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Issue BRIEF

Findings From the 2010 EBRI/MGA Consumer Engagement in Health Care Survey

By Paul Fronstin, Employee Benefit Research Institute

SIXTH ANNUAL SURVEY: This *Issue Brief* presents findings from the 2010 EBRI/MGA Consumer Engagement in Health Care Survey. This study is based on an online survey of 4,508 privately insured adults ages 21–64 to provide nationally representative data regarding the growth of consumer-driven health plans (CDHPs) and high-deductible health plans (HDHPs), and the impact of these plans and consumer engagement more generally on the behavior and attitudes of adults with private health insurance coverage.

ENROLLMENT LOW BUT GROWING: The survey finds continued slow growth in consumer-driven health plans: In 2010, 5 percent of the population was enrolled in a CDHP, up from 4 percent in 2009. Enrollment in HDHPs increased from 13 percent in 2009 to 14 percent in 2010. The 5 percent of the population with a CDHP represents 5.7 million adults ages 21–64 with private insurance, while the 14 percent with a HDHP represents 17.2 million people. Among the 17.2 million individuals with an HDHP, 37 percent (or 6.3 million) reported that they were eligible for an HSA but did not have such an account. Overall, 12.1 million adults ages 21–64 with private insurance, representing 9.5 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA but had not opened the account.

MORE COST-CONSCIOUS BEHAVIOR: Individuals in CDHPs were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors, such as having checked whether their plan would cover care; asked for a generic drug instead of a brand name; talked to their doctor about prescription drug options and costs; talked to their doctor about other treatment options and costs; asked their doctor to recommend a less costly prescription drug; developed a budget to manage health care expenses; and checked prices before getting care.

CDHP MORE ENGAGED IN WELLNESS PROGRAMS: CDHP enrollees were more likely than traditional plan enrollees to report that they had the opportunity to fill out a health risk assessment, and equally likely to report that they had access to a health promotion program. HDHP enrollees were less likely to report having access to a health promotion program. CDHP enrollees were more likely than traditional plan enrollees to take advantage of the health risk assessment and the health promotion program.

FINANCIAL INCENTIVES NOT A FACTOR, BUT HIT IS: Financial incentives were no more a factor for CDHP enrollees than for traditional plan enrollees when it came to participating in wellness programs. However, CDHP and HDHP enrollees were more likely than traditional plan enrollees to choose a doctor based on his or her use of health information technology (HIT).

HEALTH STATUS IS BETTER: Adults in CDHPs were significantly less likely to smoke than were adults in traditional plans, and were less likely to be obese.

INCOME NO LONGER HIGHER; EDUCATION DIFFERENCES REMAIN: While in the past, adults in CDHPs were significantly more likely than those with traditional health coverage to have a high household income, most of the income differences were not present in 2010. However, CDHP and HDHP enrollees were more likely than traditional plan enrollees to be highly educated.

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

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Introduction

Employment-based health benefits are the most common form of health insurance in the United States. In 2009, 156.1 million individuals under age 65, or 59 percent of that population, had employment-based health benefits (Fronstin, 2010). In every year since 1998, premium increases have exceeded worker earnings increases and inflation (Figure 1): Health insurance premiums have more than doubled, while worker earnings have increased 43 percent.[1]

In response, employers have been seeking ways to manage the cost increases. In recent years, employers have turned their attention to account-based health plans—a combination of health plans with deductibles of at least $1,000 for employee-only coverage and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. Employers first started offering account-based health plans in 2001, when a handful of employers began to offer health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).[2] By 2009, 15 percent of employers with 10–499 workers and 20 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan.[3] (See pg. 39 for detailed explanations of HRAs and HSAs.)

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. More recently, employers have continued to turn their attention to consumer engagement in health care more broadly. In 2001, they formed a coalition to report health care provider quality measures, and today the group is composed not only of employers but also of consumer groups and organized labor.[4] In 2005, employers started to focus on value-based insurance designs that seek to encourage the use of high-value services while discouraging the use of services when the benefits are not justified by the costs (Chernew et al., 2007).

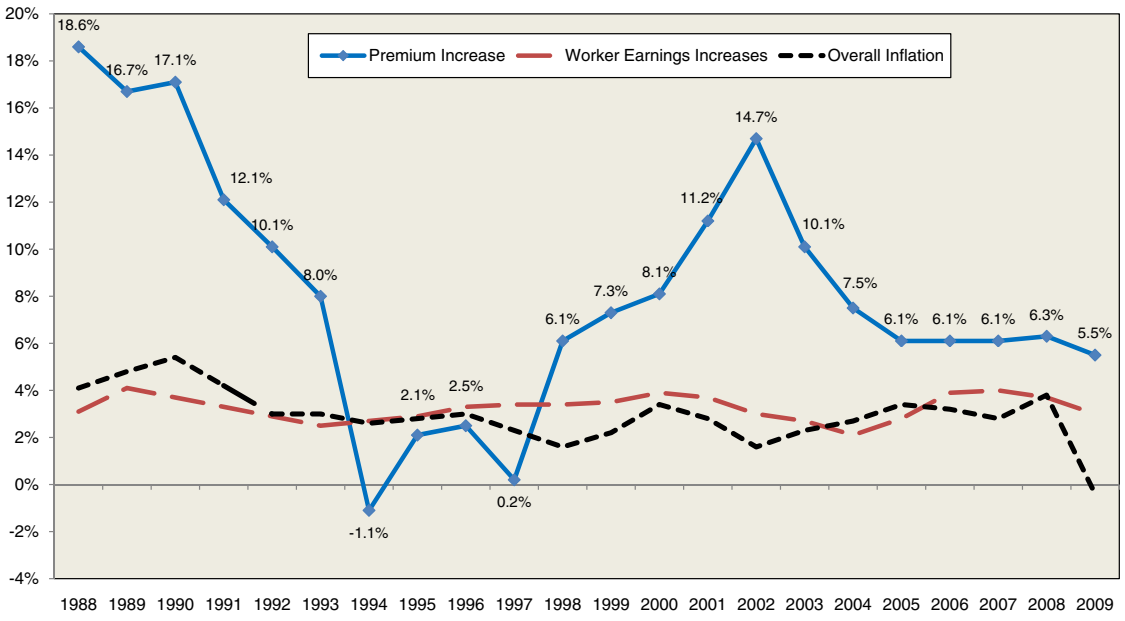
This *Issue Brief* presents findings from the 2010 EBRI/MGA Consumer Engagement in Health Care Survey. This study is based on an online survey of 4,508 privately insured adults ages 21−64 to provide nationally representative data regarding the growth of account-based health plans and high-deductible health plans (HDHPs), and the impact of these plans and consumer engagement more generally on the behavior and attitudes of adults with private health insurance coverage. The sample was randomly drawn from Synovate's online panel of more than 2 million Internet users who have agreed to participate in research surveys. This survey used a base sample of 1,996 to draw incidence rates for persons with account-based health plans and HDHPs, and the base sample was complemented with an additional random oversample of these two groups. More specifically, the oversamples were: 1) those with either an HRA or an HSA, and 2) those with a HDHP without an account but with deductibles that are generally high enough to meet the qualifying threshold to make tax-preferred contributions to such an account. High deductibles were defined as individual deductibles of at least $1,000 and family deductibles of at least $2,000.[5] The final sample included 993 in HDHPs with either an HSA or HRA (consumer-driven health plans, or CDHPs), 1,914 in HDHPs without accounts, and 1,601 in more traditional health plans.[6]

Findings from this survey are compared with findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys, and the 2008 and 2009 EBRI/MGA Consumer Engagement in Health Care Surveys. Past reports used "Comprehensive" as the descriptive label for what is now labeled more "Traditional" health plans. A label change was appropriate given that these plans are not as comprehensive as they were in the past and may no longer fit that label. Prior research has shown that cost sharing has been increasing across the board in the form of higher deductibles and co-payments, and there has been a return to coinsurance.[7]

Summary of Findings

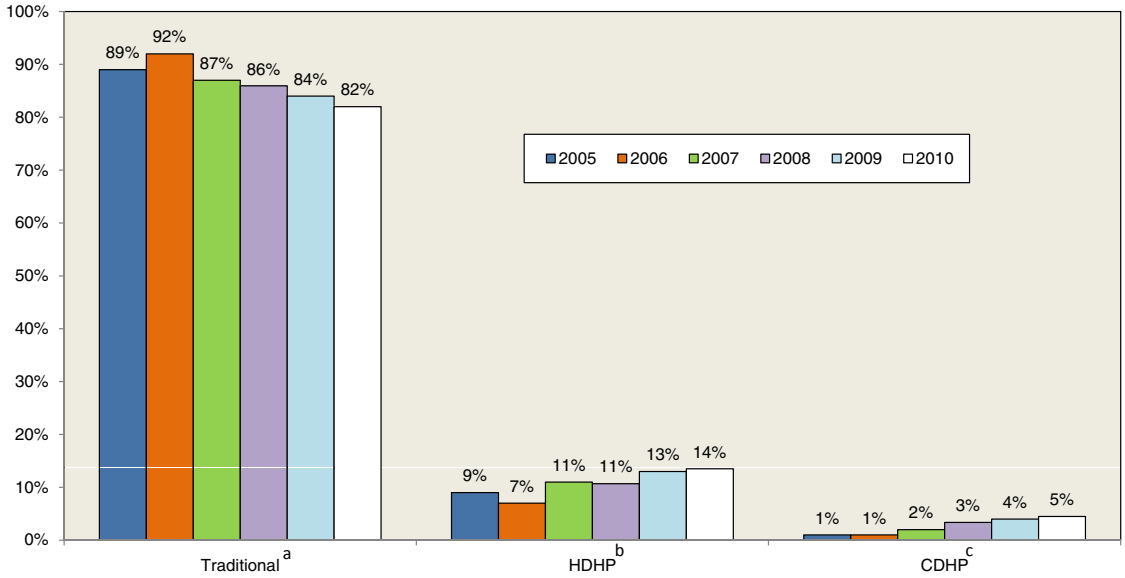
This survey finds that in 2010, 5 percent of the population was enrolled in a CDHP, up from 4 percent in 2009, and 3 percent in 2008; and enrollment in HDHPs increased from 13 percent in 2009 to 14 percent in 2010 (Figure 2). The 5 percent of the population with a CDHP represents 5.7 million adults ages 21–64 with private insurance, while the 14 percent with a HDHP represents 17.2 million people. Among the 17.2 million individuals with an HDHP, 37 percent (or 6.3 million) reported that they were eligible for an HSA but did not have such an account. Thus, overall,

Figure 1
Premium Increases Among Employers With 10 or More Employees, Worker Earnings and Inflation, 1988–2009



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

Figure 2
Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

12.1 million adults ages 21–64 with private insurance, representing 9.5 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA but had not opened the account. When their children are counted, about 21 million individuals with private insurance, representing about 12 percent of the market, were either in a CDHP or an HSA-eligible plan.

HRA and HSA enrollment is growing, but the market penetration remains relatively small and the amount of time individuals have been in these plans is lower than time enrolled in traditional coverage. Among individuals with traditional coverage, 20 percent had been in their plan for three to four years and 43 percent for five or more years. This compares with 28 percent and 16 percent, respectively, among persons in a CDHP (Figure 3). While still lower than the percentage of individuals with traditional coverage, the number of persons with CDHPs and the length of time they have been enrolled in these plans have been increasing (Figure 4).

With respect to familiarity with a CDHP, 56 percent of those with a CDHP were extremely or very familiar with it (Figure 5). In contrast, 10 percent of individuals with traditional coverage were extremely or very familiar with a CDHP, and 10 percent of individuals with an HDHP were extremely or very familiar with a CDHP.

The study also finds the following:

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

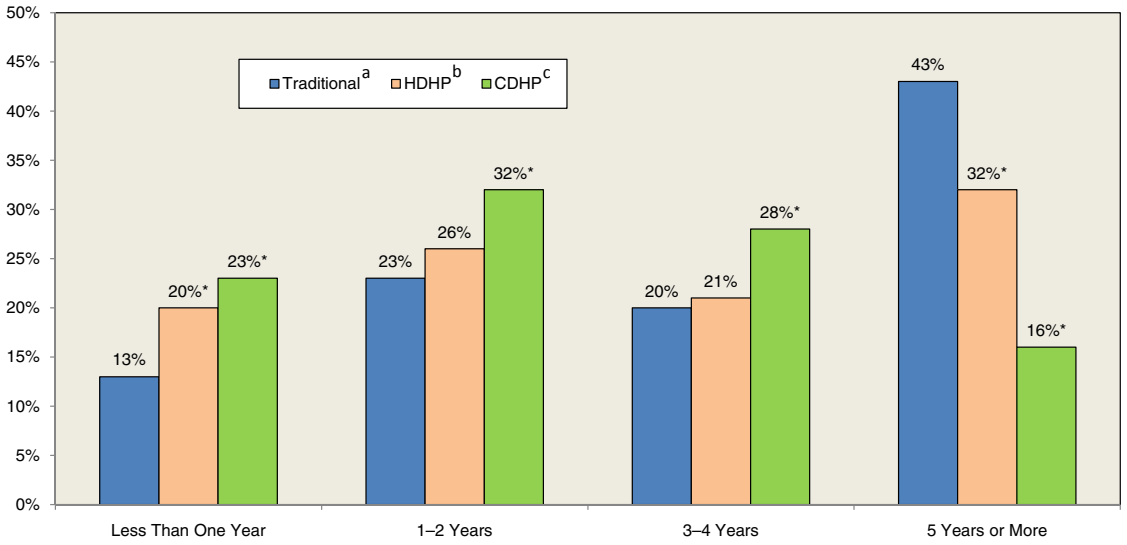
- Individuals were slightly more likely to report that they had *provider quality* information than they did *cost* information, and both CDHP and HDHP enrollees were less likely than traditional plan enrollees to report that the plan provided cost or quality information. In terms of the use of information provided by health plans, CDHP enrollees, HDHP enrollees, and traditional plan enrollees were equally likely to report that they made use of the information. CDHP and HDHP enrollees were also more likely to try to find information about their doctor's cost and quality from sources other than the health plan.

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

- Financial incentives were no more a factor for CDHP enrollees than for traditional plan enrollees when it came to participating in wellness programs. However, CDHP and HDHP enrollees were more likely than traditional plan enrollees to choose a doctor based on his or her use of health information technology (HIT). However, while CDHP enrollees were more likely than traditional plan enrollees to report that they would be interested in using select networks of high-quality doctors when combined with lower cost sharing, when it came to switching doctors if their doctor was not in the network, there was no difference by plan type. Similarly, there was also support in differing degrees for other ways patients could receive lower cost sharing, such as by actively participating in a program to maintain or improve health, by following treatment regimens, and by using scientifically proven effective care. CDHP enrollees were more likely than traditional plan enrollees to support the use of lower cost sharing to engage patients.

