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Issue BRIEF

Findings from the 2015 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey

By Paul Fronstin, Ph.D., Employee Benefit Research Institute, and Anne Elmlinger, Greenwald & Associates

AT A GLANCE

- The 2015 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS) finds that 13 percent of the privately insured population was enrolled in a consumer-driven health plan (CDHP); 11 percent was enrolled in a high-deductible health plan (HDHP); and 76 percent was enrolled in more traditional coverage. Overall, 26 million individuals with private insurance were enrolled in a CDHP—a health plan associated with a health savings account (HSA) or health reimbursement arrangement (HRA), or an HSA-eligible health plan.

- The 2015 CEHCS also finds that among individuals enrolled in CDHPs, 63 percent (16.3 million) had opened an HSA, 13 percent (3.3 million) was in an HRA, and 24 percent (6.2 million) was enrolled in an HSA-eligible health plan but had not opened an HSA.

- This study finds evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors. Specifically, those in a CDHP or HDHP were more likely than those with traditional coverage 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 doctors about prescription options and costs; asked a doctor to recommend a less costly drug; talked to their doctors about other treatment options and costs; developed a budget to manage health care expenses; and used an online cost-tracking tool provided by the health plan.

- There is also some evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to be engaged in their choice of health plan. Specifically, those in a CDHP were more likely than those with traditional coverage to say that they had talked to friends, family or colleagues about the plans; attended a meeting where health plan choices were explained; and consulted with their employer's HR staff about health plan choices. Those in an HDHP were more likely than those with traditional coverage to say that they had visited the health plan's website to learn about their plans; talked to friends, family or colleagues about the plans; used other websites to learn about their choices; and consulted with an insurance broker to understand their plan choices.

- The survey also finds that CDHP enrollees were more likely than traditional-plan enrollees to take advantage of various wellness programs, such as health-risk assessments and health-promotion programs, as well as biometric screenings. In addition, financial incentives mattered more to CDHP enrollees than to traditional-plan enrollees.

This survey was made possible with funding support from the following organizations: Blue Cross and Blue Shield Association, HealthEquity, Inc., Healthways Inc., Lincoln Financial Group, National Rural Electric Cooperative Association, Optum, Inc., and Prudential Financial, Inc.

Paul Fronstin is director of the Health Education and Research Program at the Employee Benefit Research Institute (EBRI). Anne Elmlinger is vice president, Healthcare Practice lead, with Greenwald & Associates. Any views expressed in this report are those of the authors and should not be ascribed to the officers, trustees, or other sponsors of EBRI, Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF), or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Lincoln Financial Group	

Introduction

Employment-based health benefits are the most common form of health insurance in the United States. In 2014, 161.6 million individuals under age 65, or 60 percent of that population, had employment-based health benefits (Fronstin 2015). In nearly every year since 1998, premium increases have exceeded worker-earnings increases and inflation (Figure 1). Health insurance premiums have nearly tripled, while worker earnings have increased 58 percent during that period.[1]

In response, employers have been seeking ways to manage health care cost increases. During the past decade, employers have turned their attention to consumer-driven health plans (CDHPs)—a combination of health coverage with high deductibles (at least $1,300 in 2015) and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. A handful of employers first started offering CDHPs in 2001 with health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).[2] By 2014, 27 percent of employers with 10–499 workers and 48 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, they adopted Sec. 125 cafeteria plans and flexible spending accounts (FSAs). More recently, employers have begun to take a broader view of consumer engagement in health care. Some employers have introduced more workplace wellness programs, usually in the form of health-risk assessments or biometric screenings. Employers have often provided financial incentives to increase worker participation in such programs. A few employers have introduced private, health-insurance exchanges. These programs give workers more choices for health coverage and more transparency regarding coverage choices and the costs associated with each choice.

This *Issue Brief* presents findings from the 2015 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS). This study was based on an online survey, of 3,590 privately insured adults ages 21–64, that was designed to provide nationally representative data regarding the growth of 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. The sample was randomly drawn from Ipsos' online panel of more than 775,000 Internet users who had agreed to participate in research surveys. This survey used a base sample of 2,004 to draw incidence rates for people 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, including individuals who were enrolled in an HSA-eligible health plan, but had not opened the HSA, and 2) those in a plan with an individual deductible of at least $1,300 and a family deductible of at least

$2,600, but who report that they were not eligible to open an HSA.[4] The final sample included 1,285 in a CDHP with either an HSA or HRA, 815 in an HDHP, and 1,490 in a more traditional health plan.[5]

The remainder of this report examines the findings from the 2015 CEHCS 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. It 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 telemedicine.

Findings from this survey are compared with findings from the 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008–2014 CEHCS.

Enrollment in CDHPs and HDHPs

Individuals enrolled in a plan with a deductible of at least $1,300 for individual coverage or $2,600 for family coverage who also have an HRA, or who were enrolled in an HSA-eligible health plan (regardless of whether the HSA was opened) were assigned to the CDHP group in the CEHCS. Everyone else enrolled in a plan with a deductible of at least $1,300 for individual coverage or $2,600 for family coverage was assigned to the HDHP group. Individuals enrolled in a plan with no deductible or a deductible below $1,300 for individual coverage and $2,600 for family coverage were assigned to the "traditional" coverage category. More detail about the methodology is provided in the appendix.

This survey found that in 2015, 13 percent of the population was enrolled in a CDHP; 11 percent was enrolled in an HDHP; and 76 percent was enrolled in traditional coverage (Figure 2). The 13 percent of the population with a CDHP represented about 26 million individuals with private insurance, while the 11 percent with an HDHP represented about 22 million individuals.

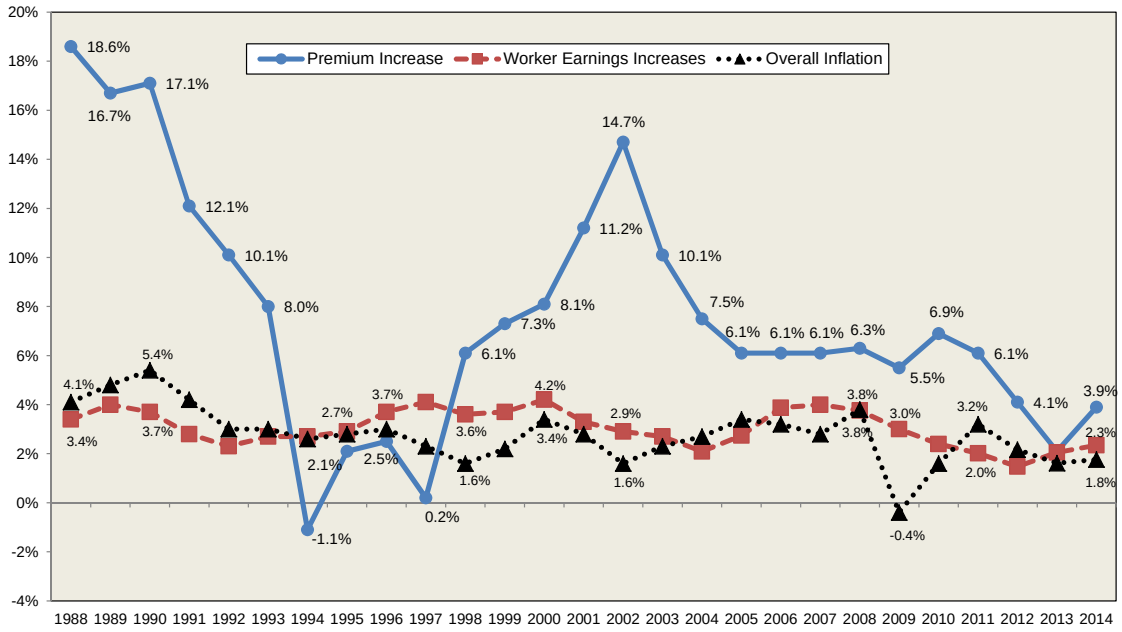
Among the 13 percent of individuals enrolled in a CDHP, 63 percent (16.3 million) had opened an HSA, 13 percent (3.3 million) were in an HRA, and 24 percent (6.2 million) were enrolled in an HSA-eligible health plan but had not opened an HSA (Figure 3). Thus, overall, 22.5 million were enrolled in an HSA-eligible health plan, and 3.3 million were in an HRA-based plan.

A number of other surveys track enrollment in CDHPs. Mercer found that 23 percent of workers with employment-based coverage were covered by a CDHP in 2014.[6] The Kaiser Family Foundation (KFF) found that 20 percent of workers were enrolled in a CDHP in 2014 and 24 percent were enrolled in 2015.[7] These surveys focus only on the employment-based market and include estimates for both HSA and HRA enrollment. An annual America's Health Insurance Plans (AHIP) survey focuses on both the group and individual markets and found that 19.7 million people were enrolled in an HSA-eligible health plan in January 2015,[8] which accounted for about 15 percent of the population with private health insurance. AHIP does not collect information on HRA enrollment. The National Health Interview Survey (NHIS) also collects information on both the group and individual markets. It found that 13.3 percent of individuals with private insurance were covered by an HSA-eligible health plan or HRA-based plan in 2014, while 23.6 percent were covered by an HDHP (without an HSA).[9] The NHIS estimates are much higher than the AHIP estimates, but NHIS includes HRA-based plans and also includes individuals with HDHPs that are not in HSA-eligible health plans. Estimates from the CEHCS are right between the AHIP estimates for HSA enrollment and the NHIS estimate for CDHP.

