EXECUTIVE SUMMARY

Employer-Sponsored Insurance Access, Affordability, and Enrollment in 2018

State and National Estimates and Implications for Low-Income Working Families

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Employer-sponsored insurance (ESI) remains the dominant form of health insurance coverage in the United States (Berchick, Barnett, and Upton 2019). However, its role has shrunk over the past two decades. The share of nonelderly people with ESI at a point in time dropped 16 percent between 1999 and 2010 (Rae et al. 2019). And although workers gained employer coverage in recent years following implementation of the Affordable Care Act (ACA) and improvement in the economy (Gangopadhyaya, Garrett, and Dorn 2018; Shartzer, Blavin, and Holahan 2018), reliance on ESI in 2018 was still far below where it was in 1999 (Rae et al. 2019). Underlying the declines in ESI coverage have been substantial increases in its costs, which have outpaced inflation and earnings (Claxton et al. 2019; Collins, Gunja, and Doty 2017; Collins, Radley, and Baumgartner 2019). Increased ESI costs have been a key driver of ESI's erosion, particularly for workers with low and middle incomes (Chernew, Cutler, and Keenan 2005; Shen and Long 2006).

This brief summarizes our report *Employer-Sponsored Insurance Access, Affordability, and Enrollment in 2018: State and National Estimates and Implications for Low-Income Working Families* (Johnston et al. 2020), which examines access to, affordability of, and reliance on ESI using data from the 2008–18 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).[1] We provide estimates for full- and part-time employees, those working in small and large firms, and those in establishments with majority and fewer low-wage employees in 2018—both nationally and by state. We further assess how ESI access, affordability, and enrollment have changed nationally since 2008.

Understanding ESI for workers in small firms, those in majority-low-wage establishments, and those working part time is particularly important, as workers in families with low incomes are more likely to be in these three work situations and to be uninsured than other workers (Williamson, Antonisse, and Tolbert 2016). Access and affordability of ESI coverage and health care is important for the health and well-being of all workers and their families. For workers in families with low incomes—below 250 percent of the federal poverty level (FPL)—enrollment in ESI is also shaped by availability of alternative coverage types, such as Medicaid and subsidized Marketplace plans. This group would be affected by policy changes under consideration, such as changes to the ESI firewall under the ACA, which limits whether people with an ESI offer can qualify for subsidized coverage through the Marketplaces; state-level decisions about Medicaid expansion; and provisions within the Medicaid program such as work requirements and cost sharing (OMB 2019; Straw 2019; Williamson, Antonisse, and Tolbert 2016).[2]

Millions of Americans have lost their jobs and access to ESI as a result of the economic fallout from the COVID-19 pandemic, and most will likely need to rely on Medicaid or Marketplace coverage while they remain unemployed (Gangopadhyaya and Garrett 2020). Affordability of coverage and care through ESI plans will remain an important factor for workers in families with low incomes who remain employed, as well as for many others who gain employment as the economy recovers. Our key findings are as follows.

National Trends between 2008 and 2018

- The share of full-time employees eligible for ESI from their own employers in private-sector establishments remained unchanged from 2008 to 2018 at approximately 80 percent, while the share of part-time employees eligible for ESI in private-sector establishments decreased from 25 percent to 15.5 percent.
- The average annual employee premium contribution to single ESI coverage increased from $1,029 to $1,427 in 2018 dollars, and the average deductible for single coverage increased from $1,013 to $1,846 in 2018 dollars. Costs for family and employee-plus-one coverage increased as well. Measured in 2018 dollars, the average annual employee premium contribution increased from $3,958 to $5,431 for family coverage and from $2,686 to $3,634 for employee-plus-one coverage. The average deductible for family coverage increased from $1,934 to $3,392.
- The share of employees in private-sector establishments enrolled in ESI from their own employer decreased from 64.2 percent to 59.1 percent for full-time employees and from 13.0 percent to 6.9 percent for part-time employees. We observe declines for full-time employees between 2009 and 2010 and again between 2014 and 2016, while declines for part-time employees were concentrated between 2013 and 2014.

Variation across and within States in 2018

ACCESS TO EMPLOYER-SPONSORED INSURANCE

- Nationally and in each state, access to ESI from one's own employer was more limited for part-time employees than for full-time employees. Nationwide, 15.5 percent of part-time employees in private-sector establishments were eligible for ESI compared with 80 percent of full-time employees. Full-time employees in small firms and establishments where the majority of employees had low wages also had more limited access to ESI (51.2 percent and 64.7 percent, respectively) relative to those in larger firms (88.7 percent) and in establishments with fewer low-wage employees (82.7 percent).

