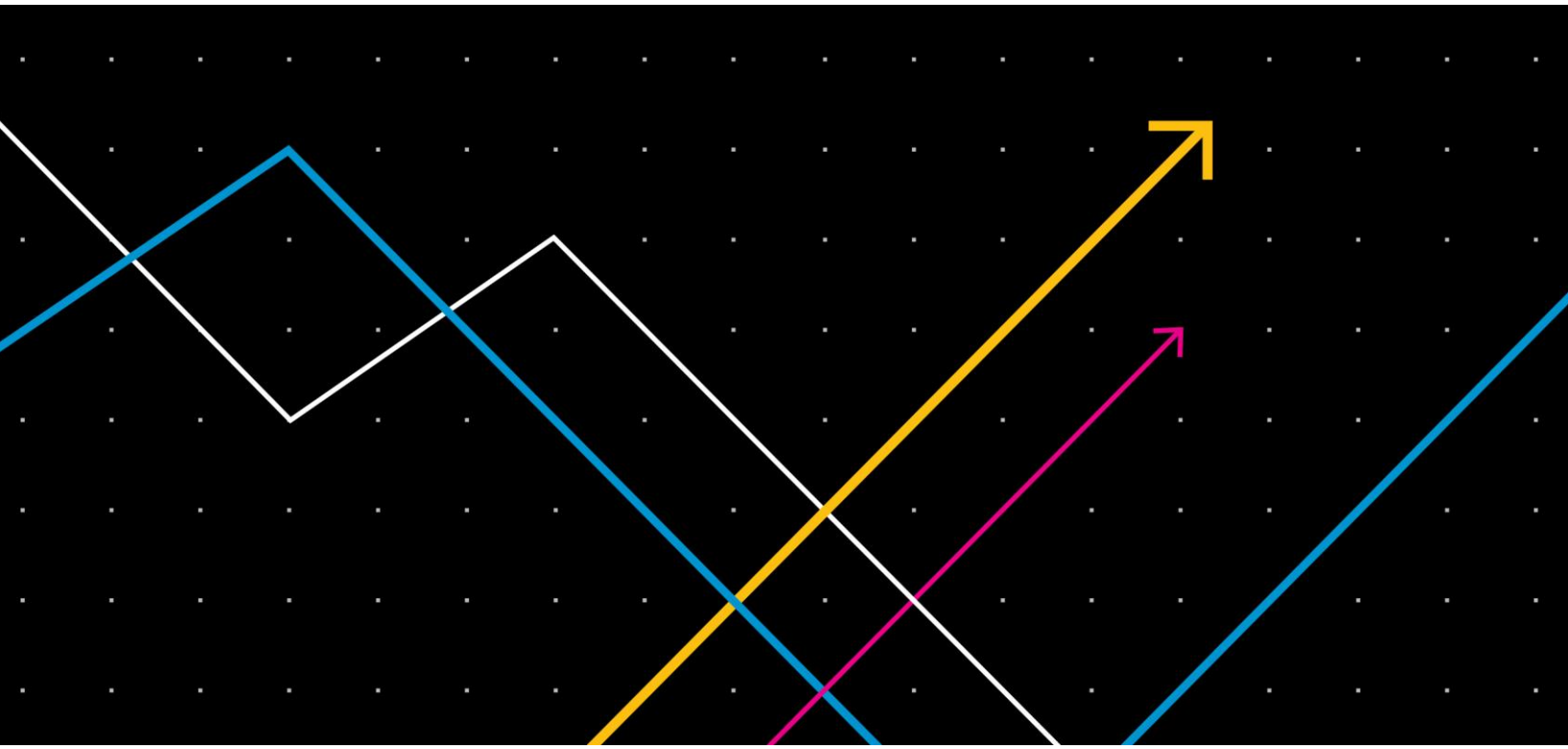

RESEARCH REPORT

Health Care Affordability in Employer versus Private Nongroup Coverage before ARPA

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Executive Summary

Many families with private health insurance face significant health care cost burdens. As policymakers seek to mitigate costs through the extension of federal subsidies and other means, it is important to understand which families have the greatest challenges paying for care.

In this report, we assess differences in health care affordability between families with employer-sponsored insurance (ESI) and those with private nongroup coverage obtained through or outside the health insurance Marketplaces. Our analysis draws on pooled 2016–19 Medical Expenditure Panel Survey data, focusing on the period before Congress introduced the enhanced Marketplace premium tax credits under the American Rescue Plan Act (ARPA) of 2021.[1] We examine multiple affordability measures among nonelderly adults in families where every person had continuous full-year coverage through ESI or a nongroup plan. Our key findings include the following:

- Adults with nongroup coverage reported larger average per-person family out-of-pocket premiums ($2,912 versus $1,126) and health care costs ($1,010 versus $825) than adults with ESI.
  - » Nongroup enrollees were more than twice as likely as those with ESI to report paying at least 10 percent of family income toward health care costs (10.5 percent versus 3.8 percent).
  - » Among low-income adults, 24.0 percent of those with nongroup coverage reported out-of-pocket health care costs exceeding 10 percent of income.
- More than 1 in 3 adults with nongroup coverage (36.4 percent) and over 1 in 5 adults with ESI (21.8 percent) reported they or a family member delayed getting or did not get medical care, dental care, or prescription drugs that they needed in the past 12 months because of the costs.
  - » The difference in delayed and forgone care between families with ESI versus nongroup coverage was particularly large among those with incomes below 400 percent of the federal poverty level (41.7 percent versus 27.0 percent).
- Adults with nongroup coverage were more likely than those with ESI to report problems paying family medical bills in the past 12 months (10.2 percent versus 6.9 percent).

- » Among those with incomes below 200 percent of the federal poverty level, nearly 1 in 7 adults with nongroup coverage or ESI (14.1 percent and 13.2 percent, respectively) reported problems paying medical bills.

- Though nongroup enrollees had lower average incomes and greater health needs than those with ESI, these differences in economic and health characteristics did not fully explain gaps in health care affordability.
  - » The higher prevalence of affordability challenges among nongroup enrollees may partially reflect their greater likelihood of having high-deductible health plans (44.6 percent versus 36.0 percent) and lower rates of dental coverage (24.4 percent versus 76.8 percent).

Over the next year, policymakers face key decisions about extending the enhanced Marketplace premium subsidies beyond 2025 and identifying other strategies for alleviating cost burdens. Members of Congress have advanced legislation (H.R. 9774/S. 5194) to make the enhanced Marketplace subsidies permanent,[2] and researchers have demonstrated that congressional action by the spring of 2025 would be needed to prevent an increase in premiums as insurers begin setting rates for 2026 (Levitis, Corlette, and O'Brien 2024). Our analysis finds that families with nongroup insurance faced significant affordability problems before ARPA, suggesting the expiration of the enhanced subsidies could exacerbate difficulties they may face in paying for coverage and care. Efforts to mitigate health costs for families with nongroup coverage are important components of a policy agenda for addressing the nation's health care affordability challenges.

Health Care Affordability in Employer versus Private Nongroup Coverage before ARPA

Introduction

Ten years after the implementation of the Affordable Care Act's (ACA) major coverage provisions, health care affordability remains a pressing challenge. Though the ACA significantly expanded coverage and affordability (Long et al. 2017; Miller and Wherry 2019), approximately 24 million Americans remain uninsured, and millions more with coverage through an employer or the private nongroup market are underinsured, dedicating a large share of their income toward health care costs (Cohen and Martinez 2023; Collins, Haynes, and Masitha 2022). Underinsured working-age adults are nearly as likely as those without coverage to owe medical debt or go without needed health care because of its cost (Collins, Haynes, and Masitha 2022).

