Benefit Insights

April/May 2013

A Newsletter for Clients and Friends of Century Benefits Group, Inc.

Why Are Health Insurance Premiums Increasing?

It was a bright and shining promise: The President and Congressional allies passed the Patient Protection and Affordable Care Act (colloquially known as "ObamaCare") amidst assertions that the law would contain health insurance costs. Indeed, President Obama claimed that his health care plan would cause premiums to decline by some $2,500 per year per family by the end of his first term.

Instead, premiums rose by 9 percent in 2011, and another 4 percent in 2012.

Health insurance costs had been rising faster than inflation for years before 2010, according to the Kaiser Family Foundation. This was true for both employers paying group plan premiums and individuals buying their own individual and family coverage on the open market.

There was a brief period where health care costs moderated. But now they are beginning another seemingly inexorable march upward. Why the increases?

Part of the answer lies in a number of new federally-mandated coverages - described as "essential benefits." The law penalizes those who seek to get a no-frills catastrophic policy with a high deductible. And the new federal law mandates, for example, that all workplace insurance plans cover a variety of common health services.

The law also restricts insurance company's ability to limit policy payouts or exclude certain newly mandated items - which naturally tends to cause premiums to increase: The more you demand your policy pay, the more it must necessarily collect in premiums.

For example:

- Insurance companies can no longer decline coverage to minors with pre-existing conditions. This creates an incentive for parents to skimp on premiums until after a child is sick or hurt - while children with high medical expenses remain in the risk pool.
- Lifetime benefit caps are now illegal. It used to be insurance companies would limit their losses to $2 million or $5 million or a similar amount over the lifetime of a single insured. The

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Welcome to the Century Benefits Group, Inc. Newsletter!

Century Benefits Group, Inc. is pleased to present you with our corporate newsletter. We hope the articles in this and future editions will provide insight into an array of employee benefit topics, which may effect your organization. Our firm works in the areas of group health and dental insurance, Group life, disability and vision insurance. Group 401(k) plans. Group and individual Medicare and Part-D plans.

As you may be aware, the Healthcare Reform Act will impact all individuals and groups effective January 1, 2014. Individuals and groups with over 50 full-time equivalent employees will have a federal mandate to have health insurance coverage or pay a tax penalty for not having coverage. Individuals may be eligible for a health insurance subsidy through a state based health benefit exchange. Effective October 1, 2014 New York will have two health insurance exchanges, one for individuals and one for small groups with 50 or less employees. Additional information can be found at www.healthbenefitexchange.ny.gov. New York will also have health insurance plans for individuals and groups outside of the New York State health insurance exchanges. During the month of May we will be hosting healthcare reform seminars in Bath (May 13), Hornell (May 9), Rochester (May 16), Hammondsport (TBD). Look for our invitation to attend.

Our goal is to provide excellent service, competitive pricing, and products tailored to meet the special needs of each client. If your address or email has changed please let us know as we want to keep you informed on future developments regarding employee benefits.

Michael King, CRSP

Century Benefits Group, Inc.
400 White Spruce Blvd. Suite C
Rochester, NY 14623
www.aboutcentury.com

Phone: (800) 458-7805
Fax: (585) 697-3048
mking@aboutcentury.com

Employers Increasingly Embracing High-Deductible Health Plans

More and more employers are offering high-deductible health plans, or HDHPs. These are specially-designed major-medical health insurance plans that come with a relatively high deductible. To compensate for the high deductible, plan participants can contribute pre-tax dollars to a health savings account, or HSA. Money in HSAs compounds tax-deferred, and funds spent for qualified health care expenses are tax free. HSAs are only available in combination with a high-deductible health plan.

Because the plan isn't on the hook for common but small expenses, HDHP/HSA plans are able to save a good deal of money in claims. Part of this savings, of course, flows back to plan sponsors in the form of reduced health care premiums.

These reduced premiums have been a key driving factor in causing employers to migrate to HDHP plans. Case in point: In 2006, only 4 percent of covered workers were covered under an HDHP; as of 2012, that figure had exploded to 19 percent. Likewise, the percentage of workers covered under a plan with at least a $1,000 deductible also exploded, from just 10 percent in 2006 to 34 percent this year. At small employers, the percentage of workers with deductibles over $1,000 was close to half.

Savings Data

According to the 2012 Kaiser Family Foundation's Employer Health Benefit Survey, the average cost to employers was $4,163 per year per worker for an individual plan, while family HDHP plans cost employers $10,409 per covered worker, on average. HMOs, on average, cost employers $4,554 for individual plans and $11,166 for family plans, on average. Other plan types are even more expensive, both for employers and workers.

