Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Trends in Small-Group Market Insurance Coverage, 2013–20

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Brief Summary

About half of small-firm employees worked in establishments that offered health insurance from 2013 to 2020, whereas more than 99 percent of large-firm employees worked in establishments that offered coverage. Yet, we find that the small-group market continues to serve as an important source of health insurance for many workers. Since the implementation of the Affordable Care Act (ACA), the small-group market has been characterized by relative stability, rather than a sudden decline as some policy analysts predicted. The main findings of our study are as follows:

- The rate at which small firms offer health insurance coverage decreased by just 2.6 percentage points from 2013 to 2020. For comparison, it declined by 10.6 percentage points from 2002 to 2012. Steady offer rates likely reflect consistent demand for employer-sponsored coverage from small-firm employees and greater stability in health insurance costs resulting from ACA reforms.
- Health insurance enrollment among small-firm employees remained relatively stable from 2013 to 2019, hovering between 8.9 and 9.6 million enrollees. Small-firm enrollment dropped to 7.9 million in 2020, likely because of decreases in small business employment resulting from the COVID-19 pandemic.
- Small declines in take-up and coverage rates were comparable across small and large firms during the study period. Take-up fell by 4.4 percentage points in the small-group market and by 4.3 percentage points in the large-group market.
- Annual premium growth in the employer-sponsored insurance (ESI) market was similar across all firm sizes; premiums for single coverage grew by an average of 3.2 percent per year in the

small-group market and by 3.7 percent in both the medium- and large-group markets. Nongroup premiums were significantly more unstable during this period, which may have affected small employers' decisions to maintain coverage.

- The share of establishments offering a self-insured plan grew from 13.2 percent in 2013 to 16.0 percent in 2020. Despite early fears that small firms would transition to self-insurance *en masse* to avoid market regulations, small firms were less likely to offer self-insurance than larger firms.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

Introduction

The passage of the ACA in 2010 affected how employers of all sizes considered health insurance offerings. By expanding Medicaid eligibility and introducing premium tax credits to the individual health insurance marketplace, the ACA boosted the attractiveness of alternatives to ESI. The law revamped the nongroup market for individual health insurance plans and defined new rules for the employer market. Most of the new rules for employers applied specifically to the state-regulated small-group market. To encourage employers to continue offering coverage, large employers may face a tax penalty if they do not offer affordable insurance options to their employees. Small employers with fewer than 50 employees, however, face no penalties for not offering coverage. Consequently, some policy analysts expected the small-group market to shrink substantially after implementation of the ACA health insurance provisions in 2014.

Those predictions did not come to pass. Many small firms continue to offer insurance, and the small-group market remains an important source of coverage for many workers and their dependents. Nevertheless, policymakers remain concerned that the small-group market could erode as health care costs rise, and they seek to understand the latest trends in offer and coverage rates as they consider policies that might shore up this coverage source. The question remains whether small employers are following the same trends as larger firms or following another path because of issues specific to their market.

In this brief, we closely examine trends in the small-group market from 2013 to 2020 and how they differ from trends in the larger employment-based market. We focus on offer rates, coverage rates, and

premiums. We rely on the annual data published from the Medical Expenditure Panel Survey Insurance/Employer Component (MEPS-IC).

Background

In this paper, we follow current federal law and define small employers as those with fewer than 50 full-time-equivalent employees.[1] Defined this way, small firms make up 96 percent of all firms across the US but employ only slightly more than one-quarter of all workers. In 2018, 34 million people were employed through small businesses, accounting for 26 percent of the US domestic workforce (excluding the self-employed workforce).[2]

Historically, small firms have been less likely to offer insurance than larger firms. This disparity can be attributed to small employers having fewer workers over which to pool administrative costs and health risks and consequently facing higher and often more volatile costs. Moreover, relative to those at medium and large firms, small-firm workers have lower wages on average (Brown and Medoff 1989; Caruso 2015) and are more likely to work part time (Headd 2000).

Before the ACA, the small-group health insurance market did not perform as well as insurance markets for medium and large firms, and its costs were higher. Unlike premiums for larger firms, premiums for small firms included the cost of underwriting based on individual worker characteristics. Small firms also faced more volatility in premiums from year to year because their premiums were experience rated (e.g., a year with a cancer diagnosis for a worker might cause a spike in next year's premium). Because of these higher costs, small firms typically offered lower-value insurance products to hold down costs. Between 2000 and 2011, small-firm offer rates declined faster than offer rates for medium and large firms, resulting in a gap that grew larger over time (Buchmueller, Carey, and Levy 2013).

Changes to the small-group market under the ACA. The ACA reformed the small-group market in several ways beginning in 2014, when the major coverage provisions were implemented. Some changes in market regulations were intended to reduce insurance costs for small employers, including a requirement that insurers use modified community rating rules, instead of traditional experience rating, to set premiums. This means premiums are no longer based on the average health status of employees in the firm; instead, premiums vary only by employee age, tobacco use, family composition, and geography. Prohibiting underwriting and experience rating eliminated the administrative costs associated with these activities. The ACA also set limits on insurer medical loss ratios, another method for lowering administrative costs relative to pre-ACA levels. In addition, the new rules require risks to be pooled over the entire small-group market within each state, thus reducing the year-to-year volatility of premiums faced by some small employers before the ACA.[3]

Other rules were designed to improve workers' financial protection by setting benefit standards. These changes could have contributed to increased costs of insurance for small employers depending on the generosity of benefits offered before the ACA. Plans offered in the small-group market (and in the nongroup market) are required to cover certain essential health benefits. Plans must also provide a

certain minimum level of financial protection. Currently, the least generous plan (bronze) must cover approximately 60 percent of incurred costs for covered benefits. Beyond these small-group-specific reforms, the ACA created and applied various other rules across markets of all sizes. For all fully insured markets, insurers cannot deny coverage on the basis of preexisting conditions and cannot refuse to renew coverage on the basis of health status.

During the debates before the ACA's implementation, some policymakers were concerned the ACA would substantially undermine ESI, including both the small- and large-group markets, because of the expansion of Medicaid eligibility and the creation of a newly attractive subsidized insurance Marketplace. Additionally, some observers emphasized the potential for adverse selection in the small-group market (Lucia et al. 2015). Small firms with healthy workers might opt to self-insure, thus exempting themselves from the single risk pool and certain other premium rating rules.[4] The evidence, however, shows that both small- and larger-group ESI markets remained strong. Research attributes this stability to various factors such as a strong economy, substantial ESI tax advantages, and the early instability of the individual marketplace (McMorrow, Blumberg, and Holahan 2020). One analysis focused on the small-group market found no statistically significant declines in overall small-firm offers in 2014 through 2015 (Vistnes et al. 2017). Moreover, many agree that the ACA did not detrimentally affect small-group market costs, as was initially expected, but instead helped stabilize health costs and expand coverage options for small-firm employees (Chase and Arensmeyer 2018; Hall and McCue 2018).

Employer decisions to offer health insurance. Employers want to attract the best available workers at the lowest cost by offering a mix of cash wages and noncash benefits such as health insurance accounts (CBO 2012). Their decisions to offer health insurance depend on competition in the labor market and the costs of alternative sources of coverage that may be available to their potential workers. Workers with low incomes, who work part time or receive low wages, may be eligible for Medicaid or subsidized Marketplace coverage. Workers with higher incomes may benefit more from the tax exclusion for employer-provided health insurance. The value of this tax exclusion increases with a worker's income (and marginal tax rate). Thus, small employers with high-income employees continue to offer ESI despite the lack of financial penalty for not doing so.[5] Similarly, we expect small firms that compete in industries with larger firms for skilled workers to be more likely than other small firms to continue to offer health insurance to their employees (Hadley and Reschovsky 2002).

