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National Health Care Spending In 2018: Growth Driven By Accelerations In Medicare And Private Insurance Spending

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ABSTRACT US health care spending increased 4.6 percent to reach $3.6 trillion in 2018, a faster growth rate than the rate of 4.2 percent in 2017 but the same rate as in 2016. The share of the economy devoted to health care spending declined to 17.7 percent in 2018, compared to 17.9 percent in 2017. The 0.4-percentage-point acceleration in overall growth in 2018 was driven by faster growth in both private health insurance and Medicare, which were influenced by the reinstatement of the health insurance tax. For personal health care spending (which accounted for 84 percent of national health care spending), growth in 2018 remained unchanged from 2017 at 4.1 percent. The total number of uninsured people increased by 1.0 million for the second year in a row, to reach 30.7 million in 2018.

Total health care spending in the United States increased 4.6 percent to reach $3.6 trillion in 2018, or $11,172 per person—a faster growth rate than the rate of 4.2 percent in 2017 and equal to the rate in 2016 (exhibit 1).[1] Just as growth was relatively stable over this period, so too was the share of the economy devoted to health care as measured by gross domestic product (GDP), which was 17.9 percent in 2016–17 and 17.7 percent in 2018.

Much of the faster spending growth in 2018 was associated not with expenditures for goods and services but instead with the net cost of health insurance (the amount of insurance spending attributed to nonmedical expenses, including administration, taxes, and underwriting gains or losses). The net cost of health insurance grew more rapidly in 2018, increasing 13.2 percent after growing 4.3 percent in 2017.[2] The faster growth in 2018 was driven primarily by the health insurance tax, a fee that was reinstated in 2018 following a one-year moratorium in 2017.[3,4] This fee was imposed on all health insurance providers beginning in 2014 as part of the funding for the Affordable Care Act (ACA). The Consolidated Appropriations Act of 2016 instituted a one-year moratorium on it for 2017.

The growth rate for total personal health care spending (expenditures for health care goods and services) was the same in 2017 and 2018 (4.1 percent) (exhibit 2). That spending accounted for 84 percent of total national health expenditures in 2018. Its stable growth of 4.1 percent in 2018 reflected mixed trends in the three largest goods and services categories: hospital care, physician and clinical services, and retail prescription drugs. Together, spending for these categories accounted for 73 percent of total personal health care expenditures. Hospital spending growth was similar in 2017 and 2018, at 4.7 percent and 4.5 percent, respectively. For physician and clinical services, spending growth slowed from 4.7 percent in 2017 to 4.1 percent in 2018, while growth in retail prescription drug spending increased from 1.4 percent in 2017 to 2.5 percent in 2018.

EXHIBIT 1

National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and annual growth, by source of funds, calendar years 2012–18

Source of funds	2012[a]	2013	2014	2015	2016	2017	2018
EXPENDITURE AMOUNT							
NHE, billions	$2,791.1	$2,875.0	$3,025.4	$3,199.6	$3,347.4	$3,487.3	$3,649.4
Health consumption expenditures	2,637.7	2,720.9	2,875.6	3,045.5	3,190.7	3,319.0	3,475.0
Out of pocket	319.2	326.9	331.8	341.7	357.2	365.2	375.6
Health insurance	2,015.8	2,079.2	2,223.0	2,373.4	2,487.5	2,592.3	2,729.0
Private health insurance	922.0	939.1	994.1	1,060.9	1,119.9	1,175.0	1,243.0
Medicare	568.5	588.9	618.5	648.8	676.8	705.1	750.2
Medicaid	422.9	445.2	497.8	542.6	565.4	580.1	597.4
Federal	243.4	256.9	305.7	342.6	358.1	359.3	370.9
State and local	179.5	188.4	192.1	200.1	207.2	220.8	226.5
Other health insurance programs[b]	102.4	105.9	112.6	121.1	125.4	132.1	138.3
Other third-party payers and programs and public health activity	302.7	314.9	320.8	330.4	346.0	361.5	370.5
Investment	153.3	154.1	149.8	154.1	156.7	168.3	174.4
Population (millions)[c]	313.3	315.5	317.9	320.1	322.5	324.6	326.6
GDP, billions of dollars	$16,197.0	$16,784.9	$17,527.3	$18,224.8	$18,715.0	$19,519.4	$20,580.2
NHE per capita	$8,908	$9,113	$9,518	$9,995	$10,379	$10,742	$11,172
GDP per capita	$51,695	$53,200	$55,143	$56,932	$58,025	$60,128	$63,004
Prices (2012 = 100.0)							
Chain-weighted NHE deflator	100.0	101.3	103.0	103.9	105.2	106.6	108.8
GDP price index	100.0	101.8	103.6	104.7	105.8	107.8	110.4
Real spending							
NHE, billions of chained dollars	$2,791	$2,839	$2,937	$3,081	$3,182	$3,272	$3,354
GDP, billions of chained dollars	$16,197	$16,495	$16,912	$17,404	$17,689	$18,108	$18,638
NHE as percent of GDP	17.2	17.1	17.3	17.6	17.9	17.9	17.7
ANNUAL GROWTH							
NHE	4.0%	3.0%	5.2%	5.8%	4.6%	4.2%	4.6%
Health consumption expenditures	4.1	3.2	5.7	5.9	4.8	4.0	4.7
Out of pocket	2.8	2.4	1.5	3.0	4.5	2.2	2.8
Health insurance	3.8	3.1	6.9	6.8	4.8	4.2	5.3
Private health insurance	3.5	1.9	5.9	6.7	5.6	4.9	5.8
Medicare	4.3	3.6	5.0	4.9	4.3	4.2	6.4
Medicaid	4.0	5.3	11.8	9.0	4.2	2.6	3.0
Federal	–1.6	5.5	19.0	12.1	4.5	0.3	3.2
State and local	12.6	4.9	2.0	4.2	3.6	6.5	2.6
Other health insurance programs[b]	2.3	3.5	6.3	7.5	3.6	5.3	4.7
Other third-party payers and programs and public health activity	7.8	4.0	1.9	3.0	4.7	4.5	2.5
Investment	2.8	0.5	–2.8	2.9	1.7	7.4	3.6
Population[c]	0.7	0.7	0.7	0.7	0.8	0.7	0.6
GDP, billions of dollars	4.2	3.6	4.4	4.0	2.7	4.3	5.4
NHE per capita	3.3	2.3	4.5	5.0	3.8	3.5	4.0
GDP per capita	3.4	2.9	3.7	3.2	1.9	3.6	4.8
Prices (2012 = 100.0)							
Chain-weighted NHE deflator	1.7	1.3	1.7	0.8	1.3	1.3	2.1
GDP price index	1.9	1.8	1.8	1.0	1.0	1.9	2.4
Real spending							
NHE, billions of chained dollars	2.3	1.7	3.5	4.9	3.3	2.8	2.5
GDP, billions of chained dollars	2.2	1.8	2.5	2.9	1.6	2.4	2.9

SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [c]Estimates reflect the Census Bureau's definition of resident-based population, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, members of the US Armed Forces overseas, and US citizens whose usual place of residence is outside of the US. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts.

EXHIBIT 2

National health expenditures (NHE) amounts and annual growth, by spending category, calendar years 2012–18

Spending category	2012[a]	2013	2014	2015	2016	2017	2018
EXPENDITURE AMOUNT							
NHE, billions	$2,791.1	$2,875.0	$3,025.4	$3,199.6	$3,347.4	$3,487.3	$3,649.4
Health consumption expenditures	2,637.7	2,720.9	2,875.6	3,045.5	3,190.7	3,319.0	3,475.0
Personal health care	2,361.1	2,431.2	2,556.0	2,710.2	2,838.3	2,954.5	3,075.5
Hospital care	902.5	937.6	978.2	1,034.6	1,089.5	1,140.6	1,191.8
Professional services	743.2	759.6	792.5	837.9	883.2	924.0	965.1
Physician and clinical services	557.1	569.6	595.7	631.2	665.6	696.9	725.6
Other professional services	76.4	78.7	83.0	87.8	92.7	97.5	103.9
Dental services	109.7	111.2	113.8	118.8	124.9	129.6	135.6
Other health, residential, and personal care	139.1	144.3	151.5	164.5	173.6	183.2	191.6
Home health care	78.3	81.4	84.8	89.2	93.0	97.1	102.2
Nursing care facilities and continuing care retirement communities	147.4	149.0	152.4	158.1	163.0	166.2	168.5
Retail outlet sales of medical products	350.6	359.3	396.6	425.9	436.0	443.2	456.3
Prescription drugs	253.0	258.2	292.4	317.1	322.3	326.8	335.0
Durable medical equipment	43.7	45.1	46.7	48.6	51.0	52.4	54.9
Other nondurable medical products	53.9	56.0	57.5	60.2	62.7	64.1	66.4
Government administration	34.2	37.5	42.3	42.8	44.9	44.8	47.5
Net cost of health insurance	165.2	173.3	195.3	206.7	218.8	228.3	258.5
Government public health activities	77.2	79.0	82.0	85.8	88.7	91.4	93.5
Investment	153.3	154.1	149.8	154.1	156.7	168.3	174.4
Noncommercial research	48.4	46.7	46.0	46.4	47.4	50.1	52.6
Structures and equipment	105.0	107.5	103.7	107.7	109.3	118.2	121.8
ANNUAL GROWTH							
NHE	4.0%	3.0%	5.2%	5.8%	4.6%	4.2%	4.6%
Health consumption expenditures	4.1	3.2	5.7	5.9	4.8	4.0	4.7
Personal health care	4.1	3.0	5.1	6.0	4.7	4.1	4.1
Hospital care	6.0	3.9	4.3	5.8	5.3	4.7	4.5
Professional services	3.7	2.2	4.3	5.7	5.4	4.6	4.4
Physician and clinical services	4.0	2.2	4.6	6.0	5.4	4.7	4.1
Other professional services	5.0	3.0	5.4	5.9	5.5	5.2	6.5
Dental services	1.6	1.4	2.3	4.4	5.1	3.8	4.6
Other health, residential, and personal care	5.6	3.7	5.0	8.6	5.5	5.5	4.6
Home health care	4.9	3.9	4.2	5.3	4.2	4.5	5.2
Nursing care facilities and continuing care retirement communities	1.4	1.1	2.3	3.8	3.1	2.0	1.4
Retail outlet sales of medical products	1.0	2.5	10.4	7.4	2.4	1.7	2.9
Prescription drugs	0.4	2.1	13.3	8.4	1.7	1.4	2.5
Durable medical equipment	3.4	3.2	3.6	4.1	4.9	2.9	4.7
Other nondurable medical products	2.0	3.9	2.7	4.7	4.1	2.2	3.6
Government administration	3.9	9.6	12.8	1.2	5.0	−0.2	6.0
Net cost of health insurance	4.0	4.9	12.7	5.8	5.9	4.3	13.2
Government public health activities	3.7	2.3	3.8	4.6	3.4	3.0	2.4
Investment	2.8	0.5	−2.8	2.9	1.7	7.4	3.6
Noncommercial research	−2.4	−3.5	−1.4	0.8	2.1	5.7	5.0
Structures and equipment	5.4	2.4	−3.5	3.8	1.5	8.1	3.0

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12.

