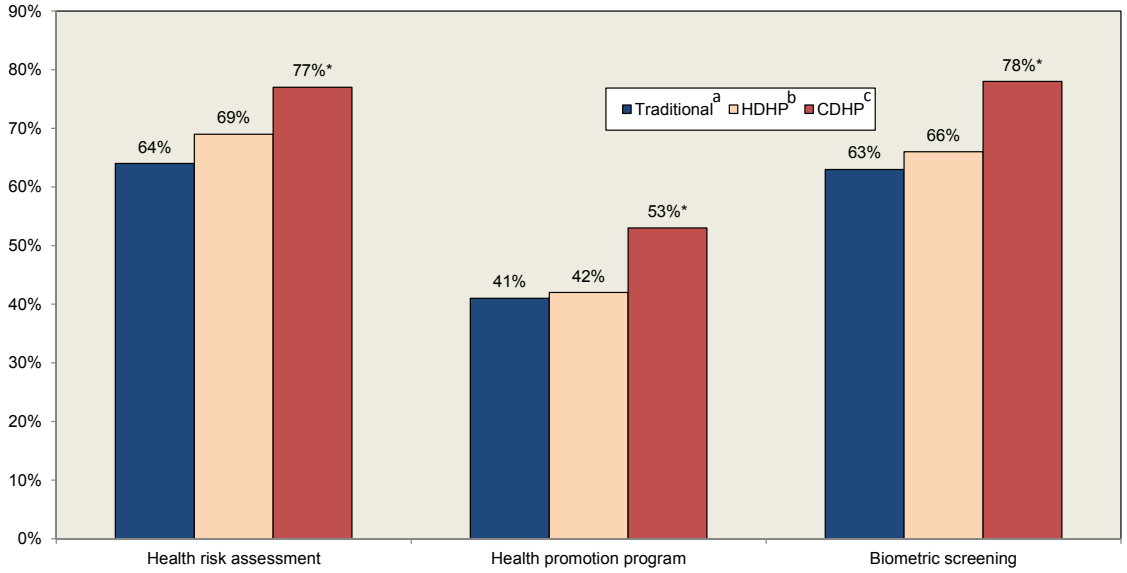
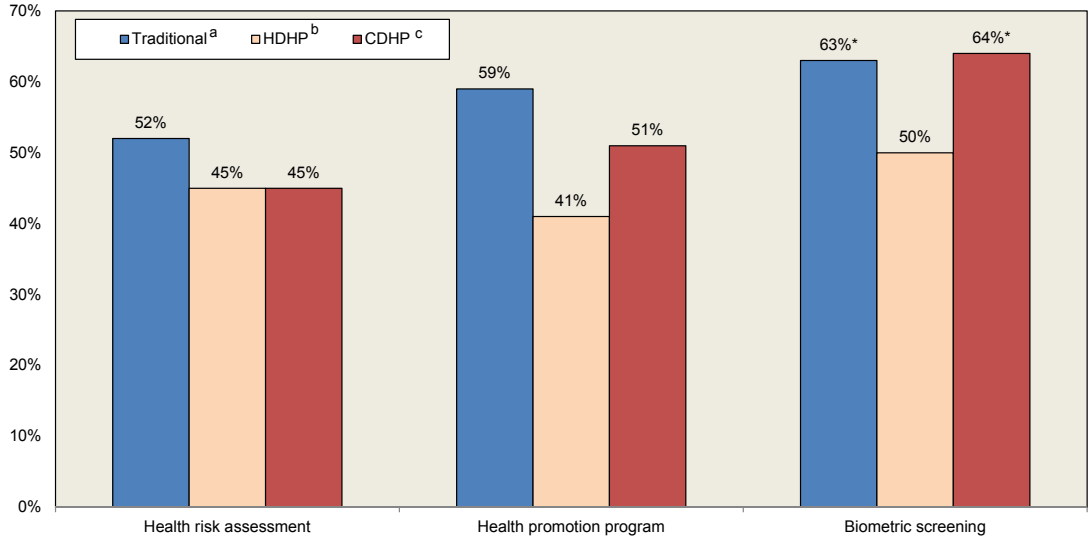
Figure 10
Individual Participates in Wellness Program Offered by Employer Among Those Offered a Wellness Program, by Type of Health Plan, 2012



