

## Findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey

*By Paul Fronstin, Ph.D., Employee Benefit Research Institute*

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### AT A GLANCE

- The 2012 EBRI/MGA Consumer Engagement in Health Care Survey finds continued slow growth in consumer-driven health plans: 10 percent of the population was enrolled in a CDHP, up from 7 percent in 2011. Enrollment in HDHPs remained at 16 percent.
- Overall, 18.6 million adults ages 21–64 with private insurance, representing 15.4 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA. When their children were counted, about 25 million individuals with private insurance, representing about 14.6 percent of the market, were either in a CDHP or an HSA-eligible plan.
- 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. While CDHP enrollees, HDHP enrollees, and traditional-plan enrollees were about equally likely to report that they made use of quality information provided by their health plan, CDHP enrollees were more likely to use cost information and to try to find information about their doctors' costs and quality from sources other than the health plan.
- CDHP enrollees were more likely than traditional-plan enrollees to take advantage of various wellness programs, such as health-risk assessments, health-promotion programs, and biometric screenings. In addition, financial incentives mattered more to CDHP enrollees than to traditional-plan enrollees.
- It is clear that the underlying characteristics of the populations enrolled in these plans are different: Adults in a CDHP were significantly more likely to report being in excellent or very good health. Adults in a CDHP and those in a HDHP were significantly less likely to smoke than were adults in a traditional plan, and they were significantly more likely to exercise. CDHP and HDHP enrollees were also more likely than traditional-plan enrollees to be highly educated.
- As the CDHP and HDHP markets continue to expand and more enrollees are enrolled for longer periods of time, the sustained impact that these plans are having on cost, quality, and access to health care services can be better understood. The eight years of consumer engagement surveys reported here provide unique data from which to measure future changes in this evolving type of health insurance.
- A significant portion of the population reported using a smartphone or a tablet. Among them, as many as one-third reported using an application (app) for health-related purposes. Among those not using an app, about one-half were very interested in using one.

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

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## Introduction

In every year since 1998, U.S. employment-based health care premium increases have exceeded worker-earnings increases and inflation (Figure 1). Health insurance premiums have nearly tripled, while worker earnings have increased 52 percent.<sup>1</sup>

In response, employers have been seeking ways to manage the cost increases. 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. A handful of employers first started offering account-based health plans in 2001 with health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health savings accounts (HSAs).<sup>2</sup> By 2012, 36 percent of employers with 500 or more workers offered either an HRA- or HSA-eligible plan, covering 16 percent of that population, up from 32 percent offering such a plan and 13 percent enrollment in 2011.<sup>3</sup> (See page 24 for detailed explanations of HRAs and HSAs.)

Additionally, 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. In 2001, they formed a coalition to report health-care-provider quality measures, and today the group is composed not only of employers but also of consumer groups and organized labor.<sup>4</sup> In 2005, employers started to focus on value-based insurance designs that seek to encourage the use of high-value services while discouraging the use of services when the benefits are not justified by the costs (Chernew et al., 2007).

This *Issue Brief* presents findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey. This study is based on an online survey of 4,498 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 2,004 to draw incidence rates for people with account-based health plans and HDHPs, and the base sample was complemented with an additional random oversample of these two groups. More specifically, the oversamples were: 1) those with either an HRA or an HSA, and 2) those with an HDHP without an account but with a deductible that is generally high enough to meet the qualifying threshold to make tax-preferred contributions to such an account. A high deductible was defined as an individual deductible of at least \$1,000 and a family deductible of at least \$2,000.<sup>5</sup> The final sample included 1,416 in an HDHP with either an HSA or HRA (consumer-driven health plans, or CDHPs), 1,608 in an HDHP without an account, and 1,416 in a more traditional health plan.<sup>6</sup>

Findings from this survey are compared with findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008–2011 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.<sup>7</sup>

## Summary of Findings

In 2012, 10 percent of the population was enrolled in a CDHP, up from 7 percent in 2011 and 5 percent in 2010; enrollment in HDHPs increased from 14 percent in 2010 to 16 percent in 2011 and remained at that level in 2012 (Figure 2). The 10 percent of the population with a CDHP represents 11.6 million adults ages 21–64 with private insurance, while the 16 percent with an HDHP represents 19.3 million people. Among the 19.3 million individuals with an HDHP, 36 percent (or 7 million) reported that they were eligible for an HSA but did not have such an account. Thus, overall, 18.6 million adults ages 21–64 with private insurance, representing 15.4 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, 25.2 million individuals with private insurance, representing 14.6 percent of the market, were either in a CDHP or an HSA-eligible plan.

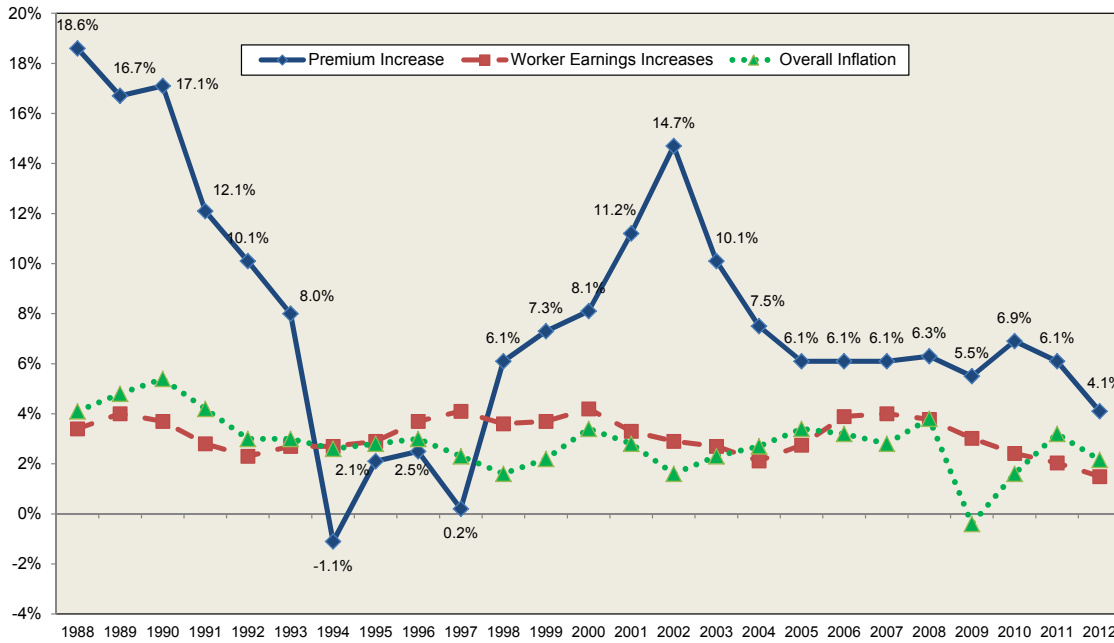
HRA and HSA enrollment is growing, but the market penetration remains relatively small,<sup>8</sup> and the amount of time individuals have been in these plans is shorter than the time others have been enrolled in traditional coverage. Among individuals with traditional coverage, 20 percent had been in their plan for three to four years and 49 percent for five or more years. This compares with 27 percent and 26 percent, respectively, among people in a CDHP (Figure 3). 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 that plan have been increasing. In 2012, 26 percent of CDHP enrollees reported that they had been in that health plan at least 5 years, up from 8 percent in 2006 (Figure 4).

With respect to familiarity with a CDHP, 62 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. Familiarity with a CDHP among those with a CDHP increased between 2011 and 2012, but was unchanged for individuals with traditional coverage or with an HDHP.

The study also finds the following:

