

Findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey

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

A T A G L A N C E

- The 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS) finds that 15 percent of the privately insured population was enrolled in a consumer-driven health plan (CDHP); 11 percent was enrolled in a high-deductible health plan (HDHP); and 74 percent was enrolled in more traditional coverage. Overall, 26 million individuals with private insurance were enrolled in a CDHP—a health plan associated with a health savings account (HSA) or health reimbursement arrangement (HRA), or an HSA-eligible health plan.
- The 2014 CEHCS also finds that among individuals enrolled in CDHPs, 57 percent had an HSA or HRA, while 43 percent were enrolled in HSA-eligible health plans but had not opened an account.
- This study finds evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors. Specifically, those in a CDHP were more likely than those with traditional coverage to say that they had checked whether the plan would cover care; asked for a generic drug instead of a brand name; talked to their doctors about prescription options and costs; checked the price of a service before getting care; asked a doctor to recommend less costly prescriptions; talked to their doctors about other treatment options and costs; developed a budget to manage health care expenses; and used an online cost-tracking tool provided by the health plan.
- There is also some evidence that adults in a CDHP were more likely than those in a traditional plan to be engaged in their choice of health plan. Specifically, those in a CDHP were more likely than those with traditional coverage to say that they had attended a meeting where health plan choices were explained; consulted with their employer's human resources (HR) staff about health plan choices; and were more likely to have consulted with an insurance broker to understand plan choices.
- The survey also finds that CDHP enrollees were more likely than traditional-plan enrollees to take advantage of various wellness programs, such as health-risk assessments, health-promotion programs, as well as biometric screenings. In addition, financial incentives mattered more to CDHP enrollees than to traditional-plan enrollees.

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

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Introduction

Employment-based health benefits are the most common form of health insurance in the United States. In 2012, 156 million individuals under age 65, or 58.5 percent of that population, had employment-based health benefits (Fronstin, 2013). In nearly every year since 1998, premium increases have exceeded worker-earnings increases and inflation (Figure 1). Health insurance premiums have nearly tripled, while worker earnings have increased 58 percent during that period.¹

In response, employers have been seeking ways to manage the cost increases. During the past decade, employers have turned their attention to consumer-driven health plans (CDHPs)—a combination of health coverage with high deductibles (at least \$1,250 in 2014) and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. A handful of employers first started offering CDHPs in 2001 with health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).² By 2014, 27 percent of employers with 10–499 workers and 48 percent of employers with 500 or more workers offered either an HRA- or HSA-eligible plan.³

Employers have been interested in bringing aspects of consumer engagement into health plans for many years. As far back as 1978, they adopted Sec. 125 cafeteria plans and flexible spending accounts (FSAs). More recently, employers have begun to take a broader view of consumer engagement in health care. Some employers have introduced more workplace wellness programs, usually in the form of health-risk assessments or biometric screenings. Employers have often provided financial incentives to increase worker participation in such programs. A few employers have introduced private health insurance exchanges. These programs give workers more choices for health coverage and more transparency regarding coverage choices and the costs associated with each choice.

This *Issue Brief* presents findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS). This study was based on an online survey of 3,887 privately insured adults ages 21–64 that was designed to provide nationally representative data regarding the growth of CDHPs and high-deductible health plans (HDHPs) and the impact of these plans and consumer engagement more generally on the behavior and attitudes of adults with private health insurance coverage. The sample was randomly drawn from Ipsos' online panel of more than 775,000 Internet users who have agreed to participate in research surveys. This survey used a base sample of 1,981 to draw incidence rates for people with CDHPs and HDHPs, and the base sample was complemented with an additional random oversample of these two groups. More specifically, the oversamples were: 1) those with either an HRA or an HSA, including individuals that were enrolled in an HSA-eligible health plan, but had not opened the HSA, and 2) those

with an individual deductible of at least \$1,250 and a family deductible of at least \$2,500, but who report that they were not eligible to open an HSA.⁴ The final sample included 1,459 in a CDHP with either an HSA or HRA, 978 in an HDHP, and 1,450 in a more traditional health plan.⁵

The remainder of this report examines the findings from the 2014 CEHCS as they relate to differences and similarities among individuals enrolled in traditional health plans, CDHPs, and HDHPs. The report also examines consumer engagement more generally. It examines health care decision making, cost and quality information, participation in wellness programs, opinions about provider engagement, cost-sharing incentives related to plan type, and health information technology.

Findings from this survey are compared with findings from the 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008–2013 CEHCS.

Enrollment in CDHPs and HDHPs

Individuals with a deductible of at least \$1,250 for individual coverage or \$2,500 for family coverage who also have an HRA, or who were enrolled in an HSA-eligible health plan (regardless of whether the HSA was opened) were assigned to the CDHP group in the CEHCS. Everyone else with a deductible of at least \$1,250 for individual coverage or \$2,500 for family coverage was assigned to the HDHP group. Individuals with no deductible or a deductible below \$1,250 for individual coverage and \$2,500 for family coverage were assigned to the “traditional” coverage category. More detail about the methodology is provided in the appendix.

This survey found that in 2014, 15 percent of the population was enrolled in a CDHP; 11 percent was enrolled in an HDHP; and 74 percent was enrolled in traditional coverage (Figure 2). The 15 percent of the population with a CDHP represented about 26 million individuals with private insurance, while the 11 percent with an HDHP represented about 20 million individuals.

Among the 15 percent of individuals enrolled in a CDHP, 57 percent (or 9.3 million) had an HRA or had opened an HSA, while 43 percent were enrolled in an HSA-eligible health plan but had not opened an HSA (Figure 3).

A number of other surveys track enrollment in CDHPs. America’s Health Insurance Plans (AHIP) found that 17.4 million people were enrolled in an HSA-eligible health plan in January 2014,⁶ which accounted for about 10 percent of the population with private health insurance. Mercer found that 23 percent of workers with employment-based coverage were covered by a CDHP in 2014.⁷ The National Health Interview Survey (NHIS) found that 12 percent of individuals with private insurance were covered by a CDHP in 2014, while 24 percent were covered by an HDHP (without an HSA).⁸ The Kaiser Family Foundation (KFF) found that 20 percent of workers were enrolled in a CDHP in 2014.⁹

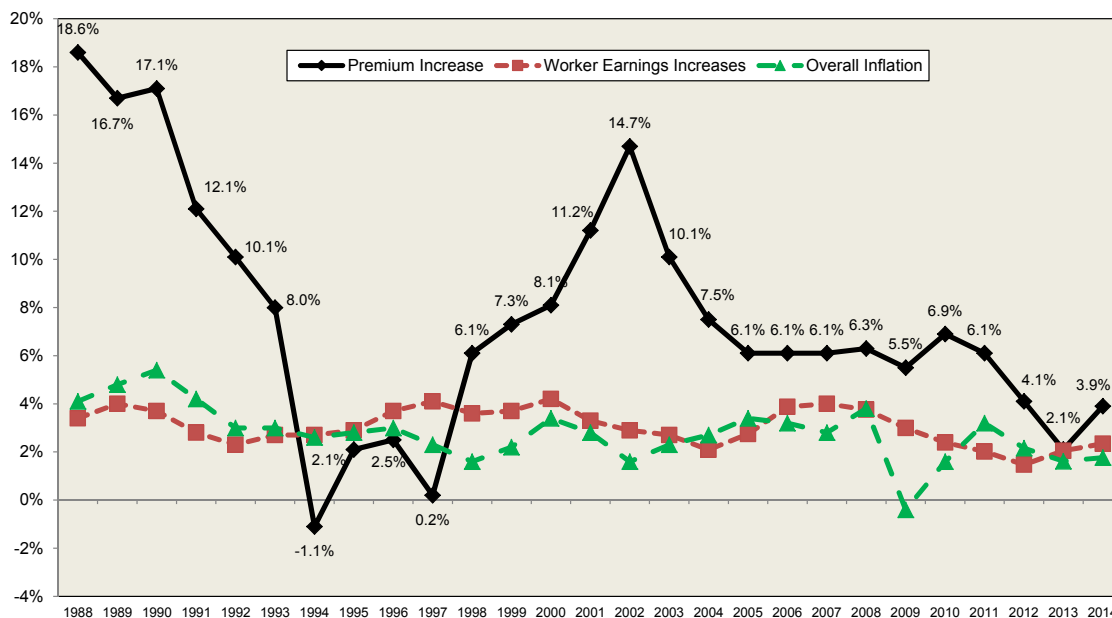
Length of Time in Health Plan

The survey found that the amount of time individuals have been in a CDHP was shorter than the time others have been enrolled in traditional coverage. Among individuals with traditional coverage, 19 percent had been in their plan for three to four years and 45 percent for five or more years. This compared with 21 percent and 30 percent, respectively, among people in a CDHP (Figure 4). While still lower than the percentage of individuals with traditional coverage, the number of people with a CDHP and the length of time they have been enrolled in a CDHP have been increasing. In 2014, 30 percent of CDHP enrollees reported that they had been in the health plan at least five years, up from 20 percent in 2006 (Figure 5).

