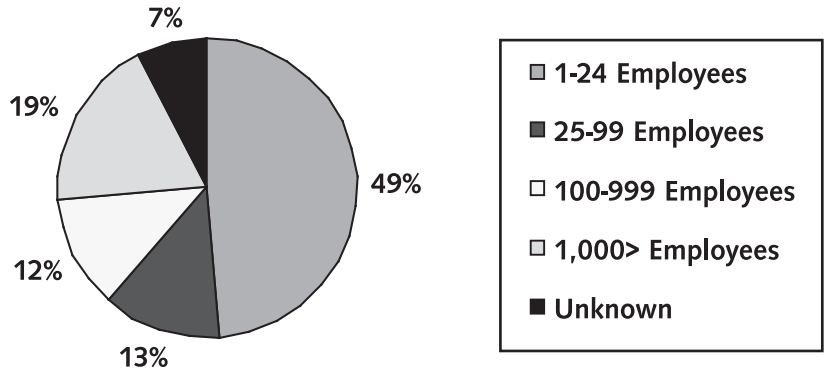
Most uninsured adults have some connection to the workforce. More than half of North Carolina's uninsured adults (ages 19–64) are full-time workers and nearly three-quarters are in a family with at least one full-time worker.[a] Uninsured workers are disproportionately employed by small firms. Although they comprise about one-quarter of all full-time workers, employees of small firms comprise nearly half of North Carolina's uninsured full-time workers. (See Figure 6.1.) Nearly one-third of workers in firms with fewer than 25 employees are uninsured, compared to fewer than 10% of employees in firms with more than 1,000 employees.

Figure 6.1
Employees of Small Firms Comprise Nearly Half of North Carolina's Uninsured, Full-Time Workers



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

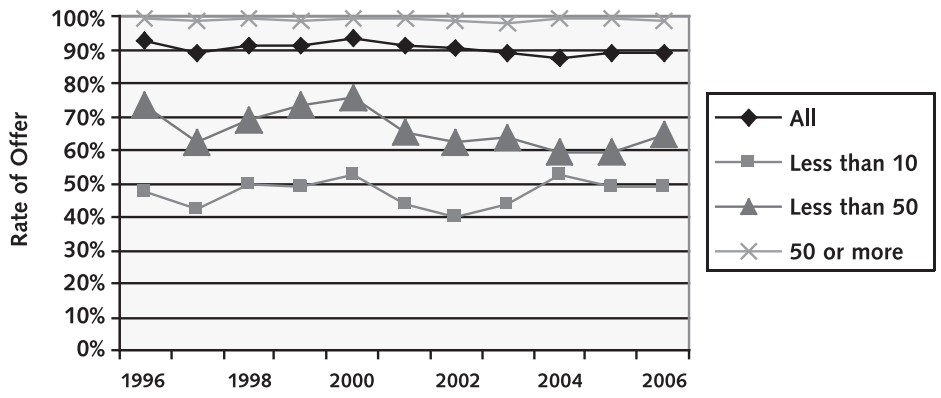
Since 1999-2000, the number of uninsured workers in firms with fewer than 25 employees has increased by 38%, from 244,000 to 337,000.

Small firms are much less likely to offer health insurance to their workers than larger firms. In North Carolina, more than 98% of full-time employees working in firms with more than 50 employees are offered employer-sponsored insurance, compared to less than 50% of those in firms with fewer than 10 employees. (See Figure 6.2.)

Since 1999-2000, the number of uninsured workers in firms with fewer than 25 employees has increased by 38%, from 244,000 to 337,000. At the same time, the number of uninsured workers in firms with greater than 1,000 employees has decreased four percent from 123,000 to 118,000. (See Figure 6.3.)

a Unless otherwise noted, all data on the uninsured are based on North Carolina Institute of Medicine analysis of the Current Population Survey's Annual Social and Economic Supplement, published by the US Census Bureau.