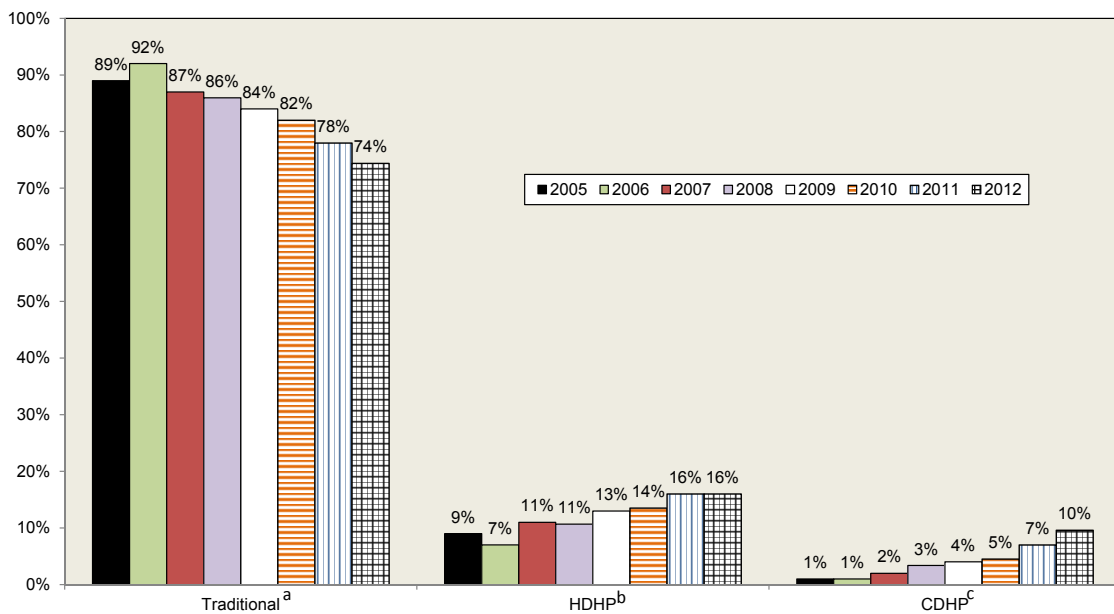
- Individuals in a CDHP were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors. They were more likely to say that they had checked whether their plan would cover care; asked for a generic drug instead of a brand name; talked to their doctor about prescription 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 in a CDHP were as likely as those with traditional coverage to report that their plan provided *doctor quality* information and they were less likely to report that their plan provided information on cost of care provided by doctors. However, when cost information was available, CDHP enrollees were more likely than traditional-plan enrollees to report that they tried to use the information. CDHP enrollees were also more likely to try to find information about their doctors' costs and quality from sources other than the health plan.
- CDHP enrollees were more likely than traditional-plan enrollees to 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 and to a biometric screening program. HDHP enrollees were less likely than traditional-plan enrollees to report having access to such programs.
- CDHP enrollees were more likely to report that they were offered a cash incentive or reward to participate in a wellness program when a program was offered. When it comes to participating in a wellness program, CDHP enrollees were more likely than traditional-plan enrollees to take advantage of the program. The top reasons CDHP enrollees gave for participating were that they were offered incentive prizes and reduced premiums. Among those not participating, the top 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.

Figure 1  
**Premium Increases Among Employers With 10 or More Employees, Worker Earnings Increases, and Inflation, 1988–2012**



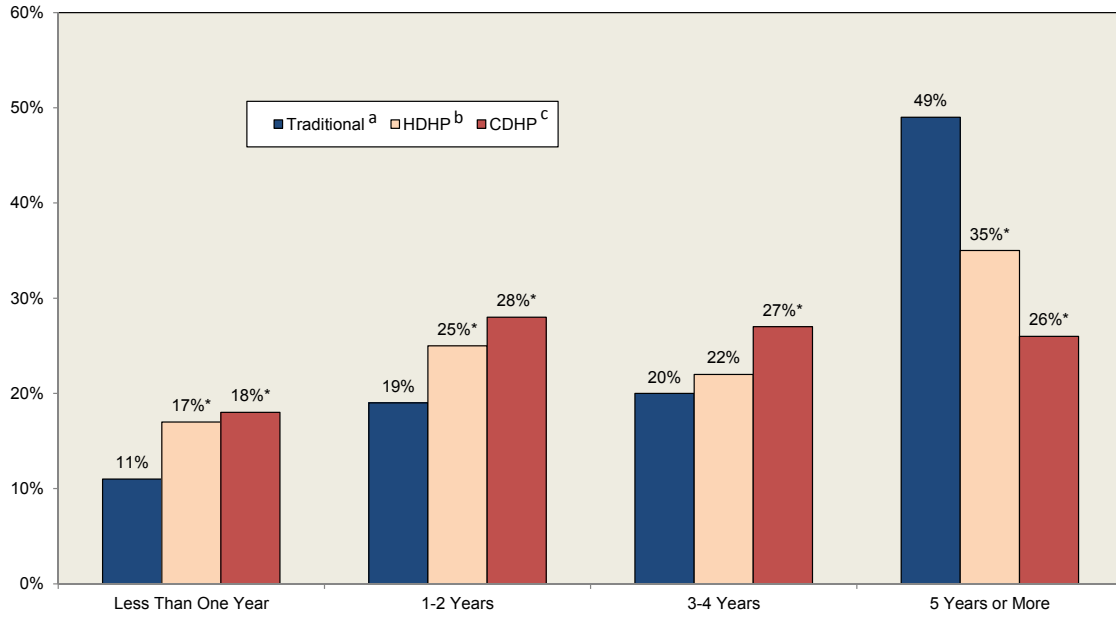
Source: Mercer, *National Survey of Employer-Sponsored Health Plans*, and Bureau of Labor Statistics.

Figure 2  
**Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2012**



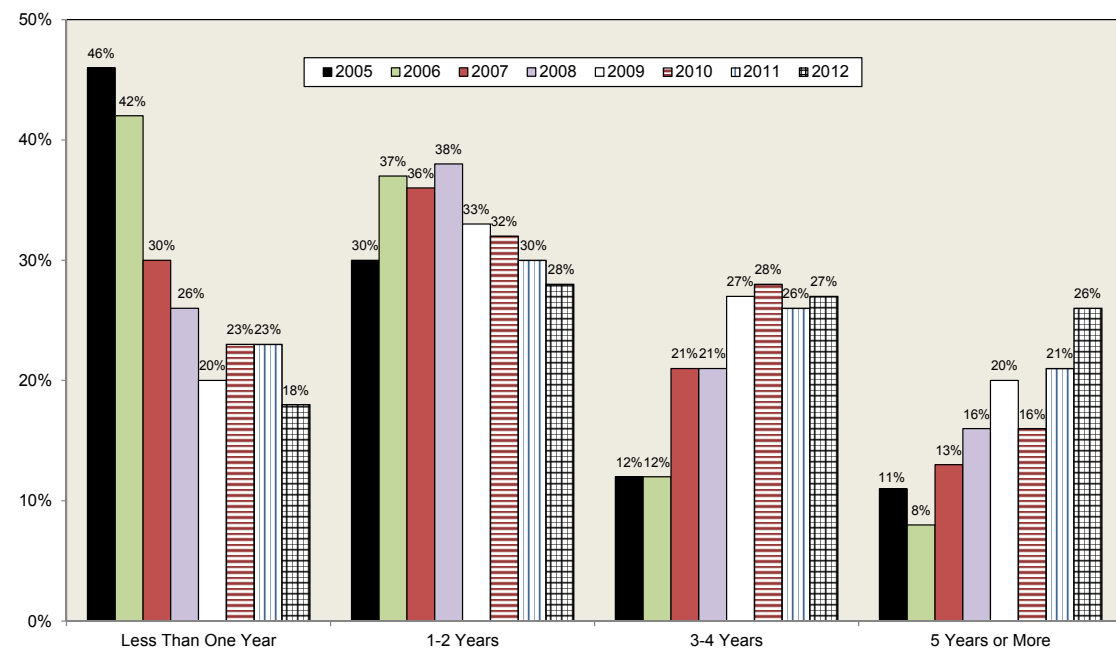
Source: EBRI/Commonwealth Fund *Consumerism in Health Care Survey, 2005–2007*; EBRI/MGA *Consumer Engagement in Health Care Survey, 2008–2012*.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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, 2012**



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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  $p \leq 0.05$  or better.

Figure 4  
**Length of Time With HRA<sup>a</sup> or HSA<sup>b</sup>, 2005–2012**



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2012.  
<sup>a</sup> Health reimbursement arrangement.  
<sup>b</sup> Health savings account.

- Differences were found among CDHP enrollees, HDHP enrollees, and traditional-plan enrollees when it came to choosing doctors based on their use of health information technology (HIT), with CDHP enrollees reporting a greater likelihood of switching to doctors who used HIT if there was a financial incentive to do so. 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, when it came to switching doctors if their doctors were not in the network, there was little difference by plan type.
- A significant portion of the population reported using a smartphone or a tablet. Among them, as many as one-third reported using an application (app) for health-related purposes. Among those not using an app, about one-half were very interested in using one.

The remainder of this report examines the findings from the 2012 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, medical homes, opinions about provider engagement, cost-sharing incentives related to plan type, and health information technology.

## Cost-Conscious Behavior

The theory behind account-based plans and plans with higher deductibles is that the cost-sharing structure will be more likely to engage individuals in their health care, compared with people enrolled in more traditional coverage. 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 and those in an HDHP were more likely than those with traditional coverage to say that they had checked whether the plan would cover care (56 percent CDHP and 54 percent HDHP vs. 45 percent traditional); asked for a generic drug instead of a brand name (53 percent CDHP and 52 percent HDHP vs. 41 percent traditional); talked to their doctors about prescription options and costs (38 percent CDHP and 39 percent HDHP vs. 30 percent traditional); talked to their doctors about other treatment options and costs (35 percent CDHP and HDHP vs. 28 percent traditional); developed a budget to manage health care expenses (26 percent CDHP vs. 16 percent traditional); checked the price of a service before getting care (32 CDHP and 27 percent HDHP vs. 23 percent traditional); and used an online cost-tracking tool provided by the health plan (23 percent CDHP vs. 11 percent traditional) (Figure 6).

