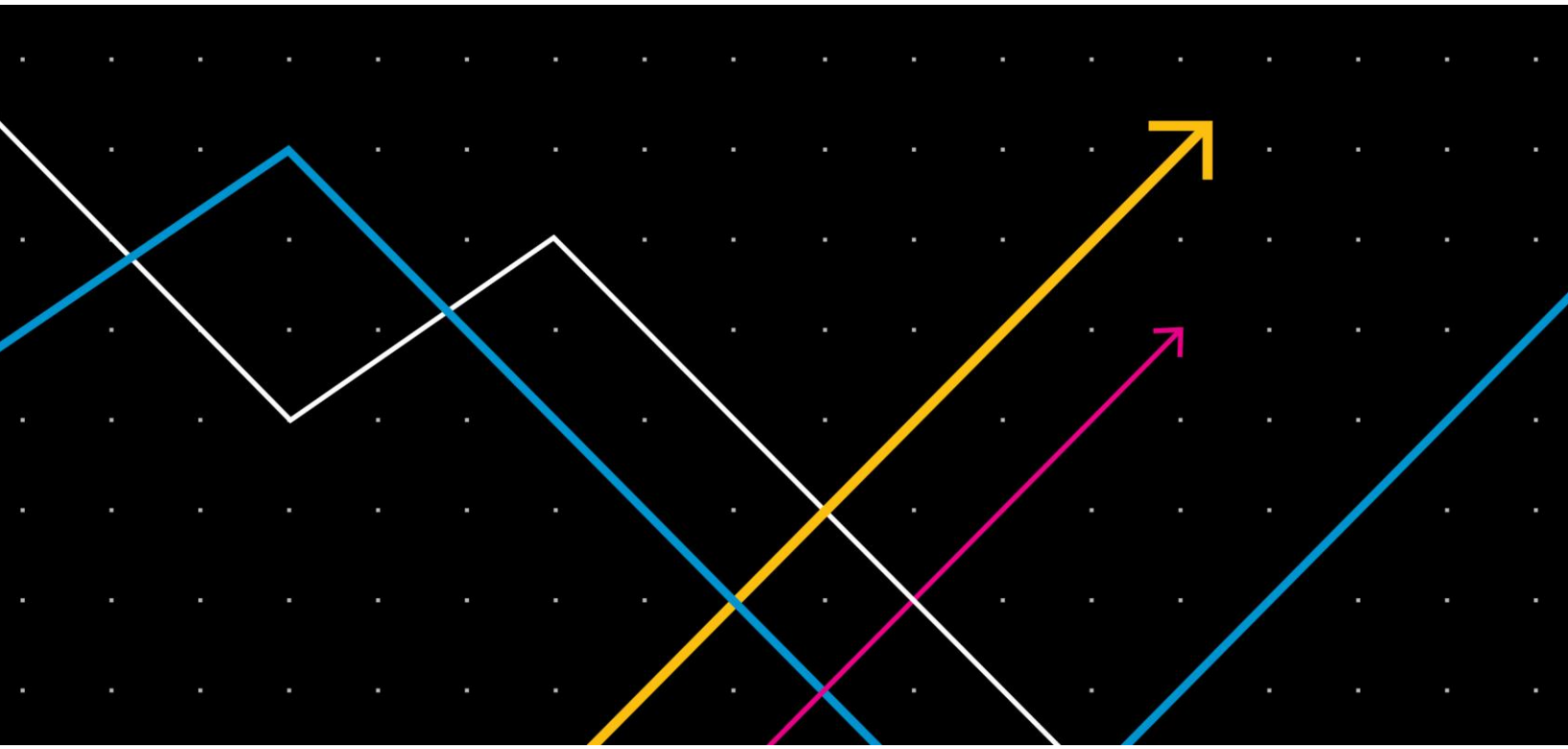

RESEARCH REPORT

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 Access, Affordability, and Enrollment in 2018

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 adults with ESI at a point in time dropped 16 percent between 1999 and 2010 (Rae et al. 2020). 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. 2020). 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).

ESI disproportionately covers workers with higher incomes and their families, while nonelderly people in families with low incomes are much less likely to have employer-sponsored coverage (Rae et al. 2020; Williamson, Antonisse, and Tolbert 2016). In 2017, nonelderly people with incomes above 400 percent of FPL were more than five times as likely as those with incomes below the poverty level to have ESI and more than twice as likely as those with incomes between 100 and 250 percent of FPL to have ESI (Rae et al. 2020). Even when considering only workers, those in households with lower incomes are much less likely to have ESI than workers in households with higher incomes (Rae et al. 2020; Williamson; Antonisse, and Tolbert 2016). Part-time workers and workers in small firms are less likely than other workers to be offered ESI (Claxton et al. 2019), and workers in low-wage occupations are less likely to be enrolled in ESI (Gangopadhyaya, Garrett, and Dorn 2018). Because workers in families with low incomes are more likely than those with higher incomes to work part time, at low-wage jobs, and for small firms (Williamson, Antonisse, and Tolbert 2016), they are at higher risk of not having access to ESI through their own employer (Straw 2019).

Beyond lacking an ESI offer, the employee premium contributions required for ESI may deter eligible workers and their families from enrolling (Garfield and Young 2015; Straw 2019; Tolbert, Orgera, et al. 2019). For example, data from a 2014 survey indicate 10 percent of all uninsured adults reported that they declined ESI because they could not afford the premium and, among employees in firms offering ESI in 2015, cost was the third most commonly cited reason for not taking up coverage (Garfield and Young 2015).[1] Costs may be an even larger barrier for workers in families with low incomes, as prior research has documented that many households with low incomes have little disposable income available after paying for housing and food (Collins, Gunja, and Doty 2017) and that many experience challenges meeting basic needs (Karpman, Zuckerman, and Gonzalez 2018), which could limit how much they can afford to spend on monthly health insurance premiums.

Even among those enrolled in ESI, coverage may not be affordable. In 2018, four in ten adults with ESI reported difficulty affording health care or health insurance costs, and workers with low incomes and their families experienced greater challenges (Hamel, Muñana, and Brodie 2019; Shartzer and Long 2014). ESI deductibles present an affordability barrier on top of premiums, and the share of ESI plans with deductibles and deductible amounts have been increasing along with premiums and outpacing increases in overall cost sharing (Claxton et al. 2018, 2019; Collins, Radley, and Baumgartner 2019; Lukanen, Hest, and Fried 2017). Deductibles are associated with affordability barriers to accessing health care, such as problems paying medical bills and delaying or skipping care because of cost (Holahan, Karpman, and Zuckerman 2016; Kirzinger et al. 2019). Further, deductibles and other out-of-pocket cost sharing in ESI likely have disproportionate adverse effects on households with low incomes, many of whom have limited savings (Hamel, Muñana, and Brodie 2019). In 2019, four in ten adults said they would not be able to cover an unexpected expense of $400, and families with low incomes were twice likely as families with higher incomes to report that they experience material hardship (Board of Governors 2019; Karpman, Zuckerman, and Gonzalez 2018). Thus, many families with low incomes would likely struggle to come up with the resources needed to cover health care expenses that could arise under ESI plans.

This report examines access to, affordability of, and reliance on ESI using data from the 2008–18 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).[2] 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.

This report also adds to prior literature (Claxton et al. 2019; Collins, Gunja, and Doty 2017; Lukanen, Hest, and Fried 2017)[3] by differentiating between full- and part-time employees and providing

state-level estimates of ESI access, affordability, and enrollment. 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 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 Affordable Care Act (ACA), which limits the extent to which 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).[4] Given the important implications of ESI access, affordability, and enrollment for workers in families with low incomes who may also be eligible for Medicaid or subsidized Marketplace coverage, the next section presents pre-COVID-19 background information on non-ESI coverage options available to low-income working families. Then, we describe the data and methods used in this analysis and present findings of ESI access, affordability, and enrollment for employees in private-sector establishments. We first present results on national changes in ESI offers, eligibility, employee premium contributions, deductibles, and enrollment between 2008 and 2018 and then variation in these same measures, as well as out-of-pocket maximums, by firm size, share of low-wage employees in the establishment, and full- versus part-time status across and within states in 2018. The concluding section discusses the implications of these findings for workers in families with low incomes, including current threats and policy options for addressing coverage gaps for the remaining uninsured.

Pre-COVID-19 Policy Context

Although ESI access, affordability, and enrollment are important for all workers and their families, the extent to which workers in families with low incomes rely on ESI depends not only on access to and affordability of ESI, but on the alternative health insurance options available to them. Both Medicaid and federally subsidized Marketplace coverage can provide affordable health insurance options for low-income working families, but current policies may limit eligibility for these types of coverage.

Most children in low-income working families are income-eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage, because the median Medicaid or CHIP eligibility threshold for

children is 255 percent of FPL and only two states have eligibility thresholds for children below 200 percent of FPL (Brooks, Roygardner, and Artiga 2019). Access to Medicaid was expanded for working adults with low incomes and their families under the ACA in states that implemented the expansion, but Medicaid eligibility is still much more limited for adults than for children, even in the 36 states (including DC) that have implemented Medicaid expansion under the ACA.[5] In expansion states, all adults with incomes below 138 percent of FPL who are citizens and certain groups of legally present noncitizens are eligible for Medicaid—a dramatic increase from pre-ACA eligibility in most states, particularly for adults without dependent children. Among these states, only DC has further extended eligibility for childless adults—to just over 200 percent of FPL.[6] Access to Medicaid is much more limited in the 15 states that have yet to implement ACA Medicaid expansion—in those states, outside pregnant women and the disabled, only some groups of parents with low incomes living with dependent children can qualify for Medicaid, leaving many adults with low incomes in working families ineligible. When available to working families in or near poverty, Medicaid is typically an affordable coverage option; eligible adults are generally not required to pay premiums and face only nominal cost sharing, although some states have received approval under waiver authority to charge premiums for those living in poverty.

Medicaid coverage for adults with low incomes is at risk as states consider new guidance from the administration supporting work requirements. The President's FY 2020 Budget proposes federal work requirements in the Medicaid program, requiring "able-bodied, working-age individuals find employment, train for work, or volunteer (community service) in order to receive welfare benefits" (OMB 2019). To date, 10 states have received approval from the Centers for Medicare & Medicaid Services for Medicaid work requirements, but a court decision to strike down the rules in Arkansas—the only state to implement its program—was recently upheld by a federal appeals court.[7] Courts have stopped similar rules in Kentucky, New Hampshire, and Michigan, and no other states have yet to implement their programs. Understanding access to and affordability of ESI for families with low incomes is critical to informing the debate surrounding Medicaid work requirements, as a stated goal of many work requirement waivers, such as the Arkansas waiver, is to facilitate transitions from Medicaid to either Marketplace coverage or ESI.[8] However, for such transitions to occur, workers in families with low incomes must be eligible for an affordable ESI offer through their employer. A recent study found that although 62 percent of Medicaid enrollees likely subject to work requirements if implemented nationwide worked in the past year, only 15 percent reported consistently working at least 20 hours a week (Karpman 2019). Less is known about the availability and affordability of ESI for this population.

The Healthy Adult Opportunity demonstration initiative, announced by the administration in January 2020, could also put Medicaid coverage at risk for adults with low incomes. This demonstration

would increase state flexibility in the financing and design of Medicaid through a block grant—allowing states to cap federal Medicaid spending, limit eligibility, increase cost sharing, and reduce benefits (Rudowitz et al. 2020).[9] If states take up this option, some adults in low-income working families could lose Medicaid eligibility, while others might face Medicaid premiums and cost sharing or lose coverage of needed services and drugs. Further, the State Medicaid Director Letter says, "states are encouraged to propose innovative plan designs consistent with the expectations set forth in this guidance and will be able to leverage employer-sponsored insurance, the individual health insurance market, or align with a coverage program designed under an applicable complementary section 1332 waiver."[10] Like the case of work requirements, some states may assume transitions from Medicaid coverage to ESI among workers with low incomes and their families as part of this opportunity.

Beyond Medicaid, the federally subsidized Marketplace coverage established under the ACA and available beginning in January 2014 was partially designed to help low-income working families access affordable health insurance. Many working families with incomes above 100 percent of FPL in nonexpansion states and above 138 percent of FPL expansion states can qualify for premium tax credits up to 400 percent of FPL and cost-sharing reductions up to 250 percent of FPL for plans available through the newly established Marketplaces. To be eligible for this new source of affordable coverage, families must not have access to affordable ESI, defined as an ESI offer for which the employee premium contribution to single coverage constitutes no more than 9.56 percent of income (in 2018)—the "ESI firewall" (Straw 2019). Further, affordability of ESI is defined for the individual and does not guarantee a corresponding offer of affordable family coverage—the "family glitch" (Buettgens, Dubay, and Kenney 2016). Together, these rules mean that individuals could face much higher costs for an ESI offer than they would pay for subsidized Marketplace coverage if they did not receive an offer.

To increase access to affordable health insurance coverage for low-income working families, the ACA's Marketplaces have two main forms of financial assistance for individuals and families with low incomes: the advance premium tax credits and the cost-sharing reductions (CSRs). The ACA caps an individual's (or family's) premium based on their annual income, with no one at or under 400 percent of FPL paying more than 9.56 percent of their income (in 2018) toward premiums for the benchmark plan (second lowest-cost silver plan available). Individuals at or under 250 percent of FPL also are eligible for cost-sharing reductions. The cost-sharing reductions increase the actuarial value (AV) of silver plans to either 73, 87, or 94 percent (where actuarial value is defined as the share of health care costs for benefits covered under the plan paid for by an insurer in an average year), with greater cost-sharing reductions available to families with lower incomes and phasing out at 250 percent of FPL (Blumberg and Wengle 2015). See table 1 for more information on Marketplace affordability.

For workers with low incomes and their families relying on ESI, policies regulating ESI will likely impact whether they have access to affordable coverage. The ACA employer mandate requires firms with more than 50 full-time equivalent employees to offer ESI coverage to full-time employees (those employed, on average, at least 30 hours a week or 130 hours a month) and their dependents or pay penalties to the federal government if one or more workers claimed premium tax credits to purchase Marketplace coverage (Garrett, Gangopadhyaya, and Dorn 2017).[11] Thus, employers do not owe a penalty for failing to offer ESI to those working part-time or employed by a firm with fewer than 50 full-time equivalent employees (Williamson, Antonisse, and Tolbert 2016). Further, although the ACA limited waiting periods for ESI enrollment to a maximum of 90 days, this means new employees could lack an ESI offer for their first three months of employment (Blavin et al. 2014). Additionally, the ACA requires plans to have out-of-pocket maximums[12]—a limit on the most a person could have to pay for covered medical services in a plan year, including deductibles, copayments, and coinsurance but not premiums or out-of-network costs—and the 2018 limits were $7,350 for individual coverage and $14,700 for family coverage.[13] But the requirement does not apply to grandfathered plans or plans not compliant with ACA market reforms, such as short-term, limited-duration plans.

Finally, with the sharp economic downturn the country is facing related to the COVID-19 pandemic, a critical question is whether both workers and the newly unemployed can get access to the health care they need without racking up medical debt that undermines their financial stability. For workers with ESI, the Families First Coronavirus Response Act requires insurance companies to cover COVID-19 testing at no cost to consumers, but patients will still be required to pay the required out-of-pocket costs for treatment.[14] To the extent that workers losing jobs also lose ESI coverage, some may be eligible for Medicaid, depending on their family income and state of residence. But the newly unemployed residing in nonexpansion states are less likely to have access to affordable health insurance than those residing in states that have implemented Medicaid expansion under the ACA (Gangopadhyaya and Garrett 2020). And although some workers losing coverage through their jobs may be eligible for federally subsidized Marketplace coverage, the special enrollment period to obtain coverage requires them to apply for Marketplace coverage within 60 days of losing their prior insurance (Blumberg et al. 2020).