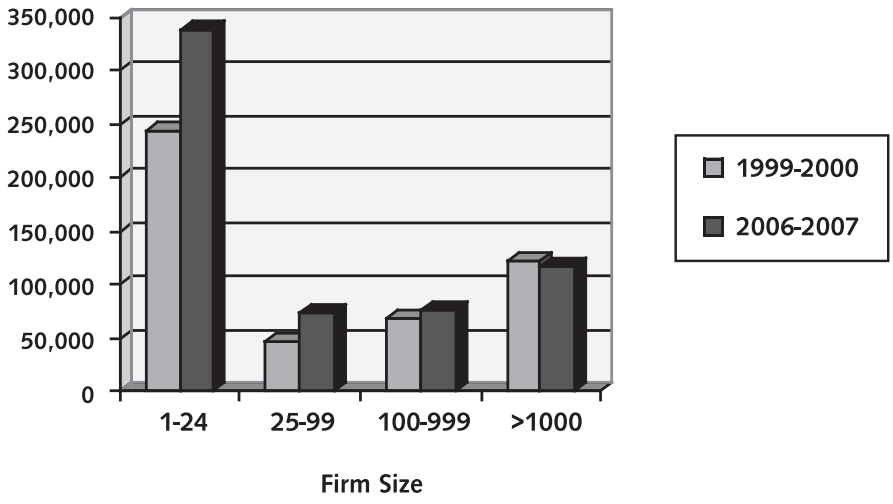
Figure 6.2
Small Firms are Less Likely to Offer Health Insurance to Full-Time Employees



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

Among firms with fewer than 50 employees, the percent who offer health insurance to their employees is lower in North Carolina (62%) than nationally (68%).

Figure 6.3
Number of Uninsured, Full-Time Workers in Firms with Less than 25 Employees has Increased



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

Among firms with fewer than 50 employees, the percent who offer health insurance to their employees is lower in North Carolina (62%) than nationally (68%). This lower rate of offer is offset somewhat by a higher percent of employees who are eligible for employer-sponsored health insurance who actually enroll.[1] (See Table 6.1.) Only 20% of employees who are eligible for coverage do not enroll, and many of the employees who decline may be covered by other sources (such as their spouse). Roughly 40% of those who work full-time for a small employer and who

Table 6.1
Own-Employer Coverage Status for Full-Time Workers at Establishments with Fewer than 50 Employees

	North Carolina	United States
Firm Does Not Offer	38%	32%
Employee Ineligible	4%	7%
Employee Eligible but Declines	11%	13%
Employee Eligible and Enrolled	47%	48%
TOTAL	100%	100%

Source: Estimates derived from Various Tables, Medical Expenditure Panel Survey Insurance Component, 2005-2006. Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Medical Expenditures Panel Survey, 2005-2006. http://www.meps.ahrq.gov/mepsweb/. Accessed December 21, 2008

have employer-sponsored insurance (ESI) are covered under someone else's plan (i.e. as a dependent). Notably, employees without ESI are more than three times as likely (38% to 11%) to be employed in a firm that does not offer insurance as they are to have declined the coverage—that is, the employer's decision whether to offer is more often the barrier to ESI coverage than the employee's decision whether to enroll.

The primary reason for the difference in offer rates between small and large firms is that small employers face higher premium costs than their counterparts in the large group market. The average premium for small (<50 employees) North Carolina firms in 2005-2006 was $4,151, which was $313 higher than the average premium for firms with 50 or more employees ($3,838).[1] These higher premiums are a result of many factors including:[2]

- ***Higher administrative loads:*** Administration costs are 25% of the base premium, on average, for small groups compared to 8%-9% for large groups.
- ***More volatile risk:*** A single high cost event can adversely impact on the premiums charged to small groups, as smaller groups have less ability to pool the high costs among a large number of employees. While North Carolina laws somewhat mitigate the amount by which premiums can be adjusted due to the health claims of the group members, small group coverage is still more expensive than for larger groups for comparable coverage.[b]
- ***Higher risk of adverse selection:*** As costs increase, fewer healthy individuals will choose to enroll, further increasing the cost to those who remain in the group.