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

## Availability and Use of Cost and Quality Information

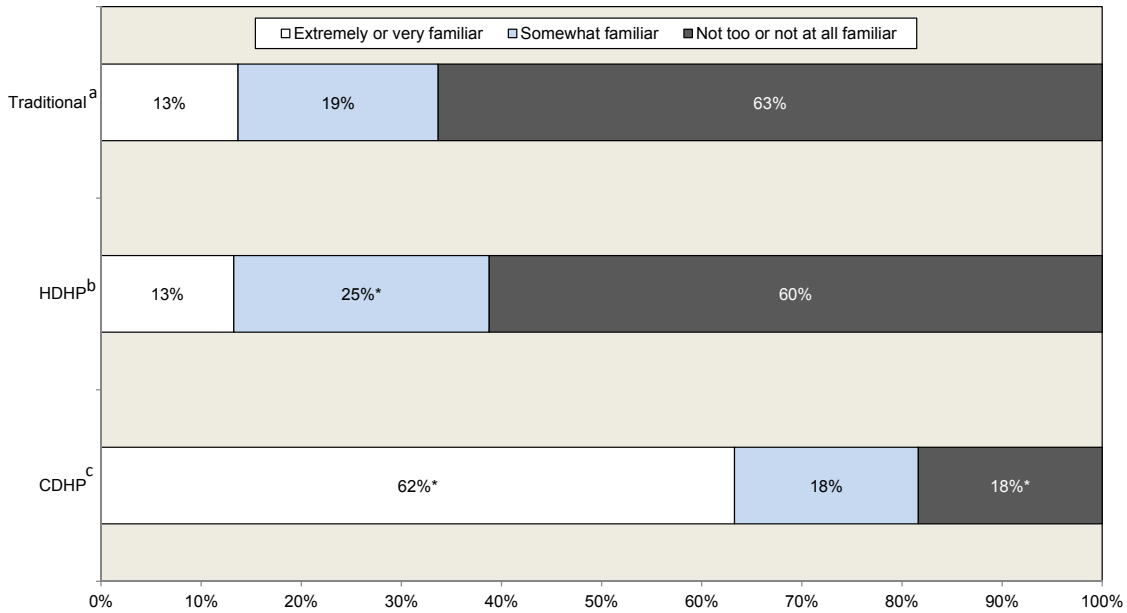
The incentives of CDHPs are designed to promote heightened sensitivity to cost and quality in people's decisions about their health care. Yet the ability to make informed decisions is highly dependent on the extent to which individuals have access to useful information.

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 *quality* information than they were that they had *cost* information. CDHP enrollees were equally likely to use quality and cost information when their health plan provided that information. Both CDHP and HDHP enrollees were less likely than traditional-plan enrollees to report that their plan provided the information. Thirty-five percent of HDHP enrollees reported access to quality information, compared with 44 percent of CDHP enrollees and 47 percent of traditional-plan enrollees (Figure 8). Similarly, 30 percent of HDHP enrollees reported access to cost information, compared with 34 percent among CDHP enrollees and 40 percent among traditional-plan enrollees.

CDHP, HDHP, and traditional-plan enrollees were about equally likely to use quality information provided by their health plans, while CDHP enrollees were more likely to use cost information. 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

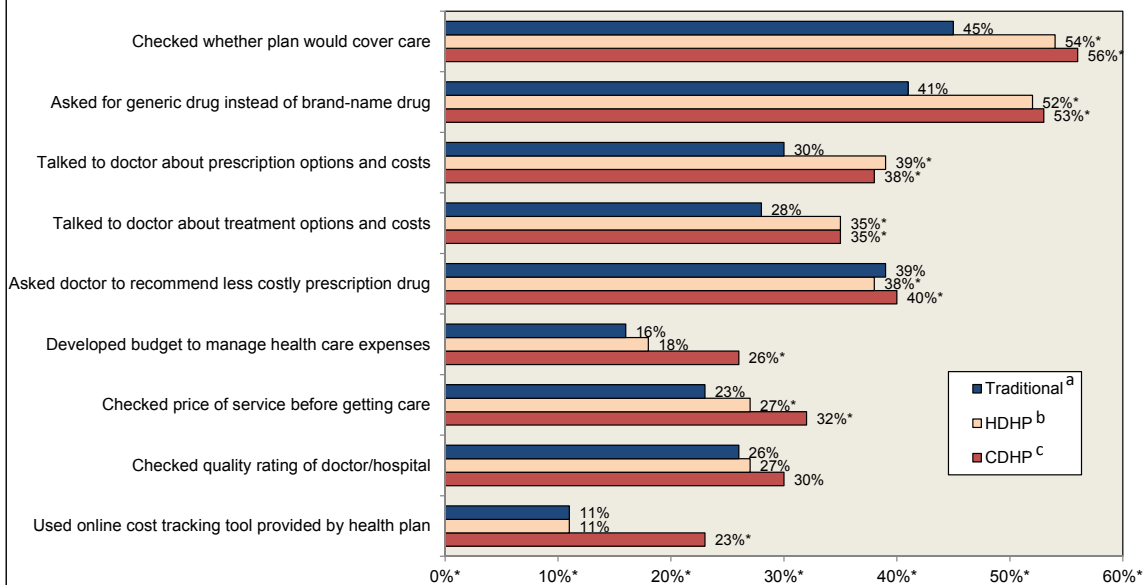


**Figure 5**  
**Familiarity With Consumer-Driven Health Plans, 2012**



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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, 2012**  
 (Percentage of privately insured adults 21–64 who received health care in last 12 months)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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, 2005–2012**  
 Base: Adults 21–64 who received some health care in last 12 months

	Traditional <sup>a</sup>												HDHP <sup>b</sup>												CDHP <sup>c</sup>											
	2005	2006	2007	2008	2009	2010	2011	2012	2005	2006	2007	2008	2009	2010	2011	2012	2005	2006	2007	2008	2009	2010	2011	2012	2005	2006	2007	2008	2009	2010	2011	2012				
Total Sample	953	1,363	1,794	1,548	1,651	1,601	1,509	1,474	417	802	1,284	1,484	1,693	1,914	1,762	1,416	163	652	805	1,077	972	993	1,432	1,608												
Checked whether health plan would cover care	51%	58%	50% <sup>^</sup>	55% <sup>^</sup>	50% <sup>^</sup>	47% <sup>^</sup>	48%	45%	61%	62%	61% <sup>*</sup>	61%	56% <sup>*</sup>	53% <sup>^</sup>	55% <sup>^</sup>	54% <sup>*</sup>	60% <sup>*</sup>	62%	60% <sup>*</sup>	63% <sup>*</sup>	61% <sup>*</sup>	53% <sup>^</sup>	59% <sup>^</sup>	56% <sup>*</sup>												
Asked for generic drug instead of brand name drug	n/a	48	46	50 <sup>^</sup>	46 <sup>^</sup>	44	46	41 <sup>^</sup>	n/a	60 <sup>*</sup>	58 <sup>*</sup>	58 <sup>*</sup>	52 <sup>^</sup>	50 <sup>*</sup>	54 <sup>^</sup>	52 <sup>*</sup>	n/a	54	54 <sup>*</sup>	58 <sup>*</sup>	56 <sup>*</sup>	51 <sup>^</sup>	53 <sup>*</sup>	53 <sup>*</sup>												
Talked to doctor about prescription options and costs	n/a	n/a	n/a	n/a	35	35	37	30 <sup>^</sup>	n/a	n/a	n/a	n/a	42	40	41	39 <sup>*</sup>	n/a	n/a	n/a	n/a	44	38	41 <sup>*</sup>	38 <sup>*</sup>												
Talked to doctor about treatment options and costs	42	44	44	45	33 <sup>^</sup>	31	33	28 <sup>^</sup>	56 <sup>*</sup>	44 <sup>^</sup>	49 <sup>^</sup>	49	37 <sup>^</sup>	36 <sup>*</sup>	39 <sup>^</sup>	35 <sup>^</sup>	58 <sup>*</sup>	46 <sup>^</sup>	47	46	40 <sup>*</sup>	33 <sup>^</sup>	36 <sup>^</sup>	35 <sup>*</sup>												
recommend less costly prescription drug	27	31	30	36 <sup>^</sup>	34	32	35	29 <sup>^</sup>	46 <sup>*</sup>	41 <sup>*</sup>	43 <sup>*</sup>	41	39 <sup>*</sup>	39 <sup>*</sup>	42 <sup>*</sup>	38 <sup>^</sup>	45 <sup>*</sup>	39 <sup>*</sup>	38 <sup>*</sup>	36	39 <sup>*</sup>	37	38	40 <sup>*</sup>												
Checked price of service before getting care	24	20	21	23 <sup>^</sup>	25	24	28 <sup>^</sup>	23 <sup>^</sup>	35 <sup>*</sup>	23 <sup>^</sup>	27 <sup>^</sup>	23 <sup>^</sup>	29 <sup>^</sup>	29 <sup>*</sup>	31 <sup>^</sup>	27 <sup>^</sup>	29	26 <sup>*</sup>	27 <sup>*</sup>	25	35 <sup>^</sup>	27 <sup>^</sup>	34 <sup>^</sup>	32 <sup>*</sup>												
Checked quality rating of doctor/hospital	18	21	20	25 <sup>^</sup>	24	24	27 <sup>^</sup>	26	22	18	19	22	22	22	27 <sup>^</sup>	27	18	19	18	23 <sup>^</sup>	27 <sup>*</sup>	22 <sup>^</sup>	27 <sup>^</sup>	30 <sup>^</sup>												
Developed budget to manage health care expenses	n/a	n/a	n/a	n/a	15	16	18	16	n/a	n/a	n/a	n/a	18	17	20 <sup>^</sup>	18	n/a	n/a	n/a	n/a	32	25 <sup>^</sup>	26 <sup>*</sup>	26 <sup>*</sup>												
Used online cost tracking tool offered by health plan	n/a	8	8	12 <sup>^</sup>	12	11	11	11	n/a	6	9 <sup>^</sup>	10	9 <sup>*</sup>	10	10	11	n/a	17 <sup>*</sup>	20 <sup>^</sup>	20 <sup>*</sup>	24 <sup>*</sup>	20 <sup>^</sup>	21 <sup>*</sup>	23 <sup>*</sup>												

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005-2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2012.

