

Sunset Public Hearing Questions for  
**LOCAL GOVERNMENT INSURANCE COMMITTEE**  
Created by Section 8-27-701, *Tennessee Code Annotated*  
(Sunset termination June 2020)

1. Provide a brief introduction to the committee, including information about its purpose, statutory duties, staff, and administrative attachment.

**RESPONSE:** The Local Government Insurance Committee is authorized in T.C.A. 8-27-701. The principal duty of the Committee as contained in TCA 8-27-702 is to establish a group insurance plan for local government and quasi-governmental organizations. The Committee also has the authority to approve voluntary benefit plans as may be necessary and reasonable. The Committee is authorized to determine the premiums, benefits package, funding method, administrative procedures, eligibility provisions and rules relating to the plans. Additionally, the Committee approves the Plan Document which is a formal outline of the plan of benefits and sets out an appeals process as authorized in the statute.

Administratively, the Local Government Insurance Committee is attached to Benefits Administration within the Department of Finance and Administration. Benefits Administration provides the personnel and other appropriate resources to the State Insurance Committee to assist in carrying out its responsibilities. Benefits Administration also provides similar support to the State and Local Education Insurance Committees.

2. Provide a list of current members of the committee and explain how membership complies with Section 8-27-701, *Tennessee Code Annotated*.

**RESPONSE:** The current members of the Committee are as follows:

- \*Stuart McWhorter, Commissioner, Department of Finance and Administration
- \*David Lillard, State Treasurer
- \*Justin Wilson, Comptroller of the Treasury
- \*Kevin Krushenski, Tennessee Municipal League appointee
- \*Nathan Brock, Tennessee County Services Association appointee

\*specifically outlined in TCA

3. Are there any vacancies on the committee? Is so, please indicate the length of the vacancies and explain what steps have been taken to fill those vacancies.

**RESPONSE:** There are currently no vacancies on the Local Government Insurance Committee.

4. How many times did the committee meet in Fiscal Year 2018 and to date in Fiscal Year 2019? Please note meetings where the committee did not have a quorum.

**RESPONSE:** The Local Government Insurance Committee met on the following dates:

July 28, 2017

August 25, 2017

October 27, 2017

May 24, 2018

June 28, 2018

August 23, 2018

December 17, 2018

January 17, 2019

February 21, 2019

May 23, 2019

There was a quorum present at each meeting.

5. What per diem or travel reimbursements do members receive? How much was paid to committee members in Fiscal Years 2018 and to date for Fiscal Year 2019?

**RESPONSE:** Members are reimbursed in accordance with the Department of Finance and Administration Policy 8 - Comprehensive Travel Regulations (Revised September, 2018). [https://www.tn.gov/content/dam/tn/finance/documents/fa\\_policies/policy8.pdf](https://www.tn.gov/content/dam/tn/finance/documents/fa_policies/policy8.pdf)

No members requested reimbursement of expenses; Mr. Krushenski's office is located in Nashville and Mr. Brock participated by teleconference.

6. What were the committee's revenues and expenditures for Fiscal Year 2018 and to date in Fiscal Year 2019? Does the committee carry a fund balance? If yes, please provide additional relevant information regarding the fund balance.

**RESPONSE:** The Local Government Insurance Committee itself receives no revenues and incurs no expenditures during the course of its operation. Revenues and expenses for the Local Government Plan are reported in the Comprehensive Annual Financial Report as local government group insurance fund in the nonmajor enterprise funds.

The Division of Benefits Administration reports to the Local Government Insurance Committee information concerning plan revenues and expenditures for the plans on a calendar year basis as benefits and premiums are determined on that time period. During FY 2018, the Local Government Plan collected over \$136 million in premiums and paid out over \$119 million in health insurance benefits and over \$7 million in expenses. As of March 31, 2019, the Local Government Plan collected over \$112 million in premiums and

paid out over \$103 million in health insurance benefits and over \$6 million in expenses.

7. Is the committee subject to Sunshine law requirements (Section 8-44-101 *et seq.*, *Tennessee Code Annotated*) for public notice of meetings, prompt and full recording of minutes, and public access to minutes? If so, what procedures does the committee have for informing the public of their meetings and making their minutes available to the public? Does the committee allow for public comment at meetings? Is prior notice required for public comment to be heard?