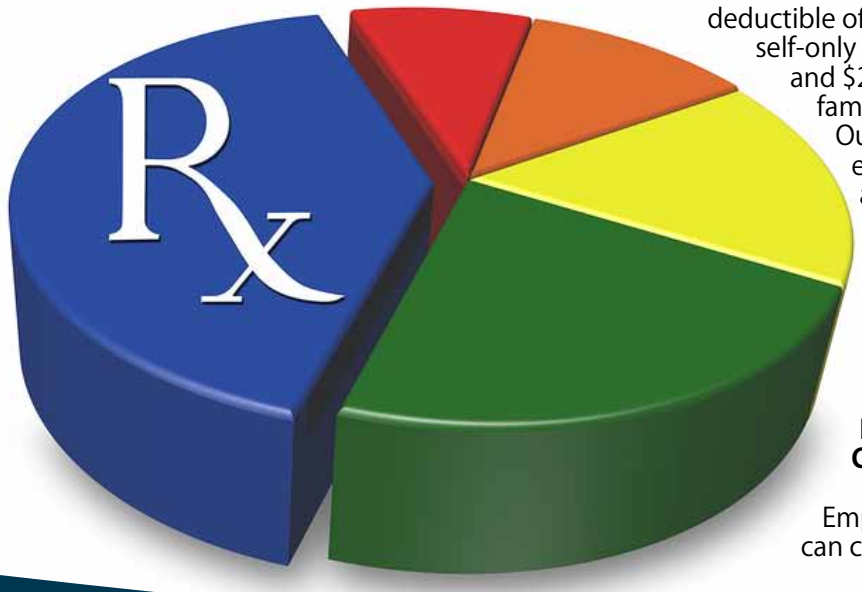
When contributions from employees and employers are combined, the total premium for HDHP workplace plans was $411 for individuals and $1,177 for families. This compares favorably with $468 per month for individual plans and $1,362 for family plans of all types.

Of course, to maximize the efficiency of these plans, the employers and employees can't simply pocket the cash savings. They should also contribute part or all of the premium savings to health savings accounts.

2013 Limits

For tax year 2013, the IRS sets an annual limit of $3,250 for contributions to individual health savings accounts. That limit is increased to $6,450 per year for family plans.

The IRS also sets a minimum annual deductible for health plans to qualify as HDHPs - and thus qualify participants to make deductible contributions to HSAs. For individuals, the health plan must feature a minimum annual deductible of $1,250 for self-only coverage, and $2,500 for family coverage. Out of pocket expenses are capped at $6,250 per year for individual coverage, and $12,500 for families.



Employer Contributions

Employers can choose to contribute to employee HSAs as part of the overall compensation package. Generally, you can't match employee contributions, because that would run afoul of comparability rules. Employers must make a comparable match among all eligible employees. Generally, employers will make contributions gradually over the plan year, since they have no control over the funds once the contribution is made.

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Communication is Key

For most employees in good health, there are advantages to going with an HDHP/HSA combination - especially for those in higher tax brackets. Premiums are lower for the employee as well as the employer, and it's easy for most workers to grasp the value of pre-tax contributions. Some workers, however, focus on the higher deductibles, rather than on the long-term benefits.

Additionally, some workers and families with people with long term, chronic illnesses that require regular medical treatment don't benefit much, or at all, from these plans. Owners and HR managers may want to make other types of plans available for workers who fall into this category.

How Obamacare Will Affect Small Business Owners

Although the Patient Protection and Affordable Care Act passed, many small business owners still do not fully understand all of its implications. Some believe that it will still be repealed, and many employers say they will not make changes until it is absolutely necessary to do so.

A recent study showed that businesses with less than 25 workers may be affected by the new law just as much as the employees of these small businesses. Issues such as the prohibition of barring people with preexisting conditions play an important role in this. One of the topics the study analyzed was where small business owners obtained health coverage. Their situations were similar to those of employees of small businesses. Just as employees of small businesses often paid for private coverage, relied on a family member, or simply went uninsured, small business owners also fell into those categories. The survey showed that about 25 percent of small business owners were uninsured. Close to 50 percent relied on a family member's coverage. Less than 20 percent of employers received coverage through the companies sponsoring their workplace plans.

The study also found that about 60 percent of non-elderly citizens received employer-sponsored health insurance benefits. About 60 percent of entrepreneurs with private insurance earned as much as 400 percent more than the poverty level, which would give them tax credits under the PPACA. More than 80 percent of the small business owners without insurance would qualify for health coverage that is subsidized.

Financial Impact On Businesses & Workers

For employers with a workforce as small as 10 or larger than 500, experts predict that the per-worker cost of health insurance will rise more than six percent in the near future. In order to reduce the impact of the cost increase, employers plan to lay the costs on workers' shoulders. While most employers do not plan to cancel their health benefits, smaller companies are more likely to cancel their plans. More than 15 percent of employers said they would likely terminate their health plans after the PPACA has been fully implemented. While many changes will not take effect until 2014, the following changes should be expected beforehand and will affect self-employed people and small businesses.

