MEDICAL BENEFITS

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INSIDE

Wolters Kluwer

HEALTH CARE COSTS

Trends in Employer Health Care Coverage, 2008–2018

Higher Costs for Workers and Their Families

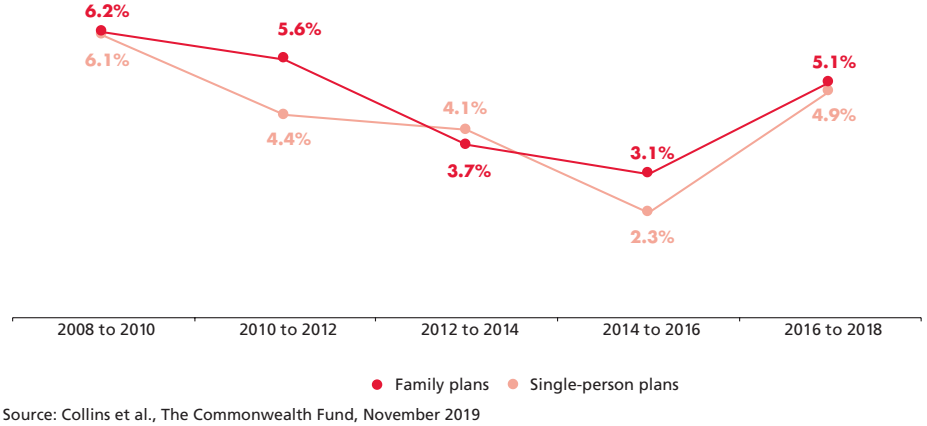
Sara R. Collins et al., The Commonwealth Fund, November 2019

"Following a slowdown between 2012 and 2016, average annual growth in employer premiums (including contributions from both employers and employees) rose at a faster pace between 2016 and 2018, rising by 4.9% for single plans and 5.1% for family plans. The average annual growth rate from 2016 to 2018 was 7% or higher in seven states for single-person plans and in eight states and the District of Columbia for family plans. In 2018, average premiums for single-person plans ranged from a low of $5,971 in Tennessee to a high of $8,432 in Alaska. In family plans, the lowest average premium was $17,337 in North Dakota and the highest was $22,294 in New Jersey **(Exhibit 1).**

U.S. workers contributed about 21% of the overall premium for single plans and 28% for family plans in 2018. This has not changed over the decade. Worker contributions to single-plan premiums averaged $1,427 in 2018. They ranged from a low of $755 in Hawaii to a high of $1,903 in Massachusetts. Contributions to family plans averaged $5,431 in 2018 and ranged from a low in Washington of $3,862 to a high of $6,597 in Virginia.

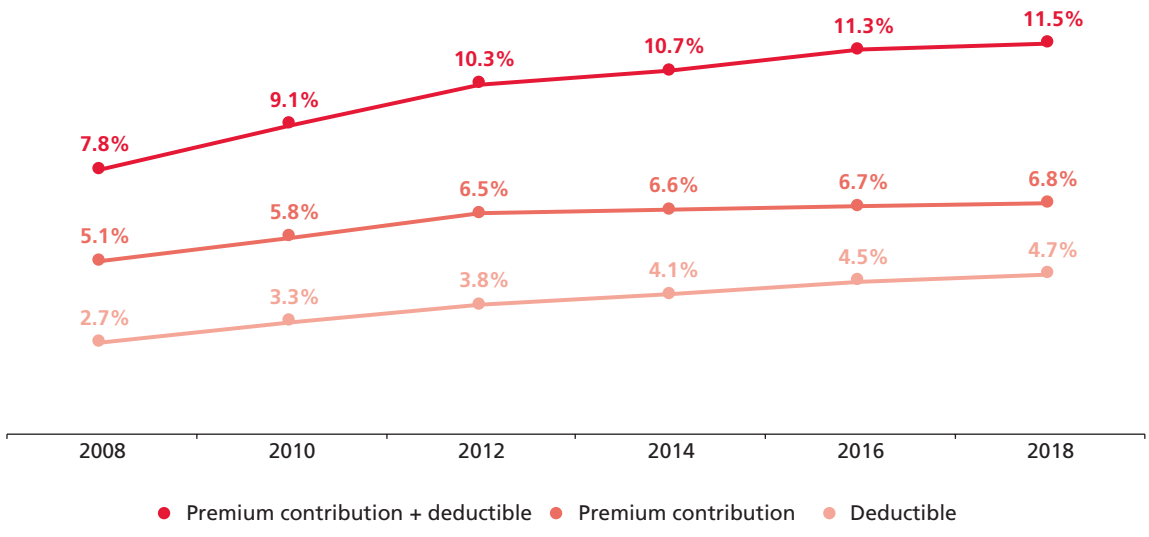
Between 2008 and 2018, employee premium contributions—for both single and family plans—grew at an average annual rate higher than 4%, going as high as 6.4% between 2010 and 2012. This was faster than growth in median household

Exhibit 1. Average annual growth in total premium cost for employer health insurance, in rolling two-year increments, 2008–2018.



Source: Collins et al., The Commonwealth Fund, November 2019

Exhibit 2. Average employee premium contribution and deductible as percent of median household income, 2008–2018.



Note: Single and family premium contributions, deductibles, and combined estimates are weighted for the distribution of single-person and family households in the state.

Source: Collins et al., The Commonwealth Fund, November 2019

income over the same time period, which ranged from –1.5% during the deep recession of 2008 to 2010 to 3.8% in 2012 to 2014.

On average, the employee share of premium amounted to 6.8% of median income in 2018. This was up from 5.1% in 2008 but has remained largely constant since 2012 **(Exhibit 2).**

The average deductible for a middle-income ($64,202) family amounted to 4.7% of income in 2018. This is up from 2.7% in 2008.

