ENTREPRENEURSHIP & ECONOMIC DYNAMISM:
Marginal Returns from Health Policy Thus Far

Tom Miller
Resident Fellow, American Enterprise Institute

Ewing Marion
KAUFFMAN
Foundation

ENTREPRENEURSHIP & ECONOMIC DYNAMISM:
Marginal Returns from Health Policy Thus Far

Tom Miller
Resident Fellow, American Enterprise Institute

This paper was funded by the Ewing Marion Kauffman Foundation. The views and opinions expressed in this paper are those of the author and do not necessarily represent the views of the Kauffman Foundation.

ENTREPRENEURSHIP & ECONOMIC DYNAMISM:

Marginal Returns from Health Policy Thus Far

INTRODUCTION

The American job-creation machine has slowed noticeably over the last fifteen years. Although the Great Recession of 2007–2009 and an unusually sluggish economic recovery that followed for several years offer some basic cause-and-effect explanations, they fail to tell the entire story. Recent research highlights the importance of young and rapidly growing firms in producing substantial increases in net jobs created. Unfortunately, the longer-term trend in the United States has been moving in a more troubling direction. The share of new startup businesses among all firms has declined noticeably since the late 1970s. The rate of business startup activity remains disappointing, even after a slight pick-up within the last few years. Reversing this trend should be an important priority in efforts to reinvigorate our economy and expand employment opportunities.

This study, funded by the Ewing Marion Kauffman Foundation, will examine the degree to which recent and future changes in national health policy may provide assistance. First, it will place health reform issues within the broader context of what we know about the key factors that shape the relative level and success of “entrepreneurship” (the development, organization, and management of a business venture). Although improved access to more affordable health insurance may help encourage more business startups and job changes, it is not among the most decisive factors.

Second, this study will analyze both the initial promises and early performance of the Affordable Care Act of 2010 (ACA) in aiming to improve the business climate for new startups, other smaller businesses, and their employees. The early record for small business tax credits and health exchanges is disappointing. Providing insurance subsidies more directly to lower-income workers has had a greater impact in increasing their access to health insurance. Overly optimistic projections of significant increases in entrepreneurial activity throughout the U.S. economy under the ACA remain unfulfilled thus far.

Third, this study will assess several possible changes in the near-term direction of national health policy in terms of their potential impact on entrepreneurial activity, business formation, and economic dynamism. Several policy adjustments in a post-ACA world after the 2016 election could alter how, but not whether, insurance coverage for younger and smaller businesses is subsidized and regulated. They include changes in tax policy for health savings accounts, expansion of private health exchanges, greater variation at the state level in how health insurance is regulated, alternatives to the individual mandate, further evolution toward defined contribution financing of health care

arrangements, and exploration of a more diverse set of tools to improve health outcomes.

ASSESSING ENTREPRENEURSHIP IN THE U.S. ECONOMY

Greater emphasis on the rate of business startups and the health of young firms reflects recent research on the significant link between entrepreneurial activity and job creation. The combination of new businesses and young firms is the primary source of net job creation.

"Small" firms are broadly defined in one leading time series of government employment data as those businesses with fewer than 500 employees. Those employers account for about 60 percent of job creation in the United States. Of course, even larger businesses still account steadily for a significant share of total jobs. But employing a large number of workers per se does not necessarily translate into creating a large number of "new" jobs.

However, using this very rough parameter for relative firm size overshoots the mark and fails to explain more important drivers of job growth. Effective analysis that digs deeper finds that job creation is due primarily to the combination of business startups and high-growth businesses (which strongly tend to be young, as well). The former account for about 20 percent of total U.S. job creation and the latter account for almost half of gross job creation.[1] "Younger" appears to be more important than simply "smaller" for job-creation purposes.

Even in the case of "new" businesses, it's important to distinguish carefully on several levels. True "startups" add much more to job creation than do new establishments of existing businesses or technically "new" firms formed by combining pre-existing establishments through merger and acquisition activity.[2] Moreover, the key indicators for job growth involve a subset of startup companies—"employer businesses"—that provide work for individuals other than the founder. Increasing levels of self-employment do not necessarily translate into dynamic economic growth, particularly when it consists of outsourced workers or sole proprietors starting businesses for nonpecuniary reasons like more time flexibility.[3] On the other hand, a much smaller cohort of "transformative" entrepreneurs launch the new high-growth firms that expand rapidly and account for a disproportionate share of net job creation.

Unfortunately, this more targeted focus on the main drivers of job growth reveals some troubling trends that have moved in the wrong direction. For example, the number of new-employer business births peaked even before the onset of the Great Recession in 2007. In more recent years, those employer businesses also have tended to start with fewer employees, grow slower, and experience lower survival rates.[4] Overall, the last

[1] Decker et al., (2014) at 9.
[2] Ibid.
[3] Hurst and Pugsley (2011).
[4] Reedy and Litan (2011).

few decades have experienced a declining share of young firms, and their economic activity, in the U.S. economy,[5] matched by a consistent downward trend in rates of job creation and job destruction.[6]

The best data available at this point indicates that companies younger than one year old contributed only 5.2 million jobs in the year ending June 2014, compared to an average of 6 million in the years leading up to the last recession, and far below a pace of 7 million to 7.5 million jobs a year in young firms during the 1990s. In contrast to slowing rates of business formation, business closures started to increase in 2005 and spike upward in 2008, with business exits not outpacing business entries for the first time in almost four decades of such data collection. Not surprisingly, the average age of U.S. businesses has been rising, with more than two-thirds of companies in business for more than five years.[7] Hathaway and Litan found that the share of firms aged sixteen years or older increased from 23 percent in 1992 to 34 percent by 2011, and their share of private-sector employees increased from 60 percent to 72 percent over those same two decades. Meanwhile, employment and firm shares declined for every other age cohort of businesses during this period.[8]

This recent pattern adds to concern that fewer startups will mean fewer high-growth firms that generate a large share of innovation and net new job creation. These types of young firms help reallocate productive resources across firms in the economy, force older big businesses to innovate or decline, and encourage career advancement through more frequent job switching.