Factors Accounting For Growth

Exhibit 3 breaks down growth in per capita national health care spending into the factors that account for such growth: the use and intensity of services, medical prices (which reflect both economywide and excess medical-specific inflation), and the changing age and sex composition of the population. Growth in per capita spending accelerated in 2018 to 4.0 percent, following a rate of 3.5 percent in 2017, as faster growth in medical prices more than offset slower growth in the use and intensity of health care goods and services. In 2018 medical price growth accounted for 2.1 percentage points of the 4.0 percent growth in per capita spending (a 53 percent share), while growth in the residual use and intensity of health

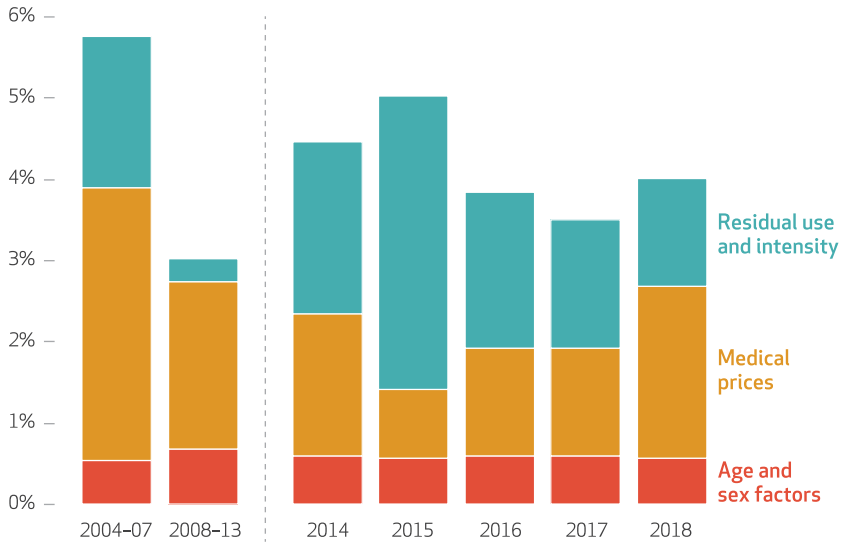
care goods and services accounted for 1.3 percentage points (a 33 percent share), and the changing age and sex mix of the population accounted for 0.6 percentage points (a 14 percent share).

Medical price growth of 2.1 percent in 2018 was faster than the rate of 1.3 percent in 2017, in part because of faster growth in economywide inflation (as measured by the GDP price index)—which increased 2.4 percent in 2018 compared to 1.9 percent in 2017 (exhibit 1). Additionally, excess medical-specific price inflation beyond economywide price inflation declined less in 2018 (–0.3 percent) than in 2017 (–0.6 percent), as faster growth in the net cost of insurance offset some of the negative excess price inflation associated with retail prescription drugs and physician and clinical services (data not shown). Although overall medical price growth in 2018 was the most rapid since 2011, the 2018 growth rate of 2.1 percent was below the average annual rate of 3.4 percent during 2004–07, but the same as the average rate of growth during 2008–13 (exhibit 3).

Residual use and intensity, which reflects changes in the use and mix of health care goods and services, grew 1.3 percent in 2018, slower than the rate of 1.6 percent in 2017.[5] The services that experienced slower growth in the use and intensity of services in 2018 included hospital care, physician and clinical services, dental services, home health care, and nursing care facilities and continuing care retirement communities. In 2018 the number of uninsured people grew by 1.0 million for the second year in a row to reach 30.7 million (exhibit 4). The increase in the number of uninsured people may have contributed to the slowdown in growth in the residual use and intensity of services, as people without health insurance may use fewer services.[6]

EXHIBIT 3

Factors accounting for growth in per capita national health expenditures (NHE), selected calendar years 2004–18



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted NHE price deflator. "Residual use and intensity" is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

Sponsors Of Health Care

In 2018 the federal government and households accounted for the largest shares of health care spending (28 percent each), followed by private businesses (20 percent), state and local governments (17 percent), and other private revenues (7 percent) (exhibit 5). Faster overall spending growth was due to spending from the federal government and private businesses, which experienced faster growth in 2018—more than offsetting slower spending growth for state and local governments and other private revenues.

For the federal government, spending growth on health care accelerated in 2018 to 5.6 percent, compared to a rate of 2.8 percent in 2017. The acceleration in 2018 was driven mainly by faster growth in the federally sponsored portion of expenditures for the Medicare program (a 32 percent share), which increased 6.5 percent in 2018 compared to 1.3 percent in 2017 (data not shown). Furthermore, growth in spending on the federal portion of Medicaid payments (a 36 percent share) accelerated to 3.2 percent in 2018 after growth of 0.3 percent in 2017—the first year that states were required to fund 5 percent of the spending for the Medicaid expansion population (exhibit 1). In the years before 2017, these costs were funded entirely by the federal government.

For state and local governments, spending on health care grew more slowly in 2018, increasing 2.5 percent after a rate of 3.6 percent in 2017 (exhibit 5). The deceleration in 2018 was driven by slower growth in state and local Medicaid spending (which represented 38 percent of total health spending for state and local governments). State and local Medicaid spending grew 2.6 percent in 2018 after growing 6.5 percent in 2017—again reflecting the increased state funding responsibility for the expansion population discussed above (exhibit 1).

Household health care spending includes out-of-pocket spending, contributions to private health insurance premiums, and contributions to Medicare through payroll taxes and the payment of premiums. In 2018 health care spending by households grew 4.4 percent—the same rate

EXHIBIT 4

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and annual growth, by source of funds, calendar years 2012–18

	2012[a]	2013	2014	2015	2016	2017	2018
PRIVATE HEALTH INSURANCE							
Expenditure (billions)	$922.0	$939.1	$994.1	$1,060.9	$1,119.9	$1,175.0	$1,243.0
Expenditure growth	3.5%	1.9%	5.9%	6.7%	5.6%	4.9%	5.8%
Per enrollee expenditure	$4,825	$4,916	$5,106	$5,296	$5,550	$5,813	$6,199
Per enrollee expenditure growth	1.9%	1.9%	3.9%	3.7%	4.8%	4.7%	6.7%
Enrollment (millions)	191.1	191.0	194.7	200.3	201.8	202.1	200.5
Enrollment growth	1.7%	0.0%	1.9%	2.9%	0.7%	0.2%	–0.8%
MEDICARE							
Expenditure (billions)	$568.5	$588.9	$618.5	$648.8	$676.8	$705.1	$750.2
Expenditure growth	4.3%	3.6%	5.0%	4.9%	4.3%	4.2%	6.4%
Per enrollee expenditure	$11,441	$11,485	$11,704	$11,951	$12,137	$12,334	$12,784
Per enrollee expenditure growth	0.3%	0.4%	1.9%	2.1%	1.6%	1.6%	3.7%
Enrollment (millions)	49.7	51.3	52.8	54.3	55.8	57.2	58.7
Enrollment growth	4.1%	3.2%	3.1%	2.7%	2.7%	2.5%	2.6%
MEDICAID							
Expenditure (billions)	$422.9	$445.2	$497.8	$542.6	$565.4	$580.1	$597.4
Expenditure growth	4.0%	5.3%	11.8%	9.0%	4.2%	2.6%	3.0%
Per enrollee expenditure	$7,278	$7,536	$7,592	$7,835	$7,948	$8,041	$8,201
Per enrollee expenditure growth	0.6%	3.5%	0.7%	3.2%	1.4%	1.2%	2.0%
Enrollment (millions)	58.1	59.1	65.6	69.3	71.1	72.1	72.8
Enrollment growth	3.3%	1.7%	11.0%	5.6%	2.7%	1.4%	1.0%
UNINSURED AND POPULATION							
Uninsured (millions)	44.7	44.1	35.5	29.5	28.7	29.7	30.7
Uninsured growth	–1.9%	–1.4%	–19.5%	–17.0%	–2.8%	3.7%	3.1%
Population (millions)[b]	313.3	315.5	317.9	320.1	322.5	324.6	326.6
Population growth	0.7%	0.7%	0.7%	0.7%	0.8%	0.7%	0.6%
Insured share of total population	85.7%	86.0%	88.8%	90.8%	91.1%	90.8%	90.6%

SOURCES Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group; and Department of Commerce, Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12. [b]Estimates are explained in exhibit 1 notes.

experienced in 2017 (exhibit 5). Out-of-pocket health spending (a 36 percent share) increased 2.8 percent in 2018, faster than the growth rate of 2.2 percent in 2017 (exhibit 1), whereas growth in contributions to employer-sponsored private health insurance premiums (a 27 percent share) slowed from 6.8 percent in 2017 to 3.4 percent in 2018 (data not shown).

Health care spending by private businesses increased at a faster rate in 2018 (6.2 percent) than in 2017 (4.8 percent) (exhibit 5), and the 2018 growth rate was the fastest since 2003 (data not shown) in spite of a slight drop in the number of people covered by employer-sponsored insurance (exhibit 5). Contributions by private businesses to employer-sponsored private health insurance premiums accounted for the largest share of private businesses' health spending in 2018 (77 percent), with such contributions increasing 7.2 percent in 2018, up from a rate of 5.5 percent in 2017.