AFFORDABILITY OF EMPLOYER-SPONSORED INSURANCE

- The national average employee contribution to premiums for single coverage in 2018 was $1,427, which represented 11.8 percent of individual income at the federal poverty level. Premium contributions vary little by firm size or the share of low-wage employees, but average employee contributions vary by state, ranging from less than $1,200 in seven states to more than $1,600 in seven states. Premium contributions by employees were greater, on average, for employee-plus-one coverage ($3,634; 22.1 percent of poverty-level income for a family of two) and family coverage ($5,431; 21.6 percent of poverty-level income for a family of four).
- For employees with family incomes at the federal poverty level, employee contributions to premiums for single, employee-plus-one, and family coverage were far higher than the federally subsidized premiums associated with 2018 Marketplace coverage, which were capped at 2.01 percent of income. Employee contributions to premiums for single coverage were more than five times the share of income as subsidized Marketplace plans and more than the combined premium-plus-deductible amount for those with poverty-level incomes. But because of the ESI firewall, which limits access to subsidized Marketplace coverage, employees would not be eligible if their ESI offer had an employee premium contribution to single coverage that constituted no more than 9.56 percent of their income.
- For employees with family incomes at 200 percent of FPL, on average, employee contributions to ESI premiums for single coverage represented a slightly lower share of income than Marketplace premiums (5.9 percent of income for ESI versus 6.3 percent of income for Marketplace). But ESI was less affordable than Marketplace coverage for employee-plus-one (11.1 percent of income for ESI versus 6.3 percent of income for Marketplace) and family coverage (10.8 percent of income for ESI for a family of four versus 6.3 percent of income for Marketplace).
- Close to nine in ten (87.3 percent) employees enrolled in ESI had a deductible in 2018; the average amount was $1,846 for those enrolled in single coverage with a deductible and $3,392 for those enrolled in family coverage with a deductible. These were well above the deductibles for the Marketplace plans typically available to individuals with low incomes, which ranged from $0 to just over $600 for those with incomes at the federal poverty level and from $0 to just over $1,600 for those with incomes at 200 percent of FPL. The share of employees enrolled

in ESI with a deductible was above 80 percent in all but four states, and more than 90 percent of employees with ESI had a deductible in most states. Deductibles for single coverage ranged from $1,308 in Washington, DC, and $1,451 in Utah to $2,447 in Maine.

- More than nine in ten (92.3 percent) employees enrolled in single-coverage ESI had an out-of-pocket maximum in 2018, but the average amount ($4,416) represented more than a third of their annual income at the poverty level. This amount is more than four times the out-of-pocket maximum for Marketplace coverage at 100 percent of FPL ($1,020) and nearly twice the maximum for Marketplace coverage at 200 percent of FPL ($2,218). Looking at employees enrolled in family-coverage ESI, 93.3 percent had an out-of-pocket maximum at an average amount of $8,375.

ENROLLMENT IN EMPLOYER-SPONSORED INSURANCE

- In 2018, enrollment in an employee's own ESI in private-sector establishments was substantially higher among full-time employees (59.1 percent) than part-time employees (6.9 percent). ESI enrollment was also higher among full-time employees in large firms (65.8 percent) and establishments where less than 50 percent of employees had low wages (62.7 percent) than in small firms (37.1 percent) or establishments with mostly low-wage employees (39.0 percent). Across states, ESI enrollment among full-time employees ranged from less than half of employees in two states to more than two-thirds in two states, while enrollment among part-time employees was a tenth or less in all but four states.

This analysis shows that certain groups of workers were not eligible for ESI from their own employer in 2018, and among those eligible ESI may not have been an affordable coverage option. Part-time employees and those working in small firms or majority-low-wage establishments were much less likely to be eligible for ESI than full-time employees and people working for larger firms and establishments with fewer low-wage employees.

When considered as a share of income for families with low incomes, average required employee premium contributions, deductible amounts, and out-of-pocket maximums often consumed a large share of household resources. On average, employee premium contributions were well above the federally subsidized premiums associated with 2018 Marketplace coverage for families with income at the federal poverty level, and for single coverage annual deductibles were greater, on average, than required premium contributions at both 100 percent and 200 percent of FPL. Similarly, out-of-pocket maximums for ESI coverage were more than four times the national average out-of-pocket maximum for both single and family Marketplace coverage at 100 percent of FPL and nearly twice the maximum at 200 percent of FPL. These patterns hold up in almost every state and highlight systematic and widespread gaps in access to affordable ESI that may be especially pronounced for workers in families with low incomes. Low ESI enrollment rates, particularly for part-time employees and those in small firms or establishments with majority low-wage employees, reflect these gaps. Without access to affordable ESI, workers and their families are at risk of uninsurance, financial hardship, unmet health care needs, and poor health outcomes (Shartzer, Long, and Anderson 2016; Sommers, Gawande, and Baicker 2017).