Across the country, average deductibles relative to median income were 5% or more in 18 states and ranged as high as 6.7% in Mississippi. Added together, the total cost of premiums and potential spending on deductibles across single and family policies climbed to $7,388 in 2018.

The average annual growth in the combined costs of premiums and deductibles outpaced average annual growth in median income between 2008 and 2018 in every state. For people with middle incomes, these combined costs amounted to 11.5% of income in 2018. This is up from 7.8% in 2008. In 2018, premiums and deductibles were 10% or more of median income in 42 states, up from seven states in 2008. Five states (Arkansas, Florida, Louisiana, Mississippi, and Nevada) have combined costs of 14% or more of median income.

Data [are] from the Medical Expenditure Panel Survey–Insurance Component, which surveyed more than 40,000 private-sector employers in 2018 on their health insurance plans." MB

The 22-page report is available online. Web site: www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018

MEDICAL BENEFITS

Editors: Joyce Anne Grabel, Elaine Stattler
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Persistency in High-Cost Health Care Claims: "It's Where the Spending Is, Stupid"

Paul Fronstin and M. Christopher Roebuck, Employee Benefit Research Institute, October 24, 2019

"Generally, 20% of those insured by employer-based health benefits in the U.S. account for 80% of total spending on health care services, with 10% of the population accounting for 70% of spending, 5% responsible for 56% of spending, and 1% accounting for 28% of spending.

When considering persistency of these high-cost claims, the study found 27% were in the top 10% of spending for at least one year, while 73% were never in the top 10%. Among the 27% who were ever in the top 10%, 21% were in the top 10% only one or two years, 4% were in the top 10% for three or four years, and only 2% were in the top 10% each of the five years.

Individuals temporarily in the top 10% of claimants had characteristics similar to those in the top 10% for all five years studied. Sixty-three percent of those persistently in the top 10% of claimants, as well as 59% those in the top 10% for three to four years, were ages 50 to 64, compared with 30% among those never in the top 10%. In addition, persistently high-cost claimants were also much more likely to be the spouse of the policyholder.

The 5.8 million individuals examined in this study used $38 billion in health care in 2017. The 2% of the population in the top 10% of spending every year between 2013 and 2017 accounted for 19% of total spending in 2017. In contrast, the 73% of the population who were never in the top 10% in spending during 2013 through 2017 accounted for only 20% of spending in 2017.

One-third of individuals persistently in the top 10% of claimants had diabetes. Among individuals in the top 10% of claimants for five years, 51% of those with diabetes also had hypertension; and about one-quarter of those with diabetes also had respiratory disease, back problems and/or connective tissue disease, among other less prevalent conditions.

Outpatient services, such as diagnostic services, accounted for 46% of total health care spending for those never in the top 10%. Prescription drugs accounted for 26% of total health care spending, and office visits to primary care physicians and specialists accounted for 18%. In contrast, among those in the top 10% for all five years, prescription drugs accounted for 52% of total health care spending, outpatient services accounted for 29%, and office visits accounted for three percent of spending.

Inpatient services accounted for 27% of total spending for those in the top 10% for one to two years, and 22% among those in the top 10% three to four years, but only 15% among those in the top 10% in all five years. This suggests that one-time events that individuals recover from, such as knee and hip replacements, drove more of the spending for those temporarily in the top 10% than those persistently in the top 10%."

The data on use of health care services, health conditions, and spending for this study comes from claims on 5.8 million policyholders and dependents with employment-based health benefits who could be followed for the entire 2013 through 2017 period." MB

The 23-page report is available online. Membership is required. Web site: www.ebri.org/publications/research-publications/issue-briefs/content/persistency-in-high-cost-health-care-claims-it-s-where-the-spending-is-stupid

Retail Drug Prices, Out-of-Pocket Costs, and Discounts and Markups Relative to List Prices

Trends and Differences by Drug Type and Insurance Status, 2011 to 2016

G. Edward Miller, PhD, et al., Agency for Healthcare Research and Quality, Research Findings #44, October 2019

"From 2011 to 2016, the share of outpatient prescriptions filled with nonspecialty single-source drugs fell by 11.0 percentage points from 22.2% to 11.2%, while the share of prescriptions filled by nonspecialty generics increased by 11.9 percentage points from 71.5% to 83.4%. Over the same period, specialty drugs rose from 1.2% to 2.0% of fills, and nonspecialty originators fell from 5.2% to 3.4% of fills.

In 2016, there were a number of significant differences by insurance status in the percentages of prescriptions filled with each type of drug. Medicare Part D enrollees filled a smaller share of prescriptions with specialty drugs (1.6%) and a larger share of prescriptions with generics (85.1%) than persons who were covered by Medicaid (2.4% and 81.9%, respectively) or private insurance (2.4% and 82.2%, respectively). The uninsured filled a smaller share of prescriptions with nonspecialty single-source drugs (8.4%) than those covered by Medicaid (12.8%), private insurance (11.4%), or Medicare Part D (10.8%), and filled a larger share of prescriptions with generics (86.3%) than Medicaid recipients (81.9%) and the privately insured (82.2%) **(Exhibit 3).**

Exhibit 3. Percentage of outpatient prescriptions filled with specialty, single source, originator, and generic drugs, by insurance status, 2016.

Insurance status		Patent status		
	Specialty	Single source	Originator	Generic
Total	2.0%	11.2%	3.4%	83.4%
Medicare Part D	1.6	10.8	2.6	85.1
Private	2.4	11.4	4.0	82.2
Medicaid	2.4	12.8	3.0	81.9
TRICARE or VA	1.17*	11.7	3.7	83.4
Uninsured	2.0	8.4	3.4	86.3

Source: Miller et al., Agency for Healthcare Research and Quality, Research Findings #44, October 2019

As expected, there are wide differences in average and median retail unit prices (RUPs) by specialty and patent status. Median RUPs for specialty drugs increased by almost 50% from $26.52 in 2011 (in 2016 dollars) to $38.75 in 2016. From 2011 through 2016, median RUPs for nonspecialty single-source drugs rose 84%, from $4.57 to $8.43, and average RUPs more than doubled, from $8.60 to $21.42. For nonspecialty generic drugs, median RUPs rose from $.24 to $.30, and average RUPs rose from $.66 to $1.00.