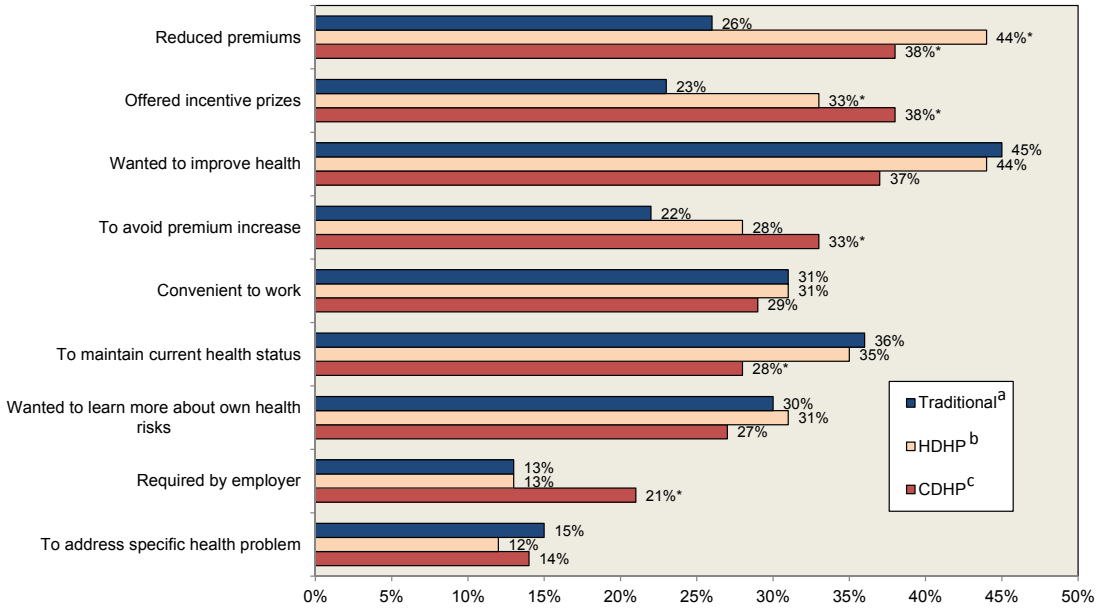
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan 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
Employer Offers Cash Incentive or Reward for Participating in Wellness Program, Among Workers Whose Employer Offers Wellness Program, by Type of Plan, 2012



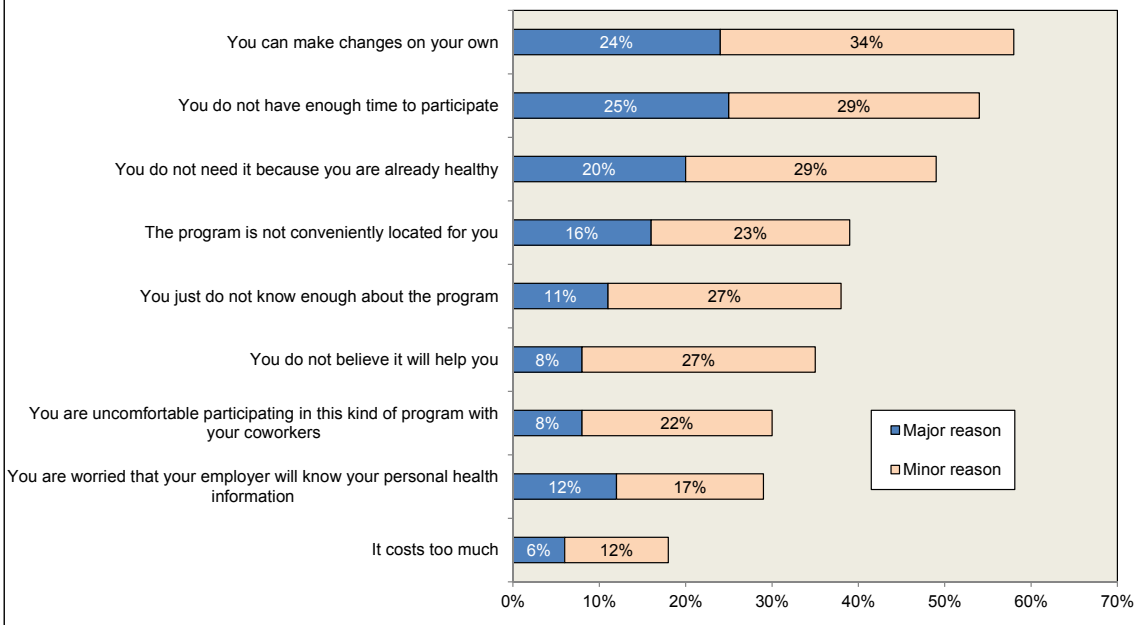
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan 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 Participating in Employers Wellness Program, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[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 13
Reasons for Not Participating in Employers Wellness Program Among Those Offered but Not Participating in Program, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Opinions about Provider Engagement

The 2012 EBRI/MGA Consumer Engagement in Health Care Survey included questions regarding the ways in which providers of health care services engage their patients. Over 80 percent of plan participants, regardless of plan type, strongly or somewhat agreed that their doctor communicated with them so that they could really understand what the doctor was saying and reported that their doctor was informed and up-to-date on their medical history (Figure 16). Roughly 80 percent reported that their doctor was accessible for appointments when the respondents were sick. Roughly 70 percent reported that their doctor understands them as a person, including their work and personal life, and beliefs, and that their doctor coaches them on staying healthy rather than just treating their health problems. Just over one-half report that their doctor provides information on after-hours care, and 21–28 percent report that their doctor is accessible by email.

Medical Homes

In 2012, the EBRI/MGA Consumer Engagement in Health Care Survey for the first time added a series of questions related to whether an individual had a "medical home." To have a medical home, the respondent must have indicated that he or she had a personal/family doctor; had timely access to care; had a doctor who knows medical history; had a provider who knew him or her as a person; and had a provider who was coordinating care. Forty percent of traditional-plan enrollees, 42 percent of HDHP enrollees, and 44 percent of CDHP enrollees were determined to have a medical home based on the criteria above, though the differences were not statistically significant (Figure 17).

Cost-Sharing Incentives

Unlike past years, there were differences by plan type. About one-fifth (21 percent) of individuals with traditional coverage reported that they would change doctors to one who used HIT if cost sharing was lower, compared to 23 percent among HDHP enrollees and 28 percent among CDHP enrollees (Figure 18). Similarly, 23 percent of individuals with traditional coverage and HDHP enrollees reported that they would change doctors to one who used HIT if cost sharing was higher, compared to 32 percent among CDHP enrollees.