Unlike the AHIP, Kaiser, and Mercer surveys, the CEHCS has found that enrollment in CDHPs had fallen between 2013 and 2014, and again between 2014 and 2015. It is possible that prior year estimates from the CEHCS were too high, causing it to look like enrollment had declined when in fact enrollment had not declined. Another reason for the apparent decline in enrollment could be that the estimates were within the margin of error. This would mean that the apparent decline was not a real decline. Other surveys have found select years with stagnant growth[10] or segments of the population where declines have occurred. Most recently, NHIS found a decline in enrollment in both CDHPs and HDHPs between 2014 and the first half of 2015.[11] Similarly, AHIP found a decline in HSA enrollment in the small-group

Figure 1

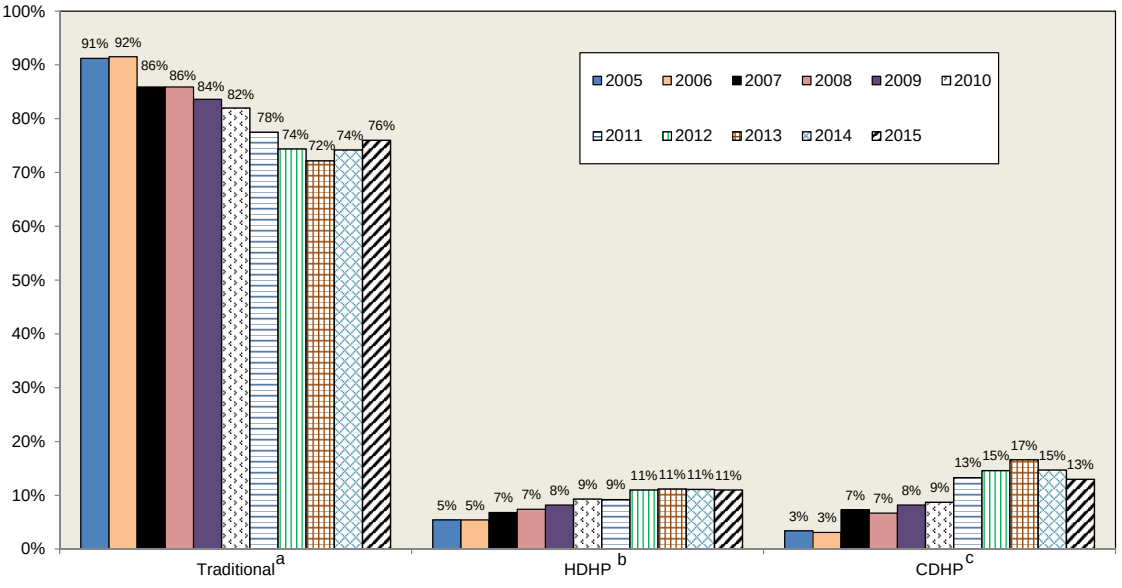
Premium Increases Among Employers With 10 or More Employees, Worker Earnings and Inflation, 1988–2014



Source: Mercer, *National Survey of Employer-Sponsored Health Plans* (www.mercer.com/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html), and Bureau of Labor Statistics.

Figure 2

Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2015



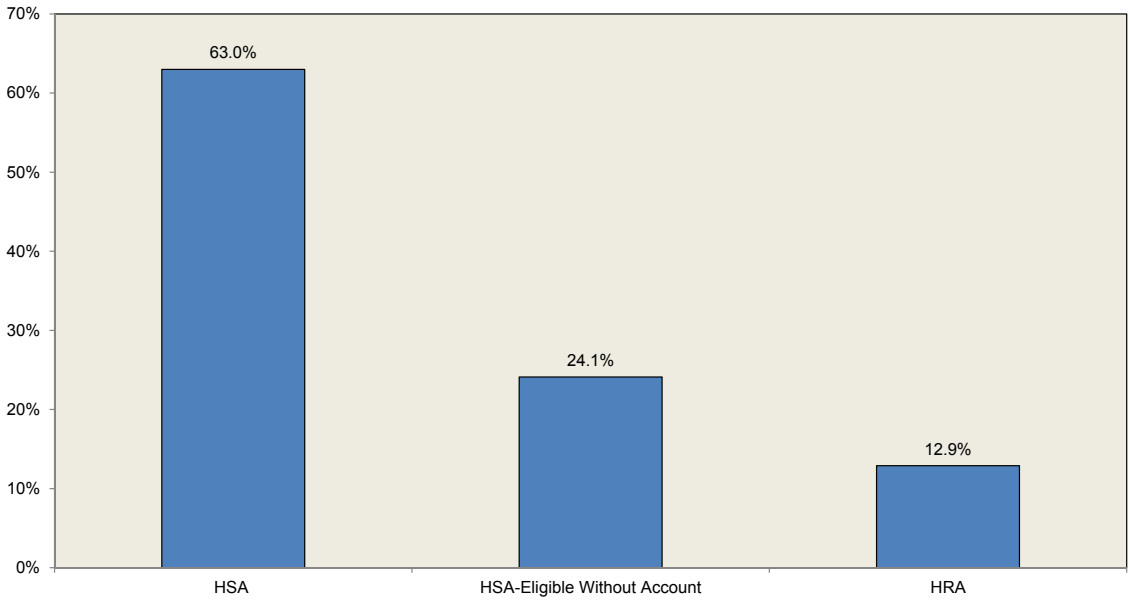
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2015.

[a] Traditional = health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;

[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;

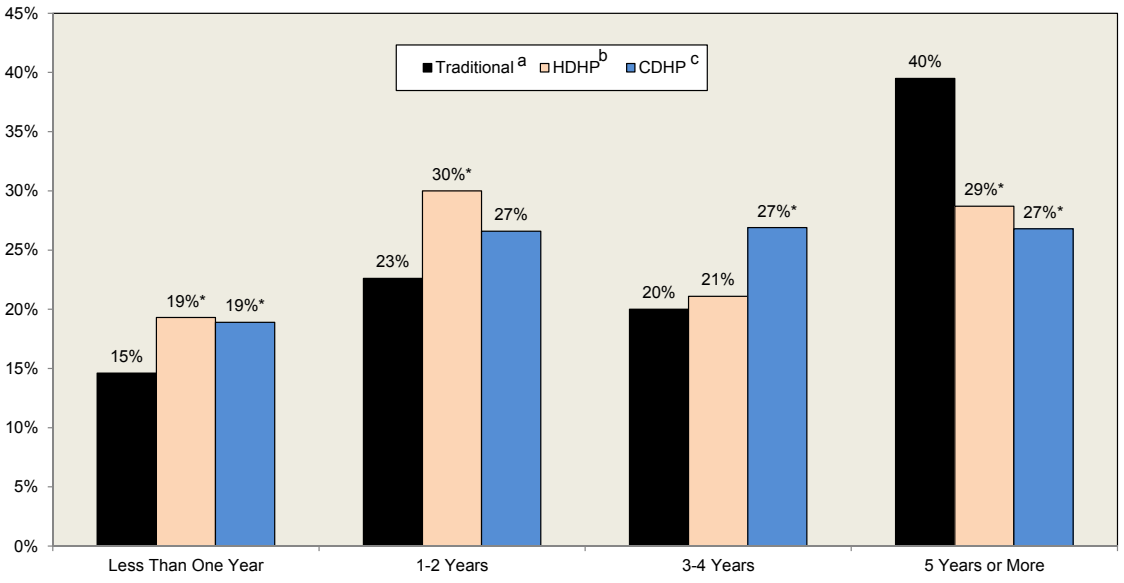
[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.

Figure 3
HSA[a] and HRA[b] Enrollment Rates, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Health savings account.
[b] Health reimbursement arrangement.

Figure 4
Number of Years Covered by Current Health Plan, by Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = Health plan with no deductible or <$1,300 (individual), <$2,500 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

market. While all of these surveys have their limitations, and none of them provide the kind of precision necessary to measure enrollment in CDHPs and HDHPs and specific year-to-year changes are often suspect, taken together, they indicate that growth is occurring.

Length of Time in Health Plan

The survey found that the amount of time individuals have been enrolled in a CDHP was shorter than the time others have been enrolled in traditional coverage. Among individuals with traditional coverage, 20 percent have been in their plan for three to four years and 40 percent for five or more years. This compared with 27 percent and 27 percent, respectively, among people in a CDHP (Figure 4). While still lower than the percentage of individuals with traditional coverage, the number of people with a CDHP and the length of time they have been enrolled in a CDHP have been increasing. In 2015, 27 percent of CDHP enrollees reported that they have been in the health plan at least five years, up from 20 percent in 2006 (Figure 5).

