FAQ – Plan decision process, plan designs, premium and committee questions:

Questions:

- I'm very concerned with the HIGH increases on the premiums and the limited facilities that are available in the narrow network. I'm afraid of the strain it is putting on employees. How was it decided that this plan was the best option for FBISD?
- I agree with….. These premiums have largely increased and feel very limited to medical options with the narrow network. Was there a committee formed for these decisions?
- I would also like to know how these decisions were made, especially since there were no raises this year.
- When did the insurance committee meet this year?

Response:

The board and administration faced difficult decisions this year. We did not make these decisions lightly and our team members and students are at the heart of every decision made. Administration did not stand up the benefits committee primarily due to the pandemic and its impact on our time and resources. In the past, we have shared sensitive health data that does not leave the room. In a virtual environment, it would have been difficult to control this data.

Our plan structure has included a broad and narrow network since we enrolled with Aetna. The District's goal is to provide several benefit plan options to select from. The plans are evaluated by our consultants with Gallagher. They have experts that compile our claims data, health trends, utilization, etc. The plan spend (fees, claims, stop loss insurance) is compared to the revenues (premiums and rebates). There are two ways to increase needed revenue – additional contributions (increased District and employee premiums) or adjust/reduce plan benefits (increase deductible and or coinsurance, copays, etc.) – or a combination of the two. There is a balance between increasing revenues and eliminating benefits. The experts recommend the revenue (premium) adjustments needed to maintain an actuarially sound plan. The experts did not recommend implementing any major shifts in our benefits to make up the plan shortfall.

Regardless of whether an employer is self-funded (Flour Bluff) or fully insured (TRS Active care) –projections (expected medical/rx claims plus expenses to run the plan) are evaluated throughout the year coupled with the actual results to determine the appropriate needed revenue (District contributions plus employee contributions) to balance against plan expenses (Medical/Rx claims plus expenses to run the plan). This process will continue going forward.

The Benefits Committee will meet this year to discuss the short year and re-enrollment. We may have to discuss major plan changes at that time dependent on the plan performance in the coming months. We look forward to working with the committee and hearing their input on cost saving plan changes.

Question: An increase in premiums equates a pay cut for FBISD employees due to the freezing of salaries this year.

Response: This has been a problem for the district even when we were able to implement a pay increase. That is why we have chosen to shift our plan year to align our benefit changes with our annual compensation discussions. This will allow the board to make the compensation and benefit decisions as part of the annual budget adoption and eliminate the January surprise.

Question: If my math is correct, the plan premiums (at least for Narrow plan) from this year to the next are upwards of 50-75% increases. Is there any expectation that these huge increases will be somewhat mitigated by the Summer re-enrollment "discount" that was mentioned earlier?

Response: The comparison of rates schedule is on the employee website. I am not sure where the concept of a re-enrollment "discount" was conceived. We have elements of the plan like the flexible spending account that is prorated for the short year. While we are in the pandemic environment, it is even more challenging to predict how the plan will perform. We will be working with Gallagher throughout the next six to eight months to evaluate our plan performance and make recommendations for that renewal. We cannot guarantee what the rates or benefits will be at that time. Our goal is and will continue to be to provide the best health care we can while striving to control the cost.

Question: How do our rates compare to other local districts?

Response: The District's benefit plans offering compares very favorably with the Districts in the Coastal Bend region. The District assimilates the information routinely to make sure that the District is competitive with the surrounding Districts. Additionally, the District is required by the TEA to report and provide information about its plans biannually compared with the benefit offering and plan cost offered through TRS Active Care.

You can see other districts benefits and premium schedule on their website. Most districts are part of TRS and the TRS insurance information is on that website. A true comparison is difficult without analyzing the benefits provided. For instance, CCISD has similar narrow and broad network plans but they have no out of network benefits and coinsurance provisions. TRS insurance programs have you paying 25% to 50% after deductible on brand name medications and specialty medications. We believe our benefits package is providing our employees with a quality care product. These more restrictive covenants would most likely cost our employees more out of pocket up front.

