

More Workers Eligible for Health Coverage Despite Lack of Growth in Employer Offer Rates

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

AT A GLANCE

This paper examines the percentage of employers offering health insurance from 2008–2018, with a focus on 2013–2018, to better understand how health insurance offer rates may have been affected by the Patient Protection and Affordable Care Act of 2010 (ACA) in addition to the Great Recession of 2007–2009 and the subsequent economic recovery. The data come from the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Many employers were expected to drop workplace health insurance with the introduction of the ACA, and some have done so. Since 2013, the percentage of employers with 1,000 or more employees offering health benefits to workers has been consistently above 99 percent, but smaller establishments have shown a steady, though not precipitous, decline in offer rates. For the smallest employers studied, those with fewer than 10 employees, the offer rate declined from 28 percent in 2013 to 21.7 percent in 2016.

However, in 2017, the overall percentage of private-sector employers offering health benefits increased for the first time since 2008. In 2008, 56.4 percent of private-sector employers offered health benefits. By 2016, it was down to 45.3 percent. It then increased to 46.9 percent in 2017. Yet, the increase in offer rates did not continue in 2018.

Despite the lack of an increase in offer rates, the percentage of workers eligible for health coverage through their job continued its upward trend. Between 2014 and 2018, the percentage of workers eligible for health coverage increased from 75.4 percent to 78 percent. This increase was likely due to changes in the composition of the work force. We found a shift to full-time employment, fewer workers considered low-wage, and a shift to larger firms.

There were years before 2017 when offer rates increased in various specific establishment size segments, perhaps due to the strengthening economy and lower unemployment rates.

Between 2017 and 2018, the increase in offer rates did not continue for most employer sizes. They increased slightly for employers with 10–24 employees, 100–999 employees, and 1,000 or more employees. They fell slightly for those with fewer than 10 employees and 25–99 employees.

This paper discusses the context for the recent trends and suggests factors that may influence future trends.

Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). This *Issue Brief* was written with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF), or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Introduction

What impact is the Patient Protection and Affordable Care Act of 2010 (ACA) having on availability of health coverage in the workplace? Are large employers continuing to offer coverage or are they choosing to pay the penalty? And what are small employers, free of a pay-or-play mandate, doing — continuing to maintain plans, setting up plans to help their employees satisfy their individual mandates, migrating to the new health exchanges, or moving away from offering health coverage? How has employee eligibility changed?

The Patient Protection and Affordable Care Act of 2010 (ACA) requires employers with 50 or more employees to either offer health insurance coverage or pay a penalty. Employers with fewer than 50 employees are exempt from this provision. However, the law includes a number of provisions intended to make it easier for small employers to obtain coverage for their employees. They include insurance market reforms, the Small Business Health Options Program (SHOP) or health insurance exchanges, and small employer tax credits. The ACA also requires that individuals have health insurance coverage or pay a penalty, though the Tax Cuts and Jobs Act of 2017 eliminated the financial penalty for not having health insurance starting in 2019.

Since the ACA was enacted in 2010, there have been numerous predictions that employers would drop coverage:

- The Congressional Budget Office (CBO) issued several predictions that between 5 and 20 million fewer people would have employment-based health coverage in 2019 as a result of fewer employers offering health coverage after the ACA.¹
- Ezekiel Emanuel, former senior health advisor to President Obama, predicted as recently as 2014 that fewer than 20 percent of workers would have coverage through their jobs by 2025.²
- In 2012, S&P Capital IQ Global Markets Intelligence projected that by 2020, 90 percent of workers with employment-based coverage would be shifted to individual coverage in public exchanges.³

There were also contrary views at the time. A number of studies concluded that there would be relatively little net change in the number of people with employment-based coverage in the short term as a result of the ACA, but there was less certainty on the longer-term effects.⁴ In addition, a 2016 *New York Times* story concluded that "... those predictions were largely wrong. Most companies, and particularly large employers that offered coverage before the law have stayed committed to providing health insurance."⁵

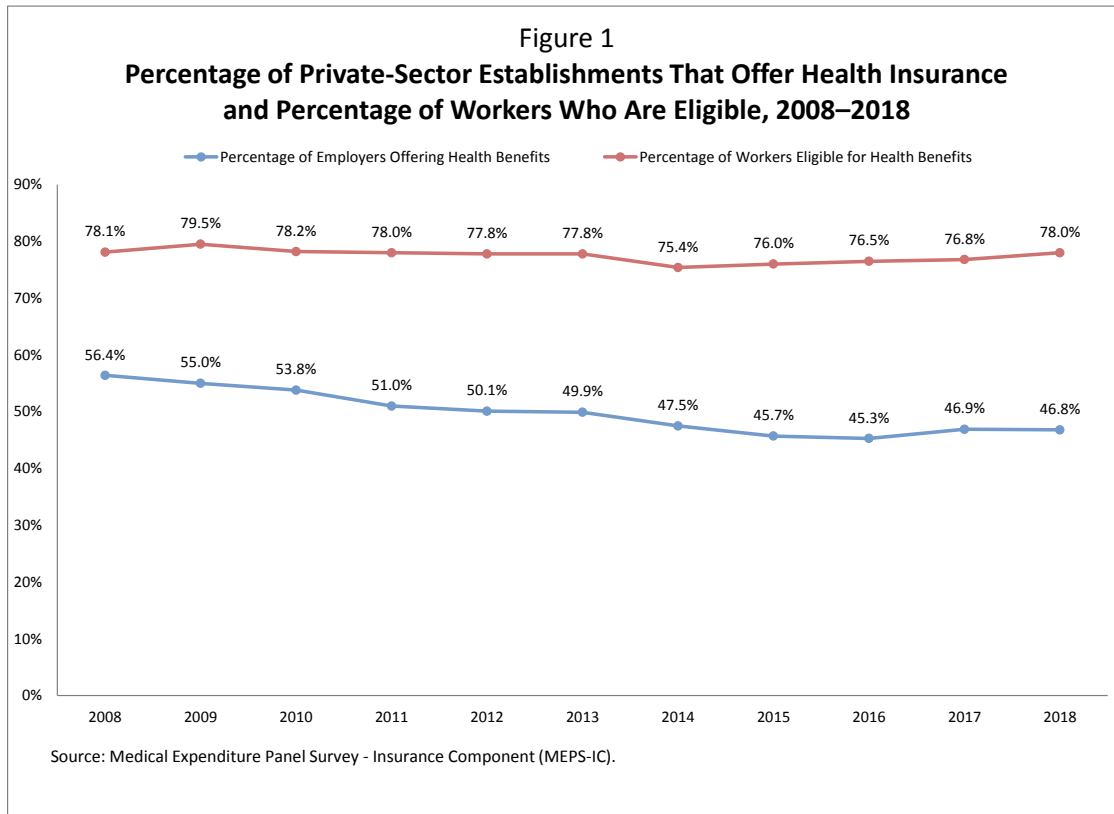
There are now several years of post-ACA-enactment data that, combined with pre-ACA data, help identify the trends in the availability of health plans by private-sector employers of various sizes. In this paper, we use data from the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC) to examine how the availability of employment-based health insurance has been changing. The MEPS-IC is a survey of private- and public-sector employers fielded by the U.S. Census Bureau for the Agency for Healthcare Research and Quality (AHRQ). The survey has been fielded annually since 1996 (with the exception of 2007). Over 40,000 private-sector establishments were interviewed in 2018.⁶