TABLE 1

Marketplace Affordability Measured in Annual Premiums and Deductibles as Percent of Annual Income and in Dollars by Federal Poverty Level (FPL), 2018

	AI of 100% of FPL			AI of 138% of FPL			AI of 150% of FPL			AI of 200% of FPL		
State	Prem. (% AI)	Ded. ($)	PPD (% AI)	Prem. (% AI)	Ded. ($)	PPD (% AI)	Prem. (% AI)	Ded. ($)	PPD (% AI)	Prem. (% AI)	Ded. ($)	PPD (% AI)
AL	2.01	100.00	2.8	3.32	100.00	3.9	4.03	100.00	4.6	6.34	411.79	8.0
AK[a]	2.01	250.00	3.7	3.32	250.00	4.5	4.03	250.00	5.1	6.34	750.00	8.8
AZ[a]	2.01	50.00	2.4	3.32	50.00	3.6	4.03	50.00	4.3	6.34	846.76	9.8
AR[a]	2.01	194.43	3.6	3.32	194.43	4.5	4.03	194.43	5.1	6.34	663.85	9.1
CA[a]	2.01	75.00	2.6	3.32	75.00	3.8	4.03	75.00	4.4	6.34	650.00	9.0
CO[a]	2.01	165.36	3.4	3.32	165.36	4.3	4.03	165.36	4.9	6.34	65.59	6.6
CT[a]	2.01	37.40	2.3	3.32	37.40	3.5	4.03	37.40	4.2	6.34	644.89	9.0
DE[a]	2.01	100.00	2.8	3.32	100.00	3.9	4.03	100.00	4.6	6.34	500.00	8.4
DC[a, d]	2.01	200.00	3.7	3.32	200.00	4.5	4.03	200.00	5.1	6.34	800.00	9.6
FL	2.01	230.35	3.9	3.32	230.35	4.7	4.03	230.35	5.3	6.34	920.72	10.1
GA	2.01	223.18	3.8	3.32	223.18	4.6	4.03	223.18	5.3	6.34	872.54	9.9
HI[a]	2.01	0.00	2.0	3.32	0.00	3.3	4.03	0.00	4.0	6.34	50.00	6.5
ID	2.01	40.52	2.3	3.32	40.52	3.6	4.03	40.52	4.3	6.34	415.01	8.0
IL[a]	2.01	332.18	4.7	3.32	332.18	5.3	4.03	332.18	5.9	6.34	546.80	8.6
IN[a]	2.01	634.36	7.2	3.32	634.36	7.1	4.03	634.36	7.5	6.34	1,232.21	11.4
IA[a]	2.01	100.00	2.8	3.32	100.00	3.9	4.03	100.00	4.6	6.34	500.00	8.4
KS	2.01	500.00	6.1	3.32	500.00	6.3	4.03	500.00	6.8	6.34	750.00	9.4
KY[a]	2.01	256.65	4.1	3.32	256.65	4.8	4.03	256.65	5.4	6.34	886.85	10.0
LA[a]	2.01	121.63	3.0	3.32	121.63	4.0	4.03	121.63	4.7	6.34	677.60	9.1
ME	2.01	250.00	4.1	3.32	250.00	4.8	4.03	250.00	5.4	6.34	755.75	9.5
MD[a]	2.01	0.00	2.0	3.32	0.00	3.3	4.03	0.00	4.0	6.34	500.00	8.4
MA[a, c]	0.00	0.00	0.0	0.00	0.00	0.0	0.00	0.00	0.0	2.17	0.00	2.2
MI[a]	2.01	204.34	3.7	3.32	204.34	4.5	4.03	204.34	5.2	6.34	637.07	9.0
MN[a]	1.19	0.00	1.2	1.15	0.00	1.1	2.44	0.00	2.4	3.95	0.00	4.0
MS	2.01	575.00	6.7	3.32	575.00	6.7	4.03	575.00	7.2	6.34	675.00	9.1
MO	2.01	317.05	4.6	3.32	317.05	5.2	4.03	317.05	5.8	6.34	1,507.61	12.5
MT[a]	2.01	0.00	2.0	3.32	0.00	3.3	4.03	0.00	4.0	6.34	554.88	8.6
NE	2.01	100.00	2.8	3.32	100.00	3.9	4.03	100.00	4.6	6.34	500.00	8.4
NV[a]	2.01	600.00	7.0	3.32	600.00	6.9	4.03	600.00	7.3	6.34	750.00	9.4
NH[a]	2.01	175.00	3.5	3.32	175.00	4.4	4.03	175.00	5.0	6.34	1,150.00	11.1

State	AI of 100% of FPL			AI of 138% of FPL			AI of 150% of FPL			AI of 200% of FPL		
	Prem. (% AI)	Ded. ($)	PPD (% AI)	Prem. (% AI)	Ded. ($)	PPD (% AI)	Prem. (% AI)	Ded. ($)	PPD (% AI)	Prem. (% AI)	Ded. ($)	PPD (% AI)
NJ[a]	2.01	200.00	3.7	3.32	200.00	4.5	4.03	200.00	5.1	6.34	300.00	7.6
NM[a]	2.01	49.98	2.4	3.32	49.98	3.6	4.03	49.98	4.3	6.34	315.40	7.6
NY[a, b]	0.00	0.00	0.0	0.00	0.00	0.0	0.00	0.00	0.0	1.0	0.00	1.0
NC	2.01	313.51	4.6	3.32	313.51	5.2	4.03	313.51	5.8	6.34	765.03	9.5
ND[a]	2.01	181.26	3.5	3.32	181.26	4.4	4.03	181.26	5.0	6.34	726.57	9.3
OH[a]	2.01	555.21	6.6	3.32	555.21	6.6	4.03	555.21	7.1	6.34	1,198.51	11.3
OK	2.01	0.00	2.0	3.32	0.00	3.3	4.03	0.00	4.0	6.34	50.00	6.5
OR[a]	2.01	100.00	2.8	3.32	100.00	3.9	4.03	100.00	4.6	6.34	793.80	9.6
PA[a]	2.01	32.17	2.3	3.32	32.17	3.5	4.03	32.17	4.2	6.34	422.33	8.1
RI[a]	2.01	0.00	2.0	3.32	0.00	3.3	4.03	0.00	4.0	6.34	800.00	9.6
SC	2.01	200.00	3.7	3.32	200.00	4.5	4.03	200.00	5.1	6.34	1,000.00	10.5
SD	2.01	313.20	4.6	3.32	313.20	5.2	4.03	313.20	5.7	6.34	788.51	9.6
TN	2.01	55.54	2.5	3.32	55.54	3.6	4.03	55.54	4.3	6.34	255.39	7.4
TX	2.01	204.52	3.7	3.32	204.52	4.5	4.03	204.52	5.2	6.34	1,322.89	11.8
UT	2.01	100.00	2.8	3.32	100.00	3.9	4.03	100.00	4.6	6.34	391.67	8.0
VT[a]	2.01	0.00	2.0	3.32	0.00	3.3	4.03	0.00	4.0	6.34	1,100.00	10.9
VA	2.01	51.56	2.4	3.32	51.56	3.6	4.03	51.56	4.3	6.34	579.18	8.7
WA[a]	2.01	558.82	6.6	3.32	558.82	6.7	4.03	558.82	7.1	6.34	1,652.86	13.1
WV	2.01	540.08	6.5	3.32	540.08	6.5	4.03	540.08	7.0	6.34	912.55	10.1
WI	2.01	238.54	4.0	3.32	238.54	4.7	4.03	238.54	5.3	6.34	740.67	9.4
WY	2.01	50.00	2.4	3.32	50.00	3.6	4.03	50.00	4.3	6.34	650.00	9.0

Source: Urban Institute analysis of the 2018 RWJF HIX Compare individual market dataset, https://hixcompare.org/.

Notes: [a] State expanded Medicaid before the 2018 plan year. Most individuals living here at 100 percent of FPL and 138 percent of FPL would qualify for Medicaid, but we display Marketplace affordability for those who qualify for Marketplace financial assistance but not Medicaid. [b] State operates a Basic Health Plan, enrolling all legal residents in enhanced subsidy plans. [c] Massachusetts operates a program called ConnectorCare, providing enhanced subsidies (premiums and deductibles) for all individuals under 300 percent of FPL. [d] DC has expanded Medicaid eligibility to all childless adults under 200 percent of FPL. We display the Marketplace affordability for those ineligible for Medicaid. AI = Annual Income. PPD = Premium-Plus-Deductible. Ded. = Deductible. Prem. = Premium.

Methods

We use data from Medical Expenditure Panel Survey Insurance Component (MEPS-IC) tables, available from the Agency for Healthcare Research and Quality (AHRQ), to describe measures of access to ESI among employees in private-sector establishments; affordability of single, employee-plus-one, and family coverage for employees in private-sector establishments; and enrollment in one's own establishment's ESI among employees in private-sector establishments. We first present ESI access, affordability, and enrollment results for the United States overall, by establishments' firm size and the share of low-wage employees in the establishment and by employee's part- or full-time status for years 2008–18. We also present results for each state overall, by establishments' firm size and the share of low-wage employees in the establishment and by employees' part- or full-time status for 2018.

Measures for this analysis are directly from the MEPS-IC. MEPS-IC data are collected and reported at the establishment level, defined as "a particular workplace or physical location where business is conducted."[15] Establishments are a smaller unit of analysis than firms, defined as "a business entity consisting of one or more establishments under common ownership or control." We report MEPS-IC measures for employees in all private-sector establishments and report measures stratified by establishments' firm size (fewer than 50 employees or 50 employees or more) and the share of low-wage employees in the establishment (50 percent or more low-wage employees or less than 50 percent low-wage employees). We refer to establishments in firms with fewer than 50 employees as "small firms" and those with 50 or more employees as "large firms." A "low-wage employee" is an employee earning at or below the 25th percentile for all hourly wages in the US.[16] We also report measures by employees' part- and full-time status. "Full-time" is working 35 or more hours a week, and "part-time" is working fewer than 35 hours a week.

Considering the subgroups described above, in 2018, most employees worked in large firms (73.7 percent) and establishments where less than 50 percent of employees were low wage (78.1 percent). More than three-quarters (78.2 percent) of employees in private-sector establishments were working full time, while 21.8 percent were part-time employees. When considering only full-time employees, rates of working in large firms and establishments where less than half of employees were paid low wages were higher than for all employees—76.7 percent and 85.2 percent, respectively.

Data are not presented for estimates suppressed by AHRQ because of small sample sizes or high rates of unreliable estimates. Estimates considered unreliable by AHRQ are reported and flagged as such. These estimates have a high relative standard error and should be interpreted with caution.[17] Because of the large number of unreliable estimates when disaggregated by firm size and the share of

low-wage employees in the establishment, we only present estimates for part-time employees in all private-sector establishments, not by firm size or the share of low-wage employees in the establishment. Not all measures in the MEPS-IC are reported by the share of low-wage workers in the establishment; we report estimates as they are available from MEPS-IC.

Access to Employer-Sponsored Insurance

Our measures of access at the national level include the MEPS-IC-reported percentage of employees in private-sector establishments that offer health insurance and the percentage of employees eligible for ESI in private-sector establishments that offer health insurance. At the national and state levels, we calculate and report the percentage of employees eligible for a health insurance offer in all private-sector establishments (not limited to establishments that offer insurance).

Affordability of Employer-Sponsored Insurance

At the national and state levels, we measure affordability as the average annual employee contribution to their ESI premium for a single plan across establishments. We report the same estimates for employee-plus-one and family coverage in the appendix. We also report the share of employees enrolled in ESI (any plan type) with a deductible and the average individual deductible for employees enrolled in single coverage across establishments. At the state level, we report the share of employees enrolled in single coverage ESI with an out-of-pocket maximum and the average out-of-pocket maximum amount for employees enrolled in single coverage across establishments (comparable estimates are not available historically). In the appendix, we report deductible and out-of-pocket maximum estimates for family coverage (estimates are not available for employee-plus-one coverage).

We report premium contributions and deductibles for all years in real 2018 dollars, calculated using the full-year average "Consumer Price Index for All Urban Consumers: All Items."[18] We also report these costs as the share of annual income at the federal poverty level for each year. We use poverty guidelines for a single person for individual coverage, for a family of two for employee-plus-one coverage, and for a family of four for family coverage. These income-based poverty levels change over time and in 2018 were $12,140 for a single adult, $16,460 for a family of two, and $25,100 for a family of four.[19] We chose to report premium contributions as a share of income at the federal poverty level to capture individuals and families living in poverty. Further, this income level allows for comparisons between ESI, Medicaid (for which adults with incomes at the federal poverty level are eligible in Medicaid expansion states), and Marketplace coverage (for which federal subsidies are available

beginning at 100 percent of FPL for those not eligible for Medicaid). Finally, estimates as a share of income at 100 percent of FPL can be easily converted to other income levels through multiplication (e.g., divide by 2.5 to calculate the share of income at 250 percent of FPL).

To assess ESI affordability relative to Marketplace plans, we present annual Marketplace premiums as a share of annual income, annual deductibles in dollars, and combined annual premiums and deductibles as a share of annual income for a range of individuals with lower incomes (100 percent of FPL, 138 percent of FPL, 150 percent of FPL, and 200 percent of FPL). We use each rating region's benchmark plan to calculate the percent of annual income and weight by rating region population to calculate the statewide average. Given the income levels we present, we use the benchmark deductibles for two different cost-sharing variants—the 94 actuarial value and the 87 actuarial value—for individuals whose incomes fall between 100 and 150 percent of FPL and 151 and 200 percent of FPL, respectively. We also calculated the national average benchmark out-of-pocket maximum, weighted by rating region population, for single and family coverage for these two cost-sharing variants. We find that in 2018 the national average out-of-pocket maximum for single Marketplace coverage was $1,020 for the 94 actuarial value cost-sharing reduction variant (100–150 percent of FPL) and $2,218 for the 87 actuarial value cost-sharing reduction variant (151–200 percent of FPL). We used the 2018 RWJF HIX Compare dataset[20] to gather this information on deductibles and out-of-pocket maximums. Additionally, because New York, Massachusetts, and Minnesota all offered Basic Health Plans or enhanced financial assistance in 2018, we use these plan designs as opposed to the qualified health plan cost-sharing reduction variants.[21] The rating region populations are aggregated using county-level population estimates from the US Census Bureau.

Enrollment in Employer-Sponsored Insurance

To provide insights into employee take-up of health insurance at the national level, we report the MEPS-IC measure of the percentage of employees enrolled in ESI from their own employer in private-sector establishments that offer health insurance. At both the national and state levels, we calculate and report the percentage of employees enrolled in ESI from their own employer in all private-sector establishments (not limited establishments that offer insurance). None of these enrollment estimates are limited to employees eligible for an ESI offer nor do they capture enrollment in ESI through a family member—such as a spouse's or parent's ESI plan.

Statistical Analysis

All statistical significance tests comparing state estimates with the national average are adjusted to account for the share of the national average each state represents. Further, because this analysis makes multiple state-to-national comparisons, if standard errors are left unadjusted, we expect that some of these differences would be significant simply by chance. To limit the number of false positives, we use the Benjamini-Hochberg procedure (Benjamini and Hochberg 1995) for multiple comparisons using a false discovery rate of .05. Estimates either suppressed or flagged as unreliable by AHRQ are excluded from Benjamini-Hochberg rankings and not tested for significance against national estimates. This adjustment is applied to the standard errors on the difference between state and US estimates. The Benjamini-Hochberg adjustment results in a conservative number of statistically significant differences but less so than the traditional Bonferroni adjustment (Williams, Jones, and Tukey 1999).

Limitations

The MEPS-IC data used for this analysis are aggregated to the state or national level. Further, data are reported at the establishment level, rather than the employee level. Thus, these estimates represent establishment-level averages and not the experiences of specific individuals. For example, the average employee premium contribution is first reported as the average among all employees enrolled in ESI coverage at an establishment and then averaged across establishments to the state level. In the case of cost measures, by limiting the sample to employees enrolled in ESI, the average cost of ESI offers may be underestimated—if employees are less likely to enroll in higher-cost coverage.

Further, we are unable to measure the actuarial value of ESI plans. Thus, comparisons in access, affordability, and enrollment over time and between states do not necessarily represent equal comparisons, as the actuarial value of plans offered by private employers may have changed over time or vary across states. For example, increases in the dollar value of deductibles could be associated with declines in copayments, but this information is not available in the MEPS-IC data.

Finally, although we describe access to, affordability of, and enrollment in ESI for groups of employees more likely than others to be workers in families with lower incomes, such as part-time employees and employees in majority low-wage establishments, this analysis cannot measure outcomes for workers with low incomes, specifically. And because measures are specific to the establishment, we are unable to measure whether individuals are covered by an ESI plan outside of that offered by their establishment—such as ESI coverage through a spouse's or parent's employer. Therefore, enrollment estimates likely underestimate the share of employees with any ESI coverage.

Results

In this section, we first present findings on patterns of ESI access, affordability, and enrollment nationally from 2008 to 2018, and then at the state level for 2018. To supplement the 50-state tables included in this report, state-specific appendices that describe access to, affordability of, and enrollment in ESI in each state are forthcoming.

National Trends in ESI Access, Affordability, and Enrollment

ACCESS TO EMPLOYER-SPONSORED INSURANCE

To access ESI coverage through their own employer, employees must first work at an establishment that offers ESI. They must then be eligible for this offer—usually determined by the number of hours they work per week and their tenure as an employee. As noted above, provisions of the ACA may have affected both whether employers offer coverage and the eligibility rules for these offers. Here, we report the percent of employees in private-sector establishments that offer ESI (table 2), the percent of employees eligible for ESI in private-sector establishments that offer ESI (table 3), and the percent of employees eligible for ESI in all private-sector establishments—not only those offering ESI (table 4) for years 2008–18. We investigate patterns by establishment firm size, the share of low-wage employees in the establishment, and employee part- or full-time status.