FAQ – Plan network questions:

Question: If you are on the narrow network and you have children what is the other option since Driscoll is not an option?

Response: The narrow network plan has a robust provider list and includes services at the HCA Hospitals – Bay Area, Doctors Regional. Please refer to Aetna's website for additional information. If there is a provider deficiency, it is possible to apply and get pre-approval for use of a specialist or Driscoll and it might be treated as in-network. There is no guarantee that it will be approved and you will want to get that approval in writing from Aetna prior to receiving any care.

The High Deductible Health plan does include coverage for Driscoll in network. As discussed in the presentations, we recommend that you review your past health care needs and each plan cost to make the best health care decision for your family. In addition, please review the Maximum Out-of-Pocket Matrix to help determine which benefit plan and network suits you and your family's needs.

Question: So if I need Driscoll on my plan I need the 3000 Broad? Which is $1823/month for employee plus family? Is that correct?

Response: The monthly premium for the 3000 Board Network Family is $1,823.92. This is not the only plan with Driscoll Children's Hospital. Driscoll is also in network on the High Deductible Plan. As discussed in the presentations, we recommend that you review your past health care needs and each plan cost to make the best health care decision for your family. In addition, please review the Maximum Out-of-Pocket Matrix to help determine which benefit plan and network suits your family's needs.

Question: So am I to understand that if I were to use the 4000 plan, and then went to Spohn for a procedure, that I would then need to pay up to $12,000 of that procedure cost? I thought we didn't need to worry about in/out of network changes with the 4000 plan.

Response: If you are part of the High Deductible 4000 plan, it utilizes Aetna's broader network and Spohn is in network and the deductible is $4,000. The high deductible plan **does have a specific network** and it is **costly** to go out of network. The out of network deductible is $12,000. It is costly on all plans to go out of network. We strongly encourage employees to double check the network prior to having any care.

Question: What's the difference in narrow and broad plan?

Response: The primary difference is the in-network access to Doctors and facilities. The narrow network, by definition, is a smaller selection of Doctors and facilities in the Corpus Christi area. Aetna has negotiated preferred pricing with these Doctors resulting in lower premiums and lower cost to the plan. We encourage employees to check the list for their providers prior to enrolling. The narrow network does not provide access to the Driscoll or Spohn hospital systems. Seeking out of network services is costly on any plan.

The broad plan Network is an expanded group of Doctors and facilities. If you are on the narrow plan, you have access to the broad plan when you travel outside of the geographic area. Corpus Christi area includes: Sinton, Aransas Pass, Mathis, Gregory, Ingleside, Odem, Alice, Premont, Orange Grove, Kingsville, Riviera and Padre Island.

Question: Where do we see the doctors and hospitals that are on broad and narrow???

Response: Go to https://www.aetna.com/individuals-families/find-a-doctor.html

login or set up as a new user and once your in the correct network you can search for doctors.

Aetna Choice POS II – ASC 3000 Low Plan
Or
Aetna Choice POS II- ASC Savings Choice Network
Or
Aetna Choice® HDHP

Question: So the narrow plan, my dr delivers babies at Spohn South and I see a specialist so I am now responsible for all because they are not in my plan?

Response: It would be covered as Out-of-Network. We suggest that you log into the Aetna website and use the tools to price services. You can also call Aetna and request assistance on the estimated costs. It is important to make an informed decision that is best for your individual circumstances.

FAQ – Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA) questions:

Note: Both of these accounts are managed by Infinisource. If you have a current account, you can log into your account and they have great resources online. You may also contact Infinisource: 800-300-7715

Question: Does the Flex card roll over?

Response: No, the flex card does not roll over. You must use your money up before the plan year ends. You may refer to page 10 in the employee benefit handbook. https://flourbluffschools.net/wp-content/uploads/2020/11/Flour-Bluff-ISD_BG-2021-w-hyperlinks-V10-updated_2.pdf

Question: Can I use my flex till march?

Response: No, the plan closes 12/31/2020. You will have a grace period to turn in receipts until 3/15/2021.

