ebri.org
Employee Benefit Research Institute

December 2009 • No. 337

Issue BRIEF

Findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey

By Paul Fronstin, Employee Benefit Research Institute

EXECUTIVE SUMMARY

FIFTH ANNUAL SURVEY: This *Issue Brief* presents findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey, which provides nationally representative data regarding the growth of consumer-driven health plans (CDHPs) and high-deductible health plans (HDHPs), and the impact of these plans and consumer engagement more generally on the behavior and attitudes of adults with private health insurance coverage. Findings from this survey are compared with four earlier annual surveys.

ENROLLMENT LOW BUT GROWING: In 2009, 4 percent of the population was enrolled in a CDHP, up from 3 percent in 2008. Enrollment in HDHPs increased from 11 percent in 2008 to 13 percent in 2009. The 4 percent of the population with a CDHP represents 5 million adults ages 21–64 with private insurance, while the 13 percent with a HDHP represents 16.2 million people. Among the 16.2 million individuals with an HDHP, 38 percent (or 6.2 million) reported that they were eligible for a health savings account (HSA) but did not have such an account. Overall, 11.2 million adults ages 21–64 with private insurance, representing 8.9 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA, but had not opened the account.

MORE COST-CONSCIOUS BEHAVIOR: Individuals in CDHPs were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors. They were more likely to say that they had checked whether the plan would cover care; asked for a generic drug instead of a brand name; talked to their doctor about prescription drug options, other treatments, and costs; asked their doctor to recommend a less costly prescription drug; developed a budget to manage health care expenses; checked prices before getting care; and used an online cost-tracking tool.

CDHP MORE ENGAGED IN WELLNESS PROGRAMS: CDHP enrollees were more likely than traditional plan enrollees to report that they had the opportunity to fill out a health risk assessment, whereas they were equally likely to report that they had access to a health promotion program. CDHP enrollees were more likely than traditional plan enrollees to participate when a program was offered. Among those not participating, they did not participate because they could make changes on their own; they lacked time; and they were already healthy.

FINANCIAL INCENTIVES MATTER: Financial incentives for healthy behavior mattered more to CDHP enrollees than traditional plan enrollees. Financial incentives were a larger factor for CDHP enrollees than for traditional plan enrollees when it came to participating in wellness programs, choice of doctor, and the use of health information technology, as well as patient engagement using e-mail and the Web.

HEALTH STATUS IS BETTER, INCOME HIGHER: Adults in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans. Adults in CDHPs and HDHPs were significantly less likely to smoke than were adults in traditional plans, and were significantly more likely to exercise. People in CDHPs were also less likely to be obese compared with adults enrolled in a traditional health plan. Adults in CDHPs were significantly more likely than those with traditional health coverage to have a high household income. CDHP and HDHP enrollees were also more likely than traditional plan enrollees to be highly educated.

Paul Fronstin is director of the Health Research and Education Program at EBRI. This *Issue Brief* was written with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

This survey was made possible with support from American Express, BlueCross BlueShield Association, Express-Scripts, IBM, John Deere & Co., Kaiser Permanente, MetLife, Pfizer, and The Commonwealth Fund.

Recommended Citation: Paul Fronstin, "Findings From the 2009 EBRI Consumer Engagement in Health Care Survey," *EBRI Issue Brief,* no. 337 (December 2009).

Report availability: This report is available on the Internet at www.ebri.org

Table of Contents

Figures

Introduction

Employment-based health benefits are the most common form of health insurance in the United States. In 2008, 160.6 million individuals under age 65, or 61.1 percent of that population, had employment-based health benefits (Fronstin, 2009a). In every year since 1998, premium increases have exceeded worker earnings increases and inflation (Figure 1): Health insurance premiums have more than doubled while worker earnings have increased 30 percent.[1] In response, employers have been seeking ways to manage the cost increases. In recent years, employers have turned their attention to account-based health plans—a combination of health plans with deductibles of at least $1,000 for employee-only coverage and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. Employers first started offering account-based health plans in 2001 when a handful of employers began to offer health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).[2] By 2008, 9 percent of employers with 10–499 workers and 20 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan.[3]

Employers have been interested in bringing aspects of consumer engagement into health plans for many years. As far back as 1978, employers adopted Sec. 125 cafeteria plans and flexible spending accounts. More recently, employers have continued to turn their attention to consumer engagement in health care more broadly. In 2001, employers formed a coalition to report health care provider quality measures, and today the group is composed not only of employers but also consumer groups and organized labor.[4] In 2005, employers started to focus on value-based insurance designs that seek to encourage the use of high-value services while discouraging the use of services when the benefits are not justified by the costs (Chernew, et al., 2007).

This *Issue Brief* presents findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey. This study is based on an online survey of 4,226 privately insured adults ages 21–64 to provide nationally representative data regarding the growth of account-based health plans and high-deductible health plans (HDHPs), and the impact of these plans and consumer engagement more generally on the behavior and attitudes of adults with private health insurance coverage. The sample was randomly drawn from Synovate's online panel of more than 2 million Internet users who have agreed to participate in research surveys. This survey used a base sample of 2,007 to draw incidence rates for persons with account-based health plans and HDHPs, and the base sample was complemented with an additional random oversample of these two groups. More specifically, the oversamples were: 1) those with either an HRA or an HSA, and 2) those with a HDHP without an account but with deductibles that are generally high enough to meet the qualifying threshold to make tax-preferred contributions to such an account. High deductibles were defined as individual deductibles of at least $1,000 and family deductibles of at least $2,000.[5] The final sample included 972 in HDHPs with either an HSA or HRA (consumer-driven health plans, or CDHPs), 1,603 in high-deductible health plans without accounts (HDHPs), and 1,651 in more traditional health plans.[6]

Findings from this survey are compared with findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008 EBRI/MGA Consumer Engagement in Health Care Survey. Past reports used "Comprehensive" as the descriptive label for what is now labeled more "Traditional" health plans. A label change was appropriate given that these plans are not as comprehensive as they were in the past and may no longer fit that label. Prior research has shown that cost sharing has been increasing across the board in the form of higher deductibles and co-payments, and there has been a return to coinsurance.[7]

Summary of Findings

This survey finds that in 2009, 4 percent of the population was enrolled in a CDHP, up from 3 percent in 2008, and 2 percent in 2007; and enrollment in HDHPs increased from 11 percent in 2008 to 13 percent in 2009 (Figure 2). The 4 percent of the population with a CDHP represents 5 million adults ages 21–64 with private insurance, while the 13 percent with a HDHP represents 16.2 million people. Among the 16.2 million individuals with an HDHP, 38 percent (or 6.2 million) reported that they were eligible for an HSA but did not have such an account. Thus, overall,

11.2 million adults ages 21–64 with private insurance, representing 8.9 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA, but had not opened the account.[8]

HRA and HSA enrollment is growing, but the market penetration remains relatively small and the amount of time individuals have been in these plans is lower than time enrolled in traditional coverage. Among individuals with traditional coverage, 20 percent had been in their plan three to four years and 44 percent five or more years. This compares with 27 percent and 20 percent, respectively, among persons in a CDHP (Figure 3). While lower than individuals with traditional coverage, the number of persons with CDHPs and the length of time enrolled in these plans has been increasing.[9]

With respect to familiarity with a CDHP, 61 percent of those with a CDHP were extremely or very familiar with it (Figure 4). In contrast, 9 percent of individuals with traditional coverage were extremely or very familiar with a CDHP, and 11 percent of individuals with an HDHP were extremely or very familiar with a CDHP.

The study also finds the following:

- Individuals in CDHPs were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors. They were more likely to say that they had checked whether their plan would cover care; asked for a generic drug instead of a brand name; talked to their doctor about prescription drug options and costs; talked to their doctor about other treatments and costs; asked their doctor to recommend a less costly prescription drug; developed a budget to manage health care expenses; checked prices before getting care; and used an online cost-tracking tool.

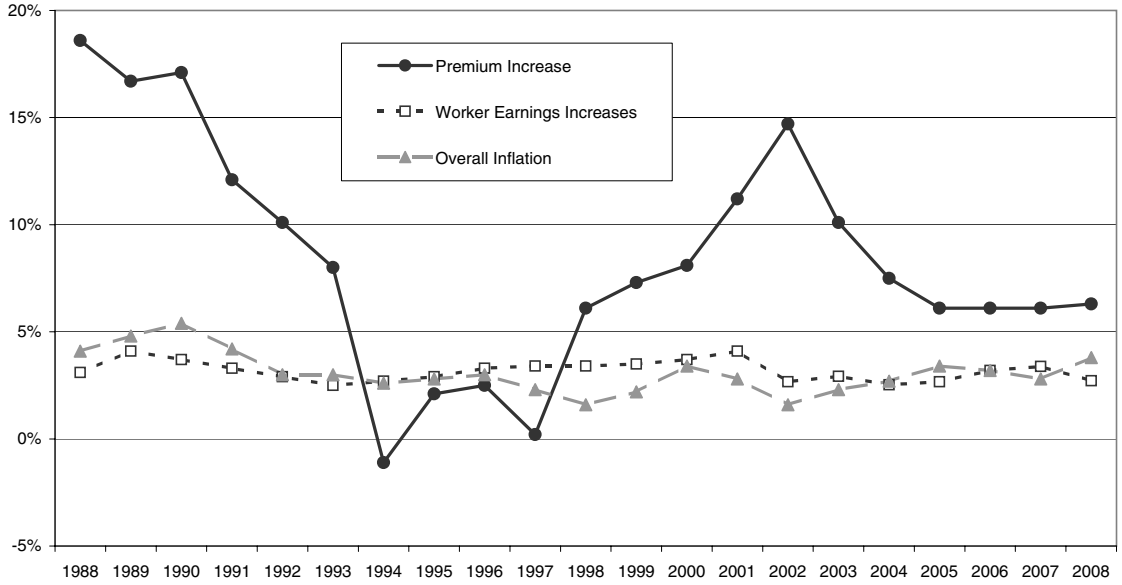
- Individuals were more likely to report that they had provider quality information than cost information, and HDHP enrollees were less likely than traditional plan enrollees to report that the plan provided cost or quality information. There was no difference in the percentage of CDHP and traditional plan enrollees reporting the availability of cost and quality information. In terms of use of information provided by health plans, CDHP were more likely than traditional plan and HDHP enrollees to have reported that they made use of the information. CDHP and HDHP enrollees were also more likely to try to find information about cost and quality of their doctor from sources other than the health plan.

- When asked about sources of information on the benefits offered by the health plan, the majority of respondents, regardless of plan type, reported that they received that information in a printed handbook or booklet. However, individuals in CDHPs were much more likely than those in traditional plans to receive information about their health benefits either through a Web site or via e-mail. CDHP and HDHP enrollees were also more likely than traditional plan enrollees to prefer to receive information through e-mail and a Web site.

- CDHP enrollees were more likely than traditional plan enrollees to report that they had the opportunity to fill out a health risk assessment, whereas they were equally likely to report that they had access to a health promotion program. HDHP enrollees were less likely to report having access to a health promotion program. When it comes to participating in a wellness program, CDHP enrollees were more likely than traditional plan enrollees to take advantage of the health risk assessment and the health promotion program. Among those not participating, they did not participate because they could make changes on their own; they lacked time; and they were already healthy. Reasons for lack of participation did not differ by plan type.

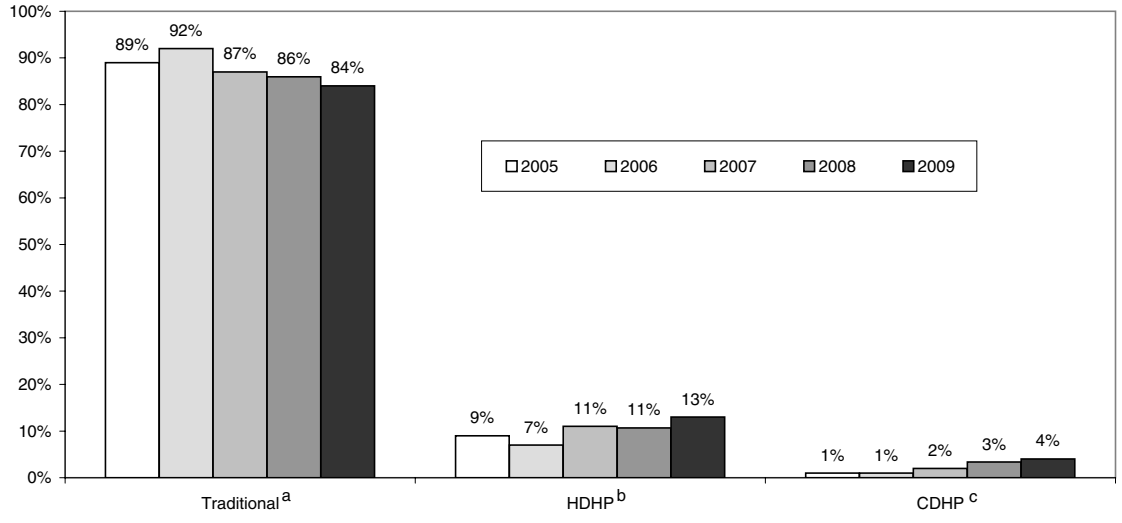
- Financial incentives mattered more to CDHP enrollees than to traditional plan enrollees. Financial incentives were more a factor for CDHP enrollees than for traditional plan enrollees when it came to participating in wellness programs, choice of doctor and the use of health information technology, as well as patient engagement using e-mail and the Web. However, while CDHP enrollees were more likely than traditional plan enrollees to report that they would be interested in using select networks of high–quality doctors when combined with lower cost sharing, when it came to switching doctors if their doctor was not in the network, there was no difference by plan type. Similarly, there was also support in differing degrees for other ways patients could receive lower cost sharing,

Figure 1
Premium Increases Among Employers With 10 or More Employees, Worker Earnings and Inflation, 1988–2008



Source: Mercer National Survey of Employer-Sponsored Health Plans and Bureau of Labor Statistics.

Figure 2
Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2009



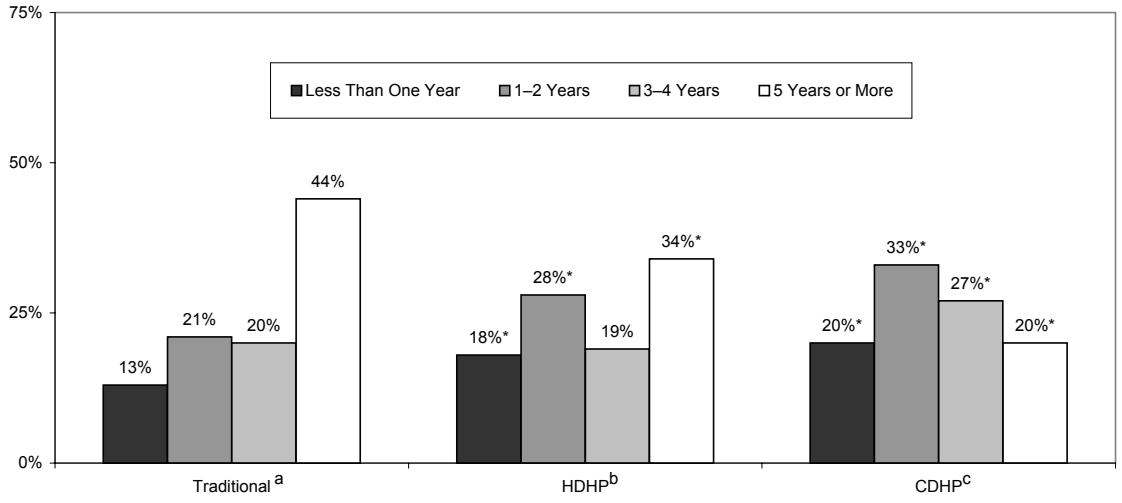
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

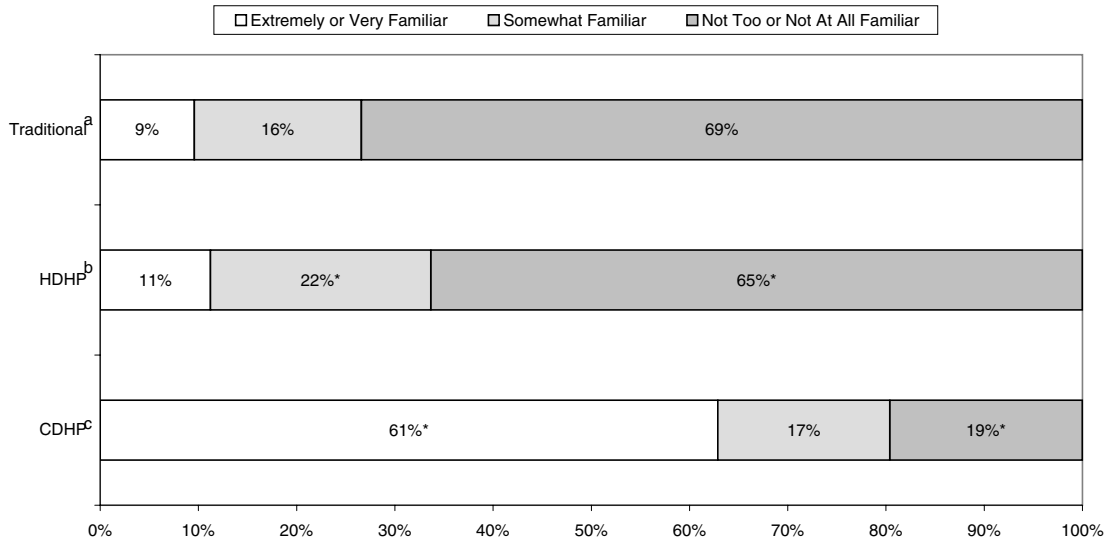
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 3
Number of Years Covered by Current Health Plan, by Type of Health Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 4
Familiarity With Consumer-Driven Health Plans, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

such as by actively participating in a program to maintain or improve health, by following treatment regimens, by using less invasive procedures, and by using scientifically proven effective care, CDHP and HDHP enrollees were more likely than traditional plan enrollees to support the use of lower cost sharing to engage patients.