Familiarity With CDHP

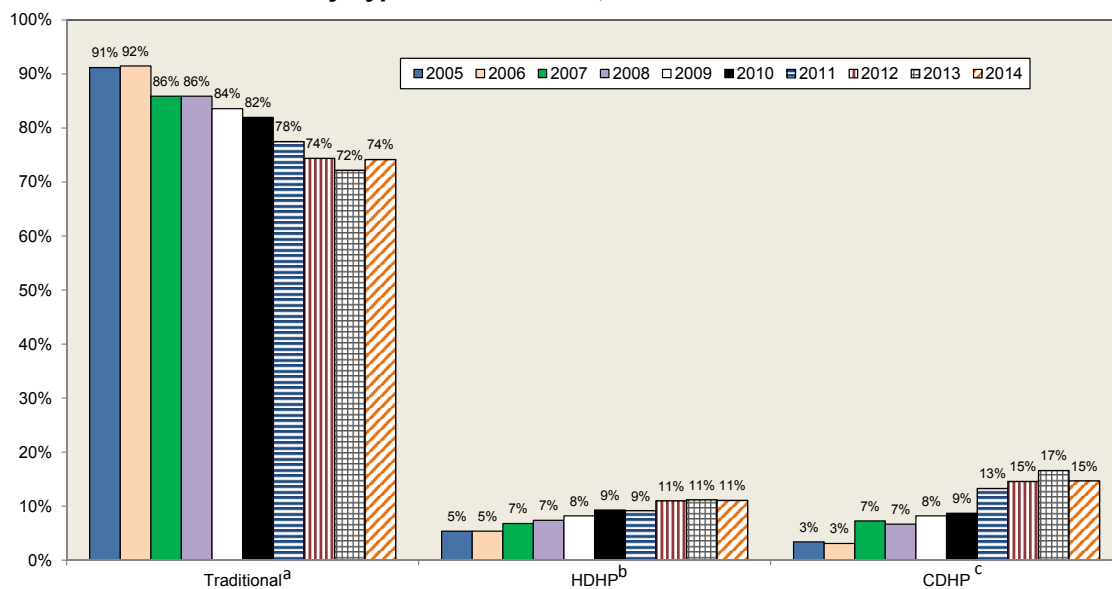
The survey found that most people with a CDHP were familiar with it. Two-thirds (64 percent) of those with a CDHP were extremely, very, or somewhat familiar with it (Figure 6). In contrast, 34 percent of individuals with traditional coverage were extremely, very, or somewhat familiar with a CDHP, and 30 percent of individuals with an HDHP were familiar with a CDHP.

Figure 1
Premium Increases Among Employers With 10 or More Employees, Worker Earnings and Inflation, 1988–2014



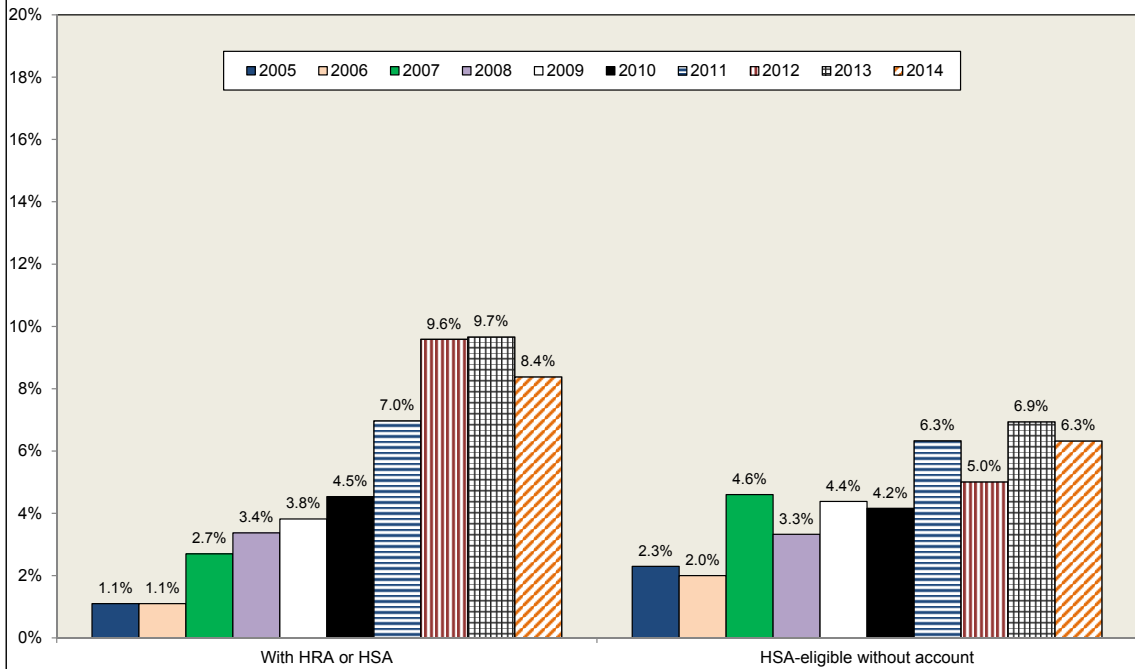
Source: Mercer, *National Survey of Employer-Sponsored Health Plans* (<http://www.mercer.com/content/mercer/global/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html>), and Bureau of Labor Statistics.

Figure 2
Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2014



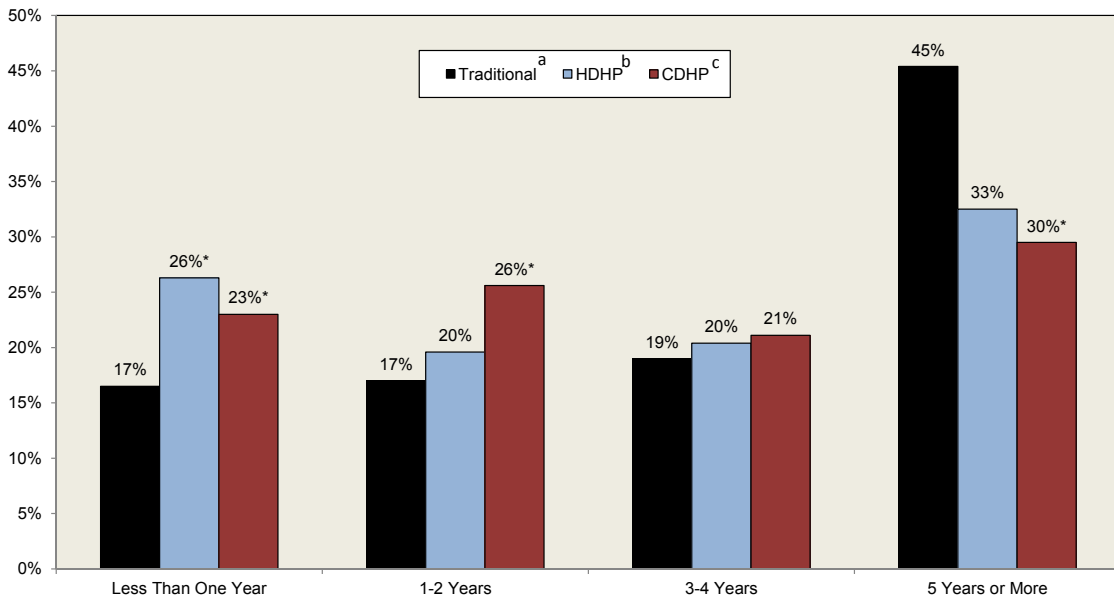
Source: EBRI/Commonwealth Fund *Consumerism in Health Care Survey, 2005–2007*; EBRI/Greenwald & Associates *Consumer Engagement in Health Care Survey, 2008–2014*.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.