Recent policies to improve affordability in private health insurance have focused on reducing the cost of Marketplace nongroup plans. People who are ineligible for public coverage and who lack affordable employer-sponsored insurance (ESI) may qualify for Marketplace tax credits that cap the percentage of income they must pay in premiums for a benchmark silver plan.[3] The 2021 American Rescue Plan Act (ARPA) enhanced these premium tax credits and expanded eligibility—changes that were later extended through 2025 under the Inflation Reduction Act (IRA). Marketplace enrollees with low incomes can also receive cost-sharing reductions (CSRs) that lower the amount they pay toward deductibles, copayments, and coinsurance when receiving covered health services. Eleven states have created state-funded subsidy programs to further reduce premiums and health care costs.[4]

ESI is primarily subsidized through the federal tax code. Employer-paid premiums are excluded from federal income and payroll taxes, and employee contributions are also generally excluded from taxable income.[5] ESI plans cover around 83–85 percent of health care costs on average, a higher actuarial value than most Marketplace plans that are not eligible for CSRs (Actuarial Research Corporation 2017; Fronstin et al. 2021).[6]

Despite these private insurance subsidies, cost growth continues to pressure families financially. Between 2013 and 2023, average premiums for family ESI coverage increased 47 percent, from about $16,350 to $24,000, with employee contributions accounting for about one-quarter of total premiums (Claxton et al. 2023). Over the same period, average deductibles for single ESI coverage increased by 53 percent, from $1,135 to $1,735 (Claxton et al. 2023). People with nongroup coverage face even greater out-of-pocket cost exposure, with the average deductible for all Marketplace plans reaching about $3,000 in 2024 and exceeding $5,000 for unsubsidized silver plans (Thorpe, Allen, and Joski 2015).[7]

As policymakers seek to mitigate health costs, it is important to understand where families with private insurance face the largest affordability gaps and what these gaps may look like if the ARPA/IRA subsidies expire. In this report, we use multiple measures to compare affordability among families with ESI versus nongroup coverage in 2016–19, the period after ACA-related coverage gains stabilized and before the ARPA/IRA subsidies. Our analysis uses pooled 2016–19 data from the Medical Expenditure Panel Survey Household Component (MEPS) to provide reliable estimates for a nationally representative sample of adults ages 18 to 64 in families where every person had continuous full-year coverage either through ESI or a nongroup plan. We focus on the following outcomes:

- per-person family out-of-pocket premiums and health care costs
- whether family out-of-pocket health care costs exceeded 10 percent of family income
- whether families delayed getting or did not get needed health care in the past 12 months because they could not afford it
- whether families had problems paying medical bills in the past 12 months

We compare these outcomes for families with ESI versus nongroup coverage, both overall and within selected income groups, and assess whether differences in affordability persist after controlling for differences in families' demographic, health, and economic characteristics. For further details, see the Methods section.

Our study adds to the literature on health care affordability by providing the first post-ACA estimates for comparable samples of families with full-year ESI and nongroup coverage at different income levels used to determine eligibility for Marketplace subsidies in the pre-ARPA period and by analyzing out-of-pocket premium and health care cost burdens for these groups separately rather than using a combined measure (Banthin and Bernard 2006; Bernard, Selden, and Fang 2023; Blumberg, Holahan, and Buettgens 2015; Blumberg, Banthin, and Simpson 2021; Glied and Zhu 2020; Goldman et al. 2018; Kielb, Rhyan, and Lee 2017). Overall, we find higher out-of-pocket burdens, delayed and

forgone care because of costs, and problems paying medical bills among families with nongroup coverage relative to families with ESI, which are not fully explained by differences in their socioeconomic and health characteristics.

Over the next year, policymakers face important decisions about whether to extend the enhanced ARPA/IRA subsidies beyond 2025 and, more broadly, how to alleviate the burden of health costs for families with private insurance. Without congressional action to extend the subsidies in the coming months, Marketplace premiums may increase, exacerbating families' affordability challenges (Levitis, Corlette, and O'Brien 2024). In the sections below, we provide new evidence to inform these debates and describe policy implications from our findings.

Results

Characteristics of Adults with ESI and Nongroup Coverage

Differences in health care affordability among families with ESI versus nongroup coverage may reflect differences in family composition and socioeconomic, health, and health plan characteristics, as shown in table 1. Because working-age adults with nongroup insurance were more likely than those with ESI to live in families with a mix of coverage types (e.g., in which a parent has private insurance and their children have Medicaid or Children's Health Insurance Program coverage), and we exclude these mixed-coverage families from our analysis, adults in our nongroup sample were less likely to be married or living with dependent children.[8]

We found important differences in economic characteristics. Adults in families with nongroup coverage were much more likely than those with ESI to be self-employed (38.4 percent versus 5.8 percent) and less likely to work full-time (53.4 percent versus 76.1 percent), reducing their likelihood of having access to health insurance through a job. Nongroup enrollees were over four times as likely as adults with ESI to have incomes below 200 percent of the federal poverty level (FPL) (27.5 percent versus 6.4 percent), the threshold at which families may qualify for both Marketplace premium subsidies and the most generous CSRs. Nearly two-thirds of adults with ESI had incomes above 400 percent of FPL (65.8 percent versus 38.5 percent of nongroup enrollees), the threshold above which eligibility for premium subsidies ended before ARPA.

Consistent with prior research, adults with nongroup coverage were generally older and more likely to report fair or poor health status or a disability, characteristics associated with greater health care

needs and spending (Blavin, Karpman, and Zuckerman 2016; Karpman, Long, and Bart 2018; Khavjou et al. 2020).[9] These differences suggest that the nongroup population could face greater health care cost burdens with more limited resources than the ESI population, irrespective of how their health plans are structured. Despite their worse average health, however, nongroup enrollees were more likely to have high-deductible plans (44.6 percent versus 36.0 percent), potentially exposing them to higher cost-sharing when they received care. Nongroup enrollees were also more likely to select HMO plans (42.2 percent versus 31.3 percent), which generally minimize premiums and cost-sharing by offering narrower provider networks and employing tighter utilization management. Only 24.4 percent of adults with nongroup coverage had full-year dental insurance, compared with 76.8 percent of adults with ESI.[10]

TABLE 1

Selected Characteristics of Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage, 2016–19

	ESI	Nongroup
Demographic characteristics		
Female	49.0%	50.8%
Male	51.0%	49.2%
Ages 18–34	32.8%	26.6%**
Ages 35–49	33.8%	23.2%**
Ages 50–64	33.3%	50.1%**
Married	58.3%	42.1%**
Lives with children under 18 in their family	35.4%	14.7%**
Employment status		
Employed	90.7%	84.0%**
Self-employed	5.8%	38.4%**
Works full-time	76.1%	53.4%**
Family income		
At or below 200% of FPL	6.4%	27.5%**
Above 200% and at or below 400% of FPL	27.8%	34.0%**
Above 400% of FPL	65.8%	38.5%**
Health and disability status		
Reported fair or poor health status	11.6%	14.1%**
Reported a disability	6.1%	8.5%**
Plan characteristics		
Enrolled in a Marketplace plan	n/a	73.3%
Enrolled in a high-deductible health plan	36.0%	44.6%**
Enrolled in an HMO plan	31.3%	42.2%**
Had dental coverage all year	76.8%	24.4%**
Sample size	25,622	1,656

Source: Medical Expenditure Panel Survey-Household Component, 2016–19.

Notes: ESI = employer-sponsored insurance; FPL = federal poverty level; HMO = health maintenance organization. Pooled estimates reflect annual averages for 2016–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year. High-deductible plan refers to individual/family deductibles of at least $1,300/$2,600 in 2016–17 and $1,350/$2,700 in 2018–19. Female and male refer to the respondent's sex. Employment

status, self-employment, and fair/poor health status are reported for any interview round. Full-time work is reported for all interview rounds during the year. Disability includes hearing, vision, cognitive, ambulatory, self-care, or independent living difficulties.
*/** Estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

