Employer-Sponsored Insurance Stays Strong, with No Signs of Decay under the ACA: Findings through March 2016

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At a Glance

- Employer-sponsored insurance coverage, offer, and take-up rates remained unchanged among nonelderly workers from June 2013 to March 2016.
- Coverage, offer and take-up rates were stable for workers in small and large firms and for workers with high and low incomes.
- These rates remained stable among workers most susceptible to declines if ESI were to erode under the ACA (e.g., those with low education, in racial and ethnicity minority groups, and in areas with stronger public options). ESI offer rates increased among workers with the lowest level of education, and offer and coverage increased among Hispanic workers.

Before the changes introduced under the Affordable Care Act (ACA), employer-sponsored insurance (ESI) coverage had been declining. Between 2000 and 2012, for example, ESI coverage rates for nonelderly workers fell 11 percent, from 76.9 percent to 69.4 percent. Among workers in firms with fewer than 50 employees, coverage rates fell 17 percent, from 61.1 percent to 52.4 percent.[1] Some have argued that the changes introduced under the ACA would accelerate this trend because the greater availability of coverage outside of work would make it easier for employers to stop offering coverage.[2] The subsidies provided in the ACA, along with the availability of Medicaid for most adults up to 138 percent of the federal poverty level (FPL) in states that expanded Medicaid (Medicaid expansion states), may lead to changes in employer decisions to offer coverage and employee decisions to take up those offers. If ESI erodes as more people take up other coverage, the government cost of the ACA will increase, potentially to a point at which the cost of subsidies and expanded Medicaid coverage may make the law unaffordable.

However, although there was some expectation that the long-term decline in ESI would continue or worsen with the changes introduced under the ACA, several federal and private surveys find that ESI coverage has remained stable or has actually increased since the end of 2013 (Blavin et al. 2014, 2015; Carmen, Eibner, and Paddock 2015; Collins, Gunja, and Beutel 2015). These findings are consistent with the increases in ESI coverage rates observed in Massachusetts following the implementation of that state's health reform (Long and Stockley 2010).

This brief updates a previous study that examined changes in ESI coverage, offer, and take-up rates from June 2013, just before the rollout of major provisions of the ACA, to March 2015 (Blavin et al. 2015). This updated analysis has two major contributions. First, it includes 12 additional months in the study period (through March 2016) to highlight the longer-term experience of workers—overall and by income and firm size—under the ACA. Although it is too soon to know the long-term course of ESI, we are now over two years into the implementation of the ACA's major insurance coverage expansions. Accordingly, if such a drop off in employer coverage were to occur, we should begin to see it. Second, this analysis also focuses on specific groups of workers that

would most likely experience declines in offer, take-up, and coverage if ESI were to erode under the ACA. In addition to low-income workers in small firms, we look at changes in ESI among workers with low education levels, workers in racial and ethnicity minority groups, and workers in areas with stronger public options (i.e., Medicaid expansion states versus nonexpansion states).

Similar to our previous findings, we continue to find little to no change in ESI offer, take-up, or coverage rates under the ACA, overall and among groups where we would expect to see the first cracks.

Background

The ACA has the potential to affect employers' financial incentive to offer health insurance to their workers. All else equal, easier availability of coverage, particularly subsidized coverage, outside of employment relationships would reduce the incentives firms face to offer health insurance to their employees. Thus, the establishment of individual insurance Marketplaces under the ACA and the availability of sliding-scale federal subsidies for individuals with family incomes between 100 and 400 percent of FPL could reduce the incentive for firms to offer coverage, particularly for firms with a large share of low-wage workers eligible for more-generous subsidies. Similarly, the Medicaid expansion could reduce worker take-up of ESI and reduce the total health care costs of firms that offer affordable coverage because workers can enroll in Medicaid without a penalty to employers.