<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).

<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.

<sup>c</sup> 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.

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

plan. Specifically, about 3 in 10 CDHP and 1 in 4 HDHP enrollees sought other sources of information, while about one-fifth of traditional-plan enrollees did so.

## Participation in Wellness Programs

Employers and insurers offer a number of different types of wellness benefits—programs designed to promote health and to prevent disease. The 2012 EBRI/MGA Consumer Engagement in Health Care Survey examined availability and participation in three types of wellness programs: a health risk assessment, a health promotion program that included a number of different types of benefits, and biometric screening.<sup>9</sup>

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, 49 percent of CDHP enrollees reported that their employer offered a health risk assessment, compared with 33 percent of traditional-plan enrollees and 25 percent of HDHP enrollees (Figure 9). Asked about the availability of health-promotion programs, 55 percent of CDHP enrollees and 41 percent of traditional-plan enrollees reported that their employer offered such a program. One-third (34 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, 44 percent of CDHP enrollees reported that their employer offered such a program, compared with 32 percent among traditional-plan enrollees and 26 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. Three-quarters (77 percent) of CDHP enrollees participated in health-risk assessments, compared with 64 percent of traditional-plan enrollees (Figure 10). One-half (53 percent) of CDHP enrollees participated in health-promotion programs, compared with 41 percent of traditional-plan enrollees. Nearly four-fifths (78 percent) of CDHP enrollees participated in biometric screenings, compared with 63 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. Nearly two-thirds (63 percent) reported a cash incentive or reward for participating in the health risk assessment; one-half reported a cash incentive or reward for participating in a health promotion program, and nearly two-thirds (64 percent) reported a cash incentive or reward for a biometric screening (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). CDHP enrollees were also more likely than traditional-plan enrollees to report that they participated to avoid premium increases and that their employers required participation.

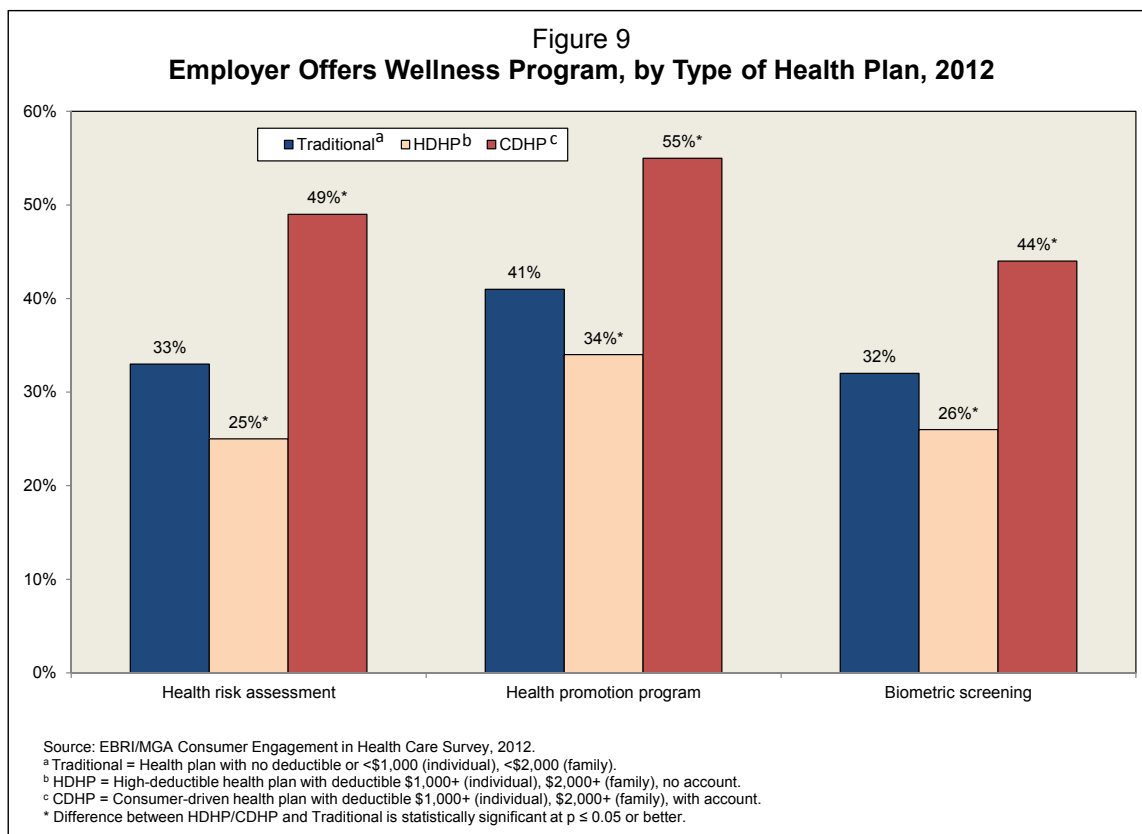
The survey also asked respondents their reasons for not participating in their employer's wellness program. Nearly 60 percent responded that they did not participate because they could make changes on their own (Figure 13): 24 percent cited this as a major reason, and 34 percent cited it as a minor reason for not participating. Lack of time was the second-most-popular reason for not participating, with 25 percent citing it as a major reason, and 29 percent reporting it as a minor reason. Forty-five percent did not participate because they were already healthy (20 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.

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. 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 cash incentives, time off, or premium differences (Figure 14). And unlike in 2011, CDHP enrollees are no longer more responsive to higher cost sharing for prescription drugs or office visits (Figure 15). Financial incentives to participate still mattered to all individuals, regardless of plan type. It was found that, concerning most questions, between about 60 percent and 80 percent of participants said they would participate in wellness programs if there was some type of financial incentive to do so.

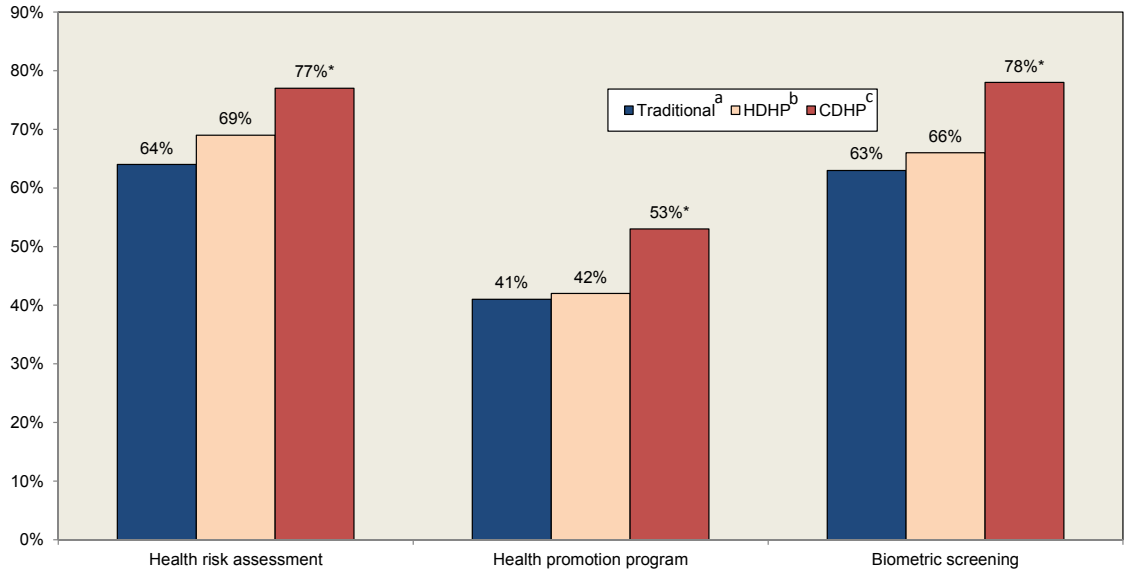
**Figure 8**  
**Availability and Use of Quality and Cost Information Provided by Health Plan and Effort to Find Information From Other Sources, 2012**

	Traditional <sup>a</sup>	HDHP <sup>b</sup>	CDHP <sup>c</sup>
Health plan provides information on quality of care provided by doctors	47%	35%*	44%
Health plan provides information on cost of care provided by doctors	40	30*	34*
Of those whose plans provide info on quality, how many tried to use it for doctors	46	47	53
Of those whose plans provide info on cost, how many tried to use it for doctors	42	42	53*
Tried to find information from sources other than health plan on cost and quality of care provided by doctors	21	25*	31*

Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.