Private Health Insurance

Private health insurance expenditures accounted for 34 percent of total national health care spending in 2018 and reached $1.2 trillion (exhibit 1). Spending in this category increased 5.8 percent in 2018, which was a faster rate than the 4.9 percent growth experienced in 2017. Private health insurance spending for medical goods and services grew 4.5 percent in 2018, similar to the growth rate of 4.3 percent in 2017, while the net cost of private health insurance (which represents 64 percent of the total net cost of health insurance) increased rapidly in both years—9.5 percent in 2017 and 15.3 percent in 2018 (data not shown).

The 4.5 percent growth in medical goods and services paid for by private health insurance reflected mixed trends in underlying goods and services, as spending for hospital care, retail prescription drugs, dental services, and other professional services grew more rapidly in 2018

EXHIBIT 5

National health expenditures (NHE) amounts, annual growth, and percent distribution, by type of sponsor, calendar years 2012–18

Type of sponsor	2012[a]	2013	2014	2015	2016	2017	2018
EXPENDITURE AMOUNT							
NHE, billions	$2,791.1	$2,875.0	$3,025.4	$3,199.6	$3,347.4	$3,487.3	$3,649.4
Businesses, household, and other private revenues	1,572.2	1,615.3	1,666.1	1,742.6	1,828.0	1,921.0	2,013.1
Private businesses	564.9	573.6	599.0	622.7	652.8	684.2	726.8
Household	807.7	834.4	862.5	908.1	950.5	992.5	1,035.7
Other private revenues	199.5	207.3	204.6	211.7	224.7	244.3	250.7
Governments	1,218.9	1,259.8	1,359.2	1,457.0	1,519.4	1,566.3	1,636.3
Federal government	731.3	751.9	835.1	908.1	951.9	978.5	1,033.8
State and local governments	487.6	507.9	524.2	548.9	567.5	587.8	602.5
ANNUAL GROWTH							
NHE	4.0%	3.0%	5.2%	5.8%	4.6%	4.2%	4.6%
Businesses, household, and other private revenues	5.3	2.7	3.1	4.6	4.9	5.1	4.8
Private businesses	4.5	1.5	4.4	4.0	4.8	4.8	6.2
Household	4.4	3.3	3.4	5.3	4.7	4.4	4.4
Other private revenues	11.5	3.9	–1.3	3.5	6.1	8.7	2.6
Governments	2.5	3.4	7.9	7.2	4.3	3.1	4.5
Federal government	0.2	2.8	11.1	8.7	4.8	2.8	5.6
State and local governments	6.1	4.2	3.2	4.7	3.4	3.6	2.5
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	56	56	55	54	55	55	55
Private businesses	20	20	20	19	20	20	20
Household	29	29	29	28	28	28	28
Other private revenues	7	7	7	7	7	7	7
Governments	44	44	45	46	45	45	45
Federal government	26	26	28	28	28	28	28
State and local governments	17	18	17	17	17	17	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12.

while spending growth for physician and clinical services, nursing home care, home health care, and durable medical equipment decelerated.

The net cost of private health insurance reached $164.3 billion and grew 15.3 percent in 2018, its fastest rate of increase since the 2003 increase of 20.7 percent (data not shown).[7] The faster growth in the net cost was driven in large part by the reinstatement of the health insurance tax in 2018, following a one-year moratorium in 2017.[8]

Private health insurance enrollment declined slightly (–0.8 percent) in 2018, primarily because of declines in enrollment in other directly purchased plans (non-Marketplace plans) and employer-sponsored insurance plans (exhibit 4). Enrollment in other directly purchased plans declined by 1.4 million people, as average premiums increased.[9,10] For employer-sponsored private health insurance coverage, enrollment declined 0.2 percent, as data indicate that employees took up offers of insurance at a slightly lower rate in 2018.[11] Per enrollee, spending for private health insurance was $6,199, an increase of 6.7 percent over 2017. This is the highest per enrollee spending growth rate since the 2004 growth rate of 7.5 percent but similar to the growth rate of 6.6 percent in 2009, when personal health care spending was the main driver. In 2018 the net cost of private health insurance was the significant factor behind the rapid growth (data not shown).

Medicare

Medicare spending represented 21 percent of all national health care spending in 2018 and reached $750.2 billion (exhibit 1). Total Medicare spending growth accelerated in 2018 to 6.4 percent, compared to a rate of 4.2 percent in 2017. Medicare enrollment growth was fairly steady, accelerating 0.1 percentage point to 2.6 percent (exhibit 4). Accordingly, per enrollee Medicare expenditures grew more rapidly in

2018, increasing 3.7 percent from a growth rate of 1.6 percent in 2017. The low per enrollee expenditures in 2017 reflected slow growth in Medicare private plan spending resulting from the suspension of the health insurance tax.

Medicare spending on non–personal health care, which includes government administration and the net cost of insurance for Medicare private health plans, was one of the drivers of faster growth in the program in 2018.[12] Growth in non–personal health care spending rose from a decline of 2.4 percent in 2017 to an increase of 16.0 percent in 2018, largely as a result of faster growth in the net cost of insurance as private Part C and Part D plans adjusted their premiums to reflect the expiration of the moratorium on the health insurance tax (data not shown). In addition, growth in Medicare government administrative expenditures rebounded from a decline in 2017 to positive growth in 2018, contributing to the acceleration in Medicare non–personal health care spending in 2018. The decline in Medicare administrative expenditures in 2017 was largely attributable to the impact of recoveries for excess Medicare administrative expenses that had been paid by the federal government prospectively in prior years. These recoveries more than offset government administrative costs that had been disbursed during 2017. In contrast, Medicare personal health care spending accelerated just one percentage point, from a rate of 4.7 percent in 2017 to 5.7 percent in 2018, as spending growth for most goods and services accelerated in 2018.

Fee-for-service Medicare spending accounted for 64 percent of overall Medicare spending in 2018, down slightly from a 66 percent share in 2017 as a result of slower growth in fee-for-service enrollment compared to Medicare Advantage enrollment. In 2018 spending in fee-for-service Medicare grew 3.5 percent, after a smaller increase of 1.4 percent in 2017. In both 2017 and 2018 fee-for-service Medicare enrollment remained steady at thirty-eight million people, accounting for 65 percent of total Medicare enrollment in 2018. Growth in per enrollee fee-for-service Medicare expenditures accelerated from 1.5 percent in 2017 to 3.6 percent in 2018. This faster growth was influenced by faster per enrollee expenditure growth for physician and clinical services—which was attributable, in turn, to an increase in the volume and intensity of services and an acceleration in spending growth for physician-administered drugs. Additionally, faster growth in Medicare spending for durable medical equipment resulted from an increase in the volume and mix of products consumed, following numerous years of declines associated with the implementation of competitive bidding for these products.

Medicare private health plan spending (the majority of which is associated with Medicare Advantage plans) increased 11.8 percent in 2018, faster than the rate of 9.9 percent in 2017. Enrollment in Medicare private health plans increased 7.9 percent in 2018, about the same rate as in 2017. Continued faster enrollment growth in these plans, compared to fee-for-service Medicare, increased the share of enrollment in private plans to 35 percent of total Medicare enrollment in 2018. At the same time, Medicare private health plans also continued to account for a larger portion of total Medicare spending, at 36 percent in 2018—a 6-percentage-point increase since 2014. Per enrollee spending for Medicare private health plans grew 3.6 percent, which was faster than per enrollee growth of 1.7 percent in 2017 mostly because of faster growth in the net cost of insurance for private plans that resulted from the reinstatement of the collection of the health insurance tax.

Medicaid

Medicaid spending by federal and state and local governments accounted for 16 percent of national health care spending and reached $597.4 billion in 2018 (exhibit 1). Medicaid spending increased 3.0 percent in 2018 after growing 2.6 percent in 2017. The faster growth in 2018, which was influenced by the net cost of insurance, was partly offset by a deceleration in enrollment growth and slower spending growth for Medicaid managed care goods and services.

Medicaid enrollment growth most recently peaked in 2014, when numerous states expanded eligibility to certain adults, but growth slowed each year thereafter (exhibit 4). Medicaid enrollment is estimated to have increased 1.4 percent in 2017 and 1.0 percent in 2018. The slower growth in Medicaid enrollment in 2018 was largely the result of stronger economic growth.[13] Medicaid per enrollee spending growth accelerated to 2.0 percent in 2018 from 1.2 percent in 2017, primarily because of the increased growth in the net cost of insurance—which was driven both by the decrease in recovery payments from Medicaid managed care plans to the federal government and by the health insurance tax.[14]

Medicaid hospital spending, which accounted for a third of total Medicaid spending, increased 2.0 percent in 2018 compared to 1.9 percent in 2017 (data not shown), as a slowdown in growth in Medicaid managed care payments was more than offset by faster growth in Medicaid supplemental payments to hospitals.[15] The second- and third-largest Medicaid services—other health, residential, and personal health care services

and physician and clinical services—both experienced slower spending growth in 2018, at rates of 4.9 percent (down from 6.0 percent in 2017) and 2.9 percent (down from 4.2 percent in 2017), respectively. For Medicaid other health, residential, and personal care services, the slower growth in spending in 2018 resulted partly from slower growth in nonwaiver services, such as school-based and rehabilitative services. For Medicaid physician and clinical services, the deceleration in spending growth reflected slower growth in Medicaid managed care payments for physician and clinical services as well as slower growth in fee-for-service payments to clinics.

Medicaid state and local spending grew 2.6 percent in 2018, a slower rate than the rate of 6.5 percent in 2017 (exhibit 1). The faster growth in 2017 was largely attributable to the initial requirement that states fund 5 percent of the costs for the expansion population. Federal spending grew slightly faster than state and local spending, increasing 3.2 percent in 2018 after growing only 0.3 percent in 2017. States that expanded Medicaid to eligible adults were required to fund 6 percent of the costs for this population in 2018, up one percentage point from the 5 percent rate in 2017.

