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Why Do Small Firms Offer Health Insurance in Spite of the Employer Mandate Exemption?

Roger Lee Mendoza
Department of Management
College of Business and Economics
California State University-Los Angeles

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IMPORTANCE The policy exemption of small firms with less than 50 workers from mandatory employee healthcare coverage under the Affordable Care Act (ACA) has led to a bifurcated outcome. Slightly more than half of these firms continue to offer employee health insurance. No juried research has yet been published concerning the underlying interests and motivations of small firms in choosing to do so. Besides filling the void in the scholarly literature, our findings have important implications on business operational risk, especially considering that 96% of all U.S. firms are small.

OBJECTIVES In light of the ACA "pay-or-play" exemption and the substantial financial burden that they have to assume, we investigate why most small firms still offer health insurance to their workers. The corollary question is how these firms manage to provide coverage amid high and rising insurance costs.

EVIDENCE We used the public dataset of the Employer Health Benefits, Annual Survey for five consecutive years (2015–2019) following full implementation of ACA market reforms. We report responses from over 1,700 representative samples of all types of employers during each of those years. In addition, legal and regulatory provisions pertinent to small firm health insurance were content-analyzed.

FINDINGS Statutory tax and other regulatory incentives to small firm healthcare coverage exist, but they can be offset by restrictive and burdensome qualification requirements. A compensating wage differential plays an important role in steering small business owners toward the human resource objectives of health insurance. To the extent that premiums are considered reasonable, tax incentives are attractive enough, and/or group insurance makes the business owner better off than getting it elsewhere or remaining uninsured, it is likely that a small firm will offer healthcare coverage in lieu of paying a higher (and costlier) wage to their workers. The ACA provides considerably more protections to those insured in group plans, but there are inherent exposure risks to small firms as plan sponsor. Key differences in the structure and attributes of plans offered by small and large firms suggest how small firms, often relying on brokers and agents, mitigate costs and risks as plan sponsors while remaining ACA-compliant.

CONCLUSION AND RELEVANCE The value of healthcare coverage to owner and firm (employer rewards) intertwine with job satisfaction outcomes (employee rewards) in motivating small firm sponsorship, notwithstanding the limited beneficial impact of statutory firm incentives and the substantial costs of premiums and plan administration. The resulting relationship between healthcare coverage, financial risk, and human resource objectives have long-run consequences on employer health plan design and structure, benefit offerings, and insurance costs. This is particularly important since both employer and employee typically contribute to health insurance premiums in small firms.

Why Do Small Firms Offer Health Insurance in Spite of the Employer Mandate Exemption?

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California State University-Los Angeles

ABSTRACT

The largest source of healthcare coverage in the U.S. for the non-elderly population (age < 65) and their dependents is employer-sponsored health insurance. In light of the exemption of small firms (< 50 full-time employees) from the "pay-or-play" mandate of the federal Affordable Care Act (ACA) and the substantial costs of employee health insurance to any employer, we investigate why most small firms still offer coverage, and how they manage to do so. We used the Kaiser Family Foundation (KFF)/Health Research and Education Trust (HRET) public dataset (2015–2019) for this purpose. Findings suggest that coverage objectives, strategic choices, and human resource practices in small firms initially pass through the lens of the business owner's comparative advantages. On that basis, a compensating wage differential might be opted. Healthcare coverage, financial risk, and human resource management intertwine, with long-run consequences on employer health plan design and structure, benefit offerings, and insurance costs. This is particularly important considering that both employer and employee typically contribute to health insurance premiums in small firms. And considering that 96% of all U.S. firms are small, the findings of this study have implications on business operational risk.

Keywords: small firm; compensating wage differential; employer-sponsored health insurance; Affordable Care Act (ACA); risk management; comparative advantage

JEL classification codes: I13; I18; J31

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This work is dedicated to the author's parents.

Introduction

The largest source of healthcare coverage in the U.S. for the non-elderly population (age < 65) and their dependents is employer-sponsored health insurance. Also known as group health insurance, employer-sponsored health insurance covers 157 million people or 58% of the non-elderly population. It is equally the largest single form of healthcare coverage in the U.S. (Kaiser Family Foundation [KFF], 2019). The fully insured group market serves employers and their employees who are enrolled in fully insured health plans, by which the employer pays premiums to the insurer in exchange for the latter's coverage of the costs of, and financial risks associated with, the employees' healthcare for a defined period of time. The fully insured group market includes both small group and large group plans, but it excludes employer-sponsored plans that are completely or partially self-funded (Morrisey, 2020).

In contrast to the large group market, there is a dearth of academic literature on the small group market. And of the five major insurance markets in the U.S. (individual, small group, large group, Medicare Advantage, and Medicaid managed care), there has been little policy discussion about the fully insured, small group market (Hall & McCue, 2018). This is particularly telling considering that American business is overwhelmingly small business. Firms with less than 10 workers make up as much as 62% of all employers, while those with less than 20 workers represent more than 89% of employers (U.S. Census Bureau, 2016).

The federal Affordable Care Act (ACA) defines a small employer as having at least one but no more than 100 employees. States have the discretion of limiting pools to firms with 50 or fewer employees. A small employer with less than 50 full-time employees (FTEs) is automatically exempt from the so-called "pay or play" mandate of the ACA. This subset of U.S. firms is the subject of our study. On the other hand, the employer mandate requires that any firm with 50 or more FTEs (or a combination of full-time and part-time employees equivalent to 50 FTEs) either provide "affordable" and "minimum value" healthcare to their workers and dependents or else pay a hefty tax penalty toward a publicly provided system that covers uninsured Americans (Internal Revenue Code [IRC], Section 4980H, 2015). More than 96% of all U.S. firms qualify for the employer mandate exemption based on the ACA threshold of 49 (or less) FTEs (U.S. Census Bureau, 2016). There are more than 13 million covered lives under small group health insurance (America's Health Insurance Plans [AHIP], 2019).