Yet, whether small firms offer health insurance coverage varies substantially. Though many small firms such as restaurants and retail stores primarily employ low-wage and part-time workers, other small firms, such as professional services firms, primarily employ full-time and high-wage workers. Thus, average trends for all small firms may hide differences among them. Though one study found no overall reduction in small firms' offers of health insurance coverage in 2014 through 2015, its authors found different results when breaking down offer rates by subgroups of small firms; low-wage firms and firms with fewer than 10 employees had higher likelihoods of dropping coverage (Vistnes et al. 2017).

Data and Analytic Approach

This brief uses estimates from the MEPS-IC. The Agency for Healthcare Research and Quality sponsors the MEPS-IC, and the US Census Bureau collects the data annually.[6] The survey is administered at the employer level and asks questions related to health insurance offers, coverage, costs, and benefit options. This analysis focuses specifically on private-sector trends and excludes data on public-sector employees. In 2020, the private-sector sample had a 56.1 percent response rate and included about 45,700 business establishments.[7] The MEPS-IC data are especially valuable when examining small business trends because the survey has a larger sample than other surveys of employers. Moreover, the up-to-date address information from the Census Bureau's Governments Master Address File means the survey is good at tracking the frequent business closures and start-ups that disproportionally influence the small-firm subsample.

This brief focuses on 2013 to 2020 to examine how the small-group market fared after the implementation of the 2014 market reforms.[8] We define small firms as those with fewer than 50 employees, consistent with current law in most states.[9] In some instances, we break down small firms further to determine how trends vary across segments within the market. To provide more context for the trends displayed in the small-group market, we also look at medium-sized firms, generally defined as having 100 to 999 employees, and large firms, defined as having 1,000 or more employees. Because of predefined MEPS-IC firm sizes, however, some of our figures omit firms with 50 to 99 employees, and others display different classifications for medium- and large-size firms. However, we maintain a consistent small-firm definition of fewer than 50 employees.

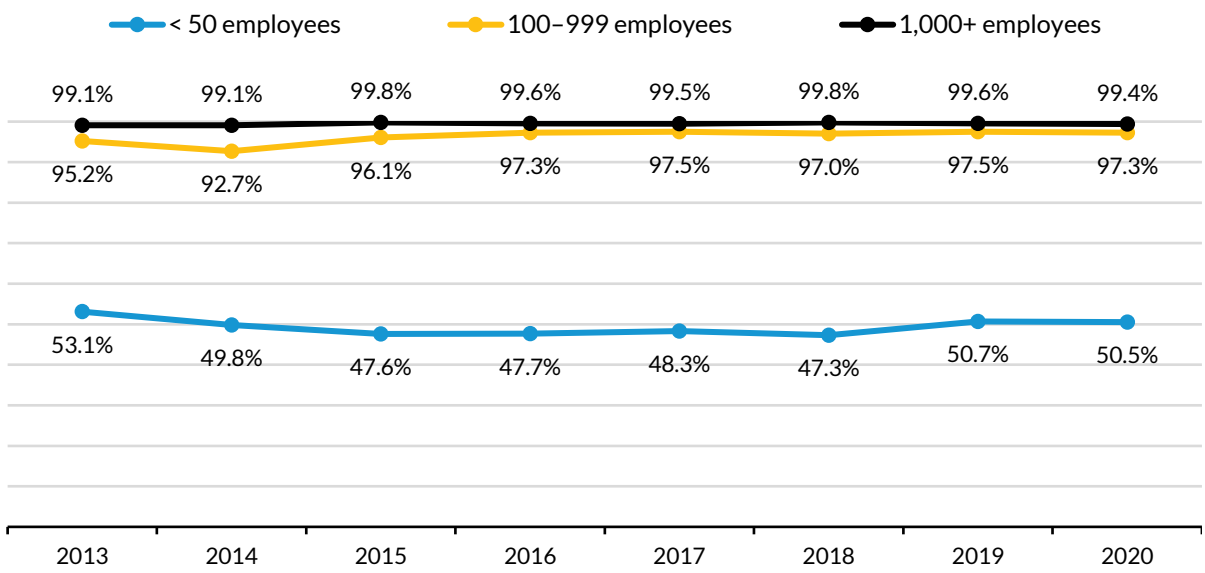
We report employee-weighted estimates of key outcomes because they provide a robust, policy-relevant way of understanding how the small-group market has evolved in terms of the number of people (rather than the number of firms) affected.

Results

In this section, we discuss changes in several coverage and cost outcomes from 2013 to 2020 to determine how the small-group market has evolved since the ACA's implementation. We look specifically at trends in employer offers, eligibility, employee take-up, overall coverage rates, premiums, contributions, and self-insurance rates. To give these numbers more historical context, we sometimes refer to trends that occurred between 2002 and 2012.

FIGURE 1

Share of All Private-Firm Employees Whose Establishments Offer Insurance, 2013–20



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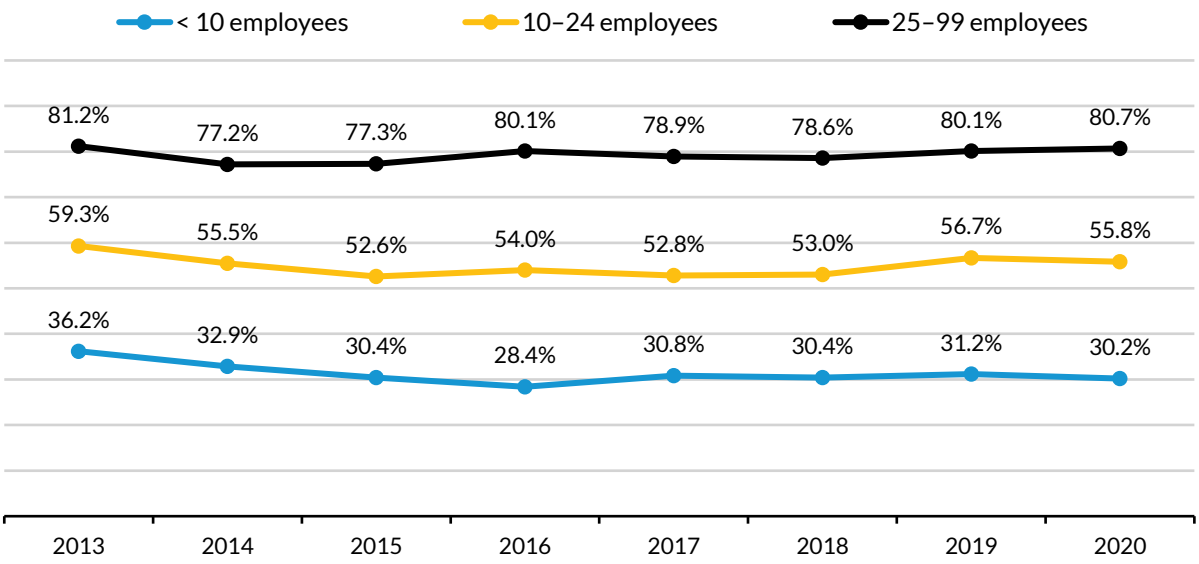
Source: Medical Expenditure Panel Survey Insurance/Employer Component summary tables from the Agency for Healthcare Research and Quality, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp.
Note: We omit firms with 50 to 99 employees because this category is not tabulated in publicly available data.

