



# CHANGES IN EMPLOYER-SPONSORED HEALTH INSURANCE AT THE STATE LEVEL, 2013–2017

September 2018



# INTRODUCTION

- The nation's attention has recently focused on health insurance coverage purchased through Affordable Care Act marketplaces, but it is important to remember that the majority of individuals in the United States are enrolled in health insurance through an employer.
- The following chartbook presents highlights from our analysis of state-level changes in the experiences of private-sector employees who had Employer-Sponsored Insurance (ESI).
- This chartbook focuses on employee cost sharing from 2016 to 2017 and only presents statistically significant changes as tested at the 95% confidence level.
- These analyses used estimates from the [Medical Expenditure Panel Survey - Insurance Component \(MEPS-IC\)](#), recently produced by the [Agency for Healthcare Research and Quality \(AHRQ\)](#).

## Companion products for this chartbook include data back to 2013:

- Individual profiles for each state, highlighting ESI trends
- 50-state data tables
- [A 50-state interactive map](#) showing levels of, and changes in, average annual premium for single coverage in 2017, with links to state profile pages
- [A blog](#) on ESI premium and enrollment in high-deductible plans in 2017
- [A blog](#) on ESI coverage and costs in 2017

*Click here to access these ESI companion products!*

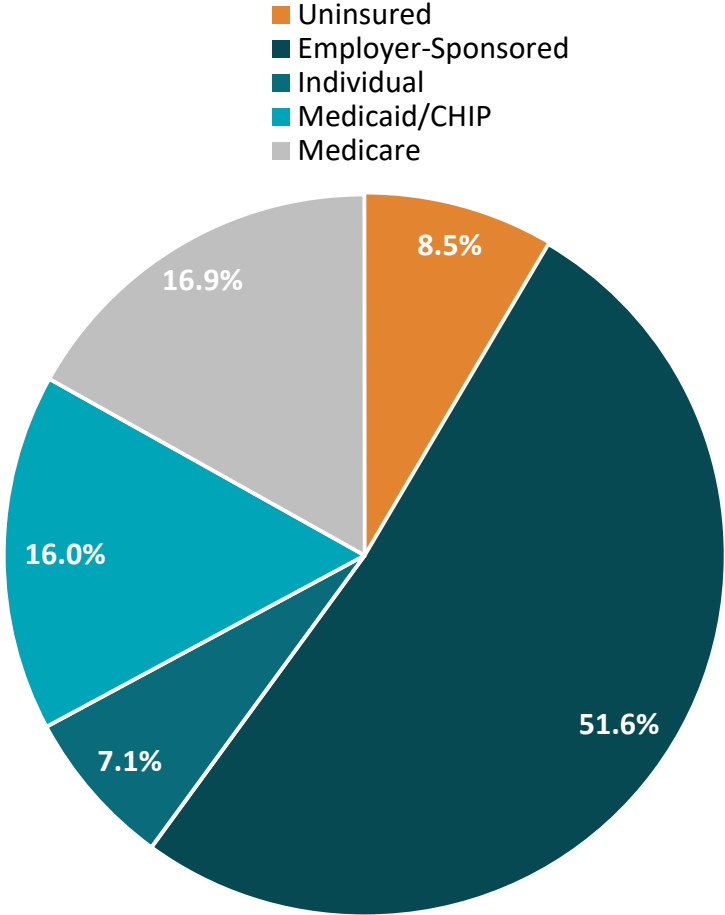


# ESI ACCESS AND COVERAGE

# EMPLOYER-SPONSORED INSURANCE

- The majority of non-elderly Americans get their health insurance coverage from an employer, whether from their own employer or the employer of a family member (e.g., a spouse or parent).

United States: Primary Source of Health Insurance, 2016

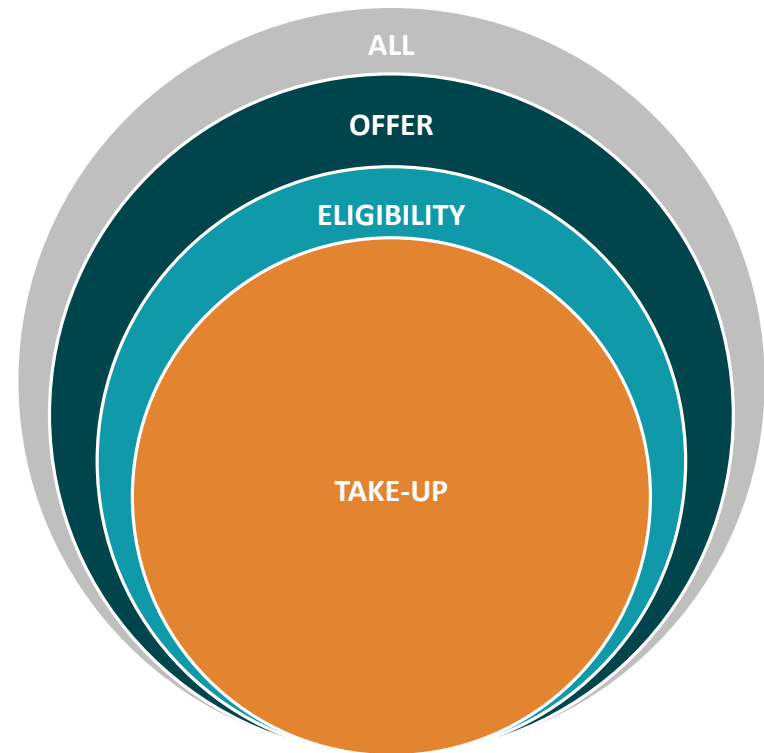


**Note:** Due to rounding, the sum of percentages in the figure may not be 100%.  
**Source:** SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org.

# EMPLOYER-SPONSORED INSURANCE

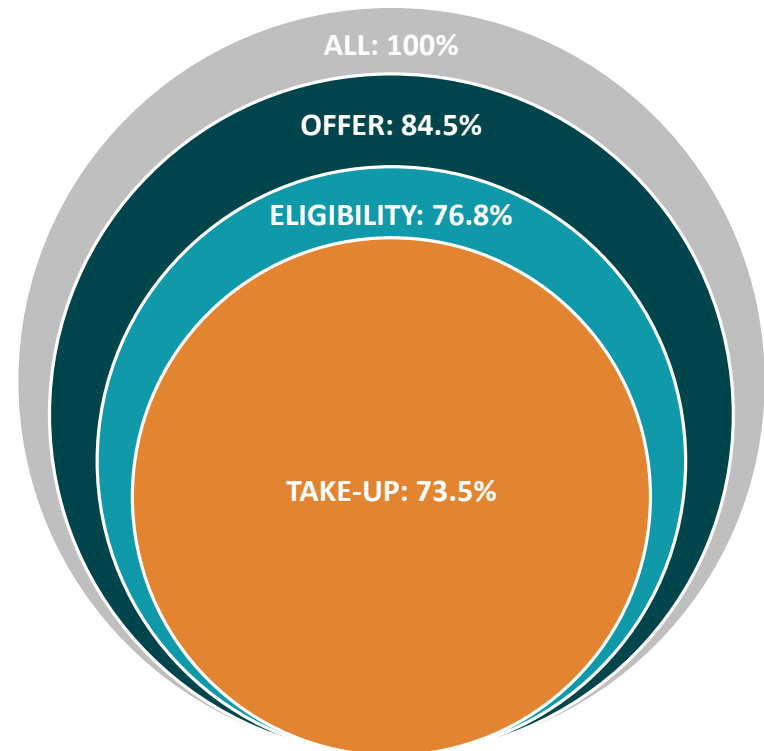
- Employee access to ESI has three components:

- 1. Employee Offer:** An employee must work in an establishment that offers coverage.
- 2. Employee Eligibility:** An employee must meet the criteria established by the employer to be eligible for coverage that is offered. (For example, he/she might have to work a minimum number of hours per pay period or complete a minimum length of service with the employer in order to be eligible.)
- 3. Employee Take-Up:** The employee must decide to enroll in—or “take up”—the offer of ESI coverage.