Overall Trend

In 2018, the overall percentage of workers employed by private-sector employers who were eligible for health benefits increased, continuing a trend that started in 2015. In 2018, 78 percent of workers employed by private-sector employers were eligible for health benefits, up from 75.4 percent in 2014 (Figure 1).

This increase occurred in 2018 despite the fact that the percentage of private-sector employers offering health benefits did not increase. In 2018, 46.8 percent of private-sector employers offered health benefits, essentially unchanged from 46.9 percent in 2017. As will be discussed in more detail below, there have been years before 2017 when offer rates increased in various specific establishment size segments.

The juxtaposition between the two trends suggests that workers have been migrating to jobs that are more likely to offer health coverage. We found evidence to support this in the form of a shift to full-time employment, fewer workers considered low-wage, and a shift to larger firms.



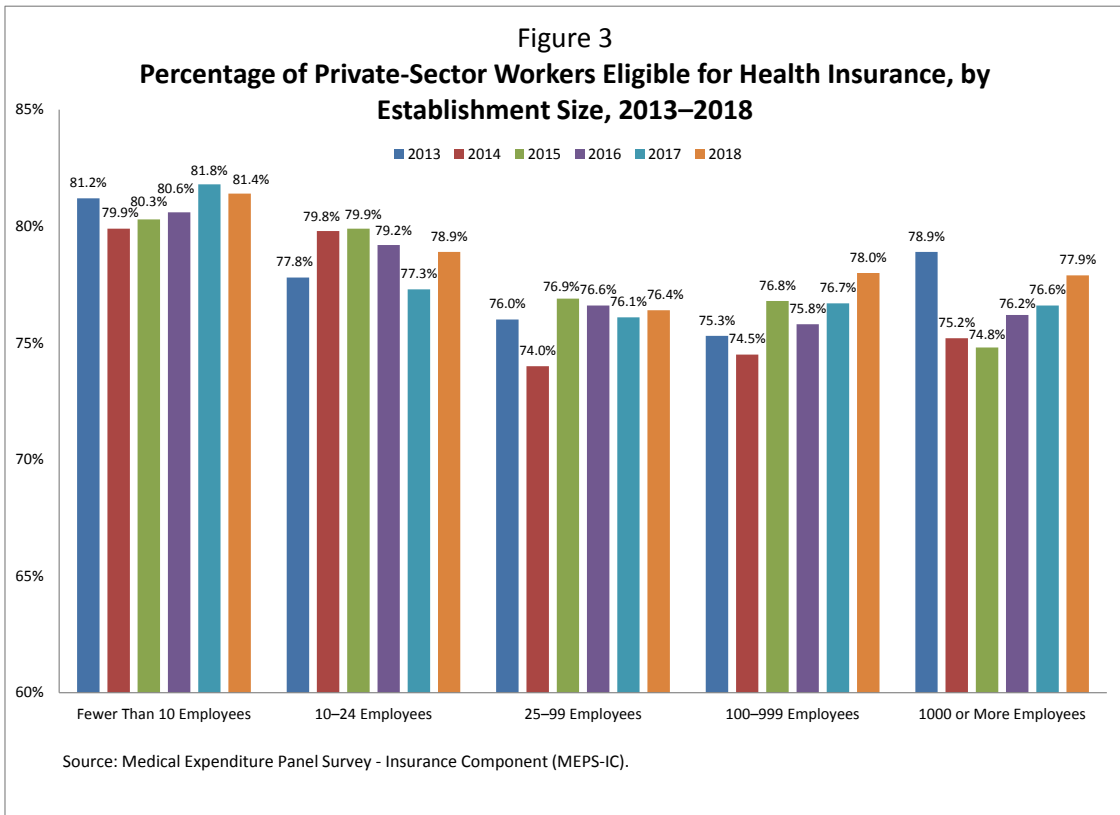
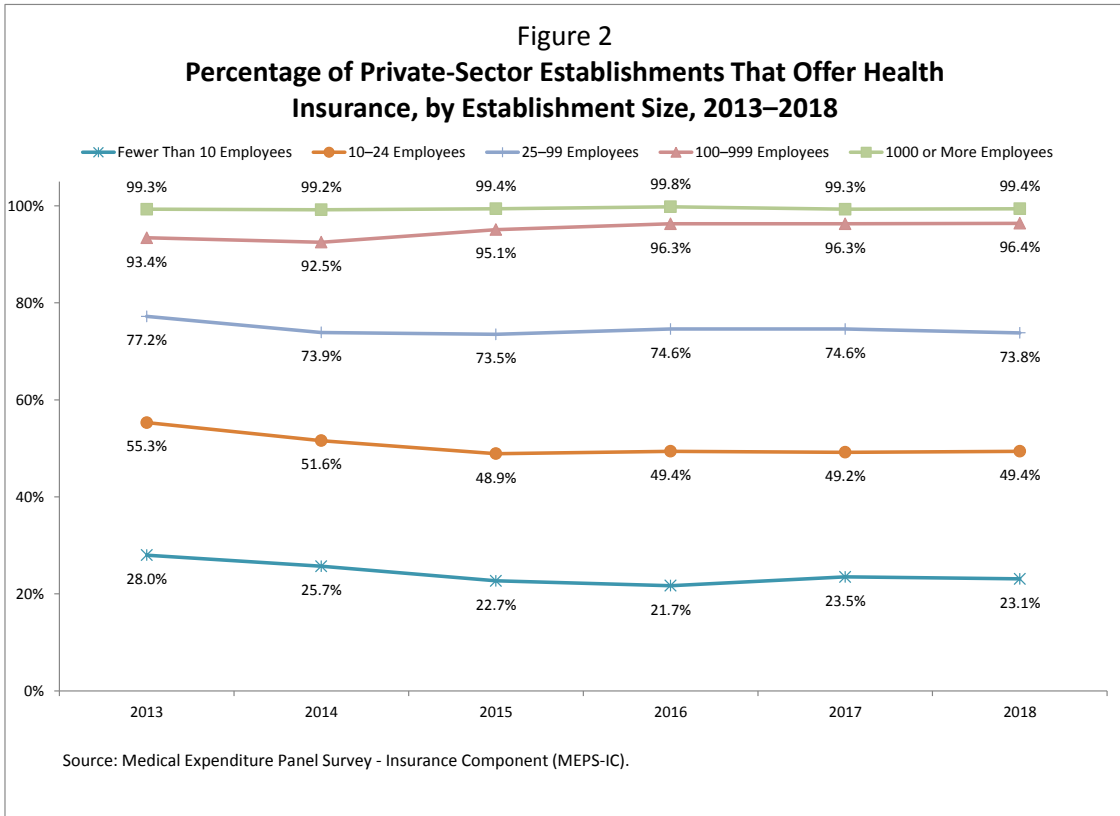
Availability of Health Coverage by Establishment Size