Possible factors behind this slowdown in business dynamism and entrepreneurial activity could include a changing business and regulatory climate that increases adjustment costs, favors larger incumbent players, impedes job reallocation, and raises the costs of expansion.[9] For example, since 2004, the annual ease of "Doing Business" index compiled by the World Bank has dropped the United States from the top ranking in the world in 2004 to as low as number seven in terms of ease of doing business and providing an entrepreneur-friendly environment—an aggregate measure of seven areas of business regulation and property rights protection—in recent years.[10] The U.S. economy scores even lower when it comes to its environment for starting a business.[11]

---

[5] The ratio of new firms to the total of all firms in the U.S. economy steadily decreased, from 15 percent in 1978 to 8 percent by 2011. Litan (2015).
[6] Decker et al., (2014) at 14-16.
[7] See Harrison (2015).
[8] Hathaway and Litan (2014).
[9] See, for example, Bailey and Thomas, (2015). But see Goldschlag and Tabarok (2014) (finding that federal regulation by itself has had little or no effect on declining dynamism).
[10] The United States ranked #6 in "Doing Business" in 2011, #4 in 2010, 2012, 2013, and 2014, and #7 in the 2015 and 2016 annual reports. The World Bank (2015).
[11] The United States ranked #4 in the world in this category in 2007 and 2008, but dropped to #8 in 2010, #13 in 2012 and 2013, #20 in 2014, #44 in 2015, and #49 in 2016. Ibid.

HAVE RECENT POLICY REFORMS ALREADY BOOSTED ENTREPRENEURSHIP & ECONOMIC GROWTH?

Theories tend to outrun empirical evidence in various proposals that focus too narrowly on any one particular factor to explain and address the recent downturn in the rate of business startups and their pace of expansion. In fact, several recent quarters of good, if not consistent, economic growth have helped to reduce the unemployment rate significantly, albeit with less of an increase in the overall labor participation rate (reflecting less of a decline in the levels of discouraged or involuntarily part-time workers) and few signs of healthy productivity growth. Even some recent reports of improvement in the new business startup rate need to be tempered with the caution that early signs of increased levels of self-employment and business creation are not the same as increases in the formation of firms that will employ other workers and grow rapidly. The time lag of several years in generating useful information from federal tax data about employer business formation trends suggests further caution in concluding that prospects for entrepreneurship in the United States have brightened substantially.

To provide some context, consider that, by one measure (the Business Dynamics Statistics database compiled at the U.S. Census Bureau), new formation of business firms finally rebounded slightly in 2011, after four years of decline from its peak of more than 560,000 new businesses created in 2006 to a low point of fewer than 390,000 new firms started in 2010.[12] New business formation continued to inch upward for several more years (401,000 in 2011, 411,000 in 2012), before dropping slightly in 2013 to 406,000.[13]

Another somewhat different measure of entrepreneurial activity—the Startup Activity Index created by the Kauffman Foundation—finds that the rate of new entrepreneurs increased in 2014 to .31 percent (310 out of 100,000 adults started new businesses each month, on average) from .28 percent (280 out of 100,000 adults) in 2013. But, although this short-term uptick in the annual rate of new entrepreneurs represents the largest year-over-year increases in startups in the last two decades, such activity still remains below historical norms after a long-term decline in the annual rate of startups that began even before the Great Recession and tends to follow the business cycle.[14]

A more refined measure of new business activity that has higher economic growth potential is the “opportunity share of new entrepreneurs” within the overall Startup Activity Index. This variable calculates the relative share of new entrepreneurs each year who were not unemployed and not looking for a job before they started their new ventures. This contrasts with the remaining share coming out of unemployment, who—out of necessity in facing limited job opportunities—are more likely to start businesses with lower growth potential. In 2014, approximately eight out of ten new entrepreneurs were not previously unemployed.

---

[12] Hathaway, Bell-Masterson, and Stangler (2013).
[13] United States Census Bureau.
[14] Fairlie et al. (2015).

This is a substantially higher share than found in the 2010 Kauffman Index of Entrepreneurship at the end of the Great Recession in 2009, when the number of opportunity entrepreneurs was at its lowest point since such data measures began in 1996.[15]

The third measure of startup activity in this Kauffman Index involves "startup density," or the number of newly established employer businesses by total population. It increased from 128.8 for every 100,000 people in 2013 to 130.6 per 100,000 in 2014. However, this latest startup density figure remains below typical historical rates, after falling sharply for four consecutive years (from 2009 to 2012). A higher rate of new businesses with employees is considered an important early indicator for job creation and economic growth.

A different measure of trends in small business growth and success, the Main Street Entrepreneurship Index, does not offer encouragement. This index provides an indicator of the prevalence of local small businesses (the number of established small businesses and the number of business owners in a particular location). Small businesses in this index are defined as ones with fewer than fifty employees and existing for longer than five years.

The latest MSE Index for 2015 did experience a one-year increase from 2014, which reversed a six-year downward trend and represented the second-largest year-over-year growth in more than two decades. However, the 2015 index figure still remains below its pre-recession levels, and its primary indicators of long-term trends in Main Street Entrepreneurship do not look as encouraging.[16]

As important as macroeconomic policy variables may be in helping to dampen or augment the ups and downs of business cycles, we should acknowledge that several other policy levers also shape the environment for formation of high-growth businesses. For example, the federal tax code remains less friendly to new and small businesses. Unlike larger incumbent competitors, these new and small businesses usually lack the early profits or capital-intensive investments to make full use of various tax breaks. Access to credit is a persistent challenge, but it has been worsened by the post-recession consolidation within the banking sector that reduced the role of smaller community banks. The sheer complexity of federal regulation poses a disproportionate burden on newer and smaller businesses, as well. Lack of progress in education and immigration reform continues to limit improvement in the quantity and quality of skilled workers that potential high-growth firms need to find and hire.

[15] Kauffman Foundation (2015).

[16] Those measures involve the Rate of Business Ownership—the percentage of adults owning businesses in a given month—and Established Small Business Density—the number of established small employer businesses in the total population. Fairlie et al. (2015).

DOES HEALTH POLICY MAKE A DIFFERENCE?

We also need to consider more carefully the degree to which recent changes in health policy have affected the outlook for high-growth entrepreneurial ventures to launch, succeed, and grow; as well as for workers in smaller firms to move more easily to better jobs. Any positive steps in the right direction would be welcomed. However, economic research in this area remains more suggestive than definitive. It has focused primarily on the issues of reducing job lock and, secondarily, with improving access to more affordable insurance coverage for small businesses and the self-employed, reducing disparities in the tax and regulatory treatment of small versus large businesses, and evaluating health-policy-related disincentives to job and wage growth.