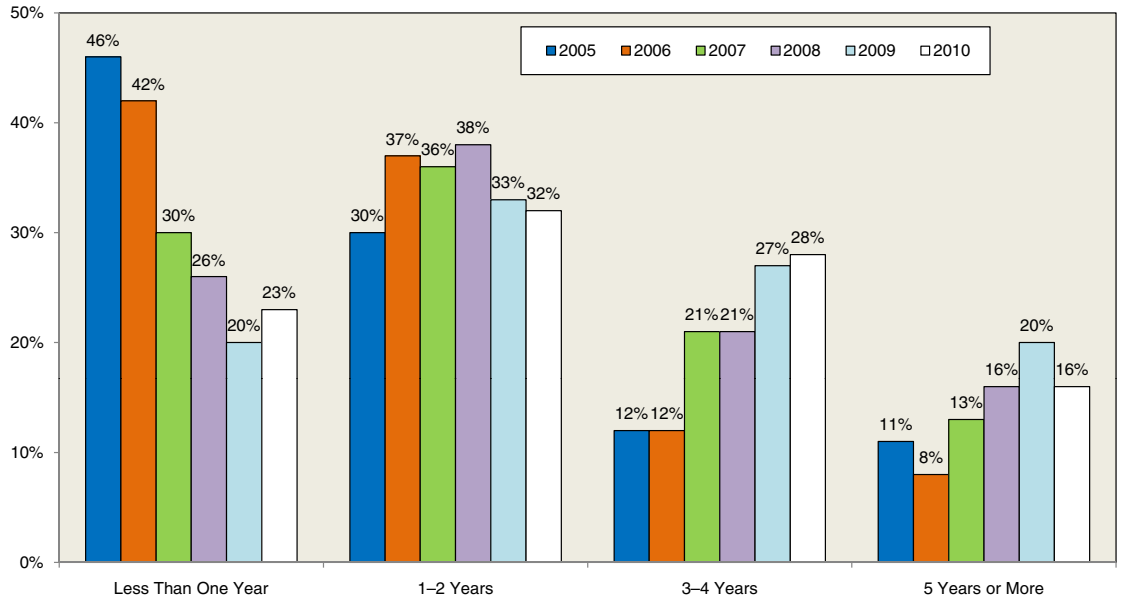
- In 2010, adults in CDHPs were significantly less likely to smoke than were adults in traditional plans, and were less likely to be obese.

Figure 3
Number of Years Covered by Current Health Plan, by Type of Health Plan, 2010



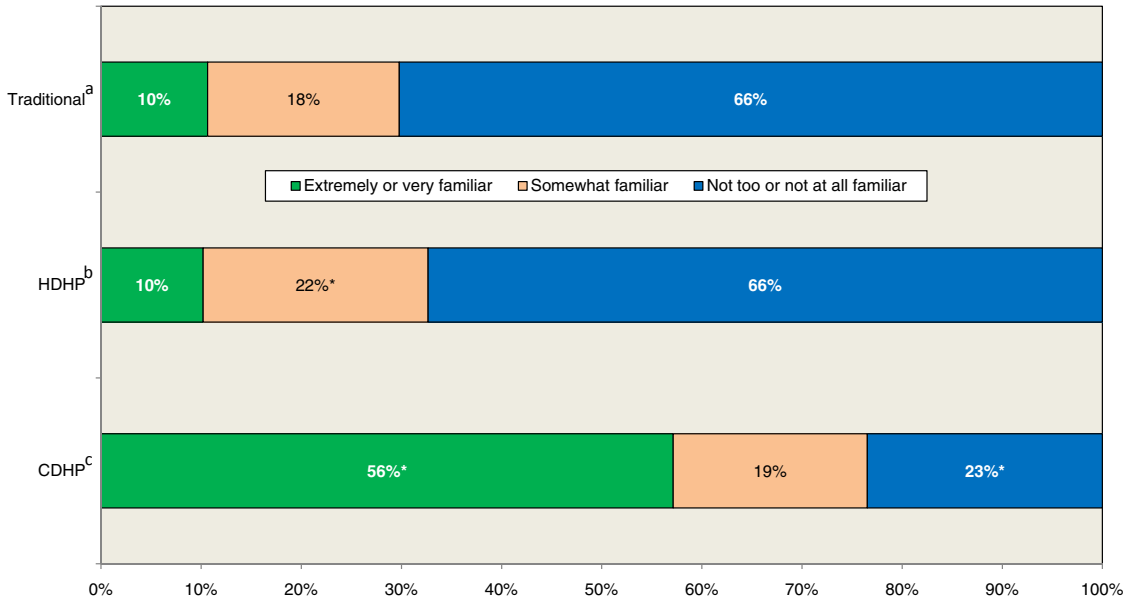
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 4
Length of Time With HRA[a] or HSA,[b] 2005–2010



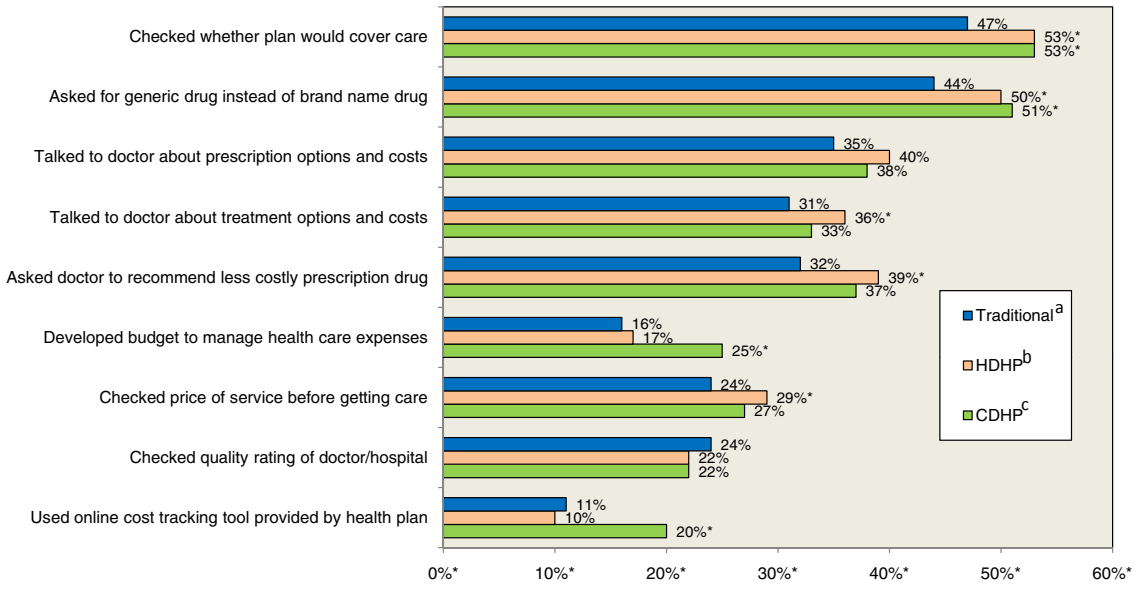
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 5
Familiarity With Consumer-Driven Health Plans, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 6
Cost-Conscious Decision Making, by Type of Health Plan, 2010
(Percentage of privately insured adults 21–64 who received health care in last 12 months)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
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* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

- While in the past, adults in CDHPs were significantly more likely than those with traditional health coverage to have high household income, most of the income differences were not present in 2010. However, CDHP and HDHP enrollees were more likely than traditional plan enrollees to be highly educated. There were few differences by plan type as they relate to gender, age, and race.

- Among individuals with employment-based health benefits, those in CDHPs were more likely than those with traditional coverage to have a choice of health plan. Two-thirds of individuals with an employment-based CDHP reported that the employer contributed to the account. Among persons eligible to contribute to an account, 13 percent did not contribute anything.

- In 2006, the survey found that individuals in CDHPs and HDHPs were less likely to be satisfied with the quality of care received than those in traditional plans, but during 2007–2010 this gap in satisfaction disappeared because quality satisfaction increased significantly among those with CDHPs. The gap in satisfaction rates for quality of care remained between traditional enrollees and HDHP enrollees. The differences in overall satisfaction levels by plan type found in all prior years of the survey were unchanged in the 2010 survey: Traditional plan enrollees were more likely than CDHP and HDHP enrollees to be extremely or very satisfied with the overall plan in all years of the survey. Differences in satisfaction with out-of-pocket costs may explain a significant portion of the difference in overall satisfaction rates between traditional plan, HDHP, and CDHP enrollees.

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

- There was no significant variation in the frequency with which people with chronic conditions followed their treatment regimen across plan types, with one exception.

- This year's survey finds very few instances where the percentage of individuals reporting that they or a family member delayed or avoided getting health care due to the cost increased or decreased.

The remainder of this report examines the findings from the 2010 EBRI/MGA Consumer Engagement in Health Care Survey as they relate to differences and similarities among individuals enrolled in traditional health plans, CDHPs, and HDHPs. The report also examines consumer engagement more generally. 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 value-based insurance design, health status and enrollee characteristics, choice of health plan, premiums, plan choice, contribution behavior among those with a CDHP, satisfaction and attitudes, and health care use and access issues.

Cost-Conscious Behavior

The theory behind account-based plans and plans with higher deductibles is that the cost-sharing structure is a tool that will be more likely to engage individuals in their health care, compared with persons enrolled in more traditional coverage. This study finds evidence that adults in CDHPs and HDHPs were more likely than those in traditional plans to exhibit a number of cost-conscious behaviors. Specifically, those in CDHPs and HDHPs were more likely than those in traditional coverage to say that they had checked whether the plan would cover care (53 percent CDHP and HDHP vs. 47 percent traditional); asked for a generic drug instead of a brand name (51 percent CDHP, 50 percent HDHP vs. 44 percent traditional); talked to their doctor about other treatment options and costs (36 percent HDHP vs. 31 percent traditional); asked their doctor to recommend a less costly prescription drug (39 percent HDHP vs. 32 percent traditional); developed a budget to manage health care expenses (25 percent CDHP vs. 16 percent traditional); checked the price of a service before getting care (29 percent HDHP vs. 24 percent traditional); and used an online cost-tracking tool provided by the health plan (20 percent CDHP vs. 11 percent traditional) (Figure 6).

Trends

There has been no clear increase in the share of CDHP enrollees who report cost-conscious decision-making over the five years of the survey (Figure 7). However, among traditional plan enrollees, a statistically significant increase in the percentage reporting cost-conscious decision-making between 2007 and 2008 was followed by a statistically significant decrease in cost-conscious behavior in some of the answers. Other than with respect to checking whether the health plan would cover care, there were no statistically significant decreases between 2009 and 2010 among individuals with traditional coverage. In contrast, there was a statistically significant across-the-board drop between 2009 and 2010 in the percentage of individuals with a CDHP reporting cost-conscious decisions. As mentioned above, despite this drop, CDHP enrollees were more likely than those in traditional plans to exhibit a number of cost-conscious behaviors.

Availability and Use of Cost and Quality Information

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

The survey asked if an individual's health plan provided information on cost and quality of providers. Individuals were more likely to report that they had, and tried to use, *quality* information available than *cost* information, and both CDHP and HDHP enrollees were less likely than traditional plan enrollees to report that the plan provided the information. Nearly 30 percent of HDHP enrollees reported access to quality information, compared with 34 percent of CDHP enrollees and 45 percent of traditional plan enrollees (Figure 8). Similarly, just one-quarter of HDHP enrollees reported access to cost information, compared with 30 percent among CDHP enrollees and 41 percent among traditional plan enrollees.

CDHP, HDHP, and traditional plan enrollees were about equally likely to use information provided by their health plans. However, CDHP and HDHP enrollees were more likely than traditional plan enrollees to try to find information on cost and quality from sources other than the health plan. Specifically, about one-quarter of CDHP and HDHP enrollees sought other sources of information, while one-fifth of traditional plan enrollees did so.

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 2010 EBRI/MGA Consumer Engagement in Health Care Survey examined availability and participation in two types of wellness programs: a health risk assessment and a health promotion program that included a number of different types of benefits.[8]

It found that CDHP enrollees are more likely than traditional plan enrollees to report that they had the option to fill out a health risk assessment. Specifically, 38 percent of CDHP enrollees reported that their employer offered a health risk assessment (Figure 9), compared with 29 percent of traditional plan enrollees and 25 percent of HDHP enrollees. When asked about the availability of health promotion programs, 45 percent of CDHP enrollees and 39 percent of traditional plan enrollees reported that their employer offered such a program. The difference between CDHP and traditional plan enrollees was not statistically significant. However, 30 percent of HDHP enrollees reported the availability of a health promotion program, significantly lower than offer rates among CDHP and traditional plans enrollees.

CDHP enrollees were more likely than traditional plan enrollees to take advantage of participating in a wellness program, either the health risk assessment or the health promotion program. Three-quarters of CDHP enrollees participated in the health risk assessment, compared with 60 percent of traditional plan enrollees (Figure 10). Similarly, 52 percent of CDHP enrollees participated in a health promotion program, compared with 41 percent of traditional plan enrollees.

The EBRI/MGA Consumer Engagement in Health Care Survey asked respondents their reasons for not participating in their employer's wellness program. Slightly more than 60 percent responded that they did not participate because they

Figure 7

Trends in Cost-Conscious Decision Making, by Type of Health Plan, 2005–2010

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

	Traditional[a]						HDHP[b]						CDHP[c]					
	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010
Total Sample	953	1,363	1,794	1,548	1,651	1,601	417	802	1,284	1,484	1,693	1,914	163	652	805	1,077	972	993
Checked whether health plan would cover care	51%	58%	50%^	55%^	50%^	47%^	61%	62%	61%*	61%	56%*	53%*^	60%*	62%	60%*	63%*	61%*	53%*^
Asked for generic drug instead of brand name drug	n/a	48	46	50^	46^	44	n/a	60*	58*	58*	52*^	50*	n/a	54	54*	58*	56*	51*^
Talked to doctor about prescription options and costs	n/a	n/a	n/a	n/a	35	35	n/a	n/a	n/a	n/a	42	40	n/a	n/a	n/a	n/a	44	38
Talked to doctor about treatment options and costs	42	44	44	45	33^	31	56*	44^	49*^	49	37^	36*#	58*	46^	47	46	40*	33^#
Asked doctor to recommend less costly prescription drug	27	31	30	36^	34	32	46*	41*	43*	41	39*	39*	45*	39*	38*	36	39*	37
Checked price of service before getting care	24	20	21	23^	25	24	35*	23^	27*^	23^	29^	29*	29	26*	27*	25	35*^	27^
Checked quality rating of doctor/hospital	18	21	20	25^	24	24	22	18	19	22	22	22	18	19	18	23^	27*	22^
Developed budget to manage health care expenses	n/a	n/a	n/a	n/a	15	16	n/a	n/a	n/a	n/a	18	17	n/a	n/a	n/a	n/a	32	25*^
Used online cost tracking tool offered by health plan	n/a	8	8	12^	12	11	n/a	6	9^	10	9*	10	n/a	17*	20*^	20*	24*	20*^

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

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

Difference between 2005 and 2010 is statistically significant at the p ≤ 0.05 or better.

