Chapter 5

Private Options to Increase Health Insurance Coverage

Employer-sponsored health insurance is the primary source of health insurance for North Carolinians under the age of 65. In 2005, approximately 61% (4.5 million) of nonelderly North Carolinians were covered by employer-sponsored health insurance. However, this reflects a 9% decline in the percentage of North Carolina employees covered by employer-sponsored insurance since 2000. This drop has been concentrated among small employer groups with less than 25 employees. In developing strategies to reduce the number of uninsured in our state, it is important to understand why this population has such difficulty accessing employer-sponsored health insurance and what options may improve access.

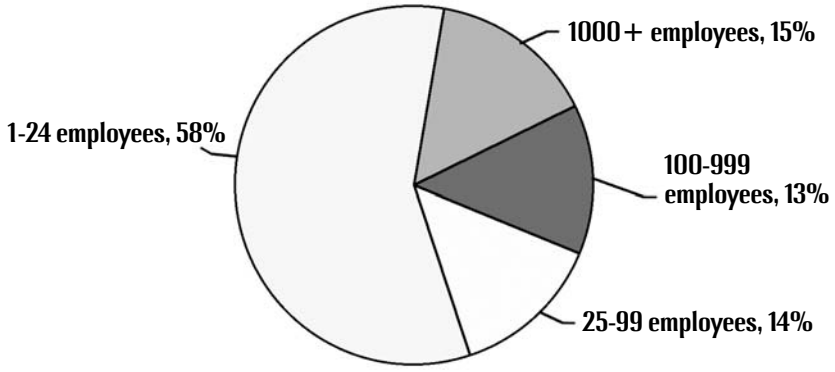
Workers in Small Firms

Employees of small firms are much less likely to have health insurance through their job than employees of large firms.

Thirty percent of the working population in North Carolina works in a small firm with fewer than 25 employees.[1] The population of full-time employees in small firms has a much lower rate of coverage under employer-sponsored insurance than full-time employees in large firms. Only 51% of full-time workers in small firms were covered by employer-sponsored insurance, compared to 89% of workers at large firms.

Although some workers can access health insurance coverage through their spouse or a public program, 34% of all full-time workers in small firms are uninsured, compared to 6% of workers in the largest firms. As a result, full-time, uninsured workers in small firms account for more than half (58%) of all uninsured, full-time workers in North Carolina (see Chart. 5.1).[1]

Chart 5.1
Uninsured Full-Time Workers by Firm Size (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey 2004-2005 (CPS) (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

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North Carolina small-firm employees are less likely to be offered health insurance by their employer than nationally (see Table 5.1), but those who are offered insurance are more likely to enroll than other employees nationally.[2] There are many potential reasons why North Carolina small employers may be less likely to offer health insurance to their employees. Higher health insurance premiums could be one reason for lower offer rates. In fact, North Carolina has higher health insurance premiums for small employers than nationally. Combined data from 2002 and 2003 indicate that the average total premium for North Carolina small firms with fewer than 50 employees was $3,597 per year, compared to a national average of $3,499 (see Table 5.1). By contrast, the average premium for larger firms with at least 50 employees was lower in North Carolina ($3,206) than it was nationally ($3,286).

Table 5.1
Health Insurance Offer Rates and Average Premium Costs in Businesses with Fewer than 50 Employees (2002-2003)

State	Percent Offered Coverage	Average Premium Cost	Percent Who Are Offered Who Enroll
North Carolina	**57.2%**	**$3,597**	**67.6%**
United States	62.6%	$3,499	61.0%

Source: Holmes M. Analyses of 2002 and 2003 Medical Expenditure Panel Survey; Insurance Component, 2002, 2003 (Tables II.B.2, II.C.1, II.C.2). Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends.

Of course, there are many factors driving healthcare costs and thus health insurance premiums.[a] Evaluating the causes of higher health insurance premiums was beyond the scope of the Task Force's charge. However, the fact that the average premium for large employers is below the national average yet the average premium for small employers is above the national average leads one to question whether statewide factors are responsible for the higher small employer premiums. One would expect that factors affecting the state as a whole, such as physician practice patterns, would affect all premiums, not just those in small groups. Regardless of the exact cause, this fact demonstrates one potential cause of the financial pressures inhibiting small employers from offering health insurance coverage.

Policy Options

Healthy North Carolina

Due to the relative difficulty workers at small firms have accessing employer-sponsored health insurance, the Task Force chose to focus its energy on developing health insurance options that would encourage small employers to offer employer-sponsored insurance to their employees. The Healthy North Carolina program is one such option. A Healthy North Carolina program was discussed in Senate Commerce Committee in the 2005 Session as a Proposed Committee Substitute to Senate Bill 255 (PCS to First Edition S255-CSRD). As outlined in PCS 255, Healthy North Carolina was designed to emulate the Healthy New York (Healthy NY) program, which is a public-private

a See, for example, Chapter 4 in this report on Healthcare Cost Drivers.

partnership that utilizes government reinsurance to reduce the cost of health insurance products on the private market for uninsured individuals, small employers, and self-employed/independent contractors that meet certain eligibility requirements.[b]

The Healthy NY program has two main components (see Appendix G for full summary of the Healthy NY program).

