



The LEWIN GROUP

Options to Expand Health Insurance Coverage for Workers in Small Businesses in North Carolina

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OVERVIEW

This brief highlights policy options that encourage small employers to provide or subsidize health care benefits for their employees. The first section provides background for understanding the key challenges that small employers face in the private health insurance market. The second section provides a snapshot of current coverage trends in North Carolina's small group market in recent years. The final section summarizes common policy approaches that states have considered or have used to reduce the number of individuals without health insurance in the small group market.

BACKGROUND

Overview of Employer-Based Health Insurance Trends in North Carolina

About 4.5 million North Carolinians receive employer-based health care benefits.¹ While the proportion of people receiving health care benefits through their job has declined in recent decades, the system of employer-sponsored health insurance continues to provide coverage to the majority (nearly 57%) of the state's non-elderly population.²

In general, workers in smaller firms are less likely to be offered employer-based health insurance than those working in larger firm, both in North Carolina and nationally. In 2005, consistent with national trends, only about 42% of North Carolina firms with less than 50 employees offered employer-based health insurance, compared to over 95% for firms with more than 50 employees.³ The exhibit below displays recent comparisons of employer-based coverage trends, by firm size, in North Carolina and the United States.

Percentage of private sector employers by firm size in NC and the US that offer health insurance coverage (2005)

Firm Size	2005	
	NC	US
1-9 employees	37.2%	35.7%
10-24	49.9%	64.0%
25-99	84.4%	82.6%
100-999	92.6%	94.2%
1000+	100.0%	98.9%
TOTAL	56.7%	56.3%

Source: Medical Expenditure Panel Survey, MEPSnet/IC
Trend Query: Percent of private-sector establishments that offer health insurance by firm size (2005).

Some small business workers who do not get coverage through their employer may be able to access health insurance through a family member's employer or through a public program (e.g.,

Medicaid). They may also seek individual coverage in the private market. However, many workers of small firms simply go without coverage. Approximately half (55.3%) of the state's uninsured population is employed by, or is a family member of someone who works for, a firm with fewer than 25 employees.⁴ Between 2001 and 2006, the total uninsured population grew by three percentage points nationally. During that time, the percentage of individuals without insurance working for firms with fewer than 25 workers jumped 8-percentage points nationally.⁵ In North Carolina over the same period, the percentage of workers in small employers (fewer than 25 workers) covered by employer-based insurance grew by a comparatively steep 14 percentage points.

What Explains the Gap in Employer-based Insurance Coverage between Smaller and Larger Firms?

To identify viable policy approaches to assist small firms and the workers of small firms to access health insurance coverage, it is necessary to understand some of the underlying factors driving trends in coverage.

Large employers have some natural advantages over small employers in the market for health insurance. Insurance markets typically function best for large, well-defined populations for which clear information regarding health care status and risk profiles are available. When insured groups are large (e.g., large employer groups) the risks of unanticipated and costly medical events can be distributed across large risk pools. Therefore, insurance premiums reflect a stable and actuarially "fair" assessment of groups' health care experience. Further, per capita administrative costs are relatively low because they are spread out over many premium-paying individuals. Even with these advantages, the high costs of health care have led many large employers to trim benefits or shift more health care costs to workers.

Many of the characteristics of health insurance for large employers are lacking in the small group market. Smaller groups are typically unable to establish large and stable risk pools over which to spread the risk of high health care costs. Small groups can be particularly vulnerable to insurers' underwriting and pricing practices designed to avoid the possibility of adverse selection. Moreover, small groups are less able to establish economies of scale in the administration of health benefits. Smaller employer groups are also disadvantaged, relative to larger groups, since many "lack the resources, the expertise, and the inclination to cope effectively with the complex task of buying health insurance."⁶

These and other factors have contributed to higher insurance premiums being offered to small employers relative to the premiums typically available to larger employers. In North Carolina, for example, the average annual health insurance premium for workers in the smallest firms (with fewer than 10 employees) was \$3,998 in 2004, compared to \$3,684 for firms with more than 100 employees.⁷ Importantly, these figures only account for those employers who actually provided or subsidized coverage for their workers. In 2004, only 39% of North Carolina firms with less than 50 employees actually offered health insurance to their employees, compared to 93% of firms with more than 50 employees.⁸ Thus, many employers choosing not to offer coverage would have faced even higher premiums. Indeed, surveys suggest that most small employers (about 80%) not offering health insurance do not do so because of the high costs of coverage.⁹

Despite all of the challenges that smaller firms face receiving comparable premium offers relative to larger employers, the underlying factor influencing firms' decisions about whether to offer insurance coverage to workers is the actual value of premiums themselves. Thus, simply reducing or eliminating the *differences* between the average premiums available to large and small employer groups may not fully address the gap in coverage between employers of different sizes. For myriad reasons, smaller employers are typically more price sensitive than larger employers. Thus, while employers of all sizes have had to cope with medical cost growth consistently exceeding the general rate of inflation, small employers are especially susceptible to the rising cost of care.