However, there are several reasons why ESI could remain stable and possibly increase under the ACA. First, workers receive substantial benefits through the tax system from obtaining coverage through employers. This, in turn, gives employers a strong financial incentive to offer coverage, though those incentives are greater for workers with higher incomes because of higher marginal tax rates. With the exception of the "Cadillac tax," a 40 percent excise tax on high-cost employer health coverage beginning in 2020, nothing in the ACA changes the tax treatment of ESI. Thus, the strong financial incentives for employers to offer coverage are maintained.

Second, the ACA contains a new requirement that employers with more than 50 workers, if at least one of their full-time employees received subsidies for the purchase of coverage in the Marketplace, provide ESI meeting certain standards or face a penalty. Although the employer requirement should help maintain employer offers, the final rules were delayed until January 2015[3] and 2016 (for smaller firms) and thus should currently have little effect. Third, tax credits are available for small firms, but the take-up of these credits appears fairly limited at this point. Similarly, availability of small-business health options program (SHOP) Marketplaces also hold promise to make it easier for employers to obtain coverage, but these too have been difficult to get off the ground.

Finally, with the individual mandate, individuals are required to have coverage or pay a tax penalty. Employers may find it increasingly advantageous to their recruitment of workers to offer coverage. The combination of the individual mandate and the tax exclusion of employer contributions to health insurance create powerful incentives for the continuation of ESI.

Prior research on this topic has been summarized by Blavin and colleagues (2014).

Data and Methods

The Urban Institute has used its Health Reform Monitoring Survey (HRMS) to examine trends in health insurance coverage since the first quarter of 2013. The HRMS is one of several surveys,

including those conducted by federal agencies and other private research organizations, that have found a decline in the share of nonelderly adults without health insurance since the implementation of the key coverage provisions of the ACA. Between September 2013 and March 2016, 15.5 million nonelderly adults have gained coverage (Karpman, Long, and Zuckerman 2016).

Building on the earlier related studies, we use the HRMS to examine changes in ESI coverage, take-up, and offer rates from June 2013 to March 2016, before and after the implementation of the ACA's major coverage expansions. The overall sample size for the HRMS is roughly 7,500 nonelderly adults per round. The HRMS provides early feedback on changes under the ACA to complement the more robust impact assessments as federal survey data become available.[4]

In this analysis, we define workers as nonelderly adults ages 18 to 64 who report working for pay or who are self-employed. The HRMS asks adults who do not report having ESI coverage whether their employer or a family member's employer offers health insurance that could cover the respondent. Adults who report having ESI coverage are presumed to have an offer through their own or a family member's employer. The ESI take-up rate is defined as the share of workers who report ESI among all workers who have an offer of coverage. For both ESI coverage and offers, the source within the family—self or another worker—is unobservable in the HRMS.

It is important to note that other surveys have slightly different definitions of offer and take-up of ESI. For instance, in the Current Population Survey, offer is defined as the percentage of workers who report that their employer offers health insurance to at least some of its employees, and take-up is defined as the percentage of eligible workers—those who report being eligible for offered coverage—who took offered coverage. In addition, other major data sources for ESI offer and take-up (e.g., the Medical Expenditure Panel Survey Insurance Component) are collected through employers rather than workers and may not fully reflect the experiences of workers and their families.

We analyzed these outcomes among key subpopulations of workers, including by firm size (fewer than 50 workers versus 50 workers or more) and by family income (below 250 percent of FPL versus 250 percent of FPL or more [to ensure sufficient sample size]). In contrast to previous briefs, we also include estimates by race and ethnicity (white non-Hispanic, black or other non-Hispanic, and Hispanic), educational attainment (less than high school degree, high school, some college, college), and residence in a Medicaid expansion or nonexpansion state.[5] We also report changes by expansion status and family income, with emphasis on those potentially eligible for Medicaid (incomes at or below 138 percent of FPL) and subsidized Marketplace coverage (incomes from 139 to 399 percent of FPL).[6] We exclude workers who do not report work status or firm size from the analysis.

