Employer-Sponsored Insurance for Low- and Moderate-Income Children

Employer-sponsored insurance has long been a major source of health coverage for children in the United States. More than half of all children are covered by employer-sponsored insurance, although whether or not a child has access to and is covered by employer-sponsored insurances varies by family income. One-third of children now covered by separate CHIP would likely transition to employer-sponsored insurance should funding for CHIP expire at the end of fiscal year 2017, as under current law.

Employers generally are not required to offer health insurance and they have considerable flexibility to design the coverage they offer their employees. They can change benefit design including covered benefits, employee premiums, or cost sharing, or stop offering coverage altogether in response to factors such as rising cost of coverage or the availability of workers. In recent years, fewer employers have offered coverage, and workers have seen both their contributions toward the cost of coverage and cost-sharing requirements rise. Certain employers could face financial penalties for not offering employees affordable coverage that meets minimum value requirements.[1]

This fact sheet provides background information on employer-sponsored insurance for low- and moderate-income children—including availability, affordability, and benefits covered—that may be relevant to future discussions on policies affecting children's health insurance coverage.

Where Do Children Get Insurance?

Most low- to moderate-income children were covered by Medicaid or CHIP in 2014.

- Nationally, most children (69 percent) 18 years old or younger in families with incomes below 200 percent of the federal poverty level (FPL) had public coverage in 2014, including Medicaid and CHIP, compared to 27 percent with private health insurance and about 9 percent who did not have health insurance (Census 2015).[2]
- The total number of children (under 18 years old) enrolled in exchange coverage grew from 497,522 in 2014 to 956,894 in 2016 (ASPE 2016, ASPE 2014).

Children's access to employer-sponsored insurance coverage differs significantly by income.

- In 2013, one in four children in families with incomes below 138 percent FPL had a parent who was offered employer-sponsored insurance compared to 59 percent of children in families with incomes

between 139 and 200 percent FPL and 69 percent of children in families with income between 201 and 250 percent FPL (MACPAC 2015b).

Children's access to employer-sponsored insurance depends on the firm in which their parent is employed.

- Nearly six in ten (57 percent) firms offered health benefits to their employees in 2015 (Claxton et al. 2015).
- Among firms that offered coverage, 96 percent of small firms and 99 percent of large firms offered coverage to spouses in 2015.
- Few firms that offered coverage did not offer coverage to other dependents, including children, in 2014 (8 percent of small firms and 1 percent of large ones) (Claxton et al. 2014).

Firms with a high proportion of low-wage workers are less likely to offer health insurance to their employees than firms with a low proportion of low-wage workers.

- The Kaiser Family Foundation/HRET Survey of Employer Health Benefits found that 28 percent of low-wage firms offered health insurance to their employees in 2015, in contrast to 55 percent of firms with fewer low-wage workers (Claxton et al. 2015).[3]
- The Medical Expenditure Panel Survey, conducted by the Agency for Healthcare Research and Quality, found that 36 percent of low-wage private firms offered health insurance to their employees in 2014, while 54 percent of private firms with fewer low-wage employees offered health insurance (MACPAC 2015c).[4]

Few firms offer health coverage to part-time and temporary workers.

- Low-income children were more likely to have a parent that works part-time than children in moderate and high-income families in 2013. Of children in families with incomes at or below 138 percent FPL 13.5 percent had parents who worked part time compared to 6.9 percent of children with incomes between 139 and 200 percent FPL, 3.9 percent of children with incomes between 201 and 250 percent FPL, 2.2 percent of children with incomes between 251 and 400 percent FPL, and 1.1 percent of children in families with income above 400 percent FPL (MACPAC 2015c).
- About one in five firms (19 percent) offering health benefits offered coverage to part-time workers in 2015.
- Three percent of firms offered coverage to temporary workers in 2015, although larger firms (200 or more workers) were more likely to offer coverage to such employees than small firms (3-199 workers) (Claxton et al. 2015).

Many factors affect the likelihood that a firm offers health insurance to its employees.

- Larger firms were more likely to offer health insurance to their employees (Claxton et al. 2015); low-wage workers with families are more likely to be employed in small firms and less likely than all other workers to be employed in large firms (Acs and Nichols 2007).

- The likelihood that a firm offers insurance varies by industry. For example, 90 percent or more of state and local governments offered health insurance in 2015. Retail firms and agricultural firms were among those least likely to offer coverage (Claxton et al. 2015, MACPAC 2015c).
- Low-wage workers with families are more likely to work in agriculture than all other workers, and less likely to work in public administration. On the other hand, low-wage workers are less likely to work in retail than all other workers (Acs and Nichols 2007).

Who is Eligible for Employer-Sponsored Coverage?

While health insurance eligibility has been relatively stable since 1999, it varies by firm characteristics.