Small businesses have always been less likely to offer coverage than larger businesses. In 2020, 50.5 percent of small-firm employees worked for an establishment that offered health insurance, compared with about 97 and 99 percent of employees in medium and large firms. Small-firm offer rates were about 53 percent in 2013, decreased slightly between 2014 and 2018, and then increased to 50.5 percent by 2020. Across the study period, small-firm offer rates fell by just 2.6 percentage points, while medium- and large-firm offer rates were largely stable, increasing slightly. Before the ACA, however, small-firm offer rates decreased by more than 10 percentage points, from 63.5 percent in 2002 to 52.9 percent in 2012 (data not shown). In contrast to some predictions, the small-group insurance market stabilized in the wake of the ACA. The stability in employer offer rates may reflect reduced costs and volatility as a result of market reforms that eliminated underwriting, set minimum loss ratios, and established community-rated premiums and standard benefit packages, among other changes.

FIGURE 2

Share of Employees in Small and Medium-Sized Private Firms Whose Establishments Offer Insurance, 2013–20



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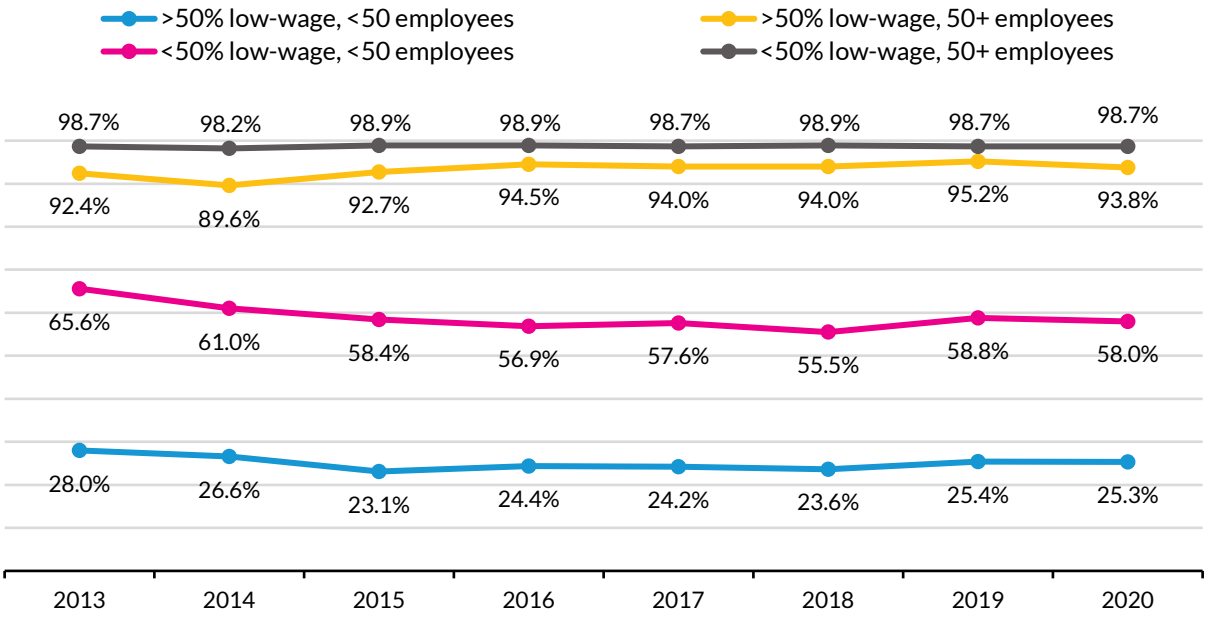
Source: Medical Expenditure Panel Survey Insurance/Employer Component summary tables from the Agency for Healthcare Research and Quality, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp.

Figure 2 highlights the differences in employer offer rates between small- and medium-firm subgroups. The smaller the firm size, the less likely that employers offer insurance. Offer rates for firms with fewer than 10 employees fell from 36.2 percent in 2013 to 28.4 percent in 2016 and had rebounded slightly to 30.2 percent by 2020. Offer rates for firms with 10 to 24 employees followed a similar pattern, declining from 59.3 percent in 2013 and ending at 55.8 percent in 2020. Small and medium-sized firms with 25 to 99 employees exhibited even more stable offer rates than the smaller-sized firms.

FIGURE 3

Share of Employees in All Private Firms Whose Establishments Offer Insurance, by Wage Level and Firm Size, 2013–20



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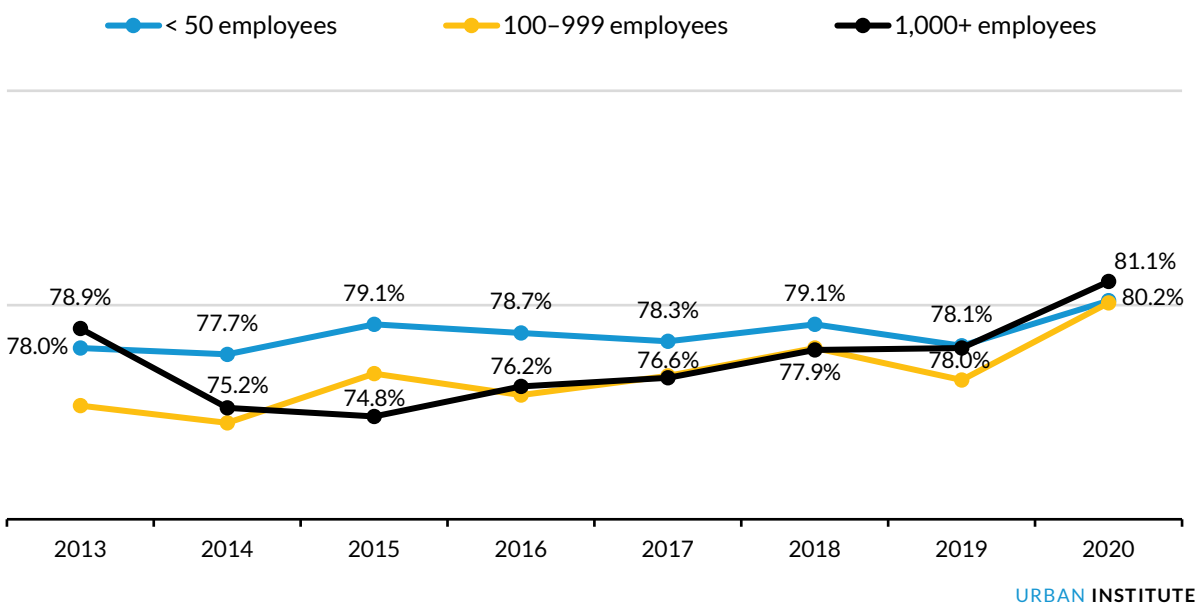
Source: Medical Expenditure Panel Survey Insurance/Employer Component summary tables from the Agency for Healthcare Research and Quality, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp.

Establishments with a larger share of low-wage workers were less likely to offer coverage to their employees, and this difference was greater among small firms than among larger firms. Because the value of the employer tax exclusion for health insurance rises with income, low-wage firms were less likely than high-wage firms to offer insurance. In 2020, only about one-quarter of workers employed by small, low-wage firms were employed in firms that offered health insurance; this is slightly lower than the 28 percent offer rate for this group in 2013. The gap in offer rates between low- and higher-wage small firms consistently exceeded 31 percentage points between 2013 and 2020.