- In 2009, adults in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans. Adults in CDHPs and HDHPs were significantly less likely to smoke than were adults in traditional plans, and they were significantly more likely to exercise. People in CDHPs were also less likely to be obese compared with adults enrolled in a traditional health plan.

- Adults in CDHPs were significantly more likely than those with traditional health coverage to have a high household income. CDHP and HDHP enrollees were also more likely than traditional plan enrollees to be highly educated. There were few differences by plan type as they relate to gender, age, and race.

- CDHP enrollees are no longer more likely than traditional plan enrollees to work for small firms, but HDHP enrollees were still more likely than those in traditional plans to be sole proprietors or to be employed in small firms.

- Among individuals with employment-based health benefits, those in CDHPs were more likely than those with traditional coverage to have a choice of health plan. Two-thirds of individuals with an employment-based CDHP reported that the employer contributed to the account. Among persons eligible to contribute to an account, 11 percent did not contribute anything.

- In 2006, the survey found that individuals in CDHPs and HDHPs were less likely to be satisfied with the quality of care received than those in traditional plans, but during 2007–2009, this gap in satisfaction between those in traditional plans and those with CDHPs disappeared because satisfaction increased significantly among those with CDHPs. The gap in satisfaction rates for quality of care remained between traditional enrollees and HDHP enrollees. The differences in overall satisfaction levels by plan type found in all prior years of the survey were unchanged in the 2009 survey: Traditional plan enrollees were more likely than CDHP and HDHP enrollees to be extremely or very satisfied with the overall plan in all years of the survey. Differences in satisfaction with out-of-pocket costs may explain a significant portion of the difference in overall satisfaction rates between traditional plan, HDHP, and CDHP enrollees.

- As before, this year's survey finds that individuals in CDHPs and HDHPs were both less likely than those in traditional plans to recommend their health plan to a friend or co-worker and less likely than those with traditional plans to stay with their current health plan if they had the opportunity to switch plans.

- There was no significant variation in the frequency with which people with chronic conditions followed their treatment regimen across plan types, with one exception: CDHP enrollees with allergies were less likely than traditional plan enrollees with allergies to follow their treatment regimen. Generally, these 2009 findings are in contrast to somewhat mixed findings in 2007. In 2007, people in CDHPs with arthritis and hypertension were significantly less likely to say that they followed their treatment regimens for their conditions carefully. But people in CDHPs with depression were significantly more likely to say they followed their treatment regimens carefully than did those with traditional coverage.

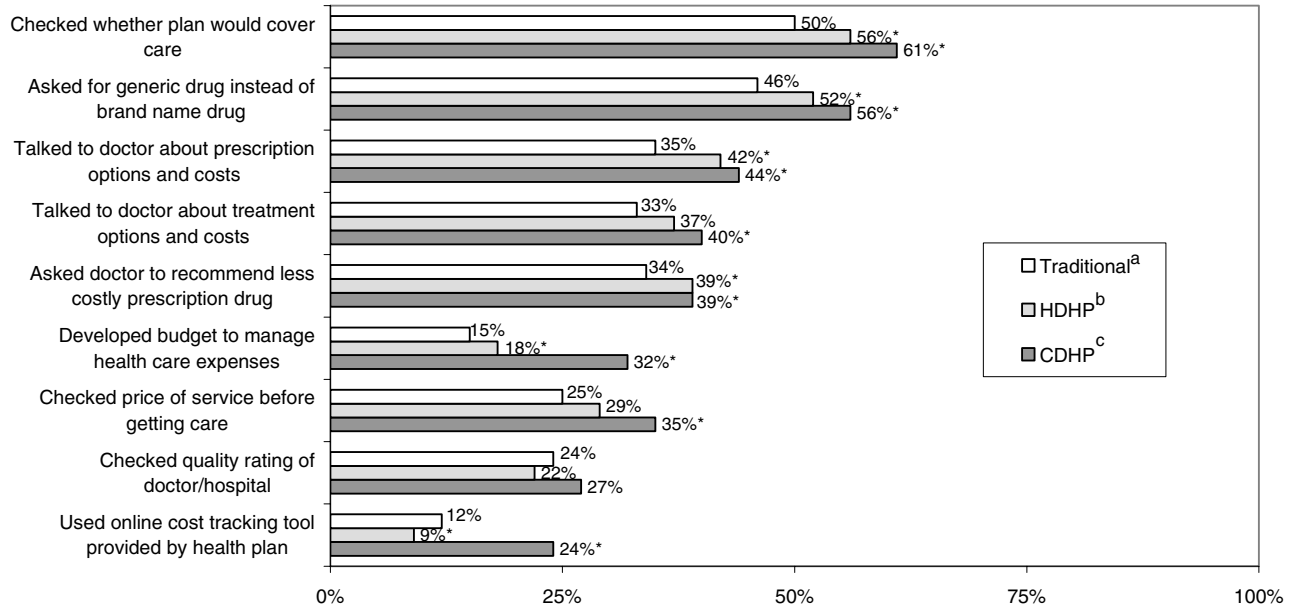
- This year's survey finds a reduction in the percentage of individuals with traditional coverage reporting that they or a family member delayed or avoided getting health care due to the cost. The results were unchanged for individuals in HDHPs, with one exception: There was a decline in the percentage of HDHP enrollees with no health problem who reported an access issue. Among individuals with a CDHP, the percentage reporting that they skipped doses to make the medication last longer increased and the change was statistically significant, for the entire group, for the subgroups with health problems and for households with $50,000 or more in income. Furthermore, the differences in access issues between CDHP enrollees and individuals in traditional plans, which were not statistically significant in 2008, became so in 2009.

The remainder of this report examines the findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey as they relate to differences and similarities among individuals enrolled in traditional health plans, CDHPs, and HDHPs. The report also examines consumer engagement more generally. The report examines health care decision-making, cost and quality information, participation in wellness programs, opinions about provider engagement, cost-sharing incentives related to plan type and value-based insurance design, health status and enrollee characteristics, choice of health plan, premiums, plan choice, contribution behavior among those with a CDHP, satisfaction and attitudes, and health care use and access issues.

Cost-Conscious Behavior

The theory behind account-based plans and plans with higher deductibles is that the cost-sharing structure is a tool that will be more likely to engage individuals in their health care, compared with persons enrolled in more traditional coverage. This study finds evidence that adults in CDHPs were more likely than those in traditional plans to exhibit a number of cost-conscious behaviors. Specifically, those in CDHPs were more likely than those in traditional coverage to say that they had checked whether the plan would cover care (61 percent CDHP vs. 50 percent traditional); asked for a generic drug instead of a brand name (56 percent CDHP vs. 46 percent traditional); talked to their doctor about prescription drug options and costs (44 percent CDHP vs. 35 percent traditional); talked to their doctor about other treatment options and costs (40 percent CDHP vs. 33 percent traditional); asked their doctor to recommend a less costly prescription drug (39 percent CDHP vs. 34 percent traditional); developed a budget to manage health care expenses (32 percent CDHP vs. 15 percent traditional); checked the price of service before getting care (35 percent CDHP vs. 25 percent traditional); and used an online cost-tracking tool provided by the health plan (24 percent CDHP vs. 12 percent traditional) (Figure 5).

Figure 5
Cost-Conscious Decision Making, by Type of Health Plan, 2009
Percentage of privately insured adults ages 21–64 who received health care in last 12 months



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Trends

There has been no clear increase in the share of CDHP enrollees who report cost-conscious decision making over the five years of the survey (Figure 6). However, a statistically significant increase in the percentage of traditional plan enrollees reporting cost-conscious decision making between 2007 and 2008 was followed by a statistically significant decrease in cost-conscious behavior in some of the answers from individuals in traditional coverage.

Availability and Use of Cost and Quality Information

In theory, the incentives of CDHPs are designed to promote heightened sensitivity to cost and quality in people's decisions about their health care. Yet the ability of people to make informed decisions is highly dependent on the extent to which they have access to useful information.

The survey asked if an individual's health plan provided information on cost and quality of providers. Individuals were more likely to report that they had *quality* information available than *cost* information, and HDHP enrollees were less likely than traditional plan enrollees to report that the plan provided the information. There was no difference in the percentage of CDHP and traditional plan enrollees reporting the availability of cost and quality information. About 40 percent of CDHP and traditional plan enrollees reported access to quality information, compared with 29 percent of HDHP enrollees (Figure 7). Similarly, just over one-third of CDHP and traditional plan enrollees reported access to cost information, compared with one-quarter of HDHP enrollees.

CDHP enrollees were more likely than traditional plan and HDHP enrollees to use information provided by their health plans. About 6 in 10 CDHP enrollees indicated that they had made use of the information about the quality of their doctors, compared with less than 50 percent among traditional plan and HDHP enrollees. Cost information was used by 36 percent of HDHPs enrollees, 41 percent of traditional plan enrollees, and 54 percent of CDHP enrollees. CDHP enrollees and HDHP enrollees were more likely than traditional plan enrollees to try to find information on cost and quality from sources other than the health plan. Specifically, 28 percent of CDHP enrollees and 24 percent of HDHP enrollees sought other sources of information, while 17 percent of traditional plan enrollees did so.

When it comes to sources of information about the health benefits offered by the health plan, the majority of respondents, regardless of plan type, reported that they received that information in a printed handbook or booklet. Specifically, 60 percent of traditional plan enrollees, 59 percent of HDHP enrollees, and 56 percent of CDHP enrollees received printed information (Figure 8). However, individuals in CDHPs were much more likely than those in traditional plans to receive information about their health benefits either through a Web site or via e-mail. One-half (49 percent) of CDHP enrollees received information about their health plan benefits via a Web site, compared with 34 percent in traditional plans. Similarly, 43 percent of CDHP enrollees received information via e-mail, compared with 27 percent in traditional plans. Few people receive information in person, by telephone, or in other ways, and the differences by plan type are not statistically significant. There was a significant difference, however, in the percentage of respondents reporting that they did *not* get information about their plan benefits. HDHP enrollees were most likely to report not having received information (11 percent), compared with 8 percent among traditional plan enrollees, and 4 percent among CDHP enrollees.

A printed document was a preferred choice of information about health plan benefits for those enrolled in traditional plans and HDHPs, with slightly more than one-half preferring that option (Figure 9). While one-half of CDHP enrollees preferred to receive printed information, 51 percent also preferred to receive information via e-mail and 45 percent preferred to receive information through a Web site. CDHP and HDHP enrollees were more likely than traditional plan enrollees to prefer to receive information through e-mail and a Web site.

Participation in Wellness Programs

Employers and insurers offer a number of different types of wellness benefits—programs designed to promote health and to prevent disease. The 2009 EBRI/MGA Consumer Engagement in Health Care Survey examined availability and

Figure 6

Trends in Cost-Conscious Decision Making, by Type of Health Plan, 2005–2009

Base: Adults 21–64 who received some health care in last 12 months

	Traditional[a]					HDHP[b]					CDHP[c]				
	2005	2006	2007	2008	2009	2005	2006	2007	2008	2008	2005	2006	2007	2008	2009
Total Sample	953	1,363	1,794	1,548	1,651	417	802	1,284	1,484	1,693	163	652	805	1,077	972
Checked whether health plan would cover care	51%	58%	50%^	55%^	50%^	61%	62%	61%*	61%	56%*	60%*	62%	60%*	63%*	61%*
Asked for generic drug instead of brand name drug	n/a	48	46	50^	46^	n/a	60*	58*	58*	52*^	n/a	54	54*	58*	56*
Talked to doctor about treatment options and costs	42	44	44	45	33^	56*	44^	49*^	49	37^	58*	46^	47	46	40*
Asked doctor to recommend less costly prescription drug	27	31	30	36^	34	46*	41*	43*	41	39*	45*	39*	38*	36	39*
Checked price of service before getting care	24	20	21	23^	25	35*	23^	27*^	23^	29^	29	26*	27*	25	35*^
Checked quality rating of doctor/hospital	18	21	20	25^	24	22	18	19	22	22	18	19	18	23^	27*
Used online cost tracking tool offered by health plan	n/a	8	8	12^	12	n/a	6	9^	10	9*	n/a	17*	20*^	20*	24*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p≤ 0.05 or better.

^ Difference from prior year shown is statistically significant at p≤ 0.05 or better.

Difference between 2005 and 2009 is statistically significant at the p≤ 0.05 or better.

Figure 7

Availability and Use of Quality and Cost Information Provided by Health Plan and Effort to Find Information From Other Sources, 2009

	Traditional[a]	HDHP[b]	CDHP[c]
Health plan provides information on quality of care provided by doctors	42%	29%*	41%
Health plan provides information on cost of care provided by doctors	36	25*	35
Of those whose plans provide info on quality, how many tried to use it for doctors	45	47	61*
Of those whose plans provide info on cost, how many tried to use it for doctors	41	36	54*
Tried to find information from sources other than health plan on cost and quality of care provided by doctors	17	24*	28*

Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

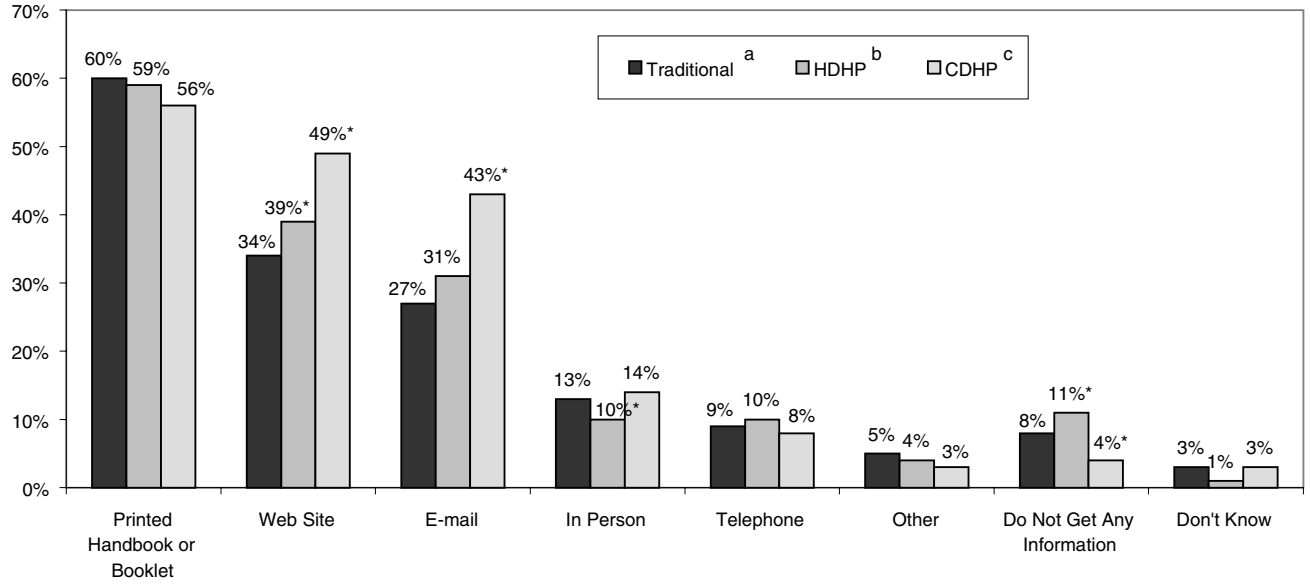
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

participation in two types of wellness programs: a health risk assessment and a health promotion program that included any of a number of different types of benefits.[10] It found that CDHP enrollees are more likely than traditional plan enrollees to report that they had the option to fill out a health risk assessment. Specifically, 41 percent of CDHP enrollees reported that their employer offered a health risk assessment (Figure 10), compared with 31 percent of traditional plan enrollees and 22 percent of HDHP enrollees. When asked about the availability of health promotion programs, 48 percent of CDHP enrollees and 44 percent of traditional plan enrollees reported that their employer offered such a program. The difference between CDHP and traditional plan enrollees was not significant. However, 29 percent of HDHP enrollees reported the availability of a health promotion program, significantly lower than offer rates among CDHP and traditional plans enrollees.

CDHP enrollees were more likely than traditional plan enrollees to take advantage of participating in a wellness program, either the health risk assessment or the health promotion program. Slightly more than 70 percent of CDHP enrollees participated in the health risk assessment, compared with 56 percent of traditional plan enrollees (Figure 11). Similarly, 53 percent of CDHP enrollees participated in a health promotion program, compared with 42 percent among traditional plan enrollees.