Generally, large employers have stayed the course by continuing to offer health coverage to their workers. Nearly all large employers offered health coverage before enactment of the ACA and continued to do so through 2018. Over this period, the percentage of employers with 1,000 or more employees that offered coverage was consistently above 99 percent and was 99.4 percent in 2018 (Figure 2).

In contrast to large employers, small and medium-sized companies did not stay the course. The percentage of small and medium-sized employers offering health benefits fell between 2013 and 2014, the year that most major provisions of the ACA took effect, though this continued a trend that started as far back as 2009.⁷ Interestingly, in August 2016, the *Wall Street Journal* reported on anecdotal evidence that some small companies that had dropped health benefits were restoring the benefits.⁸ National data collected since then bears this out: there appears to be the beginning of a rebound in employment-based coverage offer rates in every establishment size category below 1,000 starting between 2015 and 2017. The rebound stalled in 2018 not only in aggregate but also generally when examining the trend by firm size.

The percentage of workers eligible for health coverage (the eligibility rate) by establishment size is shown in Figure 3 — and trends here are less clearly defined. However, with the exception of establishments with 10–24 employees, eligibility rates increased between 2014 and 2018. Since 2014, the percentage of workers eligible for health insurance in establishments with fewer than 10 employees has increased from 79.9 percent to 81.4 percent. Similarly, the

eligibility rate increased from 74 percent to 76.4 percent among workers in establishments with 25–99 employees between 2014 and 2018. It increased from 75.2 percent to 77.9 percent among workers in establishments with 1,000 or more workers between 2014 and 2018.



Why Might More Workers Be Eligible for Health Coverage at a Time When Employers Are Not More Likely to Offer It?

Despite the fact that the percentage of employers offering health coverage in 2018 did not increase, we found that the percentage of workers eligible for health benefits continued a longer-term trend. The juxtaposition between the two trends suggests that workers have been migrating to jobs that are more likely to offer health coverage. We found evidence to support this.

We found a long-term shift to full-time employment, fewer workers considered low-wage, and a shorter-term shift to larger firms. The percentage of employers reporting that 75 percent or more of their workers were employed full time increased from 63 percent to 69 percent between 2014 and 2018 (Figure 4). Similarly, the percentage of workers in firms with low-wage workers comprising at least 50 percent of the work force fell from 29 percent in 2013 to 22 percent in 2018 (Figure 5). And, more recently, the percentage of workers employed in large establishments (those with 1,000 or more employees) increased from 46 percent to 48 percent between 2016 and 2018 (Figure 6).

Full-time workers are more likely than those employed part time to be offered health benefits. Similarly, larger firms are more likely than smaller firms to offer health benefits. These shifts, along with others, are not large, but they are large enough to result in an increased percentage of workers who are eligible for health benefits through their job.

