SELF-FUNDED HEALTHCARE OVERVIEW

FREQUENTLY ASKED QUESTIONS

BENEFITS QUESTIONS

- For general benefits questions, contact Risk Management Benefits Team- Lori Beining, Monica LaRocco, and Tracy Urello- at 727-588-6197 or Risk-Benefits@pcsb.org.
- For specific questions about your individual plan or claims, contact the on-site Aetna Claims Advisor- Catherine Jackson- at 727-588-6367 or PCS.JACKSONC@pcsb.org.

DISTRICT HEALTH PLAN

- PCS has a self-funded health insurance plan. This plan is more cost effective than a fully insured model because the employer pays only for the health care services employees actually use, rather than fixed insurance premiums.
- As of May 2026, 8,333 employees and retirees participate in the plan, with 15,510 total members including dependents and spouses.
- Health care costs over the years have increased:

	2023	2024	2025
School District Contributions	$110,187,731	$112,604,926	$117,164,897
Employee Contributions	$32,257,103	$32,202,114	$32,929,069
Total Contributions	$142,444,834	$144,807,040	$150,093,966
Total Costs	$146,344,917	$146,923,464	$170,654,889
Total Gain/(Loss)	($3,900,083)	($2,116,424)	($20,560,923)

SELF-FUNDED INSURANCE

1. What is a self-funded health care plan?

A self-funded health care plan is where the employer (PCS) pays employees' medical claims directly instead of paying a traditional insurance company to assume the financial risk. PCS has had a self-funded health care plan since 2016. Self-funded plans give employers greater flexibility to customize benefits, access to claims data to better manage costs and wellness programs and allow for flexibility to tailor claims to our workforce needs.

2. Why is the fund balance in a self-funded health care plan important?

Self-funded health plans are required by Florida law to maintain a minimum surplus, commonly referred to as a fund balance (FL OIR 112.08 60-Day Surplus Requirement), equal to at least 17% of annual plan costs (approximately 60 days of expected claims). This reserve helps ensure the plan can pay medical claims, absorb unexpected high-cost claims, and remain financially stable during periods of rising healthcare costs or unusually high utilization.

SELF-FUNDED INSURANCE (continued)

3. Does the PCS self-funded health insurance plan have a fund balance of at least 17%?
No. Due to higher-than-expected medical and pharmacy claims and several years of keeping employee costs relatively stable, the plan's reserve has been significantly reduced. The PCS health care plan had a $20 million deficit in fiscal year 2025. This eliminated nearly all of the fund balance. The District contributed an additional $6 million in 2025 to help stabilize the fund, and rebuilding the reserve remains a priority.

4. Since the fund balance is low, what has been done to build it back up?
Because the fund balance is currently below the required reserve level, changes were made to the 2026 health plan to improve the financial position of the plan and begin rebuilding the reserve. Depending on the plan selected, these changes included premium increases and adjustments to deductibles, copays, coinsurance, and other cost-sharing features.

These changes alone will not immediately restore the fund balance. Rebuilding the reserve will take time and will depend on actual claims experience, utilization, enrollment, and overall plan performance. This also includes additional strategies to reduce costs, improve plan performance, and strengthen the fund balance over time.

5. What happens if the self-funded health care plan does not meet the state required fund balance?
If the health plan is unable to rebuild and maintain the required reserve, the District may be required to transition to a fully insured health plan in the near future. Based on current market estimates, a fully insured plan could increase overall healthcare costs by approximately 40%, representing more than $80 million in additional annual expense paid for by the District and employees.

NEGOTIATING RATES

1. How are annual employee contributions to health care plan determined?
Annual premiums (which are paid through payroll deductions over 10 months) and plan design changes are negotiated through the Employee Wellbeing and Satisfaction (EWBS) Committee each year. Members of EWBS review the self-funded health care plans performance and future trends to make necessary adjustments.

2. How are members of EWBS chosen?
EWBS is comprised of members of PCTA, PESPA, SEIU, and FOP as well as representatives from the District's Risk Management, Finance, and Human Resources departments. Members of each bargaining unit have a representative that speaks for the bargaining unit and ultimately recommends the best course of action for the self-funded health care plan.

3. What types of changes are made by EWBS?
EWBS may recommend changes to premiums for employees, dependents, and spouses. Additionally, EWBS may recommend plan design changes. Plan design changes may include deductibles, co-insurance, pharmacy costs, urgent care/emergency costs, and more. Ultimately, EWBS must ensure that revenue and expenses are balanced within the plan.

