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# EMPLOYER-SPONSORED HEALTH INSURANCE IN TENNEESSEE: WHAT IS HAPPENING TO COVERAGE?

## I. WHAT IS THE ISSUE?

Employer-sponsored insurance (ESI) is the mainstay of health insurance coverage in the United States. In 2014, 61.8 percent of all Americans who were insured at any time during the year and 83.9 percent of those with any form of private health insurance were covered by ESI.[1] Over the past several years, however, the performance of this system has been challenged. National data have indicated declines in the number of firms offering ESI and in the proportion of persons covered through ESI. For example, the proportion of all firms offering ESI fell from 69.0 percent in 2010 to 55.0 percent in 2014.[2]

Most recently, the impacts of various provisions of the Patient Protection and Affordable Care Act (ACA) on the ESI market have been of particular concern. Now, after more than four years of ACA implementation, data from national surveys have begun to provide empirical evidence on the early impact of the ACA on ESI. In this report, we will examine some of these data for the state of Tennessee to explore the ACA's impact on such key performance characteristics of ESI as the proportion of

[1]J. C. Smith and C. Medalia, *Health Insurance Coverage in the United States, 2014* (Washington, DC: United States Census Bureau, U.S. Department of Commerce, September 2015).

[2]Kaiser Family Foundation and the Health Research and Education Trust, *Employer Health Benefits. 2014 Annual Report* (Menlo Park, CA, and Chicago, IL: Kaiser Family Foundation and the Health Research and Education Trust, 2015).

Tennessee employers that offer health insurance and the percentage of workers who are covered.

## II. WHAT IS THE BACKGROUND?

The ACA has many components that interact in complex ways to impact ESI coverage,[3] and several of these components may be expected to increase ESI coverage.[4] These include: (a) the continuation of the tax advantages of ESI to employers and employees that allow, for example, the former group to treat their contributions to employee healthcare costs as business expenses and the latter group to not include the value of ESI as taxable income; (b) the individual insurance mandate that may be expected to increase ESI enrollment by eligible workers; (c) the availability of lower-cost ESI options through Small Business Health Option (SHOP) plans for smaller companies; (d) tax credits for small businesses with limited average salaries; and (e) "pay or play" penalties on larger employers who choose not to offer ESI to workers when at least one then receives a federal subsidy in the Marketplace.

Other components of the ACA have been projected to substantially reduce insurance coverage. These include: (a) the availability of subsidized insurance plans through the Marketplace health insurance exchanges that may be less expensive to employees than ESI coverage; (b) expanded Medicaid eligibility leading to "crowd-out" of private coverage by public-sector alternatives; (c) excise taxes on high-cost plans,

[3]For additional information, see, for example, *Affordable Care Act. Summary of Provisions Affecting Employer-Sponsored Insurance* (Berkeley, CA: University of California Berkeley, July 2014).

[4]F. Blavin, A. Shartzer, S. K. Long, and J. Holahan, "An Early Look at Changes in Employer-sponsored Insurance under the Affordable Care Act," *Health Affairs* 34(1):170-177, 2015.

the so-called “Cadillac tax” to be enacted in 2018; and (d) reduced pressure on employers to offer coverage as other options become available for their employees.

Projections of the resulting net impact of ACA have varied widely. A survey of 1,300 companies by McKinsey and Company suggested that 9.0 percent of employers would definitely and an additional 21.0 percent would likely stop offering ESI after full ACA implementation; more than 50.0 percent of employers with a high level of expertise in the ACA responded that they would definitely or probably stop offering ESI.[5] The Congressional Budget Office projected a more modest decline in ESI of 6.0-8.0 million covered individuals.[6] In contrast, the RAND Corporation suggested that ESI coverage would increase by 8.0 million.[7]

The impacts of the ACA are compounded by other factors. These include the ongoing, pre-ACA trend of falling ESI coverage and the improving economy that may be anticipated to expand both ESI offering and enrollment by eligible employees. The net effect of these countervailing forces is thus an empirical question.

[5]McKinsey and Company, “How US Health Care Reform will Affect Employee Benefits.” Available at http://www.mckinsey.com/. Accessed October 16, 2015.

[6]Congressional Budget Office, “Effects of the Affordable Care Act on Health Insurance Coverage - Baseline Projections. March 2015 Baseline.” March 2015. Available at https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf. Accessed October 16, 2015.