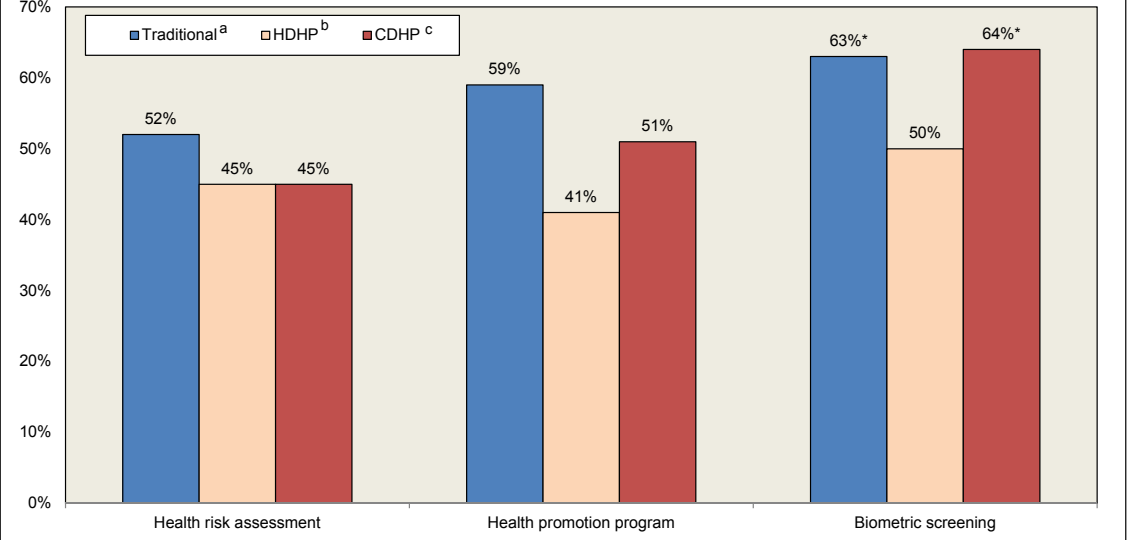


**Figure 10**  
**Individual Participates in Wellness Program Offered**  
**by Employer Among Those Offered a Wellness Program,**  
**by Type of Health Plan, 2012**



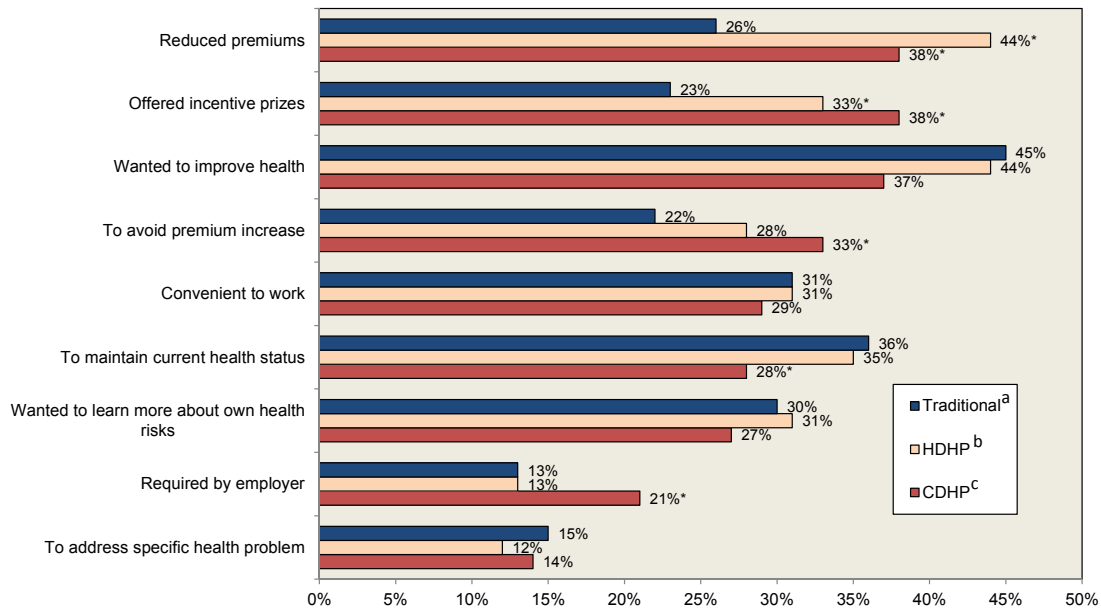
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup>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

**Figure 11**  
**Employer Offers Cash Incentive or Reward for Participating in**  
**Wellness Program, Among Workers Whose Employer Offers**  
**Wellness Program, by Type of Plan, 2012**



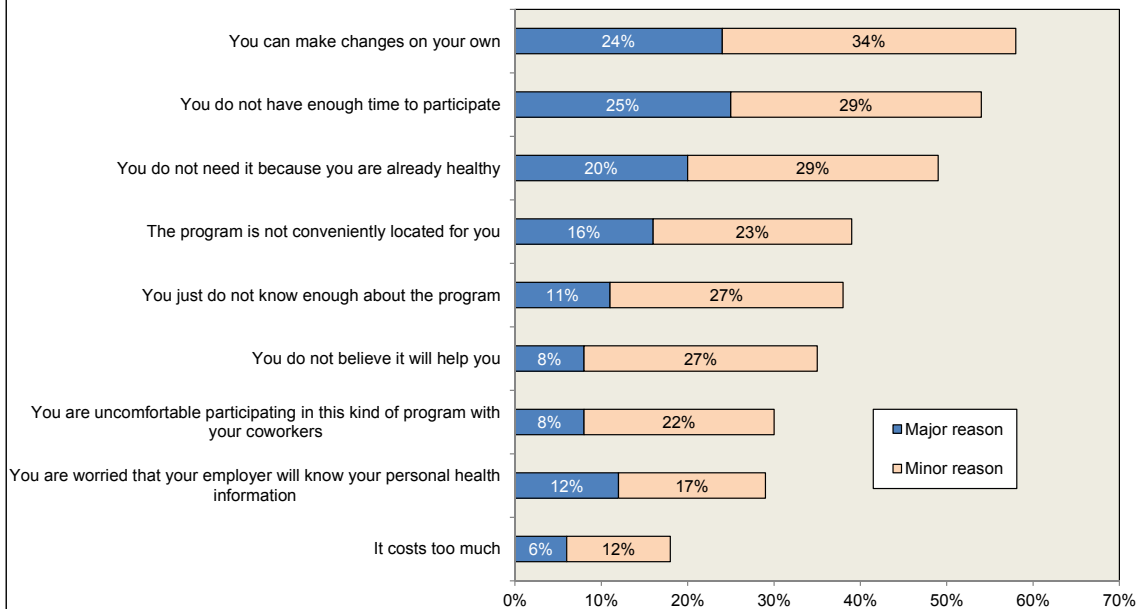
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup>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

**Figure 12**  
**Reasons for Participating in Employers Wellness Program, 2012**



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.

**Figure 13**  
**Reasons for Not Participating in Employers Wellness Program Among Those Offered but Not Participating in Program, 2012**



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

## Opinions about Provider Engagement

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

## Medical Homes

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

## Cost-Sharing Incentives

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

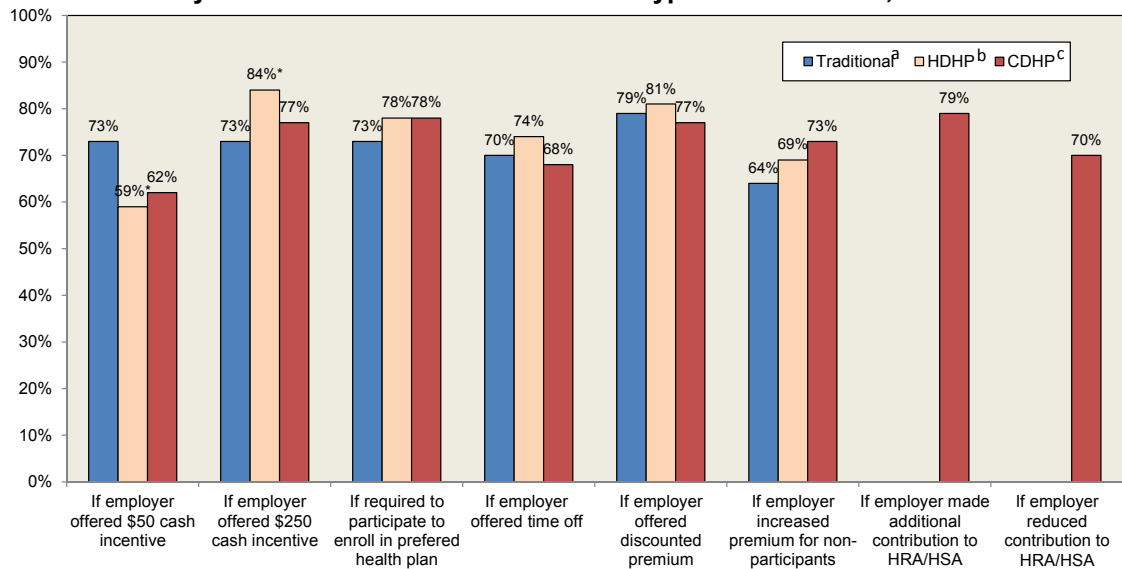
Like the responses on HIT and cost sharing as incentives to switch to a doctor who uses HIT, when more specific questions were asked, statistically significant differences were found among CDHP enrollees, HDHP enrollees, and traditional-plan enrollees. CDHP enrollees were found to be more likely than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