Figure 3
HSA and HRA Enrollment Rates, 2005–2014



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 4
Number of Years Covered by Current Health Plan, by Type of Health Plan, 2014



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Cost-Conscious Behavior

The theory behind CDHPs and HDHPs is that the cost-sharing structure is a tool that will be more likely to engage individuals in their health care, compared with people enrolled in more traditional coverage. This study found evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors. Specifically, among privately insured adults ages 21–64 who received health care in the past 12 months, those in a CDHP were more likely than those with traditional coverage to say that they had checked whether the plan would cover care (55 percent CDHP vs. 43 percent traditional); asked for a generic drug instead of a brand name (44 percent CDHP and 42 percent HDHP vs. 35 percent traditional); talked to their doctors about prescription options and costs (38 percent CDHP vs. 29 percent traditional); checked the price of a service before getting care (37 percent CDHP and 34 percent HDHP vs. 27 percent traditional); asked a doctor to recommend less costly prescriptions (35 percent CDHP and 33 percent HDHP vs. 23 percent traditional); talked to their doctors about other treatment options and costs (34 percent CDHP vs. 26 percent traditional); developed a budget to manage health care expenses (23 percent CDHP vs. 17 percent traditional); and used an online cost-tracking tool provided by the health plan (20 percent CDHP vs. 12 percent traditional) (Figure 7).

Health Plan Choice Decisions

There was also some evidence that adults in a CDHP were more likely than those in a traditional plan to be engaged in their choice of health plan. Specifically, those in a CDHP were more likely than those with traditional coverage to say that they had attended a meeting where health plan choices were explained (37 percent CDHP vs. 30 percent traditional); consulted with their employer’s HR staff about health plan choices (35 percent CDHP vs. 25 percent traditional); and that they consulted with an insurance broker to understand plan choices (19 percent CDHP vs. 12 percent traditional) (Figure 8). CDHP and traditional plan enrollees were equally likely to report that they visited health plans’ websites to learn about their plans; talked to friends, family, and colleagues about the plans; used other websites to learn about their choices; asked health plans to send information in the mail; and talked to their doctor or other health professional about the plans.

There were also differences between HDHP and traditional plan enrollees. HDHP enrollees were more likely than traditional plan enrollees to report that they visited health plans’ websites to learn about their plans; used other websites to learn about their choices; and that they consulted with an insurance broker to understand plan choices. HDHP enrollees were less likely than traditional plan enrollees to have talked to friends, family, and colleagues about the plans; attended a meeting where choices were explained; consulted with their employer’s HR staff about choices; asked health plans to send information in the mail; and also were less likely to have talked to their doctor or other health professional about the plans.

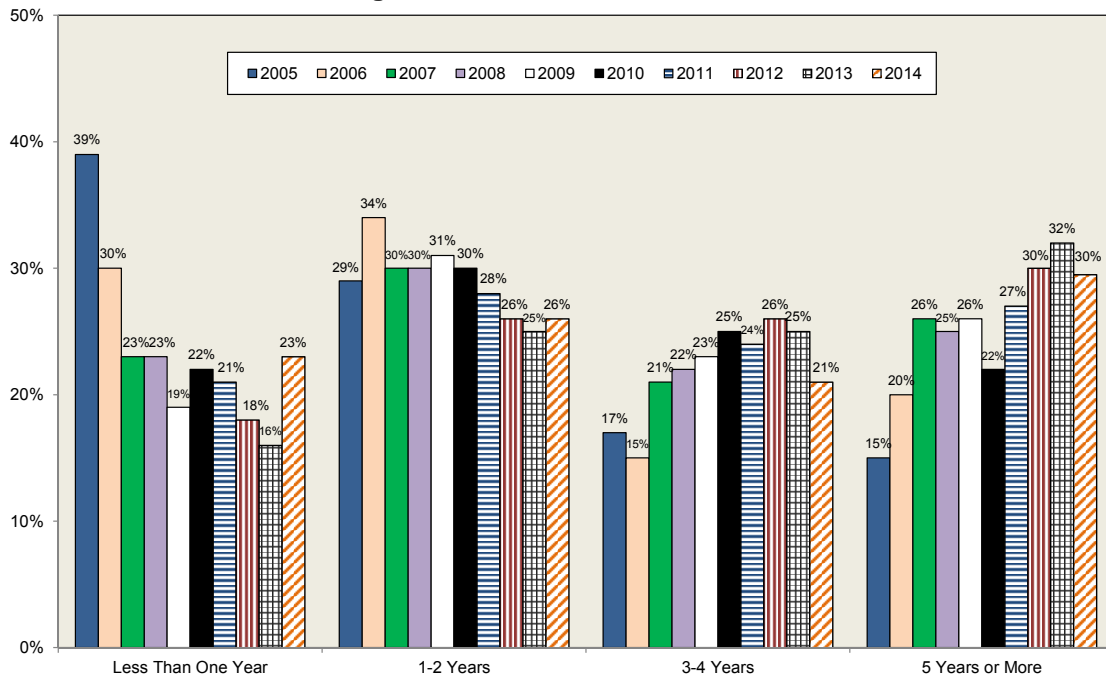
Availability and Use of Cost Information

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

The survey asked if participants tried to find the cost of health care services before getting care and found that CDHP enrollees and HDHP enrollees were more likely than traditional plan enrollees to report that they tried to find cost information (Figure 9). CDHP enrollees and traditional plan enrollees were equally likely to have found information from various sources. HDHP enrollees were less likely than traditional plan enrollees to have found information from a health plan’s printed materials. Otherwise, HDHP and traditional plan enrollees were equally likely to have found information from various sources.

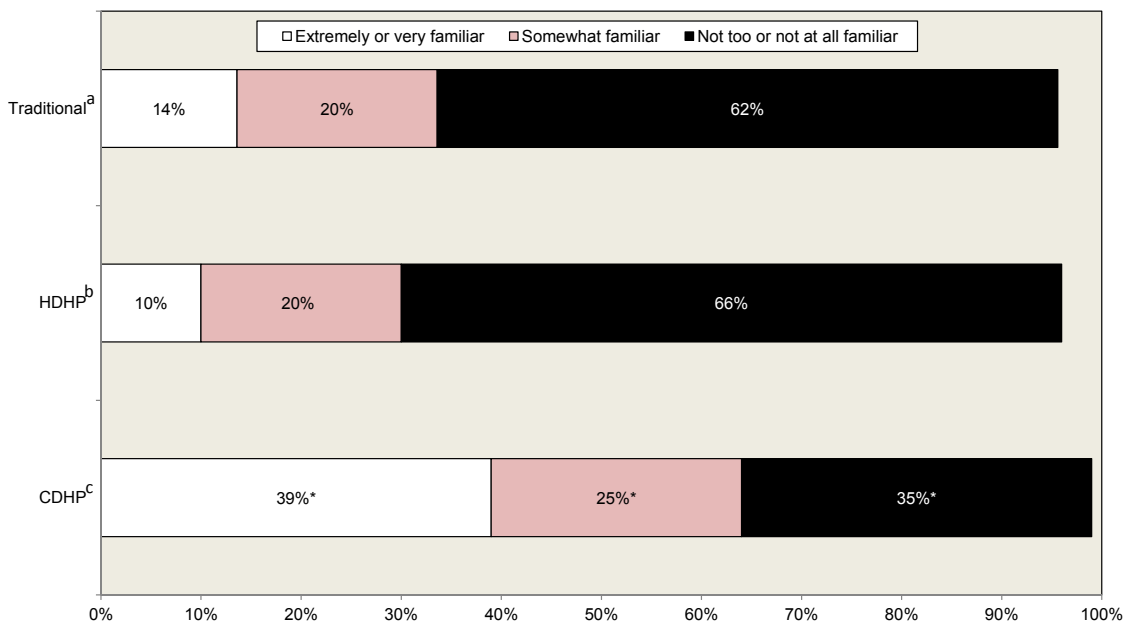
Among individuals who sought cost information, CDHP and traditional plan enrollees were equally likely to have sought cost information on a range of health care services (Figure 10). In most instances, HDHP and traditional plan enrollees