Out-of-Pocket Cost Burdens

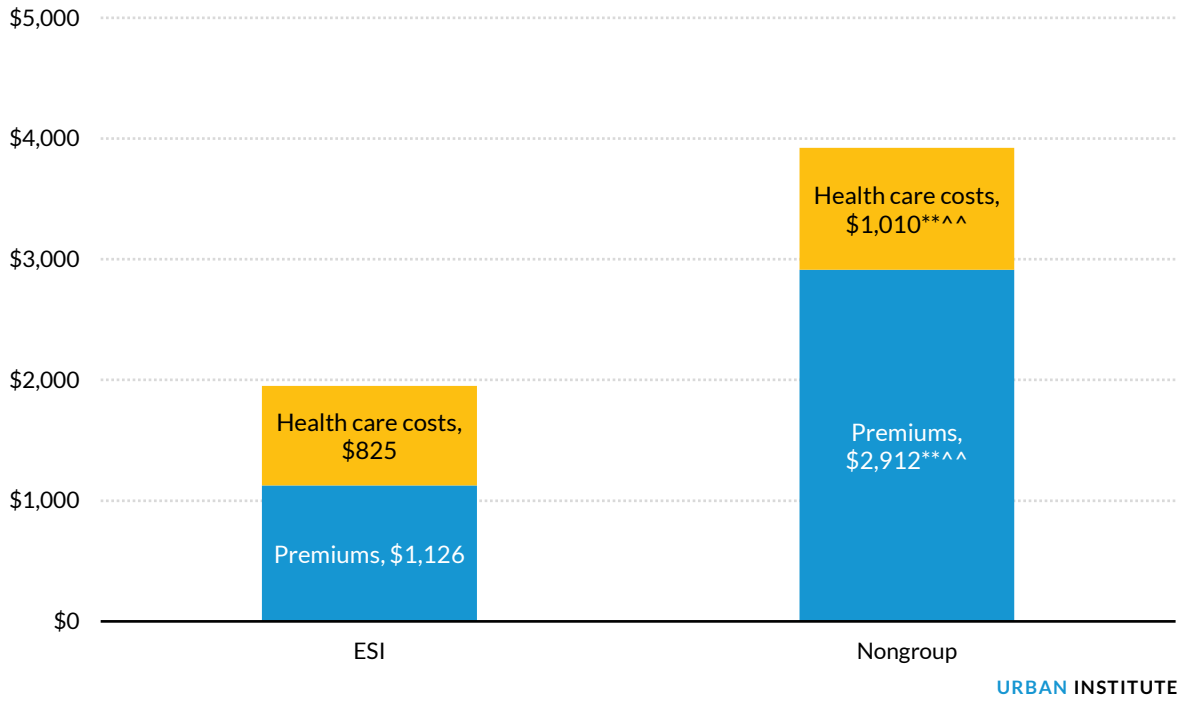
Because health care affordability challenges manifest in different ways, using multiple measures provides a more complete picture of difficulties in affording care than any single measure (Bernard, Selden, and Fang 2023; Kielb, Rhyan, and Lee 2017). Families may pay high out-of-pocket costs for premiums and medical bills, forcing tradeoffs between health care and other needs. Families may also forgo care because of its cost or have trouble paying bills if they do receive care. We first assess differences in out-of-pocket cost burdens.

Figure 1 shows that adults with nongroup coverage reported per-person family out-of-pocket premiums nearly three times as large as premiums reported by adults with ESI ($2,912 versus $1,126 in 2019 dollars). The out-of-pocket ESI premiums shown in figure 1 only include contributions paid by employees and have been adjusted downward to account for their favorable tax treatment. Premium contributions withheld from employee paychecks account for only a portion of total ESI premiums (Miller and Keenan 2023), and thus, the estimated gap between out-of-pocket nongroup and ESI premiums is to be expected since the lower ESI premiums partially reflect the omission of employer contributions from the data.

Nongroup enrollees also had higher average per-person out-of-pocket health care costs ($1,010 versus $825). These differences in both out-of-pocket premiums and health care costs were largely unchanged after adjusting for differences in family-level characteristics between the two groups, including family size, age, sex, race/ethnicity, nativity, educational attainment, income, diagnosed chronic conditions, disability status, census region, and survey year (appendix table A.1).

FIGURE 1

Average Per-Person Family Out-of-Pocket Health Spending among Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage, 2016–19



Source: Medical Expenditure Panel Survey-Household Component, 2016–19

Notes: ESI = employer-sponsored insurance. Pooled estimates reflect annual averages for 2016–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year. Out-of-pocket costs are shown in 2019 dollars.

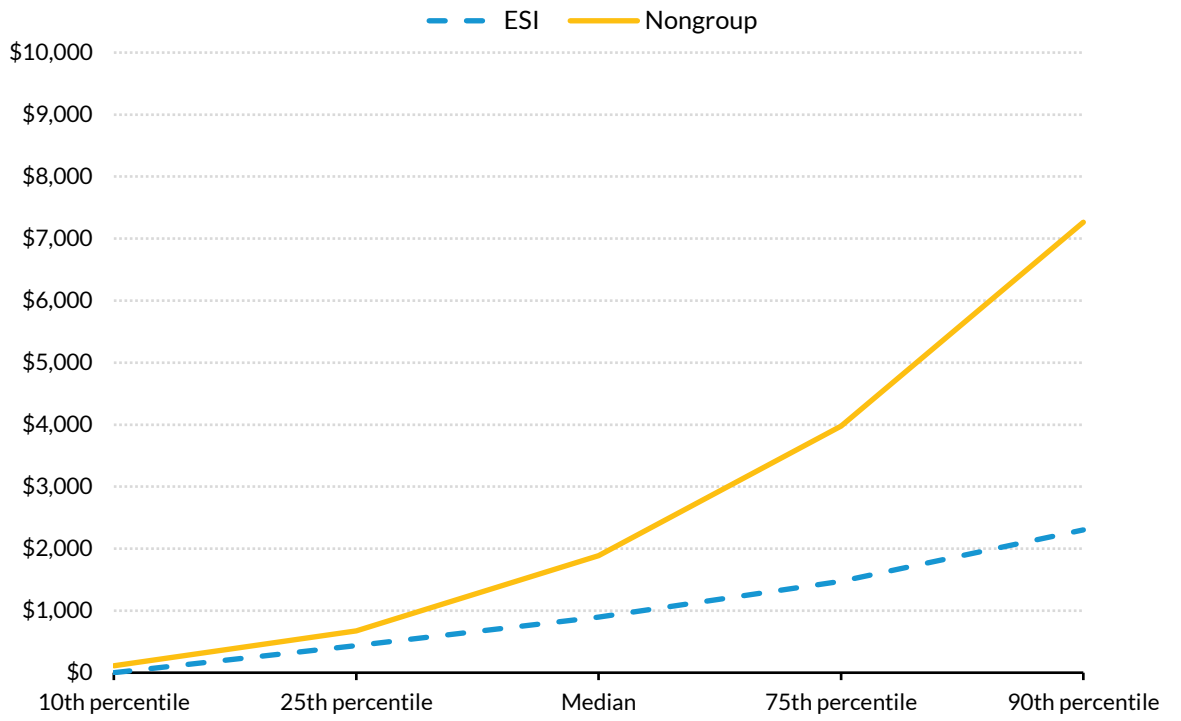
*/** Unadjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

^/^^ Regression-adjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

Figure 2 shows the distributions of out-of-pocket premiums for families with private insurance. The median nongroup premium was about twice the median reported by adults with ESI (about $1,900 versus $900), and this differential widened as premiums increased for both groups. For example, the reported nongroup premium at the 90th percentile was more than three times as high as the premium for ESI (about $7,300 versus $2,300). As noted above, the ESI out-of-pocket premiums shown in figure 2 only reflect employee contributions, which account for a relatively small share of total ESI premiums.

FIGURE 2

Distribution of Per-Person Family Out-of-Pocket Premiums among Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage, 2016–19



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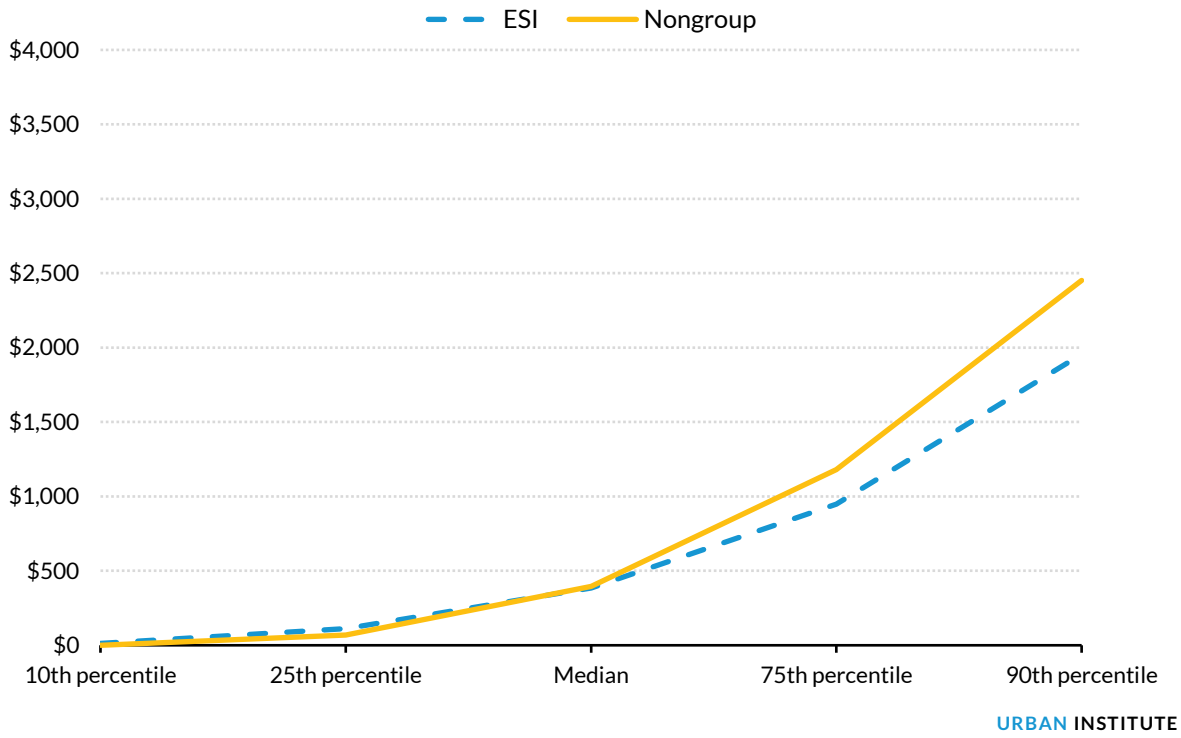
Source: Medical Expenditure Panel Survey-Household Component, 2016–19.
Notes: ESI = employer-sponsored insurance. Pooled estimates reflect annual averages for 2016–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year. Out-of-pocket costs are shown in 2019 dollars.