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

## Patient Use of Technology

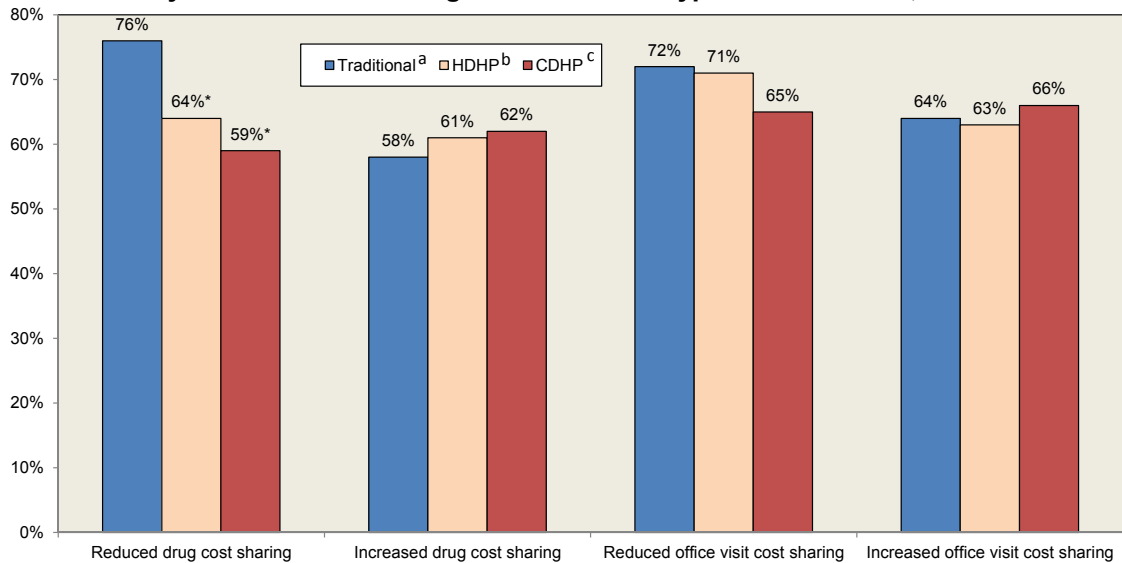
The survey found that about three-fifths of the adult population with private health insurance had used a smartphone within the past year, and about 40 percent had used a tablet. Among those with a smartphone or tablet, 27–32 percent used a smartphone application, or “app,” for nutrition information;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

**Figure 14**  
**Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Financial Incentives and Type of Health Plan, 2012**



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.

**Figure 15**  
**Percentage of Individuals Reporting That They Would Probably Participate in Employer Wellness Program, by Various Cost Sharing Incentives and Type of Health Plan, 2012**

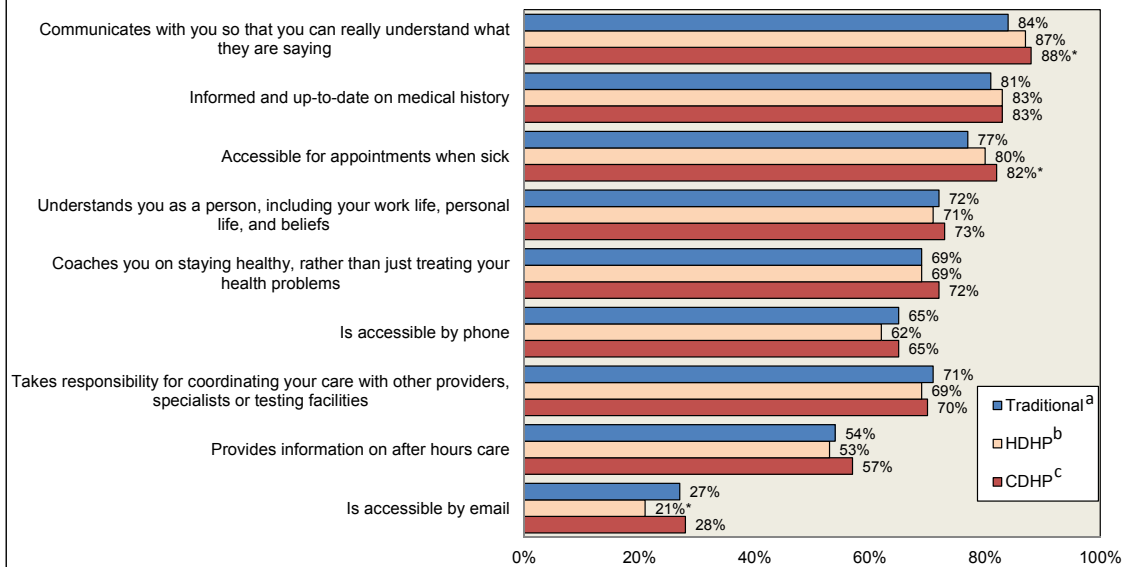


Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.



**Figure 16**  
**Agreement With Statements about Various Provider Engagement Tools, by Type of Health Plan, 2012**

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



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

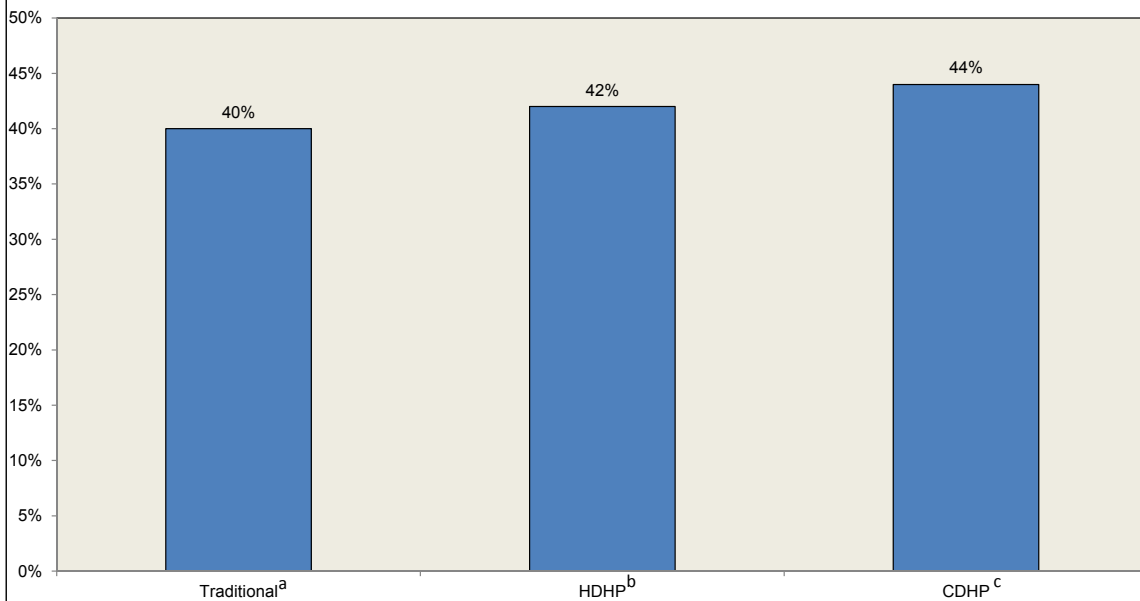
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).

<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.

<sup>c</sup> 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.

**Figure 17**  
**Individual Has a "Medical Home," 2012**



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

Note: To have a medical home, the respondent must: have a personal/family doctor; have timely access to care; have a doctor who knows medical history; have a provider that knows them as a person; and have a provider who is coordinating care.

<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).

<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.

<sup>c</sup> 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.