Figure 5
Length of Time With CDHP, 2005-2014



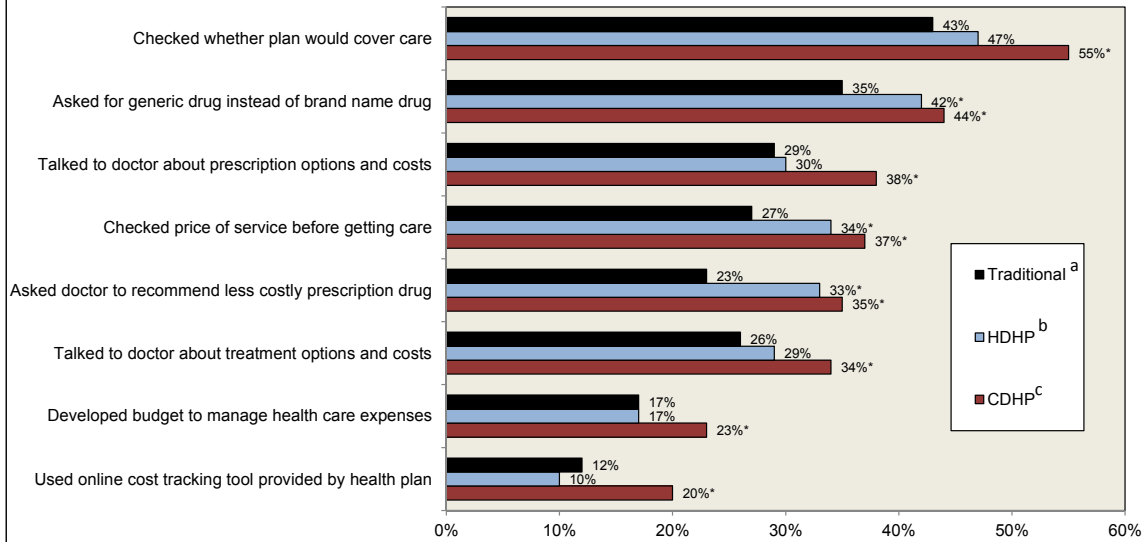
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 6
Familiarity With Consumer-Driven Health Plans, 2014



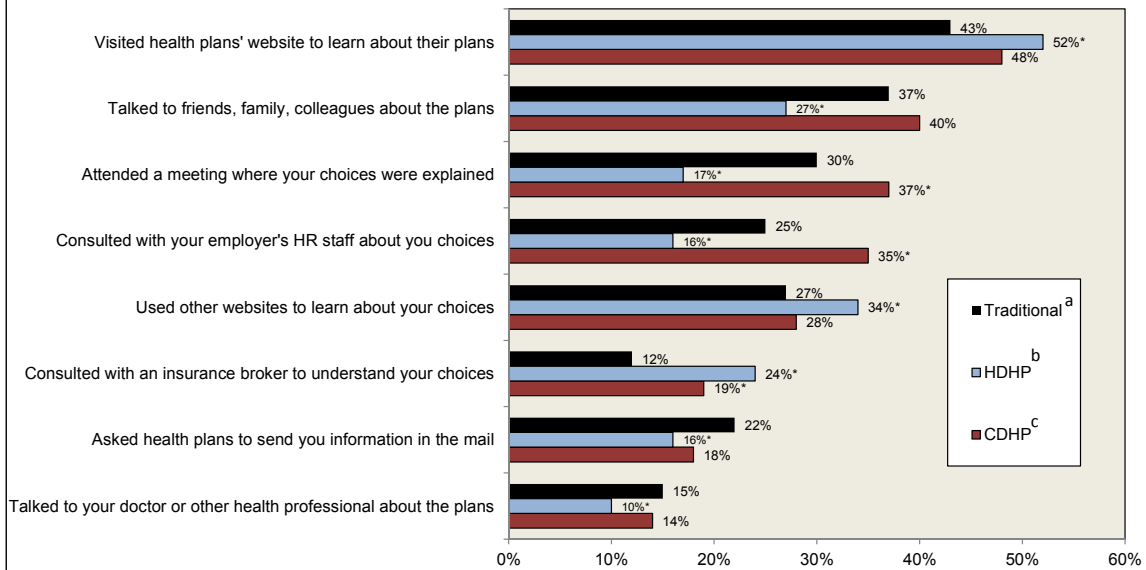
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 7
Cost-Conscious Decision Making, by Type of Health Plan, 2014
 (Percentage of privately insured adults 21–64 who received health care in last 12 months)



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 8
Informed Decision Making for Health Plan Choice, by Type of Health Plan, 2014



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

were also equally likely to have sought cost information. However, HDHP enrollees were less likely than traditional plan enrollees to have sought information on dental and vision care.

Among individuals seeking cost information, 67–80 percent sought information on cost sharing; 47–59 percent sought information on what insurance would and would not pay toward the cost of care; 42–48 percent sought cost information on provider costs; and about one-quarter sought information on total provider charges (Figure 11). There were no differences in the type of cost information sought by plan type, with one exception: CDHP enrollees were more likely than traditional plan enrollees to have sought information on what insurance would and would not pay toward the cost of care.

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 2014 CEHCS examined availability and participation in three types of wellness programs: a health-risk assessment, a health-promotion program to address a specific health issue, and a biometric screening.¹⁰

The survey 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, 46 percent of CDHP enrollees reported that their employer offered a health-risk assessment, compared with 36 percent of traditional-plan enrollees (Figure 12). About one-fifth (22 percent) of HDHP enrollees reported the availability of a health risk assessment program, significantly lower than offer rates among CDHP and traditional-plan 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-quarter (24 percent) of HDHP enrollees reported the availability of a health promotion program, significantly lower than offer rates among CDHP and traditional-plan enrollees. When asked about biometric-screening programs, 47 percent of CDHP enrollees reported that their employer offered such a program, compared with 35 percent among traditional-plan enrollees and 23 percent among HDHP enrollees.

CDHP enrollees were more likely than traditional-plan enrollees to participate in health-risk assessments, health-promotion programs, and biometric screenings when they are offered by their employers. Three-quarters (75 percent) of CDHP enrollees participated in a health-risk assessment, compared with 58 percent of traditional-plan enrollees (Figure 13). About one-half (53 percent) of CDHP enrollees participated in a health-promotion program, compared with 44 percent of traditional-plan enrollees. Nearly four-fifths (77 percent) of CDHP enrollees participated in a biometric screening, compared with 60 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. Just over three-fifths (63 percent) reported a cash incentive or reward for participating in the health-risk assessment; one-half (53 percent) reported a cash incentive or reward for participating in a health-promotion program, and two-thirds (65 percent) reported a cash incentive or reward for a biometric screening (Figure 14). The main reasons enrollees participated were to improve or maintain health (Figure 15). CDHP enrollees were more likely than traditional plan enrollees to report that they participated to reduce premiums, while they were less likely to report that they participated to improve their health. Otherwise, there were no differences by plan type.

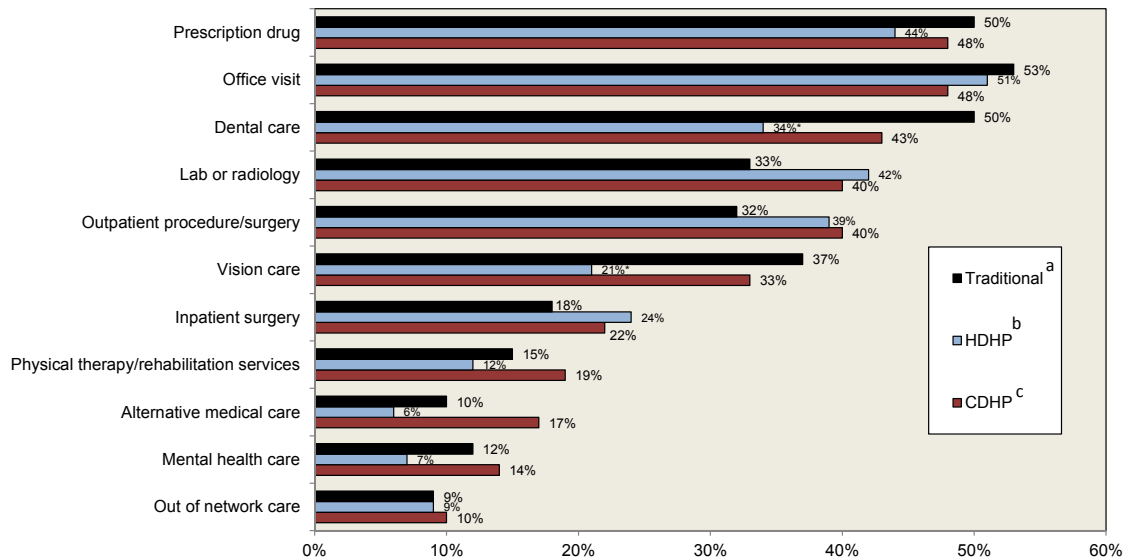
The survey also asked respondents their reasons for not participating in their employer's wellness program. About 60 percent responded that they did not participate because they could make changes on their own (Figure 16): 28 percent cited this as a major reason, and 33 percent cited it as a minor reason for not participating. Lack of time was the second-most-popular reason for not participating, with 27 percent reporting it as a major reason, and 33 percent reporting it as a minor reason. About one-half (48 percent) did not participate because they were already healthy (19 percent reported it as a major reason, and 29 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.