Like the responses on HIT and cost sharing as incentives to switch to a doctor who uses HIT, when more specific questions were asked, statistically significant differences were found among CDHP enrollees, HDHP enrollees, and traditional-plan enrollees. CDHP enrollees were found to be more likely than traditional-plan enrollees to report that they would switch doctors to one who had a secure website for patients to access test results and make appointments, used a tablet or handheld computer to review health records and add updates during office visits, and used e-mail to interact with patients (Figure 19).

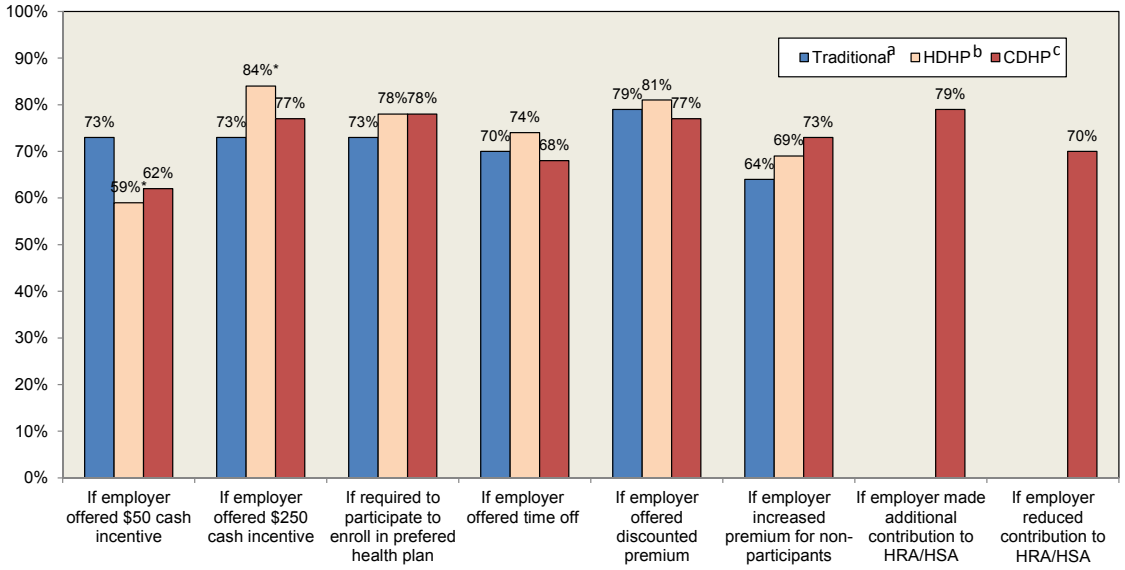
The 2012 survey examined opinions regarding the appropriate use of lower cost sharing as an incentive to change the way individuals use the health care system. Results show across-the-board interest in select networks composed of only medical providers with records of high-quality care when combined with lower cost sharing. Eleven percent of individuals in CDHPs and 10 percent of individuals with HDHPs and with traditional coverage were extremely interested in using select networks when combined with lower cost sharing (Figure 20). CDHP and HDHP enrollees were more likely than traditional-plan enrollees to be somewhat interested in the concept, with 38 percent of CDHP enrollees, 42 percent of HDHP enrollees, and 33 percent of traditional-plan enrollees somewhat interested. There was also interest in changing doctors to one in a select network, and there were few statistically significant differences by plan type (Figure 21).

Patient Use of Technology

The survey found that about three-fifths of the adult population with private health insurance had used a smartphone within the past year, and about 40 percent had used a tablet. Among those with a smartphone or tablet, 27–32 percent used a smartphone application, or "app," for nutrition information; 25–29 percent used one for general health information; 23–27 percent used one for weight management or diets; and 23–26 percent used one for exercise

Figure 14

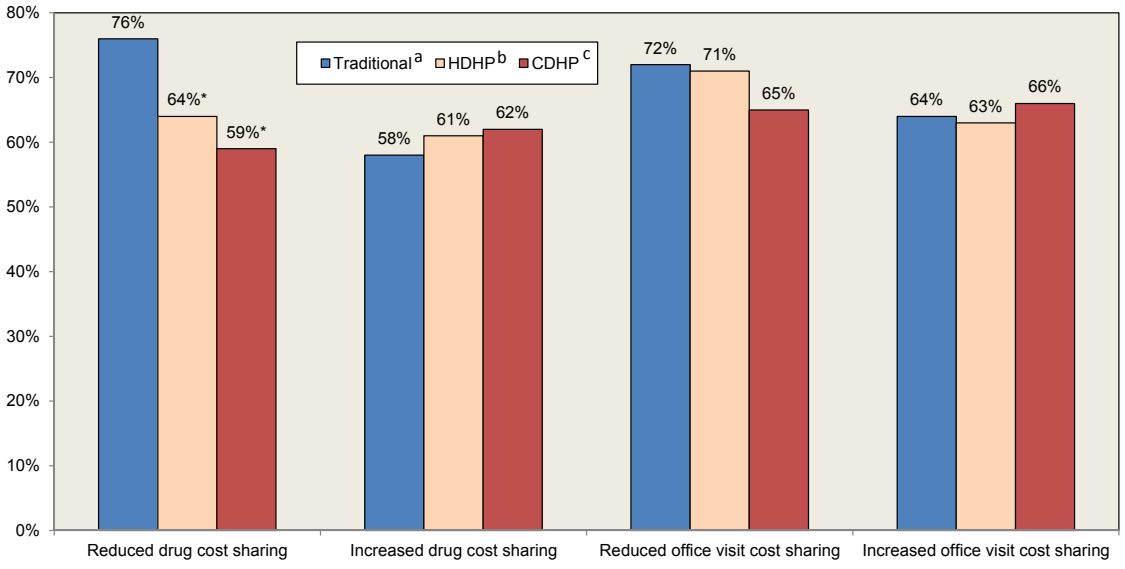
Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Financial Incentives and Type of Health Plan, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[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 15

Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Cost Sharing Incentives and Type of Health Plan, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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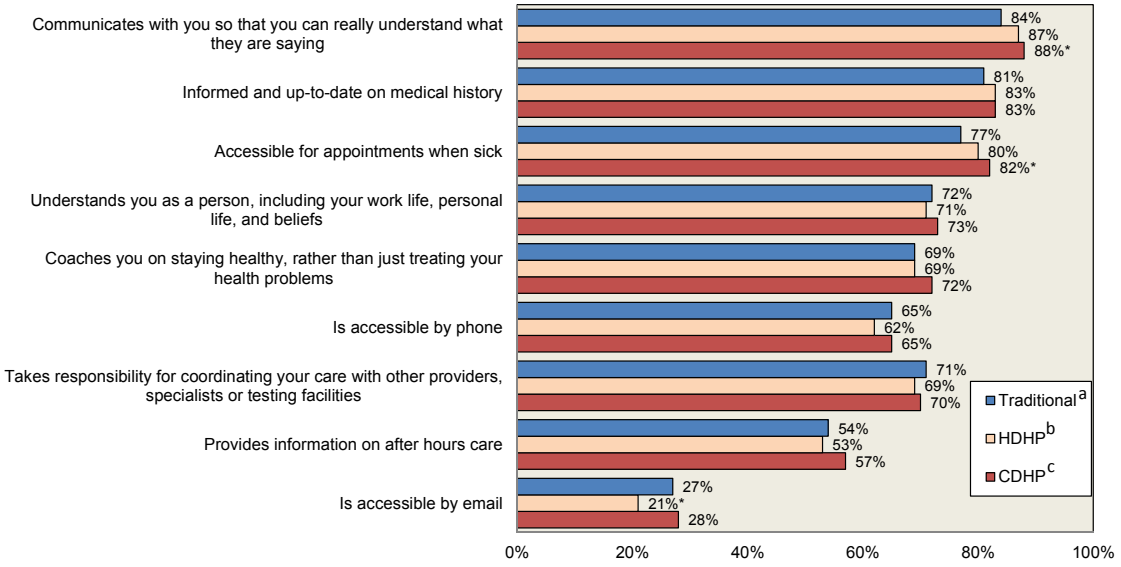
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 16

Agreement With Statements about Various Provider Engagement Tools, by Type of Health Plan, 2012

(Percentage Strongly or Somewhat Agreeing With Statement, Among Those with Usual Source of Care)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
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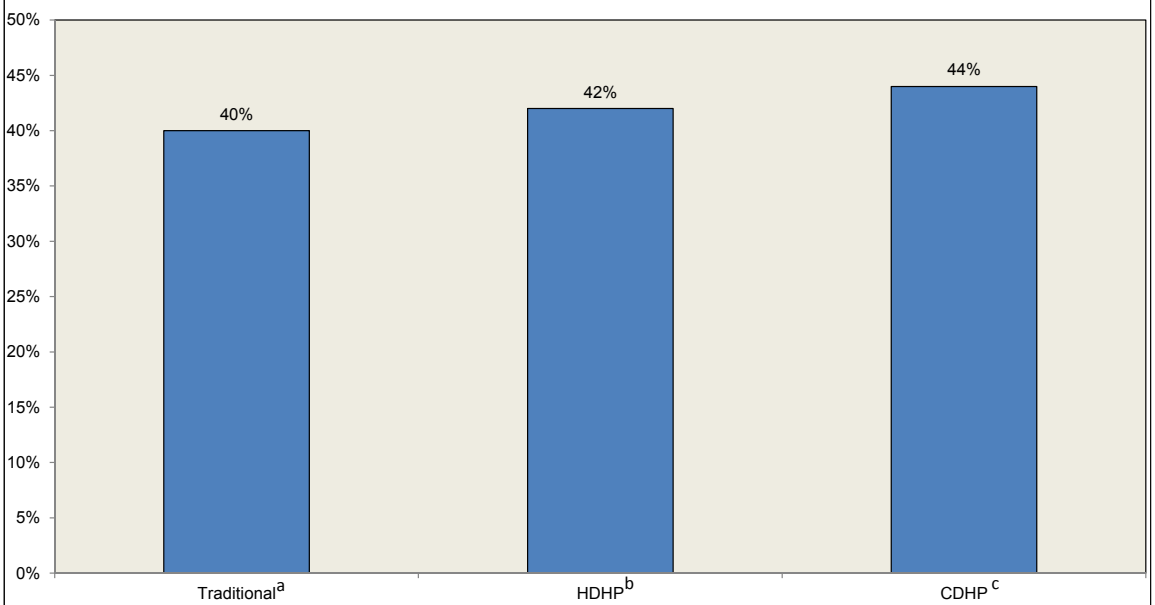
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 17

Individual Has a "Medical Home," 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
Note: To have a medical home, the respondent must: have a personal/family doctor; have timely access to care; have a doctor who knows medical history; have a provider that knows them as a person ; and have a provider who is coordinating care.
[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.

programs (Figure 22). There were no differences in the use of smartphone or tablets for health-related purposes by plan type, with the exception of medical claims history, where it was found that 11 percent of CDHP enrollees used such an app, compared with 6 percent among traditional-plan and 5 percent among HDHP enrollees.