1 The program is targeted to the types of workers considered to be most at risk of being uninsured: small businesses with fewer than 50 employees, where 30% of employees earn wages of $33,000 or less and the employer has not offered health insurance coverage in 12 months; individuals meeting income eligibility requirements who do not have health insurance, have been employed in the past 12 months, and are not eligible for public insurance or other group coverage; and sole proprietors[c] meeting income eligibility requirements who have not had health insurance for the past 12 months.

2 The state acts as a reinsurer, reimbursing private health plans for 90% of claims falling within a certain range of claims costs, from $5,000 to $75,000, called the "reinsurance corridor." This reinsurance reduces the expected medical costs to the health plan, allowing private insurers to reduce premiums for the product, compared to similar products offered in the private market.

The Healthy North Carolina program proposed in PCS to First Edition S255-CSRD was developed based upon the Healthy NY program. The proposed Healthy North Carolina program and the existing Healthy NY program differed on both of the points above. That is: (a) the Healthy North Carolina proposal did not include income eligibility criteria to target low-income individuals, and (b) the reinsurance corridor outlined was different. There were other important differences between the proposed North Carolina program and the New York program. Specifically, the benefit design proposed for North Carolina was rich, in terms of covered services and level of coverage, as compared to the existing private, small-group market, while the benefits under the New York program are pared back from the private, small-group products in that state. In addition, the proposal for North Carolina was based on a requirement that all health insurers would participate in the program, while the New York program is based solely upon health management organization (HMO) plans. These differences will impact the size of the program's premiums.

The following outlines the three categories of groups eligible to enroll in the Healthy North Carolina program as outlined in PCS 255.

1 *Small employers* qualify if they meet all the following characteristics.

- Employ fewer than 50 employees in North Carolina.
- Did not offer employer-sponsored insurance in the previous 12 months.

b In 2000, the State of New York instituted Healthy NY, a program aimed at increasing health insurance coverage for citizens of New York. Available at www.healthyny.com. Accessed January 11, 2006.

c The Healthy NY program defines sole proprietor as "the sole owner and employee of a business." This is the meaning of the phrase in this chapter, as opposed to the legal classification of a business (e.g. contrasted with "corporation" or "partnership").

- Assure that 75% of eligible employees participate.
- Contribute at least 50% of the premium.

2 *Individuals* would qualify if they meet all the following characteristics.

- Are currently employed.
- Have no group coverage and are not eligible for employer-sponsored group coverage and/or Medicare.

3 *Self-Employed/Independent Contractors* would qualify if they meet all the following characteristics.

- Are not currently insured.
- Have not been insured in the previous 12 months.
- Are not eligible for employer-sponsored coverage.

The benefit package outlined in PCS 255 is somewhat broader than the typical small group plan in North Carolina and, more significantly, provides for higher levels of coverage (through lower deductibles, copayments, and co-insurance) than products currently offered to small groups. Covered services would include hospital care, outpatient care, physician services, maternity services, preventive care, diagnostic and laboratory services, emergency care, therapeutic care, and blood and blood product coverage. Deductibles and copayments outlined in the proposal are listed in Table 5.2.

Table 5.2
Proposed Healthy North Carolina Benefit Deductibles and Copayments (PCS 255)

Inpatient hospital services	$500 copayment per hospitalization
Surgical services	Copayment of the lesser of either 20% of the cost of the service, or $200.
Outpatient surgical facility charges	$75 copayment
Emergency department services (ED)	$50 copayment, waived if hospitalized following ED visit.
Pre-natal care	$10 copayment
All other services	$20 copayment

The proposal in PCS 255 also required an annual evaluation of the program to be conducted by an independent contractor and paid for with fund monies. The evaluation would analyze program enrollment, the relationship between premium levels and program enrollment, and program cost experience. The contractor would also conduct surveys of covered members, participating insurers, and qualifying small employers, individuals, and self-employed persons.