[7]C. Eibner, P. S. Hussey, and F. Gerosi, “The Effects of the Affordable Care Act on Workers’ Health Insurance Coverage,” *New England Journal of Medicine* 363:1393-95.

## III. WHAT HAVE BEEN THE ESI TRENDS IN TENNESSEE?

For this report, we examined selected data from the most recent and previous releases of the Medical Expenditure Panel Survey (MEPS).[8] Specifically, we analyzed results from the Insurance Component (MEPS-IC) of the surveys that includes responses from a sample of 39,000 private and public employers, including data on the types (if any) of health insurance that are offered, the proportion of employees eligible for coverage, and the proportion who enroll.[9]

Firms Offering ESI. The final enrollment of an employee in an ESI plan occurs in several stages. First, the employer must offer one or more ESI plans to its employees. Second, the employee must be eligible for the coverage that is offered; an employer may elect to cover only selected categories of workers and their family members. And third, the eligible employee must choose to enroll. Information on each of these steps will be presented in this section.

Trends in the proportion of Tennessee firms offering ESI between 2010 and 2014 (the most recent year with available data) are shown in Exhibit I. Data are presented for all firms and for firms stratified by size, with large firms defined as those with 50 or more employees and small firms as those with fewer than 50 employees.

The trend lines in Exhibit I show that the proportion of all Tennessee firms offering ESI declined from 55.9 percent in 2010 to 48.5 percent in 2014, a decline of 7.4

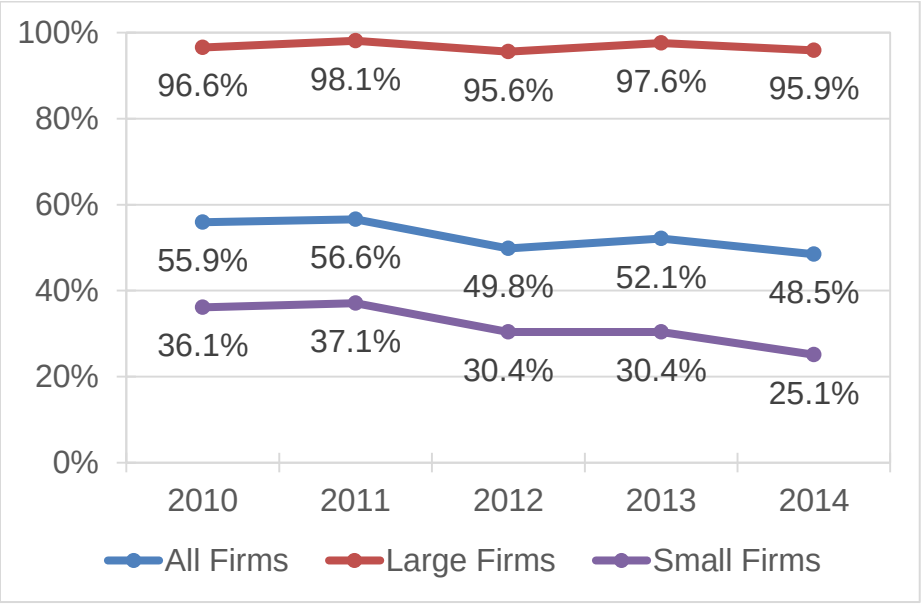
[8]The Medical Expenditure Panel Survey (MEPS). Available at: http://meps.ahrq.gov/mepsweb/.

[9]For more details, see http://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp.

percentage points. This represents a decrease of approximately 6,360 firms offering coverage to employees.

For each year, the proportion of large firms offering ESI significantly exceeded the proportion of small firms that did so. Most of the decrease in the overall number of firms offering ESI was related to the decline in small firms offering coverage. The proportion of small firms fell by 11.0 percentage points (from 36.1% to 25.1%) between 2010 and 2104, whereas the percentage of large companies fell by 0.7 percentage points (from 96.6% to 95.9%). As a result, the gap in offering rates between large and small firms increased over the study period.