How have employer-sponsored health insurance offer rates changed over time?

- Between 2008 and 2018, the share of employees in private-sector establishments that offer health insurance fell from 91.0 percent to 88.8 percent for full-time employees and from 74.8 percent to 69.7 percent for part-time employees. These declines generally occurred in years 2010 through 2012 and again between 2013 and 2014 (table 2).
- Declines in the share of employees with an offer were driven by declines among employees in small firms, where the share of employees in private-sector establishments that offer health insurance fell from 68.8 percent to 56.1 percent for full-time employees and from 41.2 percent to 27.6 percent for part-time employees. We only observe declines before 2016.
- We do not observe significant differences in the share of employees in private-sector establishments that offer health insurance between 2008 and 2018 when limited to large firms. But we do observe small differences between 2018 and years 2010 to 2015, indicating that offer rates fell toward the middle of 2008 to 2018 but then rose in the past four years. These large firms with high offer rates employ the majority of employees in private-sector

establishments in the US—76.7 percent of full-time employees and 63.0 percent of part-time employees (data not shown)

- We observe declines in the share of employees in private-sector establishments that offer health insurance for those with both majority and fewer low-wage employees. The share of employees with an offer in establishments with majority low-wage employees fell from 81.5 percent to 78.6 percent for full-time employees and from 70.2 percent to 65.2 percent for part-time employees. Offer rates fell from 93.6 percent to 90.6 percent for full-time employees and from 80.5 percent to 73.7 percent for part-time employees in establishments with fewer low-wage employees.

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TABLE 2

Percent of Employees in Private-Sector Establishments That Offer Health Insurance by Employee Full-time Status, Firm Size, and Share of Low-Wage Employees in the Establishment, 2008–18

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
2008	91.0*	74.8*	68.8*	41.2*	98.4	92.9	93.6*	80.5*	81.5*	70.2*
2009	91.0*	74.2*	67.6*^	39.0*^	98.6	94.5	93.5*	82.3*	82.3*	67.8
2010	90.1*^	73.4*	66.3*	36.0*^	98.0*^	94.4	93.2*	80.6*	79.3^	67.9
2011	89.4*^	71.2^	63.7*^	33.6*^	97.9*	92.5*^	93.0*	79.9*	76.5^	64.8^
2012	88.7^	71.0	61.5*^	33.3*	97.7*	92.8*	92.3*^	79.3*	76.3	65.4
2013	88.8	71.4*	61.9*	33.1*	97.7*	93.8	92.0*	78*	77.0	66.5
2014	87.8*^	69.1^	58.7*^	31.1*	97.3*	90.3*^	90.9^	74.7^	75.9*	64.9
2015	88.3	69.1	56.4^	28.2^	98.6^	92.6*^	90.8	74.6	76.3	64.5
2016	88.5	69.4	56.3	28.2	98.9	93.7	90.5	73.5	78.2	65.6
2017	88.7	70.0	56.8	29.3	98.6	93.7	90.8	74.5	77.5	65.5
2018	88.8	69.7	56.1	27.6	98.7	94.5	90.6	73.7	78.6	65.2

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between full-time and part-time employees in all subgroups are significant in all years. Differences between small and large firms and between establishments with majority and fewer low-wage employees are significant for all years for both full-time and part-time employees. FT = full-time employees. PT = part-time employees

How has eligibility for employer-sponsored health insurance changed over time?

- Between 2008 and 2018, when limited to private-sector establishments that offer ESI, the share of employees eligible for ESI from their own employer increased from 87.4 percent to 90.1 percent, generally between 2008 and 2009, for full-time employees. The share of eligible employees fell from 33.4 percent to 22.3 percent over the same period among part-time employees, with a pronounced decline from 30.1 percent in 2013 to 20.8 percent in 2014 (table 3).
- Considering the same sample—limited to employees in private-sector establishments that offer ESI—gains in eligibility among full-time employees were observed for those in both small and large firms and those in establishments with majority and fewer low-wage employees, occurring before 2012 for all groups. Declines for part-time employees were observed for those in larger firms, establishments with majority low-wage employees, and establishments with fewer low-wage employees. Declines for part-time employees in large firms and establishments with majority low-wage employees were concentrated between 2013 and 2014, falling from 32.0 percent to 21.0 percent and from 27.3 percent to 12.0 percent, respectively.
- Between 2008 and 2018, the share of employees eligible for ESI from their own employer in all private-sector establishments—not only those that offer ESI—remained unchanged for full-time employees (79.5 percent in 2008 and 80.0 percent in 2018). This consistent eligibility rate is partly because of declines in offer rates that counteract increases in eligibility rates within establishments that offer ESI. The share of part-time employees eligible at all private-sector establishments fell from 25.0 percent to 15.5 percent, with the largest decline between 2013 and 2014 (table 4).
- The consistent eligibility rate among full-time employees at all private-sector establishments conceals a decrease from 61.9 percent to 51.2 percent among full-time employees in small firms—with declines observed between 2009 and 2015—and an increase from 85.4 percent to 88.7 percent among full-time employees in large firms—with gains observed between 2008 and 2009 and again between 2014 and 2015. We observe a gradual decline from 84.1 percent to 82.7 percent among full-time employees in establishments with fewer low-wage employees and no significant change among full-time employees in establishments with majority-low-wage employees (62.8 percent in 2008 and 64.7 percent in 2018).
- We observed declines for part-time employees in small firms (9.8 percent to 6.4 percent), large firms (33.1 percent to 21.0 percent), establishments with majority low-wage employees (17.6 percent to 9.5 percent), and establishments with fewer low-wage employees (33.8 percent to 21.0 percent). We found declines in small firms from 2009 to 2010 and in establishments with fewer low-wage employees from 2011 through 2014. Declines in large firms and those with majority low-wage employees were greatest between 2013 and 2014, when we observe declines from 30.0 percent to 19.0 percent and from 18.2 percent to 7.8 percent, respectively.

TABLE 3

Percent of Employees Eligible for ESI in Private-Sector Establishments That Offer Health Insurance by Employee Full-time Status, Firm Size, and Share of Low-Wage Employees in the Establishment, 2008–18

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
2008	87.4*	33.4*	89.9*	23.9	86.8*	35.6*	89.8*	42.0*	77.1*	25.1*
2009	89.1^	34.2*	90.8	27.6*^	88.7^	35.8*	91.2^	39.1*	80.4^	29.4*^
2010	88.3*	33.0*	90.0*	24.9	87.9*	34.7*	91.0	38.0*	77.6*^	28.4*
2011	88.5*	33.7*	91.3^	23.1	87.9*	35.9*	90.9	43.0*^	77.8*	25.3*
2012	88.9*	31.4*^	90.8	23.4	88.5*	33.0*^	91.4	37.1*^	78.1*	26.7*
2013	89.0*	30.1*	91.3	21.0	88.5*	32.0*	91.0	33.4*^	80.1	27.3*
2014	89.3	20.8^	92.3	19.9*	88.7*	21.0^	91.5	31.0	79.4	12.0*^
2015	89.3	20.5	92.0	22.3	88.8	20.2	91.4	29.7	77.9*	11.5*
2016	89.2	20.1*	91.9	19.4*	88.8	20.3	90.8	28.9	80.1	11.1*
2017	89.8	20.0*	91.9	19.8	89.4	20.0*	91.1	26.2^	81.5	12.8
2018	90.1	22.3^	91.3	23.2	89.9	22.2^	91.3	28.5	82.3	14.6

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between full-time and part-time employees in all subgroups are significant in all years. Differences between small and large firms and between establishments with majority and fewer low-wage employees are significant for all years for both full-time and part-time employees. FT = full-time employees. PT = part-time employees.

TABLE 4

Percent of Employees Eligible for ESI in Private-Sector Establishments by Employee Full-Time Status, Firm Size, and Share of Low-Wage Employees in the Establishment, 2008–18

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
2008	79.5	25.0*	61.9*	9.8*	85.4*	33.1*	84.1*	33.8*	62.8	17.6*
2009	81.1*^	25.4*	61.4*	10.8*	87.5*^	33.8*	85.3*^	32.2*	66.2^	19.9*
2010	79.6^	24.2*	59.7*^	9.0*^	86.1*^	32.8*	84.8*	30.6*	61.5^	19.3*
2011	79.1	24.0*	58.2*^	7.8*	86.1*	33.2*	84.5*	34.4*	59.5*	16.4*^
2012	78.9*	22.3*^	55.8*^	7.8*	86.5*	30.6*^	84.4*	29.4*^	59.6*	17.5*
2013	79.0*	21.5*	56.5*	7.0	86.5*	30.0*	83.7*	26.1*^	61.7	18.2*
2014	78.4*	14.4^	54.2*^	6.2	86.3*	19.0^	83.2	23.2^	60.3*	7.8*^
2015	78.9*	14.2	51.9^	6.3	87.6^	18.7*	83.0	22.2	59.4*	7.4*
2016	78.9*	13.9*	51.7	5.5	87.8	19.0	82.2	21.2	62.6^	7.3*
2017	79.7	14.0*	52.2	5.8	88.1	18.7*	82.7	19.5	63.2	8.4
2018	80.0	15.5^	51.2	6.4	88.7	21.0^	82.7	21.0	64.7	9.5

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between full-time and part-time employees in all subgroups are significant in all years. Differences between small and large firms and between establishments with majority and fewer low-wage employees are significant for all years for both full-time and part-time employees. FT = full-time employees. PT = part-time employees.

AFFORDABILITY OF EMPLOYER-SPONSORED INSURANCE

Among employees eligible for an ESI offer from their own employer, the employee premium contributions required for ESI may deter workers in low-income families from enrolling in coverage (Garfield and Young 2015; Straw 2019; Tolbert, Orgera, et al. 2019). Beyond premiums, the presence and dollar value of annual deductibles may also deter enrollment in ESI because of anticipated costs associated with using the coverage. Alternatively, families with low incomes may choose ESI plans with higher deductibles to obtain lower premiums—sacrificing the actuarial value of their plan in exchange for reduced monthly costs. Once enrolled in ESI, deductibles may limit the extent to which covered individuals can afford to use health care and may put them at risk of going without needed care or incurring medical debt or other financial burdens when they do use care. Collectively, high premiums and deductibles contribute to the rising share of individuals with ESI who are considered underinsured because of high out-of-pocket costs relative to income, which reached 24 percent in 2016 (Collins, Gunja, and Doty 2017). Underinsured adults report similar rates of problems paying medical bills or paying off medical debt as uninsured adults but higher rates of problems getting needed care because of cost than insured individuals not considered underinsured (Collins, Gunja, and Doty 2017). Here, we consider affordability among employees enrolled in ESI, reporting the average annual employee premium contribution to ESI for single coverage among employees enrolled in ESI in private-sector establishments (table 5), the share of employees enrolled in ESI with a deductible in private-sector establishments (table 6), and the average dollar value of a deductible for single coverage among employees enrolled in an ESI plan with a deductible in private-sector establishments (table 6) for years 2008–18. We investigate patterns by establishment firm size and, when available, the share of low-wage employees in the establishment.

How have employee premium contributions to employer-sponsored health insurance changed over time?

- Measured in 2018 dollars, average annual employee premium contributions to single ESI coverage increased by 39 percent from $1,029 in 2008 to $1,427 in 2018 and increases were observed for nearly all years except from 2017 to 2018 (table 5). Premiums for employee-plus-one and family coverage also increased over this period, by 35 percent and 37 percent, respectively (appendix tables A.1 and A.2).
- In all years, average annual employee premium contributions to single coverage were higher for employees in large firms than small firms and higher for employees in establishments with majority low-wage employees than those in establishments with fewer low-wage employees. Increases in premium contributions during this period were slightly greater for employees in

small firms than in large firms and those in establishments with fewer low-wage employees compared with majority low-wage employees.

How have deductibles for employer-sponsored insurance changed over time?

- Across establishments, the average share of employees enrolled in ESI who had a deductible increased 23 percent, from 70.7 percent in 2008 to 87.3 percent in 2018, and increases were observed throughout the period. We observe this increase for employees in both small and large firms, although the increase was greater in large firms. For 2013–18, the share of employees with a deductible was greater in large than small firms (table 6).
- The average deductible amount for single coverage among enrolled employees with a deductible, measured in 2018 dollars, increased by 82 percent—from $1,013 in 2008 to $1,846 in 2018—and increases were observed for nearly all years except from 2017 to 2018. Again, we observe this increase for employees in both small and large firms, but a greater percentage increase in large firms. In all years, the deductible amount was greater in small firms than large firms.
- The average deductible amount for family coverage also increased from 2010 to 2018, by 75 percent—from $1,934 in 2008 to $3,392 in 2018, on average (appendix table A.3).

TABLE 5

Average Annual Employee Premium Contribution to ESI for Single Coverage among Employees Enrolled in ESI in Private-Sector Establishments Overall and by Firm Size and Share of Low-Wage Employees in the Establishment, 2008–18

		Firm Size		Share of Low-Wage Employees in the Establishment	
	All private-sector establishments	Less than 50 employees	50 or more employees	Less than 50%	50% or more
2008	1,029*	926*	1,058*	997*	1,171*
2009	1,120*^	976*	1,158*^	1,104*^	1,192*
2010	1,175*^	1,044*	1,212*	1,148*	1,303*^
2011	1,217*^	1,072*	1,255*	1,195*^	1,326*
2012	1,223*	1,071*	1,261*	1,201*	1,327*
2013	1,261*	1,126*	1,296*	1,229*	1,424*^
2014	1,309*^	1,098*	1,358*^	1,272*	1,506
2015	1,330*	1,128*	1,376*	1,301*	1,530
2016	1,386*^	1,272^	1,410	1,367^	1,517
2017	1,450^	1,319	1,476^	1,420^	1,644^
2018	1,427	1,351	1,443	1,405	1,583

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between small and large firms are significantly different for all years, as are differences between establishments with majority and fewer low-wage employees. Dollars for all years are adjusted to 2018 dollars using the full year average Consumer Price Index for All Urban Consumers: All Items.

TABLE 6

Percent of Employees Enrolled in ESI with a Deductible and Average Individual Deductible (in Dollars) for Single Coverage in Private-Sector Establishments Overall and by Firm Size, 2008–18

	All Private-Sector Establishments		Private-Sector Firms with Less than 50 Employees		Private-Sector Firms with 50 or More Employees	
	% in a plan with a deductible	Avg. deductible ($)	% in a plan with a deductible	Avg. deductible ($)	% in a plan with a deductible	Avg. deductible ($)
2008	70.7*	1,013*	70.9*	1,373*	70.6*	912*
2009	73.8*^	1,073*^	73.5*^	1,502*^	73.8*^	962*^
2010	77.5*^	1,180*^	75.7*^	1,666*^	77.8*^	1,056*^
2011	77.8*	1,254*^	76.3*	1,743*^	78.1*	1,128*^
2012	79.6*^	1,276*	79.5*^	1,780*	79.7*	1,149*
2013	81.3*	1,372*^	79.5*	1,827*	81.6*^	1,260*^
2014	83.9*^	1,435*^	80.8*	1,885*	84.4*^	1,336*^
2015	85.4*^	1,633*^	82.1	2,081*^	86.0*^	1,537*^
2016	84.5*	1,774*^	81.7	2,202*^	85.0*	1,690*^
2017	87.5^	1,852^	82.3	2,188*	88.4^	1,786^
2018	87.3	1,846	83.0	2,327^	88.1	1,754

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences in the share in a plan with a deductible between small and large firms are significant for 2010 and 2013–18. Differences in average deductible between small and large firms are significant for all years. Dollars for all years are adjusted to 2018 dollars using the full year average Consumer Price Index for All Urban Consumers: All Items.

ENROLLMENT IN EMPLOYER-SPONSORED INSURANCE

The extent to which employees rely on ESI from their own employer for their health insurance coverage depends on rates at which firms offer ESI to their employees, the extent to which employees are eligible for ESI from their own employer, the required employee premium contributions, and the quality of the coverage available—including the size of the deductible they face. Take-up of ESI is also affected by the distribution of employees across firms as well as available alternative sources of coverage including ESI through a family member's employer, Medicaid, and subsidized Marketplace coverage—which was designed, in part, to help provide more affordable coverage to workers with low incomes. Although low-wage workers experienced significant gains in coverage following the ACA (Garrett, Gangopadhyaya, and Dorn 2017),[38] these gains include all coverage types (e.g., Medicaid, Marketplace, family member's ESI, and own ESI). Here, we focus on enrollment in ESI from an employee's own employer, reporting the share of employees enrolled in ESI from their own employer in private-sector establishments that offer ESI (table 7) and the share of employees enrolled in ESI from their own employer in all private-sector establishments—not only those offering ESI (table 8)—for 2008–18. We investigate patterns by firm size, the share of low-wage employees in the establishment, and employee part- or full-time status.

