



9-2009

What Every City Needs to Know about Health, Dental and Life Insurance (2009)

Don Darden

Municipal Technical Advisory Service

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Recommended Citation

Darden, Don, "What Every City Needs to Know about Health, Dental and Life Insurance (2009)" (2009).

MTAS Publications: Full Publications.

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WHAT EVERY CITY NEEDS TO KNOW ABOUT HEALTH, DENTAL AND LIFE INSURANCE

Don Darden, Municipal Management Consultant
September 2009

THE UNIVERSITY of TENNESSEE 

MUNICIPAL TECHNICAL ADVISORY SERVICE

In cooperation with the Tennessee Municipal League



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September 2009

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The Municipal Technical Advisory Service (MTAS) was created in 1949 by the state legislature to enhance the quality of government in Tennessee municipalities. An agency of the University of Tennessee Institute for Public Service, MTAS works in cooperation with the Tennessee Municipal League and affiliated organizations to assist municipal officials.

By sharing information, responding to client requests, and anticipating the ever-changing municipal government environment, MTAS promotes better local government and helps cities develop and sustain effective management and leadership.

MTAS offers assistance in areas such as accounting and finance, administration and personnel, fire, public works,

law, ordinance codification, and wastewater management. MTAS houses a comprehensive library and publishes scores of documents annually.

MTAS provides one copy of our publications free of charge to each Tennessee municipality, county and department of state and federal government. There is a \$10 charge for additional copies of "What Every City Needs to Know about Health, Dental and Life Insurance."

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INTRODUCTION

Many municipalities in Tennessee offer some kind of health, dental and life insurance program for their employees. Today there are more types of insurance and more choices than ever before. Local decision makers sometimes are confused by terms such as HMO, PPO, fee-for-service, self funded, partially self funded, POS, HIPAA, term and whole life insurance, and other unfamiliar jargon.

The purpose of this publication is to explain the various kinds of health, dental and life insurance products available for local governments and provide practical assistance for you to develop a fair and equitable procurement process for purchasing such insurance.



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WHAT EVERY CITY NEEDS TO KNOW ABOUT HEALTH, DENTAL AND LIFE INSURANCE

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■ HEALTH INSURANCE

GROUP INSURANCE

Most employees and their families obtain their health insurance through their employers. They have coverage because a family member has coverage at work. This is called group insurance. It generally is the least expensive form of insurance. Another protection commonly found with group insurance is that pre-existing conditions may be covered (with no wait time). If the employee loses his or her job, the family does not necessarily lose its group health insurance coverage due to passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1985. This law provides that if an employee works for an employer with 20 or more employees and leaves the job or is laid off, the employee can continue to receive health insurance coverage for at least 18 months. COBRA benefits also may apply for reduction of hours worked, divorce, and change of dependent status.

Many group health insurance programs also provide life insurance. But buying life insurance coverage in a health insurance policy is like buying copy paper from a company that sells copier machines. Paper is not its main business, but it will sell it to you if your city is willing to pay the price. It is not uncommon for a health insurance program to provide life insurance coverage costing as much or more than \$1 per \$1,000 of coverage. Buying life insurance in a separate policy may represent a savings of at least 50 percent of this cost. A city with 200 employees providing \$20,000 of life insurance on each employee could save as much as \$2,600 annually on life insurance premiums simply

by bidding the insurance to companies whose primary business is selling life insurance.

Smaller cities may not provide group insurance coverage for their employees. If your city does not provide such coverage, you should encourage employees to look into obtaining group coverage through professional associations, clubs or other organizations. Many organizations offer health insurance plans to their members.

ADMINISTRATIVE/EMPLOYEE TIPS

- Someone at city hall needs to be familiar with and manage the city's policies on health, dental and life benefits. It is very important to know the amount of the deductible (the amount the employee is required to pay before the policy begins paying), coinsurance (the amount the employee is required to pay above the deductible), the amount or percentage of coverage provided by the plan, the effective date of coverage, and the kind of coverage. The policy should provide coverage for more than a single disease. A regular health plan generally provides adequate coverage.
- The city should shop carefully. Policies differ significantly by coverage and cost. The city should always look at more than one policy and make comparisons.
- The city should make sure that the policy protects employees and their dependents from large medical costs.



- It also is imperative that city employees know (1) the coverage provided in their group policy, and (2) if their plan specifies a provider network, and if so, the names of physicians, hospitals and other medical facilities in the network. Most plans provide a penalty for care received outside the provider network. That is to say, a plan that ordinarily would pay 90 percent on medical coverage might pay only 70 percent to an out-of-network provider. Not only will they lower the percentage paid, but they will pay only the percentage of allowable charges. Anything over the reasonable and customary or maximum allowable charge usually is the member's responsibility as well as the 30 percent coinsurance. In some cases the plan might not pay at all. The out-of-pocket maximum expense might be \$1,500 for services received from network providers and \$3,000 or more for services provided outside the network.
- Employees have a joint responsibility to ensure they receive care from participating providers. A common claim issue occurs when an in-network doctor refers a patient to a nonparticipating specialist or hospital. It is important that both the patient and the doctor identify providers who are in the network. This includes specialists, laboratories, ancillary providers and hospitals. The employee must follow closely the medical care provided and assure that all care provided, except in cases of bona fide emergencies, is from network providers in order to avoid more costly medical care. Employees should not be hesitant to ask for another referral when their primary physician refers them to a specialist who is not in the network. Failure to do this likely will mean added expense.
- Another problem occurs when an employee or his dependents go to an emergency room for routine medical care. Receiving care in an emergency room does not make the care provided "emergency" care. Insurance policies specify what constitutes emergency care.

