Task Force *for a* Healthier North Carolina

Recommendations on Small Employers and the Provision of Affordable Health Coverage in North Carolina

November 2007

Lieutenant Governor Beverly Perdue
Chair, Health and Wellness Trust Fund Commission

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The Task Force for a Healthier North Carolina is a partnership between the Health and Wellness Trust Fund and the University of North Carolina at Chapel Hill.

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On November 16, 2006, Lieutenant Governor Beverly Perdue, Chair of the Health and Wellness Trust Fund Commission, announced the formation of the Task Force for a Healthier North Carolina. The Task Force was given the charge to hold public forums and make recommendations on strategies to improve access to health insurance in North Carolina, including: access to prescription drug coverage for seniors; access to public health insurance for children; and access to affordable health insurance coverage for small employers. The Task Force for a Healthier North Carolina was created by a grant from the NC Health and Wellness Trust Fund Commission (HWTF). The Lewin Group was commissioned to prepare background policy briefs and to provide analytical support.

The Task Force for a Healthier North Carolina held a public meeting to explore strategies to improve access to affordable health insurance coverage for workers in small businesses on June 8, 2007. The Task Force invited presentations from the following individuals or organizations:

Cindy Avrette, *Principal Legislative Analyst, NC General Assembly, Research Division*

John Friesen*, Vice-President, Chief Actuary, A&U, Blue Cross and Blue Shield of NC*

Mark A. Hall, *J.D., Professor of Law and Public Health, Wake Forest University*

Ken Lewis, *President, FirstCarolinaCare*

Steve Millard*, Executive Director, Council of Smaller Enterprises (COSE)*

Barbara Morales Burke, *Chief Deputy Commissioner, NC Department of Insurance*

Steve Neu, *Vice President, Key Account Sales and Account Management, United Healthcare of the Carolinas*

Jack Rodman, *President & CEO, North Carolina Business Group on Health*

Pam Silberman, *President and CEO, NC Institute of Medicine*

E. Norris Tolson, *Vice Chairman, Board of Directors, NC Biotechnology Center; Secretary, NC Department of Revenue*

The Task Force respectfully submits the following recommendations on strategies to improve access to affordable health insurance for small employers.

Background and Findings

The Uninsured and Small Employers in North Carolina

Small business is a vital sector of North Carolina's economy. One in four workers works for a small employer with fewer than 10 employees and only 23 percent of these workers have health insurance coverage. In 2006, 54 percent of North Carolinians employed by businesses with fewer than 100 employees, 40 percent of those working in businesses with fewer than 25 employees, and 23 percent of those working in businesses with fewer than 10 employees had employer-sponsored coverage.[1] Affordability is the number one reason cited by small employers for not offering coverage to employees and their families. In contrast, larger employers have some natural advantages in provision of health insurance coverage. Due to a larger, more stable population, they are able to distribute risk more evenly. In addition, per capita costs for benefit administration are lower because the cost can be spread across more employees.

For a full background report on small employers and health insurance coverage in North Carolina, see http://www.healthwellnc.com/LewinSmallBusinessCoveragereport.pdf.

Past and Present Initiatives for Improving Small Employer Provision of Health Insurance

North Carolina has attempted three major reforms to improve access to affordable health insurance coverage for small employers since the early 1990s: a voluntary purchasing pool, regulation of the small group market, and a small employer tax credit for provision of health insurance. There is also one excellent model of a community-based initiative.

Caroliance: A Voluntary Purchasing Pool

In 1995, North Carolina's small business purchasing pool, Caroliance, began enrolling members. Experts who presented at the June public meeting concluded that the state-run pool yielded to adverse selection for two primary reasons. First, insurers were reluctant to participate because of a real or perceived estimate that the pool would attract only high-risk, high-cost participants. Second, without an employer or individual mandate, higher-risk members drove out lower-risk members by raising the premium levels. This cyclical behavior, known as "the death spiral," has caused the failure of many state-sponsored health insurance purchasing pools.[2]