The EBRI/MGA Consumer Engagement in Health Care Survey asked respondents their reasons for not participating in their employer's wellness program. Nearly 60 percent responded that they did not participate because they could make changes on their own (Figure 12): One-quarter (26 percent) cited this as a major reason and one-third cited it as a minor reason for not participating. Lack of time was the second-most popular reason for not participating, with 22 percent reporting it as a major reason and 32 percent reporting it as a minor reason. Forty-six percent did not participate because they were already healthy (17 percent reported it as a major reason and 29 percent reported it as a minor reason). There were no differences in the answers to this series of questions by plan type.

Figure 8
Sources of Information for Health Plan Benefits, by Type of Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p $\leq$ 0.05 or better.

Even among persons not participating in their employer's wellness program, financial incentives to participate still matter, regardless of plan type, and they seem to matter more to individuals enrolled in CDHPs. Seventy percent of traditional plan enrollees reported that they would probably participate if a cash incentive was provided, compared with 86 percent of CDHP enrollees and 76 percent of HDHP enrollees (Figure 13). Similarly, 81 percent of CDHP enrollees said they would probably participate if their employer offered time off, compared with 70 percent of HDHP enrollees and 66 percent of traditional plan enrollees. If the employer increased premiums for nonparticipants, 77 percent of CDHP enrollees, 62 percent HDHP enrollees, and 53 percent of traditional plan enrollees said they would participate.

Opinions About Provider Engagement

For the first time, the 2009 EBRI/MGA Consumer Engagement in Health Care Survey included questions regarding the importance of various ways in which providers of health care services engage their patients. Eighty-seven percent of traditional plan enrollees and 90 percent of both HDHP and CDHP enrollees reported that it was extremely or very important that their doctor communicated with them so that they could really understand what the doctor was saying (Figure 14). While not large, the difference between traditional plan enrollees and CDHP and HDHP enrollees was statistically significant. Approximately three-quarters of individuals reported that it was extremely or very important that their doctor 1) worked with them to find realistic changes that they could make to improve health, and 2) took responsibility for coordinating their care with other providers, specialists, or testing facilities. Three-quarters of traditional plan enrollees, 73 percent of HDHP enrollees, and 70 percent of CDHP enrollees reported that it was extremely or very important that their doctor understood them as a person, with the difference between traditional plan and CDHP enrollees statistically significant. About two-thirds of individuals, regardless of plan type, think it is extremely or very important that their doctor coaches them about staying healthy rather than just treating their health problems. And about one-third of individuals, regardless of plan type, think it is extremely or very important that their doctor use medical terminology during patient-provider discussions.

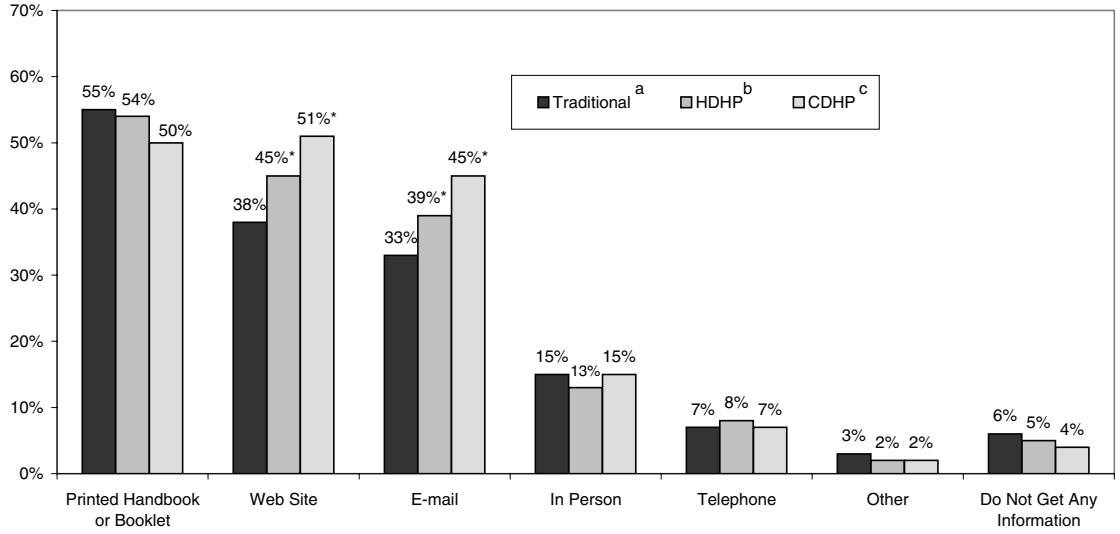
Cost-Sharing Incentives

Questions were first asked in 2008 about cost-sharing variations as an incentive regarding choice of provider, but 2009 marked the first year that questions were asked regarding health information technology (HIT). CDHP enrollees were found to be more likely than traditional plan enrollees to report that they were extremely or very likely to change doctors if cost sharing was lower when using a doctor who used HIT. Thirty-one percent of CDHP enrollees would change to doctors who used HIT in response to lower cost sharing, compared with one-quarter of traditional plan enrollees (Figure 15).

CDHP enrollees would also be more likely than traditional plan enrollees to switch doctors to one who used e-mail to deliver lab tests, allowed the individual to schedule appointments online, and answered patient questions via e-mail (Figure 16). Overall, about 60 percent of CDHP enrollees, and 50 percent of traditional plans enrollees, would change doctors to those using HIT for lab tests, online appointments, and e-mail consultations. There was no difference by plan type when it came to allowing patients to request and receive a referral online.

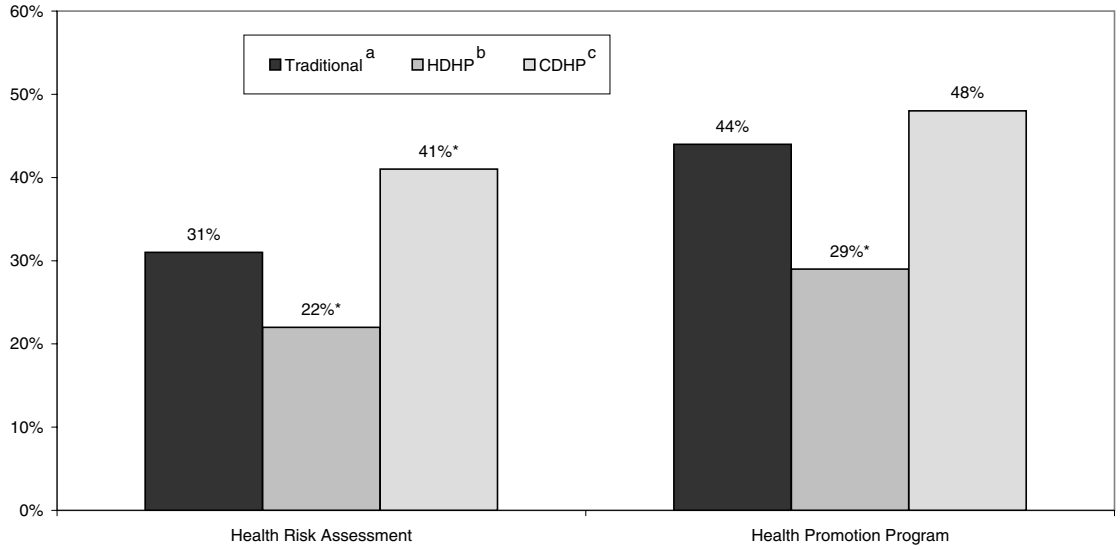
The 2009 survey again examined opinions regarding the appropriate use of lower cost sharing as an incentive to change the way individuals use the health care system. Results continued to show across-the-board strong interest in select networks composed of only medical providers with records of high-quality care when combined with lower cost sharing. One-fifth of individuals in CDHPs, 17 percent of individuals with HDHPs, and 14 percent of individuals with traditional coverage were extremely interested in using select networks when combined with lower cost sharing (Figure 17). CDHP enrollees were also more likely than traditional plan enrollees to be very interested in the concept, with 33 percent of CDHP enrollees interested and 26 percent of traditional plan enrollees interested. There was less interest in changing doctors to one in a select network combined with lower cost sharing. About 10 percent of individuals were extremely likely to change, and one-fifth was very likely, with no statistically significant differences by plan type (Figure 18). Slightly more than one-third, regardless of plan type, was somewhat likely to change to a select network.

Figure 9
Preferred Source of Information for Health Plan Benefits, by Type of Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

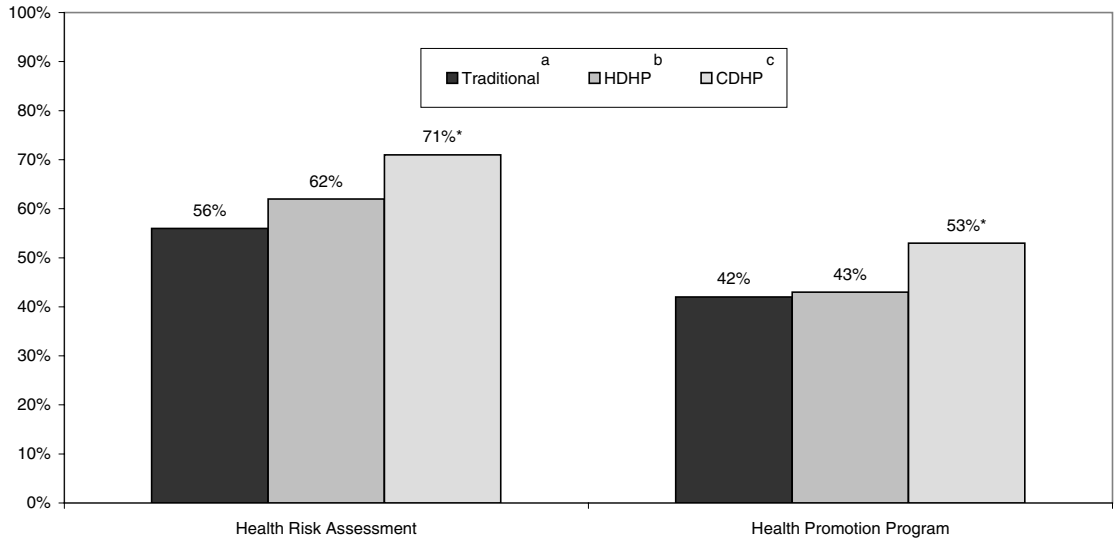
Figure 10
Employer Offers Wellness Program, by Type of Health Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 11

Individual Participates in Wellness Program Offered by Employer Among Those Offered a Wellness Program, by Type of Health Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

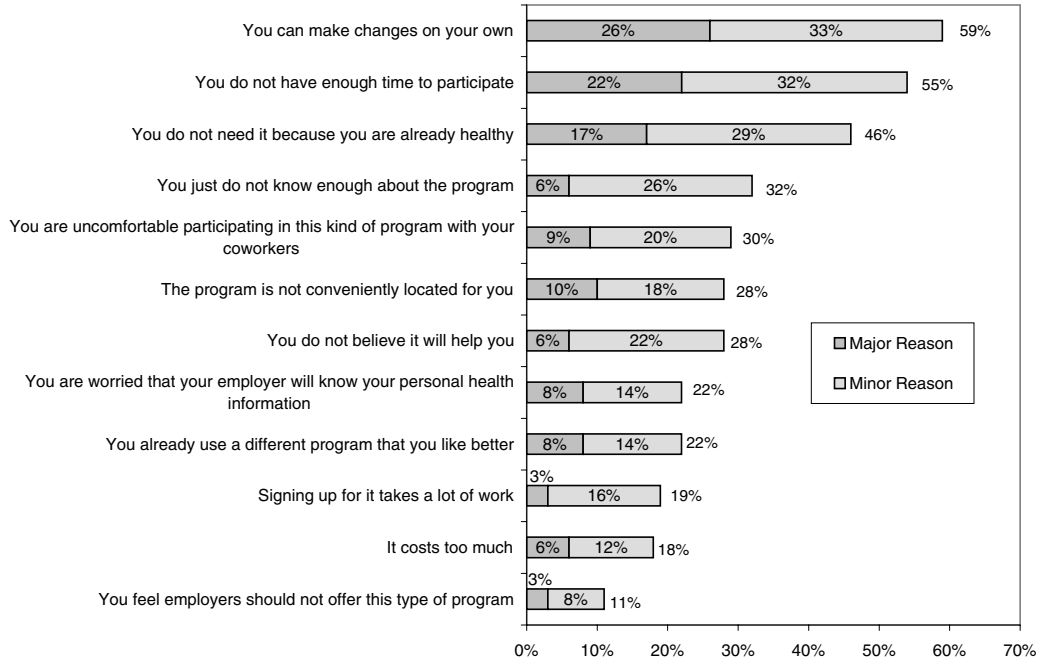
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 12

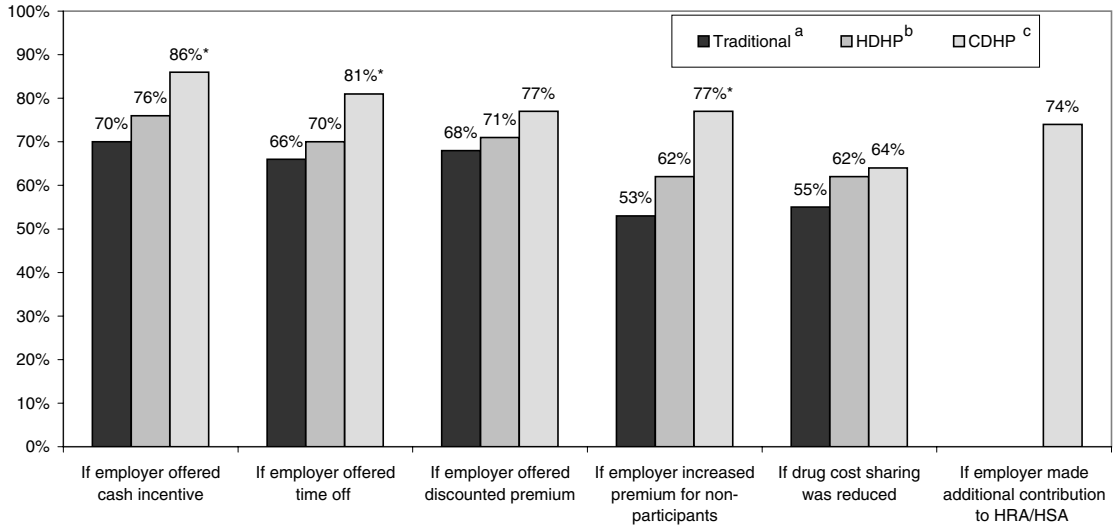
Reasons for Not Participating in Employer's Wellness Program Among Those Offered but Not Participating in Program, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 13

Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Financial Incentives and Type of Health Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

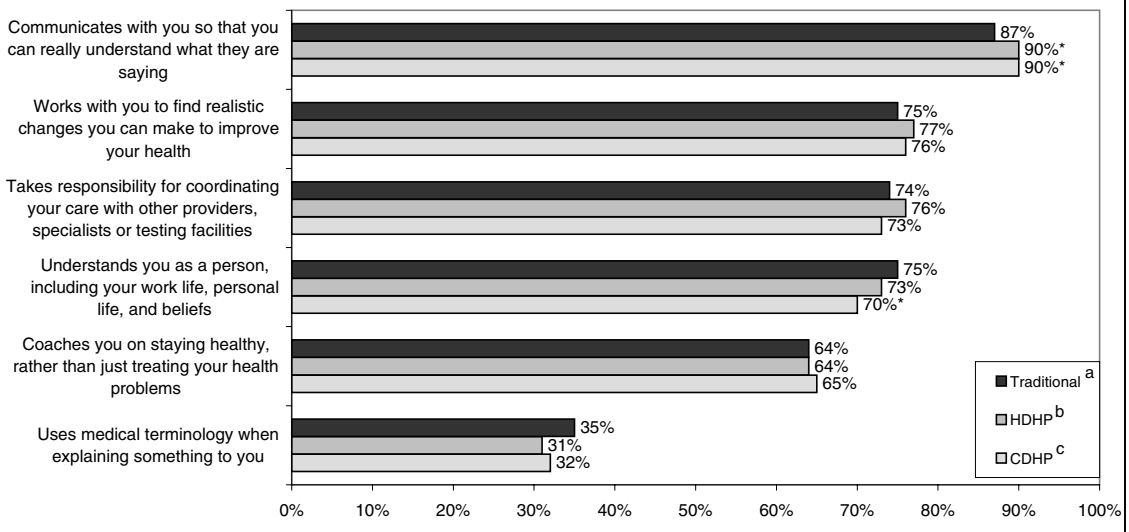
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 14

Importance of Various Provider Engagement Tools, by Type of Health Plan, 2009

(Percentage Reporting Extremely or Very Important)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

A series a questions were asked regarding whether individuals agreed or disagreed with various ways patients could receive lower cost sharing, findings shown in Figure 19. Sixty percent of CDHP enrollees, 59 percent of HDHP enrollees, and 54 percent of traditional plan enrollees agreed that patients who are actively participating in a program to maintain or improve their health should pay less for health care services than patients who are not participating in the program. The difference between both CDHP and HDHP enrollees versus traditional plan enrollees was small in number but statistically significant. Similar support was found for individuals who follow their treatment regimen. About one-half of individuals thought that patients using less invasive procedures should have lower cost sharing, with both CDHP and HDHP enrollees significantly more likely than traditional plan enrollees to agree with the statement. About 40 per-cent of individuals thought that patients using scientifically proven effective care should have lower cost sharing, while about 30 percent thought there should be lower cost sharing for patients using high-quality doctors.

Health Plan Features and Demographics

By law, people in high-deductible health plans can have the cost of preventive services excluded from their deductible. This provision in the legislation was designed to encourage those with high deductibles to get preventive services and regular screening tests like mammograms and colonoscopies. The survey asked people with deductibles whether the deductible applied to all medical care or whether some services were excluded. Nearly 6 in 10 (57 percent) of adults in CDHPs, including those with coverage through their employers (56 percent), reported that their deductible applied to all medical care (Figure 20). Sixty-three percent of those in CDHPs with coverage through the individual market reported their deductible applied to all health care services.

Health Status and Demographics

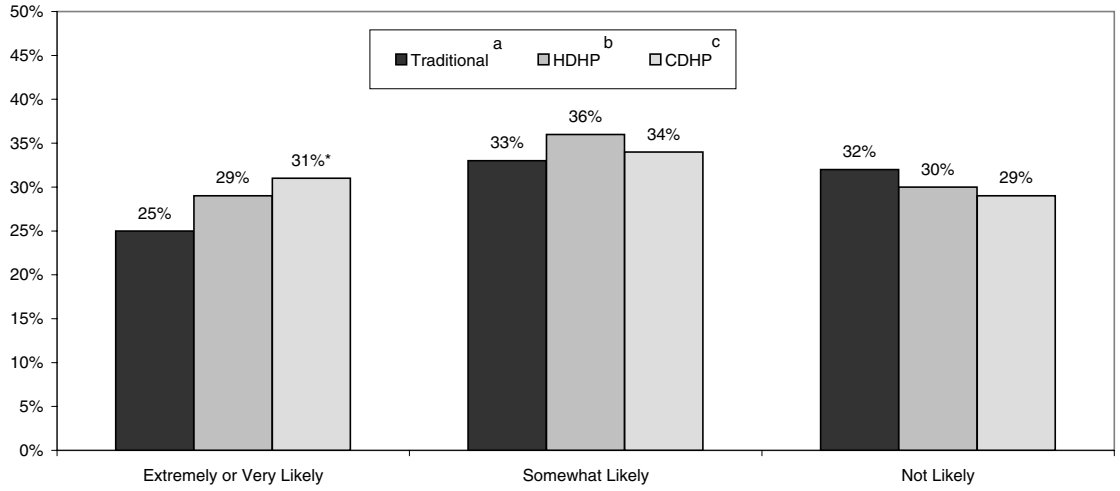
Figure 21 contains data on various demographic and health status variables from each of the surveys conducted between 2005 and 2009. These data may explain some of the differences in behavior and attitudes that were observed between traditional plan enrollees, HDHP enrollees, and CDHP enrollees, as presented in Figures 5–19. In 2008, adults in CDHPs were significantly more likely to self-report being in excellent or very good health, than those with HDHPs or traditional health coverage, but the difference in self-reported health status in 2009 was no longer statistically significant because of a slight (but not statistically significant) increase in the percentage of traditional plan enrollees reporting they were in excellent or very good health, combined with a slight (but not statistically significant) decrease in the percentage of CDHP enrollees reporting they were in excellent or very good health. However, the survey also asked respondents whether they had chronic conditions.[11] Unlike the lack of differences in self-reported health status, the survey found that individuals in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans: 46 percent of those in CDHPs reported a chronic health problem, compared with 52 percent among those in traditional plans and 54 percent among HDHP enrollees.

Adults in CDHPs and HDHPs were also significantly less likely to smoke than were adults in traditional plans: 13 percent of those in CDHPs and HDHPs smoked, compared with 18 percent of those with traditional coverage (Figure 21). People in CDHPs were also more likely to exercise and they were less likely to be obese compared with adults enrolled in a traditional health plan.

There were some statistically significant demographic differences among individuals enrolled in the three types of health plans. Individuals enrolled in CDHPs were significantly more likely than those in traditional plans to have a high household income: 34 percent of those in CDHPs had incomes of $100,000 or more compared with 27 percent of those in traditional plans. CDHP and HDHP enrollees were also more likely than traditional plan enrollees to be highly educated, which may also explain the differences in behaviors and attitudes between the groups. There were few differences between CDHP, HDHP, and traditional enrollees related to gender, age, and race.

Figure 15

Likelihood of Changing Doctor if Cost Sharing Was Lower When Using Doctors Who Use Health Information Technology (HIT) and Current Doctor Does Not Use HIT, by Type of Health Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

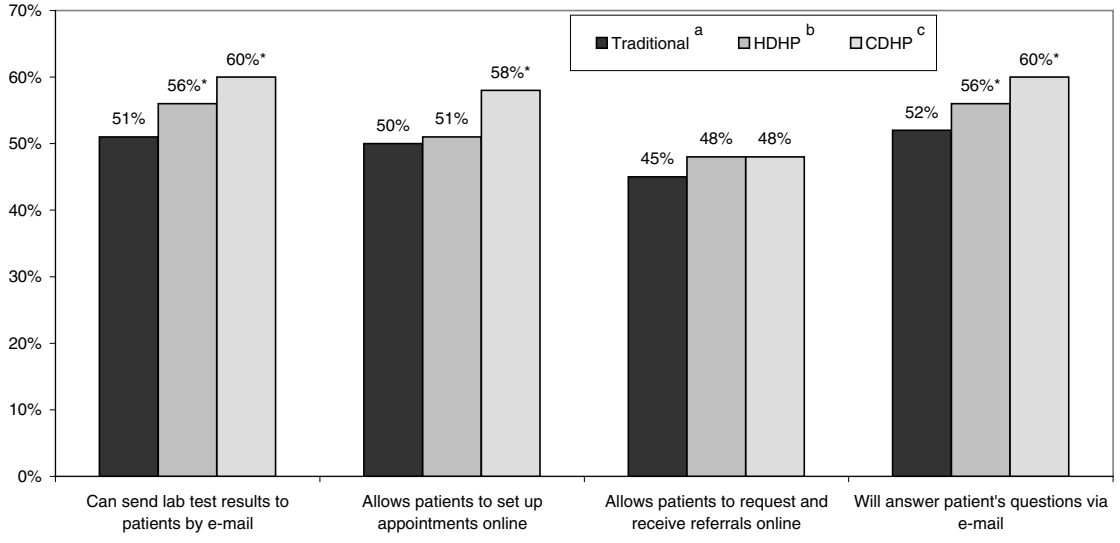
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 16

Likelihood of Choosing Doctor by Their Use of Health Information Technology (HIT), by Type of Health Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[z] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

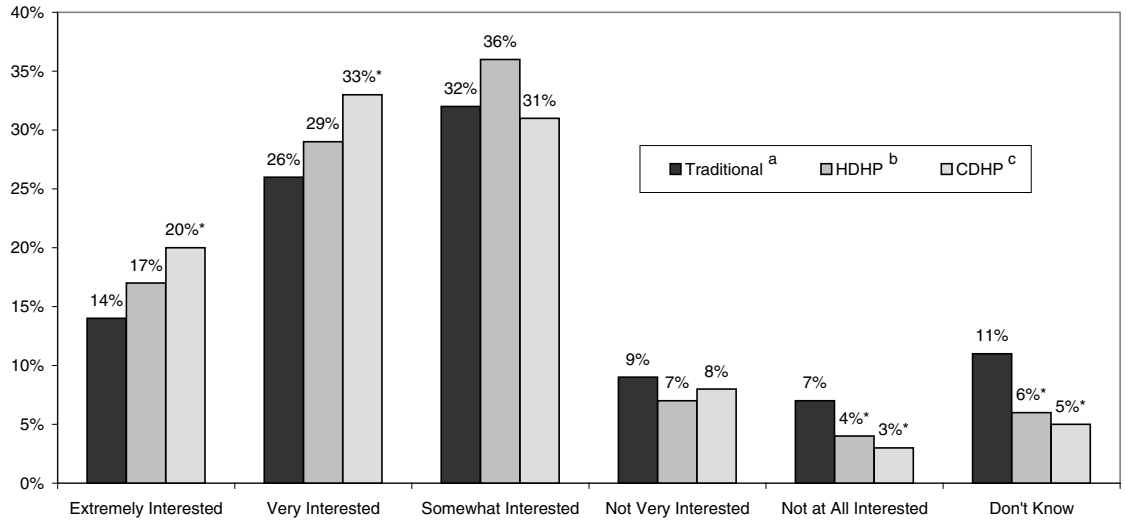
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 17

Interest in Using Select Networks Composed of Only Medical Providers With Records of Providing High-Quality Care Combined With Lower Cost Sharing, by Type of Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

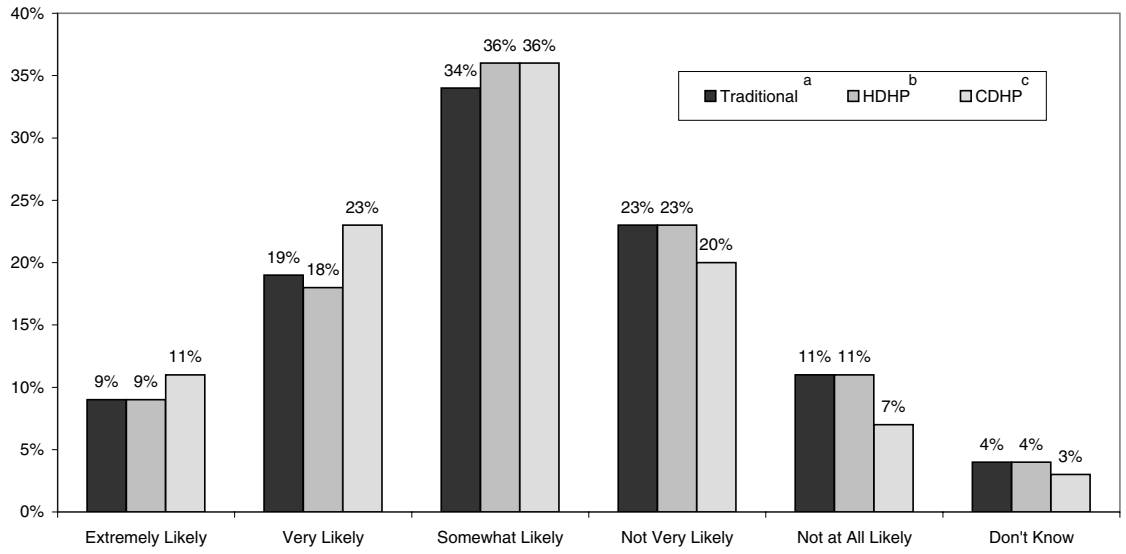
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 18

Likelihood of Changing to Select Network if Current Doctor Was Not in Select Network, by Type of Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

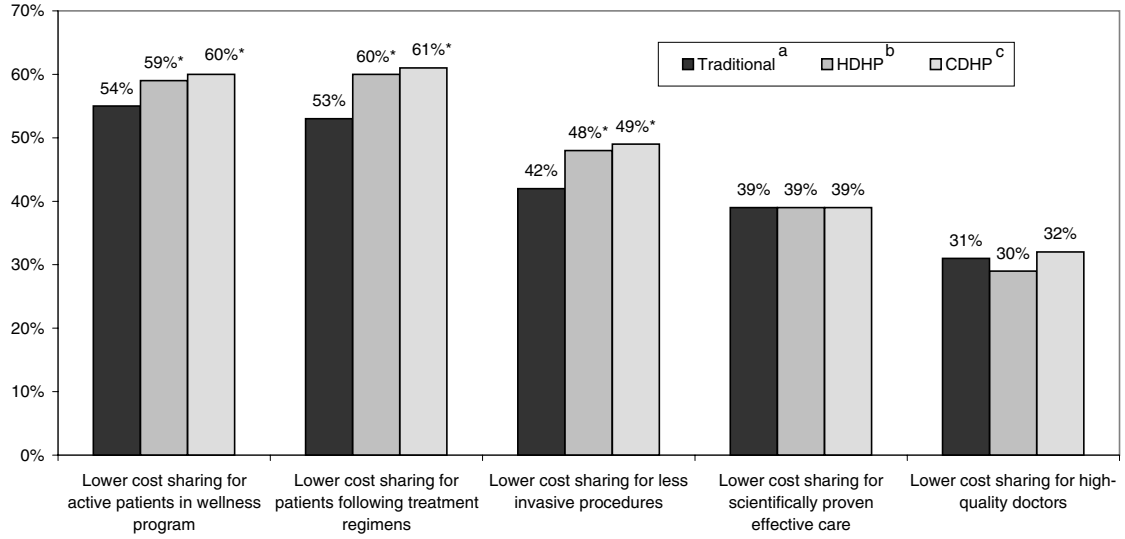
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 19

Agreement With Statements About Proposed Ways to Engage Consumers in Managing Health Care Costs, by Type of Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

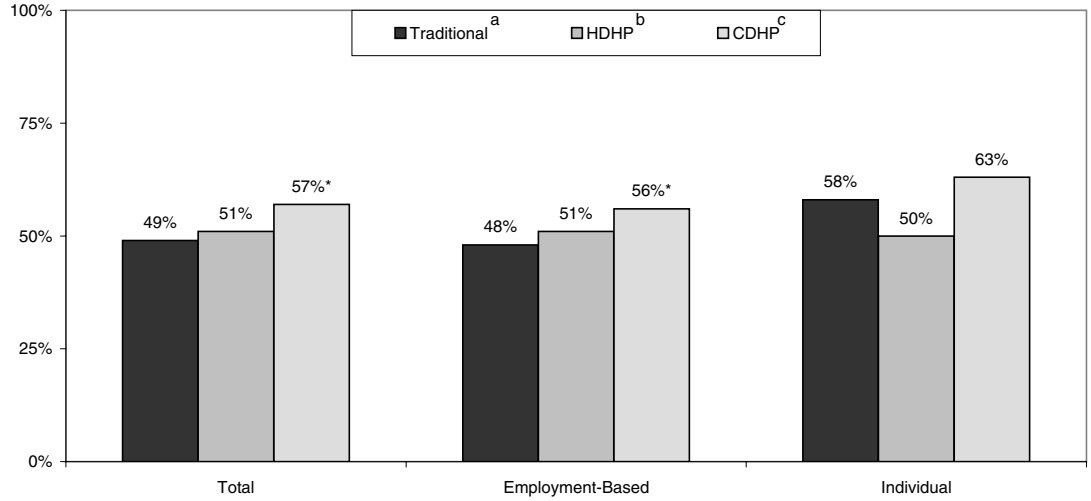
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 20

Percentage of Adults Whose Deductibles Apply to All Medical Services, by Coverage Source, 2009

(Percentage of privately insured adults ages 21–64, who have a deductible)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Trends

CDHP enrollees are no longer more likely than traditional plan enrollees to work for small firms, but HDHP enrollees were still more likely than those in traditional plans to be sole proprietors or to be employed in small firms.

During the 2005–2009 survey period, the CDHP population became significantly higher income. In 2009, 34 percent were in households with incomes of $100,000 or more, up from 22 percent in 2005 (Figure 21). Just 13 percent of adults with CDHPs lived in households with incomes under $50,000, down from 33 percent in 2005. In contrast, there was little change in the income distribution of people enrolled in traditional plans, with 27 percent in households with $100,000 or more in income.

No statistically significant year-to-year change was observed in the percentage of the population reporting that they were in excellent or very good health, though the longer-term trend appears to be upward. Also, no statistically significant year-to-year changes were observed in the percentage with at least one chronic condition, with a health problem, in the percentage of the population considered obese, and in the percentage reporting that they exercise regularly.

Choice of Health Plan, Premiums, and Reasons for Choosing Plan

Among individuals covered by an employment-based health plan, those in CDHPs were more likely than those with traditional coverage to have a choice of health plan, followed by those enrolled in HDHPs. Seventy percent of CDHP enrollees had a choice of health plan, compared with 60 percent of individuals in traditional plans, and 51 percent of those with a HDHP (Figure 22). These results are in contrast to findings from 2005 and 2006, when individuals with traditional coverage were more likely to have a choice of health plan than individuals enrolled in CDHPs (Figure 23). The survey also found that the percentage of individuals in a CDHP with a choice of health plan grew from 47 percent to 70 percent between 2005 and 2009. This may be due to the simple fact that an increasing percentage of the CDHP population works for an employer with 500 or more employees, as shown in Figure 21.

When individuals have a choice of health plan, there are many reasons why an individual may choose a particular health plan. When asked about the main reason for enrolling in a plan, 47 percent of CDHP enrollees reported that they enrolled because of the lower premium, while 47 percent reported that the opportunity to save money in the account for future years was a main reason for enrolling in that plan (Figure 24). Among individuals with traditional health coverage, 40 percent cited the good network of providers and 35 percent report the low out-of-pocket costs as the main reasons for enrolling in the plan.

Among the population with traditional coverage and a choice of plan, 39 percent were offered a CDHP or HDHP, and 34 percent were not offered it, but 27 percent did not know if they were offered it (Figure 25). Among the 39 percent who were offered either a CDHP or HDHP, 14 percent were offered a CDHP, 13 percent were offered a HDHP, and 12 percent were offered an HDHP and did not know if they were offered an account.

Individuals with HDHPs reported that they had not opened an HSA for a number of reasons:

- Thirty-one percent reported that they did not see the need for the account.
- Thirty percent reported that they did not have the money to fund the account.
- Seventeen percent reported that the tax benefits were not attractive enough.
- Thirteen percent reported that their employer would not have contributed to the account.
- Eleven percent reported that it was too much trouble to open and/or manage the account.
- Seven percent reported that it was either too complicated or they did not understand the option.

Figure 21

Selected Demographics, by Type of Health Plan, 2005–2009

	Traditional[a]					HDHP[b]					CDHP[c]				
	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009
Total sample	1,358	1,506	1,918	1,714	1,651	487	930	1,404	1,634	1,603	186	722	895	1,184	972
Gender															
Male	49%	49%	50%	48%	50%	53%	49%	51%	50%	48%	57%	50%	57%*	54%*	52%
Female	51	51	50	52	50	47	51	49	50	52	43	50	43*	46	48
Married	60	74	78	67	78	61	55*	64*	62*	64*	59	61*	70*	71	70*
Has children	34	42	47	42	44	33	35*	37*	37	39*	40	44	45	46	49
Age															
21–34	27	33	34	33	28	18*	24*	21*	20*	25	20*	24*	20*	23*	28
35–44	26	23	22	23	23	25	25	24	24	24	31	32*	31	30	28
45–54	29	26	27	26	28	34	29	30	29	27	34	28	30	28	27
55–64	17	18	18	19	21	24	22	25*	26*	25	15	16	19	19	16*
Race/Ethnicity															
White, non-Hispanic	71	71	71	72	70	94*	83*	78*	77	72	93*	81	75	76	72
Minority	28	29	29	28	30	6*	17*	22*	24	27	7*	19	25	24	28
Household Income															
Less than $30,000	15	12	15	14	11	11	17*	12*	9*	10	11	13	6*	4*	3*
$30,000–$49,999	19	20	18	19	17	19	30*	18	14*	16	22	24	13	10*	10*
$50,000–$99,999	34	38	36	36	38	36	35	38	40	43*	33	43	41	40	45*
$100,000–$149,999	14	14	14	14	17	11	5*	14	19*	16	13	7*^	20*	25*	24*
$150,000 or more	7	7	7	9	10	4	3*	9	9*	8	9*	4*^	11*	15*	10
Education															
High school graduate or less	32	38	42	33	35	14*	17*	14*	13*	14*	6*	11*	11*	10*	8*
Some college, trade or business school	31	29	29	31	31	36	36*	30	28	26	28	33*	24	22*	24*
College graduate or some graduate work	24	22	20	24	23	34	35*	40*	42*	42*	46*	41*	41*	44*	46*
Graduate degree	13	11	9	12	11	16	12	17*	17*	18*	20*	15	24*	24*	21*
Self-Rated Health Status															
Excellent/very good	42	54	49	56	59	50	53	54*	54	59	58*	60*	65*	66*	64
Good	45	35	38	34	32	36	34	35	34	30	34	33	29*	30	27
Fair/poor	13	12	13	10	9	53	13	10	12	11	9	7*	6*	5*	8
At least one chronic health condition**	54	49	49	52	52	56	50	53*	56	54	48	43*	45	45*	46*
Health problem***	57	51	53	54	54	57	53	55	57	57	49	44*	46*	45*	49*
Obese	36	30	27	26	31	33	28	30	29	28	26*	30	25	23	23*
Smokes cigarettes	23	24	24	20	18	14*	18*	14*	15*	13*	14*	14*	15*	13*	13*
No regular exercise	24	25	25	25	21	15*	25	20*	21	19	16*	19*	17*	17*	13*
Firm Size (base: employed full- or part-time)															
Self-employed with no employees	2	4	3	2	3	9*	9*	9*	7*	7*	8*	5	6*	7*	5
2–49	15	19	19	16	15	31*	32*	27*	26*	25*	39*	32*	28*	25*	21*
50–199	8	10	11	12	11	9	14	14	13	15*	8	12	11	13	12
200–499	9	8	9	8	10	6	8	7	7	7*	5*	10	8	7	7*
500 or more	54	45	43	50	48	33*	29*	36	38*	37*	36*	31*	40	42	48

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at $p \leq 0.05$ or better.

** Arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure or stroke.

*** Health problem defined as fair or poor health or one of eight chronic health conditions.

Contribution Behavior and Account Balances

Among individuals with a CDHP, some receive employer contributions to the account, while others do not. HRA enrollees will get employer contributions but are unable to make their own contribution. Individuals with an HSA can contribute their own money to the account and may or may not also receive employer contributions. Two-thirds (63 percent) of individuals with an employment-based CDHP (including both those covered as an individual and those with family coverage) reported that the employer contributed to the account, while 32 percent reported that they did not receive employer contributions, and 5 percent did not know if the employer contributed (Figure 26).[12]

Among the 63 percent with an employer contribution, 10 percent received less than $500, 24 percent between $500–$999, 26 percent received between $1,000–$1,499, 11 percent received between $1,500–$1,999, and 22 percent received $2,000 or more (Figure 27). Employer contributions vary, however, by whether an individual has employee-only or family coverage. Individuals with employee-only coverage are most likely to get an employer contribution between $500–$750, while those with family coverage are most likely to get an employer contribution of at least $1,000 (Figure 28). In fact, 73 percent of individuals with family coverage get a contribution of at least $1,000, with 29 percent getting $1,000–$1,499, 14 percent getting $1,500–$1,999, and 30 percent getting at least $2,000.

Overall, among persons eligible to contribute to an account, 11 percent did not contribute anything, with 17 percent of those with household income below $50,000 and 9 percent of those with household income of at least $50,000 contributing nothing (Figure 29). The most significant difference in contributions by household income can be seen in the likelihood of contributing at least $2,000 to the account. About 41 percent of individuals with household income of at least $50,000 contributed $2,000 or more to the account, whereas 13 percent of those with household income of less than $50,000 contributed $2,000 or more to the account.

Individual contributions to the account also vary by whether an individual has single coverage or family coverage. Specifically, individuals with single coverage are more likely than those with family coverage to contribute less than $1,000 to the account, whereas individuals with family coverage are more likely than those with single coverage to contribute at least $2,000 (Figure 30). Overall, 25 percent of individuals with single coverage contributed at least $2,000, while 42 percent of those with family coverage contributed at least $2,000 to the account.

Concerning length of time that CDHP enrollees have had their account, 8 percent enrolled in the past six months, another 20 percent in the past year, and 36 percent in the past two years (Figure 31). One-quarter (26 percent) report being in the account three to four years, and 9 percent report having the account for five years or more.

Concerning account balance, 6 percent had no balance while 20 percent had $3,000 or more (Figure 32). Overall, 44 percent had less than $1,000 in the account at the time of the survey, and 9 percent did not know how much was in the account. Concerning rollovers, 10 percent rolled over nothing while 41 percent rolled over at least $1,000 at the end of 2008 (Figure 33).

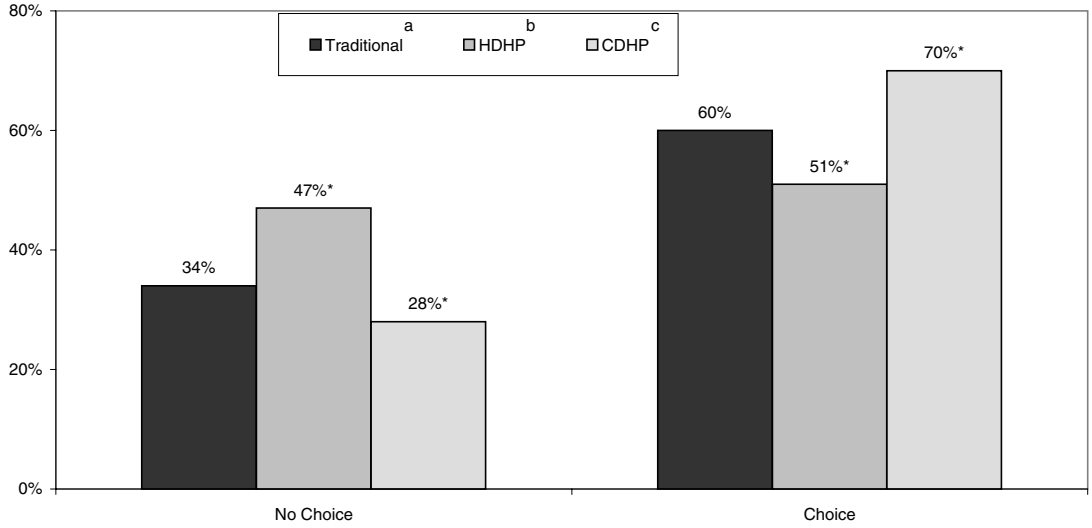
Satisfaction and Attitudes

Respondents were asked a series of questions regarding their attitudes toward their health plan and satisfaction with regard to various aspects of their health care. Questions were asked about overall satisfaction with the health plan as well as satisfaction related to quality of care received, out-of-pocket expenses, and choice of doctor. Roughly three-quarters of plan enrollees, whether enrolled in a traditional plan, a CDHP, or an HDHP were extremely or very satisfied with choice of doctor, and the results have been consistent since 2005 (results not shown).

The 2006 survey found that individuals in CDHPs and HDHPs were less likely to be satisfied with the quality of care received than those in traditional plans. However, in 2007, the gap in satisfaction between those in traditional plans and those with CDHPs disappeared because satisfaction increased significantly among those with CDHPs and remained unchanged through 2009 (Figure 34). The previously observed gap in satisfaction rates for quality of care received remained between traditional enrollees and HDHP enrollees.

Figure 22

Percentage of Individuals Covered by Employment-Based Health Benefits With Choice and No Choice of Health Plan, by Type of Health Plan, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

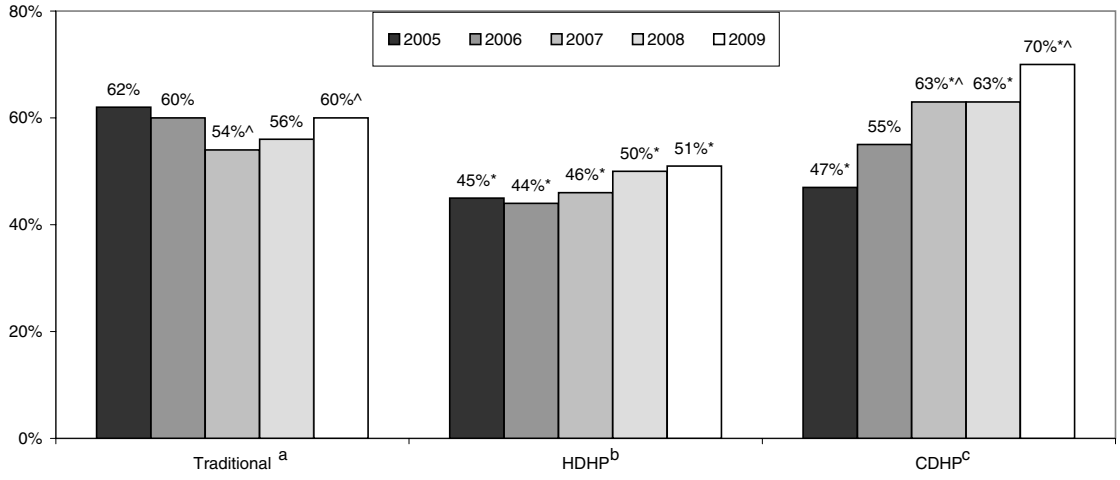
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 23

Percentage of Individuals Covered by Employment-Based Health Benefits With a Choice of Health Plan, by Type of Health Plan, 2005–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.

Difference between 2005 and 2009 is statistically significant at the p ≤ 0.05 or better.

Figure 24

Main Reason for Deciding to Enroll in Current Health Plan, Among Individuals With a Choice of Health Plan or in the Non-Group Market, by Type of Health Plan, 2009

	Traditional[a]	HDHP[b]	CDHP[c]
Lower cost of the premium	27%	39%*	47%*
Low out-of-pocket costs for the doctor	35	15*	6*
Good network of physicians and hospitals/doctor in the network	40	40	27*
Prior experience with the plan	25	23	15*
Specific benefits offered by the plan	21	13*	12*
Plan's good reputation, recommended by others	11	10	9
Prescription drug coverage	35	23*	10*
Familiar type of coverage, simple to understand	22	21	9*
Easy access to care	19	17	8*
Opportunity to save money in the account, rollover funds for future years	1	1	47*
Puts you in control of your health care dollars, you make choices of how your account is spent	6	7	31*
Not much paperwork	10	14	5*
Tax benefits of the plan	3	3	24*

Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

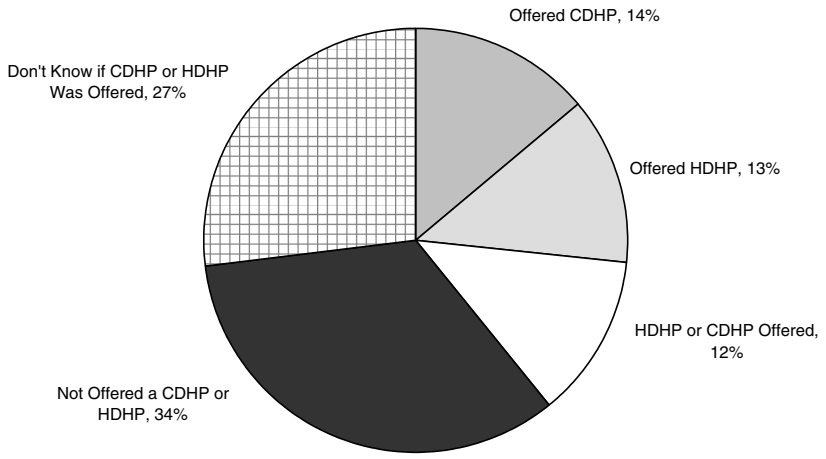
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 25

Percentage of Individuals With Traditional[a] Employment-Based Health Benefits Offered HDHP[b] or CDHP,[c] 2009



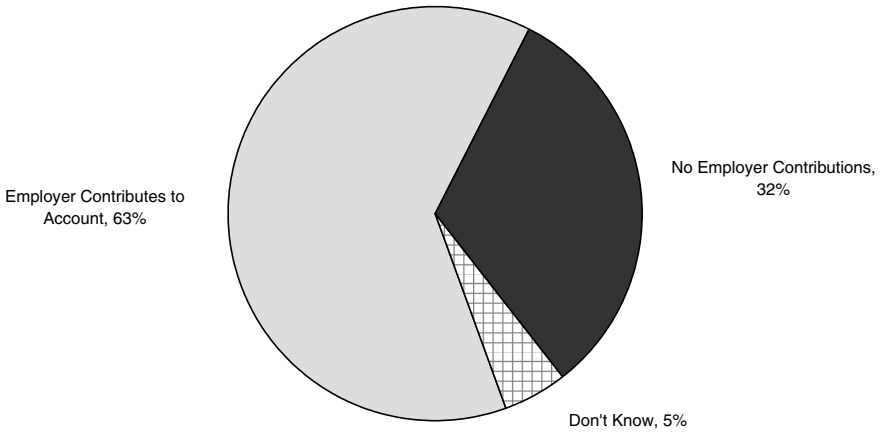
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

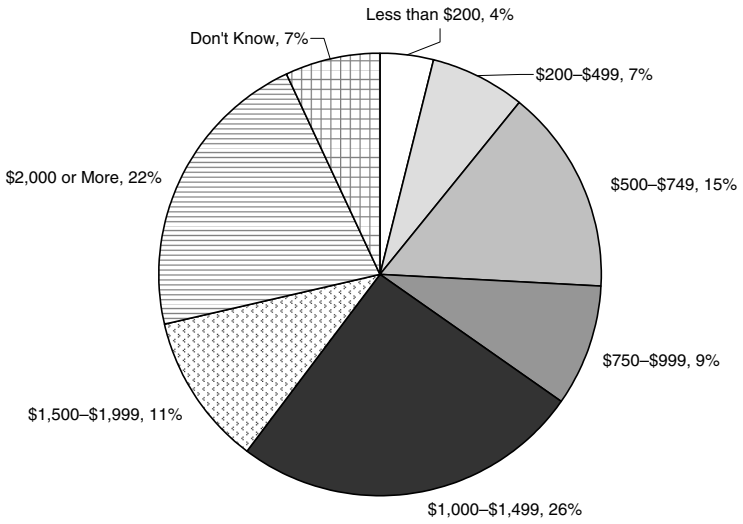
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 26
Percentage of Individuals With Employer Contribution to Account, Among Persons With Employment-Based Health Benefits and CDHP,[a] 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 27
Annual Employer Contributions to the Account, Among Persons With CDHP,[a] 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Unlike satisfaction with quality of care received, the differences in overall satisfaction levels by plan type found in all prior years of the survey continued in the 2009 findings (Figure 35). Traditional plan enrollees were more likely than CDHP and HDHP enrollees to be extremely or very satisfied with the overall plan in all years of the survey. In 2009, 66 percent of traditional plan enrollees were extremely or very satisfied with the overall health plan, compared with 52 percent among CDHP enrollees and 40 percent among HDHP enrollees. It is also worth noting that the overall satisfaction levels among CDHP enrollees increased from 37 percent to 47 percent between 2006 and 2007 and were 52 percent in 2009, while the overall satisfaction rates for traditional enrollees were unchanged.

Differences in out-of-pocket costs may explain a significant portion of the difference in overall satisfaction rates between traditional plan, HDHP, and CDHP enrollees. In 2009, 52 percent of traditional plan participants were extremely or very satisfied with out-of-pocket costs (for health care services other than for prescription drugs), while 20 percent of HDHP enrollees were satisfied and 29 percent of CDHP participants were satisfied (Figure 36).

As in previous years of the survey, individuals in CDHPs and HDHPs were found to be less likely than those in traditional plans both to recommend their health plan to a friend or co-worker and to stay with their current health plan if they had the opportunity to switch plans (Figures 37 and 38). Similar to the satisfaction questions, the percentage of CDHP enrollees reporting that they would be extremely or very likely to recommend their plan to a friend or co-worker increased from 30 percent to 39 percent between 2006 and 2007, and reached 45 percent in 2009. Over one-half (55 percent) of traditional plan enrollees were extremely or very likely to recommend their plan, compared with 32 percent of HDHP enrollees. The percentage of individuals extremely or very likely to stay with their health plan if they could switch was unchanged from 2008, with 64 percent of traditional, 49 percent of CDHP, and 38 percent of HDHP enrollees extremely or very likely to stay with their plan if they had the opportunity to switch plans.

Health Care Use and Access Issues

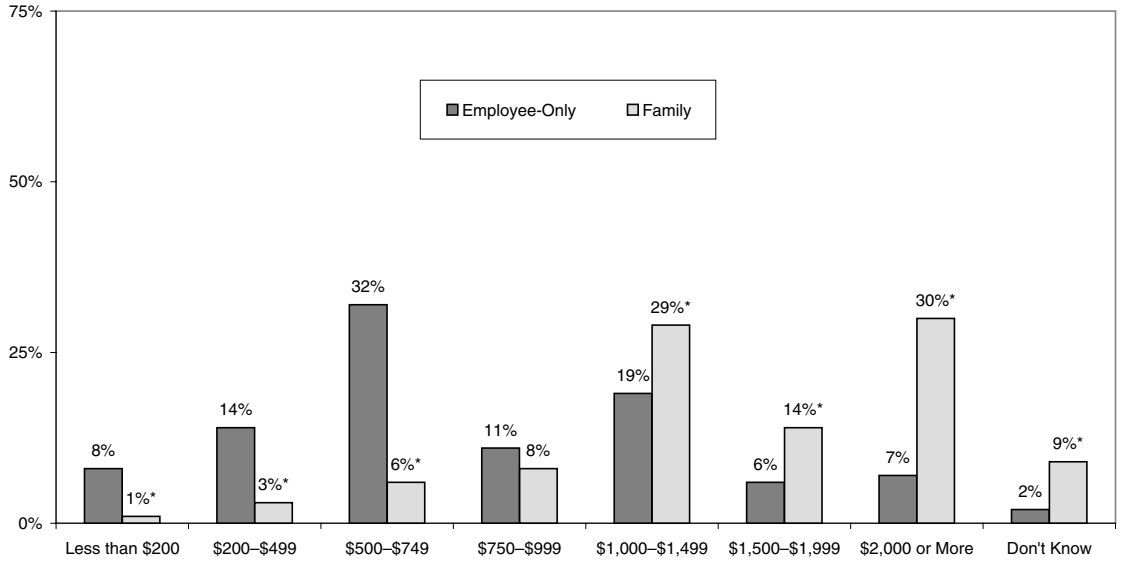
The survey asked respondents who had chronic conditions whether they agreed that they carefully followed their treatment regimens for specific conditions. There was no significant variation in the frequency with which people with chronic conditions followed their treatment regimens across plan types, with one exception: CDHP enrollees with allergies were less likely than traditional plan enrollees with allergies to follow their treatment regimen (Figure 39). Generally, the 2009 findings are in contrast to somewhat mixed findings in 2007 (Fronstin and Collins, 2008). In 2007, people in CDHPs with arthritis and hypertension were significantly less likely to say that they followed their treatment regimens for their conditions carefully. But people in CDHPs with depression were significantly more likely to say they followed their treatment regimens carefully than did those with traditional coverage.

In 2007, the survey found that adults with CDHPs and HDHPs were significantly more likely to report that they had avoided, skipped, or delayed health care because of costs than were those with more traditional coverage. In 2008, HDHP enrollees continued to be more likely than traditional plan enrollees to report that they had delayed or avoided getting any needed health care services because of costs, but the difference between traditional plan enrollees and CDHP disappeared, mostly because of the significant increase in the percentage of traditional plan enrollees reporting access issues due to costs. No significant access issues were found between CDHP enrollees and traditional plan enrollees during 2008, except among higher-income individuals, but HDHP enrollees were found to be more likely than those with traditional coverage to report access issues, especially among those with a health problem and those with household income of $50,000 or above.

In 2009, the survey found a reduction in the percentage of individuals with traditional coverage reporting that they or a family member delayed or avoided getting health care due to the cost. This decline was statistically significant for both persons with and without health problems, as well as for persons with less than $50,000 in household income (Figure 40). For the most part, the results were unchanged for individuals in HDHPs, with one exception: There was a decline in the percentage of HDHP enrollees with no health problem reporting an access issue. Among individuals with a CDHP, the percentage increased for reporting that they skipped doses to make the medication last longer, and this change was statistically significant for the entire group for the subgroups with health problems, and for households with

Figure 28

Annual Employer Contributions to the Account, Among Persons With CDHP,[a] 2009



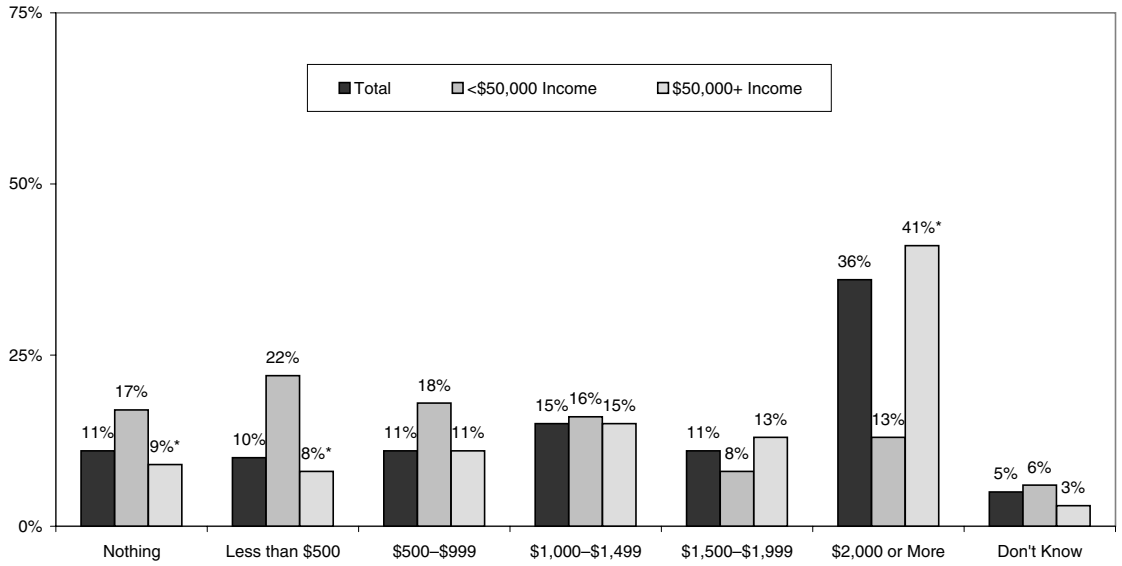
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between employee-only coverage and family coverage is statistically significant at the p ≤ 0.05 or better.

Figure 29

Annual Individual Contributions to the Account, by Household Income, Among Persons With CDHP,[a] 2009



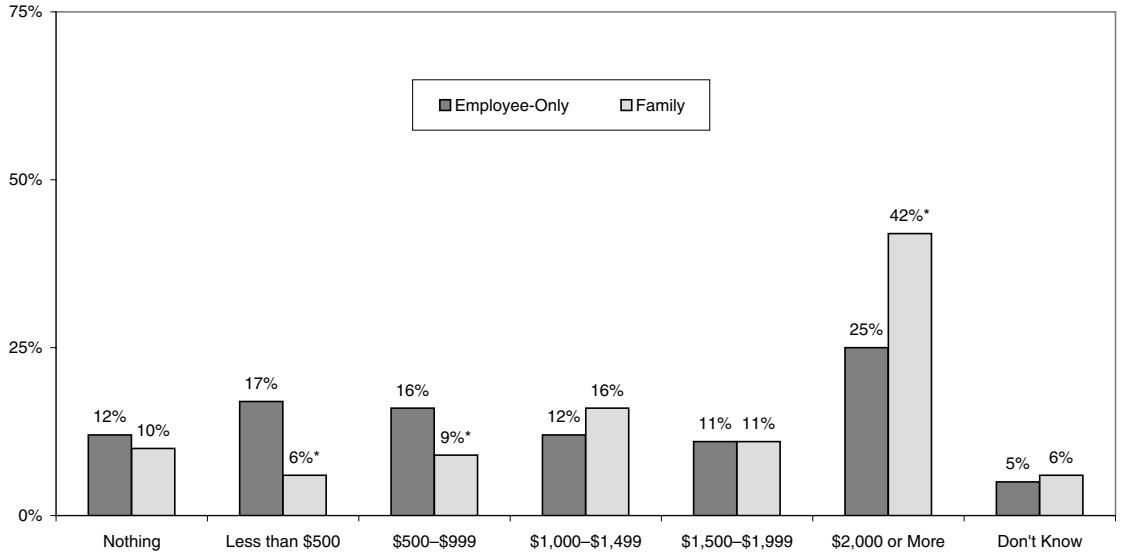
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between <$50,000 and $50,000+ is statistically significant at the p ≤ 0.05 or better.

Figure 30

Annual Individual Contributions to the Account, by Type of Coverage, Among Persons With CDHP,[a] 2009



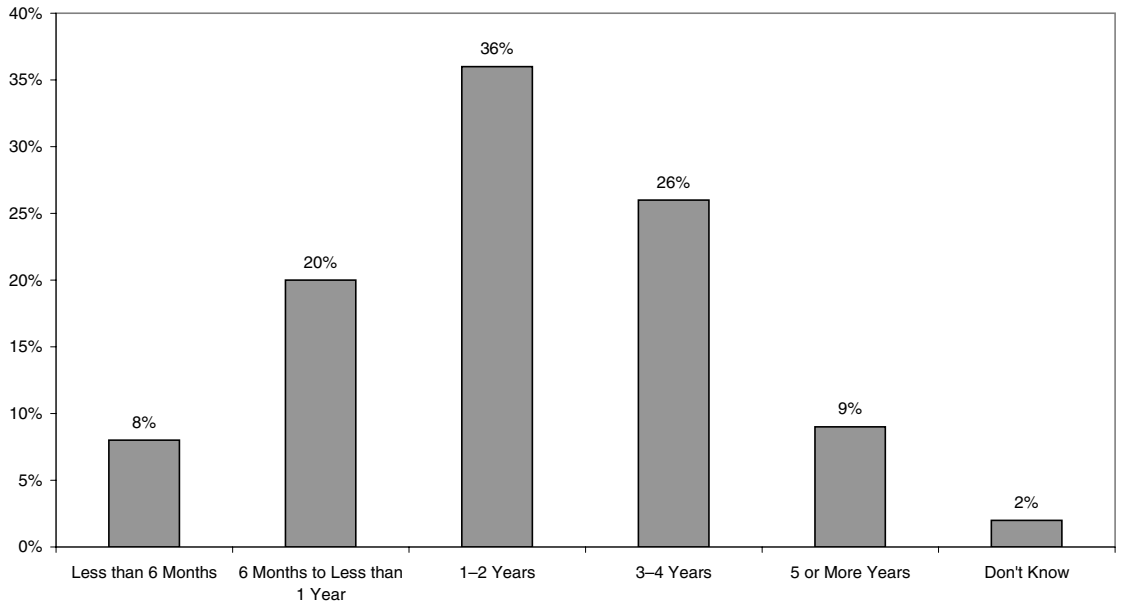
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between employee-only coverage and family coverage is statistically significant at the $p \leq 0.05$ or better.

Figure 31

Length of Time With CDHP[a] and Savings Account, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

$50,000 or more in income. Furthermore, the differences in access issues between CDHP and traditional enrollees that were not statistically significant in 2008 became so in 2009. There was an almost across-the-board difference in 2009 between traditional plan and CDHP enrollees, with CDHP enrollees being more likely than traditional plan enrollees to report some sort of access issue.

Conclusion

The 2009 EBRI/MGA Consumer Engagement in Health Care Survey finds that 4 percent of the population was enrolled in a CDHP, up from 3 percent in 2008. Enrollment in HDHPs increased from 11 percent in 2008 to 13 percent in 2009. Overall, 11.2 million adults ages 21–64 with private insurance, representing 8.9 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA, but had not opened the account.

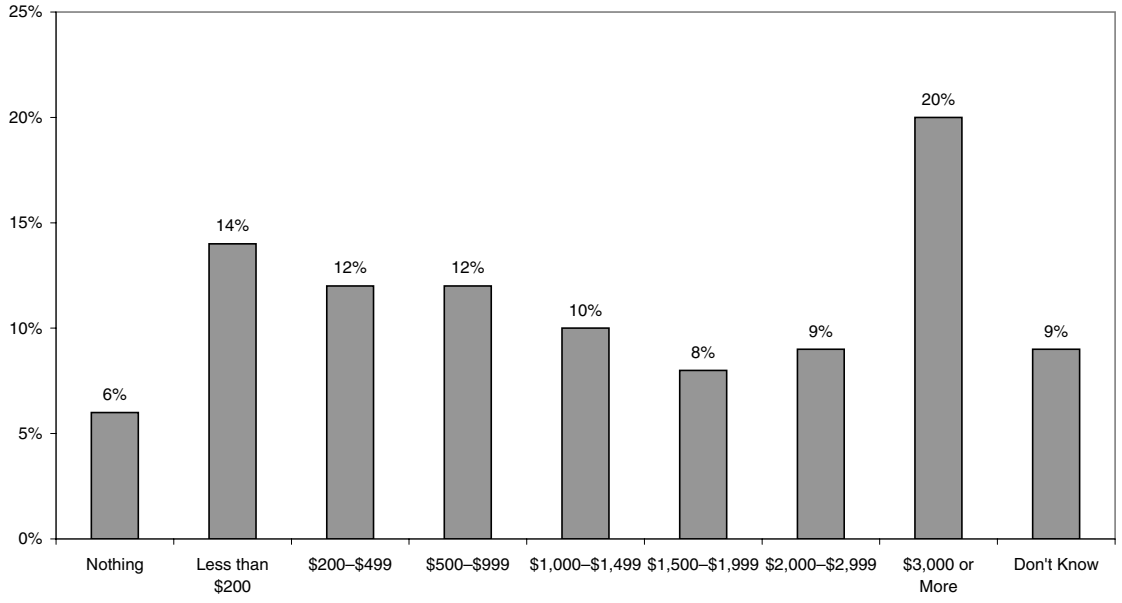
The 2009 EBRI/MGA Consumer Engagement in Health Care Survey suggests that CDHP enrollees are somewhat more cost-conscious in their decision making than those in traditional plans. CDHP enrollees were more likely than traditional plan and HDHP enrollees to have reported that they made use of the information. CDHP and HDHP enrollees were also more likely to try to find information on their doctor's cost and quality from sources other than the health plan. Individuals in CDHPs were much more likely than those in traditional plans to receive information about their health benefits either through a Web site or via e-mail. CDHP and HDHP enrollees were also more likely than traditional plan enrollees to prefer to receive information through e-mail and a Web site. CDHP enrollees were more likely than traditional plan enrollees to take advantage of the health risk assessment and participate in the health promotion programs. In addition, financial incentives mattered more to CDHP enrollees than to traditional plan enrollees.

It is not clear from the data whether the differences in consumer engagement can be attributed to plan design differences or whether various plan designs attract a certain kind of individual. Regardless, it is clear that the underlying characteristics of the populations enrolled in these plans are different. Adults in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans. Adults in CDHPs and HDHPs were significantly less likely to smoke than were adults in traditional plans, and they were significantly more likely to exercise. People in CDHPs were also less likely to be obese compared with adults enrolled in a traditional health plan. Adults in CDHPs were significantly more likely than those with traditional health coverage to have a high household income. CDHP and HDHP enrollees were also more likely than traditional plan enrollees to be highly educated.

As the CDHP and HDHP markets continue to expand and more enrollees are enrolled for longer periods of time, the sustained impact that these plans are having on cost, quality, and access to health care services will be better understood. The five years of consumer engagement surveys reported here provide a unique baseline from which to measure future changes in this evolving type of health insurance.

Figure 32

Amount Currently in Account, Among Persons With CDHP,[a] 2009



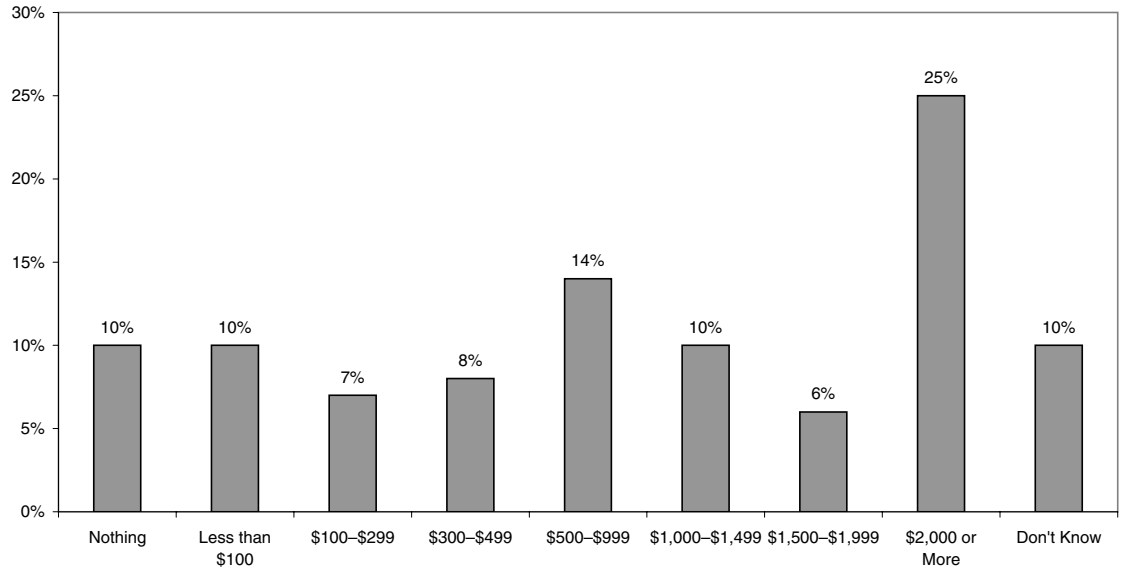
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 33

Amount Rolled Over from Past Year, 2009

(Among Persons With CDHP[a] Who Have Had Account More than One Year)

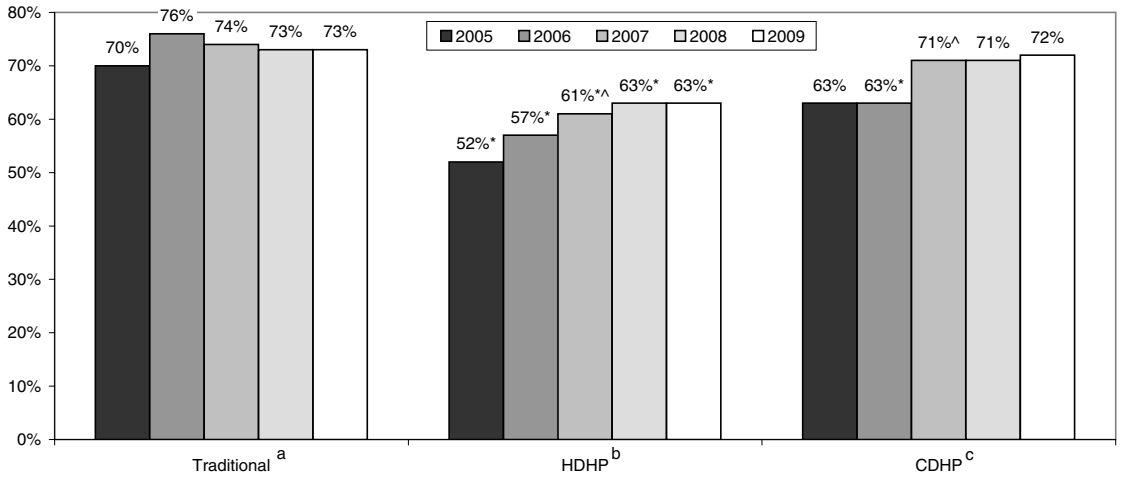


Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 34

Percentage Extremely or Very Satisfied With Quality of Health Care Received, by Type of Health Plan, 2005–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007. Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

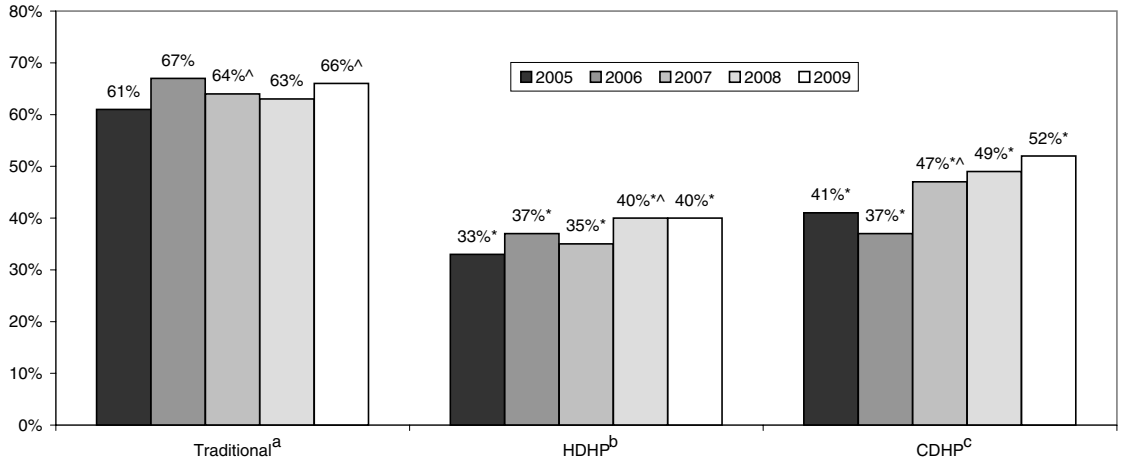
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.

Difference between 2005 and 2009 is statistically significant at p ≤ 0.05 or better.

Figure 35

Percentage Extremely or Very Satisfied With Overall Health Plan, by Type of Health Plan, 2005–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007. Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

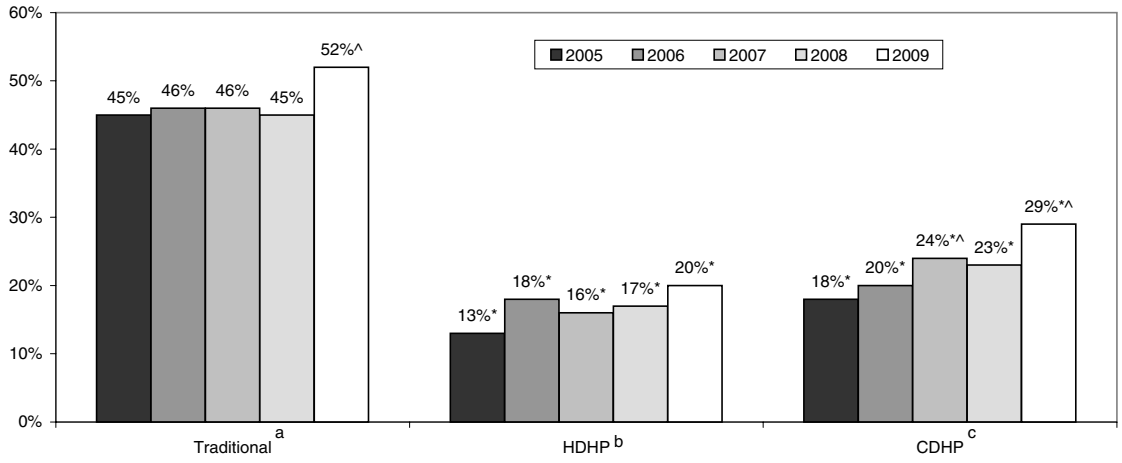
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.

Difference between 2005 and 2009 is statistically significant at p ≤ 0.05 or better.

Figure 36
Percentage Extremely or Very Satisfied With Out-of-Pocket Health Care Costs, by Type of Health Plan, 2005–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

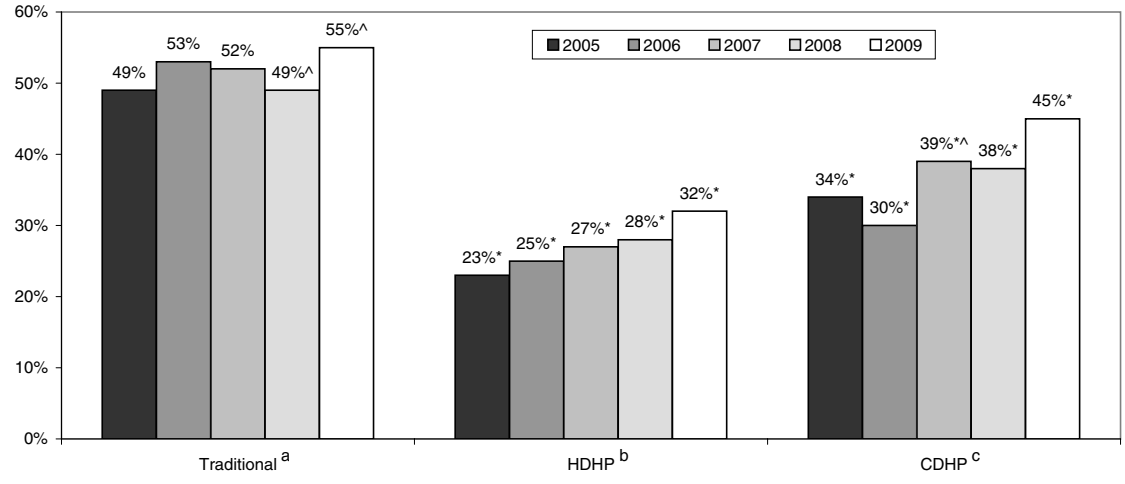
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.

Difference between 2005 and 2009 is statistically significant at p ≤ 0.05 or better.

Figure 37
Percentage Extremely or Very Likely to Recommend Health Plan to Friend or Co-Worker, by Type of Health Plan, 2005–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

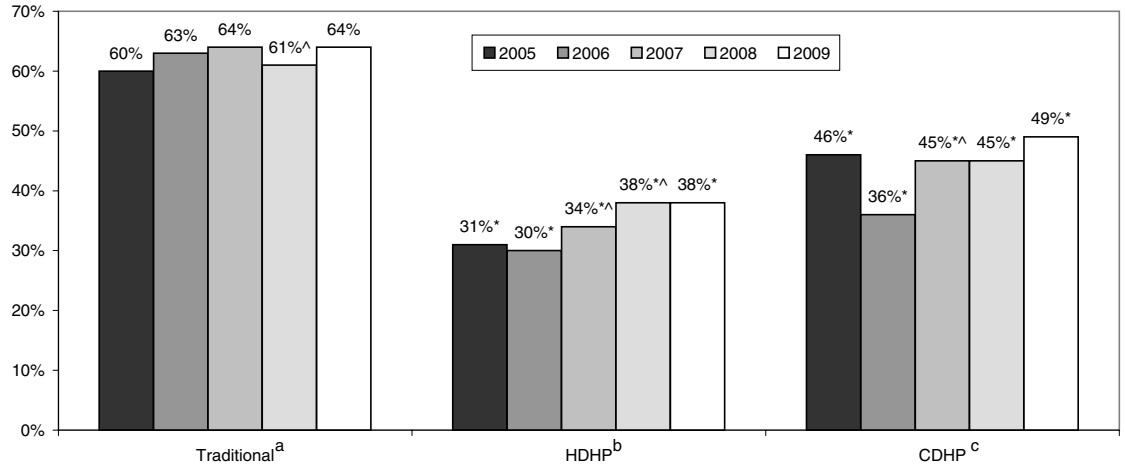
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.

Difference between 2005 and 2009 is statistically significant at p ≤ 0.05 or better.

Figure 38

Percentage Extremely or Very Likely to Stay With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan, 2005–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

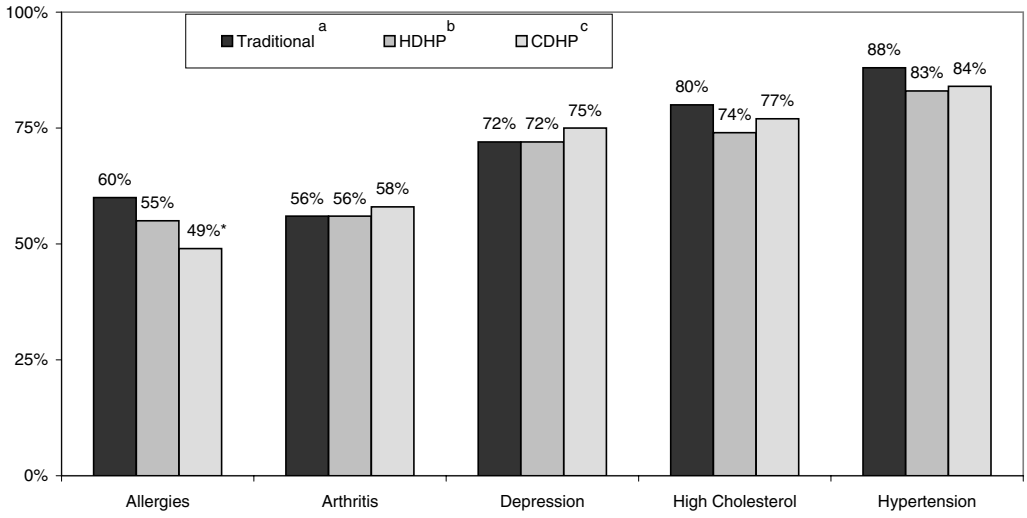
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.

Difference between 2005 and 2009 is statistically significant at p ≤ 0.05 or better.

Figure 39

Following Treatment Regimens for Five Most Prevalent Chronic Diseases, 2009

Percentage of privately insured adults ages 21–64 with chronic conditions who strongly/somewhat agree that they follow their treatment regimens very carefully



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 40
Access Issues, by Type of Health Plan, 2005–2009

	Traditional[a]					HDHP[b]					CDHP[c]				
	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009
Total Sample	1,061	1,506	1,918	1,714	1,651	463	930	1,404	1,634	1,603	185	722	895	1,184	972
Total															
Not filled a prescription due to cost (you or family members)	16%	16%	17%	15%	15%	26%*	21%*	21%*	21%*	18%*	21%	23%*	19%^	17	21*
Skipped doses to make medication last longer (of those who were given a prescription) (you or family members)	15	16	16	15	17	25*	22*	22*	22*	22*	20	23*	17^	16	23*^
Not filled a prescription due to cost or skipped doses to make medication last longer	22	22	23	21	22	32	29*	29*	31*	28*	30	31*	24^	23	31*^
Delayed or avoided getting health care due to cost (you or family members)	17	19	16^	22^	15^	31*	33*	32*	30*	28*	37*	38*	29*^	26	22*
Any of the above	29	30	28	33^	29^	44	44*	43*	43*	41*	48	49*	38*^	35	41*
Health Problem**															
Not filled a prescription due to cost	21	18	21	19	19	30*	25*	24	25*	23	26	25*	26	23	26*
Skipped doses to make medication last longer (of those who were given a prescription)	21	21	23	21	21	32*	28*	28	30*	30*	30	29*	24	22	32*^
Not filled a prescription due to cost or skipped doses to make medication last longer	29	27	29	28	29	40	35*	35	38*	36*	39	38*	34	32	40*
Delayed or avoided getting health care due to cost	20	23	18^	23^	17^	31*	37*	35	34*	34*	44*	42*	32^	32	29*
Any of the above	35	34	33	37	35	48	50*	49	49*	49*	58	55*	46^	44	49*
No Health Problem**															
Not filled a prescription due to cost	11	13	12	9^	9	48	17	17	16*	11^	15	22*	13^	12	15*
Skipped doses to make medication last longer (of those who were given a prescription)	8	11	8^	7	12^	15	15	13	12*	12	10	17	11^	10	14
Not filled a prescription due to cost or skipped doses to make medication last longer	14	18	16	13^	14	22	22	21	21*	15	20	25*	16^	16	24*
Delayed or avoided getting health care due to cost	13	16	14	21^	12^	31*	28*	27	26	20*	31*	35*	26^	22	15
Any of the above	20	25	23	29^	21^	39	38*	37	35	31*	39	44*	32^	29	32*
Less Than $50,000 Yearly Household Income															
Not filled a prescription due to cost	24	20	27^	20^	20	28	25	27	26	23	24	23	27	19^	25
Skipped doses to make medication last longer (of those who were given a prescription)	21	21	25	21	25	31	23	28	27	29	30	26	23	20	29
Not filled a prescription due to cost or skipped doses to make medication last longer	31	29	33	28	29	38	31	36	35	33	36	33	32	28	35
Delayed or avoided getting health care due to cost	24	29	26	35^	18^	41	36	40	37	39*	49*	40	34	33	38*
Any of the above	39	42	41	47^	36^	53	48	53	51	50*	56	53	48	45	50*
$50,000 or More Yearly Household Income															
Not filled a prescription due to cost	12	13	12	12	13	24*	19*	19	19*	17*	19	23*	16^	16	20*
Skipped doses to make medication last longer (of those who were given a prescription)	13	14	13	12	15^	23*	20*	19	21*	21*	16	21*	16^	15	22*^
Not filled a prescription due to cost or skipped doses to make medication last longer	18	19	18	17	21^	30	27*	27	28*	27*	28	29*	22^	22	31*^
Delayed or avoided getting health care due to cost	13	14	12^	16^	14	28*	30*	29	28*	25*	31*	37*	29^	25*	20*
Any of the above	24	25	23	26^	27	40	41*	40	40*	38*	45	47*	36^	33	40*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.
** Health problem defined as fair or poor health or one of eight chronic health conditions.
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2005 and 2009 is statistically significant at the p ≤ 0.05 or better.