MTAS recommends that all cities provide educational opportunities for their employees, explaining the coverage and how networks are established to provide medical services. If this is not accomplished, city staff likely will be required to spend a considerable amount of time placating unhappy employees and resolving insurance claims.

TYPES OF HEALTH INSURANCE

The main types of health insurance are:

1. Fee-for-service;
2. Health maintenance organizations (HMOs); and
3. Preferred provider organizations (PPOs).

There also are self-funded and partially self-funded group health insurance programs. These are discussed later because several larger local governments are using this less traditional approach to health insurance coverage.

Fee-for-Service

Fee-for-service coverage is health insurance in which a private insurance company pays for services provided to insured employees covered by the policy. Those who are covered are free to choose the hospitals and doctors who will provide their health care. The insurer pays part of the doctor and hospital bills, and it is the city or employee's responsibility to pay:

- **The premium:** Some cities pay the entire premium, while others pay either a portion of the premium or all of the individual employee's premium with the employee paying for dependent coverage.
- **A deductible:** This is the employee's expense, which is paid before insurance payments begin. For example, there might be a \$250 deductible for each person in the family with a total family deductible of \$500 when at least two people in the family have reached the individual deductible. Only expenses for health care services covered by the policy count toward the deductible.



- After paying the deductible, the employee usually shares the remainder of the doctor or hospital bill with the insurance company. The employee’s part of this payment is referred to as “coinsurance.” For example, the employee may be required to pay 20 percent while the insurance company pays 80 percent. Some policies require that the employee pay only 10 percent with the insurance company paying 90 percent.

To receive payment for fee-for-service claims, the employee may be required to fill out forms and send them to the insurance company. In most cases the doctor’s office provides this service, but some doctors do not fill out the forms. The employee should check this with the doctor prior to receiving medical services. The employee also is responsible for keeping receipts for drugs and other medical costs. It is the employee’s responsibility to keep track of medical expenses.

The amount that an insurance company will pay for a claim if both the employee and spouse are covered by and file under two different group insurance plans is limited. This is covered by a “coordination of benefits” clause that limits benefit payments to not more than 100 percent of the claim.

Most fee-for-service plans have a maximum out-of-pocket expense that the employee is required to pay on insurance claims. The maximum out-of-pocket expense is reached when expenses for the deductible and coinsurance total a certain specified amount. Policies can have maximum out-of-pocket expenses as low as \$1,000 or as high as \$5,000. In this type of plan the insurance company pays the full amount above the maximum out-of-pocket expense for the services the policy covers. The out-of-pocket expense is in addition to monthly premium payments.

There are two kinds of fee-for-service coverage: basic and major medical. **Basic** protection helps pay for a hospital room and medical care while the insured is in the hospital. It also covers some hospital services and supplies, such as X-rays and prescribed medicine. Basic coverage also helps pay the costs of surgery, whether inpatient or outpatient, and some doctor visits. **Major medical insurance** takes over where basic coverage leaves off. It covers extended high-cost illnesses and injuries.

Basic and major medical coverage sometimes are combined into one comprehensive plan. A city’s health insurance program should include both basic and major medical coverage.

Most insurance plans will pay only a “usual, customary and reasonable” fee for many services. If a doctor charges \$1,200 for a particular surgery for which most doctors in the local area charge \$900, the employee will be billed for the \$300 difference. This charge is in addition to the deductible and coinsurance. Employees should be made aware of this limitation and instructed to ask their doctor prior to delivery of the service to accept the insurance company’s payment as full payment, or shop around for a doctor who will. The following example illustrates how a fee-for-service program works:

An employee’s dependent child has surgery on his thumb, which requires the insertion of a pin to hold bones in place. Together, medical and hospital costs total \$11,279. The employee has a \$200 deductible and is required to pay 20 percent coinsurance. The maximum out-of-pocket expense is \$1,500 per claim.

Employee payments

Deductible	\$200
Coinsurance	\$1,300
Total employee payments	\$1,500
Insurance company payment	\$9,779
Total	\$11,279



In this example the coinsurance is reduced from \$2,255.80 (20 percent of the claim) to \$1,300 because the employee's policy specifies a maximum out-of-pocket expense of \$1,500.

Health Maintenance Organizations (HMOs)

A health maintenance organization is a prepaid health plan. An employee who is a member of an HMO pays a monthly premium, and the HMO provides comprehensive care for the employee and his insured dependents. These services include doctor visits, hospital stays, emergency care, surgery, lab tests, X-rays, and therapy.

HMOs provide medical care through a physician group employed by the HMO or through doctors and other health care professionals who contract with the HMO. With the exception of emergencies, the patients' choice of doctors and hospitals is limited to those that have agreements with the HMO to provide medical care.

Usually a small copayment is required for each office visit. For example, the copayment might be \$25 to \$35 for a doctor visit, \$45 for visiting a specialist and \$50 to \$150 for hospital emergency room treatment. Total medical costs likely will be lower and more predictable with an HMO than with other health insurance plans.

HMOs receive a fixed fee to provide medical care for each person insured, and it is, therefore, in their interest to make sure that their members receive basic care for medical problems before they become serious. HMOs routinely provide preventive care, such as office visits, immunizations, well-baby checkups, mammograms, and physicals. Covered services vary from plan to plan.

Employees usually like HMOs because they do not require claim forms for office visits or hospital stays. Members simply present a medical card when they arrive at the doctor's office or hospital and pay the required copayment. Sometimes HMO members

must wait longer for appointments for routine medical care than in other health plans.

