# OPEN ENROLLMENT FY16-17
# FREQUENTLY ASKED QUESTIONS

***If you have a general question that has not been addressed on this list, please email the HRDesk (HR@gilbertaz.gov) to have it added. Thank you!***

**Q-1:- Why are these changes necessary?**

*A – Our health trust fund is seeing an increase in medical and pharmacy costs, including an above ordinary number of large claims, which is negatively impacting the strength of the find. The changes are necessary to keep the fund sustainable.*

**Q-2: Why didn't employees receive any warning this was happening?**

*A – The decline in funds happened very quickly. It began in November 2015, during the 2nd quarter. It was initially identified during the quarterly Board meeting on February 16, 2016, reviewing financial reports as of December 2015. Staff informed Council at the first opportunity, which was the study session of March 1, 2016. Executive Team, Second-In-Command, and Supervisors were briefed shortly after. At the time, the Board knew we would need increases in premiums and possible plan changes but no details had been identified yet. There was a limited amount of time to make the required changes to sustain the fund. As soon as specific information was identified and approved, it was shared with employees.*

*The information regarding the trust and changes to premiums and plans is very complex information. Staff shared presentations with the Town leadership so they could give context to the information within department meetings. Because there was limited time, and because information moves quicker through the grapevine, than through town mechanisms, some employees had information before others. Our interest is in sending out information that is accurate as well as timely. In response to questions as to how this happened, staff arranged several employee sessions to explain the fund, how it works, and what is occurring that is causing these changes.*

**Q-3: I hear we are self-funded. What does that mean?**

*A – Self-funded means we pay our premiums into our health trust fund rather than pay our premiums to an insurance company. When premiums exceed expenses, we retain those funds rather than the insurance company retaining the funds. We also have more control over the premium increases, based on claims activity. A board of Trustees oversees the fund and pays out claims and fees from the fund for the plan year. The intent of the fund is to collect enough premiums for the year to cover the expenses (claims & fees) for the year, and sustain a reserve of approximately 3 months of claims, which equals approximately $3.5 - $4M.*

**Q-4: Our premium increase seems very high this year. What is a normal increase?**

*A – National increases range from 2% - 10% year over year. Regionally they range from 4% - 7% year over year. Historically we have remained well below the average, with either no increase at all, or an increase of 2% - 3%. This year, the claims activity of our members is very high and we need to collect premiums to cover those expenses.*

**Q-5: Will we have premium increases this high next year?**

*A – The premium increases this year are projected to allow the fund to break even in FY17 but not rebuild necessary reserves. The Board will monitor the claims activity through the year to determine what will be needed for increases next year. We do not yet know what the activity will be, nor do we know how long it will take to rebuild the fund. This will be a multi-year process and we anticipate increases for multiple years, however we will not know what those increases will be until we have some claims trends to analyze.*

**Q-6: Will plan options change next year?**

*A –The number of people on each of the FY17 plans, and claims activity, will determine whether additional plans are offered in FY18. The Board and Staff will evaluate throughout the year and decisions will be made in early spring 2017.*

**Q-7: How were the plans chosen?**

*A – The Health Trust Board worked with town staff and actuaries from Mayo, our plan administrator, for guidance. They look at the norm in the marketplace, both on a national and local level, and then look at our specific member demographics and our fund activity trends. There was a lot of discussion and the interest was sustaining the plan, and giving the employees some options, but not too many options to be overwhelming.*

**Q-8: Are these plans the same as our neighboring communities?**

*A – The Preferred plan is very comparable among our neighboring communities and within the marketplace, though all plans vary in some way. The Legacy plan is not common in the marketplace any longer, but the Preferred plan is among the norm for deductible plans. Many of our comparable organizations offer three plan options, including a higher deductible option. All plans vary in deductible, co-pay, and out-of-pocket amounts, which makes it difficult to compare. The Board may consider other options in future plan years.*

**Q-9: Are these premiums affordable?**

*A – The Legacy premiums are much higher than previous years however the cost-sharing is weighted very heavily to the fund. The premium for the Preferred plan is lower because that plan shifts some of the cost-sharing toward the member. This is normal in the marketplace, and it is considered "affordable" under the Affordable Care Act. This specifies that we must offer an option where the premiums are no more than 9.5% of the lowest paid employee's salary. The Preferred plan meets that requirement.*