The leading review of research on health insurance, labor supply, and job mobility is more than a decade old.[17] Gruber and Madrian found strong evidence that health insurance was an important factor in retirement decisions and the labor supply decisions of secondary earners.[18] However, it was not a major determinant of the labor supply and welfare exit decisions of low-income mothers. After assessing some conflicts in the literature,[19] they also concluded that, on balance, health insurance plays an important role in job mobility decisions. Nevertheless, Gruber and Madrian unearthed little evidence on the implications of these results for economic growth or personal welfare. They suggested that the welfare costs of job lock (insurance-induced immobility) are likely to be modest.[20]

The working premise is that individuals with health insurance who particularly value their employer-based coverage are less likely to leave those jobs—and risk losing it—than are other workers who value it less. Moreover, the cost of insurance is significantly higher in small firms, due to economies of scale in administration and higher risk premiums to guard against adverse selection in smaller risk pools. Hence, workers that are less able to obtain health insurance on comparable terms across jobs are less likely to move to jobs they might otherwise prefer. They also may become less likely to start businesses, reduce work hours, or exit the labor market. The broader economic policy concern is that such reduced labor market mobility could decrease potential gains in productivity, income, and worker satisfaction.[21]

---

[17] Gruber and Madrian (2001).

[18] For example, Gruber and Madrian concluded that, when there is a ready source of health insurance available that is not attached to one's own employer, individuals (particularly married women) are much less likely to be employed. Ibid at 22.

[19] Their summary of the literature on health insurance and job choice noted that about one-third of the papers reviewed found that health insurance significantly impacts job choice decisions made by workers, another one-third found no significant relationship, and the remaining third found varying levels of effects that are less conclusive. Ibid at 29.

[20] Earlier work by Madrian estimated that the availability of spousal health insurance increased job turnover by 25 percent, or about 4 percent of the total sample of workers studied (in which 16 percent of workers changed jobs over a twelve-month period). Madrian (1994).

[21] Monheit and Cooper (1994).

[21]United States Government Accountability Office (2011).

[21] Ibid at 7.

In December 2011, the United States Government Accountability Office reviewed more recent empirically based, peer-reviewed studies on job lock and its impact on the national economy and labor market. GAO reported that most studies found those workers who rely on employer-sponsored health benefits are less likely to change jobs, leave the labor market, become self-employed, or retire when eligible, compared to those with alternative sources of insurance coverage.[22] The effects appeared to be greatest for workers with chronic medical conditions or workers with newly diagnosed illnesses, as well as older workers without retiree health benefits.[23] However, the studies reviewed by GAO were not able to quantify the overall prevalence of job lock or assess its aggregate impact on labor markets.[24] They varied too widely in their study populations, research methods, and data sources.

The magnitude and effects of job lock also have shifted over time due to legislative and economic changes. The Health Insurance Portability and Accountability Act of 1996 imposed new requirements for portable health insurance coverage when workers switch jobs, and it also limited exclusions for coverage of pre-existing conditions.[25] The gradual decline in the level of employer-sponsored insurance amidst substantial increases in the total cost of health coverage, along with the prolonged downturn in labor markets during the Great Recession, are other offsetting factors that make it harder to isolate the effect of job lock alone in labor market decisions.

One study highlighted by the GAO involved the effect of health insurance subsidies on job lock and the likelihood of becoming self-employed. The Omnibus Consolidated and Emergency Supplemental Appropriations Act for FY 1999 gradually increased the share of the insurance premiums paid by self-employed individuals that are deductible from federal income taxes, rising from 60 percent in 1999 to a full 100 percent by 2003. Heim and Lurie estimated that this policy shift produced a 1.5 percentage point increase in the probability of being self-employed, a 1.1 percentage point increase in being primarily self-employed, and a .35 percentage point increase in the probability of being exclusively self-employed.[26] However, although the policy change to reduce the after-tax cost of health insurance for the self-employed did increase the rate of self-employment, it still only explains around a third to a half of the actual increase in self-employment during this period.

Fairlie, Kapur, and Gates provide the strongest case thus far for an “entrepreneurial lock” relationship between employer-based health insurance and entrepreneurship. Their 2011 study found that business ownership rates increased for male workers during the short period from just before age sixty-five to just over age sixty-five—unlike other short periods from just before to just after other ages between fifty-five to seventy-five.[27] They determined that this difference around age sixty-five in increased rates of

---

[24] Ibid at 5, 9.
[25] Even in the case of HIPAA, a 2006 study found that the law did not significantly reduce job lock. Sanz-de-Galdeano (2006).
[26] Heim and Lurie (2010).
[27] Fairlie, Kapur, and Gates (2011).

business ownership was due primarily to workers' access to alternative health insurance coverage (Medicare), rather than other possibly confounding age-related factors such as retirement, partial retirement, social security, and pension eligibility.

Fairlie, Kapur, and Gates first summarize previous literature on the existence or magnitude of the effect of health insurance on business creation and find little consensus. They then observe that the burden of premium costs is disproportionately high for small business establishment and for older people between ages sixty to sixty-four. Their initial findings suggest that the entrepreneurship lock for male workers with access only to employer-based insurance keeps them from starting new businesses, and it is about one-third as large as the annual rate of business creation.[28] Nevertheless, the study did not directly observe the possible effects of job lock on workers at younger ages (particularly below age sixty), which may limit how much we actually know about the magnitude of those effects on entrepreneurship across the entire working population that lacks the option of health insurance through Medicare.

Fairlie, Kapur, and Gates conclude that their results are consistent with the contention that relatively low rates of U.S. business ownership may be due to less comprehensive health insurance coverage than in other wealthy countries, and that expanding such coverage will encourage business creation. However, they stop short of estimating what would be the relative value of additional health insurance options for potential entrepreneurs who might want to choose to leave their current employment.

THE AFFORDABLE CARE ACT PROMISES TO BOOST ENTREPRENEURSHIP

Affordable Care Act advocates argued that the new health law would help small businesses and their employees, encourage more business startups, and boost job and wage growth. For example, the Obama administration's Council of Economic Advisers asserted in July 2009 that then-pending versions of health care reform legislation would reduce the current burdens on small firms and their workers in a number of ways.[29] The CEA report first highlighted how small business firms and their employees faced high broker fees, high fixed administrative costs, and adverse selection; all leading to insurance premiums that cost them up to 18 percent more than equivalent coverage for large firms. These higher insurance costs led to several other related competitive disadvantages—lower wages, smaller profits, and fewer offers of comprehensive insurance coverage.

The Obama administration claimed that proposed health care legislation then under consideration by Congress (which later became the ACA) would reduce those burdens on small firms and their workers, primarily through four new mechanisms. An insurance exchange for small businesses would allow those firms to choose among more plans to provide better coverage at lower costs. A small business tax credit, targeted at firms with a lower average level of wages, would alleviate their disproportionately high insurance costs and encourage them to offer more coverage. The legislation's employer

[28] Ibid at 161.
[29] Executive Office of the President, Council of Economic Advisers (2009).

mandate for insurance coverage would apply only to medium and large-sized firms, while exempting firms with employment levels below a certain threshold.