Small Group Market Reforms

North Carolina made regulatory changes to stabilize its small group market in the 1990s. The changes reflected a rating strategy known as "adjusted community rating with rate bands." Community rating can decrease the variance in premiums from one small group to another by pooling all of a carrier's small groups to determine pricing. The rates may then be "adjusted" depending upon a few characteristics of the specific group, such as age, sex, family composition, and geographic location. Adjusting for medical risk is limited to 25 percent of the average market rate.[3] The effects of changes made to small group regulations were incremental and difficult to predict. An expert at the meeting explained that North Carolina's regulatory changes

"serve only to redistribute market costs, but are not a vehicle for reducing the real costs of health insurance."[4] Therefore, regulatory changes to the small group market have the capacity to make current prices more equitable, but are not able to solve the problems of overall affordability and accessibility.

Small Business Health Insurance Tax Credit

The most recent state initiative involved a tax credit for small businesses to help defray the employers' premium costs. The credit, which was passed by the GA in 2005, was up to $250 per eligible employee whose total wages did not exceed $40,000 from a business with 25 or fewer workers. Anecdotal evidence suggests that the credit was too small to induce small employers to offer coverage.

Community-Based Initiatives

Community-based initiatives have been effective in connecting the uninsured with affordable health insurance.[5] For example, in North Carolina, FirstPlan is a model for providing quality, low-cost insurance products to small businesses in an eight-county region. It uses subsidies to keep low-wage workers and their dependents enrolled. FirstPlan was created by FirstHealth of the Carolinas, a not-for-profit health care system serving rural North Carolina, and is offered through its subsidiary, FirstCarolinaCare. FirstPlan is targeted to employers with 50 or fewer employees. It requires the health system, the insurance company, the providers, and the employers to collaborate in order to offer an affordable, comprehensive insurance product. Three key mechanisms were utilized to implement FirstPlan: care credits for employers (there is a 100 percent employee participation requirement); subsidized premiums for employees ($10/hour or less wage employees); and reduced provider reimbursement for low-wage employees.[6]

FirstCarolinaCare also partnered with the Moore County Chamber of Commerce to create a highly affordable plan for Chamber members. A separate initiative, called CoverMoore, involved offering further reduced premiums ($50/month) to workers making less than $10 per hour through the local Chambers. Despite aggressive outreach efforts, there was not enough interest to create a critical mass and implement the plan. According to the president of FirstCarolinaCare, Ken Lewis, the product was too complex, too exclusive, and had the appearance of uncertainty. Through their experience with the CoverMoore initiative, FirstCarolinaCare found that the young and healthy employees were not interested in health insurance even at a very low cost.[7] FirstCarolinaCare closed the initiative after identifying only 130 interested individuals. In the end, businesses that already offered coverage did not see how the initiative would eventually benefit them and reduce their premiums.[8]

The Perspective of Small Employers: Key Survey Findings

In order to better understand small business owners' views on health insurance coverage, the University of North Carolina at Chapel Hill and the NC Rural Center partnered to conduct a survey of 5,000 small employers.

Early findings include:

Small business owners lack awareness of the health insurance tax credit.

- 63 percent of survey respondents reported never having heard of the tax credit.
- Less than 2 percent of respondents indicated that they would take advantage of the health insurance tax credit.
- Small employers reported a tax credit would need to be worth approximately $1,000 in order to induce them to offer health insurance.

Small business owners are carrying much of the burden of employee premium costs as dependent coverage is suffering.

- 70 percent of employers who offer health coverage reported paying up to 75 percent of the cost of employee coverage.
- Nearly 80 percent of employers said that they did not pay any portion of dependent coverage.

Small business owners have strong preferences on health policy.

- 90 percent favored the government "providing financial incentives to encourage small employers to provide health insurance for their employees."
- 88 percent favored "allowing small businesses to join together for the purpose of purchasing health insurance."
- 50 percent favored "a state-funded, universal health care program."
- 47 percent opposed "reducing the required benefits that must be covered in insurance plans (such as coverage for immunizations, mammograms, chiropractic care, etc.) in return for lower premiums."

Health insurance is not a major factor in attracting or retaining qualified labor for many small business owners.

- Of those companies that did not offer health insurance, only half (54 percent) believed that it affected their ability "to attract or retain qualified workers."