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

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

## Conclusion

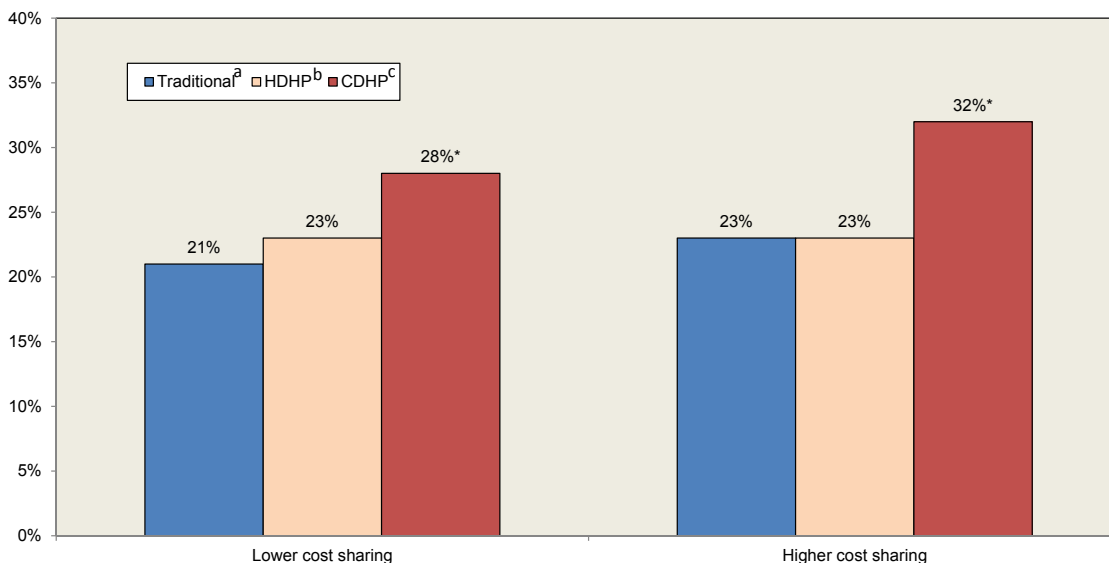
The 2012 EBRI/MGA Consumer Engagement in Health Care Survey finds continued slow growth in consumer-driven health plans: 10 percent of the population was enrolled in a CDHP, up from 7 percent in 2011. Enrollment in HDHPs remained at 16 percent. Overall, 18.6 million adults ages 21–64 with private insurance,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

The 2012 EBRI/MGA Consumer Engagement in Health Care Survey continues to find that CDHP enrollees are somewhat more cost conscious in their decision making than those in traditional plans. While CDHP enrollees, HDHP enrollees, and traditional-plan enrollees were about equally likely to report that they made use of quality information provided by their health plan, CDHP enrollees were more likely to use cost information and to try to find information about their doctors' costs and quality from sources other than the health plan. CDHP enrollees were more likely than traditional-plan enrollees to take advantage of various wellness programs, such as health-risk assessments, health-promotion programs, and biometric screenings. In addition, financial incentives mattered more to CDHP enrollees than to traditional-plan enrollees.

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

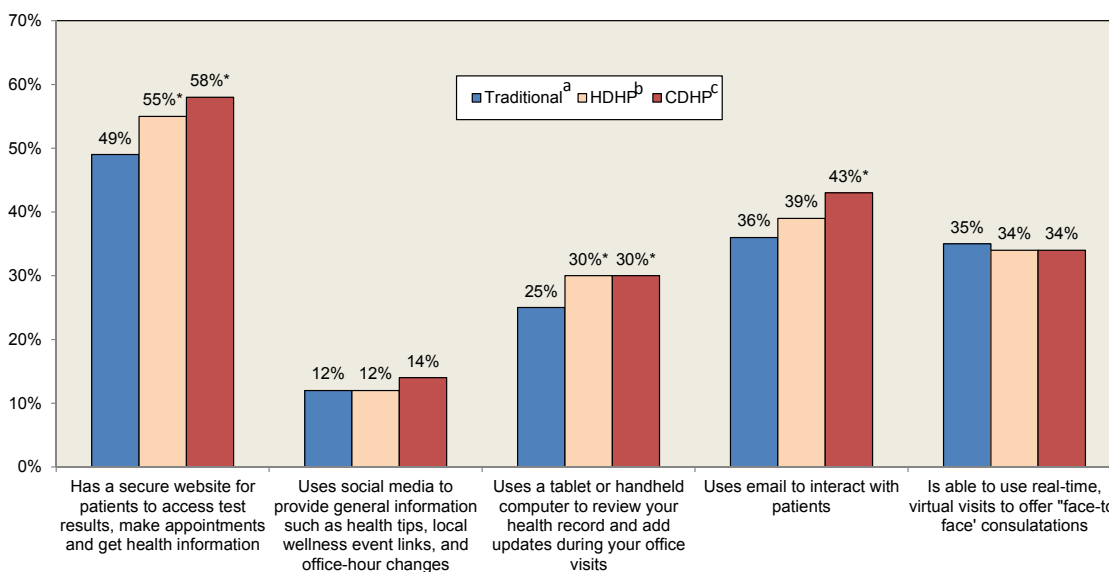
As the CDHP and HDHP markets continue to expand and more enrollees are enrolled for longer periods of time, the sustained impact that these plans are having on cost, quality, and access to health care services can be better understood. The eight years of consumer engagement surveys reported here provide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

**Figure 18**  
**Likelihood of Changing Doctor if Cost Sharing was Lower or Higher**  
**When Using Doctors Who Use Health Information Technology (HIT)**  
**and Current Doctor Does Not Use HIT, by Type of Health Plan, 2012**



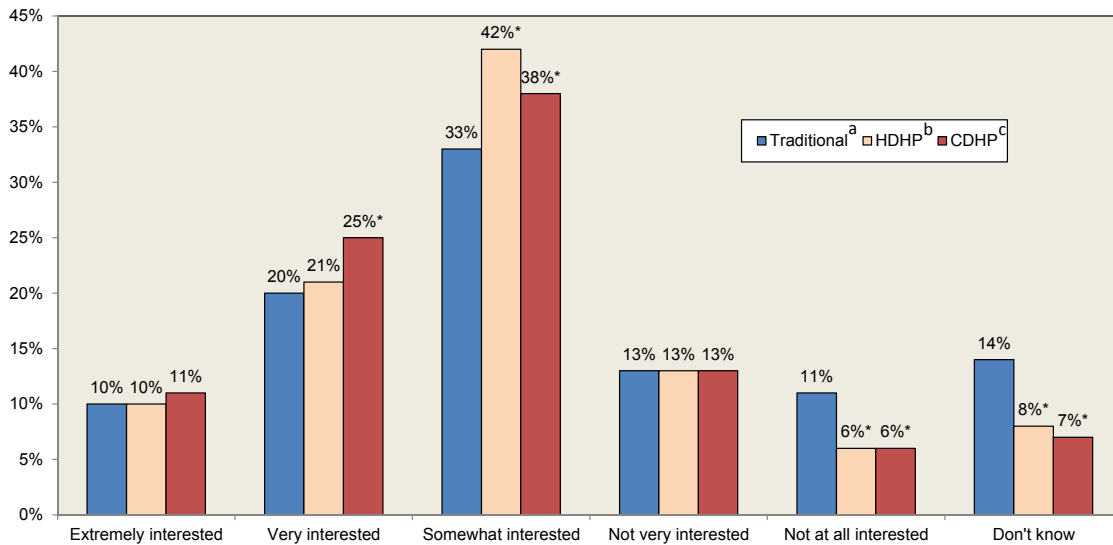
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.

**Figure 19**  
**Likelihood of Choosing Doctor by Their Use of Health**  
**Information Technology (HIT), by Type of Health Plan, 2012**



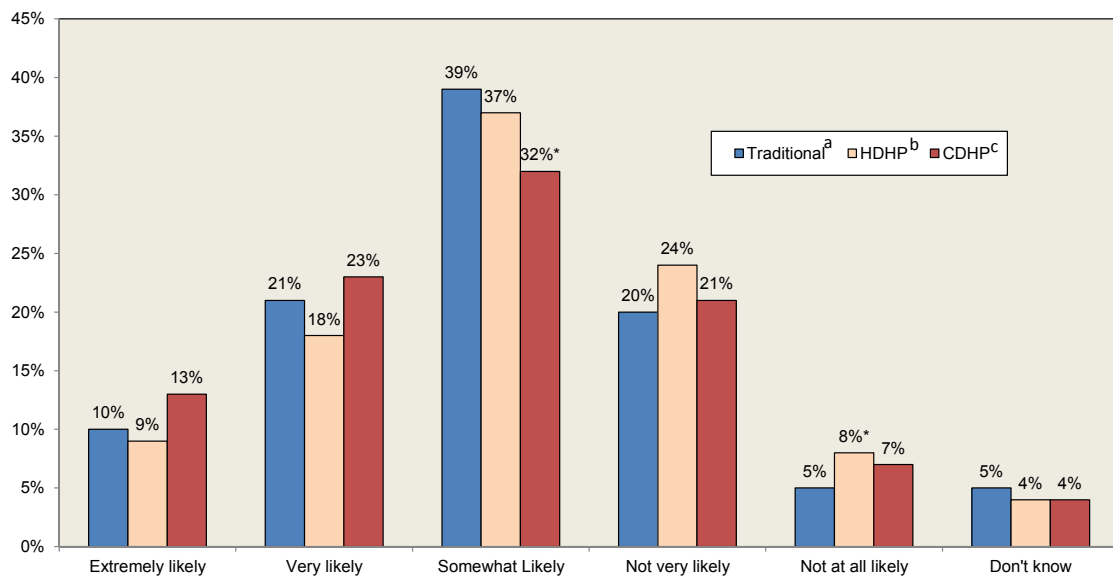
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.