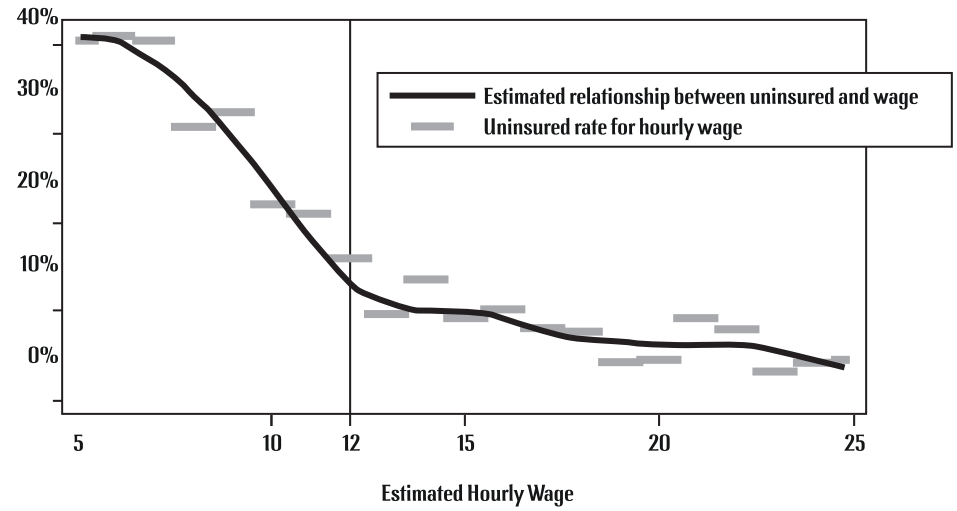
The Task Force reviewed the Healthy North Carolina proposal in PCS 255 and the Healthy NY model and felt that a number of changes could improve a Healthy North Carolina program. Some of those changes include making income eligibility standards more restrictive than outlined in PCS 255 in order to serve the population most at risk of being uninsured and make the program more financially feasible; adjusting the reinsurance corridor; aligning benefits with similar coverage available on the North Carolina private market to make the program more effective at keeping premium

costs to participants as low as possible; and introducing wellness and preventive care incentives to control costs over the long-run.

The Task Force recommended that the eligibility criteria be modified to target firms with 25 or fewer employees that employed significant numbers of low-wage workers, or low-income sole-proprietors or workers. To qualify, the firm, sole proprietor, and/or worker could not have had coverage in the last 12 months. The Task Force recommended that Healthy North Carolina initially be limited to small employers with 25 or fewer employees, as these were the employers that were least likely to offer insurance coverage. In North Carolina, only 29.4% of firms with fewer than 10 employees and 67.5% of firms with 10-24 employees offered coverage in 2002-2003.[3] In contrast, 79.3% of employers with 25-99 employees, 99.3% of employers with 100-999 employees, and 98.9% of employers with 1,000 or more employees offered coverage. Even among small employers, access to ESI is most acute in smaller firms. Of all employees of firms with less than 50 employees, more than 80% of those who were not covered by their firm's health insurance worked in a firm with fewer than 25 employees.[4]

The Task Force also recommended that the Healthy North Carolina program be limited to small employers with low-wage workers: at least 30% of the workers must be earning $12/hour or less. The Task Force picked this wage threshold because analysis of the likelihood of being uninsured suggests that $12 is an important threshold (see Chart 5.2).[1] The dark line represents the estimated relationship between the employee's wage and the likelihood of being uninsured. The gray horizontal lines are the proportion uninsured for a given wage (rounded to nearest dollar). For example, approximately 40% of full-time workers with wages between $5 and $7 are uninsured. Although the likelihood of being uninsured decreases as wages increase, the relationship is weaker at wages above $12.

Chart 5.2
Percent of Full-Time Workers Uninsured by Wage (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. Full-time workers only.

The Task Force recommended that the eligibility criteria for small employers be based on the employee's hourly wages, rather than family income, since the employer would not have access to an employees' income from other sources (for example, a spouse's income). This would ease administrative burdens on the small employer. Conversely, the Task Force recommended that eligibility for sole proprietors or workers not covered through a participating small employer be limited to individuals with family incomes up to 250% FPG ($48,375 for a family of four). Using family income is a more exact method of targeting eligibility to those families that would have financial difficulty purchasing insurance at market rates. Limiting the qualifying population is valuable because it reduces the program's overall costs to the state, while targeting those most in need.

As an example, Table 5.3 provides the income eligibility requirements for individuals

Table 5.3
Income Eligibility Requirements for Healthy NY (2006)

Family Size	Annual Household Income	Monthly Household Income
1	Up to $25,125	Up to $2,094
2	Up to $33,375	Up to $2,782
3	Up to $41,625	Up to $3,469
4	Up to $48,875	Up to $4,157
5	Up to $58,125	Up to $4,844
Each additional person	Add $8,250	Add $688

Source: Healthy NY.

and sole proprietors participating in Healthy NY.[5]

The Task Force also recommended that healthcare coverage eligibility for working individuals not otherwise covered through their employer be limited to those individuals with a strong connection to the workforce. Specifically, the Task Force recommended that those qualifying for Healthy North Carolina as individuals should demonstrate 90 days of employment in the previous 12 months (possibly for multiple employers), in addition to being employed at the time of enrollment. This will help reduce the likelihood of adverse selection (see explanation below) into the plan.