A full report on the survey findings will be released by the UNC-CH Office of Economic and Business Development and the NC Rural Center.

Key Recommendations

The Task Force recommends creation of a new state-wide Office of Small Business Health Insurance Partnerships (OSBHIP) to serve the following major needs of small employers and employees: 1) provide a single source of information on and portal to purchase private health plans; and 2) direct technical and financial assistance for small employers who wish to offer flexible and portable health insurance coverage to their employees. The Department of Insurance Seniors Health Insurance Information Program (SHIIP), an important means for seniors to access health insurance, could serve as one model for creating a necessary link between small employers (and employees) and health insurance coverage.[9]

Recommendation 1: OSBHIP should improve access to information on and/or purchase of affordable and quality health insurance coverage through creation of an online information portal and/or exchange.

Health insurance is a complicated product to research and purchase, and the amount of effort small employers must invest, per worker, is relatively high in comparison to the same amount of effort by a large employer. In addition to the affordability issue, the time and knowledge requirement is often too high a barrier to purchasing health insurance for many small employers.[10]

There is a need in North Carolina for a comprehensive source of impartial and credible information and resources for small employers seeking to purchase health insurance. Currently, the DOI has information on a few "resources that are commonly utilized by businesses to understand their insurance needs" and a list of "insurers actively marketing small employer group health insurance coverage." For example, see http://www.ncdoi.com/Consumer/consumer_business.asp.

Small employers have an uneven variety of information when shopping for health insurance. For example, independent insurance agents, health insurance companies, trade associations, and advocacy groups all provide some information (much of it available online). However, there remain two significant barriers to small business owners' accessing that information and transforming it into useful knowledge. First, the resources are scattered across many different Web sites, sponsored by many different organizations. This requires a small business owner to perform extensive online research to get the "full picture." Second, the largest source of health insurance information comes from the insurance companies themselves. Despite the efforts of the private health insurance industry to bring information and online applications to small business purchasers, there is a perception that for-profit companies might provide either biased or unmanageable information. For example, even though Blue Cross and Blue Shield of North Carolina "offers more than 1,000 benefit combinations and can customize different plans based on the needs and budget of your group health insurance program," such a large financial investment and commitment often needs the assistance of a skilled and impartial intermediary.

The portal would be a central place for making all types of health insurance information accessible to small employers and their employees. It would:

- create online tools and resources to assist small employers, workers in small firms, the self-employed, start-up businesses, and those eligible for the high-risk pool with their health insurance coverage needs;
- consolidate the online resources for health insurance available to small firms;
- provide guidelines for purchasing health insurance; and,
- introduce a "plan finder" that matches small firms and the self-employed with private health plans.

There is also a larger opportunity to create a health insurance exchange—a mechanism that facilitates the buying, selling, and administration of private health insurance. The concept is comparable to a stock exchange or a farmer's market that brings buyers and sellers together. A legal structure would be created to act as a clearinghouse for approved health insurance products, to collect and consolidate insurance premiums from individuals and employers, and to forward the payments to the insurance companies. The entity would be established to comply with federal tax law (Section 125 Cafeteria Plan) to allow employees to pay health insurance premiums with pre-tax dollars.

There might also be a larger opportunity for the OSBHIP, in partnership with the State Health Plan and the Department of Health and Human Services (DHHS), to improve access to information about the quality of providers and hospitals in a private health plan's network. For example, the U.S. Department of Health and Human Services has launched an initiative to improve consumer access to information that will help Americans compare the quality and price of health care services.[11] The initiative involves pooling data on procedures, hospitals, and physicians' services. Regional health information alliances could then collect such data and make it more accessible to consumers. The OSBHIP would take the lead in compiling and communicating plan information on a regional basis. Assisting small employers and employees to be better consumers of health care would be an important long-term strategy toward making affordable and quality health care coverage more accessible.

Recommendation 2: OSBHIP should sponsor a pilot small business premium assistance program.

Affordability is the number one reason cited by small employers for not offering health insurance. A premium assistance program, based on the CoverTN shared-responsibility model, could be as an initial step toward making insurance more affordable and accessible in North Carolina.