Among those who have never used an app for health-related purposes, about one-half were either very or somewhat interested in using one for things like nutrition information, exercise programs, weight management or diets, prescription drug prices, medical claims history, and general health information (Figure 23). Among individuals with a CDHP, 54 percent were very or somewhat interested in using an app to check the balance of the HSA or HRA.

Conclusion

The 2012 EBRI/MGA Consumer Engagement in Health Care Survey finds continued slow growth in consumer-driven health plans: 10 percent of the population was enrolled in a CDHP, up from 7 percent in 2011. Enrollment in HDHPs remained at 16 percent. Overall, 18.6 million adults ages 21–64 with private insurance, representing 15.4 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA but the enrollee had not opened the account. When their children were counted, about 25 million individuals with private insurance, representing about 14.6 percent of the market, were either in a CDHP or an HSA-eligible plan.

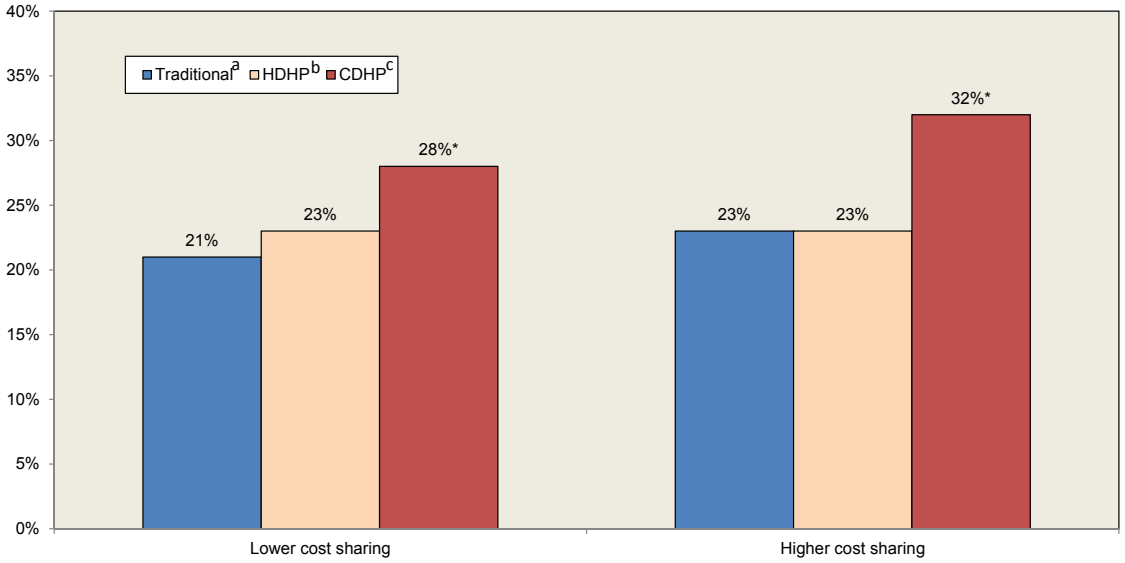
The 2012 EBRI/MGA Consumer Engagement in Health Care Survey continues to find that CDHP enrollees are somewhat more cost conscious in their decision making than those in traditional plans. While CDHP enrollees, HDHP enrollees, and traditional-plan enrollees were about equally likely to report that they made use of quality information provided by their health plan, CDHP enrollees were more likely to use cost information and to try to find information about their doctors' costs and quality from sources other than the health plan. CDHP enrollees were more likely than traditional-plan enrollees to take advantage of various wellness programs, such as health-risk assessments, health-promotion programs, and biometric screenings. 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 certain kinds of individuals. Regardless, it is clear that the underlying characteristics of the populations enrolled in these plans are different: Adults in a CDHP were significantly more likely to report being in excellent or very good health. Adults in a CDHP and those in a HDHP were significantly less likely to smoke than were adults in a traditional plan, and they were significantly more likely to exercise. People in a CDHP were also less likely to be obese compared with adults enrolled in a traditional health plan. 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 can be better understood. The eight years of consumer engagement surveys reported here provide unique data from which to measure future changes in this evolving type of health insurance.

Figure 18

Likelihood of Changing Doctor if Cost Sharing was Lower or Higher When Using Doctors Who Use Health Information Technology (HIT) and Current Doctor Does Not Use HIT, by Type of Health Plan, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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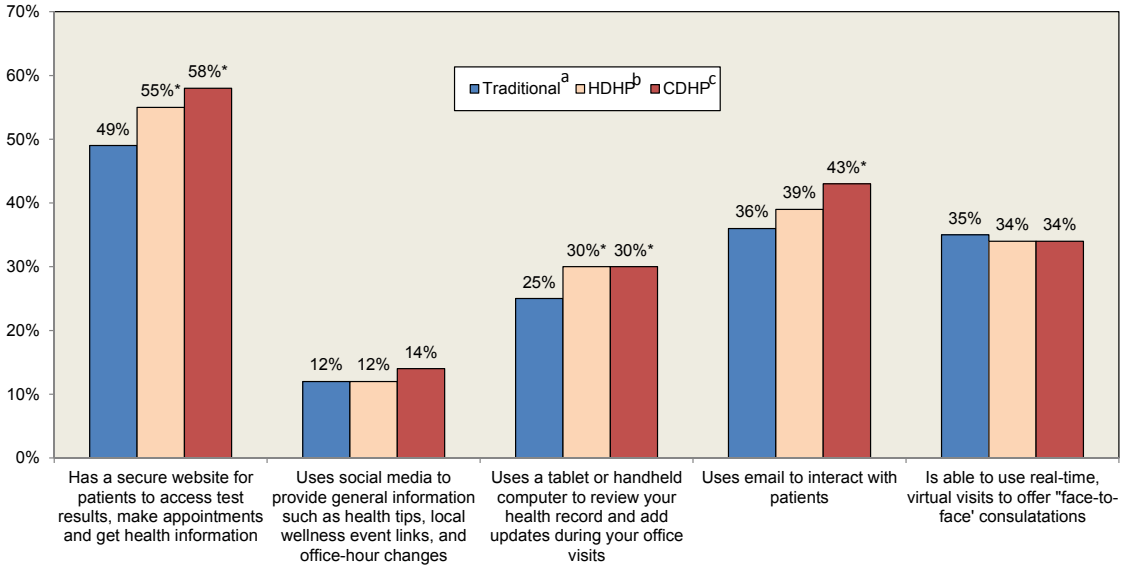
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 19

Likelihood of Choosing Doctor by Their Use of Health Information Technology (HIT), by Type of Health Plan, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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[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

Interest in Enrolling in Plan Using Select Networks Composed of Only Medical Providers With Records of Providing High-Quality Care Combined With Lower Cost Sharing, by Type of Plan, 2012

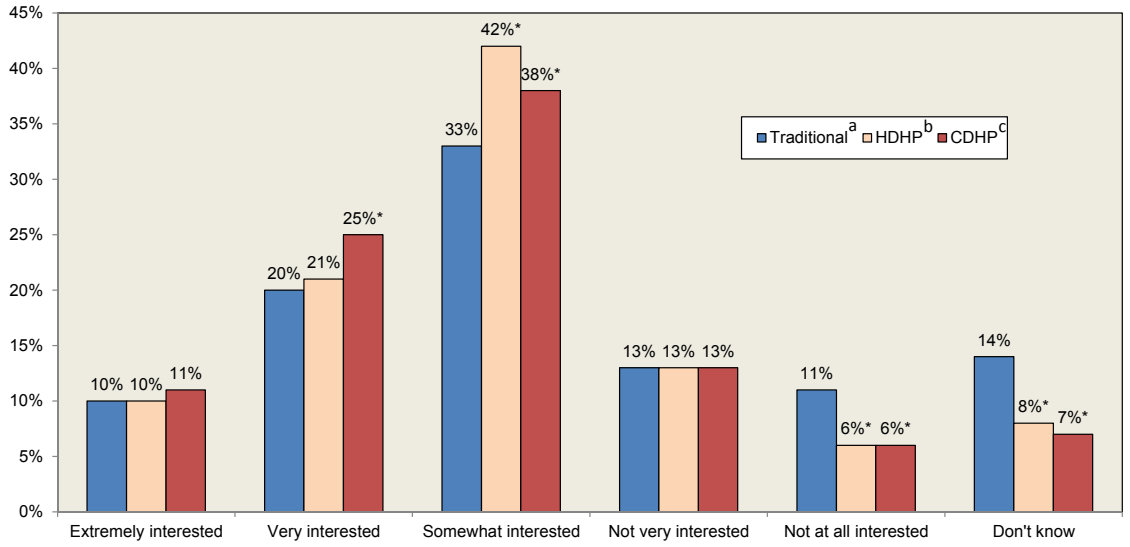

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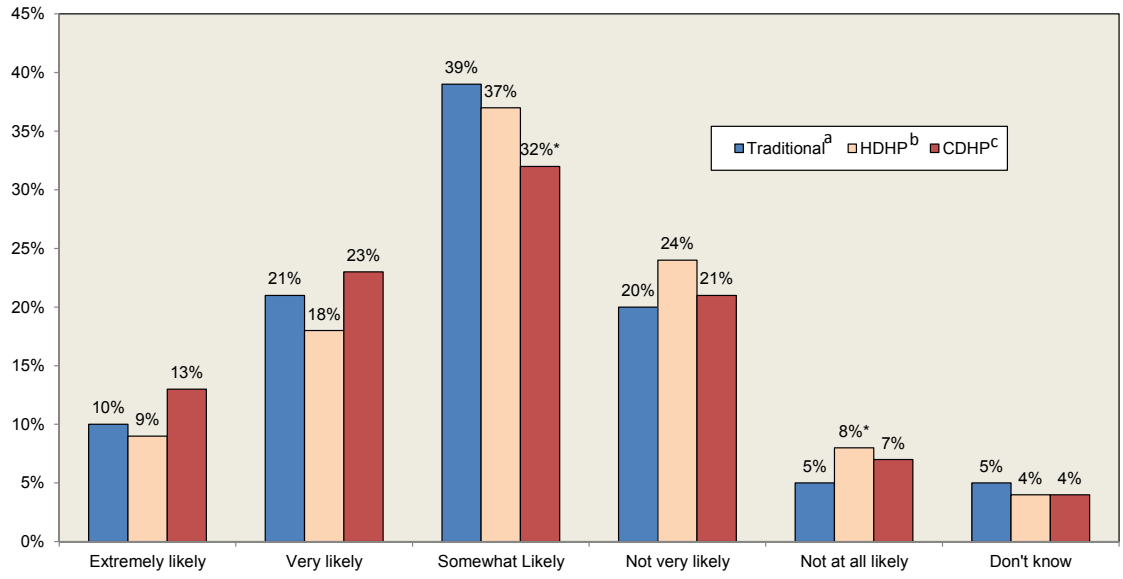
Figure 21

Likelihood of Changing to Select Network if Current Doctor Was Not in Select Network, by Type of Plan, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
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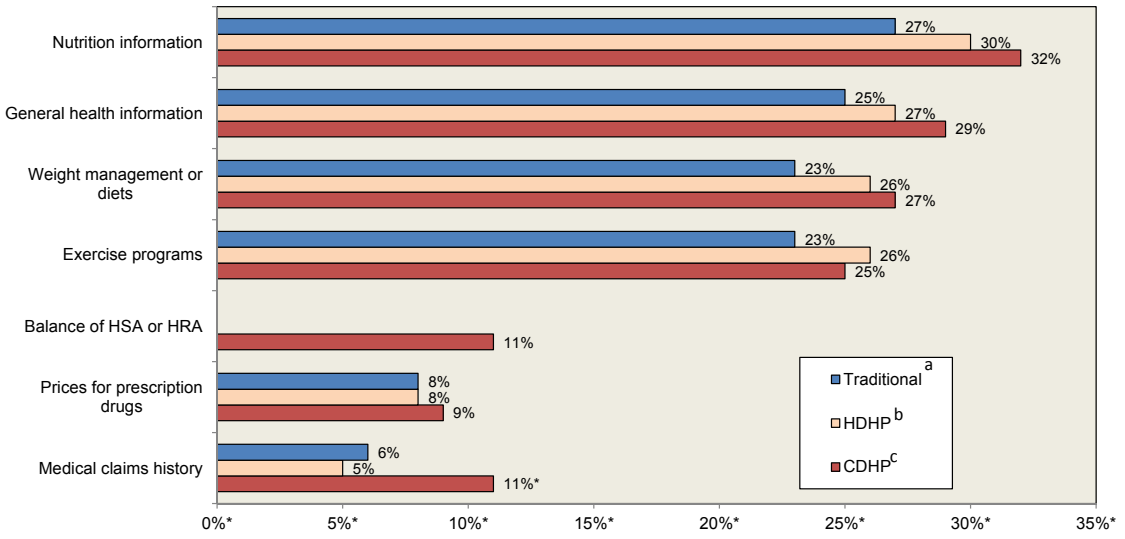
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better

Figure 22
Percentage of Individuals Reporting They Used an App More Than Once for a Smartphone or Tablet, by Various Health-Related Purposes and Type of Health Plan, 2012
(Among Those Who Use a Smartphone or Tablet)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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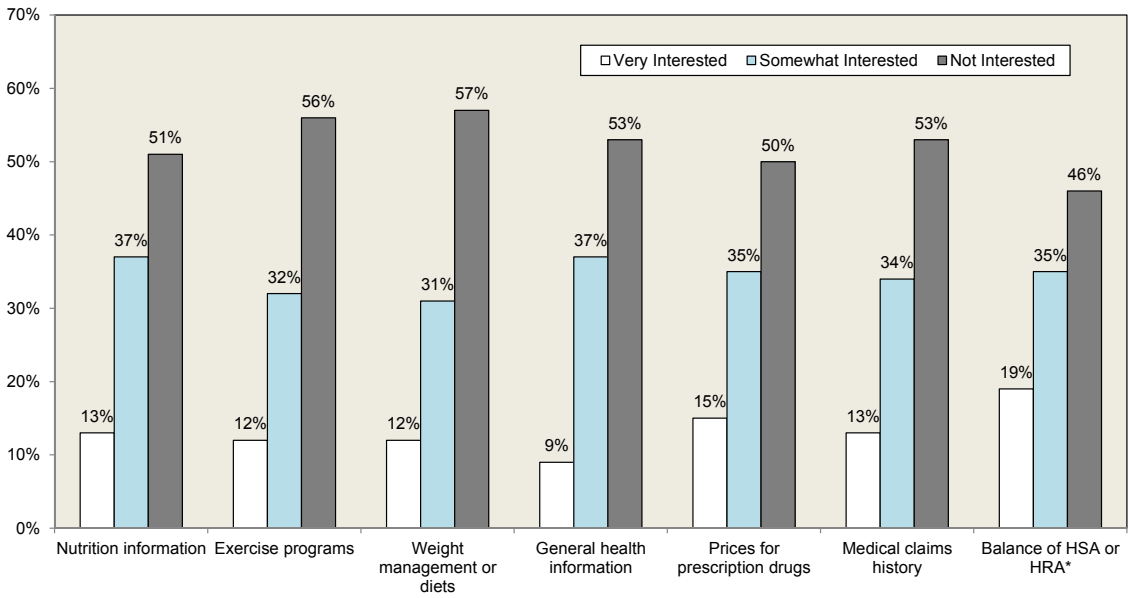
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better

Figure 23
Interest in Using an App for a Smartphone or Tablet, by Health-Related Function, 2012
(Among Those Who Never Used an App for a Smartphone or Tablet)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
* Asked of CDHP only.

