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Issue BRIEF

Findings From the 2011 EBRI/MGA Consumer Engagement in Health Care Survey

By Paul Fronstin, Employee Benefit Research Institute

SEVENTH ANNUAL SURVEY: This *Issue Brief* presents findings from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey. This study is based on an online survey of 4,703 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. Findings from this survey are compared with EBRI's findings from earlier surveys.

ENROLLMENT CONTINUES TO GROW: The survey finds continued growth in consumer-driven health plans: In 2011, 7 percent of the population was enrolled in a CDHP, up from 5 percent in 2010. Enrollment in HDHPs increased from 14 percent in 2010 to 16 percent in 2011. The 7 percent of the population with a CDHP represents 8.4 million adults ages 21–64 with private insurance, while the 16 percent with a HDHP represents 19.3 million people. Among the 19.3 million individuals with an HDHP, 38 percent (or 7.3 million) reported that they were eligible for a health savings account (HSA) but did not have such an account. Overall, 15.8 million adults ages 21–64 with private insurance, representing 13.1 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.

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

CDHP ENROLLEES 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 they were also more likely to report that they had access to a health promotion program. CDHP enrollees were also more likely to report that they had been offered a cash incentive or reward to participate in a wellness program when a program was offered. HDHP enrollees were less likely to report having the opportunity to fill out a health risk assessment and to have access to a health promotion program.

FINANCIAL INCENTIVES MATTER: 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 but not the health promotion program. Among those participating, the reasons they gave were that they were offered incentive prizes and reduced premiums. 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. Financial incentives were more a factor for CDHP enrollees than for traditional plan enrollees when it came to participating in wellness programs.

CONSUMER USE OF TECHNOLOGY: A significant portion of the population reported using a smartphone, and 1 in 5 reported using a tablet. Among them, about one-quarter reported using an app for health-related purposes. Among those not using an app, nearly one-half were interested in using one.

Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute. 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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Findings From the 2011 EBRI/MGA Consumer Engagement in Health Care Survey

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Introduction

Employment-based health benefits are the most common form of health insurance in the United States. In 2010, 156.1 million individuals under age 65, or 59 percent of that population, had employment-based health benefits (Fronstin, 2011). 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 46 percent.[1]

In response to rising health costs, employers have been seeking ways to manage them. During the last decade, 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 2010, 16 percent of employers with 10–499 workers and 23 percent of those with 500 or more workers offered either an HRA or HSA-eligible plan.[3] (See pgs. 23–24 for detailed explanations of HRAs and HSAs.)

This *Issue Brief* presents findings from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey. This study is based on an online survey of 4,703 privately insured adults ages 21−64, and was designed 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 1,990 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.[4] The final sample included 1,432 in HDHPs with either an HSA or HRA (consumer-driven health plans, or CDHPs), 1,762 in HDHPs without accounts, and 1,509 in more traditional health plans.[5]

Findings from this survey are compared with findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008, 2009 and 2010 EBRI/MGA Consumer Engagement in Health Care Survey. Past reports used "Comprehensive" as the descriptive label for what is now labeled "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.[6]

Summary of Findings

This survey finds that in 2011, 7 percent of the population was enrolled in a CDHP, up from 5 percent in 2010, and 4 percent in 2009; and enrollment in HDHPs increased from 14 percent in 2010 to 16 percent in 2011 (Figure 2). The 7 percent of the population with a CDHP represents 8.4 million adults ages 21–64 with private insurance, while the 16 percent with a HDHP represents 19.3 million people. Among the 19.3 million individuals with an HDHP, 38 percent (or 7.3 million) reported that they were eligible for an HSA but did not have such an account. Thus, overall, 15.8 million adults ages 21–64 with private insurance, representing 13.1 percent of that market, were either in a CDHP or 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.

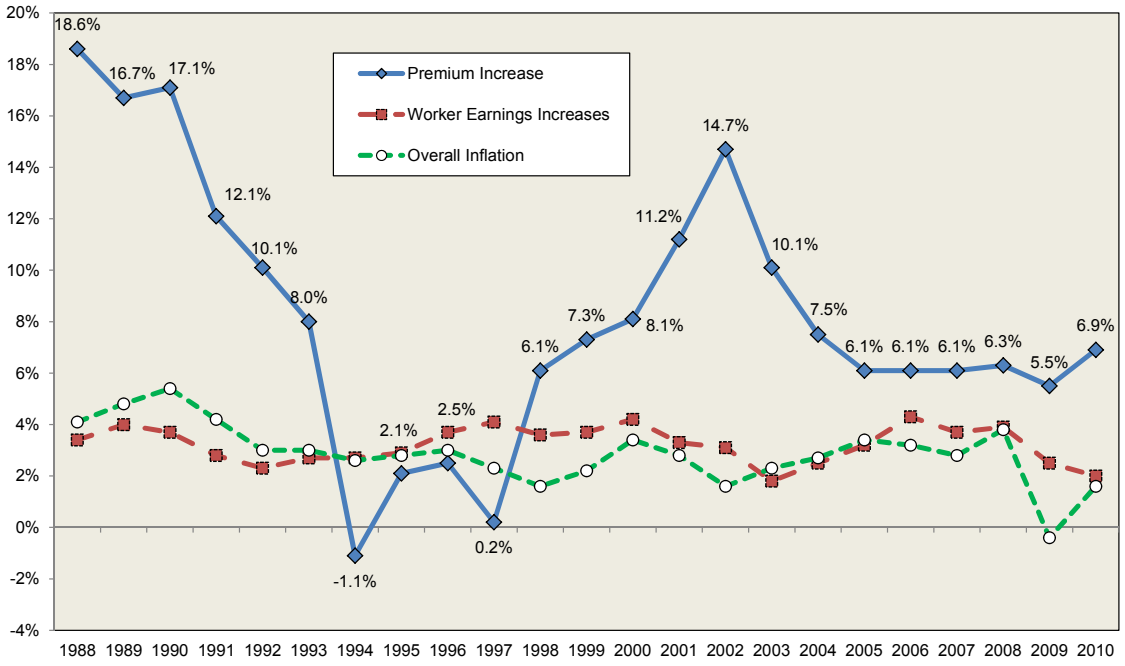
HRA and HSA enrollment is growing, but the market penetration remains relatively small, and the amount of time individuals have been in these plans is shorter than the time others have been enrolled in traditional coverage. Among individuals with traditional coverage, 18 percent had been in their plan for three to four years and 44 percent for five or more years. This compares with 26 percent and 21 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, 57 percent of those with a CDHP were extremely or very familiar with it (Figure 5). In contrast, 13 percent of individuals with traditional coverage were extremely or very familiar with a CDHP, and 13 percent of individuals with an HDHP were extremely or very familiar with a CDHP.

The study also finds the following:

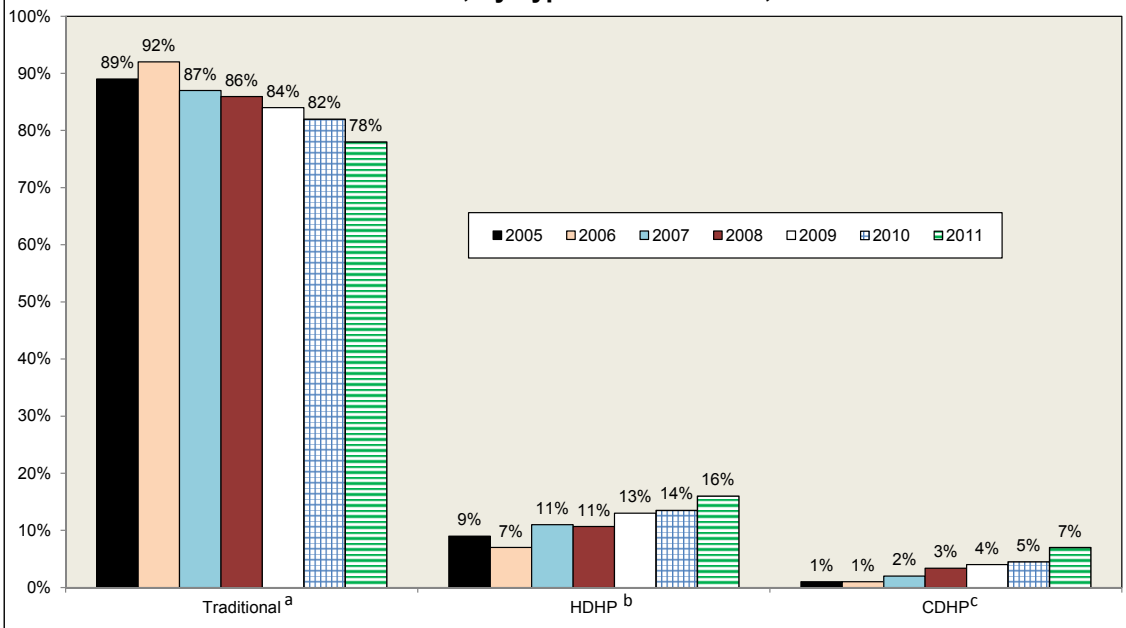
- Individuals in CDHPs were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors. They were more likely to say that they had checked whether their plan would cover care; asked for a generic drug instead of a brand name; talked to their doctor about prescription options and costs; developed a budget to manage health care expenses; checked the price of a service before getting care; 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 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. They were also more likely to report that they had access to a health promotion program. CDHP enrollees were also more likely to report that they were offered a cash incentive or reward to participate in a wellness program when a program was offered. HDHP enrollees were less likely to report having the opportunity to fill out a health risk assessment and to have 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 but not the health promotion program. Among those participating, the reasons they gave were that they were offered incentive prizes and reduced premiums. Among those not participating, the reasons given 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.
- Few differences were found among CDHP enrollees, HDHP enrollees, and those enrolled in traditional plans when it came to choosing a doctor based on his or her use of health information technology (HIT). Also, while CDHP enrollees were somewhat 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, there was no difference by plan type when it came to switching doctors if their doctor was not in the network.
- A significant portion of the population reported using a smartphone, and 1 in 5 reported using a tablet. Among them, about one-quarter reported using an app for health-related purposes. Among those not using an app, nearly one-half were interested in using one.

Figure 1
Premium Increases Among Employers With 10 or More Employees, Worker Earnings and Inflation, 1988–2010



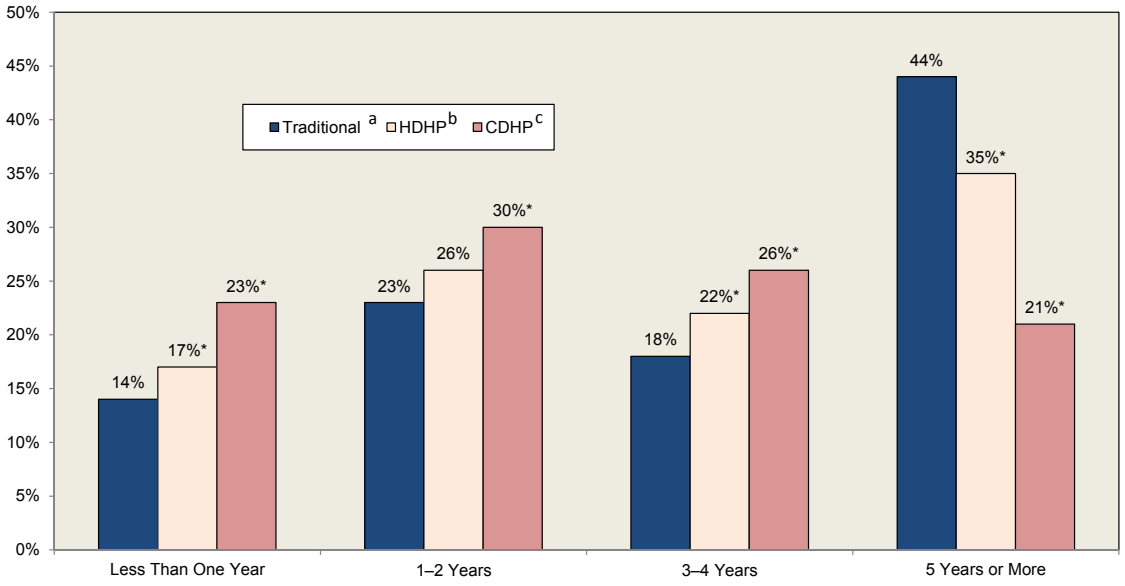
Source: Mercer, *National Survey of Employer-Sponsored Health Plans*, and Bureau of Labor Statistics.

Figure 2
Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2011



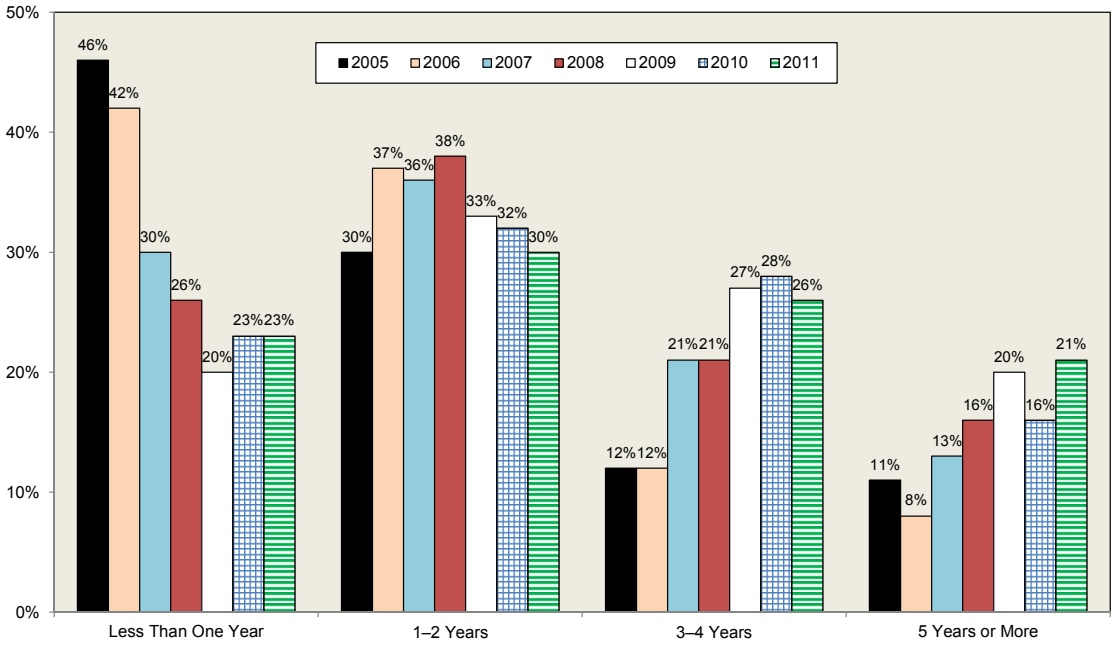
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005—2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 3
Number of Years Covered by Current Health Plan, by Type of Health Plan, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 4
Length of Time With HRA[a] or HSA,[b] 2005–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
[a] Health reimbursement arrangement.
[b] Health savings account.

The remainder of this report examines the findings from the 2011 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.

Cost-Conscious Behavior

The theory behind account-based plans and plans with higher deductibles is that the cost-sharing structure will encourage more people to be engaged, specifically compared with those 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 (59 percent CDHP and 55 percent HDHP vs. 48 percent traditional); asked for a generic drug instead of a brand name (53 percent CDHP, 54 percent HDHP vs. 46 percent traditional); talked to their doctor about prescription treatment options and costs (41 percent CDHP vs. 37 percent traditional); talked to their doctor about other treatment options and costs (39 percent HDHP vs. 33 percent traditional); asked their doctor to recommend a less costly prescription drug (42 percent HDHP vs. 35 per-cent traditional); developed a budget to manage health care expenses (26 percent CDHP vs. 18 percent traditional); checked the price of a service before getting care (34 percent HDHP vs. 28 percent traditional); and used an online cost-tracking tool provided by the health plan (21 percent CDHP vs. 11 percent traditional) (Figure 6).

There has been no clear increase in the share of CDHP enrollees who report cost-conscious decision-making over the seven years of the survey (Figure 7).

Availability and Use of Cost and Quality Information

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.

