Frequently Asked Questions – Benefits Redesign

Sumner County and Sumner County BOE
(Classified Only)
Benefits Redesign 2013

FREQUENTLY ASKED QUESTIONS

Why and When Are We Doing This?

- **Why are we going to a two-tiered medical plan?**
  - We’ve spent a great deal of time determining how we can address rising healthcare costs. To lower the cost of our healthcare, we found we had two options: 1) Increase the cost for everyone OR 2) reduce the number and severity of our claims. We feel that the best way to reduce the number and severity of claims is through encouraging healthier lifestyles among our members by being more proactive in their healthcare.

- **When does all of this start?**
  - Although there will be two plans in place July 1, 2013, for the first plan year, July 1, 2013 to June 30, 2014, EVERYONE will be in the Preferred Plan. Beginning July 1, 2014 the plan in which you are placed will be determined by the Health Risk Assessment (HRA) process.

About the HRA Process

- **What is a HRA?**
  - An HRA is a personalized health analysis with interpretations and trends. An HRA Allows a physician to explain conditions and treatments by analyzing lab results generated from a clinical blood draw and a questionnaire. Both the blood draw and questionnaire are strictly confidential. Your employer will never have access to this information.

- **What are the HRA Dates and what is my deadline for completing my HRA?**
  - You must have an HRA between February 1, 2013 and July 1, 2013. CareHere will hold on-site events at several Sumner County locations. See the HRA Schedule on: www.sumnerschools.org/benefits http://finance.sumnertn.org/services/Employee_insurance_benefits_(1) http://www.carehere.com
  - Note: If you do not have an HRA, you will automatically be placed in the Standard Plan effective July 1, 2014.

- **Are my dependent children required to have an HRA?**
  - No. Only you and your dependent spouse (if applicable) will be required to have an HRA.

**TERMS:**

**Rising healthcare costs:** Between 2010-2011 and 2011-2012 the County’s medical and drug costs rose $1,203,324 on total claims of $17,770,151. During the same period enrollment dropped 3.24%. These claim dollars were paid out of Sumner County Trust Funds.

**Preferred Plan:** The health insurance program that will include all participants who are actively working on personalized health plan.

**HRA:** “Health Risk Assessment” a measure of an individual’s health through lab processed blood samples, weight and body measurements, blood pressure readings and a confidential questionnaire.

**Standard Plan:** The health insurance program that will include all people choosing not to participate in the personalized health plan, beginning July 1, 2014. Out of Pocket expenses will be much greater under this plan.
Who sees my HRA results?

- Only you, CareHere and/or your healthcare provider will have access to your HRA results.

How much will it cost me?

- All blood draws must be completed at a remote CareHere Non-clinic site. You may have the HRA process completed at a clinic location, if you have scheduled a visit to the clinic for an unrelated event. These services are free. It is assumed that the patient will also use a CareHere provider for the analysis. If so, that service is also free. If the patient chooses to use their own doctor there may be out of pocket expense for the analysis and follow up visits. See below.

How do I schedule an HRA Blood Draw?

- Schedule online at www.carehere.com or via the toll free number 877.423.1330. You may schedule for one of the off-site HRA appointments. You must have your HRA between February 1, 2013 and July 1, 2013 for consideration in the Preferred Plan designation.

Can I see my own physician for the HRA Review?

- Yes; however, you must have the blood draw through CareHere. If you choose to see your physician to review your results, he/she must follow the guidelines set forth by CareHere and it is your responsibility to provide the proper HRA forms to CareHere by March 1, 2014. You will need to notify CareHere that you are going to follow-up with your own primary care physician.

If I choose to go to my primary care physician for my HRA review, will I be responsible for payment of the visit?

- Yes. This will occur just as any other visit. You would be responsible for any deductibles, co-pays, and out of pockets as set forth in your corresponding plan. The County’s Insurance Trust will be paying the balance as is normally the case with all in and out of network claims.

What happens if I fail to have the required HRA completed?

- You will automatically be placed in the Standard Plan on the effective date of the next policy year, as well as any of your dependents on the plan.

I recently had a HRA. Will I need to have another during the months of February through June 2013?

- It depends on when it was performed. If you had an HRA performed through CareHere On February 1, 2013, or after, that procedure can be used, otherwise, you must have the procedure completed within the dates outlined above.

TERMS:

Plan Designation: This is the certification by your chosen physician of your adherence to the personalized health plan. These decisions happen only once per year and can only be changed at that time.

HRA FORMS: These forms can be obtained from the CareHere Clinic at the time of HRA.

Effective Date: The annual date that marks the first day of each new year of coverage. You are currently on a July 1 annual effective date.