Finally, through several other less-direct mechanisms, the proposed legislation also promised to assist individuals in finding and paying for insurance coverage if they decided to launch their own companies. As sole proprietor startups, or as very small employers needing their own personal coverage (without offering employer-sponsored group coverage), those individual entrepreneurs might gain access to income-related subsidies for insurance in the legislation's individual market exchanges, and they no longer could be excluded from insurance coverage or be required to pay higher premiums if they suffered from pre-existing medical conditions.

As a combined package, this set of future ACA reforms was supposed to not only reduce the higher prices of health insurance in the individual and small group markets. It also would improve the range of career choices to better match the skills and needs of workers. By reducing job lock, the reforms hoped to encourage more workers to start their own businesses or consider working for smaller businesses.

Shortly after the ACA's final passage by Congress and its enactment into law in March 2010, then-House Speaker Nancy Pelosi praised its future effects in stimulating formation of more new businesses:

"We see it as an entrepreneurial bill. A bill that says to someone, if you want to be creative and be a musician or whatever, you can leave your work, focus on your talent, your skill, your passion, your aspirations because you will have health care. You won't have to be job locked."[30]

In March 2012, House Minority Leader Pelosi reasserted that promise:

> "You want to be a photographer or a writer or a musician, whatever—an artist, you want to be self-employed, if you want to start a business, you want to change jobs, you no longer are prohibited from doing that because you can't have access to health care, especially because you do not want to put your family at risk."[31]

The Urban Institute provided a supportive, optimistic analysis of the law's labor market effects in May 2013. Blumberg, Corlette, and Lucia summarized the empirical economics literature as strongly supporting the proposition that ACA reforms like guaranteed issue and tax credits for individual market coverage outside the employment context would "significantly increase the likelihood of self-employment."[32] They estimated that, by the end of 2014, the number of self-employed people in the United States would be 1.5 million higher than it otherwise would have been, a relative increase of more than 11 percent nationwide. Using a very simplified model that built on

---

[30] Harrington (2012).
[31] Ibid.
[32] Blumberg, Corlette, and Lucia (2013).

the Fairlie, Kapur, and Gates study, the Urban Institute researchers assumed a 13 percent increase in self-employment due to the ACA in thirty-five states that had not already adopted similar reforms in their non-group insurance markets.[33]

EARLY RESULTS IN IMPLEMENTING ACA REFORMS: LIMITED AND DISAPPOINTING, AT BEST

Assessing the results of implementing a complex set of interconnected components of health policy reform in the ACA over a number of years generally defies simple conclusions. In some cases, it's simply too early to have definitive evidence. In other cases, it's harder to separate the effects of the reforms per se from other economic and political factors. However, the evidence thus far suggests strongly that two key mechanisms touted as providing substantial relief to small businesses and new startup firms have fallen well short of initial promises. Tax credits for small businesses that provide health insurance coverage have drawn very limited interest and participation. The ACA's "SHOP" exchanges also have failed to provide a broader range of affordable and attractive choices of insurance for small businesses. Other predictions by ACA advocates that it would have significant effects in reducing levels of job lock and boosting formation of new businesses remain unsubstantiated at best. On the other hand, dire warnings by ACA opponents that its mandates, subsidies, and rating requirements for health insurance coverage would trigger sizable reductions in working hours, or lead employers to make fewer offers of insurance, also have failed to be validated in practice thus far.

For example, a GAO review in May 2012 of the law's Small Employer Health Insurance Tax Credit found that the tax credit was not large enough to incentivize employers to begin offering insurance and to begin to make that insurance more affordable.[34] The time needed and complexity involved in calculating the credit deterred claims. Most claims were limited to partial rather than full percentage (35 percent) tax credits because of restrictions related to the average wage or number of full-time employees for eligible firms.[35] The temporary nature of the tax credits (a two-year limit) also made investments in learning how to apply for and use them less attractive. GAO noted that potential solutions to these problems faced serious tradeoffs, such as less-precise targeting of employers and higher costs to the federal budget.[36]

The tax credit initially was available beginning in 2010 to all eligible small employers (prior to the expected establishment of Small Business Health Options Program—

---

[33] Ibid. Blumberg, Corlette, and Lucia attributed only partial effects from the ACA on self-employment in other states that already had enacted some of its reforms through earlier state policies.

[34] In tax year 2010, only a little more than 170,000 small employers claimed the tax credit, out of a potentially eligible pool ranging from 1.4 million to 4 million small businesses. United States Government Accountability Office (2012).

[35] In 2014, the maximum percentage of the sliding scale tax credits was increased to 50 percent for firms enrolling their workers in SHOP exchanges.

[36] For example, one proposed solution to the limited take-up of small business tax credits is to expand and simplify them by making them available to more employers and for a longer period of time. See "Senator Coons, Merkley Introduce Bill to Expand ACA Small Business Tax Credit" (2015).

SHOP—exchanges in 2014). But starting in 2014, small employers wishing to take advantage of the tax credit could do so only for premiums to which they contributed for qualified health plans offered within those new SHOP exchanges. As envisioned by the ACA, the SHOPs were supposed to allow small employers to compare available health insurance options in their states and facilitate the enrollment of their employees in coverage.

CBO originally estimated that 2 million employees would enroll in coverage through SHOPs that year, with the number of enrollees rising to 3 million in 2015 and leveling off at 4 million by 2017.[37] However, a recent GAO review of the program determined that overall enrollment was much lower than anticipated as of June 1, 2014. Enrollment for eighteen state-based SHOPS was significantly lower than expected—about 76,000 individuals in plans purchased by nearly 12,000 small employers.[38] The size of firms deciding to enroll in SHOP coverage also was quite small, with an average of 3.7 employees per employer in those businesses.

Enrollment data for the thirty-three states with federally facilitated SHOPs has been much harder to pin down. It was supposed to become available by early 2015, but CMS officials at first simply said they did not have reason to expect major differences in enrollment trends for 2014 between state and federal SHOPs. On July 2, 2015, Kevin Counihan, CEO of the Health Insurance Marketplaces at CMS (which, in November 2014, launched the HealthCare.gov portal in thirty-three states to enroll in federal SHOP Marketplaces), reported that "as of May 2015, approximately 85,000 Americans have 2015 coverage through SHOP Marketplaces, with about 10,700 small employers participating in SHOP Marketplaces."[39]

The seemingly ambiguous language used in that announcement appears to refer to all SHOP markets and obscure the likelihood that a much higher percentage of SHOP enrollment remains in state-run SHOP marketplaces, rather than federal ones.