In 2016, the privately insured had average RUPs for specialty drugs ($443.58) that were approximately two times the average RUPs for Medicaid recipients ($202.88) and Medicare Part D enrollees ($222.45), and the privately insured had higher average RUPs for nonspecialty single-source drugs ($24.47) than Medicaid recipients ($15.22) and the uninsured ($11.64).

In spite of the higher amounts paid for specialty and other brand name drugs, consumers paid a higher share of the costs of generic drugs (41.8%) than they paid for nonspecialty originators (32.1%), nonspecialty single-source drugs (20.0%), and specialty drugs (10.8%).

From 2011 to 2016, median out-of-pocket unit costs dropped by about 30 to 40% for all types of nonspecialty drugs and for all drugs combined. In particular, median out-of-pocket unit costs fell from $.67 to $.40 for nonspecialty single-source drugs, from $.50 to $.34 for nonspecialty originators, from $.11 to $.07 for nonspecialty generics, and from $.13 to $.08 across fills of all types of drugs.

Average out-of-pocket shares also fell for all types of nonspecialty drugs and for all drugs, with the out-of-pocket share for nonspecialty single-source drugs falling from 29.1% to 20.0%, for nonspecialty originators from 41.7% to 32.1%, for nonspecialty generics from 57.1% to 41.8%, and for all drugs from 49.6 to 38.4%.

The three major payers—Medicare Part D, private insurance, and Medicaid—had median discounts from average wholesale unit price (AWUP) for the three types of brand name drugs (specialty, nonspecialty single source, and nonspecialty originator) that were all close to 15% (ranging from 14.6% to 16.3%) and corresponding median markups relative to wholesale acquisition unit cost (WAUC) ranging from 0.5% to 2.9%. The uninsured had similar discounts and markups for nonspecialty single source and originator drugs but had a larger median discount for specialty drugs (20.3% below AWUP) which resulted in a 4.4% median discount from WAUC.

From 2011 to 2016, there was no significant change in markups or discounts for specialty drugs. For nonspecialty single-source drugs, markups above the WAUC declined at both the average (from 15.8% to 7.9%) and median (from 3.9% to 0.9%) with corresponding increases in the discount from AWUP at the average (from 5.1% to 16.5%) and median (from 13.5% to 16.3%). For generic drugs, average markups above the WAUC increased (from 128.1% to 231.4%), while median markups decreased (from 17.7% to 9.6%), and average and median discounts from the AWUP both increased (from 43.7% to 48.8% and from 73.0% to 76.1%, respectively).

Estimates are drawn from analyses of Medical Expenditure Panel Surveys." MB

The 24-page report is available online. Web site: meps.ahrq.gov/data_files/publications/rf44/rf44.pdf

WORKPLACE HEALTH AND BENEFITS

Tobacco Product Use and Cessation Indicators Among Adults—United States, 2018

MeLisa R. Creamer, PhD, et al., *Morbidity and Mortality Weekly Report,* November 15, 2019

"The prevalence of adult cigarette smoking has declined in recent years to 14.0% in 2017. However, an array of new tobacco products, including e-cigarettes, has entered the U.S. market.

Among U.S. adults in 2018, 19.7% (estimated 49.1 million) currently used any tobacco product, 16.5% (41.2 million; 83.8% of current tobacco users) used any combustible tobacco product, and 3.7% (9.3 million; 18.8% of current tobacco users) used two or more tobacco products. Cigarettes were the most commonly used tobacco product (13.7%; 34.2 million). Prevalence estimates of use of the other tobacco products in 2018 were as follows:

- Cigars (3.9%; 9.6 million);
- E-cigarettes (3.2%; 8.1 million);
- Smokeless tobacco (2.4%; 5.9 million); and
- Pipes (1.0%; 2.6 million).

Exhibit 4. Percentage of persons aged 18 years or older who reported tobacco product use every day or some days, by tobacco product and selected characteristics, 2018.

Demographic	Any tobacco product	Any combustible product	Cigarettes	Cigars/Cigarillos/ Filtered little cigars	Pipe/Water pipe/ Hookah	E-cigarettes	Smokeless tobacco	≥ 2 tobacco products
Overall	19.7%	16.5%	13.7%	3.9%	1.0%	3.2%	2.4%	3.7%
Sex								
Men	25.8	20.6	15.6	6.8	1.5	4.3	4.7	5.9
Women	14.1	12.8	12.0	1.1	0.6	2.3	–	1.7
Age group in years								
18–24	17.1	11.2	7.8	4.1	—	7.6	—	4.1
25–44	23.8	20.0	16.5	5.0	1.5	4.3	3.2	5.5
45–64	21.3	18.7	16.3	3.7	0.6	2.1	2.4	3.3
≥65	11.9	10.3	8.4	2.1	—	0.8	1.4	1.3
Education (adults aged ≥25 years)								
0–12 years (no diploma)	25.9	23.1	21.8	2.8	—	2.5	2.9	4.2
GED	41.4	38.6	36.0	—	—	—	—	9.7
High school diploma	25.2	21.7	19.7	4.0	—	2.7	3.6	4.9
Some college, no degree	24.7	21.2	18.3	4.4	—	4.1	2.8	5.0
Associate degree	21.3	18.0	14.8	4.3	—	3.0	3.1	3.9
Undergraduate degree	13.0	10.6	7.1	3.7	1.1	2.2	1.5	2.0
Graduate degree	8.2	7.0	3.7	3.1	—	—	—	—
Income								
<$35,000	26.2	23.2	21.3	3.8	1.7	4.0	2.1	5.5
$35,000–$74,999	21.0	17.8	14.9	4.1	0.9	3.5	2.6	4.1
$75,000–$99,999	20.2	16.5	13.3	3.9	—	3.7	2.9	3.7
≥100,000	14.3	10.8	7.3	4.2	—	2.7	2.4	2.4
Health insurance coverage								
Private insurance	17.2	13.7	10.5	3.9	0.9	3.0	2.5	3.1
Medicaid	27.8	25.3	23.9	3.8	—	4.2	—	5.5
Medicare only (≥65 years)	12.6	10.9	9.4	—	—	—	—	—
Other public insurance	23.0	20.4	17.4	4.2	—	3.3	—	4.7
Uninsured	29.9	26.4	23.9	5.1	—	5.0	2.8	7.1

