

SCHOOLS HEALTH INSURANCE FUND

2020/2021 RISK MANAGEMENT PLAN

Effective: July 1, 2020

Adopted: May 27, 2020

The RISK MANAGEMENT PLAN for the Schools Health Insurance Fund (the "SHIF"), for the SHIF Year beginning July 1, 2020 and ending on June 30, 2021 shall be as set forth below:

1.) COVERAGE OFFERED

- Medical

The medical plans offered by the SHIF include standard "preferred provider organization", "traditional", "point of services", "tiered", and "health maintenance organization" plan designs and such other plan designs as approved by the Board of Trustees and the Commissioner of the Department of Banking and Insurance. These plans have both in network and out of network benefits and are customized to the needs and specifications of the members. The SHIF also offers "low cost plans" to allow members options to comply with contribution requirements under Chapter 78. Included as options are: a health savings account, a core PPO program, and a buy up PPO program, an HMO program and a Consumer Directed Health Plan. The SHIF will also offer Medicare Advantage programs for retirees.

- Dental

The SHIF offers customized dental plans as required by the members.

- Prescription

The SHIF offers customized prescription plans as required by the members including plans that are coordinated with the low cost medical plans.

- Vision

The SHIF offers customized vision plans as required by the members.

2.) LIMITS OF COVERAGE

Limits of coverage vary by member and plan design.

3.) RISK RETAINED BY THE SHIF

Medical and Prescription

- Specific Retention: \$450,000
- Aggregate Retention: Not applicable, aggregate reinsurance or stop loss not obtained
- Specific Limit: Unlimited
- Aggregate Limit: Not applicable

Dental Aggregate Retention: None - Self insured with risk retained by SHIF

Vision Aggregate Retention: None - Self insured with risk retained by SHIF

4.) ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.

The SHIF complies with statutory accounting standards and establishes reserves on the probable total claim costs at the conclusion of the SHIF Year. Each month, the accrual in the general ledger for claim reserves, including IBNR, is adjusted based on earned underwriting income and the number of months since the inception of the SHIF Year. This accrual is periodically adjusted, but not less frequently than annually, in accordance with the actuary's certifications.

5.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the SHIF Year, the SHIF adopts a budget for the upcoming year based on the most recent census, the claims experience for the current SHIF Year and other applicable accounting and actuarial factors. Per employee rates are computed for each line of coverage for each SHIF member, and are approved by the SHIF as a part of the budget adoption process. These rates are used to compute the monthly assessment for each member of the SHIF members based on the updated census, and monthly billings are mailed to the SHIF members approximately 15 days before the beginning of the month. The billing also includes the member's updated census for verification each month by the local entity. Retroactive adjustments for enrollment changes are limited to 2 months. Former employees (COBRA, Conversion and some Retirees) are billed directly by the SHIF.

Members that renew on July 1 have the option of taking a payment deferment by paying their June assessment in the subsequent month of July. Members that renew on January 1 have the option of taking a payment deferment by paying their December assessment in the subsequent month of January. Members that choose to take such deferments shall advise the SHIF Executive Director's office in writing at least one month prior to taking the deferment

6.) COVERAGE PURCHASED FROM INSURERS AND PARTICIPATION IN THE MUNICIPAL REINSURANCE HEALTH INSURANCE FUND (MRHIF)

The SHIF provides coverage on a self-insured basis, and secures excess insurance to cap the SHIFs' specific (i.e. per enrolled covered person per policy year) retention. The SHIF is a member of the Municipal Reinsurance Health Insurance Fund (MRHIF). The MRHIF retains claims above the SHIF's local specific retention and purchases an excess insurance policy that is filed with the Department of Banking and Insurance in accordance with the applicable regulations. The MRHIF also has the ability to purchase an aggregating specific excess insurance policy on behalf of the SHIF and the other members.

7.) REINSURANCE

SHIF provides for reinsurance through its membership in the Municipal Reinsurance Health Insurance Fund.

8.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the SHIF, a prospective member's benefit program is reviewed by the actuary to determine its projected claim cost. In this evaluation, the actuary takes into consideration:

- age/sex factor as compared to the average for the existing SHIF membership;
- the plan of benefits for the prospective member; and
- loss data if available.