Cost—and its long-run business risk implications—remains the prime disincentive to small firms (Long, Rae & Claxton, 2016; Mayer, 2020). Smaller risk pools (which result in higher premium costs, assuming benefits are held constant), higher administrative costs per worker, and lack of dedicated staff to compare and select among employer health plan options and administer health benefits make small firms much less likely to offer health insurance and promote employee health than larger employers (Agency for Healthcare Research and Quality [AHRQ], 2020). Still, more than half of all small firms with less than 50 FTEs offer health insurance in spite of the declining trend in small firm coverage (Miller, 2016; Hall & McCue, 2018). Thus, the question for scholarly investigation is why these small firms (< 50 FTEs) do so notwithstanding their statutory exemption from the "pay-or-play" mandate. A corollary question is how small sponsoring employers manage to pay for group insurance in light of

the substantial costs of healthcare coverage to them. In addressing these research questions, we hope to fill in some of the existing gaps in the literature on healthcare risk and insurance management.

Related Literature

There is a scarcity of academic literature on small firm health insurance under the ACA. Most juried studies address questions of funding and benefits coverage, take-up rates, and the consequences of provision to small business workers. However, no juried research has yet been published concerning the underlying interests and motivations of small firm owners and insurers in offering employee health insurance, particularly in light of the ACA's employer mandate exemption. For this reason, this study inquires into the objectives and expectations of employers in sponsoring health insurance and, equally important, how they offer coverage in light of the financial burden that they have to assume. The interface between healthcare coverage, financial risk, and employer incentives has long-run implications on health plan design, employee benefits, and costs that this study addresses.

Some of the earliest juried works approached small firm health insurance from a learning curve. Blumenthal and Collins (2014), for instance, reported that ACA statutory provisions and implementing regulations could (at least initially) be confusing and intimidating to many small firm owners in deciding whether to insure their workers. Buchmueller et al. (2013) underscored the complexity of owner calculations in considering employee wages, policy regulations, and taxes relative to insurance premium and other costs, which could eventually motivate small firms to drop coverage. However, Pasek et al. (2015) assert that the learning curve among small firms should improve over time to reduce the initial propensity to drop employee healthcare coverage.

A larger number of studies focused on the cost implications of small firm healthcare coverage. Long et al. (2016) found that cost and its long-run business risk implications constitute the prime disincentives for small firm owners to insure their workers. Krizan et al. (2014) and the AHRQ (2020) found that offering healthcare coverage, whether voluntarily or mandated, is not only more financially but also more administratively burdensome to these owners compared to their large firm counterparts. Others specifically suggest that employer costs could be substantial depending on employee count, hours worked, and turnover rates. The unpredictability of insurance premiums raises their transaction costs. Thus, White and Needham (2022) conclude that coverage decisions that small business owners make eventually boil down to a question of sustainability that encompasses firm resources and employee reactions to change. Hossain et al. (2019) further find that small firms tend to focus more on the costs of statutory compliance under the ACA and neglect viable strategies to accommodate it. We take these cost-related disincentives among small firms as a given and look at the flip side of the equation by determining what factors could possibly incentivize their owners to insure workers for healthcare coverage in spite of their corresponding cost implications.

Some studies concentrate on firm size distribution. Bailey and Weber (2015) looked into health insurance benefit mandates in relation to firm size. These mandates refer to state laws that require health plans to cover additional services beyond what the

ACA stipulates. The authors find that benefit mandates tend to distort firm size since large firms are more easily able to self-insure and thus avoid these mandates, leaving small firms with relatively higher costs. An earlier study by Haltiwanger et al. (2013) suggests that such distortions may, in fact, have negative consequences on aggregate productivity and job growth. Although our study does not seek to relate firm size to benefit mandates, this subset of the literature helped us choose which plan aspects and characteristics to consider in contrasting small from large firms.

Other studies have sought to assess small firm health insurance in terms of employee impact. Healthcare access appears to be the most frequently examined. The first of these studies, conducted by Eibner et al. (2010), was about offer rates (i.e., the probability that employers will offer insurance coverage to their workers). They predicted that offer rates in small firms will rise from 57% to almost 80% once the ACA and related policies are fully in effect. For his part, Lennon (2021) contrasted the ACA's "employer mandate" for large firms (to insure workers for healthcare) and the Small Business Health Options Program (SHOP), an insurance exchange that helps small businesses compare health plans and enroll in coverage for their employees. Lennon estimated a 3.5 percentage point increase in insurance availability among workers at smaller firms after 2013 but conceded that greater insurance availability did not necessarily translate into increases in coverage rates. Lennon (2021) also found limited evidence that the ACA actually improved healthcare access or measures of health status for small firm workers.

Kattih et al. (2019), on the other hand, compared health insurance take-up rates in large and small firms. Using the same public database we used in this study, the authors find a statistically significant decrease in take-up rates (by 1.96 up to 2.67 percentage points) in small firms compared to large firms following the ACA's implementation. However, the authors were unable to determine which factor(s) specifically led to decreased rates. Because offer, access, and take-up rates have been considerably addressed in these studies, we did not calculate rate changes and effects over time. Rather, we approached offer, take-up, and coverage rates by differentiating between small and large firm workers in terms of plan and benefit choices offered by their employers.

Neither does our study measure for firm impact. Although quite rare in the relevant literature, there have been a few evaluative studies of the consequences of employee healthcare coverage to sponsoring small firms. One such study by Chase and Arensmeyer (2018) analyzed small firm enrollment data and discovered that the ACA helped stabilize healthcare costs for many small firm sponsors, with premium rate increases declining by about one-half starting with the ACA's full implementation in 2014. The uninsured rate for small firm employees was shown to have also fallen by nearly 10 percentage points after 2014. However, the AHRQ (2020) found that small firms still tend to be saddled with higher administrative costs of insuring per worker in comparison to large firms. This helps explain the declining trend in small firm healthcare coverage in the last couple of years.

Having grounded this study on the relevant academic literature, we believe this is the first to address why small firms choose to offer healthcare coverage to their

employees in spite of their exemption under the ACA and how they seek to mitigate the financial burden and consequences associated with such provision.

Methods

The small firm/business (< 50 FTEs) is the unit of analysis in this study, rather than the insured small firm employee. Any reference to "small firm" in this study is based on such employee count, unless qualified in instances where the definition extends to the 100-FTE maximum in other ACA provisions. A large firm under the ACA is one with 101 or more FTEs, which is also the way in which this term is used in this study. In identifying and analyzing firm choices and decision making, we compare small firms offering health insurance to large firms along several coverage dimensions.