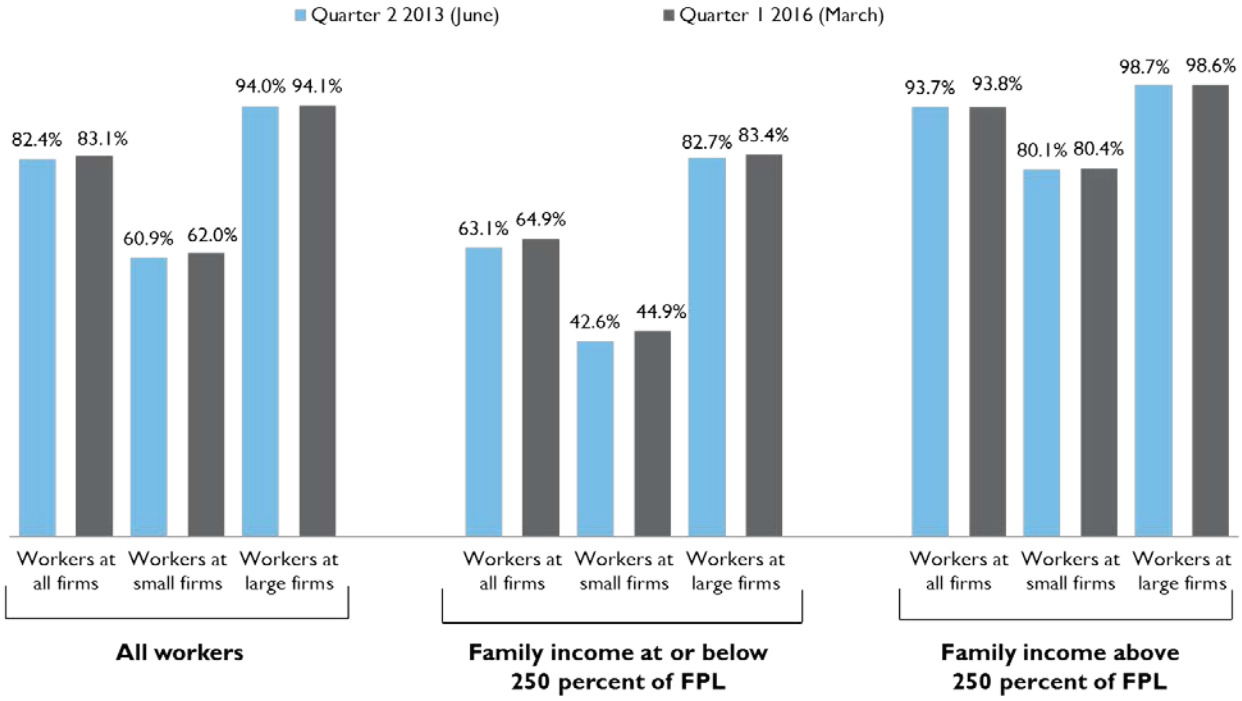
Although each round of the HRMS is weighted to be nationally representative, it is important in examining changes over time that we base our estimates on comparable samples. For example, if the share of those with ESI grows simply because more respondents were older or from higher income groups in one round of the survey, it would be incorrect to associate such a change with the ACA coverage provisions. As such, we report regression-adjusted trends that correct for the effects of observed shifts in the characteristics of the survey respondents across the survey.[7]

Results

By Income and Firm Size

Figures 1–3 present ESI offer, take-up, and coverage rates, respectively, for nonelderly workers in June 2013 and March 2016 overall and by family income and firm size. As shown in figure 1, no statistically significant changes occurred in ESI offer rates over the study period. Offer rates stayed roughly constant at 82 to 83 percent for all workers, 61 to 62 percent for workers in small firms, and 94 percent for workers in large firms. This stability also holds true when we look at lower- and higher-income workers. For workers with family incomes less than 250 percent of FPL, we see small increases in offer rates in all firm size categories, though none are statistically significant.