Key factors behind the disappointing enrollment numbers include delayed implementation in 2014 of several key promised features in the SHOP exchanges, particularly online enrollment and employee choice of multiple plans in all federally facilitated, and in some of the state-established, SHOP exchanges. The relatively small number of employers that are interested in enrolling largely do so to be eligible for the small business tax credit. But, as noted above, those credits remain too small and administratively complex to motivate many employers to enroll in SHOP exchanges.

Another factor discouraging enrollment was transitional relief the Obama administration proposed as a state-based option in November 2013. It expanded the ability of many small employers to renew plans that existed before SHOPS were established and, in some cases, to keep renewing them until October 2016.

---

[37] CBO (2014).
[38] United States Government Accountability Office (2014).
[39] Counihan (2015). See also Galewitz (2015).

GAO concluded that price competition may not be a significant factor, because average SHOP plan premiums are likely to remain similar to prices for non-SHOP plans.[40] Those other small-group plans are subject to the same ACA requirements as SHOP plans for guaranteed issue, adjusted community rating, actuarial value tiers, and essential health benefits, as of January 2014. However, SHOP plans may face growing competition with plans offered within private exchanges, online health coverage marketplaces managed by private benefits consulting firms, or insurers that can provide employee choice without as many of the requirements the ACA has for SHOP plans.

GAO cited limited employer awareness of SHOP plans availability for enrollment, along with greater emphasis by federal and state policymakers on highlighting the coverage options for the ACA's new individual market exchanges. Broker resistance to marketing SHOP plans may be another limiting factor behind their early slow growth.[41]

Although states have the option to expand the availability of SHOP plans to larger employers (those with up to 100 full-time employees) in January 2016, if they have chosen to limit them initially to businesses with no more than fifty employees, there is no particular evidence to suggest that this will improve the enrollment numbers significantly.[42] Moreover, any such expansion in the upper limits of firm size for SHOP participation seems even less likely after Congress enacted in October 2015 another significant change in the ACA's small business rules. The latter revision allows states to continue to define "small employer" under the health law so that companies with fifty-one to 100 workers will not become subject to the ACA's small group insurance reform provisions in 2016, particularly the requirements to offer a comprehensive package of health benefits.

A recent look at the effect of changes in individual market insurance premiums on levels of job lock suggests that the ACA had a much smaller effect on job lock, labor market mobility, and self-employment than originally anticipated. Sachs found that, when ACA-like health reforms in Massachusetts lowered the price of individual market coverage in that state by 33 percent within two years, it increased the turnover rate for workers in that state with employer-sponsored insurance by 0.068 percent—only a 1.04 percent change in the rate of job lock prior to reform.[43] Sachs tested the hypothesis that reducing the price of individual market insurance alternatives should diminish the attractiveness of employer-sponsored health insurance (ESI) benefits and make individual workers more likely to change jobs when opportunities offering higher-productivity matches with their skills arise.

Sachs controlled for other important variables, such as spousal insurance options, the likelihood that ESI is correlated with having a "good" job, turnover propensity of certain

---

[40] Ibid. Gabel et al. (2015) recently noted that insurance carriers can set premiums for plans offered in SHOP exchanges lower than the premiums they offer elsewhere, and that average premiums for plans of similar actuarial value may be 7 percent lower in SHOP exchanges.
[41] Ibid.
[42] United States Government Accountability Office (2014), at 25.
[43] Sachs (2013).

types of workers, firm size, and the state's macroeconomic environment. Her model estimated that having ESI reduces job turnover by 7.6 percent, a noticeably smaller effect than those of earlier studies. The study did not examine the separate job lock effect of ACA provisions for guaranteed issue and community rating on a more narrow slice of the working population—individuals with preexisting health conditions—because Massachusetts already provided similar protections before its more recent round of health reforms were enacted in 2006.

Mulligan provides the most prominent critique of the ACA's labor market effects.[44] His research highlights several incentives in the law that he asserts will affect work schedules and productivity. Mulligan points first to the mandate on larger employers to offer coverage to full-time employees. He then notes the implicit tax at work in the way that full-time employment (with an offer of affordable, qualified ESI coverage) would prevent eligibility for subsidized coverage in the ACA's individual market health exchanges. Finally, he emphasizes how the ACA's sliding scale, income-based, exchange-coverage subsidies produce another implicit tax on a worker's earnings. He concludes that the combination of these various tax incentives will tend to distort work schedules and reduce the nation's weekly employment per person by at least 3 percent and national income by 2 percent. However, those effects under a new law are expected to take time to develop. His model estimates the above consequences as of 2016.

Thus far, labor market evidence has not fully caught up to this underlying theory. It shows some evidence of fewer hours—with more Americans working just under the employer mandate's penalty cutoff point of thirty hours per week. However, earlier overall increases in involuntary part-time work have declined from their post-recession peak, and the monthly number of Americans employed full-time has increased to various degrees over the last two years.[45]

The Congressional Budget Office also supports Mulligan's forecasts to some degree. It estimates that the ACA will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024, although almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive.[46] CBO's February 2014 analysis of the budget and economic outlook over the next decade finds that some provisions will raise effective tax rates on earnings from labor and thus will reduce the amount of labor that some workers choose to supply. Because the health insurance subsidies that the act provides to some people will be phased out as their income rises, they create an implicit tax on additional earnings. For other people, the act imposes

[44] Mulligan (2014).
[45] See, for example, King (2015). However, more Americans are working just under the thirty-hours-a-week cut-off point for employer mandate calculations, and fewer are working just over that threshold, compared with mid-2013. Cunningham (2015). The percentage shifts are about 1.5 percent in each case.
[45] Congressional Budget Office (2014).

higher taxes on labor income directly. On the other hand, CBO observes that the ACA also will exert conflicting pressures on the quantity of labor that employers demand, primarily during the next few years.

CBO also estimates that the ACA will cause a reduction of roughly 1 percent in aggregate labor compensation over the 2017–2024 period, compared with what it would have been otherwise. The reduction in CBO's projections of hours worked represents a decline in the projected number of full-time-equivalent workers of about 2.0 million in 2017, rising to about 2.5 million in 2024. The estimated reduction stems almost entirely from a net decline in the amount of labor that workers choose to supply, rather than from a net drop in businesses' demand for labor.[47]

All of the above-referenced ACA policies and their shortcomings represent, at best, indirect approaches that are falling far short in encouraging greater levels of entrepreneurship and more startups of rapid-growth firms.