The actuary then recommends a relativity factor to either the SHIF's base rates or to the rates being paid by the entity. The Board of Trustees of the SHIF must approve the rates recommended by the actuary before the prospective member is approved for membership in the SHIF.

To manage potential volatility that could result from rapid growth, the SHIF:

- limits growth in medical membership to 20% of the prior year's medical enrollment;
- limits growth in counties outside of its traditional footprint (Camden, Gloucester, and Burlington) and outside the counties of Sussex (9 current members), Hunterdon (5 current members), and Warren (7 current members) to 5% of the prior year's enrollment;
- prohibits cross subsidization of rates between new members; and
- requires new members to use all Rx utilization management standards adopted by the SHIF.

The SHIF may require enrollment audits for new and existing members to assure that benefits are paid only for persons meeting eligibility requirements.

Rates for all members are adjusted at the beginning of each SHIF year to reflect the new budget. The adjustment reflects the overall cash flow needs of the SHIF, and actuarial factors needed to assure that individual entity rates reflect the risk profile of the member. The SHIF may implement individual entity loss ratio adjustments based upon recommendations from the SHIF actuary. The SHIF may also adopt mid-year rate changes to reflect changes in plan design, participation in lines of coverage, utilization management, or a budget amendment. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, the rates for the other lines of coverage may be adjusted and the member shall not be eligible for membership in the dropped line of coverage for a three (3) year period.

Loss experience data used by the SHIF to determine loss ratio adjustments will be made available no more frequently than twice per year to members at no additional cost. "Loss experience data" is defined as monthly claims and assessments for a three (3) year period including de-identified specific claims at 50% of the SHIF's self-insured retention. Requests for additional claims data from SHIF members will be considered based upon the availability of data, the feasibility of extracting the data, and conditioned upon the member reimbursing the SHIF or its vendors for data extraction and formatting costs.

As part of the renewal process, the Board of Trustees shall, at least annually, review surplus retention objectives and status.

Additionally, claims agents shall formally report to the SHIF at least annually on network contract changes and the potential financial impact of such changes on the prospective charges and fees.

9.) RATING PERIODS

Rating periods for school board members generally coincide with the SHIF fiscal year but customized rating periods can be offered to members.

10.) FACTORS IF RATES FOR MEMBERS JOINING THE SHIF DURING A SHIF YEAR ARE TO BE ADJUSTED.

Unless otherwise authorized as part of the offer of membership, when a member joins during a SHIF year, the member's initial rates are only valid through the end of the then current SHIF year at which time the rates are adjusted for all members to reflect the new budget.

11.) TERMINATION OF MEMBERSHIP

Former members of the SHIF cannot rejoin the SHIF for a period of three (3) years after the date of the termination of their membership in the SHIF.

12.) PROVISION FOR PLAN ALTERNATIVES

The SHIF offers employees the option of selecting various PPO/POS, tiered option plans and other plan designs dependent upon the collective bargaining agreements applicable that member. Generally, it is the policy of the SHIF to encourage selection of POS and other cost saving plan designs as opposed to traditional indemnity plans, and the SHIF provides promotional material to assist members in employee communication programs concerning optional plan designs.

13.) OPEN ENROLLMENT PROCEDURES

All members have an open enrollment period no later than the first month of their joining the SHIF. Participating employees also have an annual open enrollment with changes effective at the beginning of the SHIF Year.

14.) COBRA AND CONVERSION OPTIONS

The SHIF provides COBRA coverage at a rate equal to the member's current rate and benefit plan design, plus the appropriate administrative charge. The SHIF has arranged for a COBRA administrator to enroll eligible participants and to collect the premium. Where provided for in a member's plan document, the SHIF provides a conversion option at rates established by the SHIF. Unless otherwise specified in the member's plan document, the conversion option duplicates the conversion option offered by the SEHBP. The SHIF's coverage for individuals covered under COBRA or conversion options shall terminate effective the date the member withdraws from the SHIF, or otherwise ceases to be a member of the SHIF or in the event of nonpayment of applicable charges.

15.) DISCLOSURE OF BENEFIT LIMITS

The SHIF discloses benefit limits in plan booklets provided to all covered employees.