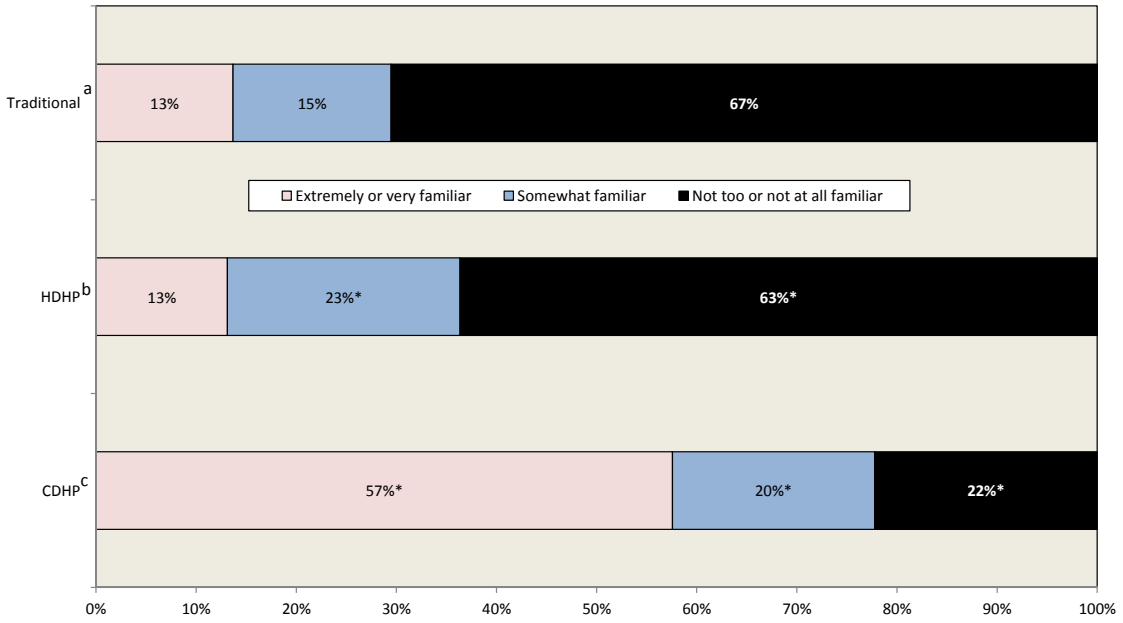
The survey asked if an individual's health plan provided information on providers' cost and quality. Individuals were more likely to report that they had, and tried to use, *quality* information than they were *cost* information, and both CDHP and HDHP enrollees were less likely than traditional plan enrollees to report that the plan provided the information. Thirty-five percent of HDHP enrollees reported access to quality information, compared with 40 percent of CDHP enrollees and 44 percent of traditional plan enrollees (Figure 8). Similarly, 30 percent of HDHP enrollees reported access to cost information, compared with 31 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 nearly 1 in 3 CDHP and HDHP enrollees sought other sources of information, while one-quarter of traditional plan enrollees did so.

Participation in Wellness Programs

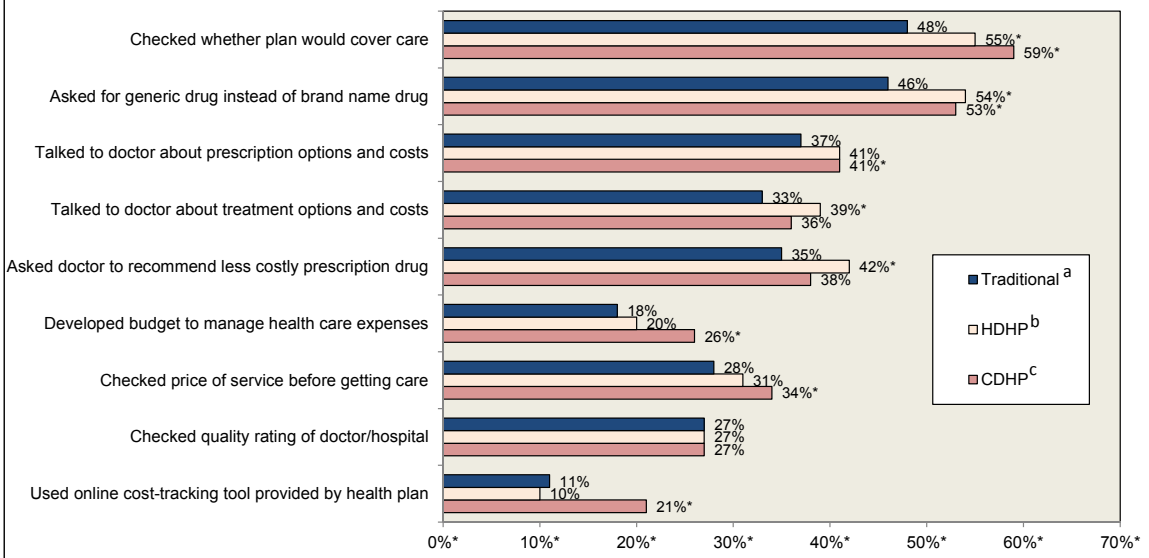
Employers and insurers offer a number of different types of wellness benefits—programs designed to promote health and to prevent disease. The 2011 EBRI/MGA Consumer Engagement in Health Care Survey examined availability and participation in two specific types of wellness programs: a health risk assessment and a health promotion program that included a number of different types of benefits.[7]

Figure 5
Familiarity With Consumer-Driven Health Plans, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 6
Cost-Conscious Decision Making, by Type of Health Plan, 2011
(Percentage of privately insured adults 21–64
who received health care in last 12 months)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 7

Trends in Cost-Conscious Decision Making, by Type of Health Plan, 2005–2011

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	2011	2005	2006	2007	2008	2009	2010	2011	2005	2006	2007	2008	2009	2010	2011
Total Sample	953	1,363	1,794	1,548	1,651	1,601	1,509	417	802	1,284	1,484	1,693	1,914	1,762	163	652	805	1,077	972	993	1,432
Checked whether health plan would cover care	51%	58%	50%^	55%^	50%^	47%^	48%	61%	62%	61%*	61%	56%*	53%*^	55%*^	60%*	62%	60%*	63%*	61%*	53%*^	59%*^
Asked for generic drug instead of brand name drug	n/a	48	46	50^	46^	44	46	n/a	60*	58*	58*	52*^	50*	54*^	n/a	54	54*	58*	56*	51*^	53*
Talked to doctor about prescription options and costs	n/a	n/a	n/a	n/a	35	35	37	n/a	n/a	n/a	n/a	42	40	41	n/a	n/a	n/a	n/a	44	38	41*
Talked to doctor about treatment options and costs	42	44	44	45	33^	31	33	56*	44^	49*^	49	37^	36*	39*^	58*	46^	47	46	40*	33^	36^
Asked doctor to recommend less costly prescription drug	27	31	30	36^	34	32	35	46*	41*	43*	41	39*	39*	42*	45*	39*	38*	36	39*	37	38
Checked price of service before getting care	24	20	21	23^	25	24	28^	35*	23^	27*^	23^	29^	29*	31^	29	26*	27*	25	35*^	27^	34*^
Checked quality rating of doctor/hospital	18	21	20	25^	24	24	27^	22	18	19	22	22	22	27^	18	19	18	23^	27*	22^	27^
Developed budget to manage health care expenses	n/a	n/a	n/a	n/a	15	16	18	n/a	n/a	n/a	n/a	18	17	20^	n/a	n/a	n/a	n/a	32	25*^	26*
Used online cost tracking tool offered by health plan	n/a	8	8	12^	12	11	11	n/a	6	9^	10	9*	10	10	n/a	17*	20*^	20*	24*	20*^	21*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011

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

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

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

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

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

Figure 8

Availability and Use of Quality and Cost Information Provided by Health Plan and Effort to Find Information From Other Sources, 2011

	Traditional[a]	HDHP[b]	CDHP[c]
Health plan provides information on quality of care provided by doctors	44%	35%*	40%*
Health plan provides information on cost of care provided by doctors	41	30*	31*
Of those whose plans provide info on quality, how many tried to use it for doctors	50	51	54
Of those whose plans provide info on cost, how many tried to use it for doctors	46	45	49
Tried to find information from sources other than health plan on cost and quality of care provided by doctors	24	27	31*

Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

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

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

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

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

The survey found that CDHP enrollees were more likely than traditional plan enrollees to report that they had the option to complete a health risk assessment. Specifically, 44 percent of CDHP enrollees reported that their employer offered a health risk assessment (Figure 9), compared with 34 percent of traditional plan enrollees and 27 percent of HDHP enrollees. When asked about the availability of health promotion programs, 52 percent of CDHP enrollees and 42 percent of traditional plan enrollees reported that their employer offered such a program. One-third of HDHP enrollees reported the availability of a health promotion program, which is lower (by a statistically significant amount) than offer rates among CDHP and traditional plans enrollees.

