

Consumer Engagement in Health Care: Findings from the 2016 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey

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

AT A GLANCE

The EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS) provides reliable national data on the growth of high-deductible plans and their impact on the behavior and attitudes of health care consumers with employment-based coverage or individually purchased coverage. It also looks broadly at consumer engagement and value-based health insurance design. Now in its 11th year, it is co-sponsored by the Employee Benefit Research Institute (EBRI) and Greenwald & Associates with support from seven private organizations.

The 2016 survey was conducted online August 11–24, using the Ipsos consumer panel. A total of 3,295 adults with private health insurance coverage through an employer, purchased directly from a carrier, or purchased through a government exchange participated in the survey. However, most survey participants (82 percent) received coverage through an employer. The data were weighted by gender, age, education, region, income, and race/ethnicity to reflect the actual proportions in the population ages 21–64 with private health-insurance coverage.

This *Issue Brief* identifies the key findings of the 2016 survey:

- **Health plans with high deductibles are increasingly common.** Fourteen percent of privately insured adults were enrolled in a consumer-driven health plan (CDHP)—a health plan associated with a health savings account (HSA) or health reimbursement arrangement (HRA); 14 percent also were enrolled in a high-deductible health plan (HDHP)—a plan with a deductible of \$1,300 or more for single coverage; at least \$2,600 for family coverage—not linked to an HSA or HRA; and 73 percent were enrolled in more traditional coverage. Among individuals with traditional coverage, a growing number have the option to choose a CDHP. Those who choose a CDHP are also remaining enrolled for a longer time.
- **More than half (56 percent) of CDHP enrollees opened an HSA, taking advantage of growing employer contributions.** Among individuals enrolled in CDHPs, 56 percent (16.3 million) opened an HSA, 19 percent (5.5 million) were in an HRA, and 25 percent (7.3 million) were enrolled in an HSA-eligible health plan but had not opened an HSA. It was more common for employers to contribute to an HSA in 2016 than in the past, and the dollar amount also increased. Seventy-eight percent of CDHP enrollees reported that their employer contributed to the account in 2016, up from 67 percent in 2014. Furthermore, 20 percent of CDHP enrollees reported an employer contribution of at least \$2,000 in 2016, up from 10 percent in 2014. Similarly, 42 percent reported an employer contribution of \$1,000–\$1,999 in 2016, up from 36 percent in 2014.
- **Consumer behaviors are linked to CDHP enrollment.** Adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors. For example, those in a CDHP were more likely to say that they had checked whether the plan would cover care (54 percent CDHP vs. 44 percent traditional); asked for a generic drug instead of a brand name (48 percent CDHP vs. 37 percent traditional); and that they had used an online cost-tracking tool provided by the health plan (31 percent CDHP

vs. 20 percent traditional). CDHP and HDHP enrollees were also more likely than traditional-plan enrollees to report that they tried to find cost information before getting care. Nearly one-half of HDHP enrollees, and 43 percent of CDHP enrollees said they had searched for the cost information, compared with 32 percent among traditional-plan enrollees.

- ***CDHP enrollees are part of a robust health program strategy.*** Individuals enrolled in CDHPs were more likely than those enrolled in HDHPs or with traditional coverage to report that they had a choice of health plans. Two-thirds of CDHP enrollees had a choice of health plan, compared with 49 percent among HDHP enrollees and 50 percent among traditional plan enrollees. CDHP enrollees were more likely than traditional-plan enrollees to report that they participated in biometric screening programs when offered: Over 80 percent of CDHP enrollees participated, compared with 64 percent among traditional-plan enrollees.

These survey findings suggest that the inclusion of a high deductible—whether via a HDHP or CDHP—is correlated with more engaged individuals. Further, given that CDHP enrollees are more consistently offered funds for their HSA, had a choice of health plans at enrollment and offered wellness programs, CDHP enrollees are more likely to consistently engage in those cost-conscious consumer behaviors.