FIGURE 4

Share of All Eligible Private Firm Employees Whose Establishments Offer Health Insurance, 2013–20



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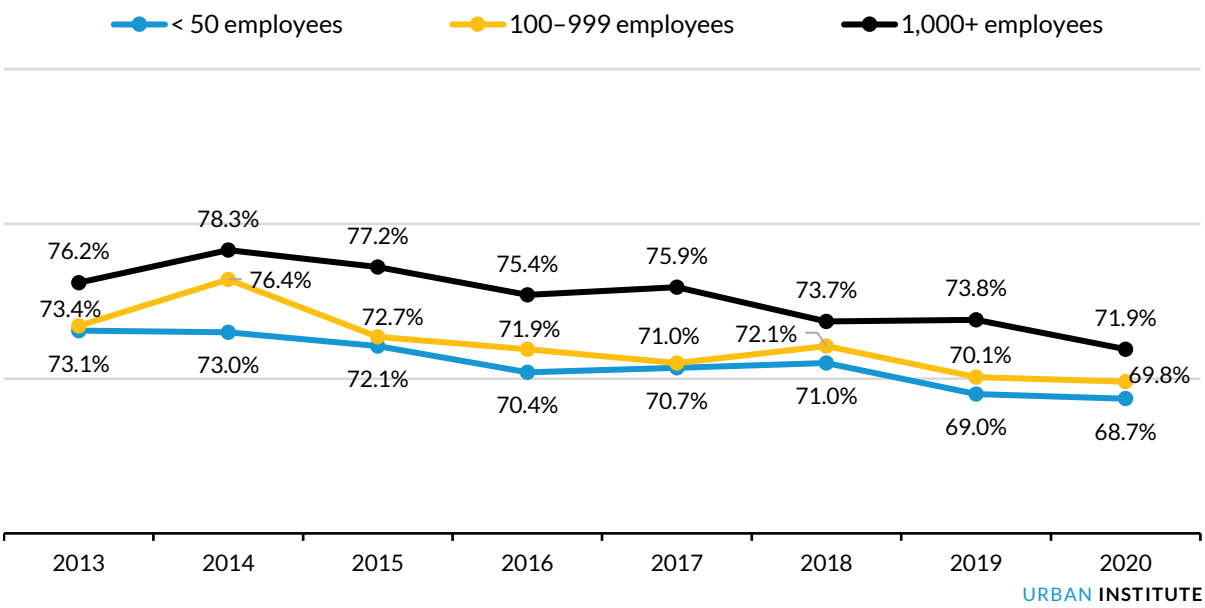
In addition to deciding whether to offer coverage, firms must also determine who will be eligible for coverage. Figure 4 shows how eligibility has changed across firms that offer health insurance. From 2013 to 2020, eligibility across small-firm employees increased by 2.2 percentage points (from 78.0 to 80.2 percent). From 2013 to 2019, eligibility remained relatively stable. The increase in the share of workers eligible for coverage across all firm sizes in 2020 may reflect survey response issues related to the pandemic. Large reductions in employment may have affected the share of workers who were eligible for coverage. Overall, eligibility remained similar across firm sizes.

FIGURE 5

Share of Eligible Private Firm Employees Who Enroll in Insurance in Offering Establishments (Take-Up Rate), 2013–20

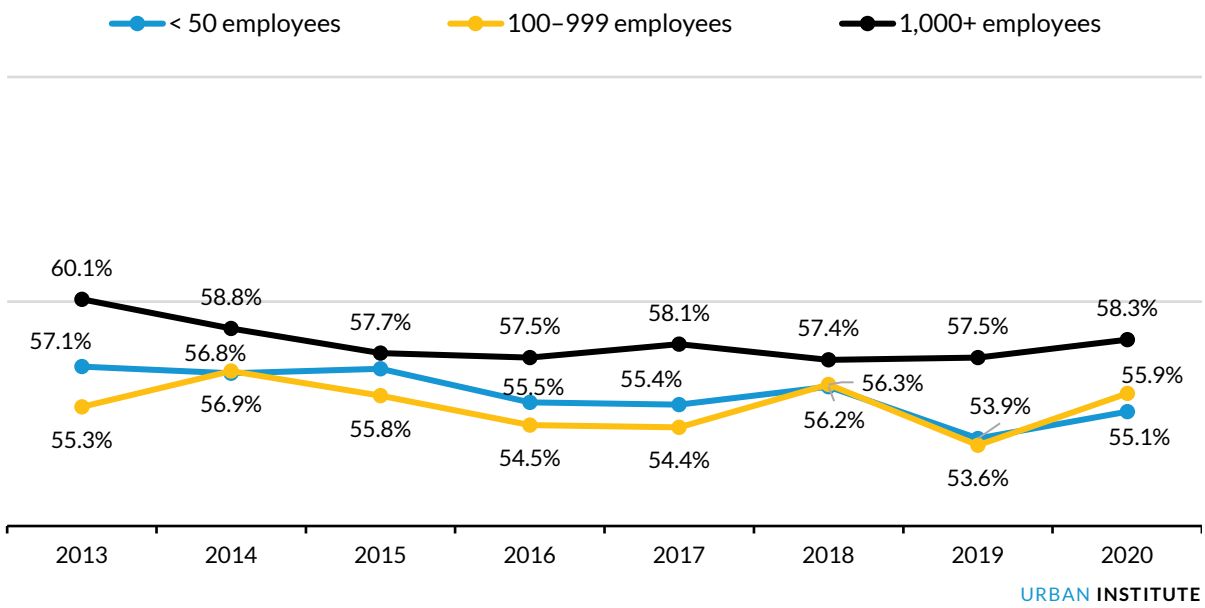


Source: Medical Expenditure Panel Survey Insurance/Employer Component summary tables from the Agency for Healthcare Research and Quality, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp.
Note: We omit firms with 50 to 99 employees because this category is not tabulated in publicly available data.

Employees decide whether to take up coverage offered by their employers. Figure 5 shows enrollment rates for eligible employees of establishments that offer coverage. A small one-year increase in employee take-up rates occurred among medium and large firms—but not small firms—in 2014. Since then, take-up rates have fallen steadily across firms of all sizes. Small firms exhibited a relatively consistent 4.4 percentage-point decrease in employee take-up rates from 2013 to 2020, compared with a decrease of 3.6 and 4.3 percentage points in medium and large firms. Though most workers enroll in offered coverage, others may enroll in coverage through a family member, sign up for Medicaid, or go uninsured. The nongroup market is not an option for most of these workers, because workers who have an affordable offer of coverage through their own employer or a family member's employer are generally ineligible for subsidized coverage in the Marketplace.

