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Employment-Based Health Benefits System Continues Its Resilience: Challenges May Be on the Horizon

A Look at Employers Offering Health Benefits and Worker Eligibility

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

AT A GLANCE

Many employers were expected to drop workplace health insurance with the introduction of the Patient Protection and Affordable Care Act of 2010 (ACA), and some have done so. But, as this paper finds, there is considerable variation in the trends around those offering health insurance as well as in eligibility for health insurance benefits depending on establishment size and other factors.

This paper examines the percentage of employers offering health insurance from 2008–2021, with a focus on 2013–2021, to better understand how health insurance offer rates may have been affected by the 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).

The data show:

- In 2017, the overall percentage of private-sector employers offering health benefits increased for the first time in nearly a decade. In 2008, 56.4 percent of private-sector employers offered health benefits. By 2016, it was down to 45.3 percent. By 2021, it was up to 49.2 percent.
- In 2021, the overall percentage of workers employed by private-sector employers who were eligible for health benefits was unchanged. However, since 2014, the percentage of workers eligible for health benefits has been trending upward.
- Since 2013, the percentage of employers with 1,000 or more employees offering health benefits to workers has been consistently near or above 99 percent.
- Smaller establishments have shown more variability in offer rates. For the smallest employers studied, those with fewer than 10 employees, the offer rate declined from 28 percent in 2013 to 22.3 percent in 2021 but increased to 24.6 percent in 2021.

It is highly unlikely that larger and medium-sized employers will conclude that offering their own health plan is not crucial to the attraction and retention of workers. Despite the recent talk of whether the United States is in a recession, unemployment rates fell throughout 2022 and are currently at historically low levels. However, 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. This did not occur during the COVID-19 pandemic.

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. The tax exclusion of employment-based health coverage could be changed, an old idea which has recently come to light again. The Biden Health Care Plan and individual coverage health reimbursement arrangements (ICHRAs) may disrupt the strong link between employment and health coverage.

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Introduction

The impact of the Patient Protection and Affordable Care Act of 2010 (ACA) on availability of health coverage in the workplace has been the subject of considerable debate. 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 several 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 because 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 2014, 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]

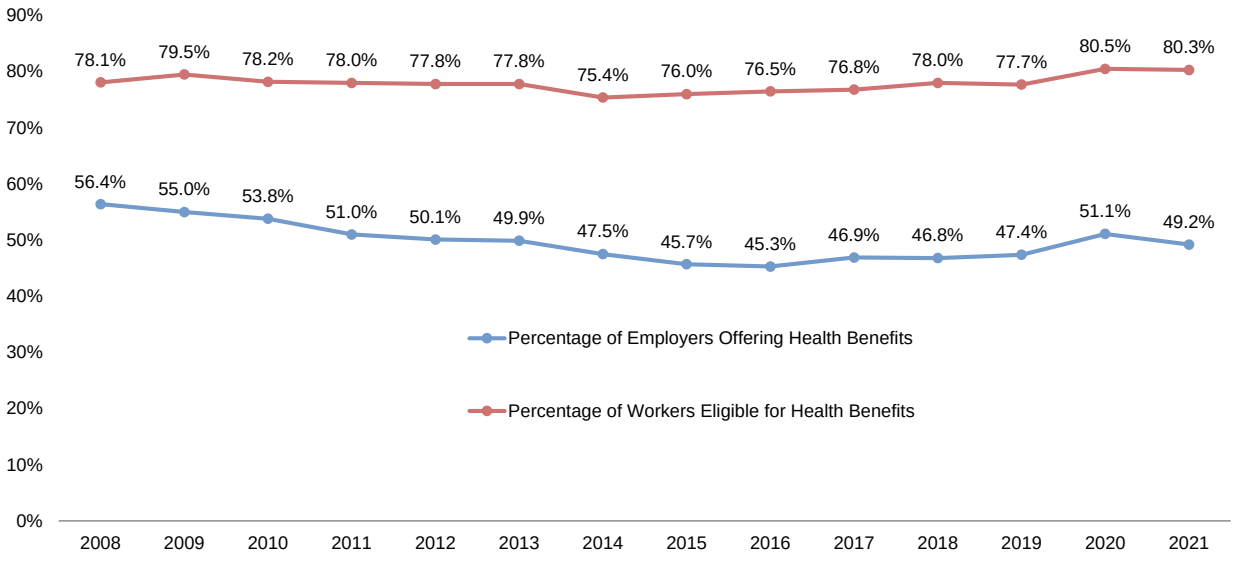
There are now years of post-ACA-enactment data that, combined with pre-ACA data, help identify the trends in the availability of health plans by private-sector employers of various sizes. In this paper, we use data from the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC) to examine how 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). Nearly 40,000 private-sector establishments were interviewed in 2021.[6]

Overall Trend

In 2021, the overall percentage of workers employed by private-sector employers who were eligible for health benefits was unchanged. However, since 2014, the percentage of workers eligible for health benefits has been trending upward.