# EMPLOYER-SPONSORED INSURANCE, 2017

- In 2017, there were 125 million private-sector employees in the U.S. and 7.4 million establishments (see Methods and Notes).
- Employee access to ESI:
  - 1. Employee Offer:** 84.5% of employees worked in establishments that offered ESI (106 million employees).
  - 2. Employee Eligibility:** 76.8% of employees who worked in establishments that offered coverage were eligible to enroll (81 million employees).
  - 3. Employee Take-Up:** 73.5% of eligible employees enrolled in coverage (60 million employees).

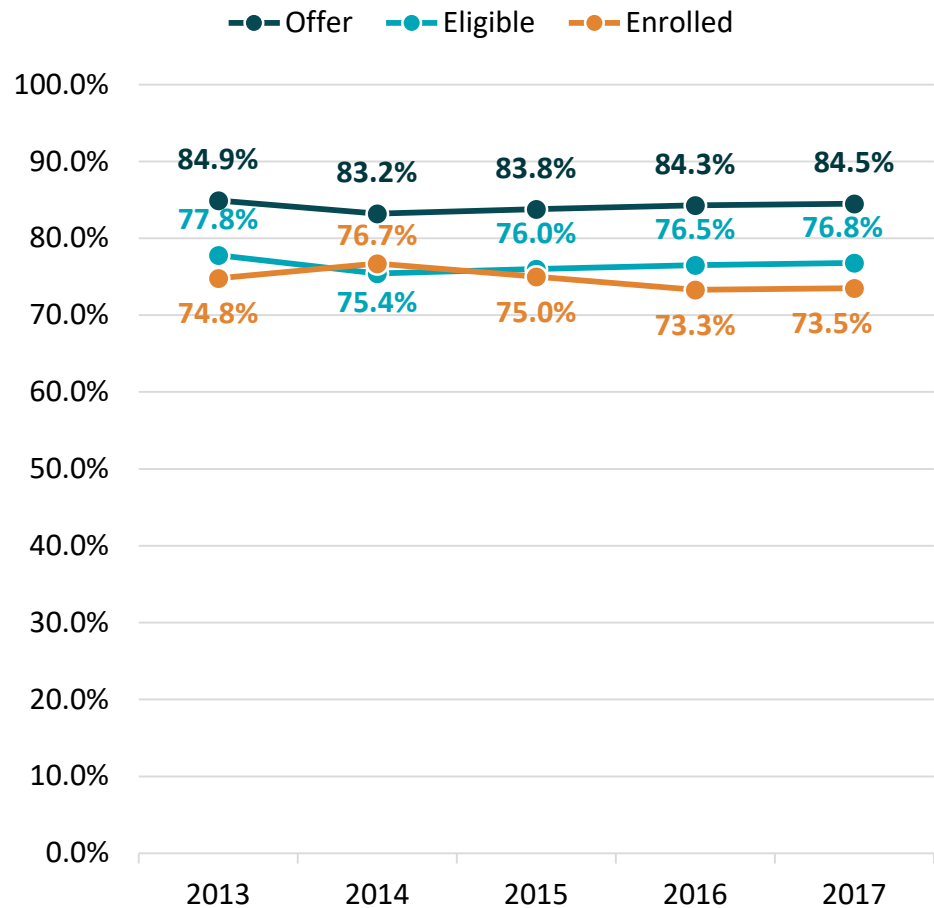


Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# EMPLOYER-SPONSORED INSURANCE OFFER, ELIGIBILITY, AND TAKE-UP, 2017

- While the percent of establishments offering coverage increased from 45.3% to 46.9% between 2016 and 2017 (not shown), there were no significant changes in the percent of employee offer, employee eligibility, or employee take-up.
- Only one state (**South Carolina**) saw a change in the percent of eligible employees enrolled in ESI between 2016 and 2017, where the percent of eligible employees increased from 73.8% to 80.3%.
- Offer, eligibility, and take-up rates continued to vary by state in 2017:
  - i. Employee offer rates ranged from 92.3% in the **District of Columbia** to 69.5% in **Wyoming**.
  - ii. The percent of employees eligible for ESI at offering establishments varied from a high of 82.3% in **Alabama** to a low of 71.1% in **Vermont**.
  - iii. The percent of ESI-eligible employees who enrolled (take-up rate) ranged from a high of 80.3% in **South Carolina** down to 66.0% in **New Mexico**.

Percent of Employees with an Offer, Who Were Eligible, and Who Enrolled in Coverage



Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.



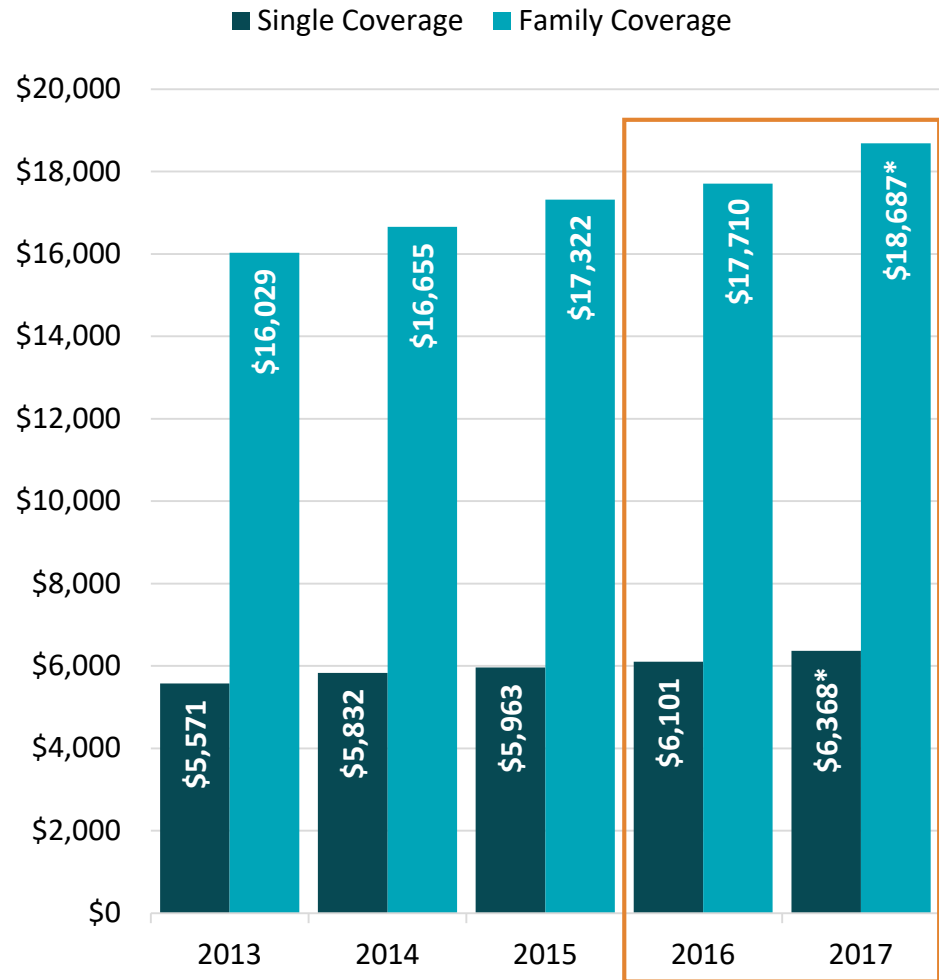
# ESI AVERAGE ANNUAL PREMIUM AND DEDUCTIBLE