Familiarity With CDHP

The survey found that most people with a CDHP were familiar with it. Over two-thirds (69 percent) of those with a CDHP were extremely, very, or somewhat familiar with it (Figure 6). In contrast, 37 percent of individuals with traditional coverage were extremely, very, or somewhat familiar with a CDHP, and 39 percent of individuals with an HDHP were familiar with a CDHP.

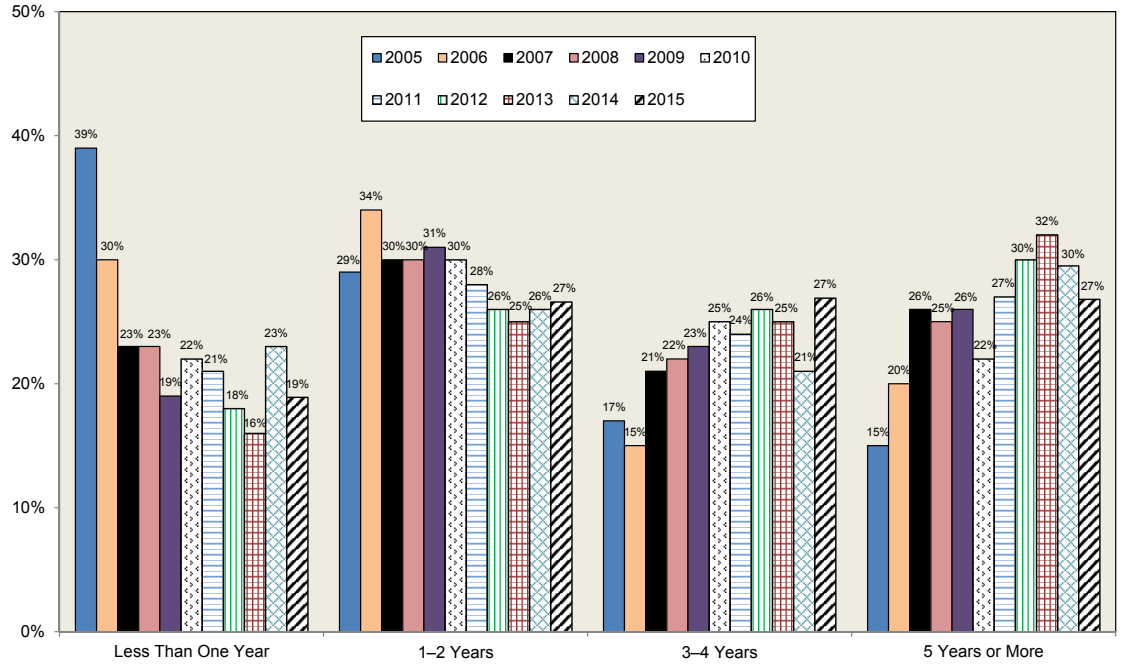
Cost-Conscious Behavior

The theory behind CDHPs and HDHPs is that the cost-sharing structure is a tool that will be more likely to engage individuals in their health care, compared with people enrolled in more traditional coverage. This study found evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors. Specifically, among privately insured adults ages 21–64 who received health care in the past 12 months, those in a CDHP or HDHP were more likely than those with traditional coverage to say that they had checked whether the plan would cover care (54 percent CDHP and 55 percent HDHP vs. 46 percent traditional); asked for a generic drug instead of a brand name (47 percent CDHP and 52 percent HDHP vs. 36 percent traditional); talked to their doctors about prescription options and costs (39 percent CDHP and 41 percent HDHP vs. 30 percent traditional); asked a doctor to recommend less costly prescriptions (39 percent CDHP and 40 percent HDHP vs. 29 percent traditional); talked to their doctors about other treatment options and costs (36 percent CDHP and 40 percent HDHP vs. 31 percent traditional); developed a budget to manage health care expenses (27 percent CDHP and 28 percent HDHP vs. 21 percent traditional); and that they had used an online cost-tracking tool provided by the health plan (23 percent CDHP and 27 percent HDHP vs. 18 percent traditional) (Figure 7).

Health Plan Choice Decisions

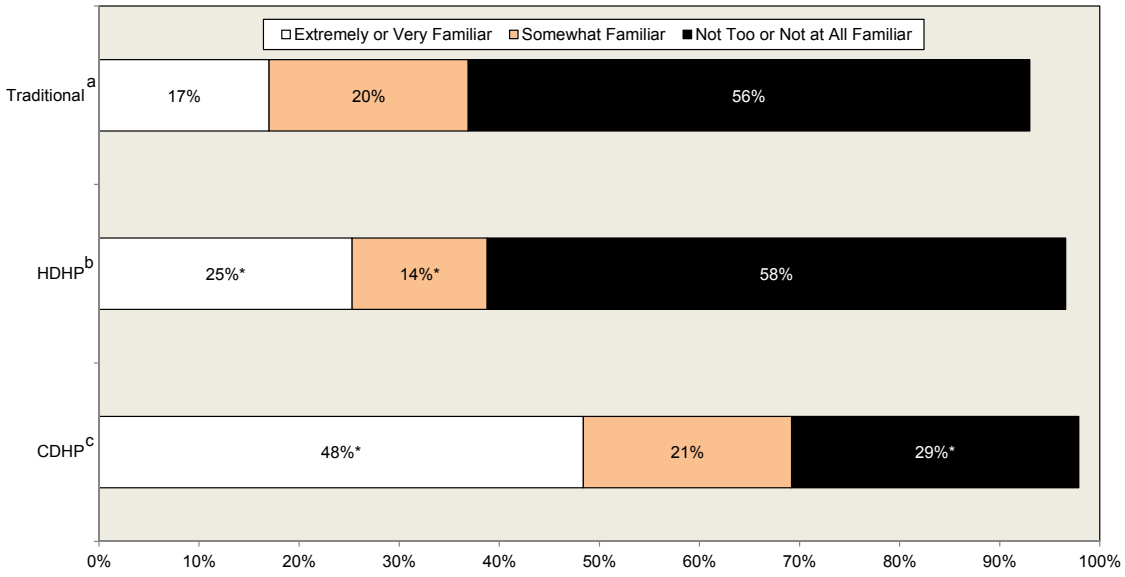
There was also some evidence that adults in a CDHP and an HDHP were more likely than those in a traditional plan to be engaged in their choice of health plan. Specifically, those in a CDHP were more likely than those with traditional coverage to say that they had talked to friends, family or colleagues about the plans (46 percent CDHP vs. 38 percent traditional); attended a meeting where health plan choices were explained (43 percent CDHP vs. 27 percent traditional); and consulted with their employer's HR staff about health plan choices (36 percent CDHP vs. 29 percent traditional) (Figure 8). Those in an HDHP were more likely than those with traditional coverage to say that they had visited the health plan's website to learn about their plans (61 percent HDHP vs. 50 percent traditional); talked to friends, family or colleagues about the plans (48 percent HDHP vs. 38 percent traditional); used other websites to learn about their choices (42 percent HDHP vs. 29 percent traditional); and that they had consulted with an insurance broker to understand plan choices (28 percent HDHP vs. 19 percent traditional). CDHP and traditional-plan enrollees were equally likely to report that they visited health plans' websites to learn about their plans; used other websites to learn

Figure 5
Length of Time With CDHP,* 2005–2015



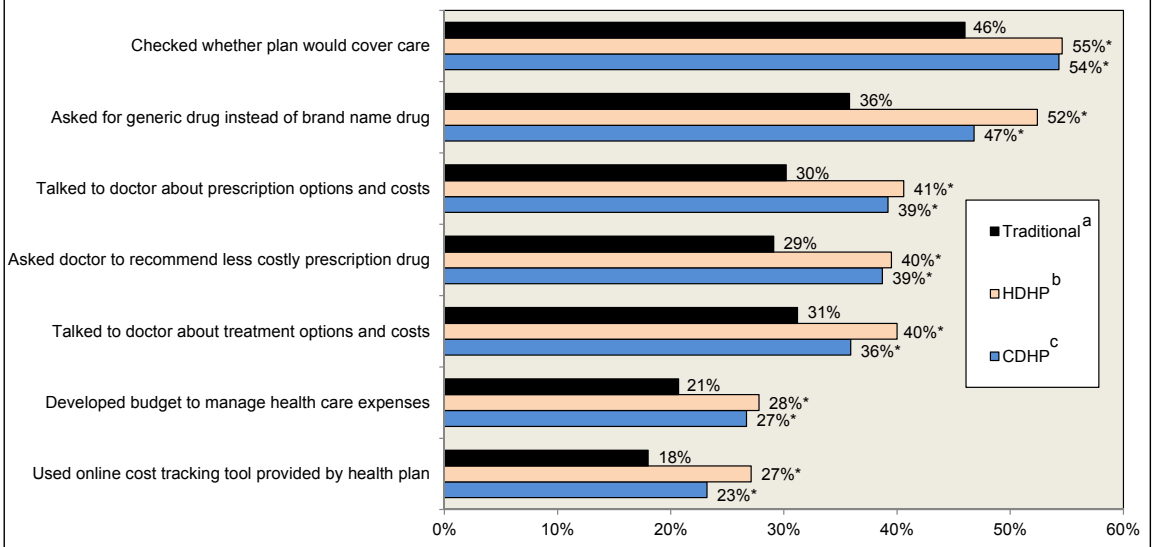
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2015.
* Consumer-driven health plan.