Hospital Care

Hospital care spending increased at about the same rate in both 2017 and 2018 (4.7 percent and 4.5 percent, respectively) to reach $1.2 trillion in 2018, or 33 percent of total health care spending (exhibit 2). Hospital prices increased 2.4 percent in 2018 compared to 1.7 percent in 2017, while nonprice factors (such as the use and intensity of services) grew more slowly in 2018.[16] Growth in total inpatient days was slower in 2018 at 0.7 percent, after 1.7 percent growth in 2017.[17]

Hospital care was paid for largely by private health insurance, Medicare, and Medicaid, which together accounted for over three-quarters of all hospital expenditures in 2018. Spending for hospital care by private health insurance (a 40 percent share) increased at 5.9 percent, and such spending by Medicare (a 25 percent share) increased at 4.6 percent—faster than in 2017—while Medicaid hospital spending growth remained around 2 percent (data not shown). Slower growth in other private hospital revenue and out-of-pocket spending for hospital services, combined with a decline in spending from the Department of Defense, more than offset the faster growth in private health insurance and Medicare spending for hospital services in 2018.

Physician And Clinical Services

Spending for physician and clinical services increased 4.1 percent in 2018, reaching $725.6 billion or 20 percent of total health care expenditures (exhibit 2). This increase followed faster growth of 4.7 percent in 2017, and spending growth slowed for the third consecutive year. Nonprice factors such as the use and intensity of services contributed to the slowdown, while prices for physician and clinical services increased 0.7 percent after growing 0.4 percent in 2017.[18] While growth in spending for clinical services (6.0 percent) continued to outpace such growth for physician services (3.6 percent) in 2018, each experienced slower growth than in 2017.

Spending growth for physician and clinical services was driven by slower growth in spending by private health insurance, Medicaid, and other private revenues. For private health insurance spending, which accounted for 43 percent of total physician and clinical expenditures, growth slowed in 2018 to a rate of 3.9 percent, compared to an increase of 4.6 percent in 2017 (data not shown). For Medicaid (an 11 percent share), expenditure growth also slowed in 2018, increasing 2.9 percent compared to 4.2 percent in 2017. Furthermore, other private revenues (which includes philanthropy and other non–patient care income) declined 3.2 percent in 2018, following much larger average annual growth of 11.4 percent during 2015–17. Medicare spending (a 23 percent share) partially offset the overall slowdown in spending growth for physician and clinical services. It accelerated to 7.8 percent in 2018 from 5.9 percent in 2017, primarily because of an increase in the volume and intensity of services and an acceleration in spending growth for physician-administered drugs.[19]

Retail Prescription Drugs

Spending on retail prescription drugs increased 2.5 percent in 2018 to $335.0 billion, and the share of national health spending for this category of goods and services remained unchanged at 9 percent (exhibit 2).[20] The 2.5 percent increase in prescription drug spending in 2018 was faster than the 1.4 percent increase in 2017, as increased spending on new oncology and autoimmune drugs was partially offset by a decline in price growth and the continued increase in the use of generic drugs.[21]

In 2018 faster growth in nonprice factors helped drive the increase in total retail prescription drug spending growth, while price growth for both generic and brand-name drugs slowed. The number of prescriptions dispensed (based on thirty days' supply) increased 2.7 percent,

which was faster than the 2017 growth rate of 1.8 percent.[21] Recently, the average days' supply has increased, as studies have shown that this leads to better adherence by patients.[21]

Retail prescription drug prices declined by 1.0 percent in 2018, reflecting a decline in generic drug prices and slower and relatively low growth in prices for brand-name drugs.[21,22] Additionally, greater use of generic drugs in 2018 put downward pressure on prices, even though the change in the generic dispensing rate was the smallest since 2000—an increase of just 0.3 percentage points to 85.6 percent.[23] Despite the increase in the generic share of the total number of drugs dispensed, brand-name medications increased their share of spending by 2 percentage points in 2018 (from 76.7 percent to 78.7 percent).[21]

The four largest payers—private health insurance (a 40 percent share), Medicare (32 percent), out-of-pocket expenditures (14 percent), and Medicaid (10 percent)—account for more than 96 percent of retail prescription drug spending. The three largest payers of prescription drugs all experienced accelerating growth in 2018, with private health insurance and out-of-pocket spending growing 0.8 percent and 0.6 percent, respectively, after declines in spending in 2017 of 0.4 percent and 2.2 percent, respectively (data not shown). Medicare prescription drug spending increased 5.9 percent in 2018 after 4.8 percent growth in 2017, while Medicaid spending growth slowed from 2.7 percent in 2017 to 1.4 percent in 2018.

Conclusion

Health care spending increased 4.6 percent in 2018, a faster rate than in 2017 but a lower growth rate than that of the overall economy, which increased 5.4 percent in 2018. For health care, the relative stability in spending growth since the insurance expansions in 2014 and 2015 reflects continued low growth in medical prices, which is influenced by both low economy-wide price growth and negative excess medical price inflation, as well as relative stability in health insurance enrollment.

The slight acceleration in health care spending growth in 2018 reflected faster growth in non–personal health care spending, particularly in the net cost of health insurance. Price growth was faster for health insurance because of the impact of the reinstated health insurance tax, which had been suspended in 2017. Personal health care spending grew at the same rate in 2018 as in 2017, as slower growth in the use and intensity of services was offset by faster growth in prices for most health care services.

Except for the slight uptick that was driven primarily by the one-time impact of the reinstated health insurance tax, growth in 2018 was relatively stable. Still, changes may be on the horizon. In 2019 that tax was suspended and Medicaid coverage was expanded in five additional states, while at the same time the individual mandate penalty was effectively repealed.[24] In addition, the results of the upcoming comprehensive revision of the National Health Expenditure Accounts will be reflected in the release of next year's health spending report detailing trends through 2019.[25] ■

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NOTES

1 All data from the National Health Expenditure Accounts discussed in this article can be accessed at CMS.gov. Historical: downloads [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [last updated 2019 Dec 6; cited 2019 Dec 12]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

2 The types of private health insurance for which net cost of insurance is estimated include fully insured group/commercial insurance, direct purchase or nongroup insurance, self-insured insurance, and the health portion of property and casualty insurance. Also included in the net cost of insurance are Medicare Advantage and stand-alone Medicare Part D plans, Medicaid managed care plans, Children's Health Insurance Program (CHIP) managed care plans, and the majority of workers' compensation insurance.

3 Internal Revenue Service. Affordable Care Act provision 9010—health insurance providers fee [Internet]. Washington (DC): IRS; [last updated 2019 Sep 6; cited 2019 Nov 7]. Available from: https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

4 American Academy of Actuaries. Drivers of 2018 health insurance premium changes [Internet]. Washington (DC): The Academy; 2017 Jul [cited 2019 Nov 7]. (Issue Brief). Available from: https://www.actuary.org/content/drivers-2018-health-insurance-premium-changes

5 Growth in the use and intensity of health care goods and services includes changes in both the use and the mix (or intensity) of the goods and services consumed. It is calculated as a residual and reflects

growth in nominal health care spending less growth in the population, changes in the age and sex mix of the population, and medical price growth. As a residual, use and intensity cannot be estimated separately. The sum of the factors might not equal the total because of rounding.

6 Meer J, Rosen HS. Insurance and the utilization of medical services. Soc Sci Med. 2004;58(9):1623–32.

7 The net cost of private health insurance does not include the net cost of insurance for Medicare Advantage and stand-alone Medicare Part D plans, Medicaid managed care plans, CHIP managed care plans, and the majority of workers' compensation insurance.

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10 Fehr R, Cox C, Levitt L. Data note: changes in enrollment in the individual health insurance market through early 2019 [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2019 Aug 21 [cited 2019 Nov 7]. Available from: https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/

11 Henry J. Kaiser Family Foundation. Employer health benefits: 2018 annual survey [Internet]. San Francisco (CA): KFF; 2018 Oct 3 [cited 2019 Nov 7]. Available from: https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-3-employee-coverage-eligibility-and-participation/

12 Non–personal health care includes all government costs associated with the administration of Medicare Parts A (Hospital Insurance), B (Supplementary Medical Insurance), and D (prescription drug coverage), as well as the net cost of private health insurance associated with Medicare Advantage and Part D prescription drug private health plans.

13 Rudowitz R, Hinton E, Antonisse L. Medicaid enrollment and spending growth: FY 2018 and 2019 [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2018 Oct 25 [cited 2019 Nov 7]. Available from: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2018-2019/

14 Recovery payments reflect money recovered by the federal government from managed care organizations as a result of favorable prior-period experience.

15 Supplemental payments are additional payments beyond the amount paid under the standard fee schedule. These payments are intended to account for the difference between what Medicaid paid and what Medicare would have paid for the same service. See Medicaid and CHIP Payment and Access Commission. Supplemental payments [Internet]. Washington (DC): MacPAC; [cited 2019 Nov 7]. Available from: https://www.macpac.gov/subtopic/supplemental-payments/

16 Bureau of Labor Statistics. Producer Price Index industry data, series report: series ID PCU622---622--- [Internet]. Washington (DC): BLS; [cited 2019 Nov 7. Available for download from: https://data.bls.gov/cgi-bin/srgate

17 Census Bureau. Business and industry: time series/trend charts: hospitals: U.S. total—not seasonally adjusted total inpatient days [Internet]. Washington (DC): Census Bureau; 2019 Sep 6 [cited 2019 Nov 7]. Available from: https://www.census.gov/econ/currentdata/dbsearch?program=QSS&startYear=2003&endYear=2019&categories=622A&dataType=INPAT&geoLevel=US&notAdjusted=1&submit=GET+DATA&releaseScheduleId=

18 Authors' analysis of Producer Price Index data for North American Industry Classification Codes 6211 and 6215 as of September 2019. See Bureau of Labor Statistics. Producer Price Indexes [Internet]. Washington (DC): BLS; [cited 2019 Nov 7]. Available from: http://www.bls.gov/ppi/

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21 IQVIA Institute for Human Data Science. Medicine use and spending in the U.S.: a review of 2018 and outlook to 2023. Parsippany (NJ): The Institute; 2019 May 9.

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24 Sisko AM, Keehan SP, Poisal JA, Cuckler GA, Smith SD, Madison AJ, et al. National health expenditure projections, 2018–27: economic and demographic trends drive spending and enrollment growth. Health Aff (Millwood). 2019;38(3):491–501.

25 Every five years the National Health Expenditure Accounts undergo a comprehensive revision that includes the incorporation of newly available source data, methodological and definitional changes, and benchmark estimates from the Census Bureau's quinquennial economic census. During these comprehensive revisions, the entire National Health Expenditure Accounts time series is opened for revision.