**RESPONSE:** The Local Government Insurance Committee is subject to Sunshine law requirements for public notice of meetings. Effective in 2017 and years thereafter, the Committee voted to approve a schedule of regular meetings for the following year. The schedule of regular monthly meetings is posted at the beginning of each year on the state website calendar of events and on the BA website. Additionally, the Local Government Insurance Committee meetings are live streamed for viewing by the public. Effective January 1, 2019 approved minutes are posted on the Division's website under the "Insurance Committee" heading. The Committee does not have a formal comment policy. People seeking to speak before the Committee have made requests to address the Committee before the meeting.

8. In addition to the disclosure requirements placed on some ex officio members of the committee by Section 8-50-501, *Tennessee Code Annotated*, does the committee have any policies in place to address the potential conflicts of interest by committee members, committee employees, or other state employees who work with the committee in any capacity?

**RESPONSE:** There is no specific requirement in state statute regarding the Insurance Committee members and conflict of interest. Committee members are subject to the general conflict of interest statute, TCA 12-4-101. In addition, Commissioners and Constitutional Officers are required to make disclosures of income and conflicts of interest under TCA 8-50-501 and 2-10-115. This would include some but not all Committee members. Committee members do not sign annual written disclosure agreements. Benefits Administration employees who work on procurements follow the Central Procurement Office's Policy Number 2013-009 on business conduct & ethics and are required to complete an annual attestation stating that the employee will not participate in any portion of a procurement where a potential conflict of interest exists.

9. Has the committee established rules and regulations as authorized in Section 8-27-101(d), *Tennessee Code Annotated*, and what is the citation for the rules?

**RESPONSE:** No. The Committee has not promulgated rules and regulations as authorized in 8-27-101(d). As noted above, the Committee approves the Plan Document, which governs the administration of the Local Government Plan and details plan

eligibility and benefits available through the Plan. The Local Government Plan document is found on the Partners for Health website here:

<https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/lgpd2019.pdf>

10. Briefly describe each of the contracts the committee has entered into with insurance companies, claims administrators, or other organizations as authorized in Section 8-27-103, *Tennessee Code Annotated*.

**RESPONSE:** Please see Attachment A.

11. Section 8-27-102, *Tennessee Code Annotated*, provides that the committee may delegate to a subcommittee or to the Division of Benefits Administration the ability to resolve disputes regarding eligibility and enrollment for the plans and the benefit structure of the plans administered by the committee. How has that authority been delegated and what policies or procedures are in place to facilitate the dispute resolution process and assure fairness of the process.

**RESPONSE:** The Committee delegated in August 1991 to Benefits Administration the ability to resolve disputes regarding eligibility and enrollment for the plans. The Affordable Care Act requires that treatment or medical claim denials be reviewed by an independent review organization after the carrier appeals are exhausted by the member. Therefore, treatment and/or medical claim denials are not reviewed by Benefits Administration.

The Benefits Administration Review Team (BART) reviews disputes regarding eligibility and enrollment for the plans. Please see Attachment B for a description of this process.

12. What were the committee's major accomplishments during Fiscal Year 2018 and to date in Fiscal Year 2019?

**RESPONSE:** The local government insurance committee's key responsibility is to approve the group insurance plan, including determining the premiums, benefits package, funding method, administrative procedures, eligibility provisions, and rules relating to the plans. In order to fulfill this responsibility, the Committee makes decisions to ensure a comprehensive, affordable and sustainable package of benefits. Through prudent fiscal and programmatic management the Committees kept premium increases below market, while offering excellent benefits. Specific accomplishments include:

- During FY 2018, the Committee approved a 4.6% premium increase for CY2018. For 2019, the Committee approved a 2% premium increase
- Completed competitive procurements for Decision Support System, Benefits Consulting and Actuarial Services, and Population Health contract in 2018 for disease management services

- Completed the creation of a single Insurance & Benefits and Partners for Health website to improve member and customer communications
- Improved customer service by adding a real-time chat feature to phone and email interactions and the ability to upload applications and supporting documentation directly into our customer support system

13. What reports does the committee prepare on its operations, activities, and accomplishments? Who receives those reports? Please provide a link to any such reports issued in Fiscal Year 2018 and to date in Fiscal Year 2019.