# ESI PREMIUMS CONTINUED TO RISE

- In 2017 the **average single-coverage premium** rose \$267 to \$6,368, a 4.4% increase from 2016.
- In 2017 the **average family-coverage premium** rose \$977 to \$18,687, a 5.5% increase from 2016.

### Average Annual Premium, 2013-2017



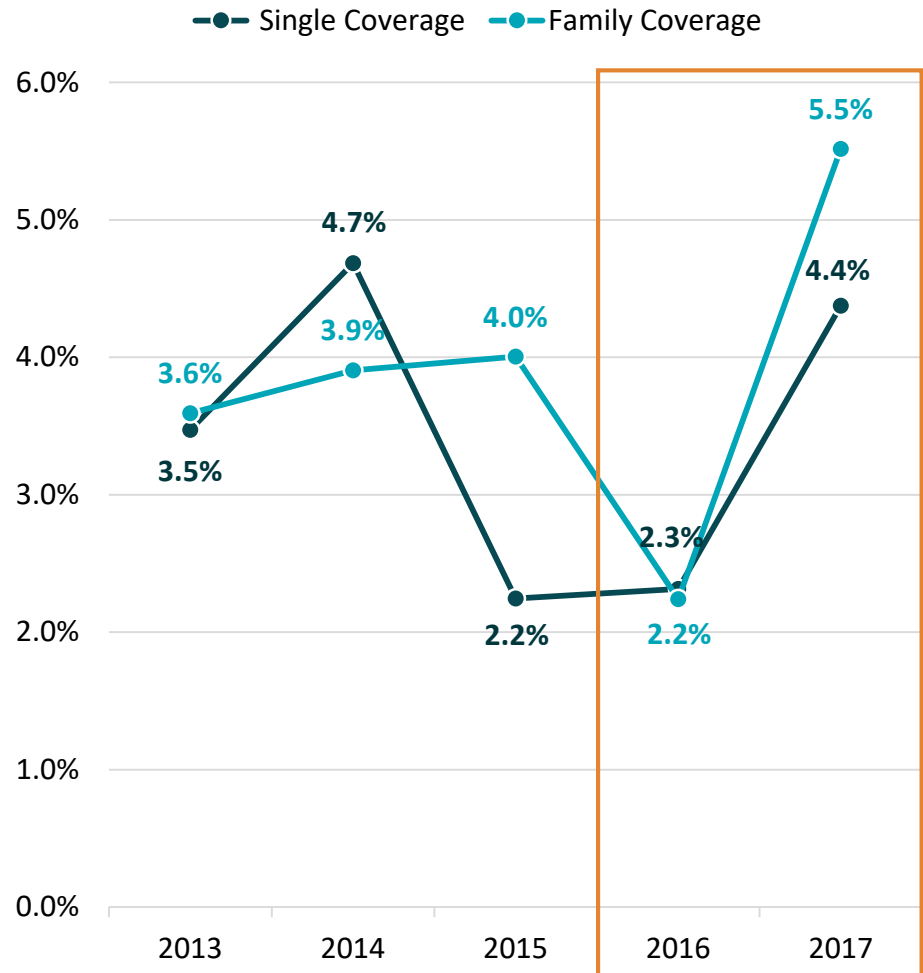
\* Significant difference between 2016 and 2017 estimates at the 95% confidence level.

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# ESI PREMIUM GROWTH RATES INCREASED BETWEEN 2016 AND 2017

- After two years at just over 2%, the growth rate in the average premium for single coverage increased from 2.3% to 4.4% between 2016 and 2017.
- After growth rates that ranged between 2% and 4%, the average premium for family coverage increased from 2.2% to 5.5% between 2016 and 2017.

Annual Premium Growth Rate, 2013-2017



\* Significant difference between 2016 and 2017 estimates at the 95% confidence level.

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# STATE VARIATION IN ESI PREMIUM

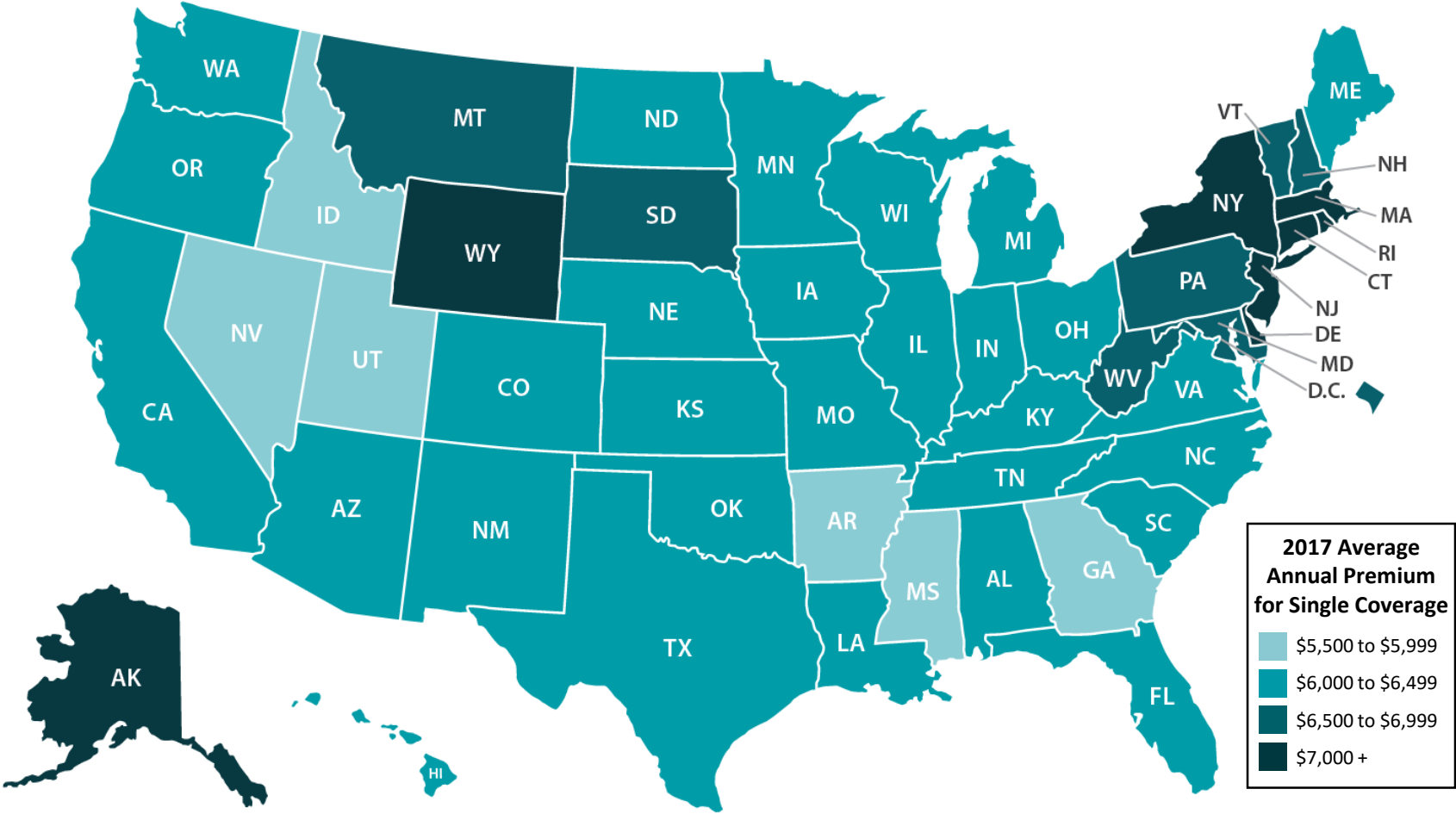
- There was wide and significant variation among states in average single-coverage premiums in 2017 (see page 12).
- **Arkansas** had the lowest average premium for single coverage in 2017 at \$5,722 and **Alaska** had the highest average premium at \$7,964.