The challenges that small employers face in the market for health insurance are particularly problematic in North Carolina since small employers represent a relatively large proportion of the state's total workforce. About one in four workers in the state (25%) work for employers with fewer than ten employees. Over one in three workers (36%) work for employers with less than 25 employees. Over half (53%) of the state's working population is employed by a firm with less than 100 employees. Moreover, the small business workforce has increased its share of the total state workforce in recent years. The percentage of North Carolina workers employed by small employers (with less than 25 employees) grew from 33% in 2001 to 38% in 2006.

The lack of health insurance coverage among workers in small employers is an important and growing policy challenge in North Carolina. The next section highlights several state-level approaches that may assist small businesses in the provision of health insurance.

Policy Options to Expand Insurance Coverage in the Small Group Market

Tax Credits and Deductions

Employer-based health insurance has been closely connected to the nation's tax system since the federal government declared in 1954 that employer contributions would not be taxed as income. Since then, the tax implications of health care benefits have figured prominently in both the growth of employer-sponsored health insurance and in health reform efforts.

Tax credits and tax deductions are two tax-based incentives to expand employer-based health coverage by subsidizing the employer's cost of providing coverage. While tax credits are applied after employers' tax liabilities are determined, tax deductions allow eligible employers to deduct amounts paid toward employee premiums from taxable income before tax liabilities are determined. These tax incentives are intended to reduce employers' income taxes to the extent that employers incur qualifying health care expenditures or premiums. Thus, such approaches are designed to induce smaller employers to offer insurance coverage to their employees.

However, there are concerns about the relative efficiency of such proposals. Broadly available tax credits or deductions may simply reward those employers already offering health care coverage. Moreover, using the tax code to change employer behavior may not ultimately be effective if employers must finance expensive health care premiums before tax benefits are actually available. To be effective, tax-based approaches must ultimately lower the relative prices that employers or individuals face enough to make premiums affordable.

To address these concerns, policymakers can establish “targeted” tax benefits and make them available before premium payments are due for employers with lower-paid employees or those not currently offering coverage. This could more effectively yield the desired policy effects at a lower cost in public tax expenditures. Moreover, since the tax liabilities of employers can vary substantially, policymakers can also establish “refundable” tax credits that are available to employers regardless of their tax liability. This would mean that the effective value of tax incentives is not reduced for employers with lower tax liabilities. More importantly, however, a significant challenge is ensuring that the amount of tax credits or deductions made available is sufficient to bring insurance premiums in range of affordability from the perspective of small employers.

In 2006, the General Assembly passed legislation that would allow small employers (with 25 or fewer workers) providing health benefits for all employees to take a state tax credit for the employer’s costs in providing the benefits.¹⁰ To be eligible, the employer must pay at least 50% of the premiums for health coverage that meets or exceeds the minimum provisions of a basic health care plan of coverage recommended by the Small Employer Carrier Committee. The credit is equal to a maximum of \$250 for each employee covered whose annual wage and salary payments do not exceed \$40,000.

Premium Assistance

An alternative approach to encourage small employers to offer health care coverage for their workers is to use public funds to directly subsidize the cost of employer-based health insurance premiums. Premium assistance programs can be targeted to small employers or directly to individuals, usually previously uninsured individuals with relatively modest incomes. Either way, the goal is to create additional incentives for small employers or other hard-to-insure groups or individuals to offset the higher premiums they are offered by private insurers.

Under the Balanced Budget Act of 1997, Congress authorized states to establish premium assistance programs for low-income children and their families under the State Child Health Insurance Program (SCHIP). A major benefit to states was federal matching funds for such programs. As a result, several states are experimenting with employer-based premium assistance programs as part of their broader HIFA waiver requests.¹¹

Previous studies examining the experience and impact of state premium assistance programs suggest several lessons for policymakers. First, such programs can be very difficult to administer for states. Second, experience shows that some populations, such as uninsured individuals with limited experience with health care insurance or the health care system, may be particularly difficult to attract to premium assistance programs.¹² Such programs may need to include extensive outreach efforts to educate eligible families about the importance of health insurance and how it works.