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

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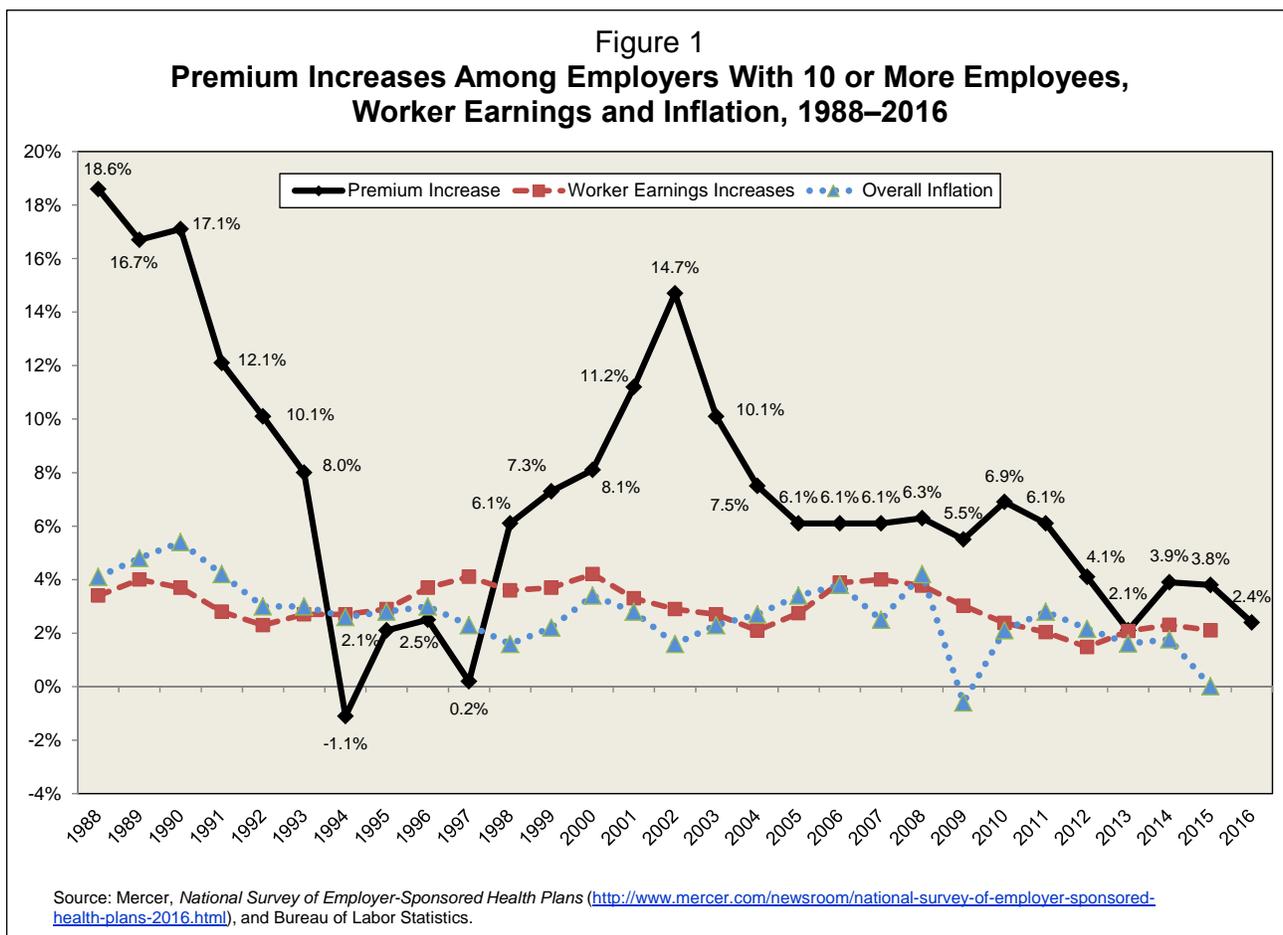
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Introduction

Employment-based health benefits are the most common form of health insurance in the United States. In 2015, 164 million individuals under age 65, or 60 percent of that population, had employment-based health benefits.¹ In nearly every year since 1998, premium increases have exceeded worker-earnings increases and inflation (Figure 1). Health insurance premiums have nearly tripled, while worker earnings have increased 58 percent during that period.²

In response, employers have been seeking ways to manage health care cost increases. During the past decade, employers have turned their attention to consumer-driven health plans (CDHPs)—a combination of health coverage with high deductibles (at least \$1,300 for individual coverage in 2016) and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. A handful of employers first started offering CDHPs in 2001 with health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).³ By 2016, 25 percent of employers with 10–499 workers and 61 percent of employers with 500 or more workers offered either an HRA- or HSA-eligible plan.⁴