Tennessee's CoverTN requires that employees, employers, and the state share equally in the cost of health insurance premiums. Tennessee's plan for workers in small firms is portable. The state contracts with Blue Cross Blue Shield–Tennessee to offer two products with an average total monthly premium of $150, including the employee's, employer's, and the state's share. Premiums vary around this amount based on age, tobacco use, and body mass index. The benefits package emphasizes primary and preventive services with no deductibles and modest

copays. Tennessee received a federal Health Resources and Services Administration (HRSA) grant to pilot this small business health insurance coverage initiative. According to CoverTN officials, enrollment had reached 9,672 employees by August 2007. This is an impressive enrollment number, since CoverTN only started enrollment in March 2007.

The program focuses on preventive services and primary care. BCBS–TN offers coverage for up to six physician visits per year, with a $20 copay per visit and no deductible.[12] Coverage also includes some annual hospital care, generic pharmacy coverage, outpatient services, lab services, and mental health services.[13] If an employee exceeds their number of doctor visits, they can still get care, but at a higher rate.[14] Employees with preexisting conditions are subject to a 12-month waiting period before receiving care for the condition.[15]

The Task Force urges the creation of a two-year "pilot" premium assistance plan with start-up funding from and in partnership with several health care foundations. For example, to be eligible for assistance, a limited number of small employers and employees would *each* pay 1/3 of an average premium cost of a basic health plan. The remaining 1/3 of the monthly premium would be provided by the pilot program from external grant funds. If the premium assistance program is successful beyond the two-year pilot period, more sustainable state funding should be identified.

Recommendation 3: OSBHIP should provide technical and financial assistance to small employers who currently offer health insurance to offer that coverage as a Section 125 premium-only plan (POP).

Section 125 Plans give employees additional benefits by allowing pre-tax deductions for expenses such as health care, child care, and dependent care. Employees can deduct the cost of these items regularly from their gross salary and avoid paying federal, state, or FICA taxes on the deducted income.[16] For more information on 125 premium-only plans, see http://www.hra4u.com/content/pop.htm.

As one example, Massachusetts employers with 11 or more full-time-equivalent employees must adopt and maintain a Section 125 Plan. The larger program is being administered by the Commonwealth Health Connector Authority, commonly referred to as the Connector.[17]

Recommendation 4: OSBHIP should provide technical and financial assistance to small employers who offer workplace wellness programs.

Unhealthy lifestyles have led to increasing medical and insurance costs for employers small and large.[18] Workplace wellness and disease management programs have become increasingly popular avenues for cost containment. Federal and state tax credits to employers to implement a qualified workplace wellness program have become more common.[19,20]

The overall success of wellness programs may be in part attributable to the prevalence of preventable health conditions.[21] For example, a review of 15 years of research literature found that companies with health-promotion programs showed an average of $3.50 savings in reduced absenteeism and health care costs for every dollar spent. Other factors, such as reductions in on-

the-job injuries and in work-related stress levels, were also cited as tangible benefits to workplace wellness programs.[22]

The Health and Wellness Trust Fund, Blue Cross Blue Shield of North Carolina, and OSBHIP could partner to promote wellness in the workplace and design a competitive grants program for small employers who need start-up finances for wellness programs. For example, the Health and Wellness Trust Fund program, Fit Together, provides advice on free and low-cost ways to improve employee health. In addition, under the Blue Cross Blue Shield of North Carolina program called Get Fit Blue, members can receive discounts on gym memberships, personal training, health-related magazines, and nutrition counseling.

Recommendation 5: OSBHIP should support community-based pilots and encourage replication of successful community-based models.