Doctors who are employees of the HMO may have offices in HMO-owned buildings at one or more locations in the community. In some HMOs independent groups of doctors are under contract to provide medical care to HMO members. These "individual practice associations" (IPAs) are made up of private physicians in private offices who agree to treat HMO members.

In most HMOs members select a doctor to serve as their primary care provider, or, if they don't choose a doctor, one is assigned. This doctor monitors the health of his or her patients and takes care of most of the family's health care, including making necessary referrals to specialists and other health care providers. HMO members usually do not receive any benefits if they see a specialist without a referral from the primary care doctor whose responsibility it is to manage their medical care.

Before contracting for HMO coverage, it is a good idea to talk to people who are enrolled in the HMOs you are considering and ask their opinions of the services and the care provided.

T.C.A. § 56-32-223 provides that every public and private employer (except metropolitan governments with populations of 400,000 or more according to the 1980 federal census or any subsequent federal census) that offers a health benefit plan and employs at least 25 employees shall afford at least two qualified health maintenance organizations the opportunity to bid or to provide health care services. This dual offering is contingent upon written requests being received from the health maintenance organizations for inclusion in the employer's health benefit plan and provided the health maintenance organizations are different types or models.



No employer in Tennessee is required to pay more for health benefits as a result of this law than would otherwise be required to provide health benefits to its employees.

Point-of-Service (POS) Plans

A point-of-service (POS) plan provides benefits within a network of medical providers — just like an HMO – but it also allows the insured to receive care outside the network. When members elect to receive out-of-network care they pay more.

In this plan the employee chooses a primary care provider from a list of doctors provided by the insurance company. This doctor supervises and coordinates medical care for patients and makes referrals to specialists and other health professionals. The employee also is given a list of provider hospitals, and it is the employee's responsibility to make sure that he receives medical care at one of these hospitals. Failure to do so may mean a reduced rate of coverage; however, unlike in an HMO, there will be some level of coverage. This insurance program has features of both the HMO and fee-for-service plan in that outside the network it operates like a traditional insurance plan.

Preferred Provider Organizations (PPOs)

A preferred provider organization combines fee-for-service and HMO provisions. Under a PPO plan, the employees' choice of health care provider determines the level of benefits. By choosing "preferred" providers (those in the network), they receive maximum coverage for most services. If they choose a nonpreferred provider, they still receive coverage, but out-of-pocket costs are higher, and they may have to fill out and submit claim forms. Also they usually must pay a deductible and coinsurance for out-of-network services.

When the insured goes to a doctor in a PPO, it is not necessary to fill out forms. Paperwork usually is completed by the doctor's staff. Often, there is a small copayment for office visits.

Those who join a PPO choose a primary care physician who supervises their health care. Most PPOs insure preventive care, which usually includes doctor visits, well-baby care, immunizations and mammograms.

OTHER TYPES OF HEALTH INSURANCE AND BENEFITS

Self-funded Programs

Most self-funded programs actually are partially self funded, in that they are a combination of insurance and employer pay. Small claims are paid out of premiums set aside by the employer, and large claims are paid by an insurance company. Individual claims of less than \$10,000, for example, may be paid by the employee in the form of coinsurance with the remainder paid by the employer. The amount of individual claims in excess of \$10,000 would, in this case, be paid by an insurance company. This is referred to as a "specific" stop loss because it prevents any single claim from costing the city more than \$10,000. There also is another type of stop loss in which all of the claims combined are insured above a certain dollar amount. This stop loss commonly is referred to as an "aggregate" stop loss. The program may provide an aggregate stop loss of \$750,000. In this case, all of the claims added together cannot cost the employer more than \$750,000 because claims in excess of that amount are insured and paid by the insurance company. Thus, the city can know that its maximum insurance cost for the year is fixed. The employer may administer the program or may contract with a third-party administrator to coordinate and process medical claims submitted by or on behalf of the employee and dependents.



Using the example on page three, payment under a self-funded program would look like this:

Employee payments

Deductible	\$200
Coinsurance	\$1,300
Total employee payments	\$1,500
Employer payment	\$8,500
Insurance company payment	\$1,279
Total	\$11,279

The \$8,500 is paid by the employer from premiums set aside to cover medical claims. The insurance company is responsible for only that part of the claim that is more than \$10,000.

Now, using the same example, let’s assume that an employee has open heart surgery. The total cost of all medical and hospital services is \$47,880.

Employee payments

Deductible	\$200
Coinsurance	\$1,300
Total employee payments	\$1,500
Employer payment	\$8,500
Insurance company payment	\$37,880
Total	\$47,880

Here the employee and employer pay the first \$10,000 of the claim. The insurance company pays the balance of \$37,880. The employee is not required to pay 20 percent coinsurance because his maximum out-of-pocket expense is \$1,500.

Now let’s make the assumption, using the example above, that at the beginning of the year, premiums for payment of claims, including the cost of administration, total \$689,000. The city has a \$10,000 individual claim stop loss and an aggregate stop loss of \$689,000. This means that when the total of all claims equals \$689,000, the insurance company begins to pay. Let us assume that the employee in our example has an emergency appendectomy, the cost is \$19,993, and the city already has paid out \$685,000 for individual claims of less than \$10,000 each.