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

To shed light on these issues, this *Issue Brief* presents findings from the 2016 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS)—a study designed to provide nationally representative data regarding the growth of CDHPs and high-deductible health plans (HDHPs) and the impact of these plans on the behavior and attitudes of adults with private health-insurance coverage. Now in its 11th year, this study was based on an online survey of 3,295 privately insured adults ages 21–64. The sample was randomly drawn from Ipsos’ online panel of more than 775,000 internet users who had agreed to participate in research surveys. This survey used a base sample of 1,995 to draw incidence rates for people with CDHPs and HDHPs, and the base sample was complemented with an additional random oversample of these two groups. More specifically, the oversamples were: 1) those with either an HRA or an HSA, including individuals who were enrolled in an HSA-eligible health plan, but had not opened the HSA, and 2) those in a plan with an individual deductible of at least \$1,300 and a family deductible of at least \$2,600, but who report that they were not eligible to open an HSA.⁵ The final sample included 1,106 in a CDHP with either an HSA or HRA, 803 in an HDHP, and 1,386 in a more traditional health plan.⁶

More Than a Quarter (28 percent) of Americans With Private Insurance Are Enrolled in CDHPs or HDHPs

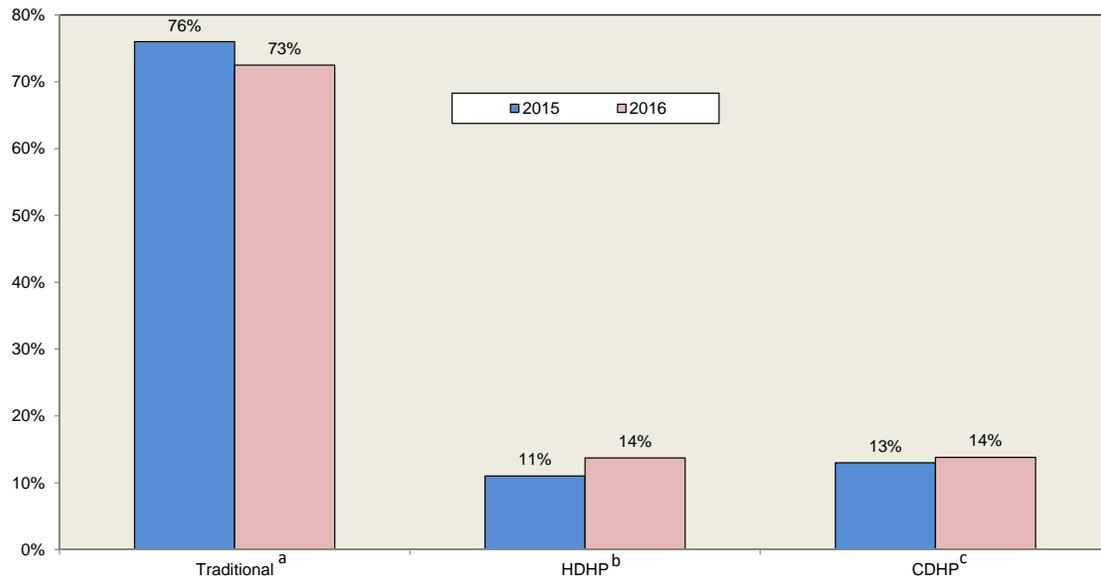
This survey used the 2016 minimum Internal Revenue Service (IRS) deductible amounts as a threshold to define a high-deductible health plan. Further, it distinguished whether someone’s high-deductible health plan was or wasn’t linked to an account—either an HRA or an HSA, even if they hadn’t opened the HSA. Specifically, if an individual was enrolled in an HSA-eligible health plan (regardless of whether the HSA was opened) or in a plan with a deductible of at least \$1,300 (individual coverage) or \$2,600 (family coverage) that also had an HRA, they were assigned to the CDHP group. Everyone else enrolled in a plan with a deductible of at least \$1,300 for individual coverage or \$2,600 for family coverage was assigned to the HDHP group. Individuals enrolled in a plan with no deductible or with a deductible below the minimum IRS HDHP deductible threshold were assigned to the “traditional” coverage category. More detail about the methodology is provided in the appendix.

This survey found that in 2016, 14 percent of the population was enrolled in a CDHP; 14 percent were enrolled in an HDHP; and 73 percent was enrolled in traditional coverage (Figure 2). The 14 percent of the population with a CDHP represented about 29 million individuals with private insurance, while the 14 percent with an HDHP represented another 29 million individuals.