Question: These broad and narrow plans don't have HSA, correct? Only the 4,000?

Response: Yes, that is correct. However, the 3000 Low Broad Network and 3000 Narrow Network have a Flex Spending account. Page 10 of the Employee Benefits Booklet, https://flourbluffschools.net/wp-content/uploads/2020/11/Flour-Bluff-ISD_BG-2021-w-hyperlinks-V10-updated_2.pdf

Question: Is HSA different than flex?

Response: The most significant difference between flexible spending accounts (FSA) and health savings accounts (HSA) is that the employee controls an HSA and allows contributions to roll over, while FSAs are less flexible and are owned by an employer and do not allow funds to roll over to the next plan year.

Question: Can you eventually pull your money out of HSA if you eventually choose not to have an HSA?

Response: Yes, you can withdraw funds from your HSA at any time. But if you use your HSA funds for any reason other than to pay for a qualified medical expense, those funds will be taxed as ordinary income, and the IRS will impose a 20% penalty.

Question: If you put in $50 per month into your HSA, then FBISD matches that and put s $50 in as well, but if you put $200 each month, FBISD will only match $100.

Response: FBISD contributes a flat $100 to your HSA, it is not a matching contribution.

Question: Does HSA require receipts?

Response: Both plans require you to keep receipts. The FSA will ask you to provide receipts to validate the expenditure. The FSA manager is responsible for validating the distribution.

The HSA requires you to maintain the receipts to validate all distributions from your HSA. Per IRS publication 969 – "You must keep records sufficient to show that the distributions were exclusively to pay or reimburse qualified medical expenses, the qualified medical expenses hadn't been previously paid or reimbursed from another source, and the medical expenses hadn't been taken as an itemized deduction in any year. Don't send these records with your tax return. Keep them with your tax records."

Question: Are there any restrictions on what kind of medical care HSA funds can go to?

Response: A list of HSA-eligible expenses is available on the IRS website, www.irs.gov, in IRS Publication 502. The benefits book has a short list on Page 9 in the Handbook: https://flourbluffschools.net/wp-content/uploads/2020/11/Flour-Bluff-ISD_BG-2021-w-hyperlinks-V10-updated_2.pdf

For specifics, you may also contact Infinisource: 800-300-7715

Question: I tried using my flex account for vision, and I was denied

Response: There may have been some confusion. FSA dollars can be used for all prescription eyewear purchases including prescription sunglasses, single vision, progressives, computer lenses, and contact lenses! Flex money can also be used for routine eye exams, contact lens evaluations, and all other medical eye exams. Please reach out to Infinisource to determine why your card was turned down. You may be able to submit the receipt for reimbursement.

Question: Why did the FSA maximum go down??

Response: It is pro-rated for the short 8 month plan year.

Question: Can the "family" on the HSA be considered a parent and 1 dependent?

Response: That is considered "Employee and children". Your child has to be under the age of 26. Relationship to You: For a child to qualify as your dependent, he or she needs to be your biological child, your stepchild, your adopted child, or a foster child you are taking care of.

Question: FBISD puts $100 a month in the HSA, but how much would I have to contribute?

Response: You are not required to add any contributions to the HSA if you choose not to.

Question: Do FSA accounts need to be spent within the 8 months? Or do we have until Dec. 31?

Response: Your FSA must be spent by 8/31/2021.

Question: Will Flour Bluff still be depositing $100 per month in the HSA account?

Response: Yes, Flour Bluff will still be depositing $100 per month in the HSA's.

Question: If my husband is not on my medical plan, can I still use my HSA to pay for his medical expenses as needed?

Response: You can use your HSA to cover qualified medical expenses for you, your spouse, and any dependent children included on your income tax return as long as they are not on a qualified Flex spending account.

FAQ – Pharmacy and Express Scripts questions:

Question: I was VERY upset over the HIGH price on the Express Scripts options. My son's prescription is NOT available through home delivery AND, it went from a $10 price to $160 per month. What are my options?