FIGURE 6

Share of Private-Firm Employees Who Enroll in Insurance in Offering Establishments (Coverage Rate), 2013–20



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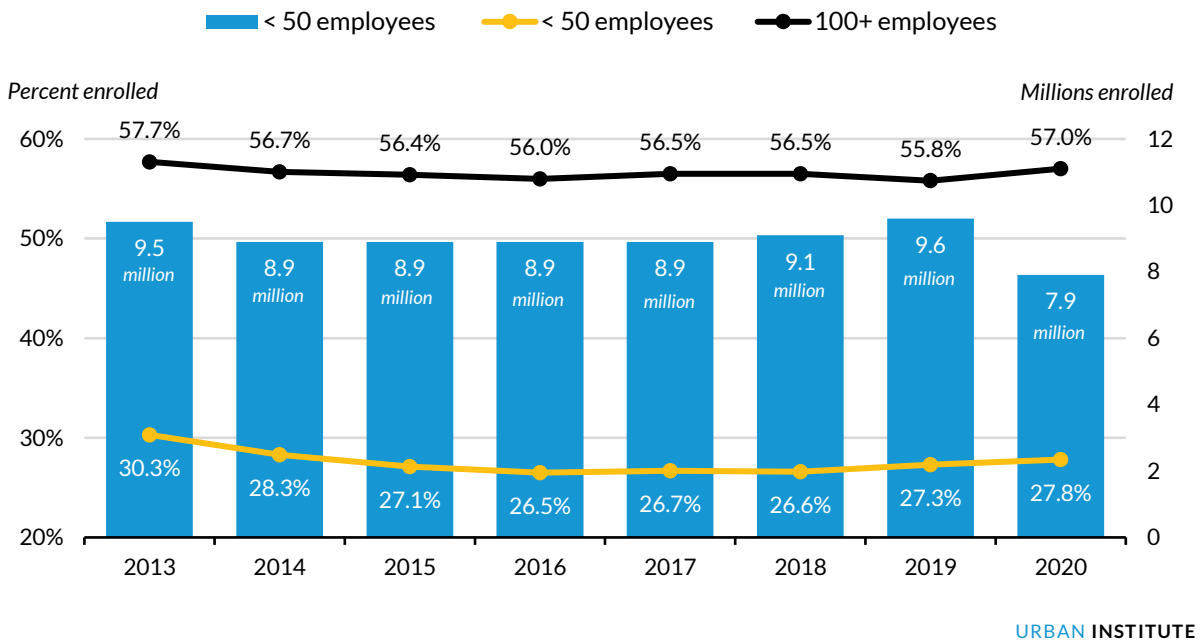
In figure 6, the coverage rate reflects both eligibility for and take-up of coverage in firms that offer health insurance. Whereas take-up rates show enrollment with respect to eligible employees, coverage rates show enrollment with respect to all employees in offering firms. Coverage rates among employees who work for firms that offer insurance were similar across all firm sizes at more than half of the workforce. From 2013 to 2020, small-firm coverage rates decreased by 2 percentage points (from 57.1 to 55.1 percent). Previously, small firms' take-up of coverage was as high as 62.7 percent in 2002, declining to 57.7 percent by 2012 (data not shown). This downward trend is not unique to the small-group market and has been prevalent across all firm sizes for decades. From 2013 to 2020, large-firm coverage rates decreased by 1.8 percentage points, while medium-sized firms' coverage rates remained relatively the same.

FIGURE 7

Share of Private-Firm Employees in All Establishments Who Enroll in Insurance (Overall Coverage Rate), 2013–20



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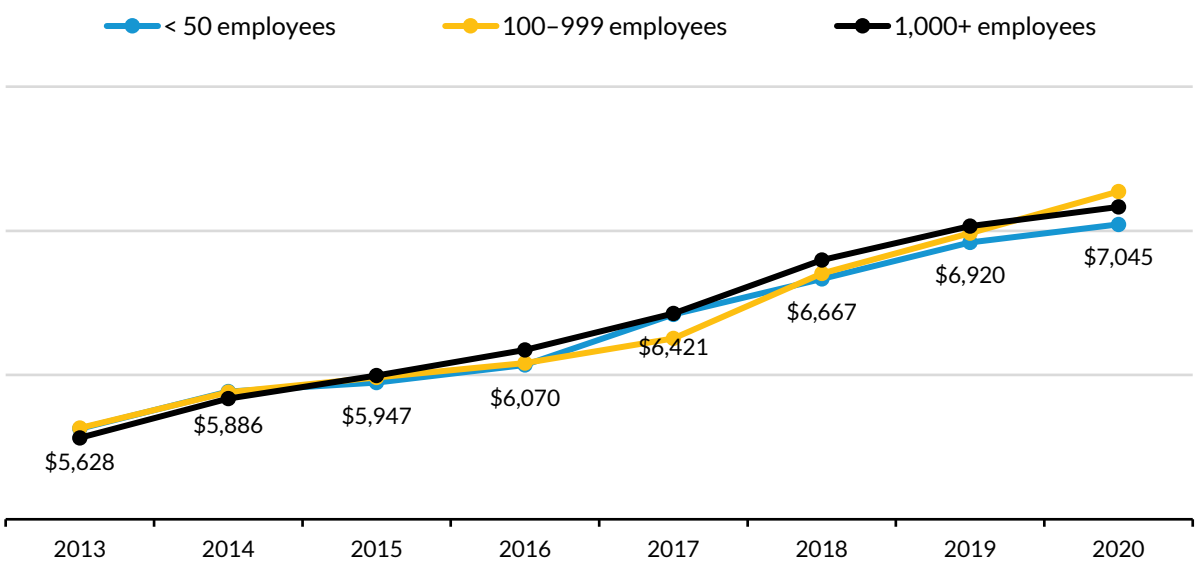
Note: We omit firms with 50 to 99 employees because our focus is on small firms.

Figure 7 shows coverage rates as shares of all employees in all small and large firms, including firms that do not offer insurance. For small firms, the figure also displays coverage in millions of people to provide additional context. The figure accounts for lower offer rates among small firms and eligibility and take-up rates. From 2013 to 2020, more than one-quarter of all small-firm employees received health insurance through their jobs, compared with more than one-half of large-firm employees. In 2013, 30.3 percent of all small-firm employees, or 9.5 million workers, were enrolled in ESI coverage. From 2014 to 2017, small-firm enrollment held steady at 8.9 million people, before increasing slightly by 2019. However, enrollment diminished to 7.9 million by 2020. This decrease is likely attributable to reductions in small-firm employment resulting from the pandemic (Miller and Keenan 2021). The small-group market accounts for a small share of total ESI coverage in the United States, but that share remained relatively stable in the period we examine.

FIGURE 8

Average Total Cost of Premiums for Single Coverage, 2013–20



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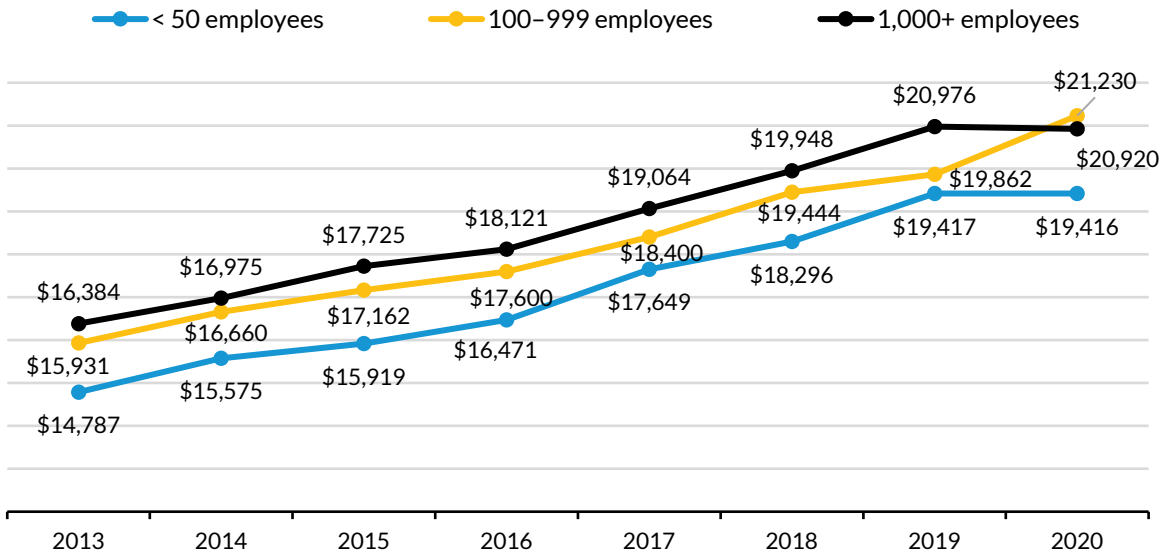
Source: Medical Expenditure Panel Survey Insurance/Employer Component summary tables from the Agency for Healthcare Research and Quality, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp.
Notes: We omit firms with 50 to 99 employees because this category is not tabulated in publicly available data. The values shown are for small-group premiums.