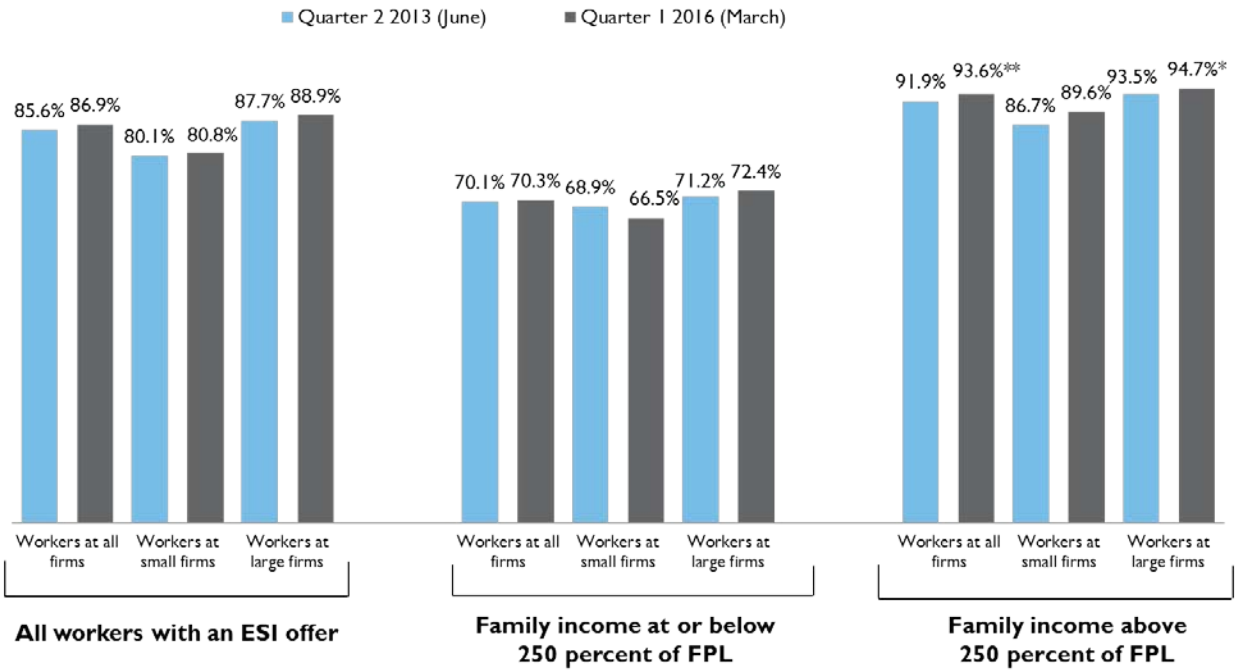
Figure 1. Share of Workers Ages 18 to 64 with an Offer of Employer-Sponsored Insurance Coverage in June 2013 and March 2016, by Family Income Category and Firm Size



Source: Health Reform Monitoring Survey, quarter 2 2013 and quarter 2 2016.
Notes: Estimates are regression adjusted. FPL is federal poverty level. Workers include nonelderly adults who are working for pay or self-employed. Small firms include firms with fewer than 50 workers and self-employed adults. Large firms include those with 50 or more workers. Respondents are coded as having an ESI offer if their own or a family member's employer offers health insurance or if they report having ESI coverage.
*/**/*** Estimate for March 2016 differs significantly from the June 2013 estimate at the 0.1/0.05/0.01 levels, using two-tailed tests.

ESI take-up rates (figure 2) also remain unchanged among workers with an ESI offer, at about 86 to 87 percent for all workers, 81 to 82 percent for workers in small firms, and 88 to 89 percent for workers in large firms. For workers with family incomes above 250 percent of FPL, a small and statistically significant increase occurred in take-up rates, primarily driven by workers at large firms.