Among the 14 percent of individuals enrolled in a CDHP, 56 percent (16.3 million) had opened an HSA, 19 percent (5.5 million) were in an HRA, and 25 percent (7.3 million) were enrolled in an HSA-eligible health plan but had not opened an HSA (Figure 3). Thus, overall, 22.5 million were enrolled in an HSA-eligible health plan.

A number of other surveys track enrollment in CDHPs. Mercer found that 29 percent of workers with employment-based coverage were covered by a CDHP in 2016.⁷ The Kaiser Family Foundation (KFF) also found that 29 percent of workers were enrolled in a CDHP in 2016.⁸ These surveys focus only on the employment-based market and include estimates for both HSA and HRA enrollment. An annual America’s Health Insurance Plans (AHIP) survey focuses on both the group and individual markets and found that 19.7 million people were enrolled in an HSA-eligible health plan in January 2015,⁹ which accounted for about 13 percent of the population with private health insurance. AHIP does not collect information on HRA enrollment.

Figure 2
Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2015–2016



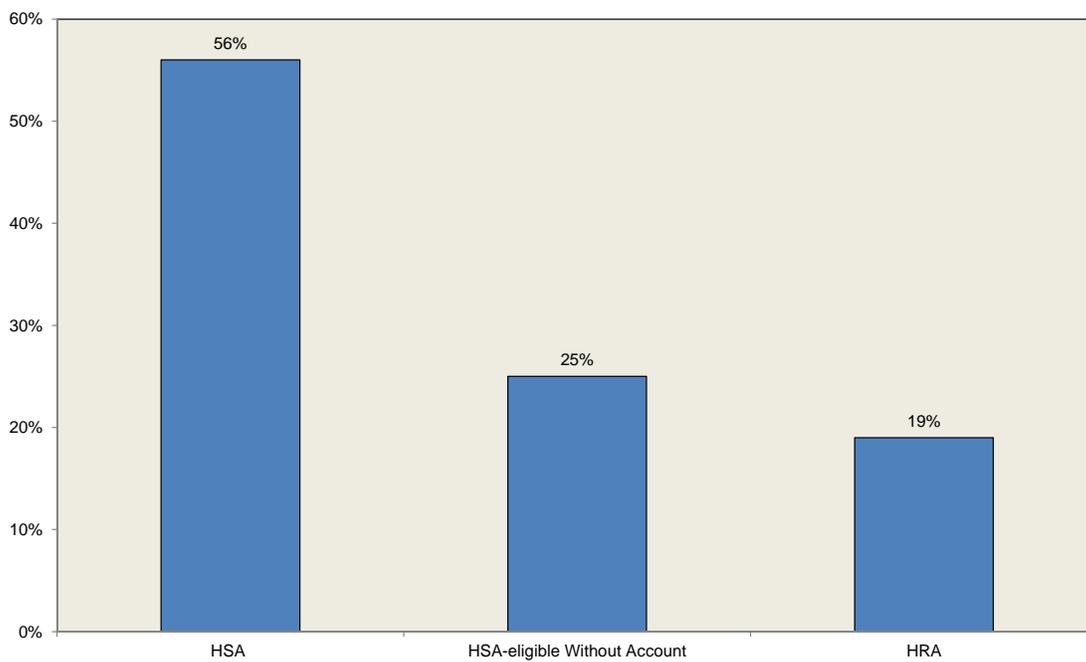
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015–2016.

^a Traditional = health plan with no deductible or <\$1,300 (individual), <\$2,600 (family) in 2016.

^b HDHP = High-deductible health plan with deductible \$1,300+ (individual), \$2,600+ (family), not HSA-eligible in 2016.

^c CDHP = Consumer-driven health plan with deductible \$1,300+ (individual), \$2,600+ (family), with HRA, HSA, or HSA-eligible in 2016.

Figure 3
HSA and HRA Enrollment Rates, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.

The National Health Interview Survey (NHIS) also collects information on both the group and individual markets. It found that 15.2 percent of individuals with private insurance were covered by an HSA-eligible health plan or HRA-based plan in early 2016, while 24 percent were covered by an HDHP (without an HSA).¹⁰ The NHIS estimates were much higher than the AHIP estimates, but NHIS included HRA-based plans and also includes individuals with HDHPs that were not in HSA-eligible health plans. The CEHCS is unique in that it looks at both the individual and group markets. Further, it looks at the unique attributes of individuals in a health plan with and without an associated account.