In 2021, 80.3 percent of workers employed by private-sector employers were eligible for health benefits, up from 75.4 percent in 2014 (Figure 1).

Figure 1
Percentage of Private-Sector Establishments That Offer Health Insurance and Percentage of Workers Who Are Eligible, 2008–2021



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

The percentage of workers eligible for health benefits was unchanged between 2020 and 2021 despite the fact that the percentage of private-sector employers offering health benefits fell. It fell from 51.1 percent in 2020 to 49.2 percent in 2021.

The finding that in 2021 the percentage of private-sector employers offering coverage and the percentage of workers eligible for such coverage increased might be surprising, given the impact that the COVID-19 pandemic had on the economy and the labor market and the rebound that took effect in 2021. First, while low unemployment rates at the time were perhaps a major factor influencing whether an employer would continue to offer health benefits, an employer's decision to offer health benefits in 2021 was made in 2020, during the COVID-19 pandemic, at a time before vaccines were widely available. Note however that the findings may suffer from a selection bias. Firms that shut down because of the COVID-19 pandemic, forcing their workers to lose health benefits, may not have responded to the survey in 2020, causing the offer rate to be higher in 2020 than it actually was. In fact, the 2020 finding could be seen as a blip in a longer-term upward trend. With the exception of 2020, the 49.2 percent offer rate in 2021 continued the longer-term trend toward higher offer rates that started in 2016.

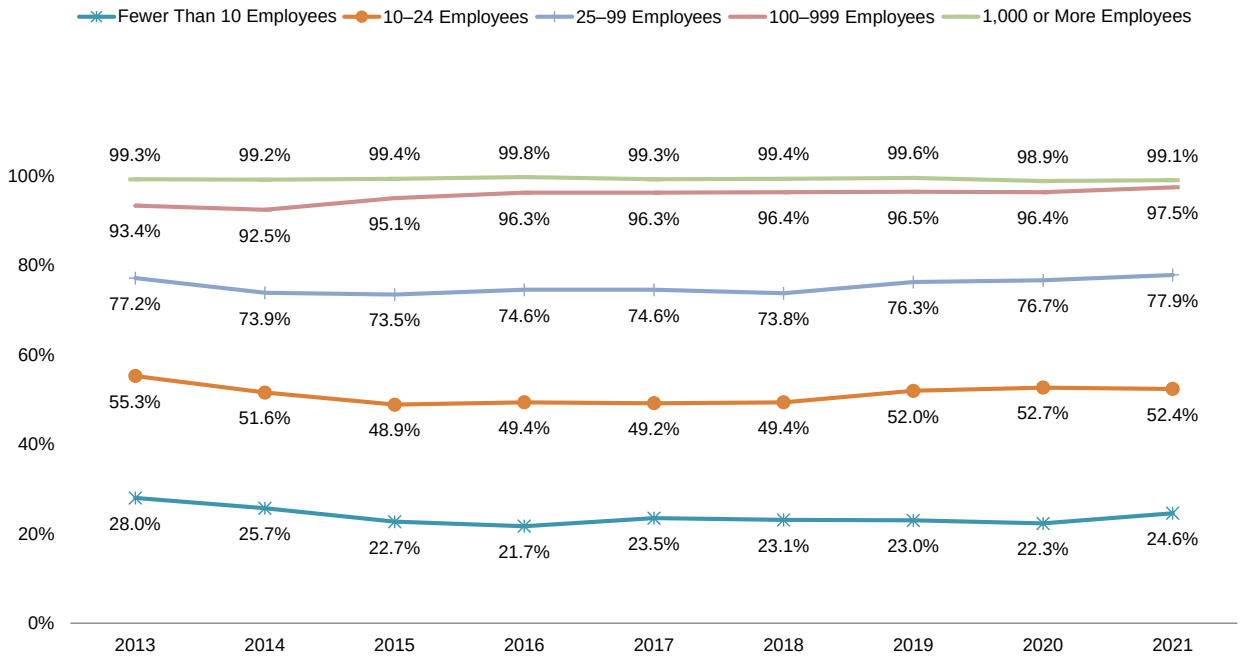
Availability of Health Coverage by Establishment Size

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 2020. Over this period, the percentage of employers with 1,000 or more employees that offered coverage was consistently near or above 99 percent (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 bear 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 continued through 2021.