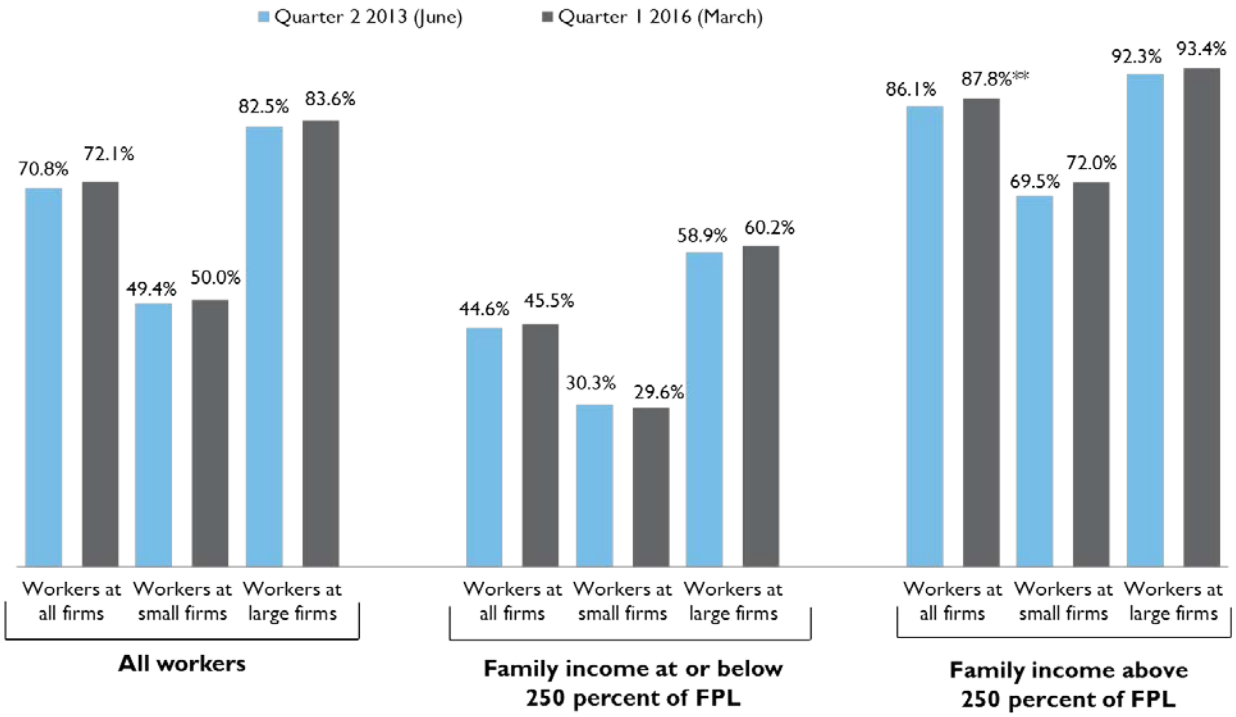
Figure 2. Share of Workers Ages 18 to 64 Who Accepted an Offer of Employer-Sponsored Insurance Coverage in June 2013 and March 2016, by Family Income Category and Firm Size



Source: Health Reform Monitoring Survey, quarter 2 2013 and quarter 2 2016.
Notes: Estimates are regression adjusted. FPL is federal poverty level. Workers include nonelderly adults who are working for pay or self-employed. Small firms include firms with fewer than 50 workers and self-employed adults. Large firms include those with 50 or more workers. Respondents are coded as having an ESI offer if their own or a family member's employer offers health insurance or if they report having ESI coverage.
The sample in this figure includes only those with an offer of employer-sponsored insurance coverage.
*/**/*** Estimate for March 2016 differs significantly from the June 2013 estimate at the 0.1/0.05/0.01 levels, using two-tailed tests.

Overall ESI coverage rates among workers also remained unchanged. ESI remained at 71 to 72 percent for all workers, 49 to 50 percent for workers in small firms, and 83 to 84 percent for workers in large firms. Consistent with the take-up findings, ESI increased among higher-income workers, from 86.1 percent in June 2013 to 87.8 percent in March 2016. The increases in ESI coverage among higher-income workers by firm size are not statistically significant.