16.) PARTICIPATION RULES WHEN ALL OR PART OF THE PREMIUM IS DERIVED FROM EMPLOYEE CONTRIBUTIONS

All assessments, including additional assessments and dividends are the responsibility of the member, not the employee or former employee. Employee contributions, if any, are solely an internal policy of the member which shall not impact on the member's obligations to the SHIF or confer any additional rights to the employees. Where the SHIF directly bills an employee, (i.e. COBRA, etc.), this shall be considered as a service to reduce the member's administrative burden, and the member shall be responsible in the event of non-payment.

17.) RETIREES

The SHIF duplicates coverage for eligible retirees and uses the rates established by the SHIF actuary. The SHIF's coverage of a retiree shall terminate effective the date the member local unit withdraws from the SHIF, or otherwise ceases to be a member of the SHIF or in the event of nonpayment of applicable charges.

18.) NEWBORN CHILDREN

All plan documents will have the following language:

"You may remove family members from the policy at any time, but you may only add members within sixty (60) days of the change in family status (marriage, birth of a child, etc.). It is your responsibility to notify your employer of needed changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium) will not take place until you have formally requested that change. Newborn children, but not grandchildren of an eligible employee, shall be automatically covered from birth for sixty (60) days, even if not enrolled within the required sixty (60) days. In the event of an eligible dependent giving birth to a child, (a grandchild) benefits for any hospital length of stay in connection with childbirth for the mother or newborn grandchild will apply for up to 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, the mother's or newborn grandchild's attending provider, after consulting with the mother, may discharge the mother or her newborn grandchild earlier than 48 hours (or 96 hours as applicable)."

19.) PLAN DOCUMENT

The SHIF prepares a plan document and benefit plan booklets for each member local unit (or each employee bargaining group within a member local unit as the case may be), and an employee handbook provides a summary of the coverage provided by the plan. Each booklet (or certificate) shall contain at least the following information and be provided to all covered employees within thirty (30) days of coverage being effective.

A.) General Information

- Enrollment procedures and eligibility;
- Dependent eligibility;
- When coverage begins;
- When coverage may be changed;
- When coverage ends;
- COBRA provisions;
- Conversion privileges; and
- Enrollment forms and instructions.

B.) Benefits

- Definitions;
- Description of each benefit, inclusive of;

Eligible services and supplies;
Deductibles and co-payments; and
Examples as needed;
Exclusions.
Retiree coverage, before age 65 or after (if any).

C.) Claims Procedures

- Submission of claim. In accordance with plan document.
- Proof of loss. In accordance with plan document
- Appeal procedures. Shall be in accordance with applicable law. See Plan Document and SHIF Risk Management Plan and Bylaws

D.) Cost Containment Programs - In accordance with plan document.

- Pre-admission.
- Second surgical opinion.
- Other cost containment programs.
- Application and level of employee penalties.

20.) BENEFITS CURRENTLY PROVIDED TO COVERED EMPLOYEES BY EACH MEMBER AND BENEFITS PROPOSED TO BE PROVIDED BY THE SHIF.

PROVIDED IN EACH PLAN DOCUMENT

21.) PROCEDURES FOR THE CLOSURE OF SHIF FUND YEARS

Approximately six months after the end of a SHIF year, the SHIF evaluates the results to determine if dividends or additional assessments are warranted. Most claims are paid within twelve months of year end, and at that time the SHIF begins to consider closing the year, unless excess insurance recoveries are pending or litigation is likely. The SHIF has determined that maintaining and retaining a surplus equal to two and a half (2.5) months of the current year claim expenses is a benchmark prior to a dividend being declared from surplus generated by claims operations.

When the SHIF determines that a SHIF year should be closed:

- A reserve is established by the actuary to cover any unpaid claims or IBNR
- The SHIF decides on the final dividend or supplemental assessment.
- A closure resolution is adopted transferring all remaining assets and liabilities of that SHIF year to the “Closed SHIF Year/Contingency Account”.
- Each member’s pro rata share of the residual assets are computed and added to its existing balance in the Closed SHIF Year/Contingency Account.
- Any member that has withdrawn from the SHIF shall receive its remaining share of the Closed SHIF Year/Contingency Account on the following schedule:
 - 3rd year after withdrawal – 25% of balance
 - 4th year after withdrawal – 25% of balance
 - 5th year after withdrawal – 25% of balance
 - 6th year after withdrawal – Remaining balance

