Why Group Insurance is MORE VALUABLE than ever

JME
Insurance Agency

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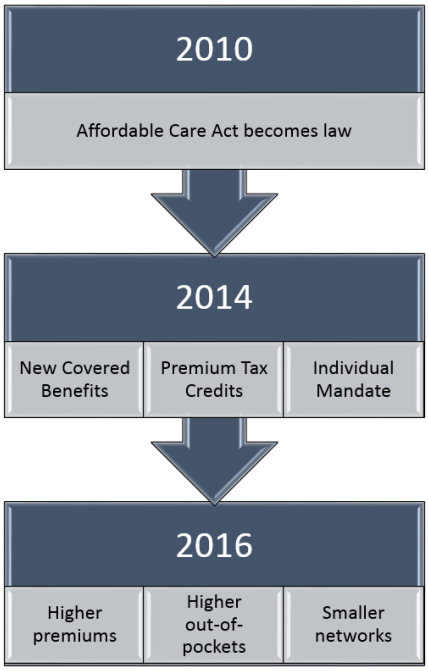
Six years ago, the Affordable Care Act was signed into law. With it came massive changes to the individual health insurance market, including a **guaranteed issue** provision which meant that people could not be turned down or charged more for pre-existing medical conditions; **new covered benefits** including maternity and mental health services; and **subsidies** to help people pay their monthly premiums.



At the time, some employers wondered whether their group health plan would still be a valuable benefit to employees since many of the features that made employer-sponsored coverage attractive to workers were now available to everyone. In fact, some employees reported that individual market coverage was actually more comprehensive and less expensive than their group health plan, which really made employers question the ROI of their employee benefits package.

What a difference a year or two makes!

It's now 2016, just over two years after the first ACA open enrollment period in the individual market, and things are a mess. Insurance companies have found that the individuals purchasing coverage through Healthcare.gov are sicker than they had originally anticipated and, as many feared, that not enough young, healthy people are signing up. As a result, many insurance companies have suffered huge losses and have had to take some drastic steps to stop the bleeding while keeping premiums from spiraling out of control.

Major Changes to Individual Market Coverage

While far from comprehensive, here's a list of some of the big changes in the individual market which have made the plans less desirable to consumers.

Deductibles and Out-of-Pockets Have Increased

In 2017, the maximum out of pocket is increasing to $7,150 for single coverage and $14,300 for family coverage.

Significantly. In the bronze level of the individual marketplace, it's hard to find a plan with a deductible lower than $6,000, and most plans have a total out-of-pocket exposure of $6,850 for individuals and twice that amount for families. In 2017, the maximum out of pocket is increasing to $7,150 for single coverage and $14,300 for family coverage, and you can bet that most plans will once again raise their stop-loss limits. Many people who have health insurance feel that it doesn't cover anything and worry that they could be wiped out financially if they have an unexpected illness or injury.

Copayments Are Disappearing

This doesn't mean that it's now free to go to the doctor or pick up prescriptions—just the opposite. The up-front copayments that members are used to paying when they visit the doctor or get a monthly medication are quickly being dropped from bronze- and silver-level plans, forcing consumers to pay the full price when they need medical care. Instead of paying $30, for instance, when they go to the doctor, members now have to pay whatever amount the insurance company has negotiated with the in-network physician, and that amount is credited toward the deductible and out-of-pocket maximum.

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The good news is that people with a **Health Savings Account** can pay these expenses with tax-free dollars, but the bad news is that, after paying their monthly premium, a lot of people don't have money to fund their HSA. This is causing some individuals to go without needed medical care, and postponing treatment often leads to higher costs as the conditions continue to get worse.

Modified Drug Formularies

To reduce costs and at the same time discourage people with chronic conditions from signing up for coverage, some insurance companies have modified their preferred drug lists, moving some drugs to higher cost-sharing tiers and dropping some from the plan's drug formulary altogether. While healthier individuals aren't really impacted by these moves, those with ongoing conditions are forced to pay a lot more.

Smaller Provider Networks

The most recent and perhaps the most disturbing change for a lot of people is that most insurance companies offering individual coverage have reduced the size of their contracted provider networks while eliminating non-network benefits altogether. This means that anyone with a favorite doctor or hospital now must choose carefully when selecting a plan; picking the wrong one could mean that they have to change providers. And many health care providers, including facilities known for treating serious illnesses, have made the decision to stop accepting most if not all plans purchased through Healthcare.gov, forcing consumers to choose between the doctors and hospitals they depend on and the financial assistance they need.