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Health Benefits In 2019: Premiums Inch Higher, Employers Respond To Federal Policy

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ABSTRACT **The annual Kaiser Family Foundation Employer Health Benefits Survey found that in 2019 the average annual premium for single coverage rose 4 percent to $7,188, and the average annual premium for family coverage rose 5 percent to $20,576. Covered workers contributed 18 percent of the cost for single coverage and 30 percent of the cost for family coverage, on average, with considerable variation across firms. Fifty-seven percent of firms offered health benefits to at least some of their workers. While some larger firms reported that take-up dropped because of the elimination of the individual mandate penalty, the overall share of workers covered at their own firm (61 percent) was similar to that in recent years. Large employers reported taking a variety of steps to address the opioid epidemic over the past few years. Our findings offer some context for the role of health insurance reform in the 2020 election cycle.**

Employer-sponsored health insurance is the largest source of coverage in the United States, covering about 153 million nonelderly people.[1] This article presents findings from the twenty-first annual Henry J. Kaiser Family Foundation Employer Health Benefits Survey.[2] As in past years, the survey asked firms about eligibility for and enrollment in their health benefits programs, as well as about the characteristics of up to four of their largest health plans. Additional questions in 2019 explored firms' responses to changes in the Affordable Care Act (ACA) and to the opioid crisis in the US.

Study Data And Methods

SURVEY SAMPLE The sample for the annual Kaiser Employer Health Benefits Survey includes private firms and nonfederal government employers with three or more employees. In total, 9,972 firms were sampled. Of the over three million firms within the survey population, 2,012 firms completed the full survey. Firms with more than nine employees that completed the survey in either 2017 or 2018 were included in the 2019 sample; the remainder of the sample was randomly chosen within firm-size and industry categories.

The overall response rate for 2019 was 27 percent. Seventy-two percent of responding firms completing the survey had also participated in the survey in at least one of the past two years. To increase the sample size for estimating the percentage of firms that offer coverage, we asked respondents that declined to participate in the full survey, "Does your company offer a health insurance program as a benefit to any of your employees?" Including the 2,012 firms that completed the full survey, 4,395 firms answered this question, for a response rate of 58 percent.

METHODS To produce nationally representative estimates, we developed weights specific to employers, workers, covered workers, and workers within each of four specified health plan types. To control for item nonresponse bias, we imputed missing data following a hotdeck approach, which replaces missing information for a firm with observed values from a similar firm.

Differences referred to in the text use a p value of 0.05 as the threshold for significance. Starting in 2019 we stopped adjusting our weights for nonresponse. This had a negligible impact on most estimates, with the largest impact on the firm offer rate. For more information on this and our sampling and methods, see the online appendix.[3]

SURVEY QUESTIONS Each year benefit managers are asked about the characteristics of their firm's largest health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) plan, and high-deductible health plan with a savings option (HDHP/SO). The latter were defined as plans that have a deductible of at least $1,000 for single coverage and $2,000 for family coverage and that either offer a health reimbursement arrangement (HRA) or are eligible for a health savings account (HSA).[4] In this article, unless a different number of employees is specified, *small firm* refers to employers with 3–199 workers and *large firm* to employers with 200 or more workers. Throughout the article, we define *firms with many lower-wage workers* as those in which 35 percent or more earn $25,000 or less annually.

Study Results

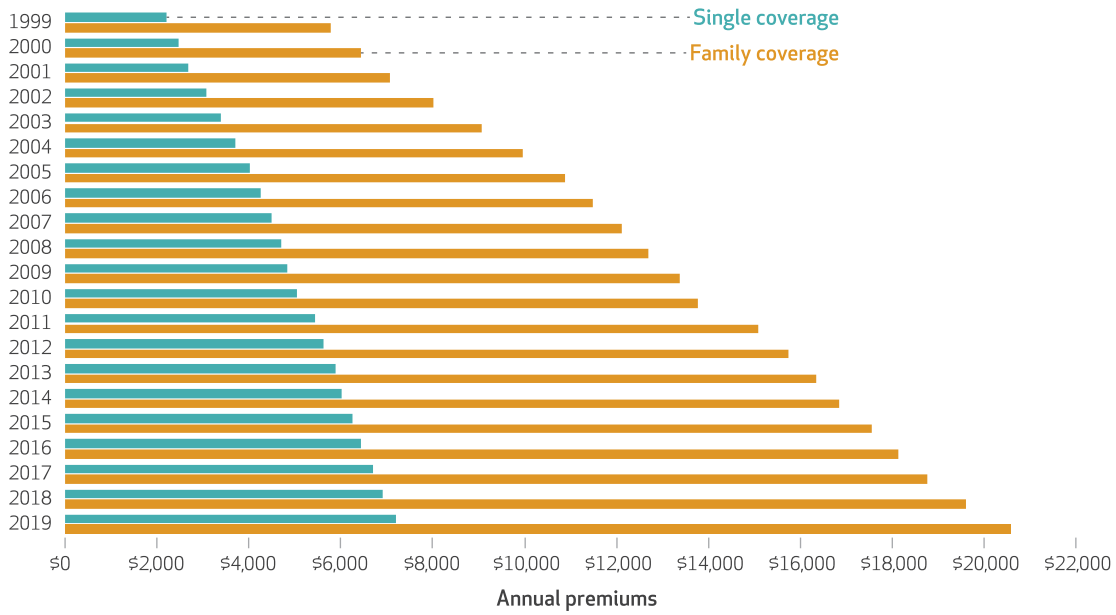
COST OF COVERAGE AND WORKER CONTRIBUTIONS In 2019 the average annual premium for workers covered by their own firms was $7,188 for single coverage and $20,576 for family coverage (exhibit 1). Compared to premiums in 2018, the average single premium increased by 4 percent, and the average family premium increased by 5 percent. Over the past five years the average premium for family coverage has risen 22 percent—more than inflation (8 percent) or increases in workers' earnings (14 percent).[5,6]

Compared to these overall average premiums, the average premium for workers in HDHP/SOs was lower, and the average premium for workers in PPOs was higher, for both single and family coverage. Average premiums for single and family coverage were lower for workers at private for-profit employers than for those in plans sponsored by public or not-for-profit employers. Single and family premiums were lower, on average, for workers in firms with a higher proportion of lower-wage workers than for those in firms with a smaller share of such workers (exhibit 2).

On average, covered workers contributed 18 percent of the premium for single coverage and 30 percent of the premium for family coverage in 2019, similar to the percentages in 2018. Covered workers in small firms contributed a lower share of the premium for single coverage than workers in large firms did (16 percent versus 19 percent) but a higher share of the premium for family coverage (40 percent versus 26 per-

EXHIBIT 1

Average annual premiums for single and family coverage, 1999–2019



SOURCES Henry J. Kaiser Family Foundation (KFF) Employer Health Benefits Surveys, 2018–19, and KFF and Health Research and Educational Trust Employer Health Benefits Surveys, 1999–2017. **NOTES** All of the estimates except for 2009, 2014, and 2016 single coverage are significantly different from the estimate for the previous year shown ($p < 0.05$). The estimates for 1999 were not tested for significance.

EXHIBIT 2

Average annual premiums and worker contributions for single and family coverage, 2019

	Total premium ($)		Worker contribution			
			Dollar amount		Percent	
	Single	Family	Single	Family	Single	Family
All firms	7,188	20,576	1,242	6,015	18	30
PLAN TYPE						
HMO	7,238	20,697	1,058	6,009	15	31
PPO	7,675**	21,683	1,454**	6,638	20	32
POS	7,185	19,838	1,072	6,945	16	36
HDHP/SO	6,412**	18,980**	1,071**	4,866**	17	26**
REGION						
Northeast	7,296	21,441	1,382	5,978	19	28
Midwest	7,220	20,179	1,430**	5,702	21**	29
South	7,036	20,367	1,253	6,629**	18	34**
West	7,300	20,549	909**	5,402	13**	27
FIRM SIZE						
Small	7,218	20,236	1,035	7,805	16	40
Large	7,175	20,717	1,330**	5,271**	19**	26**
LOWER-WAGE WORKERS						
Few	7,233	20,709	1,245	5,968	18	30
Many	6,189**	17,633**	1,168	7,047	19	41**
HIGHER-WAGE WORKERS						
Few	7,118	20,032	1,213	6,358	18	33
Many	7,253	21,079**	1,269	5,697	18	28**
FIRM OWNERSHIP						
Private for-profit	6,809**	20,148**	1,341**	6,193	20**	32**
Public	7,994**	21,055	1,172	5,467	14	26
Private not-for-profit	7,575**	21,261	1,057**	5,937	14**	29

SOURCE Henry J. Kaiser Family Foundation (KFF) Employer Health Benefits Survey, 2019. **NOTES** Data are weighted by covered workers. For plan type, significance denotes difference from "all firms." For region and firm ownership, significance denotes difference from all other firms not in the indicated category. For firm size, significance denotes difference between large and small firms (those with 200 or more workers and those with 3–199 workers, respectively). For wage level, significance denotes difference between firms with at least 35 percent of workers at the indicated wage level and firms with fewer than 35 percent of workers at that wage level. Firms with many lower-wage workers are those in which at least 35 percent of workers earn less than the twenty-fifth percentile of national earnings ($25,000 or less per year in 2019). Similarly, firms with many higher-wage workers are those in which at least 35 percent earn more than the seventy-fifth percentile of national earnings ($63,000 or more per year in 2019). Wage cut-offs are based on Bureau of Labor Statistics Occupational Employment Statistics from 2018. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option. $^{**}p < 0.05$

cent). In dollars, average annual worker contributions in 2019 were $1,242 for single coverage and $6,015 for family coverage.

Among all large employers offering health benefits, including those sponsoring only one plan, 32 percent said that employees had a financial incentive to choose a lower-cost health plan, such as a lower premium contribution (data not shown). These employers said that their employees could save a maximum of $107 monthly, on average, if they chose the lowest-cost single plan available to them.

ENROLLMENT ACROSS PLAN TYPES Forty-four percent of covered workers were enrolled in a PPO in 2019. Thirty percent of covered workers were enrolled in an HDHP/SO; 19 percent in an HMO; 7 percent in a POS plan; and less than 1 percent in a conventional, or indemnity, plan.

