

Solutions Spotlight

July 2010

Retirement Readiness by the Numbers

A recent Hewitt & Associates study, consisting of more than two million employees at 84 large U.S. companies, found the average employee will need 15.7 times their final pay in retirement resources to maintain their current standard of living. The survey reveals that Social Security is expected to provide 4.7 times final pay, on average, for employees entitled to full retirement income benefit. This leaves 11 times final pay needed, from other sources, to achieve the full 15.7 multiple. The analysis goes on to conclude that 18 percent of employees who contribute to a defined contribution plan and do so over their full career are expected to achieve retirement readiness. On average, this should produce 13.3 times their final pay (including Social Security) leaving 2.4 times pay unfunded. When factoring in recent market volatility, the average worker who relies solely on their defined contribution plan is projected to meet 74 percent of their retirement income needs. This figure increases to 91 percent for those who are also covered by an active or frozen defined benefit plan.

There is some good news. Workers can significantly improve their situation by making a few small adjustments:

- **Start Saving Today.** Approximately 26 percent of workers who are eligible for a defined contribution plan do not contribute.
- **Regularly Increase your Contribution rate.** Even as little as a 1 percent increase in your contribution rate per year for 5-10 years may keep you on track to meet most of your financial needs at retirement.
- **Work Longer.** Delaying retirement to age 67 can significantly reduce your savings shortfall.

A good employee education and communication plan can help employees meet their retirement goals. Contact Forrest Ross at fross@whafs.com or 800-362-7121 for more information on education and communication strategies that encourage positive savings habits and help employees achieve retirement readiness.

Article courtesy of Retirement Plan Advisory Group

Keeping Your Plan's Grandfather Status

In the June newsletter, we covered the general concept of grandfathered plans under health care reform (those plans that were in place on March 23, 2010), and which parts of the new health care law apply to grandfathered plans, such as dependent coverage to age 26 and children's pre-existing conditions. We also noted that we were awaiting government guidance as to how a plan can be changed without losing grandfathered status. On June 17, 2010, the Departments of Treasury, Labor and Health and Human Services issued interim final rules that made important clarifications on maintaining grandfather status. In evaluating whether to keep your plan, it is important to review the following rules related to maintaining grandfather status.

The regulation allows employers and insurers to make "routine" changes to plans without losing grandfather status. Routine changes will include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws. Under the rules, plans will lose their "grandfather" status if there are significant cuts to benefits or increases to out-of-pocket spending for consumers. However, premium changes are not taken into account when determining whether or not a plan is grandfathered. Compared to policies in effect on March 23, 2010, grandfathered plans:

- **Cannot Significantly Cut or Reduce Benefits:** For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- **Cannot Raise Co-Insurance Charges:** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.
- **Cannot Significantly Raise Co-Payment Charges:** Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next two years, it will lose its grandfathered status.
- **Cannot Significantly Raise Deductibles:** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points.
- **Cannot Significantly Lower Employer Contributions:** Many employers pay a portion of their employees' premium for

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insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15 percent to 25 percent).

- **Cannot Add or Tighten an Annual Limit on What the Insurer Pays:** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, the plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit.
- **Cannot Change Insurance Companies:** If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

Disclosure Requirement - Model Notice

The regulation on grandfathered plans requires a plan to disclose to consumers every time it distributes materials whether the plan believes that it is a grandfathered plan and therefore is not subject to some of the additional requirements of the Affordable Care Act. The plan must also provide contact information for enrollees to have their questions and complaints addressed. Model language that can be used to satisfy this disclosure requirement is available at <http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc>, and is also provided in the interim final rules.

Recordkeeping

Under the interim final rules, to maintain status as a grandfathered health plan, a plan or issuer must also maintain records documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan.

Ways Grandfather Status Can Be Revoked

To prevent health plans from using the grandfather rule to avoid providing consumer protections, the regulation:

- Revokes a plan's grandfathered status if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections
- Revokes a plan's grandfathered status if it is bought by or merges with another plan simply to avoid complying with the law.

For more information on this regulation, visit http://www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html and <http://healthreform.gov/about/grandfathering.html> for Fact Sheets and FAQs. To view the interim final rules, visit <http://www.dol.gov/federalregister/HtmlDisplay.aspx?DocId=23967&AgencyId=8&DocumentType=2>.

For more on grandfathered plans generally, including a timeline of required key changes to grandfathered plans, go to <http://www.benefitsessentials.com/employeebenefits.aspx?ItemID=46114>.

Article courtesy of HR and Benefits Essentials.

Survey: Group Health Insurance Rates Climbing

A survey released recently by the Council of Insurance Agents & Brokers reveals that group health insurance rates are increasing on a wide scale for 2011 renewals.

- For small accounts (50 or fewer employees), 86 percent saw increases and half of those increased 11 to 20 percent.
- 58 percent of medium-sized accounts (51-500 employees) are seeing increases of 6 to 15 percent.
- Of large group accounts (501 or more employees), 51 percent saw rate increases of 6 to 15 percent.

Employers of all sizes are looking at plan design changes in response to the rate increases, including strategies to shift more cost to employees and implementing consumer-driven plans.

Did You Know?

The IRS has announced that HSA limits will remain the same in 2011 as they are now:

- Maximum HSA contribution: \$3,050 (single), \$6,150 (family)
- Minimum plan deductible: \$1,200 (single), \$2,400 (family)
- Maximum out-of-pocket for employee expenses: \$5,950 (single), \$11,900 (family)

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