HEALTH POLICY ALTERNATIVES

The ACA already has survived several "near-death" experiences in legal challenges to several of its key provisions. In June 2012, the Supreme Court narrowly upheld, in *NFIB v. Sebelius*, the health law's individual mandate to purchase health insurance as an exercise of the power of Congress to levy taxes, rather than as part of its constitutional power to regulate interstate commerce. In June 2015, the Court upheld, in *King v. Burwell*, the legality of an Internal Revenue Service rule that authorized payment of insurance tax credit subsidies for exchange-based coverage in as many as thirty-eight states that did not establish their own exchanges but rely on federally-facilitated ones instead.

If the Court had ruled differently—in favor of the plaintiffs challenging the IRS rule—it would have eliminated further tax credits in federal exchange states. Because of how enforcement of several other ACA provisions are tied to exchange enrollees' receipt of those credits, a decision invalidating the IRS rule as contrary to the ACA's statutory text also would have eliminated the law's employer coverage mandate and substantially reduced the scope of the law's individual mandate to purchase insurance in as many as thirty-eight states that have not established, or no longer operate, their own ACA-compliant exchange.

However, the possibility of such a decision in *King* spurred further planning in Republican policy circles for how a post-ACA health care market might operate, as well as the degree to which it would be subsidized and regulated. Both the House and Senate subsequently passed different versions of a budget reconciliation bill last fall that targeted key provisions of the ACA, such as repeal of its individual and employer mandates, and even prepared to repeal and replace the law's subsidies for coverage in all ACA exchanges and in states with expanded Medicaid programs. In December 2015, Congress passed other legislation to extend and revise various tax provisions, including

[47] Ibid.

delays in enforcement of the ACA's taxes on high-cost employer health plans, health insurance premiums, and medical devices.

With a presidential campaign year ahead in which the Republican nominee is likely to propose new efforts to overturn or roll back some, if not all, provisions of the ACA, the uncertainties ahead—both in terms of national politics and policymaking complexity—remain daunting. Resolving them will affect the incentives and opportunities facing many categories of patients, purchasers, and providers, including current and future entrepreneurs.

Given the current slowing of enrollment growth in ACA exchanges and signs of a rise in health care costs overall, the more likely result in the near-term is that the next phase of ACA-like exchanges in many states will evolve to become somewhat less regulatory. They will still gain federal subsidies that become somewhat less income-based. Enforcement of the employer mandate is likely to remain ambivalent at best (after being delayed completely for 2014 and partly for 2015). The limited impact of the individual mandate will be reduced further, if it is not replaced by different types of coverage incentives.

An important question remaining somewhat further over the horizon is what other types of broader ACA reforms—beyond incremental repair work—are worth considering, particularly in terms of how they might improve future prospects for greater levels of entrepreneurship and new, rapid-growth business formation. If the goal is to help make the ACA's efforts to promote pro-entrepreneur policies work better, policymakers should reexamine the tradeoff between narrow, income-based targeting of insurance coverage subsidies in SHOP exchanges (small business tax credits for employers) and individual market exchanges (premium assistance tax credits for the low-income self-employed and other workers), on the one hand, and the barriers to employment and wage growth they produce, on the other hand. A highly progressive distributional structure for ACA insurance subsidies tends to impose speed barriers on small startup firms that have the potential to grow rapidly. Tying the onset of employer mandate penalties to a given level of full-time employees also discourages more rapid growth of smaller businesses.

These interrelated issues of targeting, adequacy, and incentive effects are not new ones in the structuring of federal subsidy programs. If the primary policy goal is more rapid growth of promising startup firms, rather than maintaining them at smaller levels with sufficient insurance coverage, a transition toward flatter insurance subsidy levels (either fixed dollar amounts or in less-graduated, income-related tiers of tax credits) or more time-limited ones, should be considered. On the employer mandate front, its employer-size thresholds currently attach at a point where they tend more to discourage additional hiring growth than to stimulate new insurance coverage offers, on the margin. Either removing this politically troubled provision entirely, or triggering its enforcement thresholds to cover substantially smaller firms, would at least better accomplish one of those two potentially conflicting objectives.

A limited case can be made for the benefits of the ACA's individual market exchange coverage in providing the security of access to insurance, without additional premium upcharges or coverage exclusions, for would-be sole proprietors with serious preexisting health conditions. However, one policy alternative both to the ACA's universal ban on health-status-related underwriting in the individual insurance market and its accompanying individual mandate to purchase federally qualified insurance would be to extend to the market the current-law portability guarantee for the employer-sponsored group market under the Health Insurance Portability and Accountability Act of 1996. This approach would ensure that anyone who maintains continuous coverage at the minimum levels of insurance required is protected against higher premiums or reduced coverage due to changes in their health status.[48] Other individuals falling through the cracks of continuous coverage could be provided with additional subsidized protection against more extreme risk-based underwriting through federally subsidized high-risk-pool coverage.[49]

The SHOP exchange experiment has been disappointing thus far. At times, it may appear to represent a hasty political solution in search of a larger problem, but smaller business owners still could use some alternative insurance pooling mechanisms that provide greater choices of affordable health coverage than the pre-ACA small group market generally provided. The better route ahead might involve evolution of newer private exchange alternatives, which can provide smaller firms with back-office administrative efficiencies, a more customized menu of insurance coverage choices, and a wider range of employee choices.[50]

One way to enhance this private-sector-driven reform would be to reconsider recent regulations that restrict employers' defined contribution payments for insurance coverage only to ACA-compliant small-group coverage.[51] Allowing employee choices within employer-subsidized defined contribution health benefit plans to extend to their selection of other individual market plans would substantially expand the ability of startup business owners to provide more attractive but lower cost choices to their workers.