22.) MAXIMUM APPROVAL AMOUNT FOR CERTIFYING & APPROVING OFFICER

1. The SHIF Treasurer may issue checks or initiate wire transfers in payment of medical, Rx, and dental claims, as submitted by the third party administrator responsible for handling the SHIF’s claims, as necessary in order to fulfill the SHIF’s claim funding obligations under the applicable service provider contract between the SHIF and the third party administrator. The certifying and approving officer shall prepare a report of all claims approved by him or her in aggregate by year and line of coverage. This report shall be submitted to the Board of Trustees of the SHIF at their next scheduled meeting. The Board of Trustees shall review and approve the actions of the certifying and approving officer. In the event claims approved and paid by the certifying and approving officer is not approved by the Board of Trustees, they shall direct appropriate action to be taken.

2. Delta Dental shall issue checks for the payment of dental claims in the amount of \$.0 to \$5,000 on the adjudication and signature solely of duly authorized Delta Dental personnel.

3. All dental claims, if any, in excess of \$5,000 shall require the approval, at a regularly scheduled meeting, of the Board of Trustees of the SHIF after obtaining appropriate certifications and making such other inquiries as are reasonable. Checks issued pursuant to any such approval shall be countersigned by a duly authorized representative of the Executive Director.

4. The terms "claims" as herein utilized shall refer to the issuance of any particular check, provided however that no bills shall be split for the purpose of avoiding the requirements hereof.

5. In addition to the claim payment procedure, Delta Dental shall also notify the Board of Trustees in writing whenever the cumulative payments to any covered person for a single illness or injury (including related illnesses and injuries) exceeds \$30,000.

23.) "RUN-IN" or "RUN-OUT" LIABILITY

The SHIF covers the "run-out" liability of all members - i.e., liability for claims incurred but not reported by a former SHIF member during the period it was a member. Upon approval of the Board of Trustees, the SHIF may also cover the run-in liability of a perspective member (i.e., the liability for claims incurred but not reported by a prospective member in connection with the provision of health benefits during the period prior to joining the SHIF). When the SHIF covers run-in liability, the prospective member shall be assessed the expected ultimate cost of run-in claims, as certified by the SHIF's actuary and approved by the Board of Trustees. The assessment shall be paid entirely within the SHIF Year the member joined the SHIF.

24.) CLAIM AUDIT

The SHIF retains a claim auditor experienced in auditing self-insured health plans. The audit will be conducted upon completion of the first SHIF Year after the SHIF's inception and at least once every three (3) years thereafter. The SHIF can conduct this audit on its own, or in a cooperative effort with other health joint insurance funds through the Municipal Reinsurance Health Insurance Fund.

25.) AUTHORITY OF CLAIM APPEAL COMMITTEE AND INDEPENDENT REVIEW ORGANIZATIONS

- The TPA shall initially review all appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.
 - The TPA shall provide the Program Manager, Executive Director and the SHIF Attorney with a copy of the memo, which has been prepared concerning the appeal.
 - The TPA, Program Manager, Executive Director and SHIF Attorney shall confer concerning the merits of an appeal and they shall render a decision concerning the appeal provided that the appeal is