Notes: GED = General Educational Development certificate. Dashes = prevalence estimates with a relative standard error >30% that are not presented. Any tobacco product use = use every day or some days of at least one tobacco product (for cigarettes, persons who reported use either every day or some days and had smoked ≥ 100 times during their lifetime). Any combustible tobacco product use = use every day or some days of at least one combustible tobacco product: cigarettes; cigars, cigarillos, filtered little cigars; pipes, water pipes, or hookahs. Multiple tobacco product use = use either every day or some days for at least two or more of tobacco products.

Source: Creamer et al., *Morbidity and Mortality Weekly Report,* November 15, 2019

During 2017 to 2018, the prevalence of e-cigarette use increased from 2.8% to 3.2%, and the prevalence of smokeless tobacco use increased from 2.1% to 2.4%. No significant changes occurred in the use of the other tobacco products included in this study. Among current tobacco product users, daily use was reported by 74.6% of cigarette smokers, 59.1% of smokeless tobacco users, 42.6% of e-cigarette users, and 15.8% of cigar smokers

The prevalence of any current tobacco product use was higher among males (25.8%) than among females (14.1%) and among persons aged 25 to 44 years (23.8%), 45 to 64 years (21.3%), and 18 to 24 years (17.1%) than among those aged ≥65 years (11.9%). Current tobacco product use was also higher among non-Hispanic American Indian/Alaska Native adults (32.3%), non-Hispanic multiracial adults (25.4%), non-Hispanic whites (21.9%), non-Hispanic blacks (19.3%), and Hispanic adults (13.8%) than among non-Hispanic Asian adults (10.0%), as well as among those who lived in the Midwest (23.6%) or the South U.S. Census regions (21.4%) than among those who lived in the West (15.3%) or the Northeast (17.5%). The prevalence of current tobacco product use was also higher among persons who had a GED (41.4%) than among those with other levels of education and among those who were divorced, separated, or widowed (22.6%) or single, never married, or not living with a partner (21.1%) than among those married or living with a partner (18.4%) **(Exhibit 4).**

Current tobacco product use was higher among persons with an annual household income less than $35,000 (26.2%) than those in higher-income groups, as well as among lesbian, gay, or bisexual adults (29.2%) than among those who were heterosexual (19.5%). Prevalence also was higher among adults who were uninsured (29.9%), insured by Medicaid (27.8%), or had some other public insurance (23.0%) than among those with private insurance (17.2%) or Medicare only (12.6%); among those who had a disability/limitation (24.3%); and those who had serious psychological distress (36.7%).

Among adult cigarette smokers, the prevalence of making a quit attempt in the past 12 months increased from 52.8% in 2009 to 55.1% in 2018. Recent successful smoking cessation increased from 6.3% in 2009 to 7.5% in 2018. The quit ratio for cigarette smoking increased from 51.7% in 2009 to 61.7% in 2018.

The 2018 National Health Interview Survey Sample Adult component included 25,417 adults aged 18 and over." MB

The seven-page report is available online. Web site: www.cdc.gov/mmwr/volumes/68/wr/mm6845a2.htm

A Consumer-Centered Future of Health

2019 Global Health Care Consumer Survey

David Betts and Leslie Korenda, The Deloitte Center for Health Solutions, November 21, 2019

"Between a third and half of consumers use digital tools to measure their fitness and health, and between 20% and 35% of consumers use at-home monitoring devices. Our global survey found that Singapore and Canada had the highest percentage of fitness tracker usage-with other countries behind by less than 10%. In 2018, 42% of U.S. consumers said they used tools to measure fitness and to track health improvement goals, up significantly from just 17% in 2013 **(Exhibit 5).**

One-third to half of consumers are willing to share their health data in emergency situations (either to alert family members or emergency responders). Approximately 20% of consumers across the U.S. and global surveys would be willing to share their de-identified health data with organizations that do health care research—ranging from 18% of Germans to 26% of Canadians. In the United States, 39% were willing.

Between 13% and 29% of consumers in the seven countries we surveyed have had a virtual visit/consultation with a care provider. Consumers in Denmark and Singapore have more virtual visits than other countries surveyed. Consumers in Germany were least likely to have a virtual visit. In most countries, 'completely/very satisfied' levels hovered between 35% and 46%. In the United States, the percentage was higher—at 77%—which may reflect the fact that it has offered virtual visits for longer than most of the other surveyed countries. Interestingly, Singapore had the highest use of virtual visits; however, the country had the lowest rate of people that said they were 'completely/very satisfied' with their visit (35%).

Many consumers are interested in using tools to compare pricing and read user reviews. The level of interest tends to be highest when consumers have more exposure to out-of-pocket spending. Nearly half (49%) of U.S. consumers and 45% of those in Singapore said they are interested in using such tools.

