

Notes

Employer and Worker Contributions to Account-Based Health Plans, 2006–2010, p. 2

EXECUTIVE SUMMARY

Employer and Worker Contributions to Account-Based Health Plans, 2006–2010

CONSUMER-DRIVEN HEALTH SURVEYS: This report presents findings from the 2010 EBRI/MGA Consumer Engagement in Health Care Survey, as well as earlier surveys, examining the availability of health reimbursement arrangement (HRA) and health savings account (HSA)-eligible plans (consumer-driven health plans, or CDHPs). It also looks at employer and individual contribution behavior.

EMPLOYER CONTRIBUTION LEVELS FALLING: The percentage of workers reporting that their employer contributes to the account was unchanged. But among those with an employer contribution, overall contribution levels have fallen.

INDIVIDUAL CONTRIBUTION LEVELS INCREASING: Individuals with employee-only coverage increased their contribution levels, but those with family coverage did not. Persons in lower-income households were more likely to report that they increased their contributions; however, those in higher-income households did not.

Employer and Worker Contributions to Account-Based Health Plans, 2006–2010

by Paul Fronstin, *Employee Benefit Research Institute*

Introduction

Employers have been interested in bringing aspects of consumerism into health plans for many years. As far back as 1978, they adopted Sec. 125 cafeteria plans and flexible spending accounts. More recently, employers have been increasingly turning their attention to consumer engagement in health care. In 2001, they introduced 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. A few employers first started offering account-based health plans in 2001, when they began to offer health reimbursement arrangements (HRAs).¹ In 2004, they started offering health plans with health savings accounts (HSAs).² By 2009, 15 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 also taken a broader approach to consumer engagement through various other initiatives.⁴

This report presents findings from the 2008, 2009, and 2010 EBRI/MGA Consumer Engagement in Health Care Survey and the 2006 and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys.⁵ It examines the availability of HRA and HSA-eligible plans (consumer-driven health plans, or CDHPs), as well as employer and individual contribution behavior.

CDHP Eligibility

According to the 2010 EBRI/MGA Consumer Engagement in Health Care Survey, about 5.7 million adults ages 21–64 with private health insurance, or 5 percent of the adult population with private health insurance, were enrolled in an HRA or had a high-deductible plan with an HSA in 2010, up from 4 percent in 2009. An additional 6.3 million adults ages 21–64 with private health insurance, or 4.5 percent, reported that they were eligible for an HSA but did not have such an account. Thus, overall, 12.1 million adults ages 21–64 with private insurance, representing 9.5 percent of that market, were either in a CDHP or a high-deductible plan that was eligible for an HSA, but had not opened an account.

It was found that a significant percentage of workers with traditional health benefits were eligible for account-based health plans. Among individuals with traditional employment-based health benefits and a choice of health plan, 38 percent were eligible for an HRA or HSA-based plan in 2010, about the same percentage as were eligible for such plans in 2008 and 2009 (Figure 1).