Premiums for single coverage grew at similar rates across all firm sizes during our study period. For small firms, average single premiums were $5,628 in 2013 and rose to $7,045 in 2020. The average annual growth rate was 3.2 percent. Medium and large firms saw similar premium levels and growth rates during the period. The cost of single premiums temporarily spiked in 2017, reaching 5.7 percent in the small-group market (a $351 increase). However, this premium growth was not sustained. Overall, single premiums increased by 25 percent from 2013 to 2020. Looking at historical trends, single premium growth among small firms was 2.9 percentage points higher in 2002 through 2012 (at 6.1 percent annually). Medium and large firms also saw much higher annual premium growth from 2002 to 2012.

FIGURE 9

Average Total Cost of Premiums for Family Coverage, 2013–20



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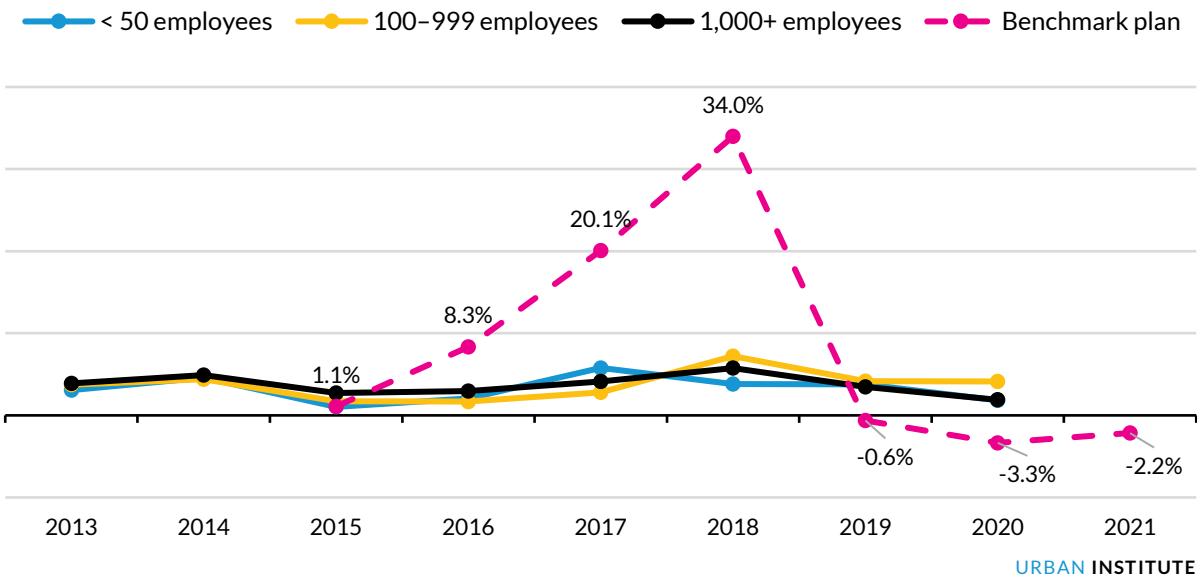
Note: We omit firms with 50 to 99 employees because this category is not tabulated in publicly available data.

Premiums for family coverage also grew at similar rates across all firm sizes between 2013 and 2020. Average small-group family premiums were $14,787 in 2013 and had increased to $19,416 by 2020, averaging 3.7 percent growth per year. Medium and large firms experienced comparable annual growth rates of 4.0 and 3.7 percent. The premium increases experienced by small firms were more volatile than the increases in the larger markets. Similar to what occurred with small-group single premiums, small-group family premiums also spiked in 2017, increasing by 7.2 percent. From 2002 to 2012, small firms saw average family premiums grow by 6.7 percent annually, compared with 7.7 percent for medium firms and 7.6 percent for large firms. Overall, small-group family premiums increased by 31 percent from 2013 to 2020.

FIGURE 10

Percent Change in Average Total Cost of Premiums for Single Coverage since the Previous Year, 2013–20



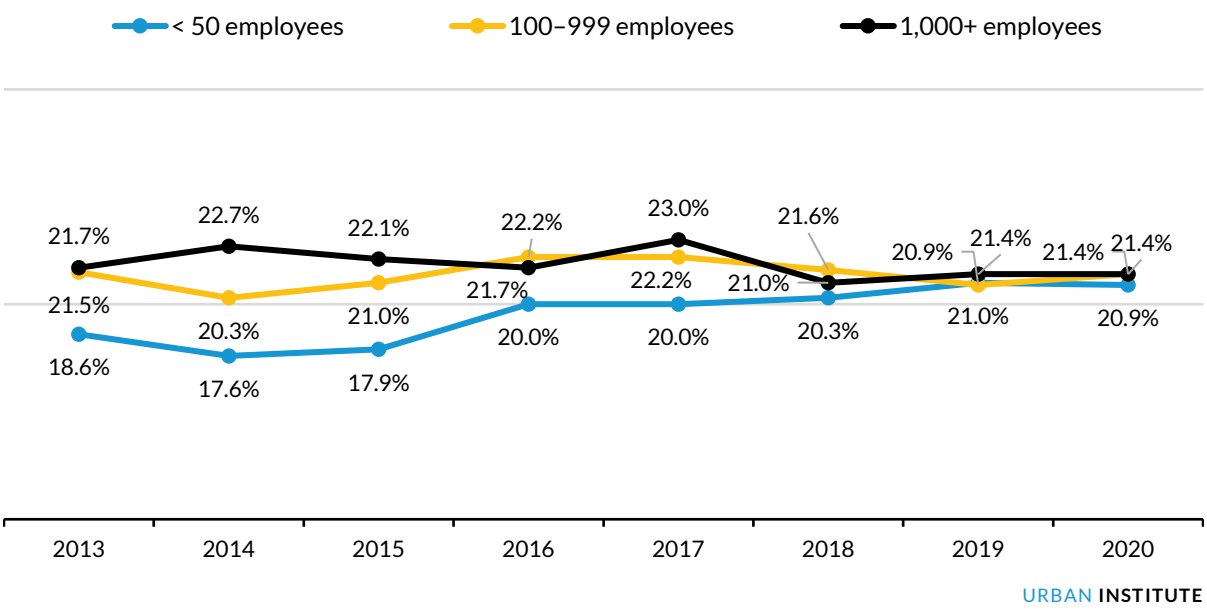
Sources: Medical Expenditure Panel Survey Insurance/Employer Component summary tables from the Agency for Healthcare Research and Quality, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp; and Kaiser Family Foundation State Health Facts.

Note: We omit firms with 50 to 99 employees because this category is not tabulated in publicly available data.