To further minimize the possibility of adverse selection into the plan, the Task Force agreed with the minimum employer participation requirements as set out in PCS 255. To participate, small employers should be required to pay at least 50% of the employees' premium costs and must ensure that at least 75% of eligible employees who do not have other insurance coverage enroll in the plan. Generally, people who are less healthy and likely to incur higher healthcare costs are more likely to enroll and pay for health insurance than those who are healthier (otherwise known as "adverse selection"). Thus, low participation rates—with higher-risk individuals—will increase the average cost per eligible. For example, one study that modeled the effect of adverse selection for a new health insurance product targeted to the uninsured suggested that claims would be 2.29 times higher if only 25% of those eligible participated compared to what would be expected if all eligible people enrolled (see Table 5.4).[6] At 75% participation,

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Table 5.4
Percentage of High and Low Utilizers by Different Enrollment Pentration Levels and Expected Claims Costs Compared (Minnesota, 1991)

Overall Penetration (Enrollment among Eligibles)	Penetration of High Utilizers	Penetration of Low Utilizers	Expected Relative Claims Costs
25%	65%	15%	229%
50%	85%	41%	156%
75%	95%	70%	122%
100%	100%	100%	100%

Source: Bluhm WF. The Minnesota Antiselection Model. Actuarial Research Clearinghouse 199. Vol. 2. Actuarial Education and Research Fund 1991 Practitioners Award Winner.

Reinsurance in the $15,000 to $75,000 corridor might lower premiums by roughly one sixth.

the expected claims cost would be 1.22 times higher than with full participation. The Task Force recommended an additional tax subsidy for small employers who: pay more than 50% of the employees' premium costs, contribute toward the cost of dependent coverage, or have greater than a 75% participation rate among eligible employees who have no other coverage. Providing an additional tax subsidy should help reduce the costs to the employer and the employee, thus making it more likely that small firms and/or low-income employees can afford coverage.

The Task Force also emphasized the importance of ensuring that a Healthy North Carolina program would offer lower-cost premiums than what is currently available on the private market. Therefore, it was suggested that the benefits covered under Healthy North Carolina plans reflect those currently available in the North Carolina market. The benefits described above in the Healthy NY program and PCS 255 are better than what is available, on average, in the private market. Therefore, it was suggested that the benefits be reduced to keep premium costs as low as possible. However, Task Force members recommended that the plan include mental health coverage because excluding this coverage may lead to greater utilization of other health services, such as physician's services or hospitalizations.

The Task Force also recommended including well visits and preventive care incentives, such as an annual physical or a smoking cessation program. Members could be encouraged to use preventative services through deductible or co-pay reductions or a free wellness visit upon initial enrollment. To the extent that preventive care lowers healthcare utilization in more expensive settings, such as the emergency department and inpatient hospital care, enticing members to engage in preventive care will have long-run cost savings. Prescription drug coverage has also been shown to have long-run cost savings. Healthy NY has an option for prescription drug coverage and Task Force members felt that prescription drug coverage should also be available in a Healthy North Carolina plan.

In order for private insurers to invest the resources necessary to develop a Healthy North Carolina product, they must feel confident that the Healthy North Carolina program has long-term viability. If appropriations are insufficient, health plans may discount the value of the reinsurance pool and the premium decrease may be less than anticipated. Therefore, the state will need to appropriate multi-year, adequate, and ongoing funds for a Healthy North Carolina reinsurance program.

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For example, the state of New York allocated $89.4 million to the Healthy NY program in 2003, $49.2 million in 2004, and $22 million for the first half of 2005, allowing unexpended funds to be carried over to future years.

The key element of this plan is the effect of the reinsurance corridor on the expected medical claims borne by the private insurer. A reduction in the claims risks decreases premium costs. Estimates place the expected effect of a $5,000 to $75,000 corridor (the current Healthy NY design) at roughly 32% of claims; the expected decrease due to a $15,000 to $75,000 corridor (the PCS 255 proposal) is roughly 16% of the medical cost.[d,7] This latter number translates to roughly $600 per member per year in 2006. However, the Task Force suggested conducting further analysis of the effects of different reinsurance corridors on premium costs before finalizing a reinsurance corridor for a Healthy North Carolina program. The goal of that analysis should be to determine a reinsurance corridor that would effectively reduce premiums for a Healthy North Carolina insurance product by at least 30% compared to what enrollees would be quoted in the private market.

The Task Force also recognized the need to market the plan in order to achieve sufficient enrollment and spread risk across a large population. Thus, it recommended that funds be allocated for outreach and education and that insurers provide competitive commissions to brokers to encourage them to actively sell the Healthy North Carolina product. These provisions make it more likely that enrollment in the plan will be large enough to reduce risk within the covered population.