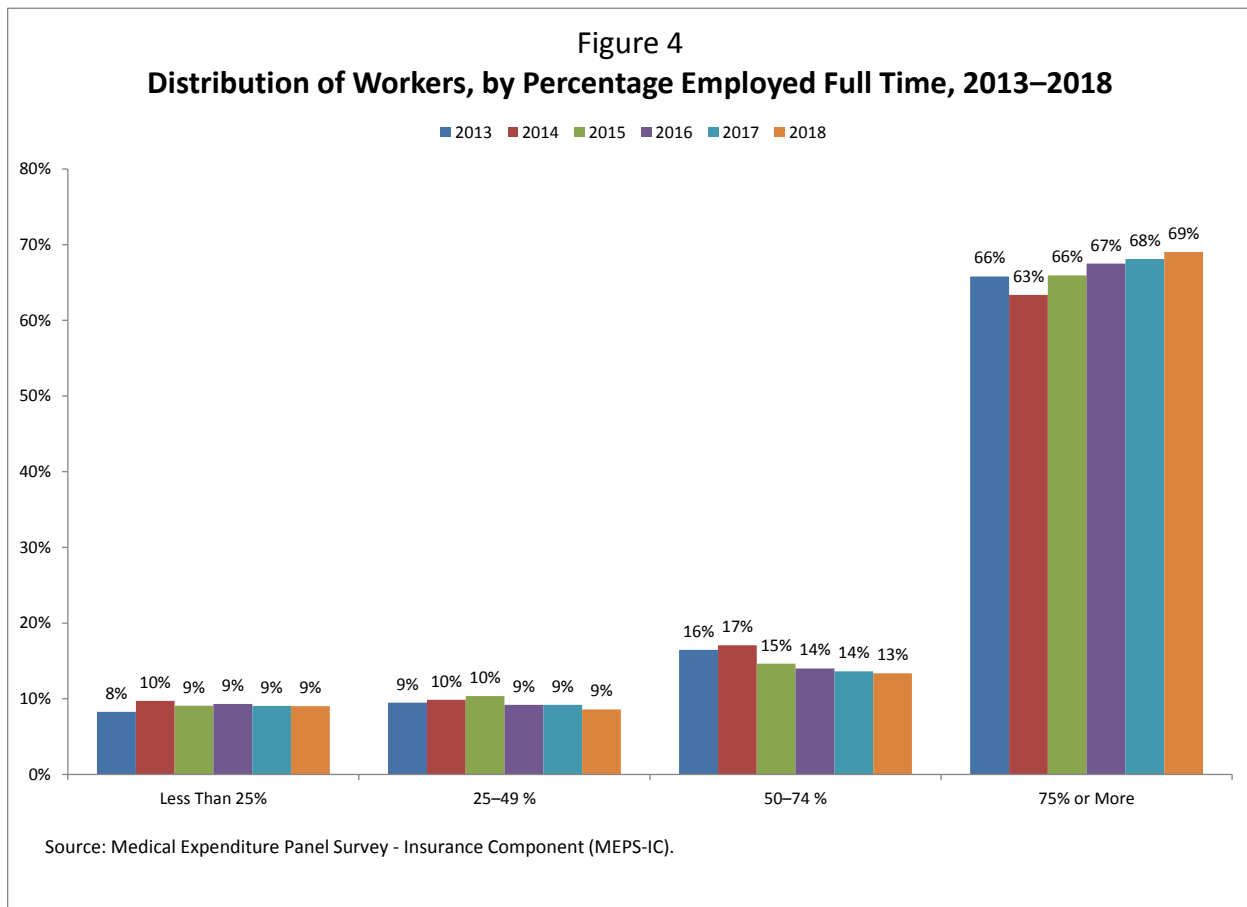
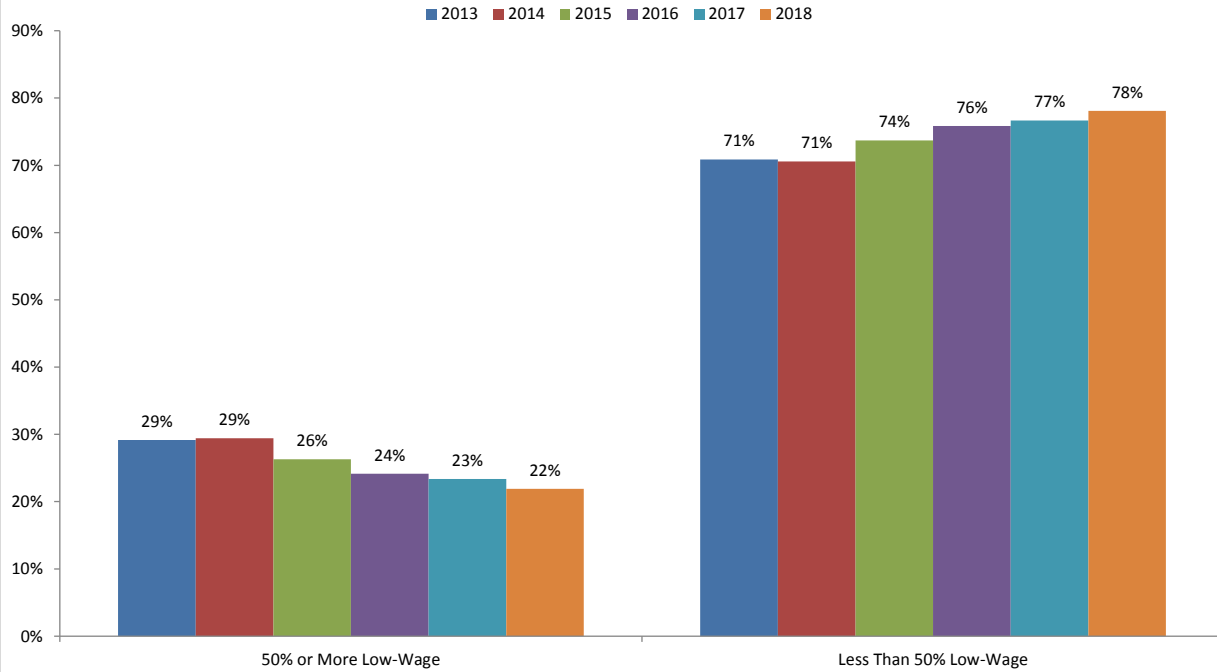
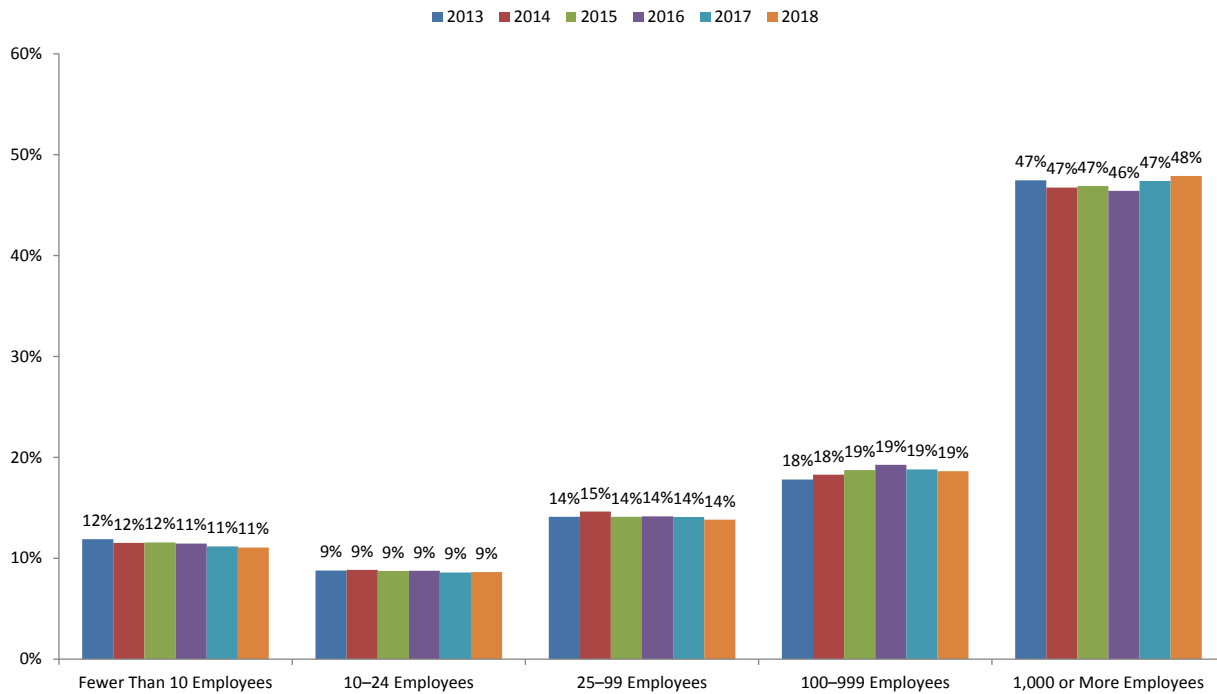