Sixty-four percent of covered workers were employed in a firm that offers more than one type of health plan, including 75 percent of covered workers in large firms and 37 percent in small firms. At 45 percent of firms that offered an HDHP/SO, at least some workers could choose only an HDHP/SO, while 55 percent of these firms allowed workers to choose between an HDHP/SO and other plan types.

ENROLLMENT IN SELF-FUNDED PLANS Employers generally fund the benefits they offer by either purchasing insurance from a health insurer (insured plans) or paying the cost of some or all benefits directly (self-funded plans). In 2019, 61 percent of covered workers were in a plan that is completely or partially self-funded, including 80 percent of covered workers in large firms and 17 percent of covered workers in small firms.

As in 2018, there were no big changes in the market for employer-sponsored coverage in 2019.

These percentages are similar to those in 2018.

In recent years a complicated funding option, often called level-funding, has become more widely available to small employers. Level-funded arrangements are partially self-funded plans with extensive stop-loss coverage that significantly reduces the risk retained by the employer. The plan administrator (often an insurer) calculates an expected monthly expense for the employer, which includes a share of the estimated annual cost for benefits, a premium for the stop-loss protection, and an administrative fee. The employer pays this "level" amount, with the potential for a reconciliation between the employer and the plan administrator at the end of the year. These plans operate as self-funded arrangements, which means that they are not subject to many state or federal standards—including the benefit and rating rules applicable in the small-group market.

The complexity of these arrangements may lead to confusion among employers about the nature of their plan, particularly because they are making periodic payments that resemble premiums. We asked small firms whether they offer a level-funded plan. Eight percent of covered workers at small firms offering a fully insured plan (and 11 percent at all small firms) worked for a firm that indicated that the plan was level-funded.

COST SHARING The ACA requires employer-based health plans to provide access to certain preventive services without any out-of-pocket spending. For all other services, virtually all enrollees must pay a portion of the cost of care when they receive a service. Most enrollees are in a plan with a general annual deductible, which is the amount the enrollee must pay out of pocket before most services (other than preventive care) are covered by the health plan. In some cases, the deductible is limited to inpatient care or might not apply to certain services, such as prescription drugs or office visits. Most enrollees also must pay either a copayment or coinsurance amount when they use care, after they have met their deductible or when it does not apply. A copayment is a specified dollar amount, while coinsurance is a percentage of the cost of the services received.

▶ **GENERAL ANNUAL DEDUCTIBLES:** Eighty-two percent of covered workers were enrolled in a plan with a general annual deductible for single coverage in 2019, similar to the percentage in 2018. The average deductible among covered workers in a plan with a general annual deductible was $1,655 for single coverage, similar to the amount in 2018 but a significant increase from 2014 ($1,217). The average deductible for single coverage was higher for workers in small firms ($2,271) than for those in large firms ($1,412).

There continues to be considerable variation in single deductible amounts: Among covered workers in a plan with a general annual deductible, 31 percent were in a plan with a single deductible of less than $1,000, while 14 percent were in a plan with a single deductible of $3,000 or more (exhibit 3). Among those with a deductible, the percentage of covered workers enrolled in a plan with a single annual deductible of $3,000 or more has doubled from its 2014 level of 7 percent. Thirteen percent of all covered workers were enrolled in a plan with a deductible of $3,000 or more for single coverage in 2019 (data not shown).

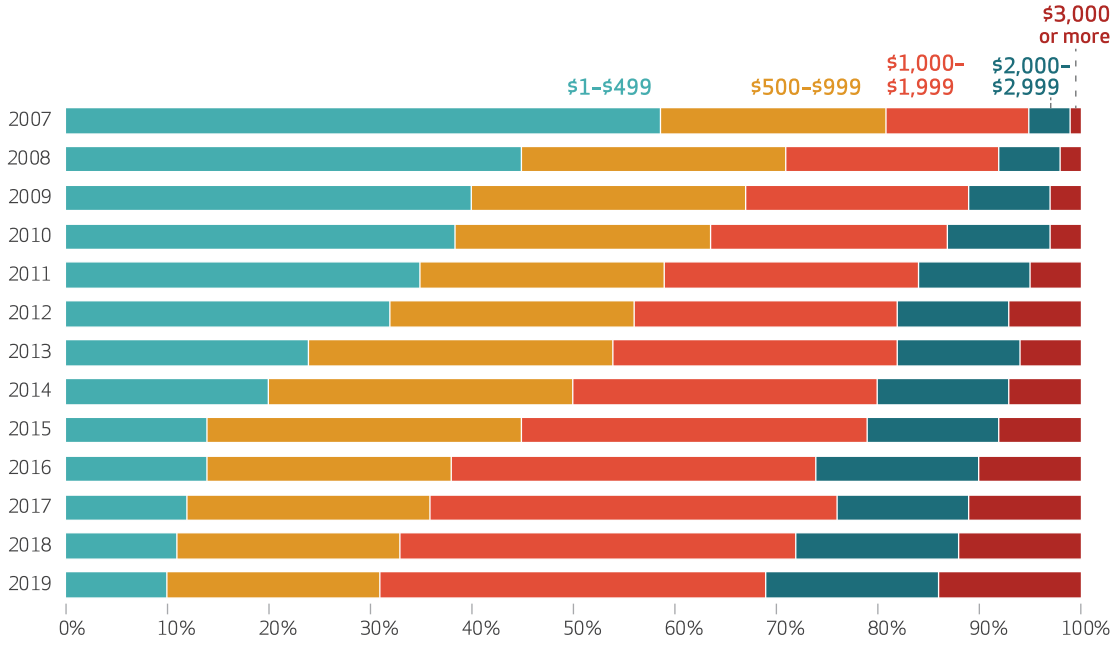
▶ **INPATIENT HOSPITAL SERVICES:** Eighty-five percent of covered workers faced some type of cost sharing if they were hospitalized in 2019, separate from any general annual deductible required under their health plan. Of those facing cost sharing, 66 percent had a coinsurance requirement, and 14 percent had a copayment. The average coinsurance rate was 20 percent, and the average copayment was $326 per admission.

▶ **PHYSICIAN OFFICE VISITS:** Sixty-seven percent of covered workers had a copayment and 25 percent had a coinsurance requirement for a primary care physician office visit in 2019, similar to the percentages in 2018. The average copayment was $25, and the average coinsurance rate was 18 percent. For office visits with a specialist, 66 percent of covered workers were in a plan with a copayment, and 26 percent were in a plan with coinsurance. The average copayment for a specialist physician office visit was $40, and the average coinsurance rate was 19 percent.

▶ **PRESCRIPTION DRUGS:** Virtually all workers with employer-based coverage have coverage for prescription drugs. Eighty-four percent of workers with drug coverage were enrolled in a plan with three or more tiers of drugs in 2019. Among these workers, average copays were $11 for drugs on the first tier (often called generics), $33 for those on the second (often called preferred

EXHIBIT 3

Distribution of general annual deductibles for single coverage, by plan type, 2007–19



SOURCES Henry J. Kaiser Family Foundation (KFF) Employer Health Benefits Surveys, 2018–19, and KFF and Health Research and Educational Trust Employer Health Benefits Surveys, 2007–17. **NOTES** Average general annual deductibles are for in-network providers. In 2019, 82 percent of covered workers were enrolled in a plan with a general annual deductible. The distribution was significantly different ($p < 0.05$) from the previous year only in 2008.

drugs), $59 for those on the third, and $123 for those on the fourth tier.

Many employers provide enrollees with the opportunity to fill prescriptions through the mail. In many cases, the plan provides a financial incentive, such as lower cost sharing, to encourage enrollees to use this process. In 2019 a very small share of covered workers (2 percent) were in plans that covered only retail prescription drugs provided through the mail. For employees whose coverage for prescription drugs was not exclusively mail order, 55 percent were enrolled in plans with financial incentives to use this process for at least some types of prescriptions.

AVAILABILITY OF COVERAGE In 2019, 56 percent of small firms and 99 percent of large firms offered health benefits to at least some of their workers, with an overall offer rate of 57 percent. Since the majority of firms in the country are small, and firms with 3–9 employees represent about 60 percent of all firms, the overall offer rate is controlled by the smallest firms. Offer rates increased with firm size: In 2019, 47 percent of firms with 3–9 workers offered health benefits, compared to 67 percent of firms with 10–49 workers, 93 percent of firms with 50–199 workers, and 99 percent of firms with 200 or more workers.

Despite the vast majority of firms being small, most workers are employed in large firms, so a large share of workers (90 percent) were employed by firms that offered coverage to at least some of their workers. A meaningful share of these workers, however, were not covered at their firm. Only 80 percent of employees who worked for firms that offered coverage in 2019 were eligible to enroll in a plan offered by the firm, and only 76 percent took up that offer to enroll. The result is that 61 percent of the workers in firms offering health benefits were enrolled in a plan offered by their firm, similar to the percentage in 2018.

PROVIDER NETWORK POLICIES AND PRACTICES How health plans construct their provider network options can affect the cost of care and its quality. Large shares of employers offering health benefits said that they were "very satisfied" (42 percent) or "satisfied" (42 percent) with the choice of provider networks offered by their insurer or plan administrator (exhibit 4). Employers offering health benefits were less satisfied with the costs of the network options available to them, with only 11 percent saying that they were "very satisfied" and 46 percent saying that they were "satisfied." When asked about the most important factor in assessing a provider network, respondents split almost equally among "the number and convenience of pro-

EXHIBIT 4

Among firms offering health benefits, their views of their provider networks, by firm size, 2019

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
CHOICE OF PROVIDER NETWORKS AVAILABLE					
Small firms	41%	42%	11%	4%	2%
Large firms	53	39	7	1	1
All firms	42	42	11	4	2
COST OF PROVIDER NETWORKS AVAILABLE					
Small firms[a]	11%	46%	20%	18%	5%
Large firms	21	56	14	8	1
All firms	11	46	20	18	5

	Most important factor in assessing a provider network is the providers':			
	Number and convenience	Cost	Quality	Other
Small firms	30%	33%	36%	1%
Large firms	34	26	33	6[b]
All firms	30	33	36	1

SOURCE Henry J. Kaiser Family Foundation (KFF) Employer Health Benefits Survey, 2019. **NOTE** Small and large firms are defined in the notes to exhibit 2. [a]Difference between small and large firm distributions is significant ($p < 0.05$). [b]Difference between small and large firm estimates is significant ($p < 0.05$).

viders" (30 percent), "the cost of providers" (33 percent), and "the quality of providers" (36 percent).

