Request for Proposals
for
Employee Health Insurance

(RFP#10-21; Due 6/16/10 by 4:00pm)

City of Killeen
101 N. College Street
Killeen, TX 76541

City of Killeen

TO: Interested Insurance Carriers

RE: Request for Proposal
City of Killeen

May 18, 2010

Insurance Carriers:

I am writing to your company on behalf of the City of Killeen, hereafter referred to as the "Planholder", requesting that you prepare a proposal reflecting your charges for Health Insurance. Our current Health Insurance is underwritten by Scott & White Health Plan.

The City of Killeen is one of the largest local employers with approximately 1,200 full time employees providing police and fire protection, airport services, a convention center, library services, water and sewer services, and parks and recreation as well as many others.

Submission of Proposals: Three (3) copies of all proposal documents, exhibits and answers to specific questions shall be sealed and submitted no later than June 16, 2010 at 4:00 p.m to:

Delivery Address:
City of Killeen
Attn: Purchasing Department
101 North College Street
Killeen, TX 76541

MARK ENVELOPE: "RFP NO. 10-21 HEALTH INSURANCE"

Late proposals will not be accepted.

Selection: Recognizing the fact that there are very important considerations involved in selecting an insurance carrier, the Planholder is not bound to accept the lowest proposal. The Planholder reserves the right to reject any or all proposals or to accept any proposal deemed advantageous to the Planholder. The award of the contract shall be made to the responsible offerer whose proposal is determined to be the lowest evaluated offer resulting from negotiation, taking into consideration the relative importance of price and other evaluation factors set forth in the Request for Proposals in accordance with Texas Local Government Code, Chapter 252. Proposals will be evaluated based on the following criteria and in the following order (with #1 being the most important):

1. OFFERER'S GROSS PREMIUM
2. OFFERER'S AVAILABILITY OF LOCAL PHYSICIANS & HEALTH CARE FACILITIES
3. OFFERER'S QUALIFICATIONS/EXPERIENCE
4. OFFERER'S SUPPORT/SERVICES PROVIDED
5. OFFERER'S RETENTION CHARGES

Please complete and return the enclosed forms, which include: Proposal form including declaration of compliance, questionnaire and references.

QUALIFICATIONS

1. All companies submitting proposals must be licensed by the State of Texas and be permitted to contract with the State or any of its subdivisions. Further, it is preferred that companies be recommended in the latest edition of Best's Life Insurance Reports with a general policyholder's rating of A.

2. Companies who fall under the guidelines of the Texas Political Subdivision Uniform Group Benefits Act (Chapter 172 Local Government Code) and the Interlocal Cooperation Act (Article 4413 (32e) Vernon's Texas Civil Statutes will be acceptable.

3. The most recently audited financial statement must be attached to the proposal submitted.

PLAN ADMINISTRATION QUALIFICATIONS

Planholder Responsibility

The Planholder will provide for payroll deductions of premium and advise the carrier of additions/deletions from the coverage. The Planholder will assist in the logistics of the enrollment process.

Selected Carrier Responsibility

The carrier will provide claim forms, claim instructions, employee booklets outlining the benefits and instructions on filing a claim, identification cards, enrollment and orientation materials, and other appropriate communication materials deemed necessary by the Planholder to properly administer the Plan of Benefits.

The carrier will provide the following monthly claim reports:

1) Summary of Paid Claims
2) Summary of Paid Claims by Covered Person (employee, dependent)
3) Summary of Paid Claims by Benefits
4) Upon request, summary of Claims in excess of $10,000 including diagnoses and prognosis

GENERAL INFORMATION AND INSTRUCTIONS

1. All proposals must be received at the designated location by the deadline shown. Proposals received after the deadline shall be considered void and unacceptable. The City of Killeen is not responsible for non-delivery of mail, carrier, etc.

2. Proposals are anticipated to provide a 12-month rate guarantee, with a contract period of October 1, 2010, through September 30, 2011, and three optional 12 month periods beginning October 1, 2011 and extending through September 30, 2014. However, the Planholder reserves the right to accept a guarantee of less than or more than 12 months if it is in the Planholder's interest. Premium rates proposed must be firm and not subject to change based upon enrollment.

3. The Planholder reserves the right to reject any and all proposals and to accept any proposal deemed advantageous to the Planholder. Since there are important considerations involved in selecting a carrier, in addition to rates, the Planholder will not be required to accept the lowest proposal. In addition to cost, service will also serve as a basis for award of the contract.