How has enrollment in employer-sponsored health insurance from an employee's own employer changed over time?

- Between 2008 and 2018, when limited to private-sector establishments that offer ESI, the share of employees enrolled in ESI from their own employer decreased from 70.5 percent to 66.6 percent for full-time employees and from 17.4 percent to 9.9 percent for part-time employees (table 7). Enrollment declines for part-time employees were concentrated in 2014 following implementation of ACA coverage provisions, while declines for full-time employees were found in 2015 and 2016. We observe declines for full-time employees for all establishment classifications, again primarily in 2015 and 2016, although declines for full-time employees in establishments with fewer low-wage employees began in 2013. We found declines for part-time employees for all establishment classifications except small firms, where enrollment in 2018 was not significantly different from 2008.
- Between 2008 and 2018, the share of employees enrolled in ESI from their own employer in all private-sector establishments—not only those that offer ESI—decreased from 64.2 percent in 2008 to 59.1 percent in 2018 for full-time employees and from 13.0 percent in 2008 to 6.9 percent in 2018 for part-time employees (table 8). We observe enrollment 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 following implementation of ACA coverage provisions. We found declines in enrollment for full- and part-time employees in all establishment classifications, although the timing of declines varies by classification.

TABLE 7

Percent of Employees Enrolled in Their Own Employer's ESI in Private-Sector Establishments that Offer Health Insurance by Employee Full-Time Status, Firm Size, and Share of Low-Wage Employees in the Establishment, 2008–18

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
2008	70.5*	17.4*	69.7*	11.8	70.7*	18.8*	74.3*	26.7*	54.7*	8.6*
2009	70.9*	15.3*	69.9*	13.4*^	71.1*	15.8*^	75.1*	22.4*^	53.9*	8.4*
2010	70.0*	14.2*	69.0*	12.6*	70.3*	14.6*	74.6*	21.3*	51.4	7.8*
2011	70.1*	14.1*	69.5*	10.2^	70.2*	14.9*	74.4*	21.4*	51.1	7.5*
2012	69.9*	13.1*	68.7*	11.3	70.1*	13.5*^	74.2*	20.4*	51.4	7.0*
2013	68.9*	12.6*	68.0*	9.9	69.1*	13.1*	72.9*^	18.6*	51.0	7.2*
2014	70.1*^	9.8^	68.8*	9.1	70.3*^	9.9^	73.9*^	16.3*^	51.9	4.1^
2015	68.6*^	8.9	67.5	11.0	68.8*^	8.6^	72.6*^	15.0	46.2*^	3.0*^
2016	66.8^	8.4*	65.6^	9.4	67.0^	8.3*	70.2^	13.3	46.5*	3.4
2017	67.4	8.4*	66.2	8.5*	67.7	8.4*	70.3	12.6	49.3	3.7
2018	66.6	9.9^	66.1	10.6^	66.7	9.8^	69.2	14.1	49.6	4.6

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between full-time and part-time employees in all subgroups are significant for all years. Differences between small and large firms among full-time employees are significantly different for 2008, 2010, 2012, 2013, 2014, and 2017. Differences between small and large firms among part-time employees are significantly different for 2008, 2009, 2011, 2012, 2013, and 2015. Differences between establishments with majority and fewer low-wage employees are significant for all years for both full-time and part-time employees. FT = full-time employees. PT = part-time employees.

TABLE 8

Percent of Employees Enrolled in Their Own Employer's ESI in Private-Sector Establishments by Employee Full-Time Status, Firm Size, and Share of Low-Wage Employees in the Establishment, 2008–18

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
2008	64.2*	13.0*	48.0*	4.9*	69.6*	17.5*	69.5*	21.5*	44.6*	6.0*
2009	64.5*	11.4*	47.3*	5.2*	70.1*	14.9*	70.2*	18.4*	44.4*	5.7*
2010	63.1*^	10.4*	45.7*^	4.5*^	68.9*	13.8*	69.5*	17.2*	40.8^	5.3*
2011	62.7*	10.0*	44.3*^	3.4^	68.7*	13.8*	69.2*	17.1*	39.1	4.9*
2012	62.0*	9.3*	42.3*^	3.8*	68.5*	12.5*^	68.5*	16.2*	39.2	4.6*
2013	61.2*	9.0*	42.1*	3.3	67.5*	12.3*	67.1*^	14.5*^	39.3	4.8*
2014	61.5*	6.8^	40.4*^	2.8	68.4*	8.9^	67.2*	12.2*^	39.4	2.7^
2015	60.6*^	6.1	38.1^	3.1	67.8*	8.0*	65.9*^	11.2	35.3*^	1.9*^
2016	59.1^	5.8*	36.9	2.7	66.3^	7.8*	63.5^	9.8^	36.4	2.2
2017	59.8	5.9*	37.6	2.5	66.8	7.9*	63.8	9.4	38.2	2.4
2018	59.1	6.9^	37.1	2.9	65.8	9.3^	62.7	10.4	39.0	3.0

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between full-time and part-time employees in all subgroups are significant in all years. Differences between small and large firms and between establishments with majority and fewer low-wage employees are significant for all years for both full-time and part-time employees. FT = full-time employees. PT = part-time employees.

Access, Affordability, and ESI Insurance in 2018, by State

ACCESS TO EMPLOYER-SPONSORED INSURANCE BY STATE

Here, we report eligibility for ESI coverage among employees working in private-sector establishments for 2018, nationally and by state. We investigate patterns by establishment firm size, the share of low-wage employees in the establishment, and employee part- or full-time status.

How does eligibility for employer-sponsored health insurance vary by state, firm size, the share of low-wage employees in the establishment, and employee part-time status?

- In 2018, access to ESI was more limited for part-time employees and those in small firms (table 9). Nationally, 80.0 percent of full-time employees in private-sector establishments were eligible for ESI from their own employer compared with only 15.5 percent of part-time employees, and full-time employees were more likely to be eligible for ESI than part-time employees in all states. State full-time eligibility ranged from 65.1 percent in Montana and 69.4 percent in Alaska to 85.5 percent in Ohio, 87.8 percent in DC, and 88.6 percent in Hawaii, while part-time eligibility ranged from 5.3 percent in Kansas and 7.9 percent in South Carolina to 32.4 percent in Hawaii.
- Among full-time employees, those in small firms were less likely to be eligible (51.2 percent) than those in larger firms (88.7 percent), and this pattern holds for all states except Hawaii. Eligibility in small firms ranged from 34.8 percent in North Carolina and 36.7 percent in South Carolina to 63.9 percent in Rhode Island, 76.7 percent in DC, and 85.2 percent in Hawaii, while eligibility in large firms ranged from 81.7 percent in Alaska to 94.3 percent in Alabama and 94.5 percent in Nebraska.
- Also, among full-time employees, those in establishments where at least half of employees were paid low wages were less likely to be eligible (64.7 percent) than those in establishments with fewer low-wage employees (82.7 percent), and this difference was significant for the US overall and 35 states. Eligibility in establishments with majority low-wage employees ranged from 43.8 percent in Alaska to 81.9 percent in Hawaii and Alabama and 82.6 percent in Massachusetts, while eligibility in establishments with fewer low-wage employees ranged from 68.9 percent in Montana and 72.0 percent in Wyoming to 88.0 percent in Missouri, 88.5 percent in Ohio, and 89.5 percent in Hawaii.

TABLE 9

Percent of Employees Eligible for ESI in Private-Sector Establishments by Employee Full-Time Status, Firm Size, and Share of Low-Wage Employees in the Establishment, 2008–18

	All Private-Sector Establishments		Firm Size		Share of Low-Wage Employees in the Establishment	
			Less than 50 Employees	50 or More Employees	Less than 50%	50% or More
	FT	PT	FT	FT	FT	FT
US	**80.0**	**15.5**	**51.2**	**88.7**	**82.7**	**64.7**
AL	84.8*	16.3	56.3	94.3*	85.9	81.9*
AK	69.4*	13.1	39.9*	81.7*	74.1*	43.8*
AZ	78.4	16.1	50.7	85.6	78.9	72.9
AR	76.4	8.4^	44.0	86.9	78.7	69.5
CA	80.6	18.8	54.9	88.2	82.6	63.1
CO	76.5	10.7	45.5	87.0	77.8	68.4
CT	81.1	11.7	57.4	89.2	83.5	55.2
DE	77.4	15.0	49.1	86.1	79.0	70.5
DC	87.8*	21.7	76.7*	90.5	87.9*	+
FL	75.6	13.5	43.8	86.1	76.6	72.3
GA	78.2	11.9	41.5*	88.4	81.4	63.3
HI	88.6*	32.4*	85.2*	89.8	89.5*	81.9*
ID	72.3*	13.3	38.1*	90.0	75.8*	57.7
IL	77.7	18.1	51.4	84.9	81.8	43.3
IN	81.8	9.6*	50.7	90.7	84.6	69.1
IA	83.3	13.1	56.9	92.2	84.5	74.1
KS	78.4	5.3*	53.2	86.7	81.8	64.8
KY	81.4	12.9	53.3	89.0	85.7	60.7
LA	79.1	11.3	51.6	88.7	82.1	71.0
ME	76.8	14.6	44.4	91.0	79.5	61.3
MD	79.4	18.6	60.8*	85.9	82.4	55.2
MA	84.6*	15.1	57.7	92.0	84.7	82.6*
MI	82.5	15.2	52.9	91.1	85.3	61.3
MN	83.2	12.0	54.0	91.3	85.4	65.8
MS	79.7	10.5^	54.6	86.8	85.4	66.3
MO	84.4*	15.2	55.4	93.3	88.0*	64.2
MT	65.1*	9.0*	37.4*	82.8	68.9*	46.9
NE	81.6	10.6	38.3*	94.5*	84.0	65.2
NV	79.0	16.0	48.2	87.3	80.3	75.5*

	All Private-Sector Establishments		Firm Size		Share of Low-Wage Employees in the Establishment	
			Less than 50 Employees	50 or More Employees	Less than 50%	50% or More
	FT	PT	FT	FT	FT	FT
NH	83.0	13.9	61.0*	91.2	84.6	68.1
NJ	77.1	16.3	55.9	84.2	81.7	49.3
NM	71.4*	11.8	41.1*	83.4	74.3*	61.8
NY	78.4	17.9	55.8	86.4	81.1	54.0
NC	78.9	16.1	34.8*	92.3	82.5	68.2
ND	82.4	10.2*	58.9	91.7	83.2	72.7
OH	85.5*	18.1	53.9	93.2*	88.5*	69.7
OK	80.5	11.9^	56.2	88.5	82.7	73.1
OR	79.6	14.8	50.8	92.0	80.8	50.3
PA	84.1*	20.7	59.0*	90.9	86.8*	64.7
RI	79.0	8.3*	63.9*	84.6	81.4	65.8
SC	78.2	7.9*	36.7*	90.6	81.0	62.8
SD	76.7	12.0	47.4	89.1	79.5	63.1
TN	81.3	13.0	52.5	88.1	84.9	70.2
TX	80.3	12.5	46.9	89.2	84.8	58.7
UT	77.7	10.8	37.7*	87.9	80.9	56.2
VT	73.1*	11.6	45.0	88.4	73.6*	65.6
VA	78.9	22.9	54.0	86.3	81.6	63.0
WA	80.5	23.4	54.4	90.6	81.2	73.7
WV	78.7	8.9*	42.9	89.0	82.4	68.6
WI	80.2	14.7	49.5	88.6	82.9	59.3
WY	71.5*	8.4*	37.5*	90.2	72.0*	68.7

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, + = suppressed estimate, excluded from significance testing * state average differs significantly from US average at the .05 level or higher. Differences between full-time and part-time employees are significant for the US and in all states, differences between small and large firms are significant for the US and for all states except HI, differences between establishments with majority and fewer low-wage employees are significant for the US and for all states except AL, AZ, AR, CO, DC, DE, FL, HI, IA, ME, MA, NV, ND, VT, WA, and WY. FT = full-time employees. PT = part-time employees.

AFFORDABILITY OF EMPLOYER-SPONSORED INSURANCE BY STATE

Among employees enrolled in ESI, we report on employee contributions to ESI premiums, the share of employees enrolled in an ESI plan with a deductible, and the average deductible amount for employees in ESI plans with deductibles. We also report the share of employees enrolled in an ESI plan with an out-of-pocket maximum—a limit on the most a person could have to pay for covered medical services in a plan year, including deductibles, copayments, and coinsurance but not including premiums or out-of-network costs—and the average out-of-pocket maximum amount. As noted earlier, the ACA requires plans to have out-of-pocket maximums,[22] and the 2018 limits were $7,350 for individual coverage and $14,700 for family coverage.[23] But the requirement does not apply to grandfathered plans or plans not compliant with ACA market reforms, such as short-term, limited-duration plans. Further, employer plans often have lower cost sharing than these limits.[24] We present national and state estimates and investigate patterns by establishment firm size, the share of low-wage employees in the establishment, and employee part- or full-time status.

How do employee premium contributions to employer-sponsored health insurance vary by state, firm size, the share of low-wage employees in the establishment, and employee part-time status?

- In 2018, the average annual employee contribution to ESI premiums for single coverage among employees in private-sector establishments was $1,427 and represented 11.8 percent of income at 100 percent of FPL (table 10). This was more than five times the share of income required for contributions to premiums for subsidized Marketplace plans in 2018 (2.0 percent of income at 100 percent of FPL) and more than the combined premium-plus-deductible costs in all states (table 1).
- Across states, average annual employee premium contributions to single coverage ranged from $755 in Hawaii (5.4 percent of income at 100 percent of FPL) and $955 in Washington (7.9 percent) to $1,807 in Rhode Island (14.9 percent) and $1,903 in Massachusetts (15.7 percent).
- The average employee contribution to employee-plus-one coverage was $3,634 and represented 22.1 percent of income for a family of two at 100 percent of FPL (appendix table A.4). Only two states had average premium contributions significantly different from the US average: Washington ($2,558; 15.5 percent of income at 100 percent of FPL) and Texas ($4,271; 25.9 percent).
- The average employee contribution to family coverage was $5,431 and represented 21.6 percent of income for a family of four at 100 percent of FPL (appendix table A.5). Premium contributions ranged from $3,862 in Washington (15.4 percent of income at 100 percent of FPL) and $4,280 in Michigan (17.1 percent) to $6,358 in DC (25.3 percent) and $6,597 in Virginia (26.3 percent).

- Nationally, average employee premium contributions to single coverage were somewhat higher in large firms ($1,443; 11.9 percent) compared with small firms ($1,351; 11.1 percent). But this pattern was only found for eight states; differences in premium contributions in small and large firms were not significant for the remaining states. Premium contributions in small firms ranged from $767 in Oregon (6.3 percent) and $789 in Montana (6.5 percent) to $2,016 in Virginia (16.6 percent) and $2,124 in Massachusetts (17.5 percent), while premium contributions in large firms ranged from $923 in Hawaii (6.6 percent) and $951 in Washington (7.8 percent) to $1,771 in Rhode Island (14.6 percent) and $1,859 in Massachusetts (15.3 percent).
- Average employee premium contributions to single coverage were also somewhat higher in establishments with majority low-wage employees ($1,583; 13.0 percent) compared with those with fewer low-wage employees ($1,405; 11.6 percent), but differences by the share of low-wage employees in the establishment were only significant for six states. Premium contributions in establishments with fewer low-wage employees ranged from $758 in Hawaii (5.4 percent) and $919 in Washington (7.6 percent) to $1,757 in Rhode Island (14.6 percent) and $1,859 in Massachusetts (15.3 percent), while only Ohio had a premium contribution ($735; 5.3 percent) that differed significantly from the US average for establishments with majority low-wage employees.

How do deductibles for employer-sponsored health insurance vary by state, firm size, and employee part-time status?

- Nationally, more than eight in ten employees (87.3 percent) enrolled in ESI in a private-sector establishment had a deductible in 2018. The share ranged from 44.4 percent in Hawaii to 64.6 percent in DC and 67.4 percent in California to more than 97 percent of employees enrolled in ESI in Utah, Indiana, Nebraska, Maine, and South Dakota (table 11).
- Nationally, a larger share of employees in large firms (88.1 percent) had a deductible than employees in small firms (83.0 percent). We found this national pattern consistent at the state level for California, Delaware, Georgia, Hawaii, Louisiana, and Texas. But in Alaska employees in small firms were more likely to have a deductible than those in large firms. The share of enrollees in small firms with a deductible ranged from 26.0 percent in Hawaii and 61.1 percent in California to over 98 percent in Alaska, Utah, South Dakota, and Montana, while the share of enrollees in large firms with a deductible ranged from 49.8 percent in Hawaii to 64.0 percent in DC and 68.7 percent in California to 98 percent and over in Nebraska, Maine, and South Dakota.
- Among employees enrolled in a single coverage plan with a deductible, the average dollar amount of the deductible in 2018 was $1,846—more than their contribution to premiums and well above deductibles required for Marketplace coverage for individuals with low incomes

(table 1). Across states, deductibles for single coverage ranged from $1,308 in DC and $1,451 in Utah to $2,322 in Connecticut, $2,337 in New Hampshire, and $2,447 in Maine (table 11).