We selected and analyzed the SPSS-formatted, public-use dataset of the Employer Health Benefits, Annual Survey (EHB-AS) for five consecutive years (2015–2019) following the full implementation of the ACA's market reforms. This survey has been conducted since 1999 by the KFF and the Health Research and Educational Trust (HRET). Through more than 1,700 annual interviews of representative samples of public, private not-for-profit, and private for-profit employers, the EHB-AS generates single, point-in-time snapshots of employer-sponsored health benefits, the costs of coverage, and topical health insurance issues (e.g., wellness programs, employer practices, etc.).

This study provides a time-series, cross-sectional analysis of the EHB-AS dataset. We disaggregated survey data, first by firm size so that our small firm sample conforms to the ACA employer mandate exemption, and then by specific insurance attributes based on the research questions of this study. We statistically tested small firm data for significance ($p < .05$). We then tabulated pertinent data for univariate analysis in the six succeeding analytical sections of this paper. Owing to limitations on the number of exhibits permitted by the journal, some tabulations had to be compressed and/or combined into one.

Supplemental data on employer characteristics was gathered from eHealth's annual *Small Business Health Insurance Report*. Some of these reports contain employer surveys, conducted in various or alternating years, that we found useful in offering a snapshot of national costs and trends in healthcare coverage among small firms with less than 50 employees. In addition, content-analysis was done on legal and regulatory provisions pertinent to these small firms.

Findings

Statutory Incentives

The ACA applies essentially the same set of regulations to the small group market as it does the individual market from which the self-employed, uninsured employees, and subsidized but Medicaid-ineligible low income workers tend to buy healthcare coverage (Hall and McCue, 2018). Consumer protections in small group and individual health insurance include: a standard (minimum) set of essential health benefits (EHBs); the prohibition against using preexisting conditions for eligibility and pricing; modified community rating (meaning, insurers cannot vary rates based on health status); a

maximum pre-enrollment wait time of 90 days; guaranteed issue and renewal of insurance regardless of health status; and a limit on the percentage of premium that insurers can devote to profits or overhead known as a minimum medical loss ratio (MLR). The ACA further established economic incentives for small firms to offer health insurance. But major drawbacks stem from, or in relation to, such statutory incentives.

Healthcare tax credits, equal to 50% of employer premiums, are offered by the ACA to any sponsoring firm with less than 25 FTEs, which represents about 92.5 of all U.S. firms (U.S. Census Bureau, 2016). Tax credits are meant to encourage employer premium contributions and allow qualified firms to compete with large firms for talent. However, the stipulated criteria is quite onerous and confusing to many employers (Miller, 2016). In offering SHOP-only plans to their FTEs, the average annual employee salary in a firm must be less than an annually indexed amount ($54,200 in 2019), and the employer has to pay 50% or more of the premium for at least a single coverage plan. The tax credits are not applicable to the owner's premiums, exclude administrative costs beyond $13,000, and apply for a maximum of two tax years. Hiring the 26th employee under this incentive scheme ostensibly has an immediate budgetary impact because it automatically disqualifies the employer from the tax credits. The result is that these statutory credits are largely unused by small firms (Miller, 2016).

One hundred percent of employer-paid premium cost in any health plan (including health savings accounts [HSAs] and health reimbursement arrangements [HRAs]) is deductible from federal business taxes by an employer of any size. However, less than 20% of small firm owners consider this as an incentive to sponsor health insurance. This is the case even among small firms with more (50 to 100) workers that are subject to the employer mandate. The increasing cost of coverage to the employer since the ACA's enactment could thus outweigh the tax benefit, although it may be an incentive to some employers. Since 2010, offer rates have, in fact, decreased among small firms to the current 55–45 ratio of sponsoring to non-sponsoring small firms (Miller, 2016). The effect of the covid-19 pandemic on offer rates has yet to be determined.

Following the ACA's full implementation in 2014, small firms that have no more than 100 employees could obtain group insurance from any of the following sources: 1) the SHOP exchange/marketplace created by the ACA; 2) by direct purchase from an insurance carrier; and 3) through an insurance broker or agent.

Before the ACA's passage, insurers routinely charged small businesses higher premiums of 18% or more because it costs more to insure smaller groups of individuals, whose collective risk could be higher than a much larger group with risk more spread out. The ACA groups small firms in SHOP (or a comparable state exchange) as part of one greater risk pool, granting firms that buy insurance through SHOP or similar state exchanges the same kind of group purchasing power that larger businesses enjoyed exclusively, pre-ACA (National Conference of State Legislatures [NCSL], 2018).

Ever since the ACA took effect, the SHOP exchange has been the least used by small firms with less than 50 FTEs. Only about 13% of them purchased from this exchange (KFF/HRET, 2015; KFF/HRET, 2016). Although rates were group-discounted, almost two-thirds of surveyed small business owners found the SHOP exchange plans either expensive or restrictive. At least 70% of small firm workers had to enroll in any of them. Two-thirds of these owners eventually found better plan rates elsewhere or

through their brokers and agents (KFF/HRET, 2015; KFF/HRET, 2016). With risk pools declining in size and mix in the next four years, the federally facilitated SHOP exchange, covering 33 states, closed by the end of 2017. Most of the remaining one dozen (or so) state-based SHOP exchanges have taken the federal approach of directing small employers to insurance carriers or to SHOP-registered agents and brokers (Jost, 2017). In about half of these states, small businesses can also pool together (through purchasing pools or Consumer Operated and Oriented Plans [CO-Ops]) to buy SHOP insurance and association health plans (AHPs).

Direct purchases from insurance companies entail heavy transaction costs on the part of the employer. Health insurance markets in the U.S. are "characterized by imperfect information, complex products, and substantial search frictions" (Karaca-Mandic et al., 2018). Particularly time-consuming and administratively demanding are search and information costs (e.g., comprehending and comparing plans), as well as bargaining and decision costs, including matching plan offerings to employee demographics and preferences, and estimating the compensating differential (Morrisey, 2020).