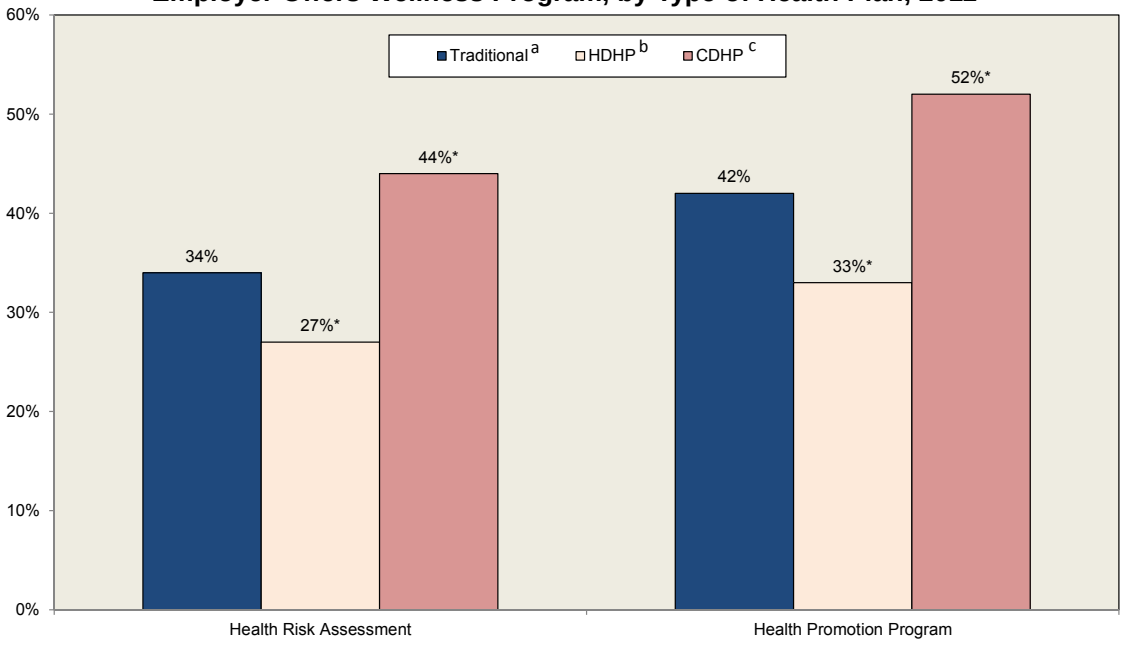
CDHP enrollees were more likely than traditional plan enrollees to participate in the health risk assessment, but not the health promotion program. Three-quarters (73 percent) of CDHP enrollees participated in the health risk assessment, compared with 62 percent of traditional plan enrollees (Figure 10). One-half of CDHP enrollees participated in a health promotion program, compared with 45 percent of traditional plan enrollees.

CDHP enrollees were also more likely than traditional plan enrollees to report that their employer offered a cash incentive or reward for participating in a wellness program. Two-thirds reported a cash incentive or reward for participating in the health risk assessment and 57 percent reported a cash incentive or reward for participating in a health promotion program (Figure 11). Why did they participate? CDHP enrollees were more likely than traditional plan enrollees to report that the incentive prizes and reduced premiums were the main reasons (Figure 12).

The survey also 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 could make changes on their own (Figure 13), with 29 percent citing this as a major reason and 33 percent as a minor reason for not participating. Lack of time was the second most-cited reason for not participating, with 25 percent reporting it as a major reason and 27 percent reporting it as a minor reason. Forty-five percent did not participate because they said they were already healthy (22 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.

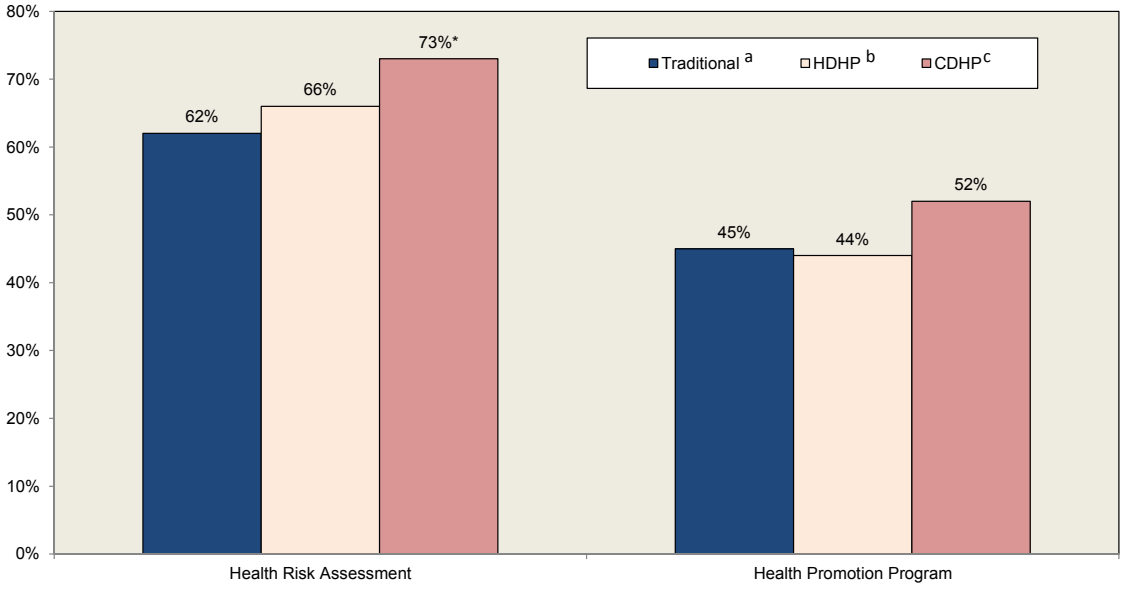
Figures 14 and 15 contain findings from a series of questions related to the impact that financial incentives could have on participation in wellness programs. This year, CDHP enrollees appear to be more responsive to higher premiums and cost sharing. CDHP enrollees were found to be more likely than traditional plan enrollees to report that they would probably participate in a wellness program if their employer increased premiums for nonparticipants (Figure 14). Among nonparticipants, CDHP enrollees were also more likely than traditional plan enrollees to report that they would participate in a wellness program if their employer increased drug or office visit cost sharing (Figure 15). Financial

Figure 9
Employer Offers Wellness Program, by Type of Health Plan, 2011



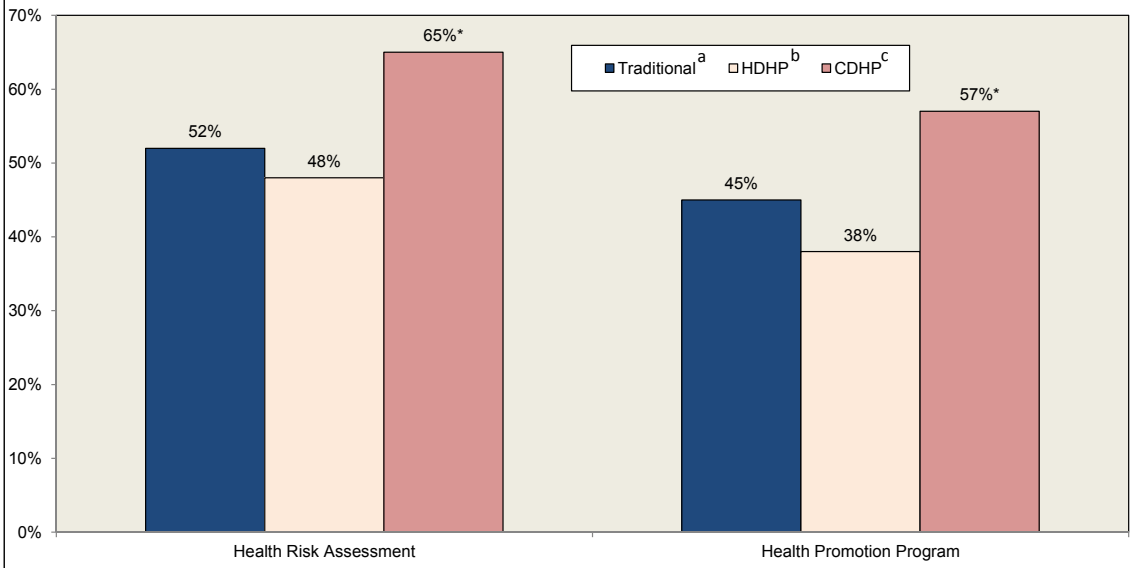
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 10
Individual Participates in Wellness Program Offered by Employer Among Those Offered a Wellness Program, by Type of Health Plan, 2011