Employee payments

Deductible	\$200
Coinsurance	\$1,300
Total employee payments	\$1,500
Employer payment	\$4,000
Insurance company payment	\$14,493
Total	\$19,993

In this situation the employee pays the deductible and coinsurance, the total of which cannot exceed the \$1,500 maximum out-of-pocket expense. The employer normally would be required to pay the balance owing on the small claim of \$8,500, with the insurance company paying \$9,993. However, in this case the total of all claims paid by the city cannot exceed \$689,000. Since the city already has paid \$685,000, the city is responsible for paying only \$4,000, and the insurance company pays the balance of \$14,493.

An obvious advantage of a self-funded program is that the city pays only the cost of insurance claims and the administrative costs of processing them, which may be done by a city staff member but usually is provided through a third-party administrator. If premium revenue exceeds claims and expenses, the city keeps the excess, whereas, insurance companies keep their excess premium revenue in the form of profit.



A disadvantage of many self-funded programs is slowness of claims processing. It often is necessary for the city to advance funds to pay claims that exceed the total amount of monthly premiums set aside. Once this payment and premiums are expended, it is not uncommon for a third-party administrator simply to hold the claims until funds (premiums) from which claims may be paid are received from the employer.

CAFETERIA BENEFIT PROGRAM/ FLEX SPENDING

Federal legislation allows cities to establish cafeteria benefit programs that let employees use pretax dollars to pay for group health premiums, other qualified insurance premiums (dental, life, etc.), unreimbursed medical expenses and more. Under this type of program, the city sets aside a total dollar amount for employee benefits, and each employee chooses how much to spend on his or her benefits. Because benefits are funded with pretax dollars, the employee saves on FICA and federal taxes, and the employer saves on FICA and OASI (Social Security).

In a cafeteria plan, also called a flex spending program, the employee determines the amount that is to be deducted from each paycheck. The city maintains a record of the amount deducted for each employee. When the employee or dependents incur medical costs that generally are not covered by insurance, the employee is allowed to pay for these services from funds in his flex spending account. It is called “flex spending” because employees make their own decisions as to what services to pay for from the benefit plan.

Here’s an example of how the plan works: Shortly before the beginning of the year, the employee determines that he will need new eyeglasses (\$320), his son will need contact lenses (\$220), and his daughter will need braces (\$3,200). The employee knows, therefore, that he will need \$3,740 for

medical expenses for the year. He has his employer deduct \$71.92 from his weekly paycheck to cover these expenses, which are not covered by health insurance. OASI payments saved by the employee on \$3,740 total \$286.11 (7.65 percent x \$3,740). If the employee is in the 15 percent income tax bracket, he saves \$561 in income taxes. That is a total savings to the employee of \$847.11 by using the cafeteria benefit plan.

When the employee purchases his new glasses for \$320, he presents the receipt to the city recorder or other paying agent, and the city reimburses the employee from his account in the amount of \$320. The same procedure is used for other eligible expenses. The plan has flexibility to allow the \$3,740 to be spent on any federally approved eligible expense. The employee may have intended to use \$3,200 for braces but later realized that he needed to use a large part of his account to pay coinsurance. The plan has flexibility to allow for such expenses.

A potential disadvantage is that an employee might identify \$3,000 in medical expenses for the coming year and spend only \$2,000. The employee is not refunded the difference. The employee also might identify \$2,000 in estimated eligible medical expenses and actually spend \$3,000. In this case, the employee would be eligible for only a \$2,000 reimbursement under the plan. Generally, though, it isn’t a problem for employees to identify medical expenses they will incur during the year.

Why would an employer, such as a city, want to offer a flex spending plan for its employees? First, it helps employees pay for needed medical care without financial hardship. It allows the employee to reduce the amount of federal taxes he owes, leaving more of his income for other needs. And finally, and no less important, the city may save a sizeable amount of money depending on the size of its payroll. A city of 200 employees, each of



whom has set aside \$1,000 for cafeteria benefits, would have a savings of \$15,300 in OASI. A city with 200 employees who set aside \$1,500 each would save \$22,950 during the year.

■ DENTAL INSURANCE

Thirty years ago dental insurance was not a common benefit. Today most cities that provide health insurance also provide some option for dental coverage, but larger cities with more than 500 employees are most likely to have dental coverage. It is estimated that more than 100 million Americans have dental coverage.

Although the prevalence of dental coverage has increased dramatically, many employers do not consider dental benefits to be as important as medical coverage. When employers look at what benefits to offer employees, dental plans are at the “bottom of the pile.”

The biggest difference between medical and dental benefit plans is that medical costs are unpredictable and sometimes catastrophic. Most dental problems are preventable through regular checkups and cleanings. In fact, the average dental claim is less than \$200.

Dental plans provide incentives for patients to get regular, routine care that is vital in preventing dental problems and diagnosing and dealing with them while they are still minor. Most dental plans require the patient to assume a larger part of the costs for treatment than for preventive procedures. Premiums may vary from \$10 to \$80 per month for a family, with managed care (dental HMO) plans being the least expensive.

Let's take a look at the major types of dental plans.

INDEMNITY PLANS

Under an indemnity plan, the insured can visit any dentist, so there is never a question as to whether the family dentist is in the plan. Students who are away at school, employees who travel, and those who work for employers with multiple locations have ready access to dental care. Employers should make sure that the dental plan pays claims at a high level (80 to 90 percent) of usual, customary and reasonable cost.

A traditional indemnity plan usually provides these benefits:

- A choice of any dentist;
- Preventive services are covered at 100 percent with no deductible;
- There is 20 percent coinsurance for nonpreventive services;
- No employer contribution is required;
- Claims are paid directly to the dentist or the employee;
- Claims are based on 80 to 90 percent of usual, customary and reasonable costs;
- Toll-free customer service hot lines are provided;
- There is a two-year rate guarantee; and
- Coverage is available from top-rated insurance carriers.