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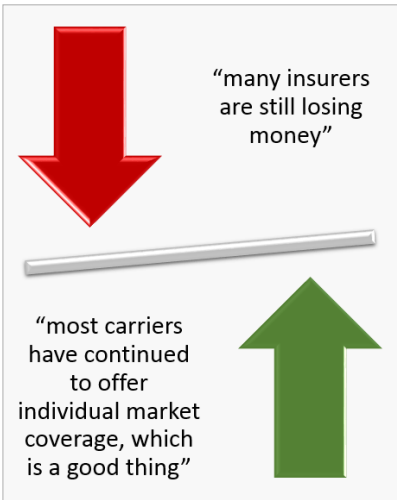

Mixed Results

So far, the efforts by insurance companies to reduce their losses while keeping premiums under control have been only moderately successful. While most carriers have continued to offer individual market coverage, which is a good thing, many insurers are still losing money, even with all of the changes, and most consumers who are not receiving a subsidy to help pay for the cost of their coverage would argue that monthly premiums are far from affordable.

Even worse, most experts expect premiums to rise even faster next year. That's because several of the ACA programs which were designed to reduce the risk to insurance companies during the first three years of guaranteed issue—the risk adjustment, reinsurance, and risk corridors provisions—are due to expire in 2017. Without these protections, insurance companies may be forced to raise their rates even faster than before.

And some insurance companies, like UnitedHealthcare, have made the decision to stop offering individual health plans through Healthcare.gov in most states. There's some concern that other insurers will make a similar decision. On top of that, recent mergers and acquisitions, like Aetna's purchase of Humana and Anthem's acquisition of Cigna, could further reduce competition in the market, which will give consumers fewer plans to choose from.

LONG STORY SHORT

- Fewer insurance companies will be offering individual health coverage in 2017, and the plans will be more expensive and less comprehensive than many consumers would like.
- This will cause people to look for other options.

Employers to the Rescue!

Employers offer benefits as a recruitment and retention tool.

"With all of the recent changes to non-employer-sponsored coverage, many businesses are finding that their group health plan is more popular with employees than ever before."

The apparent demise of the individual market is making employer-sponsored health coverage more valuable than ever to employees. For years, employee benefits in an effort to attract and retain quality employees. While there was no "employer mandate" until recently (for companies with 50 or more employees), most employers saw a value in offering benefits: they served as a great recruitment and retention tool.

With all of the recent changes to non-employer-sponsored coverage, many businesses are finding that their group health plan is more popular with employees than ever before. While some workers, particularly low-income individuals who would qualify for significant tax credits in the individual market to help their families obtain health insurance, may still do better outside of the group plan, the numerous changes in the individual market are causing ACA enrollment to decline: there were fewer people signed up for coverage through Healthcare.gov at the end of the 2016 open enrollment period than there were one year earlier. At the same time, enrollment in employer-sponsored coverage is on the rise; many employees who may have waived coverage in the past are now choosing to enroll in their group health plan.

What this means for the employer, of course, is that group health coverage now offers a higher ROI than in recent years; it's even a better recruitment and retention tool than it was before.

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The Individual Mandate – Another Benefit of Employer Coverage

2016 Individual Mandate Penalty: Greater of

- $695 per adult
  $347.50 per child
  (up to $2,085 per family)
- 2.5% of applicable household income

To this point, we've talked about all of the reasons that people who know they need health insurance would consider employer coverage to be a better option than an individual plan. But, as employers know all too well, not everyone considers health insurance to be a priority, so the fact that the group plan is more comprehensive and less costly than individual coverage may not mean much to some employees.

The good news for employers is that people are now required to have health insurance or pay a penalty thanks to the ACA's individual mandate. Employees who may otherwise have declined the group health coverage may realize that their share of the monthly premium is significantly less than the penalty they would pay if they went without health insurance (a minimum of $695 for an individual or 2.5% of the employee's household income). This is something that employers should definitely be talking about during their enrollment meetings.

A Tax-Free Gift to Employees

The point is this: when companies offer group health insurance and other employee benefits, these benefits are a tax-free gift to the employees. And if a company is going to go to the trouble and expense of offering benefits, it makes sense to offer something the employees will appreciate.

Now, thanks to the individual mandate and some of the recent developments in the individual market, employer-sponsored health insurance is more valuable and more popular than ever. Employers who do a good job of communicating this to their employees have a valuable tool to reduce turnover and increase employee satisfaction.

About JME Insurance Agency

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