Length of Time in CDHPs is Increasing

As expected, the CEHCS found that CDHP enrollees have been in their plans a shorter time period than those enrolled in traditional coverage, but that has been shifting. Among individuals with traditional coverage, 19 percent said they have been in their plan for three to four years and 35 percent for five or more years (Figure 4). This compared with 31 percent and 27 percent, respectively, among people in a CDHP. While still lower than the percentage of individuals with traditional coverage, the number of people with a CDHP and the length of time they have been enrolled in a CDHP have been increasing. In 2016, 31 percent of CDHP enrollees reported that they have been in the health plan three to four years, up from 21 percent in 2014 (Figure 5). This may indicate that those in a CDHP are sticking with these types of plans once they have enrolled.

CDHPs Offered as a Choice of Several Health Plans

The survey found individuals enrolled in CDHPs were more likely than those enrolled in HDHPs or with traditional coverage to report that they had a choice of health plans. Two-thirds of CDHP enrollees had a choice of health plan, compared with 49 percent among HDHP enrollees and 50 percent among traditional plan enrollees (Figure 6). One-third (31 percent) of CDHP enrollees had a choice of three or more plans, compared with 27 percent among traditional and 23 percent among HDHP enrollees. Furthermore, 30 percent of CDHP enrollees said they had a choice of two plans, compared with 24 percent among HDHP enrollees and 19 percent among traditional plan enrollees.

Availability of CDHPs Has Increased

Among individuals with traditional coverage, the availability of CDHPs has increased. Thirty percent reported that they were offered a CDHP by their employer in 2016, up from 20 percent in 2015 (Figure 7). Note that the percentage of respondents reporting that they did not know if they were offered either a CDHP or HDHP fell, but remained relatively high at 28 percent. This indicates that more individuals may have had access to CDHPs but did not know it. This may be an opportunity for employers and insurers to provide more educational tools and resources to engage individuals in their choice of health plan.

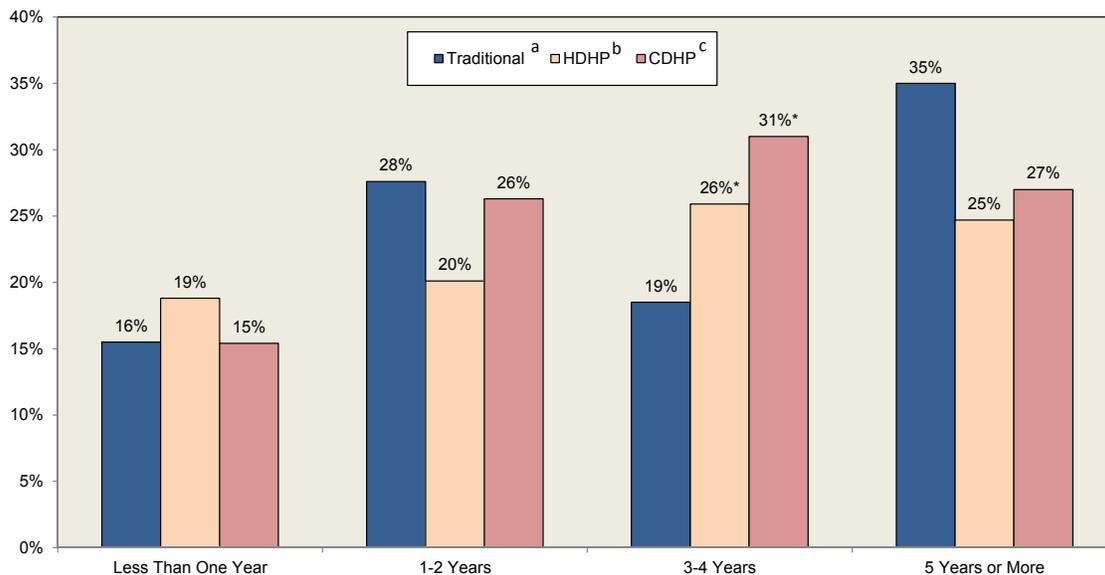
Employer Contributions to CDHPs Have Increased

The percentage of individuals enrolled in a CDHP with an employer contribution towards their HSA or HRA has been increasing. Nearly 4 in 5 (78 percent) of CDHP enrollees reported that their employer contributed to the account in 2016, up from 67 percent in 2014 (Figure 8). Furthermore, employer contribution levels have been increasing. In 2016, 20 percent of CDHP enrollees reported an employer contribution of at least \$2,000, up from 10 percent in 2014 (Figure 9). Similarly, 42 percent reported an employer contribution of \$1,000–\$1,999 in 2016, up from 36 percent in 2014.