NEGOTIATING RATES (continued)

4. What share of the plan do employees pay as compared to the district?
Employees pay approximately 20% of the annual cost of health care. The District pays approximately 80%.

5. Why can't the district continue to fund overages in the plan?
Over the past several years, the District has used available operating funds to help offset health plan deficits. Because Florida law restricts how public funds may be used, the District cannot transfer money from restricted funds—such as capital projects, food service, or grants—to pay health insurance claims. Since the operating revenue has been relatively flat over the last five years due to small increases from the state and declining enrollment, those resources are no longer sufficient to absorb ongoing increases in healthcare costs.

6. Can the district cut operating costs to cover increases in health care?
Yes. In the last two years, the District has reduced its budget over $90 million to cover rising costs in health care, utilities, and employee benefits, including workers' compensation, life insurance, and Florida Retirement System (FRS) contributions, as well as to fund salary increases. This includes a reduction of over 1,000 positions as student enrollment has declined.

7. With so many employees, why can't the district negotiate better health costs?
The District continually works with its consultants, third-party administrator, pharmacy benefit manager, and provider networks to negotiate competitive pricing, review high-cost claims, evaluate pharmacy strategies, and identify cost-saving opportunities while maintaining quality care.

While the District works to secure the most competitive rates possible, there are limits to how much costs can be reduced through negotiation alone. Insurance premiums are influenced by several factors, including the overall health and claims experience of the covered group, rising healthcare and prescription drug costs, local hospital and provider pricing, and market conditions.

8. What improvements might employees see in the future?
The District will continue exploring opportunities to enhance employee health and reduce long-term healthcare costs. Potential future initiatives may include: wellness clinics, care management programs, expanded preventative care and wellness programs, enhanced health education, and other options.

The goal of these initiatives is to create a healthier workforce while helping keep the health plan financially sustainable. When employees have better access to preventive care, education, and care management, they are more likely to address health concerns early—often avoiding more serious illnesses and expensive treatments later. This helps improve health outcomes, enhances the employee experience, and supports efforts to keep future healthcare costs as affordable as possible for everyone.

9. How do other districts charge their employees for health care?
Most Florida school districts contribute a significant portion of the cost of employee health insurance for a basic plan. Employees typically pay more if they choose a higher-cost health plan or enroll in a spouse or dependents. The amount employees pay varies by district and is based on factors such as health care costs, plan design, and collective bargaining agreements.

NEGOTIATING RATES (continued)

10. Are other districts struggling with health care costs?
Yes. Rising healthcare costs are a challenge for school districts across Florida and throughout the country. Increases in medical and hospital costs, prescription drug expenses, and overall healthcare utilization have led many districts to experience higher insurance premiums. While each district's costs vary based on its employee population, claims experience, and local healthcare market, managing rising healthcare expenses is a common challenge facing public employers statewide.

NEXT STEPS

1. What can we expect to happen next?
The proposed health plan rates and design changes will be presented to the School Board for consideration and approval.

Risk Management will communicate all Annual Enrollment information—including plan changes, premiums, educational resources, and enrollment deadlines—through district email, the weekly Risk Management Update, the employee benefits website, and other communication channels.

Annual Enrollment will take place from October 14, 2026- November 2, 2026, giving employees the opportunity to review benefit options and make elections for the 2027 plan year.

2. When can I make changes to my benefits?
Employees can make changes to their benefits each year during Annual Enrollment which will take place from October 14, 2026- November 2, 2026. During this period, you can enroll in, change, or cancel your medical coverage and other eligible benefits.

Outside of Annual Enrollment, you may only make changes if you experience a qualifying life event, such as marriage, divorce, the birth or adoption of a child, or a loss of other health coverage. Any changes must be made within the required timeframe following the qualifying event.

Visit Changing Your Insurance/Life Events page for more information.

3. What can I tell employees is their role?
The ultimate goal is better health, better use of healthcare resources, and sustainable benefits. Employees have an important role in a successful healthcare program by using preventative services, choosing the appropriate place for care, understanding available benefits, participating in wellness and care-management resources, and making informed healthcare decisions can help improve individual health and the overall health of the program.

BENEFITS QUESTIONS

- For general benefits questions, contact Risk Management Benefits Team- Lori Beining, Monica LaRocco, and Tracy Urello- at 727-588-6197 or Risk-Benefits@pcsb.org.
- For specific questions about your individual plan or claims, contact the on-site Aetna Claims Advisor- Catherine Jackson- at 727-588-6367 or PCS.JACKSONC@pcsb.org.