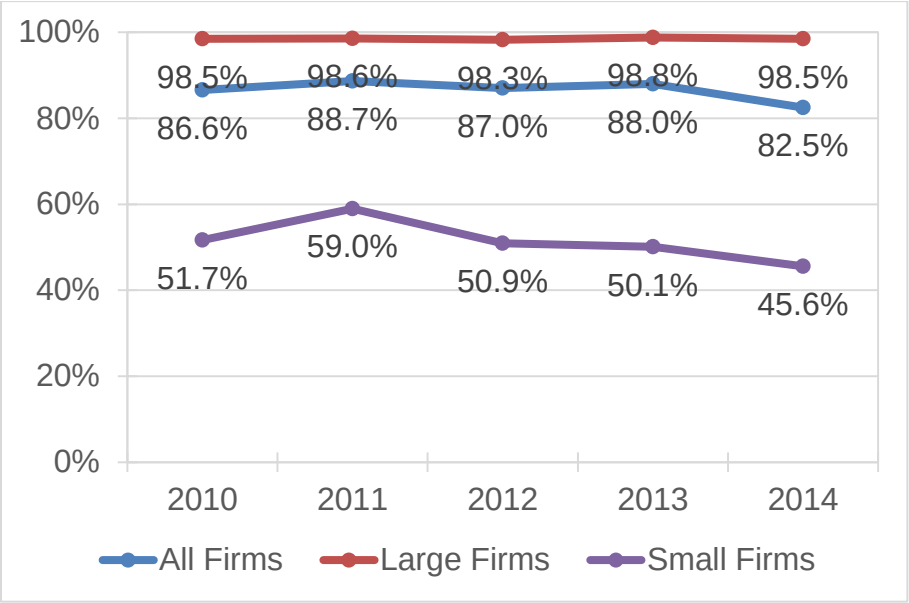
**Exhibit I: Trends in Percentage of Tennessee Firms Offering Employer-Sponsored Insurance, 2010-2014**




Source: Authors' analysis of MEPS-IC data. Large firms are those with 50 or more employers. Small firms have fewer than 50 employees.

Trends in the proportion of employees working in Tennessee firms that offer ESI are shown in Exhibit II. The trends were similar to those for the proportion of firms offering ESI. The proportion of employees in all firms offering ESI fell by 6.2 percentage points over the period, from a peak of 88.7 percent in 2011 to 82.5 percent in 2014. For small firms, only 45.6 percent of their employees had access to ESI in 2014, a 13.4 percentage point decline from the peak of 59.0 percent in 2011. Here, too, the difference between large and small firms increased over time.

**Exhibit II: Trends in Percentage of Employees Working in Tennessee Firms Offering Employer-Sponsored Insurance, 2010-2014**



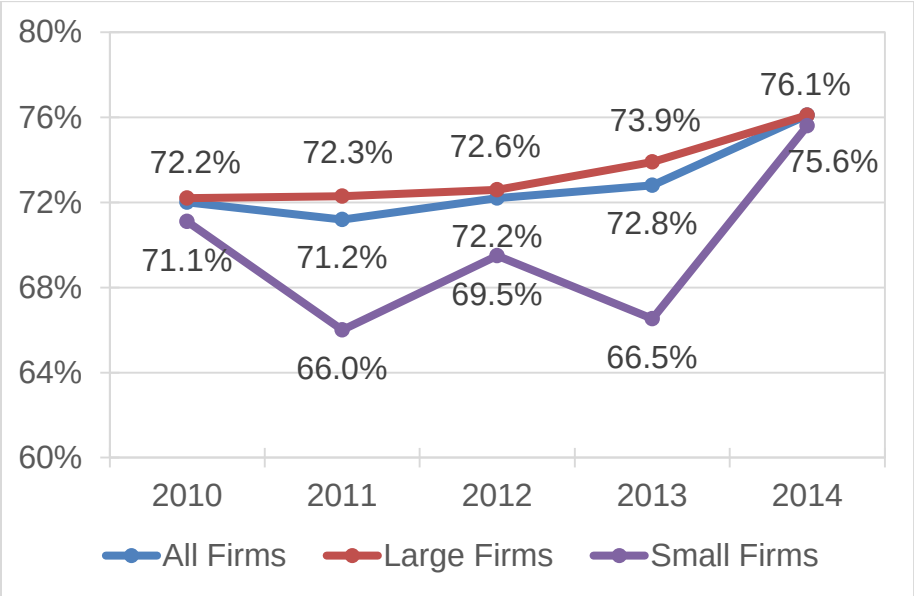

Source: Authors' analysis of MEPS-IC data. Large firms are those with 50 or more employers. Small firms have fewer than 50 employees.

Employee Eligibility. The second stage in enrolling in ESI requires that an employee working in a company that offers ESI meet the firm's eligibility requirements.

