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# Findings From the 2008 EBRI Consumer Engagement in Health Care Survey

***By Paul Fronstin, EBRI***

- ***Fourth annual survey***: This *Issue Brief* presents findings from the 2008 EBRI Consumer Engagement in Health Care Survey, which provides 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. Findings are compared with the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys.
- ***Enrollment low but growing***: In 2008, 3 percent of the population was enrolled in a consumer-driven health plan (CDHP), up from 2 percent in 2007 and 1 percent in 2006. Enrollment in HDHPs remained at 11 percent. Overall, 9.8 million adults ages 21–64 with private insurance (representing 6.6 percent of that market) were in either a CDHP or an HDHP that was eligible for an HSA, but had not opened the account.
- ***Higher income, better health:*** As before, this year's survey found that adults in CDHPs were significantly more likely than those with traditional health coverage to have high household income, to be in better health, and to exhibit healthy behavior.
- ***Satisfaction gaps:*** CDHP enrollees in 2008 continue to have no difference in satisfaction with quality of care compared with those in traditional plans, but a satisfaction gap remains for HDHP enrollees. Differences in *overall* satisfaction levels (higher satisfaction with traditional plans) were reinforced in the 2008 findings.
- ***Choice of plan:*** Among individuals with employment-based health benefits, those in CDHPs were more likely than those with traditional coverage to have a choice of health plan. This contrasts with findings from 2005 and 2006, when individuals with traditional coverage were more likely to have a choice of health plan than individuals enrolled in CDHPs. Two-thirds of individuals with an employment-based CDHP reported that the employer contributed to the account. Among those eligible to contribute to an account, 15 percent contributed nothing.
- ***Cost-related access issues:*** In 2008, HDHP enrollees continued to be more likely than traditional plan enrollees to report that they had delayed or avoided getting any needed health care services because of costs. But the difference between traditional plan enrollees and CDHP disappeared, mostly because more traditional plan enrollees reported access issues due to costs.
- ***More cost-conscious behavior:*** Individuals in CDHPs and HDHPs exhibit more cost-conscious behavior in their health care decision making than individuals with traditional health insurance.
- ***Strong interest in reduced cost sharing***: There was across-the-board strong interest in consumer engagements that could lower patient cost sharing, such as select networks (medical providers with records of high quality care), health promotion programs, and using scientifically proven effective care.

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

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## *Introduction*

Employment-based health benefits are the most common form of health insurance in the United States. In 2007, 162.5 million individuals under age 65, or 62.2 percent of that population, had employment-based health benefits (Fronstin, 2008).

In every year since 1998, health insurance premium increases have exceeded worker earnings increases and inflation (Figure 1): Health insurance premiums have more than doubled, while worker earnings have increased only 30 percent (calculated from Figure 1). In response, employers have been seeking ways to manage the cost increases. In recent years, employers turned their attention to account-based health plans—a combination of health plans with deductibles of at least $1,000 for employee-only coverage and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. Employers first started offering account-based health plans in 2001, when a handful of employers began to offer health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).[1] By 2007, 7 percent of employers with 10–499 workers and 11 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan.[2]

Employers have been interested in bringing aspects of consumerism into health plans for many years. As far back as 1978, employers adopted Sec. 125 cafeteria plans and flexible spending accounts. More recently, employers have been increasingly turning their attentions to consumer engagement in health care more broadly. In 2001, employers formed a coalition to report health care provider quality measures, and today the group is composed not only of employers but also consumer groups and organized labor.[3] 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).

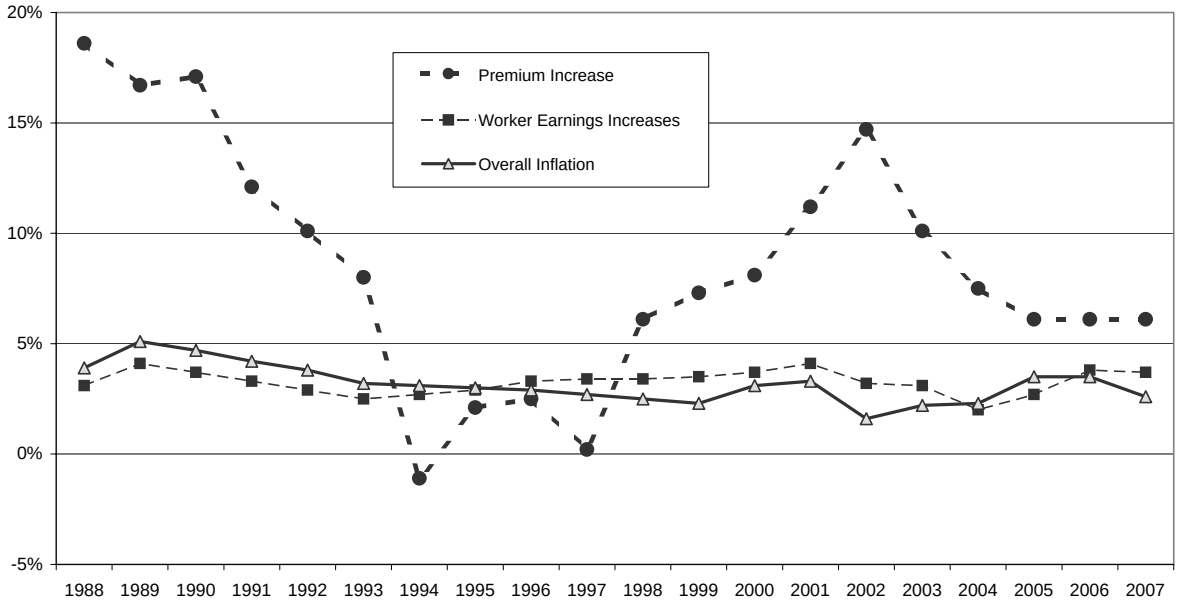
This *Issue Brief* presents findings from the 2008 EBRI Consumer Engagement in Health Care Survey. For this study, an online survey of 4,532 privately insured adults ages 21–64 was conducted to provide nationally representative data regarding the growth of account-based health plans and HDHPs and the 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 sample of more than 2 million Internet users who agreed to participate in research surveys. A base sample of 2,008 participants was used to draw incidence rates for persons with account-based health plans and HDHPs, and the base sample was complemented with an additional random oversample of these two groups. More specifically, the oversamples were: 1) those with either an HRA or an HSA, and 2) those with a HDHP without an account but with deductibles that are generally high enough to meet the qualifying threshold to make tax-preferred contributions to such an account. High deductibles were defined as individual deductibles of at least $1,000 and family deductibles of at least $2,000.[4] The final sample included 1,184 in HDHPs with either an HSA or HRA (CDHPs), 1,634 in HDHPs without accounts, and 1,714 in more traditional health plans.[5]

Findings from this survey are compared with findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys. In past reports, the term *comprehensive* was used as the descriptive label for what are now labeled *traditional* health plans. A label change was in order given that these plans are not as comprehensive as they were in the past and may no longer be comprehensive. Prior research has shown that cost sharing has been increasing across the board in the form of higher deductibles and co-payments and a return to coinsurance (Fronstin, 2007).[6]

## *Summary of Findings*

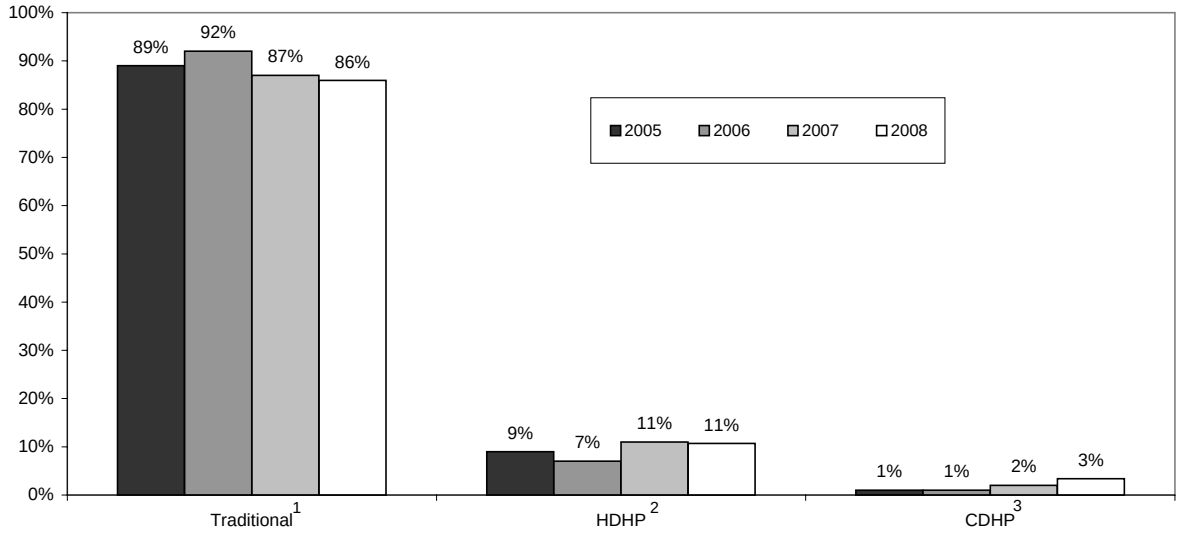
This survey finds that in 2008, 3 percent of the population was enrolled in a CDHP, up from 2 percent in 2007, and enrollment in HDHPs remained at 11 percent (Figure 2). The 3 percent of the population with a CDHP represents 4.2 million adults ages 21–64 with private insurance, while the 11 percent with a HDHP

Figure 1
**Premium Increases Among Employers With 10 or More Employees, Worker Earnings Increases and Inflation, 1988–2007**




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, 2005–2008**




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

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

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

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

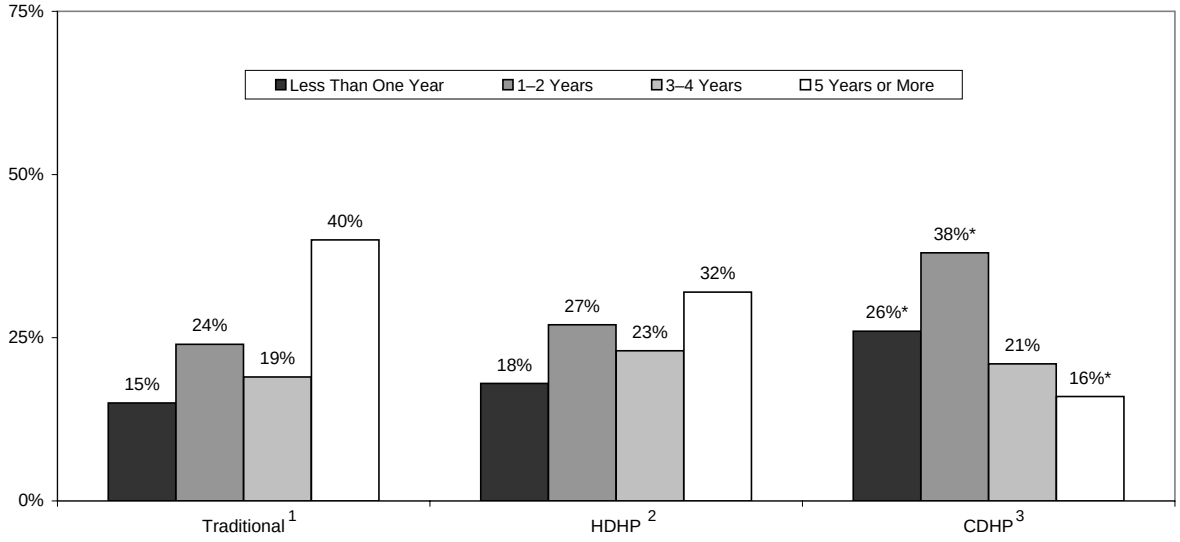
represents 13.4 million people. Among the 13.4 million individuals with an HDHP, 42 percent, or 5.6 million, reported that they were eligible for an HSA but did not have such an account. Thus, overall, 9.8 million adults ages 21–64 with private insurance (representing 7.9 percent of that market) were either in a CDHP or were in an HDHP that was eligible for an HSA, but had not opened the account. (See section on enrollment starting on pg. 38 for more information about other research that has estimated the size of the CDHP and/or HDHP market.)

HRA and HSA enrollment is growing, but the market penetration remains relatively small, and the plans are still relatively new and unknown to many individuals with private insurance. Among persons with CDHPs, 37 percent had been covered by their health plan three years or longer in 2008 (Figure 3), up from 21 percent in 2006 (data not shown). Among traditional plan and HDHP enrollees, 59 percent and 55 percent, respectively, had been covered by their health plan three years or longer in 2008. With respect to familiarity with a CDHP, 59 percent of those with a CDHP were extremely or very familiar with a CDHP (Figure 4). In contrast, only 8 percent of individuals with traditional coverage were extremely or very familiar with a CDHP, and only 10 percent of individuals with an HDHP were extremely or very familiar with a CDHP.

The study also finds the following:

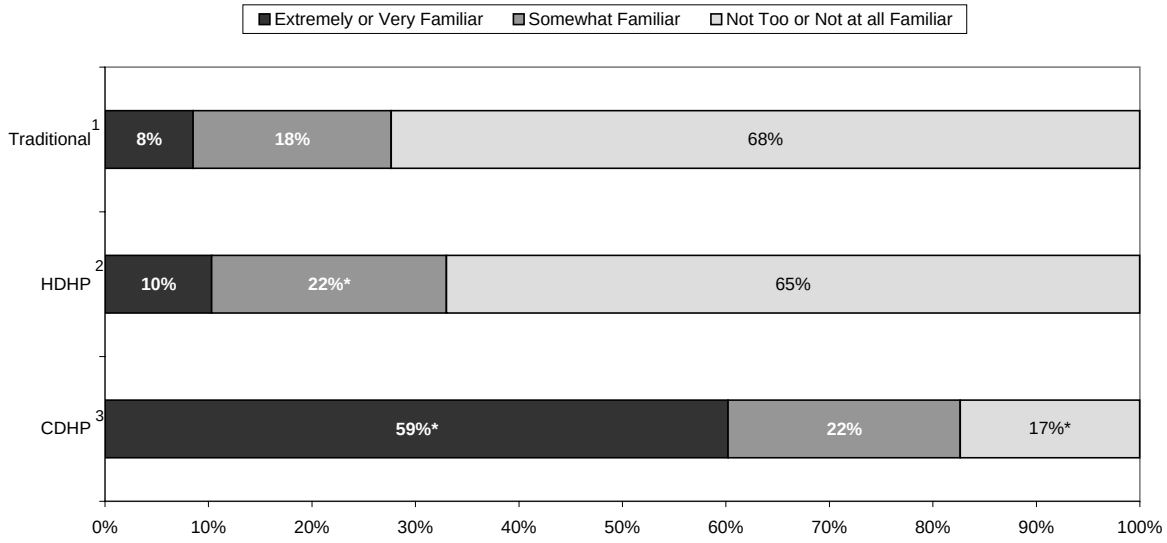
- In 2008, adults in CDHPs were significantly more likely to be in excellent or very good health than those with HDHPs or more traditional coverage. People in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans. Adults in CDHPs were significantly less likely to smoke than were adults in traditional plans, and they were significantly more likely to exercise.
- Adults in CDHPs were significantly more likely than those with traditional health coverage to have high household income. Furthermore, those in CDHPs reported significantly higher income since 2005. Those enrolled in CDHPs and HDHPs were also significantly less likely to be between the ages of 21 and 34 compared with those in traditional plans, and along with those in HDHPs, more likely to be college graduates. There were few differences between CDHP, HDHP, and traditional enrollees related to marital status, presence of children, age, and race.
- Workers in both CDHPs and HDHPs were more likely than those in traditional plans to be sole proprietors or to be employed in small firms. However, over the four years of the survey, workers enrolled in CDHPs became significantly more likely to be employed in large firms.
- In 2006, it was found that individuals in CDHPs and HDHPs were less likely than those in traditional plans to be satisfied with the quality of care they received. However, between 2006 and 2007, the gap in satisfaction between those in traditional plans and those with *CDHPs* disappeared because satisfaction increased significantly among those with CDHPs and remained unchanged in 2008. The satisfaction gap in quality of care remained between traditional enrollees and *HDHP* enrollees. The differences in *overall satisfaction* levels by plan type found in all prior years of the survey were reinforced in the 2008 findings; however, overall satisfaction levels among CDHP enrollees increased between 2006 and 2007 and remained at 49 percent in 2008, while satisfaction rates for traditional enrollees were unchanged. Differences in out-of-pocket costs may explain a significant portion of the difference in overall satisfaction rates between traditional plan, HDHP, and CDHP enrollees.
- As in previous years of the survey, it was found that individuals in CDHPs and HDHPs were both less likely than those in traditional plans to recommend their health plan to a friend or co-worker and less likely than those with traditional plans to stay with their current health plan if they had the opportunity to switch plans. However, the percentage of CDHP enrollees reporting that they would be extremely or very likely to recommend their plan to a friend or co-worker or stay with their plan if they had the opportunity to switch increased between 2006 and 2007, and remained at 38 percent in 2008, while it was unchanged for traditional and HDHP enrollees.
- There was a nearly across-the-board increase between 2006 and 2007 in the percentage of CDHP enrollees who reported that their health plan was easy to understand, that the plan encourages adoption of a healthier lifestyle, provides information to help choose among providers, and will

Figure 3
**Number of Years Covered by Current Health Plan, by Type of Health Plan, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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.
Note: Percentages may not sum to totals due to rounding.

