February 19, 2020

2019 Employee Survey Results and Comments

On behalf of the District's Health Care Committee (HCC), we wish to thank those employees who participated in the 2019 Employee Survey regarding the District's Health Care Benefits. The District's Health Care Committee is composed of 5 members of the ETA, one member from each of the other collective bargaining units, and 5 District administrators.

The purpose of the employee survey

The survey provides employees an opportunity to give the HCC feedback on service issues and plan benefits. This feedback is used by the HCC to review any service issues and the design of plan benefits. This survey was first established in 2006.

Understanding the District's medical plans

Sixty-four percent of the respondents felt that they had an excellent or good understanding of the District's medical plans; 30% an average understanding; and 6% a poor or very poor understanding.

Perception of leading costs

When asked how you would rank what your perceive to be the leading costs to the District's medical premiums, the respondents ranked the following:

- Most important: Claims Cost
- Important: Utilization
- Somewhat important: Inflation
- Least important: Healthcare Reform

Meeting your family needs

When asked whether the District's current healthcare program meets their needs and their family needs, 75% of the respondents strongly agreed or agreed and 25% disagreed or strongly disagreed.

Comparison of District's plans to other nearby employers

Employees were asked whether they agreed with the following statement -- School District U-46's plan is comparable those offered by other employers within a 30 mile radius of Elgin: 63% strongly agreed or agreed, 5% neither agreed or disagreed, and 32% disagreed or strongly disagreed.

United Healthcare Customer Service

When asked whether United Healthcare Customer Service assisted them in resolving questions about their medical plan, 45% of the respondents strongly agreed or agreed, 12% disagreed or strongly disagreed, and 43% did not contact customer service.

The survey gave employees an opportunity to suggest changes to the healthcare program and explain why as well describe any concerns employee had. 523 employees had suggestions and 462 employees expressed concerns. We would like to address some of the suggestions and concerns below.

The Role of United Healthcare

There were a number of comments about the role of United Healthcare (UHC). The District's medical and dental plans are self-insured. The design of those programs has been delegated to the HCC. UHC is the third-party administrator of the plans designed by the District. The responsibilities of the third-party administrator include:

- The processing claims in accordance to the plan designs;
- The use of the network of providers (and the resulting savings from the network discounts negotiated);
- Case management;
- Wellness program platforms; and
- Other services made available.

The third-party administrator is paid on a fixed fee, which is not dependent on whether a claim is paid or denied. The third-party administrator could be any entity, such as UHC, Aetna, Blue Cross Blue Shield. United Healthcare was chosen through a competitive process that focused on quality of customer service, size and make-up of its network, and the network discounts negotiated.

How a high-deductible health plan works

The District offers two high deductiple health plans with a health savings account (HDHP w/ HSA). In order to have a health savings account, a HDHP must meet certain criteria established by Federal Regulations for high-deductible health plans, including having a minimum deductible for single and family coverage, having maximum out-of-pocket limits, and meeting other requirements. The minium deductible and maximum out-of-pocket maximums are indexed for inflation.

One of the important requirements of a HDHP w/ HSA is that **no benefits are payable by the plan until the deductible has been met** by the individual or family. There are only two exceptions to this requirement – preventive care (as defined by the Federal Regulations) and certain preventive medications. [For a list of those prescriptions that meet the exception, go to Preventive Medications. Please note that certain of the prescriptions listed may be excluded by the plan.]

Payment of preventive care claims

A number of respondents were concerned that certain claims were not paid as preventive care by UHC. The provider must list the services as preventive care in order for UHC to process the claim as preventive. The provider must follow certain guidelines when coding claims.

Embedded Deductables and Out-of-Pocket Maximums are generally good for you.

In the most recent survey, there were many comments about the embedded deductables as hurting the employee and his/her family. Actually, by having embedded deductables and out-of-pocket maximus are good for you and your family.