PREFERRED PROVIDER ORGANIZATIONS (PPOS)

Adding a PPO to a voluntary dental plan lets the insured choose a dentist from a state or national network of participating dentists. The insured still can receive care from any dentist he wishes, even those outside the network. However, the insured bears more of the cost of service delivered by an out-of-network dentist. If the insured uses a PPO dentist, he will receive care at discounted fees (usually 20 percent) and be assured of no balance billing above the negotiated fees.



DENTAL MANAGED CARE PROGRAMS (DHMO)

Dental managed care plans offer a broad range of services through a network of providers while helping reduce dental care costs.

The insured selects a personal dentist from a directory of participating dentists. Each covered member of the family may select a different dentist. Benefits are reduced if the insured uses a dentist who is not in the network. Advantages of a managed care plan include:

- No annual maximums;
- No annual or lifetime deductibles;
- Higher benefit levels than with traditional plans; and
- Low out-of-pocket expenses compared to traditional plans.

■ LIFE INSURANCE

There are four basic kinds of life insurance: term, whole, universal and variable.

TERM INSURANCE

Term insurance covers the policyholder for a specific period of time (a term). It is most often the least expensive of all life insurance products and the kind that most Tennessee cities make available to their employees.

There are two types of premiums: level term and annual renewable. Level term premiums remain constant over the life of the policy, while premiums for annual renewable increase as the insured ages. When a term policy expires, there are three options: drop the policy, renew it, or convert the policy to a permanent insurance product at a higher premium. Some policies are guaranteed renewable. That is, the employee is not required to have another physical examination in order to renew the policy when the term expires. Most policies have a conversion feature that allows the employee to convert to

a permanent policy later without having to take a physical examination. This feature often attracts employees who are in poor health.

WHOLE LIFE INSURANCE

Whole life insurance combines a death benefit and a savings plan. Premiums for this type policy almost always are paid by the employee.

A whole life policy has two elements: the mortality charge that is the part of the premium that pays for insurance coverage and a reserve or savings component that earns interest. As the employee grows older, the part that goes into the reserve decreases while the mortality charge increases. Some companies credit the reserve with an annual dividend, depending on the insurer's loss and investment performance. The cash surrender value is what the employee gets if he cashes in the policy. This can be paid in cash or in paid up insurance.

There are problems with using whole life insurance as a savings program. First, the policy's advertised rate of return usually is based on a set of hypothetical numbers called the "policy illustration" that is sometimes inflated. Generally, whole life investments return less than mutual fund investments. Another problem is that whole life is expensive, and employees who have low or average incomes may be unable to afford all of the insurance that is needed to meet the needs of their families.

UNIVERSAL LIFE INSURANCE

Universal life is a variation of whole life. The difference is that with universal life the pure insurance part of the policy (the term portion) is separated from the investment (cash) part of the policy. Where the whole life investment portion is invested in bonds and mortgages, the investment part of universal life is invested in money market funds. The cash value part of the policy is set



up as an accumulation fund. Investment income is credited to the accumulation fund. The death benefit part (term insurance) is paid for out of the accumulation fund. The cost of the term insurance is paid for on a mortality basis (age of the insured and amount of coverage). Unlike whole life insurance, the cash value of universal life insurance grows at a variable rate.

Normally there is a guaranteed minimum interest rate on such policies; no matter how badly investments perform, the insured is guaranteed a certain minimum return on the cash portion. If the insurance company does well with its investments, the interest return on the cash part will increase.

VARIABLE LIFE INSURANCE

Under variable life insurance plans, a mortality charge is combined with a savings component. The policy holder chooses from a number of options offered by the insurer. Premiums for this type of insurance program most often are paid by the employee. The savings vehicle usually is one of several investments that are similar to mutual funds. Companies commonly offer 10 different portfolios, including stock, bond and money market funds. The insurance company manages these funds, collecting fees for administering the insurance and managing the portfolios.

There are two basic types of variable life. One demands a fixed premium. The other, variable universal life, has a flexible premium like universal life. Variable returns can fluctuate along with financial markets. A sudden decline in the stock market can easily deplete the policy's cash value. This insurance is not appropriate for people who rely on short term investments.

It generally is better to purchase term insurance and make separate investments in diversified mutual funds.

THE BID PACKAGE

T.C.A. § 6-56-304 requires health, dental and life insurance to be bid unless it is purchased from the state or other government agency. As previously noted, it is advisable to advertise separately for coverage for each type of insurance. A health insurance provider that is in the business of providing medical coverage also may provide dental and life coverage and generally at higher cost. Separate bids often yield more competitive rates.

The bid package for health and dental insurance should include the following information:

1. Name and address of the city advertising for sealed bids;
2. Location of bid specifications and procedures for obtaining specifications;
3. Date and time of prebid conference, if required; and
4. Special instructions, such as:
 - A. Bids to be submitted in accordance with specifications stipulated in bid document(s) and on forms in the package, sealed in an envelope and clearly marked "SEALED BIDS FOR GROUP [HEALTH, DENTAL, LIFE] (*specify*) INSURANCE."
 - B. The city reserves the right to accept or reject any or all bids received.

The bid package for life insurance can be much simpler than for health or dental insurance since it does not include a range of services.

Examples of invitations to bid are included in the appendices.