These costs have led as many as 87% of our surveyed small firms to use brokers and agents in purchasing SHOP insurance and other ACA-compliant, private group insurance. Brokers and agents play a significant role in helping employers navigate insurance markets and products (Karaca-Mandic et al., 2018).

Employer Propensities

Table 1 indicates that firm size is a strong predictor of group health insurance among small employers (r = 0.84). The larger the number of FTEs, the greater is the probability that a small firm will offer at least single healthcare coverage. The positive correlation is observed in both the pre-ACA and ACA periods. It is likewise evident in small firms that are subject to the employer mandate (50–100 workers) but nonetheless benefit from certain statutory provisions (e.g., SHOP plans). The average number of mandate-exempt firms that insured over the five-year period (2015–2019) ranged from approximately 45% (i.e., with 3–9 employees) to 63% (10–24 employees) to 78% (25–49 employees). Around 92% of small firms with at least 50 workers chose to sponsor health insurance. Small businesses that do not offer it tend to be smaller, rely more heavily on a part-time workforce, and employ lower-income workers.

Table 1: Employer-sponsored health insurance by firm size (%)

Firm size (# employees)	2000 (x = 68)	2002 (x = 65)	2004 (x = 62)	2006 (x = 60)	2008 (x = 62)	2010 (x = 68)	2015 (x = 56)	2016 (x = 55)	2017 (x = 53)	2018 (x = 56)	2019 (x = 56)
<10	57	58	52	49	50	59*	47	46	40	47	47
10-24	80	70*	74	73	78	76	63	61	66	64	63
25-49	91	87	87	87	90*	92	82	80	78	71*	77
50-199	97	95	92	92	94	95	92	91	92	91	93

*Estimate is statistically different from the immediately preceding year, whether or not the preceding year is indicated on Table 1 ($p<.05$). Because KFF-HRET surveys collect information from a large sample of all U.S. firms, even seemingly large differences among them may not necessarily be statistically significant from year to year.

Table 2 shows that statistically significant offer criteria in small firms are employee attraction, retention, and productivity. But these can be considered in a way that health insurance also establishes some comparative advantages to the firm and/or its owner. Motivating factors from the employer's standpoint appear to propel these human resource objectives in Table 2. One is premium affordability, especially after the previously discussed tax breaks/credits for employer contributions are considered by the owner. The other is whether the owner can take advantage of less expensive group health insurance than they could get on their own (e.g., from the individual market), instead of possibly going uninsured. Between one-fourth to one-third of sponsoring firm owners in Table 2 indicated that they cannot afford to purchase insurance on their own and/or determined they may be better off under a group insurance plan. These circumstances could drive a good fit between the firm-sponsored plan benefits and the owner's (and their family's) needs. As one anecdotal account succinctly put it, "many employers choose to offer health care benefits... so that they themselves can take advantage of less expensive health insurance than they could get on their own as well as tax breaks for the contributions made by the business" (Wolters Kluwer, 2020). In this regard, nine out of 10 small business owners use brokers or agents to help select the plan that they will sponsor for their firm (KFF/HRET, 2015-2019). These third parties help find owners competitive premium and cost-sharing rates in offering small group plans (Morrisey, 2020), which forms an important element in a small firm owner's cost-calculus for sponsoring health insurance to which we shall return in another section of this paper.

Table 2: Small firm incentives in sponsoring health insurance (%)*

Employer incentives**	2013	2015	2017	2018	2019
To recruit and retain the best workers/talent	31	34	64	66	63
Employer's moral obligation	44	40	40	43	44
To encourage workforce productivity	8	9	48	27	36
Owner and/or employees generally cannot afford to buy on their own (better off with group insurance)	32	29	28	26	34
For company tax benefits/credits	-	-	-	11	15

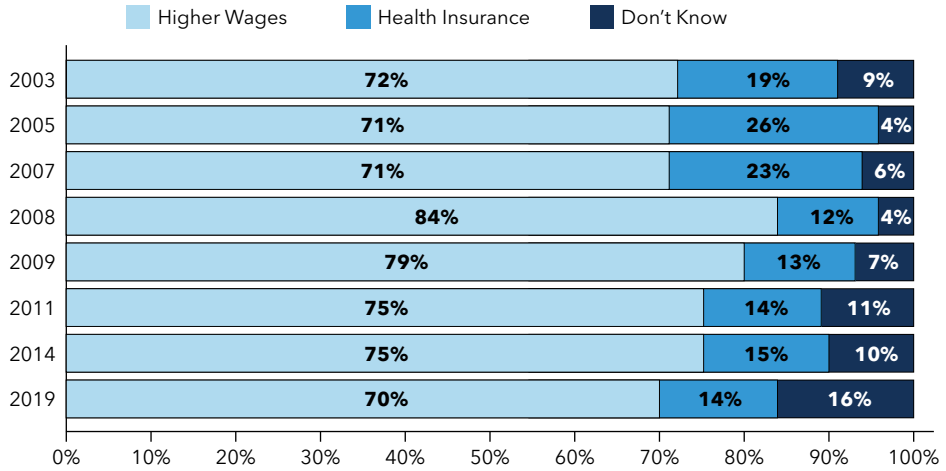
*Total for each year may not sum up to 100 due to multiple coverage incentives to firm/owner. Employer incentive question was asked only in years indicated on Table 2.

**Excludes incentives identified by <10 percent of surveyed firms/owners.
–Not surveyed/reported during reporting year.

The employer incentives that stem from the affordability of premiums and cost-sharing to, and the strategic advantages of group health insurance for, the small business owner are reinforced by a compensating wage differential depicted in Figure 1. Invariably referred to as the equalizing difference, the wage differential is an additional amount of (cash or non-cash) compensation that a worker is offered in order to motivate them to accept or remain in a given job, relative to other, more desirable jobs that the worker could perform. Specifically, the wage differential in this context refers to "the composition of pay packages, including vacations, pensions, and other fringe benefits as substitutes for direct cash wage payments" (Rosen, 1986: 641). Healthcare

coverage may thus be offered to workers to motivate them to accept or perform their jobs by way of compensating for lower wages or fewer opportunities for advancement in a small firm (Rosen, 1986; Kaufman, 2005). Asked in the KFF/HRET surveys whether they believe their insured employees would rather receive an additional $2 per hour wage increase instead of group health insurance, around three out of every four small business owners consistently responded in the affirmative over the years, as shown in Figure 1. However, these owners are also unlikely to opt for an actual wage increase in place of healthcare coverage that they have chosen to offer to their employees and for their and their firm's benefit or advantage.