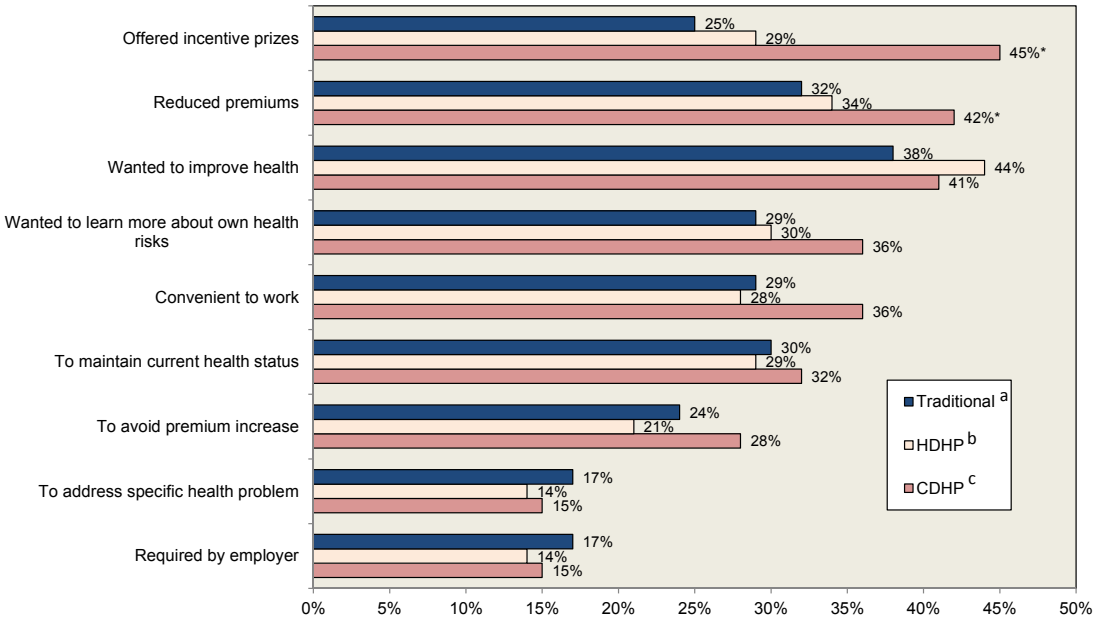
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 11
Employer Offers Cash Incentive or Reward for Participating in Wellness Program, Among Workers Whose Employer Offers Wellness Program, by Type of Plan, 2011



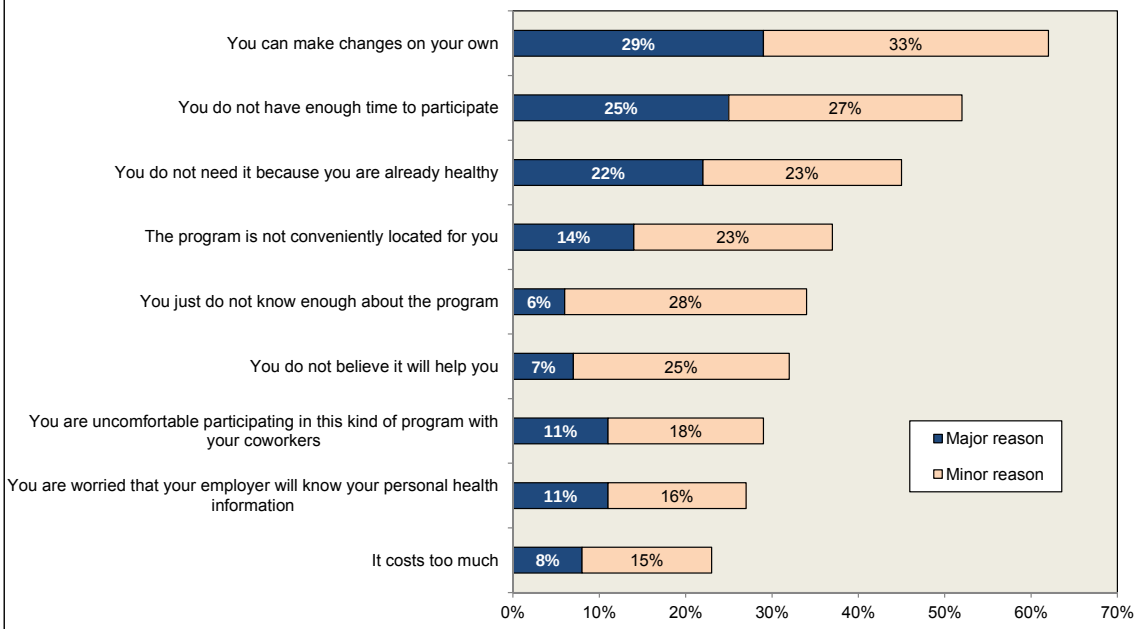
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 12
Reasons for Participating in Employer's Wellness Program, 2011



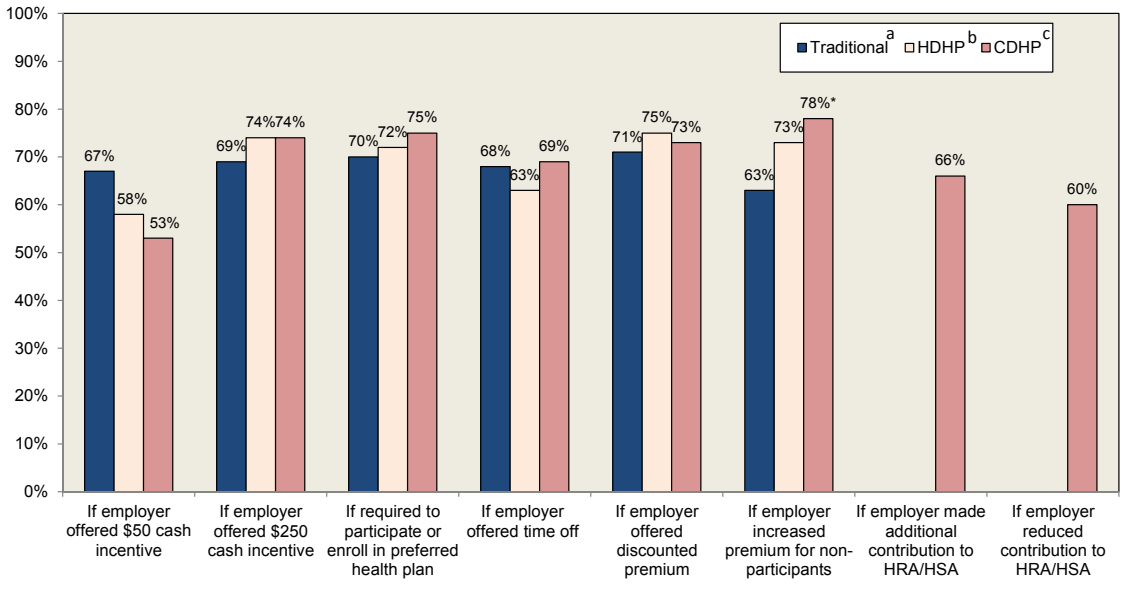
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family)
[b] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 13
Reasons for Not Participating in Employer's Wellness Program Among Those Offered but Not Participating in Program, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

Figure 14
Percentage of Individuals Reporting that They Would Probably Participate in Employer's Wellness Program, by Various Financial Incentives and Type of Health Plan, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[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.

incentives to participate still mattered to all individuals, regardless of plan type. Nearly 70 percent of participants said they would participate in a wellness program if there was some type of financial incentive to do so.