Figure 9
Availability and Use of Cost Information, 2014

	Traditional ^a	HDHP ^b	CDHP ^c
Tried to find the cost of health care services before getting care	21%	29%*	36%*
Found information	74	60*	73
Health plan's website	54	44	53
Health plan's customer service department	34	32	39
Printed material from health plan	30	15*	28
Provider's office	18	30	27
Provider's website	19	21	25
Other websites	7	12	4

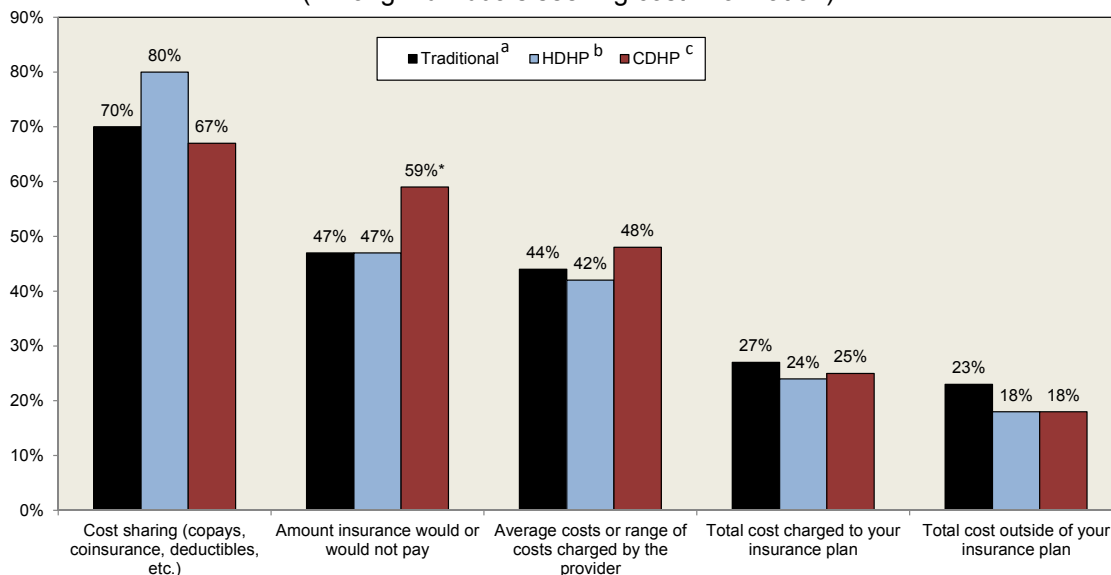
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 10
Types of Cost Information Sought,
by Type of Health Plan, 2014
(Among individuals seeking cost information)



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 11
Types of Cost Information Found,
by Type of Health Plan, 2014
(Among individuals seeking cost information)



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.

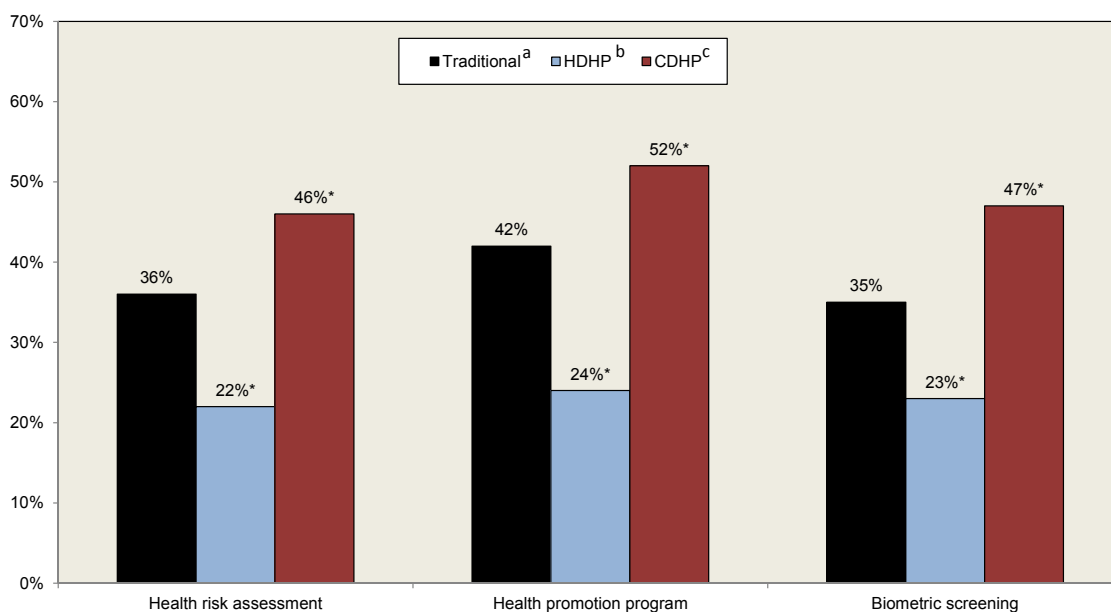
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.

^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.

^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.

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

Figure 12
Employer Offers Wellness Program, by Type of Health Plan, 2014



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.

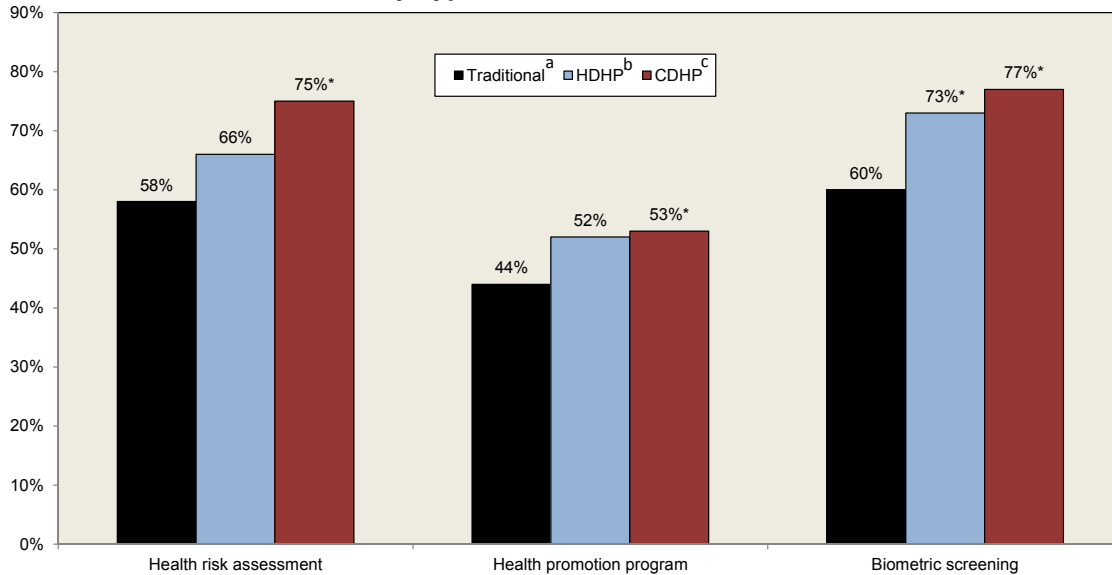
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.