- Among employees enrolled in family coverage with a deductible, the average dollar amount in 2018 was $3,392, ranging from $2,362 in DC and $2,729 in Massachusetts to over $4,000 in South Dakota, Colorado, Minnesota, and New Hampshire (appendix table A.6).
- Nationally, deductibles were larger in small firms ($2,327) than in large firms ($1,754). And we found this pattern of significantly higher deductibles in small firms in 26 states. The average deductible in small firms ranged from $1,488 in Hawaii and $1,559 in Arkansas to just over $3,000 in Texas and New Hampshire, while the average deductible in large firms ranged from $1,187 in DC and $1,405 in Utah to $2,203 in Vermont and $2,363 in Maine.

TABLE 10

Average Annual Employee Premium Contribution to ESI for Single Coverage among Employees Enrolled in ESI in Private-Sector Establishments Overall and by Firm Size and Share of Low-Wage Employees in the Establishment, 2018

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)
US	**1,427**	**11.8**	**1,351**	**11.1**	**1,443**	**11.9**	**1,405**	**11.6**	**1,583**	**13.0**
AL	1,453	12.0	1,512	12.5	1,441	11.9	1,465	12.1	1,414	11.6
AK	1,154*	7.6*	1,387	9.1	1,096*	7.2*	1,132*	7.5*	1,387	9.1
AZ	1,554	12.8	1,351	11.1	1,590	13.1	1,528	12.6	1,788	14.7
AR	1,375	11.3	1,206	9.9	1,404	11.6	1,293	10.7	1,622	13.4
CA	1,202*	9.9*	1,005*	8.3*	1,250*	10.3*	1,194*	9.8*	1,289	10.6
CO	1,289	10.6	923*	7.6*	1,373	11.3	1,245	10.3	1,570	12.9
CT	1,672*	13.8*	1,658	13.7	1,676*	13.8*	1,655*	13.6*	1,945	16.0
DE	1,340	11.0	1,268	10.4	1,356	11.2	1,337	11.0	1,355	11.2
DC	1,369	11.3	1,065	8.8	1,438	11.8	1,359	11.2	+	+
FL	1,472	12.1	1,351	11.1	1,496	12.3	1,468	12.1	1,487	12.2
GA	1,476	12.2	1,709	14.1	1,445	11.9	1,432	11.8	1,747	14.4
HI	755*	5.4*	310^	2.2^	923*	6.6*	758*	5.4*	735*	5.3*
ID	1,199	9.9	1,227	10.1	1,191*	9.8*	1,129*	9.3*	1,607	13.2
IL	1,548	12.8	1,226	10.1	1,607	13.2	1,550	12.8	1,524	12.6
IN	1,383	11.4	1,410	11.6	1,379	11.4	1,341	11.0	1,611	13.3
IA	1,592	13.1	1,491	12.3	1,613	13.3	1,552	12.8	1,969	16.2
KS	1,255*	10.3*	1,111	9.2	1,287	10.6	1,244	10.2	1,305	10.7
KY	1,633	13.5	1,590	13.1	1,641	13.5	1,666	13.7	1,395	11.5
LA	1,584	13.0	1,497	12.3	1,603	13.2	1,598	13.2	1,529	12.6
ME	1,461	12.0	1,591	13.1	1,429	11.8	1,481	12.2	1,334	11.0
MD	1,588	13.1	1,521	12.5	1,603	13.2	1,527	12.6	2,059	17.0
MA	1,903*	15.7*	2,124*	17.5*	1,859*	15.3*	1,823*	15.0*	3,588	29.6
MI	1,433	11.8	1,126	9.3	1,477	12.2	1,393	11.5	1,877	15.5
MN	1,575	13.0	1,435	11.8	1,605	13.2	1,549	12.8	1,787	14.7
MS	1,365	11.2	1,257	10.4	1,389	11.4	1,346	11.1	1,425	11.7
MO	1,403	11.6	1,629	13.4	1,362	11.2	1,399	11.5	1,435	11.8
MT	1,115*	9.2*	789*	6.5*	1,228	10.1	1,075*	8.9*	1,400	11.5
NE	1,388	11.4	1,326	10.9	1,395	11.5	1,390	11.4	1,368	11.3

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)	AAEC ($)	AAEC (% of AI at 100% FPL)
NV	1,355	11.2	832*	6.9*	1,438	11.8	1,222	10.1	1,740	14.3
NH	1,618	13.3	1,794	14.8	1,571	12.9	1,560	12.9	2,112	17.4
NJ	1,598	13.2	1,740	14.3	1,559	12.8	1,633*	13.5*	1,311	10.8
NM	1,558	12.8	1,157	9.5	1,655	13.6	1,318	10.9	2,482	20.4
NY	1,578	13.0	1,771	14.6	1,532	12.6	1,572	12.9	1,663	13.7
NC	1,295*	10.7*	1,533	12.6	1,261*	10.4*	1,254	10.3	1,455	12.0
ND	1,246*	10.3*	1,252	10.3	1,244*	10.2*	1,243	10.2	1,300	10.7
OH	1,632*	13.4*	1,337	11.0	1,677*	13.8*	1,596	13.1	1,886	15.5
OK	1,293	10.7	1,125	9.3	1,339	11.0	1,283	10.6	1,321	10.9
OR	1,061*	8.7*	767*	6.3*	1,152*	9.5*	1,057*	8.7*	1,205	9.9
PA	1,351	11.1	1,021*	8.4*	1,418	11.7	1,341	11.0	1,420	11.7
RI	1,807*	14.9*	1,936	15.9	1,771*	14.6*	1,757*	14.5*	2,114	17.4
SC	1,427	11.8	1,216	10.0	1,460	12.0	1,437	11.8	1,372	11.3
SD	1,541	12.7	1,523	12.5	1,545	12.7	1,529	12.6	1,619	13.3
TN	1,410	11.6	1,052	8.7	1,461	12.0	1,350	11.1	1,620	13.3
TX	1,413	11.6	1,605	13.2	1,382	11.4	1,412	11.6	1,421	11.7
UT	1,183*	9.7*	967	8.0	1,204*	9.9*	1,171*	9.6*	1,294	10.7
VT	1,456	12.0	1,526	12.6	1,437	11.8	1,457	12.0	1,440	11.9
VA	1,746*	14.4*	2,016*	16.6*	1,693	13.9	1,611	13.3	2,651	21.8
WA	955*	7.9*	966	8.0	951*	7.8*	919*	7.6*	1,490	12.3
WV	1,353	11.1	1,172	9.7	1,385	11.4	1,240	10.2	1,678	13.8
WI	1,596	13.1	1,758	14.5	1,573	13.0	1,544	12.7	2,117	17.4
WY	1,385	11.4	1,317	10.8	1,403	11.6	1,270	10.5	2,061	17.0

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.

Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, + = suppressed estimate, * state average differs significantly from US average at the .05 level or higher, differences between small and large firms are significant for the US and for CA, CO, HI, MT, NV, OR, PA, and TN, differences between establishments with majority and fewer low-wage employees are significant for the US and for MA, MT, NV, VA, WV, and WI. PT = part-time employees. AI = annual income. AAEC = average annual employee contribution.

TABLE 11

Percent of Employees Enrolled in ESI with a Deductible and Average Individual Deductible (in dollars) for Single Coverage in Private-Sector Establishments Overall and by Firm Size, 2018

	All Private-Sector Establishments		Firm Size			
			Less than 50 Employees		50 or More Employees	
	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)
US	**87.3**	**1,846**	**83.0**	**2,327**	**88.1**	**1,754**
AL	87.8	1,569	79.7	1,591*	89.4	1,565
AK	94.3*	1,797	98.3*	2,051	93.5*	1,730
AZ	93.1*	2,166*	97.8*	2,897*	92.3	2,029
AR	94.4*	1,501*	89.1	1,559*	95.2*	1,492*
CA	67.4*	1,680*	61.1*	2,157	68.7*	1,571*
CO	93.0*	2,005	86.7	2,424	94.3*	1,918
CT	87.9	2,322*	90.9	2,988*	87.3	2,147*
DE	90.4	1,710	76.8	2,227	92.5*	1,613
DC	64.6*	1,308*	67.4*	1,824	64.0*	1,187*
FL	90.8*	1,963	84.3	2,485	91.9*	1,867
GA	95.4*	1,917	86.9*	3,082	96.4*	1,772
HI	44.4*	1,308	26.0*	1,488*	49.8*	1,273
ID	94.1*	1,894	95.7	2,585	93.7*	1,670
IL	85.1	1,752	77.1	2,158	86.3	1,684
IN	97.3*	1,873	97.0*	2,640	97.4*	1,741
IA	93.0*	2,130*	93.2*	2,399	92.9*	2,074
KS	95.4*	1,715	94.9*	1,806*	95.5*	1,694
KY	92.6*	1,833	85.3	2,140	93.6*	1,780
LA	94.4*	1,656	85.0	1,625*	96.2*	1,662
ME	98.1*	2,447*	96.9*	2,797*	98.3*	2,363*
MD	83.2	1,511*	80.6	1,623*	83.8	1,488*
MA	83.9	1,454*	80.0	1,624*	84.6	1,422*
MI	94.0*	1,732	87.8	1,783*	95.0*	1,726
MN	95.9*	2,045*	94.7*	2,698	96.1*	1,902
MS	94.1*	1,695	97.2*	1,670*	93.6*	1,701
MO	86.5	1,931	92.9*	2,326	85.4	1,854
MT	95.0*	2,116*	99.2*	2,400	93.8	2,010
NE	97.8*	1,842	95.9*	2,725	98.0*	1,738
NV	82.7	2,001	75.8	2,381	83.7	1,953
NH	94.0*	2,337*	93.8*	3,053*	94.0*	2,145*
NJ	85.8	1,770	83.6	2,016	86.2	1,705
NM	92.6*	1,615	85.1	1,726*	94.0*	1,591
NY	75.2*	1,554*	74.8	1,963	75.3*	1,454*
NC	88.2	2,070*	90.1	2,606	87.9	1,991*
ND	94.4*	1,742	91.0*	1,564*	95.2*	1,791
OH	90.3	1,932	87.5	2,612	90.7	1,836
OK	93.3*	1,683	97.0*	2,096	92.5*	1,565*
OR	93.0*	1,954	92.6*	2,289	93.1*	1,851
PA	90.4*	1,831	86.5	2,294	91.1	1,740
RI	89.6	1,849	93.9*	1,620*	88.5	1,919
SC	95.3*	1,721	89.1	2,327	96.0	1,633
SD	98.5*	2,241*	98.5*	2,556	98.5*	2,165*
TN	94.3*	2,235*	90.1	2,804*	94.9*	2,159*
TX	93.6*	1,982	87.9	3,032*	94.3*	1,817

	All Private-Sector Establishments		Firm Size			
			Less than 50 Employees		50 or More Employees	
	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)
UT	97.1*	1,451*	98.4*	1,937	96.9*	1,405*
VT	93.2*	2,192*	91.7*	2,147	93.6*	2,203*
VA	90.6	1,886	90.5*	2,170	90.6	1,830
WA	95.6*	1,706	97.5*	2,282	95.2*	1,536*
WV	91.2	1,885	91.3*	2,377	91.2	1,796
WI	94.1*	1,914	88.1	2,363	95.0*	1,858
WY	96.0*	1,999	94.8*	1,986	96.2*	2,002*

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.
Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, * state average differs significantly from US average at the .05 level or higher, differences in the share in a plan with a deductible between small and large firms are significant for the US and for AK, CA, DE, GA, HI, LA, and TX, differences in the average deductible between small and large firms are significant for the US and for AZ, CA, CO, CT, DE, FL, GA, IA, IL, IN, ME, MN, MO, NE, NH, NY, NC, OH, OK, PA, SC, SD, TN, TX, UT, and WA.

How do out-of-pocket maximums for employer-sponsored health insurance vary by state, firm size, and employee part-time status?

- More than nine in ten employees (92.3 percent) enrolled in single-coverage ESI in a private-sector establishment in the US had an out-of-pocket maximum in 2018. The share of employees enrolled in ESI who had an out-of-pocket maximum ranged from 83.7 percent in Hawaii, 87.1 percent in Rhode Island, 87.2 percent in Pennsylvania, and 87.9 percent in California to 97.5 percent in Georgia, 98.2 percent in South Dakota, and 98.5 percent in Nebraska (table 12).
- Nationally, a larger share of employees with single coverage in large firms (93.4 percent) had an out-of-pocket maximum than employees in small firms (87.3 percent). This pattern was true and statistically significant for about one-quarter of states. The share of enrollees in small firms with an out-of-pocket maximum ranged from 70.7 percent in Hawaii to 96.3 percent in Indiana, 96.4 percent in Vermont, and 97.8 percent in South Dakota, while the share of enrollees in large firms with an out-of-pocket maximum ranged from 87.9 percent in California and 88.5 percent in Rhode Island to 98 percent and above in Wisconsin, South Dakota, Georgia, Washington, Maine, and Nebraska.
- Among employees enrolled in a single coverage plan with an out-of-pocket maximum in 2018, the average dollar amount was $4,416. This amount was more than four times the national average out-of-pocket maximum ($1,020) for single Marketplace coverage at 100 percent of FPL and nearly twice the amount ($2,218) for single Marketplace coverage at 200 percent of FPL (data not shown). Across states, out-of-pocket maximums for single coverage ranged from $3,270 in Hawaii and $3,272 in DC to $5,061 in South Carolina and $5,213 in Nevada.

- Nationally, out-of-pocket maximums were somewhat larger in small firms ($4,730) than in large firms ($4,357), but among states with significant differences by firm size, out-of-pocket maximums were larger in small firms in some states and in large firms for other states.
- Among employees enrolled in family coverage, 93.3 percent had an out-of-pocket maximum in 2018 and the average dollar amount was $8,375. Three states had significantly lower maximums: $6,206 in DC, $7,316 in Illinois, and $7,378 in North Dakota (appendix table A.7).

TABLE 12

Percent of Employees Enrolled in ESI with an Out-of-Pocket Maximum and Average Individual Out-of-Pocket Maximum (in dollars) for Single Coverage in Private-Sector Establishments Overall and by Firm Size, 2018

	All Private-Sector Establishments		Firm Size			
			Less than 50 Employees		50 or More Employees	
	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)
US	**92.3**	**4,416**	**87.3**	**4,730**	**93.4**	**4,357**
AL	89.3	4,585	71.6	5,094	93.0	4,502
AK	94.2	4,728	90.1	4,919	95.2	4,683
AZ	94.5	4,565	89.3	5,229	95.4	4,456
AR	91.1	4,059	82.6	3,517*	92.6	4,143
CA	87.9*	4,066*	87.8	4,720	87.9*	3,906*
CO	94.9	4,473	91.2	4,911	95.8	4,377
CT	90.8	4,668	88.8	4,954	91.3	4,600
DE	95.0	4,422	92.8	4,383	95.5	4,431
DC	93.1	3,272*	90.3	3,463*	93.7	3,231*
FL	96.9*	4,759*	92.8	4,803	97.7*	4,750*
GA	97.5*	4,630	90.8	5,841*	98.5*	4,479
HI	83.7*	3,270*	70.7*	2,920*	88.7	3,376*
ID	90.6	4,636	81.2	5,221	93.7	4,472
IL	96.1*	3,825*	92.6	3,746*	96.8	3,839*
IN	96.2*	4,294	96.3*	5,043	96.2	4,164
IA	94.7	4,122	89.7	4,344	95.7	4,079
KS	93.2	4,462	89.8	4,067	94.0	4,546
KY	95.0	4,253	90.9	4,232	95.8	4,257
LA	91.4	4,519	87.6	4,013*	92.3	4,627
ME	96.9*	4,874*	88.3	5,546*	98.9*	4,730
MD	94.4	3,935*	84.8	4,226	96.5	3,878*
MA	91.7	4,233	80.1	4,779	94.0	4,141
MI	92.3	4,599	84.0	4,399	93.5	4,625
MN	95.1	4,147*	93.7	4,354	95.4	4,103*
MS	95.2	4,365	89.2	4,202	96.6*	4,400
MO	87.4	4,389	82.4	4,734	88.3	4,330
MT	93.6	4,436	89.8	4,921	95.0	4,277
NE	98.5*	4,187	95.5*	4,545	98.9*	4,146
NV	94.4	5,213*	86.2	5,162	95.7	5,220*

	All Private-Sector Establishments		Firm Size			
			Less than 50 Employees		50 or More Employees	
	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)
NH	94.5	4,506	84.3	5,342*	97.2*	4,315
NJ	92.5	4,319	86.3	4,312	94.2	4,320
NM	94.7	4,404	88.8	5,100	96.1	4,249
NY	88.5	4,303	83.8	4,824	89.7	4,186
NC	86.7	4,896*	80.4	5,368*	87.6	4,835*
ND	95.0	3,631*	92.0	3,218*	95.8	3,743*
OH	90.4	4,352	80.9	4,713	91.9	4,304
OK	89.0	4,267	85.0	4,502	90.0	4,208
OR	96.3*	4,665	92.6	4,858	97.4*	4,608
PA	87.2*	4,843*	79.9	4,925	88.7	4,828*
RI	87.1*	4,244	82.1	3,581*	88.5*	4,417
SC	95.3	5,061*	83.0	5,084	97.2*	5,058*
SD	98.2*	4,445	97.8*	4,786	98.3*	4,363
TN	91.4	4,653	94.2	5,346*	91.0	4,551
TX	94.4	4,537	92.6	5,143*	94.7	4,439
UT	95.1	4,569	93.9	4,446	95.3	4,580
VT	95.8*	4,748	96.4*	4,501	95.6	4,816
VA	92.9	4,371	88.7	4,374	93.7	4,371
WA	94.6	4,448	81.1	5,161	98.6*	4,274
WV	90.4	4,868	92.0	5,177	90.1	4,811
WI	95.8*	4,387	78.0	4,575	98.3*	4,367
WY	97.0	4,582	95.4	4,475	97.4	4,611

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.
Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, * state average differs significantly from US average at the .05 level or higher, differences in the share in a plan with an out-of-pocket maximum between small and large firms are significant for the US and for AL, GA, HI, ID, ME, MA, MI, NH, OH, PA, SC, WA, and WI, differences in the average out-of-pocket maximum between small and large firms are significant for the US and for AZ, CA, GA, ID, IN, LA, ME, MA, MT, NH, NM, NY, NC, ND, RI, TN, TX, and WA. In 2018, the national average out-of-pocket maximum for single Marketplace coverage was $1,020 for the 94 actuarial value cost sharing reduction variant (100–150% FPL) and $2,218 for the 87 actuarial value cost-sharing reduction variant (151–200% of FPL).