Figure 4
**Familiarity With Consumer-Driven Health Plans, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
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[3] 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.
Note: Percentages may not sum to totals due to rounding.

protect them in the event of an expensive illness. The percentage of individuals agreeing with these statements in 2008 was unchanged from 2007 levels.

- Among individuals with employment-based health benefits, those in CDHPs were more likely than those with traditional coverage to have a choice of health plan. These results are in contrast to findings from 2005 and 2006, when individuals with traditional coverage were more likely to have a choice of health plan than individuals enrolled in CDHPs. Two-thirds of individuals with an employment-based CDHP reported that the employer contributed to the account. Among persons eligible to contribute to an account, 15 percent did not contribute anything.
- There was no significant variation across plan types in the frequency with which people with chronic conditions followed their treatment regimens. This is in contrast to somewhat mixed findings in 2007. Furthermore, the 2007 survey found that adults with CDHPs and HDHPs were significantly more likely to report that they had avoided, skipped, or delayed health care because of costs than were those with more traditional coverage. In 2008, the survey found that HDHP enrollees continued to be more likely than traditional plan enrollees to report that they had delayed or avoided getting any needed health care services because of costs; however, the difference between traditional plan enrollees and CDHP disappeared, mostly because of the significant increase in the percentage of traditional plan enrollees reporting health care access issues due to costs. No significant access issues were found between CDHP enrollees and traditional plan enrollees during 2008, except among higher-income individuals, but HDHP enrollees were more likely than those with traditional coverage to report access issues, especially among those with a health problem and those with household income of $50,000 or above.
- Individuals were more likely to report that they had *health quality* information than to report having *health cost* information, and CDHP and HDHP enrollees were less likely than traditional plan enrollees to say that the plan provided the information. In terms of use of information provided by health plans, CDHP and traditional plan enrollees were more likely than HDHP plan enrollees to report that they made use of the information about quality of doctors. CDHP enrollees were also more likely to try to find information on the cost and quality of doctors from sources other than the health plan.
- Individuals in CDHPs and HDHPs exhibit more cost-conscious behavior in their health care decision-making than individuals with traditional health insurance. Adults in CDHPs and HDHPs were more likely to consider costs in their decisions about health care. Those in CDHPs and HDHPs were more likely than those in traditional plans to ask their doctor to recommend a less costly prescription drug. There was no change in the share of CDHP enrollees who reported cost-conscious decision making over the four years of the survey, but there was a significant increase in the percentage of traditional plan enrollees reporting cost-conscious decision making, which would explain why some of the previously found significant differences disappeared.
- For the first time, the 2008 EBRI Consumer Engagement in Health Care Survey examined opinions regarding the appropriate use of lower cost sharing as an incentive to change the way individuals use the health care system. It found across-the-board strong interest in select networks composed of only medical providers with records of high-quality care combined with lower cost sharing. There was less interest in changing to a select network combined with lower cost sharing. There was also support (to a degree) regarding other ways patients could receive lower cost sharing, such as by actively participating in a program to maintain or improve health, by following treatment regimens, by using less-invasive procedures, and by using scientifically proven effective care.

The remainder of this report examines the findings from the 2008 EBRI Consumer Engagement in Health Care Survey as they relate to differences and similarities between individuals enrolled in traditional health plans, CDHPs, and HDHPs. The report also examines consumer engagement more generally. It examines health plan features, enrollee characteristics, satisfaction and attitudes, choice of health plan, premiums, plan choice, contribution behavior among those with a CDHP, health care use, access issues, cost and quality information, health care decision making, and cost sharing incentives related to value-based insurance design.

## *Health Plan Features and Demographics*

The majority of privately insured adults have deductibles, regardless of plan type. More than 3 in 5 (62 percent) of adults enrolled in traditional plans reported that they had a deductible. Among adults with single-person coverage in traditional plans, 38 percent had no deductible, 33 percent had a deductible below $500, 16 percent had a deductible between $500 and $999, and 13 percent either did not know if they had a deductible or did not know what their deductible was (Figure 5). Among adults with family coverage in traditional plans, 44 percent had no deductible, 34 percent reported that the deductible was below $999, 12 percent reported that it was between $1,000 and $1,999, and 10 percent either did not know if they had one or what it was.

Among adults with single-person coverage and enrolled in a HDHP, 58 percent reported a deductible of between $1,000 and $1,999, 29 percent had deductibles between $2,000, and $4,999, and 8 percent had deductibles of $5,000 or more. Eighty percent of those in HDHPs with family coverage had a deductible of between $2,000 and $4,999, and 15 percent were in a plan with a deductible of $5,000 or higher.

Among CDHP enrollees with single-person coverage, 49 percent had a deductible below $2,000; 40 percent had deductibles between $2,000 and $4,999, and 8 percent had deductibles of $5,000 or more. Among people with family coverage who were enrolled in a CDHP, 70 percent reported that they were covered by a plan with a family deductible of $2,000 to 4,999 and 28 percent reported a deductible of $5,000 or more.

By law, people in high-deductible health plans can have the cost of preventive services excluded from their deductible. This provision in the legislation was designed to encourage those with high deductibles to get preventive services and regular screening tests like mammograms and colonoscopies. The survey asked people with deductibles whether the deductible applied to all medical care or whether some services were excluded. More than one-half (56 percent) of adults in CDHPs, including those with coverage through their employers (53 percent), reported that their deductible applied to all medical care (Figure 6). Seventy-one percent of those in CDHPs with coverage through the individual market reported their deductible applied to all health care services.

## *Health Status and Demographics*

Figure 7 contains data on demographic and health status variables from each of the surveys conducted between 2005 and 2008. In 2008, adults in CDHPs were significantly more likely to be in excellent or very good health than those with HDHPs or traditional health coverage. Two-thirds of adults with CDHPs said their health was excellent or very good compared with just over one-half (54 percent) of those with HDHPs and 56 percent of those with traditional health coverage (Figure 7).

The survey asked respondents whether they had chronic conditions. For analytic purposes, reports of chronic health conditions and fair or poor health were combined into an indicator of health problems. People were defined as having a health problem if they said they were in fair or poor health or had at least one chronic health condition out of the following: arthritis, asthma, emphysema or lung disease, cancer, depression, diabetes, heart attack or other heart disease, high cholesterol, hypertension or high blood pressure, or stroke. People in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans: 45 percent of those in CDHPs reported a health problem, compared with 54 percent among those in traditional plans, and 57 percent among those with HDHPs.

Adults in CDHPs were significantly less likely to smoke than were adults in traditional plans: 13 percent of those in CDHPs smoked, compared with 20 percent of those with traditional coverage (Figure 7). People in CDHPs were also slightly more likely to exercise but they were no less likely to be obese compared with adults in other health plans.

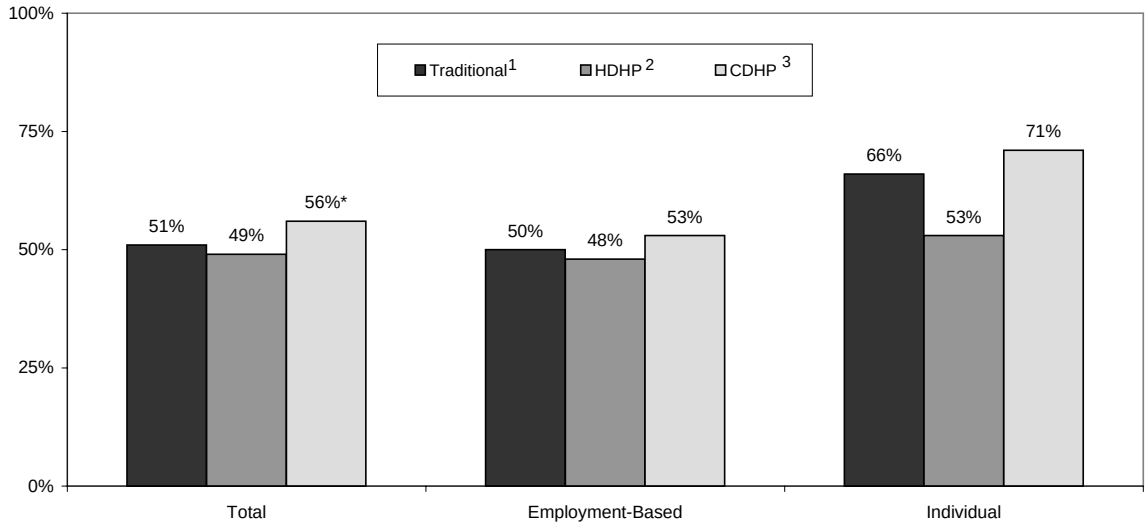
There were some statistically significant demographic differences among adults enrolled in the three types of health plans. Adults enrolled in CDHPs were significantly more likely than those in traditional plans to have high household income: 40 percent of those in CDHPs had incomes of $100,000 or more, compared to 23 percent of those in traditional plans. Those enrolled in CDHPs and HDHPs were also significantly less likely to be between the ages of 21 and 34 compared to those in traditional plans, and, along

Figure 5
**Annual Deductibles and Premiums, by Type of Health Plan, 2008**

| | Traditional[1] | HDHP[2] | CDHP[3] |
|---|---|---|---|
| Total Sample | 1,714 | 1,634 | 1,184 |
| Single Person Deductible | | | |
| No deductible | 38% | N/A | N/A |
| $1–$499 | 33 | N/A | N/A |
| $500–$999 | 16 | N/A | N/A |
| $1,000–$1,999 | N/A | 58% | 49% |
| $2,000–$4,999 | N/A | 29 | 40 |
| $5,000 or higher | N/A | 8 | 8 |
| Family Deductible | | | |
| No deductible | 44 | N/A | N/A |
| $1–$999 | 34 | N/A | N/A |
| $1,000–$1,999 | 12 | N/A | N/A |
| $2,000–$4,999 | N/A | 80 | 70 |
| $5,000 or higher | N/A | 15 | 28 |
| Premium (Family) | | | |
| None | 14 | 9 | 8* |
| Less than $1,200 | 16 | 9* | 12 |
| $1,200–$2,399 | 23 | 20 | 23 |
| $2,400–$3,599 | 15 | 19 | 18 |
| $3,600 or more | 20 | 33* | 27* |
| Don't know | 13 | 10 | 12 |

Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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 6
**Percentage of Adults Whose Deductibles Apply to All Medical Services, by Coverage Source, 2008**
(Percentage of privately insured adults ages 21–64)




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.

Figure 7

**Selected Demographics, by Type of Health Plan, 2005–2008**

| | Traditional[1] | | | | HDHP[2] | | | | CDHP[3] | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 |
| Total sample | 1,358 | 1,506 | 1,918 | 1,714 | 487 | 930 | 1,404 | 1,634 | 186 | 722 | 895 | 1,184 |
| Gender | | | | | | | | | | | | |
| Male | 49% | 49% | 50% | 48% | 53% | 49% | 51% | 50% | 57% | 50% | 57%* | 54%* |
| Female | 51 | 51 | 50 | 52 | 47 | 51 | 49 | 50 | 43 | 50 | 43* | 46 |
| Married | 60 | 74 | 78 | 67 | 61 | 55* | 64* | 62* | 59 | 61* | 70* | 71 |
| Has children | 34 | 42 | 47 | 42 | 33 | 35* | 37* | 37 | 40 | 44 | 45 | 46 |
| Age | | | | | | | | | | | | |
| 21–34 | 27 | 33 | 34 | 33 | 18* | 24* | 21* | 20* | 20* | 24* | 20* | 23* |
| 35–44 | 26 | 23 | 22 | 23 | 25 | 25 | 24 | 24 | 31 | 32* | 31 | 30 |
| 45–54 | 29 | 26 | 27 | 26 | 34 | 29 | 30 | 29 | 34 | 28 | 30 | 28 |
| 55–64 | 17 | 18 | 18 | 19 | 24 | 22 | 25* | 26* | 15 | 16 | 19 | 19 |
| Race/Ethnicity | | | | | | | | | | | | |
| White, non-Hispanic | 71 | 71 | 71 | 72 | 94* | 83* | 78* | 77 | 93* | 81 | 75 | 76 |
| Minority | 28 | 29 | 29 | 28 | 6* | 17* | 22* | 24 | 7* | 19 | 25 | 24 |
| Household Income | | | | | | | | | | | | |
| Less than $30,000 | 15 | 12 | 15 | 14 | 11 | 17* | 12* | 9* | 11 | 13 | 6* | 4* |
| $30,000–$49,999 | 19 | 20 | 18 | 19 | 19 | 30* | 18 | 14* | 22 | 24 | 13 | 10* |
| $50,000–$99,999 | 34 | 38 | 36 | 36 | 36 | 35 | 38 | 40 | 33 | 43 | 41 | 40 |
| $100,000–$149,999 | 14 | 14 | 14 | 14 | 11 | 5* | 14 | 19* | 13 | 7*^ | 20* | 25* |
| $150,000 or more | 7 | 7 | 7 | 9 | 4 | 3* | 9 | 9* | 9* | 4*^ | 11* | 15* |
| Education | | | | | | | | | | | | |
| High school graduate or less | 32 | 38 | 42 | 33 | 14* | 17* | 14* | 13* | 6* | 11* | 11* | 10* |
| Some college, trade, or business school | 31 | 29 | 29 | 31 | 36 | 36* | 30 | 28 | 28 | 33* | 24 | 22* |
| College graduate or some graduate work | 24 | 22 | 20 | 24 | 34 | 35* | 40* | 42* | 46* | 41* | 41* | 44* |
| Graduate degree | 13 | 11 | 9 | 12 | 16 | 12 | 17* | 17* | 20* | 15 | 24* | 24* |
| Self-Rated Health Status | | | | | | | | | | | | |
| Excellent/very good | 42 | 54 | 49 | 56 | 50 | 53 | 54* | 54 | 58* | 60* | 65* | 66* |
| Good | 45 | 35 | 38 | 34 | 36 | 34 | 35 | 34 | 34 | 33 | 29* | 30 |
| Fair/poor | 13 | 12 | 13 | 10 | 53 | 13 | 10 | 12 | 9 | 7* | 6* | 5* |
| *At least one chronic health condition*** | 54 | 49 | 49 | 52 | 56 | 50 | 53* | 56 | 48 | 43* | 45 | 45* |
| *Health problem**** | 57 | 51 | 53 | 54 | 57 | 53 | 55 | 57 | 49 | 44* | 46* | 45* |
| Obese | 36 | 30 | 27 | 26 | 33 | 28 | 30 | 29 | 26* | 30 | 25 | 23 |
| Smokes cigarettes | 23 | 24 | 24 | 20 | 14* | 18* | 14* | 15* | 14* | 14* | 15* | 13* |
| No regular exercise | 24 | 25 | 25 | 25 | 15* | 25 | 20* | 21 | 16* | 19* | 17* | 17* |
| Firm Size (base: employed full- or part-time) | | | | | | | | | | | | |
| Self-employed with no employees | 2 | 4 | 3 | 2 | 9* | 9* | 9* | 7* | 8* | 5 | 6* | 7* |
| 2–49 | 15 | 19 | 19 | 16 | 31* | 32* | 27* | 26* | 39* | 32* | 28* | 25* |
| 50–199 | 8 | 10 | 11 | 12 | 9 | 14 | 14 | 13 | 8 | 12 | 11 | 13 |
| 200–499 | 9 | 8 | 9 | 8 | 6 | 8 | 7 | 7 | 5* | 10 | 8 | 7 |
| 500 or more | 54 | 45 | 43 | 50 | 33* | 29* | 36 | 38* | 36* | 31* | 40 | 42 |

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

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

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

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

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

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

*** Health problem defined as fair or poor health or at least one chronic condition.

## Health Savings Accounts

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

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

In order for an individual 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 $1,100 for self-only coverage and $2,200 for family coverage. (Minimum deductible amounts are increasing to $1,150 and $2,300 in 2009.) Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $5,800 for self-only coverage and $11,000 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit will be indexed to inflation in the future. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services. An individual can have a health plan with a deductible and maximum out-of- pocket limit that qualifies him or her to make a tax-free contribution to an HSA, but the individual is 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 $2,900 for self-only coverage and $5,800 for family coverage in 2008, increasing to $3,000 and $5,950 in 2009.