The proportion of eligible employees for all firms declined from 79.1 percent to 74.2 percent. The rate for large firms fell (from 79.3% in 2010 to 73.2% in 2014), but it rose for small firms (from 77.8% in 2010 to 80.3% in 2014). Thus, by 2014, the proportion of employees eligible for ESI was greater in small than in large firms (80.3% vs. 73.2%).

Eligible Employee Take-up. Finally, an eligible employee must choose to enroll or "take up" the insurance coverage offered. Trends in take-up rates are shown in Exhibit III, expressed as the proportion of eligible employees who enrolled in ESI plans.

**Exhibit III: Trends in Percentage of Eligible Employees Working in Tennessee Firms Offering Employer-Sponsored Insurance Who Enrolled for Coverage, 2010-2014**



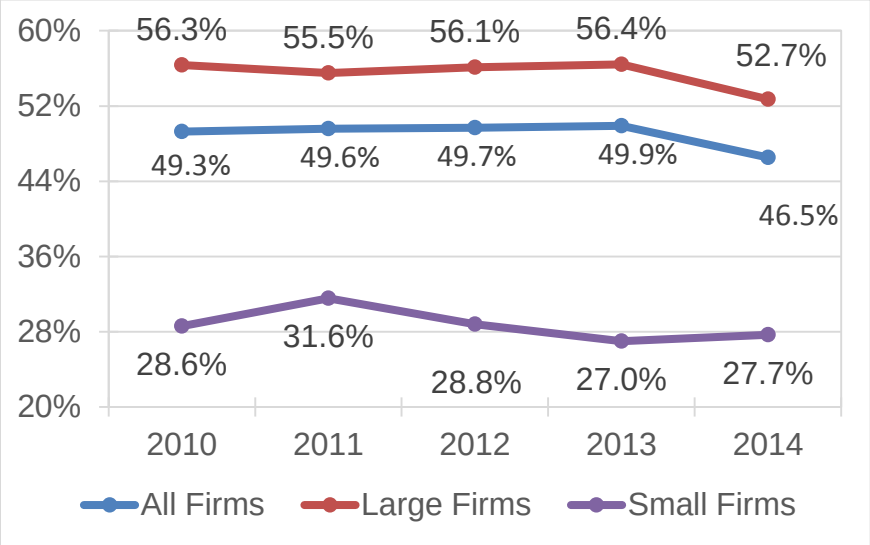

Source: Authors' analysis of MEPS-IC data. Large firms are those with 50 or more employers. Small firms have fewer than 50 employees.

The take-up rates among eligible employees of large firms rose steadily from 72.2 percent in 2010 to 76.1 percent in 2014. For those in small firms, the proportion

fell from 2010 (71.1%) to 2013 (66.5%) but then rose to 75.6 percent in 2014. Thus, the take-up rate was lower for small than for large firms until 2014 when the rates were similar.

Overall Changes in Coverage. The net effect of these three stages, described as the overall take-up rate, is reflected in the proportion of all employees working in firms that do and that do not offer ESI who enrolled in an employer-sponsored plan. This final enrollment rate thus reflects the "bottom line" function of the employer-based health insurance system that serves as the basis for private coverage in the United States. These overall trends in ESI take-up are shown in Exhibit IV.

**Exhibit IV: Trends in Percentage of Employees Working in Tennessee Firms Offering ESI Who Enrolled for Coverage, 2010-2014**