Figure 5
Distribution of Workers, by Percentage of Low-Wage Employees, 2013–2018



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 6
Distribution of Workers, by Establishment Size, 2013–2018



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

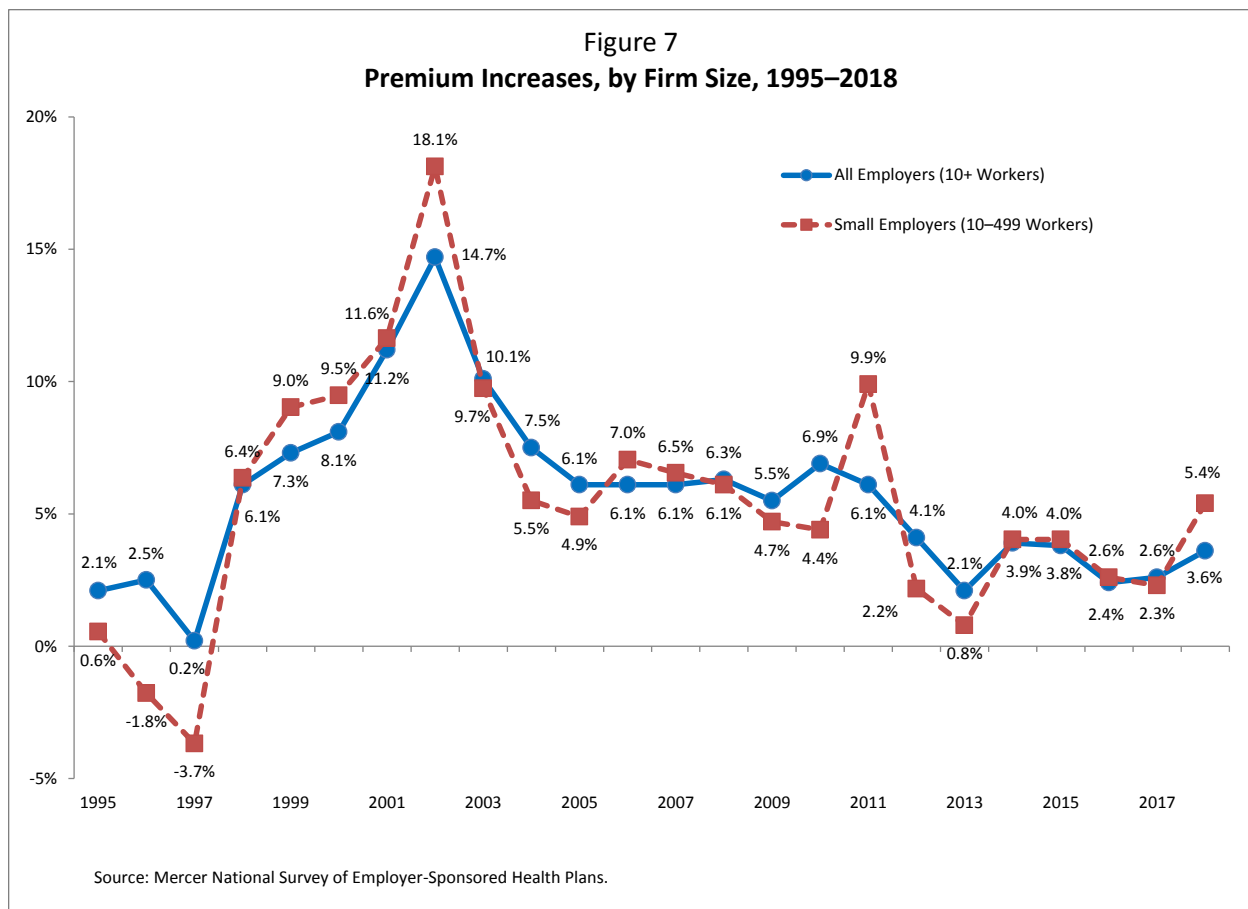
Why Did Small Employers Drop Health Coverage in the Past?