Figure 1: Employer assessment of compensating wage differential*



*No statistically significant differences in percentage distributions ($p < .05$) were observed from year to year during period covered.

Source: KFF (2019). Employer health benefits: 2019 annual survey. San Francisco, CA: KFF. Wage differential question asked of sampled small firms/owners was whether they believe their employees would rather receive an additional $2.00 per hour in salaries/wages in lieu of employer-sponsored health insurance. This question was asked in the KFF-HRET surveys only in years indicated on Figure 1.

Take-up rates among small and large firms are compared in Table 3. Take-up measures the proportion of eligible employees who eventually enroll in health insurance offered by their employer. This excludes workers who opted out of receiving coverage from their employer because federally subsidized insurance from the individual market and (broader) access to Medicaid under the ACA offered better alternatives to small group insurance.

Table 3: Eligibility and take-up rates in small firms sponsoring health insurance (%)

Employee / Employer	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
Employees eligible for employer health insurance	83*	79*	83	80	83*	80*	83*	79*	84*	80*
Eligible employees who participate in employer health insurance (take-up rate)	76*	79*	77*	79*	76*	78*	74*	77*	73*	78*

*Eligibility or take-up rate is statistically different between small and large firms in the given year ($p < .05$).

Even among small firms, the five-year take-up rate is high, averaging over 75%. It is only slightly, albeit statistically, different (r = 0.73; p = 0.44) from the take-up rate in large firms (x = 79.6%) during the same period. On the one hand, this finding appears to support the propensity of small business owners to offer health insurance as an equalizing difference for a higher wage, which could be more costly to a small firm, as wage increases over time are factored into a $2 additional wage (see Figure 1). On the other hand, high take-up rates in small firms seem to validate the value-added contribution of health insurance to the human resource management goals of attracting, retaining, and incentivizing productivity among small firm workers (see Table 2). High take-up in this sense reinforces the strategic motivational role that small business owners ascribe to employer-sponsored health insurance in Table 2. It appears to validate studies that identify health insurance as the deciding factor in employee attraction and retention from an employee standpoint (Chamberlain and Tian, 2016; AHIP, 2018).

Organizational Plan Structure and Attributes

Certain plan attributes statistically differ between small and large firms. They provide insights into how small firms are able to finance healthcare coverage despite its substantial and ever increasing costs.

The number and type of insurance offerings distinguish small firms from their larger counterparts, as shown in Table 4. Approximately eight in 10 small firms offered only one type of plan, typically a preferred provider organization (PPO) (x = 46%). On average, this plan type enrolls around 40% of small firm workers. Search and information, bargaining and decision, and legal compliance costs in choosing a plan to offer are more burdensome to small business owners as the reviewed literature reminds us (Buchmueller et al., 2013; Blumenthal and Collins, 2014; Krizan et al., 2014). In contrast, large firms are equally likely to offer one (45%) or two (42%) plan types. They are also more than four times likelier to offer three or more plan types than small firms.

Table 4: Small and large firm health insurance by plan structure (%)

Plan Structure	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
Plan types (#) offered:										
-One	84*	52*	84*	47*	83*	45*	81*	42*	76*	39*
-Two	12*	39*	14*	37*	15*	42*	16*	45*	20*	47*
-Three or more	3*	9*	2*	16*	2*	13*	3*	13*	4*	14*
Type of plan:										
-Conventional indemnity	1	2	2	2	2	1	<1*	1*	3	1
-HMO	17	23	22	27	17*	31*	32	25	26	26
-PPO	49*	77*	34*	73*	49*	73*	49*	75*	48*	78*
-POS	27*	14*	33*	17*	28*	10*	14	11	24*	14*
-HDHP (may have HSA, HRA, other SOs)	25*	41*	27*	51*	23*	53*	27*	58*	27*	57*
Plan coverage:										
-Single coverage only	2	0	11	0	5	0	5	0	6	0
-Spouse	98	100	89	99	94	100	97	99	94	99
-Children and other dependents	96	100	88	100	92	100	95	100	94	100

*Percentage distribution is statistically different between small and large firms for the given year (p < .05).

Statistically higher numbers of large firms, averaging 75% from 2015 to 2019, offered a PPO. High-deductible health plans (HDHPs) ranked second among the plan offerings of a large firm (52%). A plan is considered an HDHP if the individual/family deductible met or exceeded the IRS-prescribed annual deductible threshold ($1,350 for single coverage and $2,700 for family coverage in 2019). Traditionally paired with HSAs, HDHPs have much lower premiums than a fully insured plan (e.g., PPO, health maintenance organization [HMO], point of service [POS], exclusive provider organization [EPO]). The major disadvantage of an HDHP is the staggering out-of-pocket risks to the insured and their family because the deductible is also way higher (Morrisey, 2020). These financial risks, along with lower average wages in small firms, may suggest why only one in four small firms offered an HDHP in Table 4. The same risk-aversion is observed among small firms adopting a self-funded plan. An average of only 15% of small firms in Table 4 chose to self-insure compared to more than 62% of large employers. Self-funding transfers risk exposure directly to the employer (Park, 2000; Morrisey, 2020).

In terms of actuarial value, either nearly or slightly more than one-half of small firms tend to offer a silver-tier plan or its equivalent. This plan carries a 70% actuarial value, which is the portion of medical expenses that a health plan generally covers compared to the insured's expected cost-sharing responsibility (in this case, 30%). A silver plan has lower monthly premiums, but it also has higher cost-sharing requirements than the gold and platinum plans, which respectively carry 80% and 90% actuarial values. Most large firms prefer to offer a gold-tier plan or its equivalent.