Most proposals for alternatives to ACA-style insurance coverage subsidies for smaller employers begin and end with reform of the tax treatment of health insurance payments. The ultimate objective usually is to establish a level playing field for all types of

---

[48] Miller (2012); Antos et al. (2015)
[49] Miller (2013).
[50] Most of the initial growth for this product has been in the mid-market sector of employers. Kalish (2015). For a more skeptical view of the future growth of private exchanges, see Market Outlook (2015).
[51] See Notice 2013-54, issued by the Department of Treasury on September 13, 2013, which set forth specific rules relating to the purchase of an individual market plan through certain funding arrangements established by an employer. According to Notice 2013-54, a Section 105 Medical Reimbursement Plan and a Revenue Ruling 61-146 arrangement—which are considered "group health plans" under the Internal Code—will fail to comply with the ACA's restrictions on annual limits on plan benefits because (1) these reimbursement arrangements are considered to impose an annual limit up to the cost of the individual market plan purchased with the arrangement and (2) the arrangements are not "integrated"[51] with another group health plan that otherwise meets this new requirement.

insurance purchasers, including entrepreneurs starting new businesses and their employees. The policy variations involve how to get there, or at least how to close the gap between more generous tax subsidies for employer-sponsored group insurance and the lesser ones for other types of coverage available to workers in small and new businesses. One basic approach is to provide to the self-employed and other individuals without access to ESI some alternative, tax subsidies roughly equivalent to those under the tax exclusion for the latter type of group coverage. The options here include fully extending the equivalent tax deduction (including against payroll taxes as well as federal income taxes) to the individual-market health insurance expenses of the former type of business proprietors and their employees.[52] Or, they could instead involve fixed-dollar tax credits that may, or may not, be adjusted for age and geographic location.[53]

The biggest political and administrative stumbling block here is whether to reduce the future value of ESI subsidies so that they become much closer in amount to the new tax subsidies for other types of insurance coverage.

Another way to move toward greater parity in insurance coverage subsidies through the tax code is to take advantage of recent growth in use of tax-advantaged health savings accounts (HSAs) in combination with higher-deductible insurance. Two significant reforms would first allow the use of HSA funds to pay health insurance premiums and then extend the deductibility for individual (as opposed to employer) contributions to HSAs to apply to federal payroll, as well as federal income, taxes.[54]

CONCLUSION

Beyond moving closer to equal tax treatment of health insurance purchases across all types of buyers, simplifying and streamlining federal rules for small-group health insurance requirements, and trying to make SHOP-like insurance marketplaces work better, the health-insurance-specific set of policy reform options ahead remain limited in a post-ACA environment. The bigger payoff to small and new businesses with rapid growth potential involves the same broader set of health policy reforms that would help all potential insurance customers: those that would help to reduce further the rate of growth in health care costs while maintaining or improving the value of care that they decide to purchase. Less-explored policy reform opportunities involve moving behind the limited levers for health insurance financing and regulation involved directly in most ACA-replacement proposals by Hill Republicans. Improving access and use of more actionable information about the value of different health care choices, enhancing the productivity of health care treatment decisions, and bolstering the key determinants of population health that extend far beyond the level and quality of health services provided are more ambitious, but oft-neglected, components of comprehensive health reform. Addressing those issues more effectively is not unique to health care purchasers who happen to be potential entrepreneurs and owners of new businesses.

---

[52] Miller (2014); Miller (2013).
[53] Antos et al. (2015); The Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act: A Legislative Proposal (2014*).*
[54] Antos et al. (2015); Miller (2013).

At the same time, any more-targeted health policy reforms regarding declining levels of new business formation and faster growth of young firms should focus on the right baseline for measurement of their effects. The key metrics do not relate to assisting small businesses per se or to boosting levels of self-employment alone. The crucial policy payoff involves enabling more explosively successful rapid-growth firms to launch and expand.

Hence, broader reforms to reverse the recent trends toward declining levels of new business formation and slower growth of those young firms must reach well beyond health policy to be more effective. They primarily involve improving the overall economic climate in which new and younger businesses operate so that their opportunities to succeed and grow larger are better. Aside from a more successful approach to pro-growth macroeconomic policy, effective reforms must improve the human and health capital of prospective employees and employers. This involves such issues as enhancing the quality and quantity of educational opportunities, slowing the buildup of crippling student debt loads, expanding skills-based immigration pathways (particularly for foreign graduate students with degrees in science, technology, engineering, and mathematics), improving access to capital markets for smaller businesses, reversing the tax code's bias toward corporate debt finance that favors older and larger firms, and reducing the complexity and scope of current regulatory barriers to market entry by new businesses and the disincentives to grow larger that they present.

Putting into proper perspective the issues of incremental health policy reform versus more transformation economic and social policy change means recognizing the former's potential to make life somewhat easier or more difficult for current and prospective entrepreneurs, but acknowledging that more extensive reforms in areas well beyond health policy will be far more decisive.

REFERENCES

Antos, Joseph, James C. Capretta, Lanhee J. Chen, Scott Gottlieb, Yuval Levin, Thomas P. Miller, Ramesh Ponnuru, Avik Roy, Gail R. Wilensky, and David Wilson. 2015. "Improving Health and Health Care: An Agenda for Reform," American Enterprise Institute.

Bailey, James, and Diana Thomas. 2015. "Regulating Away Competition: The Effect of Regulation on Entrepreneurship and Employment," Mercatus Center Working Paper, http://mercatus.org/sites/default/files/Bailey-Regulation-Entrepreneurship.pdf.

Blumberg, Linda J., Sabrina Corlette, and Kevin Lucia. 2013. "The Affordable Care Act: Improving Incentives for Entrepreneurship and Self-Employment," Urban Institute.

Congressional Budget Office. 2014. "The Budget and Economic Outlook: 2014–2024," https://www.cbo.gov/publication/45010.

Congressional Budget Office. 2014. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act," https://www.cbo.gov/publication/45231.

Counihan, Kevin. 2015. "Update on SHOP Marketplaces for Small Businesses," The CMS Blog, http://blog.cms.gov/?s=Update+on+SHOP+marketplaces+for+small+businesses.

Cunningham, Paige. 2015. "Obamacare's Small Effect on Jobs," *Washington Examiner*, http://www.washingtonexaminer.com/obamacares-small-effect-on-jobs/article/2564118.

Decker, Ryan, John Haltiwanger, Ron Jarmin, and Javier Miranda. 2014. "The Role of Entrepreneurship in U.S. Job Creation and Economic Development," *Journal of Economic Perspectives*, 28(3): 3–24.

Executive Office of the President, Council of Economic Advisers. 2009. "The Economic Effects of Health Care Reform on Small Businesses and Their Employees."

Fairlie, Robert W., Kanika Kapur, and Susan Gates. 2011. *Journal of Health Economics* 30: 146–162.

Fairlie, Robert W., Arnobio Morelix, E.J. Reedy, and Joshua Russell. 2015. "The Kauffman Index, Startup Activity, National Trends 2015," Kauffman Foundation.

Fairlie, Robert W., Joshua Russell, Arnobio Morelix, and E. J. Reedy. 2015. "The Kauffman Index, Main Street Entrepreneurship, National Trends 2015," Kauffman Foundation.