Figure 6
Familiarity With Consumer-Driven Health Plans, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = Health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 7
Cost-Conscious Decision Making, by Type of Health Plan, 2015
(Percent of privately insured adults ages 21–64
who received health care in last 12 months)



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
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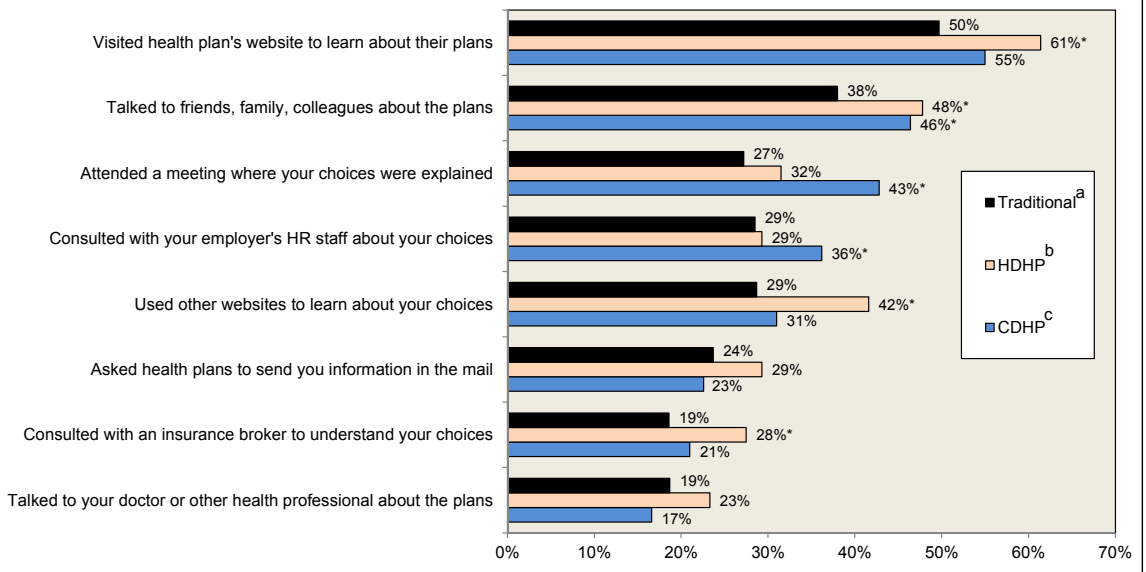
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 8
Informed Decision Making for Health Plan Choice, by Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
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about their choices; asked health plans to send information in the mail; consulted with a broker; and that they had talked to their doctor or other health professional about the plans. HDHP and traditional-plan enrollees were equally likely to report that they had attended a meeting where their choices were explained; consulted with their employer's HR staff about health plan choices; asked health plans to send them information in the mail; and that they had talked to their doctor or other health professional about the plans.

Availability and Use of Cost Information

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

The survey asked if participants tried to find the cost of health care services before getting care and found that CDHP enrollees and HDHP enrollees were more likely than traditional-plan enrollees to report that they tried to find cost information (Figure 9). Plan type had no impact on whether enrollees had found information from various sources, with one exception: HDHP enrollees were more likely than traditional-plan enrollees to have found information from the health plan's customer service department. Otherwise CDHP, HDHP and traditional-plan enrollees were equally likely to have found information from various sources.

Figure 9
Availability and Use of Cost Information, 2015

	Traditional[a]	HDHP[b]	CDHP[c]
Tried to find the cost of health care services before getting care	26%	42%*	40%*
Found information:	74	75	70
Health plan's website	60	56	55
Health plan's customer service department	35	48*	30
Printed material from health plan	24	29	19
Provider's office	18	21	26
Provider's website	19	29	17
Other websites	5	4	5

Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = Health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
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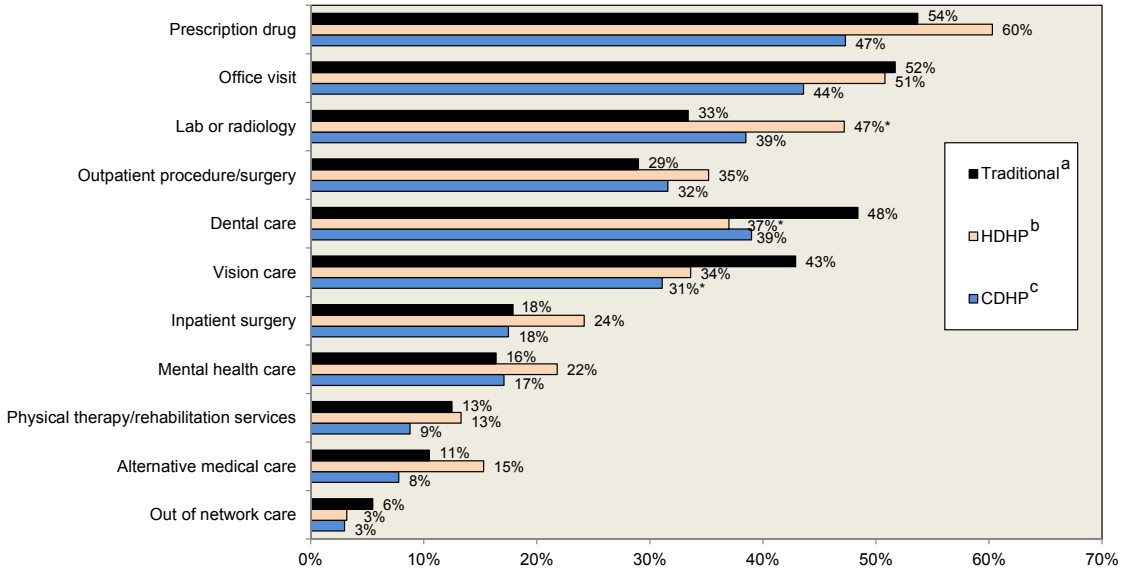
* Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Among individuals who sought cost information, CDHP and traditional-plan enrollees were equally likely to have sought cost information on a range of health care services (Figure 10). However, CDHP enrollees were less likely than traditional-plan enrollees to have sought information on vision care. In most instances, HDHP and traditional-plan enrollees were also equally likely to have sought cost information; however, HDHP enrollees were less likely than traditional-plan enrollees to have sought information on dental care and they were more likely to have sought information on lab and radiology costs.

Among individuals seeking cost information, 66–68 percent found information on cost sharing; 42–47 percent found information on what insurance would and would not pay toward the cost of care; 46–60 percent found cost information on provider costs; 21-28 percent found information on the total cost of health care services charged to their insurance plan; and 12–16 percent found the total cost outside of their insurance plan (Figure 11). There were no differences in the type of cost information sought by plan type, with one exception: HDHP enrollees were more likely than traditional-plan enrollees to have sought information on the average or range of costs charged by health care providers.

Figure 10
Types of Cost Information Sought, by Type of Health Plan, 2015
(Among individuals seeking cost information)



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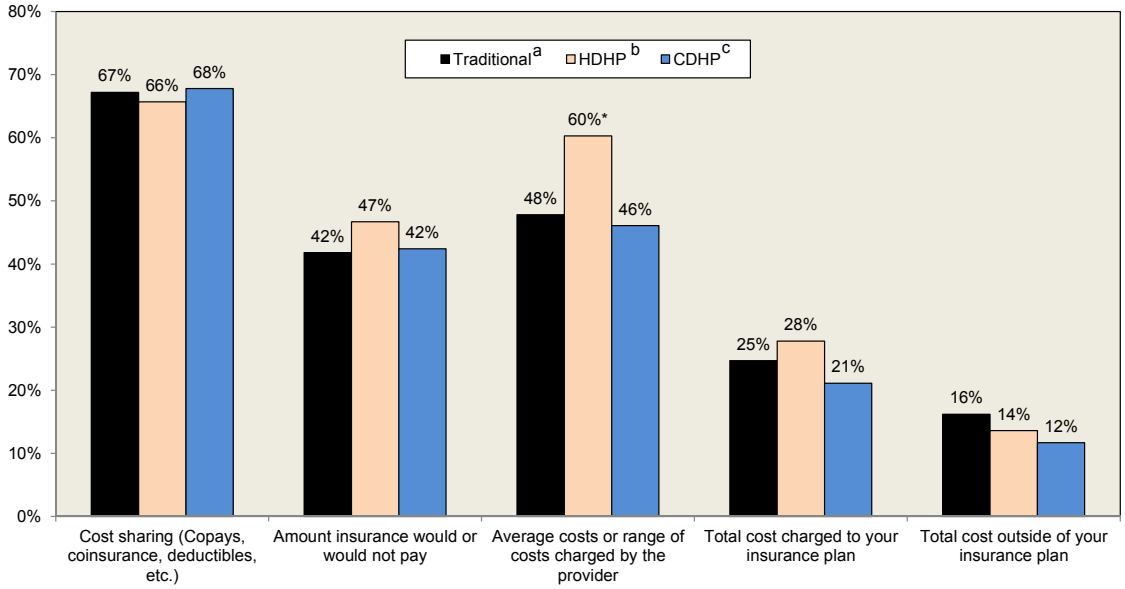
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 11
Types of Cost Information Found, by Type of Health Plan, 2015
(Among individuals seeking cost information)



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

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 2015 CEHCS examined availability and participation in three types of wellness programs: a health-risk assessment, a health-promotion program to address a specific health issue, and a biometric screening.[12]

The survey found that CDHP enrollees were more likely than traditional-plan enrollees to report that they had the option to participate in all three types of wellness programs. Specifically, 46 percent of CDHP enrollees reported that their employer offered a health-risk assessment, compared with 35 percent of traditional-plan enrollees and 37 percent of HDHP enrollees (Figure 12). When asked about the availability of health-promotion programs, 51 percent of CDHP enrollees, 38 percent of HDHP enrollees, and 42 percent of traditional-plan enrollees reported that their employer offered such a program. When asked about biometric-screening programs, 47 percent of CDHP enrollees reported that their employer offered such a program, compared with 35 percent among traditional-plan enrollees and 36 percent among HDHP enrollees.