Recommendation 5.1:

The NC General Assembly should enact a Healthy North Carolina program, targeted to low-income, uninsured, working individuals, employers of firms with 25 or fewer employees, and self-employed/independent contractors, which offers more affordable health insurance products than what are currently available in the North Carolina marketplace. The health insurance benefits and associated cost-sharing should be closely aligned with current small-group products, with the inclusion of coverage for mental health and prescription drugs.

a) **Eligibility guidelines for the Healthy North Carolina program should be as follows:**

   i) **Employer eligibility is limited to employers with 25 or fewer employees that have not provided group coverage for employees within the last 12 months. At least 30% of the employees must be low income (defined as having an hourly wage of $12 or less, indexed annually by the Medical Component of the Consumer Price Index). To qualify, at least 75% of the eligible employees who do not have other health insurance coverage must elect coverage under this plan. Qualified employers must contribute at least 50% of the premium cost for individual coverage. Qualified employers should receive an additional tax credit to help subsidize some of the premium costs paid in excess of 50% of the premium costs for the individual if: the employer contributes more than 50% of the premium cost for individual coverage, the employer contributes toward the cost of dependent coverage,**

d These estimates were intended to convey the magnitude of the effect on the premium. A more rigorous actuarial analysis would yield more accurate estimates.

or the employer has greater than 75% participation rate among employees who do not have other coverage.

ii) Eligibility for self-employed individuals and independent contractors is limited to those who reside in North Carolina, are low income with family incomes equal to or less than 250% of the federal poverty guidelines, are not currently insured and have not been for the past 12 months, are not eligible for employer-sponsored group coverage, and are not eligible for Medicare.

iii) Individual eligibility is limited to low-income, uninsured individuals with incomes equal to or less than 250% of the federal poverty guidelines who reside in North Carolina, are employed at the time of enrollment and have been employed for a minimum of 90 days in the preceding 12 months, have no group coverage and are not eligible for employer-sponsored group coverage, were not insured within the last 12 months, and are not eligible for Medicare.

b) The NC General Assembly should appropriate sufficient ongoing funds to pay the reinsurance for products offered through Healthy North Carolina and to pay for additional tax credits for employers who contribute more than 50% of the premium cost for eligible employees or toward dependent coverage, or if the employer has greater than 75% participation rate among employees who do not have other coverage.

i) The reinsurance corridor should be set at a level that will result in 30% lower premiums within the Healthy North Carolina program compared to comparable coverage in the private market. Actuarial analysis should be conducted to determine the appropriate reinsurance corridor for meeting the goals of the Healthy North Carolina program.

ii) The Healthy North Carolina program should be authorized to use program funds separately or in concert with the private industry agent community to conduct outreach and education to inform the public about the availability of the new program.

iii) The administrators of the Healthy North Carolina program should be authorized to use program funds to pay for evaluations of the program, to include, but not be limited to: program enrollment, the relationship between premium levels and program enrollment, program cost experience, and eligibility criteria. The evaluation should also make use of surveys of covered members, participating insurers and qualifying small employers, individuals, and self-employed individuals. The findings shall be reported to the NC General Assembly on a routine basis, along with any recommendations for programmatic changes.

c) The insurers should market the program and encourage brokers and others to sell the Healthy North Carolina product by offering competitive commissions.

Small Group Reform

In the 1990s, North Carolina altered its methodology for setting health insurance rates for the "small-group" market, which guide the insurance rates for small-employer groups with 1-50 employees. Small-employer groups have historically been less likely to offer coverage, largely because of the premiums. Moreover, prior to the enactment of the small-group laws, many small employers were simply

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refused coverage by insurers who deemed them to be undesirable risks. In the 1990s, there were also huge variations in the premiums charged to small employers —even those that had similar employment characteristics to other small employers. The small-group reform of the 1990s was an effort to ensure that every small employer could purchase some form of small-group health insurance (i.e., "guaranteed issue rights") to spread the health risks of small employer groups across the entire small-group market, to reduce variations in premium rates, and to make health insurance more affordable for the average small-employer group. The federal law known as the Health Insurance Portability and Accountability Act (HIPAA), enacted in 1997, expanded the guaranteed issue rights previously adopted in North Carolina.

More than 80% of North Carolina workers who work in a firm that does not offer health insurance are governed by small-group rating laws.

The currently used rating methodology, developed in the 1990s, is called an "adjusted community rating with rate bands." The "community rate" is the statewide expected per person annual claims cost for an insurer's entire book of small-group business. The "adjusted community rate" is the differentiation in premium costs from the community rate for a particular small group, based on the small group's "case characteristics," which are defined as age, sex, family composition, and geographic location (see page 86). The rating bands are added to allow some variation from the adjusted community rate, to reflect actual or expected differences in claims experience or administrative costs at the group level. However, this variation is limited to a 20% increase from or reduction to the adjusted community rate.

The central idea behind the adjusted community rate with rate bands is to limit premium variation charged to small groups with similar characteristics and to help make insurance coverage more affordable. Thus, some small groups pay premiums lower than what they would pay if they were rated as an independent small group, while others pay higher premiums. However, there is still substantial variation among groups with differing employee characteristics. For example, the premium for a small group employer may vary widely between a firm with young, healthy employees in a geographically less expensive area and a firm with an older workforce in a geographically expensive area. Premiums may vary by as much as 1,200% for groups with different age composition, geographic location, and expected utilization.