- (a) In an amount not greater than \$5,000.00 and/or
 - (b) Has been reviewed and recommended for approval by an independent, third party medical review consultant.
- If the decision of the TPA, Program Manager, Executive Director and SHIF Attorney is to pay the claim, then the TPA is hereby authorized to issue the necessary check in payment of the claim.
 - The Board of Trustees of the SHIF shall formally confirm the decision of the TPA, Program Manager, Executive Director and SHIF Attorney to pay the claim and ratify the payment issued pursuant to that decision at the next meeting of the Board of Trustees.
 - If the decision of the TPA, Program Manager, Executive Director and SHIF Attorney is to deny the claim, the appeal shall be subject to the “adverse benefit determination” appeal process that is required pursuant to applicable law. The plan participant (hereinafter sometimes referred to as “claimant”) shall at that time be advised that the adverse benefit determination may be appealed to the SHIF's Independent Review Organization (“IRO”). The claimant's identity shall be revealed only upon the written request of the claimant. A copy of such written request with respect to disclosure of the claimant's name shall be sent to the Program Manager.
 - a. An appeal of an adverse benefit determination must be filed by the claimant within four (4) months from the date of receipt of the notice of the adverse benefit determination. The claimant shall submit a written request to the Program Manager to appeal an adverse benefit determination and/or final internal adverse benefit determination made by the TPA and the written request shall be accompanied by a copy of the determination letter issued by the TPA.
 - 1. The Program Manager will conduct a preliminary review within five (5) business days of the receipt of the request for an external review. There is no right to an external review by the IRO if (i) the claimant is not or was not eligible for coverage at the time in question or (ii) the adverse benefit determination or final internal adverse benefit determination is based upon the failure of the claimant or covered person to meet requirements for eligibility under the Plan or (iii) the claimant is not eligible due to the benefit/coverage being an excluded benefit or not included as a covered benefit. The Program Manager shall notify the claimant if (a) the request is not eligible for external review; (b) that additional information is needed to make the request complete and what is needed to complete the request; or (c) the request is complete and is being forwarded to the IRO.
 - 2. The Program Manager shall then forward an eligible, complete request for external review to the IRO designated by the SHIF who shall be required to conduct its review in an impartial, independent and unbiased manner and in accordance with applicable law.

3. The assigned IRO will provide timely written notice to the claimant of the receipt and acceptance for external review of the claimant's request and shall include a statement that the claimant may submit, in writing and within ten (10) business days of the receipt of the notice, additional information which shall be considered by the IRO when conducting the external review. Upon receipt of any information submitted by the claimant, the IRO, within one (1) business day, shall forward the information to the Program Manager who may reconsider the adverse benefit determination or final internal adverse benefit determination and, as a result of such reconsideration, modify the adverse benefit determination or final internal adverse benefit determination. The Program Manager shall provide prompt written notice of any such modification to the claimant and the IRO.

4. The Program Manager, within five (5) business days of the assignment of the IRO, shall deliver to the IRO any documents and information considered in making the adverse benefit determination or the final internal adverse benefit determination. The IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination if the Program Manager does not provide such information in a timely manner. In such event, the IRO shall notify the claimant and the Program Manager of the decision within one (1) business day.

5. The IRO shall complete the external review and provide written notice of its final external review decision within forty-five (45) days of the receipt of the request for the external review. In the case of a request for expedited external review of an adverse benefit determination or final internal adverse benefit determination where delay would seriously jeopardize the life or health of the claimant or the ability to regain maximum function, the IRO shall provide notice of the final external review decision as expeditiously as possible but in no event more than 72 hours after the receipt of the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Program Manager within 48 hours after providing that notice in the case of an expedited external review. The IRO shall deliver notice of its final external review decision to both the claimant and the Program Manager for all external reviews conducted. The notice of decision shall contain:

(i) a general description of reason for the external review with sufficient information to identify the claim, claim amount, diagnosis and treatment codes and reason for previous denial;

(ii) the date the IRO was assigned and date of the IRO's decision;

(iii) references to the documentation/information considered;

(iv) a discussion of the rationale for the IRO's decision and any evidence-based standards relied upon in making the decision;

(v) a statement that the decision is binding on the claimant and the SHIF subject to the claimant's right to seek judicial review of the same; and

(vi) that the claimant may contract the New Jersey health insurance consumer assistance office at NJ Department of Banking and Insurance, 20 West State Street, PO Box 329, Trenton, NJ 08625, phone (800) 446-7467 or (888)

393-1062 (appeals) website: <http://www.state.nj.us/dobi/consumer.htm> e-mail address: ombudsman@dobi.state.nj.us/

26.) ENROLLMENTS AND TERMINATIONS PAST 60 DAYS

Enrollments and terminations can be processed up to 60 days in the past. Should there be a need to enroll or terminate an employee past 60 days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims Committee will anonymously review each request, including the financial impact to the Fund. The Committee will approve/deny the request within 45 days.

27.) PARTIAL MONTH ENROLLMENTS

When processing enrollments and terminations, the Fund will charge a member for a full month rate for an employee that is enrolled between the 1st and the 15th of the month, but will charge the member in the following month if an enrollment occurred between the 16th and the 31st of the month. If a member should term between the 1st and the 15th of the month, the Fund will not charge the member a rate for the enrollment, but will charge a full month rate if a member terms between the 16th and the 31st of the month.