**RESPONSE:** On behalf of the Committee Benefits Administration prepares an annual report covering the activities of all three Insurance Committees. The Annual Reports are prepared every calendar year, as benefit and premium changes, if approved, occur every calendar year. Data reflecting cost and utilization are reported in the Annual Report and reflect the year's experience. The Annual Report also includes relevant financial information from the most recent CAFR. The 2018 annual report has not yet been prepared, as the calendar year cost and utilization data are not available in our datawarehouse until May, due to normal claims runout timing. The most recent Annual Report is found on the Partners for Health website here:  
[https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/2017\\_annual\\_report.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/2017_annual_report.pdf)

14. Describe any items related to the committee that require legislative attention and your proposed legislative changes. Are any changes needed in the committee's enforcement powers or in level of regulatory activity?

**RESPONSE:** None at this time.

15. Should the committee be continued? To what extent and in what ways would the absence of the committee endanger the public health, safety or welfare?

**RESPONSE:** The Local Government Insurance Committee acts much like the board of directors for a large scale insurance plan involving the provision of benefits to over 26,625 local government agency employees, retirees, and their covered dependents. It is the position of Benefits Administration that the Committee represents an effective mechanism for establishing direction, both administrative and financial, for this purpose of providing and maintaining health insurance plans to local government agencies. Without the ability for local government agencies to pool covered lives in a consolidated risk pool, many of these agencies would not be able to provide affordable comprehensive health insurance to their employees.

## ATTACHMENT A

### Benefits Administration 2019 CONTRACT SERVICES

VENDOR NAME	CONTRACT PURPOSE	START DATE	END DATE	IC Committee Approval
ActiveHealth	This contract helps members achieve their health goals by offering a variety of programs in which members can voluntarily engage. Services include disease management, wellness challenges, biometric screenings, as well as many other online resources.	8/1/2018	12/31/2023	State, Local, and Education Committee
ActiveHealth	This contract provides a voluntary weight management program for State Plan members.	8/1/2018	12/31/2023	State, Local, and Education Committee
AON Consulting Inc.	This contract provides actuarial, OPEB, and consulting services for the State Group Insurance Program.	10/1/2018	12/31/2024	State, Local, and Education Committee
Blue Cross Blue Shield of Tennessee	This contract provides self-insured PPO administrative services for State Group Insurance Program members for the East Grand Region.	9/1/2015	8/31/2022	State, Local, and Education Committee
Blue Cross Blue Shield of Tennessee	This contract provides self-insured PPO administrative services for State Group Insurance Program members for the Middle Grand Region.	9/1/2015	8/31/2022	State, Local, and Education Committee
Blue Cross Blue Shield of Tennessee	This contract provides self-insured PPO administrative services for State Group Insurance Program members for the West Grand Region.	9/1/2015	8/31/2022	State, Local, and Education Committee
Caremark PCS Health LLC	This contract provides pharmacy benefits manager (PBM) services for all members of the State Group Insurance Program.	12/15/2014	6/30/2020	State, Local, and Education Committee
CIGNA Health and Life Insurance Company	This contract provides self-insured PPO administrative services for State Group Insurance Program members for the Middle Grand Region.	9/1/2015	8/31/2022	State, Local, and Education Committee
CIGNA Health and Life Insurance Company	This contract provides self-insured PPO administrative services for State Group Insurance Program members for the East Grand Region.	9/1/2015	8/31/2022	State, Local, and Education Committee
CIGNA Health and Life Insurance Company	This contract provides self-insured PPO administrative services for State Group Insurance Program members for the West Grand Region.	9/1/2015	8/31/2022	State, Local, and Education Committee
CIGNA Health and Life Insurance Company	This contract provides self-insured PPO administrative services for State Group Insurance Program members across all regions of the State.	7/1/2016	6/30/2022	State, Local, and Education Committee
CIGNA Health and Life Insurance Company	This contract provides voluntary dental coverage for members of the State Group Insurance Program. It is fully funded by member premiums.	10/1/2015	12/31/2019	State, Local, and Education Committee
Davis Vision	This contract provides voluntary vision-coverage for eligible State Group Insurance Program members. It is fully funded by member premiums.	8/1/2017	12/31/2022	State, Local, and Education Committee