Median per-person family out-of-pocket health care costs were roughly $400 for each group (figure 3). At the 90th percentile, however, out-of-pocket costs were nearly $2,500 for adults with nongroup coverage compared with about $2,000 for adults with ESI. Out-of-pocket burdens also rose more rapidly for people with nongroup coverage than those with ESI as total health spending increased (appendix table A.2), possibly because of their higher average deductibles.

FIGURE 3

Distribution of Per-Person Family Out-of-Pocket Health Care Costs among Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage, 2016–19

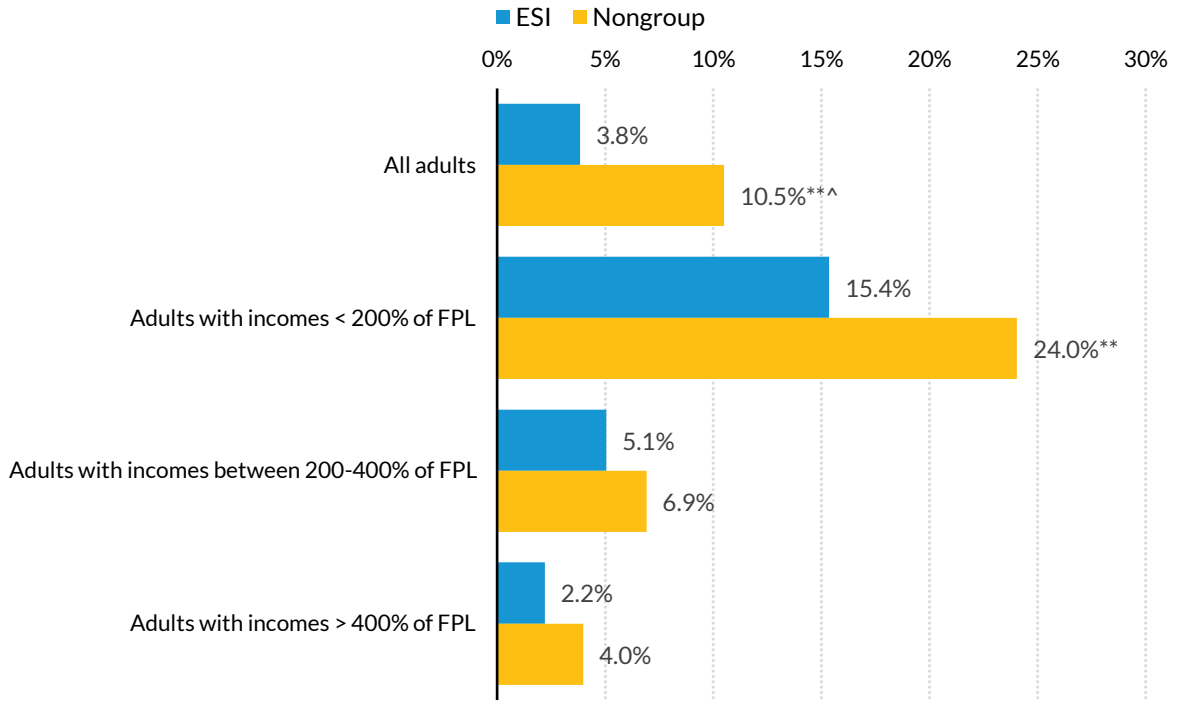


Source: Medical Expenditure Panel Survey-Household Component, 2016–19.
Notes: ESI = employer-sponsored insurance. Pooled estimates reflect annual averages for 2016–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year. Out-of-pocket costs are shown in 2019 dollars.

With lower average incomes and higher out-of-pocket health care costs, adults with nongroup coverage were more than twice as likely as those with ESI to report paying at least 10 percent of family income toward health care costs (10.5 percent versus 3.8 percent; figure 4).[11] Among low-income adults, 24.0 percent of those with nongroup coverage reported out-of-pocket health care costs exceeding 10 percent of income, compared with 15.4 percent of those with ESI.

FIGURE 4

Share of Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage Reporting Family Out-of-Pocket Health Care Costs Exceeding 10 Percent of Income, 2016–19



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Source: Medical Expenditure Panel Survey-Household Component, 2016–19.

Notes: ESI = employer-sponsored insurance; FPL = federal poverty level. Pooled estimates reflect annual averages for 2016–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year.

*/** Unadjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

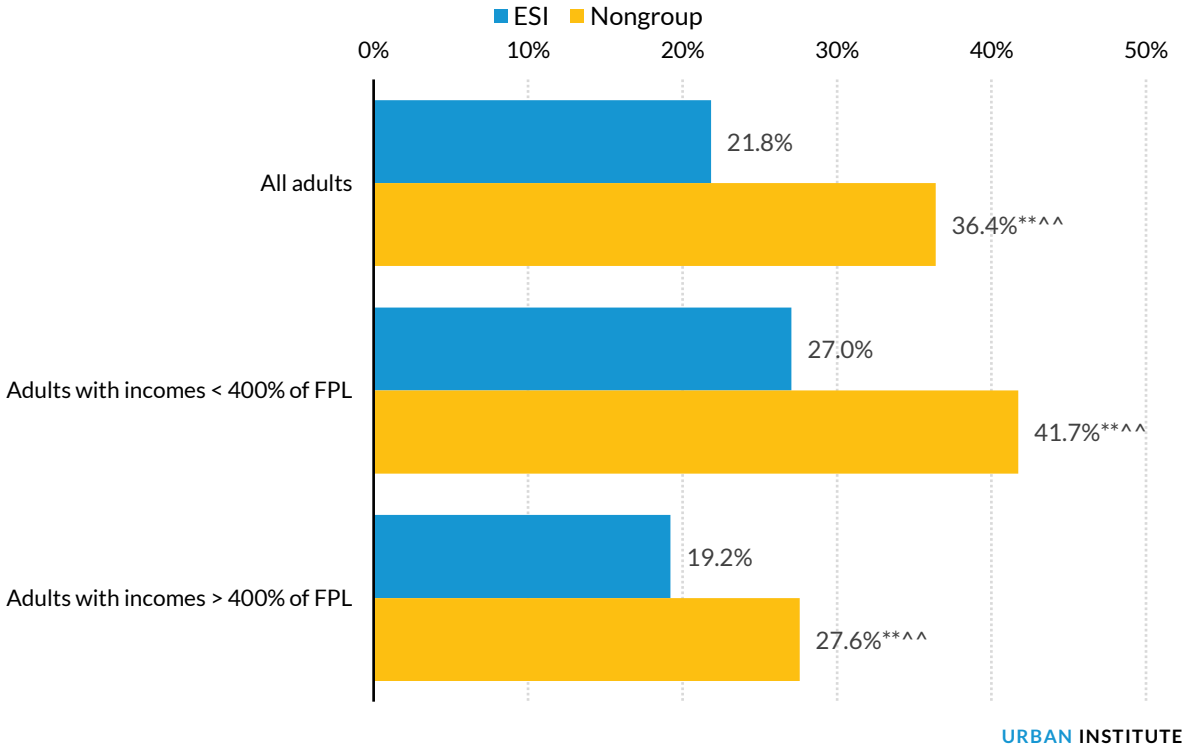
^/^^ Regression-adjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

Delayed and Forgone Care

Figure 5 shows the share of adults reporting they or a family member delayed getting or did not get health care—including medical care, dental care, or prescription medications—that they needed in the past 12 months because of the costs. For this analysis, we only used 2018–19 data because of changes in the MEPS questionnaire in 2018, and we combined the low and moderate-income groups to increase the precision of estimates and our ability to detect meaningful differences.