Figure 8

Availability and Use of Quality and Cost Information Provided by Health Plan and Effort to Find Information From Other Sources, 2010

	Traditional[a]	HDHP[b]	CDHP[c]
Health plan provides information on quality of care provided by doctors	45%	28%*	34%*
Health plan provides information on cost of care provided by doctors	41	24*	30*
Of those whose plans provide info on quality, how many tried to use it for doctors	45	49	49
Of those whose plans provide info on cost, how many tried to use it for doctors	40	39	48
Tried to find information from sources other than health plan on cost and quality of care provided by doctors	20	24*	24*

Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).

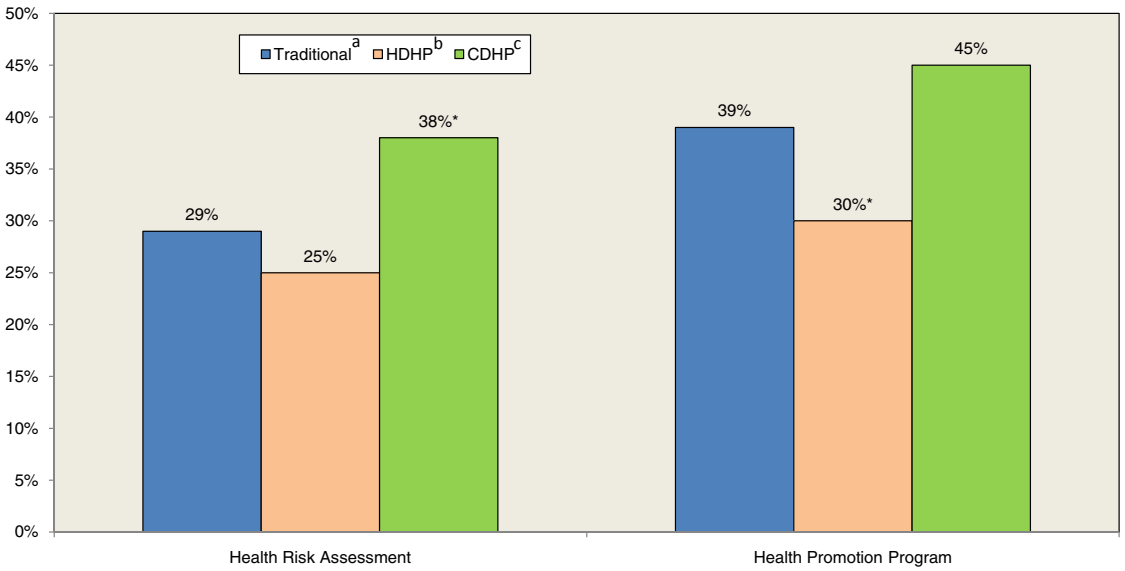
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

[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 9

Employer Offers Wellness Program, by Type of Health Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
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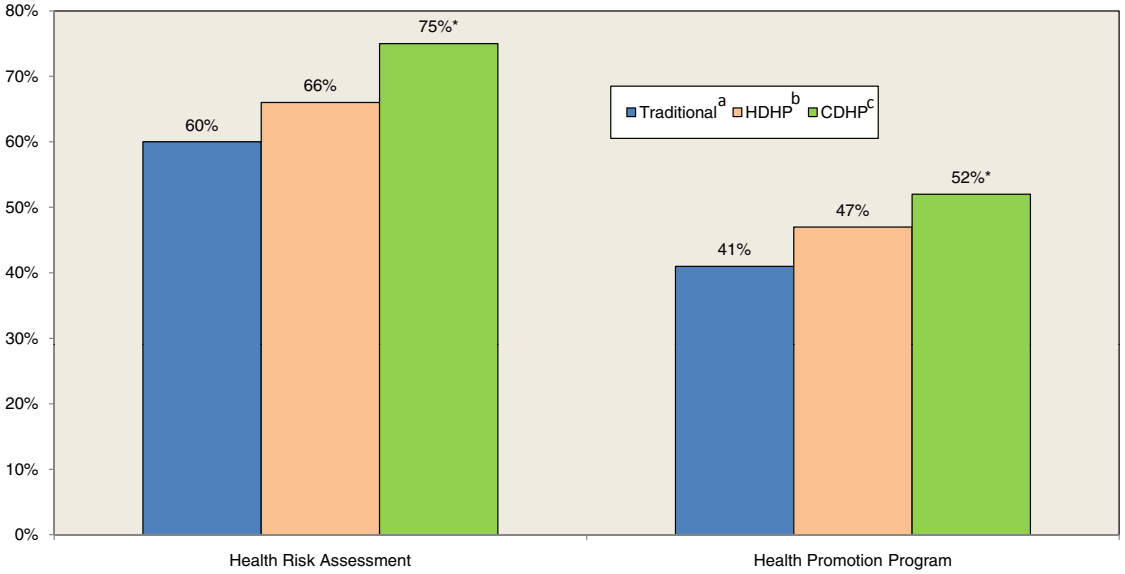
Figure 10

Individual Participates in Wellness Program Offered by Employer, Among Those Offered a Wellness Program, by Type of Health Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
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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.

could make changes on their own (Figure 11): 32 percent cited this as a major reason and 31 percent cited it as a minor reason for not participating. Lack of time was the second most popular reason for not participating, with 24 percent reporting it as a major reason and 27 percent reporting it as a minor reason. Forty-three percent did not participate because they were already healthy (20 percent reported it as a major reason and 23 percent reported it as a minor reason). For the most part, there were no differences in the answers to this series of questions by plan type. However, CDHP enrollees were more likely than traditional plan enrollees not to participate because they were worried that their employer would know their personal health information, and they were more likely not to participate because they were uncomfortable participating with their coworkers.

Figures 12 and 13 contain findings from a series of questions related to the impact that financial incentives could have on participation in wellness programs. Even among persons not participating in their employer's wellness program, financial incentives to participate still matter to all individuals, regardless of plan type. Unlike in 2009, financial incentives did not seem to matter more to individuals enrolled in CDHPs. It was found that individuals are more likely to report that they would probably participate in wellness program when their costs were reduced, as compared with when their costs are increased. For instance, 79 percent of CDHP enrollees would probably participate in a wellness program if the employer offered a discounted premium, whereas 70 percent would if the employer increased premiums for nonparticipants. Similarly, just over 70 percent would probably participate if either drug or office visit cost sharing was reduced, whereas less than 60 percent would participate if cost sharing for drugs or office visits was increased.

Opinions About Provider Engagement

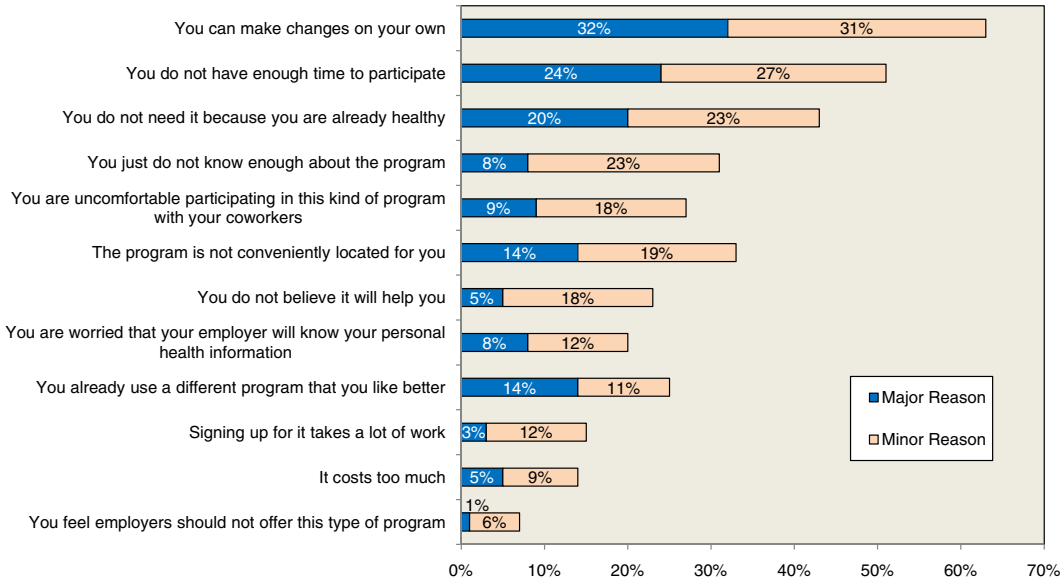
The 2010 EBRI/MGA Consumer Engagement in Health Care Survey included questions regarding the importance of various ways in which providers of health care services engage their patients. Eighty-one percent of traditional plan enrollees and nearly 90 percent of both HDHP and CDHP enrollees reported that it was extremely or very important that their doctor communicated with them so that they could really understand what the doctor was saying (Figure 14). While not large, the difference between traditional plan enrollees and CDHP and HDHP enrollees was statistically significant. Slightly more than 70 percent of individuals reported that it was extremely or very important that their doctor work with them to find realistic changes that they could make to improve their health, while about 70 percent or slightly less reported that it was extremely or very important that their doctor was 1) accessible by phone; 2) took responsibility for coordinating their care with other providers, specialists, or testing facilities; and 3) understood them as a person, with the difference between traditional plan and CDHP enrollees statistically significant. About two-thirds of individuals with traditional coverage, 69 percent with an HDHP, and 74 percent with a CDHP think it is extremely or very important that their doctor coach them about staying healthy rather than just treating their health problems. And about one-half of individuals, regardless of plan type, think it is extremely or very important that their doctor use medical terminology during patient-provider discussions. Only between 19 percent and 26 percent think it is extremely or very important that their doctor be accessible by e-mail.

Cost-Sharing Incentives

Questions were asked in 2008 about cost-sharing variations as an incentive regarding choice of provider, but 2009 marked the first year that questions were asked regarding health information technology (HIT), and these questions were asked again in 2010. There was no difference by plan type when it came to changing doctors if cost sharing was lower or higher when using a doctor who used or did not use HIT. About one-quarter of individuals reported that they would change doctors to one who used HIT if cost sharing was lower, and about one-quarter reported that they would change doctors to one who used HIT if not doing so increased their cost sharing (Figure 15).

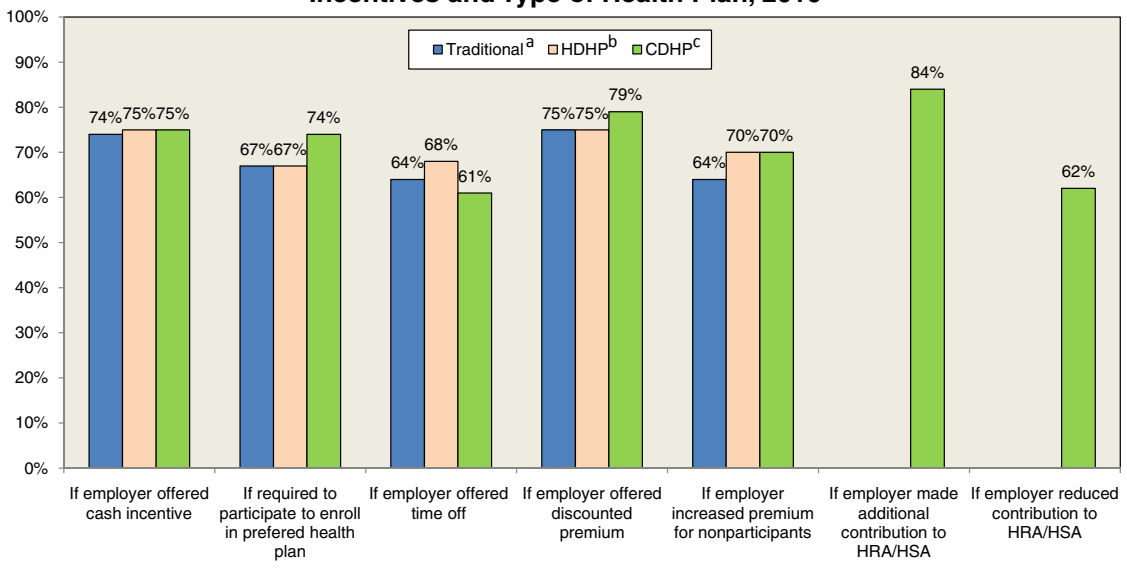
Unlike the general question on HIT and cost sharing as incentives to switch to a doctor who uses HIT, when more specific questions were asked it was found that CDHP and HDHP enrollees were more likely than traditional plan enrollees to choose a doctor based on his or her use of HIT. CDHP and HDHP enrollees were found to be more likely than traditional plan enrollees to switch doctors to one who used e-mail to deliver lab tests, allowed the individual to schedule appointments online, allowed patients to request and receive referrals online, answered patient questions via

Figure 11
Reasons for Not Participating in Employers Wellness Program Among Those Offered but Not Participating in Program, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

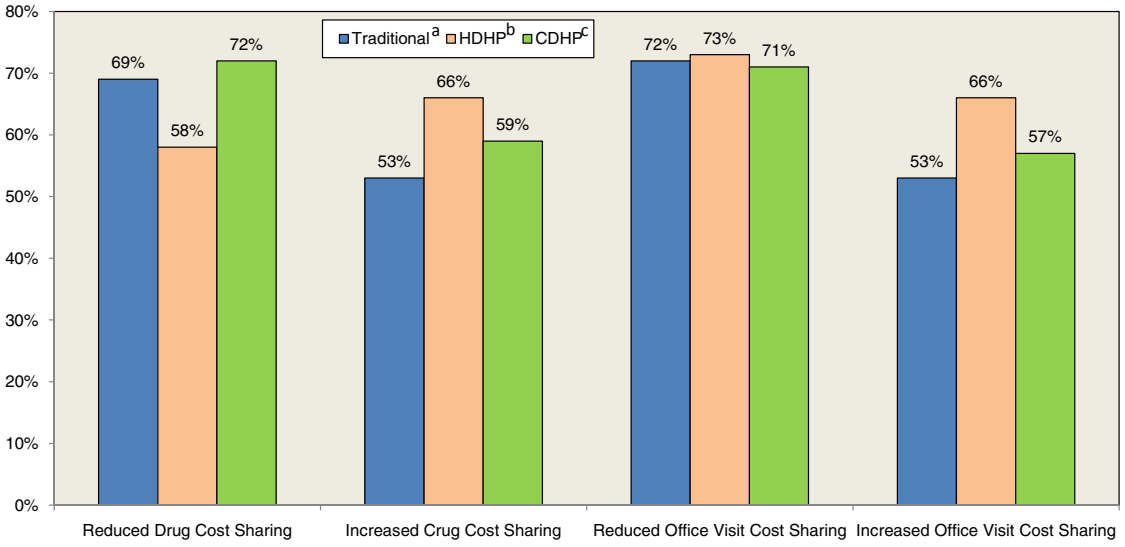
Figure 12
Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Financial Incentives and Type of Health Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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