^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.

^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.

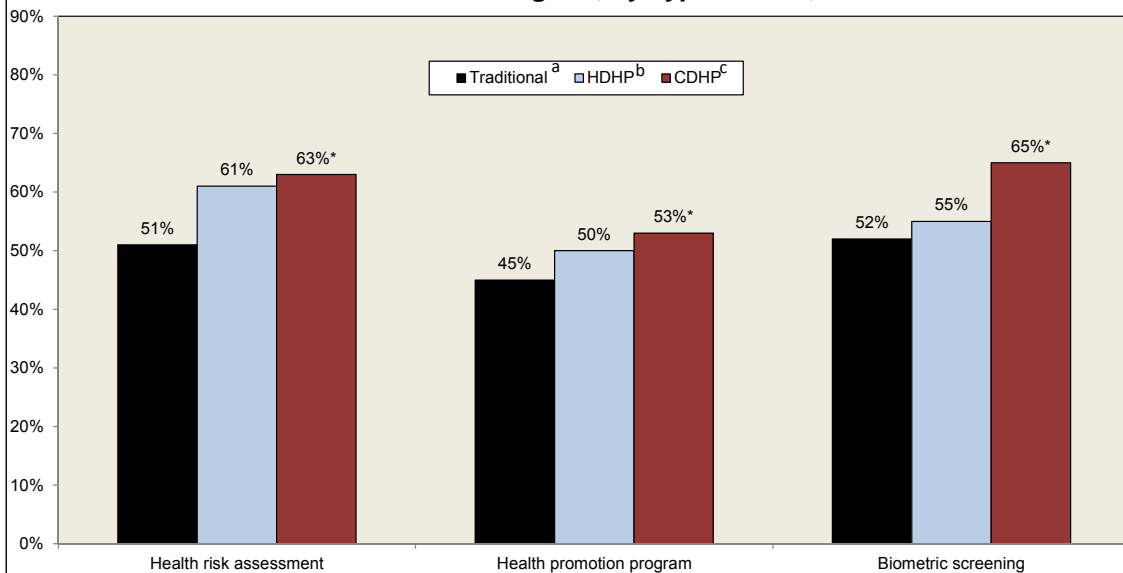
* Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 13
Individual Participates in Wellness Program Offered by Employer, Among Those Offered a Wellness Program, by Type of Health Plan, 2014



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 14
Employer Offers Cash Incentive or Reward for Participating in Wellness Program, Among Workers Whose Employer Offers Wellness Program, by Type of Plan, 2014



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figures 17 and 18 contain findings from a series of questions related to the impact that financial incentives could have on participation in wellness programs. As in past years, there were very few differences by plan type. There were no differences between CDHP and traditional-plan enrollees when it came to time off (Figure 17). However, CDHP enrollees were more likely than traditional plan enrollees to report that they would probably participate if they were offered a \$250 cash incentive, and CDHP enrollees were more likely than traditional plan enrollees to report that they would probably participate if the employer increased premiums for non-participants. When it came to the impact of cost sharing, there were no differences by plan type (Figure 18). However, cost-sharing incentives to participate still mattered to many individuals, regardless of plan type. It was found that, concerning most questions, between about 56 percent and about 69 percent of participants said they would participate in wellness programs if there was some type of financial incentive related to cost sharing for office visits and prescription drugs.

Patient Use of Technology

In 2014, the CEHCS continued to ask about consumer use of technology to engage in health-related activities. The survey found that 76 percent of the adult population with private health insurance had used a smartphone more than once within the past year, and nearly 58 percent had used a tablet (up from about 60 percent and 40 percent, respectively, from 2012). Among those who used a smartphone or tablet, 20–29 percent used an app for nutrition information; 20–27 percent used one for general health information; 15–26 percent used one for weight management or diets; and 21–29 percent used one for exercise programs (Figure 19). There were few differences by plan type.

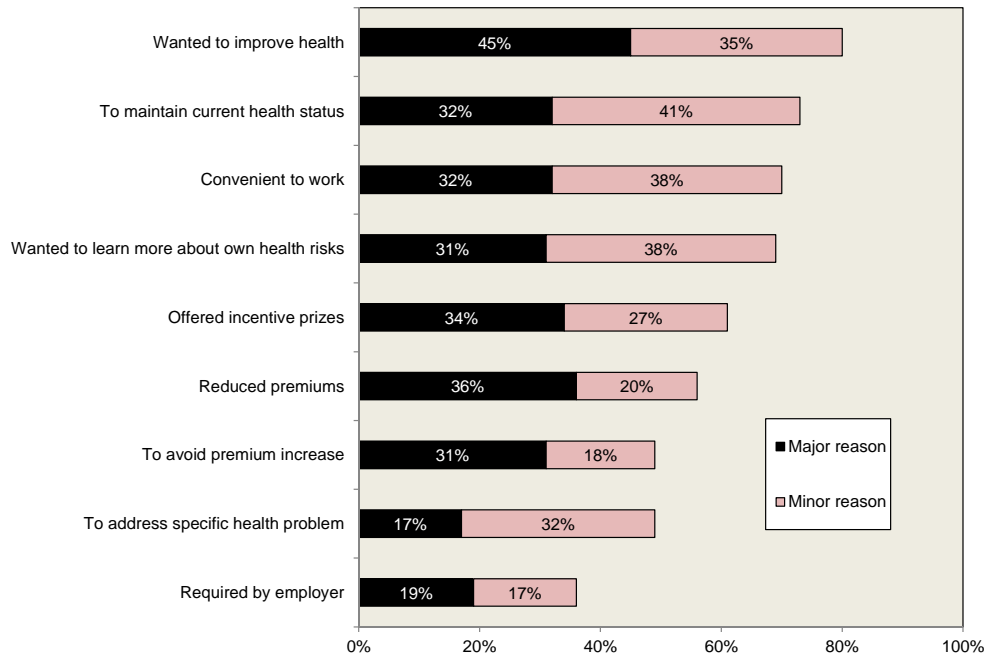
Among those who have never used an app for health-related purposes, about 38–49 percent are very or somewhat interested in using one for things like nutrition information, exercise programs, weight management or diets, prescription drug prices, medical-claims history, and for general health information (Figure 20). Among individuals with a CDHP, 53 percent were very or somewhat interested in using an app to check the balance of the HSA or HRA.

Conclusion

The 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS) found continued slow growth in consumer-driven health plans (CDHPs): 15 percent of the population was enrolled in a CDHP. Enrollment in high-deductible health plans (HDHPs) was 11 percent. Overall, 26 million individuals with private insurance were enrolled in a CDHP.

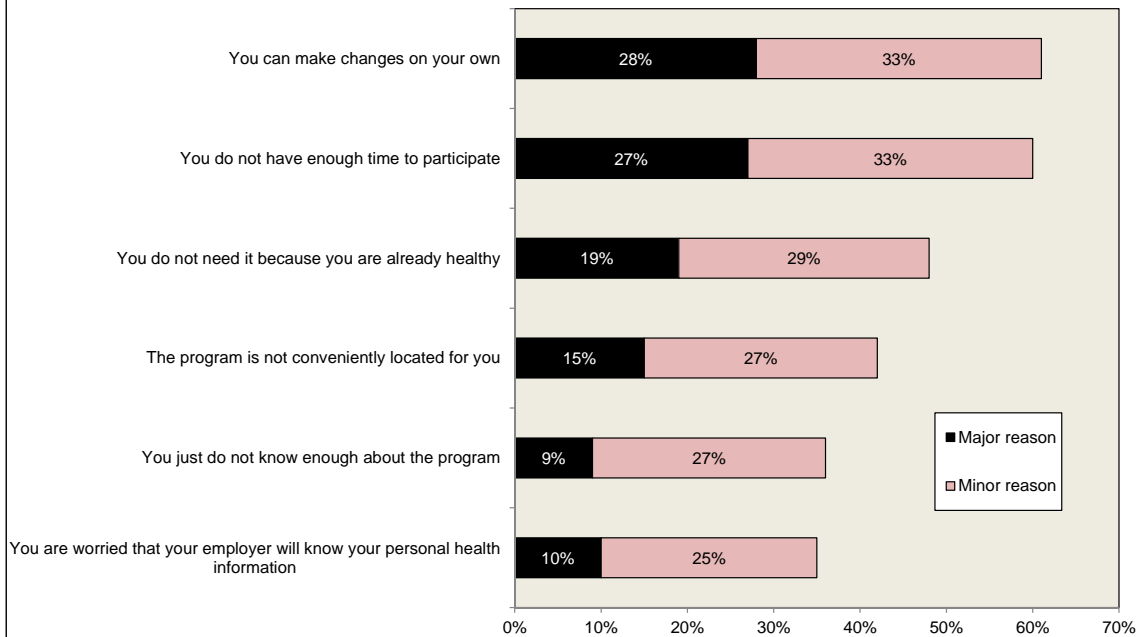
The 2014 CEHCS continued to find that CDHP enrollees were more cost conscious in their decision making than those in traditional plans. CDHP enrollees were more likely to use resources to pick their health plan and more likely to use cost information before getting health care services. CDHP enrollees were more likely than traditional-plan enrollees to take advantage of various wellness programs, such as health-risk assessments, health-promotion programs, and biometric screenings. In addition, financial incentives mattered more to CDHP enrollees than to traditional-plan enrollees.