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2012 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 health care plans, reasons for choosing a 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 2008-2011 EBRI/MGA Consumer Engagement in Health Care Survey. The 2012 EBRI/MGA Consumer Engagement in Health Care Survey was conducted within the United States between August 8 and August 17, 2012, through a 15-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. About 2,000 adults (n=2,004) ages 21−64 who had health insurance through an employer or who 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 37 percent (32 percent for the base sample or national sample, and 43 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 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 had an account, such as a health savings account (HSA) or health reimbursement arrangement (HRA) with a rollover provision that they could 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 included individuals with an HSA-eligible health plan but may also have included individuals with a high deductible who are not eligible to contribute to an HSA. Individuals with traditional health coverage included those in 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 characteristics of this group were that they either had no deductible or deductibles that were below current thresholds that would qualify for HSA tax preference, and that they did not have an HRA-based plan.

Because the base sample (national sample) included only 198 individuals in a CDHP and 332 individuals with an HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 1,218 individuals with a CDHP and 1,276 individuals with an HDHP, resulting in a total sample (base plus oversample) of 1,416 for the CDHP group and 1,608 for the HDHP group. After factoring out the base sample—the 198 individuals with a CDHP and the 332 individuals with an HDHP—there were 1,474 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 ages 21–64 with private health insurance coverage.[10] 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 45,000 online panel members who met the study's criteria (having private insurance and being 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 nonrandom, studies have demonstrated that such surveys, when carefully designed, obtain results comparable with random-digit-dial telephone surveys. Taylor (2003), for example, provided 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

Consumer-Driven Health Plans

These refer to account-based health plans that include either a health savings account (HSA) or a health reimbursement arrangement (HRA), described in more detail below.

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 as taxable income. Tax-free distributions are also allowed for certain premiums.

The HSA is owned by the individual with the high-deductible health plan and is completely portable. There is no use-it-or-lose-it rule associated with an HSA, 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 $1,200 for self-only coverage and $2,400 for family coverage (minimum deductible amounts are indexed to inflation but remain at $1,200 and $2,400 in 2012). Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $6,050 for self-only coverage and $12,100 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit are indexed to inflation. A network plan may impose a higher deductible and an out-of-pocket limit for out-of-network services. Individuals can have a health plan with a deductible and maximum out-of-pocket limit that qualifies them to make a tax-free contribution to an HSA, but they are not required to make a contribution or to 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 $3,100 for self-only coverage and $6,250 for family coverage in 2012.

To be eligible for an HSA, an individual 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.[11] 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.[12] An individual also may not make an HSA contribution if he or she is 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 2012, 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 the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 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 20 percent penalty (increased from 10 percent in 2010 as a result of the Patient Protection and Affordable Care Act of 2010 (PPACA)), 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. An HRA is typically combined with a high-deductible health plan, though this is not required. An HRA 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. An employee may view the account as if money was actually being deposited into an account, but an employer does not incur expenses associated with the arrangement until an employee incurs a claim. By contrast, were an employer to set up the HRA on a funded basis, the employer 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. An employer can also let an employee use an HRA to purchase health insurance directly from an insurer. Since unused funds are allowed to roll over, an employee is able to accumulate funds over time. An employer can allow a former employee 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. An employer is not required to make the unused balance available to a worker when he or she leaves.

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).

_____. "Availability, Contributions, Account Balances, and Rollovers in Account-Based Health Plans, 2006–2009." *EBRI Notes,* no. 11 (Employee Benefit Research Institute, November 2009): 2–12.

_____. "Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey." *EBRI Issue Brief,* no. 376 (Employee Benefit Research Institute, September 2012).

Fronstin, Paul, and Sara R. Collins. "Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey." *EBRI Issue Brief,* no. 215 (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 box on pg. 24 and in Fronstin (2002 and 2004).

[3] See www.mercer.com/pressrelease/details.htm?idContent=1491670

[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 characteristics of these plans are that they either have no deductibles or deductibles that are below current thresholds that would quality for tax-preferred HSA contributions or that are generally associated with HRAs.

[7] See Fronstin (2007) and http://ehbs.kff.org/pdf/2012/8345.pdf

[8] While growing, the CDHP market is still below 20 percent enrollment. According to the Kaiser Family Foundation, Health Research and Education Trust 2012 survey, 19 percent of workers were enrolled in a CDHP (see http://ehbs.kff.org/pdf/2012/8345.pdf). Mercer (see www.mercer.com/pressrelease/details.htm?idContent=1491670) found that 16 percent of workers were enrolled in a DCHP in 2012.

[9] The specific question was 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 of developing.
- Programs for improving your health, like for weight loss, walking or other exercise, nutrition, stress management, smoking cessation, and so on.
- Biometric screenings, which are measurements or blood work to determine your health status, including blood pressure, cholesterol, weight, height, etc.

[10] In theory, a random sample of 2,000 yields a statistical precision of plus or minus 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.

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

[12] 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.

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