With grant support from a W. K. Kellogg Foundation initiative, “Community Voices: Health Care for the Underserved,” FirstHealth of the Carolinas developed and launched FirstPlan, a group of health care coverage products tailored to small businesses and offered through a wholly owned subsidiary, FirstCarolinaCare. Organized as a taxable, nonprofit insurer, fully licensed and regulated by the North Carolina Department of Insurance, FirstCarolinaCare operates a provider network that works together with hospitals, physicians, and the business community.[23] FirstHealth offers subsidies to low-income workers and premium discounts if employers meet certain criteria. Launched in 2002, the plan had enrolled 1,375 workers in 132 businesses after two and a half years of operation.[24]

In FirstHealth's region, fewer than 50 percent of small business employees are covered. FirstPlan was specifically designed to enroll and mainstream the working uninsured, and toward that end, emphasizes disease management for high-risk enrollees and a strong educational component to teach them how to use the system effectively. With FirstHealth of the Carolinas acting as convener, this plan was forged around the principle of shared responsibility and participation, and would not have succeeded without strong partnerships in the community to develop one-on-one relationships with the small businesses whose employees it was meant to help.[25]

Leaders of FirstHealth of the Carolinas viewed the FirstPlan model as a way to spread the costs of covering the uninsured working for small employers across many participants:

- The health system accepts reduced reimbursement, utilizes grants, and subsidizes remaining funding requirements.
- The physician network agrees to reduce reimbursement for lower-paid insured and participates in a medical management model.
- The insurer provides the claims-processing and education components to implement the plan.
- The small business owner provides premium contributions of at least 50 percent and enjoys the best rates if all employees are covered, whether through FirstCarolinaCare or another carrier.

Many experts conclude that universal coverage in North Carolina may indeed require some form of mandate to ensure that the risks and costs are shared across a larger population.

Conclusion and Next Steps

An Office of Small Business Health Insurance Partnerships (SBHIP) that provides information and technical and financial assistance to small employers would be a small and incremental step in the right direction. However, many of the experts who presented at the Task Force's public meeting believed that an individual mandate would be required to ensure affordable health coverage. Without a mandate, they argued, the young and healthy will "opt out" and drive up premiums.

The key lesson learned from North Carolina's purchasing cooperative, Caroliance, is that voluntary participation in a health insurance purchasing pool will lead to "market failure." Without full participation, the insurance market becomes overwhelmed by the unhealthy, high-risk members who have higher medical costs.

Some health care leaders believe that an employer mandate might be necessary to address the uninsured.[26] Others experts conclude that "in addition to avoiding adverse selection problems, mandatory approaches reduce cost shifting, prevent employer crowd out, and avoid insurers cherry picking the best risks."[27]

Health insurance is based upon the principle of shared risk. If most people are basically healthy, then they can afford to pay into a pool of money that is sufficiently large to cover the big expenses incurred by the few who are really ill. The Task Force recognizes that an employer and/or individual mandate is controversial and complex, but it is an issue that must be addressed with broader public debate and discussion as North Carolina decides its own path toward affordable and quality health insurance coverage for all residents. In the meantime, an Office of Small Business Health Insurance Partnerships that offers innovative technical and financial assistance is an important first step.