ENROLLMENT IN EMPLOYER-SPONSORED INSURANCE BY STATE

Here, we report enrollment in ESI coverage from one's own employer among employees working in all private-sector establishments—not only those offering ESI—for 2018, nationally, and in each state. As noted above, these estimates only include take-up of ESI offered by an employee's own employer, not ESI coverage obtained through a family member's employer. They also do not reflect non-ESI coverage, such as enrollment in Medicaid or Marketplace plans. We investigate patterns by establishment firm size, the share of low-wage employees in the establishment, and employee part- or full-time status.

How does enrollment in employer-sponsored health insurance from an employee's own employer vary by state, firm size, and employee part-time status?

- In 2018, enrollment in an employee's own ESI was more common for full-time employees in private-sector establishments than for part-time employees (table 13). Nationally, enrollment in ESI was substantially higher among full-time employees (59.1 percent) than part-time employees (6.9 percent), and full-time employees were also more likely to be enrolled in ESI than part-time employees in all states. Across states, ESI enrollment among full-time employees ranged from 46.9 percent in New Mexico and 49.1 percent in Montana to 67.0 percent in Missouri and 74.2 percent in Hawaii, while enrollment among part-time employees ranged from 2.4 percent in West Virginia and 2.6 percent in Kansas to 18.0 percent in Washington and 20.1 percent in Hawaii.
- Among full-time employees, enrollment in an employee's own ESI was less common in small firms (37.1 percent) than in larger firms (65.8 percent), and this pattern was significant for all states except Hawaii and Nevada. Enrollment among full-time employees in small firms ranged from 25.0 percent in Nebraska and 26.5 percent in North Carolina to 57.4 percent in DC and 72.1 percent in Hawaii, while enrollment among full-time employees in large firms ranged from 54.9 percent in New Mexico, 60.2 percent in New Jersey, and 60.3 percent in Oklahoma to 74.8 percent in Hawaii and Oregon.
- Also, among full-time employees, enrollment in an employee's own ESI was less common in establishments with majority low-wage employees (39.0 percent) than in establishments with fewer low-wage employees (62.7 percent), and this pattern was significant for all but five states. Enrollment among full-time employees in establishments with majority low-wage employees ranged from 24.8 percent in Alaska to 49.1 percent in Nevada, 51.9 percent in DC, and 70.3 percent in Hawaii, while enrollment among full-time employees in establishments with fewer low-wage employees ranged from 50.7 percent in New Mexico, 53.0 percent in Montana, and 53.8 percent in Wyoming to 71.7 percent in Missouri and 74.6 percent in Hawaii.

TABLE 13

Percent of Employees Enrolled in Their Own Employer's ESI in Private-Sector Establishments by Employee Full-Time Status, Firm Size, and Share of Low-Wage Employees in the Establishment, 2018

	All Private-Sector Establishments		Firm Size		Share of Low-Wage Employees in the Establishment	
			Less than 50 Employees	50 or More Employees	Less than 50%	50% or More
	FT	PT	FT	FT	FT	FT
US	**59.1**	**6.9**	**37.1**	**65.8**	**62.7**	**39.0**
AL	55.6	5.3^	36.8	61.8*	65.7	31.4
AK	53.4*	7.9	30.9	62.9*	58.6	24.8*
AZ	55.2	10.0	36.2	60.1	57.3	35.7
AR	57.3	5.0^	33.1	65.2	62.6	42.3
CA	58.1	9.8*	42.2*	63.0*	60.1	41.8
CO	55.8	5.8	35.6	62.8*	57.5	45.6
CT	62.1	5.9	39.9	69.7*	64.6	36.0
DE	57.4	7.7	33.2	64.8	58.7	51.9*
DC	66.4*	9.7	57.4*	68.6	66.5	+
FL	57.1	5.6^	34.5	64.5	59.7	47.4
GA	57.0	4.6	28.5*	64.9	61.2	37.1
HI	74.2*	20.1*	72.1*	74.8*	74.6*	70.3*
ID	59.0	7.6	32.7	72.6*	63.6	39.6
IL	59.2	7.4	36.2	65.4	63.1	25.6
IN	60.1	4.4	36.3	67.0	64.0	41.7
IA	61.6	6.2	40.8	68.5*	64.1	40.7
KS	57.8	2.6*	40.4	63.5	61.5	42.8
KY	60.6	4.2*	35.3	67.4	67.4	29.1
LA	55.4	2.6^	36.0	62.1*	61.9	37.4
ME	58.6	7.8	31.4	70.4*	61.7	40.8
MD	55.6	11.3	37.1	62.1	57.4*	41.0
MA	59.5	5.3	39.0	65.1	60.9	37.3
MI	62.2	5.6	35.8	69.8*	65.3	37.7
MN	62.9	4.7	40.4	69.2*	64.8	47.9
MS	59.8	3.1^	38.8	66.0	69.0	38.3
MO	67.0*	5.9	41.6	74.7*	71.7*	39.9
MT	49.1*	5.7	29.9	61.3*	53.0*	30.5
NE	60.9	5.9	25.0*	71.6*	64.3	38.5
NV	58.2	7.3	33.7	64.7	61.5	49.1*
NH	61.2	6.1	36.5	70.4*	63.2	43.6
NJ	54.8	7.1	38.5	60.2*	58.6	31.6^
NM	46.9*	6.8	26.8*	54.9*	50.7*	34.1
NY	55.0*	6.3	37.2	61.2*	57.4*	32.0
NC	60.8	5.8^	26.5*	71.2*	68.3*	38.7
ND	64.7*	5.1	43.9	73.0*	66.3	43.3
OH	63.9*	5.4	38.8	70.1*	69.0*	37.5
OK	55.3	4.1^	40.4	60.3*	57.9	46.7
OR	64.5	9.1	40.3	74.8*	65.8	30.9
PA	61.7	7.0	43.8*	66.6	63.9	45.8
RI	56.7	3.9*	41.6	62.1*	59.1	43.2
SC	61.2	3.3^	27.2*	71.4*	64.0	46.2
SD	57.6	6.3	34.4	67.5	62.8	33.1
TN	59.3	2.9^	35.8	65.0	64.9	42.2
TX	60.6	6.0	34.0	67.8	66.4*	32.9

	All Private-Sector Establishments		Firm Size		Share of Low-Wage Employees in the Establishment	
			Less than 50 Employees	50 or More Employees	Less than 50%	50% or More
	FT	PT	FT	FT	FT	FT
UT	62.2	5.3^	27.6*	71.0*	65.9	37.6
VT	54.3	4.6	31.0	67.1*	54.8*	46.9
VA	58.7	11.4	39.3	64.5	62.2	38.4
WA	64.0	18.0*	44.9	71.4*	66.5	37.5
WV	55.1	2.4*	29.1*	62.6*	60.6	40.4
WI	60.1	7.8	32.3	67.8	63.5	35.0
WY	50.8*	4.7	27.5*	63.8*	53.8*	37.0

Source: Urban Institute analysis of 2008–18 Medical Expenditure Panel Survey-Insurance Component data.
Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, + = suppressed estimate, * state average differs significantly from US average at the .05 level or higher, differences between full-time and part-time employees are significant for the US and for all states, differences between small and large firms are significant for the US and for all states except HI and NV, differences between establishments with majority and fewer low-wage employees are significant for the US and for all states except DC, DE, HI, NJ, and VT. FT = full-time employees. PT = part-time employees.

Discussion

This analysis shows that in 2018—a time with high employment and following implementation of the ACA's major coverage provisions—ESI remained out of reach for certain groups of workers. 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 those in other establishments. For low-income workers eligible for ESI, required contributions to premiums and deductible amounts often constituted a large share of household resources. On average, employee premium contributions were well above the payments required for federally subsidized Marketplace coverage and, for single coverage, annual deductibles were greater, on average, than required premium contributions. Similarly, out-of-pocket maximums for ESI coverage were more than four times the national average out-of-pocket maximum for single and family Marketplace coverage at 100 percent of FPL and nearly twice the national average 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 many workers with low incomes and their families faced in 2018. Low enrollment in one's own ESI, particularly for part-time employees and employees in small firms and low-wage establishments, reflects these gaps—although we cannot determine whether these employees were enrolled in ESI from a different establishment through a family member.

Millions of Americans have lost their jobs and access to ESI in the economic fallout related to 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. Without access to affordable coverage, these families are at risk of being uninsured and experiencing financial hardship, unmet health care needs, and poor health outcomes (Sommers, Gawande, and Baicker 2017; Shartzer, Long, and Anderson 2016).

The ACA included many provisions designed to expand access to and improve affordability of health insurance coverage. But beyond the employer mandate, the out-of-pocket limit requirement, the limit on waiting periods, and new essential health benefit standards for the small group market, few provisions targeted ESI (Blavin et al. 2014). Although we do not observe large increases in eligibility for full-time employees in large firms following the employer mandate to offer coverage to full-time workers, the sharp decline in eligibility for part-time employees in large firms from 2013 to 2014 suggests that firms may have responded to the availability of new coverage sources through Medicaid expansion and subsidized Marketplace coverage by restricting eligibility for part-time workers to whom the employer mandate did not apply. Overall, 9.5 million workers and 5.2 million of their family members gained health insurance coverage between 2010 and 2015, and more than 85 percent of these coverage gains were through Medicaid or Marketplace plans (Gangopadhyaya, Garrett, and Dorn 2018; Garrett, Gangopadhyaya, and Dorn 2017).

Here, we focus on policy options that could further expand access to affordable coverage for workers with low incomes and their families. Workers with low incomes could benefit from proposals to reduce costs of health care generally by protecting against surprise medical bills (Pollitz et al. 2019) and reducing drug prices[25] or by reducing payment rates by establishing a public option (Blumberg et al. 2020) or implementing single-payer health care reform (Blumberg et al. 2019). States could follow the lead of Hawaii—an outlier with higher-than-average eligibility and enrollment and lower-than-average costs—which has mandated employer health insurance coverage with minimum standards of benefits since 1974 (Neubauer 1993). Future reforms could also target ESI by regulating the actuarial value of coverage or limiting employee contributions to premiums, but such policies would come with significant tradeoffs that could make some families worse off because of reductions in wages or changes in other employment practices (Blavin et al. 2014).

We next consider policies that could lower uninsurance in low-income working families by increasing access to Medicaid and subsidized Marketplace coverage. Expanding access to Medicaid and

subsidized Marketplace coverage would not likely have adverse employment consequences and could even have positive wage effects in addition to reducing financial barriers to needed health care.

Implementation of the ACA Medicaid expansion in all states would lead to further reductions in uninsurance among those in working families with incomes below 138 percent of FPL. Studies have shown that Medicaid expansion reduces uninsurance among adults with low incomes and has positive coverage effects for children (Courtemanche, Marton, and Yelowitz 2016; Garrett and Gangopadhyaya 2016; Hudson and Moriya 2017; McMorrow et al. 2017). Likewise, state coverage for children in families with low and middle incomes through Medicaid and CHIP could help address coverage gaps among workers and their family members (Kenney et al. 2016; Saloner et al. 2015; Wherry, Kenney, and Sommers 2016). But people eligible for Medicaid may face barriers to enrollment and retention such as a lack of awareness about eligibility, burdensome paperwork required for enrollment determination and redetermination processes, and frequent renewal requirements. Streamlined eligibility systems combined with outreach and community-based assistance efforts, longer eligibility periods, and ex-parte renewals through which states automatically renew eligibility based on available data could reduce these barriers and increase Medicaid coverage rates (Brooks, Park, and Roygardner 2019).

Other Medicaid policies, such as work requirements, premiums, and changes potentially adopted under Healthy Adult Opportunities waivers, may exacerbate coverage problems among workers with low incomes and their family members. Work and community engagement requirements, which have been approved in multiple Medicaid programs since 2018 but so far blocked by the courts, pose risks of Medicaid coverage losses for individuals in low-income working families (Gangopadhyaya, Johnston, et al. 2018, Gangopadhyaya, Kenney, et al. 201b; Karpman, Hahn, and Gangopadhyaya 2019; Karpman, Zuckerman, and Gonzalez 2018). Medicaid enrollees who face work requirements are at risk of losing coverage because of difficulties navigating reporting processes, satisfying documentation requirements even when they work the required number of hours, or finding enough consistent work hours each week throughout the year. Several states have used waiver authority to impose premiums on Medicaid enrollees, including those with incomes below the federal poverty level (Brooks, Roygardner, and Artiga 2019). Prior studies have shown that premiums in Medicaid and CHIP reduce coverage among those targeted (Dague 2014; Guy et al. 2017; Hadley et al. 2006; Kenney, Hadley, and Blavin 2006; Ku and Coughlin 1999).

States could follow the lead of a handful of states that have taken steps to address affordability concerns for those with incomes between 138 percent and 200 percent of FPL. Washington, DC, for example, expanded Medicaid eligibility to adults with incomes of up to 200 percent of FPL. Minnesota and New York have implemented the Basic Health Program, which reduces premiums and out-of-

pocket cost sharing for those eligible for Marketplace coverage with incomes below 200 percent of FPL. The extent to which Basic Health Programs could successfully reduce costs for workers with low incomes and their families likely depends on the current premiums, number of participating insurers, and risk pool in the state's Marketplace. Beyond Basic Health Programs, states like Massachusetts, California, and Vermont have supplemented premium and cost-sharing subsidies to make coverage and care more affordable for people with low and middle incomes qualifying for Marketplace coverage.[26] Because prior studies show that premiums affect take-up of Medicaid and other types of coverage, maintaining no-cost or low premiums for families with low incomes on Medicaid and with Marketplace coverage is likely key to promoting access to insurance for workers with low incomes and their families (Artiga, Ubri, and Zur 2017; Kenney et al. 2006, 2007).

Access to affordable insurance coverage for individuals in working families could also be expanded with changes to the rules that determine whether individuals and families with an ESI offer can qualify for subsidized Marketplace coverage. First, under current law, the "firewall" prevents employees with an ESI offer deemed affordable from receiving Marketplace subsidies. Because ESI offers are considered affordable if the single coverage offered to the worker costs less than about 10 percent of income and has an actuarial value of at least 60 percent, this affordability threshold is not a difficult one for a plan to meet. Consequently, some low-income employees will face significantly higher costs for a lower-quality ESI plan than what would be available to them according to their income if they were eligible for Marketplace subsidies. Second, the "family glitch" means that affordability is determined based on the cost an employee faces for individual coverage and does not consider the costs of employee-plus-one or family coverage. If an employee's offer for individual coverage is deemed affordable, not only are they not eligible for Marketplace subsidies, but neither are their family members—even if family coverage is very expensive relative to income (Straw 2019). Eliminating the firewall and family glitch and allowing those in low-income working families to receive Marketplace subsidies regardless of their eligibility for ESI could improve access and affordability of coverage and care for this population (Blumberg et al. 2019; Straw 2019).[27] Beyond allowing more workers with low incomes and their families to access coverage through the Marketplace, increasing premium subsidies and cost-sharing reductions available for Marketplace coverage could improve access to affordable coverage for this population (Blumberg et al. 2018).