FIGURE 5

Share of Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage Reporting Any Delayed or Forgone Care Because of Costs in the Past 12 Months, 2018–19



Source: Medical Expenditure Panel Survey-Household Component, 2018–19.

Notes: ESI = employer-sponsored insurance; FPL = federal poverty level. Pooled estimates reflect annual averages for 2018–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year.

*/** Unadjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

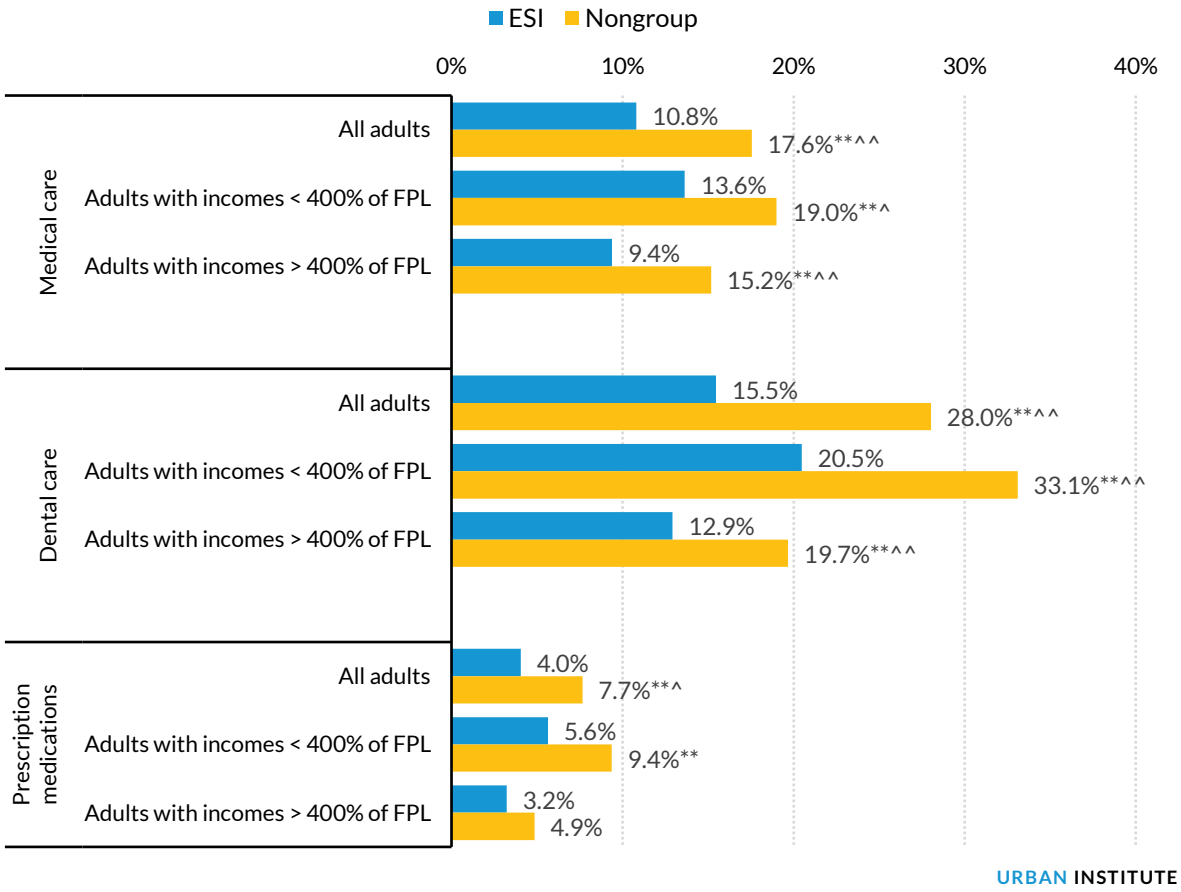
^/^^ Regression-adjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

Adults with nongroup coverage were more likely than adults with ESI to report at least one cost-related barrier to care (36.4 percent versus 21.8 percent). This difference persisted after accounting for each group's characteristics. The difference in delayed and forgone care was particularly large among adults with incomes below 400 percent of FPL (41.7 percent versus 27.0 percent).

Figure 6 shows that, overall, nongroup enrollees were more likely than those with ESI to report delaying or forgoing medical care (17.6 percent versus 10.8 percent), dental care (28.0 percent versus 15.5 percent), and medications (7.7 percent versus 4.0 percent). Within each income group, nongroup enrollees were more likely to report difficulty getting medical care and dental care, the latter of which likely reflects their lower rates of dental coverage.

FIGURE 6

Share of Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage Reporting Delayed or Forgone Medical Care, Dental Care, and Prescription Medications Because of Costs in the Past 12 Months, 2018–19



Source: Medical Expenditure Panel Survey-Household Component, 2018–19.

Notes: ESI = employer-sponsored insurance; FPL = federal poverty level. Pooled estimates reflect annual averages for 2018–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year.

*/** Unadjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

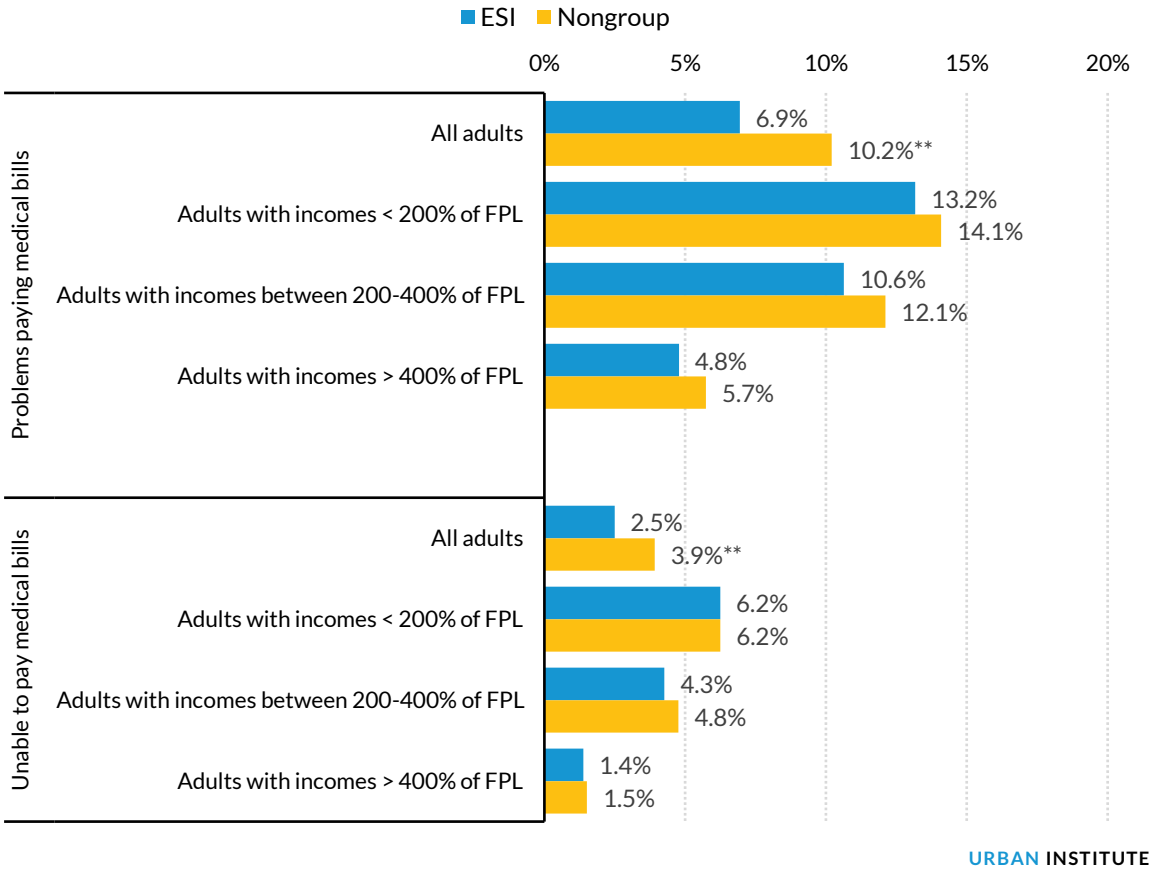
^/^^ Regression-adjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

Problems Paying Medical Bills

Adults with nongroup coverage were more likely than those with ESI to report problems paying family medical bills in the past 12 months (10.2 percent versus 6.9 percent; figure 7), but this difference was not statistically significant after accounting for differences in each group's characteristics. We did not find significant differences by coverage type in problems paying medical bills within any of the income groups examined.