While there is still substantial variation among small groups based on age, sex, and geographical location of the group, small-group reform laws helped reduce the variation among similarly situated groups. Effectively, small-group reform laws helped to reduce the prices that could be charged to the highest cost groups. To do this, the laws also increased the prices that could be charged to the lowest-cost groups. In a sense, the groups paying below-market premiums (highest-cost groups) are subsidized by the groups facing above-market premiums (lowest-cost groups). Overall, the effect of small-group reform laws on health insurance coverage in the small-group market is unclear.

Due to this complicated relationship, the ramifications of modifying the rating policy are difficult to predict. One theoretical approach to the relatively high uninsurance rate in small employers is to lower the rate banding to, for example, 15%. This would decrease premiums for the most expensive groups, perhaps enticing some higher-cost groups to offer employer-sponsored insurance to their employees. On the other hand, health plans would be receiving less revenue for the high cost groups (all groups

with premiums above the 15% cap would pay lower premiums). If covering these less healthy groups caused a resulting increase in claims experience, then the average claims cost (community rate) would rise, thereby increasing the rate for all groups, including the healthier ones. To make up for this revenue loss, insurers may charge higher premiums for healthy groups, which could price healthier small employers out of the market. Conversely, loosening the rate bands, say to 25%, would allow healthier groups to obtain insurance at even cheaper rates—perhaps enticing some to buy coverage—but would make insurance even more expensive for the sicker groups. As shown through these examples, it is unclear whether tightening the insurance bands would ultimately lead to an increase or decrease in coverage.

The Task Force was limited in its ability to project all the potential ramifications of changes to the rules governing rate-setting in the small-group market. In addition to small-group rating laws, there are other factors that affect the premiums charged to small employers or the willingness of small employers to offer coverage. For example, overall medical inflation impacts premium prices (see Chapter 4). There has also been a consolidation in the number of insurers selling health insurance in the small-group market, which might lead to less price competition.[e]

Recommendation 5.2: The NC General Assembly should authorize and fund a study, to be conducted by the NC Department of Insurance, of the impact of small-group reform in North Carolina and potential reforms to the existing small-group reform laws that may increase healthcare coverage among small-employer groups.

a) The study shall consider whether changes to any element of North Carolina's current small-group rating system, to the definition of small employers, or to how rating requirements apply to small employers of different sizes could be expected to result in increased coverage among small employers. In evaluating these questions, the experiences of other states' small-group rating systems should be considered.

b) The NC Department of Insurance should convene a group that includes representation from small businesses, brokers, underwriters, and other experts who can review the data and determine whether changes are needed to existing small-group reform laws.

c) Funding for this study would enable the Department to secure data and expertise from consultants that otherwise would not be available to the Agency.

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e In 2003, there were 32 small-group carriers (29 in 2005). The top five carriers (BlueCross BlueShield of NC, United Healthcare NC, Mega Life & Health Insurance, MAMSI Life and Health, and Wellpath Select) provided health insurance to 84.6% of the groups. BlueCross BlueShield of NC provided insurance to 45.6% of the covered groups. Small-group insurers covered over 53,000 groups or more than 547,000 lives. Burke BM. NC Department of Insurance. (March 2005). Nationwide, small-group markets have become less competitive in since 2002. See "Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market in 2004." Government Accountability Office Report GAO-06-155R. October 13, 2005. Available at http://www.gao.gov/new.items/d06155r.pdf. Accessed March 17, 2006.

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The Task Force thought it was time to review the small-group rating laws enacted in the 1990s to determine if additional changes are needed to make health insurance coverage more affordable. Due to the complicated nature of the small-group rating laws and their interaction with the other provisions of small-group reform laws, the increased consolidation in the small-group insurance industry, and the concern that small employers are dropping health insurance coverage for their workers, the Task Force recommends:

In particular, it is important to understand how these reforms have affected insurance coverage in North Carolina with respect to premiums, cost equity, rates of coverage, and availability of group insurance. Included in the review, should be consideration of the definition of small group (e.g., associations, groups of one), and evaluation should include a comparison to processes in other states and consideration of an employer's industry, size, and geographic location.

The NC Department of Insurance (NC DOI) convened a group to study the small-group laws, in accordance with the recommendations of the Task Force. The Task Force applauds the Department for moving forward on this recommendation, but recognizes that NC DOI will be able to conduct a more thorough study of the issues if it is provided ample resources. For example, the ability of NC DOI to contract with outside consultants that have data from other states will greatly increase the ability of NC DOI to perform a comprehensive analysis. Thus, the Task Force recommends that the NC General Assembly provide the funding necessary to thoroughly study small-group reform laws in North Carolina.