4. The Carrier must submit evidence of ability to service the group without undue requirements of the Planholder's employees. Each Carrier should list as references groups that it services that are approximately the size of the City of Killeen. References may be checked if deemed advisable. (Form provided)

5. Your proposal must conform in all respects to the specifications outlined in this letter and attached exhibits. If your company's practice prohibits you from submitting a proposal on the same basis as outlined in the specifications, you may submit a proposal on a basis that is in accordance with your practice. Please state clearly, in detail, any deviation from the specifications outlined in this letter with complete reference to the provision from which the deviation is being made.

6. Proposals must be based on benefits similar to the current plan; the current plan includes vision care. The current plan is fully insured however all options for health care coverage will be considered. Other options proposed may include, HMO, PPO, HRA, HSA and/or Major Medical, fully insured and/or self insurance options and/or any other health insurance options that may meet the city's needs for insurance. (Plan of current benefits provided) The current plan with Scott & White is through an agent; a proposal submitted to provide health care benefits may be though an agent or directly with a provider.

7. HIPAA Compliance with Privacy & Confidentiality guidelines will be required.
   Specifically, Plan Sponsor certifies that:

   PHI will not be used or disclosed other than as permitted by plan documents or required by law;
   Any agents and subcontractors of plan sponsor have agreed as part of their contracts with Plan Sponsor to the same restrictions and conditions with regard to use of PHI;
   PHI shall not be used for employment or benefit-related decisions

8. Proposals must include coverage on all eligible full-time employees and with optional coverage available for dependent coverage. Fulltime is defined as 40 hours or more per week. Dependent is defined as the employees' spouse and/or children from birth to age 26. Adopted children, stepchild (ren) or foster child (ren) who are in a legal parent-child relationship are also classified as eligible dependents. Children who are currently disabled will be covered as long as they are totally disabled and dependent upon support from their parents.

9. Waiting period: Newly hired non-civil service employees and their dependents must complete at least a 90 day waiting period before becoming eligible for coverage. Newly hired civil service employees and their dependents must wait until the 1st of the month following date of hire before becoming eligible for coverage.

10. Eligibility: All full-time non-civil service employees and their dependents are eligible on the 1st of the month following 90 days of employment. All full-time civil service employees and their dependents are eligible the 1st of the month following date of hire. Retired employees and their dependents may continue participation after retirement through their continued payment of premiums or under COBRA. Terminated employees may continue coverage under COBRA.

11. The employee has the option of electing to pre-tax 125 premiums for out of pocket expenditures for health insurance coverage.

12. Currently the employer pays 100% of the employee premium for the cost of one plan of coverage, 0% of the dependent premium for any plan coverage and 0% of the retiree premium for any plan coverage. Retires are eligible if they elect coverage immediately. If they do not elect coverage at retirement, they are not allowed to come back onto the plan after they retire at any time. This is subject to approval by the governing body.

13. Please complete the appropriate enclosed proposal forms, which include:
    Proposal form including rate information
    Questionnaire
    References
    Fee Schedule
    Summary/Comparison of benefits (in excel)

All who submit proposals, including the current carrier or administrator, shall complete the proposal forms provided. An authorized official of the carrier must sign all proposal forms submitted.

FAILURE TO COMPLETE ALL PROPOSAL FORMS MAY RESULT IN PROPOSAL BEING DISQUALIFIED

ATTACHMENTS:
Attachment A is the form to provide your information.

Attachment B-1 is the form for your Health Insurance costs quotation based on a fully funded plan.
Attachment B-2 is the form for your Health Insurance costs quotation based on a self funded/self insured plan.
Attachment C is the form to provide a comparison of the plan benefits submitted in the proposal to provide a comparison to current plans.
Attachment D is the form to provide information on references.

EXHIBITS:
Exhibit A - Current health plan benefits summary.
Exhibit B – Health insurance premium rates, claims and participation history.
Exhibit C - Census data for all full time employees.
Exhibit D - Census data for retirees and COBRA participants.
Exhibit E –Questionnaire -Contains specific questions for your company to answer. You need not repeat the questions. However, please make certain your answers are numbered to correspond to the appropriate question numbers. Please do not refer to sections of your proposal as this may disqualify your company.
Exhibit F – Claims Data for current plans; additional information on claims/claimants may be provided to those who are preparing a response to this request for proposals in accordance with HIPPA regulations.