Figure 2
Percentage of Private-Sector Establishments That Offer Health Insurance, by Establishment Size, 2013–2021

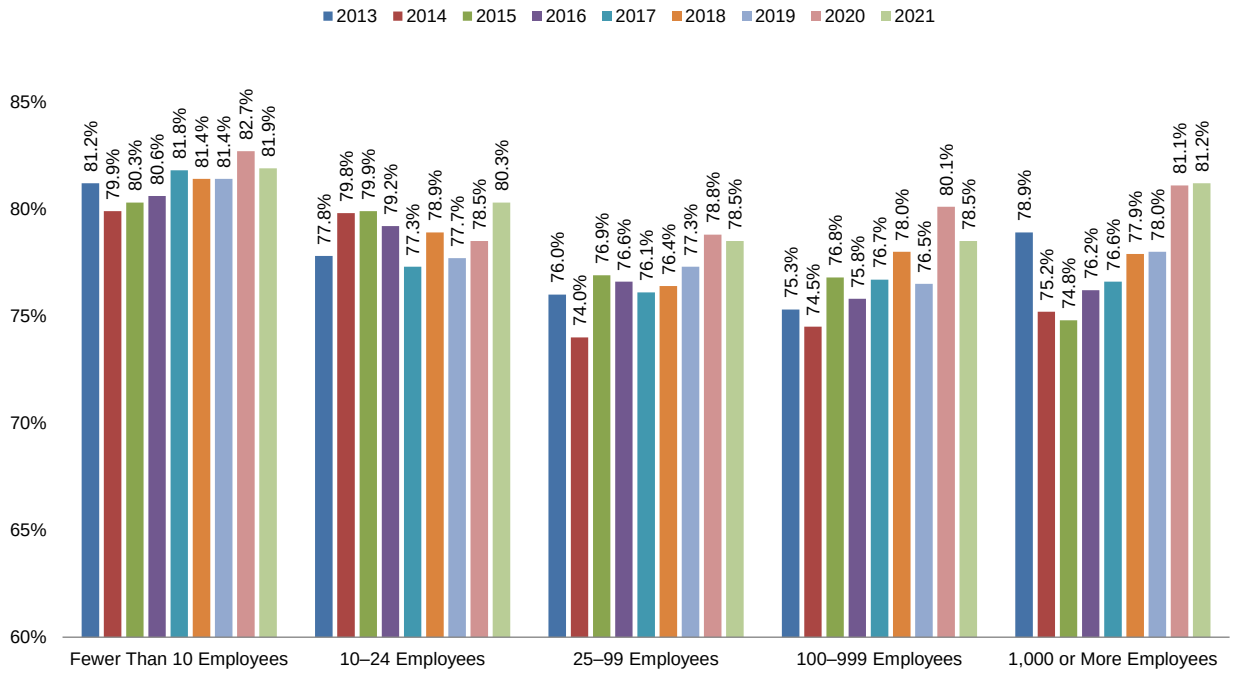


Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

There is a disconnect between the overall trend in offer rates and the trend by establishment size. The overall rate fell between 2020 and 2021, but for nearly every establishment size, it increased. And the decline for firms with 10–24 employees was not large enough to explain the overall decline. Instead, the overall decline is a quirk that is due to the changing composition of the distribution of establishments by size, driven mostly by establishments with fewer than 10 employees. These establishments had by far the lowest health insurance offer rates — below 25 percent since 2015. In 2019, they accounted for 58 percent of firms, and in 2021, they accounted for 57 percent of firms. However, in 2020, they accounted for only 52 percent of firms.[9] As such, the overall rate was less affected by their lower offer rate in 2020, which explains why the overall 2020 offer rate was so much higher than it was in 2019 and 2021.