Appendix A: SAMPLE HEALTH INSURANCE REQUEST FOR BID PROPOSAL

NOTE: THIS NOTICE SHALL BE PUBLISHED IN THE LOCAL NEWSPAPER
OF GENERAL CIRCULATION IN THE CITY OF _____
THE WEEK _____, 20_____.
CITY OF _____, TENNESSEE

Health Insurance REQUEST FOR BID PROPOSAL

Sealed bids for group health insurance will be received by the city of _____, Tennessee, until _____ (date/local time) at the _____ city hall, located at _____ (address) Tennessee, and opened by the mayor, purchasing director, or other official as required by the governing body, and read publicly. Bids received after the stated time, postmarks notwithstanding, shall be rejected. The insurance to be provided will include coverage as shown in Plan Benefits.

Bid specification packages are available at the city business office at city hall, _____ (address), Tennessee, _____ (ZIP code), or by calling _____ (phone number). All bidders are encouraged to attend a prebid conference at the city business office on _____ (date) at _____ (local time).

Bids are to be submitted in accordance with specifications stipulated in the bid documents and on the forms contained in the package. They are to be sealed in an opaque envelope and clearly marked "Sealed Bids for Group Health Insurance." The city reserves the right to accept or reject any or all bids received.

BID SPECIFICATIONS

I. General Bid Specifications and Requirements for Health Insurance

- A. Coverage shall be effective _____ (date) or on a later date requested, in writing, to the bidder by the city of _____. Coverage shall be guaranteed for a minimum of 12 months from the effective date at the same premium rate quoted in the bid. It is the city's intent to renew the coverage after the initial coverage period by negotiation with the bidder. Such renewal process may be conducted annually. The city must be notified 45 days in advance of the contract anniversary date of any premium increases.
- B. If exceptions from coverage are made, exceptions must be clearly stated on each coverage.
- C. Envelopes containing the bids shall be sealed and marked "Sealed Bids for Group Health Insurance."
- D. The bidder is required to examine carefully the specifications and risks to be covered. It will be assumed that the bidder has made such investigations and is fully informed as to the extent and character of the hazards and requirements of the specifications. No warranty is made or implied as to information contained in these specifications.



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- E. All bids shall show or conform to the following, in addition to other information required on the bid form:
 - 1. Name of proposed insurance company;
 - 2. Insurance company rating from A.M. Best's Insurance Guide or appropriate financial documents to assure that the bidder is a stable, sound and responsible company. Only companies rated "A" or better will be considered; and
 - 3. Insurance companies must be authorized to do business in the state of Tennessee.
 - F. All bids shall have an attachment thereto giving a description of services to be supplied as part of the insurance coverage. A brief description of claims or adjustment service shall be included.
 - G. Cancellation, termination or expiration of the policy by the insurer or insured shall require 90 days notice.
 - H. All bidders must agree in writing to furnish the city with a quarterly report of all incurred claims.
 - I. All bidders must agree to furnish an annual statement of loss experience within 15 days following the anniversary of the policy, including a detailed analysis of pending claims.
 - J. All policies are to cover any new employees under the same conditions as provided under initial implementation of the coverage.
 - K. No oral interpretation will be made to any bidder as to the meaning of the bid specifications or any part thereof. Every request for interpretation shall be made in writing to the mayor or purchasing director of the city of _____. Any inquiry received seven or more days prior to the date fixed for opening of bids will be given consideration. Every interpretation made to a bidder will be in the form of an addendum to the bid specifications and, when issued, will be on file in the city business office at least three days before bids are opened. In addition, all addenda will be mailed to each person holding bid specifications, but it shall be the bidder's responsibility to make inquiry as to the addenda issued. All such addenda shall become part of the bid specifications, and all bidders shall be bound by such addenda, whether or not received by the bidders. Bidders must acknowledge in writing receipt of addenda and include this acknowledgment with their bids.
 - L. Bids will be received by the mayor or purchasing director of the city of _____ (local time), _____ (date), and opened publicly by the governing board or official designated by the governing board. Bids received after the above stated time, postmarks notwithstanding, shall be rejected.
 - M. No bid shall be withdrawn for a period of 90 days subsequent to the opening of the bids, without consent of the governing body of _____, Tennessee.



- N. Successful bidder shall be required to provide on site training and a question and answer session for all city employees. Also, the successful bidder shall be required to provide a toll free customer service line between 8 a.m. and 5 p.m. each work day for city employee access to the insurance provider. User friendly claim forms shall be furnished to the city with detailed instructions that can be provided to employees.
- O. The governing body will make the award as soon as practicable to the best (lowest responsible) bidder, price and other factors considered. The governing board reserves the right to reject or accept any or all bids received.
- P. For additional information, contact the _____ (*mayor or purchasing director*).
- Q. A pre bid conference for all persons desiring to bid is scheduled in the city council chambers on _____ (*date*) at _____ (*local time*). All bidders are encouraged to attend.

City of _____, Tennessee.

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) is designed to protect workers from losing their health insurance coverage when they change jobs, lose their jobs, or become self employed. It does so by placing new restrictions on pre existing condition exclusions, coverage termination, and limitations based on health status. The act applies to group health plans (including those for cities) that cover two or more employees. HIPAA coverage applies to any health insurance coverage offered in connection with a group health plan, including limited scope dental and vision benefits, long term care benefits, medical supplement plans, and specific disease or illness policies.

HIPAA improves the availability and portability of health coverage by:

- Limiting exclusions for pre existing medical conditions;
- Providing credit for prior health coverage and notifying new group health plans of previous coverage;
- Providing new enrollment rights to individuals who lose other health coverage or have a new dependent;
- Prohibiting discrimination in enrollment and premiums based on health status;
- Guaranteeing renewability of health insurance coverage; and
- Preserving a state's traditional role in regulating health insurance.