Policy Year: The span of time which marks the beginning and ending of a coverage year. Since your effective date is July 1, your policy year is July 1 through June 30.
• What if I don’t meet all the benchmarks in my HRA? Does that automatically put me in the Standard Plan?
  • The ONLY at-risk category that automatically will put you into the Standard Plan is the use of tobacco products. You will, however, have the opportunity to stop using tobacco prior to your plan designation. Aside from tobacco use, benchmarks are goals. You only have to be working towards them to be on the Preferred Plan, as certified by your physician.

• What if an issue is found in my HRA? Does that automatically put me in the Standard Plan?
  • No. For the first plan year (July 1, 2013 to June 30, 2014), EVERYONE will be in the Preferred Plan.
  • For the next plan year (July 2014 to June 30, 2015), the ONLY at-risk category that automatically puts you into the Standard Plan is the use of tobacco products. However, you will have an opportunity to stop using tobacco prior to your plan designation.
  • For example, you discover you have high blood pressure during your HRA, and your blood pressure remains high the following year. As long as you have followed your individual action plan to address this issue, you would still be placed in the Preferred Plan, even if your BP remains high. There is no “magic number” in any category that places you in one plan or the other. Working with your physician, or on-site personnel, addressing the condition(s) is the only determining factor in your placement.

• Will I be on my own to work on the plan developed between my provider and myself? Will I have any tools available to me and at what cost?
  • You will not be on your own. First, the provider is there to assist you and answer your questions and concerns. Second, if your HRA results identifies a concern, your CareHere representative will enroll you in CareHere Connect. Within this system you will have access to various health coaches by email or by phone. These are professionals that can meet with you personally. This is NOT a web service or “800” number. You will have access to your own personal site that is populated with the data that was gained from the HRA event. You will be assigned tasks each week that can help you stay on course and educate you regarding your own condition. THIS SERVICE IS FREE.

• If my spouse is covered on my plan and does not cease tobacco use or follow his/her action plan during the year, does that mean I will be enrolled in the Standard Plan too?
  • Yes. Both the employee and the spouse must comply with all criteria to qualify for the Preferred Plan. Family coverage cannot be split between Standard and Preferred. This boosts the sense of team and will help increase success rates, making a healthier population.

**TERMS:**

**Benchmarks:** Goals set by physician, based on HRAs, that plan participants have to be actively working towards in order to remain on the preferred plan. These do not have to be met; only working towards.

**Individual Action Plan:** This is your personalized health plan derived from the aforementioned HRA. This plan will be developed between you and your physician.

**CareHere Connect:** This is an online place where an individual can go to access all of the information and personal assistance they need to change and improve their health behavior and condition. It is confidential and includes a social networking piece if the patient chooses to use it.
How will I be notified as to which plan I will be enrolled in?

- You will be notified by the employer.

Plan Designation Can Change Year to Year

- If I am on the Standard Plan one year, is it possible for me to move to the Preferred Plan the following year?
  - Yes. If your CareHere provider (or your physician) determines that you are following your plan of action, as defined, you will qualify for the Preferred Plan the following year if that determination can be made prior to the March 1st deadline prior to the upcoming plan effective date of July 1st of that year.

Other Plan Changes

- Can I go to an out-of-network provider on either plan?
  - The first year of the plan (July 1, 2013 through June 30, 2014), you may use in-network and out-of-network providers (see plan summary for deductible amounts). **However, beginning July 1, 2014, the Preferred Plan will NOT include out-of-network benefits.** This means if you are on the Preferred Plan, you will have to pay 100% of the cost for out-of-network providers. In addition, effective July 1, 2014 if you are on the Standard Plan and use out-of-network Provider, there is no cap on what you can be responsible for after you satisfy your deductible.

- I noticed that the prescription drug plan has changed quite a bit. I take a drug that is VERY expensive and is not available from the clinic. I may not be able to afford the new retail percentage. What can I do?
  - Check with your doctor and see if there is an alternate drug or generic available that is less expensive.
  - Some drug manufacturers offer special programs for those who cannot afford certain drugs. Speak with your doctor or druggist.

- How will my deductibles be figured with the plan year change?
  - Currently, all annual deductibles are figured from January 1 through December 31 of each calendar year. Beginning July 1, 2013 deductible and out of pocket expenses will be calculated on a plan year form July 1 through June 30. In order not to penalize someone who has accumulated deductible and out of pocket expenses during the first half of 2013, there will be a one-time opportunity to accumulate deductible and out of pocket expenses for an 18-month period from January 1, 2013 to June 30, 2014. **Please note this is a one-time added benefit.**

**TERMS:**

Retail Percentage: This is the percentage of the total cost of a drug, in a “Retail” setting, such as CVS, Walgreens, Kroger, for which a plan participant is responsible.
**TERMS:**

**Tobacco Cessation:** These are programs that use personal counseling, group meetings, and certain prescription drugs to overcome the habit of using tobacco products.