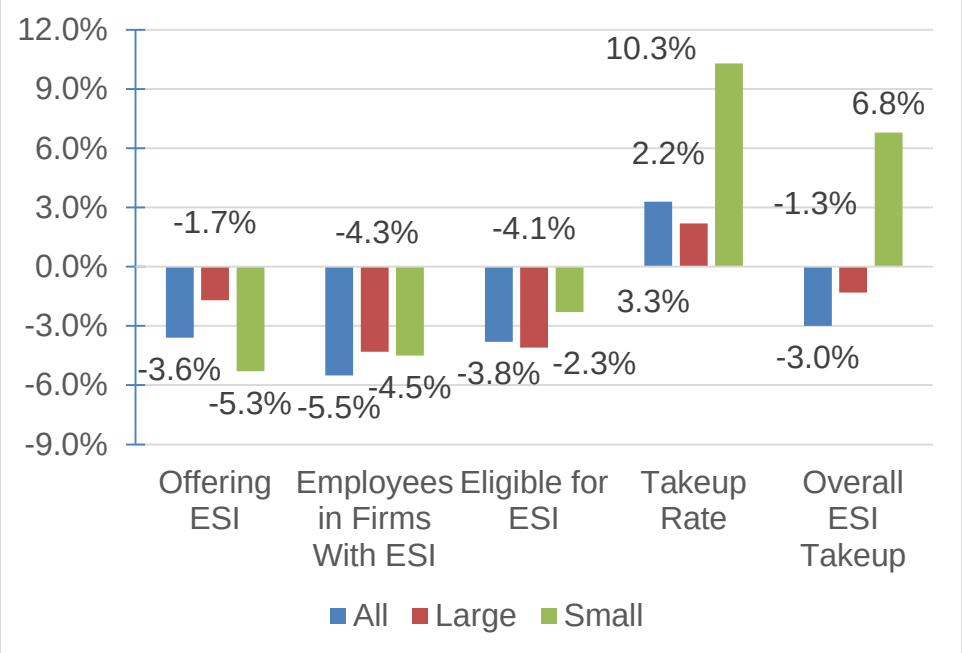

Source: Authors' analysis of MEPS-IC data. Large firms are those with 50 or more employers. Small firms have fewer than 50 employees.

In each year examined, fewer than half of all employees were enrolled in ESI, with a decline in general across the time period. In 2014, 46.5 percent of all employees

were enrolled. The rate was substantially higher among employees of large firms (52.7%) than for smaller ones, although only slightly more than one-half of large-firm employees were enrolled in ESI plans. Only slightly more than one-quarter (27.7%) of employees of small firms were enrolled in ESI in 2014.

Changes from 2013 to 2014. Finally, changes in ESI functions between 2013 and 2014 (shown in Exhibit V) are especially relevant as they may reflect early impacts of the ACA. During this period, coverage through Marketplace health insurance exchanges became available as an option, the individual mandate went into effect, and the impacts of Medicaid expansion continued to evolve.

**Exhibit V: Percentage Point Changes in ESI Measures between 2013 and 2014**




Source: Authors' analysis of MEPS-IC data. Large firms are those with 50 or more employers. Small firms have fewer than 50 employees.

As shown in Exhibit V, the proportion of firms offering ESI, the proportion of all employees working in those firms, and the proportion of those employees eligible for coverage all fell for both large and small Tennessee companies.

In contrast, the take-up rate among eligible employees rose, especially among small firms (an increase of 10.3 percentage points). The net impact was a large increase in overall take-up rate (that is, the proportion of all employees who enrolled in ESI) in small firms (6.8%) and a small decrease in large firms (-1.3%). This increase from 2013 to 2014 was greater than for any other one-year interval.

## IV. WHAT DO THESE TRENDS SUGGEST?

The information presented in Exhibits I through V highlight several aspects of ESI in Tennessee. First, as in the nation,[10] the proportion of firms offering ESI fell between 2010 and 2014 (Exhibit I), with a corresponding decline in the proportion of employees working in firms that offer coverage (Exhibit II). These changes likely reflect the rising costs of health insurance as well as the interacting impact of a slowly-recovering economy after the "great recession" triggered by the 2007 housing collapse and the ensuing financial crisis.

Second, the trend was substantially greater among small firms than among larger ones (Exhibits I and II), leading to an overall increase in the gap between the two firm groups. By 2014, only one-fourth of small businesses offered coverage and fewer than half of the employees in these firms worked for firms that offered ESI. As in national

[10]Agency for Healthcare Research and Quality. *MEPS Insurance Chartbook, 2014* (Washington, DC: U.S. Department of Health and Human Services, August, 2015).

data, small firms have historically offered ESI less often than larger ones. Reasons may include, as examples, smaller risk pools leading to higher premiums and higher administrative costs for smaller firms.[11] According to a recent survey, the high employer cost of coverage was most commonly given as the most important reason for not offering ESI.[12]

Third, these changes have been compounded by changes in the proportion of employees in firms that do offer ESI who are eligible to enroll. The eligibility rate fell in large firms, although it rose modestly among small firms. The increase in smaller firms may reflect ACA-related tax credits and insurance market changes, increased interest by employees, or other factors.

Fourth, the take-up rate, expressed as the proportion of eligible enrollees who opted to enroll in ESI plans, rose for large firms over the five-year period. This increase occurred even though employee costs rose and benefits declined over the interval. For small firms, however, the take-up rate declined until 2014 when it increased substantially, as discussed below.