The percentage of consumers who look up cost information for health services has nearly doubled over the last three years from 14% to 27%. As consumers increasingly use these tools, they may be more willing to switch doctors, devices, or hospitals because they have more

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LEGAL PULSE

Guidance on ACA Reporting for 2019

On December 2, the Treasury Department and the Internal Revenue Service (IRS) released Notice 2019-63 relating to information reporting required under the Affordable Care Act (ACA) for 2019. The notice provides guidance on three important issues:

- The deadline for distributing Forms 1095-B and 1095-C to plan participants/employees is extended from January 31, 2020, to March 2, 2020.
- The notice creates a new enforcement policy that waives penalties for failing to distribute Forms 1095-B to participants if certain conditions (described below) are met.
- The notice continues the IRS policy of not imposing penalties for incorrect or incomplete information when reporting entities act in good faith and distribute and file the required forms on time.

The new enforcement policy has limited usefulness to large employers, which are still required to distribute Form 1095-C to full-time employees. However, these employers may find the policy helpful if they also send information about self-insured coverage to employees who do not work full time (*e.g.*, retirees).

Background

The ACA created new reporting requirements related to enforcement of the individual shared responsibility penalty, the employer shared responsibility penalty and the premium assistance tax credits (available to certain individuals when purchasing coverage through the federal Marketplace/state Exchanges). When implementing these reporting requirements, large employers generally follow the following processes:

- Large employers meet their responsibilities by distributing Forms 1095-C to full-time employees and filing those forms along with the associated transmittal form (Form 1094-C) with the IRS.
- Large employers that sponsor self-insured group health plans meet their responsibilities as a large employer by completing Parts I and II of Form 1095-C and their responsibilities as a coverage provider by completing Part III of Form 1095-C.
- Large employers with self-insured plans covering individuals who are not full-time employees (*e.g.*, full-year retirees, part-time employees) have the option to provide coverage information using Form 1095-C or Form 1095-B.

New Relief for 2019

Treasury and IRS acknowledge in the notice that Congress reduced the ACA's individual shared responsible penalty to zero effective January 1, 2019. This means that individuals do not need to receive a Form 1095-B documenting their enrollment in coverage for 2019. Nonetheless, since Congress did not change the reporting rules, reporting entities are still required to comply with the reporting laws. Notice 2019-63 states that the IRS will not impose a penalty if a coverage provider fails to distribute Form 1095-B to plan participants when the following two conditions are met:

1. The reporting entity posts a notice prominently on its Web site stating that individuals may receive a copy of their 1095-B upon request. This notice must provide an email address and physical address to which a request may be sent, as well as a telephone number to use for asking questions.
2. The reporting entity provides Form 1095-B to any responsible individual within 30 days of the date the request is received.

This relief only applies to the Form 1095-B, not to Form 1095-C. However, if a large employer uses the Form 1095-C to report coverage of an individual who is not a full-time employee for any month of 2019, the enforcement relief would apply.

This relief does not affect the requirement to file these forms with the IRS by the required deadline, which means that reporting entities will still need to complete and file all required forms. The deadline for filing these forms is February 28, 2020 (if filing on paper) or March 31, 2020 (if filing electronically, which is required when filing 250 or more forms of either type).

Other Relief

The notice continues two types of relief provided in prior years:

- The IRS is extending the deadline for distributing these forms to plan participants/employees from

January 31, 2020, to March 2, 2020. Of course, reporting entities that choose to take advantage of the Section 6055 relief discussed above would not have to meet this deadline.

- The IRS is extending its enforcement policy of waiving penalties for incorrect or incomplete information provided the reporting entity has acted in good faith and distributed and filed the forms on time. As noted above, there is no change in the deadlines for filing forms with the IRS.

The IRS has released draft reporting forms and instructions for the 1095-B, 1095-C, 1094-B and 1094-C, but has not yet released the final versions of these forms. Final forms should be posted on the IRS website soon. The draft forms are the same as the 2018 forms and the draft instructions indicate no change in the way reporting entities complete the forms for 2019. MB

Source: Sibson Consulting, December 5, 2019. Web site: www.sibson.com/publications-videos/hot-topics/guidance-on-affordable-care-act-reporting-for-2019?utm_source=publication&utm_medium=email&utm_campaign=HT-ACA

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Exhibit 5. Percentage of respondents who used any technologies in the last 12 months for health purposes, 2018–2019.

	Australia	U.K.	Canada	Denmark	Netherlands	Germany	Singapore	U.S.
Measure fitness and health improvement goals	40%	37%	43%	39%	37%	35%	53%	42%
Monitor health issue	21	21	27	21	21	24	35	27
Receive alerts or reminders to take medications	17	15	20	17	19	18	21	21
Measure, record, or send date about medication being taken	13	11	15	16	19	13	21	20
Order a repeat prescription supply	18	38	29	49	36	22	16	48

Notes: Technologies = Web sites, smartphone/tablet apps, personal medical devices, or fitness monitors to, *e.g.*, measure exercise, diet, weight, and sleep or monitor blood sugar, blood pressure, breathing function, or mood.

David Betts and Leslie Korenda, The Deloitte Center for Health Solutions, November 21, 2019

information on who and what tools provide the best prices and the highest quality." MB

The 24-page report is available online. Web site: www2.deloitte.com/us/en/insights/industry/health-care/global-health-care-trends-survey.html

Medical Expenditures Panel Survey, Insurance Component 2018 Chartbook

Agency for Healthcare Research and Quality, September 2019

"Between 2017 and 2018, there was no significant change in the overall percentage of private-sector employees (47.8% in 2018) enrolled in a health insurance plan offered by their employers. There was also no significant change in the enrollment rate in any firm-size category.

There was no significant change in the overall percentage of employees working at establishments where insurance was offered between 2017 (84.5%) and 2018 (84.6%).

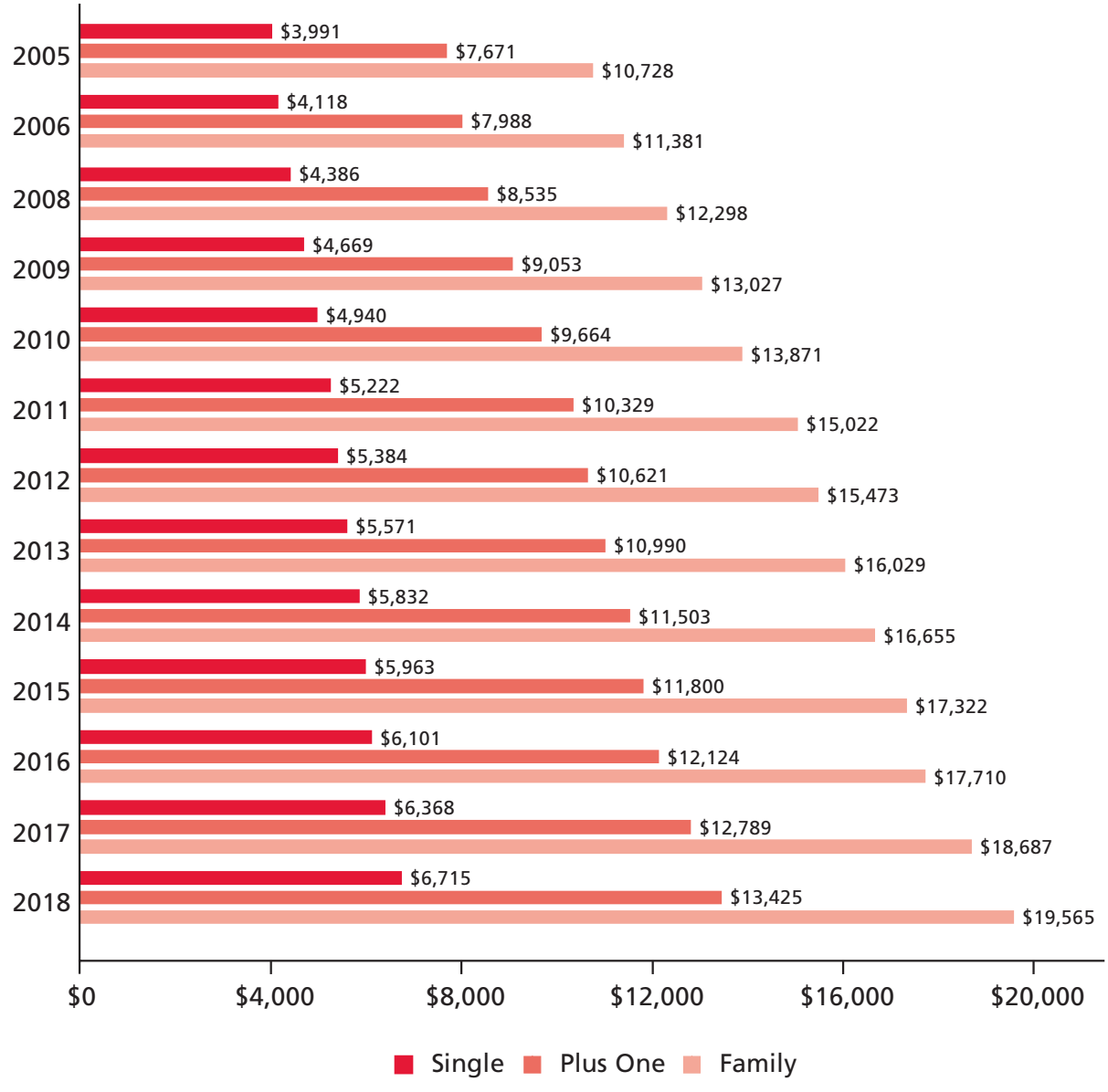
In 2018, almost all employees (99.0%) in firms with 100 or more employees worked at establishments that offered health insurance. In comparison, about half (47.3%) of employees at firms with fewer than 50 employees worked where health insurance was offered.

Among establishments that offered insurance, 56.5% of employees were enrolled in coverage through their employer and 78.0% were eligible for health insurance. Among eligible employees, 72.4% were enrolled in their employer's health insurance. There was no significant change in the coverage rate between 2017 and 2018 overall or in any firm-size category.

Among employees in establishments that offered health insurance, the eligibility rate increased from 76.8% in 2017 to 78.0% in 2018. The rate in 2018 was higher than eligibility rates observed from 2014 to 2017.

The percentage of employees with a choice of plans increased between 2017 and 2018, from 72.4% in 2017 to 75.7% in 2018. The availability of plan choice was significantly higher in 2018 than in 2005 for small employers (37.8% vs. 18.2%), medium employers (56.4% vs. 32.1%), and large employers (84.7% vs. 69.0%).

Exhibit 6. Average total premiums per enrolled employee for single, employee-plus-one, and family coverage, 2005–2018.



Source: Agency for Healthcare Research and Quality, September 2019

Between 2017 and 2018, there was no significant change in the percentage of offering establishments that self-insured at least one plan overall. However, this percentage declined at establishments in firms with fewer than 10 employees (from 17.7% to 13.1%) and with 25 to 99 employees (from 16.0% to 12.9%) and increased at establishments in firms with 1,000 or more employees (from 78.6% to 81.6%).

In 2018, average annual health insurance premiums per enrolled employee with private-sector employer coverage were $6,715 for single coverage, $13,425 for employee-plus-one coverage, and $19,565 for family coverage. These amounts represent increases of 5.4% for single coverage, 5.0% for employee-plus-one coverage, and 4.7% for family coverage over 2017 levels. Between 2005 and 2018, premiums for the three types of coverage grew by between

68.3% and 82.4%, with average annual growth rates between 4.1% and 4.7%.

