Will Health Insurance Premiums Really Go Down?

If you listened to President Barack Obama and some members of Congress talk about health care, you would most certainly believe that your premiums will miraculously go down now that they have passed their very complex health insurance reform bill. On numerous occasions, Candidate Obama stated that a family would see its health insurance premiums go down by $2,500 per year if reforms were passed. You also were told — and might believe — that millions more Americans now will be insured and jobs will flourish. I am going tell you why none of that is going to happen. (This article is based upon information that was available as of March 25.) Let’s take a look at the sections of the Senate bill that impact costs:

1. **Minimum Medical Loss Ratios:** Insurance carriers pay policyholder medical bills in one of two ways: Either through the premium dollars they collect or through investment returns. Currently, in the individual health market, about 75 cents of every dollar is paid out in claims. The balance goes to pay taxes, network management fees, set-asides for required reserves, marketing materials, rate filings, distribution fees, coordination of other governmental programs; about 2.2 percent is left over for profit. The Senate bill requires establishing a minimum loss ratio of 80 percent for individual plans and group plans below 100 lives; 85 percent for groups above 100 lives. What does that mean for the policyholder? Well, less involvement with insurance agents for a start. Agents are very likely to be eliminated from the entire process, or paid so minimally that it will be non-productive for them to sell or offer health insurance for individuals or small groups. Policyholders also may see a reduction in services from the insurance carrier in areas such as case management, disease management, online tools, and the like.

2. **Fees and Taxes:** Beginning in 2014, the bill imposes an $8 billion fee/tax on health insurance companies with $50 million in profits, and assesses the tax on a prorated basis to insurance companies based on profits. Here is the problem. For one of our major carriers here in Florida alone, this new, non-budgeted tax amounts to $116 million. According to industry sources, this tax alone could raise a family’s premiums by $290 to $360 per year.

3. **Community Rating Models:** In Florida, people currently pay according to their age, gender, geographic location, family composition, and overall health as a group. Smaller groups pay by a rate chart, and each person pays according to his own demographics. Larger groups simply blend those demographics into a single or composite rate. If you look at a rating chart today, the lowest figure is for a 20- to 24 year-old male; the highest, a 60- to 64-year-old male. The cost spread between these categories is typically 1:7 or 1:9 times greater (i.e., if the male cost is $100, the female is $700 or $900 on average.) The Senate bill says that this spread has to be 1:3. So, if the lowest rate is $100, the highest rate is $300. The only considerations can be tobacco use and geographic location. They do not want women to pay more than men, even though, statistically, women use far more health care services prior to age 55 than men. Despite the big outcry that carriers must cover preventative care at no cost to the member, premium considerations for wellness are allowed on group plans only “under certain circumstances.” So, if you are a 24-year-old male marathon runner in the best of health, you will be subsidizing the cost of the 64-year-old, 400-pound diabetic with a heart condition. Younger, healthy people will be subsidizing the premiums of the old and the sick. If the initial fines or penalties are as little as $325 per year to take a pass on health-care insurance, most healthy people will wait
until they get sick to hop into the system. The very people — the young and the healthy — who you want to participate in your health pool will have very little incentive to do so, because the carriers will have to cover pre-existing conditions immediately. This is the kind of thing that drives up rates for everyone.

4. **Minimum Benefit Plan Designs:** Many people have resorted to purchasing higher deductible plans to lower premiums or have been taking advantage of lowering their taxes with preferential treatment of HSAs. However, under the Senate bill, a health plan that had a deductible higher than $2,000 for an individual or $4,000 for a family would not be considered “creditable.” They will also prohibit annual limits or lifetime maximums on “essential benefits.” All individual plans will have to cover maternity. Plans will have to cover oral and vision care for children — including “children” to the age of 26. Think about the plan you have now and how much it would be to upgrade it to the minimum benefit standards set forth in this plan.

5. **Reduction of Medicare Reimbursements to Providers:** According to the actuarial and consulting firm Milliman, Inc., every family already pays an average of $1,800 per year in health insurance premium to make up for the underpayments of Medicare. This is often referred to as “cost shifting.” In order to get the total cost of reform to come in below the $1 trillion mark, this reform bill assumes a 21 percent reduction in Medicare reimbursements starting in 2012 and continuing through 2019 — the very time that many Baby Boomers are becoming Medicare eligible.

6. **Employer Mandates:** Unemployment and underemployment today is about as bad as many of us have seen in our lifetimes. Employers are struggling with receivables and many are tapping into personal savings just to keep the doors open. With the exception of growth in law firms, the federal government and mental health facilities, most businesses are struggling. An employer does not have to offer coverage; however, if they employ 50 or more full-time equivalent employees and have at least one full time employee receiving a premium assistance tax credit, they will be required to pay a fine of $2000 per employee, the first 30 employees being exempt. They also cannot make employees wait more than 90 days for coverage. If they do, they will have to pay a $600 fine for every employee not permitted to enroll within that time span.

7. **Individual Mandate:** Just because you don’t work for a company that employs 50 or more people, don’t think that you are exempt from the mandate. You will be required to purchase a “qualified health plan” by Dec. 31, 2013. Failure to do so will result in an IRS penalty of the greater of one percent (two percent in 2015) of your household income, or fixed-dollar amounts that range from $325 per person in 2015 all the way up to $695 by 2016.

8. **Cadillac Plan Tax:** As noted above, health premiums are made up of many factors, including age and geographic location. The federal government picked an arbitrary figure of $10,200 if you are a single person and $27,500 for a family, and decided that any plan that costs more than that per year must have been purchased by a rich person; they imposed an additional 40 percent excise tax for having such a plan. Those figures include not only your health insurance premiums, but any employer contributions to an HRA, FSA, HSA or other supplementary health insurance coverage. However, the reality is that people who tend to have these plans are older people, labor unions, and employees of non-profit corporations.

9. **Additional New Taxes:** The bill contains:
   a. A new $2 billion tax on the manufacturers of prescriptions
   b. A new 10 percent tax on indoor tanning
c. An increase on Medicare payroll taxes from 2.9 to 3.8 percent (that is a 31 percent increase) for single people making $200,000 or more and married people making $250,000 or more

d. A stipulation that you will no longer be able to use your FSA, HRA or HSA to purchase over-the-counter drugs

e. A new $2 billion tax on the makers of medical devices such as pacemakers, and the like

10. Expansion of Medicaid: One of the ways the federal government intends to get more people insured is by expanding the definition of Medicaid eligibility to 133 percent of the poverty level. The cost of Medicaid is shared between the federal government and the states. The problem is, states cannot print money and most have balanced budget amendments so they cannot run a deficit. Of the estimated 4 million uninsured people in Florida, this expansion would add approximately 1.7 million more people to the Medicaid rolls, costing our state billions of dollars. How will Florida pay for that? Our Medicaid budget is already strained to the limit. Will lawmakers have to raise sales taxes, property taxes, perhaps institute an income tax? If they do not raise taxes, what services will have to be cut? Schools, fire, police? Nothing is free. No matter how the state intends to pay for this additional burden, trust me, as a citizen, you will feel it one way or the other.

The bottom line is health insurance premiums merely finance the cost of health care. There is nothing in any of these proposals that will greatly impact the cost of that care. There is no tort reform; there are no incentives to improve quality or delivery of health care; and until our society decides that living a healthy lifestyle is important, we will continue to increase our incidences of morbid obesity, diabetes, heart disease and more. Insurance is expensive because health care is expensive — there is no magic in this.

What can you do? Be vigilant. Be informed. Call your senators and representatives. Let them know you will remember in November what they did in March.

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