There are several plausible reasons for the decline in the availability of health coverage among smaller employers that occurred until recently, including rising health care costs, fear of rising health care costs, availability of non-group insurance in the public exchange, the 2007–2009 recession, labor market weakness, and post-recession business softness and uncertainty.

Historically, smaller employers have been less committed to offering health coverage than larger employers. One often-cited reason has been that smaller establishments, more than larger ones, frequently face higher and more volatile increases in health insurance premiums (Figure 7).⁹

When the 2007–2009 business recession occurred and unemployment rates rose to around 10 percent, many smaller employers that had been offering health coverage plans dropped them, leading to fewer workers with such coverage.¹⁰

The availability of coverage among small employers continued to decline after 2009 as business and labor/employment softness and uncertainty continued — as reflected in lower gross domestic product (GDP) growth and business profitability, higher unemployment rates, and projections of higher health care costs. Indeed, the business and labor/employment experiences associated with the recession and the sluggish subsequent years may have made many employers — and workers¹¹ — more cautious about taking on financial commitments they might not be able to fulfill in the future, particularly in another business slowdown.

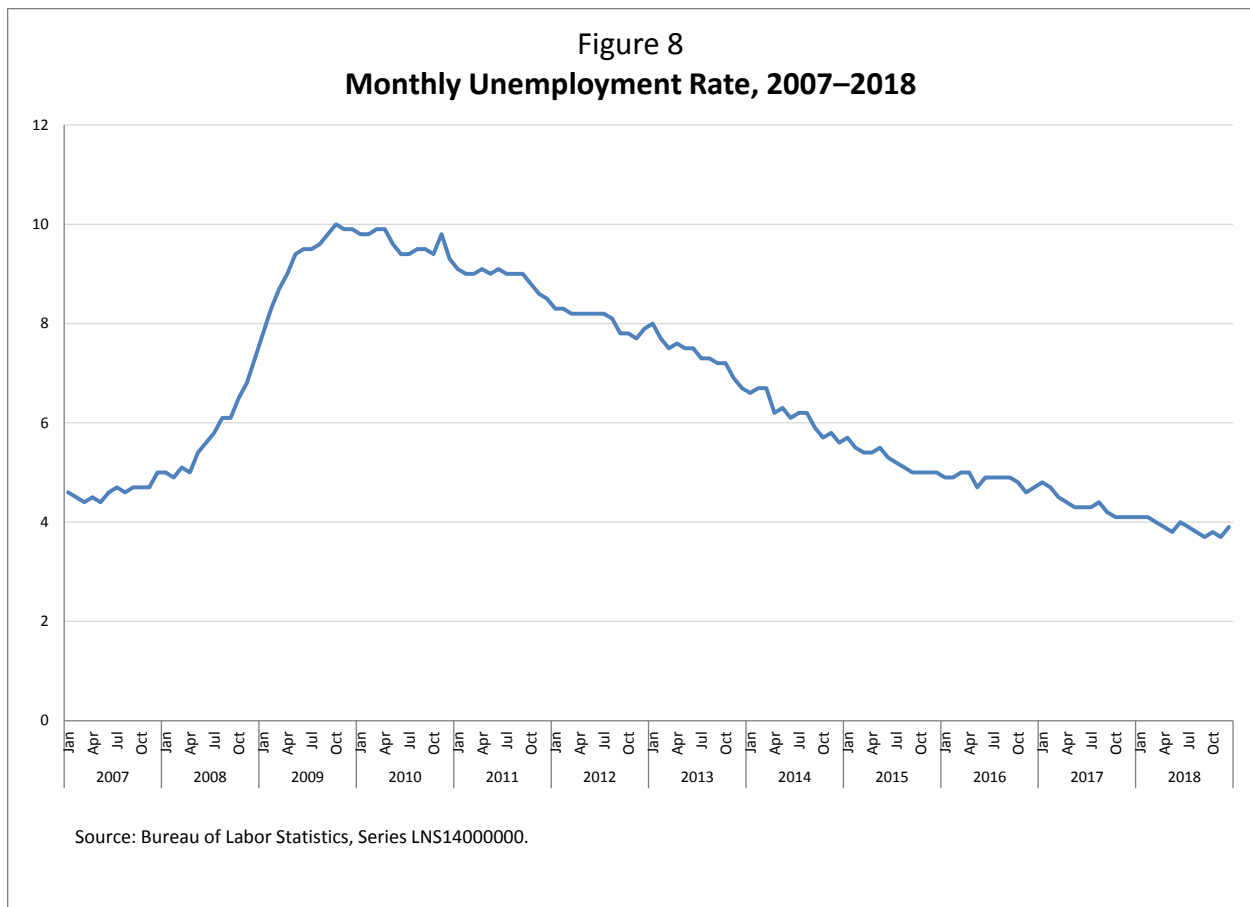


These factors may have been reinforced by the enactment of the ACA in 2010 and then the incremental application¹² of those requirements to smaller employers, for a couple of reasons:

- The ACA requirements may have convinced many smaller employers that offering health coverage would become a more regulated and expensive benefit — something to stay away from.
- Workers with smaller establishments could get health coverage in ACA-mandated public exchanges where they could not be denied coverage for pre-existing conditions, premiums would not vary with health status, subsidies would be available for those with income below 400 percent of the federal poverty level, and in many cases there would be more plan choices than smaller employers are typically able to provide.

In other words, for many smaller employers, the business, labor/employment, and health care environments all tended to change the cost-benefit calculation against offering health coverage — greater costs and risks, with reduced differentiation, attraction, and retention benefits.