These findings indicate that workers with low incomes and their families are likely to face systematic and widespread gaps in access to affordable ESI no matter where they live. Lack of access to affordable ESI is associated with a greater risk of uninsurance, which in turn leads to financial hardships, health care needs, and worse 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 56.3 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 with at least one adult working in a firm (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, particularly given the current push for work requirements in Medicaid and debates about whether and how to restructure ACA Marketplaces with respect to who can qualify for subsidized coverage. The State Medicaid Director work requirements letter as well as 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 (Rae et al. 2020). For example, the Ohio community engagement 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 seen by low-wage workers following implementation of the ACA, which were driven by gains in Medicaid and subsidized Marketplace coverage (Garrett, Gangopadhyaya, and Dorn 2017; Shartzer, Blavin, and Holahan 2018).

As millions are losing their jobs because of the COVID-19 public health and economic crises, some newly unemployed workers may be eligible to maintain ESI from their former employer through the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage option, which allows workers who lose their jobs to maintain their ESI coverage but requires workers to pay both the employee and the employer contribution to premiums. Because paying the combined employer and employer contributions is likely cost-prohibitive for workers who have lost their jobs, policymakers have proposed legislation to fully subsidize COBRA coverage, allowing workers who lose their jobs and had ESI coverage to maintain that ESI coverage for free.[28] If newly unemployed workers have a family member with an ESI offer, job loss is a qualifying event to allow the family to switch plans midyear. To increase flexibility in taking up these coverage options, the federal government recently extended deadlines for special enrollment in plans regulated by the Employee Retirement Income Security Act (ERISA), creating a special enrollment period lasting until 60 days after the announced end of the national emergency.[29]

Still, many newly jobless Americans will look to Medicaid and Marketplace coverage to maintain their health insurance coverage. The newly unemployed residing in nonexpansion states are less likely to have access to affordable health insurance than those residing in states that have implemented

Medicaid expansion under the ACA (Gangopadhyaya and Garrett 2020). And while some workers losing jobs and coverage may be eligible for federally subsidized Marketplace coverage, the existing special enrollment period to obtain coverage midyear requires them to apply for Marketplace coverage within 60 days of losing their prior insurance (Blumberg et al. 2020). And although the federal government has extended deadlines for special enrollment in coverage regulated by ERISA, the special enrollment period for Marketplace coverage has not been extended. 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 current COVID-19 pandemic and economic crisis. Therefore, policymakers will also want to make sure that that workers in families with low incomes who are able to maintain their employment have access to affordable health insurance coverage and health care. Many workers in families with low incomes will likely require Medicaid or subsidized Marketplace coverage, rather than ESI, to have affordable health insurance coverage. Meeting the health needs of workers in families with low incomes, 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.

Appendix. Additional Data Tables

TABLE A.1

Average Annual Employee Premium Contribution to ESI for Employee-Plus-One Coverage among Employees Enrolled in ESI in Private-Sector Establishments Overall and by Firm Size and Share of Low-Wage Employees in the Establishment, 2008–18

		Firm Size		Share of Low-Wage Employees in the Establishment	
	All Private-Sector Establishments	Less than 50 employees	50 or more employees	Less than 50%	50% or more
2008	2,686 *	2,848 *	2,660 *	2,636 *	2,976 *
2009	2,766 *	3,100 *	2,714 *	2,773 * ^	2,719 * ^
2010	2,876 *	3,265 *	2,814 *	2,831 *	3,170 * ^
2011	3,055 * ^	3,285 *	3,020 * ^	2,570 * ^	2,979 *
2012	3,088 *	3,285 *	3,059 *	2,615 *	2,871 *
2013	3,168 *	3,359 *	3,143 *	3,122 * ^	3,498 ^
2014	3,285 * ^	3,474 *	3,260 * ^	3,216 *	3,815
2015	3,412 * ^	3,659 *	3,380 * ^	3,355 * ^	4,046
2016	3,532 ^	3,640 *	3,517 ^	3,489 * ^	4,027
2017	3,617	3,852	3,589	3,574	4,129
2018	3,634	4,017	3,584	3,621	3,780

Source: Urban Institute analysis of 2008-2018 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between small and large firms are significantly different for all years except 2013, 2014, 2016, and 2017, differences between establishments with majority and fewer low-wage employees are significant for all years except 2009 and 2018. Dollars for all years are adjusted to 2018 dollars using the full year average Consumer Price Index for All Urban Consumers: All Items

TABLE A.2

Average Annual Employee Premium Contribution to ESI for Family Coverage among Employees Enrolled in ESI in Private-Sector Establishments Overall and by Firm Size and Share of Low-Wage Employees in the Establishment, 2008–18

		Firm Size		Share of Low-Wage Employees in the Establishment	
	All Private-Sector Establishments	Less than 50 employees	50 or more employees	Less than 50%	50% or more
2008	3,958 *	4,033 *	3,946 *	3,899 *	4,390 *
2009	4,067 *	4,249 *	4,033 *	4,052 * ^	4,172 *
2010	4,284 * ^	4,740 * ^	4,201 *	4,241 * ^	4,621 * ^
2011	4,424 *	4,627 *	4,391 * ^	4,386 *	4,729 *
2012	4,633 * ^	4,775 *	4,610 * ^	4,560 *	5,178 * ^
2013	4,764 *	4,556 *	4,797 *	4,725 *	5,101 *
2014	4,793 *	4,695 *	4,808 *	4,705 *	5,587 * ^
2015	4,990 * ^	4,860 *	5,009 * ^	4,935 * ^	5,673 *
2016	5,185 * ^	4,719 *	5,254 ^	5,108 * ^	6,254 ^
2017	5,346	5,546 ^	5,317	5,282	6,196
2018	5,431	5,854	5,372	5,360	6,441

Source: Urban Institute analysis of 2008-2018 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences between small and large firms are significantly different for 2009, 2010, 2016, and 2018, differences between establishments with majority and fewer low-wage employees are significant for all years except 2009. Dollars for all years are adjusted to 2018 dollars using the full year average Consumer Price Index for All Urban Consumers: All Items

TABLE A.3

Percent of Employees in Private-Sector Establishments Enrolled in ESI with a Deductible and Average Family Deductible (in dollars) for Family Coverage Overall and by Firm Size, 2008-2018

	Firm Size											
	All Private-Sector Establishments				Less than 50 Employees				50 or More Employees			
	Share in a plan with a deductible (%)		Avg. deductible ($)		Share in a plan with a deductible (%)		Avg. deductible ($)		Share in a plan with a deductible (%)		Avg. deductible ($)	
2008	70.7	*	1,934	*	70.9	*	2,786	*	70.6	*	1,790	*
2009	73.8	* ^	2,061	* ^	73.5	* ^	3,105	* ^	73.8	* ^	1,885	* ^
2010	77.5	* ^	2,274	* ^	75.7	* ^	3,289	* ^	77.8	* ^	2,103	* ^
2011	77.8	*	2,479	* ^	76.3	*	3,717	* ^	78.1	*	2,291	* ^
2012	79.6	* ^	2,539	*	79.5	* ^	3,844	*	79.7	*	2,343	*
2013	81.3	*	2,685	* ^	79.5	*	4,053	* ^	81.6	* ^	2,486	* ^
2014	83.9	* ^	2,801	* ^	80.8	*	4,042	*	84.4	* ^	2,627	* ^
2015	85.4	* ^	3,088	* ^	82.1		4,333	^	86	* ^	2,924	* ^
2016	84.5	*	3,211	* ^	81.7		4,122		85	*	3,080	* ^
2017	87.5	^	3,479	^	82.3		4,556	^	88.4	^	3,334	^
2018	87.3		3,392		83		4,364		88.1		3,263	

Source: Urban Institute analysis of 2008-2018 Medical Expenditure Panel Survey-Insurance Component data.

Notes: * estimate differs significantly from 2018 at the .05 level or higher. ^ estimate differs significantly from the previous year at the .05 level or higher. Differences in the share in a plan with a deductible between small and large firms are significant for 2010 and 2013-2018. Differences in average deductible between small and large firms are significantly significant for all years. Dollars for all years are adjusted to 2018 dollars using the full year average Consumer Price Index for All Urban Consumers: All Items

TABLE A.4

Average Annual Employee Premium Contribution to ESI for Employee-Plus-One Coverage among Employees in Private-Sector Establishments Enrolled in ESI Overall and by Firm Size and Share of Low-Wage Employees in the Establishment, 2018

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)
United States	**3,634**	**22.1**	**4,017**	**24.4**	**3,584**	**21.8**	**3,621**	**22.0**	**3,780**	**23.0**
Alabama	3,530	21.4	3,227	19.6	3,589	21.8	3,615	22.0	3,063	18.6
Alaska	3,524	17.1	4,494	21.8	3,413	16.6	3,574	17.4	2,611*	12.7*
Arizona	3,857	23.4	4,164	25.3	3,815	23.2	3,815	23.2	5,206	31.6
Arkansas	3,840	23.3	4,344	26.4	3,791	23.0	3,731	22.7	4,494	27.3
California	3,498	21.3	3,229	19.6	3,536	21.5	3,497	21.2	3,504	21.3
Colorado	3,390	20.6	3,851	23.4	3,328	20.2	3,334	20.3	3,859	23.4
Connecticut	3,486	21.2	4,108	25.0	3,406	20.7	3,478	21.1	3,746	22.8
District of Columbia	4,002	24.3	4,216	25.6	3,958	24.0	3,895	23.7	+	+
Delaware	3,784	23.0	6,098	37.0	3,538	21.5	3,900	23.7	3,142	19.1
Florida	3,930	23.9	4,336	26.3	3,871	23.5	3,981	24.2	3,673	22.3
Georgia	3,724	22.6	4,100	24.9	3,681	22.4	3,830	23.3	2,729^	16.6
Hawaii	3,068	16.2	2,487*	13.1*	3,163	16.7	3,085	16.3	2,802	14.8
Idaho	3,165	19.2	3,034	18.4	3,191	19.4	3,151	19.1	3,256^	19.8
Illinois	3,302	20.1	3,547	21.5	3,271	19.9	3,288	20.0	+	+
Indiana	3,422	20.8	4,575	27.8	3,275	19.9	3,474	21.1	2,606	15.8
Iowa	3,688	22.4	3,499	21.3	3,725	22.6	3,723	22.6	3,109	18.9
Kansas	3,292	20.0	2,672*	16.2*	3,425	20.8	3,292	20.0	3,295	20.0
Kentucky	3,703	22.5	4,968	30.2	3,554	21.6	3,726	22.6	3,373	20.5
Louisiana	4,195	25.5	5,958*	36.2*	3,911	23.8	4,290*	26.1*	3,717	22.6
Maine	3,896	23.7	4,985	30.3	3,707	22.5	3,995	24.3	3,029^	18.4
Maryland	3,813	23.2	3,407	20.7	3,880	23.6	3,826	23.2	3,629	22.0
Massachusetts	4,035	24.5	4,421	26.9	3,984	24.2	3,880	23.6	+	+
Michigan	3,383	20.6	2,920	17.7	3,442	20.9	3,329	20.2	4,383	26.6
Minnesota	3,832	23.3	4,022	24.4	3,818	23.2	3,872	23.5	3,173	19.3
Mississippi	3,185	19.3	3,762	22.9	3,141	19.1	3,073	18.7	3,759	22.8
Missouri	3,490	21.2	3,308	20.1	3,514	21.3	3,492	21.2	3,470	21.1
Montana	3,232	19.6	2,306*	14.0*	3,476	21.1	3,237	19.7	3,198	19.4

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)
Nebraska	3,596	21.8	2,942	17.9	3,641	22.1	3,596	21.8	3,596	21.8
Nevada	3,219	19.6	2,724	16.5	3,258	19.8	3,081	18.7	3,679	22.4
New Hampshire	4,066	24.7	5,996	36.4	3,787	23.0	3,858	23.4	8,377*	50.9*
New Jersey	3,615	22.0	4,355	26.5	3,524	21.4	3,765	22.9	2,253^	13.7
New Mexico	3,776	22.9	3,344	20.3	3,829	23.3	3,252	19.8	7,604^	46.2
New York	3,597	21.9	4,210	25.6	3,496	21.2	3,654	22.2	2,751	16.7
North Carolina	3,537	21.5	4,895	29.7	3,454	21.0	3,585	21.8	3,310	20.1
North Dakota	3,379	20.5	4,014	24.4	3,306	20.1	3,422	20.8	2,596	15.8
Ohio	3,525	21.4	3,343	20.3	3,548	21.6	3,473	21.1	4,177	25.4
Oklahoma	3,764	22.9	3,778	23.0	3,761	22.8	3,760	22.8	3,790	23.0
Oregon	3,364	20.4	4,027	24.5	3,235	19.7	3,368	20.5	+	+
Pennsylvania	3,481	21.1	3,446	20.9	3,487	21.2	3,398	20.6	4,585	27.9
Rhode Island	4,066	24.7	5,201*	31.6*	3,925	23.8	4,171	25.3	3,534	21.5
South Carolina	3,222	19.6	4,260	25.9	3,144	19.1	3,151	19.1	4,150	25.2
South Dakota	3,643	22.1	3,343	20.3	3,682	22.4	3,666	22.3	3,409	20.7
Tennessee	4,023	24.4	4,776	29.0	3,931	23.9	3,910	23.8	4,665	28.3
Texas	4,271*	25.9*	6,090*	37.0*	4,080	24.8	4,271*	25.9*	4,272	26.0
Utah	3,196	19.4	3,555	21.6	3,166	19.2	3,175	19.3	3,520	21.4
Vermont	3,507	21.3	3,434	20.9	3,525	21.4	3,451	21.0	4,517	27.4
Virginia	4,002	24.3	4,235	25.7	3,955	24.0	3,873	23.5	5,246	31.9
Washington	2,558*	15.5*	3,898	23.7	2,405*	14.6*	2,517*	15.3*	3,650	22.2
West Virginia	3,222	19.6	4,040	24.5	3,147	19.1	2,982	18.1	4,411	26.8
Wisconsin	3,468	21.1	4,105	24.9	3,396	20.6	3,352	20.4	5,305	32.2
Wyoming	3,036	18.4	4,950	30.1	2,767*	16.8*	2,900*	17.6*	4,038	24.5

Source: Urban Institute analysis of 2018 Medical Expenditure Panel Survey-Insurance Component data.

Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, + = suppressed estimate, excluded from significance testing, * state average differs significantly from US average at the .05 level or higher, differences between small and large firms are significant for the US and for DE, KS, LA, NH, RI, TX, WA, and WY, differences between establishments with majority and fewer low-wage employees are significant for AK, AZ, MI, NH, WV, and WI.