Figure 15
Reasons for Participating in Employer's Wellness Program, 2014



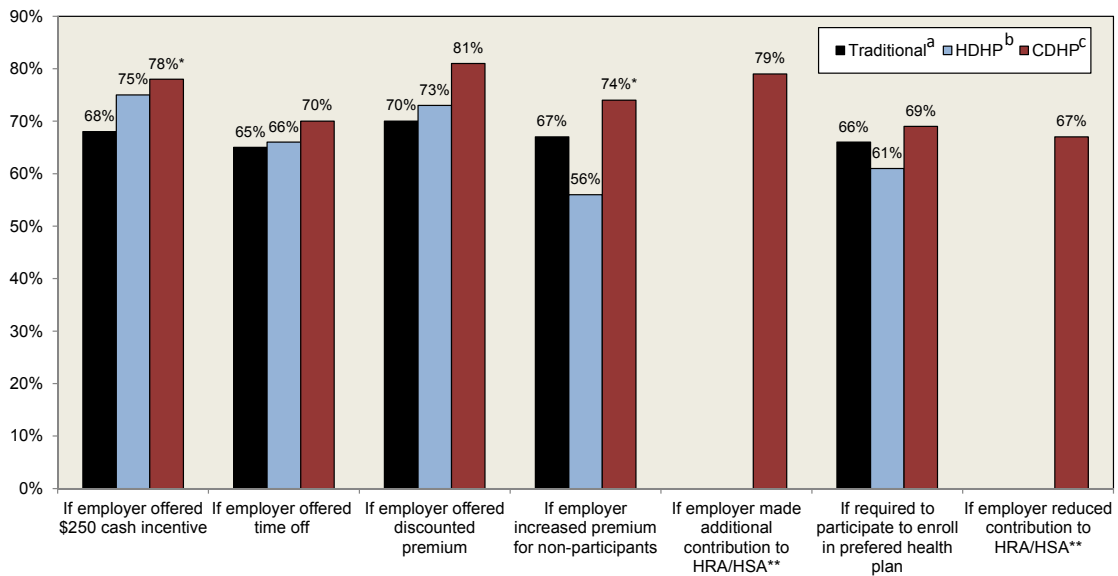
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.

Figure 16
Reasons for Not Participating in Employer's Wellness Program Among Those Offered but Not Participating in Program, 2014



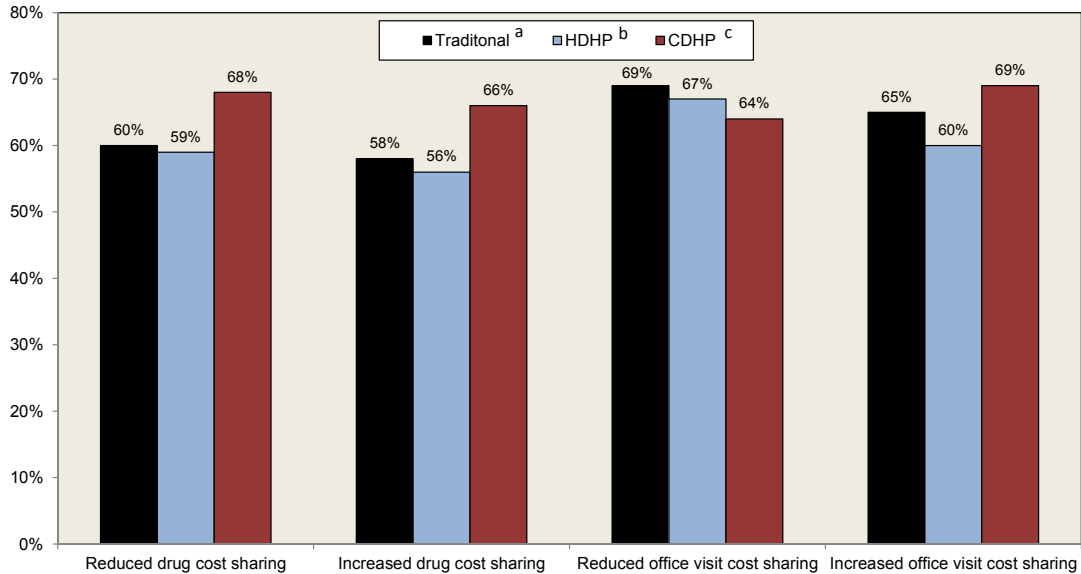
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.

Figure 17
Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Financial Incentives and Type of Health Plan, 2014



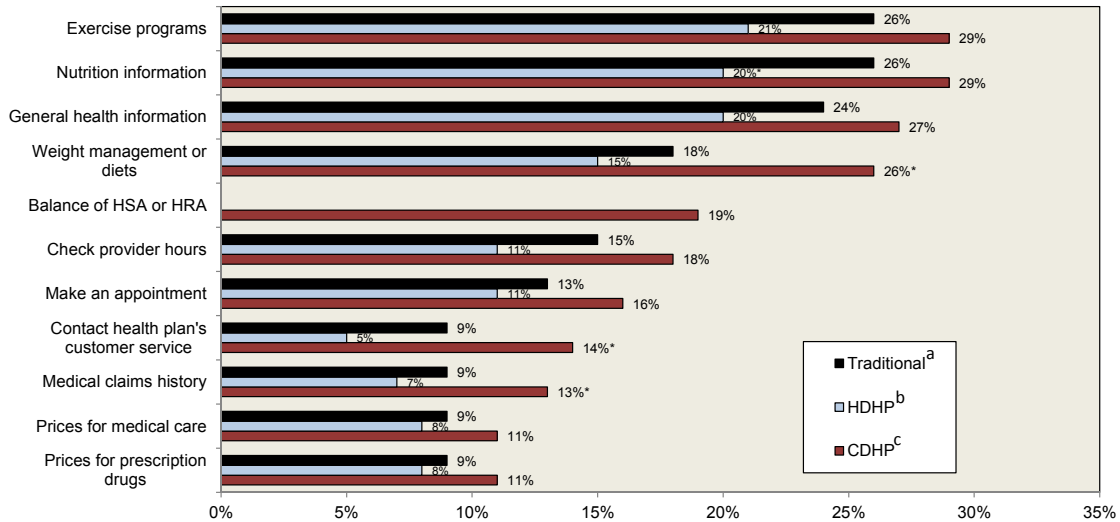
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.
 ** Asked of CDHP only.