The average premium for small (<50 employees) North Carolina firms in 2005-2006 was $4,151, which was $313 higher than the average premium for firms with 50 or more employees ($3,838).

b North Carolina small group laws require insurers to use a community rate for all the small groups they cover as the starting point in setting rates. Insurers can then vary the rates charged for any specific employer based on the age and sex of the employees and geographic location. Insurers can also adjust rates up or down by 25%, based on the claims experience of the specific group.

In addition to facing higher premiums, small employers tend to be more sensitive to costs than larger employers. Research has shown that for every 10% increase in premiums, the probability that a business will offer insurance coverage to its employees is reduced by seven percentage points for firms with less than 100 employees and two percentage points for firms with between 100 and 1,000 employees. Large firms, with greater than 1,000 employees, have very little sensitivity to premium costs.[3]

The Health Access Study Group evaluated several strategies for decreasing the number of low-income uninsured workers in small firms. These strategies include the premium assistance programs discussed in Chapter 5, as well as other strategies discussed below. These additional strategies include using Section 125 plans to lower the cost of insurance to workers in small firms, eliminating groups of one from the small group market, and using public subsidies to lower the cost of health insurance for small employers.

Research has shown that for every 10% increase in premiums, the probability that a business will offer insurance coverage to its employees is reduced by seven percentage points for firms with less than 100 employees and two percentage points for firms between 100 and 1,000 employees.

Section 125 Plans

One advantage of enrolling in employer-sponsored insurance (ESI) is an employee's ability to exclude health insurance premiums from his or her taxable wage base. In order to be eligible for this favorable tax treatment, the employer must establish a Section 125 (§125), or cafeteria plan. Under these plans, an employee's portion of health insurance premiums are sheltered from federal income taxes, Social Security and Medicare payroll taxes (FICA), and North Carolina state income taxes. Section 125 plans also reduce the FICA tax liability of the employer even if the employer does not contribute to the premium cost. (See Table 6.2 for an example of the tax benefits of a §125plan.) The primary benefit of a §125 plan is having the premium payments excluded from federal income tax. As such, the program has a larger benefit for those in higher income brackets.

In addition to providing a tax shelter for employee payments towards group employer coverage, §125 plans can also be used to shelter employee payments towards individual health insurance that meet certain requirements and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from a former employer.[4] Section 125 plans that are used only to shelter employee health premiums are called premium-only plans. Table 6.2 provides an example of tax savings under a premium-only plan. Note that the actual amount of savings will depend on the family's income and tax filing status, as well as the health insurance premium amount. The employer also benefits from establishing a §125 plan, regardless of whether the employer pays for part of the premium price. If an employee uses a §125 plan to purchase insurance in the private market, his or her taxable income will be reduced, thereby reducing the employer's share of the FICA taxes. The decrease in FICA taxes may be sufficient to offset any costs an employer incurs in establishing the §125 plan.

Table 6.2
Sample Tax Savings from Section 125 Tax Sheltering

	Monthly	Annually
Employee premium (before tax savings)	**$250**	**$3,000**
Tax savings through Section 125 plan:		
■ Federal income tax @15%	$38	$450
■ FICA tax @ 7.65%	$19	$230
■ State income tax @6%	$15	$180
Total employee tax savings	$72	$860
Net cost of coverage after tax savings	$178	$2,140
Percentage savings	29%	29%
Employer savings (from reduction in FICA)	$19	$239

Source: Calculations by the North Carolina Institute of Medicine. Data from: Neuschler E. Section 125 ("cafeteria") plans. Presented to: the North Carolina Institute of Medicine Health Access Study Group; December 10, 2008; Morrisville, NC.

Section 125 plans are not available to self-employed individuals or the unemployed. Small firms offering insurance are less likely to have §125 plans than larger employers. Nationally, 92% of employees in firms with 100 or more workers offering health coverage have a §125 plan, compared to only 35% of employees in firms with 2-9 workers and 50% of employees in firms with 10-24 workers.[5] In addition to lowering the cost of health insurance to an employee, the use of §125 plans can also help lower the cost of state subsidy programs (such as that proposed by the Study Group in Chapter 5), by reducing the net cost of the insurance premium that needs to be subsidized.[4]

Nationally, 92% of employees in firms with 100 or more workers offering health coverage have a section 125 plan, compared to only 35% of employees in firms with 2-9 workers and 50% of employees in firms with 10-24 workers.