Fourteen percent of employers with fifty or more employees that offered health benefits had a high-performance or tiered network as part of their largest health plan—the same percentage that did so in 2018 (data not shown). These arrangements place providers into tiers based on their cost, quality, or efficiency and have incentives for employees to choose better-performing providers. Among large employers with a high-performance or tiered provider network, 73 percent said that the network tiers were based both on cost or efficiency and on quality, 13 percent said that they were based on cost or efficiency, 9 percent said that they were based on quality, and 4 percent said that they were based on some other factor.

Another approach is for health plans to have a narrow provider network, with fewer providers than other networks have. This permits the plan to negotiate lower payment rates but also reduces enrollee choices. Five percent of employers offering health benefits said that they offered a narrow-network plan in 2019, similar to the percentage in 2018.

Employers and health plans can use other approaches to encourage or direct enrollees toward particular providers. Thirty-eight percent of firms with 1,000 or more workers, including 52 percent of firms with 5,000 or more workers, reported having "centers of excellence" or a similar program to direct enrollees to particular providers for treatment of specified conditions in their largest health plan. Another approach, in which an employer contracts directly with certain hospitals or health systems that otherwise are not in the network, was being used by 8 percent of large firms that sponsored a self-funded health plan.

Some employers also are taking steps to restrict coverage for certain services to in-network providers. Four percent of large firms reported ending out-of-network coverage for certain services in the previous two years. Some employers reported eliminating coverage for most or all nonemergency services, while others mentioned restrictions for certain services—such as mental health services, dialysis, bariatric surgery, transplants, or preventive care.

ALTERNATIVE SITES OF CARE

▶ **RETAIL HEALTH CLINICS:** Retail health clinics are typically located in retail stores, supermarkets, or pharmacies and provide treatment for minor illnesses and preventive care. Among large firms offering health benefits, 77 percent covered services provided in retail health clinics in their largest health plan—an increase from 67 percent in 2014. Among large firms providing coverage for services delivered in retail clinics, 13 percent had lower cost sharing for a visit to a retail clinic than for one to a physician's office.

▶ **TELEMEDICINE:** Telemedicine refers to health care services provided through telecommunications to a patient by a provider in a different location. This can include a video chat or remote monitoring, but it does not include email

or web-based videos that do not entail interaction with a health professional. In 2019, 65 percent of small firms and 82 percent of large firms offering health benefits provided coverage for telemedicine services in their largest health plan. The percentage of large firms doing so has increased since 2018. Among large firms providing coverage for telemedicine, 53 percent had lower cost sharing for using telemedicine as compared to a visit to a physician's office.

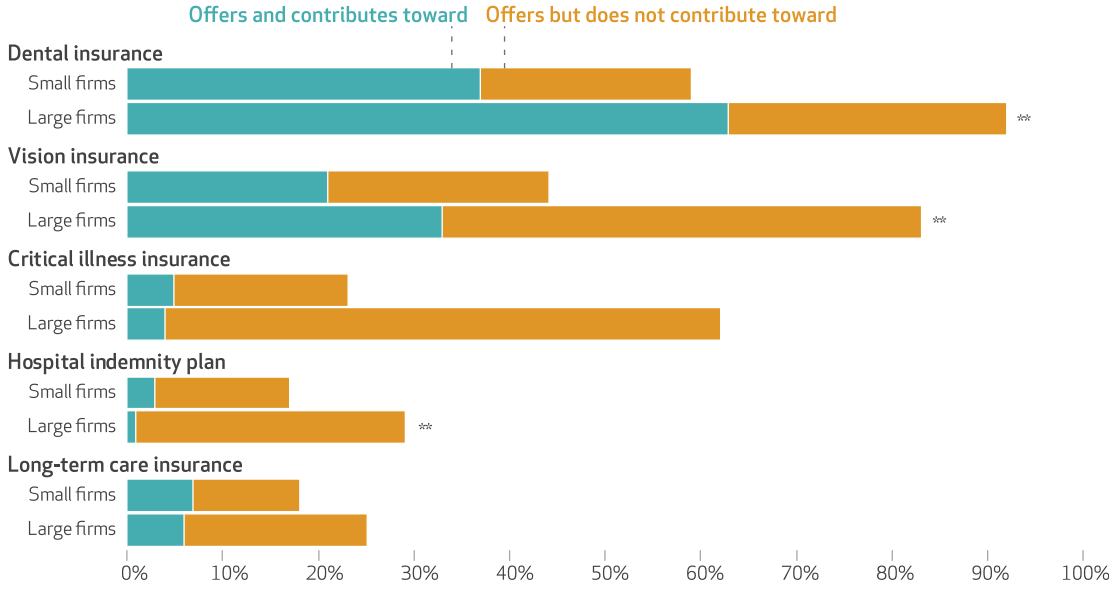
▶ **ON-SITE HEALTH CLINICS:** Some employers provide health services to their employees through health clinics established by the employer at or near their place of work.[7] These clinics may treat work-related injuries and may also provide other health services. Nineteen percent of large firms that offered health benefits, including 36 percent of firms with 5,000 or more workers, provided benefits through a health clinic at or near one of their worksites in 2019.

SUPPLEMENTAL AND VOLUNTARY COVERAGE Many firms offer supplemental benefits to their workers, separate from their health plans. Among firms offering health benefits in 2019, 59 percent of small firms and 92 percent of large firms offered a dental insurance program, 44 percent of small firms and 83 percent of large firms offered a vision insurance program, and 23 percent of small firms and 62 percent of large firms offered a critical illness insurance plan (exhibit 5). Employers sometimes contribute toward the cost of these benefits, while in other cases, employees pay the entire cost.

REPEAL OF THE INDIVIDUAL INSURANCE REQUIREMENT PENALTY Beginning with tax year 2019, the ACA's federal tax penalty for people who did not have health insurance, sometimes called the individual mandate penalty, was essentially eliminated. Even though employers with more than fifty full-time-equivalent employees are still required to offer health benefits to their full-time employees, there was uncertainty about whether the repeal of the individual mandate penalty would affect the share of workers electing to take up coverage. Among employers with at least fifty employees that offered health benefits, 9 percent said that they believed the repeal of the requirement reduced the percentage of employees and their dependents who took up the firm's coverage in 2019 (data not shown). Among employers that reported lower enrollment, 75 percent said that the reduction was greater among lower-paid employees and their dependents, compared to other workers.

EXHIBIT 5

Among firms offering health benefits, percent of firms that offer supplemental insurance benefits in addition to benefits offered through the health plan, by firm size, 2019



SOURCE Henry J. Kaiser Family Foundation (KFF) Employer Health Benefits Survey, 2019. **NOTES** Small and large firms are defined in the notes to exhibit 2. Critical illness insurance provides a cash benefit when an enrollee is diagnosed with a specified condition, such as cancer. Hospital indemnity plans provide a cash benefit when an enrollee is admitted to the hospital or has a certain type of outpatient surgery. Long-term care insurance covers assistance with daily living not generally covered by health insurance, such as care from a home health worker or in a nursing home. The survey asks firms that offer health benefits if they offer or contribute to supplemental benefits that are separate from any their health plans might include. Significance refers to the difference from the estimate for all other firms not in the indicated size category. $^{**}p < 0.05$

Even if political support for a new public health insurance program wanes, concerns about affordability are unlikely to do so.

HIGH-COST PLAN TAX The high-cost plan tax, or so-called Cadillac tax, is an excise tax that will be assessed on plans with high premiums, beginning in 2022. Under the ACA, the tax was originally scheduled to begin in 2018. However, it has been delayed twice, and recently the House of Representatives passed a bill that would repeal the provision entirely. If the law takes effect in 2022, we previously estimated that 21 percent of employers offering health benefits would have at least one plan whose premium and account contributions would exceed the taxing thresholds. When potential flexible spending account contributions are included, as specified by the law, the percentage climbs to 31 percent.[8] Among employers with fifty or more employees that offered health benefits, only 16 percent said that they believe the tax will actually take effect in 2022. The possibility that it will take effect could influence employers with higher-cost plans to begin to make changes to lower their plan costs. Among employers with fifty or more employees that offered health benefits, 11 percent said that the upcoming tax was "very important" to their health benefit plan decisions in 2019, with 21 percent rating it "somewhat important," 30 percent "not too important," and 33 percent "not at all important."

HEALTH SCREENING AND MONITORING Employers have a variety of programs to assess the health of employees and encourage them to live in more healthy ways.

▶ **HEALTH RISK ASSESSMENTS:** Forty-one percent of small firms and 65 percent of large firms offering health benefits gave their employees the opportunity to complete a health risk assessment, similar to the percentages in 2018. These assessments ask employees, and sometimes their family members, questions about their medical history and lifestyle to identify health problems and risks. Among large firms providing employees with an opportunity to complete a health risk assessment, 50 percent had financial incentives to encourage employees to complete the assessment.

▶ **BIOMETRIC SCREENING:** Twenty-six percent of small firms and 52 percent of large firms offering health benefits gave their employees the opportunity to complete a biometric health screening. This type of screening is an in-person health examination conducted by a health professional to measure a person's risk factors such as cholesterol, blood pressure, and body mass index. Among large firms providing employees with the opportunity to complete a biometric assessment, 58 percent had financial incentives to encourage employees to complete the screening.

Some firms also have financial rewards or penalties tied to employees being able to meet specified biometric outcomes, such as maintaining blood cholesterol or body mass index below specified levels. Fourteen percent of large firms offering health benefits had financial incentives tied to employees' meeting biometric outcomes, similar to the percentage in 2018. These firms were asked about the maximum incentive or penalty an employee could receive that was related to meeting a biometric outcome. Among large firms, the maximum incentive was $150 or less in 17 percent of firms, $151–$500 in 28 percent of firms, $501–$1,000 in 13 percent of firms, and more than $1,000 in 11 percent of firms. For the remaining 31 percent of large firms, the incentive for meeting a biometric outcome was combined with incentives for completing other health activities as well.