The percentage of workers eligible for health coverage (the eligibility rate) by establishment size is shown in Figure 3. Eligibility rates are trending upward, but the trends are not quite a straight line. Even though small employers are least likely to offer health benefits, workers in smaller firms are most likely to be eligible for health benefits when they are offered. This phenomenon is due to historical minimum participation and minimum contribution requirements in the states. States generally require that a minimum percentage of workers offered coverage must enroll or have coverage from another source. As a result, it is common for small employers to offer coverage to all workers, and it is also more common than in larger firms for the employer to pay the entire premium for employee-only coverage.

Figure 3
Percentage of Private-Sector Workers Eligible for Health Insurance, by Establishment Size, 2013–2021



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

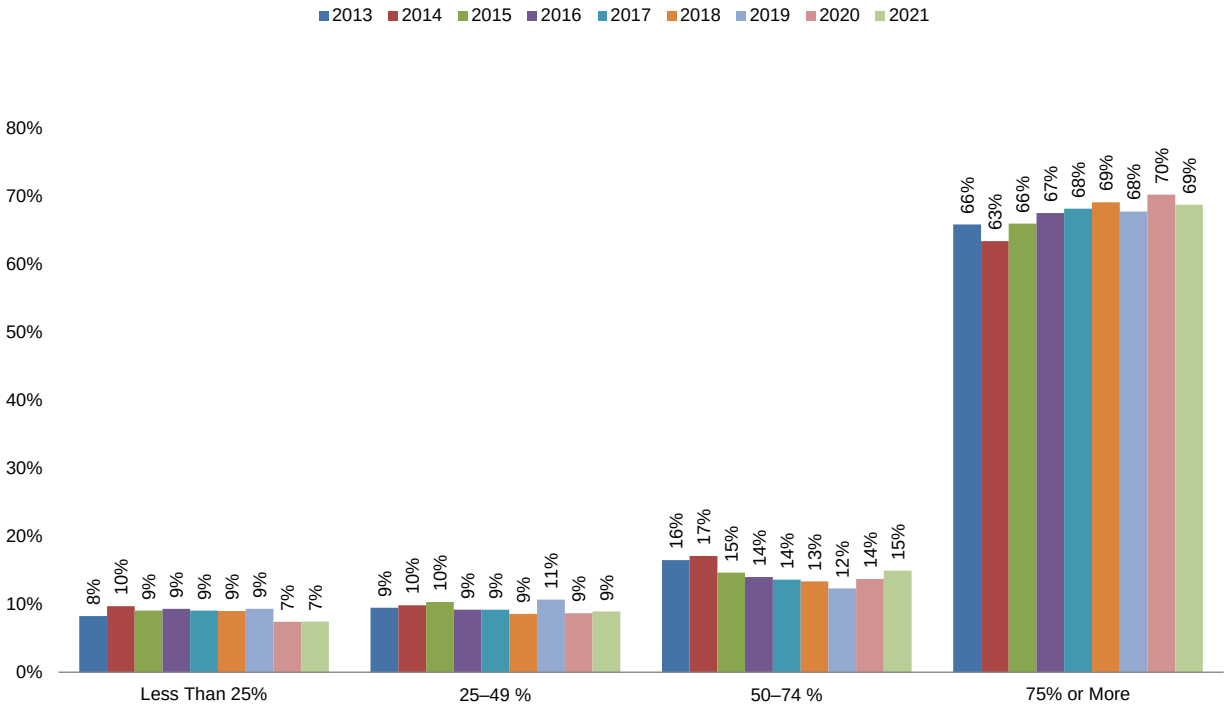
Why Might More Workers Be Eligible for Health Coverage?

We found that the percentage of workers eligible for health benefits continued a longer-term trend. While increasing offer rates is one reason why more workers are eligible for coverage, we also found that workers have been migrating to jobs that are more likely to offer health coverage.

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 2021 (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 16 percent in 2021 (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 49 percent between 2016 and 2021 (Figure 6).