Response: In this situation, consult express scripts website. There you can shop for the best price on certain medications and find generic equivalents and what prescriptions are included in our plan. https://www.express-scripts.com/#/

Question: I thought Aetna and CVS had a partnership?

Response: CVS owns Aetna. Although Express Scripts works with Aetna, it is separately owned by Cigna. Express Scripts will price your medication at available pharmacies. They also have an App for your phone to get pricing and other information quickly. See the flyer on the website.

FAQ – RediMD and Minute Clinic questions:

Question: Is there a Walgreens version of the minute clinic? Should we get our prescriptions from only CVS?

Response: No, Walgreens does not have a participating version of the CVS Minute Clinic program. Express Scripts manages our pharmacy plan. Please visit their website to see if your medications are in network at a particular pharmacy.

Question: No copay for RediMD on all plans?

Response: The district has negotiated a zero copay for the 3000 Broad Network or 3000 Narrow Network. The IRS regulations guiding a qualified high deductible plan do not allow this benefit. There is a charge of $40 for the 4000 High Deductible plan.

Question: Do I have to pay for CVS Minute Clinic if I have the HDHP?

Response: Yes, you will be charged towards your deductible. Contact CVS Minute Clinic to get accurate pricing.

Question: Are x-Rays available at the Minute Clinics?

Response: Services rendered at any location are up to the provider and the network agreements with Aetna. You can visit the Aetna site to locate services.

For information on the Minute Clinic you can visit
https://www.cvs.com/minuteclinic/services/minor-injuries/N-d8Z3a3jlZd5

Minute Clinic locations:https://www.cvs.com/minuteclinic/clinic-locator/?q=78413

FAQ – Other questions:

Question: Why has the emergency copay doubled this year during a pandemic?

Response: The costs of emergency room care continues to rise as well as our plan utilization of the emergency room. Gallagher recommended the increase in the co-pay to assist the plan in covering the costs. The plan continues to waive the co-pay if the visit to the emergency room results in an admission to the hospital.

Question: Are Covid tests covered 100% in all plans?

Response: Federal mandate dictates coverage for testing at In-network providers and out-of-network providers. Flour Bluff is providing inpatient treatment of COVID-19 at zero cost share at In-network providers and out-of-network providers. For outpatient COVID-19 treatment, standard employee cost share applies based on the employee's plan. Cost share is waived for inpatient treatment only.

Question: Is all of this information on premiums available right now on the website or another website?

Response: Yes, https://flourbluffschools.net/employee-hub/

Question: Is information available on our website about other insurance like vision, dental, etc.?

Response: Yes, https://flourbluffschools.net/2020-2021-employee-benefits/

Question: Can we get a "side by side" on the comparisons between the premiums from last year to this year????

Response: A comparison is posted on the website - https://flourbluffschools.net/wp-content/uploads/2020/11/Premium-Comparison.pdf

Question: Where can we find the slide of changes?

Response: The whole zoom presentation is on the "Employee Hub" You can refer to slide 11

https://flourbluffschools.net/wp-content/uploads/2020/11/Benefits-Presentation-2021-final.pdf

Question: at the end of the meeting, can we enroll?

Response: Yes, you may begin enrolling now.

Question: This may seem obtuse, but if we fund our own health plan, what does Aetna do for us? I don't understand what Aetna does for us besides tell us who is in and out of our network and send us bills...lol

Response: We could not navigate the complexities of our health care systems without Aetna. They also negotiate discounts and agreements with providers that are beneficial to our members by providing lower cost for services.

Question: Which Plan has been eliminated?

Response: The 1500 Broad Plan

Question: If I reached my deductible before 8 months, do I have to restart the deductible over?

Response: The district is planning to implement some hold harmless measures. This will be addressed at renewal time in the summer.

Question: Did the maximum out of pocket go up on the narrow plan from last year?

Response: Page 11 of the Slide presentation shows the max out of pocket for the Narrow In-Network Increased from $4000.00/8,000.00 to $6000.00/12,000.00