Figure 3. Share of Workers Ages 18 to 64 with Employer-Sponsored Insurance Coverage in June 2013 and March 2016, by Family Income Category and Firm Size



Source: Health Reform Monitoring Survey, quarter 2 2013 and quarter 2 2016.
Notes: Estimates are regression adjusted. FPL is federal poverty level. Workers include nonelderly adults who are working for pay or self-employed. Small firms include firms with fewer than 50 workers and self-employed adults. Large firms include those with 50 or more workers.
*/**/*** Estimate for March 2016 differs significantly from the June 2013 estimate at the 0.1/0.05/0.01 levels, using two-tailed tests.

By Educational Attainment

If ESI were to erode under the ACA, we would expect that, as with low-income workers, workers with lower levels of education would be more susceptible to declines. However, we find that the ESI offer rate among adult workers without a high school degree increased 8.8 percentage points, from 50.9 percent in June 2013 to 59.7 percent in March 2016 ($p < 0.1$; table 1). This change appears to be driven by an increase in offer among workers with low education levels in small firms (data not shown, because of small sample size). The observed increases ESI take-up and coverage rates are not statistically significant at conventional levels. Table 1 also shows no statistically significant changes in any outcomes among high school graduates and those with some college education.

Table 1. Share of Workers Ages 18 to 64 with an Offer of Employer-Sponsored Insurance Coverage in June 2013 and March 2016, by Educational Attainment

	June 2013	March 2016	Percentage-point change
Less than high school			
Sample size	198	281	
Offer	50.9%	59.7%	8.8%*
Take-up	67.7%	69.1%	1.5%
Coverage	34.6%	40.7%	6.0%
High school			
Sample size	922	1281	
Offer	76.4%	76.7%	0.3%
Take-up	80.4%	82.6%	2.2%
Coverage	61.8%	63.1%	1.2%
Some college			
Sample size	1588	1599	
Offer	81.7%	83.0%	1.3%
Take-up	84.2%	85.0%	0.7%
Coverage	68.9%	70.7%	1.8%
College			
Sample size	2297	2017	
Offer	93.1%	92.0%	-1.1%*
Take-up	92.0%	92.9%	0.9%
Coverage	85.6%	85.4%	-0.2%

Source: Health Reform Monitoring Survey, quarter 2 2013 and quarter 2 2016.
Notes: Estimates are regression adjusted. FPL is federal poverty level. Workers include nonelderly adults who are working for pay or self-employed.
*/**/*** Estimate for March 2016 differs significantly from the June 2013 estimate at the 0.1/0.05/0.01 levels, using two-tailed tests.

In contrast, the ESI offer rate among college graduates decreased 1.1 percentage points, from 93.1 percent in June 2013 to 92.0 percent in March 2016 ($p < 0.1$). This change is driven by a statistically significant 6.1 percentage-point decline in offer rates among college graduates in small firms (data not shown). No change occurred in offer rates among all workers because the decline in offer rates among college graduates swamps the increase among the lowest education group. ESI take-up and coverage rates among this group remained unchanged.

By Race and Ethnicity

Table 2 shows changes in outcomes by race and ethnicity. In general, ESI offer, take-up, and coverage rates remained stable for non-Hispanic groups. The one exception is a 1.7 percentage-point increase in take-up among white, non-Hispanic workers; that rate increased from 88.6 percent in June 2013 to 90.3 percent in March 2016.