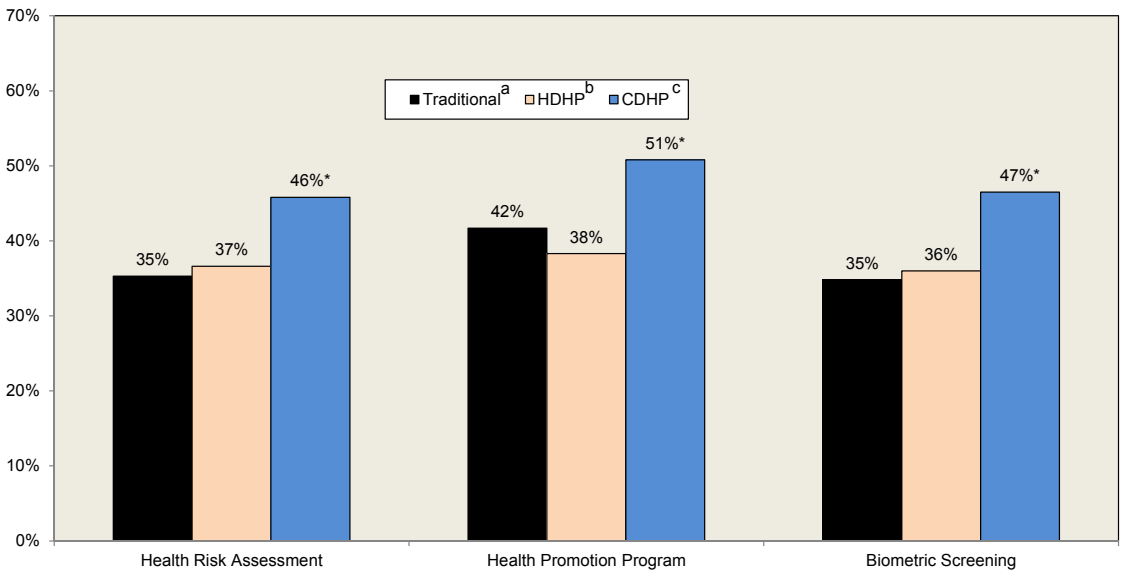
CDHP enrollees were more likely than traditional-plan enrollees to participate in health-risk assessments and biometric screenings. Nearly 80 percent of CDHP enrollees participated in a health-risk assessment, compared with 66 percent of traditional-plan enrollees (Figure 13). About three-quarters (76 percent) of CDHP enrollees participated in a biometric screening, compared with 66 percent of traditional-plan enrollees. HDHP enrollees were also more likely than traditional-plan enrollees to report that they had participated in the biometric screening program (82 percent HDHP vs. 66 percent traditional) or the health promotion program (67 percent HDHP vs. 50 percent traditional).

CDHP and HDHP enrollees were also more likely than traditional-plan enrollees to report that their employer offered a cash incentive or reward for participating in a wellness program. Nearly 70 percent (69 percent) of CDHP enrollees and 75 percent of HDHP enrollees reported a cash incentive or reward for participating in the health-risk assessment compared with 60 percent among traditional-plan enrollees; 61 percent of CDHP enrollees and 70 percent of HDHP enrollees reported a cash incentive or reward for participating in a health-promotion program compared with 50 percent among traditional-plan enrollees, and 68 percent of CDHP and HDHP enrollees reported a cash incentive or reward for a biometric screening, compared with 55 percent among traditional-plan enrollees (Figure 14). The main reasons enrollees participated in an employer's wellness program were because they were offered incentive prizes, to reduce premiums, it was convenient, and to improve health (Figure 15). CDHP enrollees were more likely than traditional-plan enrollees to report that they participated in order to reduce premiums or to avoid premium increases. HDHP enrollees were more likely than traditional-plan enrollees to report that they participated because they were offered incentive prizes, to avoid premium increases, because they wanted to learn more about their own health risks, because they were required to by their employer, and to address specific health problems.

The survey also asked respondents their reasons for not participating in their employer's wellness program. Seven out of 10 (68 percent) responded that they did not participate because they could make changes on their own (Figure 16): 32 percent cited this as a major reason, and 36 percent cited it as a minor reason for not participating. About 6 in 10 (61 percent) respondents said that they did not participate because they were already healthy (28 percent reported it as a major reason, and 33 percent reported it as a minor reason). Lack of time was the third-most-popular reason for not participating, with 23 percent reporting it as a major reason, and 33 percent reporting it as a minor reason. For the most part, there were no differences in the answers to this series of questions by plan type.

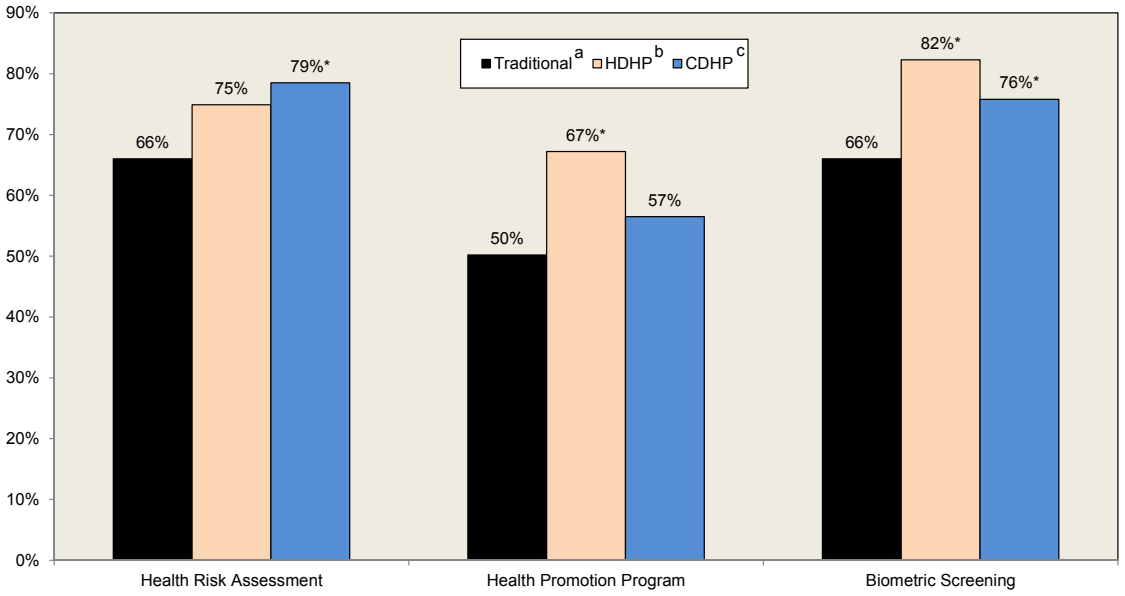
Figures 17 and 18 contain findings from a series of questions related to the impact that financial incentives could have on participation in wellness programs. As in past years, there were a few differences by plan type. CDHP enrollees were more likely than traditional-plan enrollees to report that they would probably participate if the employer increased premiums for non-participants, or if they were required to participate to enroll in the preferred health plan (Figure 17). There were no differences between HDHP and traditional-plan enrollees. When it came to the impact of cost sharing, there were also just a few differences by plan type (Figure 18). CDHP enrollees were more likely than traditional-plan enrollees to participate if there was an increase in drug-cost sharing, or a decrease in office-visit cost sharing for wellness program participants. Overall, however, cost-sharing incentives to participate still mattered to many