▶ **WEARABLE DEVICES:** Some employers also are collecting health information from employees or dependents through mobile technology such as phone applications or wearable devices (for example, Fitbit or Apple Watch). Among large firms offering health benefits, 18 percent collected information from employees through mobile apps or wearable technology, similar to the percentage in 2018. Ten percent of large firms offering health benefits reported providing wearable technology to employees as part of a health improvement program.

RESPONSES TO OPIOID CRISIS Employers have been challenged over the past several years as the number of people with opioid addition has greatly increased. Overprescribing and insufficient monitoring of people who have been prescribed pain medications helped fuel the increase in addiction. Employers have responded in a number of ways, including educating workers and their dependents, modifying health plans to reduce opioid availability, monitoring the use of opioids, and expanding treatment for people who be-

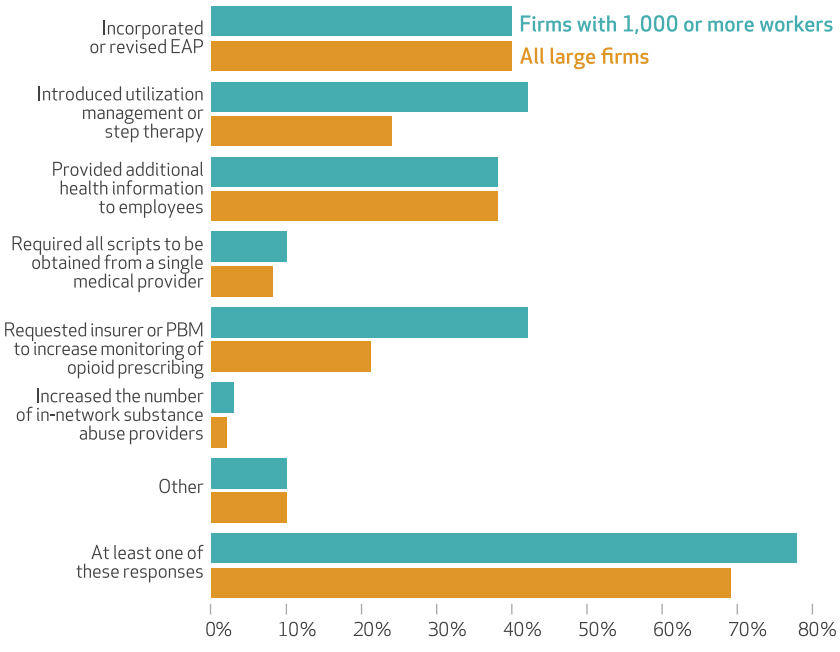
come dependent on them—as well as changing employee assistance programs and corporate drug policies.

We asked large employers offering health benefits about specific changes that they have made in the past five years in response to the growing opioid epidemic. Forty percent said that they had initiated or revised an employee assistance program, 24 percent modified coverage for opioids to incorporate utilization management or step therapy, 38 percent provided additional health information to employees, 8 percent required enrollees with high use to obtain prescriptions from only one provider, 21 percent asked their insurer or pharmacy benefit manager to increase monitoring of opioid use, and 2 percent increased the number of substance abuse providers in their networks (exhibit 6).

We also asked large employers how much the opioid epidemic had affected the productivity of their workforce. Most respondents said that the epidemic had "little impact" (37 percent) or "no impact" (39 percent) on productivity (data not shown). Employers with 200–999 workers were more likely than larger employers to say that there had been no impact (44 percent versus 19 percent). Employers with 5,000 or more workers were more likely than other firms with at least 200 employees to say that they did not know (33 percent), while employers with 200–999 workers were less likely than larger firms to say they did not know (14 percent).

EXHIBIT 6

Among large firms offering health benefits, percent of firms taking various actions in response to the opioid crisis, by firm size, 2019



SOURCE Henry J. Kaiser Family Foundation (KFF) Employer Health Benefits Survey, 2019. **NOTES** Many employers that selected "other" indicated that they limited the number of pills that can be given per prescription. An employee assistance program (EAP) is a program that offers short-term counseling for substance abuse or relationship issues, for example. Step therapy requires enrollees to try alternatives before opioids are covered. Large firms are defined in the notes to exhibit 2. PBM is pharmacy benefit manager.

Discussion

As in 2018, there were no big changes in the market for employer-sponsored coverage in 2019. Premiums continued to grow faster than inflation or workers' earnings, but at rates that are modest when compared to the high premium growth that this survey tracked in the early 2000s. Firm offer rates were higher than in 2017, but only for the smallest firms. The rapid growth in deductibles since the mid-2000s has slowed since 2017. The shares of workers eligible for and covered by their own employer also have been stable for several years.

Given this relative stability in premium growth and coverage, the vibrant public debate about whether the United States needs a public insurance program to replace or be an alternative to private coverage might come as a surprise. At the time of this writing, every leading Democratic candidate in the 2020 presidential primary race was supporting some type of public program that would, or could, enroll a substantial share of the nonelderly who currently have employer-based coverage. One reason may be the widespread concerns about affordability voiced by people in employer-based plans.

In a recent survey of adults with employer-based coverage conducted by the Kaiser Family Foundation and the *Los Angeles Times*, 40 percent of respondents said that they had difficulty affording health insurance or health care or had problems paying medical bills.[9] About one-half of respondents said that they or a family member had skipped or postponed getting health care or prescriptions in the past twelve months due to costs. People with higher deductibles were more likely to report problems with affordability and were more likely to say that their insurance had gotten worse over the past five years, compared to people with lower deductibles.[10]

It may be that the significant increase in deductibles over the past decade or so has fed concerns about the affordability of care. The average deductible among all covered workers has increased by 162 percent since 2009, as more covered workers became subject to deductibles and as deductible levels rose for those who had them. Typical deductibles for people with employer coverage are higher than the assets that many of those with private coverage have managed to save.[11]

Another factor that could be fueling affordability concerns is the high premium contributions that some workers face, particularly for family coverage. Fifteen percent of covered workers, including 35 percent of covered workers in small firms, were in a plan with a worker contribution of more than half of the premium for family coverage in 2019 (data not shown). The average worker's share for family coverage at firms with a relatively high share of lower-wage workers was 41 percent. It is reasonable to ask whether family coverage would be financially accessible to many of the workers in these firms.

Even if political support for a new public health insurance program wanes, concerns about affordability are unlikely to do so. There is little reason to think that employer plans are going to become more generous, particularly for people with lower wages—for whom affordability problems are the most acute. In fact, a recession could lead to just the opposite: less availability of employer-sponsored health coverage and accelerated cost shifting to workers. If the nation engages in another high-profile health reform debate, the affordability of health care for the large number of people with employer coverage could be front and center. ■

As part of the Peterson Center on Healthcare's work on the Peterson-Kaiser Health System Tracker, some additional questions on provider networks were included in the 2019 survey. The authors thank Tricia Neuman, Gretchen Jacobson, Karen Pollitz, Larry Levitt, and Cynthia Cox for their contributions. [*Published online September 25, 2019.*]

NOTES

1 The Henry J. Kaiser Family Foundation's estimate of employer-sponsored insurance coverage (ESI) uses a hierarchy for people with multiple sources of coverage. For example, people covered by ESI and Medicaid or Medicare are counted as enrolled in the public program rather than in ESI. Thus, our estimate of ESI differs from that of the Census Bureau. Of the 268 million nonelderly people in the United States, 153 million (57.1 percent) are covered by employer coverage. See Henry J. Kaiser Family Foundation. The uninsured and the ACA: a primer: key facts about health insurance and the uninsured amidst changes to the Affordable Care Act: supplemental tables [Internet]. San Francisco (CA): KFF; 2019 Jan [cited 2019 Aug 20]. Available from: http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Supplemental-Tables

2 Henry J. Kaiser Family Foundation. Employer health benefits: 2019 survey [Internet]. San Francisco (CA): KFF; 2019 Sep [cited 2019 Sept 25]. Available from: http://ehbs.kff.org/

3 To access the appendix, click on the Details tab of the article online.

4 The survey treats high-deductible plans that can be paired with a savings option (HDHP/SO) as a distinct plan type, even if the plan would otherwise be considered a PPO, HMO, POS plan, or indemnity plan. In 2019 federal law requires a deductible of at least $1,350 for single coverage and $2,700 for family coverage for high-deductible health plans qualified to offer health savings accounts. See Internal Revenue Service. Health savings accounts and other tax-favored health plans [Internet]. Washington (DC): IRS; 2019 Mar 4 [cited 2019 Aug 20]. (IRS Publication No. 969). Available from: https://www.irs.gov/pub/irs-pdf/p969.pdf

5 Bureau of Labor Statistics. Consumer Price Index All Urban Consumers (current series) [Internet]. Washington (DC): Department of Labor; [cited 2019 Aug 23]. Available from: https://beta.bls.gov/dataViewer/view/timeseries/CUUR0000SA0

6 Wage data are from the Bureau of Labor Statistics and based on the change in total average hourly earnings of production and nonsupervisory employees. See Bureau of Labor Statistics. Employment, hours, and earnings from the Current Employment Statistics survey (National) [Internet]. Washington (DC): Department of Labor; 2019 [cited 2019 Aug 23]. Available from: https://beta.bls.gov/dataViewer/view/timeseries/CES0500000008

7 Starting in 2019, we asked firms if they offered either a near-site or on-site clinic. Near-site clinics are health care facilities located near a worksite that contract to deliver services to employees.

8 Rae M, Claxton G, Levitt L. How many employers could be affected by the high-cost plan tax? [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2019 Jul 12 [cited 2019 Aug 20]. Available from: https://www.kff.org/private-insurance/issue-brief/how-many-employers-could-be-affected-by-the-high-cost-plan-tax/

9 Hamel L, Muñana C, Brodie M. Kaiser Family Foundation/LA Times survey of adults with employer-sponsored health insurance [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2019 May [cited 2019 Aug 20]. Available from: http://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance

10 Kirzinger A, Muñana C, Wu B, Brodie M. Data note: Americans' challenges with health care costs [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2019 Jun 11 [cited 2019 Aug 20]. Available from: https://www.kff.org/report-section/data-note-americans-challenges-with-health-care-costs-appendices/

11 Rae M, Claxton G, Levitt L. Do health plan enrollees have enough money to pay cost sharing? [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2017 Nov 3 [cited 2019 Aug 20]. Available from: https://www.kff.org/health-costs/issue-brief/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing/