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## The More Things Change, the More They Stay the Same: An Analysis of the Generosity of Employment-Based Health Insurance, 2013–2019

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### AT A GLANCE

**"The future ain't what it used to be." - Yogi Berra**

In this paper we explore trends in actuarial value — or relative generosity of health plans — in the employment-based health coverage market since the implementation of the major coverage provisions of the Affordable Care Act (ACA) in 2014. Because there is a concern that workers would migrate to lower actuarial value (AV) plans in the exchanges if the Biden Health Care Plan were adopted, it is also important to know whether workers are already enrolling in lower AV plans in the employment-based market as a result of the ACA. In our analysis, we observe:

- Both average and median AV were about 83 percent in each year from 2013 to 2019.
- There were differences in average AV by plan type. The average AV for enrollees in health maintenance organizations (HMOs)/exclusive provider organizations (EPOs) was highest. This was followed by the AV of enrollees in fee-for-service plans. Preferred provider organization (PPO) and point of service (POS) enrollees saw an average AV of 85 percent and 84 percent, respectively. Not surprisingly, plans linked to spending accounts had the lowest AVs.
- Average AV increased for every type of health plan between 2013 and 2019.
- We did not find that demographics significantly affected plan choice.
- We did find variation in AV by industry. Workers in retail trade, agriculture, forestry, fishing, construction, finance, insurance, and real estate are in the lowest AV plans.

As opposed to group coverage, health insurance purchased in the individual market tends to be somewhat less generous in benefits, on average.

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## **Introduction**

Health insurance plans come in many different shapes and sizes, both in terms of how cost sharing is designed as well as other plan features. Deductibles, copayments, and coinsurance are forms of patient cost sharing that often vary in a complex way that makes it difficult for workers and their families to compare and evaluate their health plan options. Other plan features may vary as well, such as the breadth and depth of provider networks, and the list of prescription drugs (known as a formulary) and other health care services that may or may not be covered benefits.

### **About Actuarial Value**

Actuarial value (AV) is a summary measure that may be used by consumers and regulators to compare the relative generosity of health plans. Actuarial value is the percentage of covered, allowed health care expenses that is paid by the plan. “Covered” health care costs are defined as costs for services and products that are covered by the health insurance policy. “Allowed” health care costs are the total payment amount upon which the health insurer will apply the benefits design. The remainder of the allowed health care expenses is called cost sharing and is paid by the enrollee. For example, an enrollee visits the doctor for a routine physical exam, which is a covered benefit of this plan. The doctor bills \$150 for this office visit, but the contractually set rate is \$100, so the “allowed” cost is \$100 and the remaining \$50 is written off by the physician (Appendix Figure 1). Under the plan’s benefits, visits to the primary care physician require a copayment of \$20. Thus, the enrollee pays \$20 and the physician receives \$80 from the plan for a total of \$100. AV may range from as low as 60 percent for a health benefits design that will pay just over one-half of the cost of covered, allowed health care expenses to as high as 100 percent for a plan that is designed to completely pay for covered, allowed health care expenses.

AV is measured on a standard population basis. For example, in a health plan with an AV of 80 percent, the plan would expect to pay 80 percent of the expenses of a standard population, which is generally meant to reflect the demographics and health status distribution of the people who will be covered by the plan, and on average, the covered individuals in the plan would pay the remaining 20 percent as cost sharing. Of course, because people have different health conditions with varying health care needs, any particular plan member may pay more or less than 20 percent of their own covered health care expenses.

Although AV does not measure the premium nor the percentage of the premium that workers may be required to pay as their employee contribution, premiums are often correlated with AV.<sup>1</sup> Plans with a higher AV will almost always have higher premiums than lower AV plans unless there is a significant difference in other aspects of the plan, such as benefits covered, extent of the network, characteristics of the drug formulary, or restrictions on utilization of high-cost services.

The purpose of this paper is to explore trends in actuarial value (AV) in the employment-based market since the implementation of the major coverage provisions in the Patient Protection and Affordable Care Act (ACA) in 2014.<sup>2</sup> To better understand the risk of workers migrating to lower AV plans in the exchanges, it is important to know whether such a downward trend in AV is already occurring in the employment-based market. This paper also examines how AV varies by various worker demographics and industry. The next section discusses how actuarial value became to be known in the ACA and its relevance to the proposed Biden Health Care Plan. The following section discusses data and methods. After that we present our main findings.

## **Actuarial Value, the ACA, and the Biden Health Care Plan**

When the ACA passed in 2010, it brought attention to actuarial value. Most of the attention was centered on the health plans that were going to be offered in the nongroup exchanges. The ACA categorized health plans into four metallic tiers — platinum, gold, silver, and bronze. The intent of labeling health plans by their metallic tier was to make it easier for consumers to compare health plans in the exchanges. Platinum plans have an AV of 90 percent, gold plans have an AV of 80 percent, silver plans have an AV of 70 percent, and bronze plans have an AV of 60 percent (regulations allow the actual AV to approximate the specified AV, so a silver plan may have an AV of 72 percent, for example). The ACA required employers with 50 or more full-time-equivalent employees to offer health plans that provided a minimum value of at least 60 percent. In other words, these employers had to provide health plans with at least a 60 percent AV. These plans could not exclude coverage for inpatient or outpatient services. Other requirements had to be met in addition to the AV requirement. Employers that failed to provide such plans were subject to a financial penalty.

There was concern when the ACA passed that the requirement that employers offering health coverage provide plans with at least 60 percent AV would incentivize employers to reduce the generosity of their plans to the 60 percent floor. Using data from mostly the large group market, this paper will show that this has not happened. A similar concern exists today that the proposed Biden Health Care Plan would lead workers to drop employment-based coverage for ACA exchange coverage and/or would lead employers to stop offering traditional health benefits because of three provisions:

- Increasing the ACA's premium subsidies and expanding subsidy eligibility.
- A "public option" health plan.
- A Medicare "buy-in" program for 60- to 64-year-olds

The American Rescue Plan Act of 2021 included the first provision of the Biden Health Care Plan. It eliminated the income limit on subsidies, allowing individuals in families with incomes above 400 percent of the federal poverty level (FPL) to be eligible for subsidized health insurance coverage in the ACA exchanges. It also increased subsidies for families with incomes between 100 percent and 400 percent of the federal poverty level. However, both provisions are only in effect for 2021 and 2022.

The Biden Health Care Plan proposes permanently increasing the ACA's premium subsidy levels. It also includes several provisions that are not in the American Rescue Plan Act of 2021. For instance, it would expand who is eligible for subsidized health insurance. More specifically, the plan would allow workers to get subsidized coverage in the ACA exchanges even if they are offered what is considered affordable health insurance coverage through their job.

Workers may leave employment-based plans for a number of reasons. Even if they are offered affordable coverage from their employer, under the Biden Health Care Plan, they would qualify for subsidized coverage in the ACA exchanges if they met the income requirements, which may drive them away from employment-based plans, especially if a public-option health plan is less expensive as well. Furthermore, employers may stop offering coverage if the private health plans they offer cannot compete with the public option. Their workers may prefer ACA exchange coverage over employment-based plans if it is less expensive and/or more generous.

The question then becomes what health plans do if workers lose their employer offering and must obtain coverage through an exchange. On the one hand, workers would lose employer subsidies for coverage. In 2020, workers paid on average 17 percent of the premium for employee-only coverage and 27 percent for family coverage.<sup>3</sup> This may lead them to choose less costly exchange health plans, which tend to have lower AVs. On the other hand, more generous subsidies that are tied to the second-lowest-cost gold plan as opposed to the second-lowest-cost silver plan may mean that workers are more likely to purchase higher AV plans, or plans with an AV that is closer to what is typically offered in employment-based coverage.

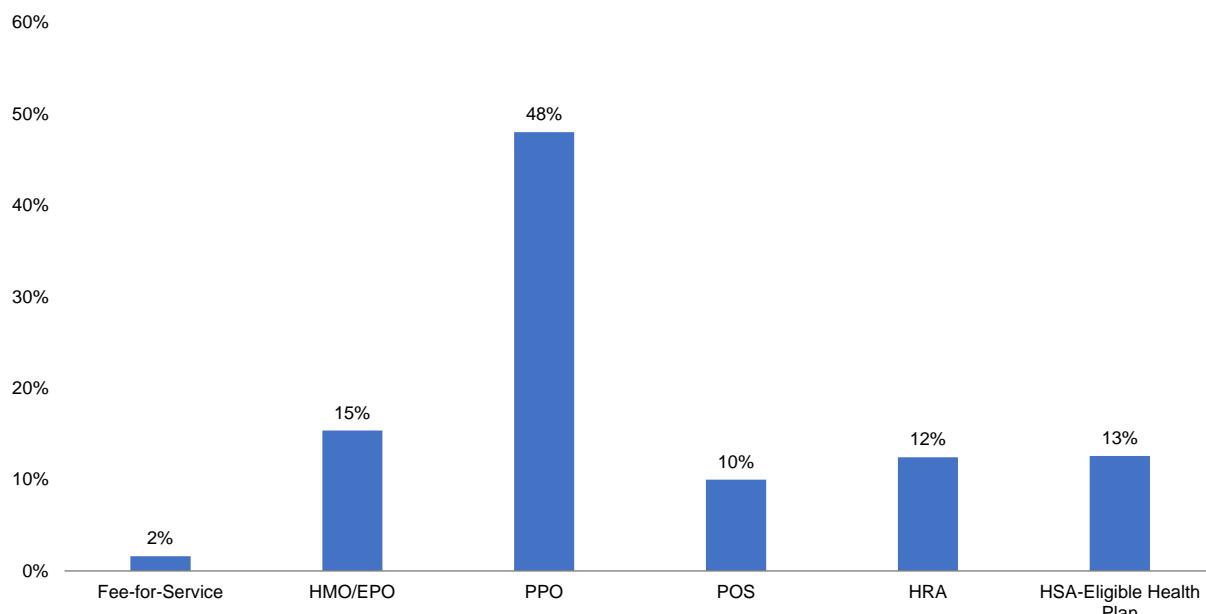
## Data and Methods

This study makes use of the IBM® MarketScan® Commercial Claims and Encounters (CCAE) Database as well as the IBM® MarketScan® Benefit Plan Design Database (BPD). The CCAE Database contains member enrollment information as well as adjudicated inpatient and outpatient medical and pharmacy claims. The BPD contains data on the main elements of health plan benefit design, including deductibles, coinsurance rates, copayments, and maximum out-of-pocket (MOOP) amounts.

Data from 2013 through 2019 were used for this study. In any given year between 2013 and 2018, the CCAE Database and BPD contained data on between 23 and 25 million workers and their dependents with employment-based health benefits. In 2019, the size of the database fell to 20 million workers and dependents.

*Health Plan Enrollment* – About one-half of the sample (48 percent) were enrolled in a preferred provider organization (PPO) in 2019 (Figure 1). Health maintenance organizations (HMOs) and exclusive provider organizations (EPOs) accounted for 15 percent. Point-of-service (POS) plans accounted for 10 percent. Health plans coupled with a health reimbursement arrangement (HRA) accounted for 12 percent. Health savings account (HSA)-eligible health plans accounted for 13 percent. Fee-for-service plans only accounted for 2 percent of health plan enrollment.

Figure 1  
Distribution of Sample by Plan Enrollment, 2019

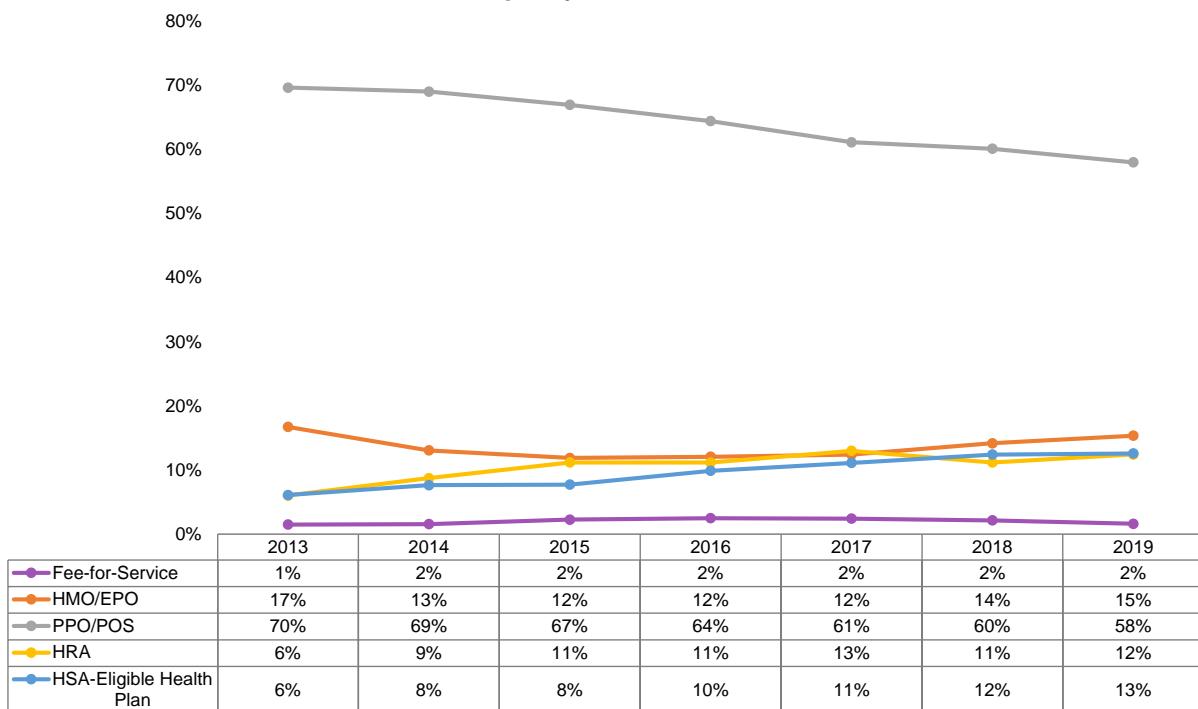


Source: Employee Benefit Research Institute estimates based on administrative enrollment data.  
HMO = health maintenance organization. EPO = exclusive provider organization. PPO = preferred provider organization. POS = point-of-service plan.  
HRA = health reimbursement arrangement. HSA = health savings account.

The trend has been away from PPO/POS enrollment and toward HRAs and HSA-eligible health plans. Between 2013 and 2019, the percentage of plan participants in a PPO/POS plan fell from 70 percent to 58 percent (Figure 2). Enrollment in HRAs and HSA-eligible health plans doubled from 6 percent each in 2013 to 12 percent for HRAs and 13 percent for HSA-eligible health plans.

*Gender and Age* – Plan members were split evenly between males and females in 2019 (Figure 3). When looking at enrollment by age, 37 percent were under age 26, 15–16 percent were in each of the 26–34, 35–44, 45–54, and 55–64 age groups, and 1 percent were 65 or older (Figure 4).

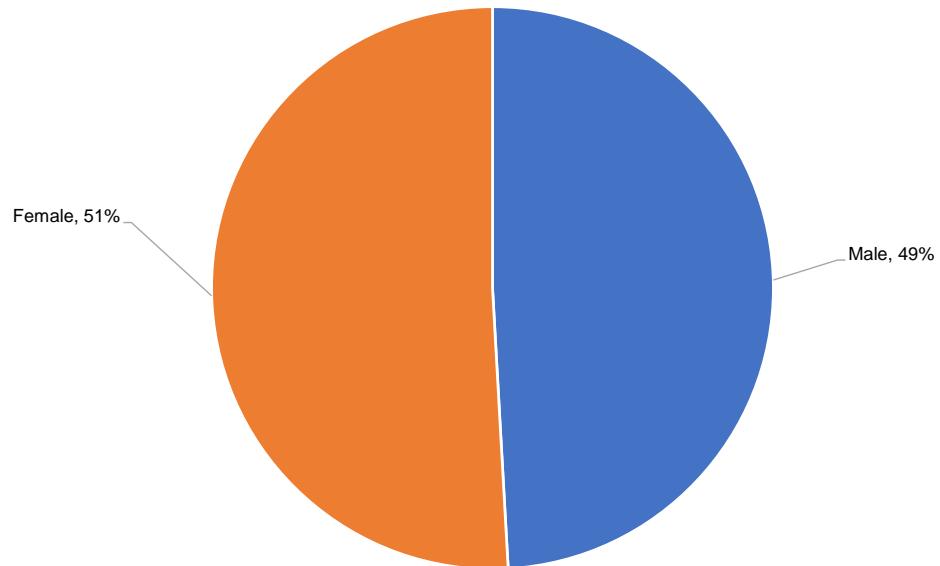
**Figure 2**  
**Distribution of Sample by Plan Enrollment,\* 2013–2019**



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

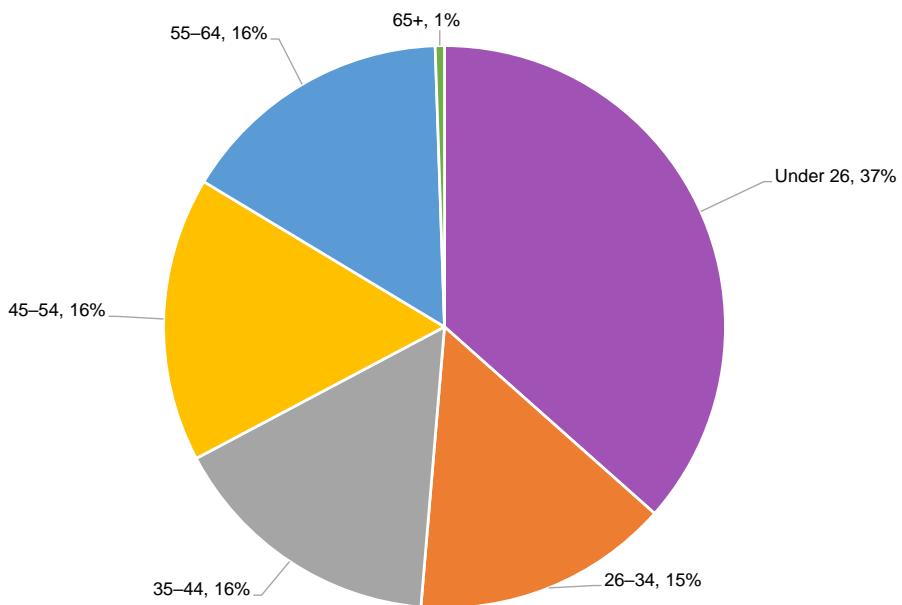
\*HMO = health maintenance organization. EPO = exclusive provider organization. PPO = preferred provider organization. POS = point-of-service plan. HRA = health reimbursement arrangement. HSA = health savings account.

**Figure 3**  
**Distribution of Sample by Plan Member Gender, 2019**



Source: Employee Benefit Research Institute estimates based on administrative enrollment data.

**Figure 4**  
**Distribution of Sample by Plan Member Age, 2019**



Source: Employee Benefit Research Institute estimates based on administrative enrollment data.

*Relation to Policyholder* – One-half (49 percent) of the sample were policy holders in 2019 (Figure 5). Spouses represented 17 percent of the sample, and dependent children (and other dependents) represented one-third (34 percent) of the sample.

*Employment Status of Policyholder* – Most of the sample were either full-time workers or their dependents (78 percent) in 2019 (Figure 6). Very few were either part-time workers, early retirees, or COBRA beneficiaries. The remainder (17 percent) were not determined.

*Industry* – The distribution of the sample by industry is shown in Figure 7. Manufacturing and services made up 60 percent of the sample.

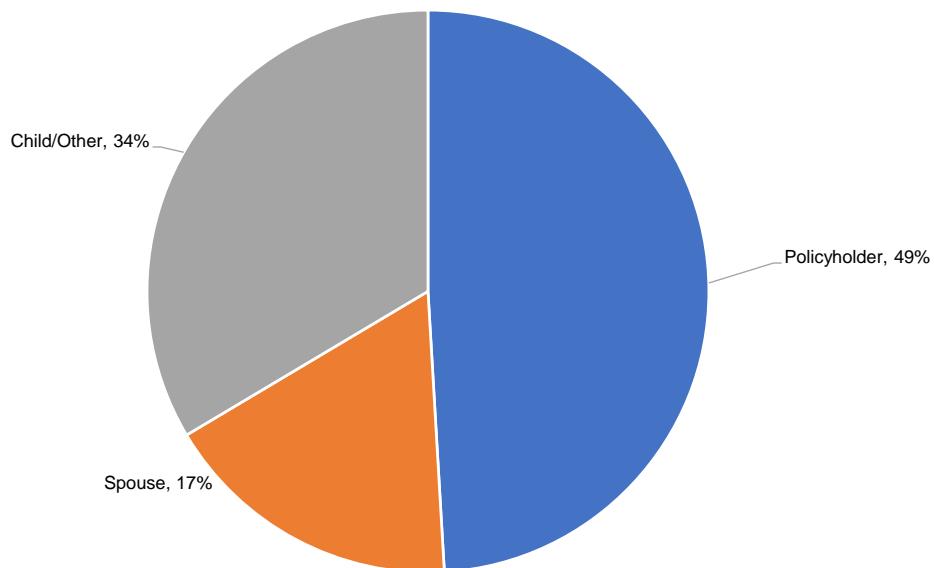
Two limitations of the CCAE Database and BPD are that (1) there is no group identifier, and (2) the plan’s actuarial value is not provided. We came up with a method to create groups and AV.

In order to calculate an AV for each policyholder (and their associated dependents), the sample was divided into synthetic “covered population” groups using the information on plan design in the BPD database. These synthetic groups were based on the various unique combinations of cost-sharing variables. These variables included individual and family deductibles; copayments for emergency department visits, inpatient stays, primary care physician office visits, and specialty physician office visits; and coinsurance for emergency department visits, inpatient stays, and office visits.<sup>4</sup> Workers who all had the same set of benefits were placed in the same “covered population group.” In addition to covered benefits, the covered population groups included the same plan type (HMO, PPO, etc.), industry, and union status.

The total number of covered population groups created range from 2,200 to 3,000, depending on the year. Most plan members were part of groups with 10,000 or more covered lives. The size of the groups tended to be larger. However, the distribution by group size was more evenly distributed (Figure 8).

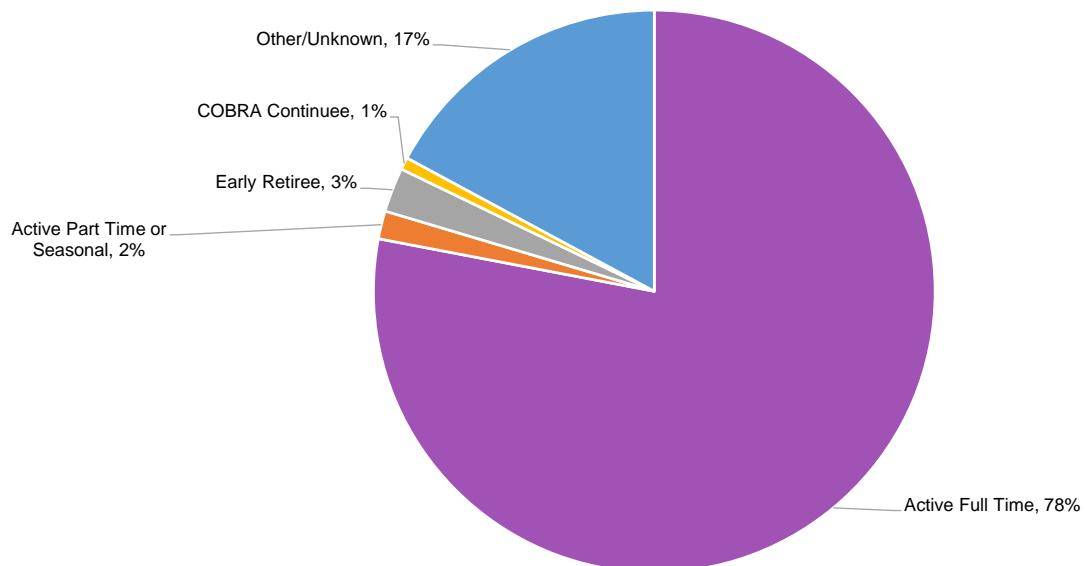
Once the covered population groups were created, total allowed health care expenses and total cost sharing were calculated for each group. AV was then calculated as the ratio of total cost sharing divided by total allowed health care expenses. Each worker (and dependent) in the synthetic group was assigned the same AV.

Figure 5  
**Distribution of Sample by Relationship to Policyholder, 2019**



Source: Employee Benefit Research Institute estimates based on administrative enrollment data.

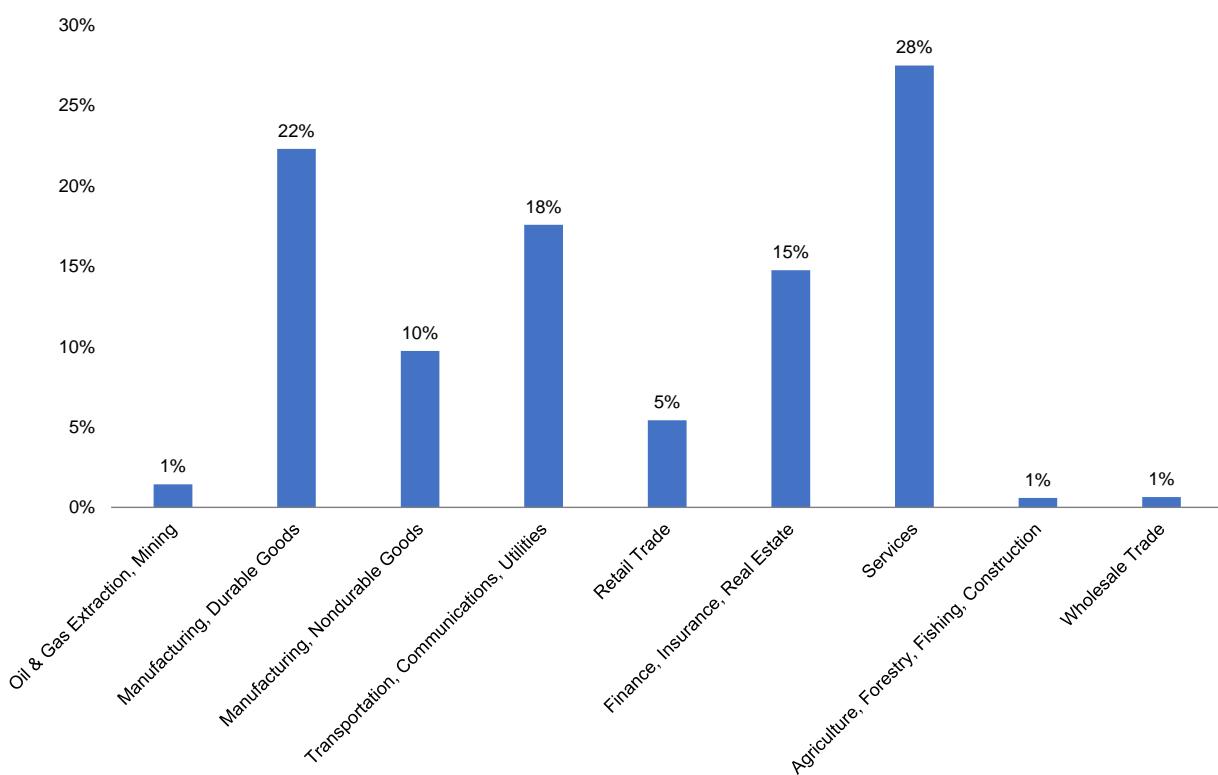
Figure 6  
**Distribution of Sample by Employment Status of Policyholder, 2019**



Source: Employee Benefit Research Institute estimates based on administrative enrollment data.

Note: Not shown on figure are Medicare-eligible retirees, retiree (status unknown), long-term disability, and surviving spouse/dependent, because each category makes up less than 0.5 percent of the sample.

**Figure 7**  
**Distribution of Sample by Industry of Policyholder, 2019**



Source: Employee Benefit Research Institute estimates based on administrative enrollment data.

**Figure 8**  
**Distribution of Sample by Synthetic Group Size, 2019**

	Number of Plan Members	Distribution of Plan Members	Number of Groups	Distribution of Groups	Average Actuarial Value	Median Actuarial Value
Total	19,966,383	100%	7,223	100%	83.5%	83.1%
Under 50	35,667	0.2%	3,598	50%	75.7%	80.1%
50–99	24,472	0.1%	347	5%	80.0%	81.9%
100–499	349,468	2%	1,309	18%	82.3%	84.2%
500–999	396,653	2%	549	8%	82.1%	83.5%
1,000–4,999	2,390,239	12%	857	12%	82.6%	83.9%
5,000–9,999	1,795,527	9%	244	3%	82.3%	83.3%
10,000 or More	14,974,357	75%	319	4%	83.9%	83.1%

Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

## Variation in AV by Group Size

With the possible exception of small groups (firms with fewer than 50 employees), AV was remarkably consistent across firm size. The largest firms had the most generous benefits, but the AV for this group averaged only 1.5 percentage points more than the overall average. As expected, the smallest groups tended to have slightly lower AVs, but our sample size is too small for this group size for us to be very confident of this result. The data shown in Figure 8 are weighted by plan members, which is skewed to larger firms. When the data are weighted by group — giving more

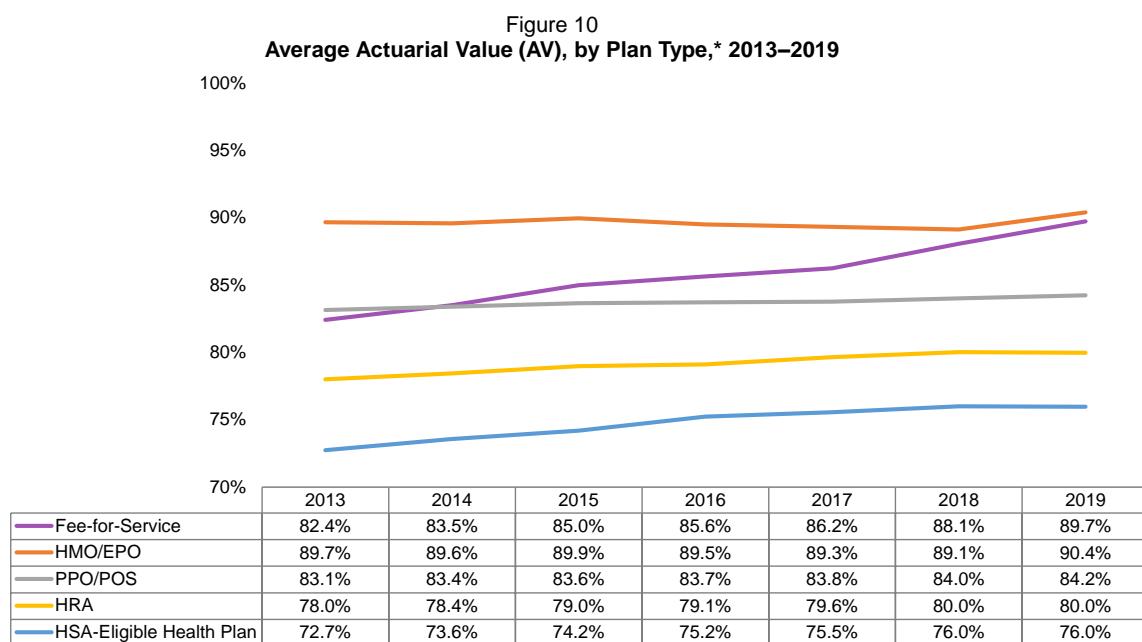
weight to smaller firms — the overall average AV is closer to 79 percent. Other than the smallest groups, the average and median were very tightly clustered.

## Trends in AV

Both the average and median AV were about 83 percent in each year from 2013 to 2019 (Figure 9). Average AV increased for every type of health plan year over year (Figure 10). Despite rigorous requirements around what can be excluded from deductibles, average AV also increased in HSA-eligible health plans. The movement of workers from PPOs to HRAs and HSA-eligible health plans (Figure 2) would be expected to lower overall average and median AV. Yet it doesn't appear to be the case that they did. Despite higher deductibles, employers may have enhanced health benefits just enough to see AV increase if they were doing so to be competitive in a tight labor market.

Figure 9 Average and Median Actuarial Value (AV), 2013–2019		
	Average AV	Median AV
2013	82.9%	83.5%
2014	82.8%	83.1%
2015	82.9%	83.0%
2016	82.9%	83.2%
2017	82.9%	82.4%
2018	83.3%	83.2%
2019	83.5%	83.1%

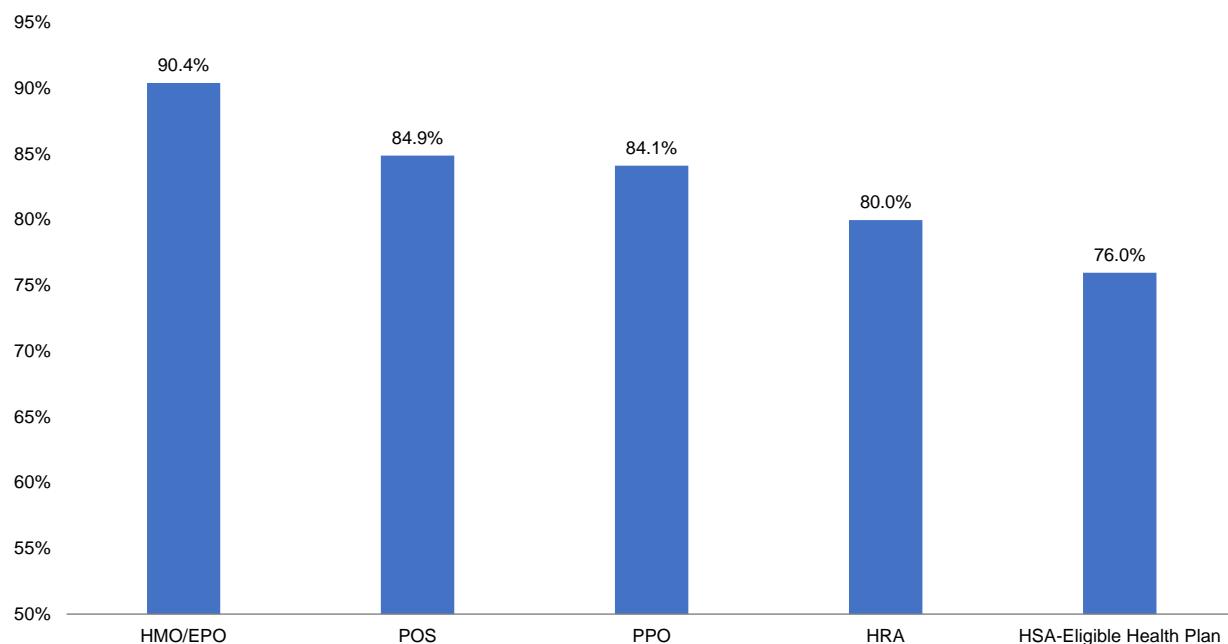
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.



## Variation in AV by Plan Type

The average AV for enrollees in HMOs/EPOs was highest at 90.4 percent (Figure 11). This finding is not surprising since HMOs have traditionally balanced relatively generous benefits with tighter restrictions on utilization and provider networks. PPO and POS enrollees saw an average AV of 85 percent and 84 percent, respectively. HRAs had an average AV of 80 percent, while HSA-eligible health plans had an average AV of 76 percent. It is important to note that the AV for HSA-eligible health plans does not take into account any employer contributions to a worker's HSA.

Figure 11  
Actuarial Value, by Enrollee Plan Type,\* 2019



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

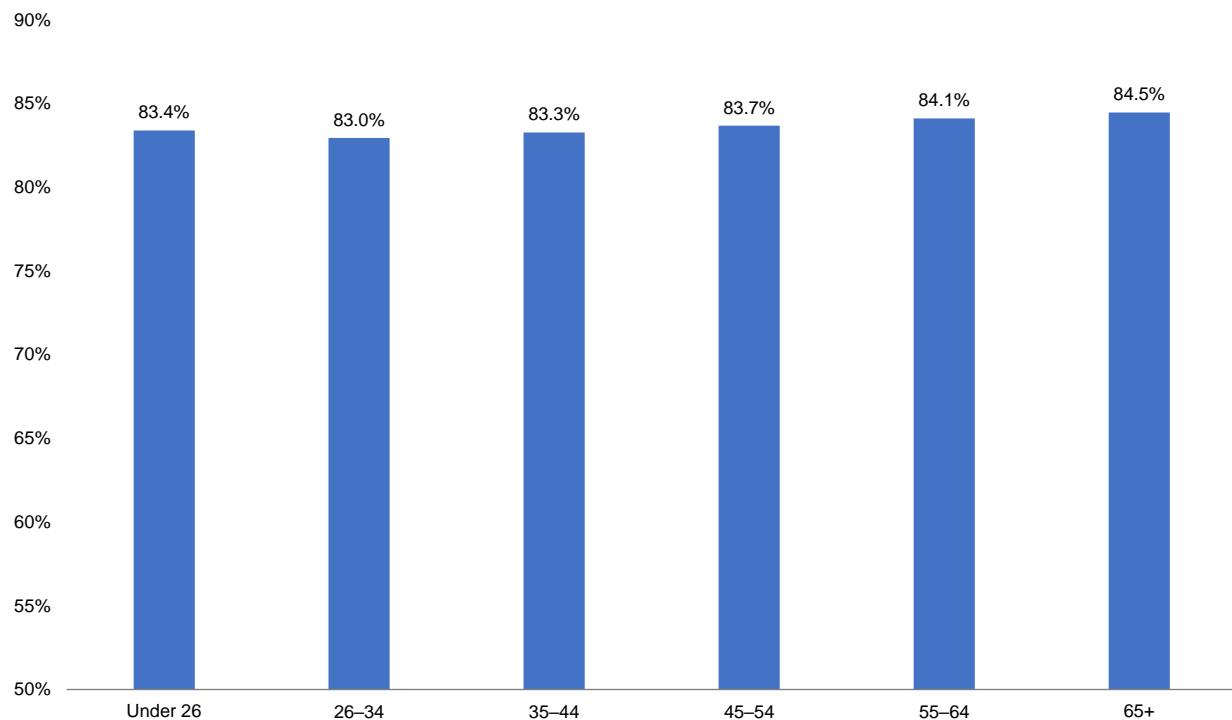
\*Fee-for-service excluded because category comprises only about 2 percent of enrollees.

HMO = health maintenance organization. EPO = exclusive provider organization. PPO = preferred provider organization. POS = point-of-service plan. HRA = health reimbursement arrangement. HSA = health savings account.

## Variation in AV by Worker Demographics

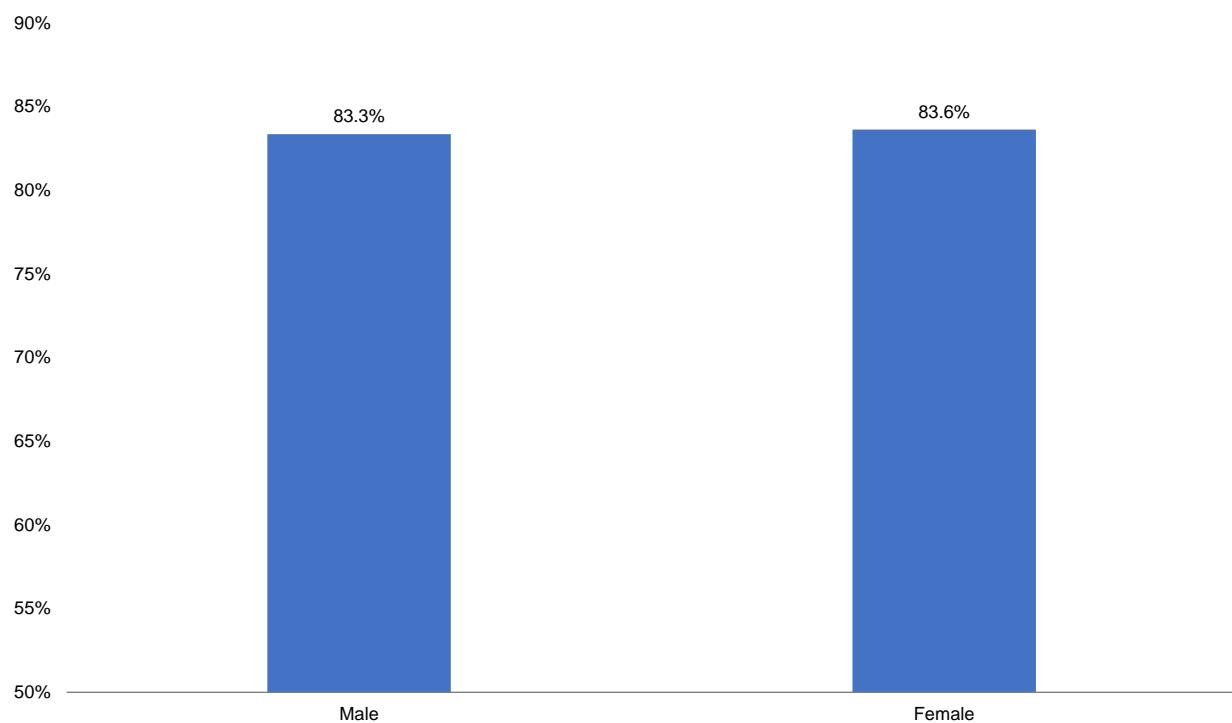
Different workers may choose different types of health plans depending on their needs. For example, older workers may be more likely than younger workers to choose more comprehensive plans because they expect to use more health care services. We do not find such sorting to be the case. Younger workers were in plans with an average AV of 83 percent, while older workers were in plans with an average AV of 84 percent (Figure 12). Similarly, there was little difference in average AV by gender (Figure 13).

**Figure 12**  
**Actuarial Value, by Enrollee Age, 2019**



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

**Figure 13**  
**Actuarial Value, by Enrollee Gender, 2019**

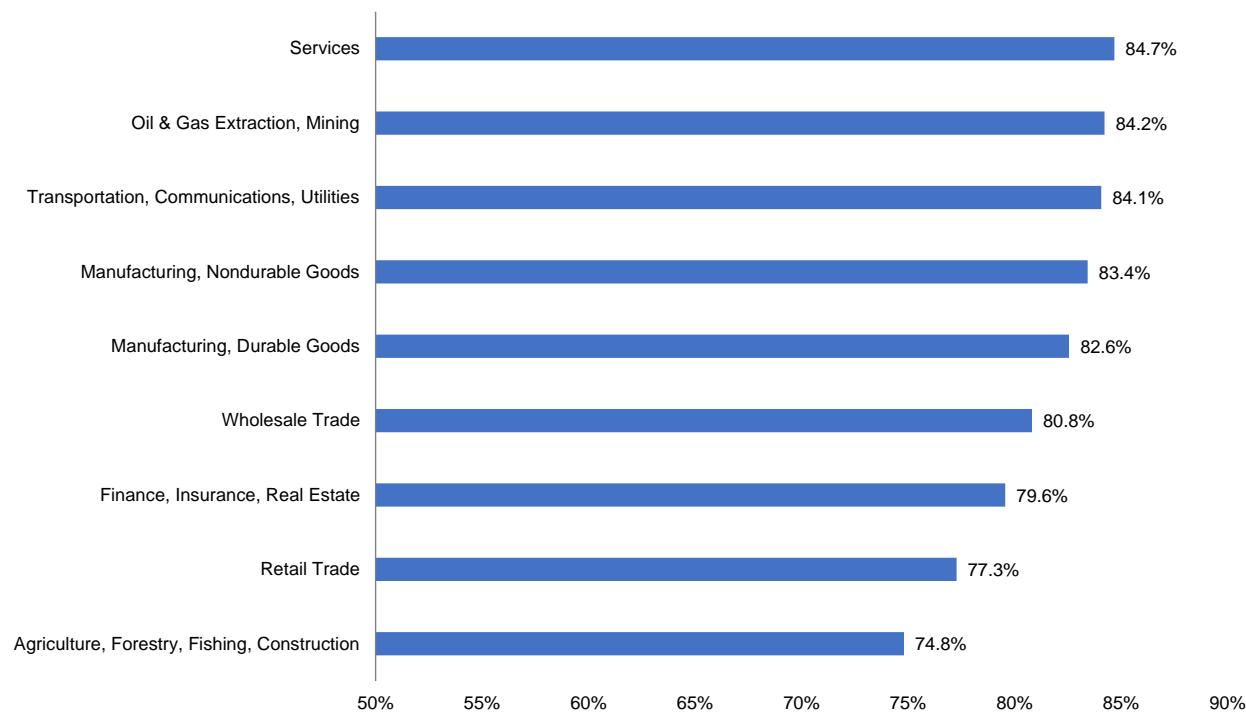


Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

## Variation in AV by Industry

We do find variation in AV by industry. Workers in agriculture, forestry, fishing, and construction were in the lowest AV plans (75 percent) while those in the service sector were in the highest AV plans (85 percent) (Figure 14).

Figure 14  
Actuarial Value, by Enrollee Industry, 2019



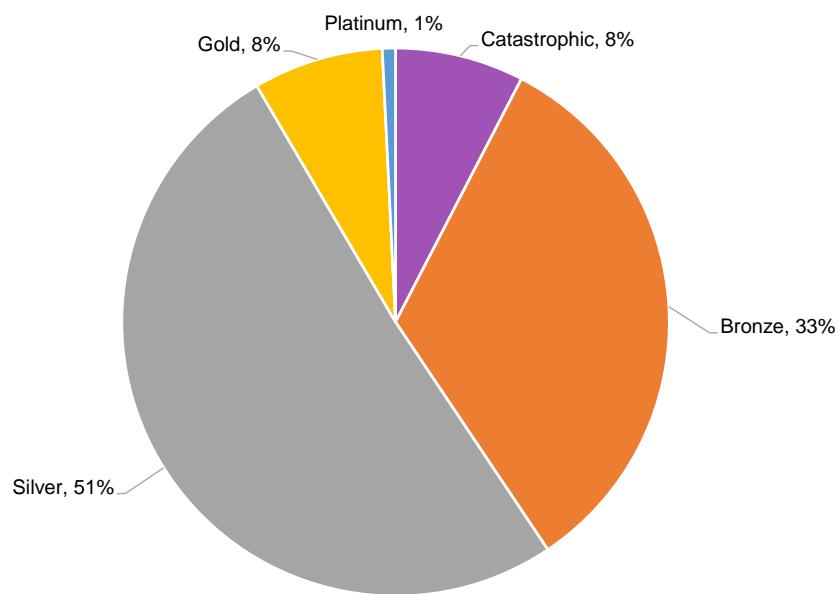
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

## Plan Choice in the ACA Exchanges

As opposed to group coverage, health insurance purchased in the individual market tends to be somewhat less generous in benefits, on average. While AV averages about 83 percent in employment-based health plans according to the calculations in this study, plans purchased in the individual market average an actuarial value of 76 percent, based on a weighted average of the proportion of plans purchased by metallic level — catastrophic (50 percent AV), bronze (60 percent AV), silver (70 percent AV), gold (80 percent AV), and platinum (90 percent AV) — and the three cost-sharing reduction levels (available to individuals with incomes below 250 percent FPL) — 73 percent, 87 percent, and 94 percent. Over 90 percent of exchange enrollees chose a silver (51 percent), bronze (33 percent), or catastrophic (8 percent) metallic tier (Figure 15).

Several factors may explain the somewhat-lower AV typically seen in the individual market. First, consumers probably have more choices in the individual market than would typically be offered by an employer, and that includes benefit offerings with lower actuarial values. Second, while the tax credit is linked to the consumer's income, it is also based on the second-lowest-cost silver policy, meaning that it is a fixed number of dollars. Consumers can use their tax credit to purchase a policy of any metal tier, and while many choose silver, a sizable number purchase bronze because the premium after applying the tax credit is often zero, or close to it. Third, because the tax credit is based on a silver policy with an actuarial value of 70 percent, it is typically the case that the consumer purchases either a silver policy or a bronze and only rarely trades up to a gold policy. Fourth, even under the American Rescue Plan Act of 2021 (ARPA) credits but certainly under the original ACA tax credit income levels, some people simply did not qualify for a tax credit and had to pay the entire amount of the premium. They may have been more likely to purchase a lower-AV policy.

Figure 15  
Enrollment by Metallic Tier, Marketplace Exchange During 2021 Open Enrollment



Source: "Marketplace Plan Selections by Metal Level." Kaiser Family Foundation, Open Enrollment 2021. <https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-metal-level-2/>

## Limitations of the Analysis

There are a number of limitations with using AV in order to evaluate health plan generosity. First, AV does not take into account health plan networks and prescription drug formularies. To the degree providers are not included in a network or prescription medicines are not included in a formulary, plan members use out-of-network or non-formulary medications, and the claims for which are not submitted for reimbursement, the cost sharing for those services is not counted toward AV. Furthermore, even if plan members did not use out-of-network providers or non-formulary medications, such limits that affect their use is a form of plan generosity that is not being measured.

AV does not take into account employer contributions to either an HRA or HSA. In some cases, the employer contribution to an HRA is structured in a way that the account must be used first, and, therefore, cost sharing is negated. If the HRA is structured that way, the employer HRA contribution is accounted for in AV. However, if workers can tap the HRA when they want to either pay for health care directly or reimburse themselves for payments they made for health care, then the employer contribution is not counted in AV. Employer contributions to HSAs are never counted toward AV. To the degree employers make HRA or HSA contributions that workers can use to offset cost sharing, those contributions would increase AV if they were included.

AV does not necessarily predict the percentage of total health care spending that any particular individual will spend out of pocket. AV is calculated on the basis of the covered population. Individual plan members may spend a greater or lesser percentage out of pocket relative to their total health care spending. For example, plan members with very high spending may pay a smaller percentage out of pocket relative to their total use of health care, because they may exceed their deductible and/or reach their out-of-pocket maximum. In contrast, plan members who use very few health care services will pay a higher percentage, especially if they do not reach their deductible. Essentially, plan members who do not reach their deductible may be paying 100 percent of their health care costs, and the health plan is paying zero percent. (Some services, such as preventive care, are covered in full without the deductible applying.)

Similar to out-of-network providers, AV does not take into account spending on health care services that are excluded from coverage entirely. For example, some plans do not cover services like chiropractor services or infertility drugs or treatments. The spending on these services would not be counted when AV was calculated.

One of the limitations of the research in this paper is that the small group market may not have been adequately represented. Prior research has found that deductibles in the small group market are higher than deductibles in the large group market.<sup>5</sup> This suggests that AV in the small group market may be lower than what we found in the large group market.

Finally, AV does not take into account the premiums that workers pay for their health coverage. In 2020, workers paid on average 17 percent of the premium for employee-only coverage and 27 percent for family coverage.<sup>6</sup> The amount that workers pay for premiums does not count toward the percentage of total spending on health care services paid by workers through various forms of cost sharing.

## Conclusion

According to our analysis, employment-based health benefits have not declined in value since enactment of the ACA. If anything, AV has improved slightly over the intervening years. However, we do find variation in AV, in particular, by industry. Those industries with lower AV may not be in a position to improve health benefits and may question the value in providing such benefits were there a viable alternative.

Coverage provided through employers is the most common form of coverage for Americans under age 65. While ACA individual market coverage has garnered a lot of attention since it was first offered in the exchanges beginning in 2014, it still covers a relatively small proportion of the under-65 U.S. population. Employer coverage is more generous and, considering the employer contribution, a very good value for most workers. Employer coverage is also very stable, with the percentage of Americans holding this type of coverage increasing from 70.5 percent to 72.7 percent between 2013 and 2019.<sup>7</sup>

While the ACA ultimately did not cause many employers to drop or reduce the value of the coverage they offered, other policy actions could do so — even though employers appear reluctant to stop offering such coverage. Lawmakers will have to balance the value of helping people obtain a sufficient level of health insurance in the ACA market while preserving the incentives that help to shore up enrollment in employer coverage. Policy proposals under consideration to help the individual market should consider potential unintended consequences in the employment-based health insurance market.

## Appendix

Appendix Figure 1 Explanation of Benefits							
SERVICE		HEALTH COVERAGE BENEFITS APPLIED			PATIENT RESPONSIBILITY		
SERVICE	AMOUNT BILLED BY PROVIDER	DISCOUNTS AND REDUCTIONS	AMOUNT COVERED (ALLOWED)	HEALTH PLAN RESPONSIBILITY	DEDUCTIBLE AMOUNT	COPAY PAID BY PATIENT	TOTAL PATIENT COST
ADULT OFFICE VISIT	\$150	\$50	\$100	\$80	\$0	\$20	\$20

## Endnotes

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<sup>1</sup> The premium is the price of the health insurance policy, which reflects the expected cost of the covered health care services after the worker's cost sharing (i.e., copayments, coinsurance, and deductibles) as well as the administrative costs of the policy (enrollment, claims payment, etc.). Typically, workers and their employers purchase employment-based insurance together, with the worker paying a relatively small fraction of the total premium (in 2020, the worker share averaged 17 percent) and the employer paying for the remainder.

<sup>2</sup> The major provisions of the ACA that took effect in 2014 include the availability of health coverage through exchanges, subsidies for people with family income below 400 percent of the federal poverty level who purchase coverage through exchanges, modified community rating of health insurance premiums, and guaranteed issue of exchange coverage.

<sup>3</sup> See Figure 6.1 in <https://www.kff.org/report-section/ehbs-2020-section-6-worker-and-employer-contributions-for-premiums/>.

<sup>4</sup> Another limitation of the BPD database is that cost-sharing information for prescription drugs is not available.

<sup>5</sup> See Figure 7.3 in <https://www.kff.org/report-section/ehbs-2020-section-7-employee-cost-sharing/>.

<sup>6</sup> See Figure 6.1 in <https://www.kff.org/report-section/ehbs-2020-section-6-worker-and-employer-contributions-for-premiums/>.

<sup>7</sup> See [https://www.ebri.org/docs/default-source/fast-facts/ff-319-healthtrends-6dec18.pdf?sfvrsn=f6973e2f\\_2](https://www.ebri.org/docs/default-source/fast-facts/ff-319-healthtrends-6dec18.pdf?sfvrsn=f6973e2f_2) for 2013–2017 and author estimates for 2018–2019.