Additionally, the effectiveness of programs that are targeted to individuals – and not small employers directly – may depend on the degree to which employers actually offer health insurance coverage to workers, as many do not.¹³ This is because even with the availability of premium assistance, individuals still need a source for coverage. If their employer does not offer coverage, individuals may have to seek health insurance through the individual market in order to use premium assistance benefits.

Reinsurance

Reinsurance compensates health plans that enroll high-cost individuals or groups by functioning as secondary insurance for insurance carriers. When insurance claims for a particular enrollee or group exceed a predetermined level, the responsibility for paying for a portion of those claims shifts from the insurer to the reinsurer. This arrangement affords insurers some protection against high cost claimants or groups and reduces the potential impact of adverse selection.

Advocates of reinsurance contend that such arrangements can reduce the barriers faced by those with poor health status. However, private reinsurance is currently available in the marketplace, which raises questions about the role for government in establishing or subsidizing reinsurance arrangements. That said, the benefits that health plans receive from reducing their exposure to high cost enrollees or groups can be largely offset by the cost of reinsurance. Thus, a possible rationale for government-sponsored or subsidized reinsurance is to maximize the extent to which health plans do receive the benefits from reinsurance so that those benefits can be passed on to small employers in the form of reduced premiums.

States can establish reinsurance arrangements in concert with other policy efforts, such as premium assistance or limited benefit plans. The Healthy New York program, for example, which has been operational since 2001, is perhaps the best-known state effort to use state subsidization of reinsurance as a key mechanism to provide coverage for workers in small employers. Program eligibility for “streamlined” benefit packages is limited to small employers (50 or fewer workers) employing workers with modest wages^a who have not been offered employer-based health coverage in the previous twelve months.¹⁴ Under the program, the state of New York acts as a reinsurer to reimburse private insurance carriers for 90% of the claims costs between \$5,000 and \$75,000 per individual. Below \$5,000 and above \$75,000, insurance carriers are fully responsible for medical costs. Despite limited initial enrollment, Healthy New York now covers more than 100,000 previously uninsured individuals.

In 2006, the North Carolina Institute of Medicine Task Force on Covering the Uninsured recommended that the state establish a publicly subsidized health insurance product that would be available for small employers with 25 or fewer employees, sole proprietors, or employees not offered health insurance through their jobs.¹⁵ A key part of the proposal was for the state to act as a reinsurer to reduce the premium costs for small employers by at least 30% from what is available in the private market. Price sensitive small employers, it was argued, would take advantage of these discounts to provide health insurance coverage to their employees for the first time.

The recommendation of the Task Force to establish a Healthy North Carolina program was based on the Healthy New York model. Legislation to enact and finance the proposal was introduced in the General Assembly as Senate Bill 1512, which remains under consideration by the legislature.

^a At least 30% of the employees must earn wages of \$35,500 or less.

Purchasing Pools for Small Employers

Policymakers in several states have experimented with purchasing pools as a way to make health insurance more affordable for small employers and/or individuals purchasing health insurance. The basic premise underlying purchasing pools is that by aggregating large numbers of small employers into consolidated purchasing arrangements, smaller purchasers can achieve the same market advantages that large employers enjoy. Thus, advocates of purchasing pools argue that they can result in more favorable premiums for participating groups or individuals relative to what they could achieve outside of pooling arrangements.

Analysts have studied small group pooling arrangements and have found that, in general, they have not resulted in lower premiums for participating groups.¹⁶ Moreover, pooling arrangements or purchasing alliances have not dramatically increased small employer health insurance offer rates.¹⁷ Although purchasing pools are designed to mimic the purchasing clout of large employers and other major purchasers (and thereby achieve more affordable premiums), voluntary pools differ from large employers for at least two reasons.

First, since purchasing pools are typically voluntary, participating small employers can choose to enter and exit the pool. If and when more affordable options avail themselves on the open market, small employers are likely to decline participating in special purchasing pooling arrangements and instead obtain more affordable coverage outside of the pool. Small employers that are able to obtain more affordable options on the open market are more likely to be lower-risk groups. This has the effect of leaving small employer groups with higher-risk populations inside the purchasing pool, which in turn causes prices for remaining groups to escalate still further. A purchasing pool with higher-than-average health care risk is by definition more expensive to insure. Even very large purchasing pools cannot exert market influence to command better rates unless they can demonstrate and maintain stable participation by eligible groups, including relatively low-risk groups that can help to subsidize higher-risk participants.