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.[7] 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.[8] Individuals also may not make an HSA contribution if they are claimed as dependents 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 2008, a $900 catch-up contribution is allowed. A $1,000 catch-up contribution will be phased-in by 2009.[9]

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 his HSA (although he must have been covered by a high-deductible health plan at the time the funds were placed in the HSA). Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under Internal Revenue Code (IRC) Sec. 213(d). Distributions for premiums for COBRA, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare other than for Medigap, are also tax-free. This means that distributions used to pay Medicare Part A or B, Medicare Advantage plan premiums, and the employee share of the premium for employment-based retiree health benefits are allowed on a tax-free basis.

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

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

**Health Reimbursement Arrangements**

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

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

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

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

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

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

with those in HDHPs, more likely to be college graduates. There were few differences between CDHP, HDHP, and traditional enrollees related to marital status, presence of children, age, and race.

## Work Status

People in both CDHPs and HDHPs were more likely than those in traditional plans to be sole proprietors or to be employed in small firms. One-quarter of workers in HDHPs and CDHPs were employed in firms with fewer than 50 workers, compared with 16 percent of those in traditional plans (Figure 7). There was little difference in the share of enrollees who worked for companies with 500 or more employees when comparing CDHP enrollees to traditional plan enrollees, though HDHP enrollees were less likely than traditional plan enrollees to be employed in larger firms.

## Trends

Over 2005–2008, adults enrolled in CDHPs reported significantly higher income. In 2008, 40 percent were in households with incomes of $100,000 or more, up from 22 percent in 2005 (Figure 7). Just 14 percent of adults with CDHPs lived in households with incomes under $50,000, down from 33 percent in 2005. In contrast, there was little change in the income distribution of people enrolled in traditional plans, with 23 percent in households with $100,000 or more in income.

In addition, over the four years of the survey, people enrolled in CDHPs became significantly more likely to be employed in large firms and less likely to be sole proprietors or employees of small companies. In 2005, nearly half (47 percent) of CDHP enrollees were sole proprietors or worked in companies of fewer than 50 employees. By 2008, that percentage had fallen to one-third (32 percent). Employment of CDHP enrollees in companies of 500 or more workers climbed from 36 percent to 42 percent.

The survey noted an across-the-board increase in the percentage of the population reporting that they were in excellent or very good health—but, interestingly, no change in the percentage with at least one chronic condition, with a health problem, who were obese, or in the number of workers, and no increase in the percentage reporting that they exercise regularly.

## *Satisfaction and Attitudes*

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

With respect to quality of care received, the 2006 survey found that individuals in CDHPs and HDHPs were less likely to be satisfied than those in traditional plans. However, between 2006 and 2007, the gap in satisfaction between those in traditional plans and those with CDHPs disappeared because satisfaction increased significantly among those with CDHPs and remained unchanged in 2008 (Figure 8). The gap in quality of care satisfaction rates remained between traditional enrollees and HDHP enrollees.

Unlike satisfaction with quality of care received, the differences in overall satisfaction levels by plan type found in all prior years of the survey were reinforced in the 2008 findings (Figure 9). Traditional plan enrollees were more likely than CDHP and HDHP enrollees to be *extremely* or *very* satisfied with the overall plan in all years of the survey. In 2008, 63 percent of traditional plan enrollees were *extremely* or *very* satisfied with the overall health plan, compared with 49 percent among CDHP enrollees and 40 percent among HDHP enrollees. It is also worth noting that satisfaction levels among CDHP enrollees increased from 37 percent to 47 percent between 2006 and 2007 and remained at 49 percent in 2008, while satisfaction rates for traditional enrollees were unchanged. In addition, there was an increase in HDHP enrollee satisfaction from 35 percent in 2007 to 40 percent in 2008.

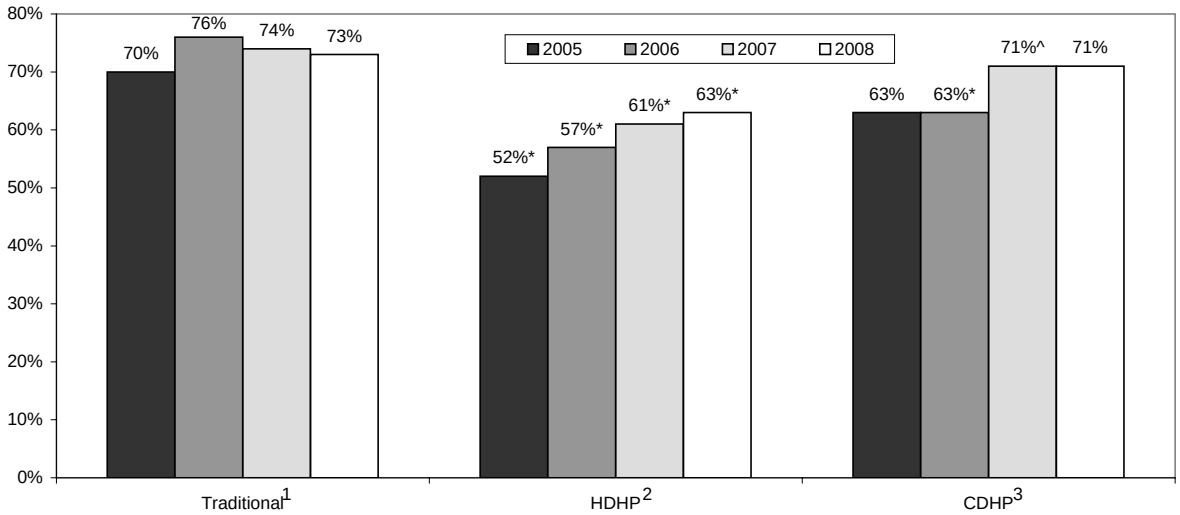
Differences in out-of-pocket costs may explain a significant portion of the difference in overall satisfaction rates between traditional plan, HDHP, and CDHP enrollees. In neither type of health plan were a majority of enrollees *extremely* or *very* satisfied with the out-of-pocket costs in their health plan, but there are significant differences by plan type. In 2008, only 45 percent of traditional plan participants were *extremely* or *very* satisfied with out-of-pocket costs, while only 17 percent of HDHP enrollees were satisfied and only 23 percent of CDHP participants were satisfied (Figure 10).

As in previous years of the survey, it was found that individuals in CDHPs and HDHPs were both less likely than those in traditional plans to recommend their health plan to a friend or co-worker and less likely than those with traditional plans to stay with their current health plan if they had the opportunity to switch plans (Figures 11 and 12). Similar to the satisfaction questions, the percentage of CDHP enrollees reporting that they would be *extremely* or *very* likely to recommend their plan to a friend or co-worker or stay with their plan if they had the opportunity to switch increased from 30 percent to 39 percent between 2006 and 2007, and remained at 38 percent in 2008, while it was unchanged for traditional and HDHP enrollees.

Individuals with CDHPs and HDHPs were less likely than those with traditional insurance to say that their health plan is easy to understand (Figure 13). HDHP enrollees were less likely than CDHP enrollees and individuals with traditional coverage to report that their health plan encourages them to adopt a healthier lifestyle. With respect to information made available by the health plan provided to individuals to help them

Figure 8

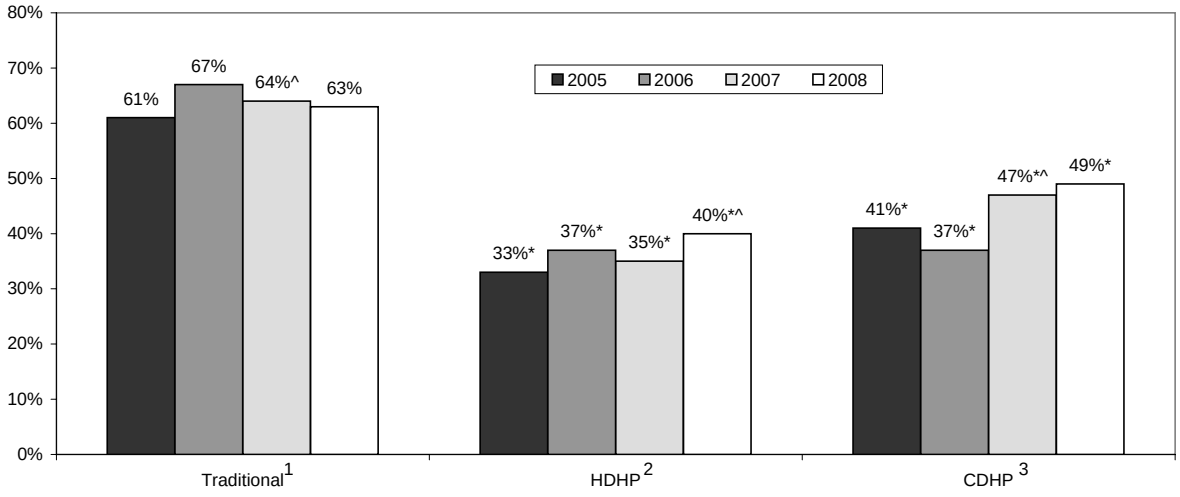
**Percentage Extremely or Very Satisfied With Quality of Health Care Received, by Type of Health Plan, 2005–2008**




Source: 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2005 and 2008 is statistically significant at p ≤ 0.05 or better.

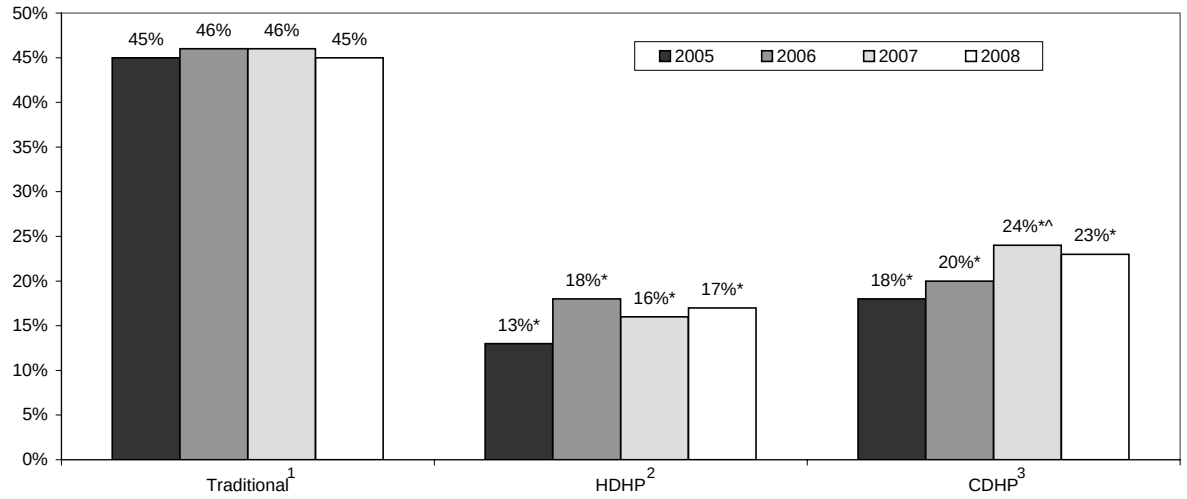
Figure 9

**Percentage Extremely or Very Satisfied With Overall Health Plan, by Type of Health Plan, 2005–2008**



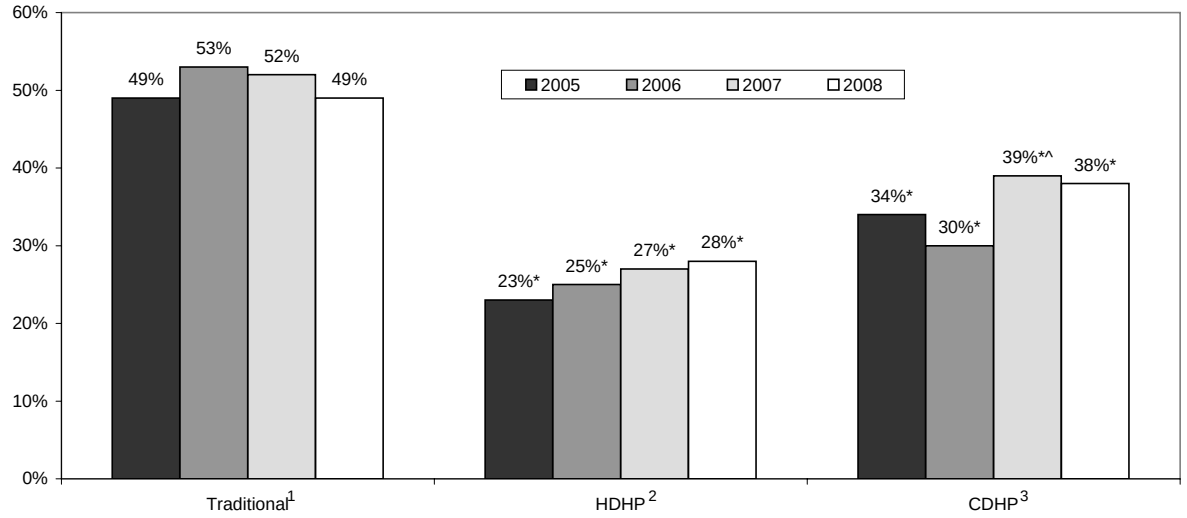

Source: 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2005 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 10
**Percentage Extremely or Very Satisfied With Out-of-Pocket Health Care Costs, by Type of Health Plan, 2005–2008**




Source: 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), w/ account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2005 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 11
**Percentage Extremely or Very Likely to Recommend Health Plan to Friend or Co-Worker, by Type of Health Plan, 2005–2008**




Source: 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2005 and 2008 is statistically significant at p ≤ 0.05 or better.

choose from among different health care providers, CDHP and HDHP are still less likely than traditional enrollees to report that their plan provides this information. Three-quarters of CDHP enrollees and 72 percent of individuals in traditional plans reported that their health plan would protect them in the event of an expensive illness, compared with 67 percent among individuals enrolled in HDHPs.

While there has been very little significant change over time to the health plan view questions, there was a nearly across-the-board increase between 2006 and 2007 in the percentage of CDHP enrollees who reported that:

- Their health plan was easy to understand (increasing from 45 percent to 53 percent).
- The plan encourages adoption of a healthier lifestyle (increasing from 52 percent to 63 percent).
- The plan provides information to help choose among providers (increasing from 56 percent to 61 percent).
- The plan will protect them in the event of an expensive illness (increasing from 69 percent to 76 percent) (Figure 14).

The percentage of individuals agreeing with these statements in 2008 was unchanged from 2007 levels for CDHP enrollees.