- About 70 percent of workers in low-wage firms were eligible for coverage compared to 80 percent in firms with fewer low-wage workers in 2015.
- Other firm characteristics that affect the likelihood that employees are eligible for coverage include type of industry, whether a firm has some union workers, whether workers are predominantly younger or older, and whether the firm is public or private not-for-profit (Claxton et al. 2015).

What is the Cost of Health Insurance Premiums to Families?

- The total average annual employer-sponsored insurance premium for family coverage was $17,545 in 2015. On average, workers contribute $4,955, or about 29 percent of premium costs.
- Total average premiums for family coverage have almost doubled since 1999, although the growth in premiums was lower from 2010 to 2015 than from 2000 to 2005 (Claxton et al. 2015).

The share of premium paid by employees has remained relatively stable even as the amount that employees pay has increased.

- The average share of family premiums paid by covered workers has fluctuated between 26 and 30 percent since 1999.
- At the same time, the average amount that covered workers contribute for family coverage more than doubled, from $1,543 in 1999 to $4,955 in 2015.
- Between 2010 and 2015, growth in workers' contributions to premiums outpaced growth in inflation and earnings (Claxton et al. 2015).

Average total health insurance premiums vary considerably.

- About one in five covered workers faced total family coverage premiums less than 80 percent of the average (less than $14,036 annually) in 2015.
- But, 18 percent of covered workers faced total family coverage premiums greater than 120 percent of the average ($21,054 or more, annually) in 2015.

Health insurance premiums vary by firm characteristics (e.g., firm size, industry, whether the firm employs union workers, and firm ownership) and plan type.

- The total average annual premium for family coverage (including worker and employer contributions) in small firms (those with 3 to 199 workers) was $16,625 in 2015, whereas the total average annual premium for covered workers in large firms (those with 200 or more employees) was $17,938.
- Firms with some union workers had higher premiums than firms without union workers in 2015.
- Private for-profit firms had lower premiums compared to public firms and private non-profit firms in 2015.
- Preferred provider organizations (PPOs) had the highest total average annual premium, and high-deductible health plans with a savings option such as a health savings account had the lowest average annual premium in 2015 (Claxton et al. 2015).
- Health insurance premiums do not vary by employee income within a firm, although a few firms have policies that vary worker contribution to premiums by income (see below).

The average annual worker contribution also varies by firm characteristics and plan type.

- Workers in large firms pay a smaller share of the total premium than covered workers in small firms (Claxton et al. 2015). However, low-income workers with families are more likely to work in small firms and less likely to work in large firms than all other workers (Acs and Nichols 2007).
- Firms without any union workers required higher worker premium contributions for family coverage than firms with some union workers in 2015.
- Six percent of covered workers were in firms that bore the full cost of insurance coverage in 2015.
- Fifteen percent of covered workers were in firms that required employees to pay more than half the cost of health insurance in 2015, but data on the number of low-income workers with families in these firms are not available (Claxton et al. 2015).

Employers differ in the progressivity of their health insurance offerings.

- In 2015, covered workers in firms with many low-wage workers faced lower total premiums for family coverage relative to firms with fewer low-wage workers ($16,182 compared to $17,665) but workers contribute a larger share of premiums (41 percent compared to 28 percent) (Claxton et al. 2015).
- As the size of the firm increases, so does the likelihood that the firm requires low-wage workers to contribute less to the premium (Claxton et al. 2014). For example, less than 1 percent of firms with 3-24 workers have such a policy compared to 21 percent of firms with 5,000 or more workers in 2014.

Most covered workers must meet a deductible before health insurance will cover the cost of health care services.

- Most (84 percent) of private-sector employees were enrolled in a plan with a deductible for family coverage in 2014, up from 48 percent in 2002 (the first year in which data were collected) (MACPAC 2015c).However, data on the number of children in low-income families that face a deductible, and the average amount of that deductible, are not available.

- Annual deductibles have increased steadily since 2006, although the increase varies by plan type. For example, the average general annual deductible for family coverage increased by 23 percent among high-deductible health plans from 2006 to 2015, by 95 percent for PPO plans, 101 percent for POS plans, and 267 percent for HMO plans (Claxton et al. 2015).
- However, the majority of covered workers were in plans that cover physician office visits and prescription drugs before the deductible has been met in 2015 (Claxton et al. 2015).
- The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) limits the cost sharing that a covered worker must pay in a year, often referred to as the annual out-of-pocket maximum. Non-grandfathered plans annual out-of-pocket maximum cannot exceed $13,200 for family coverage in 2015, and that limit will increase to $13,700 in 2016.

Most covered workers also face cost-sharing requirements for primary care and specialty physician office visits.

- About 7 in 10 (68 percent) covered workers are required to make a copayment for visits to primary care and specialty physicians, and about one-quarter are in plans that require coinsurance for such visits.[5]
- The average copayment for a primary care office visit was $24 in 2015, and the average copayment for a specialty care office visit was $37. The average coinsurance was 18 percent and 19 percent, respectively.
- Over time, more workers are paying higher copayments. More than one in four (28 percent) covered workers had a $30 copayment or higher in 2015, compared to 8 percent in 2006 (Claxton et al. 2015).