Figure 12
Employer Offers Wellness Program, by Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 13
Individual Participates in Wellness Program Offered by Employer, Among Those Offered a Wellness Program, by Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
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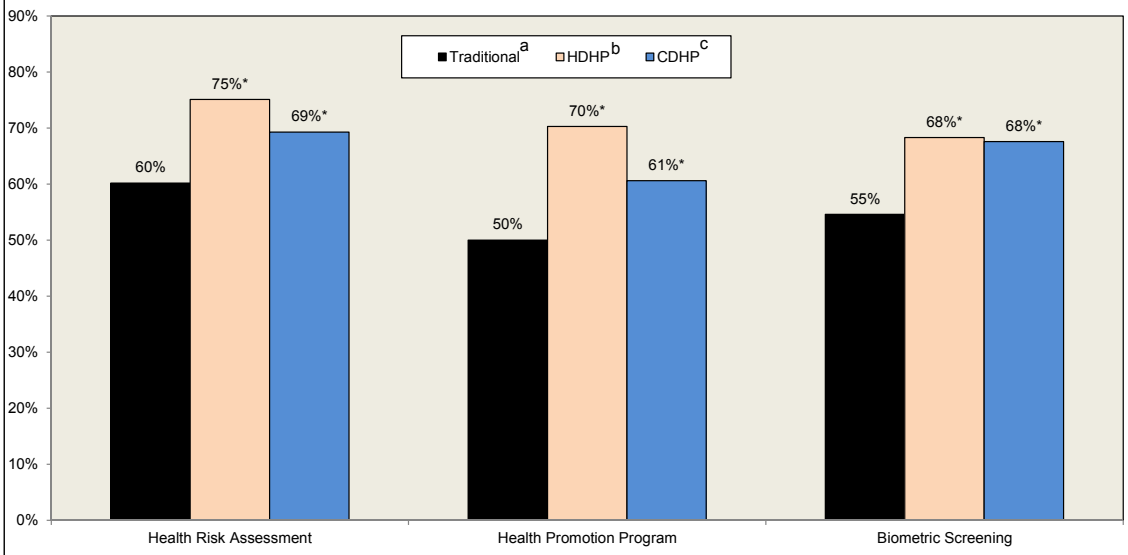
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 14

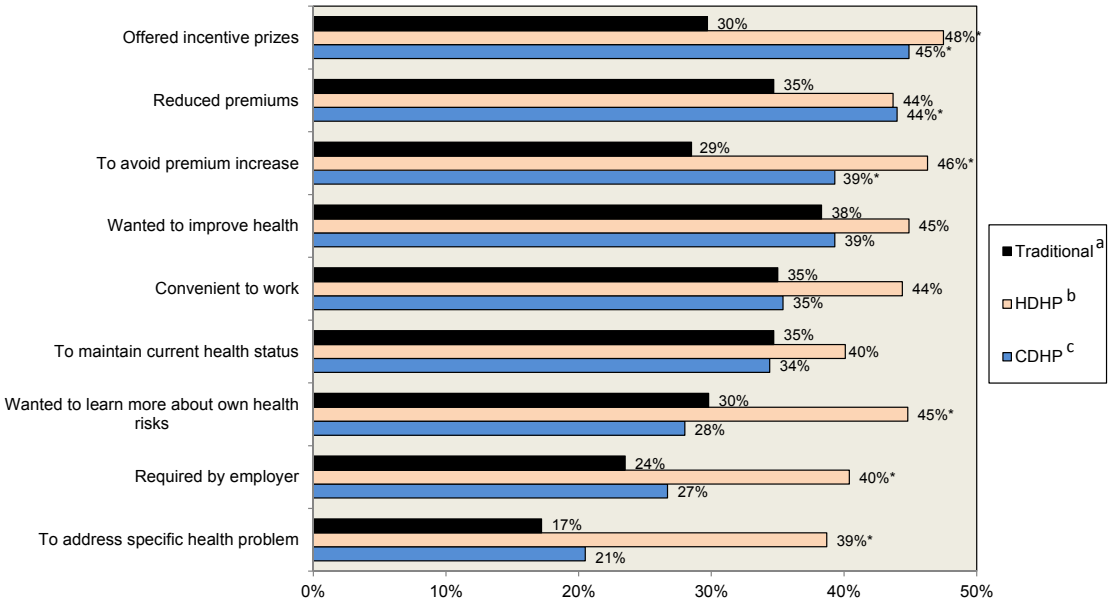
Employer Offers Cash Incentive or Reward for Participating in Wellness Program, Among Workers Whose Employer Offers Wellness Program, by Type of Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

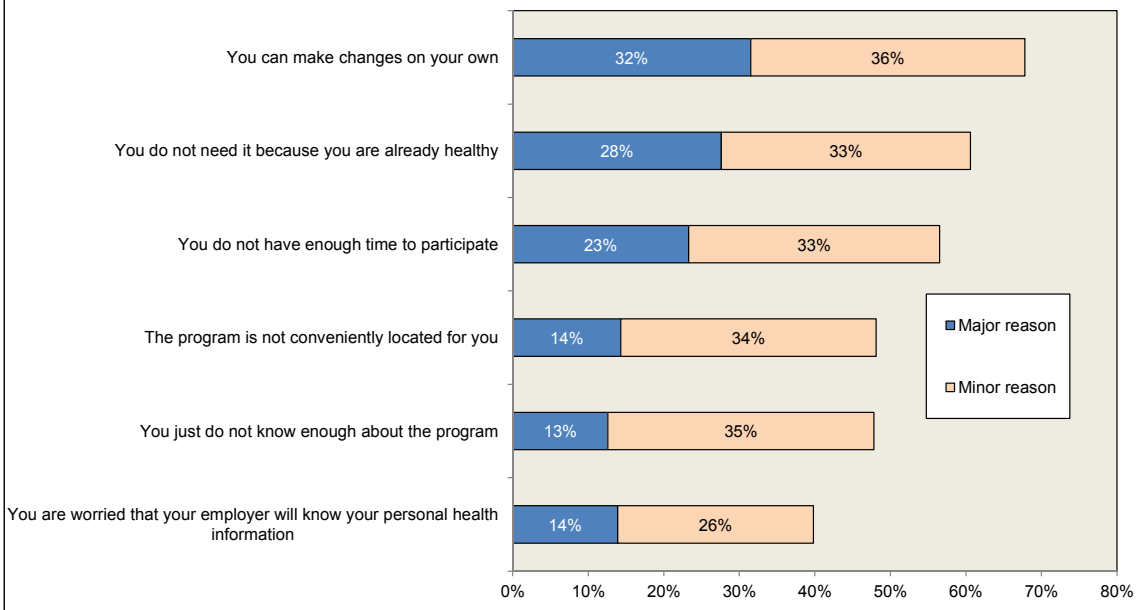
Figure 15

Reasons for Participating in Employer's Wellness Program, by Plan Type, 2015



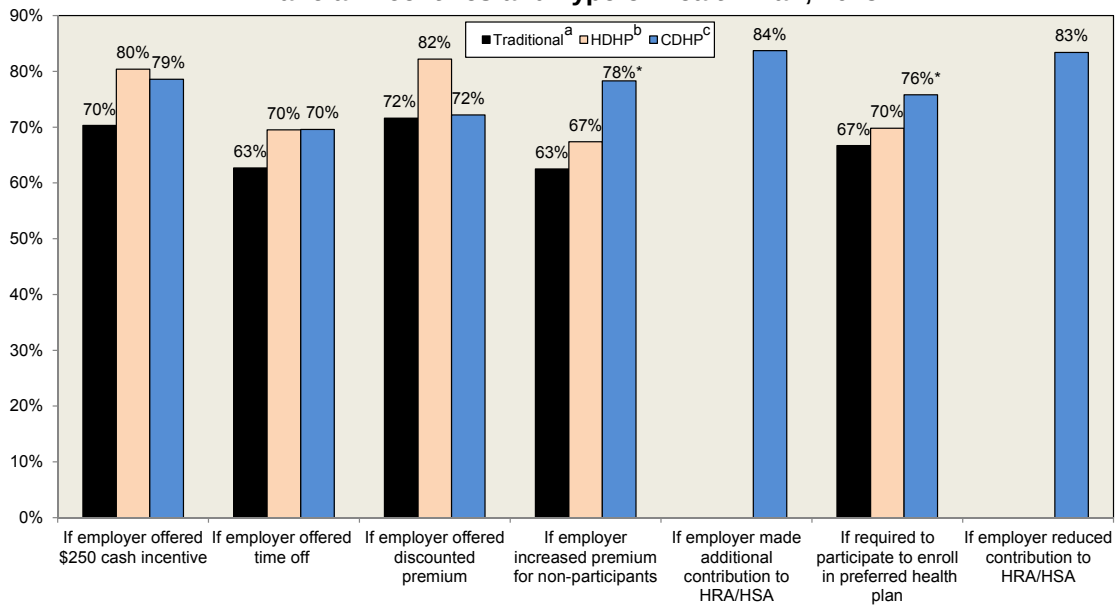
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
[c] CDHP = Consumer-driven health plan withd eductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 16
Reasons for Not Participating in Employer's Wellness Program Among Those Offered but Not Participating in Program, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.

Figure 17
Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Financial Incentives and Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
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* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

individuals, regardless of plan type. It was found that, concerning most questions, between about 57 percent and about 79 percent of participants said they would participate in wellness programs if there was some type of financial incentive related to cost sharing for office visits and prescription drugs. One incentive unique to CDHP was also found to be potentially effective: 84 percent of CDHP enrollees said they would participate in a wellness program if their employer increased their HSA contribution.