In 2017, circumstances appeared to change again for some small employers, making it more advantageous to offer health coverage. With respect to health insurance premiums, for the last few years, premium increases have been relatively low and less volatile. With respect to the economy and the labor market, the unemployment rate has continued to trend down. It was below 5 percent for most of 2016, trending down to 4.1 percent by the end of 2017 (Figure 8). When unemployment is low, recruiting and retaining workers becomes a bigger challenge for employers, including some smaller employers, which in turn often means improving compensation and benefits.



Large and Medium-Sized Employers in the Future?

While the percentage of employers sponsoring a health plan has been relatively steady for large and medium-sized employers, some have predicted that even these employers — traditionally more committed to offering health coverage to their workers — will begin to move away from offering those benefits in the future.¹³ There's no doubt that many of these employers have already made significant changes in the nature of the coverage that is offered, moving from defined benefit to defined contribution approaches that include more individual cost-sharing (both through employee premiums or contributions and employee out-of-pocket expenses) and decision-making responsibilities; shifting to private health insurance exchanges; adopting wellness programs; and more generally supporting greater consumer engagement in health care.¹⁴

More larger and medium-sized employers may continue to reduce their involvement in their own health plans, increasingly concluding that offering their own health plans is not crucial to the attraction and retention of their employees — so why take on the costs and risks? When the next business slowdown (and corresponding rise in unemployment rates) takes hold, it will be interesting to see if fewer larger and medium-sized employers continue to offer health coverage.

It's also possible that certain public policy changes, if adopted, may drive some employers — large and small alike — away from offering health benefits and cause some workers to care less about whether they get health coverage from their employer. For example, the tax exclusion of employment-based health coverage could be changed, as has been proposed in the past.¹⁵ Similarly, while the excise tax on high-cost plans (aka the Cadillac tax) has been delayed numerous times, the tax may take effect at some point.

While there are many reasons to expect employers to move away from offering health benefits, there are also reasons to expect employers to continue offering them. Large employers may continue to sponsor their own health plans because of the concern that employees and their dependents may be impacted by continued volatility in both choice and premiums in the non-group market. Employers may also be hesitant to move away from offering coverage because of the uncertainty of the future of ACA and what that might mean for the availability of non-group coverage. Employers may continue to offer benefits because they need healthy employees and may think that they can do a better job of investing in worker health than either the non-group market or the government. Finally, employers may be hesitant to move away from offering health coverage simply because of the strong economy and lower unemployment rates, which make it hard to drop such a benefit in an environment where it is challenging to recruit and retain workers.

Health Reimbursement Arrangements and the Future of Health Benefits in the Workplace

In June 2019, the Trump administration issued a final rule¹⁶ to expand the use of stand-alone health reimbursement arrangements (HRAs) by employers of all sizes. This rule follows the regulations¹⁷ issued by the departments of Treasury, Labor, and Health and Human Services in October 2018 — at the direction of an executive order by President Trump.

HRAs are employer-funded health plans that reimburse employees for qualified medical expenses. They are typically combined with a high-deductible health plan. Distributions from HRAs for qualified medical expenses are made on a tax-favored basis. Unused funds are allowed to roll over, at the discretion of employers. Under the final rule, employers would be able to offer a stand-alone HRA that workers could then use to purchase health insurance in the non-group market. The HRA would have to be used to purchase ACA-compliant plans and would have to meet ACA affordability requirements in order for the employer to meet the shared responsibility requirement. The HRA would not be subject to ERISA if certain conditions are met. There is no limit to the amount of money that an employer can contribute to an HRA.

The administration expects around 800,000 employers will offer stand-alone HRAs by 2024 and beyond. As a result, some 10.7 million individuals would be covered by such an HRA by 2027 and 6.8 million fewer workers (and their dependents) would have traditional employment-based health coverage.

It is no surprise that there would be fewer people with traditional employment-based health coverage. Employers have been interested in the concept of “defined contribution (DC) health” coverage, and giving workers an HRA that they can use to purchase coverage in the non-group market may be an attractive means of moving to DC health. Employers never moved in the direction of giving workers a fixed contribution to purchase health insurance for a number of reasons. Historically, they were hesitant to drop group coverage in favor of offering individual policies because the non-group market was not considered a viable alternative to the employment-based system. And, more recently, even with the advent of private health insurance exchanges, employers did not embrace them as the initial hype would have expected us to believe.¹⁸

There is no question that the HRA provision gives employers the means to drop traditional health coverage and go to a “DC health”-type plan. One of the concerns is that employers will try to structure their plans in such a way to send high-risk employees to the individual market. The regulations include a number of provisions to prohibit such a discriminatory practice. However, what if only employers facing the highest premiums in the group market adopted HRAs? If such a phenomenon occurred, the non-group market would not become more stable and may see average premiums increase. In contrast, the group market would see a reduction in average premiums as higher-risk groups left.

Employers may require that there be a viable non-group market for their employees to go to before moving to HRAs. Stability in premiums may be one requirement, which may make it less likely that multi-state employers move to HRAs given the variation in premium growth across states. The quality of the benefits offered is another consideration. For instance, the prevalence of narrow network plans in the non-group market may be something that continues to hold employers back from HRAs. And of course there is always the uncertainty of future changes in the non-group market, as employers have no control over that marketplace and would have no control over how workers spent HRAs in the non-group market.

There are a number of unanswered questions. Which employers would go in this direction, under what circumstances, and for which employees? Would it vary by firm size? Do the strength of the economy and labor market conditions factor in? The next recession will be the first recession in history since the insurance market reforms were put into place by the ACA. It will be the first time in history that a recession is paired with the inability of insurance companies to deny people coverage for pre-existing conditions or to charge them more for such conditions. It will also be the first time that health insurance premiums for people under 400 percent of the federal poverty level are subsidized by the federal government during a recession in a meaningful way. Employers may decide that they no longer need to offer health benefits to be competitive in the labor market during the next recession, and the combination of the insurance market reforms and the ability to give workers tax-free money to purchase health insurance on their own may finally put the future of employment-based health coverage to the test.