CDHPs are Increasingly Familiar, Even to Those Not Enrolled

The survey found that most people with a CDHP were familiar with it. Over two-thirds (70 percent) of those with a CDHP were extremely, very, or somewhat familiar with it (Figure 10). In contrast, 40 percent of individuals with traditional coverage were extremely, very, or somewhat familiar with a CDHP, and 44 percent of individuals with an HDHP were familiar with a CDHP. Familiarity with CDHPs has increased over time. For example, in 2014, 64 percent of CDHP enrollees, 30 percent of HDHP enrollees, and 34 percent of traditional plan enrollees reported they were familiar with CDHPs.

Figure 4
Number of Years Covered by Current Health Plan,
by Type of Health Plan, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.

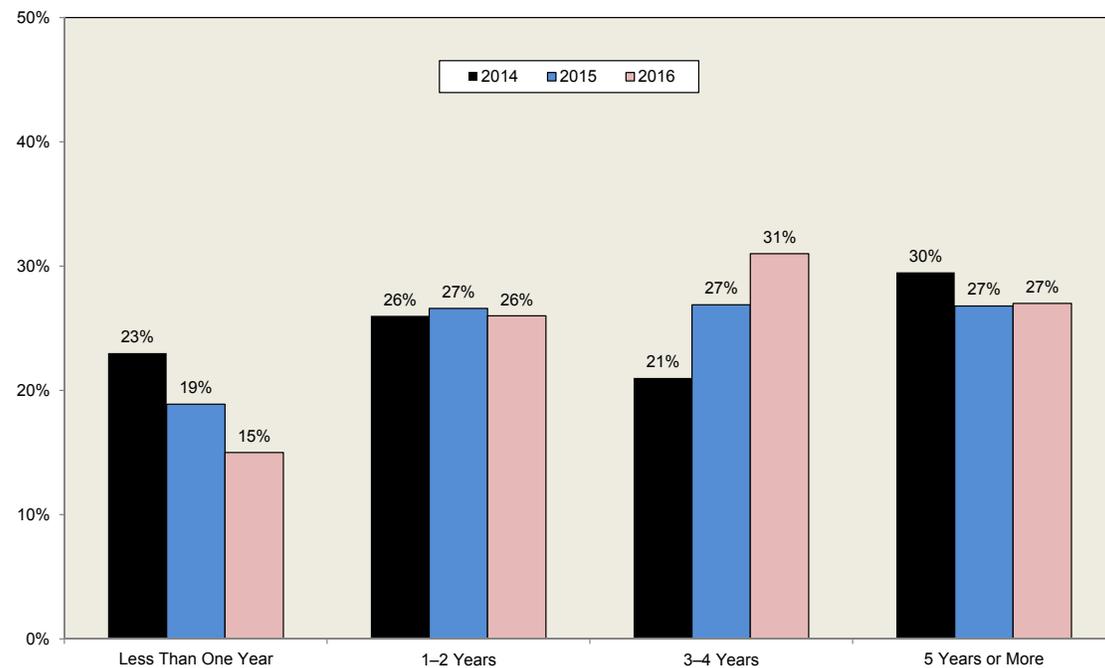
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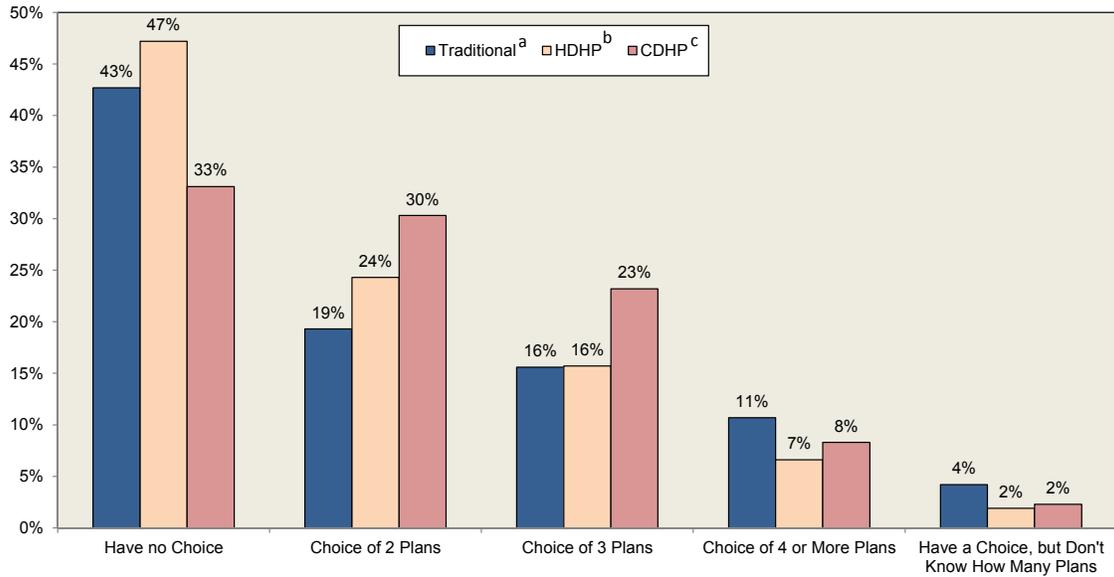
* Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 5
Length of Time With CDHP, 2014–2016