Figure 10 compares premium growth rates for single coverage in the employer-sponsored market and in the individual marketplace. We look specifically at changes in the average nongroup premium of the second-lowest-cost silver plan for a 40-year-old.[10] From 2016 to 2018, nongroup premiums were significantly more unstable than premiums in the employer-sponsored market because of changes in Marketplace regulations and laws. In 2018, specifically, individual premiums grew by 34 percent as insurers responded to the Trump administration's announcement that the federal government would no longer provide reimbursement for cost-sharing reductions.[11] Thereafter, from 2019 to 2021, benchmark premiums grew more slowly than premiums in the employer market. Premium volatility in the Marketplace may have contributed to small employers' decisions to continue offering group coverage to their employees, rather than dropping insurance so workers could enroll in the nongroup Marketplace.

FIGURE 11

Employee Contribution Rate for Single Premiums, 2013–20



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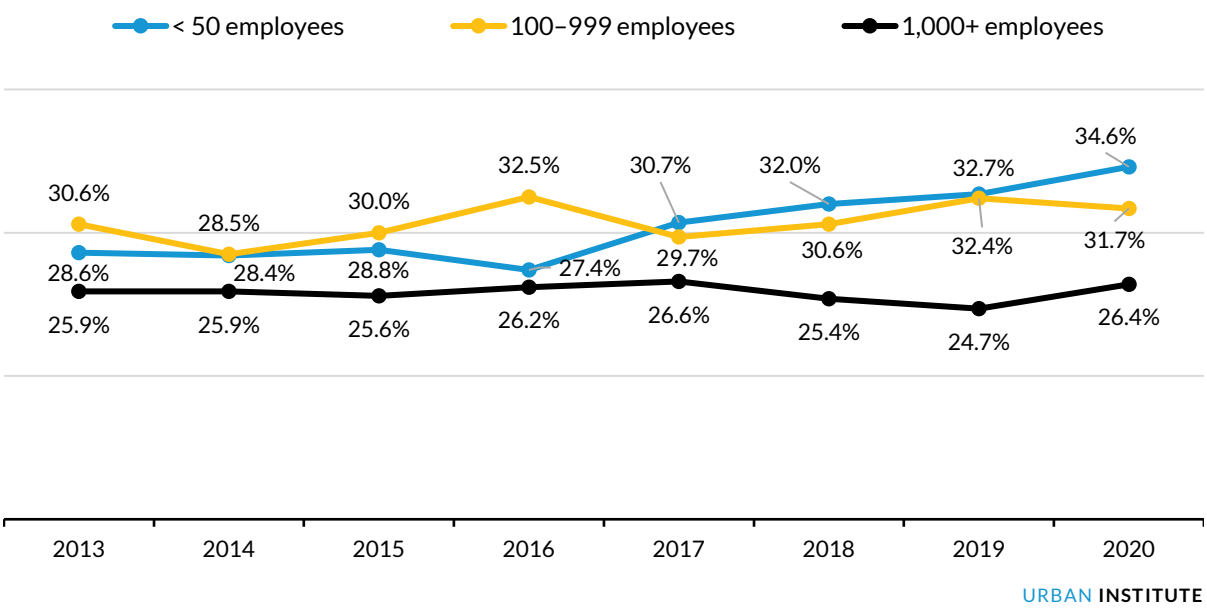
Small-group employee contribution rates rose by 2.3 percentage points over the study period. Employee contribution rates for single premiums in the small-group market have been rising steadily since the turn of the century. Conversely, single premiums for medium- and large-group employees have remained comparatively stable. Consequently, contribution rates had converged across all firm sizes by 2020, meeting at about 21 percent. In 2002, employee contribution rates were only 14.2 percent for small firms, compared with 19.1 percent and 18.5 percent for large and medium firms.

FIGURE 12

Employee Contribution Rate for Family Premiums, 2013–20



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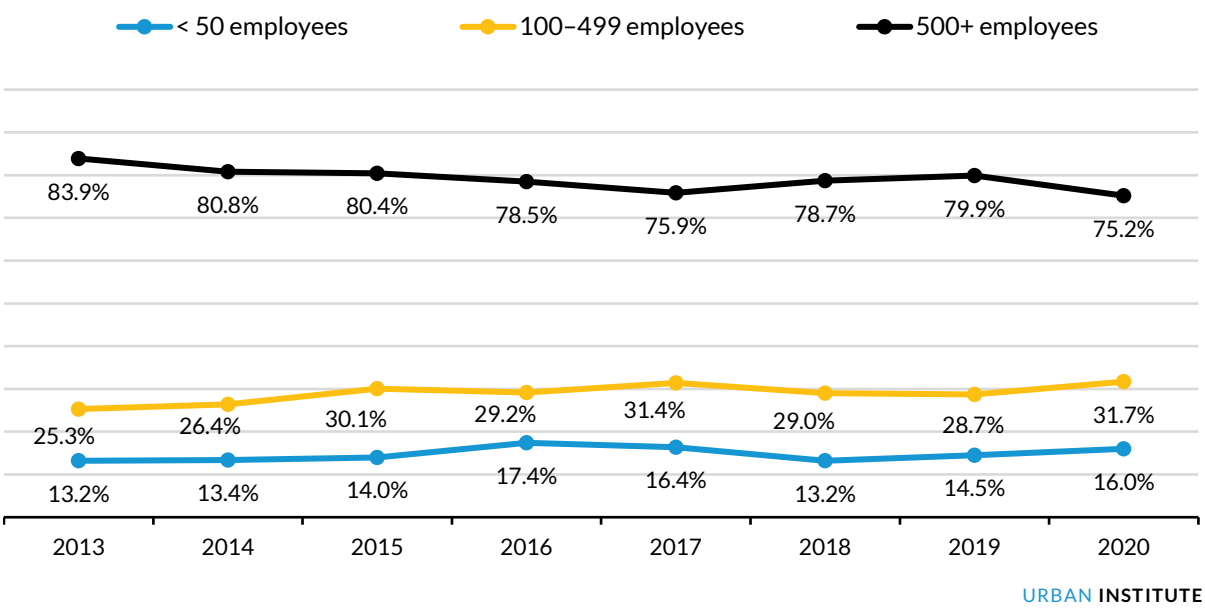
Employees' contributions to small-group family coverage increased by 4 percentage points over the study period. Such rates remained stable in the initial half of the period but spiked after 2016, reaching 34.6 percent by 2020. This is higher than both the average employee contributions for medium-sized firms (31.7 percent) and large firms (26.4 percent). Employees working in firms with fewer than 10 employees have maintained the lowest contribution rates across all firm sizes for both single and family premiums over the past two decades (data not shown).

FIGURE 13

Share of All Private Establishments Offering a Self-Insured Plan, 2013–20



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Small firms were much less likely than larger firms to offer a self-insured plan. The share of small firms offering a self-insured plan was 13.2 percent in 2013 and reached a historical high of 17.4 percent in 2016, before decreasing slightly to 16.0 percent in 2020. Though many people predicted that small firms would aim to avoid ACA market reforms by self-insuring, this did not happen on a large scale. From 2002 to 2012, small firms self-insured at a relatively steady rate, between 12 and 13 percent. From 2017 to 2020, self-insurance rates among small firms averaged about 15 percent. The savings and reduced volatility stemming from the ACA small-group market reforms may have outweighed the costs of those provisions, thus dampening the need to self-insure (which carries its own risks). Given that premiums reflect the previous year's market characteristics, the higher levels of self-insurance among small employers in 2016 may be partially responsible for the premium hikes in 2017 shown in figures 8 through 10.