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- **What happens if I miss a scheduled CareHere Clinic appointment?**
  - Effective February 1, 2013, after an Employee or Spouse misses ONE scheduled appointments without some attempt to notify the clinic to cancel or reschedule the appointment; the employee will be charged $50 as a "No Show" fee. The method of payment is being set up and details will be posted soon. Failure to pay the fee will suspend clinic privileges until the fee is submitted. Suspended clinic privileges could place your preferred plan status at risk. Unlike retail doctors, CareHere doctors do not see multiple patients at one time. When there is a “No Show” all of the fixed costs, including salaries for that twenty-minute time slot, are covered by all of the other employees of the County, out of the Trust.

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**Wellness Programs**

- **Does Sumner County offer tobacco cessation programs?**
  - Yes. Programs are offered through CareHere. Contact CareHere for more information on this and other great programs that are available to you.

- **Are there any other additional costs if my spouse or I do not stop using tobacco products?**
  - In addition to remaining in the Standard Plan a tobacco product user will be charged $50 per month effective 7-1-2014. This amount will be assessed as part of your health insurance premiums and collected bimonthly (24 times a year.) If an employee has Family Coverage, and the employee and spouse use tobacco products, then the additional charge will be for the employee and spouse or a total of $100 per month. It must be clear that both the employee and the spouse have to be free of tobacco use to be covered under the preferred plan.
Helpful Tips

- **To help reduce pharmacy cost**
  - Always ask your doctor if a generic drug is available. Helpful information about generic products:
    - Many times the difference between name brand and generic has to do with time release agents determining how often you must take the medicine.
    - The ingredients of a generic drug are tested under the same FDA regulations as name brand. Many times they have the same ingredients. You should have your pharmacist explain the difference to you. If they do not know or do not have time to speak with you, consider changing pharmacies.
    - Most generics are manufactured by the same companies that manufacture name brands and often in the same facility.

- **Why are prescriptions given away at the on-site clinic?**
  - Although drugs are given to the patient, they are not free to the Trust. CareHere checks their purchase price against the cost to the plan through BCBS/Medco.
  - CareHere will only stock a drug that they can purchase for the County at a price below the BCBS/Medco product price. If they cannot save Sumner County money, CareHere does not stock the item and will instead write the patient a prescription.
  - Many times the drug you get at Walmart or other discount drug stores for $4.00 might cost the County $1.00.
  - CareHere does not mark up the cost of the drugs given out in the clinic. The Trust is charged exactly what CareHere pays for the drug.
  - Drugs must be pre-packaged (sealed) to be dispensed in the clinic without a pharmacist.
  - NO NARCOTIC DRUGS ARE EVER STORED OR DISPENSED THROUGH THE CLINIC.

- **My doctor is not in the network or has dropped out of the network. Why?**
  - Three of the common reasons a doctor, hospital, or other provider is not in a network are:
    - Networks require that a provider agree to reduce their charges by a certain percentage. Some providers have all the patients they need and do not want to receive less for their services.
    - Networks conduct extensive credentialing (checking a providers history, outcomes, complaints, etc) and some do not measure up to the standards of the network.
Some networks have multiple payment centers while others have one or two. Providers spend a great deal of resources in dealing with insurance companies and trying to receive payment for the larger portion of your expense.

- **How can I get my doctor in our network?**
  - Ask the provider to join and let them know that if they do not you will have to change doctors or hospitals.

- **My doctor has always been in our network. Can I assume that they are in the network the next time I go to the doctor?**
  - No. You should ask at the front desk EVERY time you go in; before you are seen by the staff.
  - A doctor group may be in a network but an individual doctor in that group may not be. So, you should ask.

- **If I go into the hospital for surgery can I assume that everyone who works on me will be in the network just because the hospital is in my network?**
  - No. There are doctors who are employees of the hospital called “hospitalists.” These doctors will be in the network. However surgeons, anesthesiologists, those who take and read x-rays, CT scans and MRI’s are generally contracted and may not be in the network.
  - You should make it clear in the business office, when you schedule your stay, that you expect everyone who works on you will be in the network. Let them know that you will not be responsible for any extra charge for the use of a non-network provider working within their facility. Get it in writing.

**Reminder!**

- **You must get your HRA blood draw**
  - You must have an HRA between February 1, 2013 and July 1, 2013.
  - After having your HRA completed, you must review the results with a provider and develop a plan to address any identified issues.
  - You must work any program developed by you and your physician for 180 days.
  - Your progress must be certified by your physician and submitted to CareHere for processing and ultimate notification to the employer for plan placement by March 1, 2014.