3.10%	7.91%
*** Larger [3]**	**16.62%**	**3.77%**	**12.77%**
Smaller [7]	**11.70%**	**4.82%**	**9.46%**
Total [10]	**14.62%**	**4.22%**	**11.39%**

The composite ratios for medical care coverage and for prescription drug coverage reflect the distribution of claims prevailing on each MCHBP and in aggregate for all MCHBPs, between medical care claims and prescription drug claims.

Actuarial Analysis of Prescription Drug and Medical Care Claims for Insurance Carriers

As discussed earlier in this report, an analysis was conducted on the claim reserves for six selected insurance carriers: four carriers doing business in the upstate regions of New York State and two carriers doing business in the downstate regions of

New York State. The analysis was conducted on the combined HMO and indemnity lines of business for these six carriers.

Plans of benefits for these insurance carriers covered the broad spectrum of the lines of business for these carriers, including both government programs such as Medicare and Medicaid, and commercial lines of business such as large groups, small groups, Direct Pay and Healthy NY plans.

In aggregate for all insurance carriers combined, the claims added up to about $19 billion per year, for both medical care coverage and prescription drug coverage combined.

The analysis was conducted on the claim reserves established at three specific dates at December 31, 2006, December 31, 2007 and December 31, 2008. Actual claim run outs on the claim reserves at these dates were monitored for a 12 month period following the selected dates.

The results were tabulated separately for each of the three dates and in aggregate for the three dates combined. The ratios of claim reserves to incurred claims were 11.60% at December 31, 2006, 11.35% at December 31, 2007 and 11.19% at December 31, 2008, for an overall ratio of 11.38% for all three dates combined. All these ratios are composite ratios for combined medical care coverage and prescription drug coverage.

While this last ratio of 11.38% is very similar to the ratio of 11.39% illustrated in Table IV, earlier herein for all ten MCHBPs, it should be kept in mind that the distribution of claims between medical care coverage and prescription drug coverage is very different for the MCHBPs, where prescription drugs account for about 31.06% of all claims, and for the insurance carriers where prescription drugs account for only about 11.97% of all claims.

For all MCHBPs, claims for prescription drug coverage represent about 31.06% of total claims for combined medical care and prescription drug coverage. This percentage of 31.06% is significantly above similar percentage for insurance carriers, where the percentage is about 11.97%.

Higher percentages of prescription drugs are due to the fact that MCHBPs cover mostly unionized workers. Union groups tend to have very low copays for prescription drugs compared to traditional large and small groups. Furthermore, insurers that offer Medicare Advantage plans exclude the Medicare Part D prescription drugs from claim reserves.

Table V, below compares the results of the analyses on the ten MCHBPs and on the insurance carriers.

Table V – Comparison of Prescription Drugs Ratios and Reserve Ratios for MCHBPs and Insurers

	Drug Percent	Reserve Ratios
MCHBPs	31.06%	11.39%
MCHBPs Alternate*	11.97% *	13.08%*
Ins. Carriers	11.97%	11.38%

* Alternate results illustrated for the MCHBPs, using the same lower distribution of prescription drug claims observed for the insurance carriers.

Adjustments for Explicit Margins for Fluctuations

Actuarial Standards of Practice (ASOP) requires that the claim reserves determined by actuaries should incorporate some adjustments for a margin for fluctuations in the claims.

Given the level of the annualized claims involved in the MCHBPs, and the potential for tax implications on the municipalities that result from adverse misestimation of the reserves, it is recommended that an explicit margin of 10.0% be added to the claim reserves.

The experienced factors illustrated in Table IV for average medical and average prescription drug ratios of claim reserves to incurred claims exclude any provision for such margins for fluctuations. Table VI illustrates the experienced factors as developed for Table IV, and the experienced factors adjusted for a 10.0% margin for claim fluctuations:

Table VI - Experience Factor Adjusted for a 10.0% Margin

	Medical	**Drugs**	**Composite**
No Margins	14.62%	4.22%	11.39%
Incl. 10% Margin	16.08%	4.65%	12.53%

Summary and Conclusion

Given the fluctuations by MCHBP in the experienced reserve factors at the end of a given calendar year or fiscal year, as a percentage of incurred claims for the calendar year or fiscal year, it is not feasible to recommend a unique factor to be applicable for all MCHBPs.

On the other hand, the MCHBPs often do not have the proper actuarial expertise to evaluate the prevailing conditions at the time the claim reserves are being established, particularly the smaller MCHBPs. Therefore it is not feasible for MCHBPs to establish their own claim reserves based on conditions prevailing at the time the claim reserves are being established.

Consequently, the Department of Financial Services recommends that the claim reserves be determined separately for medical care claims and for prescription drug claims. Based on its review of claims data from existing municipal cooperative health benefit plans and selected commercial insurers, the Department further recommends that, for medical care claims, the claim reserves would be set as an amount reflecting application of actuarial principles and percentage of incurred claims based on prevailing conditions including a 10.0% margin for claim fluctuations, but no less than 17.0% of incurred claims.

For prescription drug claims, the claim reserves would be set as an amount reflecting application of actuarial principles and based on prevailing conditions as determined by the Superintendent including a 10.0% margin for claim fluctuations but no less than 5.0% of incurred claims.

Increased flexibility in minimum claims reserve requirements, based on sound actuarial principles and analysis, would increase the ability of municipalities to establish MCHBPs.