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey, an online survey that examines issues surrounding consumer-directed health care, including the cost of insurance, the cost of care, satisfaction with health care, satisfaction with their health care plan, reasons for choosing their plan, and sources of health information. It also presents findings from the 2005, 2006 and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008 EBRI/MGA Consumer Engagement in Health Care Survey. The 2009 EBRI/MGA Consumer Engagement in Health Care Survey was conducted within the United States between August 8 and August 20, 2009, through a 14-minute Internet survey. The national or base sample was drawn from Synovate's online panel of Internet users who have agreed to participate in research surveys. Over 2,000 adults (n=2,007) ages 21 to 64 who have health insurance through an employer or purchased directly from a carrier were drawn randomly from the Synovate sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 27.4 percent (21 percent for the base sample or national sample, and 38 percent for the oversample). The margin of error for the national sample was ±2.2 percent.

To examine the issues mentioned above, the sample was divided into one of three groups: those with a consumer-driven health plan (CDHP), those with a high-deductible health plan (HDHP), and those with traditional health coverage. Individuals were assigned to the CDHP and HDHP group if they had a deductible of at least $1,000 for individual coverage or $2,000 for family coverage. To be assigned to the CDHP group, they must also have an account, such as a health savings account (HSA) or health reimbursement arrangement (HRA) with a rollover provision that they can use to pay for medical expenses or the ability to take their account with them should they change jobs. Individuals with only a flexible spending account (FSA) were not included in the CDHP group.

Individuals were assigned to the HDHP group if they did not have an account used for health care expenses with a rollover provision or portability if they changed jobs. This group includes individuals with HSA-eligible health plans but may also include individuals with high-deductibles who are not eligible to contribute to an HSA. Individuals with traditional health coverage include a broad range of plan types, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), other managed care plans, and plans with a broad variety of cost-sharing arrangements. The shared characteristic of this group is that they either have no deductible or deductibles that are below current thresholds that would quality for HSA tax preference, and that they do not have an HRA-based plan.

Because the base sample (national sample) included only 94 individuals in a CDHP and 262 individuals with a HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 879 individuals with a CDHP and 1,340 individuals with a HDHP, resulting in a total sample (base plus oversample) of 972 for the CDHP group and 1,603 for the HDHP group. After factoring out of the base sample the 94 individuals with a CDHP and the 262 individuals with a HDHP, there are 1,651 individuals in the sample with traditional health coverage.

In addition to being stratified, the base sample was also weighted by gender, age, education, region, income, and race/ethnicity to reflect the actual proportions in the population age 21–64 with private health insurance coverage.[13] The CDHP and HDHP oversamples were weighted by gender, age, income and race/ethnicity, using the demographic profile of the CDHP and HDHP respondents to the omnibus survey described below.

To efficiently identify respondents who would qualify for the CDHP and HDHP oversamples, the study used Synovate's omnibus survey of more than 87,000 online panel members who met the study's criteria (having private insurance and age 21–64.) The following three questions were used in the June and July Omnibus Surveys to identify likely CDHP and HDHP respondents:

[ALL THREE QUESTIONS TO BE ASKED OF THOSE AGE 21-64]

1. Which of the following best describes your current health insurance status:

   I have health insurance through a government plan such as Medicare, Medicaid, or Veterans benefits.....1

I have health insurance through my job or the job of another family member (such as spouse or parent).....2
I have health insurance that I purchase from a health insurance company 3
I have other health insurance (specify _____) 4
I do not have health insurance currently 5

[IF Q1 = 1,5, SKIP THE OTHER 2 QUESTIONS]

2. Which of the following best describes your health plan's deductible:

[A deductible is the amount you have to pay before your insurance plan will start paying any part of your medical bills.]

No deductible
Individual or Single Coverage
My deductible is less than $1,000
My deductible is $1,000 or more
Don't know amount of individual deductible
Family Coverage
My deductible is less than $2,000 for me and my family
My deductible is $2,000 or more for me and my family
Don't know amount of family deductible
Don't know if have deductible

3. Do you have a special account or fund you can use to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal care accounts, Personal medical funds, or Choice funds, and are different from employer-provided Flexible Spending Accounts.

Yes
No
Not sure

While panel Internet surveys are non-random, studies have demonstrated that such surveys, when carefully designed, obtain results comparable to random-digit-dial telephone surveys. Taylor (2003), for example, provides the results from a number of surveys that were conducted at the same time using the same questionnaires both via telephone and online. He found that the use of demographic weighting alone was sufficient to bring almost all of the results from the online survey close to the replies from the parallel telephone survey. He also found that in some cases propensity weighting (meaning the propensity for a certain type of person to be online) reduced the remaining gaps, but in other cases it did not reduce the remaining gaps. Perhaps the most striking difference in demographics between telephone and online surveys was the under-representation of minorities in online samples.

Definitions

Health Savings Accounts

A health savings account (HSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. Contributions to the account are deductible from taxable income, even for individuals who do not itemize their taxes, and tax-free distributions for qualified medical expenses are not counted in taxable income. Tax-free distributions are also allowed for certain premiums.

HSAs are owned by the individual with the high-deductible health plan and are completely portable. There is no use-it-or-lose-it rule associated with HSAs, as any money left in the account at the end of the year automatically rolls over and is available in the following year.

In order to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than $1,150 for self-only coverage and $2,300 for family coverage (minimum deductible amounts are increasing to $1,200 and $2,400 in 2010). Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $5,800 for self-only coverage and $11,600 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit are indexed to inflation. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services. An individual can have a health plan with a deductible and maximum out-of-pocket limit that qualifies him or her to make a tax-free contribution to an HSA, but the individual is not required to make a contribution or open an account.

Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer and deductible from adjusted gross income if made by the individual. The maximum annual contribution is $3,000 for self-only coverage and $5,950 for family coverage in 2009, increasing to $3,050 and $6,150 in 2010.

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.[14] Individuals enrolled in Medicare are not eligible to make HSA contributions, although they are able to withdraw money from the HSA for qualified medical expenses and certain premiums.[15] Individuals also may not make an HSA contribution if claimed as a dependent on another person's tax return.

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2009, a $1,000 catch-up contribution was allowed. The catch-up contribution is not indexed to inflation.

Distributions from an HSA can be made at any time. An individual need not be covered by a high-deductible health plan to withdraw money from the HSA (although he or she must have been covered by a high-deductible health plan at the time the funds were placed in the HSA). Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under Internal Revenue Code (IRC) Sec. 213(d). Distributions for premiums for COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare other than for Medigap, are also tax-free. This means that distributions used to pay Medicare Part A or B, Medicare Advantage plan premiums, and the employee share of the premium for employment-based retiree health benefits are allowed on a tax-free basis.

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 10 percent penalty, which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

Individuals are able to roll over funds from one HSA into another HSA without subjecting the distribution to income and penalty taxes as long as the rollover does not exceed 60 days. Rollover contributions from Archer MSAs are also permitted. Earnings on contributions are also not subject to income taxes.

Health Reimbursement Arrangements

A health reimbursement arrangement (HRA) is an employer-funded health plan that reimburses employees for qualified medical expenses. HRAs are typically combined with a high-deductible health plan, though this is not required. HRAs can also be offered on a stand-alone basis or with comprehensive insurance that does not use a high deductible. Employees are eligible for an HRA only when their employer offers such a health plan.

Employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. For example, the amount of money that is placed in the account, the level of the deductible, and the comprehensiveness of the health insurance are all subject to variation. Employers often cover certain preventive services in full, not subjecting them to the deductible. Employers can offer comprehensive health insurance that covers 100 percent of health care costs after the deductible has been met or they may offer coverage with cost sharing after the deductible is met. If employers choose to pay less than 100 percent of health care expenses after the deductible has been met, they then have the option of designing the plan with or without a maximum out-of-pocket limit.

There is no statutory requirement that an employee have a high-deductible health plan in order to also have an HRA. However, it is standard practice among employers that an employee must also choose a high-deductible health plan in order to have an HRA.

HRAs are typically set up as notional arrangements and exist only on paper. Employees may view the account as if money was actually being deposited into an account, but employers do not incur expenses associated with the arrangement until an employee incurs a claim. By contrast, were employers to set up the HRA on a funded basis, they would incur the full expense at the time of the contribution, even if an employee had not incurred any expenses.

HRAs can be thought of as providing "first-dollar" coverage until funds in the account are exhausted. Leftover funds at the end of each year can be carried over to the following year (at the employer's discretion), allowing employees to accumulate funds over time, and, in principle, creating the key incentive for individuals to make health care purchases responsibly. Employers can place restrictions on the amount that can be carried over.

Distributions from an HRA for qualified medical expenses are made on a tax-favored basis. Employers can also let employees use an HRA to purchase health insurance directly from an insurer. Since unused funds are allowed to roll over, employees are able to accumulate funds over time. Employers can allow former employees to use any leftover money in the HRA to continue to cover qualified medical expenses. Funds can be used for out-of-pocket expenses and premiums for insurance, long-term care, COBRA, and retiree health benefits. Employers are not required to make unused balances available to workers when they leave.

References

Chernew, Michael E., Allison B. Rosen, and A. Mark Fendrick. "Value-Based Insurance Design." *Health Affairs* Web Exclusive, (Jan. 10, 2007): w195-w203.

Claxton, Gary, et al. "Health Benefits In 2008: Premium Moderately Higher, While Enrollment in Consumer-Directed Plans Rises In Small Firms." *Health Affairs* Web Exclusive (Sept.24, 2008):w492-w502.

Fronstin, Paul. *Consumer Driven Health Benefits: A Continuing Evolution?* Washington, DC: Employee Benefit Research Institute, 2002.

_____. "Health Savings Accounts and Other Account-Based Health Plans." *EBRI Issue Brief,* no. 273 (Employee Benefit Research Institute, September 2004).

_____. "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" *EBRI Issue Brief,* no. 312 (Employee Benefit Research Institute, December 2007).

_____. "Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2009 Current Population Survey." *EBRI Issue Brief* no. 333 (Employee Benefit Research Institute, September 2009a).

_____. "Availability, Contributions, Account Balances, and Rollovers in Account-Based Health Plans, 2006–2009." *EBRI Notes,* no. 11 (Employee Benefit Research Institute, November 2009b).

Fronstin, Paul, and Sara R. Collins. "Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey." *EBRI Issue Brief,* no. 315 (Employee Benefit Research Institute, March 2008).

Taylor, Humphrey. "Does Internet Research 'Work'? Comparing Online Survey Results With Telephone Surveys." *International Journal of Market Research*. Vol. 42, no. 1 (August 2003).

Endnotes

[1] Calculated from Figure 1.

[2] More information about HRAs and HSAs can be found in the definitions section on pg. 39 and in Fronstin (2002 and 2004).

[3] See www.mercer.com/summary.htm?idContent=1328445

[4] See www.healthcaredisclosure.org/

[5] See Appendix for more detail on the methodology.

[6] Traditional plans include a broad range of plan types, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), other managed care plans and plans with a broad variety of cost-sharing arrangements. The shared characteristic of this group is that they either have no deductible or deductibles that are below current thresholds that would quality for a tax-preferred HSA contribution or that are generally associated with HRAs.

[7] See Fronstin (2007) and http://ehbs.kff.org/pdf/2009/7936.pdf

[8] Fronstin (2009b).

[9] See Figure 11 Fronstin (2009b).

[10] The specific questions were as follows: Does your employer offer any of the following wellness programs?

- Health risk assessment, where you answer a questionnaire and then a medical professional examines your health history to identify any conditions you may have or that you might be at risk for developing.

- Programs for improving your health, like for weight loss, walking or other exercise, nutrition, stress management, smoking cessation, and so on.

[11] For analytic purposes, reports of chronic health conditions and fair or poor health were combined into an indicator of health problems. People were defined as having a health problem if they said they were in fair or poor health or had one of eight chronic health conditions (arthritis, asthma, emphysema or lung disease, cancer, depression, diabetes, heart attack or other heart disease, high cholesterol or hypertension, high blood pressure, or stroke).

[12] According to Claxton, et al. (2008), 28 percent of employers offering coverage through HSA-qualified HDHPs do not make contributions toward the HSAs that their workers establish. This accounts for 26 percent of covered workers enrolled in HSA-qualified HDHPs.

[13] In theory, a random sample of 2,007 yields a statistical precision of ±2.2 percentage points (with 95 percent confidence) of what the results would be if the entire population ages 21–64 with private health insurance coverage were surveyed with complete accuracy. There are also other possible sources of error in all surveys that may be more serious than theoretical calculations of sampling error. These include refusals to be interviewed and other forms of nonresponse, the effects of question wording and question order, and screening. While attempts are made to minimize these factors, it is impossible to quantify the errors that may result from them.

[14] Permitted insurance also includes workers' compensation, tort liabilities, and liabilities related to ownership or the use of property (such as automobile insurance).

[15] Only Medicare enrollees ages 65 and older are allowed to pay insurance premiums from an HSA. A Medicare enrollee under age 65 cannot use an HSA to pay insurance premiums.

ebri.org
Employee Benefit Research Institute

Where the world turns for the facts on U.S. employee benefits.

Retirement and health benefits are at the heart of workers', employers', and our nation's economic security. Founded in 1978, EBRI is the most authoritative and objective source of information on these critical, complex issues.

EBRI focuses solely on employee benefits research — no lobbying or advocacy

EBRI stands alone in employee benefits research as an independent, nonprofit, and nonpartisan organization. It analyzes and reports research data without spin or underlying agenda. All findings, whether on financial data, options, or trends, are revealing and reliable — the reason EBRI information is the gold standard for private analysts and decision makers, government policymakers, the media, and the public.

EBRI explores the breadth of employee benefits and related issues

EBRI studies the world of health and retirement benefits — issues such as 401(k)s, IRAs, retirement income adequacy, consumer-driven benefits, Social Security, tax treatment of both retirement and health benefits, cost management, worker and employer attitudes, policy reform proposals, and pension assets and funding. There is widespread recognition that if employee benefits data exist, EBRI knows it.

EBRI delivers a steady stream of invaluable research and analysis

- EBRI publications include in-depth coverage of key issues and trends; summaries of research findings and policy developments; timely factsheets on hot topics; regular updates on legislative and regulatory developments; comprehensive reference resources on benefit programs and workforce issues; and major surveys of public attitudes.
- EBRI meetings present and explore issues with thought leaders from all sectors.
- EBRI regularly provides congressional testimony, and briefs policymakers, member organizations, and the media on employer benefits.
- EBRI issues press releases on newsworthy developments, and is among the most widely quoted sources on employee benefits by all media.
- EBRI directs members and other constituencies to the information they need, and undertakes new research on an ongoing basis.
- EBRI maintains and analyzes the most comprehensive database of 401(k)-type programs in the world. Its computer simulation analyses on Social Security reform and retirement income adequacy are unique.

EBRI makes information freely available to all

EBRI assumes a public service responsibility to make its findings completely accessible at www.ebri.org — so that all decisions that relate to employee benefits, whether made in Congress or board rooms or families' homes, are based on the highest quality, most dependable information. EBRI's Web site posts all research findings, publications, and news alerts. EBRI also extends its education and public service role to improving Americans' financial knowledge through its award-winning public service campaign *ChoosetoSave*® and the companion site www.choosetosave.org

EBRI is supported by organizations from all industries and sectors that appreciate the value of unbiased, reliable information on employee benefits. Visit www.ebri.org/about/join/ for more.

1100 13th Street NW · Suite 878
Washington, DC 20005
(202) 659-0670
www.ebri.org
www.choosetosave.org

ebri.org
Employee Benefit Research Institute

Issue BRIEF

EBRI Employee Benefit Research Institute Issue Brief (ISSN 0887–137X) is published monthly by the Employee Benefit Research Institute, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, at $300 per year or is included as part of a membership subscription. Periodicals postage rate paid in Washington, DC, and additional mailing offices. POSTMASTER: Send address changes to: *EBRI Issue Brief,* 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051.

Who we are

The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI's membership includes a cross-section of pension funds; businesses; trade associations; labor unions; health care providers and insurers; government organizations; and service firms.

What we do

EBRI's work advances knowledge and understanding of employee benefits and their importance to the nation's economy among policymakers, the news media, and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. **EBRI's Education and Research Fund** (EBRI-ERF) performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants.

Our publications

EBRI Issue Briefs are periodicals providing expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. ***EBRI Notes*** is a monthly periodical providing current information on a variety of employee benefit topics. EBRI's ***Pension Investment Report*** provides detailed financial information on the universe of defined benefit, defined contribution, and 401(k) plans. EBRI ***Fundamentals of Employee Benefit Programs*** offers a straightforward, basic explanation of employee benefit programs in the private and public sectors. The ***EBRI Databook on Employee Benefits*** is a statistical reference work on employee benefit programs and work force-related issues. www.ebri.org

Orders/ Subscriptions

Contact EBRI Publications, (202) 659-0670; fax publication orders to (202) 775-6312. Subscriptions to *EBRI Issue Briefs* are included as part of EBRI membership, or as part of a $199 annual subscription to *EBRI Notes* and *EBRI Issue Briefs*. Individual copies are available with prepayment for $25 each (for printed copies). ***Change of Address:*** EBRI, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, (202) 659-0670; fax number, (202) 775-6312; e-mail: subscriptions@ebri.org ***Membership Information:*** Inquiries regarding EBRI membership and/or contributions to EBRI-ERF should be directed to EBRI President/ASEC Chairman Dallas Salisbury at the above address, (202) 659-0670; e-mail: salisbury@ebri.org

EBRI Issue Brief is registered in the U.S. Patent and Trademark Office. ISSN: 0887–137X/90 0887–137X/90 $ .50+.50