Health Insurance Innovations Commission

The NC General Assembly established the Health Insurance Innovations Commission (HB 1463, SB 1223, Session 2003-2004) in July of 2004 to address two key issues: access to affordable health insurance for the state's small businesses and management of high-cost/high-frequency medical conditions. The NC General Assembly recently appointed members to the Health Insurance Innovations Commission, which has a similar goal as this Task Force. Therefore, the Commission could assist with implementing Task Force recommendations, particularly as they pertain to assistance with research and evaluation of specific programmatic ideas. The Task Force recommends:

Recommendation 5.3:

a) **The NC Institute of Medicine Covering the Uninsured Task Force supports the work of the NC Health Insurance Innovations Commission, whose statutory mandate is to investigate the problems small employers face when trying to purchase health insurance coverage, and to initiate regional demonstration projects to pilot innovative health plans.**

b) **The NC General Assembly should appropriate funds to support the work of the Health Insurance Innovations Commission.**

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Tiered Benefit Plans

Compared to the national average, North Carolina employees are less likely to work in a firm that offers employer-sponsored insurance to their employees (see Table 5.1). However, North Carolina employees who are offered employer-sponsored insurance are more likely to enroll than employees nationally. One interpretation of these facts is that while employees are willing to purchase insurance, employers are reluctant to offer it. Focus group results suggested that some individuals also would like lower-cost insurance plans, and some employers choose not to offer health insurance because they don't believe their employees could afford it. The most straightforward manner to reduce health insurance plan premiums is to limit benefits. Focus group participants expressed a willingness to offer and pay for insurance products that have limited benefits and, thus, are more affordable as long as the plans offer some primary care, hospitalization, and drug coverage.[f]

One possible avenue to encourage more employers to offer health insurance to their employees is to facilitate the offering of *tiered benefit plans*. Tiered benefit plans can exist with many different designs. The most common design has two elements. First, the employer contributes all or a substantial portion of the premium for a "base plan," which provides a more limited array of benefits than conventional plans. Second, the employee has the option to purchase a plan with additional benefits from a list of plans offered by the health plan. This type of plan design provides plans with lower costs to the employer because the benefits are lower than those conventionally provided in comprehensive plans, but allows employees to purchase a richer set of benefits if they desire.

The Tier 1 plan is estimated to cost less than half of the average small employer premium in 2003.

In order to provide some estimates of the premiums that would be likely under such a design, the Task Force directed Mercer Human Resource Consulting to develop cost estimates for one possible tiered benefit design. In practice, each health plan would design their own set of benefits, so the benefit design and associated premiums would vary, but these estimates are useful for guidance.

The tiered benefit plan for which Mercer provided cost estimates is outlined in Table 5.5. There are three "tiers" to this plan. Tier 1 is the most limited benefit plan. It covers up to four physician visits per year (up to $500) with a $25 copay. After a $500 deductible, the plan covers 80% of charges for inpatient care up to $10,000 per year. Diagnostic testing (such as X-ray and laboratory) is covered at 80% up to $250 per year. Emergency room visits, after a $75 copay, are covered up to $150 per year. Prescription drugs are covered up to $1,000 per year with a three-tier copay structure. The estimated monthly premium is $150 for adults and $92 for children. Focus group participants—both employers and individuals—typically expressed a willingness to pay $50 dollars for health insurance per month. The estimated $150, divided equally between employers and individuals, implies that participants would have to pay $75 a month. If an employee pays for the health insurance premiums using pre-taxable income, the equivalent after tax price would be approximately $60, which is only slightly higher than what participants expressed they were willing to pay ($50).

f For more details, see the Appendix D Focus Group Report.

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Table 5.5
Tiered Benefit Plan and Estimated Premiums

	Tier 1	Tier 2	Tier 3
Physician Visits **All tiers: $25 copay**	Max 4 visits, annual max $500	Max 8 visits, annual max $1,000	No visit limit, annual max $2,000
Inpatient Hospital	All tiers: 80% coverage, $500 deductible		
Annual Benefit	$10,000	$25,000	$50,000
Diagnostic Testing **All tiers: 80% coverage**	$250/year max	$500/year max	$1,000/year max
Emergency Room	$150/year max, subject to $75 copay (copay waived if admitted)		
Prescription Drugs	3 Tier copay: $15 generic; $30 brand name when generic not available; $50 brand name when generic available.		
Annual Benefit	$1,000/year	$2,000/year	$4,000/year
Mental/Behavioral Health Services	N/A	12 office visits/year with $35/visit copay. Annual Max $1,000	24 office visits/year with $35/visit copay. Annual Max $2,000
Disease Management	N/A	Disease management services for select conditions.	
Estimated Monthly Premium			
Adult	**$150**	**$232**	**$270**
Child	**$92**	**$99**	**$107**

Tier 2 doubles the coverage for office-based physician services to eight visits and $1,000 per year and increases the maximum annual inpatient benefit to $25,000. Diagnostic and prescription drug coverage also increases. Furthermore, two additional services are covered in Tier 2. Mental and behavioral health services are covered up to $1,000 per year, and disease management programs are also offered for certain conditions. This tier has an estimated premium of $232 a month for adults, which is $82 higher than the Tier 1 premium. Tier 3 increases coverage for some services for an estimated monthly premium of $270 per adult.