## Average Annual Premium for Single Coverage, 2017

|                      |                 |                |
|----------------------|-----------------|----------------|
| Top Five States      | 1. Alaska       | \$7,964        |
|                      | 2. New York     | \$7,309        |
|                      | 3. Wyoming      | \$7,257        |
|                      | 4. New Jersey   | \$7,074        |
|                      | 5. Rhode Island | \$7,048        |
| <b>United States</b> |                 | <b>\$6,368</b> |
| Bottom Five States   | 1. Utah         | \$5,568        |
|                      | 2. Arkansas     | \$5,722        |
|                      | 3. Nevada       | \$5,756        |
|                      | 4. Georgia      | \$5,849        |
|                      | 5. Idaho        | \$5,858        |

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# AVERAGE ANNUAL ESI PREMIUM FOR SINGLE COVERAGE, 2017

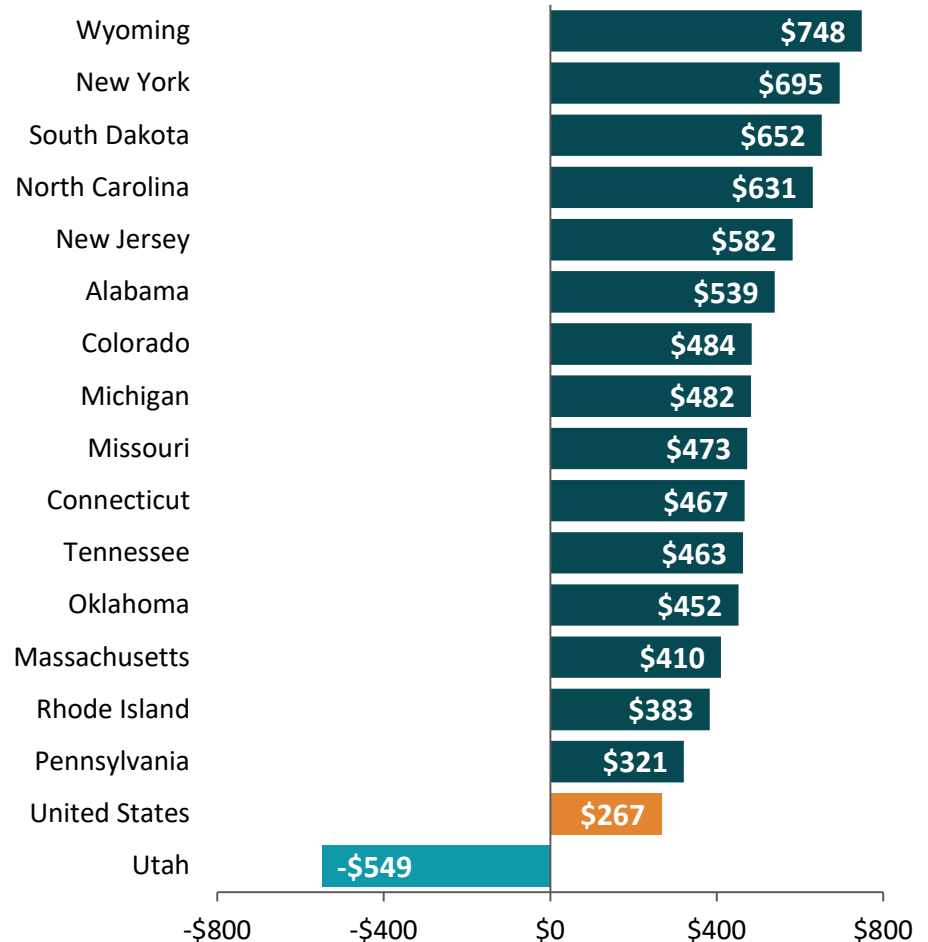


Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# STATE VARIATION IN CHANGES IN ESI PREMIUM, 2016-2017

- Nationally, the average single-coverage premium increased by \$267 (4.4%).
- Only **Utah** had a statistically significant decline (a reduction of \$549 or 9.0%).
- **15 states** had statistically significant increases in the average single-coverage premium, and all increases were above 5%.
- **Wyoming** had the largest absolute (\$748) and relative (11.5%) increases in average single-coverage premium from 2016 to 2017.

## States with Significant Changes in Average Annual Premium for Single Coverage, 2016–2017



Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# EMPLOYEES CONTRIBUTED A SUBSTANTIAL PROPORTION OF THE AVERAGE ESI PREMIUM

- Nationally, employees were, on average, responsible for 22.2% of single-coverage premium and 22.8% of family-coverage premium (not shown) in 2017.
- The average employee share of the average annual premium has been stable over time (not shown).
- The employee contribution for premiums varied significantly by state. In 2017, the employee contribution for single-coverage premium ranged from a low of 11.2% in **Hawaii**, to a high of 26.2% in **Alabama**.
- In 41 states, the employee contribution for single-coverage premium exceeded 20%.