A second and related challenge associated with small group purchasing pools has to do with the risk profile of employers participating in pooling arrangements. From the standpoint of health plans that have the option of offering coverage to small employers participating in purchasing pools, there is some risk inherent in the very existence of the purchasing pool. Since they are formed for the exclusive purpose of achieving more affordable coverage for participating individuals and groups, such pooling arrangements may in general attract participants with higher-than-average health care costs and needs. Risk pools need a strong base of low-risk groups who will contribute premiums without adding substantially to medical costs. Health plans will seek to avoid providing “favorable” coverage terms (i.e., lower premiums) for groups that have a disproportionate share of high risk groups or individuals. By contrast, health plans make comparatively better rates available to large firms because their workers have not joined together for reasons solely related to their expected health care costs.

The general challenges associated with purchasing pools played out in North Carolina over the last decade when the state became one of the first in the country to establish a small business purchasing pool in 1993 (called “Caroliance”).¹⁸ The General Assembly created a system of regional purchasing alliances designed to help small employer groups obtain better health

insurance rates than were otherwise available on the open market. Caroliance formally began operations in 1995 and existed until 2000.

Over the five-year history of Caroliance, total enrollment was modest, amounting to only about 1% of the total small group market in the state. Despite limited enrollment, Caroliance did offer some advantages for hard-to-insure small groups. Before the 1997 federal Health Insurance Portability and Accountability Act (HIPAA) was enacted, Caroliance offered higher-risk groups in North Carolina a more attractive package of benefits than was available on the open market. However, HIPAA required that insurers offer all plans on a guaranteed issue basis to small groups. As a result Caroliance was no longer the only mechanism through which high-risk small groups could gain access to comprehensive coverage. Thus, the implementation of HIPAA effectively deprived Caroliance of its central advantage for small high risk groups.

The key challenge for Caroliance, as for most purchasing pool arrangements, was that it was unsuccessful in encouraging healthy groups to participate. Rather, it became a magnet for small, high risk groups for which insurers typically prefer to avoid providing coverage. The program's marketing and design features themselves were also to blame for the program's inability to achieve a balanced risk population. Marketing and media coverage contributed to the perception that the program was designed for hard-to-insure populations. More importantly, Caroliance used a two-tier rating methodology to underwrite policies. By contrast, insurers typically use at least three or more rating tiers to establish premiums. The effect of making fewer risk distinctions in Caroliance was to effectively elevate the prices that healthy groups must pay to participate, reducing their incentive to participate.

Caroliance was also unsuccessful in encouraging a significant number of health plans to participate. Despite some early interest from several health plans, the number of plan options declined such that by 1999, Blue Cross Blue Shield of North Carolina was the only plan offering Caroliance products statewide. Health plans were reluctant to participate because of the perception, if not the reality, that Caroliance was predominantly designed for high-risk and unprofitable groups.

In its later years, Caroliance made some changes, including consolidating the regional alliances into one statewide alliance, introducing additional rating/risk tiers so that healthier groups could gain access to lower rates. However, these changes could not reverse the program's reputation or experience. Caroliance closed operations as of December 31, 2000.

Under certain conditions, purchasing pools are useful mechanisms that improve the affordability of health insurance for small employers. Pools require stable populations with balanced risk profiles to mimic the natural advantages of large groups. Government financing could help achieve this goal by enticing small employers with healthy workers into the pool. Purchasing pools could also be combined with other strategies, such as reinsurance and tax credits, discussed elsewhere in this brief. Policymakers exploring purchasing pool arrangements as opportunities to expand insurance coverage among small employers must heed the lessons from Caroliance and similar initiatives nationwide.

Regulation of the Small Employer Market

States have primary responsibility for the regulation of health insurance. In North Carolina, the Department of Insurance (DOI) issues licenses to organizations that provide health insurance coverage and monitors the financial viability and business practices of insurers. DOI reviews insurers to make certain that they guarantee the issue and renewability of insurance plans. Overseeing the regulation of health insurance premiums is another key function performed by DOI.

Given the state's role in regulating health insurance, policymakers can use regulatory approaches to address coverage issues in the small employer market. In the 1990s, the General Assembly enacted small group reform laws to stabilize the small group market. These reforms resulted in North Carolina's adoption of a rating methodology known as "adjusted community rating with rate bands", which serves as a methodology for setting premiums for small employer groups. This includes self-employed "groups of one" up to firms with 49 workers.¹⁹ The "community rating" aspect of the state's rating methodology bases premiums on the expected per-capita annual claims cost for an insurer's entire book of small group business. This means that premiums for individual groups are not underwritten based solely on specific risk characteristics. Rather, premiums are based on an insurer's entire small group business statewide. Community rating regulation condenses the variation in premiums for groups with different risk profiles, creating subsidies from healthier, lower risk groups to less healthy, higher risk groups. Groups characterized by higher risks benefit from these effective subsidies because their (higher) costs are spread across lower-risk groups that are less costly to insure.