There is no doubt that the benefits included in these tiers—especially Tier 1—are very limited. They do not provide catastrophic coverage and, thus, do not prevent personal bankruptcies due to severe illness or injury. For example, the average charge for a stay in a North Carolina hospital in 2003 was $13,761.[8] Given this charge, the annual Tier 1 benefit would be exhausted, and the plan member would be responsible for a balance of $3,761. Furthermore, this charge represents the average *facility* charge; patients are billed separately for physician services while admitted to the hospital.

However, as limited as this type of health plan is, it may be the only type of insurance affordable to some employee groups, thus it could be the only option that some employers would be willing to offer for their employees. Compared to the average monthly premium of $317 for employers with less than 50 employees in 2003,[9] the estimated total cost for Tier 1 represents a savings of approximately 60%. Although the tiered benefits plans have more limited benefits than conventional plans, they could provide some healthcare coverage to individuals who are currently without health insurance coverage.

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Currently, the only potential barrier for the effective design of tiered benefit products into the North Carolina market is the state's mandated benefit laws. The Task Force is not recommending the elimination of mandated benefits; however, some flexibility in the administration of these laws may be needed so that tiered benefit plans can be a more attractive option. Therefore, the Task Force recommends:

Recommendation 5.4: **Private insurance companies should develop and sell tiered benefit packages that offer low-cost health insurance products in North Carolina. The lowest-cost tier should offer basic healthcare coverage, which can be enhanced to include more comprehensive benefits with reduced cost sharing and higher premiums.**

Recommendation 5.5: **The NC General Assembly should provide the NC Department of Insurance authority and guidelines to apply state-mandated benefit laws in a flexible manner in those instances where strict application of such laws would preclude the approval of tiered health insurance benefit plans, or enact a law regarding the application of mandated benefits that would have a similar effect.**

One possible consequence of the introduction of tiered/limited benefit plans is that employers may drop comprehensive health insurance coverage and substitute it with tiered plans. While this could lead to an increase in the number of insured North Carolinians, it would also increase "underinsurance." Underinsurance is a term used for individuals that have health insurance coverage, but whose coverage is not comprehensive enough to make needed healthcare services for illness or injury affordable.

Current Small-Group Rating Method (per NCGS §58-50-130)

Premiums for small employer groups—those with 1-50 employees—are calculated using an "adjusted community rating with rate bands." The following four steps provide a simplified description of the premium-setting process.

Step 1: Determine the "community rate" for the company's small-group book of business.

The statewide expected per-person annual claims cost for an insurer's entire book of small-group business is known as the community rate.

Step 2: Adjust for any benefit differences based on the particular small-group plan that a small employer purchases.

For example, a small-group plan that covers prescription drugs will cost more than one that does not cover prescriptions.

Step 3: Determine the "adjusted community rate" for the specific small group, based on the group's demographics or "case characteristics."

a. Determine the age-gender-family composition of the employees to be covered by the employer. Adjust the community rate to account for these factors.

The health plan adjusts the community rate to account for the age-gender profile of the company. For example, the health plan might be underwriting a group with five employees: three males, aged 21, 25, and 58, and two females aged 32 and 54. Older employees tend to have higher medical costs; these higher costs imply an upward adjustment of the community rate. Younger employees have lower expected costs, which imply a downward adjustment.

b. Adjust the average cost per employee for geographic factors.

Even for individuals who are the same gender and age, expected claims costs can differ greatly based on where they live or work. Reasons for differences in claims cost due to geography include (but are not limited to) physician practice patterns (e.g., a tendency to hospitalize for certain conditions), consumer practice patterns (e.g., a tendency to "tough it out"), the unit cost of services (e.g., the cost of an appendectomy), and the underlying health of the population in the area (e.g., an increased rate of respiratory diseases). The average cost per employee from Step 3a. is then adjusted up or down based on geography.

Note that the resultant rate after taking into account the case characteristics, known as the adjusted community rate, can vary greatly between employer groups when there are differences in age and gender composition of each employer's workforce and/or when the employers are located in different parts of the state.

Step 4: Increase or decrease the adjusted community rate for other group-specific factors, but not by more than 20% (i.e., adjustments within the "rate bands".)

The adjusted community rate can be increased or decreased by up to 20%, based on anticipated above- or below-average administrative or claims costs. For example, a group that may have higher administrative costs, or has higher historical claims, may be banded upward. It is illegal to consider explicitly occupation or industry.

Thus, North Carolina's small-group rating is a compromise between pure community rate—where the amount of risk-spreading and subsidy from the younger/healthier/least-risky individuals to the older/less healthy/riskier individuals is maximized—and allowing rating based purely on the demographics and health status of individual groups—where the younger/healthier/least-risky individuals pay the least and the older/sicker/riskier individuals pay the most.

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