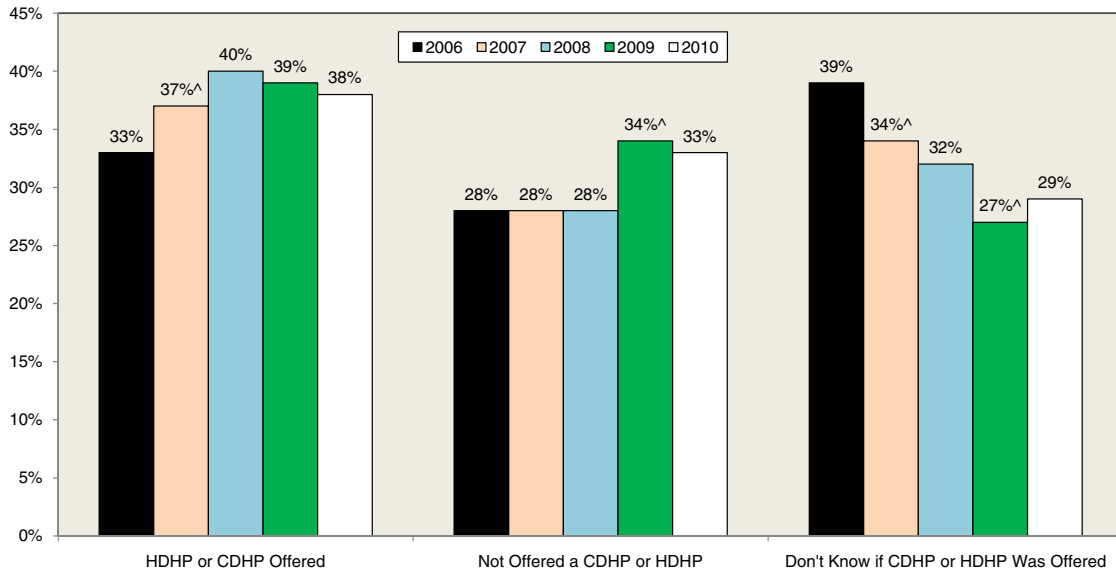
Employer Contributions

Nearly two-thirds of workers with an HRA or HSA reported that their employer contributed to the account in 2010 (Figure 2). The percentage of workers with an HRA or HSA plan whose employer contributed to the account did not change significantly after 2006, other than a drop from 67 percent in 2008 to 63 percent in 2009.

Among workers with an employer contribution, those with employee-only coverage saw their annual employer contributions increase between 2006 and 2008, but fall in 2009 and 2010. Between 2006 and 2008, the percentage reporting that their employer contributed \$1,000 or more to the account increased from 26 percent to 37 percent (Figure 3). It fell to 32 percent in 2009 and to 28 percent in 2010. The percentage of workers with an employer contribution of \$200–\$499 increased from 14 percent to 17 percent between 2009 and 2010, although the increase was not statistically significant.

Among workers with family coverage, employer contribution levels decreased as well in 2010. The percentage reporting a contribution of \$500–\$749 increased from 6 percent to 12 percent between 2009 and 2010, while the

Figure 1
Percentage of Individuals With Traditional¹ Employment-Based Health Benefits Offered HDHP² or CDHP,³ 2006–2010



Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.

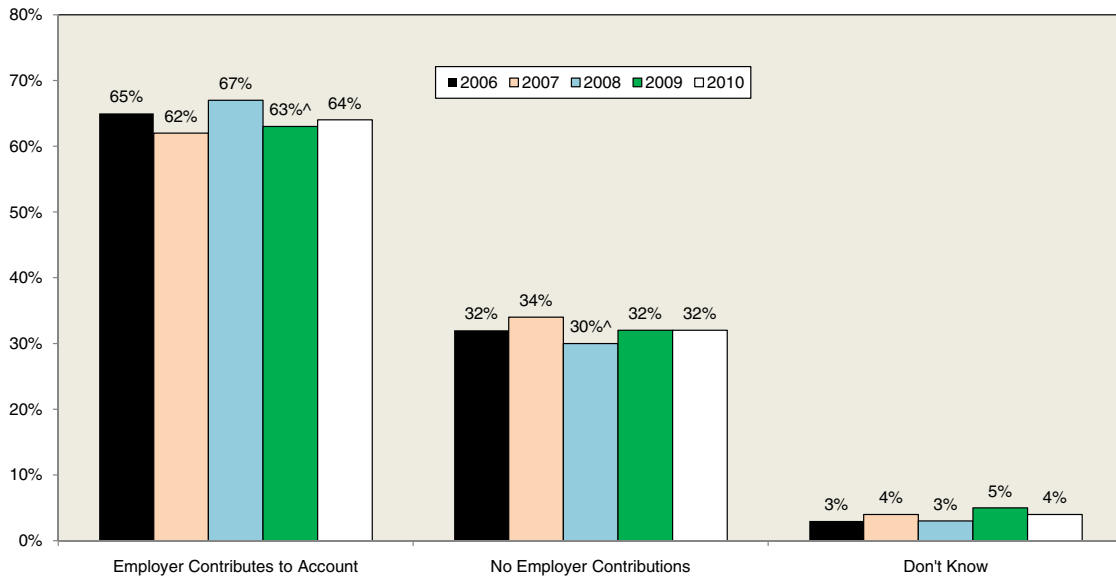
¹ Traditional = health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).

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

³ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.