		7/1/2018	12/31/2023	State, Local, and Education Committee
IBM Watson Health	Provides a data warehouse and decision support tool for all claims related to the State Group Insurance Program.			
Metropolitan Life Insurance Company	The contract delivers voluntary short-term and/or long-term disability insurance to eligible State Plan members. It is fully funded by member premiums.	11/1/2016	12/31/2019	State Committee
Metropolitan Life Insurance Company	This contract provides Voluntary dental coverage for eligible members of the State Group Insurance Program. It is fully funded by member premiums.	10/1/2015	12/31/2019	State, Local, and Education Committee
Minnesota Life Insurance Company	This contract provided basic term life insurance, basic AD&D insurance, and optional AD&D insurance for members of the State Plan and is currently in run-out with no services being delivered.	9/23/2013	12/31/2019	State Committee
Minnesota Life Insurance Company	This contract provides basic term life, basic AD&D, voluntary term life, and voluntary AD&D insurance for members of the State Plan.	9/1/2017	12/31/2023	State Committee
Optum (United Behavioral Health)	Employee Assistance Program (EAP) and Behavioral Health Organization (BHO) for members of the State Group Insurance Program.	7/1/2016	6/30/2023	State, Local, and Education Committee
PayFlex Systems USA Inc.	This contract provides Health Savings Accounts for members of the State Group Insurance Program enrolled in a Consumer Driven Health Product (CDHP) and flexible benefits for State Plan members.	9/1/2015	12/31/2020	State Committee
Pomco Inc.	This contract provides administrative services for the State's self-insured Medicare Supplement Plan for Medicare eligible members of the State Group Insurance Program.	7/1/2016	12/31/2021	State Committee
Provident Life & Accident Ins	This contract provides underwriting and administrative services for the State Voluntary Universal Life Insurance Plan. This is a closed program that the Contractor will manage until no members remain in the Plan.	9/1/2005	12/31/2037	State Committee
University Community Health Services	This contract provides the administrative service for the onsite employee health center services to State Plan employees.	6/1/2018	12/31/2023	State Committee

## **ATTACHMENT B - Description of Benefits Administration Review Team Procedures**

The Benefits Administration Review Team (BART) reviews disputes regarding eligibility and enrollment for the plans. BART consists of three Benefits Administration professionals who do not have a role in determining eligibility or enrollment for members. Requests for review are forwarded to the appeals coordinator by the Benefits Administration's service center, the plan member, or the employing agencies' agency benefit coordinator. Upon receipt of the written request for review, the appeals coordinator will date stamp the request and log its receipt on the case log. The appeals coordinator will read the request and research the issue and gather additional information, if necessary. Research includes, but is not limited to, the following:

- Review of related plan document language that was in place at the time of the issue,
- Review of eligibility and enrollment guides that were in place at the time of the issue,
- Obtaining recordings of all applicable call records and call notes,
- Contacting any persons that may have first-hand knowledge of the issue such as the employing agency benefit coordinator and human resources officer, plan member, or vendor account representatives,
- Review of any applicable TCA language, and when appropriate consulting with F&A Legal Counsel.

Once research is complete, the appeals coordinator prepares the appeal packet for distribution to the BART. The appeal packet will contain a brief summary of the issue and findings from the appeals coordinator's research, as well as, the original review request, and copies of all pertinent supporting documents. Information identifying the individual (name, member ID, address, employing agency, etc.) is redacted from all documents in the appeal packet. This process is in place to ensure that the individual gets a fair and unbiased review of his/her issue. The appeals coordinator provides the appeal packet to the BART at least 24 hours prior to the BART meeting.

The BART will review the appeals packet and direct any questions or requests for clarification to the appeals coordinator. The appeals coordinator will research and provide clarification to all team members. Team members are to refrain from discussing appeals prior to or outside the BART meetings. At the BART meeting, the appeals coordinator provides a brief overview of the facts of the appeal. BART members discuss the appeal and vote independently to either approve or deny the appeal. Each BART member must complete a ballot sheet and provide rationale for his/her vote. Decisions are based on majority vote. Once the decision has been determined, the appeals coordinator sends a letter to the individual as to the decision, rationale for the decision, and any appropriate supporting documentation of the decision (most likely plan document language).