Gabel, Jon R., Sam T. Stromberg, Matthew Green, Amy Lischko, and Heidi Whitmore. 2015. “An Early Look at SHOP Marketplaces: Low Premiums, Adequate Plan Choice in Many, but Not All, States,” *Health Affairs*, 34(5): 732–740.

Galewitz, Phil. 2015. “Small Businesses Snub Obamacare’s SHOP Exchange,” *Kaiser Health News*, http://khn.org/news/small-businesses-snub-obamacares-shop-exchange/.

Goldschlag, Nathan, and Alexander Tabarok. 2014. “Is Regulation to Blame for the Decline in American Entrepreneurship?” GMU Working Paper in Economics No. 15-11.

Gruber, Jonathan, and Brigitte C. Madrian. 2002. “Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature,” NBER Working Paper No. 8817.

Harrington, Elizabeth. 2012. “Pelosi: Obamacare Allows You to Quit Your Job and Become ‘Whatever,’” CNSNews.com, http://cnsnews.com/news/article/pelosi-obamacare-allows-you-quit-your-job-and-become-whatever.

Harrison, J.D. 2015. “The Decline of American Entrepreneurship—in Five Charts,” *Washington Post*, http://www.washingtonpost.com/news/on-small-business/wp/2015/02/12/the-decline-of-american-entrepreneurship-in-five-charts/.

Hatch, Orin. 2014. “The Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act: A Legislative Proposal,” www.hatch.senate.gov/public/_cache/files/bf0c9823-29c7-4078-b8af-aa9a12213eca/The%20Patient%20CARE%20Act%20-%20LEGISLATIVE%20PROPOSAL.pdf.

Hathaway, Ian, Jordan Bell-Masterson, and Dane Stangler. 2013. “The Return of Business Creation,” Kauffman Foundation.

Hathaway, Ian, and Robert Litan. 2014. “The Other Aging of America: The Increasing Dominance of Older Firms,” The Brookings Institution.

Heim, Bradley T., and Ithai Z. Lurie. 2010. “The Effect of Self-Employed Health Insurance Subsidies on Self-Employment,” *Journal of Public Economics* 94: 995–1007.

Hurst, Erik H., and Benjamin Wild Pugsley. 2011. “What Do Small Businesses Do?” *Brookings Papers on Economic Activity*, 2011(2): 73–142.

Kalish, Brian M. 2015. “The Year in Private Benefit Exchanges: Modest Growth, High Interest, Big Changes,” *Employee Benefit News*, http://ebn.benefitnews.com/news/exchanges/the-year-in-private-benefit-exchanges-2747954-1.html?utm_medium=email&ET=ebnbenefitnews:e5780326:1364085a:&utm_source=newsletter&utm_campaign=ebn%20insurance%20newscast-dec%2022%202015&st=email.

Kauffman Foundation. 2015. “Nation’s Startup Activity Reverses Five-Year Downward Trend, Annual Kauffman Index Reports,” http://www.kauffman.org/newsroom/2015/05/nations-startup-activity-reverses-five-year-downward-trend-annual-kauffman-index-reports.

King, Robert. 2015. “Economic Impact of Obamacare Hotly Debated,” *Washington Examiner*, http://www.washingtonexaminer.com/economic-impact-of-obamacare-hotly-debated/article/2565578.

Litan, Robert. 2015. “Start-Up Slowdown: How the United States Can Regain Its Entrepreneurial Edge,” *Foreign Affairs*, Jan/Feb 2015, https://www.foreignaffairs.com/articles/americas/2014-12-15/start-slowdown.

Madrian, Brigitte C. 1994. “Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job Lock?” *Quarterly Journal of Economics*, 109(1): 27–54.

Merkley, Jeff. 2015. “Senators Coons, Merkley Introduce Bill to Expand ACA Small Business Tax Credit,” http://www.merkley.senate.gov/news/press-releases/senators-coons-merkley-introduce-bill-to-expand-aca-small-business-tax-credit.

Miller, Thomas. 2013. “How the Debt Tussle Can Help Move Toward a Flat Tax,” American.com.

Miller, Thomas P. 2013. “Protecting America’s Sick and Chronically Ill,” Testimony before House Energy and Commerce Subcommittee on Health, April 3, 2013, http://energycommerce.house.gov/hearing/protecting-america%E2%80%99s-sick-and-chronically-ill.

Miller, Thomas P. 2012. “When Obamacare Fails: The Playbook for Market-Based Reform,” American Enterprise Institute.

Miller, Tom. 2014. **“**Debate Over How to Replace Obamacare Comes to a Fork in the Tax Code,” *Real Clear Markets,* http://www.realclearmarkets.com/articles/2014/05/07/debate_over_how_to_replace_obamacare_comes_to_a_fork_in_the_tax_code_101041.html.

Monheit, Alan C., and Philip F. Cooper. 1994. “Health Insurance and Job Mobility: Theory and Evidence,” *Industrial and Labor Relations Review,* 48(1).

Mulligan, Casey. 2014. “The Affordable Care Act and the New Economics of Part-Time Work,” Mercatus Working Paper.

Reedy, E. J., and Robert E. Litan. 2011. “Starting Smaller; Staying Smaller: America’s Slow Leak in Job Creation,” Ewing Marion Kauffman Foundation.

Sachs, Rebecca. 2013. “Job-Lock and Health Insurance Premiums: Evidence from Massachusetts Health Care Reform,” Stanford University honors thesis, https://economics.stanford.edu/sites/default/files/publications/rebeccamsachs/honorsthesis-May2-15.pdf.

Sanz-de-Galdeano, Anna. 2006. “Job-Lock and Public Policy: Clinton’s Second Mandate,” *Industrial and Labor Relations Review,* 59(3).

United States Census Bureau. 2015. “Business Dynamics Statistics: Firm Characteristics Data Tables, Firm Age,” http://www.census.gov/en.html.

United States Government Accountability Office. 2014. “Small Business Health Insurance Exchanges: Low Initial Enrollment Likely Due to Multiple, Evolving Factors,” GAO-15-58.

United States Government Accountability Office. 2012. “Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity,” GAO-12-549.

United States Government Accountability Office. 2011. “Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act,” GAO-12-166R, http://www.gao.gov/products/GAO-12-166R.

World Bank. 2016. “Doing Business 2016: Measuring Regulatory Quality and Efficiency,” http://www.doingbusiness.org/media/GIAWB/Doing%20Business/Documents/Annual-Reports/English/DB16-Full-Report.pdf.