Figure 18
Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Cost-Sharing Incentives and Type of Health Plan, 2014



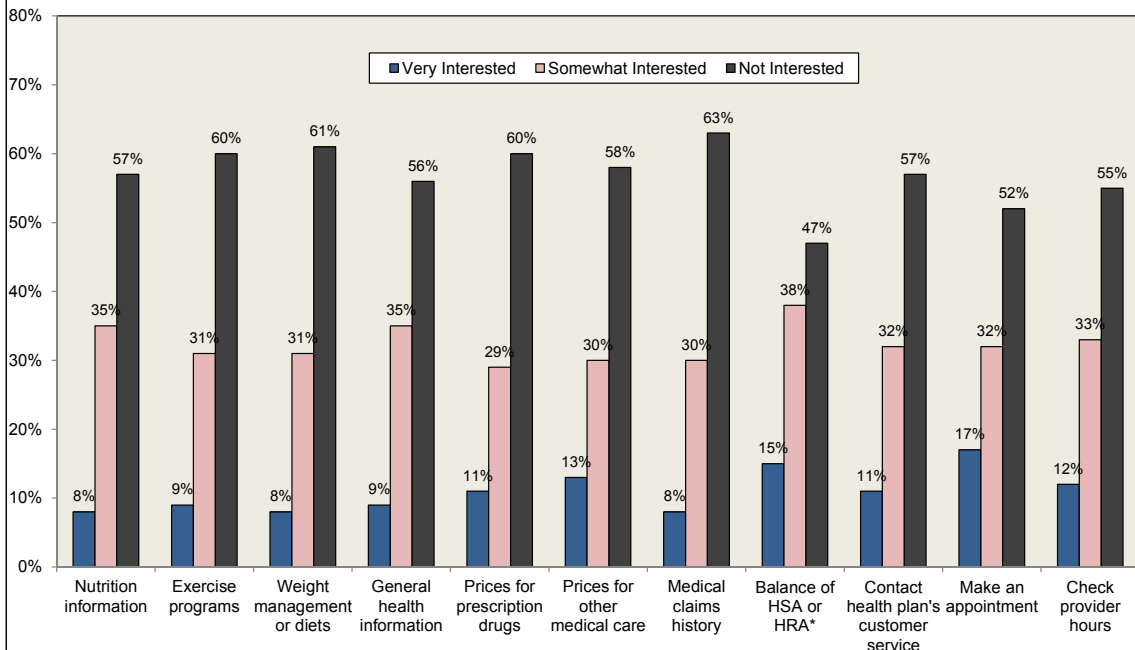
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.

Figure 19
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, 2014
 (Among Those Who Use a Smartphone or Tablet)



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
^a Traditional = Health plan with no deductible or <\$1,250 (individual), <\$2,500 (family) in 2014.
^b HDHP = High-deductible health plan with deductible \$1,250+ (individual), \$2,500+ (family), not HSA-eligible in 2014.
^c CDHP = Consumer-driven health plan with deductible \$1,250+ (individual), \$2,500+ (family), with HRA, HSA, or HSA-eligible in 2014.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 20
Interest in Using an App for a Smartphone or Tablet, by Health-Related Function, 2014
 (Among those who never used an App for a Smartphone or Tablet)



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.
 * Asked of CDHP only.

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS), an online survey that examines issues surrounding consumer-driven health care, including the cost of insurance, the cost of care, satisfaction with health care, satisfaction with health care plans, reasons for choosing a plan, and sources of health information. It also presented findings from the 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008–2013 CEHCS. The 2014 CEHCS was conducted within the United States between Aug. 7 and Aug. 27, 2014, through an 11-minute Internet survey. The national or base sample was drawn from Ipsos' online panel of Internet users who have agreed to participate in research surveys. Nearly, 2,000 adults ages 21–64 who had health insurance through an employer, purchased directly from a carrier, or purchased through a government exchange were drawn randomly from the Ipsos sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 36.3 percent (26 percent for the base sample or national sample, and 48 percent for the oversample). As a non-probability sample, traditional survey margin-of-error estimates do not apply. However, had the survey used a probability sample, the margin of error for the national sample would have been ± 2.2 percent.

To examine the issues mentioned above, the sample was divided into three groups: those with a consumer-driven health plan (CDHP), those with a high-deductible health plan (HDHP), and those with traditional health coverage. Individuals were assigned to the CDHP and HDHP groups if they had a deductible of at least \$1,250 for individual coverage or \$2,500 for family coverage. To be assigned to the CDHP group, they must also have been eligible to contribute to an HSA or had a health reimbursement arrangement (HRA) with a rollover provision that they could use to pay for medical expenses or the ability to take their account with them should they change jobs. Individuals with only a flexible spending account (FSA) were not included in the CDHP group.

Individuals were assigned to the HDHP group if they reported that they were not eligible for an HSA. The group with traditional health coverage included individuals in a broad range of plan types, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), other managed care plans, and plans with a broad variety of cost-sharing arrangements. The shared characteristics of these group members were that they either had no deductible or a deductible that was below current thresholds for HSA tax preference.

Because the base sample (national sample) included only 294 individuals in a CDHP and 237 individuals with an HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 1,165 individuals with a CDHP and 741 individuals with an HDHP, resulting in a total sample (base plus oversample) of 1,459 for the CDHP group and 978 for the HDHP group. After factoring out the base sample—the 294 individuals with a CDHP and the 237 individuals with an HDHP—there were 1,450 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 Ipsos' omnibus survey of more than 40,000 online panel members who met the study's criteria (having private insurance and being ages 21–64). The following three questions were used in the omnibus survey running from July 14 to Aug. 1, 2014, 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 company3
- I have other health insurance (specify _____)4
- I do not have health insurance currently5

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

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

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

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

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

- Yes
- No
- Not sure

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

Definitions

Consumer-Driven Health Plans (CDHPs)

CDHPs refer to health plans that have a deductible of at least \$1,250 for individual coverage and \$2,500 for family coverage in 2014, and include either a health savings account (HSA)-eligible health plan, with or without the HSA, or a health reimbursement arrangement (HRA), described in more detail below.

Health Savings Accounts

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

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

In order to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than \$1,250 for self-only coverage and \$2,500 for family coverage (minimum deductible amounts are indexed to inflation). Certain preventive services can be covered in full and are not subject to the deductible. The health plan's out-of-pocket maximum may not exceed \$6,350 for self-only coverage and \$12,700 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit are indexed to inflation. A network plan may impose a higher deductible and an out-of-pocket limit for out-of-network services. Individuals can have a health plan with a deductible and maximum out-of-pocket limit that qualifies them to make a tax-free contribution to an HSA, but they are not required to make a contribution or to open an account.

Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer and deductible from adjusted gross income if made by the individual. The maximum annual contribution is \$3,300 for self-only coverage and \$6,550 for family coverage in 2014.

To be eligible for an HSA, an individual may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.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 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 2014, a \$1,000 catch-up contribution was allowed. The catch-up contribution is not indexed to inflation.

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

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 20 percent penalty (increased from 10 percent in 2010 as a result of the Patient Protection and Affordable Care Act of 2010 (PPACA)), which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

Individuals are able to roll over funds from one HSA into another HSA without subjecting the distribution to income and penalty taxes as long as the rollover occurs within 60 days of the date funds are received. Rollover contributions from Archer Medical Savings Accounts (MSAs) are also permitted. Earnings on contributions are also not subject to income taxes.

Health Reimbursement Arrangements

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

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

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

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

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

Distributions from an HRA for qualified medical expenses are made on a tax-favored basis. Since unused funds are allowed to roll over, an employee is able to accumulate funds over time. An employer can allow a former employee to use any leftover money in the HRA to continue to cover qualified medical expenses. Funds can be used for out-of-pocket expenses and premiums for insurance, long-term care, COBRA, and retiree health benefits. An employer is not required to make the unused balance available to a worker when he or she leaves.

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Endnotes

¹ Calculated from Figure 1.

² More information about HRAs and HSAs can be found on pg. 21 and in Fronstin (2002 and 2004).

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

⁴ See Appendix for more detail on the methodology.

⁵ Traditional plans include a broad range of plan types, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), other managed care plans, and plans with a broad variety of cost-sharing arrangements. The shared characteristics of these plans are that they either have no deductibles or deductibles that are below current thresholds that would qualify for tax-preferred HSA contributions.

⁶ See <https://www.ahip.org/2014/HSA-Census-Report/>

⁷ See Figure 6 in <http://www.mercer.com/content/mercer/global/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html>

⁸ See Table 10 in <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201409.pdf>

⁹ See Exhibit 5.1 in <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>

¹⁰ The specific question was: Does your employer offer any of the following wellness programs?

- Health-risk assessment, where you answer a questionnaire and then a medical professional examines your health history to identify any conditions you may have or that you might be at risk of developing.
- Programs for improving your health, like for weight loss, walking or other exercise, nutrition, stress management, smoking cessation, and so on.
- Biometric screenings, which are measurements or blood work to determine your health status including blood pressure, cholesterol, weight, height, etc.

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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