There are several approaches states have taken to increase the number of employers offering §125 plans. Some states have mandated that certain employers offer §125 plans to employees with certain characteristics (e.g. employees who purchase non-group coverage). Other states have mandated that firms with certain characteristics (e.g. firms with at least 10 employees) provide a §125 plan, and some states require employers who participate in a specific state program to offer a §125 plan (e.g. a state-subsidized program or health insurance exchange).[4]

Study group members did not believe that requiring §125 plans to be offered would reduce premium prices sufficiently to enable many uninsured workers to purchase coverage in the non-group market without an employer contribution. In addition, there were some questions raised about whether health plans offered in the non-group market would meet the requirements for a §125 eligible health plan.[c] However,

c The state non-group laws must comport with the federal Health Insurance Portability and Accountability Act preventing discrimination based on health status to be able to use a §125 plan to shelter premiums from federal and state income taxes. (Butler PA; California HealthCare Foundation. Employer Cafeteria Plans: states' legal and policy issues. http://www.chcf.org/documents/insurance/EmployerCafeteriaPlans.pdf. Accessed January 20, 2009.)

the Study Group did not need to resolve this issue, as members did not think that the tax subsidy would be enough to enable the uninsured to purchase coverage in the non-group market.

Although the Study Group did not recommend that all employers be required to offer §125 plans, the group did recommend that small employers that purchase the public-private partnership Community Care of North Carolina-based plan, described in Chapter 5, be required to offer a §125 plan. This will help reduce the costs of the premium assistance to the state. (Please refer to Chapter 5, Recommendation 5.3 for recommendation regarding §125 plans).

Small Group Reform

In the 1990's, small group health reform laws were enacted by the North Carolina General Assembly to help stabilize the small group market. These reforms apply to self-employed groups of one as well as small businesses with 50 or fewer employees...By limiting the variance in premiums due to health status, the reforms effectively shift costs from the unhealthy to the healthy groups.

In the 1990s, small group health reform laws were enacted by the North Carolina General Assembly to help stabilize the small group market. These reforms apply to self-employed groups of one as well as small businesses with 50 or fewer employees.[d] The reforms include a requirement that insurance carriers provide insurance to small groups on a guaranteed issue basis, meaning that insurance carriers cannot deny coverage to any small groups or individuals within those groups due to health status. In addition, the reforms required that insurance carriers calculate premiums for small groups using an adjusted-community rating methodology. Under this methodology, small group premiums can vary based on the group's age, gender, industry, family composition, and geographic mix. Health status can be taken into account only on a whole group basis and only by a limited amount; specifically, rates for a small group cannot vary by more than 25% from groups with identical age, gender, industry, family composition, and geographic mix.[e] By limiting the variance in premiums due to health status, the reforms effectively shift costs from the unhealthy to the healthy groups. In other words, there is a cap on how much insurers can charge unhealthy groups, the cost of which is shifted to the healthier groups. This shift can induce healthier groups to drop coverage which results in an increase in average medical expenditures (and thus premiums) across the small group market.

In contrast to the small group market, there is no guaranteed issue requirement in the individual insurance market, and carriers can base individual premiums on the health status of those individuals applying for coverage. Because of the difference in these two insurance markets, insurance premiums for healthy individuals may be lower in the individual market than in the small group market. This creates a problem for the self-employed groups of one, who can choose between coverage in these two insurance markets. If the healthy groups of one enroll in the individual market, that leaves the sicker groups of one in the small group market, which drives up the premiums in that market.