The number of covered lives could provide another indication of cost-containment among small firms offering health insurance. Despite significant variance from year to year in Table 4 (minimum = 2%; maximum = 11%), some small firms offer single coverage only, while none of the large firms do. Spouses, children, and other dependents (e.g., same-sex partner) can be extended coverage in nine out of 10 small firm health plans and practically 100% of large firm health insurance, although there were some years in Table 4 where the differences were statistically insignificant.

Cost-sharing by the insured employee in small and large plans typically consists of copays (for physician visits and medications), deductibles (amount paid for covered treatments and services before insurance starts to pay), and coinsurance (portion paid for covered treatments and services after deductible is met and the insurance portion comes in). Insurance pays for all healthcare costs after the insured reaches the maximum out-of-pocket costs from the totality of copays, deductibles, and coinsurance for the year. Because of the greater propensity among small businesses to offer a PPO as the sole company plan, employee cost-sharing in small firms, particularly for in-network providers and services, tends to be lower than in large firms (e.g., HDHPs).

Organizational Plan Financing

Insurance financing is based mainly on the cost of premium. This consists of the *pure premium* or lost cost (claims experience losses over a given period relative to exposure/insured units) and the *loading fee* or expense ratio (covering insurer profit/mark-up for objective risk, marketing costs, benefits coordination, claims processing and adjudication, and other administrative overheads) (Green, 2021). Seven in 10 small

firms used third parties (e.g., professional employer organization [PEO]) to exclusively handle marketing and administration in 2015–2019.

Table 5 shows that annual premium costs for single or individual coverage in small firms averaged $6,622 for five years. In general, these are not statistically different from large firms (x = $6,722). The average growth rate in premiums shown on Table 5 is around 4% each year for both small and large firms. But the financial burden on small firms is much heavier, with single premium rates consistently rising each year. An eHealth survey, for example, reported that 78% of small business owners were either somewhat or very concerned about their ability to continue paying for their employees' health insurance. Moreover, 62% indicated that a premium increase of 15% would be unaffordable, forcing them to either drop coverage or shop for a new plan (eHealth, 2018).

Table 5: Average annual premiums, small and large firm health insurance, all plan types

Premium attribute	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
Average total premium ($)										
-Single coverage	6,163	6,289	6,429	6,438	6,486	6,776	6,814	6,930	7,218	7,175
-Family coverage	16,625*	17,938*	17,546*	18,395*	17,615*	19,235*	18,739*	19,972*	20,236	20,717
Average total premium by firm ownership ($)										
-Private for-profit	5,841**	5,934**	6,164**	6,021**	6,204**	6,339**	6,659*	6,665*	7,010*	6,714*
-Private not-for-profit	7,039**	6,829**	7,124**	6,863**	7,194**	7,061**	7,213*	7,281*	7,406*	7,669*
-Public	6,962**	6,860**	7,543**	7,060**	7,350**	7,549**	6,964*	7,387*	8,587*	7,923*
Average employee premium ($) contribution (% total premium)										
-Single coverage	899 (15)	1,146 (18)	1,021 (16)	1,177 (18)	1,030 (16)	1,290 (19)	1,133 (17)	1,207 (17)	1,035 (14)	1,330 (19)
-Family coverage	5,904 (36)*	4,549 (25)*	6,597 (38)*	4,719 (26)*	6,814 (39)*	5,264 (27)*	6,782 (36)*	5,046 (25)*	7,805 (39)	5,271 (25)
Average employer premium ($) contribution (% total premium)										
-Single coverage	5,264 (85)	5,142 (82)	5,408 (84)	5,261 (82)	5,456 (84)	5,486 (81)	5,681 (83)	5,723 (83)	6,723 (83)	6,138 (86)
-Family coverage	10,720 (64)*	13,390 (75)*	10,949 (62)*	13,676 (74)*	10,801 (61)*	13,971 (73)*	11,957 (64)*	14,926 (75)*	12,431 (61)	15,446 (75)

*Percentage distributions are statistically different (horizontally) between small and large firms in terms of corresponding premium-related attribute ($p < .05$).

**Percentage distributions are statistically different (vertically) only by firm ownership category within small or large firms, but *not* (horizontally) between any other premium-related attributes ($p < .05$).

It is in the family coverage premiums where small and large firms statistically differ in Table 5. The five-year average is lower among small firms ($18,152) in contrast to large firms ($19,251), although both their family premiums increased each year at an average of 5%. Since the reviewed literature finds that employer-sponsored health insurance in small firms tends to have higher loading fees, particularly administrative and marketing costs (Long et al., 2016), the lower family premiums in small firms suggest that insurance benefits are also less generous on average. Offering more affordable family coverage, even for less benefits, could nonetheless help attract and retain needed talent in small firms.

Table 5 also shows that small and large employer contributions to single plan premiums do not statistically vary, both averaging slightly more than 80% from 2015 to 2019. Most covered workers in small firms make a contribution of approximately 16% of total premium cost. However, small and large firms differ with respect to family plan contributions. Small employer contributions were consistently at about 60% of premium cost (x = 62%). Large employer contributions were consistently at a much higher rate, in the mid-70% (x = 74%), during those five years. Thus, employees in small firms pay an additional 12% more in family premiums (x = 38%) than their counterparts in large firms. The difference is likely due to the greater budgetary and other financial constraints faced by small firms and their owners in covering their workers' spouses and dependents.

Employee-paid premiums can also statistically vary when small and large firms are stratified based on firm ownership in Table 5. Higher premium rates are consistently charged employees in public firms (x = $7,481) and private, not-for-profit firms ($7,195) in contrast to private, for-profit firms ($6,376), regardless of whether these exist in small or large firms. Pricing differences may suggest more generous benefits offered by public and private not-for-profit health plans.

Organizational Risk Mitigation

Health insurance companies might resort to favorable selection, HMO-style disincentives, and other enrollee-focused strategies to reduce the risks of adverse selection and healthcare overutilization known as moral hazard (Morrisey et al., 2013; Morrisey, 2020). Small firms have less options available to them in containing the cost implications of adverse selection and moral hazard once they elect to offer coverage, but our findings suggest that some of these options could help.