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

Among individuals covered by an employment-based health plan, those in CDHPs were more likely than those with traditional coverage to have a choice of health plan, followed by those enrolled in HDHPs. More than 60 percent of CDHP enrollees had a choice of health plan, compared with 56 percent of individuals in traditional plans, and 50 percent of those with a HDHP (Figure 15). These results contrast with findings from 2005 and 2006, when individuals with traditional coverage were more likely to have a choice of health plan than individuals enrolled in CDHPs (Figure 16). Also, fewer individuals with traditional coverage have a choice of health plan, while the percentage of individuals in a CDHP with a choice of health plan grew from 47 percent to 63 percent between 2005 and 2007 and remained there in 2008. This may be due to the simple fact that an increasing percentage of the CDHP population works for an employer with 500 or more employees (Figure 7).

When individuals have a choice of health plan, the premium affects their decision regarding which plan to choose. The 2008 survey found that 49 percent of CDHP enrollees in individual and employment-based plans reported that their cost for insurance was less expensive than the other available options (Figure 17). This compares with 30 percent among both HDHP and traditional plans.

There are other reasons, however, why an individual may choose a particular health plan. When asked about the main reason for enrolling in a plan, 48 percent of CDHP enrollees reported that they enrolled because of the lower premium, while 47 percent reported that the opportunity to save money in the account for future years was a main reason for enrolling in that plan (Figure 18). Among individuals with traditional health coverage, 45 percent cited the good network of providers and 36 percent reported the low out-of-pocket costs as the main reason for enrolling in the plan.

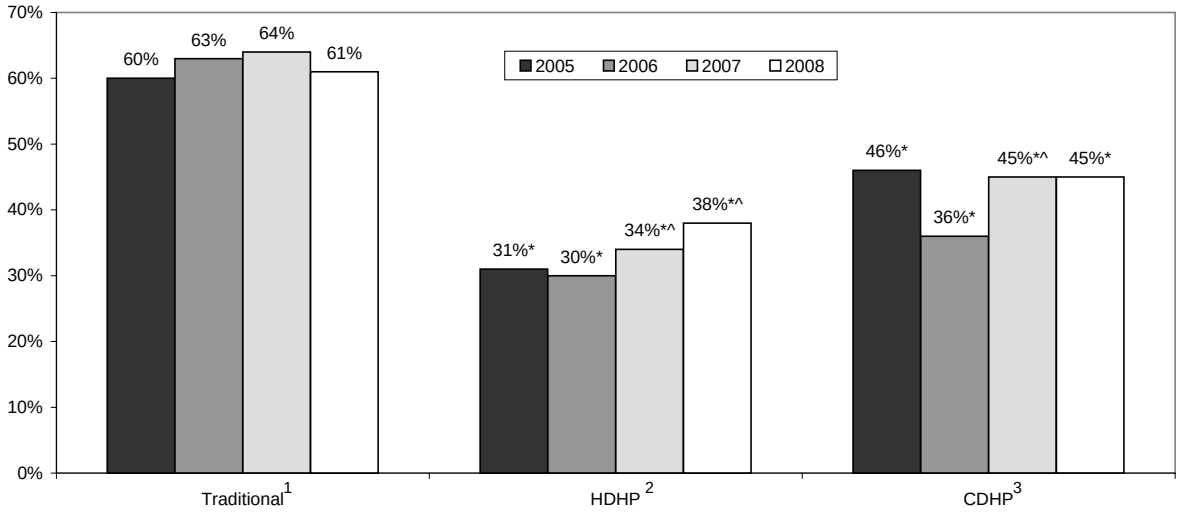
Among the population with traditional coverage and a choice of plan, 39 percent were offered a CDHP or HDHP, and 28 percent were not offered it, but 32 percent did not know if they were offered it (Figure 19). Among the 39 percent who were offered either a CDHP or HDHP, 14 percent were offered a CDHP, 15 percent were offered a HDHP, and 10 percent were offered an HDHP and did not know if they were offered an account.

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

- Twenty-eight percent reported that they did not have the money to fund the account.
- Twenty-two percent reported that the tax benefits were not attractive enough.
- Seventeen percent reported that it was too much trouble to open and/or manage the account.
- Ten percent reported that it was either too complicated or they did not understand the option.

Figure 12

**Percentage Extremely or Very Likely to Stay With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan, 2005–2008**




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

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

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

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

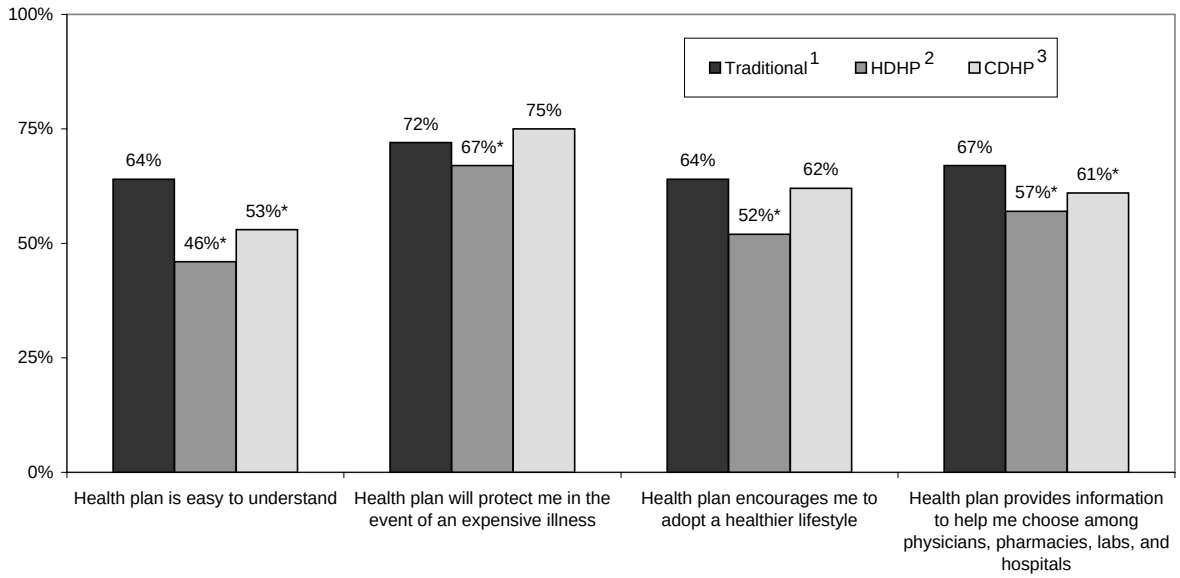
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

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

# Difference between 2005 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 13

**Agreement With Statements About Health Plan: Percentage Reporting That They Strongly or Somewhat Agree, by Type of Health Plan, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.

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

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

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

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

Figure 14
**Trends in Views of Health Plan, 2005–2008**

| | Traditional[1] | | | | HDHP[2] | | | | CDHP[3] | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 |
| Total Sample | 1,061 | 1,506 | 1,918 | 1,714 | 463 | 930 | 1,404 | 1,634 | 185 | 722 | 895 | 1,184 |
| Strongly or somewhat agree that health plan is easy to understand | 68% | 65% | 64% | 64% | 51%* | 46%* | 43%*^ | 46%* | 54%* | 45%* | 53%*^ | 53%* |
| Strongly or somewhat agree that health plan encourages adoption of healthier lifestyle | 49 | 58 | 60 | 64^# | 40* | 44* | 48* | 52*^ | 46 | 52* | 63^ | 63# |
| Strongly or somewhat agree that health plan provides information to help choose among providers | 55 | 67 | 66 | 67 | 40* | 52* | 55* | 57*# | 40* | 56*^ | 61^ | 61# |
| Strongly or somewhat agree that terms of health plan make me consider costs before seeing a doctor or filling a prescription | 40 | 46 | 47 | 50 | 61* | 61* | 60* | 61* | 72* | 73* | 74* | 69*^ |
| Strongly or somewhat agree that health plan will protect them in the event of an expensive illness | 75 | 72 | 72 | 72 | 67* | 67 | 65* | 67* | 75 | 69 | 76^ | 75 |

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

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

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

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

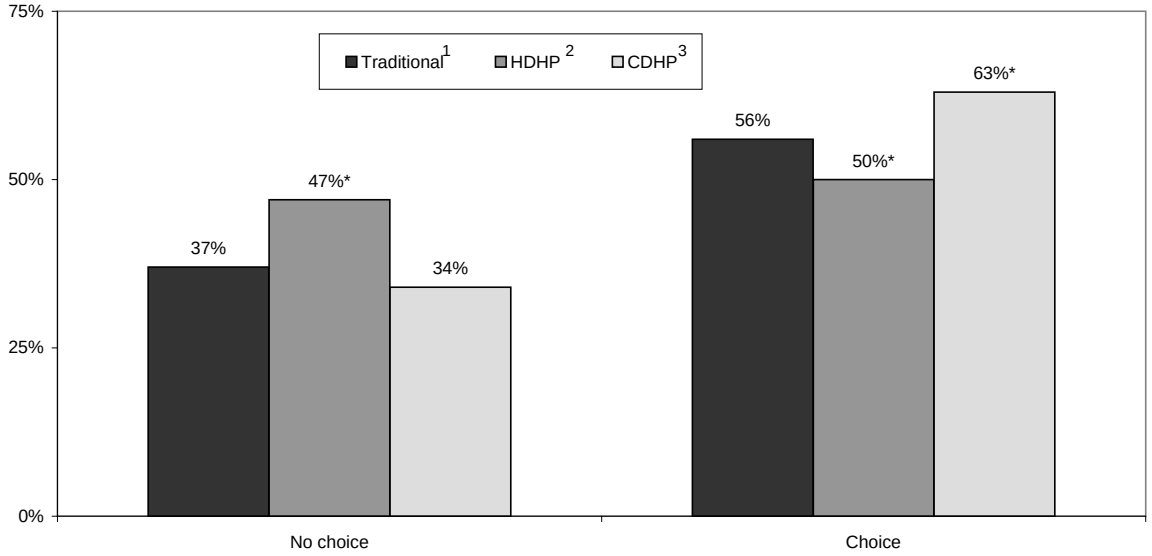
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

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

# Difference between 2005 and 2008 is statistically significant at p ≤ 0.05 or better.

Figure 15

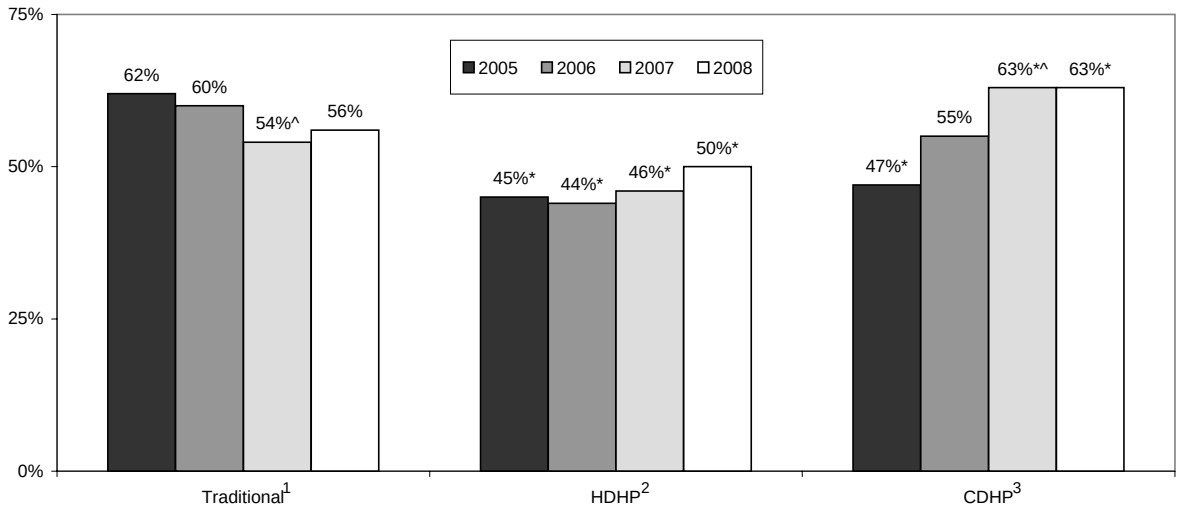
**Percentage of Individuals Covered by Employment-Based Health Benefits With Choice and No Choice of Health Plan, by Type of Health Plan, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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 16

**Percentage of Individuals Covered by Employment-Based Health Benefits With a Choice of Health Plan, by Type of Health Plan, 2005–2008**




Source: 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys; 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤ 0.05 or better.
^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.
# Difference between 2005 and 2008 is statistically significant at the p ≤ 0.05 or better.

## Contribution Behavior and Account Balances

Among individuals with a CDHP, some receive employer contributions to the account while others do not. HRA enrollees will get employer contributions but are unable to make their own contribution. Individuals with an HSA can contribute their own money to the account and may or may not also receive employer contributions. Two-thirds of individuals with an employment-based CDHP (including both those covered as an individual and those with family coverage) reported that the employer contributed to the account, while 30 percent reported that they did not receive employer contributions, and 4 percent did not know if the employer contributed (Figure 20).[10]

Among the 66 percent with an employer contribution, 12 percent received less than $500, 26 percent received between $500 and $999, 22 percent received between $1,000 and $1,499, 11 percent received between $1,500 and $1,999, and 18 percent received $2,000 or more (Figure 21). Employer contributions vary, however, by whether an individual has employee-only or family coverage. Individuals with employee-only coverage are most likely to get an employer contribution between $500 and $750, while those with family coverage are most likely to get an employer contribution of at least $1,000 (Figure 22). In fact, 59 percent of individuals with family coverage get a contribution of at least $1,000, with 25 percent getting $1,000– $1,499, 13 percent getting $1,500–$1,999 and 21 percent getting at least $2,000.

Overall, among persons eligible to contribute to an account, 15 percent did not contribute anything, with 24 percent of those with household income below $50,000 and 15 percent of those with household income of at least $50,000 contributing nothing (Figure 23). The most significant difference in contributions by household income can be seen in the likelihood of contributing at least $2,000 to the account. About 40 percent of individuals with household income of at least $50,000 contributed $2,000 or more to the account, whereas 20 percent of those with household income of less than $50,000 contributed $2,000 or more to the account.

Individual contributions to the account also vary by whether an individual has single coverage or family coverage. Specifically, individuals with single coverage are more likely than those with family coverage to contribute less than $500 to the account, whereas individuals with family coverage are more likely than those with single coverage to contribute at least $2,000 (Figure 24). Overall, 25 percent of individuals with single coverage contributed at least $2,000, while 44 percent of those with family coverage contributed at least $2,000 to the account.

Concerning the length of time that CDHP enrollees have been in the plan, 10 percent enrolled in the past six months, another 24 percent in the past year, and 41 percent in the past two years (Figure 25). Nineteen percent report being in the plan three to four years, and 4 percent report having the plan five years or more.

When it comes to the money currently in the account, 9 percent have no balance while 18 percent have $3,000 or more (Figure 26). Overall, 47 percent had less than $1,000 in the account at the time of the survey, and 11 percent did not know how much was in the account. With respect to rollovers, 16 percent rolled over nothing while 38 percent rolled over at least $1,000 in 2008 (Figure 27).