Table 2. Share of Workers Ages 18 to 64 with an Offer of Employer-Sponsored Insurance Coverage in June 2013 and March 2016, by Race/Ethnicity

	June 2013	March 2016	Percentage-point change
White, non-Hispanic			
Sample size	3799	3700	
Offer	86.7%	85.7%	-1.0%
Take-up	88.6%	90.3%	1.7%***
Coverage	76.7%	77.4%	0.7%
Black or other, non-Hispanic			
Sample size	660	766	
Offer	83.0%	82.3%	-0.7%
Take-up	85.1%	82.7%	-2.4%
Coverage	70.6%	68.5%	-2.1%
Hispanic			
Sample size	546	672	
Offer	62.7%	72.8%	10.1%***
Take-up	71.8%	74.7%	2.9%
Coverage	46.0%	53.3%	7.3%**

Source: Health Reform Monitoring Survey, quarter 2 2013 and quarter 2 2016.
Notes: Estimates are regression adjusted. FPL is federal poverty level. Workers include nonelderly adults who are working for pay or self-employed.
*/**/*** Estimate for March 2016 differs significantly from the June 2013 estimate at the 0.1/0.05/0.01 levels, using two-tailed tests.

In contrast, there were statistically significant increases in ESI offer and overall coverage rates among Hispanic workers. From June 2013 to March 2016, ESI offer rates among this group increased 10.1 percentage points, from 62.7 percent to 72.8 percent, and ESI coverage increased 7.3 percentage points, from 46.0 percent to 53.3 percent. Offer rates increased among Hispanic workers in both small and large firms but overall ESI coverage only increased among those in small firms. These changes also only occurred among lower-income Hispanic workers (data not shown).

By State Medicaid Expansion Status

Holding all else constant, if ESI were to erode under the ACA, we would expect that workers in states that expanded Medicaid would be most vulnerable because of the availability of another subsidized public insurance option. Overall, no significant changes occurred in ESI offer, take-up, or coverage rates among both low- and high-income adults in states that expanded Medicaid. However, there was a significant 2.7 percentage-point increase in take-up among adults in nonexpansion states, and there were significant increases in take-up (2.2 percentage points) and ESI coverage (2.9 percentage points) rates among higher-income adults in nonexpansion states.

Table 3. Share of Workers Ages 18 to 64 with an Offer of Employer-Sponsored Insurance Coverage in June 2013 and March 2016, by State Medicaid Expansion Status and Firm Size and Income

	Overall		< 138% FPL		138–400% FPL		400% FPL	
	June 2013	March 2016	June 2013	March 2016	June 2013	March 2016	June 2013	March 2016
Expansion state								
Sample size	3383	3198	400	386	1492	1231	1491	1581
Offer	82.8%	83.7%	46.5%	50.4%	82.4%	82.8%	95.0%	95.7%
Take-up	87.1%	87.3%	56.4%	61.7%	84.2%	83.6%	93.9%	94.3%
Coverage	72.4%	73.0%	26.9%	31.1%	69.7%	69.2%	89.3%	90.3%
Nonexpansion state								
Sample size	1622	1940	229	291	767	852	626	797
Offer	81.8%	82.1%	48.4%	52.7%	86.7%	84.3%*	95.3%	96.0%
Take-up	83.3%	86.1%**	54.2%	56.6%	82.3%	86.0%	93.0%	95.2%**
Coverage	68.4%	70.5%	27.0%	29.5%	71.3%	72.4%	88.5%	91.4%**

Source: Health Reform Monitoring Survey, quarter 2 2013 and quarter 2 2016.
Notes: Estimates are regression adjusted. PPC is percentage-point change; FPL is federal poverty level. Workers include nonelderly adults who are working for pay or self-employed.
*/**/*** Estimate for March 2016 differs significantly from the June 2013 estimate at the 0.1/.05/.01 levels, using two-tailed tests.

Conclusion

As with our previous studies, we found no evidence that ESI offer, take-up, and coverage rates fell from June 2013 to March 2016, either overall or for workers with lower incomes or in small firms. In fact, we find some evidence that ESI take-up actually increased among higher-income workers in large firms. These results likely reflect the effects of the individual mandate as well as strong tax incentives to obtain coverage from employers. Because of those tax incentives, most workers are financially better-off if they obtain ESI coverage. Consequently, employers now have increased incentives to maintain their offers for coverage and workers have increased incentives to take up that coverage when it is available.