Based on Table 6, we find that small firms are more likely to offer health insurance with higher deductibles than large firms. For instance, even if there are fewer small firms offering HDHPs, the number of their workers in single coverage HDHPs with deductibles of $2,000 or more are typically much higher than in large firms. The 2015–2019 average single coverage enrollment in these plans among small and large firms is statistically significant:

$1,000 deductible: 64%; 46%
$2,000 deductible: 42%; 17%
$3,000 deductible: 23%; 7%

Table 6: Cost/risk mitigation approaches among small and large firms sponsoring health insurance (%)

Cost/risk mitigation	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
Insured employees in (single) plans w/high annual deductible:										
≥$1,000	63*	36*	65*	41*	58*	48*	68*	54*	68*	50*
≥$2,000	39*	12*	45*	16*	37*	15*	42*	20*	45*	22*
≥$3,000	-	-	-	-	22*	6*	22*	7*	24*	9*
*Firms adopting narrow(er) network plan/s***	8	9	7	6	8*	11*	6*	10*	5*	11*
*Firms eliminating hospitals/ healthcare systems from their networks in past year***	10	6	6	5	6	4	2*	5*	1	3
Firms that searched for new plan/carrier in past year:										
-Shopped for new plan/carrier	47*	38*	52*	35*	59*	37*	62*	50*	53	49
-Shopped + changed plan/ carrier	24	24	21	27	29	26	26*	20*	18	22
Firms offering incentives to employees enrolling in spousal plan	9	11	10	12	15	13	13	12	-	-
Firms w/incentives to employees for not enrolling in employer plan (if w/out spouse/ spousal plan enrollment)	7	5	9*	15*	18	17	16	15	-	-
*Non-sponsoring firms providing funds/reimbursements for employees to buy insurance on their own****	17	-	11	-	16	-	9	-	11	-
*Non-sponsoring firms that terminated health insurance****	25	-	19	-	13	-	20	-	13	-

*Percentage distribution is statistically different between small and large firms ($p < .05$).

**Around 5% of small firms on average considered either a narrow(er) plan network (< providers) or eliminating hospitals/healthcare systems from their networks in the past year to reduce cost.

***Refers to firms that either do not offer group insurance, or have terminated it.

–Not surveyed/reported by KFF/HRET during the year.

Generally, the higher a plan's deductible, the lower the premium cost, as more risk is shifted to and absorbed by the insured, who then gains more "skin in the game" (LaMontagne, 2014; (Agarwal et al., 2017). In this sense, offering employer-sponsored health insurance turns into a balancing act between deductibles and premiums.

Because small firms pay the majority of premium costs for both single and family plans (Table 5), the owner (and the employee) generates premium cost-savings from higher deductibles. Enrollment levels in some of these small employer plans are not usually found in large firm plans (e.g., high annual deductible ≥ $3,000 in Table 6). Combined with the small firm's propensity to offer only one plan or one plan type (Table 4), health plans with higher deductibles tend to further produce administrative and other transaction cost-savings to small firms. The cost of claims processing and adjudication alone decline with reduced healthcare use (Green, 2021). However, there is no denying that the effectiveness of higher deductibles can hinge on whether workers in a small firm are predominantly well-off or low-income, younger or older, and healthy or living with a chronic condition (Agarwal et al., 2017), considering that the primary goals of small group insurance relate to employee attraction, retention, and productivity should they create certain cost advantages and incentives to the business owner (Table 2).

Table 6 further indicates that small firms, through their brokers and agents, tend to shop for new health insurance and/or insurance carrier more often during the year than large firms. In doing so, they often look for lower premiums and deductibles, as well as broader provider networks. The difference is statistically significant for all five years, except 2019. Fifty percent or more of small firms shopped for replacement plans and/or carriers to contain cost, as opposed to less than 40% of large firms, in those years. Other risk mitigation approaches sometimes used by small firms, but generally *not* any statistically different from large firms, include offering narrow(er) provider networks, eliminating hospitals or healthcare systems from their current network, and terminating their current health plan and/or carrier. These strategies are often carried out through their brokers and agents who search for more "delimited" plans to contain cost. In this sense, brokers and agents help offer health insurance at lower premiums, especially in more competitive broker/agent markets. Premiums are also less dispersed in these markets (Karaca-Mandic et al., 2018).

Many small firms pursue (or are starting to pursue) workplace health promotion programs through the insurance vehicle. These are covered benefits that help workers identify health issues *ex ante* and manage chronic conditions, including health risk assessments, biometric screenings, and fitness/wellness training and related initiatives. Like large firms, small firms do not typically offer any employee incentives or compensation either to enroll in spousal health plans or in lieu of participating in the firm's health plan offering. As depicted in Table 6, the five-year average among small firms employing either approach is less than 13%.

Benefit Alternatives

Alternatives to fully funded plans are rarely ever considered or at least implemented by small firms and their owners. Group health insurance still appears to be more cost-efficient and attractive to employees. Brokers and agents are also likely to advocate against using such alternatives in small firms, especially given their fee-based incentive.

Table 6 reports that on average, only around 13% of small firms chose to provide funding or reimbursement to their workers by way of a taxable stipend (bonus), qualified small employer health reimbursement arrangement (QSEHRA), and other

HRAs, etc. This figure does not statistically differ from large firms. Few small firms were also likely to sponsor Section 125 (cafeteria) plans, particularly tax-advantaged flexible spending accounts (FSAs) and HSAs. The disincentives of these types of plans to small firm employees include: their relatively high set-up fees; account balance expiration at plan year-end, which introduces a key financial risk; and the challenges in acquiring some desired healthcare treatments or services because Section 125 funds are reimbursed for qualified benefits rather than used directly by employees (Freedman, 2020).

Finally, around 18% of small firms in Table 6 chose to end their employer-sponsored health insurance between 2015 and 2019. However, based on our literature review, it is quite possible that other health-related benefits—including employee stipends/reimbursements, HRAs, and Section 125 plans—could have been substituted by the small business owner after plan termination, particularly if substitution offers comparative advantages to the owner and/or their firm. In this regard, the substitution effect of the relative price change (increase) of employer-sponsored health insurance could motivate the employer to switch not just to cheaper, but perhaps more, benefit alternatives.