- States must decide whether they want to use their own exchange programs or use a federal default model. Exchanges make it possible for individuals and employers with up to 100 workers to shop online for coverage options. Also, exchange enrollment will open after setup is complete.

- In years past, employers received a tax credit for up to 35 percent of their contributions to employee health plans. When the PPACA goes into effect in 2014, that rate will jump to 50 percent.

- From 2013 onward, W-2 tax forms will have an extra line showing benefits employees receive from employer-sponsored health plans. The purpose of this is to make spending and benefits more transparent. In order to gather that information, companies may have to pay more for W-2 preparation.

- Married couples earning a joint income of more than $250,000 or singles earning more than $200,000 will pay a Medicare tax of almost four percent on any annuities, dividends, investment interest, investment income, rents and royalties.

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Affordable Care Act eliminates the cap: Insurance company loss exposure on any given individual is theoretically unlimited.

- Insurance companies must now fully cover a variety of wellness checkups and preventative care services. A hotly-contested provision of the law requires insurers to provide access to birth control and contraception services with no deductibles or co-pays.
- Insurers cannot charge women higher premiums than men, even though women of child-bearing age tend to incur higher health care costs. This would tend to decrease premiums for women, while increasing premiums for men to compensate.
- Plans must allow adult children of planned members to remain in the pool well into adulthood.
- The law also limits the ability of insurance companies to charge higher premiums on older Americans. In essence, this means that insurers must raise rates on younger and healthier people in order to subsidize coverage on older Americans. As a result, younger Americans in their 20s and 30s will likely see premiums go up.
- Congress has added a 10 percent tax on medical devices. This increases costs to the consumer and insurance company alike. Premiums must rise to compensate.

Adverse Selection

Another big potential driver of premium increases is the phenomenon of adverse selection. In health insurance, this occurs when healthy people withdraw from the pool to save on premiums. The sick, however, are more likely to stay in. Insurers must then raise rates to compensate for the sicker risk pool, which forces more healthy people out of the pool, which forces carriers to raise rates and so on.

Congress attempted to ameliorate this by imposing a requirement that individuals stay covered - and charge them a special tax if they do not buy insurance. However, the penalties are much less than health insurance premiums, for the time being. Which means that many healthy individuals are deciding there is something they would rather do with their money - especially when their premiums are artificially high to subsidize older workers' health insurance premiums.

Health Insurance Exchange Programs Paired with Defined Contribution Plans

Employers' desires to limit health insurance costs and the new federal health care reform legislation are both contributing factors in the increased interest of private health insurance exchanges and defined contribution (DC) benefit plans. Recent research revealed this finding.

The report notes that reforms to the insurance market and rising costs for medical care have resulted in a heightened interest in placing limitations on health care cost exposure for employers. This is especially true of the health insurance exchange structure, which was defined in the 2010 Patient Protection and Affordable Care Act. This act is commonly referred to as the PPACA.

This research project also showed that many employers are interested in offering private health insurance exchange programs. With these options and a defined contribution approach, employers will be able to work quicker toward a massive consumer-driven market. They will also have more control when it comes to health care contribution costs, capping contributions and shifting authority to workers for controlling their own terms of personal coverage.

If and when employers start offering health exchange options with DC plans will depend on several factors. Researchers also say that that whether it will happen on a large scale is still uncertain. However, many researchers believe that employers' interests for lowering their risks with health benefits coupled with the new PPACA regulations is indicative of a field that could grow considerably.

Researchers also note that employers have been interested in the concept of mixing DC plans with health benefits far before the PPACA was even suggested. However, they never took further steps toward developing such a combination for several reasons. First, they were worried that a great number of employees would not be able to easily obtain individual coverage. Costs in the past have been very prohibitive for many individuals. Second, they did not want to drop group coverage in place of suggesting personal policies.

With the exchange structure from the PPACA unfolding and the insurance market reforms taking place, employers see this as an opportune time to make changes. By providing fixed-dollar contribution amounts to workers who want to buy their own policies, employers are also able to reduce their own health care insurance liabilities.

This research project did not find the only favorable outcomes to be enjoyed by employers. There were also benefits for workers. People who work are able to find a wider variety of competitive and attractive plans with so many insurance companies striving for their business. On the other hand, employers are able to enjoy better cost certainty, which is helpful in times of economic hardship.

CENTURY BENEFITS GROUP INC
EMPLOYEE BENEFIT ADVISORS

Century Benefits Group, Inc.
400 White Spruce Blvd. Suite C Rochester, NY 14623
www.aboutcentury.com

Phone: (800) 458-7805 • Fax: (585) 697-3048
mking@aboutcentury.com

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