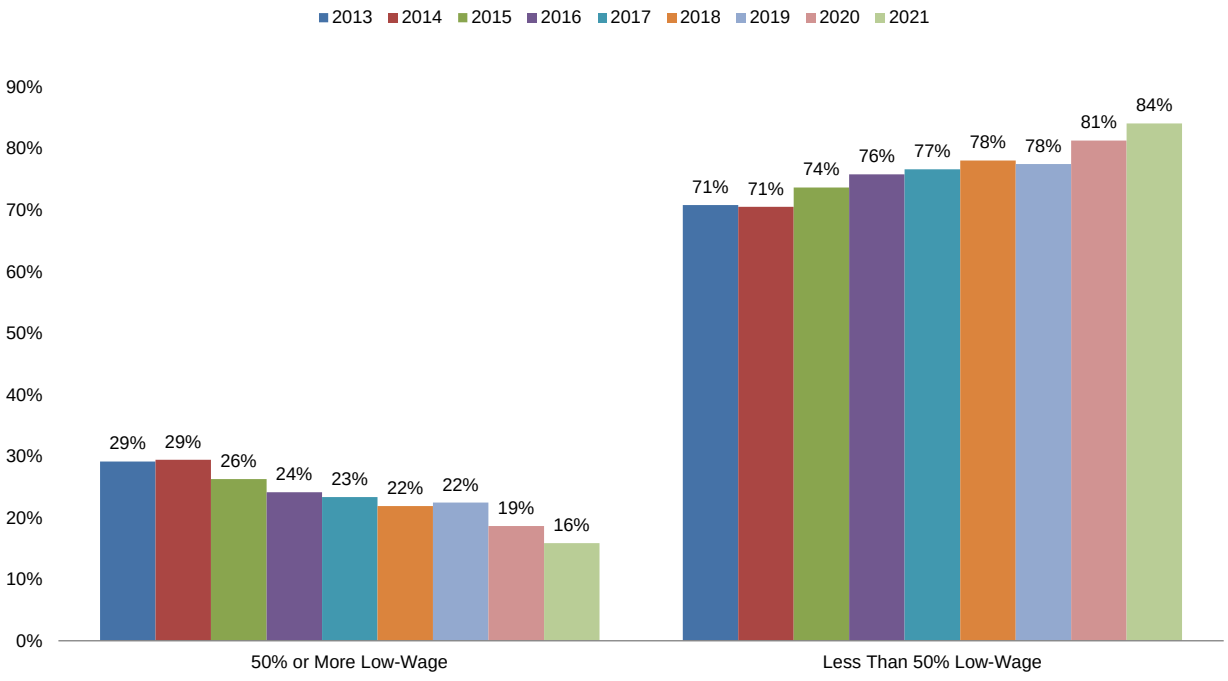
Full-time workers are more likely than those employed part time to be offered health benefits. Similarly, larger firms are more likely than smaller firms to offer health benefits. These shifts, along with others, are not large, but they are large enough to result in an increased percentage of workers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

Figure 4
Distribution of Workers by Percentage Employed Full-Time, 2013–2021



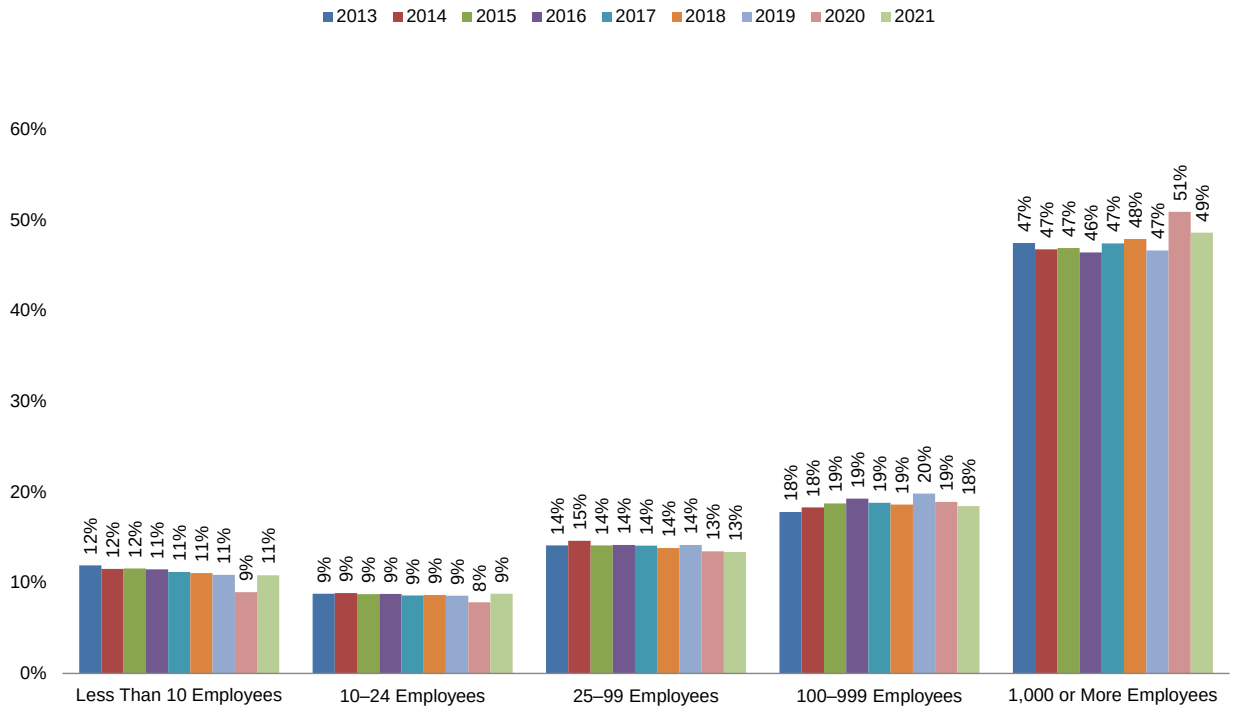
Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 5
Distribution of Workers by Percentage of Low-Wage Employees, 2013–2021