**Figure 20**  
**Interest in Enrolling in Plan Using Select Networks Composed of Only Medical Providers With Records of Providing High-Quality Care Combined With Lower Cost Sharing, by Type of Plan, 2012**



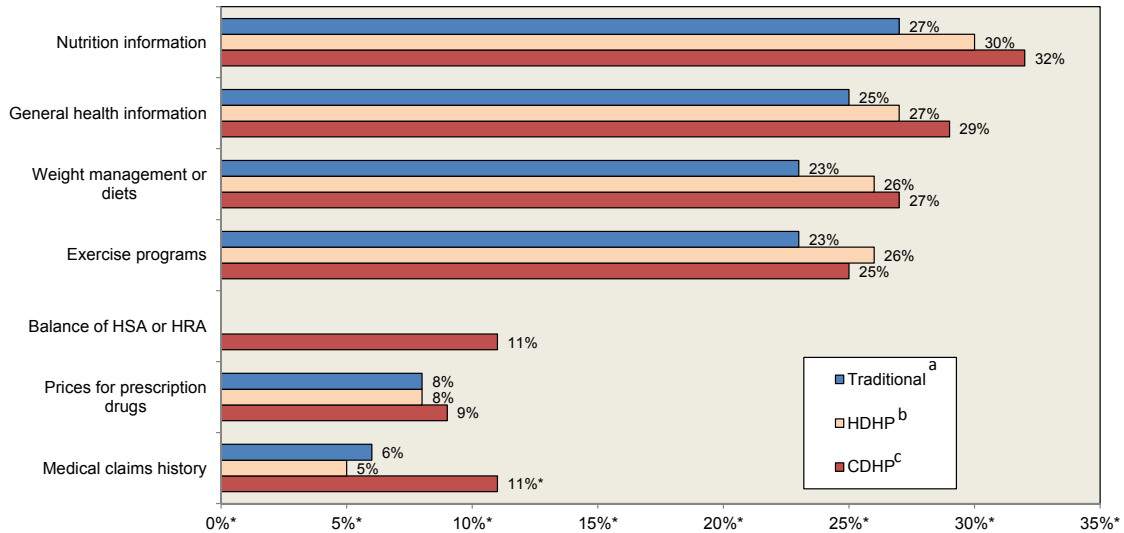
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.

**Figure 21**  
**Likelihood of Changing to Select Network if Current Doctor Was Not in Select Network, by Type of Plan, 2012**



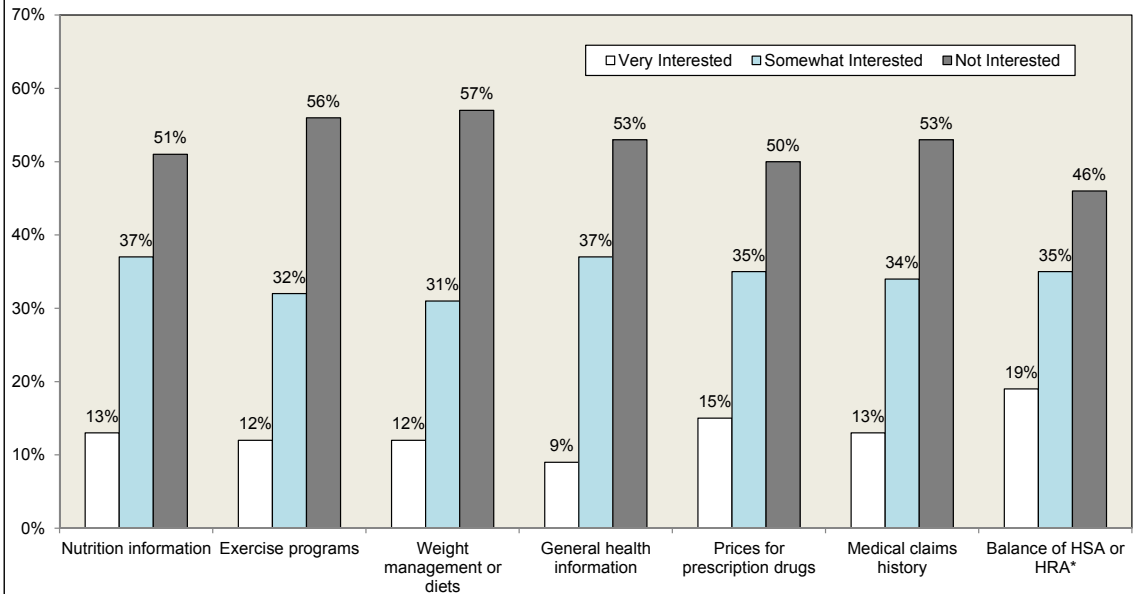
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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.

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



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.  
<sup>a</sup> Traditional = Health plan with no deductible or <\$1,000 (individual), <\$2,000 (family).  
<sup>b</sup> HDHP = High-deductible health plan with deductible \$1,000+ (individual), \$2,000+ (family), no account.  
<sup>c</sup> 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

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



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

## Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey, an online survey that examines issues surrounding consumer-directed health care, including the cost of insurance, the cost of care, satisfaction with health care, satisfaction with health care plans, reasons for choosing a plan, and sources of health information. It also presents findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008-2011 EBRI/MGA Consumer Engagement in Health Care Survey. The 2012 EBRI/MGA Consumer Engagement in Health Care Survey was conducted within the United States between August 8 and August 17, 2012, through a 15-minute Internet survey. The national or base sample was drawn from Synovate's online panel of Internet users who have agreed to participate in research surveys. About 2,000 adults (n=2,004) ages 21–64 who had health insurance through an employer or who purchased directly from a carrier were drawn randomly from the Synovate sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 37 percent (32 percent for the base sample or national sample, and 43 percent for the oversample). The margin of error for the national sample was  $\pm 2.2$  percent.

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

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

Because the base sample (national sample) included only 198 individuals in a CDHP and 332 individuals with an HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 1,218 individuals with a CDHP and 1,276 individuals with an HDHP, resulting in a total sample (base plus oversample) of 1,416 for the CDHP group and 1,608 for the HDHP group. After factoring out the base sample—the 198 individuals with a CDHP and the 332 individuals with an HDHP—there were 1,474 individuals in the sample with traditional health coverage.

In addition to being stratified, the base sample was also weighted by gender, age, education, region, income, and race/ethnicity to reflect the actual proportions in the population ages 21–64 with private health insurance coverage.<sup>10</sup> The CDHP and HDHP oversamples were weighted by gender, age, income and race/ethnicity, using the demographic profile of the CDHP and HDHP respondents to the omnibus survey described below.

To efficiently identify respondents who would qualify for the CDHP and HDHP oversamples, the study used Synovate's omnibus survey of more than 45,000 online panel members who met the study's criteria (having private insurance and being age 21–64.) The following three questions were used in the June and July omnibus surveys to identify likely CDHP and HDHP respondents:

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

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

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

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

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

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

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

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

- Yes
- No
- Not sure

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

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## Definitions

### Consumer-Driven Health Plans

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

### Health Savings Accounts

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

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

In order to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than \$1,200 for self-only coverage and \$2,400 for family coverage (minimum deductible amounts are indexed to inflation but remain at \$1,200 and \$2,400 in 2012). Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed \$6,050 for self-only coverage and \$12,100 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit are indexed to inflation. A network plan may impose a higher deductible and an out-of-pocket limit for out-of-network services. Individuals can have a health plan with a deductible and maximum out-of-pocket limit that qualifies them to make a tax-free contribution to an HSA, but they are not required to make a contribution or to open an account.

Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer and deductible from adjusted gross income if made by the individual. The maximum annual contribution is \$3,100 for self-only coverage and \$6,250 for family coverage in 2012.

To be eligible for an HSA, an individual may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.<sup>11</sup> 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.<sup>12</sup> An individual also may not make an HSA contribution if he or she is claimed as a dependent on another person's tax return.

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2012, a \$1,000 catch-up contribution was allowed. The catch-up contribution is not indexed to inflation.

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



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

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

## **Health Reimbursement Arrangements**

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

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

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

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

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

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

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## Endnotes

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<sup>1</sup> Calculated from Figure 1.

<sup>2</sup> More information about HRAs and HSAs can be found in the box on pg. 24 and in Fronstin (2002 and 2004).

<sup>3</sup> See [www.mercer.com/pressrelease/details.htm?idContent=1491670](http://www.mercer.com/pressrelease/details.htm?idContent=1491670)

<sup>4</sup> See [www.healthcaredisclosure.org/](http://www.healthcaredisclosure.org/)

<sup>5</sup> See Appendix for more detail on the methodology.

<sup>6</sup> 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 or that are generally associated with HRAs.

<sup>7</sup> See Fronstin (2007) and <http://ehbs.kff.org/pdf/2012/8345.pdf>

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

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<sup>9</sup> The specific question was as follows: Does your employer offer any of the following wellness programs?

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

<sup>10</sup> 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.

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

<sup>12</sup> 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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