[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 2
Percentage of Individuals With Employer Contribution to Account, Among Persons With Employment-Based Health Benefits and CDHP,¹ 2006–2010

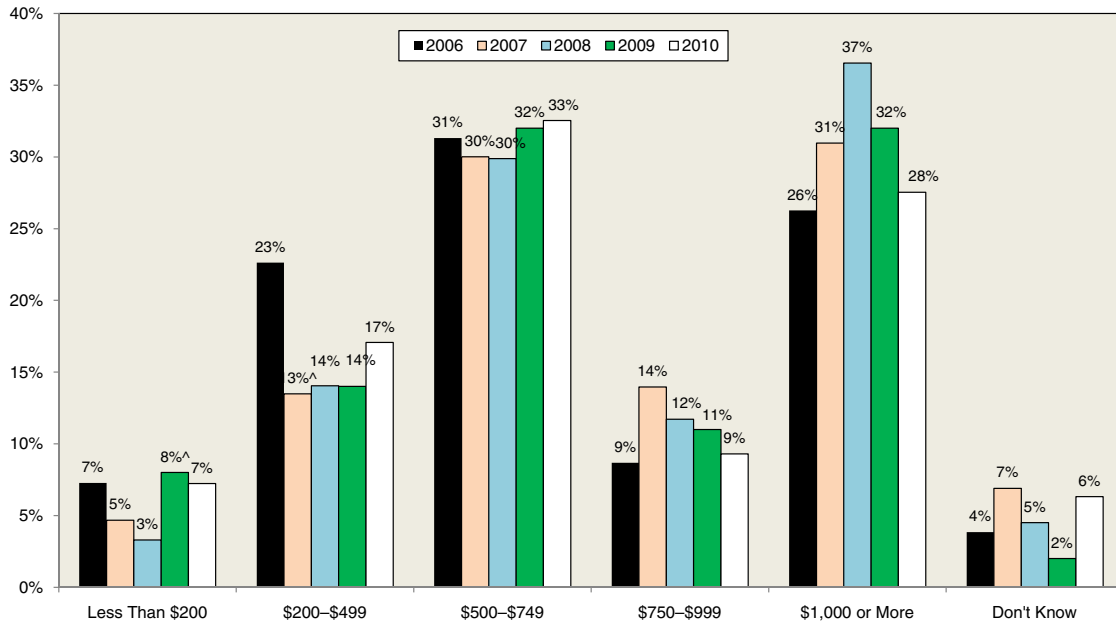


Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.

¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.

[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 3
Annual Employer Contributions to the Account,
Among Persons With Employee-Only CDHP,¹ 2006–2010

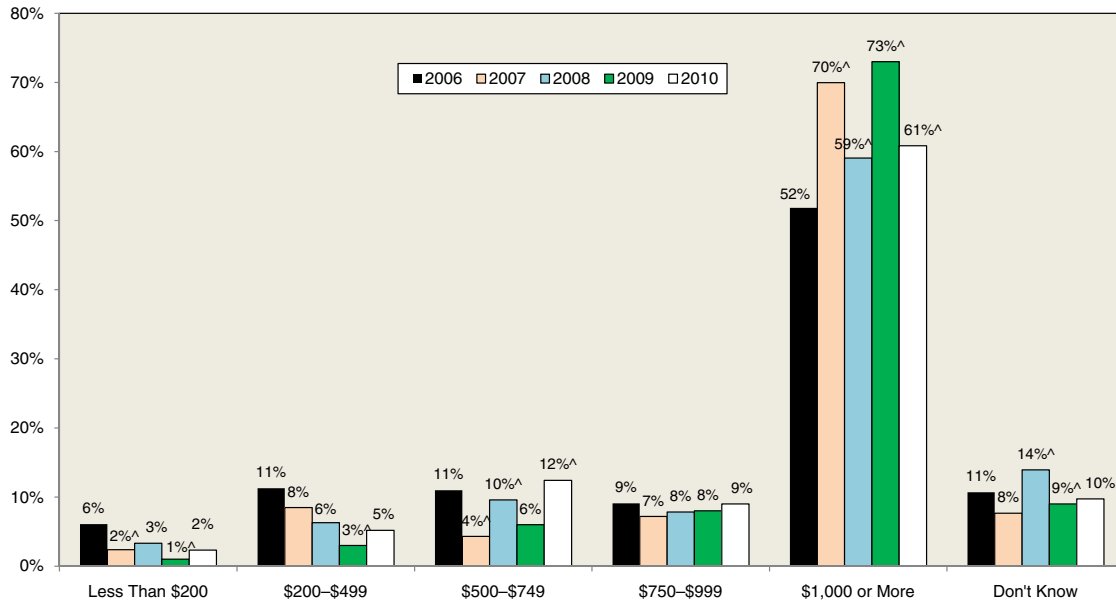


Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.

¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.

[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 4
Annual Employer Contributions to the Account,
Among Persons With Family CDHP,¹ 2006–2010



Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.

¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.

[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

percentage reporting a contribution of \$1,000 or more decreased from 73 percent to 61 percent (Figure 4). However, a majority of workers with family coverage continued to receive a contribution of \$1,000 or more.

Individual Contributions

Individuals' contributions to HSA plans have increased. Between 2006 and 2009, the percentage of individuals with employee-only coverage contributing nothing to an HSA decreased from 28 percent to 12 percent (Figure 5). It increased to 15 percent in 2010 but the change was not statistically significant. In contrast, the percentage contributing between \$1,000 and \$1,499 increased from 12 percent in 2009 to 18 percent in 2010, while the percentage contributing \$1,500 or more remained at 37 percent.

Among persons with family coverage, contribution levels were unchanged in 2010. The percentage not making any contributions was unchanged at 12 percent in 2010. The percentage contributing less than \$500 was 8 percent, while the percentage contributing \$1,500 or more was 50 percent (Figure 6). Individuals with family coverage are expected to contribute more than individuals with employee-only coverage because deductibles are higher for family coverage.

Income Differences

Generally, lower-income persons with HSAs are less likely to make a contribution to the account than higher-income persons. One-fifth of persons in households with less than \$50,000 in income did not contribute to the account in 2010 (Figure 7), compared with 12 percent of persons with \$50,000 or more in household income who did not contribute (Figure 8). For the lower-income group, the percentage contributing \$1,500 or more increased between 2009 and 2010 from 21 percent to 31 percent, but among the higher-income group, the percentage contributing \$1,500 or more fell from 54 percent to 47 percent.

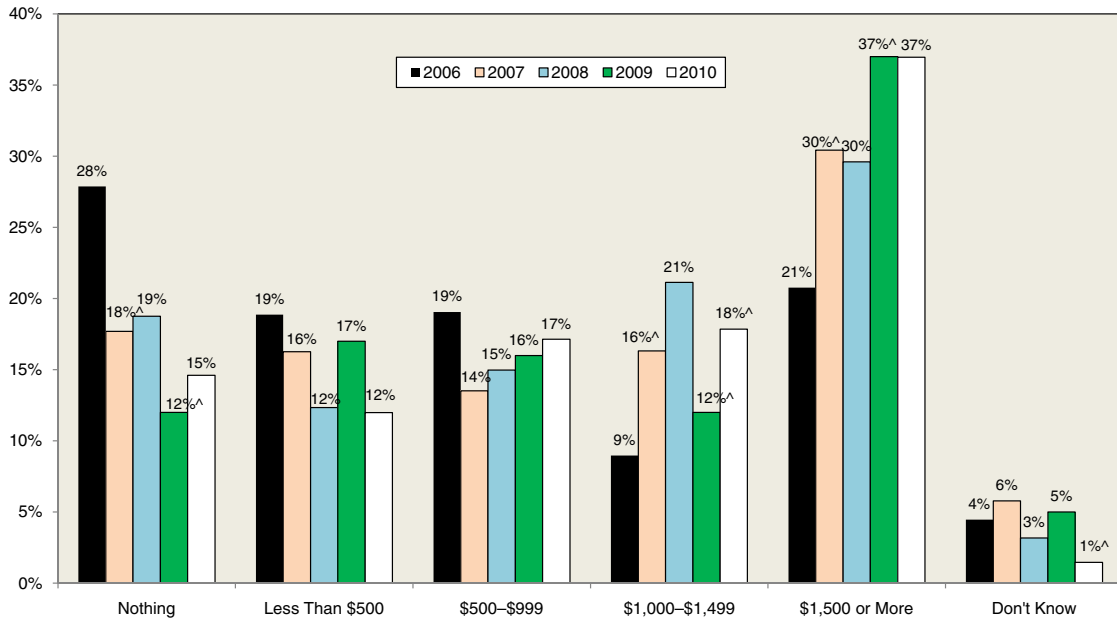
Health Differences

Persons with a health condition were slightly more likely than those without one to contribute to an HSA.⁶ Those with health problems contribute slightly more than those without health problems. Among persons without health problems, 40 percent contributed \$1,500 or more in 2010 (Figure 9). Similarly, 51 percent of those with a health problem contributed \$1,500 or more in 2010 (Figure 10).