Cities with fully or partially self funded programs may elect to be exempt from the requirements of certain aspects of HIPAA. The exemption remains in effect for a single plan year. Cities can elect to be exempt from the following requirements:

- Limitations on pre existing condition exclusion periods;
- Special enrollment periods for individuals (and dependents) losing other coverage;
- Prohibitions on discriminating against individual participants and beneficiaries based on health status;
- Standards relating to benefits for mothers and newborns; and
- Parity in the application of certain limits to mental health benefits.



II. General Information (to be provided by the city)

A. Nature of the group to be insured:

The city has approximately _____ employees in the present group working in the areas of:

- City hall (legislative, administrative, finance) _____ (number)
- Police _____ (number)
- Fire _____ (number)
- Public Works (streets, sanitation, utilities and parks) _____ (number)
- Sanitation _____ (number)
- Streets _____ (number)
- Water Department _____ (number)
- Wastewater Department _____ (number)
- Codes Enforcement _____ (number)
- Recreation _____ (number)
- Other _____ (number and specify)

Approximately _____ employees are under family coverage, and approximately _____ employees are under individual coverage.

For more details regarding insured employees and dependents please contact the city business office at _____ (phone number).

B. The current carrier is _____.

III. Proposed Plan Specifications

A. All bidders shall use the enclosed bid form.

B. All bids must provide the following:

1. Deductible and waiting period credit;
2. No lost benefits due to transfer of coverage;
3. Immediate maternity benefits for insured; and
4. Immediate coverage of transferred COBRA participants.

C. Group Health Insurance

NOTE: It is the city's intent to seek bids for coverage equal to or exceeding the existing coverage provided by _____ (current carrier).



The bidder shall provide coverage for the following:

1. Full time employees working no less than 35 hours per week;
2. Dependents of covered employees, which include:
 - a. Legally married spouse;
 - b. Unmarried natural or adopted children up to 24 years of age, if enrolled in a state approved educational or technical institution;
 - c. Stepchildren;
 - d. Grandchildren, if employee is legal guardian;
 - e. Any dependent claimed on the employee's federal income tax return.
3. Medicare. Benefit coordination as per federal law or regulations.
4. The city will comply with all COBRA requirements.

D. Summary of Benefits

Following is a brief summary of the benefits the bidder is required to provide. Each bidder may bid on either or both options.

Bidder will identify the provider network by name, address and telephone number. Bidder will specify whether bid is for HMO, POS, or conventional health insurance plan.

■ PLAN BENEFITS

		NETWORK PROVIDER	NON-NETWORK PROVIDER
Physician Office Visits	Covers both illness and injury and preventive care, and includes specialist office visits	\$25 - \$35 copayment per visit	70% of eligible expenses after deductible
Maternity Physician	Covers prenatal, delivery, and and postnatal care as well as in patient facility	80% of eligible expenses after deductible	70% of eligible expenses after deductible
■ HOSPITAL SERVICES			
Physician Services		80% of eligible expenses after deductible	70% of eligible expenses after deductible
Inpatient Facility		80% of eligible expenses after deductible	70% of eligible expenses after deductible
Outpatient Surgery Facility		\$0 copayment per visit	70% of eligible expenses after deductible
Outpatient Diagnostic Facility		\$0 copayment per visit	70% of eligible expenses after deductible
Emergency Room Services		\$50 copayment per visit	70% of eligible expenses after deductible
Outpatient Mental Health	Coverage limited to 25 outpatient or doctor visits, as provided in T.C.A. § 56-7-2360. Tennessee cities are required to provide mental health coverage on the same cost basis as physical coverage unless the group plan has from 2 to 25 employees or coverage for mental health services results in a cost increase to the group plan of more than 1%*.	\$0 copayment per visit	70% of eligible expenses after deductible
Inpatient Mental Health	Coverage limited to 20 days maximum per year. T.C.A. § 56-7-2601 does not apply to the treatment of substance abuse or chemical dependency. See note under Outpatient Mental Health.	80% of eligible expenses	70% of eligible expenses after deductible
■ COVERED PRESCRIPTION DRUGS			
Generic		\$5 copayment per prescription	70% of eligible expenses after deductible
Brand Name		\$15 copayment per prescription	
■ ROUTINE VISION CARE			
Eye Exam (once every 24 months)		\$5 - \$50 copayment per visit	Not covered
Skilled Nursing Facility Services	Covered up to 100 days per lifetime	\$0 copayment	70% of eligible expenses after deductible
Home Health Care	Covered up to 60 consecutive days per calendar year	\$0 copayment	70% of eligible expenses after deductible
Durable Medical Equipment/Prosthetics		\$0 copayment	70% of eligible expenses after deductible
Rehabilitation Services		\$0 copayment	70% of eligible expenses after deductible
Annual Deductible		Single: \$600 Family: \$1,200	Single: \$500 Family: \$1,000
Out-of-Pocket Maximum		Single: \$2,000 Family: \$3,000	Single: \$3,000 Family: \$4,000
Maximum Benefit		\$1,000,000	\$1,000,000

*Documentation of the increase must be submitted to the Department of Commerce and Insurance after 12 months of experience. A letter is required from the commissioner for the provider to be excepted from the requirement that the services be on the same cost basis as physical coverage.



City of _____

**GROUP HEALTH INSURANCE
BID FORM**

Date Bid Submitted: _____

Date City Received Bid: _____

COVERAGE PREMIUM

MONTHLY

I. Health Insurance

Employee _____

Family (employee and dependent) _____

II. Are there any exceptions from coverage in accordance with the bid specifications?

_____ Yes _____ No

IF YES, exceptions must be stated clearly below for each coverage. Attach additional sheets if necessary.