TABLE A.5

Average Annual Employee Premium Contribution to ESI for Family Coverage among Employees in Private-Sector Establishments Enrolled in ESI Overall and by Firm Size and Share of Low-Wage Employees in the Establishment, 2018

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)
United States	**5,431**	**21.6**	**5,854**	**23.3**	**5,372**	**21.4**	**5,360**	**21.4**	**6,441**	**25.7**
Alabama	5,278	21.0	5,426	21.6	5,251	20.9	5,281	21.0	5,238	20.9
Alaska	4,501 *	14.3 *	2,815 *	9.0 *	4,817	15.4	4,486	14.3	4,731 *	15.1 *
Arizona	5,786	23.1	5,489	21.9	5,833	23.2	5,746	22.9	6,915	27.5
Arkansas	5,728	22.8	6,929	27.6	5,511	22.0	5,488	21.9	7,488	29.8
California	5,376	21.4	5,535	22.1	5,351	21.3	5,199	20.7	7,795	31.1
Colorado	4,963	19.8	5,033	20.1	4,951	19.7	4,935	19.7	5,249	20.9
Connecticut	5,352	21.3	4,853	19.3	5,431	21.6	5,262	21.0	6,725	26.8
District of Columbia	6,358 *	25.3 *	6,888	27.4	6,271	25.0	6,204 *	24.7 *	+	+
Delaware	5,715	22.8	6,510	25.9	5,650	22.5	5,621	22.4	6,184	24.6
Florida	5,908	23.5	5,027	20.0	6,028	24.0	5,855	23.3	6,223	24.8
Georgia	5,846	23.3	7,293	29.1	5,712	22.8	5,693	22.7	7,702	30.7
Hawaii	5,475	19.0	4013^	13.9^	5,711	19.8	5,481	19.0	+	+
Idaho	5,211	20.8	5,982	23.8	5,111	20.4	4,684	18.7	10,012 *	39.9 *
Illinois	5,378	21.4	6,654	26.5	5,208	20.7	5,443	21.7	3243^	12.9
Indiana	4,551 *	18.1 *	4,338	17.3	4,582	18.3	4,469	17.8	5,297 *	21.1 *
Iowa	5,143	20.5	4,473	17.8	5,270	21.0	4,993	19.9	7,271	29.0
Kansas	5,248	20.9	5,527	22.0	5,195	20.7	5,314	21.2	4,619 *	18.4 *
Kentucky	5,382	21.4	7,716	30.7	5,228	20.8	5,356	21.3	6,177	24.6
Louisiana	6,288 *	25.1 *	8,859 *	35.3 *	5,861	23.4	6,236	24.8	6,673	26.6
Maine	5,375	21.4	6,917	27.6	5,202	20.7	5,276	21.0	+	+
Maryland	6,177	24.6	6,812	27.1	6,048	24.1	6,075	24.2	8,184	32.6
Massachusetts	5,693	22.7	6,177	24.6	5,618	22.4	5,498	21.9	+	+
Michigan	4,280 *	17.1 *	3,344 *	13.3 *	4,448 *	17.7 *	4,261 *	17.0 *	4,574	18.2
Minnesota	6,190	24.7	7,414	29.5	6,035	24.0	6,072	24.2	7,590^	30.2
Mississippi	5,680	22.6	6,918	27.6	5,544	22.1	5,469	21.8	6,931	27.6
Missouri	5,003	19.9	4,368	17.4	5,118	20.4	4,959	19.8	5,909	23.5
Montana	5,208	20.7	5,683	22.6	5,105	20.3	5,001	19.9	10,439	41.6

	All Private-Sector Establishments		Firm Size				Share of Low-Wage Employees in the Establishment			
			Less than 50 Employees		50 or More Employees		Less than 50%		50% or More	
	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)	Avg. annual employee contribution ($)	Avg. annual employee contribution (as % of annual income at 100% FPL)
Nebraska	5,414	21.6	4,479	17.8	5,510	22.0	5,451	21.7	4,753	18.9
Nevada	6,252	24.9	4,984	19.9	6,437	25.6	6,144	24.5	6,735	26.8
New Hampshire	5,535	22.1	5,582	22.2	5,529	22.0	5,407	21.5	7,741	30.8
New Jersey	6,253	24.9	6,589	26.3	6,194	24.7	6,208	24.7	7,769	31.0
New Mexico	4,723	18.8	5,045	20.1	4,681	18.6	4,493	17.9	6,493	25.9
New York	5,006	19.9	5,188	20.7	4,973	19.8	4,977	19.8	5,637	22.5
North Carolina	5,948	23.7	7,053	28.1	5,847	23.3	5,882	23.4	6,571	26.2
North Dakota	4,982	19.8	6,209	24.7	4,702	18.7	4,981	19.8	5,019	20.0
Ohio	5,016	20.0	4,870	19.4	5,033	20.1	4,987	19.9	5,489	21.9
Oklahoma	5,306	21.1	5,891	23.5	5,202	20.7	5,369	21.4	4,789	19.1
Oregon	5,913	23.6	6,458	25.7	5,852	23.3	5,923	23.6	+	+
Pennsylvania	5,111	20.4	4,816	19.2	5,147	20.5	5,161	20.6	4,282	17.1
Rhode Island	5,493	21.9	6,865	27.4	5,125	20.4	5,412	21.6	6,538	26.0
South Carolina	5,301	21.1	7,100	28.3	5,194	20.7	5,322	21.2	5,047	20.1
South Dakota	5,810	23.1	5,339	21.3	5,914	23.6	5,787	23.1	6,066	24.2
Tennessee	5,514	22.0	6,749	26.9	5,365	21.4	5,361	21.4	6,756	26.9
Texas	5,964	23.8	9,189 *	36.6 *	5,668	22.6	5,910	23.5	6,756	26.9
Utah	4,594 *	18.3 *	6,188	24.7	4,416	17.6	4,613	18.4	4,223 *	16.8 *
Vermont	5,334	21.3	7,216	28.7	4,947	19.7	5,421	21.6	3,904 *	15.6 *
Virginia	6,597 *	26.3 *	8,767	34.9	6,382	25.4	6,589 *	26.3 *	6,719^	26.8
Washington	3,862 *	15.4 *	6,075	24.2	3,535 *	14.1 *	3,683 *	14.7 *	10,638	42.4
West Virginia	4,371	17.4	6,201	24.7	4,203	16.7	4,072	16.2	6,611	26.3
Wisconsin	4,952	19.7	4,535	18.1	5,009	20.0	4,916	19.6	5,886	23.5
Wyoming	5,205	20.7	5,339	21.3	5,173	20.6	5,150	20.5	5,597	22.3

Source: Urban Institute analysis of 2018 Medical Expenditure Panel Survey-Insurance Component data.

Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, + = suppressed estimate, excluded from significance testing, * state average differs significantly from US average at the .05 level or higher, differences between small and large firms are significant for the US and for AK, LA, TX, UT, and VA, differences between establishments with majority and fewer low-wage employees are significant for the US and for ID, MT, WA, and WV.

TABLE A.6

Percent of Employees in Private-Sector Establishments Enrolled in ESI with a Deductible and Average Family Deductible (in dollars) for Family Coverage Overall and by Firm Size, 2018

	All Private-Sector Establishments		Firm Size: Less than 50 Employees		Firm Size: 50 or More Employees	
	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)
United States	**87.3**	**3,392**	**83.0**	**4,364**	**88.1**	**3,263**
Alabama	87.8	2,924	79.7	3,205	89.4	2,873
Alaska	94.3 *	3,225	98.3 *	3,400	93.5 *	3,190
Arizona	93.1 *	3,926	97.8 *	4,787	92.3	3,787
Arkansas	94.4 *	3,144	89.1	3,900	95.2 *	3,025
California	67.4 *	3,231	61.1 *	3,760	68.7 *	3,157
Colorado	93.0 *	4,011 *	86.7	5,280	94.3 *	3,806
Connecticut	87.9	3,784	90.9	5,775 *	87.3	3,454
Delaware	90.4	3,285	76.8	4,001	92.5 *	3,241
District of Columbia	64.6 *	2,362 *	67.4 *	3,081 *	64.0 *	2,219 *
Florida	90.8 *	3,674	84.3	4,743	91.9 *	3,540
Georgia	95.4 *	3,661	86.9	6,044 *	96.4 *	3,475
Hawaii	44.4 *	3,240	26.0 *	+	49.8 *	3,234
Idaho	94.1 *	3,249	95.7 *	5,332	93.7 *	2,966
Illinois	85.1	3,324	77.1	4,501	86.3	3,182
Indiana	97.3 *	3,199	97.0 *	5,105	97.4 *	2,918
Iowa	93.0 *	3,657	93.2 *	4,723	92.9 *	3,446
Kansas	95.4 *	3,398	94.9 *	3,481 *	95.5 *	3,382
Kentucky	92.6 *	3,248	85.3	3,878	93.6 *	3,207
Louisiana	94.4 *	3,383	85.0	3,570	96.2 *	3,356
Maine	98.1 *	3,895	96.9 *	6,098 *	98.3 *	3,650
Maryland	83.2	2,943	80.6	3,615	83.8	2,805
Massachusetts	83.9	2,729 *	80.0	3,227	84.6	2,652 *
Michigan	94.0 *	3,062	87.8	4,181	95.0 *	2,876
Minnesota	95.9 *	4,033 *	94.7 *	5,599	96.1 *	3,843 *
Mississippi	94.1 *	3,707	97.2 *	3,589	93.6 *	3,720
Missouri	86.5	3,539	92.9 *	3,896	85.4	3,467
Montana	95.0 *	3,498	99.2 *	5,740	93.8	2,993
Nebraska	97.8 *	3,272	95.9 *	5,236	98.0 *	3,087
Nevada	82.7	3,710	75.8	4,021	83.7	3,660
New Hampshire	94.0 *	4,644 *	93.8 *	7,081 *	94.0 *	4,357 *
New Jersey	85.8	3,614	83.6	4,463	86.2	3,472
New Mexico	92.6 *	3,021	85.1	5,592	94.0 *	2,725

	All Private-Sector Establishments		Firm Size: Less than 50 Employees		Firm Size: 50 or More Employees	
	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)	Share in a plan with a deductible (%)	Avg. deductible ($)
New York	75.2 *	2,888 *	74.8	3,504	75.3 *	2,766
North Carolina	88.2	3,752	90.1	5,372	87.9	3,608
North Dakota	94.4 *	3,574	91.0 *	3,634	95.2 *	3,562
Ohio	90.3	3,738	87.5	4,808	90.7	3,616
Oklahoma	93.3 *	3,201	97.0 *	4,759	92.5 *	2,909
Oregon	93.0 *	3,348	92.6 *	4,234	93.1 *	3,242
Pennsylvania	90.4 *	2,994	86.5	3,609	91.1	2,926
Rhode Island	89.6	3,795	93.9 *	3,616	88.5	3,845
South Carolina	95.3 *	3,124	89.1	3,956	96.0 *	3,080
South Dakota	98.5 *	4,002 *	98.5 *	5,160	98.5 *	3,746 *
Tennessee	94.3 *	3,879	90.1	5,669	94.9 *	3,676
Texas	93.6 *	3,547	87.9	5,422	94.3 *	3,393
Utah	97.1 *	3,164	98.4 *	3,814	96.9 *	3,092
Vermont	93.2 *	3,686	91.7 *	3,823	93.6 *	3,657
Virginia	90.6	3,043	90.5 *	3,684	90.6	2,982
Washington	95.6 *	3,139	97.5 *	4,565	95.2 *	2,909
West Virginia	91.2	2,923	91.3 *	4,218	91.2	2,806
Wisconsin	94.1 *	3,619	88.1	4,297	95.0 *	3,539
Wyoming	96.0 *	3,902 *	94.8 *	5,054	96.2 *	3,671

Source: Urban Institute analysis of 2018 Medical Expenditure Panel Survey-Insurance Component data.

Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, + = suppressed estimate, excluded from significance testing, * state average differs significantly from US average at the .05 level or higher, differences in the share in a plan with a deductible between small and large firms are significant for the US and for AK, CA, DE, GA, HI, LA, and TX, differences in the average deductible between small and large firms are significant for the US and for CT, FL, GA, ID, IN, IA, ME, MI, MN, MT, NE, NH, NJ, NM, NC, OH, OK, SD, TN, TX, WA, WV, and WY.

TABLE A.7

Percent of Employees in Private-Sector Establishments Enrolled in ESI with an Out-of-Pocket Maximum and Average Family Out-of-Pocket Maximum (in dollars) for Family Coverage Overall and by Firm Size, 2018

	All Private-Sector Establishments		Firm Size			
			Less than 50 Employees		50 or More Employees	
	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)
United States	93.3	8,375	83.6	9,025	94.7	8,294
Alabama	88.9	8,036	69.9	10,274	92.4	7,725
Alaska	96.1	9,004	91.2	7,724	97.0	9,230 *
Arizona	98.2 *	8,115	95.4 *	9,054	98.7 *	7,970
Arkansas	90.1	8,639	86.4	7,447	90.7	8,843
California	89.2	7,953	75.9	9,056	91.3	7,806
Colorado	96.1	8,476	80.6	9,406	98.8 *	8,346
Connecticut	92.4	8,985	81.5	9,181	94.1	8,959
Delaware	94.9	8,003	79.9	8,204	96.1	7,989
District of Columbia	93.1	6,206 *	82.3	7,198 *	94.8	6,066 *
Florida	98.1 *	8,631	93.0	8,646	98.8 *	8,629
Georgia	97.2 *	8,541	88.0	10,610	98.0 *	8,369
Hawaii	91.4	8,341	71.4	6,972 *	94.6	8,508
Idaho	94.3	8,380	82.5	10,889 *	95.8	8,100
Illinois	94.6	7,316 *	90.9	7,981	95.1	7,232 *
Indiana	95.2	8,140	97.1 *	9,231	95.0	7,978
Iowa	95.6	7,884	90.9	8,567	96.5	7,762
Kansas	96.6 *	8,679	87.8	7,167 *	98.3 *	8,934
Kentucky	95.3	8,203	88.1	7,714	95.7	8,233
Louisiana	92.4	8,136	91.4	7,604	92.6	8,223
Maine	94.2	8,460	92.0	10,844 *	94.4	8,199
Maryland	96.6	8,157	89.8	8,554	98.0 *	8,083
Massachusetts	92.1	7,622	65.0	9,626	96.3	7,413
Michigan	90.0	8,502	79.4	8,925	91.9	8,436
Minnesota	97.1 *	8,104	96.9 *	9,058	97.1	7,984
Mississippi	98.8 *	9,025	96.1 *	8,932	99.1 *	9,035
Missouri	93.1	8,055	86.1	7,685	94.3	8,115
Montana	96.3	7,796	91.0	9,003	97.4	7,553
Nebraska	98.8 *	8,728	97.7 *	9,005	98.9 *	8,700
Nevada	92.3	9,606	84.4	11,465 *	93.5	9,362
New Hampshire	94.0	8,373	69.5	11,222 *	97.2	8,112
New Jersey	94.1	8,807	82.5	9,392	96.2	8,720

	All Private-Sector Establishments		Firm Size: Less than 50 Employees		Firm Size: 50 or More Employees	
	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)	Share in a plan with an out-of-pocket maximum (%)	Avg. out-of-pocket maximum ($)
New Mexico	87.5	8,350	82.7	12,333 *	88.2	7,865
New York	89.3	8,570	70.4	9,393	92.8	8,454
North Carolina	84.1 *	8,936	79.2	10,478	84.6 *	8,804
North Dakota	95.1	7,378 *	90.5	6,552 *	96.1	7,556
Ohio	93.9	8,284	85.0	8,812	94.9	8,228
Oklahoma	92.9	8,599	83.1	8,965	94.6	8,542
Oregon	97.5 *	9,794	95.8 *	9,291	97.7	9,850
Pennsylvania	88.9	8,478	81.6	8,686	89.8	8,455
Rhode Island	89.8	8,921	73.6	8,226	94.1	9,067
South Carolina	95.4	8,818	79.2	7,543	96.3	8,881
South Dakota	96.4	8,541	94.9 *	9,310	96.8	8,376
Tennessee	95.5	8,397	100.0 *	9,889	94.9	8,208
Texas	93.9	8,778	88.6	9,824	94.3	8,688
Utah	96.8	8,963	97.8 *	8,750	96.7	8,987
Vermont	91.6	8,612	89.5	9,566	92.0	8,421
Virginia	97.6 *	8,667	97.0 *	8,418	97.7 *	8,691
Washington	95.3	8,458	85.8	10,846	96.7	8,145
West Virginia	90.3	9,831	89.4	9,933	90.4	9,821
Wisconsin	96.3	8,252	78.2	7,921	98.8 *	8,288
Wyoming	94.7	9,064	75.8	9,254	99.2 *	9,030

Source: Urban Institute analysis of 2018 Medical Expenditure Panel Survey-Insurance Component data.

Notes: *P*-values are adjusted using the Benjamini-Hochberg procedure for multiple comparisons. ^ = unreliable estimate, excluded from significance testing, * state average differs significantly from US average at the .05 level or higher. Differences in the share in a plan with an out-of-pocket maximum between small and large firms are significant for the US and for AL, CA, CO, CT, GA, HI, KS, MA, NH, NJ, NY, RI, SC, TN, WI, and WY. Differences in the average out-of-pocket maximum between small and large firms are significant for the US and for AL, CA, GA, ID, KS, ME, MA, NV, NH, NM, NC, TN, TX, and WA. In 2018, the national average out-of-pocket maximum for family Marketplace coverage was $2,040 for the 94 actuarial value cost sharing reduction variant (100–150% of FPL) and $4,436 for the 87 actuarial value cost sharing reduction variant (151–200% of FPL).

Notes

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[3] "State-Level Trends in Employer-Sponsored Health Insurance, 2014–2018," State Health Access Data Assistance Center, August 2019, https://www.shadac.org/ESIReport2019.

[4] 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/.

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[21] Vermont and California also have additional subsidies to increase the affordability of Marketplace plans. We do not include them here because we have focused our study on 2018 (the most recent year of ESI data available) and these subsidies began in 2020. Vermont provides additional cost-sharing subsidies to individuals and families up to 300 percent of FPL. California provides additional premium subsidies for individuals and families from 200 to 400 percent of FPL. Additionally, California provides some premium assistance for those above 400 percent and up to 600 percent of FPL. See Tolbert, Diaz, et al. (2019).

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