Conclusion

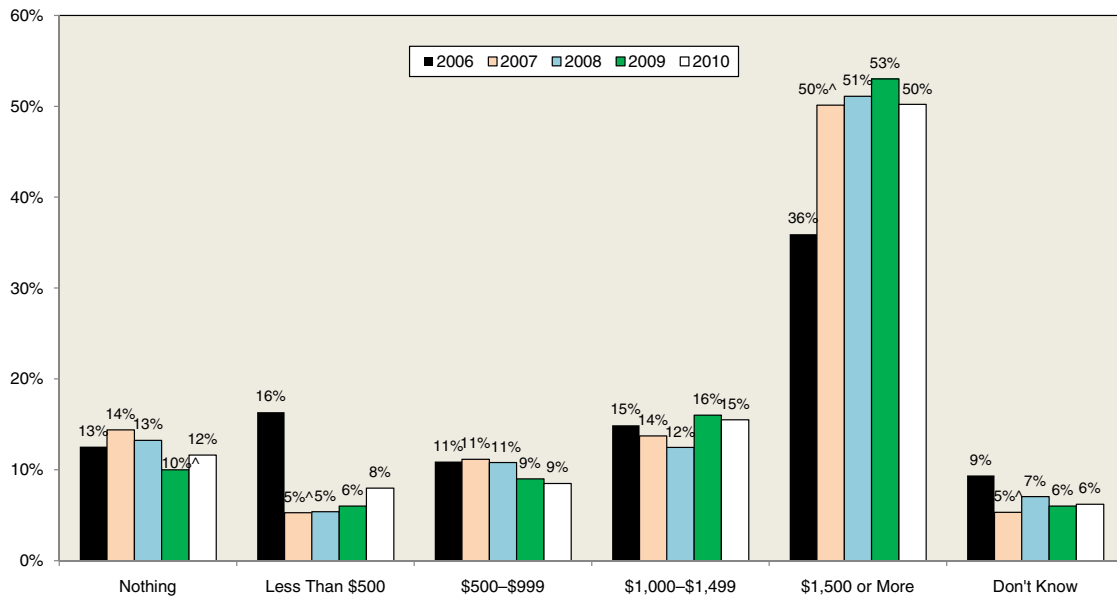
The share of the adult population with private health insurance enrolled in an HRA or had a high-deductible plan with an HSA remains small but continues to grow. For the second year in a row it was found that the percentage of workers reporting that their employer contributed to the account declined. In 2008, 37 percent of workers reported an employer contribution of \$1,000 or more. By 2010, it was down to 28 percent. This may be due to the weak economy. Workers with employee-only coverage responded by increasing their own contributions, but those with family coverage did not. Lower-income individuals increased their contributions, whereas higher-income individuals did not. Higher deductibles may also partly explain higher family contributions.

Figure 5
Annual Individual Contributions to the Account,
Among Persons With Employee-Only CDHP,¹ 2006–2010



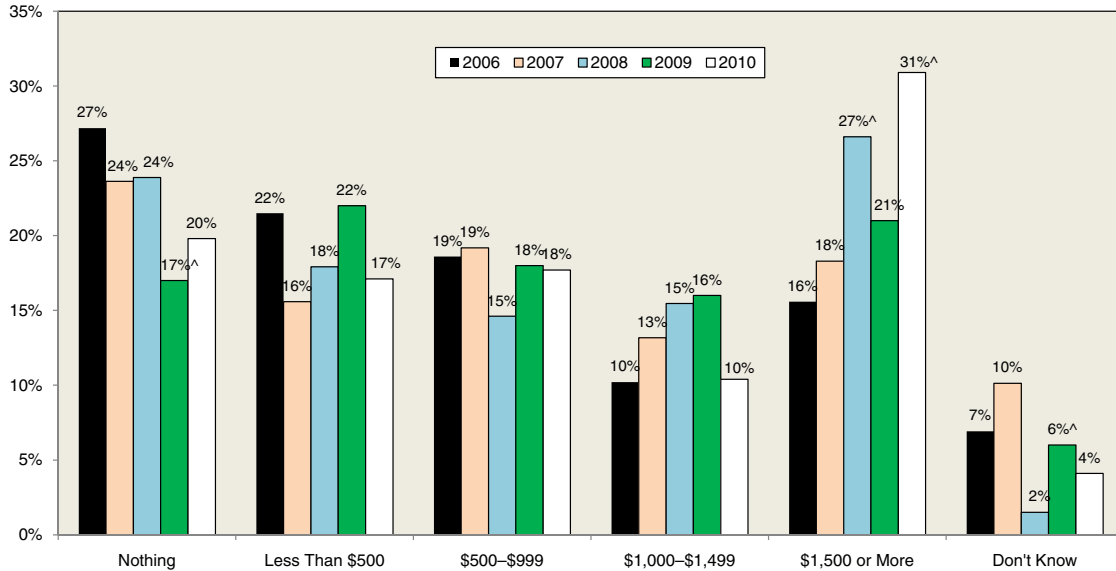
Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.
¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.
[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 6
Annual Individual Contributions to the Account,
Among Persons With Family CDHP,¹ 2006–2010



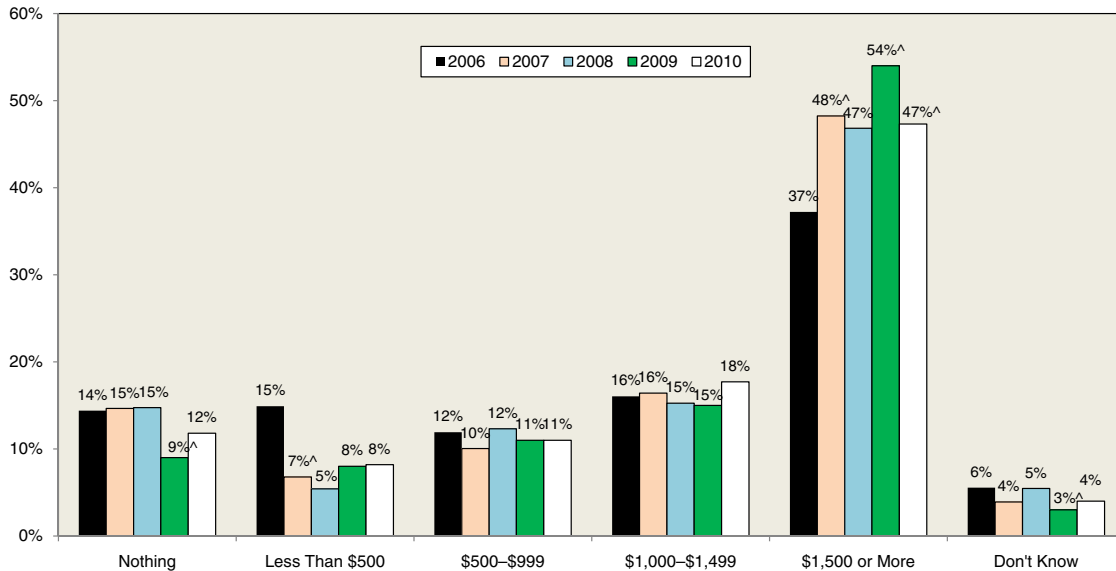
Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.
¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.
[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 7
Annual Individual Contributions to the Account,
Among Persons With Employee-Only or Family CDHP¹
and Household Income Under \$50,000, 2006–2010



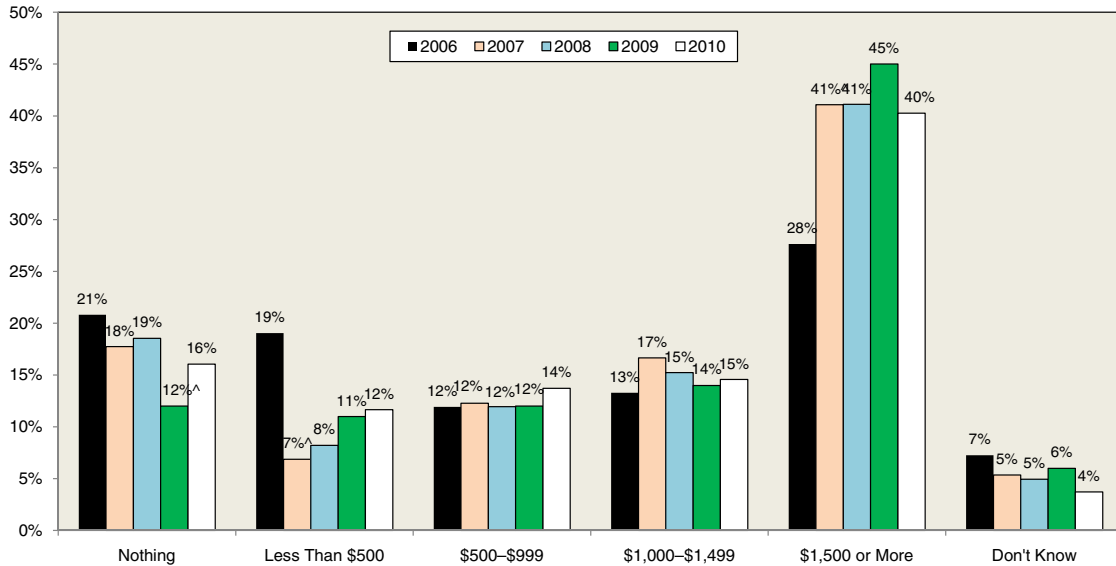
Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.
¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.
[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 8
Annual Individual Contributions to the Account,
Among Persons With Employee-Only or Family CDHP¹
and Household Income \$50,000 or More, 2006–2010



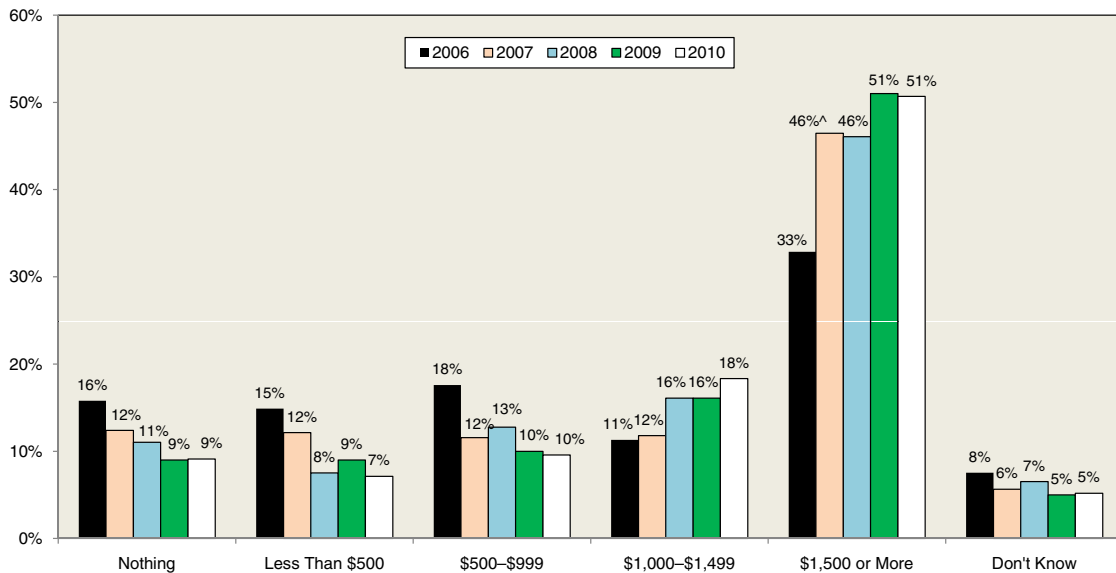
Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.
¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.
[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 9
Annual Individual Contributions to the Account,
Among Persons With Employee-Only or Family CDHP¹
and No Health Problems, 2006–2010



Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.
¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.
[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Figure 10
Annual Individual Contributions to the Account,
Among Persons With Employee-Only or Family CDHP¹
and Health Problem, 2006–2010



Source: Employee Benefit Research Institute/Commonwealth Fund Consumerism in Health Care Survey, 2006 and 2007; Employee Benefit Research Institute/MGA Consumer Engagement in Health Care Survey, 2008–2010.
¹ CDHP = Consumer-driven health plan with deductible \$1,000+ (individual), \$2000+ (family), with account.
[^] Difference from prior year shown is statistically significant at $p \leq 0.05$ or better.