FIGURE 7

Share of Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage Reporting Problems Paying Family Medical Bills in the Past 12 Months, 2016–19



Source: Medical Expenditure Panel Survey-Household Component, 2016–19.

Notes: ESI = employer-sponsored insurance; FPL = federal poverty level. Pooled estimates reflect annual averages for 2016–19. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year.

*/** Unadjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

^/^^ Regression-adjusted estimate differs from adults in families with ESI at the 0.10/0.05 level, using two-tailed tests.

For both coverage groups, families with low and moderate incomes reported the greatest difficulty with medical bills. Among those with incomes below 200 percent of FPL, nearly 1 in 7 adults with ESI or nongroup coverage (13.2 percent and 14.1 percent) reported problems paying medical bills, as did more than 1 in 10 adults with ESI and nongroup coverage who had incomes between 200-400 percent of FPL (10.6 percent and 12.1 percent).

Discussion

Overall, families with nongroup coverage faced greater affordability challenges than families with ESI in the pre-ARPA period, a gap only partially explained by their lower incomes and greater health needs. Families with nongroup coverage were more likely to report large out-of-pocket cost burdens and forgoing needed care because of its cost, which may partially reflect their higher average deductibles (Abdus, Selden, and Keenan 2016; Kielb, Rhyan, and Lee 2017). Affordability challenges were common even among nongroup enrollees whose incomes likely made them eligible for premium tax credits and CSRs, suggesting these subsidies were insufficient to fully cover their health care needs. Policymakers can take several actions to improve health care affordability for people with private insurance through the nongroup market or an employer, as discussed below.

Extending ARPA/IRA Premium Subsidies

The data for our analysis were collected in 2016–19 before ARPA enhanced premium subsidies. Along with lowering uninsurance rates, ARPA/IRA subsidies reduced per-person out-of-pocket silver plan premiums by an average of about $1,000 for low- and moderate-income Marketplace enrollees and $2,000 for those with higher incomes (Buettgens, Banthin, and Green 2022). The expiration of these enhanced subsidies after 2025 would widen gaps in out-of-pocket premiums between families with nongroup coverage and ESI, and our findings show what these gaps may look like in their absence. Though the ESI premiums reported in the MEPS only reflect employee contributions that account for a relatively small share of total premiums, it is still useful to compare out-of-pocket premiums in ESI and the nongroup market since they represent the actual out-of-pocket spending that families incur and are also an important predictor of health insurance take-up (Blumberg, Nichols, and Banthin 2001; Chernew, Frick, and McLaughlin 1997; Cutler 2002). The reduction in out-of-pocket premiums under ARPA/IRA coincided with a nearly 80 percent increase in Marketplace plan selections between 2021 and 2024, from 12 million to over 21 million (CMS 2024). Current efforts to make the enhanced subsidies permanent could help sustain these enrollment gains and prevent an increase in premiums as Marketplace insurers begin the process of setting rates for the 2026 plan year (Levitis, Corlette, and O'Brien 2024). If extended, states can also build on the ARPA/IRA subsidies to further lower or eliminate premiums for low-income families, as Connecticut, New Mexico, and New York have done.[12]

Enhancing CSRs

Though ARPA/IRA subsidies lower premiums, they do not affect underlying health care costs or the out-of-pocket cost of getting care (though some enrollees could use their additional premium subsidies to switch to a more generous plan). High deductibles and cost-sharing requirements can leave nongroup enrollees with substantial out-of-pocket cost burdens. Only half of Marketplace consumers are enrolled in silver plans with CSRs, and about one-third are enrolled in high-deductible bronze plans (CMS 2024). Potential policy solutions include (1) tying premium subsidies to gold plans, which have higher actuarial values than silver plans, and (2) further increasing CSR amounts for families with low and moderate incomes (Holahan and Simpson 2022). Some states have even eliminated deductibles and lowered coinsurance and copayments for low-income families, recognizing that tight budget constraints and limited savings make even small cost-sharing requirements an insurmountable barrier to care. For instance, California eliminated deductibles for silver-plan enrollees with incomes below 250 percent of FPL, and New York's Essential Plan, one of two Basic Health Programs established under the ACA, offers coverage with no premiums and deductibles for consumers with incomes below that threshold.[13]

Removing the ESI Firewall

People offered minimum-value ESI coverage deemed affordable (premiums costing less than 8.4 percent of income in 2024) cannot qualify for Marketplace subsidies. Because of this eligibility firewall, some people with low and moderate incomes would be better off without ESI offers, which create barriers to receiving subsidies (Baumgartner, Collins, and Radley 2020). Reducing the threshold at which ESI is deemed affordable or eliminating the firewall altogether would lower costs for people with ESI, with the tradeoff of higher federal spending (Blumberg et al. 2019). This reform could be paired with policies mitigating adverse selection and discouraging employers from dropping coverage or steering higher-cost employees toward the Marketplace, for instance, by restructuring the ACA's shared responsibility penalty for employers (Baumgartner, Collins, and Radley 2020; Straw 2019).

A recent study estimates that eliminating the firewall would induce 1.8 million people to shift out of ESI (a 1.2 percent reduction) and reduce the number of uninsured people by 1.4 million (Banthin, Skopec, and Ramchandani 2024). The reform would save households $4.4 billion annually in out-of-pocket premiums and health care costs, and federal spending would increase by $17.8 billion, primarily because of an 18 percent increase in federal spending for Marketplace premium tax credits. Our findings are consistent with this reform's relatively small projected impact on ESI coverage, as most workers and families would still be better off with ESI. On average, lower-income families with ESI were

less likely than those with nongroup coverage to pay more than 10 percent of their income toward health care costs.

Expanding Covered Services and Addressing Administrative Burdens

Some insured people experience difficulty affording services their health plans do not cover, such as dental care. Under a new CMS rule, states will soon be able to add routine adult dental services to their essential health benefit package, which nongroup and small group plans are required to cover.[14] Cost barriers may also arise from the administrative burden of getting reimbursed (Kyle and Frakt 2021). Wide variation in claim denial rates across Marketplace insurers suggests a need for greater transparency and oversight of claims and prior authorization processes (Pollitz et al. 2023).[15]

Slowing Cost Growth

Increasing access to and generosity of Marketplace subsidies and expanding benefits would further increase federal spending. The federal cost of the ESI tax subsidy was nearly $350 billion in 2023, compared with about $90 billion for nongroup and Basic Health Program coverage, with the average subsidy per enrollee higher for nongroup coverage than ESI (Swagel 2023). Policies that slow the growth of health costs, such as establishing a public insurance option, capping provider payment rates, and limiting market concentration, could mitigate the budgetary impact of additional subsidies (Holahan, O'Brien, and Wengle 2024; Simpson and Holahan 2024).

Targeting Resources Based on Need

Policymakers seeking to improve health care affordability can allocate resources most efficiently by targeting them toward people with the greatest needs, beginning with low-income families. This is also a critical strategy for reducing the number of uninsured. To that end, expanding Medicaid in the 10 states that have not adopted the ACA expansion remains a key priority, as it would lower out-of-pocket costs, reduce medical debt, and improve health care access for people with the lowest incomes (Caswell and Waidmann 2019; Gotanda et al. 2020; Miller and Wherry 2019). In states that already have expanded Medicaid, targeting additional state Marketplace subsidies toward families with low and moderate incomes could augment ARPA/IRA subsidies and facilitate smoother transitions between Medicaid and zero-premium or low-cost Marketplace plans with limited cost sharing.[16] These efforts can advance progress toward a more cohesive health insurance system that prevents gaps in coverage and access to care.