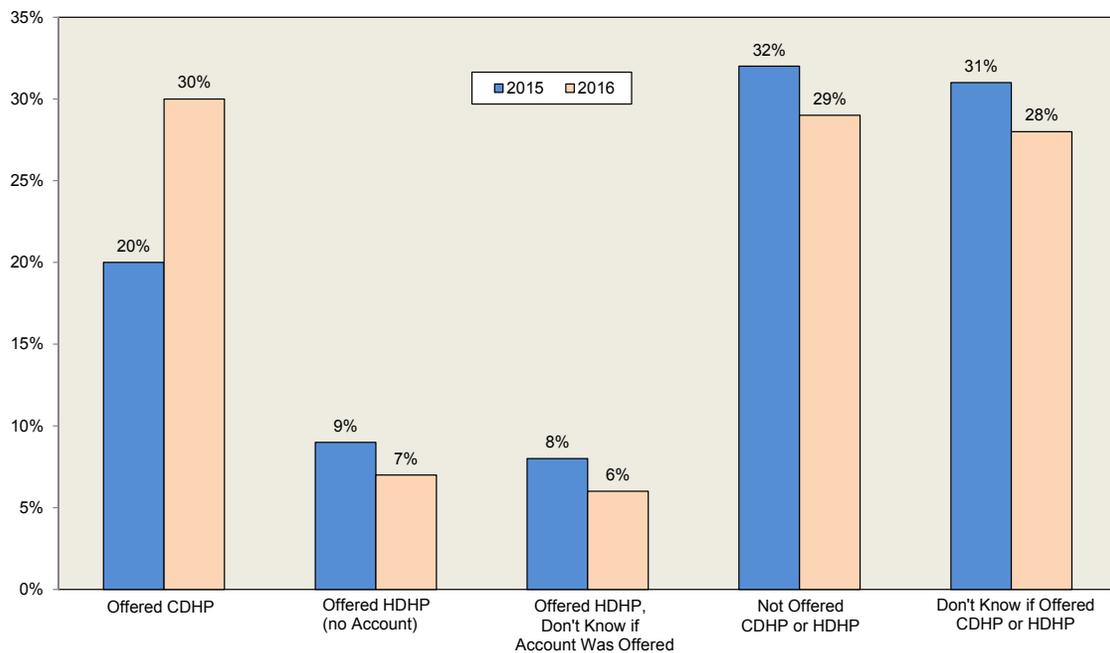
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014–2016.

Figure 6
Choice of Health Plans, by Type of Health Plan, 2016
(Among Individuals With Employment-based Coverage)