Without an embedded deductible, an employee who covers someone else in the plan (children, spouse, or family) would have to meet the full family deductible before the medical plan option in he/she is enrolled would pay benefits. With an embedded deductible, an employee who covers someone else in the plan (children, spouse, or family) would only have to meet the embedded dectuble before the medical plan would pay benefits .

Plan	Family Deductible	Embedded Deductible	Potential Savings
PPO	$2,150	$ 750	$1,400
Gold*	$3,000	$2,800	$ 200
Silver*	$4,000	$2,800	$1,200

* The embedded deductible for high deductible health plans must meet certain miniumum standards as established by Federal Regulations.

The only time when embedded deductibles are not better than having aggregate deductibles is when a single person in the family would meet the full family deductible.

The method used to establish premium equivalents

The District contracts with a nationally-recognized, independent actuary to establish the premium equivalents for each self-insured plan. These premium equivalents are reviewed each year by the HCC.

Factors in establishing the premium equivalents include such things as:

- The medical and prescription coverages
- The plan's deductible
- The plan's co-insurance and/or co-pays
- The plan's out-of-pocket maximum

The District's plans cover the features normally found in employer group health plans. They also cover many features not normally found in other employer plans, such as infertility coverage, gastric by-pass surgery, orthotics, hearing aids, breast reduction for medically-necessary reasons, and certain benefits required to be offered by school districts by the State of Illinois. These other features increase the amount of the premium equivalents.

Higher plan deductibles, co-insurance, co-pays and out-of-pocket maximums lower the amount of the premium equivalents. Lower plan deductibles, co-insurance, co-pays and out-of-pocket maximums increase the amount of the premium equivalents.

The premium equivlants are established using the following factors:

- + Current premium equivalents
- + Medical cost trends
- ± Claims experience
- ± Plan design changes
- ± Changes in plan demographics

Unfortunately, medical cost trends are much higher than general inflation. Each year, the District's outside actuary establishes medical cost trends for its client base and adjusts those for individual clients. Due to the program changes that promote a healthier life style, the District's medical cost trends tend to be about 1-2 percentage points for the general client base. However, it is still about 6.5% per year.

If the projected claims for the current year exceed what had been forecasted, the premium equivalents would increase accordingly. If the projected claims for the current year are lower than what had been forecasted, the premium equivalents would decrease accordingly.

With respect to plan design changes, the HCC looks at the effect on the premium equivalents that a variety of plan design changes will have. For example, based on the survey suggestions, certain additional features will be priced out that would increase premium equivalents. The HCC also looks at features, such as the drug exclusions that became effective January 1, 2020, that would help decrease premium equivalents.

Concern over mental health providers

A number of employees expressed concern over the number of mental health providers in Elgin. Currently, the following are within the network and are within 30 miles of Elgin:

359 Psychiatrists

Psychiatrists are medical doctors who specialize in the prevention, diagnosis, and treatment of mental or behavioral disorders. Psychiatrists can provide psychiatric evaluations, prescribe medication, and offer psychotherapy treatments. Most are board-certified in psychiatry and neurology.

432 Psychologists

Psychologists have a doctoral degree in either educational, child, clinical or counseling psychology. They can provide mental health assessments, psychological testing, and a variety of other services. Most offer psychotherapy treatments as well. Psychologists are not medical doctors.

1,713 Master Level Clinicians

Master's-Level clinicians have a master's degree in either mental health, social work, nursing, professional counseling or family therapy. They can provide assessments and a variety of psychotherapeutic interventions.

88 Nurse Masters Level

Nurse practitioners have a Master's degree in an advanced nursing education program. They are registered nurses who are trained and license to practice independently in a medical specialty. A nurse practicioner can provide a range of services, including assessment, counseling, and prescribing medication.

In addition, you can now take advantage of telemental health providers from the comfort of your own home.

Reminder: The EAP and your medical plan have the same network of providers. If you use the EAP program first (which covers 8 sessions per year *per issue*), there is no cost to you. Once you have used the EAP sessions, your medical plan would then come in play.