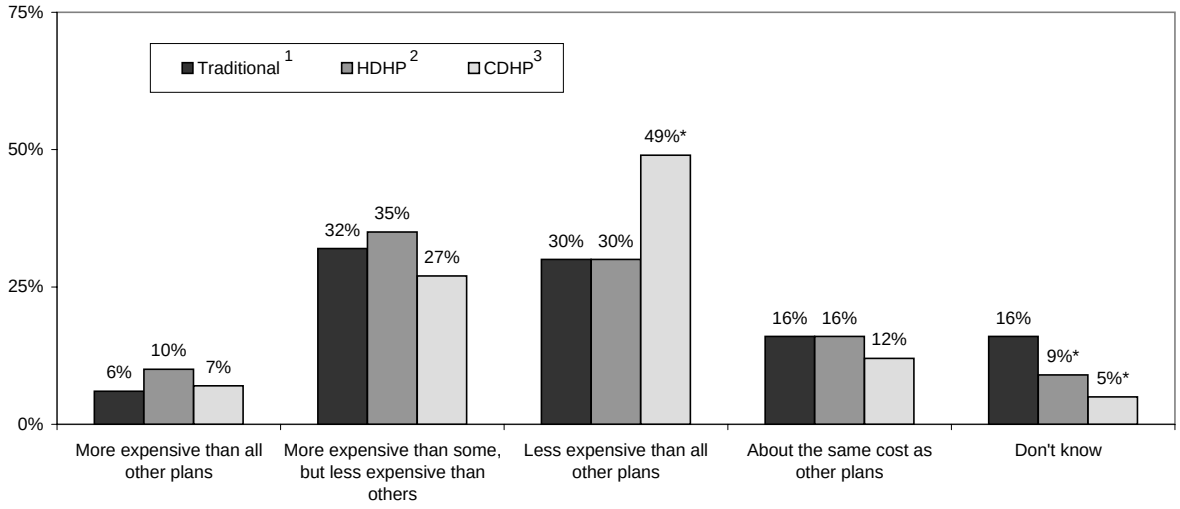
## Health Care Use and Access Issues

The survey asked respondents who had chronic conditions whether they agreed that they followed their treatment regimens for specific conditions carefully. There was no significant variation in the 2008 survey in the frequency with which people with chronic conditions followed their treatment regimens across plan types (Figure 28). This is in contrast to somewhat mixed findings in 2007 (Fronstin and Collins, 2008). In 2007, people in CDHPs with arthritis and hypertension were significantly less likely to say that they followed their treatment regimens for their conditions carefully. But people in CDHPs with depression were significantly more likely to say they followed their treatment regimens carefully than did those with traditional coverage.

The 2007 survey found that adults with CDHPs and HDHPs were significantly more likely to report that they had avoided, skipped, or delayed health care because of costs than were those with more traditional coverage. The 2008 survey found that HDHP enrollees continued to be more likely than traditional plan enrollees to report that they had delayed or avoided getting any needed health care services because of costs, but the difference between traditional plan enrollees and CDHP disappeared, mostly because of the

Figure 17

**Premium of Selected Plan Compared With Other Available Plans, Among Individuals With Choice of Plans and Those in the Individual Market, by Type of Health Plan, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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.
Note: Percentages may not sum to totals due to rounding.

Figure 18

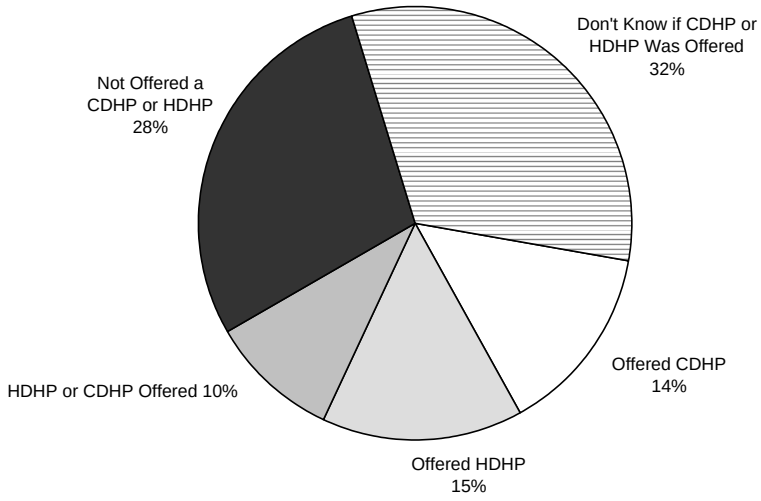
**Main Reason for Deciding to Enroll in Current Health Plan, Among Individuals With a Choice of Health Plan or in the Nongroup Market, by Type of Health Plan, 2008**

| | Traditional[1] | HDHP[2] | CDHP[3] |
|---|---|---|---|
| Lower cost of the premium | 30% | 36% | 48%* |
| Low out-of-pocket costs for the doctor | 36 | 17* | 11* |
| Good network of physicians and hospitals/doctor in the network | 45 | 44 | 33* |
| Prior experience with the plan | 26 | 24 | 11* |
| Specific benefits offered by the plan | 21 | 17 | 15 |
| Plan's good reputation, recommended by others | 22 | 15* | 6* |
| Familiar type of coverage, simple to understand | 28 | 17* | 7* |
| Easy access to care | 19 | 19 | 8* |
| Opportunity to save money in the account, rollover funds for future years | 3 | 2 | 47* |
| Puts you in control of your health care dollars, you make choices of | 7 | 7 | 28* |
| Not much paperwork | 13 | 15 | 7* |
| Tax benefits of the plan | 3 | 4 | 28* |

Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 19

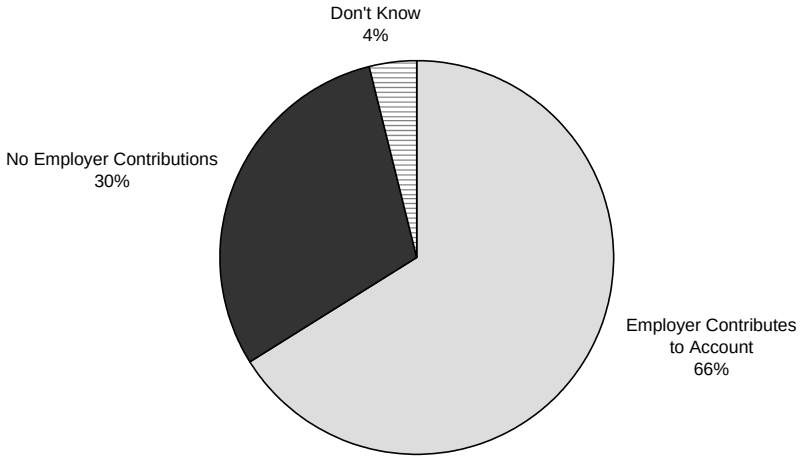
**Percentage of Individuals With Traditional[1] Employment-Based Health Benefits Offered HDHP[2] or CDHP,[3] 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 20

**Percentage of Individuals With Employer Contribution to Account, Among Persons With Employment-Based Health Benefits and CDHP,[1] 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

significant increase in the percentage of traditional plan enrollees reporting access issues due to costs (Figure 29). No significant access issues were found between CDHP enrollees and traditional plan enrollees during 2008, except among higher-income individuals, but HDHP enrollees were found to be more likely than those with traditional coverage to report access issues, especially among those with a health problem and those with household income of $50,000 or above.

## *Availability and Use of Cost and Quality Information*

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

The survey asked about the provision of information in separate questions. One question asked respondents if they agreed or disagreed with a very general statement about information. Specifically, the respondent was asked if he or she agreed with: "My health plan provides information to help me choose among physicians, pharmacies, labs, and hospitals." The kind of information provided was not defined. As reported in Figure 13, 67 percent of persons in traditional plans agreed with the statement, compared with 57 percent of those in HDHPs and 61 percent among those in CDHPs.

Separately, the survey asked if an individual's health plan provided information on cost and quality of providers. Individuals were more likely to report that they had *quality* information available than *cost* information, and CDHP and HDHP enrollees were less likely than traditional plan enrollees to report that the plan provided the information. One-third of adults in traditional plans reported that their health plans provided them with information on the quality of their doctors, compared with about one-quarter among HDHP and CDHP enrollees (Figure 30). With respect to cost information, 26 percent of traditional plan enrollees reported that it was provided by the health plan, compared with about one-fifth among HDHP and CDHP enrollees.

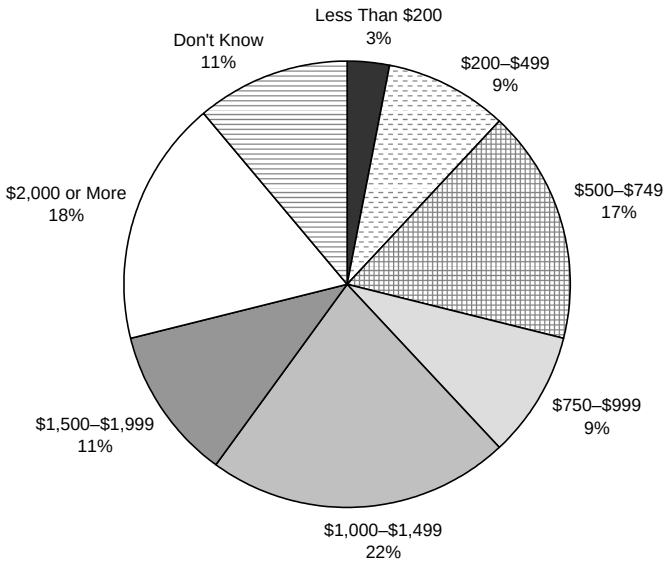
In terms of their use of information provided by their health plans, 56 percent of CDHP enrollees and 60 percent of traditional plan enrollees indicated that they had made use of the information about quality of their doctors, compared with 48 percent among HDHP enrollees. Regarding cost information, 40 percent HDHPs enrollees used it, while 49 percent of traditional plan enrollees used it, and 52 percent of CDHP enrollees used it, though the differences were not statistically significant. CDHP enrollees were more likely than traditional plan and HDHP enrollees to try to find information on cost and quality of their doctor from sources other than the health plan. Specifically, 28 percent of CDHP enrollees sought other sources of information.

People looked to a wide variety of sources for health information. A majority consulted physicians frequently and many went online to explore health information Web sites, with adults in HDHPs and CDHPs more likely to say that they went online a lot or some (Figure 31). Friends or relatives were a commonly consulted source of health information among people in all plans. About three-quarters of individuals in all plan types consulted their health plans frequently for information. More than half of individuals in all plans frequently consulted magazines or books, with those in CDHPs the most likely to do so. Fewer than half of adults in all plan types frequently looked for health information in the newspaper, and even smaller shares consulted a nurse advice or help line.

People enrolled in CDHPs and HDHPs were more likely than traditional plan enrollees to consider costs in their decisions about their health care. Nearly 70 percent of adults in CDHPs and 3 in 5 (61 percent) of those in HDHPs *strongly* or *somewhat* agreed that the terms of their coverage made them consider cost when deciding to see a doctor when sick or fill a prescription; one-half of those in traditional plans felt this way (Figure 32).

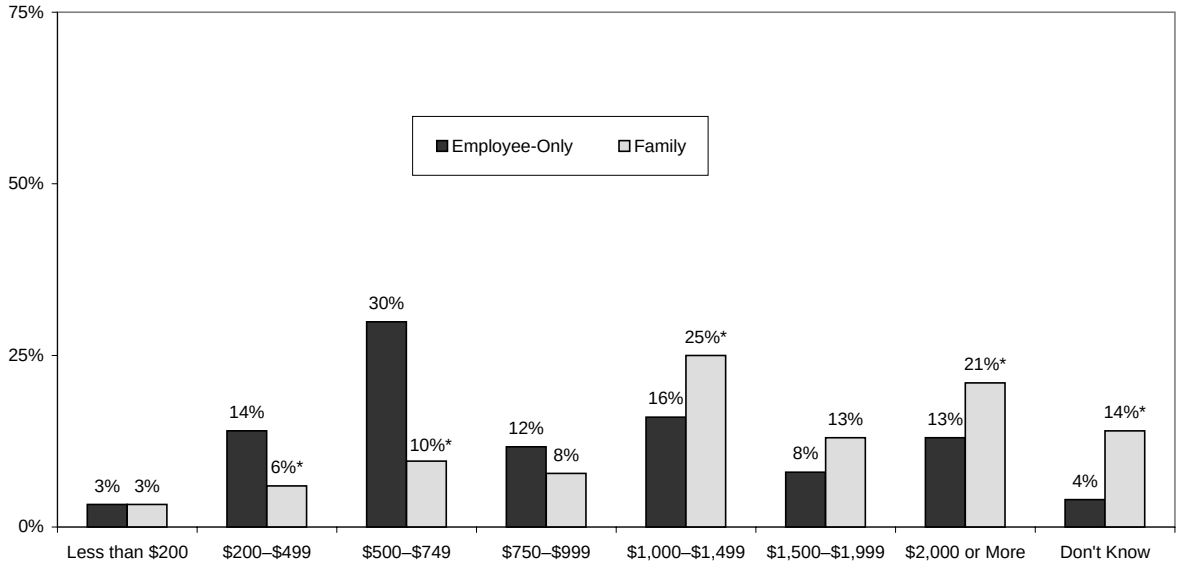
Adults in CDHPs were also more likely than those in traditional plans to say that they had checked whether the plan would cover care. Adults in CDHPs and HDHPs were more likely than those in traditional plans to ask their doctor to recommend a less costly prescription drug: About 3 in 5 said they had done this, compared with 50 percent of those in traditional plans (Figure 33). Few people participate in wellness programs offered by employers, but those in CDHPs were more likely to say they did so. Similarly, although

Figure 21
**Annual Employer Contributions to the Account, Among Persons With CDHP,[1] 2008**



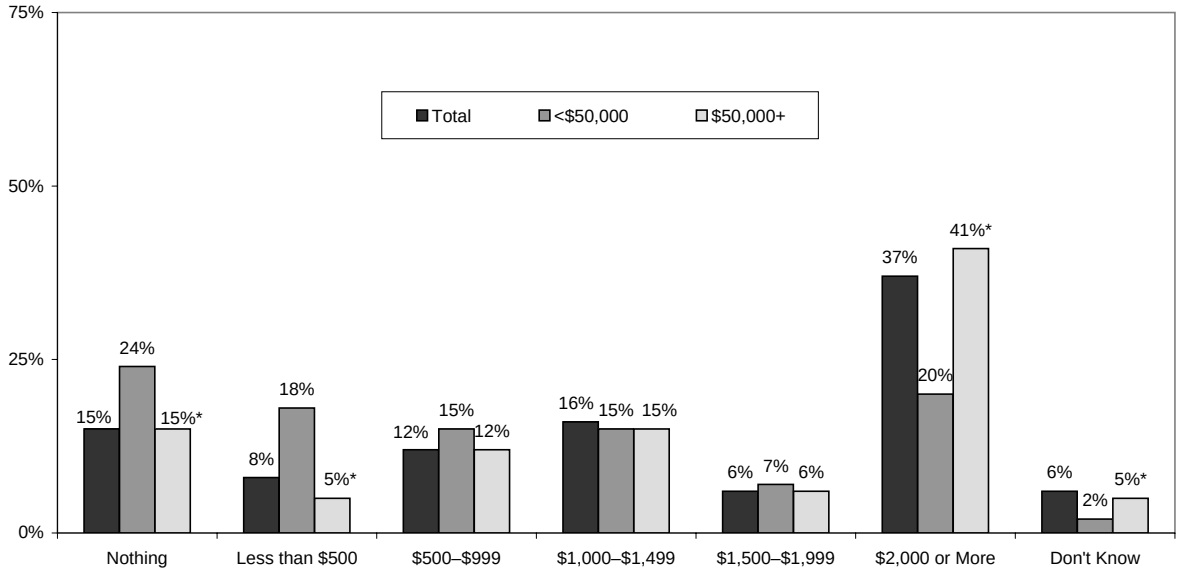

Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $,2000+ (family), with account.