What does Employer-Sponsored Insurance Cover?

The majority (98 percent) of individuals and families with employer-sponsored insurance coverage are in plans that have actuarial values of 70 percent or higher, meaning that on average, the plans pay 70 percent or more of enrollees' health expenses (ASPE 2011). The wide variation among plans and the impact of state benefit mandates makes direct comparisons based on actuarial value difficult.

- Among such employer-sponsored offerings, health maintenance organizations (HMOs) typically have the highest actuarial values, and high-deductible health plans much lower actuarial values if employers do not make any contribution to a health savings account (Peterson 2009).
- Cost-sharing and benefits can vary widely depending on the state in which the child lives, a parent's employer, and the health plan that the family selects.

Insurance offered by employers must meet minimum federal requirements to remain tax exempt.

Employer-sponsored insurance policies must cover certain federal and state-required benefits, and federal regulations limit the amount enrollees can be expected to pay out-of-pocket each year. But plans vary considerably in terms of covered benefits because these decisions are employer specific and there are few federally mandated benefits. [6,7]

- Plans must cover preventive services, including contraceptives and breast pumps for women. Plans are not required to cover mental health and substance use disorder services.
- Employer-sponsored insurance plans cannot require cost-sharing for preventive services, including some maternity services and well-child visits.[8]
- Most employer-sponsored insurance plans cover inpatient and outpatient services, physician services, and prescription drugs.
- Autism services are covered by about 69 percent of plans in small firms and 80 percent of plans in large firms.
- Half of all plans cover applied behavioral analysis therapy.
- More than half of all plans (54 percent) do not include pediatric dental coverage. Of the employers that offer separate dental coverage, many require an additional premium.
- Most benefit mandates are issued at the state level. For example, even without federal mandates, 37 states and the District of Columbia required plans to cover certain autism services (NCSL 2012). Some states require other benefits, including certain screenings, immunizations (including pediatric), and infertility treatments (MACPAC 2015d).

Less is known about the number of children that have access to specific benefits through employer-sponsored insurance. For example, data on the number of children that access to speech, physical, or occupational therapies are not available.

Endnotes

[1] Under the employer mandate provision of the Patient Protection and Affordable Care Act (§1513 of the ACA, P.L. 111-148, as amended), large employers (those with at least 50 full-time equivalent employees) will face financial penalties if they either do not offer affordable coverage to at least 95 percent of its full-time workers and their dependent children, or offer coverage that does not meet minimum essential coverage requirements. Such coverage is considered affordable if the cost for the employee,, is less than 9.5 percent of family income. Employer-sponsored plans must have an actuarial value of 60 or higher, and cover hospital and physician services, to meet minimum essential coverage standards. Employers with 100 or more employees must offer coverage to 70 percent of employees in 2015; in 2016 t employers with 50 or more employees must offer coverage to 95 percent of employees. Employers would only incur penalties if employees receive subsidized exchange coverage.

[2] Some children have both employer-sponsored and Medicaid coverage, and therefore may be included in both categories. Therefore, total does not sum to 100 percent.

[3] Low-wage firms are defined in the Kaiser/HRET survey as firms in which 35 percent of employees or more earn $23,000 annually or less (Claxton et al. 2015). Firms with fewer low-wage workers are those in which less than 35 percent of employees earn $23,000 annually or less.

[4] Low-wage employees were defined in the survey as those earning $11.50 per hour, or $24,000 annually, or less (MACPAC 2015c). A low-wage firm is defined as one in which 50 percent of employees or more are considered low-wage employees. Firms with fewer low-wage workers are those in which less than 50 percent of employees are considered low-wage employees.

[5] A copayment is a fixed dollar amount paid by a plan enrollee to a provider for services. Enrollees with coinsurance requirements must pay a fixed percentage of the allowed amount for services. The amount an enrollee with a coinsurance is required to pay for a visit will vary depending on the coinsurance requirement and the total allowed amount for the visit.

[6] For more information on covered benefits in employer-sponsored plans, including a table of coverage of selected benefit categories by source of coverage, please see chapter 3 of the March 2015 report (MACPAC 2015d).

[7] Some mandates may not apply to self-funded or self-insured plans, in which the employer assumes direct financial responsibility for employee claims. Covered workers in large firms (those with 200 or more employees) are more likely to be in a self-funded plan than those in small firms (83 percent vs. 17 percent) (Claxton et al. 2015).

[8] Non-grandfathered plans are required to provide the following services without cost-sharing: well-woman visits, screening for gestational diabetes, human papillomavirus testing, counselling for sexually transmitted infections, counselling and screening for HIV, contraceptives, breastfeeding support, supplies, and counseling, and screening and counseling for interpersonal and domestic violence (HRSA 2015).

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