Endnotes

¹ See Paul Fronstin, "Can 'Consumerism' Slow the Rate of Health Benefit Cost Increases?" *EBRI Issue Brief*, no. 247 (Employee Benefit Research Institute, July 2002).

² Paul Fronstin, "Health Savings Accounts and Other Account-Based Health Plans," *EBRI Issue Brief*, no. 273 (Employee Benefit Research Institute, September 2004).

³ See <http://www.mercer.com/press-releases/1364345>

⁴ 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 (see www.healthcaredisclosure.org/). In 2002, there was interest in tiered provider networks (see Paul Fronstin, "Tiered Networks for Hospital and Physician Health Care Services," *EBRI Issue Brief*, no. 260 (Employee Benefit Research Institute, August 2003). 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 (see Michael E. Chernew, Allison B. Rosen, and A. Mark Fendrick, "Value-Based Insurance Design," *Health Affairs Web Exclusive* (Jan. 10, 2007): w195-w203).

⁵ More information about the surveys can be found in Paul Fronstin and Sara Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans," *EBRI Issue Brief*, no. 300 (Employee Benefit Research Institute, December 2006); Paul Fronstin and Sara R. Collins, "Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey," *EBRI Issue Brief*, no. 315 (Employee Benefit Research Institute, March 2008); Paul Fronstin, "Findings from the 2008 EBRI Consumer Engagement in Health Care Survey," *EBRI Issue Brief*, no. 323 (Employee Benefit Research Institute, November 2008); and Paul Fronstin, "Findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey," *EBRI Issue Brief*, no. 337 (Employee Benefit Research Institute, December 2009).

⁶ Individuals 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).

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General Reference

U.S. Census Bureau. *Statistical Abstract of the United States: 2011*. 130th Edition. \$43. Order from GPO.

Health Care

Buck Consultants, LLC. *Working Well: A Global Survey of Health Promotion and Workplace Wellness Strategies: Survey Report*. \$325. Buck Consultants, A Xerox Company, Attn: Global Survey Resources, 50 Fremont St., 12th Floor, San Francisco, CA 94105, (800) 887-0509, www.bucksurveys.com

Health Forum LLC, an affiliate of the American Hospital Association. *AHA Hospital Statistics™*. 2011 Edition. AHA members, \$180; nonmembers, \$240. AHA Services, Inc., P.O. Box 933283, Atlanta, GA 31193-3283, (800) 242-2626, fax: (866) 516-5817, www.ahadata.com

Pension Plans/Retirement

U.S. Government Accountability Office. (1) *401(k) Plans: Improved Regulation Could Better Protect Participants from Conflicts of Interest*; (2) *Defined Contribution Plans: Key Information on Target Date Funds as Default Investments Should Be Provided to Plan Sponsors and Participants*. Order from GAO.

Social Security Reform

Gokhale, Jagadeesh. *Social Security: A Fresh Look at Reform Alternatives*. \$55 (e-book options available: 30-day ownership for \$7; perpetual ownership for \$55). University of Chicago Press, Chicago Distribution Center, 11030 South Langlely, Chicago, IL, 60628, (800) 621-2736, fax: (800) 621-8476, e-mail: orders@press.uchicago.edu, www.press.uchicago.edu/infoServices.html

Web Documents

Congressional Research Service: *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act*, http://assets.opencrs.com/rpts/R41586_20110113.pdf

The Segal Company: *Survey of Plans' 2010 Zone Status*, www.segalco.com/publications/surveysandstudies/winter2011zonestatus2010.pdf

Social Security Administration: *Annual Statistical Supplement to the Social Security Bulletin, 2010*, www.ssa.gov/policy/docs/statcomps/supplement/2010/index.html

U.S. Bureau of Labor Statistics: *State and Local Government Employee Benefits, March 2010*, www.bls.gov/opub/ted/2011/ted_20110309.htm



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