Fifth, trends in several of these measures of ESI function are similar to those observed across the nation. For example, MEPS data[13] show that the proportion of employees working in firms that offered ESI in 2014 was 83.2 percent in the U.S. and

[11]Ibid.

[12]Kaiser Family Foundation and the Health Research and Education Trust, *Employer Health Benefits. 2014 Annual Report.*

[13]Agency for Healthcare Research and Quality, *MEPS Insurance Chartbook, 2014.*

82.5 percent in Tennessee, and the take-up rate was 76.7 percent in the U.S. and 76.1 percent in our state. However, the proportions of all, as well as both large and small, firms offering ESI were substantially lower in Tennessee than in the U.S. The national rate of the proportion of firms offering ESI reported by the Kaiser Family Foundation and the Health Research and Education Trust for 2014 was 55.0 percent, whereas in Tennessee the rate was only 48.5 percent, a substantial difference of 6.5 percentage points.

The net implication of these data is that the overall effectiveness of the ESI system remained limited. Overall enrollment fell over the study period, with most employees not having insurance coverage through their employers (Exhibit IV). By 2014, fewer than half of all employees and only slightly more than one-fourth of small business employees were enrolled.

It is not known how much the limitations of ESI contributed to the state's number of uninsured. It is not known from these data how many employees not offered ESI or who did not enroll were covered by other sources of insurance, such as plans through a spouse or through public programs. In one recent survey, the availability of coverage from other sources was the second most common reason given by small firms for not offering coverage to employees.[14]

[14]Kaiser Family Foundation and the Health Research and Education Trust, *Employer Health Benefits. 2014 Annual Report.*

Sixth, the data indicate, as do national data,[15] that most of the changes in ESI parameters between 2013 and 2014, while significant, were less than predicted by the dire earlier prognoses offered by some analysts. As shown in Exhibit V, the proportion of all firms offering ESI fell by 3.6 percentage points, and the proportion of small firms fell by 5.3 percentage points. The drops, while substantial, were smaller than observed between 2011 and 2012 (2.5 percentage points for large firms, 6.7 percentage points for small, and 6.8 percentage points for all). This suggests that other systemic factors rather than or in addition to the ACA may be implicated in the decline in employer-sponsored coverage.

Most notable was the substantial increase in take-up rates between 2013 and 2014, especially for smaller firms in Tennessee. As shown in Exhibit V, the proportion of small-firm employees who were eligible for ESI who enrolled rose by over 10.0 percentage points, and the proportion in larger firms rose by over 2.0 percentage points. These increases occurred despite national trends to increasing employee costs and greater plan restrictions.[16] Although the specific causes of these changes in take-up rates cannot be determined with certainty, it is likely the implementation of the individual mandate, with its attendant penalties for not enrolling, as well as the increasing public awareness of the benefits of coverage played important roles.

[15]Blavin et al., "An Early Look at Changes in Employer-sponsored Insurance under the Affordable Care Act."

[16]Kaiser Family Foundation and the Health Research and Education Trust, *Employer Health Benefits. 2014 Annual Report.*

Other factors such as the gradually-improving general economy and moderation in the growth of healthcare costs may also have contributed. On balance, the increases in take-up rates do suggest that the role of "crowd out," that is, the likelihood that employees may opt to enroll in public coverage rather than in more expensive ESI plans even in states that did not expand Medicaid under the ACA,[17] did not have a major effect.

## V. CONCLUSION

It is too early to be confident that the moderate changes reported here do not represent the onset of larger shifts in future years related to the ongoing provisions of the ACA. Some aspects of the ACA are yet to be implemented. For example, the so-called "Cadillac tax" on the most expensive plans in 2018 may cause employers to, for example, increase deductibles, reduce covered services, etc., making coverage less attractive to employees.

It is also important to note that many factors unrelated to the ACA will impact ESI coverage. Other possible impacts include changes in laws and regulations, future market changes, changes in healthcare costs, and the role of collective bargaining. Most important, the 2016 national election and the potential subsequent health policy changes add additional uncertainties as to how external economic and political forces will affect ESI results in Tennessee. All of these forces will necessitate close

[17] R. Rudowitz, L. Snyder, and V. Smith, *Medicaid Enrollment and Spending Growth: FY 2015 & 2016* (Menlo Park, CA: The Kaiser Family Foundation, October 2015).

examination of future trends in ESI for measures of its efficacy and efficiency as a foundation of health insurance coverage in the United States and in Tennessee.

*** End of Blog ***

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