Though we would expect the elimination of groups of one from the small group market to decrease the premiums in that market, the true impact of this type of change is unknown. Additionally, the current groups of one in the small group

d NCGS 58-50-110.
e NCGS 50-58-125.

market would likely face higher premiums in the individual market which may cause them to go without insurance. Another potential consequence is that some of these individuals may qualify for and enroll in Inclusive Health, the state's high-risk pool, which could drive up costs for that program in ways that were not anticipated in its creation. Given these uncertainties, the Health Access Study Group recommends:

Recommendation 6.1

The North Carolina Department of Insurance should obtain from insurers the necessary data to study how changing the existing small group rating laws to eliminate self-employed groups of one impacts small group rates. The Department of Insurance should use the data to study:

a) The impact of changes on the cost of insurance for small groups of size 2-50, for those who, under current small group law, qualify as self-employed groups of one, and for enrollees of the high-risk pool.

b) The impact on the total number of covered lives in the small group market and the high-risk pool.

Employer/Employee Subsidies

Another approach to increasing the number of employers who offer health insurance to their employees is to provide subsidies to employers or employees. These subsidies could take several forms including tax credits, premium assistance, and reinsurance.

Tax Credits

North Carolina has a tax credit for businesses that employ 25 or fewer employees and pay at least 50% of the cost of a health plan that meets or exceeds the basic provisions of the basic health care plan recommended by the Small Employer Carrier Committee. The tax credit is equal to $250 per year for each employee whose total annual wages are $40,000 or less.[f] A survey of 5,000 small businesses in North Carolina found that 63% of businesses were not aware of the tax credit, and that the credit would need to be increased to roughly $1,000 to induce them to offer health insurance.[6] Note that the tax credits are not targeted exclusively to firms that previously had not offered insurance, so some of the tax credits are being used to support firms that previously provided health insurance to their employees.

A survey of 5,000 small businesses in North Carolina found that 63% of businesses were not aware of the North Carolina tax credit, and that the credit would need to be increased to roughly $1,000 to induce them to offer health insurance.

Other states have also tried to use tax credits to encourage small businesses to offer insurance. Montana, for example, provides refundable tax credits to small employers (2-9 employees) with employees earning $75,000 or less per year (excluding the owner) who already provide health insurance coverage to their employees. The tax credits are $100 per month for each of the employee and spouse portions of the premiums and $40 per month for the dependent portion. The tax credit is $125 per month for groups with an average age of 45 or higher. The credit cannot exceed 50% of the premiums paid. Small employers who have

f NCGS 105-129.16E.

not offered health insurance in 24 months are eligible to participate in a subsidized insurance pool. This program is also available on a first-come, first-serve basis. The program is funded through a $1 increase in the cigarette tax. Approximately 40% of the funding is used for tax credits (groups previously insured) and 60% is used for the subsidized pool (groups previously not offering insurance).[7]

Premium Assistance

Premium assistance programs provide a direct subsidy for the cost of employer-sponsored health insurance. They can be targeted to the employer or the employee and can target those who were previously uninsured. Federal Medicaid and State Children's Health Insurance Program matching funds can be used for these programs. Premium assistance programs are described in more detail in Chapter 5.

Premium assistance programs provide a direct subsidy for the cost of employer-sponsored health insurance. They can be targeted to the employer or employee and can target those who were previously uninsured.

Reinsurance

Reinsurance is used to lower premiums in the small group market by eliminating some of the volatility related to high-cost individuals. These programs work by effectively providing insurance to insurance carriers by compensating for a portion of the cost of high-cost individuals. Public reinsurance programs work to lower premium costs in the small group market, inducing more employers to join and eliminating some of the adverse selection which occurs when healthy groups and individuals opt-out of the program because it is too expensive.

Healthy NY serves as a model for states looking to implement a reinsurance program. Healthy NY is a state-subsidized reinsurance program that reimburses private health plans for 90% of health insurance claims between $5,000 and $75,000 for eligible individuals and groups.[8] Employers are eligible if they meet the following requirements:

- They have fewer than 50 employees, 30% of whom earn less than a threshold which is indexed annually ($36,500 in 2007);
- They contribute at least 50% of the premium cost;
- At least 50% of eligible employees participate in the program; and
- They have not offered health insurance to their employees in the last 12 months.