In preparing your premium quotations, please use the forms provided and include the signature of your authorized representative.

We look forward to receiving your proposal. This letter provides you with the information necessary for you to submit a proposal, which includes complete and carefully prepared information for consideration by the Planholder.

The City of Killeen is aware of the time and effort you expend in preparing and submitting proposals to the City. Please let us know of any requirements in the RFP, which are causing you difficulty in responding. We want to make this process as easy as possible so that all responsible vendors can compete for the City's business.

If you have any questions, please direct all inquiries in writing to **Brian Supak, Purchasing Manager, City of Killeen, via email to bsupak@ci.killeen.tx.us prior to 4:00 p.m. on June 2, 2010**

Sincerely,

Connie Green
City Manager
City of Killeen

Attachment A

Vendor Information

Name of Organization _____

Date Founded _____

Name of Contact Person _____

Title _____

Phone Number _____

Address _____

_____

Email _____

Fax Number _____

Attachment B-1

PROPOSAL FORM

The undersigned, does hereby declare that they have read the specifications for Group Health for the Planholder employees, and with full knowledge of the requirements, does hereby agree to furnish the administrative services in full accordance with the specifications and requirements. The undersigned also agrees to duplicate present coverage and if not, will attach itemized detail of any differences.

Please provide monthly health care costs in the table below.

	Proposed Plan 1	Proposed Plan 2	Proposed Plan 3
Employee only			
Employee & Spouse			
Employee & Children			
Employee & Family			
Retiree <65			
Retiree & Spouse			
Retiree & Children			
Retiree & Family			

Health Plan Carrier: _____

Address_____

Printed Name _____ Title_____

Signature: _____ Date_____

Attachment B-2

PROPOSAL FORM

The undersigned, does hereby declare that they have read the specifications for Group Health for the Planholder employees, and with full knowledge of the requirements, does hereby agree to furnish the administrative services in full accordance with the specifications and requirements. The undersigned also agrees to duplicate present coverage and if not, will attach itemized detail of any differences.

Please provide monthly health care costs in the table below.

	Proposed Plan 1	Proposed Plan 2	Proposed Plan 3
Deductible			
Lifetime Maximum			
Individual Stop Loss			
Aggregate Stop Loss			
Estimated Fixed Cost (Administrative)			
Estimated Maximum Annual Plan Costs			

Health Plan Carrier: _____

Address_____

Printed Name _____ Title_____

Signature: _____ Date_____

Attachment C
(Electronic format is provided/ to be completed in Excel)

Plan Design	Proposed Plan	
	In-Network Benefits	Out of Network Benefits
Annual Deductible		
Copay/Co-Insurance Limits		
Physician Co-Pay/Co-Insurance		
Specialist Co-Pay/Co-Insurance		
Emergency Room Co-Pay/Co-Insurance		
Urgent Care Co-Pay/Co-Insurance		
Inpatient Hospital Co-Pay/Co-Insurance		
Outpatient Surgery Co-Pay/Co-Insurance		
Lab & Radiology Services Co-Pay/Co-Insurance		
Out of Pocket Maximum		
Lifetime Maximum Benefit (Individual)		
Prescription Deductible/Co-Pay/Co-Insurance		
Prescription Deductible/Co-Pay/Co-Insurance (Retail)		
Prescription Deductible/Co-Pay/Co-Insurance (Maintenance)		
Outpatient Specialty Drugs Deductible/Co-Pay/Co-Insurance		
Prescription Annual Max		
Health Insurance Premiums		
Employee Only		
Employee & Spouse		
Employee & Child/ren		
Employee & Family		

Attachment D

Please provide **four** references that have been insured with your company for at least three years.

COMPANY NAME:_____ Number of employees _____
Contact
Person:_____Title:_____

Address:_____

City:_____ State _____Zip Code:_____

Phone Number:_____ Fax # _____Email:_____

COMPANY NAME:_____ Number of employees _____
Contact
Person:_____Title:_____

Address:_____

City:_____ State _____Zip Code:_____

Phone Number:_____ Fax # _____Email:_____

COMPANY NAME:_____ Number of employees _____
Contact
Person:_____Title:_____

Address:_____

City:_____ State _____Zip Code:_____

Phone Number:_____ Fax # _____Email:_____

COMPANY NAME:_____ Number of employees _____
Contact
Person:_____Title:_____

Address:_____

City:_____ State _____Zip Code:_____

Phone Number:_____ Fax # _____Email:_____