Opinions About Provider Engagement

The 2011 EBRI/MGA Consumer Engagement in Health Care Survey included questions regarding the ways in which providers of health care services engage their patients. Nearly 90 percent of plan participants, regardless of plan type, strongly or somewhat agreed that their doctor communicated with them so that they could really understand what the doctor was saying (Figure 16). About three-quarters of individuals agreed that their doctor worked with them to find realistic changes they could make to improve their health, and that the doctor understood them personally. About 70 percent or slightly more agreed 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) coached them about staying healthy rather than just treating their health problems. And about one-half of individuals, regardless of plan type, agreed that their doctor used medical terminology during patient-provider discussions. Only between 23 per-cent and 29 percent thought that their doctor should be accessible by e-mail, the only question where a difference was found by plan type.

Cost-Sharing Incentives

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 17). These findings are unchanged from 2010.

Just like the general question on HIT and cost sharing as incentives to switch to a doctor who uses HIT, when more specific questions were asked few differences were found among CDHP enrollees, HDHP enrollees, and traditional plan enrollees. CDHP enrollees were found to be more likely than traditional plan enrollees to switch doctors to one who used e-mail to answer patient questions (Figure 18). Generally, about one-half or more of plan participants, regardless of plan type, are likely to choose a doctor based on his or her use of HIT.

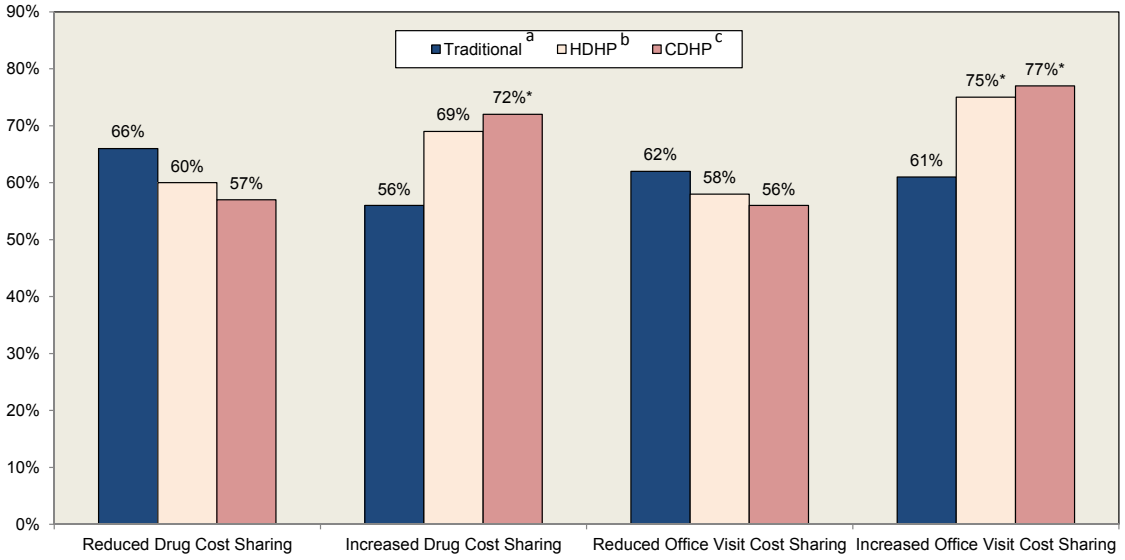
The 2011 survey examined opinions regarding the appropriate use of lower cost sharing as an incentive to change the way individuals use the health care system. Results show across-the-board interest in select networks composed of only medical providers with records of high-quality care when combined with lower cost sharing. Eleven percent of individuals in CDHPs, 10 percent of individuals with HDHPs, and 12 percent of individuals with traditional coverage were extremely interested in using select networks when combined with lower cost sharing (Figure 19). CDHP and HDHP enrollees were also more likely than traditional plan enrollees to be somewhat interested in the concept, with 40 per-cent of CDHP and HDHP enrollees interested and 35 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 20).

Patient Use of Technology

For the first time, the 2011 EBRI/MGA Consumer Engagement in Health Care Survey asked about consumer use of technology to engage in health-related activities. The survey found that about 40 percent of the adult population with private health insurance had some type of smartphone and about 7 percent had a tablet. Among those with a smartphone or tablet, nearly 30 percent used an app for nutrition information and about one-quarter used it for general health information, weight management or diets, or exercise programs (Figure 21). There were no differences in the use of smartphone or tablets for health-related purposes by plan type, with the exception of medical claims history, where it was found that 11 percent of CDHP enrollees used such an app, compared with 6 percent among traditional plan and HDHP enrollees.

Figure 15

Percentage of Individuals Reporting that They Would Probably Participate in Employer's Wellness Program, by Various Cost-Sharing Incentives and Type of Health Plan, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
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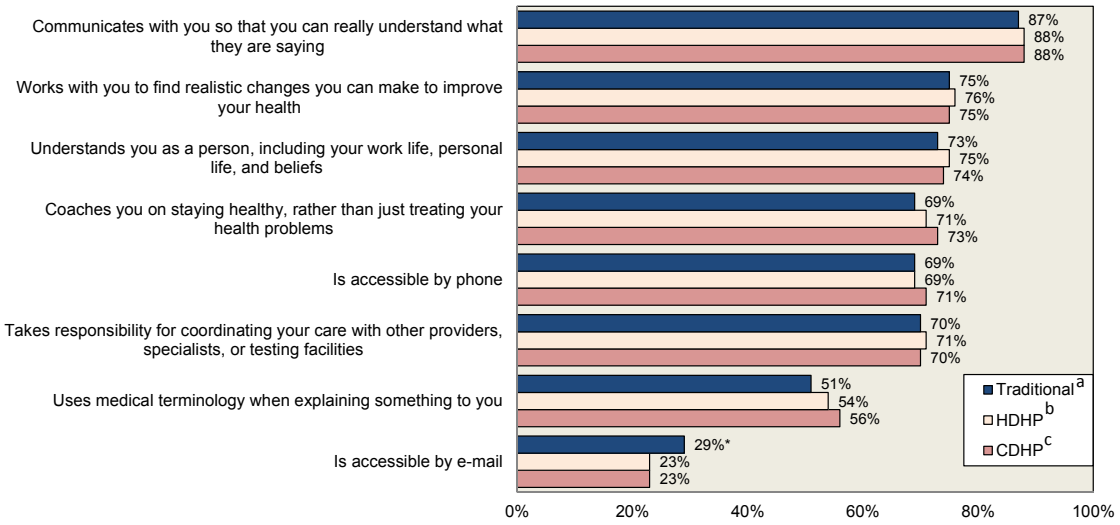
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 16

Agreement With Statements About Various Provider Engagement Tools, by Type of Health Plan, 2011

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



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
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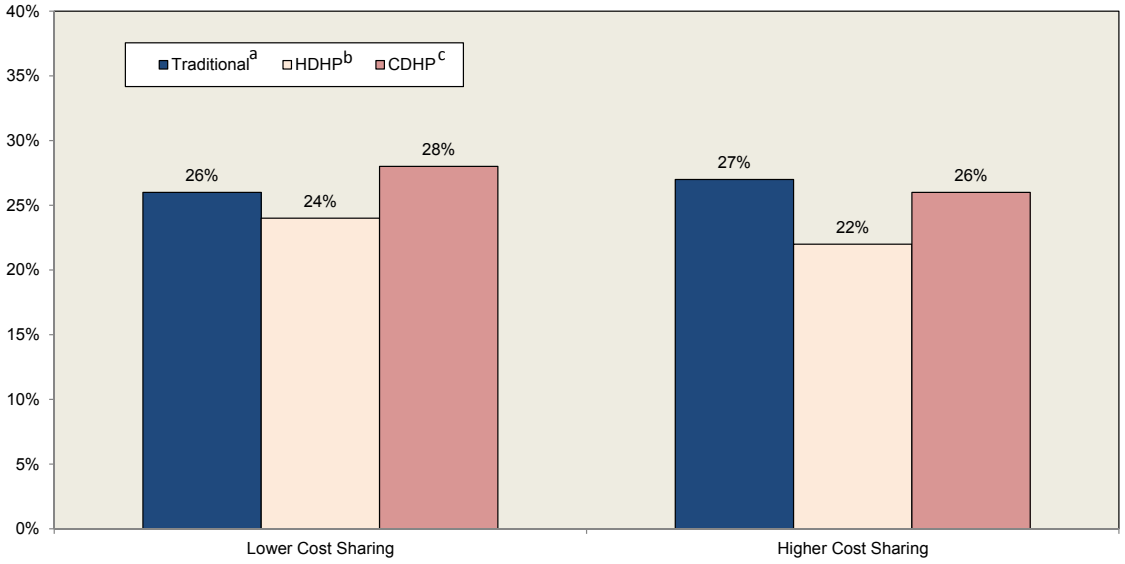
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 17