In 2018, enrolled employees paid 21.3% of total premiums for single coverage, 27.1% for employee-plus-one coverage, and 27.8% for family coverage. The employee share of total premiums in 2018 for single coverage decreased by 0.9 percentage points from its 2017 level, while the employee shares for the other two coverage types were not significantly different from their 2017 levels.

From 2005 to 2018, the percentage of premiums contributed by employees increased by 3.2 percentage points, 4.2 percentage points, and 3.7 percentage points for single, employee-plus-one, and family coverage, respectively. These increases occurred because employee contributions increased more rapidly than employer contributions over the entire period for each type of coverage. Average employee contributions in 2018 were $3,634 for employee-plus-one coverage and $5,431 for family coverage, representing increases of 2.9% and 4.1%, respectively, over 2017 levels. Employee contributions for single coverage in 2018 ($1,427) were not significantly different from average contributions in 2017 **(Exhibit 6).**

There was no significant change in the percentage of enrolled employees in a health insurance plan with a deductible from 2017 (87.5%) to 2018 (87.3%). From 2005 to 2018, the percentage of enrollees in plans with deductibles increased from 63.9% to 87.3%.

There was also no significant change in average deductible levels among single- and family-coverage enrollees in a plan with a deductible from 2017 to 2018, making 2018 the first year without a significant increase in the 2005 to 2018 period. Among enrollees with deductibles, average individual deductibles in 2018 were higher in small ($2,327) and medium ($2,369) firms than in large firms ($1,692). Family deductibles in 2018 were higher in medium firms ($4,755) than in small firms ($4,364) and both were higher than in large firms ($3,179).

The private-sector sample is composed of about 42,000 business establishments from more than 7 million establishments found on the Business Register at the U.S. Census Bureau." MB

The 302-page chartbook is available online. Web site: https://meps.ahrq.gov/data_files/publications/cb23/cb23.pdf

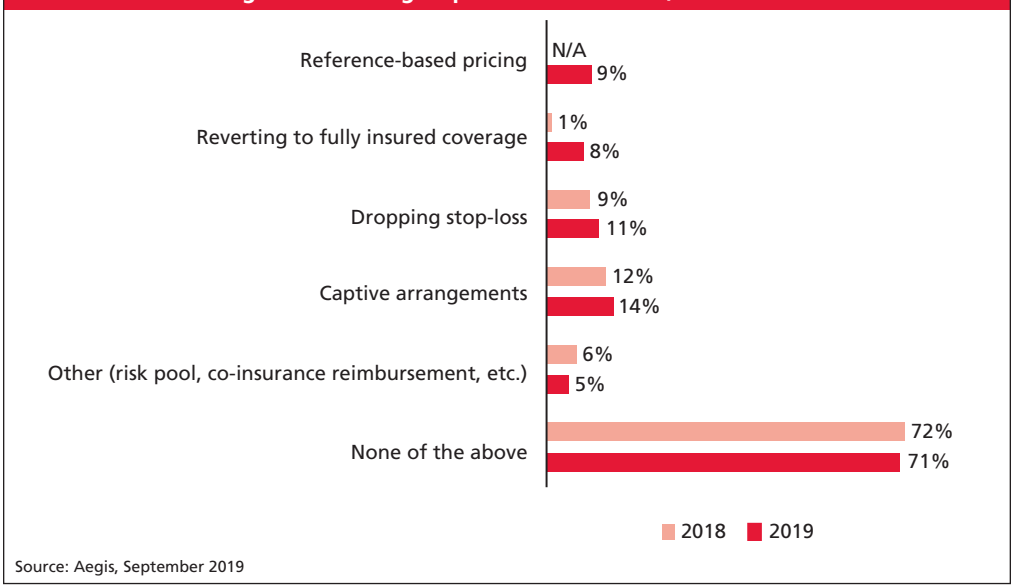
HEALTH CARE INDUSTRY

Aegis Risk Medical Stop-Loss Premium Survey

Aegis, September 2019

"The occurrence of truly catastrophic claimants—in excess of $1 million—is verified with 31% of respondents reporting such a claimant in the last two policy years. Stop-loss remains the primary focus of risk management, with 71% of respondents sharing no interest in alternate approaches.

Exhibit 7. Risk management strategies planned for review, 2018 vs. 2019.



Source: Aegis, September 2019

Excluding claimants at renewal, known as lasering, is not permitted per policy for 53% of respondents; but only 30% of those with a renewal cap. 'Mirroring' of the stop-loss policy to underlying health plan language is reported by 45%. Dividend-eligible policies are still uncommon at 6%.

Ninety-eight percent of surveyed plans cover pharmacy, an ongoing increase from about 92% in recent years. Increased high-dollar pharmacy exposure is undoubtedly causing the change, and stop-loss without pharmacy coverage is now ill-conceived.

Of respondents, 23% reported an aggregating specific deductible (ASD), with the average size being 81% of the underlying individual stop-loss (ISL). In an example, if an ISL is $200,000, the ASD, on average, is $162,000 (81%).

Aggregate coverage, against overutilization of the health plan, is most prevalent alongside ISL deductibles of $225,500 or less and enrollments around or below 1,000. It becomes less common at higher deductibles and/or enrollments-since those tend to be risk-savvier or more stable; 125% is the prevalent level, chosen by 83% of those with aggregate coverage, with 120% next at 11%.