Sole proprietors and other working individuals with incomes under 250% of the federal poverty guidelines are also eligible to participate if they have not had health insurance in the last 12 months. A standard benefit plan, with an optional drug benefit, is available through private insurers. All premiums for the program are community rated and have no adjustments. Healthy NY had nearly 150,000 members in 2007, 31% of which were employees of small firms.[8]

In the 2005-2006 Session of the North Carolina General Assembly, Senator Kerr introduced a bill that would have created "Healthy NC," a program modeled on Healthy NY. Under the proposed program, the state would reimburse health plans for 90% of the cost of enrollees with annual health care costs between $15,000 and $75,000, with the expectation that health care premiums would decrease by

30%. The program targeted working, uninsured adults and their dependents. Small employers could have participated if they had 25 or fewer employees, 30% of whom earned $12 per hour or less. In addition, the employer could not have offered health insurance in the past 12 months, 75% of employees must have participated, and the employer must have contributed at least 50% of the premium. Self-employed and other employed individuals were also eligible for the program if their family incomes were at or less than 250% FPG, they did not have insurance for the past 12 months, and they were not currently eligible for employer subsidized health insurance. The program would have used a standard benefit design offered through multiple private insurers. Premiums would have been the same for both the small group and individual participants and would have been calculated in a fashion similar to that used in the current small group market (as described in the Small Group Reform section).

The actuarial firm Milliman provided actuarial projections of the proposed plan, indicating that the program would not have been feasible in North Carolina under the market conditions existing then. Specifically, the projections indicated that the different rating structures across the individual and Healthy NC markets would lead to severe adverse selection, resulting in premium increases.[9] In other words, Milliman estimated that small group premiums under the Healthy NC program would increase rather than decrease, because the program would attract unhealthy individuals who could get insurance on the individual market only at very high premium costs. As a result, there would be no small employer participants in the program because they could get lower premiums in the regular small group market. The total cost of this program was projected to be $12.3 million for an estimated 5,100 individual enrollees.

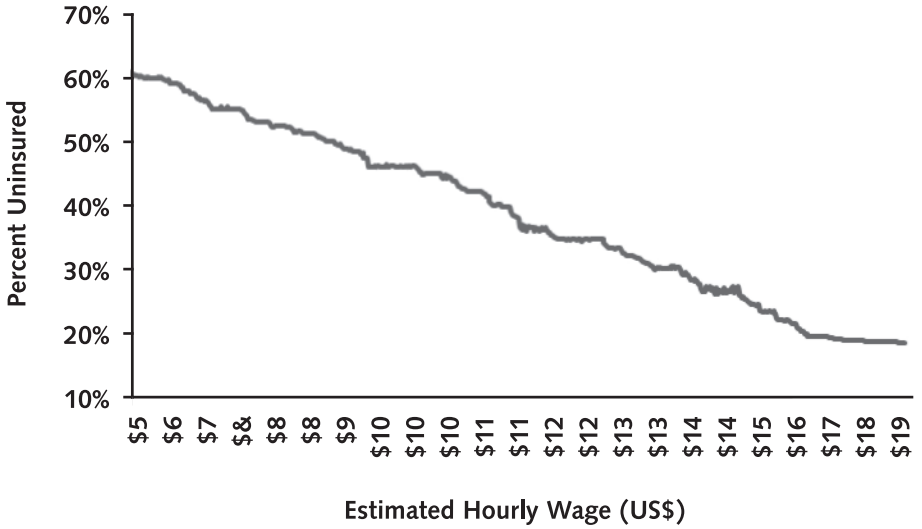
Based of this result, Milliman also estimated the impact of limiting reinsurance to the small group market. Under this scenario, reinsurance would have reduced small group premiums by 17-19%. The total program cost in 2012 was projected to be $11.3 million for an estimated 8,600 enrollees, which exceeded the reinsurance subsidy provided by the state. This would occur because premiums in the individual market are experience rated in North Carolina, whereas the Healthy NC program premiums would combine a portion of the individual and small group market using adjusted-community rating.

One key element driving the higher costs in the Milliman study was the lack of a state high-risk pool. Effectively, Healthy NC would have operated as the state's high-risk pool and covered unhealthy individuals. With North Carolina's operation of the high-risk pool beginning January 2009, the environment is different than that at the time of the Milliman study. Nevertheless, the Study Group was more interested in premium assistance programs than in reinsurance programs for one simple reason: premium assistance programs can target low-wage individuals more effectively than reinsurance programs.