Figure 22
**Annual Employer Contributions to the Account, Among Persons With CDHP,[1] 2008**



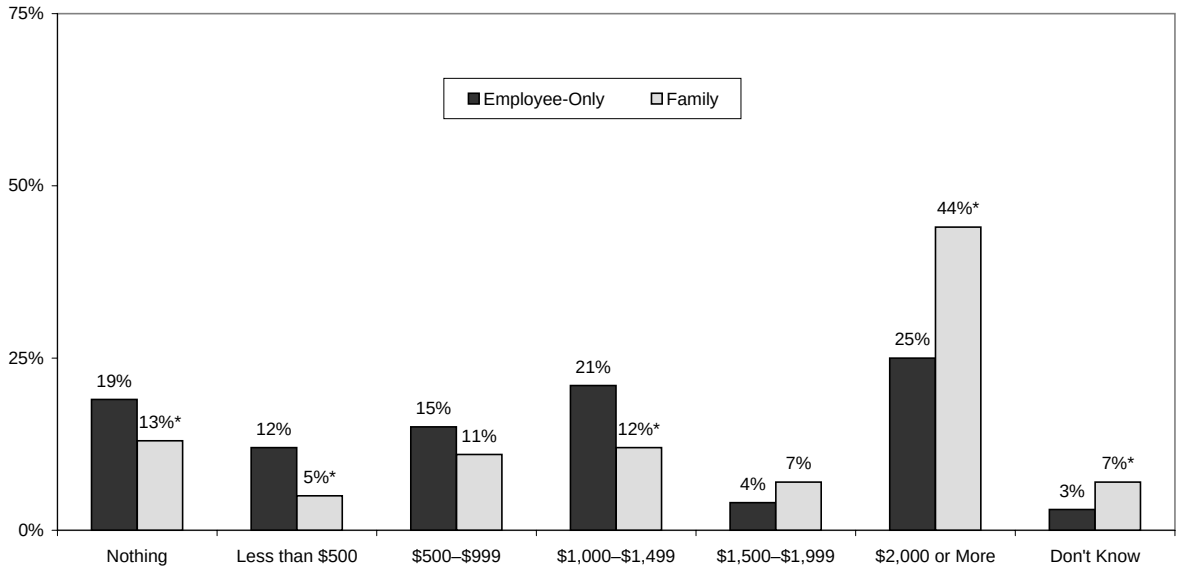

Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between employee-only coverage and family coverage is statistically significant at the p ≤ 0.05 or better.

Figure 23
**Annual Individual Contributions to the Account, by Household Income, Among Persons With CDHP,[1] 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between <$50,000 and $50,000+ is statistically significant at the p ≤ 0.05 or better.

Figure 24
**Annual Individual Contributions to the Account, by Type of Coverage, Among Persons With CDHP,[1] 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between employee-only coverage and family coverage is statistically significant at the p ≤ 0.05 or better.

only 1 in 5 adults in CDHPs used an online cost-tracking tool, their reported use is about twice the rate reported by people in HDHPs or traditional plans. Otherwise, there were no differences in cost-conscious decision making across plan types when it came to talking to doctors about treatment options and costs, asking a doctor to recommend a less costly prescription drug, checking the quality rating of a hospital or doctor, or checking the price of a health care service before getting care.

**Trends**

There has been no increase in the share of CDHP enrollees who report cost-conscious decision making over the four years of the survey (Figure 34). There was a significant increase in the percentage of traditional plan enrollees reporting cost-conscious decision making, which would explain why some of the previous significant differences in cost-conscious decision making between those covered by traditional plans and CDHP enrollees disappeared between 2007 and 2008.

## *Cost-Sharing Incentives*

For the first time, the 2008 EBRI Consumer Engagement in Health Care Survey examined opinions regarding the appropriate use of lower cost sharing as an incentive to change the way individuals use the health care system. It found across-the-board strong interest in select networks composed of only medical providers with records of high-quality care when combined with lower cost sharing. About one-fifth of individuals were *extremely* interested, one-quarter *very* interested, and one-third *somewhat* interested, although CDHP enrollees were more likely than traditional plan and HDHP enrollees to be *very* interested in the concept (Figure 35). But there was less interest in actually changing to a select network combined with lower cost sharing: About 10 percent of individuals were *extremely* likely to change, and one-fifth were *very* likely (Figure 36). Between 34 percent and 41 percent, depending on plan type, were *somewhat* likely to change to a select network.

The survey asked a series a questions regarding whether individuals agreed or disagreed with various ways patients could receive lower cost sharing. The findings are in Figure 37. Two-thirds of CDHP enrollees and nearly 60 percent of HDHP and traditional plan enrollees agreed that patients who are actively participating in a program to maintain or improve their health should pay less for health care services than patients who are not participating in the program. Similar support was found for individuals who follow their treatment regimen. About one-half of individuals thought that patients choosing less invasive procedures should have lower cost sharing. About 40 percent of individuals thought that patients using scientifically proven effective care should have lower cost sharing, while between 30 percent and 40 percent thought there should be lower cost sharing for patients using high-quality doctors.

## *Conclusion*

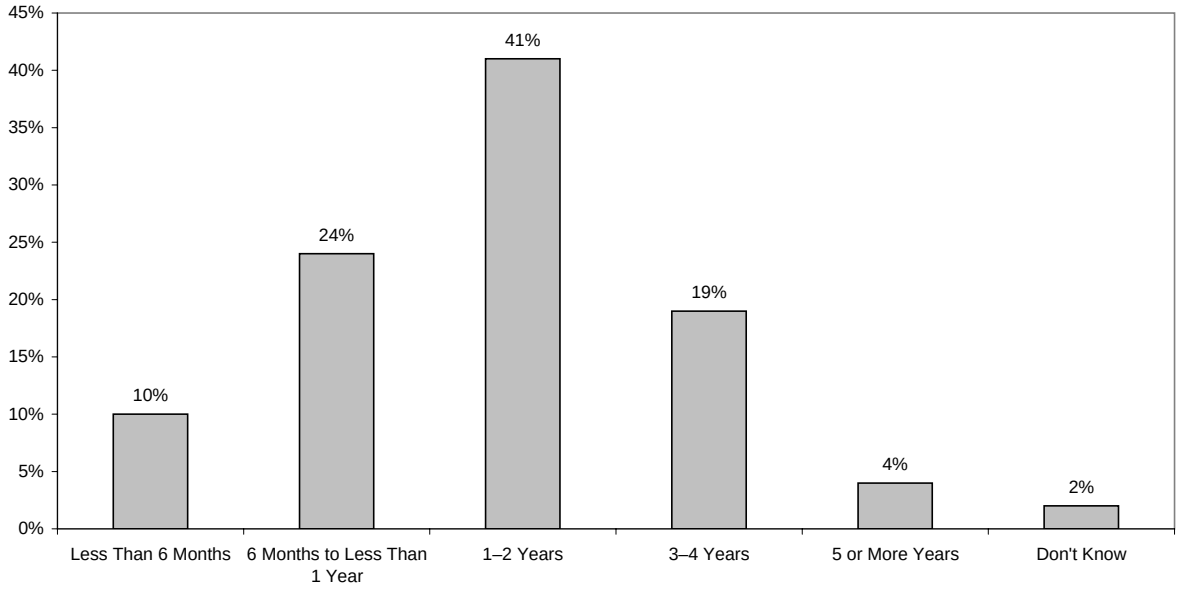
The 2008 EBRI Consumer Engagement in Health Care Survey finds that enrollment in high deductible health plans with a health savings account or health reimbursement arrangement increased from 2 percent of the U.S. adult privately insured population in 2007 to 3 percent in 2008. This represents an increase from 2.5 million people in 2007 to 4.2 million in 2008. An additional 11 percent, or 13.4 million adults, had a health plan with a deductible high enough to make them eligible for an HSA, of which 5.6 million said that they were eligible for an HSA but did not have such an account. These findings are consistent with other recent estimates of enrollment in consumer-driven health plans (See enrollment section on pg. 38).

The self-reported health status of the CDHP population improved between 2007 and 2008. The survey found that adults in CDHPs were significantly more likely to be in excellent or very good health than those with HDHPs or more traditional coverage. People in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or traditional plans. Adults in CDHPs were significantly less likely to smoke than were adults in traditional plans, and they were significantly more likely to exercise.

Similarly, adults in CDHPs were significantly more likely than those with traditional health coverage to have a high household income. Furthermore, those in CDHPs reported significantly higher income since

Figure 25

**Length of Time With CDHP[1] and Savings Account, 2008**

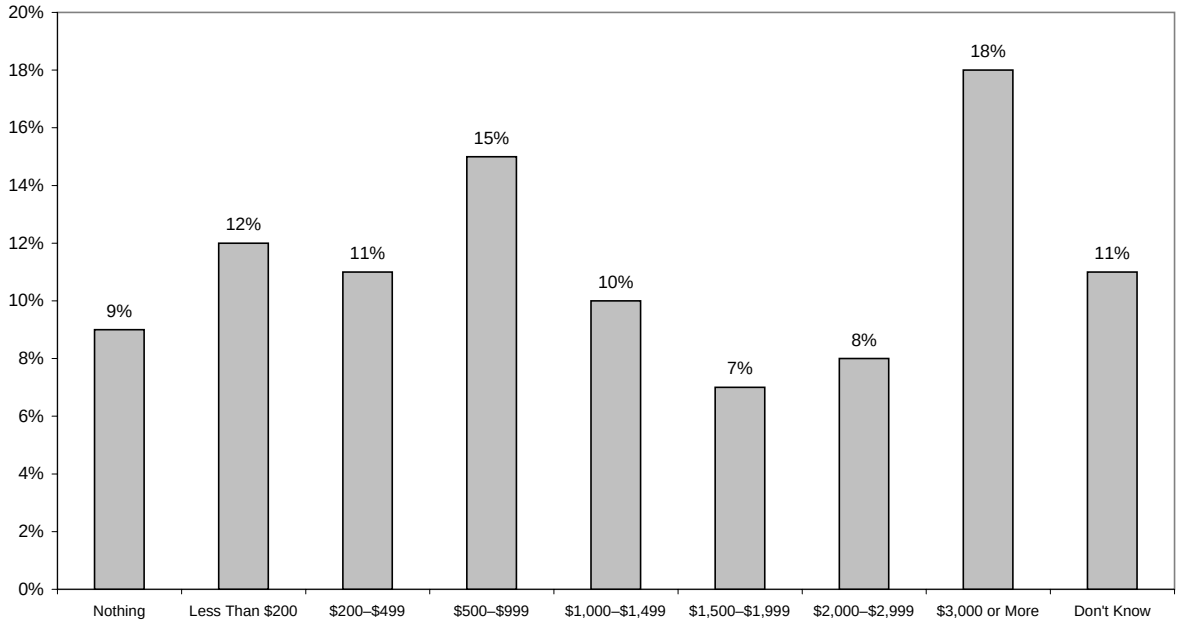



Source: 2008 EBRI Consumer Engagement in Health Care Survey.

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

Figure 26

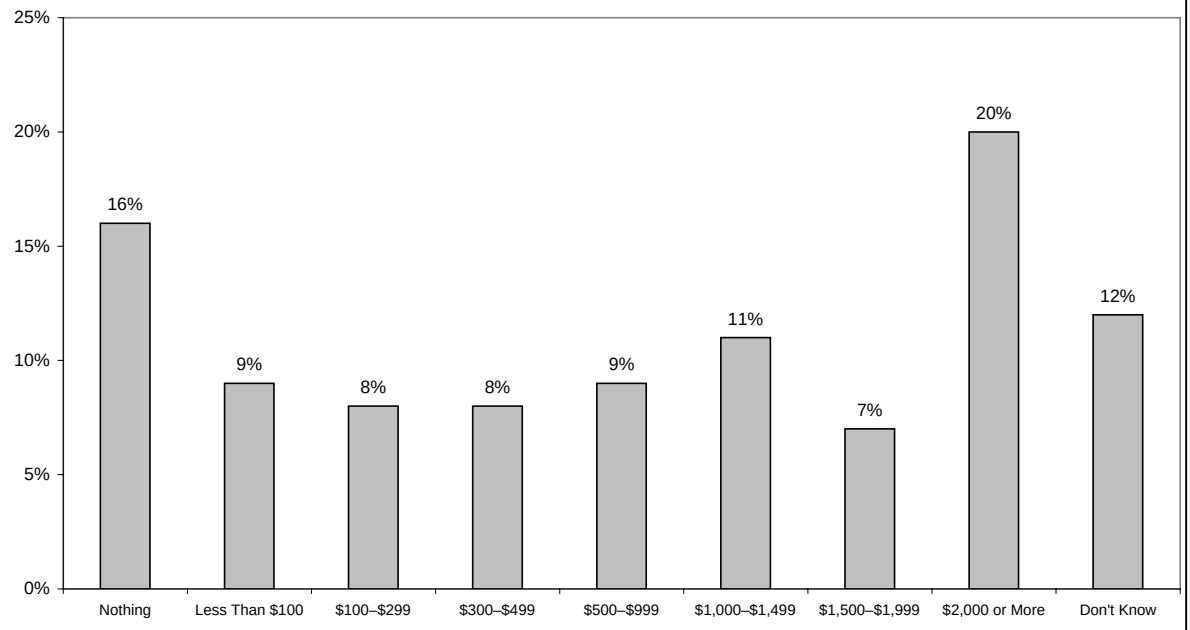
**Amount Currently in Account, Among Persons With CDHP,[1] 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.

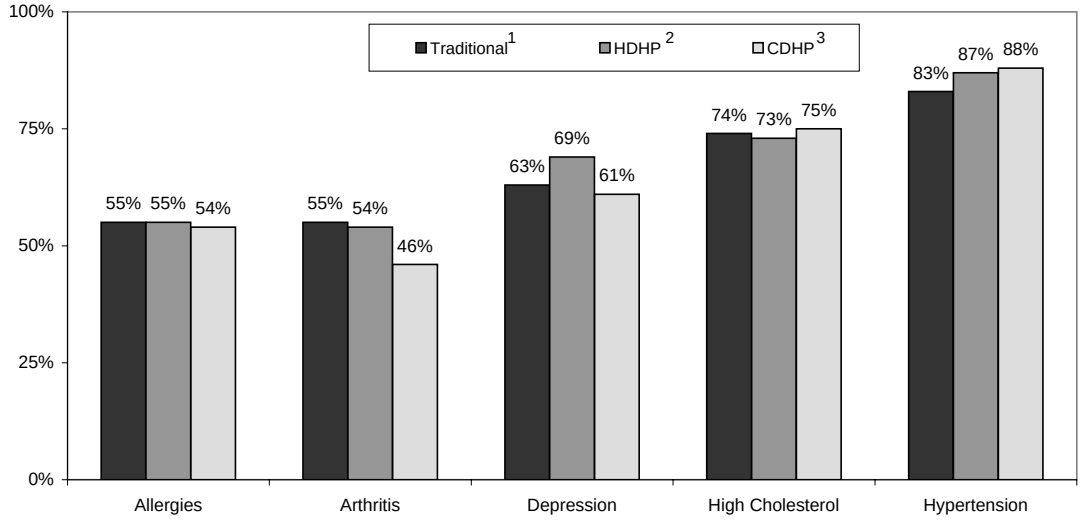
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 27
**Amount Rolled Over from Past Year, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 28
**Following Treatment Regimens for Chronic Disease, 2008**
(Percentage of privately insured adults ages 21–64 with chronic conditions who strongly/somewhat agree that they follow their treatment regimens very carefully)




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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 29