Discussion and Conclusion

It seems axiomatic that employer-sponsored health insurance protects and promotes employee health and welfare. Benefit surveys validate its straightforwardly beneficial effect. As one survey concludes, "[t]he factor with the single biggest impact on employee satisfaction was the quality of employer-provided health insurance plans" (Chamberlain and Tian, 2016). Insurers market SHOP and other ACA-compliant health plans to small business owners as a strategic or innovative aspect of employee recruitment, retention, and productivity.

Whether these benefits match the objectives and choices of the plan sponsor is another matter. It is for this reason that we sought to determine what might incentivize small firms with less than 50 workers to offer healthcare coverage when they are exempt from the "pay or play" mandate of the ACA. The corollary question we investigated is how they might continue to do so amid the continuously rising costs of health insurance and gradually declining enrollments each year (Hall and McCue, 2018). The relevant literature is scarce and typically addresses questions of funding and benefits coverage, take-up, and the business consequences of provision, rather than employer motivation and returns.

Our time-series, cross-sectional analysis of the EHB-AS dataset from 2015 to 2019 reveals that small firm decision-making is more nuanced than the primordial objective of job satisfaction associated with the recruitment, retention, and productivity motivation of needed talent. Doubtless, statutory incentives to small firm healthcare coverage exist. However, they can be offset by restrictive or burdensome qualification requirements, leading brokers and agents to assume an important role in small firm choices. Because almost nine out of every 10 small businesses employ brokers and agents, premium rates and cost-sharing arrangements offered to these firms can be quite competitive. Yet, no matter how competitive these rates may be, they have to be affordable relative to firm size and resources, as well as employee needs or

preferences. After all, the majority of premium costs for both single and family plans are paid by the small firm owner, besides the administrative and transaction costs that these owners also have to bear.

In this respect, we posit the view that a compensating wage differential intertwines with the small business owner's and/or their firm's comparative advantages. The mix can play an important role in steering the owner toward the human resource objectives of health insurance. To the extent that premium rates are deemed reasonable by the firm's owner, there are sufficient tax incentives, and/or group insurance makes the owner better off than getting it elsewhere or remaining uninsured, it is more likely that their firm will offer healthcare coverage in lieu of paying a higher (and costlier) wage to their workers. That is to say that the value of healthcare coverage and promotion to the firm and their owner (the employer incentives) go hand in hand with the expected value of employee job satisfaction in motivating small firm sponsorship, notwithstanding the limited impact of statutory firm incentives and the substantial costs of premiums and plan administration. Otherwise, the owner's cost-calculus might favor a higher wage for its workers. Three-fourths of small firm owners, in fact, believe that their employees would rather receive a higher wage than be insured health-wise. While the wage alternative could take various forms besides an hourly wage increase—including an employee stipend or bonus, reimbursement arrangement, and tax-advantaged savings accounts—future research may offer more insights into a wage-based approach and the role that individual markets might play.

Doubtless, employees who enroll in small group insurance have considerably more consumer protections as a result of the ACA's enactment in 2010, including coverage for EHBs, the use of adjusted community rating, and the ban against preexisting medical conditions for insurance eligibility and pricing. Yet, there are inherent exposure risks to the employer as plan sponsor. We found in this study some major differences in the structure and attributes of health plans in small and large firms, from which we may infer how small business owners mitigate their financial costs or risks. Approximately eight in 10 small firms choose to offer only one type of plan, usually a PPO. In contrast, large firms are likely to offer two or more plans (quantity-wise) and plan types (by design/structure), including PPOs and HDHPs. Smaller firms are more likely than large firms to offer a silver-tier plan, which has lower premium costs but more employee cost-sharing than the higher-tier plans. Some small firms tend to offer only single coverage plans, while none of the surveyed large firms exhibit the propensity to do so. The lower family premiums in small firms implies that health benefits are less generous on average. Small firms also tend to subsidize family plans at a lower rate than large firms. Small firms are much more likely to offer traditional, fully funded plans with higher deductibles than large firms to contain their administrative overheads and transaction costs. Additionally, small firms, through their brokers and agents, tend to shop for new health insurance and/or carrier more often than large firms in each of the five years addressed by this study because of premium affordability concerns. Premises considered, we thus find that small firms are generally more proactive in using certain cost or risk mitigation strategies and health promotion initiatives than large firms.

Finally, whether it makes sense to continue employer-sponsored health insurance depends on the facts and circumstances attendant in a small firm. Business operational risk will vary depending on employee demographics, including age and income distribution, firm size, firm productivity, budget and other financial implications of plan sponsorship, and the competitiveness of insurance pricing. Depending on the equalizing difference that firm sponsorship of health insurance might yield, cost-cutting can also be a major determinant. For one, if low-wage earners are numerous in a firm and heavily subsidized by the government, coverage in the ACA's (subsidized) individual market or in (access-expanded) Medicaid would definitely make more sense than the small group market. Another scenario is where a plan sponsor succeeds in reducing their cost with higher deductibles, but in a way that only discourages better take-up rates and increases worker interest in a higher wage (or perhaps a non-healthcare benefit). Of course, some small firms with similar claims experience could potentially band together in AHPs or health marts to negotiate and obtain lower premiums and cost-sharing that many large firms presently enjoy.

Again, increasing employee satisfaction and welfare and promoting employee health through insurance coverage is not as straightforward as conventional wisdom, marketing initiatives, or human resource surveys might suggest. Rather, they pass through other valuation lenses, such as the employer's personal incentive and compensating wage differential. Employers who elect to sponsor finance and manage plan offerings and benefits from the standpoint of cost-efficiency. At the organizational level, the findings of this study collectively suggest that healthcare coverage objectives, policies, strategies, and practices result from the interface between employee rewards and employer incentives. These have long-run consequences on plan design and structure, covered benefits, and costs, especially since both firm and employee typically contribute to health insurance premiums. By inquiring into the dynamics of firm decision-making, we gain theoretical and practical insights into the cost-calculus involved in offering workplace health insurance, notwithstanding a small firm's statutory exemption, substantial financial burden, and operational risks.

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