One focus of the Study Group was defining the wage below which full-time workers should receive subsidies. To help guide the recommendations, the Study Group considered the evidence of the relationship between wage and insurance coverage.

Figure 6.4 plots the percent uninsured against hourly wage. Seventeen dollars appears to be a point at which the rate of uninsurance stabilizes. Thus, $17 was the recommended ceiling for subsidies, which translates roughly to $35,000/year for a full-time employee.

Figure 6.4
Seventeen Dollars an Hour is the Approximate Hourly Wage at Which Insurance Coverage Levels Off for Full-Time Workers at Small Firms



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2005-2007, full-time workers in small firms (<25 employees).

The Health Access Study Group recommends:

Recommendation 6.2

a) The North Carolina General Assembly should provide tax subsidies or otherwise subsidize the cost of health insurance premiums for small employers. The subsidy may mirror the following example, but successful programs in other states should be reviewed to determine the appropriate levels of subsidy, income level, and employee participation to ensure that most employers and employees participate in purchasing health insurance.

b) Funding should be targeted to small employers with 15 or fewer eligible employees, at least 30% of whom are low-wage workers earning $35,000 or less per year. The North Carolina General Assembly should provide subsidies that will reduce total premiums by 30% for the low-wage workers. To qualify for a subsidy:

1) Small employers that have not previously offered health insurance coverage must pay at least 50% of the costs of employee coverage and enroll at least 75% of eligible employees who do not have other creditable coverage.

2) Small employers that currently offer health insurance coverage must pay at least 50% of the cost of employee coverage, and enroll 90% of eligible employees who do not have other creditable coverage.

3) **Health plans must include medical management of resources to reduce cost escalation.**

As an illustration of one way this might be designed, consider the following example. (See Table 6.4.) The pre-subsidy column includes current (2005-2006) premium values for small firms (<50 employees). The employer pays, on average, $3,083 per covered employee per year and the employee pays $700 for a total premium of $3,783. If the 30% subsidy were enacted, the amounts paid per high-wage (above $35,000 per year) employee remain the same. For low-wage employees, the government subsidizes 30% of the total premium, or $1,135. There are a number of possible ways to apportion the subsidy between the employer and employee, illustrated by Options 1, 2, and 3. Option 1 demonstrates the allocation if the subsidy were applied against the employer share. The employee receives no decrease in premium, but the average employer share (assuming 50% of employees qualify) decreases by 18%. Option 2 applies the 30% subsidy proportionally between the employee and the employer; each receives a 30% discount. Here, the low-wage employee receives a 30% decrease and the average employer contribution falls by 15%. Finally, Option 3 allocates as much as possible towards the employee, and the employee pays $0. The employer receives a 7% average decrease.

There are many other options not illustrated here, including an employer making the minimum contribution outlined by the recommendation ($3,783 * 50% = $1,892), leaving the low-wage employee with $757. Furthermore, these values are only an illustration and premiums may be much larger than those used here. Different firms may choose different allocation options. Firms that have not previously offered may find Option 1 most appealing; firms that have had trouble meeting the minimum participation may find Option 3 most effective at enrolling low-wage employees.

Table 6.4
State Subsidies Can be Effective at Reducing Premiums for Employers and Employees

	Pre-subsidy		With subsidy		
			Option 1	Option 2	Option 3
Worker	*All*	*High-wage*	*Low-wage*	*Low-wage*	*Low-wage*
Employer (ER) share	$3,083	$3,083	$1,948	$2,158	$2,648
Employee (EE) share	$700	$700	$700	$490	$0
Government			$1,135	$1,135	$1,135
Total	$3,783	$3,783	$3,783	$3,783	$3,783
Min EE share (% of annual income)			2.0%	1.4%	0.0%
Average ER share			2516	2621	2866
(Percent reduction)			18%	15%	7%

Source: North Carolina Institute of Medicine. Analysis of Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2005 and 2006. Two-year weighted averages.

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