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

Figure 6
Distribution of Workers by Establishment Size, 2013–2021



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

Rebound Among Smallest Employers Never Materialized

There appeared to be the beginning of a rebound in health benefits among the smallest employers between 2016 and 2017. The rebound appears to have stalled for a few years. The increase between 2019 and 2021 may be the beginning of a new trend or may be a one-time adjustment related to conditions in the labor market. Yet, smaller employers continue to be 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.[10]

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.[11] 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 workers[12] — 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 application[13] 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 incomes 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.

The bottom line, however, is that the smallest employers were never quite committed to offering health benefits. In 1996, only about one-third offered health benefits (data not shown in figure). Furthermore, while the ACA enabled such employers to offer coverage through public exchanges, there was no reason to take on a new benefit when the workers in these firms would qualify for subsidized coverage in exchanges in the absence of their employers offering them coverage.

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.[14] 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; encouraging telemedicine; and more generally supporting greater consumer engagement in health care.[15]

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? At the moment, it is highly unlikely that employers will move in this direction given current low unemployment rates. Despite the recent talk of whether the United States is in a recession, unemployment rates fell throughout 2022 and are currently at historically low levels. However, 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. This did not occur during the COVID-19 pandemic, perhaps because of the optics related to dropping health benefits in the middle of a national health emergency.

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, an old idea that has recently come to light again.[16] The Biden Health Care Plan, as discussed in the next section, may impact the strong link between employment and health coverage. The plan would effectively create incentives for workers to choose ACA exchange coverage over employment-based health coverage and for employers to stop offering employment-based health coverage.

The Potential Impact of the Biden Health Care Plan

During the campaign leading up to the 2020 presidential election, President Biden proposed policy changes that would create incentives for workers to drop employment-based health coverage for ACA exchange coverage and/or for employers to stop offering traditional employment-based health benefits. The Biden Health Care Plan includes three provisions that would make it easier for workers and employers to move away from employment-based health coverage:

- Increasing the ACA's premium subsidies and expanding subsidy eligibility.
- Adding a "public option" health plan.
- Adding a Medicare "buy-in" program for 60- to 64-year-olds.

The American Rescue Plan Act of 2021, passed in March 2021, was a step toward the Biden Health Care Plan. It eliminated the income limit on subsidies, allowing individuals in families with incomes above 400 percent of the federal poverty level (FPL) to be eligible for subsidized health insurance coverage in the ACA exchanges. It also increased subsidies for those in families with incomes between 100 percent and 400 percent of the federal poverty level. Both provisions were in effect for only two years (2021 and 2022), but the recent passage of the Inflation Reduction Act extended the enhanced subsidies through 2025.

It is unlikely that a temporary subsidy enhancement will drive workers and employers away from the employment-based health benefits system. Permanently increasing the ACA's premium subsidy levels may do that, as the Biden Health Care Plan proposes to do. The Biden Health Care Plan also includes several provisions that are not in the American Rescue Plan Act of 2021. For instance, it would expand who is eligible for subsidized health insurance. More specifically, the plan would allow workers to get subsidized coverage in the ACA exchanges even if they are offered what is considered affordable health insurance coverage through their job.