We also find that offer, take-up, and coverage rates remained stable among various types of workers that would be most susceptible to declines if ESI were to erode under the ACA. In fact, we find that the ESI offer rate actually increased among workers with the lowest level of education, and ESI offer and coverage rates significantly increased among Hispanic workers. We also found that the three ESI outcomes remained unchanged among low- and high-income adults in states that expanded Medicaid coverage. This finding most strongly suggests that the ACA has not caused employers to drop ESI coverage or caused workers to seek coverage from the ACA's Marketplace or Medicaid expansion.

As mentioned, these results are consistent with the findings from other surveys that found stability in ESI in 2014 or 2015. These results are also consistent with the predictions from several microsimulation studies conducted before the ACA and with experiences in Massachusetts under that states 2006 reform initiative. For example, the Congressional Budget Office projects that under the ACA, 4 to 9 million fewer people will have ESI each year from 2017 through 2026 than would have without the ACA (Congressional Budget Office 2016). RAND estimated that the ACA would lead to a net increase of 8.0 million people with ESI relative to a scenario without reform (Eibner, Hussey, and Girosi 2010). Other microsimulation models—for example, that of the Lewin Group and the Urban Institute—predict changes in overall ESI within the range of the estimates from RAND and the Congressional Budget Office (Blumberg et al 2012; Lewin Group 2010). Finally, the

experience from Massachusetts suggests that an individual mandate along with a relatively weak employer mandate actually increased the rate of ESI coverage (Long and Stockley 2010). Thus, findings to date all suggest that ESI should stay relatively stable under the ACA.

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About the Series

This brief is part of a series drawing on the HRMS, a survey of the nonelderly population that explores the value of cutting-edge Internet-based survey methods to monitor the ACA before data

from federal government surveys are available. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

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Notes

[1] Urban Institute calculations from the 2001 and 2013 Current Population Surveys.

[2] For example, see Holtz-Eakin and Smith (2010).

[3] Employers with plan years that do not start on January 1 will be able to begin compliance with employer responsibility at the start of their plan years in 2015. See US Department of Treasury (2014).

[4] Benchmarking of the HRMS data against federal survey data is provided in Long et al. (2014).

[5] We define expansion status based on state decisions to expand Medicaid by January 1, 2016. The states that expanded Medicaid by this date are AK, AZ, AR, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, MD, MA, MI, MN, MT, NH, NV, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV. Several of those states, including CA, CT, DC, and MN, expanded Medicaid under the ACA before 2013. Among nonexpansion states, WI has used state funding to expand eligibility to nonelderly adults with incomes up to 100 percent of FPL, and LA is planning to expand eligibility for Medicaid by mid-2016. Because our definition of states expanding Medicaid changes as more states adopt the expansion, estimates based on state Medicaid expansion status are not necessarily comparable over time.

[6] The HRMS did ask respondents about the income break at 100 percent of FPL in the pre-ACA timeframe (June 2013). We can therefore only provide an approximation for eligibility in nonexpansion states. In addition, the income measure used in the HRMS is not the same as the measure of modified adjusted gross income used to determine eligibility for Medicaid and Marketplace tax credits. Estimated levels of family income as a percentage of FPL only provide an approximation of whether respondents are in the income ranges targeted by the Medicaid expansion and Marketplace tax credits.

[7] Specifically, we control for the variables used in the poststratification weighting of the KnowledgePanel (the Internet-based survey panel that underlies the HRMS) and the poststratification weighting of the HRMS. These variables are sex, age, race and ethnicity, language, education, marital status, presence of children in the household, household income, family income as a percentage of FPL, homeownership status, Internet access, urban or rural status, and census region. In this analysis, we also control for citizenship status and participation in the previous quarter's survey (i.e., whether the respondent completed the survey in the previous quarter, was sampled in the previous quarter but did not complete the survey, or was not sampled in the previous quarter). Beginning in September 2015, we shifted to a more parsimonious regression model to better support subgroup analyses. Specifically, we collapsed detailed categories for some covariates and dropped some interaction terms.