Discussion of Results

The rate at which small firms offer employees health insurance coverage has been slowly declining since 2000, leaving many workers without the sought-after benefits associated with ESI. Before the ACA, this pattern was likely attributable to increases in health insurance costs and the higher financial burden of health insurance for small firms due to high administrative costs and limited abilities to spread risks over large numbers of employees (McMorrow, Blumberg, and Buettgens 2011). Despite early concerns that the ACA would shrink the small-group market, the ACA did not cause small employers to stop

offering their employees coverage. Moreover, in recent years, offer rates in the small-group market have remained steady. In fact, though small-firm offer rates fell slightly from 2013 to 2019, they exhibited stability relative to the steep declines experienced in the decade prior. Additionally, changes in small-group take-up and coverage rates remained comparable with those in the larger-group markets.

ESI provides several advantages to both employers and employees, because of its favorable tax treatment, which explains the continued existence of the small-group market. Though the benefits of ESI vary by wage and firm size, small-firm employees broadly continued to demand coverage. And given that employees bear the costs of their insurance through lower wages, small employers continued to offer their employees insurance in response to this demand.

Using MEPS-IC data from 2013 to 2020 to examine various small-group insurance characteristics improves understanding of how this market differs from the medium- and large-group markets and how previous predictions compare with observed outcomes. Further, this study creates a foundation for policymakers to make informed decisions about whether additional small-group interventions may be necessary to maintain market stability and improve employee coverage. Despite initial skepticism surrounding the health of the small-group market, small-firm insurance trends from 2013 to 2020 are largely a continuation of trends present since the early 2000s.

Notes

1 As of 2016, in accordance with the PACE Act (Protecting Affordable Coverage for Employees Act), states can define their small businesses as those with fewer than 100 employees. To date, California, Colorado, New York, and Vermont are the only states that have opted for this expanded definition. Most states define small businesses as those with fewer than 50 full-time-equivalent employees.

2 "2018 SUSB Annual Data Tables by Establishment Industry," US Census Bureau, May 2021, https://www.census.gov/data/tables/2018/econ/susb/2018-susb-annual.html.

3 The ACA also established state-based Small Business Health Options Program (SHOP) exchanges for small employers to purchase coverage. Employers who purchase coverage through the SHOP marketplaces could receive small business health care tax credits. However, the tax credits were available for a limited time, and insurer interest in the SHOP exchanges was limited. SHOPs are rarely recognized as providing a meaningful and competitive health insurance option for small employers. For more on this, see Rachel Schwab, Justin Giovannelli, and Kevin Lucia, "State-Based Marketplaces Find Value, Potential Opportunity for Growth in Small-Business Offering," Commonwealth Fund blog, March 18, 2020, https://www.commonwealthfund.org/blog/2020/state-based-marketplaces-find-value-potential-opportunity-growth-small-business-offering.

4 Self-insured firms are still subject to ACA minimum coverage rules.

5 For higher-income workers, this tax subsidy can add up to as much as 40 percent of the cost of premiums, when accounting for both federal and state taxes. See CBO (2012) and Maag and colleagues (2012).

6 See "MEPS-IC Sample Design and Data Collection Process," Agency for Healthcare Research and Quality, accessed December 20, 2021, https://meps.ahrq.gov/survey_comp/ic_data_collection.jsp.

[7] See "MEPS-IC Response Rates," Agency for Healthcare Research and Quality, accessed December 20, 2021, https://meps.ahrq.gov/survey_comp/ic_response_rate.jsp. For more information about the 2020 MEPS-IC sample design, see Davis (2021).

[8] MEPS-IC response rates for 2020 were lower than normal because of the pandemic. Thus, uncertainty surrounds some of the 2020 private-sector estimates. For more on this, see "Medical Expenditure Panel Survey Data Release Schedule," Agency for Healthcare Research and Quality, accessed December 20, 2021, https://meps.ahrq.gov/mepsweb/about_meps/releaseschedule.jsp.

[9] "2018 SUSB Data Tables," Census Bureau.

[10] The MEPS-IC only includes ESI market data, so data on nongroup Marketplace premiums are taken from the Kaiser Family Foundation's State Health Facts; see "Marketplace Average Benchmark Premiums," Kaiser Family Foundation, accessed December 20, 2021, https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[11] Eric Hargan (acting secretary, US Department of Health and Human Services), memo to Seema Verma (administrator, Centers for Medicare & Medicaid Services), regarding payments to insurers for cost-sharing reductions, October 12, 2017, https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf; and Dan Mangan, "Obamacare Bombshell: Trump Kills Key Payments to Health Insurers," CNBC, October 13, 2017, https://www.cnbc.com/2017/10/12/obamacare-bombshell-trump-kills-key-payments-to-health-insurers.html.

References

Brown, Charles, and James Medoff. 1989. "The Employer Size-Wage Effect." *Journal of Political Economy* 97 (5): 1027–59.

Buchmueller, Thomas, Colleen Carey, and Helen G. Levy. 2013. "Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act?" *Health Affairs* 32 (9): 1522–30. https://doi.org/10.1377/hlthaff.2013.0526.

Caruso, Anthony. 2015. *Statistics of U.S. Businesses Employment and Payroll Summary: 2012*. Washington, DC: US Bureau of Labor Statistics.

CBO (Congressional Budget Office). 2012. *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance*. Washington, DC: Congressional Budget Office and Joint Committee on Taxation.

Chase, David, and John Arensmeyer. 2018. "The Affordable Care Act's Impact on Small Business." New York: Commonwealth Fund.

Davis, Karen E. 2021. *Sample Design of the 2020 Medical Expenditure Panel Survey Insurance Component*. Rockville, MD: Agency for Healthcare Research and Quality.

Hadley, Jack, and James D. Reschovsky. 2002. "Small Firms' Demand for Health Insurance: The Decision to Offer Insurance." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 39 (2): 118–37.

Hall, Mark, and Michael J. McCue. 2018. "The Health of the Small-Group Insurance Market." New York: Commonwealth Fund.

Headd, Brian. 2000. "The Characteristics of Small-Business Employees." *Monthly Labor Review*, 13–18.

Lucia, Kevin, Sabrina Corlette, Sandy Ahn, and Lisa Clemans-Cope. 2015. *Post–Affordable Care Act Trends in Health Coverage for Small Businesses: Views from the Market*. Washington, DC: Urban Institute.

Maag, Elaine, C. Eugene Steuerle, Ritadhi Chakravarti, and Caleb Quakenbush. 2012. "How Marginal Tax Rates Affect Families at Various Levels of Poverty." *National Tax Journal* 65 (4): 759–82.

McMorrow, Stacey, Linda J. Blumberg, and Matthew Buettgens. 2011. "The Effects of Health Reform on Small Businesses and Their Workers." Washington, DC: Urban Institute.

McMorrow, Stacey, Linda J. Blumberg, and John Holahan. 2020. "Ten Years Later: Reflections on Critics' Worst-Case Scenarios for the Affordable Care Act." *Journal of Health Politics, Policy and Law* 45 (4):465–83. https://doi.org/10.1215/03616878-8255421.

Miller, G. Edward, and Patricia Keenan. 2021. "Trends in Health Insurance at Private Employers, 2008–2020." Rockville, MD: Agency for Healthcare Research and Quality.

Vistnes, Jessica P., Frederick Rohde, G. Edward Miller, and Philip F. Cooper. 2017. "Substantial Churn in Health Insurance Offerings by Small Employers, 2014—15." *Health Affairs* 36 (9). https://doi.org/10.1377/hlthaff.2017.0431.

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