Telemedicine

In 2015, the CEHCS added a series of questions about telemedicine. The survey found that, regardless of plan type, very few adults with private health insurance thought it was extremely or very important to have a telemedicine option. Between 4–10 percent thought it was extremely important, and 9–13 percent thought it was very important (Figure 19). The highest number of respondents was in the somewhat-important category, accounting for 36–43 percent. Between 25–31 percent reported that a telemedicine option was not too important, and another 15–16 percent reported that it was not at all important.

However, use of the technology did not appear to be a barrier, as a majority of respondents had previously used some kind of online video chat. CDHP and HDHP enrollees were more likely than traditional-plan enrollees to have previously used an online video chat. Fifty-one percent of traditional-plan enrollees had previously used online video chat, compared with 59 percent among HDHP enrollees and 63 percent among CDHP enrollees (Figure 20).

Despite the finding that very few respondents think it is extremely or very important to offer a telemedicine option, there is strong interest in having a telemedicine visit in various situations. Between 48–55 percent of respondents were extremely or very interested in having a telemedicine visit for after-hours urgent care (Figure 21). Between 43–49 percent was extremely or very interested in having a telemedicine visit to consult with a physician after being hospitalized for major surgery; 47–51 percent was extremely or very interested in having a telemedicine visit if it would take more than one to two hours to get to their doctor's office; and 39–48 percent was extremely or very interested in having a telemedicine visit during bad weather. Overall, regardless of the situation, about one-third of respondents were somewhat interested in having a telemedicine visit. Only 16–27 percent were not interested in a telemedicine visit.

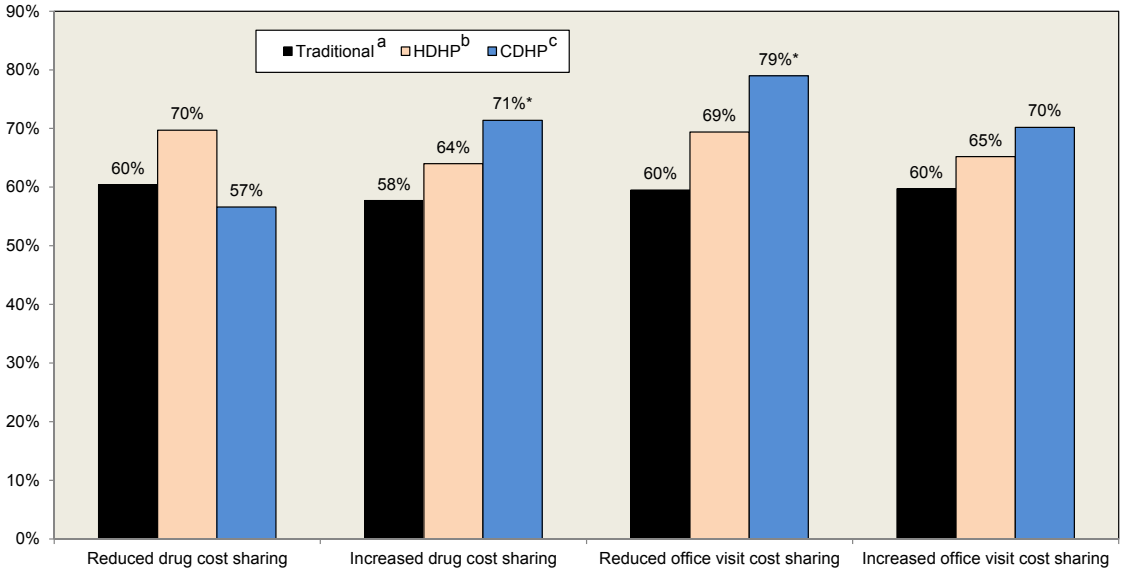
Conclusion

The 2015 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS) found that 13 percent of the population was enrolled in a CDHP; 11 percent was enrolled in an HDHP; and 76 percent was enrolled in traditional coverage. The 13 percent of the population with a CDHP represented about 26 million individuals with private insurance, while the 11 percent with an HDHP represented about 22 million individuals.

The 2015 CEHCS continued to find that CDHP enrollees were more cost conscious in their decision making than those in traditional plans. CDHP enrollees were more likely to use resources to pick their health plan and more likely to seek cost information before getting health care services. 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.

Figure 18

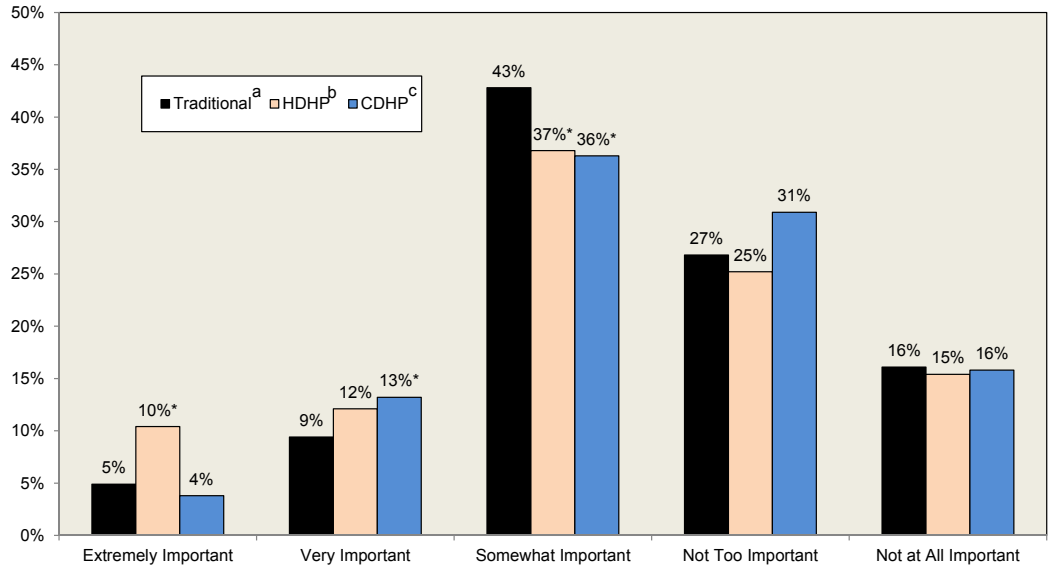
Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Cost-Sharing Incentives and Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
a Traditional = Health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
b HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
c CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