**Access Issues, by Type of Health Plan, 2005–2008**

| | Traditional[1] | | | | HDHP[2] | | | | CDHP[3] | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 |
| Total Sample | 1,061 | 1,506 | 1,918 | 1,714 | 463 | 930 | 1,404 | 1,634 | 185 | 722 | 895 | 1,184 |
| **Total** | | | | | | | | | | | | |
| Not filled a prescription due to cost (you or family members) | 16% | 16% | 17% | 15% | 26%* | 21%* | 21%* | 21%* | 21% | 23%* | 19%^ | 17 |
| Skipped doses to make medication last longer (of those who were given a prescription) (you or family members) | 15 | 16 | 16 | 15 | 25* | 22* | 22* | 22* | 20 | 23* | 17^ | 16 |
| *Not filled a prescription due to cost or skipped doses to make medication last longer* | 22 | 22 | 23 | 21 | 32 | 29* | 29* | 31* | 30 | 31* | 24^ | 23 |
| Delayed or avoided getting health care due to cost (you or family members) | 17 | 19 | 16^ | 22^ | 31* | 33* | 32* | 30* | 37* | 38* | 29*^ | 26 |
| *Any of the above* | 29 | 30 | 28 | 33^ | 44 | 44* | 43* | 43* | 48 | 49* | 38*^ | 35 |
| **Health Problem**** | | | | | | | | | | | | |
| Not filled a prescription due to cost | 21 | 18 | 21 | 19 | 30* | 25* | 24 | 25* | 26 | 25* | 26 | 23 |
| Skipped doses to make medication last longer (of those who were given a prescription) | 21 | 21 | 23 | 21 | 32* | 28* | 28 | 30* | 30 | 29* | 24 | 22 |
| *Not filled a prescription due to cost or skipped doses to make medication last longer* | 29 | 27 | 29 | 28 | 40 | 35* | 35 | 38* | 39 | 38* | 34 | 32 |
| Delayed or avoided getting health care due to cost | 20 | 23 | 18^ | 23^ | 31* | 37* | 35 | 34* | 44* | 42* | 32^ | 32 |
| *Any of the above* | 35 | 34 | 33 | 37 | 48 | 50* | 49 | 49* | 58 | 55* | 46^ | 44 |
| **No Health Problem**** | | | | | | | | | | | | |
| Not filled a prescription due to cost | 11 | 13 | 12 | 9^ | 48 | 17 | 17 | 16* | 15 | 22* | 13^ | 12 |
| Skipped doses to make medication last longer (of those who were given a prescription) | 8 | 11 | 8 | 7 | 15 | 15 | 13 | 12* | 10 | 17 | 11^ | 10 |
| *Not filled a prescription due to cost or skipped doses to make medication last longer* | 14 | 18 | 16 | 13 | 22 | 22 | 21 | 21* | 20 | 25* | 16^ | 16 |
| Delayed or avoided getting health care due to cost | 13 | 16 | 14 | 21^ | 31* | 28* | 27 | 26 | 31* | 35* | 26^ | 22 |
| *Any of the above* | 20 | 25 | 23 | 29^ | 39 | 38* | 37 | 35 | 39 | 44* | 32^ | 29 |
| **Less Than $50,000 Yearly Household Income** | | | | | | | | | | | | |
| Not filled a prescription due to cost | 24 | 20 | 27^ | 20^ | 28 | 25 | 27 | 26 | 24 | 23 | 27 | 19^ |
| Skipped doses to make medication last longer (of those who were given a prescription) | 21 | 21 | 25 | 21 | 31 | 23 | 28 | 27 | 30 | 26 | 23 | 20 |
| *Not filled a prescription due to cost or skipped doses to make medication last longer* | 31 | 29 | 33 | 28 | 38 | 31 | 36 | 35 | 36 | 33 | 32 | 28 |
| Delayed or avoided getting health care due to cost | 24 | 29 | 26 | 35^ | 41 | 36 | 40 | 37 | 49* | 40 | 34 | 33 |
| *Any of the above* | 39 | 42 | 41 | 47 | 53 | 48 | 53 | 51 | 56 | 53 | 48 | 45 |
| **$50,000 or More Yearly Household Income** | | | | | | | | | | | | |
| Not filled a prescription due to cost | 12 | 13 | 12 | 12 | 24* | 19* | 19 | 19* | 19 | 23* | 16^ | 16 |
| Skipped doses to make medication last longer (of those who were given a prescription) | 13 | 14 | 13 | 12 | 23* | 20* | 19 | 21* | 16 | 21* | 16 | 15 |
| *Not filled a prescription due to cost or skipped doses to make medication last longer* | 18 | 19 | 18 | 17 | 30 | 27* | 27 | 28* | 28 | 29* | 22^ | 22 |
| Delayed or avoided getting health care due to cost | 13 | 14 | 12 | 16^ | 28* | 30* | 29 | 28* | 31* | 37* | 29^ | 25* |
| *Any of the above* | 24 | 25 | 23 | 26^ | 40 | 41* | 40 | 40* | 45 | 47* | 36^ | 33 |

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

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

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

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

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

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

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

# Difference between 2005 and 2008 is statistically significant at the p ≤ 0.05 or better.

2005. In 2008, 40 percent of those in CDHPs had incomes of $100,000 or more, up from 22 percent in 2005. In contrast, there was little change in the income distribution of people enrolled in traditional plans: 23 percent had household incomes of $100,000 or more in 2008, compared with 21 percent in 2005.

In addition, workers in both CDHPs and HDHPs were more likely than those in traditional plans to be sole proprietors or to be employed in small firms. However, over the four years of the survey, workers enrolled in CDHPs became significantly more likely to be employed in large firms. Those in CDHPs were more likely than those with traditional coverage to have a choice of health plan. These results are in contrast to findings from 2005 and 2006, when individuals with traditional coverage were more likely to have a choice of health plan than individuals enrolled in CDHPs. Two-thirds of individuals with an employment-based CDHP reported that the employer contributed to the account. Among persons eligible to contribute to an account, 15 percent did not contribute anything.

Consistent with these trends, people in CDHPs continued to be more satisfied with their plans in 2008 than they were in 2006. In 2006 individuals in CDHPs and HDHPs were less likely than those in traditional plans to be satisfied with quality of care received, but between 2006 and 2007, the gap in satisfaction between those in traditional plans and those with CDHPs disappeared because satisfaction increased significantly among those with CDHPs and remained unchanged in 2008. However, the gap in quality of care satisfaction rates remained between traditional enrollees and HDHP enrollees. The differences in overall satisfaction levels by plan type found in all prior years of the survey were reinforced in the 2008 findings; however, overall satisfaction levels among CDHP enrollees increased between 2006 and 2007 and remained at 49 percent in 2008, while satisfaction rates for traditional enrollees were unchanged. Differences in out-of-pocket costs may explain a significant portion of the difference in overall satisfaction rates among traditional plan, HDHP, and CDHP enrollees.

As in previous years of the survey, it was found that individuals in CDHPs and HDHPs were both less likely than those in traditional plans to recommend their health plan to a friend or co-worker and less likely than those with traditional plans to stay with their current health plan if they had the opportunity to switch plans. However, the percentage of CDHP enrollees reporting that they would be *extremely* or *very* likely to recommend their plan to a friend or co-worker or stay with their plan if they had the opportunity to switch increased between 2006 and 2007, and remained at 38 percent in 2008, while it was unchanged for traditional and HDHP enrollees.

There was a nearly across-the-board increase between 2006 and 2007 in the percentage of CDHP enrollees who reported that their health plan was easy to understand, encourages adoption of a healthier lifestyle, provides information to help choose among providers, and will protect them in the event of an expensive illness. The percentage of individuals agreeing with these statements in 2008 was unchanged from 2007 levels.

There was no significant variation in the frequency with which people with chronic conditions followed their treatment regimen across plan types. This is in contrast to somewhat mixed findings in 2007. Furthermore, in 2007, the survey found that adults with CDHPs and HDHPs were significantly more likely to report that they had avoided, skipped, or delayed health care because of costs than were those with more traditional coverage. In 2008, it was found that HDHP enrollees continued to be more likely than traditional plan enrollees to report that they had delayed or avoided getting any needed health care services because of costs, but the difference between traditional plan enrollees and CDHP disappeared, mostly because of the significant increase in the percentage of traditional plan enrollees reporting access issues due to costs. There were no significant access issues between CDHP enrollees and traditional plan enrollees in the 2008 survey, except among higher-income individuals, but HDHP enrollees were found to be more likely than those with traditional coverage to report access issues, especially among those with a health problem and those with household income of $50,000 or above.

Individuals were more likely to report that they had quality information than cost information, and CDHP and HDHP enrollees were less likely than traditional plan enrollees to report that the plan provided the information. In terms of use of information provided by health plans, CDHP and traditional plan enrollees were more likely than HDHP plan enrollees to report that they made use of the information about the quality of doctors. CDHP enrollees were also more likely to try to find information on doctors' cost and quality from sources other than the health plan.

Figure 30

**Availability and Use of Quality and Cost Information Provided by Health Plan and Effort to Find Information From Other Sources, 2008**

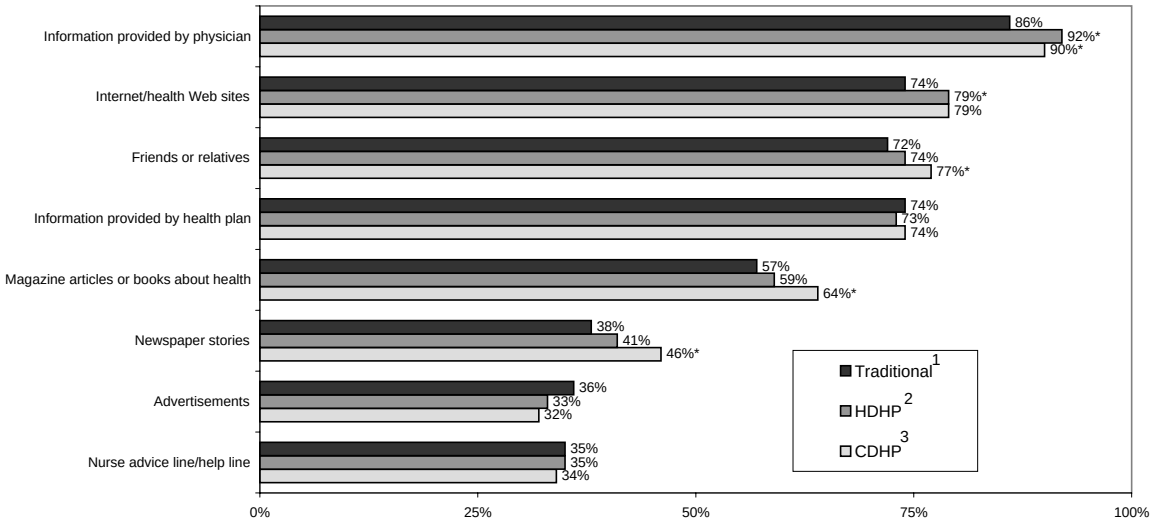
| | Traditional[1] | HDHP[2] | CDHP[3] |
|---|---|---|---|
| Health plan provides information on quality of care provided by doctors | 34% | 25%* | 27%* |
| Health plan provides information on cost of care provided by doctors | 26 | 19* | 20* |
| Of those whose plans provide info on quality, how many tried to use it for doctors | 60 | 48* | 56 |
| Of those whose plans provide info on cost, how many tried to use it for doctors | 49 | 40 | 52 |
| Tried to find information from sources other than health plan on cost and quality of care provided by doctors | 21 | 23 | 28* |

Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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 31

**Resources Used for Health Information, by Type of Health Plan, 2008**

(Percentage of privately insured adults ages 21–64 who use the following resources a lot/some)

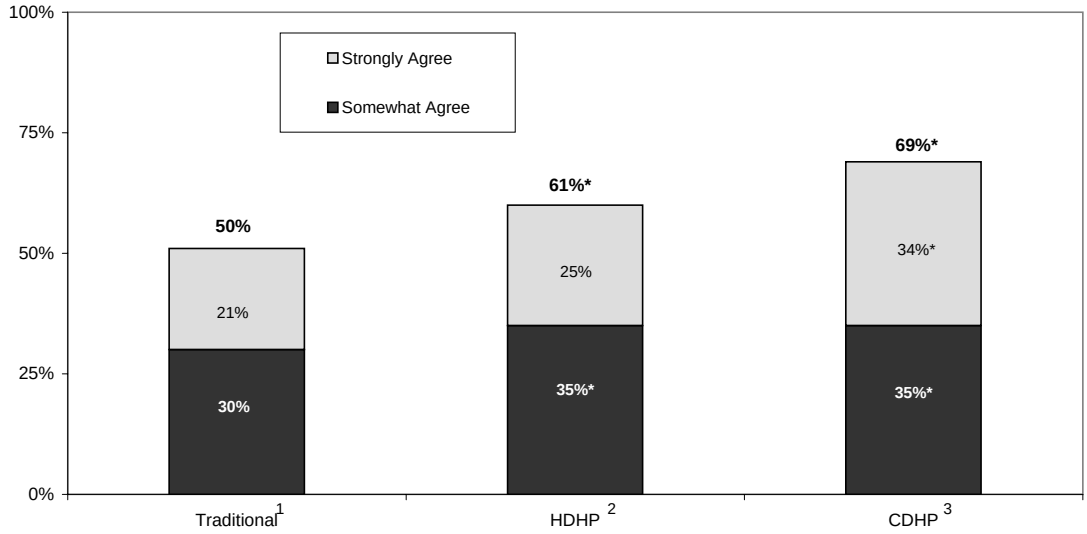



Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with 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 32

**Percentage of Adults Who Agree That Terms of Coverage Make Them Consider Cost When Deciding to Seek Health Care Services, 2008**

(Percentage of privately insured adults ages 21–64)




Source: 2008 EBRI Consumer Engagement in Health Care Survey.

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

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

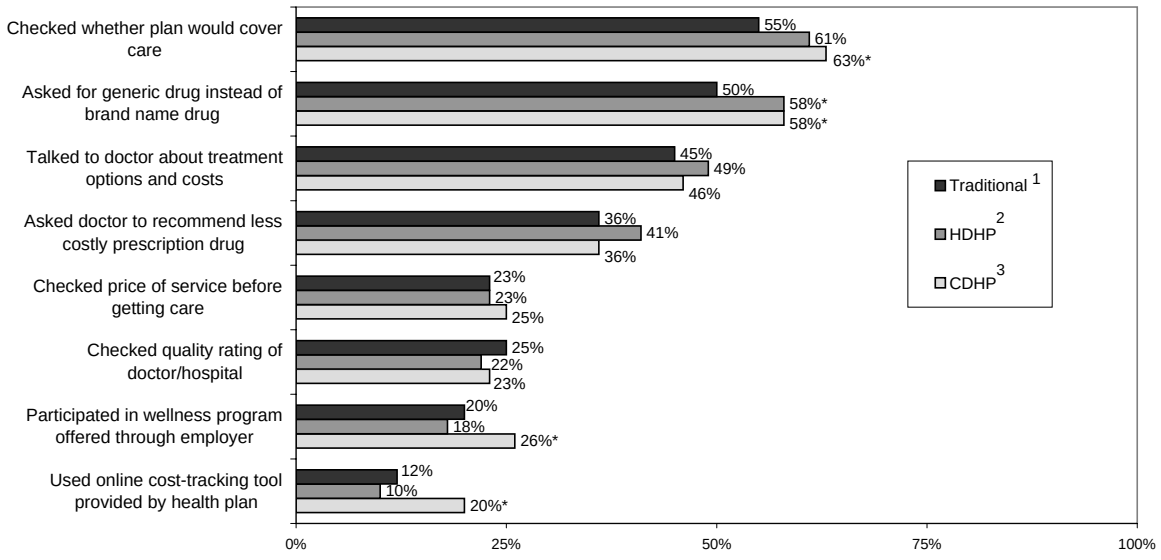
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

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

Figure 33

**Cost-Conscious Decision Making, by Type of Health Plan, 2008**

(Percentage of privately insured adults ages 21–64 who received health care in last 12 months)




Source: 2008 EBRI Consumer Engagement in Health Care Survey.

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

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

[3] 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.

Individuals in CDHPs and HDHPs exhibit more cost-conscious behavior in their health care decision-making than individuals with traditional health insurance. Adults in CDHPs and HDHPs were more likely to consider costs in their decisions about health care. Those in CDHPs and HDHPs were more likely than those in traditional plans to ask their doctor to recommend a less costly prescription drug. There was no change in the share of CDHP enrollees who reported cost-conscious decision making over the four years of the survey, but there was a significant increase in the percentage of traditional plan enrollees reporting cost-conscious decision making.

The survey found across-the-board strong interest in select networks composed of only medical providers with records of high quality care when combined with lower cost sharing. There was less interest in actually changing to a select network combined with lower cost sharing. There was also support (to a degree) regarding other ways patients could receive lower cost sharing, such as by actively participating in a program to maintain or improve health, by following treatment regimens, by choosing less invasive procedures, and by using scientifically proven effective care.

The 2008 EBRI Consumer Engagement in Health Care Survey suggests that the face of enrollees in consumer-driven health plans is continuing to change. On average, enrollees in CDHPs are significantly higher-income and healthier than in the past. They are just as likely to work for a large company, and more likely to have a choice of plan. Satisfaction with their plans is higher, although gaps still remain, and reported rates of cost-related access problems are lower, mostly because of higher rates of access issues among individuals enrolled in traditional health plans. There is evidence that CDHP enrollees are somewhat more cost-conscious in their decision making than those in traditional plans, but the behavior differences are not substantial. There is also evidence that consumer-driven health plans do not provide their enrollees with any more information about provider cost and quality than other health plan types.

As the CDHP and HDHP markets continue to expand and more enrollees are enrolled for longer periods of time, the sustained impact that these plans are having on cost, quality, and access to health care services will be better understood.