Percentage of Individuals Reporting They Would Probably Participate in Employer Wellness Program, by Various Cost Sharing Incentives and Type of Health Plan, 2010

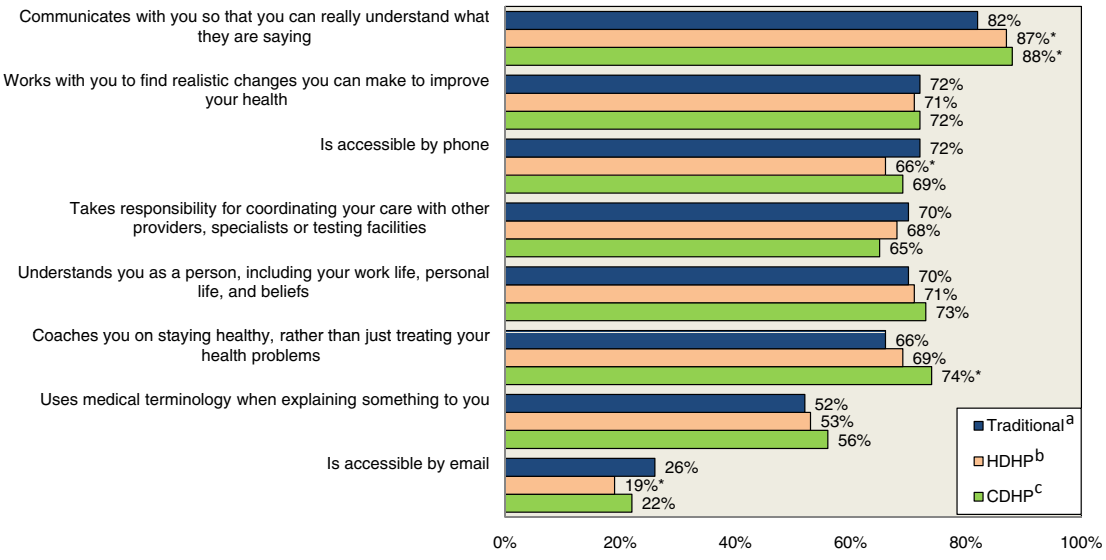


Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 14

Agreement With Statements About Various Provider Engagement Tools, by Type of Health Plan, 2010

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



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

e-mail, and was able to use real-time, virtual visits for "face-to-face" consultations (Figure 16). Generally, about one-half or more of CDHP and HDHP enrollees are likely to choose a doctor based on his or her use of HIT, whereas between 40–50 percent of traditional plans enrollees are likely to do so.

The 2010 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 strong interest in select networks composed of only medical providers with records of high-quality care when combined with lower cost sharing. Thirteen percent of individuals in CDHPs, 10 percent of individuals with HDHPs, and 9 percent of individuals with traditional coverage were extremely interested in using select networks when combined with lower cost sharing (Figure 17). CDHP enrollees were also more likely than traditional plan enrollees to be somewhat interested in the concept, with 40 percent of CDHP enrollees interested and 33 percent of traditional plan enrollees interested. There was about the same amount of interest in changing doctors to one in a select network combined with lower cost sharing, and there were no statistically significant differences by plan type (Figure 18).

A series a questions was asked regarding whether individuals agreed or disagreed with various ways patients could receive lower cost sharing (findings shown in Figure 19). Sixty-two percent of CDHP enrollees, 61 percent of HDHP enrollees, and 52 percent of traditional plan enrollees agreed that patients who are actively participating in a program to maintain or improve their health should pay less for health care services than a patient who is not participating in the program. The difference between both CDHP and HDHP enrollees vs. traditional plan enrollees was statistically significant. Similar support was found for individuals who follow their treatment regimen. About 40 percent of individuals thought that patients using scientifically proven effective care should have lower cost sharing, while about 30 percent thought there should be lower cost sharing for patients using high-quality doctors.

Health Status and Demographics

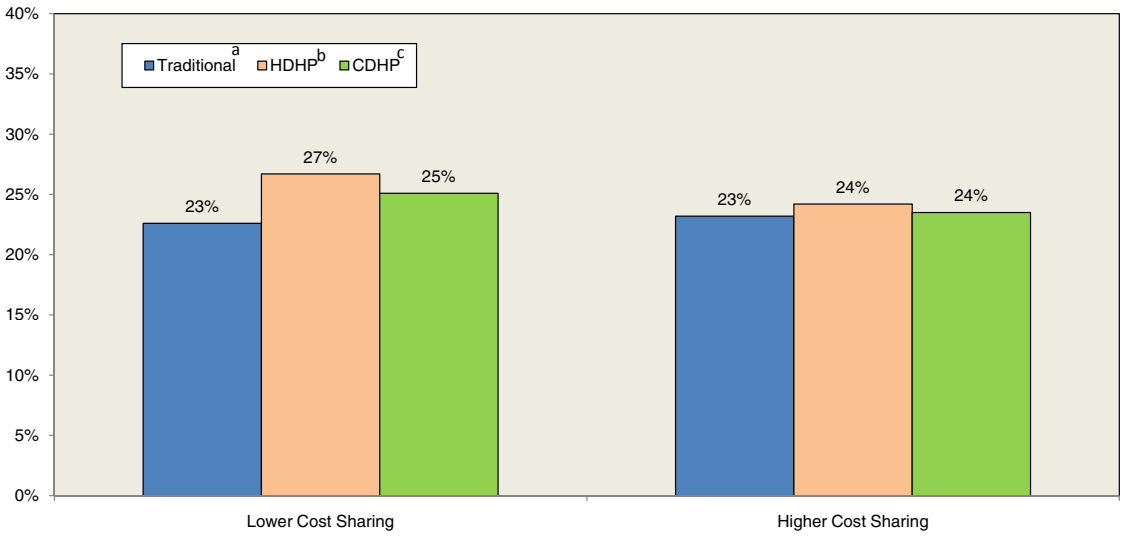
Figure 20 contains data on various demographic and health status variables from each of the surveys conducted between 2005 and 2010. These data may explain some of the differences in behavior and attitudes that were observed between traditional plan enrollees, HDHP enrollees, and CDHP enrollees, as presented in Figures 5–19. In all but one year (2009), CDHP enrollees were more likely than traditional plan enrollees to self-report being in excellent or very good health. The survey also asked respondents whether they had chronic conditions.[9] In some years (although not in 2010), the survey found that individuals in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans. In 2010, 45 percent of those in CDHPs reported a chronic health problem, compared with 50 percent among those in traditional plans and 52 percent among HDHP enrollees, although these differences are not statistically significant.

Adults in CDHPs and HDHPs were significantly less likely to smoke than were adults in traditional plans in all six years of the survey: in 2010, 9 percent of those in CDHPs, 12 percent in HDHPs, and 15 percent of those with traditional coverage smoked. People in CDHPs were also more likely to exercise in all years of the survey except 2010, and they were less likely to be obese compared with adults enrolled in a traditional health plan in some years, including 2009 and 2010.

There were some statistically significant demographic differences among individuals enrolled in the three types of health plans and changes to these findings. In past years, it was found that individuals enrolled in CDHPs were significantly more likely than those in traditional plans to have high household income. However, in 2010, while persons in CDHPs were more likely than those with traditional coverage to have household income of $50,000–$99,999, significant differences were not found at $100,000 or more. However, CDHP and HDHP enrollees were more likely than traditional plan enrollees to be highly educated, which may also explain the differences in behaviors and attitudes between the groups. There were few differences among CDHP, HDHP, and traditional enrollees related to gender, age, and race.

Figure 15

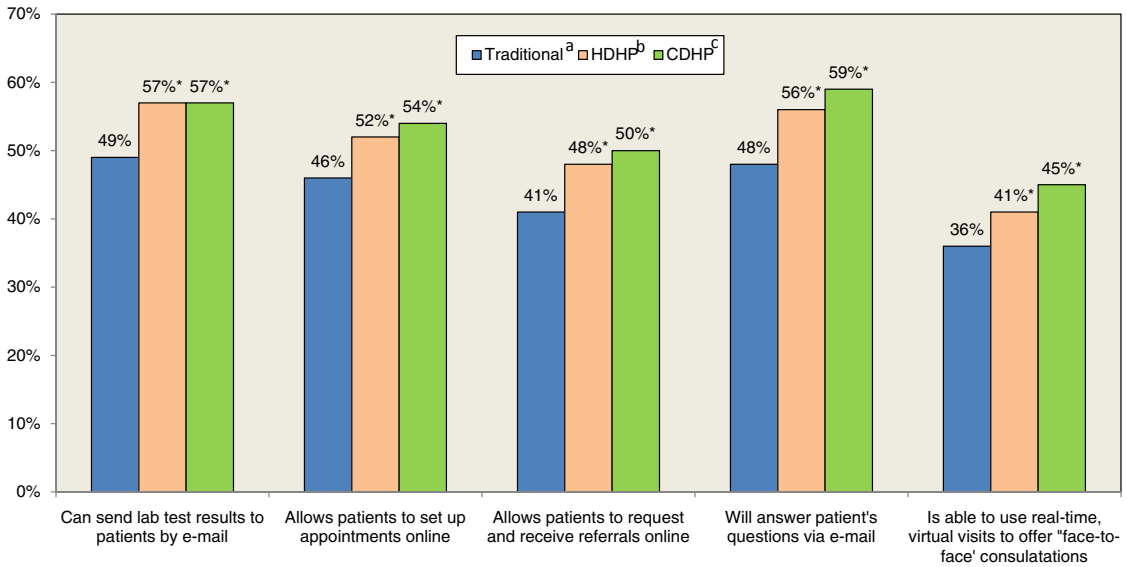
Likelihood of Changing Doctor If Cost Sharing was Lower or Higher When Using Doctors Who Use Health Information Technology (HIT) and Current Doctor Does Not Use HIT, by Type of Health Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 16

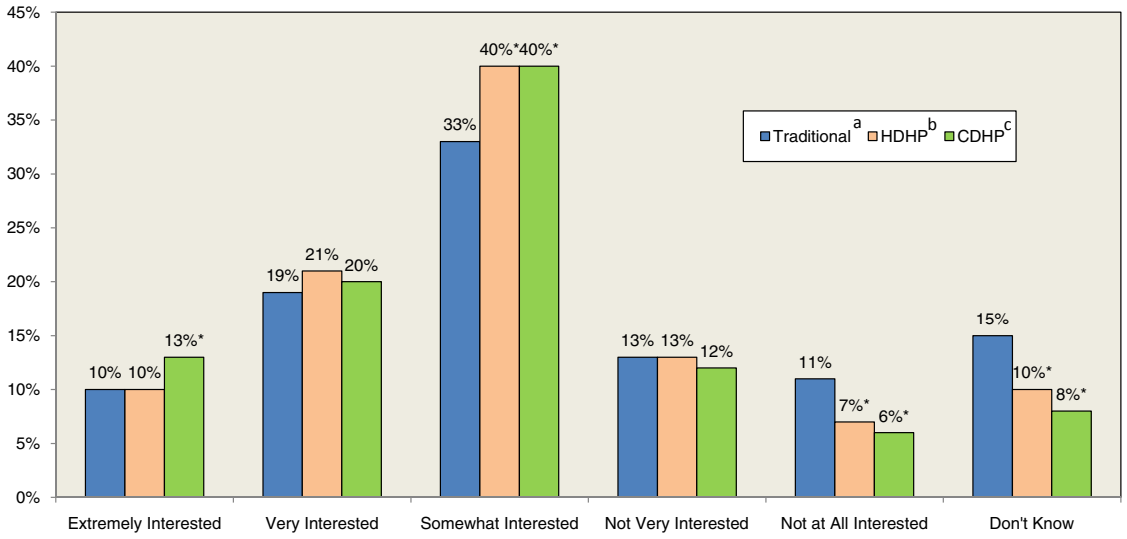
Likelihood of Choosing Doctor by Their Use of Health Information Technology (HIT), by Type of Health Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 17

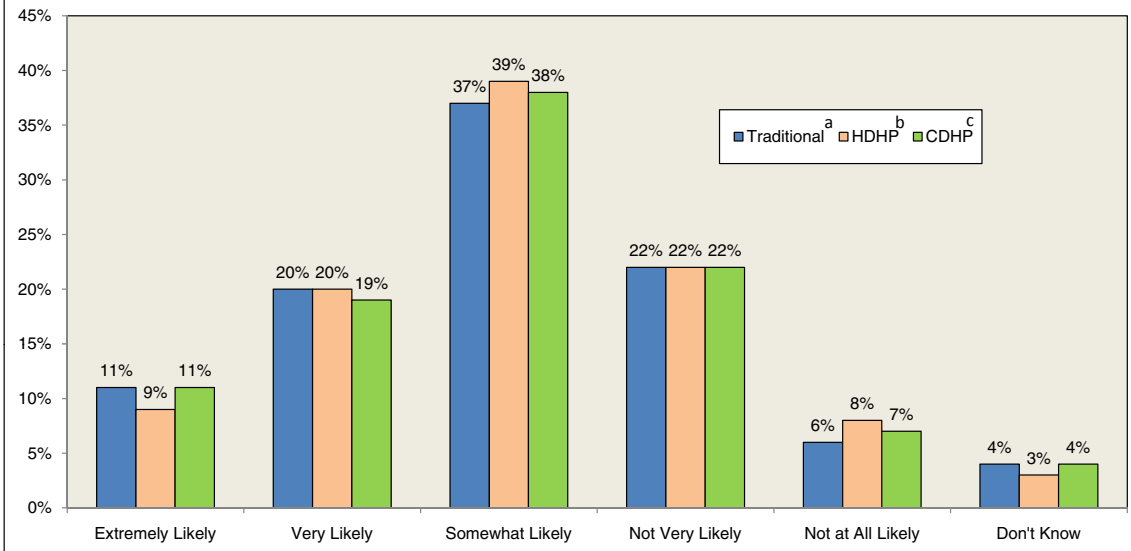
Interest in Enrolling in Plan Using Select Networks Composed of Only Medical Providers With Records of Providing High-Quality Care Combined With Lower Cost Sharing, by Type of Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

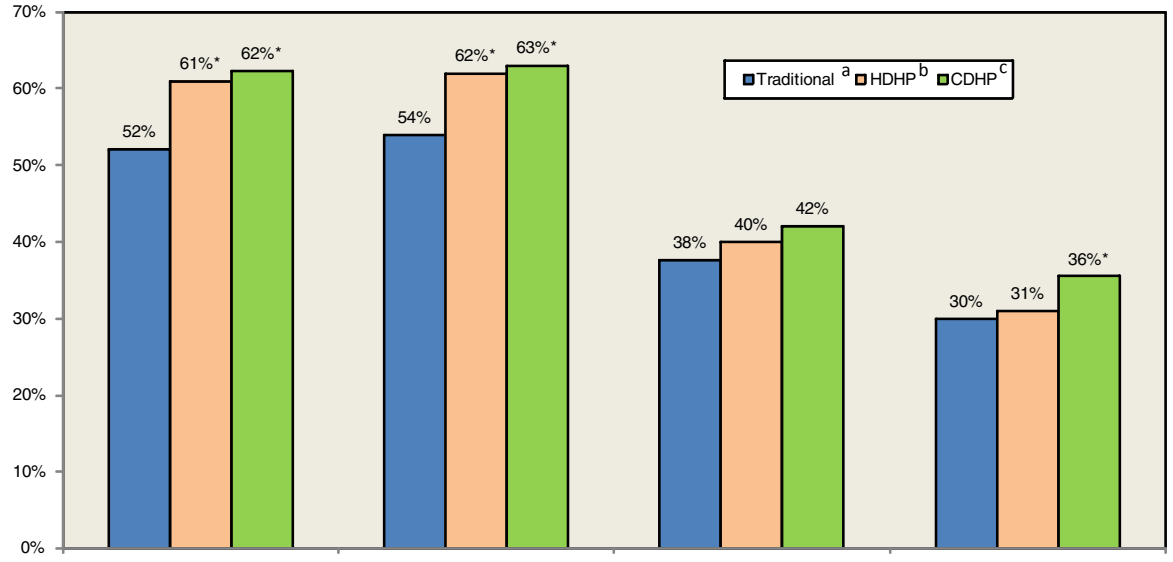
Figure 18

Likelihood of Changing to Select Network If Current Doctor Was Not in Select Network, by Type of Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better

Figure 19
Agreement With Statements About Proposed Ways to Engage Consumers in Managing Health Care Costs, by Type of Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

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

Among individuals covered by an employment-based health plan, those in CDHPs were more likely than those with traditional coverage to have a choice of health plan, followed by those enrolled in HDHPs. Sixty-five percent of CDHP enrollees had a choice of health plan, compared with 58 percent of individuals in traditional plans, and 50 percent of those with a HDHP (Figure 21). These results are in contrast to findings from 2005 and 2006, when individuals with traditional coverage were more likely to have a choice of health plan than individuals enrolled in CDHPs (Figure 22). The survey also found that the percentage of individuals in a CDHP with a choice of health plan grew from 47 percent to 70 percent between 2005 and 2009 before dropping to 65 percent in 2010. The decline from 70 percent to 65 percent between 2009 and 2010 was statistically significant. The fact that choice of health plan has been growing among CDHP enrollees at least until 2010 may be because an increasing percentage of the CDHP population works for an employer with 500 or more employees (as shown in Figure 20) and that large employers tend to offer more benefit options.

When offered a choice of health plan, there are many reasons why an individual may choose a particular plan. When asked about the main reason for enrolling in a plan, 51 percent of CDHP enrollees reported that they enrolled because of the lower premium, while 46 percent reported that the opportunity to save money in the account for future years was a main reason for enrolling in that plan (Figure 23). Among individuals with traditional health coverage, 42 percent cited the good network of providers and 36 percent report the low out-of-pocket costs as the main reasons for enrolling in the plan.

Among the population with traditional coverage and a choice of plan, 38 percent were offered a CDHP or HDHP, and 33 percent were not offered these plans, but 29 percent did not know if they were offered them (Figure 24). Among

Figure 20

Selected Demographics, by Type of Health Plan, 2005–2010

	Traditional[a]						HDHP[b]						CDHP[c]					
	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010
Total sample	1,358	1,506	1,918	1,714	1,651	1,601	487	930	1,404	1,634	1,603	1,914	186	722	895	1,184	972	993
Gender																		
Male	49%	49%	50%	48%	50%	50%	53%	49%	51%	50%	48%	46%	57%	50%	57%*	54%*	52%	44%*
Female	51	51	50	52	50	50	47	51	49	50	52	54	43	50	43*	46	48	56*
Married	60	74	78	67	78	76	61	55*	64*	62*	64*	68	59	61*	70*	71	70*	67
Has children	34	42	47	42	44	40	33	35*	37*	37	39*	40	40	44	45	46	49	47*
Age																		
21–34	27	33	34	33	28	31	18*	24*	21*	20*	25	21*	20*	24*	20*	23*	28	20*
35–44	26	23	22	23	23	23	25	25	24	24	24	27*	31	32*	31	30	28	36*
45–54	29	26	27	26	28	27	34	29	30	29	27	28	34	28	30	28	27	27
55–64	17	18	18	19	21	19	24	22	25*	26*	25	24	15	16	19	19	16*	16
Race/Ethnicity																		
White, non-Hispanic	71	71	71	72	70	70	94*	83*	78*	77	72	72	93*	81	75	76	72	78
Minority	28	29	29	28	30	30	6*	17*	22*	24	27	28	7*	19	25	24	28	22
Household Income																		
Less than $30,000	15	12	15	14	11	14	11	17*	12*	9*	10	4*	11	13	6*	4*	3*	3*
$30,000–$49,999	19	20	18	19	17	17	19	30*	18	14*	16	14	22	24	13	10*	10*	11
$50,000–$99,999	34	38	36	36	38	37	36	35	38	40	43*	47*	33	43	41	40	45*	54*
$100,000–$149,999	14	14	14	14	17	15	11	5*	14	19*	16	19*	13	7*^	20*	25*	24*	14
$150,000 or more	7	7	7	9	10	10	4	3*	9	9*	8	7*	9*	4*^	11*	15*	10	11
Education																		
High school graduate or less	32	38	42	33	35	38	14*	17*	14*	13*	14*	10*	6*	11*	11*	10*	8*	10*
Some college, trade or business school	31	29	29	31	31	28	36	36*	30	28	26	26	28	33*	24	22*	24*	25
College graduate or some graduate work	24	22	20	24	23	22	34	35*	40*	42*	42*	45*	46*	41*	41*	44*	46*	44*
Graduate degree	13	11	9	12	11	10	16	12	17*	17*	18*	18*	20*	15	24*	24*	21*	21*

(cont'd)

(Fig. 20 cont'd from previous page)

	Traditional[a]						HDHP[b]						CDHP[c]					
	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010
Self-Rated Health Status																		
Excellent/very good	42	54	49	56	59	59	50	53	54*	54	59	58	58*	60*	65*	66*	64	67*
Good	45	35	38	34	32	34	36	34	35	34	30	32	34	33	29*	30	27	28*
Fair/poor	13	12	13	10	9	7	13	13	10	12	11	10	9	7*	6*	5*	8	5
At least one chronic health condition**	54	49	49	52	52	50	56	50	53*	56	54	52	48	43*	45	45*	46*	45
Health problem***	57	51	53	54	54	51	57	53	55	57	57	54	49	44*	46*	45*	49*	46
Obese	36	30	27	26	31	29	33	28	30	29	28	27	26*	30	25	23	23*	22*
Smokes cigarettes	23	24	24	20	18	15	14*	18*	14*	15*	13*	12	14*	14*	15*	13*	13*	9*
No regular exercise	24	25	25	25	21	23	15*	25	20*	21	19	19	16*	19*	17*	17*	13*	20
Firm Size (base: employed full- or part-time)																		
Self-employed with no employees	2	4	3	2	3	3	9*	9*	9*	7*	7*	5*	8*	5	6*	7*	5	5
2–49	15	19	19	16	15	16	31*	32*	27*	26*	25*	26	39*	32*	28*	25*	21*	23
50–199	8	10	11	12	11	8	9	14	14	13	15*	13*	8	12	11	13	12	12
200–499	9	8	9	8	10	8	6	8	7	7	7*	8	5*	10	8	7	7*	7
500 or more	54	45	43	50	48	52	33*	29*	36	38*	37*	41*	36*	31*	40	42	48	49

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

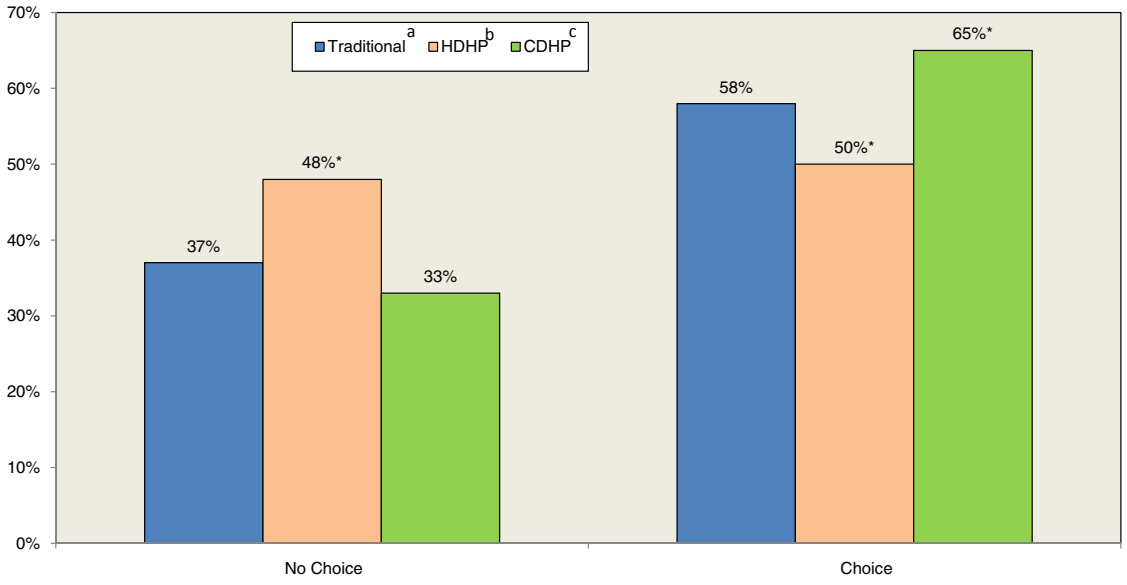
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

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

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

Figure 21

Percentage of Individuals Covered by Employment-Based Health Benefits With Choice and No Choice of Health Plan, by Type of Health Plan, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).

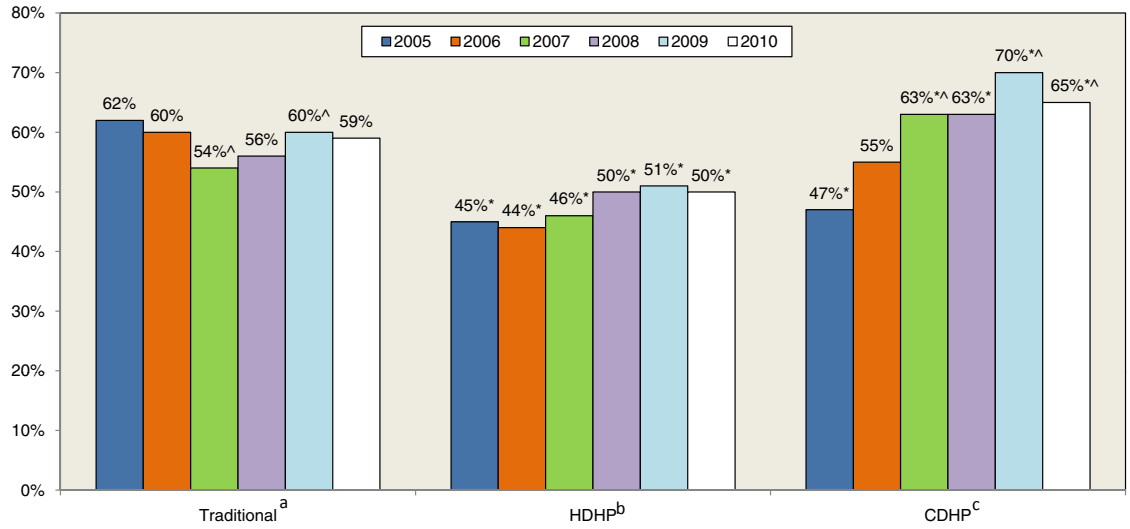
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

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

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

Figure 22

Percentage of Individuals Covered by Employment-Based Health Benefits With a Choice of Health Plan, by Type of Health Plan, 2005–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007;EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).

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

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

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

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

Difference between 2005 and 2010 is statistically significant at the p ≤ 0.05 or better.

the 38 percent who were offered either a CDHP or HDHP, 16 percent were offered a CDHP, 12 percent were offered a HDHP, and 10 percent were offered an HDHP and did not know if they were offered an account.

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

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

Figure 23

Main Reason for Deciding to Enroll in Current Health Plan, Among Individuals With a Choice of Health Plan or in the Non-Group Market, by Type of Health Plan, 2010

	Traditional[a]	HDHP[b]	CDHP[c]
Lower cost of the premium	36%	41%	51%*
Low out-of-pocket costs for the doctor	36	14*	9*
Good network of physicians and hospitals/doctor in the network	42	40	26*
Prior experience with the plan	27	22	15*
Specific benefits offered by the plan	18	17	11*
Plan's good reputation, recommended by others	10	12	6*
Prescription drug coverage	35	20*	10*
Familiar type of coverage, simple to understand	21	20	9*
Easy access to care	18	15	7*
Opportunity to save money in the account, rollover funds for future years	4	3	46*
Puts you in control of your health care dollars, you make choices of how your account is spent	4	4	25*
Not much paperwork	13	10	6*
Tax benefits of the plan	2	4	23*

Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

[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.

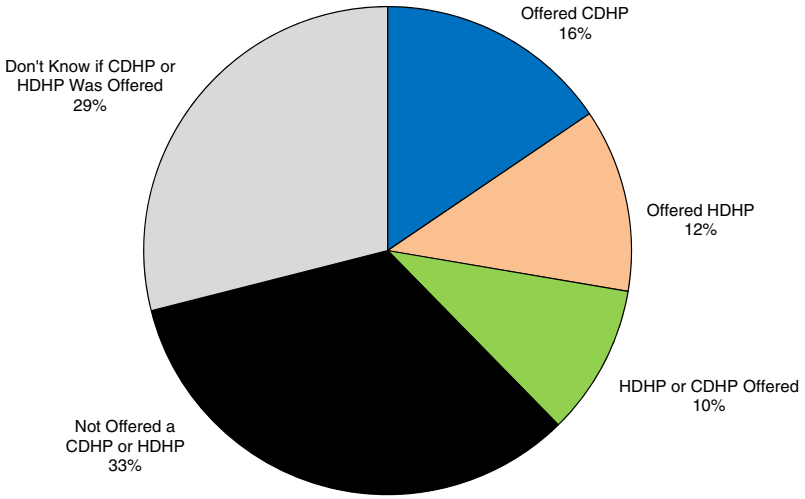
*Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Contribution Behavior and Account Balances

Among individuals with a CDHP, some receive employer contributions to the account, while others do not. HRA enrollees will get employer contributions but are unable to make their own contribution. Individuals with an HSA can contribute their own money to the account and may or may not also receive employer contributions. Two-thirds (64 percent) of individuals with an employment-based CDHP (including both those covered as an individual and those with family coverage) reported that the employer contributed to the account, while 32 percent reported that they did not receive employer contributions, and 4 percent did not know if the employer contributed (Figure 25).[10]

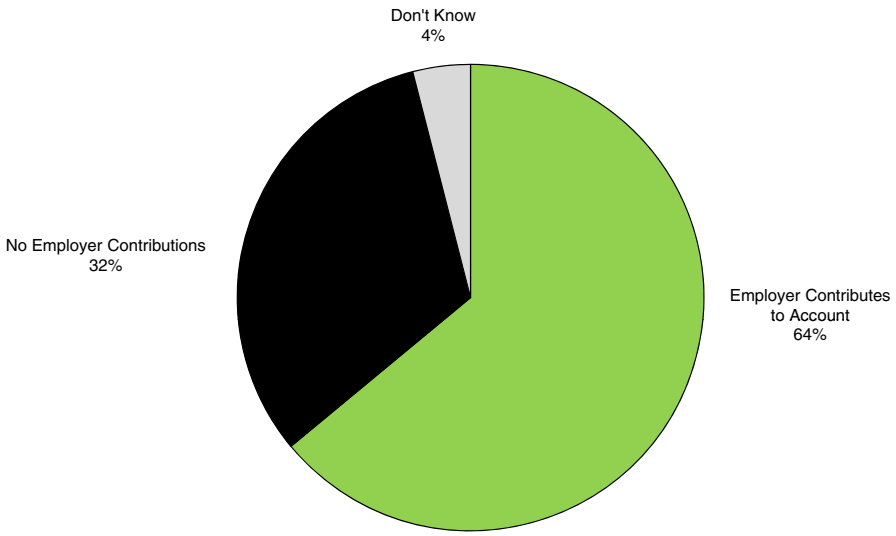
Among the 64 percent with an employer contribution, 13 percent received less than $500, 28 percent received between $500–$999, 25 percent received between $1,000–$1,499, 7 percent received between $1,500–$1,999, and 18 percent received $2,000 or more (Figure 26). Employer contributions vary, however, by whether an individual has employee-only or family coverage. Individuals with employee-only coverage are most likely to get an employer contribution between $500–$750, while those with family coverage are most likely to get an employer contribution of at least

Figure 24
Percentage of Individuals With Traditional[a] Employment-Based Health Benefits Offered HDHP[b] or CDHP,[c] 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 25
Percentage of Individuals With Employer Contribution to Account, Among Persons With Employment-Based Health Benefits and CDHP,[a] 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

$1,000 (Figure 27). In fact, 62 percent of individuals with family coverage get a contribution of at least $1,000, with 29 percent getting $1,000–$1,499, 9 percent getting $1,500–$1,999, and 24 percent getting at least $2,000.

Overall, among persons eligible to contribute to an account, 13 percent did not contribute anything, with 20 percent of those with household income below $50,000 and 12 percent of those with household income of at least $50,000 contributing nothing (Figure 28). The most significant difference in contributions by household income can be seen in the likelihood of contributing at least $2,000 to the account. About 37 percent of individuals with household income of at least $50,000 contributed $2,000 or more to the account, whereas 24 percent of those with household income of less than $50,000 contributed $2,000 or more to the account.

Individual contributions to the account also vary by whether an individual has single coverage or family coverage. Specifically, individuals with single coverage are more likely than those with family coverage to contribute less than $1,000 to the account, whereas individuals with family coverage are more likely than those with single coverage to contribute at least $2,000 (Figure 29). Overall, 30 percent of individuals with single coverage contributed at least $2,000, while 39 percent of those with family coverage contributed at least $2,000 to the account.

Concerning length of time that CDHP enrollees have had their account, 8 percent enrolled in the past six months, another 19 percent in the past year, and 35 percent in the past two years (Figure 30). One-quarter (28 percent) report being in the account three to four years, and 8 percent report having the account for five years or more.

Concerning account balance, 7 percent had no balance while 18 percent had $3,000 or more (Figure 31). Overall, 47 percent had less than $1,000 in the account at the time of the survey, and 10 percent did not know how much was in the account. Concerning rollovers, 13 percent rolled over nothing while 39 percent rolled over at least $1,000 at the end of 2010 (Figure 32).

Satisfaction and Attitudes

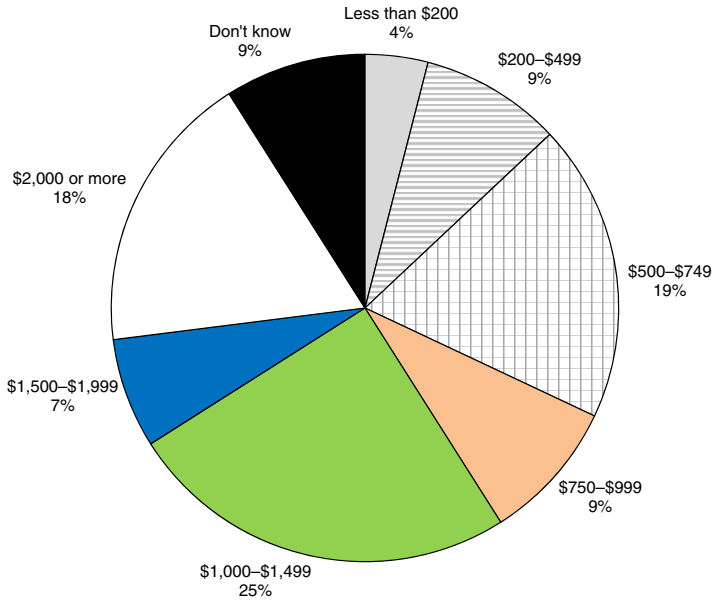
Respondents were asked a series of questions regarding their attitudes toward their health plan and satisfaction with regard to various aspects of their health care. Questions were asked about overall satisfaction with the health plan as well as satisfaction related to quality of care received, out-of-pocket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

The 2006 survey found that individuals in CDHPs and HDHPs were less likely to be satisfied with the quality of care received than those in traditional plans. However, in 2007, the gap in satisfaction between those in traditional plans and those with CDHPs disappeared because satisfaction increased significantly among those with CDHPs, and it remained unchanged through 2009 (Figure 33). Satisfaction levels dropped among people in each type of health plan between 2009 and 2010. The previously observed gap in satisfaction rates for quality of care received remained between traditional enrollees and HDHP enrollees.

Unlike satisfaction with quality of care received, the differences in overall satisfaction levels by plan type found in all prior years of the survey continued in the 2010 findings (Figure 34). Traditional plan enrollees were more likely than CDHP and HDHP enrollees to be extremely or very satisfied with the overall plan in all years of the survey. In 2010, 60 percent of traditional plan enrollees were extremely or very satisfied with the overall health plan, compared with 42 percent among CDHP enrollees and 35 percent among HDHP enrollees. It is also worth noting that the overall satisfaction levels among CDHP enrollees increased from 37 percent to 47 percent between 2006 and 2007 and were 52 percent in 2009, while the overall satisfaction rates for traditional enrollees were unchanged. Between 2009 and 2010, satisfaction with the overall health plan dropped among people in each type of health plan.

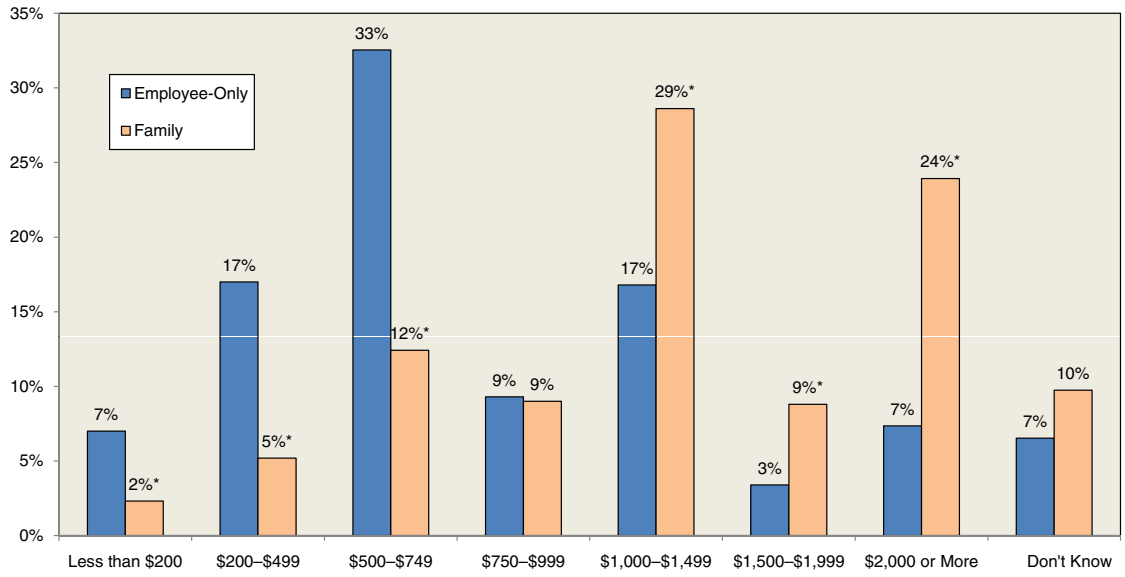
Differences in out-of-pocket costs may explain a significant portion of the difference in overall satisfaction rates between traditional plan, HDHP, and CDHP enrollees. In 2010, 41 percent of traditional plan participants were extremely or very satisfied with out-of-pocket costs (for health care services other than for prescription drugs), while

Figure 26
Annual Employer Contributions to the Account, Among Persons With CDHP,[a] 2010



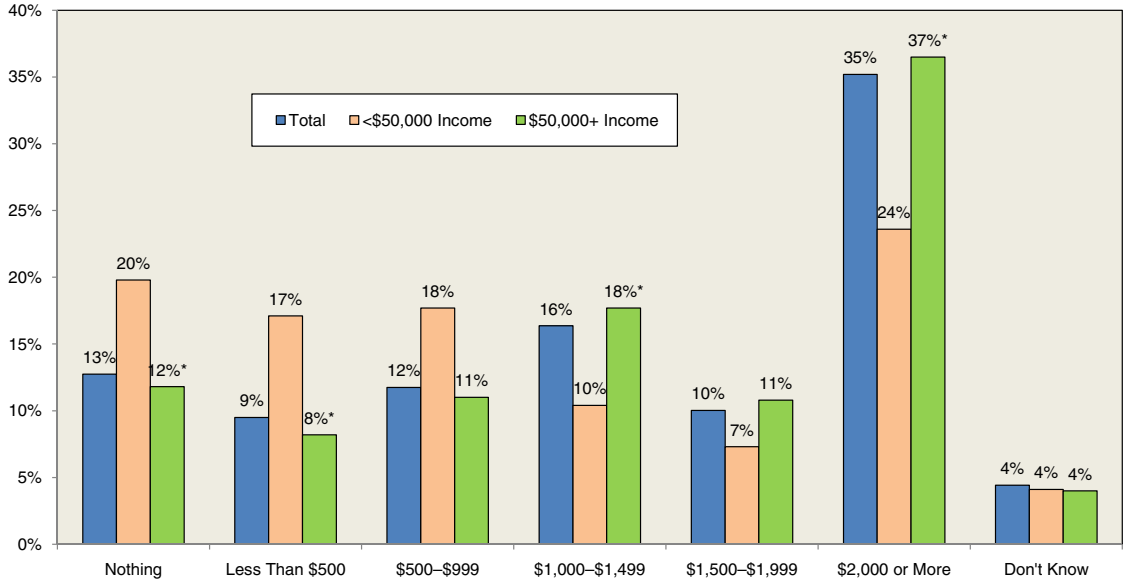
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 27
Annual Employer Contributions to the Account, Among Persons With CDHP,[a] 2010



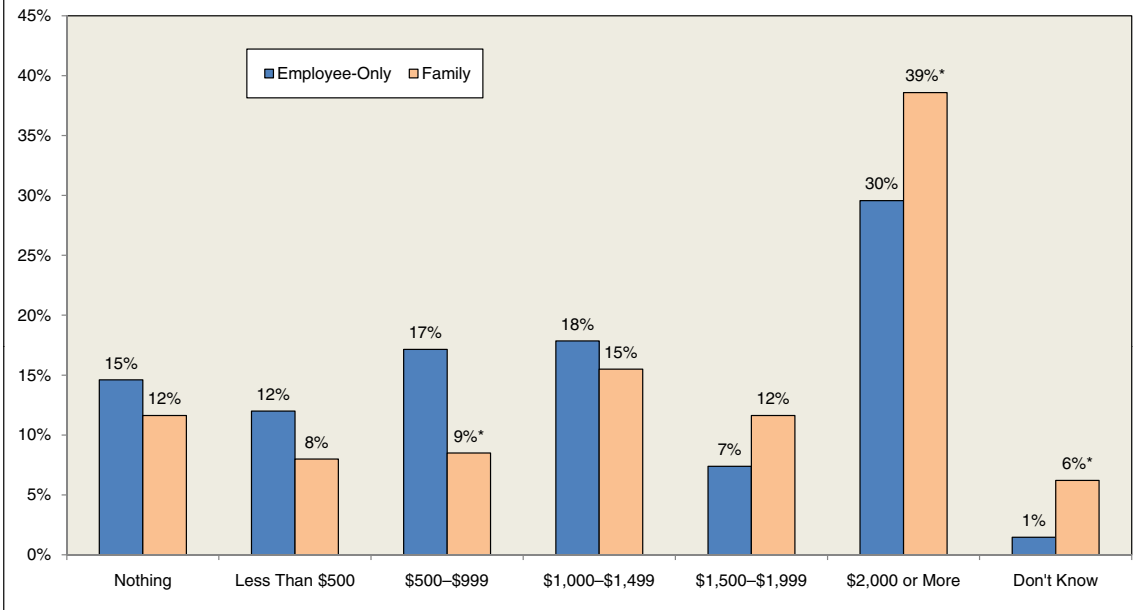
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between employee-only coverage and family coverage is statistically significant at the p ≤ 0.05 or better.

Figure 28
Annual Individual Contributions to the Account, by Household Income, Among Persons With CDHP,[a] 2010



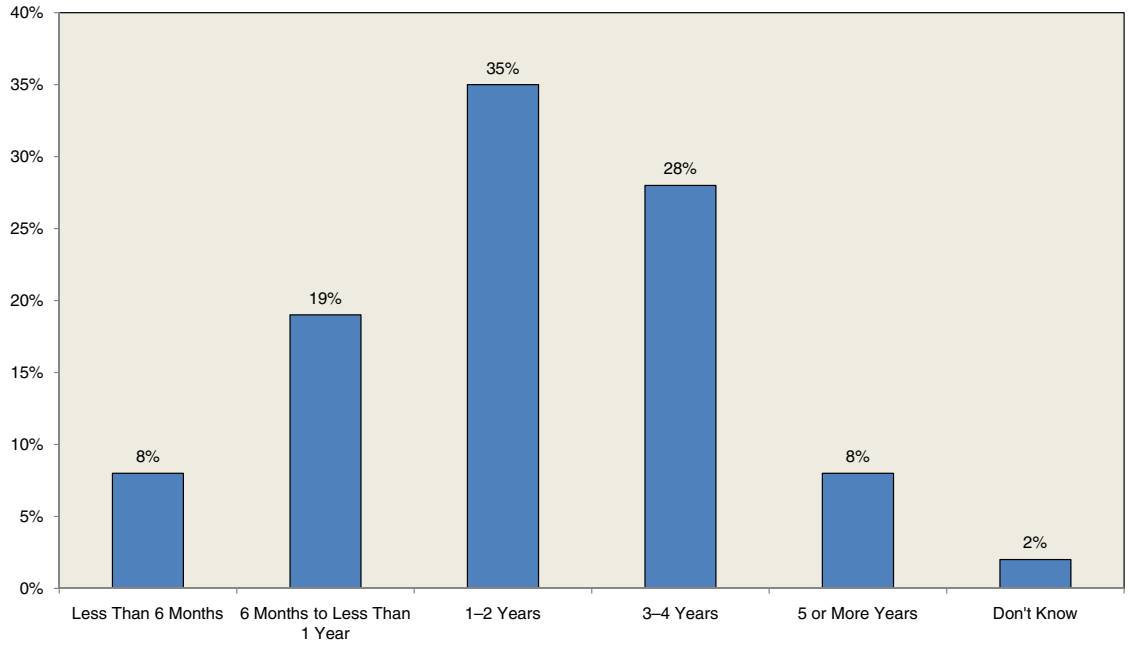
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between <$50,000 and $50,000+ is statistically significant at the p ≤ 0.05 or better.

Figure 29
Annual Individual Contributions to the Account, by Type of Coverage, Among Persons With CDHP,[a] 2010



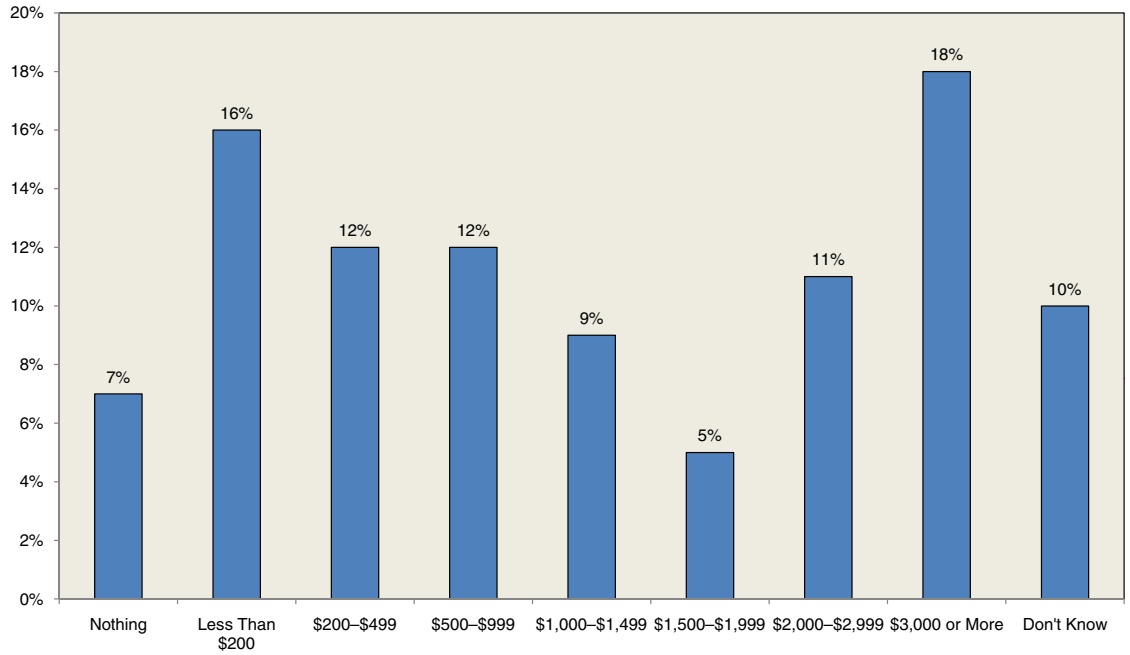
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between employee-only coverage and family coverage is statistically significant at the p ≤ 0.05 or better.

Figure 30
Length of Time With CDHP[a] and Savings Account, 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 31
Amount Currently in Account, Among Persons With CDHP,[a] 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

16 percent of HDHP enrollees were satisfied and 22 percent of CDHP participants were satisfied (Figure 35). Between 2009 and 2010, satisfaction with the out-of-pocket costs dropped among people in each type of health plan.

As in previous years of the survey, individuals in CDHPs and HDHPs were found to be less likely than those in traditional plans both to recommend their health plan to a friend or co-worker and to stay with their current health plan if they had the opportunity to switch plans (Figures 36 and 37). Similar to the satisfaction questions, the percentage of CDHP enrollees reporting that they would be extremely or very likely to recommend their plan to a friend or co-worker increased from 30 percent to 39 percent between 2006 and 2007, and reached 45 percent in 2009. It then dropped to 37 percent in 2010. One-half (48 percent) of traditional plan enrollees were extremely or very likely to recommend their plan, compared with 27 percent of HDHP enrollees. The percentage of individuals extremely or very likely to stay with their health plan if they could switch was unchanged among those with traditional coverage but dropped from 2009 levels among those with a HDHP or CDHP. Sixty-one percent of traditional, 44 percent of CDHP, and 32 percent of HDHP enrollees were extremely or very likely to stay with their plan if they had the opportunity to switch plans.

Health Care Use and Access Issues

The survey asked respondents who had chronic conditions whether they agreed that they carefully followed their treatment regimens for specific conditions. There was no significant variation in the frequency with which people with chronic conditions followed their treatment regimens across plan types, with one exception (Figure 38). Generally, the 2010 findings are in contrast to somewhat mixed findings in 2007 (Fronstin and Collins, 2008). In 2007, people in CDHPs with arthritis and hypertension were significantly less likely to say that they followed their treatment regimens for their conditions carefully. But people in CDHPs with depression were significantly more likely to say they followed their treatment regimens carefully than did those with traditional coverage.

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

In 2009, the survey found a reduction in the percentage of individuals with traditional coverage reporting that they or a family member delayed or avoided getting health care due to the cost. This decline was statistically significant for both persons with and without health problems, as well as for persons with less than $50,000 in household income (Figure 39). A continued decline was not found in 2010.

Conclusion

The 2010 EBRI/MGA Consumer Engagement in Health Care Survey finds continued slow growth in consumer-driven health plans: 5 percent of the population was enrolled in a CDHP, up from 4 percent in 2009. Enrollment in HDHPs increased from 13 percent in 2009 to 14 percent in 2010. Overall, 12.1 million adults ages 21–64 with private insurance, representing 9.5 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA but had not opened the account.

The 2010 EBRI/MGA Consumer Engagement in Health Care Survey suggests that CDHP enrollees are somewhat more cost conscious in their decision-making than those in traditional plans. CDHP enrollees were more likely than traditional plan and HDHP enrollees to have reported that they made use of available information. CDHP and HDHP enrollees were also more likely to try to find information on their doctor's cost and quality from sources other than the health plan.

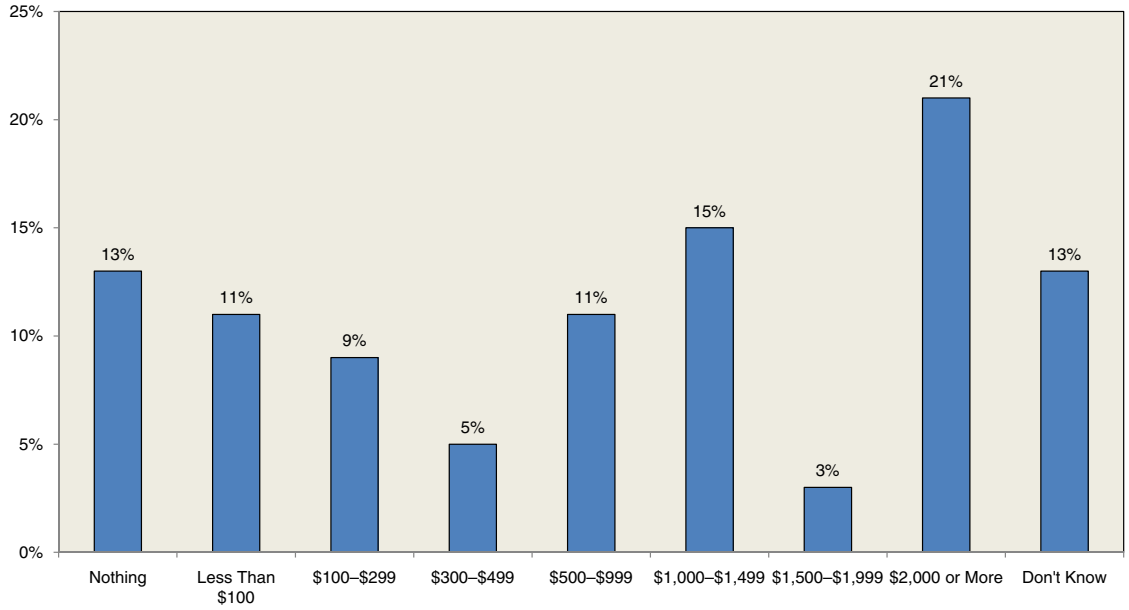
CDHP enrollees were more likely than traditional plan enrollees to take advantage of a health risk assessment and participate in health promotion programs. However, financial incentives mattered equally to CDHP and traditional plan enrollees.

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

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

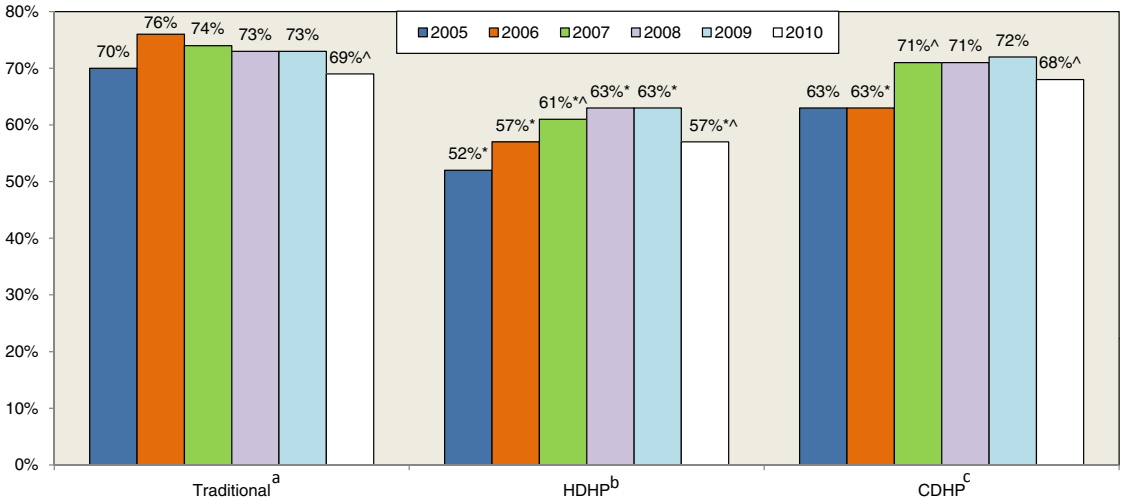
Figure 32
Amount Rolled Over from Past Year, 2010

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



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.
[a] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

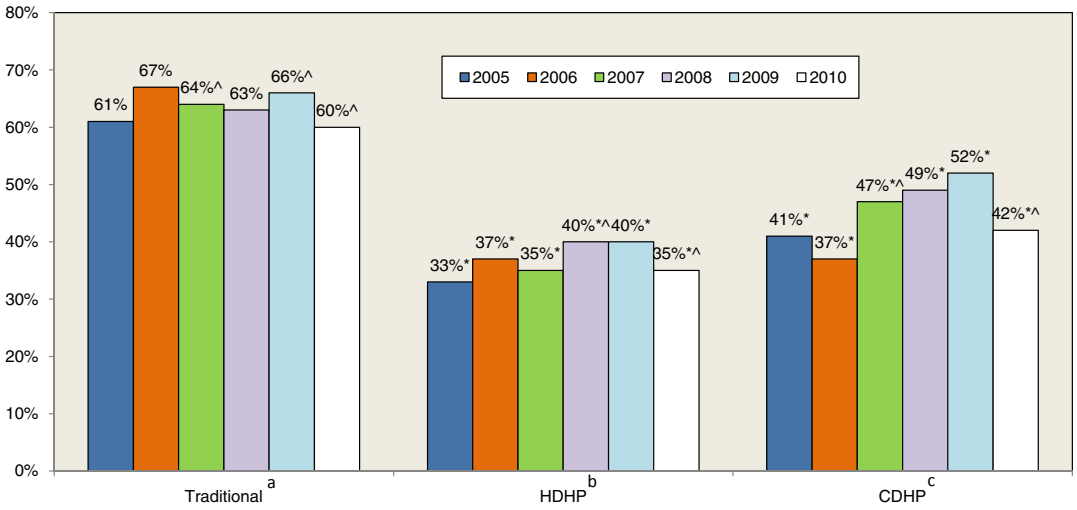
Figure 33
Percentage Extremely or Very Satisfied With Quality of Health Care Received, by Type of Health Plan, 2005–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.
^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.
# Difference between 2005 and 2010 is statistically significant at p ≤ 0.05 or better.