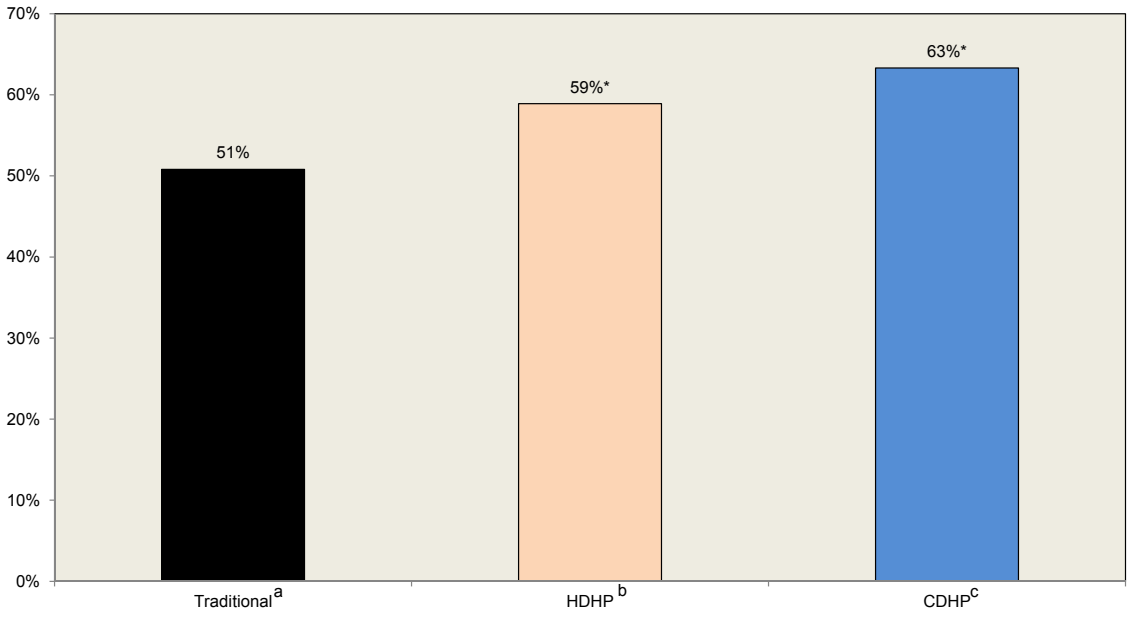
Figure 19

Importance of Having a Telemedicine Option for Getting Medical Care, by Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = Health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
[b] HDHP = High-deductible health plan with deductible $1,300+ (individual), $2,600+ (family), not HSA-eligible in 2015;
[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 20
Ever Used Any Kind of Online Video Chat, by Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = Health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
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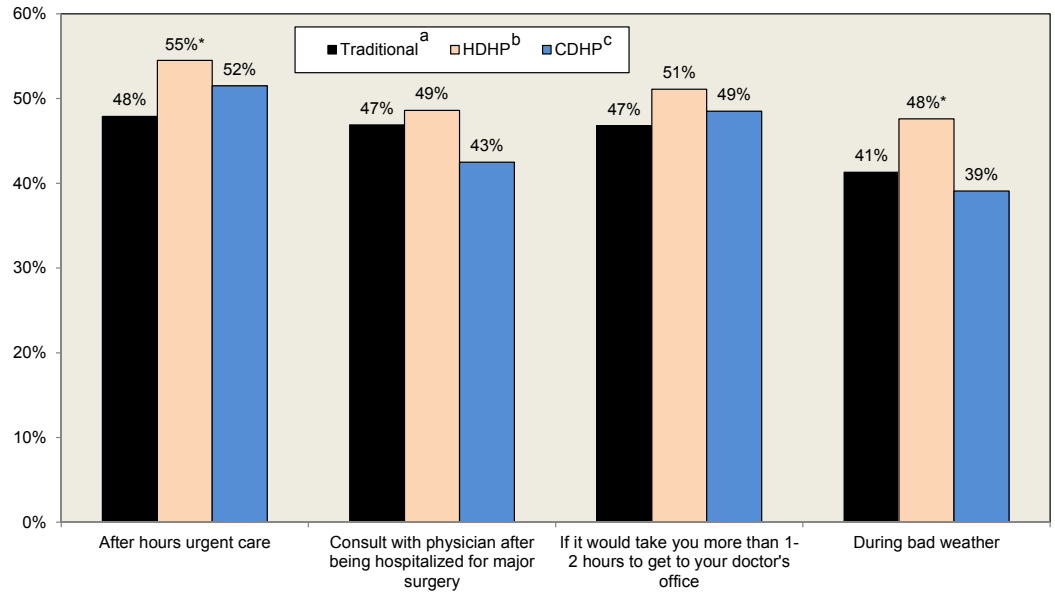
[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 21
Interest in Having a Telemedicine Visit in Various Situations, by Type of Health Plan, 2015



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015.
[a] Traditional = Health plan with no deductible or <$1,300 (individual), <$2,600 (family) in 2015;
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[c] CDHP = Consumer-driven health plan with deductible $1,300+ (individual), $2,600+ (family), with HRA, HSA, or HSA-eligible in 2015.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2015 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS), an online survey that examines issues surrounding consumer-driven 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. This *Issue Brief* also presented findings from the 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008–2014 CEHCS. The 2015 CEHCS was conducted within the United States between Aug. 4 and Aug. 21, 2015, through a 12-minute Internet survey. The national or base sample was drawn from Ipsos' online panel of Internet users who have agreed to participate in research surveys. Over 2,000 adults ages 21−64 who had health insurance through an employer, purchased directly from a carrier, or purchased through a government exchange were drawn randomly from the Ipsos sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 34.4 percent. As a non-probability sample, traditional survey margin-of-error estimates do not apply. However, had the survey used a probability sample, the margin of error for the national sample would have been ±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 groups if they had a deductible of at least $1,300 for individual coverage or $2,600 for family coverage. To be assigned to the CDHP group, they must also have been eligible to contribute to an HSA or had a 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 reported that they were not eligible for an HSA. The group with traditional health coverage included individuals 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 these group members were that they either had no deductible or a deductible that was below current thresholds for HSA tax preference.

Because the base sample (national sample) included only 259 individuals in a CDHP and 255 individuals with an HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 1,026 individuals with a CDHP and 560 individuals with an HDHP, resulting in a total sample (base plus oversample) of 1,285 for the CDHP group and 815 for the HDHP group. After factoring out the base sample—the 259 individuals with a CDHP and the 255 individuals with an HDHP—there were 1,490 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.[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 Ipsos' omnibus survey of more than 30,000 online panel members who met the study's criteria (having private insurance and being ages 21–64). The following three questions were used in the omnibus survey running from July 14 to Aug. 1, 2015, 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 (CDHPs)

CDHPs refer to health plans that have a deductible of at least $1,300 for individual coverage and $2,600 for family coverage in 2015, and include either a health savings account (HSA)-eligible health plan, with or without the 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 $1,300 for self-only coverage and $2,600 for family coverage (minimum deductible amounts are indexed to inflation). Certain preventive services can be covered in full and are not subject to the deductible. The health plan's out-of-pocket maximum may not exceed $6,450 for self-only coverage and $12,900 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 $3,350 for self-only coverage and $6,650 for family coverage in 2015.

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.[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] 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 2015, 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 occurs within 60 days of the date funds are received. Rollover contributions from Archer Medical Savings Accounts (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, if the employer sets up the HRA on a funded basis, the employer incurs the full expense at the time of the contribution, even if an employee has 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. 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.

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Endnotes

[1] Calculated from Figure 1.

[2] More information about HRAs and HSAs can be found in the box on pg. 22 and in Fronstin (2002 and 2004).

[3] See http://www.mercer.com/content/mercer/global/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html.

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

[5] 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 qualify for tax-preferred HSA contributions.

[6] See Figure 5 in www.mercer.com/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html

[7] See Exhibit 5.1 in http://kff.org/report-section/ehbs-2015-section-five-market-shares-of-health-plans/

[8] See http://www.ahip.org/epub/2015-HSA-Census/

[9] See Table XI in http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf

[10] Kaiser found no increase in CDHP enrollment between 2013 and 2014.

[11] See Table XI in http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf.

[12] The specific question was: 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.

[13] 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.

[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.

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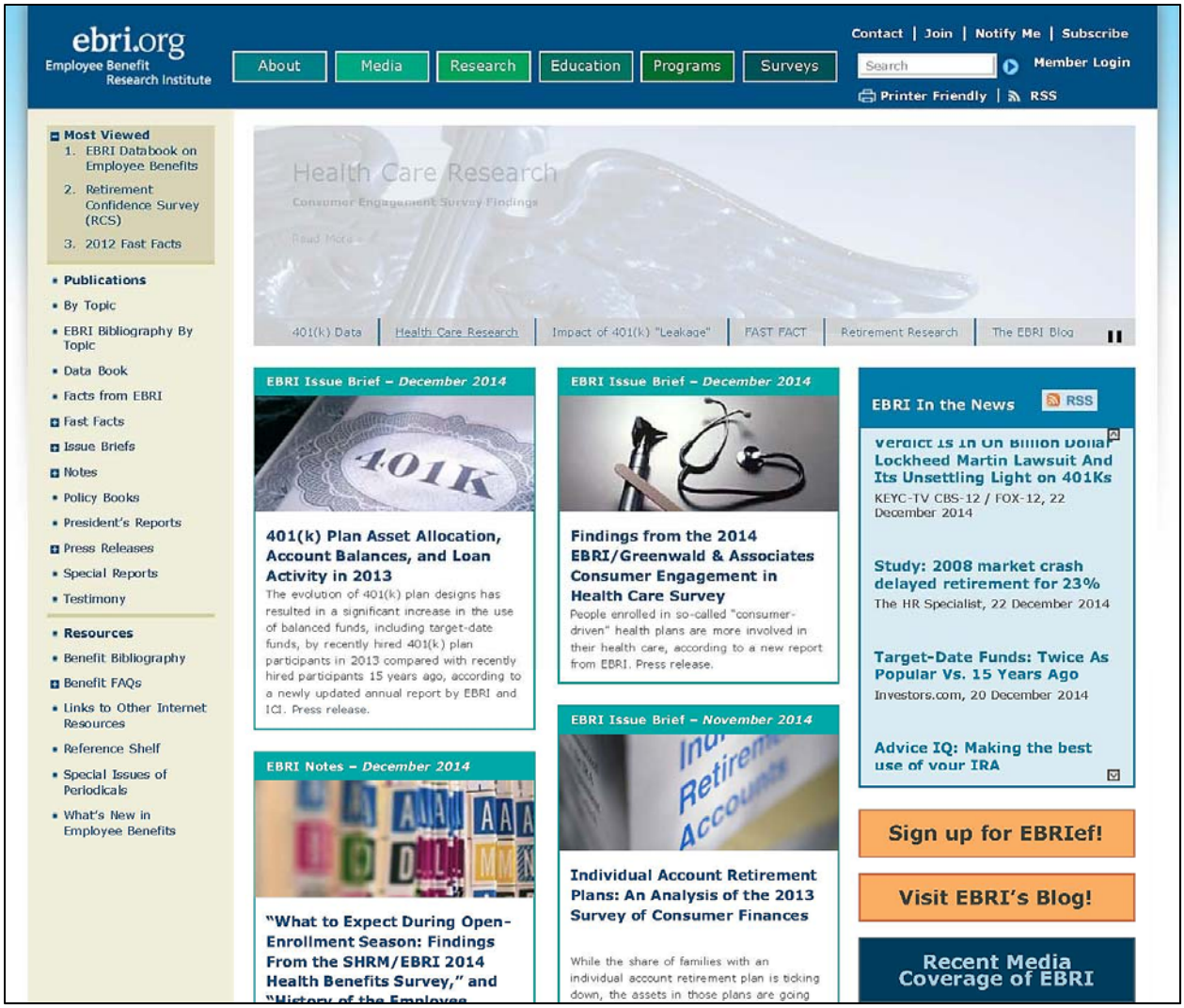

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