In North Carolina, small group premiums are also adjusted according to some individual group characteristics, including age, sex, family composition, and geographic location. These basic adjustments help to ensure that small firms with predominantly healthy workers do not face the higher premiums that would result from full community rated premiums. These adjustments are thus intended to prevent firms with lower risk characteristics from exiting the small group market altogether. In addition to these demographic-based adjustments, small group premiums can vary by up to 20% based on the estimated medical risk of specific groups. Thus, North Carolina's current small group regulatory environment seeks to strike a balance between full medical underwriting in which groups receive premium offers based solely on their own risk characteristics and full community rating in which premium variation is eliminated and premiums are set regardless of groups' risk characteristics.

The impact of regulatory approaches on small group coverage can be very difficult to predict. The net effects of regulatory reforms will depend on how individuals and groups with different risk profiles respond to changing prices and incentives. Among those currently insured, healthy individuals may drop coverage to the extent that insurance is not valued at its higher cost. However, relatively unhealthy "high-risk" firms or individuals, facing prohibitively high premiums before regulatory changes are enacted and thus lacking employer-based coverage, may now find that the cost of insurance has dropped sufficiently to induce them to purchase coverage.

In general, if regulatory changes attract more high risk groups and individuals to the small group market relative to the number of low risk groups and individuals that exit, overall premiums may increase. Thus, the effects of additional rating restrictions on insurance

coverage and premiums depend on the responses of healthy groups and individuals that drop coverage compared to the unhealthy groups and individuals gaining coverage. The more standardized premiums become (i.e., the more premium variation is condensed despite risk characteristics), the larger the potential subsidies from low to high-risk groups and the less attractive insurance will be to low-risk individuals. Policymakers should thus exercise caution in making significant changes in regulations affecting premiums as the effects can be very difficult to anticipate.

One of the recommendations of the NC Institute of Medicine Task Force on Covering the Uninsured was for the state DOI to review the state's small group reform laws to determine if there are potential modifications that could increase coverage among small employer groups. Accordingly, the DOI recommended several reforms with the goal of reducing premiums for lower-risk groups within the small group market. While this would decrease the subsidies that effectively lower the premiums of higher-risk groups, the intention of this proposed change is to encourage more low-risk groups to participate in the small group market, thus lowering the average overall claims costs in the small group market. The General Assembly continues to consider this recommendation.

Conclusions

This brief highlights several policy approaches that states have considered or experimented with in recent years to reduce the number of uninsured people working for small businesses. Some states have had much success with these approaches while other policy experiments have not yielded the outcomes that were desired. Therefore, policymakers and advocates considering new approaches for North Carolina should carefully examine the key lessons learned from past policy efforts in North Carolina as well as other states' experimentations with similar approaches.

The key theoretical assumption underlying the reform approaches described in this brief are that small employers will be more likely to offer insurance coverage to their workers when they perceive that costs of doing so are affordable. To the extent that these reforms can reduce the effective prices that employers and their employees face, many more workers in small firms may be offered private insurance options and thus may "take up" insurance. This is a desirable policy outcome, particularly if newly insured workers were previously uninsured.

However, policy efforts aimed at offsetting some of the inherent natural pricing disadvantages that small groups face, relative to larger employers, may not completely eliminate the gap in coverage between smaller and larger employers. First, even if small firms could receive the same premium offers as typical large employers, many small employers may still deem the absolute value of premiums to be prohibitively costly.

Second, there may be other reasons that workers in small firms lack insurance coverage. For example, some of the uninsured may not value insurance and thus may simply choose to go without coverage. Thus, policy approaches focusing solely on changing the relative prices that small groups and individuals working for small firms face may not completely address the myriad factors that may influence firm and individual decision-making. Policy efforts in Massachusetts and elsewhere to "mandate" individuals to purchase insurance are not based

solely on the notion that expensive premiums alone are the sole factors inhibiting insurance coverage among certain individuals. Such approaches seek to address affordability issues while simultaneously mandating coverage to induce participation in the health insurance market for those who may choose not to participate even if affordable coverage is available.

Beyond the policy options highlighted in this report, other options exist to expand insurance coverage, including expanding eligibility criteria and financing for public programs. These approaches, too, can be costly and can pose other challenges. However, the increasing number of Americans receiving health insurance coverage through public programs suggests the important role that state and federal governments play in ensuring health care coverage. Given the active state health policy reform environment of the last two decades, state policymakers have the opportunity to carefully consider the experiences of the many policy efforts that have been implemented across the country to expand both public and private insurance coverage.

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