Figure 34

Percentage Extremely or Very Satisfied With Overall Health Plan, by Type of Health Plan, 2005–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

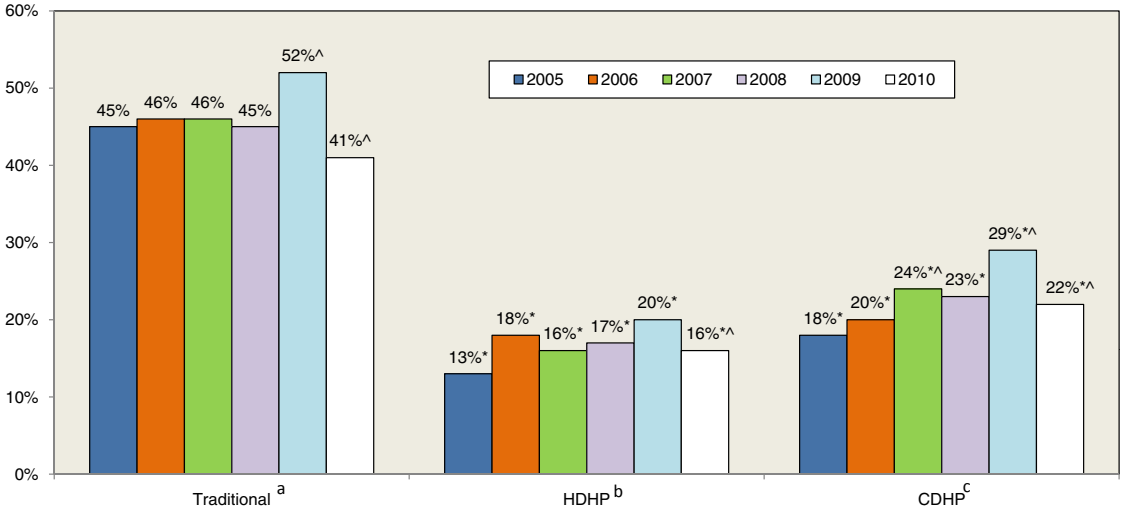
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

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

Difference between 2005 and 2010 is statistically significant at p ≤ 0.05 or better.

Figure 35

Percentage Extremely or Very Satisfied With Out-of-Pocket Health Care Costs, by Type of Health Plan, 2005–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

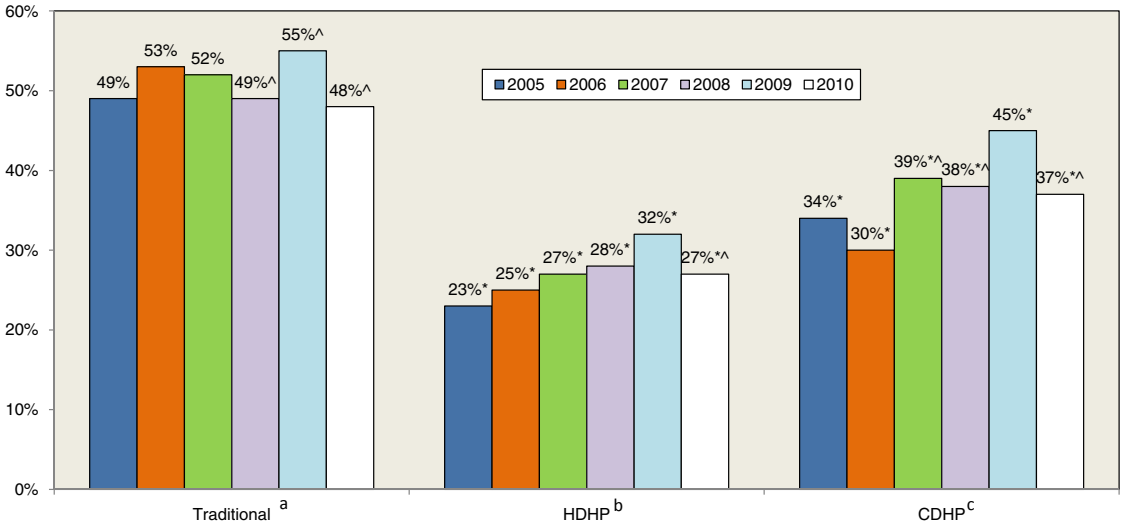
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

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

Difference between 2005 and 2010 is statistically significant at p ≤ 0.05 or better.

Figure 36

Percentage Extremely or Very Likely to Recommend Health Plan to Friend or Co-Worker, by Type of Health Plan, 2005–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

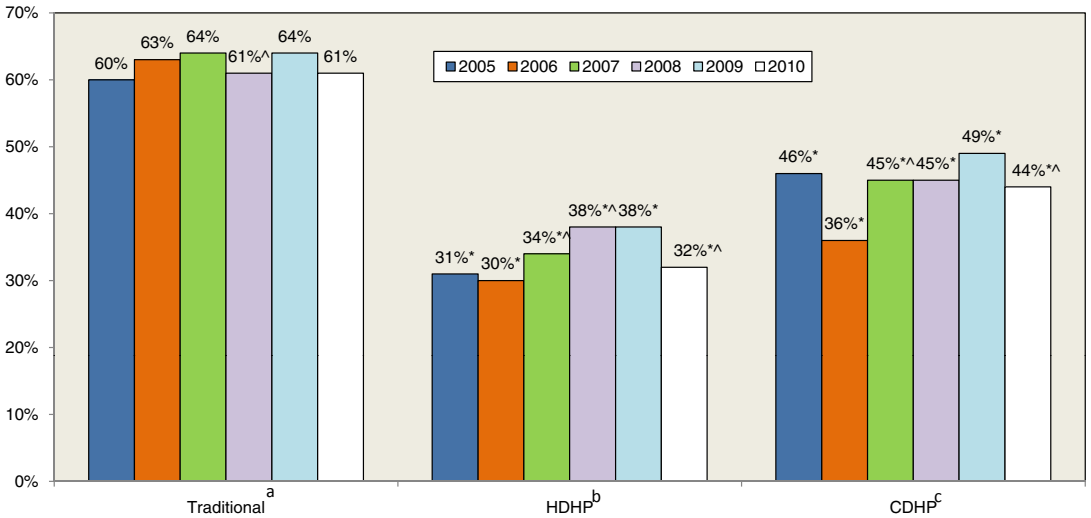
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

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

Difference between 2005 and 2010 is statistically significant at p ≤ 0.05 or better.

Figure 37

Percentage Extremely or Very Likely to Stay With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan, 2005–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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.

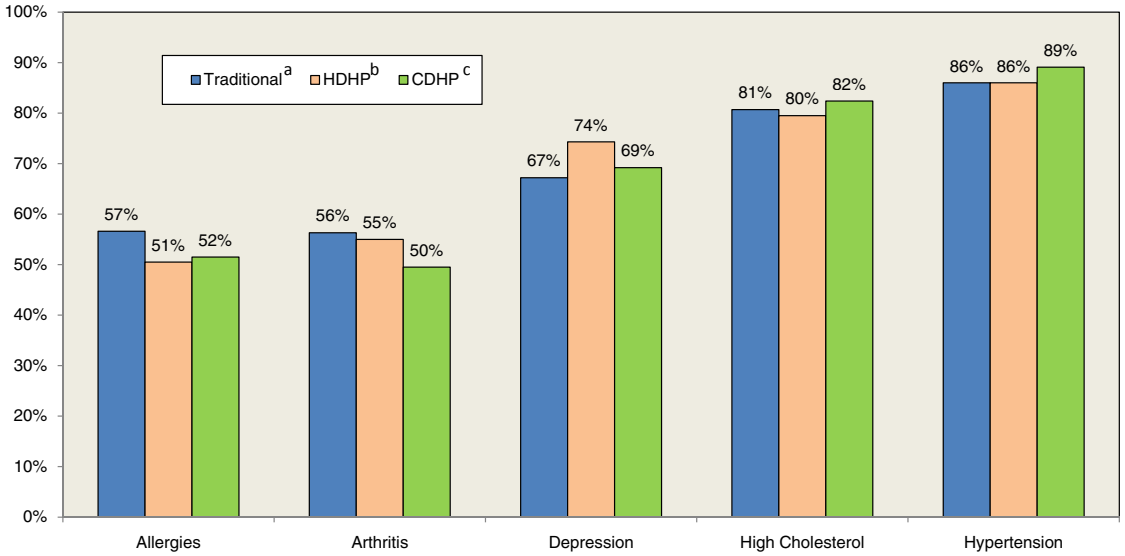
^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.

Difference between 2005 and 2010 is statistically significant at p ≤ 0.05 or better.

Figure 38

Following Treatment Regimens for Five Most Chronic Diseases, 2010

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



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$20,00 (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 39
Access Issues, by Type of Health Plan, 2005–2010

	Traditional[a]						HDHP[b]						CDHP[c]					
	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010	2005	2006	2007	2008	2009	2010
Total sample	1,358	1,506	1,918	1,714	1,651	1,601	487	930	1,404	1,634	1,603	1,914	186	722	895	1,184	972	993
Total																		
Not filled a prescription due to cost (you or family members)	16%	16%	17%	15%	15%	14%	26%*	21%*	21%*	21%*	18%*^	19%*	21%	23%*	19%^	17%	21%*	19%
Skipped doses to make medication last longer (of those who were given a prescription) (you or family members)	15	16	16	15	17	17	25*	22*	22*	22*	22*	19^	20	23*	17^	16	23*^	19
Not filled a prescription due to cost or skipped doses to make medication last longer	22	22	23	21	22	23	32	29*	29*	31*	28*	28*	30	31*	24^	23	31*^	28
Delayed or avoided getting health care due to cost (you or family members)	17	19	16^	22^	15^	12^	31*	33*	32*	30*	28*	26*	37*	38*	29*^	26	22*	23*#
Any of the above	29	30	28	33^	29^	28	44	44*	43*	43*	41*	39*	48	49*	38*^	35	41*	38*
Health Problem**																		
Not filled a prescription due to cost	21	18	21	19	19	16	30*	25*	24	25*	23	23*	26	25*	26	23	26*	24
Skipped doses to make medication last longer (of those who were given a prescription)	21	21	23	21	21	22	32*	28*	28	30*	30*	25^	30	29*	24	22	32*^	26
Not filled a prescription due to cost or skipped doses to make medication last longer	29	27	29	28	29	28	40	35*	35	38*	36*	35*	39	38*	34	32	40*	36
Delayed or avoided getting health care due to cost	20	23	18^	23^	17^	16	31*	37*	35	34*	34*	32*	44*	42*	32^	32	29*	28*
Any of the above	35	34	33	37	35	34	48	50*	49	49*	49*	46*	58	55*	46^	44	49*	48*
No Health Problem**																		
Not filled a prescription due to cost	11	13	12	9^	9	12	48	17	17	16*	11^	15^	15	22*	13^	12	15*	14
Skipped doses to make medication last longer (of those who were given a prescription)	8	11	8^	7	12^	11	15	15	13	12*	12	11	10	17	11^	10	14	13
Not filled a prescription due to cost or skipped doses to make medication last longer	14	18	16	13^	14	18^	22	22	21	21*	15	20	20	25*	16^	16	24*	21
Delayed or avoided getting health care due to cost	13	16	14	21^	12^	9^	31*	28*	27	26	20*	19*	31*	35*	26^	22	15	19*
Any of the above	20	25	23	29^	21^	22	39	38*	37	35	31*	32*	39	44*	32^	29	32*	30
Less Than $50,000 Yearly Household Income																		
Not filled a prescription due to cost	24	20	27^	20^	20	18	28	25	27	26	23	21	24	23	27	19^	25	17^
Skipped doses to make medication last longer (of those who were given a prescription)	21	21	25	21	25	22	31	23	28	27	29	25	30	26	23	20	29	18^
Not filled a prescription due to cost or skipped doses to make medication last longer	31	29	33	28	29	30	38	31	36	35	33	31	36	33	32	28	35	28
Delayed or avoided getting health care due to cost	24	29	26	35^	18^	18	41	36	40	37	39*	33*^	49*	40	34	33	38*	30
Any of the above	39	42	41	47^	36^	38	53	48	53	51	50*	36	56	53	48	45	50*	44
$50,000 or More Yearly Household Income																		
Not filled a prescription due to cost	12	13	12	12	13	13	24*	19*	19	19*	17*	19*	19	23*	16^	16	20*	19*
Skipped doses to make medication last longer (of those who were given a prescription)	13	14	13	12	15^	14	23*	20*	19	21*	21*	17	16	21*	16^	15	22*^	20*
Not filled a prescription due to cost or skipped doses to make medication last longer	18	19	18	17	21^	20	30	27*	27	28*	27*	27*	28	29*	22^	22	31*^	29*
Delayed or avoided getting health care due to cost	13	14	12^	16^	14	10^	28*	30*	29	28*	25*	24*	31*	37*	29^	25*	20*	23*
Any of the above	24	25	23	26^	27	24^	40	41*	40	40*	38*	38*	45	47*	36^	33	40*	38*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.
[a] Traditional = health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.
** Health problem defined as fair or poor health or one of eight chronic health conditions.
^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.
# Difference between 2005 and 2010 is statistically significant at the p ≤ 0.05 or better.

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2010 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 and 2009 EBRI/MGA Consumer Engagement in Health Care Survey. The 2010 EBRI/MGA Consumer Engagement in Health Care Survey was conducted within the United States between August 9 and August 24, 2010, through a 17-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=1,996) ages 21−64 who have health insurance through an employer or purchased directly from a carrier were drawn randomly from the Synovate sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 25.9 percent (20 percent for the base sample or national sample, and 34 percent for the oversample). The margin of error for the national sample was ±2.2 percent.

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

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

Because the base sample (national sample) included only 117 individuals in a CDHP and 278 individuals with a HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 876 individuals with a CDHP and 1,636 individuals with a HDHP, resulting in a total sample (base plus oversample) of 993 for the CDHP group and 1,914 for the HDHP group. After factoring out of the base sample—the 117 individuals with a CDHP and the 278 individuals with a HDHP—there are 1,601 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.[11] The CDHP and HDHP oversamples were weighted by gender, age, income and race/ethnicity, using the demographic profile of the CDHP and HDHP respondents to the omnibus survey described below.

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

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

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

I have health insurance through a government plan such as Medicare, Medicaid, or Veterans benefits.....1
I have health insurance through my job or the job of another family member (such as spouse or parent).....2
I have health insurance that I purchase from a health insurance company 3
I have other health insurance (specify _____) 4
I do not have health insurance currently 5

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

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

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

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

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

Yes
No
Not sure

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

Definitions

Health Savings Accounts

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

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

In order to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than $1,150 for self-only coverage and $2,300 for family coverage (minimum deductible amounts are increasing to $1,200 and $2,400 in 2010). Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $5,800 for self-only coverage and $11,600 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit are indexed to inflation. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services. An individual can have a health plan with a deductible and maximum out-of-pocket limit that qualifies them to make a tax-free contribution to an HSA, but the individual is not required to make a contribution nor 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 $3,050 for self-only coverage and $6,150 for family coverage in 2010.

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.[12] 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.[13] Individuals also may not make an HSA contribution if claimed as a dependent on another person's tax return.

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

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

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 10 percent penalty, which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare. In 2011, the penalty for nonqualified distributions will increase to 20 percent.

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

Health Reimbursement Arrangements

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

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

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

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

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

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

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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. 39 and in Fronstin (2002 and 2004).

[3] See www.mercer.com/press-releases/1364345

[4] See www.healthcaredisclosure.org/

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

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

[7] See Fronstin (2007) and http://ehbs.kff.org/pdf/2010/8085.pdf

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

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

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

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

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

[11] 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.

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

[13] 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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