Conclusion

Many families with private insurance through the nongroup market or an employer continue to face difficulty paying for health care. In the pre-ARPA period, these difficulties were more common among nongroup enrollees, who had lower average incomes, greater health needs, and higher enrollment in high-deductible plans. Relative to those with ESI, families with nongroup coverage faced more exposure to high out-of-pocket expenses and were more likely to delay or forgo needed care because of its cost. The extension of enhanced federal Marketplace subsidies and other efforts to mitigate premium and health care costs for families with nongroup coverage are important for addressing the nation's health care affordability challenges.

Methods

Data and Sample

We used pooled 2016–19 data from the MEPS, a nationally representative survey of the civilian noninstitutionalized population conducted by the Agency for Healthcare Research and Quality. Each MEPS panel collects detailed information on monthly health insurance coverage, health care access, and health service use and expenditures for two calendar years. Because our estimates for this period are based on four years of pooled data, they reflect averages of the annual estimates.

Our analysis focused on adults ages 18 to 64 living in families in which every member was insured with ESI for all 12 months of the year or every member was insured with nongroup coverage (either through or outside of the Marketplaces) for all 12 months of the year. We excluded families reporting any other types of coverage or a mix of coverage types. We defined families based on the health insurance unit (HIU), which consists of family members "who would typically be eligible for coverage under the adults' private health insurance family plans."[17] To construct this family unit, we started with the MEPS HIU, which includes adults and their spouses, unmarried children under age 19, and unmarried children under age 24 who are full-time students. We then used information from the MEPS Person-Round-Plan file to move people covered as dependents under another family member's health plan into that policyholder's HIU.[18]

HIUs also approximate the tax units used to determine eligibility for Marketplace subsidies. We divide the sample into three groups based on the modified adjusted gross income of the HIU as a percentage of FPL: at or below 200 percent of FPL, above 200 percent and at or below 400 percent of

FPL, and above 400 percent of FPL. These categories are defined based on eligibility for the most generous CSRs (available to people with incomes below 200 percent of FPL) and eligibility for premium tax credits (available up to 400 percent of FPL) in the pre-ARPA period. Pooling four years of data increases the precision of our estimates for these subsamples. All estimates are weighted to be nationally representative, and standard errors are adjusted for the complex design of the MEPS. Because of the survey design, pooling multiple years of data means the same families may be counted twice, but the adjusted standard errors account for these correlations.

Affordability Measures

OUT-OF-POCKET COST BURDENS

We estimate per-person family out-of-pocket premiums and health care costs, which adjust for differences in family size (Simpson, Green, and Banthin 2023). Both measures are inflated to 2019 dollars using the Consumer Price Index for medical care.[19] Health care costs include self-paid expenditures for office-based and outpatient visits, emergency department visits, inpatient stays, dental visits, home health visits, prescription fills, and other medical equipment and services. We use premium data from the MEPS Person-Round-Plan for private health insurance, dental, and vision coverage.[20] We adjust ESI premiums to account for their exclusion from federal income and payroll taxes, which better reflects the net financial burden for families. Using the National Bureau of Economic Research's TAXSIM version 35 model to calculate marginal income tax rates for each family,[21] we subtract the tax subsidy for ESI premiums from the original premium amount to calculate the adjusted out-of-pocket premium (Feenberg and Coutts 1993).[22] For cases with missing data, we impute the average monthly out-of-pocket premium based on the number of months with private coverage in the family and family demographic and health characteristics, drawing on methods used in prior work (Blumberg et al. 2014).

Out-of-pocket premiums for ESI in the MEPS only reflect the employee contribution, which accounts for less than half of the total premiums paid for ESI. We do not attempt to impute employer contributions because the incidence of these contributions is unknown (Simpson, Green, and Banthin 2023). Previous studies have found employer contributions substitute for wages and that workers bear the costs of these contributions (Anand 2016; Hager, Emanuel, and Mozaffarian 2024). We separately calculate out-of-pocket premiums and health care costs as shares of family income net of federal taxes and transfers (also inflated to 2019 dollars for consistency with the spending measures). This measure of net income provides a more accurate picture of the total resources available to families relative to

modified adjusted gross income. Net income is bottom-coded at $1,000 to avoid missing or extreme values of out-of-pocket cost burdens as a percentage of income. Aligning with previous studies, our analysis emphasizes the share of adults with family out-of-pocket health care costs exceeding 10 percent of family income (Bernard, Selden, and Fang 2023).

DELAYED AND FORGONE CARE

Families reporting delayed or forgone care include those in which someone (1) delayed seeking medical care, dental care, or prescription medications because of worry about the cost in the past 12 months or (2) needed one of these types of care but did not get it because they could not afford it. The analysis of this measure only uses 2018–19 data because of a change in the survey questionnaire in 2018.

PROBLEMS PAYING MEDICAL BILLS

This measure includes reports that anyone in the household had problems paying or was unable to pay any medical bills in the past 12 months. We also focused on the share that had any medical bills they could not pay at all. We note that the measures of delayed/forgone care and problems paying medical bills were reported for the past 12 months during interview rounds 2 and 4, completed between July and November, and therefore may not always align with the calendar year for which coverage is reported. However, our analysis of MEPS longitudinal data found that about 95 percent of people covered by ESI and 89 percent of people covered by Marketplace plans in a calendar year also had those coverage types in the last 6 months of the prior calendar year.

Analysis and Limitations

We estimate differences between adults with ESI and nongroup coverage for each affordability measure using two-tailed tests. We also estimate regression-adjusted differences using an ordinary least squares regression model that controls for family size, age, sex, race/ethnicity, nativity, educational attainment, income as a percentage of FPL, number of people diagnosed with each of the priority chronic conditions reported in the MEPS, number of people with a disability, census region, and survey year.

This analysis has several limitations, including measurement error in reported out-of-pocket premiums and health care costs, family income, and coverage type. This measurement error likely explains inconsistencies we observed between the out-of-pocket premiums reported by Marketplace enrollees and the capped premiums they likely would pay after receiving ACA Marketplace premium tax credits. Reported out-of-pocket premiums were often higher than expected, particularly among

Marketplace enrollees with low incomes. The public use data files that we analyzed also lack state identifiers, and we therefore could not adjust ESI premiums or net income for state income taxes.

Because we exclude families with other coverage types, our sample is missing a large portion of the population with nongroup coverage and ESI. Only 31 percent of adults ages 18 to 64 in families where someone had nongroup coverage during any month of the year reported that all family members had nongroup coverage and no other type of insurance for all 12 months of the year. Among working-age adults in families where someone had ESI for at least one month, 65 percent reported that all family members had ESI for all 12 months. The difference in the share of adults reporting their families were continuously insured with each coverage type likely reflects how many people turn to the nongroup market to fill temporary coverage gaps as they cycle on and off ESI or Medicaid.

Appendix

TABLE A.1

Out-of-Pocket Health Spending and Health Care Access and Affordability among Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage, 2016–19

	ESI	Nongroup	Unadjusted difference		Adjusted difference	
Per-person family out-of-pocket costs ($)						
Premiums	1,126	2,912	1,786	**	1,693	^^
Health care costs	825	1,010	185	**	147	^^
Out-of-pocket costs above 10% of income						
Health care costs	3.8%	10.5%	6.7%	**	2.0%	^
Access and affordability problems						
Any delayed or forgone care	21.8%	36.4%	14.6%	**	12.4%	^^
Medical care	10.8%	17.6%	6.7%	**	5.2%	^^
Dental care	15.5%	28.0%	12.6%	**	10.8%	^^
Medications	4.0%	7.7%	3.6%	**	2.4%	^
Problems paying family medical bills	6.9%	10.2%	3.3%	**	1.7%	
Unable to pay family medical bills	2.5%	3.9%	1.4%	**	0.4%	
Sample size	25,622	1,656				
Sample size (2018–19 only)	12,696	808				

Source: Medical Expenditure Panel Survey-Household Component (MEPS), 2016–19.

Notes: ESI = employer-sponsored insurance. Pooled estimates reflect annual averages for 2016–19. Estimates for delayed or forgone care are only shown for 2018–19 because of a change in the MEPS questionnaire in 2018. Out-of-pocket costs are shown in 2019 dollars. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year. Adjusted differences are estimated controlling for family size, number of children, number of adults in different age groups, sex, race/ethnicity, nativity, educational attainment, income as a percentage of the federal poverty level, number of people diagnosed with each of the priority chronic conditions reported in the MEPS, number of people with a disability, census region, and survey year.