Likelihood of Changing Doctor If Cost Sharing Was Lower or Higher, When Using Doctors That Use Health Information Technology (HIT) and Current Doctor Does Not Use HIT, by Type of Health Plan, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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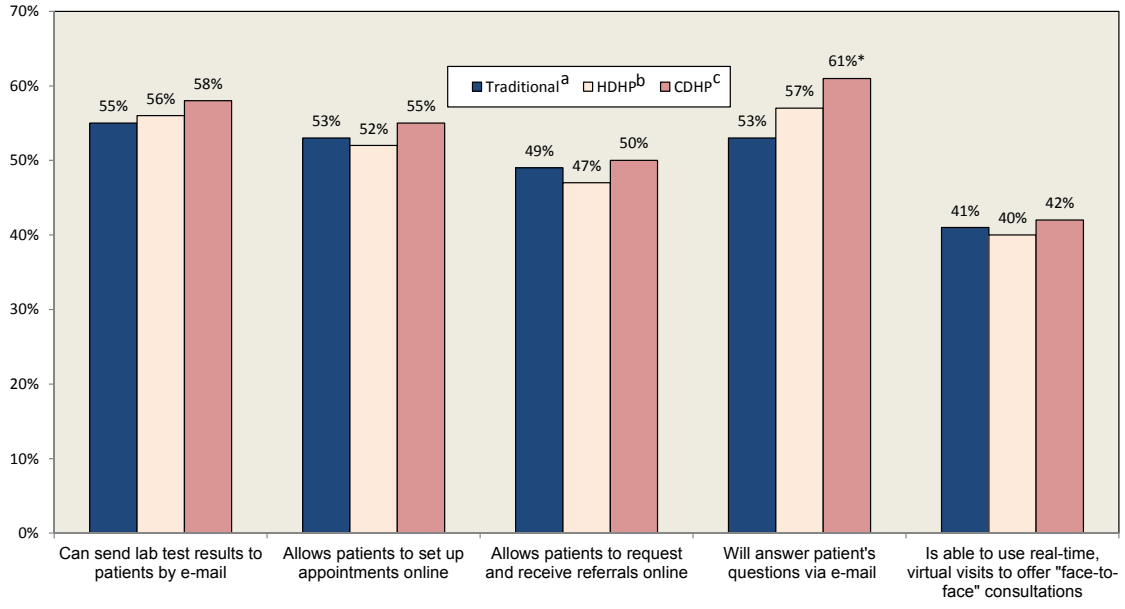
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 18

Likelihood of Choosing Doctor by Their Use Health Information Technology (HIT), by Type of Health Plan, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
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* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Among those who have never used an app for health-related purposes, nearly one-half is either very or somewhat interested in using one for things like nutrition information, exercise programs, weight management or diets, prescription drug prices, medical claims history, and general health information (Figure 22). Among individuals with a CDHP, 60 percent were very or somewhat interested in using an app to check the balance in the HSA or HRA.

Conclusion

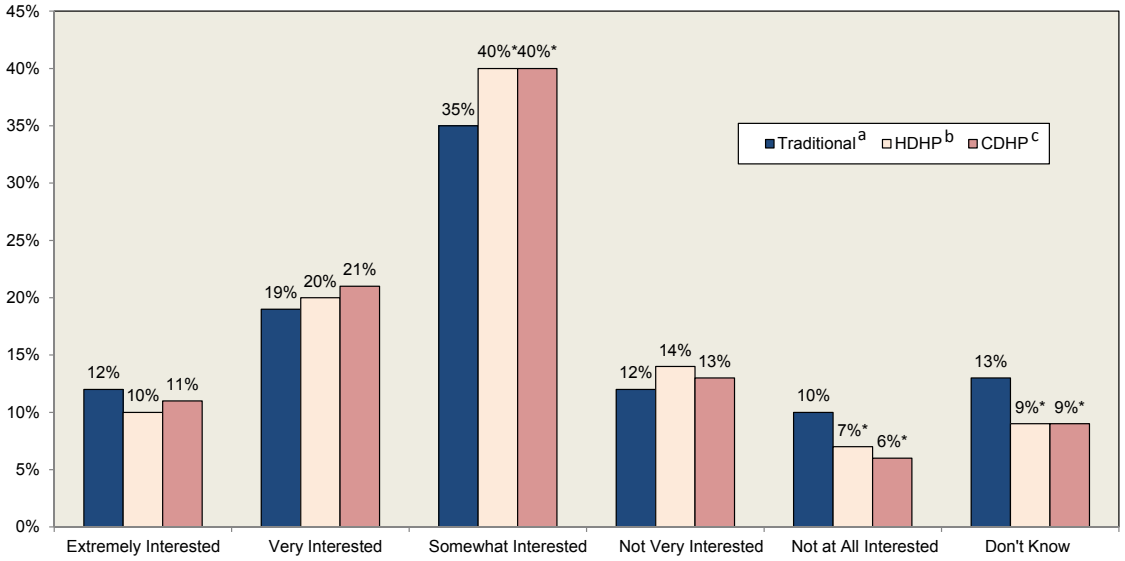
The 2011 EBRI/MGA Consumer Engagement in Health Care Survey finds continued growth in consumer-driven health plans: 7 percent of the population was enrolled in a CDHP, up from 5 percent in 2010. Enrollment in HDHPs increased from 14 percent in 2010 to 16 percent in 2011. Overall, 15.8 million adults ages 21–64 with private insurance, representing 13.1 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.

The 2011 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. While CDHP enrollees, HDHP enrollees, and traditional plan enrollees were equally likely to report that they made use of cost and quality information provided by their health plan, CDHP enrollees were 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 take advantage of a health risk assessment, but they were no more likely to participate in health promotion programs. In addition, financial incentives mattered more to CDHP enrollees than to traditional plan enrollees.

It is not clear from the data whether the differences in consumer engagement can be attributed to plan design differences or whether various plan designs attract a certain kind of individual. Regardless, it is clear that the underlying characteristics of the populations enrolled in these plans are different: Adults in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans. Adults in CDHPs and HDHPs were significantly less likely to smoke than were adults in traditional plans, and they were significantly more likely to exercise. People in CDHPs were also less likely to be obese compared with adults enrolled in a traditional health plan. 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 seven years of consumer engagement surveys reported here provide unique data from which to measure future changes in this evolving type of health insurance.

Figure 19

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, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
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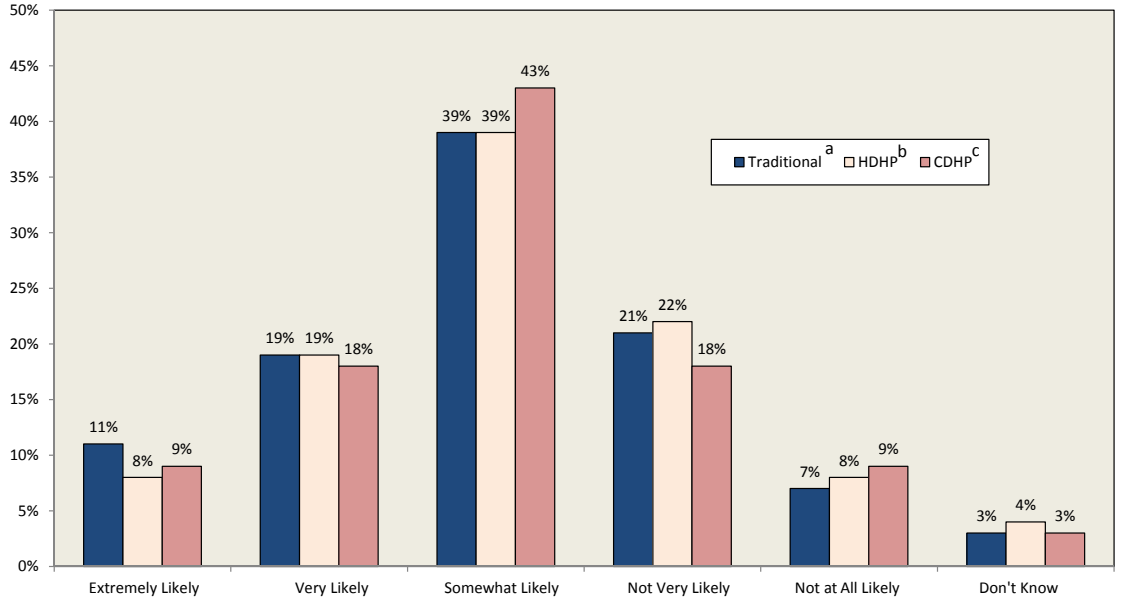
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 20

Likelihood of Changing to Select Network If Current Doctor Was Not in Select Network, by Type of Plan, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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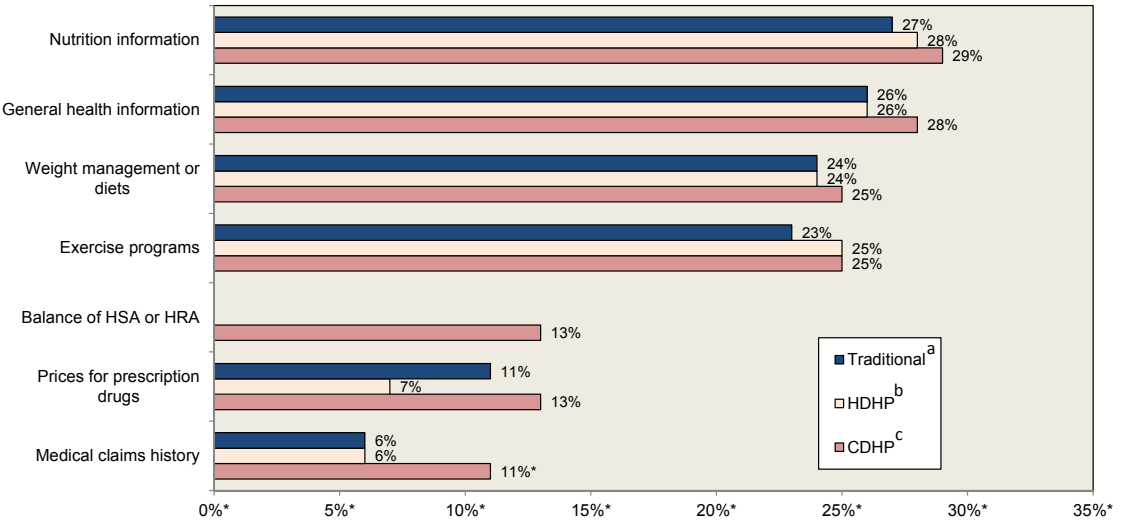
Figure 21

Percentage of Individuals Reporting that They Used an App More Than Once for a Smartphone or Tablet, by Various Health-Related Purposes and Type of Health Plan, 2011

(Among Those Who Use a Smartphone or Tablet)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
[a] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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[c] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
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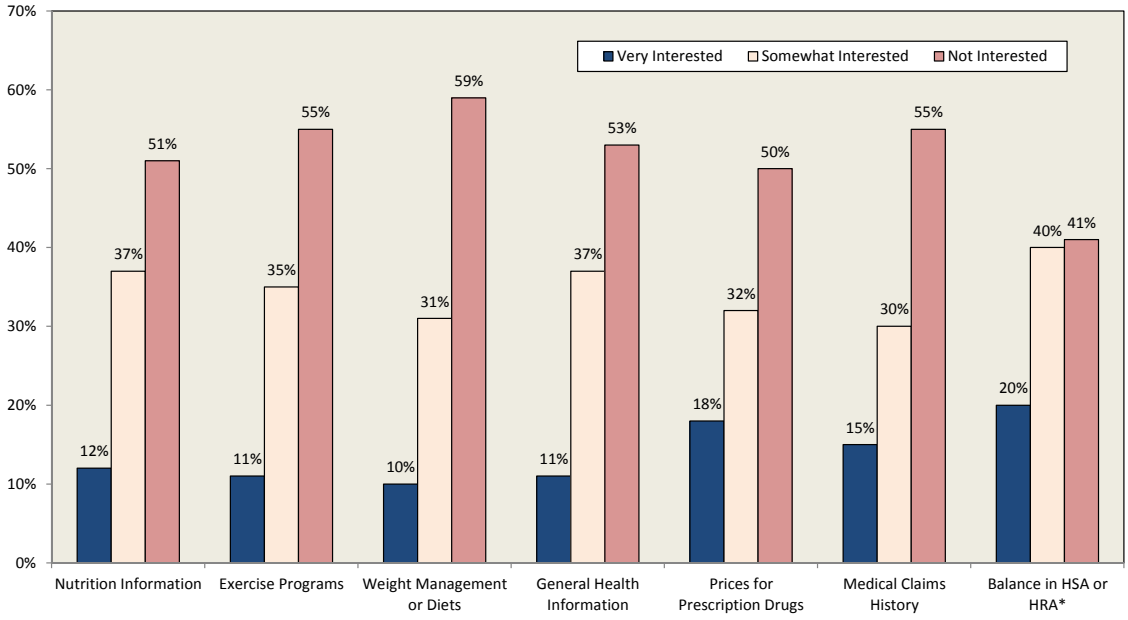
Figure 22

Interest in Using an App for a Smartphone or Tablet, by Health-Related Function, 2011

(Among those who never used an App for a Smartphone or Tablet)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.
* Asked of CDHP only.

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2011 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, 2009 and 2010 EBRI/MGA Consumer Engagement in Health Care Survey. The 2011 EBRI/MGA Consumer Engagement in Health Care Survey was conducted within the United States between August 9 and August 23, 2011, through a 15-minute Internet survey. The national or base sample was drawn from Synovate's online panel of Internet users who have agreed to participate in research surveys. About 2,000 adults (n=1,990) 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 37 percent (30 percent for the base sample or national sample, and 44 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 those with 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 151 individuals in a CDHP and 330 individuals with a HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 1,281 individuals with a CDHP and 1,432 individuals with a HDHP, resulting in a total sample (base plus oversample) of 1,432 for the CDHP group and 1,762 for the HDHP group. After factoring out of the base sample—the 151 individuals with a CDHP and the 330 individuals with a HDHP—there are 1,509 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.[8] The CDHP and HDHP oversamples were weighted by gender, age, income and race/ethnicity, using the demographic profile of the CDHP and HDHP respondents in 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 ages 21–64.) The following three questions were used in the June and July Omnibus Surveys to identify likely CDHP and HDHP respondents:

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

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

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

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

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

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

No deductible
Individual or Single Coverage
- My deductible is less than $1,000
- My deductible is $1,000 or more
- Don't know amount of individual deductible

Family Coverage
- My deductible is less than $2,000 for me and my family
- My deductible is $2,000 or more for me and my family
- Don't know amount of family deductible

Don't know if have deductible

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

Yes
No
Not sure

While panel Internet surveys are nonrandom, studies have demonstrated that such surveys, when carefully designed, obtain results comparable with random-digit-dial telephone surveys. Taylor (2003), for example, 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

Consumer-Driven Health Plans

The combination of a tax-preferred payment account with a high-deductible health plan is what is commonly referred to as a *consumer-driven health plan* (CDHP). These account-based health plans include either a health savings account (HSA) or a health reimbursement arrangement (HRA), described in more detail below.

Health Savings Accounts

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

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 $1,200 for self-only coverage and $2,400 for family coverage (minimum deductible amounts are indexed to inflation but are remaining at $1,200 and $2,400 in 2012). Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $5,950 for self-only coverage and $11,900 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit are indexed to inflation. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services. Individuals can have a health plan with a deductible and maximum out-of-pocket limit that qualifies them to make a tax-free contribution to an HSA, but they are not required to make a contribution or to open an account.

Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer and deductible from adjusted gross income if made by the individual. The maximum annual contribution is $3,050 for self-only coverage and $6,150 for family coverage in 2011.

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.[9] 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.[10] An individual also may not make an HSA contribution if he or she is claimed as a dependent on another person's tax return.

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2011, 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 20 percent penalty (increased from 10 percent in 2010 as a result of PPACA), which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

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

Health Reimbursement Arrangements

A health reimbursement arrangement (HRA) is an employer-funded health plan that reimburses employees for qualified medical expenses. 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 pgs. 23–24 and in Fronstin (2002 and 2004).

[3] See www.mercer.com/press-releases/1400235

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

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

[6] See Fronstin (2007) and http://ehbs.kff.org/pdf/2011/8225.pdf

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

[8] 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 was 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.

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

[10] Only Medicare enrollees age 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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