Overall, subsidy amounts would be higher because they would be based on the second-lowest-cost gold plan instead of the second-lowest-cost silver plan. This provision effectively lowers out-of-pocket spending, thereby moving the generosity of ACA exchange-based plans, as measured by the actuarial value (AV) of the plan, to be closer to the average AV of employment-based health coverage. Premiums as a percentage of income would be capped at 8.5 percent instead of 9.83 percent. The provision allowing workers with affordable coverage through work to get subsidized exchange coverage would give workers a new option for health insurance coverage outside of work, and the more generous subsidies would be an added incentive for workers to drop employment-based health coverage for an ACA exchange plan.

A public option health plan would give ACA-exchange enrollees a new, potentially less costly health plan option. To the degree these plans are successfully able to negotiate lower provider reimbursement rates, premiums would be lower. This would put pressure on private health plans offering coverage through exchanges to also find ways to lower premiums in order to remain competitive. If the public option is successful in reducing premiums while maintaining the generosity of coverage, employers may find it more attractive to drop coverage so that their employees could only get coverage through exchanges. In addition, even if employers did not drop coverage, workers may find the lower premium plan, combined with more generous subsidies, to be more attractive than their employment-based coverage options.

A Medicare buy-in program is a form of a public option. The differences between a public option and the Medicare buy-in program are that the latter is limited to people of a certain age (i.e., ages 60–64), and the generosity of the coverage is tied to the Medicare program. Proponents tout many benefits of a Medicare buy-in regime. Medicare features a lower reimbursement rate for most health care services and goods, which, in theory and all else equal, would equate to lower out-of-pocket costs for enrollees as compared with their employment-based health coverage. This might be especially true for workers on high-deductible plans who use a lot of health care services. Employers may benefit to the extent that older, less healthy workers are taken out of their risk pool. Older workers who would prefer to retire but remain attached to the labor market to receive employment-based coverage may benefit from enrolling.

Workers may leave employment-based health coverage for a number of reasons. Even if they are offered affordable coverage from their employer, under the Biden Health Care Plan, they would qualify for subsidized coverage in the ACA exchanges, which may drive them away from employment-based health coverage, especially if public options are less expensive as well. Furthermore, employers may stop offering coverage because the private health plans they have access to cannot compete with the public option. They may simply drop coverage if workers prefer ACA exchange

coverage over employment-based health coverage. If workers move from employment-based health coverage to ACA exchange coverage, federal government tax expenditures will move from subsidizing employment-based health coverage to ACA exchange coverage.

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 the 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 rule[17] to expand the use of stand-alone health reimbursement arrangements (HRAs) by employers of all sizes. This rule follows the regulations[18] 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 or individual coverage HRA (ICHRA) 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 ICHRA 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 Trump administration expected around 800,000 employers would offer ICHRAs by 2024 and beyond. As a result, some 10.7 million individuals would be covered by an ICHRA 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 ICHRA 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.[19]

There is no question that the ICHRA 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 several 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 ICHRAs. Stability in premiums may be one requirement, which may make it less likely that multi-state employers move to ICHRAs 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 ICHRAs. 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 ICHRAs in the non-group market.

In a forthcoming EBRI study, we found that many employers were not familiar with ICHRAs. When informed about them, the people we interviewed were skeptical that their companies would take this approach. More details will be provided in the forthcoming study, but employer opinions about ICHRAs may be related to 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 or industry? Do the strength of the economy and labor market conditions factor in?

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 an 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 5 percentage point increase in the percentage of workers eligible for health benefits between 2015 and 2021. Yet, the employment-based health benefits system faces threats. A combination of a recession, higher unemployment, the Biden Health Care Plan, and the availability of ICHRAs 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 September 2022).

[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 https://www.modernhealthcare.com/assets/pdf/CH94644513.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] Firms that shut down because of the COVID-19 pandemic may not have responded to the survey. Smaller firms may have been more likely to shut down as they generally have fewer resources to fall back on when affected by the economic climate.

[10] 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/a32fe9c3500ef0e2ddbb1505e09e10da4cac.pdf.

[11] 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.

[12] 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/.

[13] 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.

[14] See the summary of employer surveys by the U.S. Governmental Accountability Office in http://www.gao.gov/assets/600/592411.pdf and https://www.modernhealthcare.com/assets/pdf/CH94644513.PDF.

[15] See http://content.healthaffairs.org/content/34/10/1779.long.

[16] 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, and Cannon, Michael F., "End the Tax Exclusion for Employer-Sponsored Health Insurance" *Policy Analysis*, no. 928 (Cato Institute, May 2022).

[17] See https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-12571.pdf.

[18] See https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

[19] 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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