Alternative delivery and risk mechanisms are being offered or discussed with self-funded plan sponsors, including reference-based pricing and captive arrangements. However, maintaining the status quo seems most prevalent, with 71% responding 'none of the above,' consistent with recent years. Captives have the greatest interest, but slight, at 14% **(Exhibit 7).**

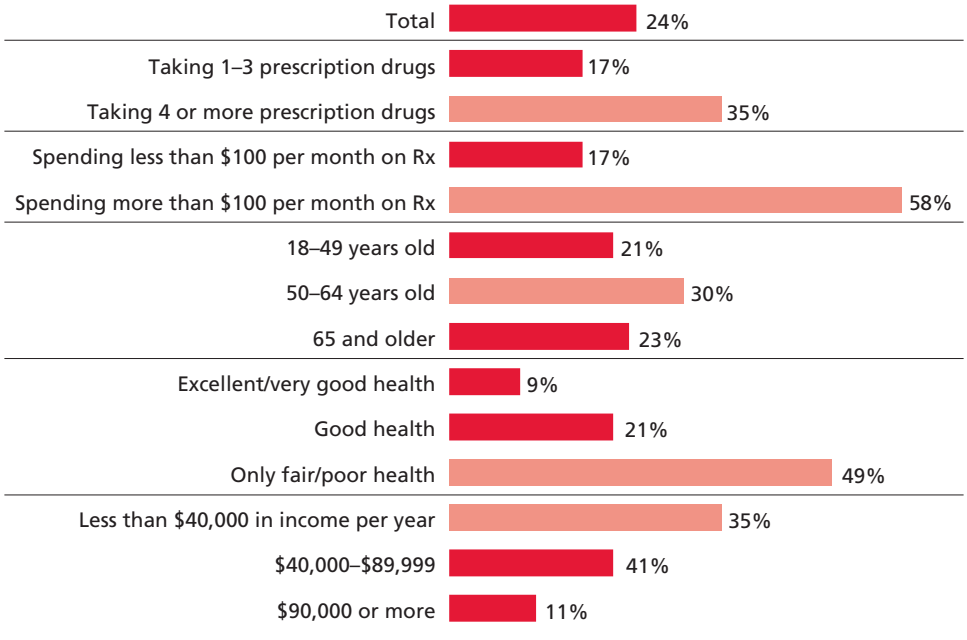
The rising occurrence of claimants $1 million or more continues to increase claims to premium loss ratios for underwriters (and erode profits). Indication exists that renewal increases may get steeper. Altogether, we illustrate a 13% marketwide leveraged trend for 2020 premiums. However, increases approaching 20% may not be uncommon.

This survey represents 539 plan sponsors covering over 940,000 employees with $464 million in annual stop-loss premium." MB

The report is available online. Web site: www.iscebs.org/Documents/PDF/2019AegisRisk.pdf

MB STAT

Who Has Difficulty Affording Their Prescription Drugs?



Source: Henry J. Kaiser Family Foundation, Public Opinion on Prescription Drugs and Their Prices, 2019. Web site: www.kff.org/slideshow/public-opinion-on-prescription-drugs-and-their-prices/

MEDICAL BENEFITS

REFERENCE DESK

Characteristics of Hospitalized and Nonhospitalized Patients in a Nationwide Outbreak of E-cigarette, or Vaping, Product Use–Associated Lung Injury—United States, November 2019

The Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), state and local health departments, and public health and clinical stakeholders are investigating a nationwide outbreak of e-cigarette, or vaping, product use–associated lung injury (EVALI). As of November 13, 49 states, the District of Columbia, and two U.S. territories (Puerto Rico and U.S. Virgin Islands) have reported 2,172 EVALI cases to CDC, including 42 EVALI-associated deaths.

This report analyzes EVALI case report information supplied by states for hospitalized and nonhospitalized patients with EVALI, including during the 2019 to 2020 influenza season. Among 2,016 EVALI patients, 1,906 (95%) were hospitalized, and 110 (5%) were not hospitalized. Demographic characteristics of hospitalized and nonhospitalized patients were similar; most were male and younger than 35 years. These patients also reported similar use of tetrahydrocannabinol-containing products.

Recent CDC laboratory testing has detected vitamin E acetate in fluid samples from a sample of 29 patients with EVALI. These findings provide direct evidence of vitamin E acetate at the primary site of injury within the lungs. However, evidence is not yet sufficient to rule out other chemicals of potential concern contributing to EVALI. MB

The report is available online. Web site: cdc.gov/mmwr/volumes/68/wr/pdfs/mm6846e1-h.pdf?deliveryName=USCDC_921-DM13575

Health, United States, 2018

This annual release from CDC features trends and current information on health status and determinants, health care utilization, health care resources, and health care expenditures. This year's update includes the following highlights:

- Significant decreases in life expectancy at birth have been observed each year since 2015 among men, while remaining stable among women.
- From 2007 to 2017, the age-adjusted death rate for drug overdose increased 82%, from 11.9 to 21.7 deaths per 100,000.
- The birth rate among teenagers aged 15 to 19 years fell by more than one-half, from 41.5 in 2007 to 18.8 live births per 1,000 teens in 2017—a record low for the United States.
- The use of e-cigarettes among students in grades 9 through 12 increased from 1.5% in 2011 to 20.8% in 2018, nearly doubling (from 11.7% in 2017) in the last year alone.
- In 2017, fewer than half (48.5%) of uninsured children aged 19 to 35 months had received the recommended combined seven-vaccine series. This was significantly lower than among the percentage of children who were covered by private health insurance (76.0%) or Medicaid (66.5%).
- In 2017, 16.2% of adults living below 100% of the poverty level delayed or did not receive needed medical care due to cost compared with 5.1% of those living at or above 400% of the poverty level.
- In 2017, personal health care expenditures in the United States totaled almost $3.0 trillion—a 3.8% increase from 2016.
- From 2007 to 2018 (preliminary estimates), the percentage of children under 18 years with no health insurance decreased 3.8 percentage points to 5.2%.

Other topics covered in *Health, United States* include natality and mortality, health conditions, risk and protective factors, financing of health care, and health insurance. Supplemental online-only detailed trend tables include suicide, illicit drug use, leisure-time physical activity, dental caries, and hospital stays. MB

The 65-page book is available online at www.cdc.gov/nchs/data/hus/hus18.pdf. Additional tables are also available online. Web site: www.cdc.gov/nchs/hus/contents2018.htm?deliveryName=USCDC_379-DM11562