## Employee Contribution for Single-Coverage Premium, 2017

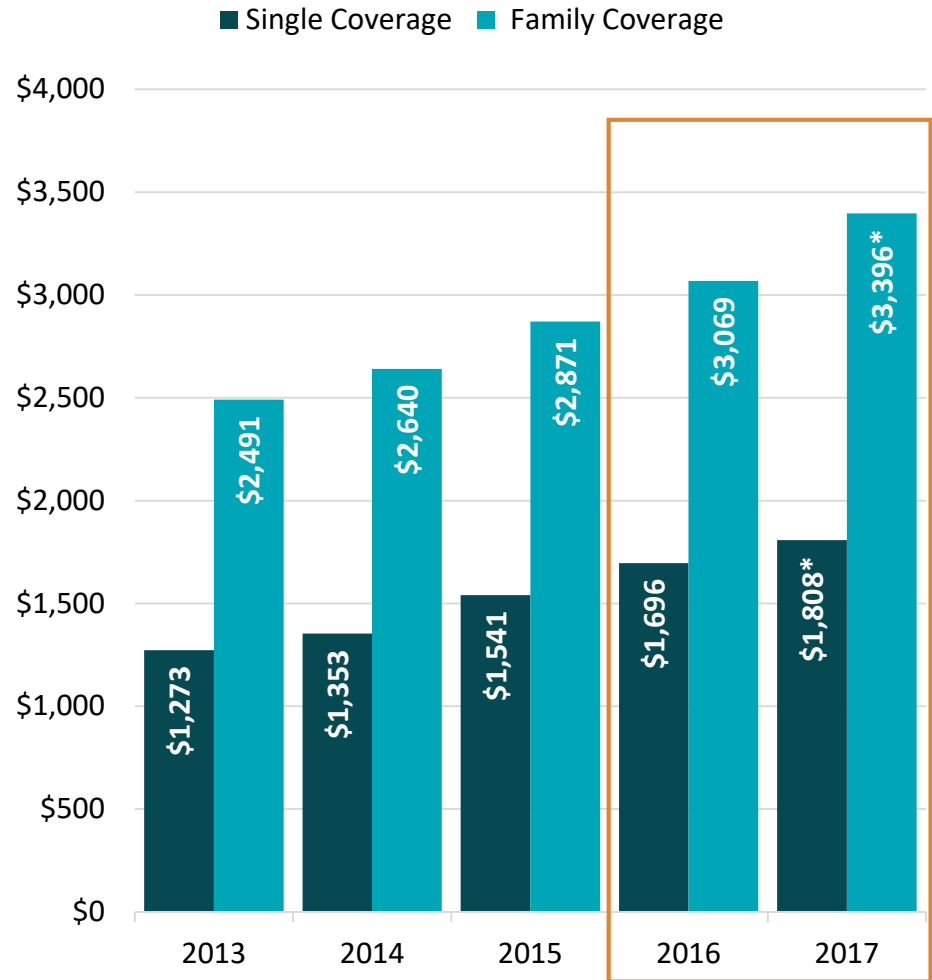
|                      |                  |              |
|----------------------|------------------|--------------|
| Top Five States      | 1. Alabama       | 26.2%        |
|                      | 2. Maryland      | 26.0%        |
|                      | 3. Virginia      | 25.8%        |
|                      | 4. Massachusetts | 24.9%        |
|                      | 5. New Hampshire | 24.7%        |
| <b>United States</b> |                  | <b>22.2%</b> |
| Bottom Five States   | 1. Hawaii        | 11.2%        |
|                      | 2. Washington    | 13.9%        |
|                      | 3. Idaho         | 15.0%        |
|                      | 4. Wyoming       | 15.9%        |
|                      | 5. Montana       | 16.6%        |

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# AVERAGE ESI DEDUCTIBLES CONTINUED TO RISE

- The majority of employees with ESI (93%) had a deductible in 2017 and this was consistent across states (not shown).
- The **average deductible for single coverage** rose \$112 to \$1,808 in 2017, a 6.6% increase from 2016.
- The **average deductible for family coverage** rose \$327 to \$3,396 in 2017, a 10.7% increase from 2016.

### Average Annual Deductible, 2013–2017



\* Significant difference between 2016 and 2017 estimates at the 95% confidence level.

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# STATE VARIATION IN AVERAGE ESI DEDUCTIBLES

- There was wide and significant variation among states in the average deductible for single coverage in 2017 (see page 17).
- In 2017 for single coverage, **Hawaii** had the lowest average deductible at \$863, and **Maine** had the highest average deductible at \$2,305.

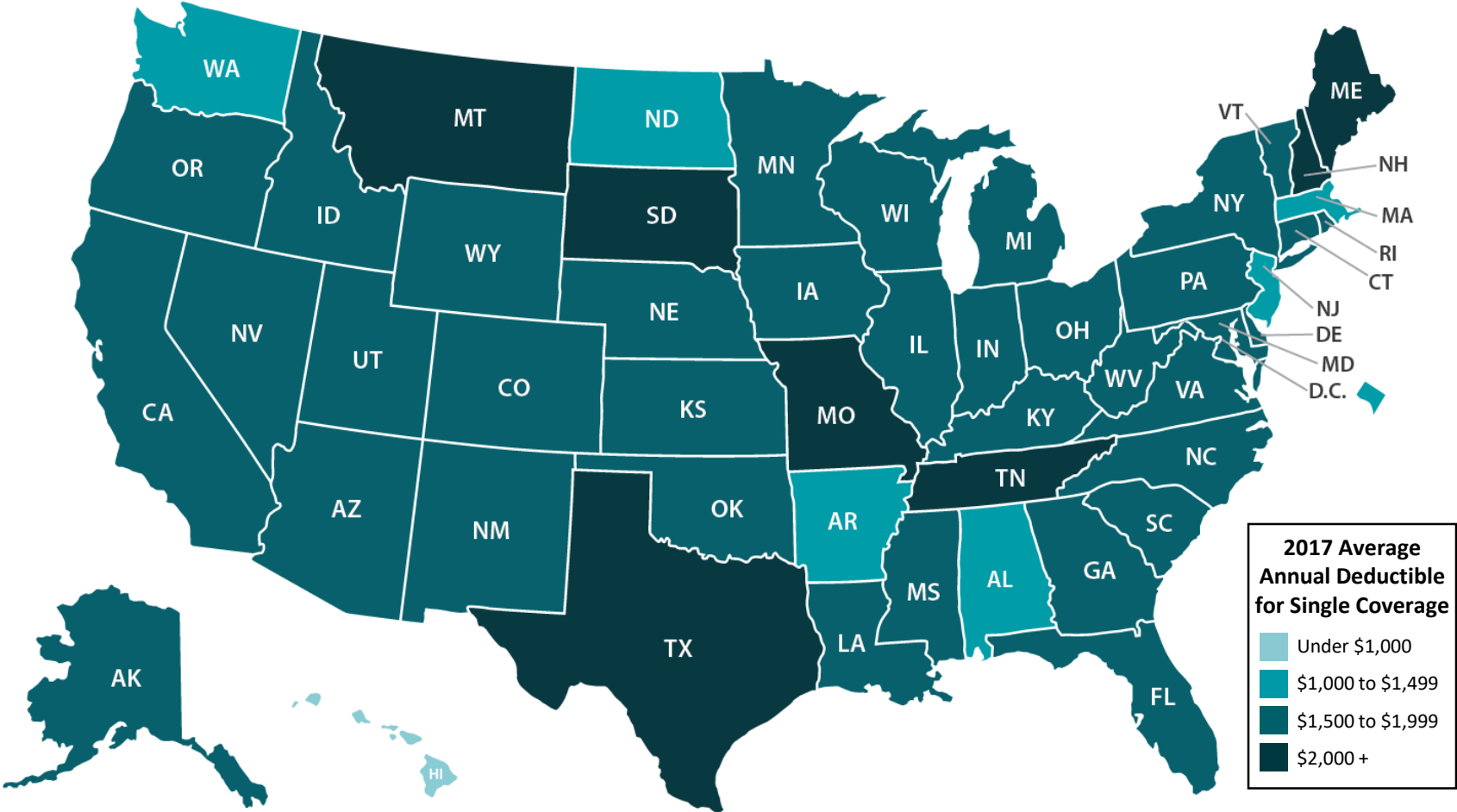
## Average Annual Deductible for Single Coverage, 2017

|                      |                         |                |
|----------------------|-------------------------|----------------|
| Top Five States      | 1. Maine                | \$2,305        |
|                      | 2. New Hampshire        | \$2,303        |
|                      | 3. Montana              | \$2,162        |
|                      | 4. Texas                | \$2,158        |
|                      | 5. Tennessee            | \$2,086        |
| <b>United States</b> |                         | <b>\$1,808</b> |
| Bottom Five States   | 1. Hawaii               | \$863          |
|                      | 2. Alabama              | \$1,243        |
|                      | 3. District of Columbia | \$1,360        |
|                      | 4. Arkansas             | \$1,384        |
|                      | 5. New Jersey           | \$1,456        |

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.



# AVERAGE ANNUAL DEDUCTIBLE FOR SINGLE COVERAGE, 2017



Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.



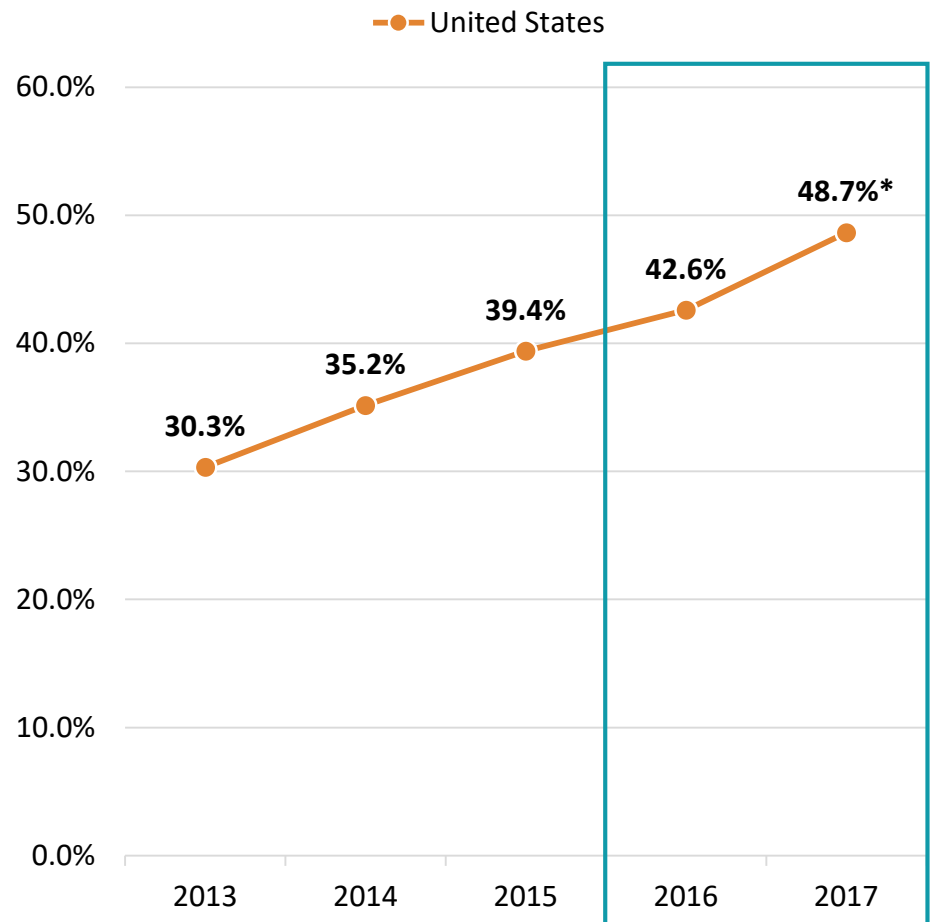
# ESI ENROLLMENT IN HIGH-DEDUCTIBLE HEALTH PLANS

# ENROLLMENT IN HIGH-DEDUCTIBLE HEALTH PLANS CONTINUES TO RISE

- In 2017, almost half of private-sector employees who had ESI were enrolled in a High-Deductible Health Plan at 48.7%
- Enrollment in High-Deductible Health Plans has been steadily rising and increased 14.2% between 2016 and 2017.

Note: For the purposes of this analysis, High-Deductible Health Plans are defined as plans that meet the minimum deductible amount required for Health Savings Account (HSA) eligibility (\$1,300 for an individual and \$2,600 for a family in 2017). This includes employees enrolled in single and family plans.

## Percent of Employees Enrolled in High-Deductible Health Plans, 2013–2017



\* Significant difference between 2016 and 2017 estimates at the 95% confidence level.

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# STATE VARIATION IN HIGH-DEDUCTIBLE HEALTH PLAN ENROLLMENT

- There was wide variation among states on this measure (see page 21).
- In 25 states, more than 50% of employees are enrolled in a High-Deductible Health Plan.
- Among states, **New Hampshire** had the highest percentage of employees enrolled in High-Deductible Health Plans (69.3%) in 2017, and **Hawaii** had the lowest percentage (9.3%).