Figure 34

**Trends in Cost-Conscious Decision Making, by Type of Health Plan, 2005–2008**

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

| | Traditional[1] | | | | HDHP[2] | | | | CDHP[3] | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 |
| Total Sample | 953 | 1,363 | 1,794 | 1,548 | 417 | 802 | 1,284 | 1,484 | 163 | 652 | 805 | 1,077 |
| Checked whether health plan would cover care | 51% | 58% | 50%^ | 55%^ | 61% | 62% | 61%* | 61% | 60%* | 62% | 60%* | 63%* |
| Asked for generic drug instead of brand name drug | — | 48 | 46 | 50^ | — | 60* | 58* | 58* | — | 54 | 54* | 58* |
| Talked to doctor about treatment options and costs | 42 | 44 | 44 | 45 | 56* | 44 | 49*^ | 49 | 58* | 46^ | 47 | 46 |
| Asked doctor to recommend less costly prescription drug | 27 | 31 | 30 | 36^ | 46* | 41* | 43* | 41 | 45* | 39* | 38* | 36 |
| Checked price of service before getting care | 24 | 20 | 21 | 23 | 35* | 23^ | 27*^ | 23^# | 29 | 26* | 27* | 25 |
| Checked quality rating of doctor/hospital | 18 | 21 | 20 | 25^ | 22 | 18 | 19 | 22 | 18 | 19 | 18 | 23^ |
| Participated in wellness program offered through employer | — | 15 | 15 | 20^ | — | 11 | 11* | 18^ | — | 20* | 21* | 26*^ |
| Used online cost-tracking tool offered by health plan | — | 8 | 8 | 12^ | — | 6 | 9^ | 10 | — | 17* | 20* | 20* |

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

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

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

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

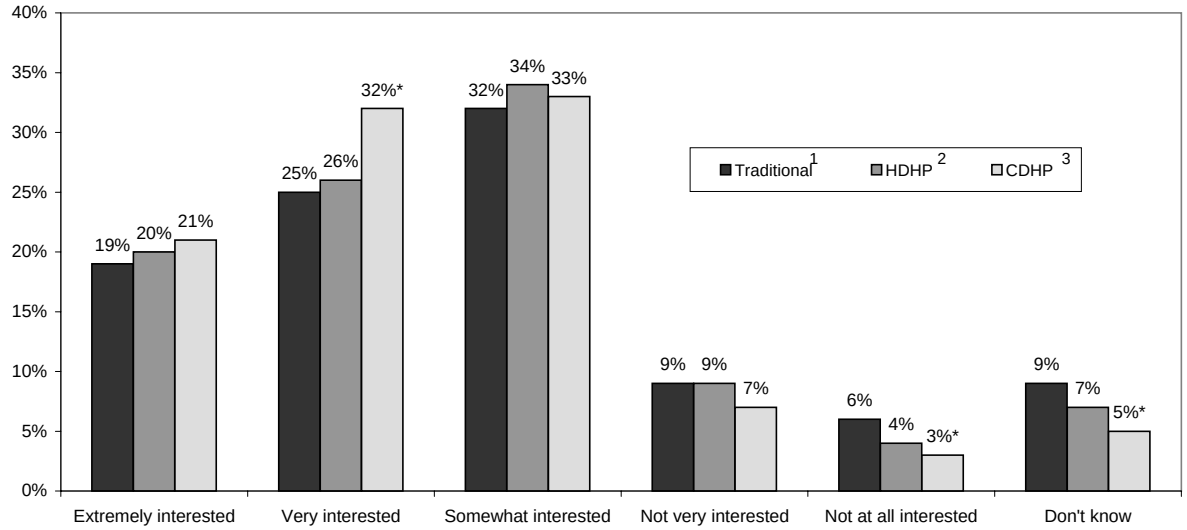
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

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

# Difference between 2005 and 2008 is statistically significant at the p ≤ 0.05 or better.

Figure 35

**Interest in Using Select Networks Composed of Only Medical Providers With Records of Providing High-Quality Care Combined With Lower Cost Sharing, by Type of Plan, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.

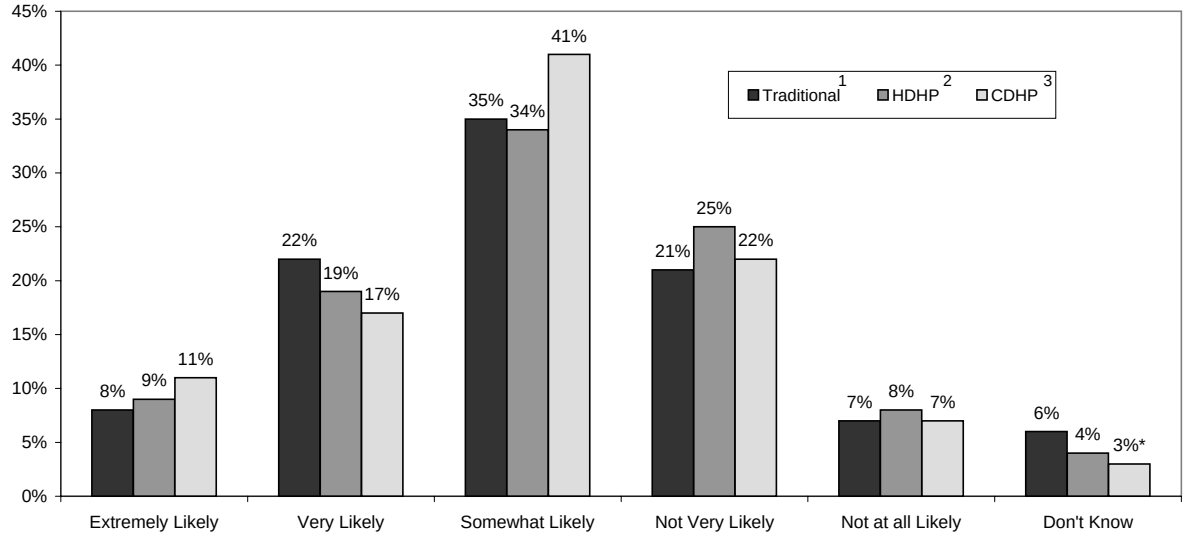
Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).

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

CDHP = Consumer-driven health plan with deductible $1000+ (individual), $2,000+ (family), with account.

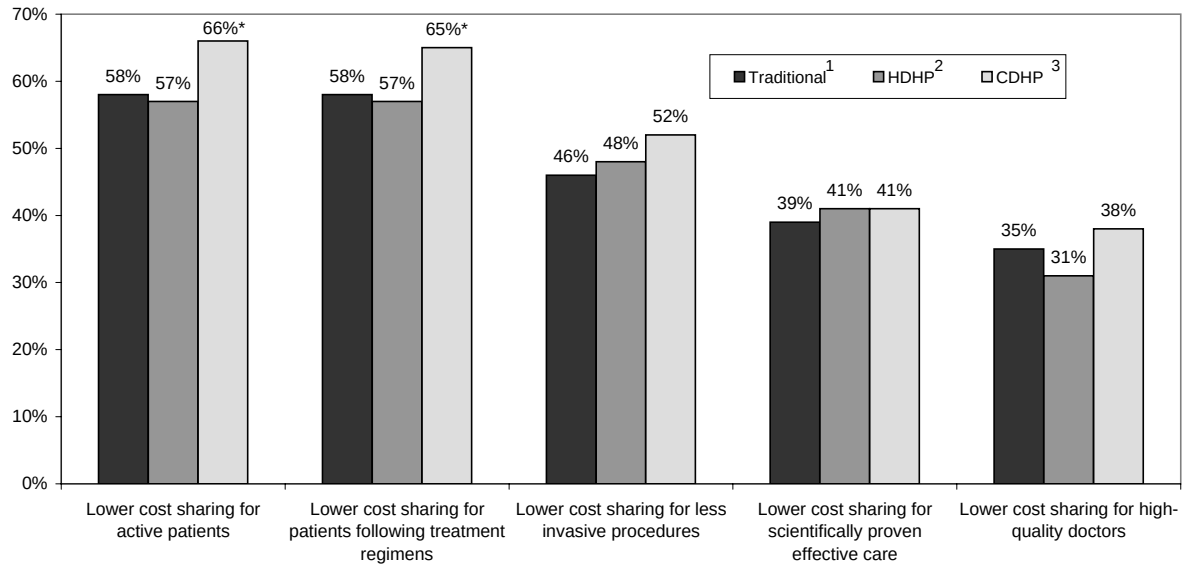
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better.

Figure 36
**Likelihood of Changing to Select Network if Current Doctor Was Not in Select Network, by Type of Plan, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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 37
**Agreement With Statements About Proposed Ways to Engage Consumers in Managing Health Care Costs, by Type of Plan, 2008**




Source: 2008 EBRI Consumer Engagement in Health Care Survey.
[1] Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] 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.

## *Enrollment in CDHPs and HDHPs*

According to the 2008 EBRI Consumer Engagement in Health Care Survey, 9.8 million adults ages 21–64 with private health insurance were enrolled in either a CDHP (a plan with an HSA or HRA) or an HDHP that was eligible to contribute to an HSA (up from 3.9 million in 2006). This represents 7.9 percent of adults ages 21–64 with private insurance (up from 6.6 percent in 2007). The EBRI survey does not include children in the survey. Any children enrolled in CDHP or HDHP plans eligible for an HSA are *not* included in the 9.8 million adults with private health insurance. The 2008 enrollment number is comparable to estimates published by other sources. A summary of the other sources is below.

### America's Health Insurance Plans (AHIP)

In 2008, AHIP conducted a census of health plans to determine the number of people enrolled in plans with an HSA or eligible for one. AHIP determined that 6.1 million people were in an HSA-eligible plan in January 2008 (up from 4.5 million in 2007 and 3.2 million in 2006). Nearly 4.6 million had coverage through the employment-based market, while an additional 1.5 million had it through the individual market. The report did not count HRA enrollees, but it does include workers, nonworking adults, and children. There is no methodology section in the report so it is unclear how many health plans reported data and how the data may have been weighted. The report includes data on HSA characteristics, but only for slightly more than 517,000 accounts. More information can be found at www.ahipresearch.org/pdfs/2008_HSA_Census.pdf

### American Association of Preferred Provider Organizations (AAPPO)

In 2007, AAPPO used the data from *Inside Consumer-Directed Care* (ICDC) and supplemented it with data from 100 health plans to determine that 10 million people were enrolled in an HRA or HSA-eligible plan. More specifically, 4.5 million people were in an HSA-eligible plan while 5.5 million were in an HRA in early 2007. As in the AHIP study, there is no methodology section in the report and very little information overall, but these data should include workers, nonworking adults, and children. The 2007 report can be found at www.aappo.org/UserFiles/File/HSASurveyandPressRelease/cdhp_report_final040207.pdf.

AAPPOs 2008 report, *2008 Study Of Consumer-Directed Health Plans* does not appear to be based on any 2008 data. The report is based mostly on 2007 data from Mercer and revised upward its 2007 estimate from 10 million to 12.5 million. The report does not mention any other specific data sources. The 2008 report can be found at www.aappo.org/UserFiles/File/HSASurveyandPressRelease/cdhp_study_2008_final.pdf.

### Consumer Driven Market Report (CDMR)

According to enrollment estimates from CDMR, more than 11 million people were enrolled in HRAs or HSA-eligible plans as of January 2008 (up slightly from 10.1 million in 2007, and 6 million in 2006). Roughly 6 million were in HSA-eligible plans and 5 million were in HRA-based plans. CDMR predicts 14 million individuals will be enrolled in account-based plans in 2009. The data reported here were obtained from Issue 7 in 2008 and available only to subscribers and possibly those who request a copy. Limited information about the methodology used to collect the data was provided in the issue.

### Inside Consumer-Directed Care (ICDC)

*Inside Consumer-Directed Care (ICDC)*, an industry newsletter published by Atlantic Information Services, has been following the movement to consumerism and growth in account-based plans for many years. The August 8, 2008, report contains enrollment data by insurer for 24 insurers, while the August 22, 2008, issue contains data from BlueCross BlueShield plans. According to the data from these two issues, 10.7 million persons were enrolled in an HRA or HSA-eligible plan. The report should include workers, nonworking adults, and children. While many insurers were not included in the analysis, Aetna, the Blues, Cigna, Humana, and United were included. Collectively, they account for about 140 million lives, and 9.3 million of the 10.7 million persons covered by an HRA or HSA-eligible. More information about ICDC can be found at www.aispub.com/Products/NewsICD.html.

### Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET)

In 2008, KFF/HRET conducted a nationally representative survey of nearly 2,000 employers of all sizes. The 2008 survey found that 5.5 million workers enrolled in either an HRA (2.2 million) or an HSA-based plan (3.2 million) (up from 3.8 million in 2007, and 2.7 million in 2006). The KFF/HRET survey does not include nonworking adults or children in its estimates. It also does not include federal employees or workers in firms with fewer than three employees. More information can be found at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.6.w492.

### Mercer

Mercer, a human resources and benefits consulting firm, conducts an annual survey of employers with at least 10 employees. Nearly 3,000 employers were surveyed in 2007. In 2007, Mercer found that 5 percent of workers with health insurance were covered by either an HRA or HSA (up from 3 percent in 2006). The Mercer study does not include nonworking adults, children, or persons who get coverage in the individual market. The survey also does not include firms with fewer than 10 employees.

The survey also found that 7 percent of employers with fewer than 500 employees offered either an HRA or HSA (up from 5 percent in 2006), while 14 percent of employers with 500 or more employees offered one of the plans (up from 11 percent in 2006). Mercer notes that adoption of these plans slowed in 2008 and predicts adoption to be moderate in 2008. See www.mercer.com/pressrelease/details.jhtml?idContent=1287790 for more information. Mercer's 2008 report was not available at the time this *Issue Brief* went to press.

## *Appendix: Methodology*

The findings presented in this *Issue Brief* were derived from the 2008 EBRI Consumer Engagement in Health Care Survey, 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 their health care plan, reasons for choosing their plan, and sources of health information. It also presents findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey. The 2008 EBRI Consumer Engagement in Health Care Survey was conducted within the United States between August 14 and August 28, 2008, through a 16-minute Internet survey. The national or base sample was drawn from Synovate's online sample of Internet users who have agreed to participate in research surveys. More than 2,000 adults (n=2,008) ages 21–64 who have health insurance through an employer or purchased directly from a carrier were drawn randomly from the Synovate sample for this base sample. This sample was stratified by gender, age, region, income, education, or race. The response rate was 19.3 percent (12 percent for the base sample or national sample, and 38 percent for the oversample). The margin of error for the national sample was plus or minus 2.2 percent.

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

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

that are below current thresholds that would quality for HSA tax preference, and they do not have an HRA-based plan.

Because the base sample (national sample) included only 79 individuals in a CDHP and 215 individuals with a HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 1,102 individuals with a CDHP and 1,419 individuals with a HDHP, resulting in a total sample (base plus oversample) of 1,184 for the CDHP group and 1,634 for the HDHP group. After factoring out of the base sample the 79 individuals with a CDHP and the 215 individuals with a HDHP, there are 1,714 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 age 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, this analysis used Synovate's omnibus survey of more than 87,000 online panel members who met the criteria for the study (having private insurance and age 21–64.) The following three questions were used in the June and July Omnibus Surveys to identify likely CDHP and HDHP respondents:

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

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

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

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

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

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

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

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

Don't know if have deductible

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

Yes
No
Not sure

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

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## *Endnotes*

[1] More information about HRAs and HSAs can be found in the boxes on pgs. 13–14 and in Fronstin (2002 and 2004).

[2] See www.mercer.com/referencecontent.htm?idContent=1287790

[3] See www.healthcaredisclosure.org/.

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

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

[6] According to data from the Kaiser Family Foundation/Health Research and Educational Trust annual employer survey, average deductibles across all health plans increased by roughly 20 percent, or about $100, in 2008. See Exhibit 7.5 in http://ehbs.kff.org/pdf/7790.pdf.

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

[8] 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.

[9] The catch-up contribution is not indexed to inflation after 2009.

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

[11] In theory, a random sample of 2,008 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.

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