*/** Unadjusted difference is statistically different from zero at the 0.10/0.05 level, using two-tailed tests.

^/^^ Regression-adjusted difference is statistically different from zero at the 0.10/0.05 level, using two-tailed tests.

TABLE A.2

Out-of-Pocket Health Spending and Health Care Access and Affordability among Adults Ages 18 to 64 in Families with ESI and Nongroup Coverage, 2016–19

	Total health care costs below median						Total health care costs above median					
	ESI	Nongroup	Unadjusted difference		Adjusted difference		ESI	Nongroup	Unadjusted difference		Adjusted difference	
Per-person family out-of-pocket costs												
Premiums	1,051	2,304	1,253	**	1,159	^^	1,188	3,598	2,410	**	2,322	^^
Health care costs	195	228	33	*	47	^^	1,346	1,894	548	**	350	^^
Out-of-pocket costs above 10% of income												
Health care costs	0.2%	0.9%	0.7%	**	-0.3%		6.8%	21.4%	14.5%	**	4.4%	^^
Access and affordability problems												
Any delayed or forgone care	17.2%	29.0%	11.8%	**	10.9%	^^	25.6%	44.8%	19.2%	**	14.0%	^^
Medical care	7.6%	11.7%	4.1%	*	2.4%		13.4%	24.3%	10.8%	**	8.5%	^^
Dental care	13.2%	24.3%	11.0%	**	10.6%	^^	17.3%	32.4%	15.1%	**	9.9%	^^
Prescription medications	2.2%	3.3%	1.2%		0.7%		5.6%	12.6%	7.0%	**	4.1%	^^
Problems paying family medical bills	4.3%	7.1%	2.8%	**	1.5%		9.2%	13.7%	4.6%	**	1.8%	
Unable to pay family medical bills	1.4%	2.5%	1.1%		0.4%		3.4%	5.5%	2.1%	*	0.0%	
Sample size	11,977	898					13,645	758				
Sample size (2018–19 only)	5,699	418					6,997	390				

Source: Medical Expenditure Panel Survey-Household Component (MEPS), 2016–19.

Notes: ESI = employer-sponsored insurance. Pooled estimates reflect annual averages for 2016–19. Estimates for delayed or forgone care are only shown for 2018–19 because of a change in the MEPS questionnaire in 2018. Out-of-pocket costs are shown in 2019 dollars. Estimates are shown for adults living in families in which everyone was insured with ESI or nongroup coverage for all 12 months of the year. Adjusted differences are estimated controlling for family size, number of children, number of adults in different age groups, sex, race/ethnicity, nativity, educational attainment, income as a percentage of the federal poverty level, number of people diagnosed with each of the priority chronic conditions reported in the MEPS, number of people with a disability, census region, and survey year.

*/** Unadjusted difference is statistically different from zero at the 0.10/0.05 level, using two-tailed tests.

^/^^ Regression-adjusted difference is statistically different from zero at the 0.10/0.05 level, using two-tailed tests.

Notes

[1] We do not use 2020 data because of the significant disruptions in employment, coverage, and health care that occurred during the first year of the COVID-19 pandemic.

[2] Congress.gov, "Text - H.R.9774 - 118th Congress (2023-2024): To Amend the Internal Revenue Code of 1986 to Expand Eligibility for the Refundable Credit for Coverage under a Qualified Health Plan," September 24, 2024, https://www.congress.gov/bill/118th-congress/house-bill/9774/text; and Congress.gov,"S.5194 - 118th Congress (2023-2024): A Bill to Amend the Internal Revenue Code of 1986 to Expand Eligibility for the Refundable Credit for Coverage under a Qualified Health Plan," September 25, 2024, https://www.congress.gov/bill/118th-congress/senate-bill/5194.

[3] The federal government subsidizes the remainder of the premium, and this credit amount can also be applied to lower- or higher-cost plans. Under current law, the ARPA/IRA-enhanced subsidies cap the premium amount Marketplace enrollees must pay for a benchmark plan at no more than 8.5 percent of income. Notably, people are ineligible for Marketplace premium and cost-sharing subsidies if they have access to an ESI plan deemed affordable, defined as a minimum-value plan (with an actuarial value of at least 60 percent) costing less than a certain percentage of their income (approximately 8.4 percent in 2024).

[4] Jason Levitis and Sonia Pandit, Supporting Insurance Affordability with State Marketplace Subsidies, State Health & Value Strategies, March 11, 2021, https://www.shvs.org/supporting-insurance-affordability-with-state-marketplace-subsidies/; Louise Norris, "Which States Offer Their Own Health Insurance Subsidies?," Healthinsurance.org, August 16, 2024.

[5] Urban-Brookings Tax Policy Center, "How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work? Key Elements of the US Tax System," accessed September 3, 2024. Other ways in which federal and state funds subsidize employer-based coverage include Medicaid premium assistance programs that provide wraparound benefits and help employees afford their share of premiums and health care costs; tax deductions for premiums paid by self-employed people; and Small Business Health Options Program tax credits (Alker et al. 2015; Rae et al. 2014).

[6] Marketplace plans are divided into the following metal tiers based on their actuarial value: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). CSRs raise the actuarial value of silver plans to 94 percent for those with incomes below 150 percent of FPL, 87 percent for those with incomes between 150-200 percent of FPL, and 73 percent for those with incomes between 200-250 percent. Marketplace enrollees may also obtain catastrophic plans with low premiums and high deductibles if they are under age 30 or qualify for a hardship exemption.

[7] KFF, "Deductibles in ACA Marketplace Plans, 2014-2024," December 22, 2023.

[8] A sensitivity test comparing affordability in ESI versus nongroup coverage among adults who were not living with children had little impact on the basic patterns in our results.

[9] Matthew McGough, Gary Claxton, Krutika Amin, and Cynthia Cox, "How Do Health Expenditures Vary across the Population?," KFF, last updated January 4, 2024, https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/.

[10] Dental coverage is typically offered separately from health insurance and is not an essential health benefit for adults under the ACA. Marketplace enrollees may purchase health plans that include dental benefits or separate dental plans. Administrative data show that only a small share of Marketplace consumers enroll in standalone dental plans. "Dental insurance for adults," Healthinsurance.org., accessed September 4, 2024, https://www.healthinsurance.org/dental/dental-insurance-for-adults/.

[11] We do not show out-of-pocket premium burdens as a percentage of income because of potential measurement error, which produces results that appear inconsistent with the maximum percentage of income families with Marketplace coverage should have paid toward the cost of premiums after receiving premium tax credits. This inconsistency was most pronounced among low-income adults and may be caused by misreporting of income, premiums, and/or coverage type.

[12] Norris, "Which States Offer Their Own Health Insurance Subsidies?."

[13] Norris, "Which States Offer Their Own Health Insurance Subsidies?."

[14] Centers for Medicare and Medicaid Services, "HHS Notice of Benefit and Payment Parameters for 2025 Final Rule," April 2, 2024, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule.

[15] Centers for Medicare and Medicaid Services, "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F," January 16, 2024, https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.

[16] Rachel Swindle and Sabrina Corlette, "What States Are Doing to Keep People Covered as Medicaid Continuous Enrollment Unwinds," The Commonwealth Fund (blog), December 6, 2023.

[17] Agency for Healthcare Research and Quality, "MEPS HC-216 2019 Full-Year Consolidated File," August 2021.

[18] Our sample included a small number of HIUs with adults ages 65 and older, but results were not sensitive to their inclusion.

[19] Agency for Healthcare Research and Quality, "Using Appropriate Price Indices for Analyses of Health Care Expenditures or Income Across Multiple Years," accessed September 6, 2024.

[20] Policyholders report monthly out-of-pocket premium amounts during the first and third interview rounds for each MEPS panel. For plans held less than 12 months of the year, we multiply the monthly premium by the number of months the plan was held. This assumes people switched plans mid-year, and the premium reported in the first survey round of the year does not apply to the remaining months. However, the results of our analysis are not sensitive to assuming the initially reported monthly premium applies to all months of the year.

[21] National Bureau of Economic Research, "Internet TAXSIM Version 35," accessed September 6, 2024.

[22] We calculate the tax subsidy for ESI premiums as ((federal income tax rate + 2*FICA rate) / (1 + FICA rate)) multiplied by the original out-of-pocket premium. See Miller and Selden (2013) and Gruber (2010).

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