[1] Aaron McKethan and Adam Wilk, "Options to Expand Health Insurance Coverage for Workers in Small Businesses in North Carolina," June 2007, The Lewin Group; http://www.healthwellnc.com/LewinSmallBusinessCoveragereport.pdf (accessed July 2007).
[2] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, 4; www.kff.org/insurance/2255-index.cfm. Janice Lawlor and Mark Hall, "Caroliance: North Carolina's Health Insurance Cooperative Needs a Doctor," *North Carolina Medical Journal* 61, no. 6 (Nov./Dec. 2000); http://www.ncmedicaljournal.com/november00/ar091100.pdf (accessed July 2007).
[3] McKethan and Wilk, "Options to Expand Health Insurance Coverage for Workers in Small Businesses in North Carolina."
[4] Barbara Morales Burke, "Regulation of Small Group Health Insurance Market," The North Carolina Biotechnology Center, Research Triangle Park, NC, June 8, 2007.
[5] Sharon Silow-Carroll, Tanya Alteras, and Heather Sacks, "Community-Based Health Coverage Programs: Models and Lessons," February 2004, The Economic and Social Research Institute; http://www.wkkf.org/Pubs/Health/CommunityBasedCoverageFINAL_00250_03763.pdf (accessed July 2007).
[6] For more information see http://www.communityhealth.dhhs.state.nc.us/OunceOfPrevention/(Charles_Frock)_Prevention_Strategies.ppt; http://aspe.hhs.gov/medicaid/july06/RoxanneLeopper.pdf.
[7] Charles Frock, "Health Care: Who Pays?" May 11, 2007, The Pilot.com; http://www.thepilot.com/stories/20070511/opinion/columns/20070511Frock.html (accessed July 2007).
[8] Ibid.
[9] http://www.ncshiip.com/Consumer/SHIIP/SHIIP.asp.
[10] Len M. Nichols, "Challenges Facing Small Employers in Purchasing Health Insurance," April 20, 2005, New America Foundation; http://www.newamerica.net/files/archive/Doc_File_2330_1.pdf (accessed July 2007).
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[12] "Q&A with CoverTN director," *Knoxville News Sentinel*, August 10, 2007; http://www.knoxnews.com/news/2007/aug/10/Harrington-Q-A-with-covertn-director/.
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[15] Ibid.
[16] John S. Bauer, "Attracting and Retaining Employees—Employer and Employee Benefits of a Cafeteria Plan," American Thoracic Society; http://www.thoracic.org/sections/career-development/practitioners-page/practice-tips/articles/tip12.html (accessed August 2007).
[17] "Health Care Access and Affordability Conference Committee Report," April 3, 2006, Massachusetts Homepage; http://www.mass.gov/legis/summary.pdf (accessed August 2007).
[18] Kenneth E. Thorpe, Curtis S. Florence, David H. Howard, and Peter Joski, "The Impact of Obesity on Rising Medical Spending," October 20, 2004, Health Tracking; http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.480/DC1 (accessed July 2007).
[19] "Workplace Wellness Program Credit," 2007 Assembly Bill 235, Wisconsin State Assembly; http://www.legis.state.wi.us/2007/data/AB-235.pdf (accessed July 2007). "Daily Health Policy Report: Capitol Hill Watch: Legislation Would Provide Tax Credits to Businesses That Offer Workers Wellness Programs," July 10, 2007, Kaiser Family Foundation; http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=46114 (accessed July 2007).

[20] The Wisconsin State Assembly is considering Assembly Bill 235, which would provide a state tax credit to employers to implement a qualified workplace wellness program. Wellness services, including smoking cessation, weight management, nutrition education, and fitness incentives, could also qualify. The credit would cost the state a maximum of $5 million in revenues annually. U.S. Senator Tom Harkin announced the introduction of legislation that would provide a tax credit to businesses that offer wellness programs to their employees. The credit would be worth 50 percent of the costs they incur up to $200 per employee for the first 200 employees and $100 per employee for the remainder of workers. The measure is expected to be considered in fall 2007.

[21] One study found that 2001 health care spending among obese individuals was 37 percent higher than costs for normal-weight individuals. For the near-elderly who fall within the obese category (35.0+ body mass index), health care costs were 60 percent higher than for their normal-weight counterparts. Along with medical advances associated with treating weight-related diseases, the rising prevalence of obesity has contributed to increasing costs. Between 1980 and 2004, the prevalence of obesity doubled to 30 percent of the adult population. The authors found that the growth in obesity accounted for 27 percent of the growth of per capita health care spending between 1987 and 2001. Thorpe et al., "The Impact of Obesity on Rising Medical Spending."

[22] Beth Baker, "Pass the Pasta, Please, and Hold the Stress," July 10, 2007, *The Washington Post*; http://www.washingtonpost.com/wp-dyn/content/article/2007/07/09/AR2007070901305.html.

[23] http://www.thepilot.com/stories/20070511/opinion/columns/20070511Frock.html.

[24] aspe.hhs.gov/medicaid/july06/RoxanneLeopperAttachment2.pdf; aspe.hhs.gov/medicaid/july06/RoxanneLeopper.pdf.

[25] Ibid.

[26] Anne Krishnan, "Greczyn Wants Coverage Required: Blue Cross Chief Suggests Mandate," May 3, 2007, *News and Observer Online*; http://www.newsobserver.com/126/story/570180.html.

[27] Rick Curis, "Promising Elements of the Massachusetts Approach: A Health Insurance Pool, Individual Mandates, and Federal Tax Subsidies," Wisconsin Family Impact Seminars; http://www.familyimpactseminars.org/s_wifis24c02.pdf (accessed August 2007).