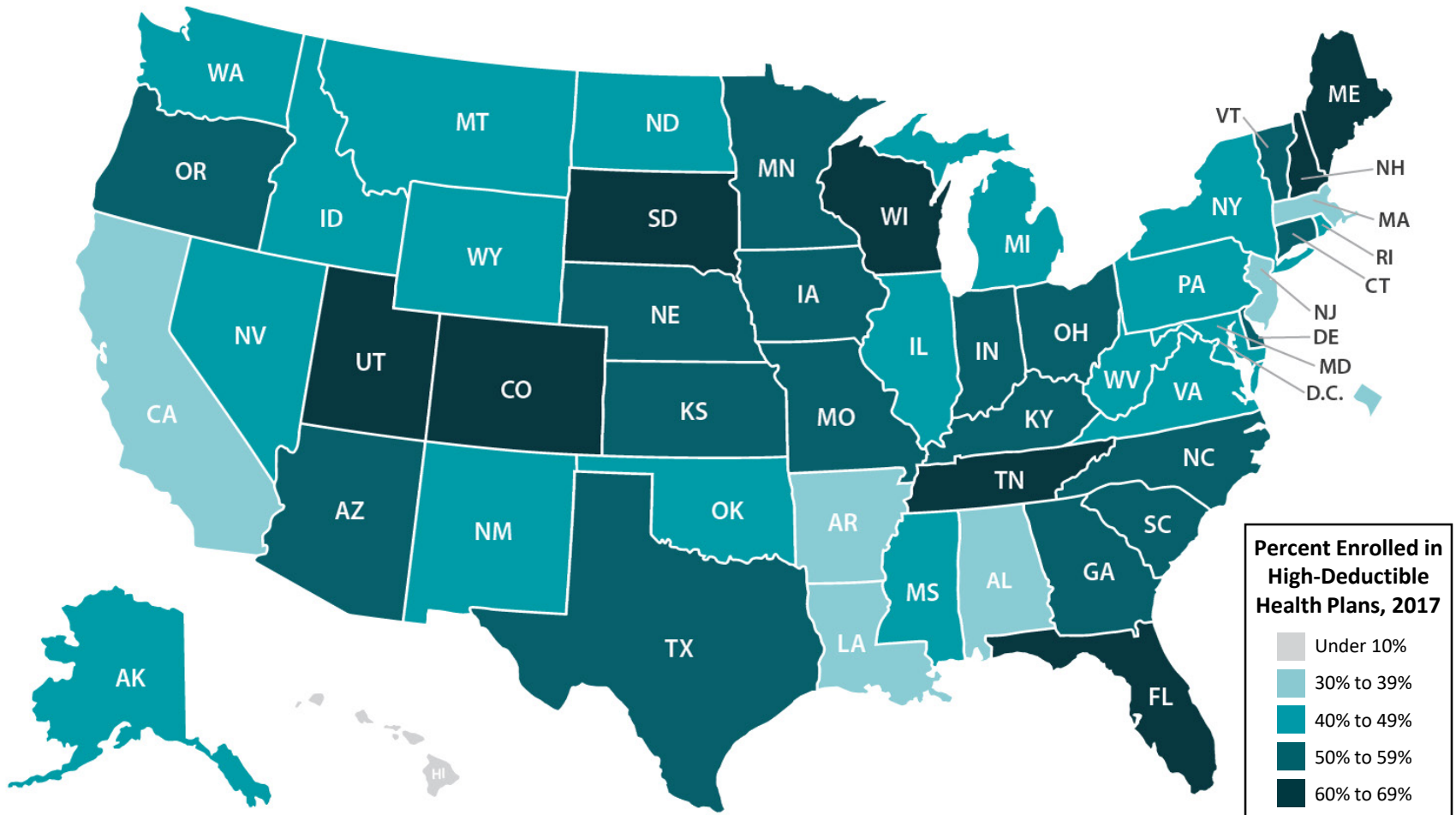
Note: For the purposes of this analysis, High-Deductible Health Plans are defined as plans that meet the minimum deductible amount required for Health Savings Account (HSA) eligibility (\$1,300 for an individual and \$2,600 for a family in 2017). This includes employees enrolled in single and family plans.

## Percent of Employees Enrolled in High-Deductible Health Plans

|                      |                         |              |
|----------------------|-------------------------|--------------|
| Top Five States      | 1. New Hampshire        | 69.3%        |
|                      | 2. South Dakota         | 67.3%        |
|                      | 3. Tennessee            | 63.3%        |
|                      | 4. Utah                 | 62.8%        |
|                      | 5. Maine                | 62.7%        |
| <b>United States</b> |                         | <b>48.7%</b> |
| Bottom Five States   | 1. Hawaii               | 9.3%         |
|                      | 2. Alabama              | 30.9%        |
|                      | 3. District of Columbia | 32.9%        |
|                      | 4. New Jersey           | 35.5%        |
|                      | 5. California           | 36.0%        |

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# HIGH-DEDUCTIBLE HEALTH PLAN ENROLLMENT, 2017



Note: For the purposes of this analysis, High-Deductible Health Plans are defined as plans that meet the minimum deductible amount required for Health Savings Account (HSA) eligibility (\$1,300 for an individual and \$2,600 for a family in 2017). This includes employees enrolled in single and family plans.

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.



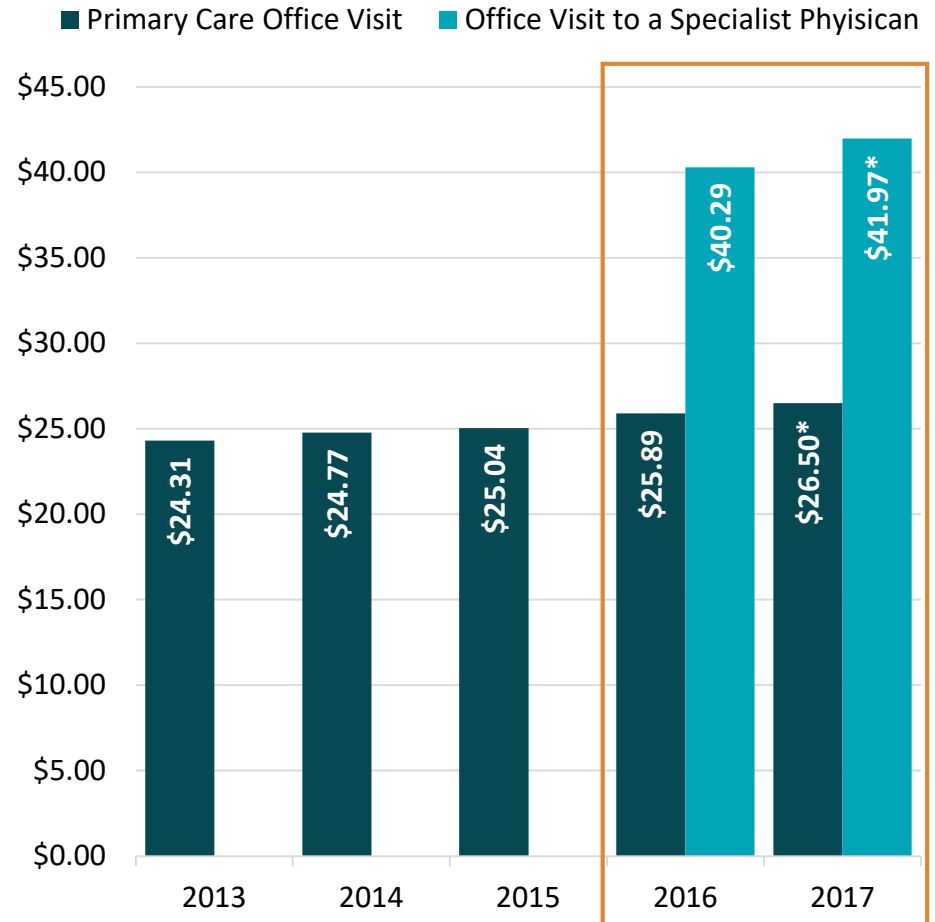
# ESI COST SHARING AND OUT-OF-POCKET LIMITS

# AVERAGE CO-PAYMENTS FOR OFFICE VISITS CONTINUED TO RISE

- The majority of employees with ESI in 2017 were enrolled in a plan with a co-payment for office visits to a general practitioner (68%) and a specialist physician (59%).
- In 2017 the average co-payment for an office visit rose \$0.61 to \$26.50, a 2.4% increase from 2016.
- In 2017 the average co-payment for a specialist physician rose \$1.68 to \$41.97, a 4.2% increase from 2016.

Note: Before 2016, the MEPS-IC did not ask how much enrollees were required to pay out-of-pocket for an office visit to a specialist physician.