This bid is submitted in accordance with the specifications and conditions contained in the bid document.

Company

BY: _____
Authorized Representative

Address

Telephone

Date



Appendix B: SAMPLE DENTAL INSURANCE REQUEST FOR BID PROPOSAL

[NOTE: Health experts today ask why any medium- or large-size dental benefit plan would NOT be self funded. The city already knows the maximum liability, and there is no catastrophic risk with dental benefits. Being fully insured with dental coverage generally does not make sense unless the city has limited or no cash flow.]

Dental Insurance REQUEST FOR BID PROPOSAL

Sealed bids for group dental insurance will be received by the city of _____, Tennessee, until _____ (date/local time) at the _____ city hall, located at _____ (address) Tennessee, and opened by the mayor, purchasing director, or other official as required by the governing body, and read publicly. Bids received after the stated time, postmarks notwithstanding, shall be rejected. The insurance to be provided will include coverage as shown below.

I. Employee and Dependent Coverage

II. Types of Expenses

Type A: Preventive and Diagnostic Dental Care

- Routine office exams — two exams per calendar year;
- Emergency palliative treatment;
- Prophylaxis (cleaning and scaling) — two cleanings per calendar year, periodontal or stand;
- Fluoride (topical treatments) — one course of treatment per calendar year for a covered individual under age 19;
- Space maintainers — for a covered dependent under age 19;
- Bitewing X-rays — two sets per calendar year;
- Full mouth or panoramic X-rays — one set in any 36 month period; and
- Sealants (topical application on posterior tooth) — one treatment per tooth in any 36 month period for a covered person up to age 19.

Type B: Basic Dental Care

- Nonroutine office visits;
- Professional visit after hours;
- Consultations;
- Routine extractions;
- Oral surgery, excluding procedures covered under any medical plan;
- Endodontics, including root canal treatment (does not include final restoration);
- Apicoectomy;
- Gingivectomies;
- Subgingival curettage or root planing (limited to four quadrants of each per calendar year);
- Periodontics (excluding periodontal maintenance);
- Fillings;
- Crowns;
- Denture repairs (including the addition of a tooth or teeth to an existing denture if such natural teeth are extracted under this plan); and
- General anesthesia when medically necessary in connection with oral or dental surgery.



Type C: Major Dental Care

- Inlays;
- Onlays;
- Crowns;
- Pontics;
- Fixed bridgework;
- Prosthodontics (full and partial dentures) — includes adjustments;
- Dentures; and
- Complex extractions.

Type D: Orthodontia

- Comprehensive full banded treatment;
- Appliances for tooth guidance, one appliance per covered person;
- Retention appliances, limited to one appliance per covered person; and
- Surgical therapy only when surgery is performed to prepare the mouth for eligible orthodontic services.

III. Reimbursement Amounts

The percentages of reimbursement for each of the four types of treatment are:

- Type A — 100% of reasonable and customary;
- Type B — 80% of reasonable and customary;
- Type C — 50% of reasonable and customary;
- Type D — 50% of reasonable and customary.

IV. Reasonable and Customary

“Reasonable and customary” means the prevailing range of fees charged in the same area by dentists of similar training and experience for service rendered or supply furnished.

V. Deductible

There is a \$25 per person (\$75 per family) annual deductible for all Type B and C services.

VI. Maximum Benefits

The maximum benefits payable for each person covered by the Dental Care Program are:

- \$1,500 in a calendar year for Types A, B and C;
- No lifetime maximum except for orthodontics (Type D); and
- \$1,500 lifetime maximum for orthodontics per covered individual.

The city reserves the right to reject any or all bids.



Appendix C: SAMPLE LIFE INSURANCE REQUEST FOR BID PROPOSAL

**Life Insurance
REQUEST FOR BID PROPOSAL**

Sealed bids for Group Term Life Insurance and Accidental Death and Dismemberment for each employee per \$1,000 of coverage will be received by the city of _____, Tennessee, until _____ (local time) _____ (date) at the _____ city hall, located at _____ (address) Tennessee, opened by the mayor, purchasing director, or other official as required by the governing body, and read publicly. Bids received after the stated time, postmarks notwithstanding, shall be rejected. The insurance to be provided will include coverage as shown below.

Employee (full time)	Rate per \$1,000
Coverage _____ (amount)	_____
Department head, manager _____ (amount)	_____

The city reserves the right to reject any or all bids.

Company

BY: _____
Authorized Representative

Address

Telephone

Date



THE UNIVERSITY of TENNESSEE

MUNICIPAL TECHNICAL ADVISORY SERVICE

The University of Tennessee does not discriminate on the basis of race, sex, color, religion, national origin, age, disability or veteran status in provision of educational programs and services or employment opportunities and benefits. This policy extends to both employment by and admission to the university.

The university does not discriminate on the basis of race, sex or disability in its education programs and activities pursuant to the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990.

Inquiries and charges of violation concerning Title VI, Title IX, Section 504, ADA or the Age Discrimination in Employment Act (ADEA) or any of the other above referenced policies should be directed to the Office of Equity and Diversity (OED), 1840 Melrose Avenue, Knoxville, TN 37996-3560, telephone (865) 974-2498 (V/TTY available) or 974-2440. Requests for accommodation of a disability should be directed to the ADA Coordinator at the UTK Office of Human Resources, 600 Henley Street, Knoxville, TN 37996-4125.

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