**Q-10: Do I have to choose a plan?**

*A – You have to choose one of the Town's plan options OR complete a Waiver of Coverage form. You are required to have insurance and could be subject to IRS fines if you do not have proof of insurance coverage.*

**Q-11: Do I have other options?**

*A – You can shop for insurance coverage on healthcare.gov, however you are not eligible for a subsidy, and you must do this within 30 days of a qualifying event. Open enrollment IS a qualifying event. Also, you may have access to insurance through a spouse's plan, or if you are 65 or older, you may have an option through Medicare. You should consider all options available to you. If you do not choose one of Gilbert's plans, you MUST complete a Waiver of Coverage form.*

**Q-12: If my spouse has open enrollment in October, can I switch plans then?**

*A – Yes. A spouse's open enrollment IS a qualifying event. You would need to complete a change form and supply proof of other coverage. The change request must occur within 30 days of the effective date of the new coverage. Other qualifying events, such as change in marital status, can also allow you to change your coverage within the plan year, outside of the open enrollment period.*

**Q-13: Can I adjust my Flex Spending, or enroll in Flex Spending now?**

*A – Flex Spending runs on a calendar year, so open enrollment for that program will be in December for a start date January 1. The change in health plans is not a qualifying event and there are several IRS compliance items that do not allow us to make changes to the plan mid-plan year. For those interested in participating, or making changes to the Flex Spending program, they must do so during open enrollment in December.*

**Q-14: Do either the Legacy or Preferred plans qualify for a Health Savings Account (HSA) or a Health Reimbursement Account (HRA)?**

*A – To qualify for an HSA or an HRA, you must be on a high deductible health plan (HDHP). In 2016, the minimum deductible amounts to qualify are $1,300 for single and $2,600 for family. Our Preferred plan offers a low deductible of $500/$1,000, therefore does not qualify. For more information on HSAs & HRAs see the IRS guidelines at https://www.irs.gov/pub/irs-pdf/p969.pdf.*

**Q-15: Is our out-of-pocket (OOP) maximum reasonable?**

*A – Out-of-pocket maximum amounts vary from plan to plan. The highest OOP maximum allowed in 2016 is $6,850 for an individual and $13,700 for a family (www.healthcare.gov). Comparatively, our OOP maximum of $2,000/$4,000 for both plans is relatively low.*

**Q-16: Why don't we have four tiers (Employee, Employee & Spouse, Employee & Children, & Family) like some of our comparable organizations?**

*A – The tier system varies among different organizations. Actuaries with our plan administrator review our demographics often to make sure we are using the tier system appropriate for the needs of our fund. The Board and Staff will evaluate this again for the FY17-18 plan year to see if changes are necessary.*

**DEFINITIONS**

**Co-insurance** – The percentage that the fund and member pay, once a co-pay and/or deductible is paid. This is up to the maximum out of pocket amount. In the Legacy plan the co-insurance is paid 100% by the fund. In the Preferred plan the co-insurance is paid 80% by the fund and 20% by the member. This is for the "paid amount" or "negotiated amount" NOT the billed amount that you will see on an Explanation of Benefits (EOB) form. Expenses for items not covered under the plan do not count toward the co-insurance.

**Deductible** – The amount the member is responsible for before the co-insurance goes into effect. Co-pays and pharmacy costs do not count toward the deductible. An individual must meet $500 in costs, and then that member is responsible for 20% in co-insurance for remaining costs for the remainder of the plan year. If family coverage, the remaining family members must reach a combined $500 to hit the $1,000 family deductible, and then the family is responsible for 20% co-insurance for all family members. The deductible must only be met once. This does not apply to the Legacy plan as there is no deductible on this plan. Expenses for items not covered under the plan do not count toward the deductible.

**Out-of-Pocket Maximum (OOP)** – The maximum amount that an individual or family will pay in a plan year, before the plan starts to pay 100% for all covered essential health benefits for the remainder of that plan year. On both plans, the individual OOP maximum is $2,000, and the family OOP maximum is $4,000. All covered expenses paid (deductible, co-pays, co-insurance, & pharmacy) count toward the OOP maximum. Expenses for items not covered under the plan do not count toward the OOP maximum.