## Average Co-payments for Primary Care and Specialist Physician Office Visit, 2013–2017



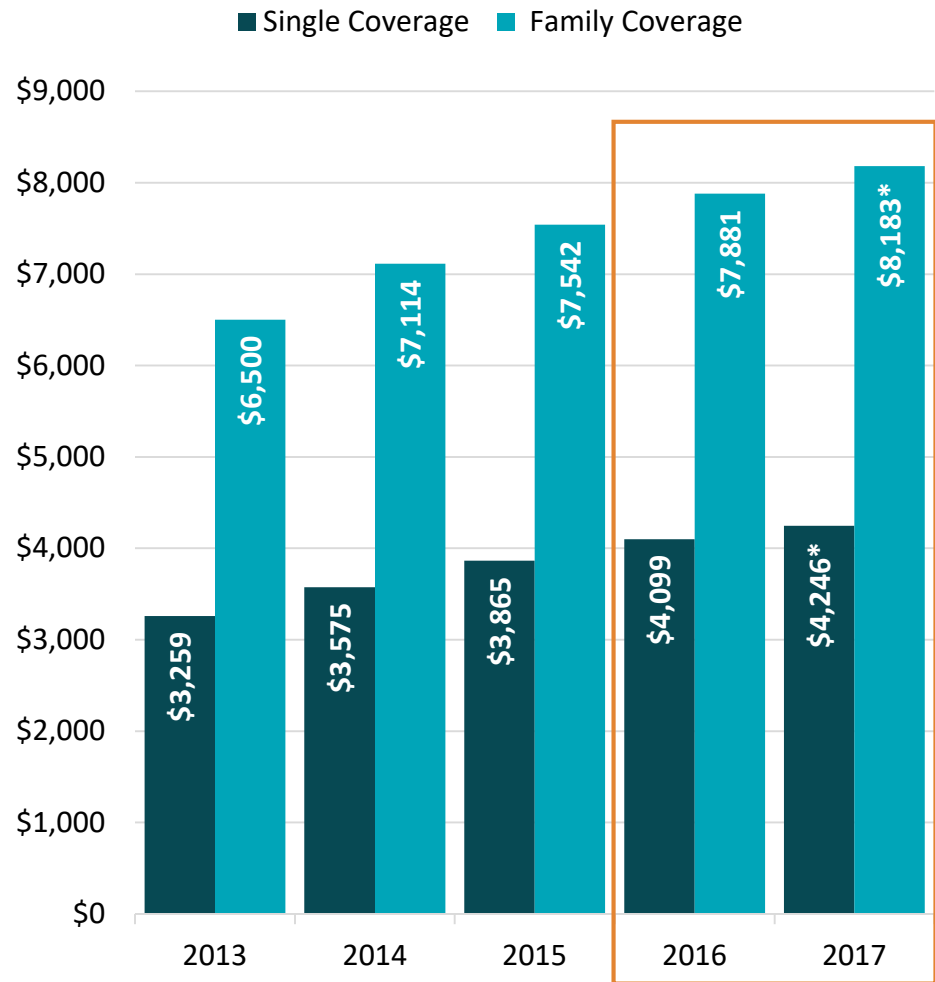
\* Significant difference between 2016 and 2017 estimates at the 95% confidence level.

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

# AVERAGE ANNUAL OUT-OF-POCKET LIMITS CONTINUED TO RISE

- The majority of employees with ESI in 2017 were enrolled in a plan with an out-of-pocket limit (93% and 94% for single and family-coverage respectively – not shown).
- In 2017, the national average out-of-pocket limit was \$4,246 for single coverage and \$8,183 for family coverage.
- Between 2016 and 2017 the average out-of-pocket limit for single coverage increased \$147, an increase of 3.6%, and the out-of-pocket limit for family coverage increased \$302, an increase of 3.8%.
- There was significant variation in average out-of-pocket limits by state, ranging from a low of \$6,476 for single coverage in North Dakota in 2017 to a high of \$9,485 in Pennsylvania (not shown).

Average Annual Out-of-Pocket Limits, 2013–2017



\* Significant difference between 2016 and 2017 estimates at the 95% confidence level.

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.



# SOME EMPLOYEES WERE SUBJECT TO A SEPARATE DEDUCTIBLE FOR PRESCRIPTION DRUGS

- Over the last decade the percentage of employees with a separate annual deductible that applies only to prescription drugs has increased.<sup>1</sup>
- In 2017, 16.1% of employees were enrolled in a plan with an annual prescription drug deductible, which averaged \$360 nationally.
- There is considerable variation in this indicator by state. In 2017 a low of 7.4% of employees in **Nebraska** had a separate prescription drug deductible compared to a high of 47.3% in **Mississippi**.
- In 10 states, more than 20% of employees had a separate annual deductible for prescription drugs.
- There was also considerable variation the size of the prescription drug deductible by state, ranging for \$161 in **Delaware** to \$990 in **Maine**.
- In 11 states, the size of the average prescription drug deductible exceeded \$500.

<sup>1</sup> Claxton G, Rae M, Long M, Damico A, Foster G, & Whitmore H. (2017). Employer Health Benefits Annual Survey 2017. Menlo Park, CA: Kaiser Family Foundation. <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017>.

## States Where More than 20% of Enrolled Employees have a Separate Deductible, for Prescription Drugs, 2017

|              |       |
|--------------|-------|
| South Dakota | 20.3% |
| Utah         | 20.6% |
| Oklahoma     | 20.6% |
| Louisiana    | 24.9% |
| Iowa         | 25.1% |
| Montana      | 26.6% |
| Arkansas     | 32.0% |
| New York     | 32.1% |
| Vermont      | 36.7% |
| Mississippi  | 47.3% |

## States with Average Annual Prescription Drug Deductible Greater than \$500, 2017

|               |       |
|---------------|-------|
| Maine         | \$990 |
| Minnesota     | \$787 |
| New Hampshire | \$779 |
| Wyoming       | \$778 |
| North Dakota  | \$776 |
| Massachusetts | \$753 |
| Vermont       | \$686 |
| Idaho         | \$595 |
| Nebraska      | \$578 |
| Utah          | \$516 |
| Hawaii        | \$510 |

Source: SHADAC analysis of the Medical Expenditure Panel Survey - Insurance Component.

## METHODS AND NOTES

- This report includes estimates for private-sector employers and employees and does not include dependents. The MEPS-IC has no data on the number of dependents covered and therefore cannot estimate total covered persons; it can only estimate employee enrollment (Primary Source of Health Insurance presented on slide 4 is based on SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.
- For calculations based on all employees we use the final weighted estimates from the MEPS-IC, which rakes to firm sizes from the Census Bureau's Business Register as part of its weighting process. For more information on the MEPS-IC weighting methodology, see MEPS Methodology Report #28 at [https://meps.ahrq.gov/data\\_files/publications/mr28/mr28.shtml](https://meps.ahrq.gov/data_files/publications/mr28/mr28.shtml).
- For the purposes of this analysis, High-Deductible Health Plans are defined as plans that meet the minimum deductible amount required for Health Savings Account (HSA) eligibility (\$1,300 for an individual and \$2,600 for a family in 2017).
- Average premium prices are not adjusted to account for variation in actuarial value.

**Source: Medical Expenditure Panel Survey - Insurance Component as analyzed by SHADAC.**

# CITATIONS

## **Suggested Citation**

Lukanen E, Hest R, and Fried B. 2017. "State-Level Trends in Employer-Sponsored Health Insurance, 2013–2017." Minneapolis, MN: State Health Access Data Assistance Center.

## **Other Contributors**

Carrie Au-Yeung provided substantial review and editing, and Lindsey Lanigan provided the design and layout.