While employers can expand the use of HRAs in 2020, the final rule may face a court challenge and is subject to congressional oversight hearings in the U.S. House of Representatives.

Conclusion

Despite predictions to the contrary, employers did not drop health benefits en masse after the ACA was passed and took effect. Immediately after the ACA passed, there continued to be a small erosion in the availability of coverage, but soon thereafter, there was a small increase in the percentage of employers offering coverage. The increase in employer offer rates combined with structural changes in the labor force resulted in a nearly 3 percentage point increase in the percentage of workers eligible for health benefits between 2015 and 2018. Yet, the employment-based health benefits system faces threats. A combination of a recession, higher unemployment, and the availability of HRAs that workers

can use to purchase health benefits through the non-group market could someday put the resilience of the employment-based health benefits system at risk.

Endnotes

¹ Note that the CBO also found that there could be 3 million *more* people with employment-based coverage under a certain set of assumptions. See Table 4 in <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf>, Table 4 in http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf, Table 2 in https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45231-ACA_Estimates.pdf, Table 2 in <https://www.cbo.gov/sites/default/files/51298-2015-03-ACA.pdf>, and Table 4 in <https://www.cbo.gov/sites/default/files/51298-2016-03-HealthInsurance.pdf> (last reviewed July 2019).

² Emanuel, Ezekiel J. "Reinventing American Health Care: How the Affordable Care Act Will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone System." *PublicAffairs* (2014).

³ See http://www.calhospital.org/sites/main/files/file-attachments/akemp_-_attachment_-_sp_report.pdf

⁴ See the summary by the U.S. Government Accountability Office in <http://www.gao.gov/assets/600/592411.pdf>

⁵ See Abelson, Reed. "Despite Fears, Affordable Care Act Has Not Uprooted Employer Coverage." *New York Times* (April 4, 2016), <http://www.nytimes.com/2016/04/05/business/employers-keep-health-insurance-despite-affordable-care-act.html>

⁶ Note that the survey collects data from private establishments, which consist of a single physical location. It is possible that some large employers could be overrepresented in the survey if more than one location was surveyed. See https://meps.ahrq.gov/mepsweb/survey_comp/ic_sample_size.jsp for more information.

⁷ See Fronstin, Paul. "After Years of Erosion, More Employers are Offering Health Coverage; Worker Eligibility Higher." *EBRI Issue Brief*, no. 455 (Employee Benefit Research Institute, August 2018), <https://www.ebri.org/health/publications/issue-briefs/content/after-years-of-erosion-more-employers-are-offering-health-coverage-worker-eligibility-higher>

⁸ See Simon, Ruth. "Some Small Businesses Restore Group Health Coverage." *Wall Street Journal* (August 21, 2016), <https://www.wsj.com/articles/some-small-businesses-restore-group-health-coverage-1471771802>

⁹ See Lee, Jason. "Are Health Insurance Premiums Higher for Small Firms?" *Research Synthesis Report No. 2*, Robert Wood Johnson Foundation (September 2002), online at <https://pdfs.semanticscholar.org/a26a/a32fe9c3500ef0e2ddb1505e09e10da4cac.pdf>

¹⁰ The Cawley et al. (2011) study found that the health insurance coverage of men is sensitive to the unemployment rate, with higher unemployment rates leading to less health insurance coverage. See Cawley, John, Asako S. Moriya, and Kosali I. Simon. "The Impact of the Macroeconomy on Health Insurance Coverage: Evidence from the Great Recession." *NBER Working Paper* No. 17600 (November 2011), <http://www.nber.org/papers/w17600>

¹¹ There is a growing body of evidence that Millennials, who make up an increasing percentage of workers, may be generally more cautious about making financial commitments. For example, compared with previous generations, Millennials who have graduated college will on average earn more money (adjusted for inflation) but face significantly higher costs of living. In addition, over one-half (55 percent) of 18- to 29-year-olds report they are watching their spending "very closely" these days, up from 43 percent of 18- to 29-year-olds who shared that view in 2006. See <http://www.pewsocialtrends.org/files/2010/10/millennials-confident-connected-open-to-change.pdf> and <http://www.pewsocialtrends.org/2014/02/11/chapter-1-education-and-economic-outcomes-among-the-young/>

¹² The ACA subjects small employers to a number of different requirements that took effect at different points in time. For example, beginning in 2014, individuals were required to have health insurance for themselves. This may have resulted in more workers taking health insurance when offered. In 2015, employers with 100 or more full-time workers were subject to a penalty if they did not offer workers affordable coverage. This provision took effect in 2016 for employers with 50–99 employees.

¹³ See the summary of employer surveys by the U.S. Governmental Accountability Office in <http://www.gao.gov/assets/600/592411.pdf> and http://www.calhospital.org/sites/main/files/file-attachments/akemp_-_attachment_-_sp_report.pdf

¹⁴ See <http://content.healthaffairs.org/content/34/10/1779.long>

¹⁵ See Fronstin, Paul. "Employment-Based Health Benefits and Taxation: Implications of Efforts to Reduce the Deficit and National Debt" *EBRI Issue Brief*, no. 360 (Employee Benefit Research Institute, July 2011), <https://www.ebri.org/health/publications/issue-briefs/content/employment-based-health-benefits-and-taxation-implications-of-efforts-to-reduce-the-deficit-and-national-debt-4846>

¹⁶ See <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-12571.pdf>

¹⁷ See <https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

¹⁸ See Fronstin, Paul. "Private Health Insurance Exchanges and Defined Contribution Health Plans: Is It Déjà Vu All Over Again?" *EBRI Issue Brief*, no. 373 (Employee Benefit Research Institute, July 2012), <https://www.ebri.org/health/publications/issue-briefs/content/private-health-insurance-exchanges-and-defined-contribution-health-plans-is-it-d%C3%A9j%C3%A0-vu-all-over-again--5092>

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