Reducing uninsurance among working families is key to making a substantial dent in the remaining number of uninsured people. Workers accounted for 64 percent of the remaining nonelderly people uninsured in 2017 (Blumberg et al. 2018) and almost 75 percent of the remaining nonelderly people uninsured who lived in a family where at least one adult worked for a firm in the previous year (that figure rises to more than 80 percent if self-employed adults are included).

Understanding access to, affordability of, and enrollment in ESI coverage has important implications for families with low incomes given the current push for work requirements in Medicaid. The State Medicaid Director community engagement letter and waiver approval letters for seven states anticipate that, with such requirements in place, working Medicaid enrollees will be able to transition to ESI or other commercial coverage.[3] For example, the Ohio waiver approval letter states, "the community engagement requirement is designed to help individuals achieve financial independence and transition into employer-sponsored or other commercial coverage." Such efforts to limit public coverage for workers threaten recent coverage gains experienced by low-wage workers following implementation of the ACA—gains that were driven by increases in Medicaid and subsidized Marketplace coverage (Garrett, Gangopadhyaya, and Dorn 2017; Shartzer, Blavin, and Holahan 2018).

Understanding access to, affordability of, and enrollment in ESI coverage is also critical to debates about whether and how to restructure ACA Marketplaces regarding who can qualify for subsidized coverage, as well as proposals aiming to lower health care costs. Employees who are not enrolled in ESI through their workplace and are not covered by a family member's ESI plan will likely need Medicaid or subsidized Marketplace coverage, rather than ESI, to access affordable health insurance coverage. As policymakers look to address the pressing needs of Americans losing their jobs because of the public health and economic crisis related to COVID-19, it will also be important to keep in mind that many groups of workers did not have access to affordable ESI coverage before the pandemic. Therefore, policymakers will also want to ensure that workers in families with low incomes who are able to maintain their employment have access to affordable health insurance coverage and health care. Meeting the health needs of these workers, in addition to the newly unemployed, will be critical to discussions about how to structure Medicaid and Marketplace coverage in the post-COVID-19 era.

Notes

1 The data and methods section of the report has more information on the MEPS-IC data and analysis methods.

2 Abby Goodnough, "Appeals Court Rejects Trump Medicaid Work Requirements in Arkansas," *New York Times*, February 14, 2020, https://www.nytimes.com/2020/02/14/health/medicaid-work-requirements.html; Tara Straw, "Beyond the Firewall: Pathways to Affordable Health Coverage for Low-Income Workers," *Health Affairs* blog, December 3, 2019, https://www.healthaffairs.org/do/10.1377/hblog20191127.362854/full/.

3 See Community Engagement State Medicaid Director Letter: Center for Medicaid and CHIP Services to State Medicaid Director, "RE: Opportunities to Promote Work and Community Engagement among Medicaid Beneficiaries," January 11, 2018, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf; Arkansas Community Engagement Waiver Approval Letter: Center for Medicaid and CHIP Services to State Medicaid Director, "RE: Healthy Adult Opportunity," January 30, 2020, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf; Indiana Community Engagement Approval Letter: Center for Medicaid and CHIP Services State Demonstrations Group

to Medicaid Director Allison Taylor, January 30, 2020, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-ca.pdf; Kentucky Community Engagement Waiver Approval Letter: Centers for Medicare and Medicaid Services to Carol H. Steckel, commissioner of the Department for Medicaid Services for the Commonwealth of Kentucky, November 20, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf; Michigan Community Engagement Waiver Approval Letter: Centers for Medicare and Medicaid Services to Governor Rick Snyder, December 21, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf; New Hampshire Community Engagement Waiver Approval Letter: Center for Medicaid and CHIP Services to Medicaid Director Henry D. Lipman, November 30, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-granite-advantage-health-care-program-ca.pdf; Ohio Community Engagement Waiver Approval Letter: Centers for Medicare and Medicaid Services to Maureen Corcoran, director of the Ohio Department of Medicaid, March 15, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/work-requirement-and-community-engagement/oh-work-requirement-community-engagement-demo-appvl-20190315.pdf; South Carolina Community Engagement Approval Letter: Centers for Medicare and Medicaid Services to Joshua Baker, director of the Department of Health and Human Services for the State of South Carolina, December 12, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-healthy-connections-works-ca.pdf.

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