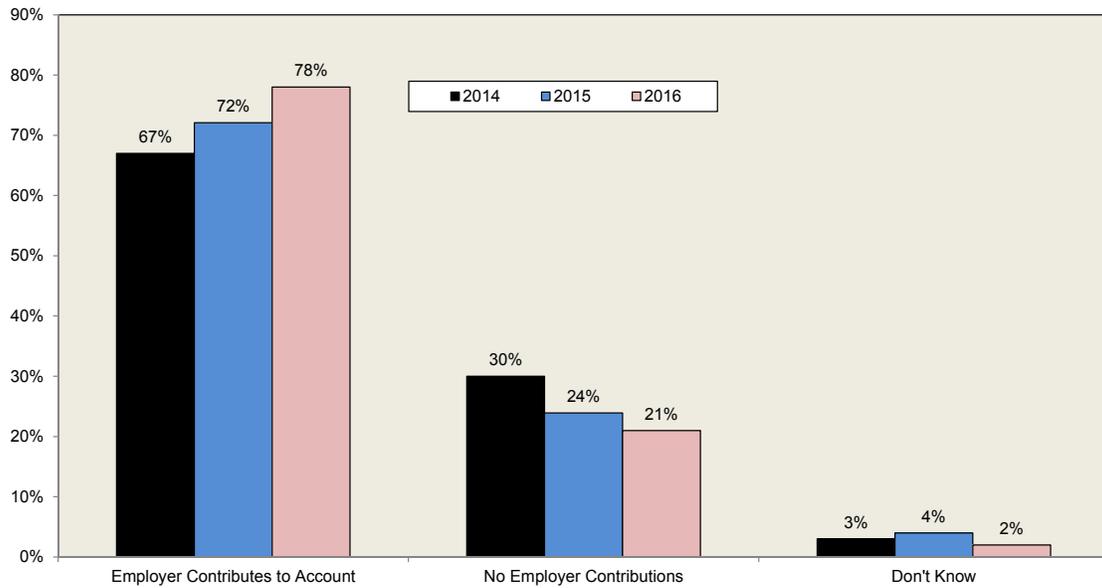
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^c CDHP = Consumer-driven health plan with deductible \$1,300+ (individual), \$2,600+ (family), with HRA, HSA, or HSA-eligible in 2016.

Figure 7
Availability of CDHP or HDHP, Among Individuals With
Employment-based Coverage and Choice of Plans, 2015–2016



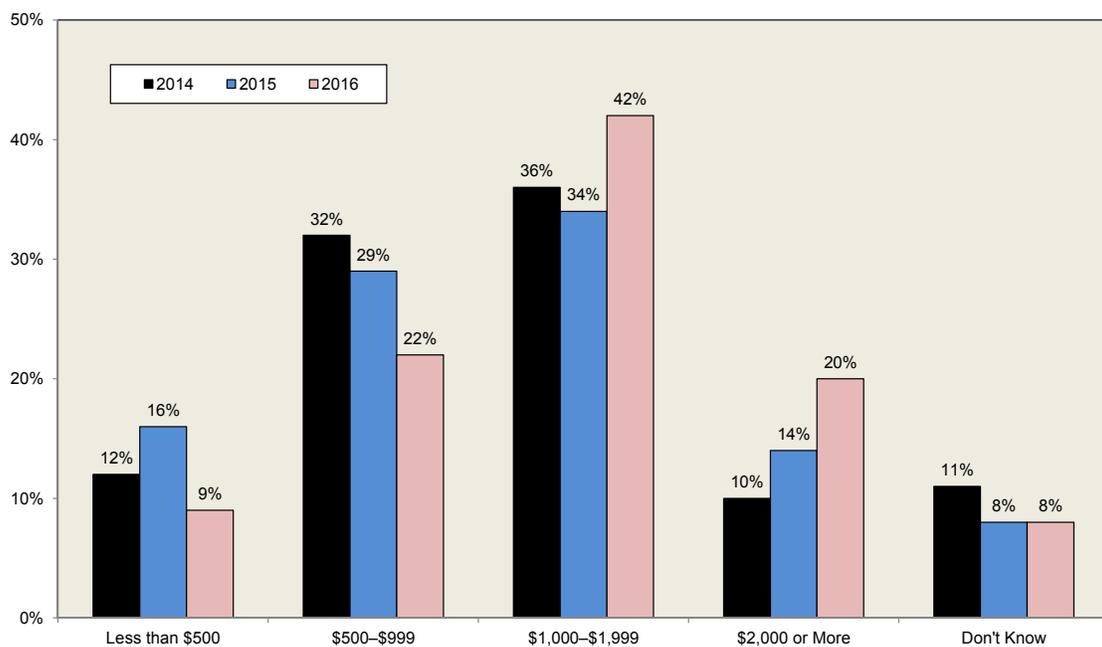
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2015–2016.

Figure 8
Percentage of Individuals With Employer Contribution
to HRA or HSA, Among People With Employment-based
Health Benefits and CDHP, 2014–2016



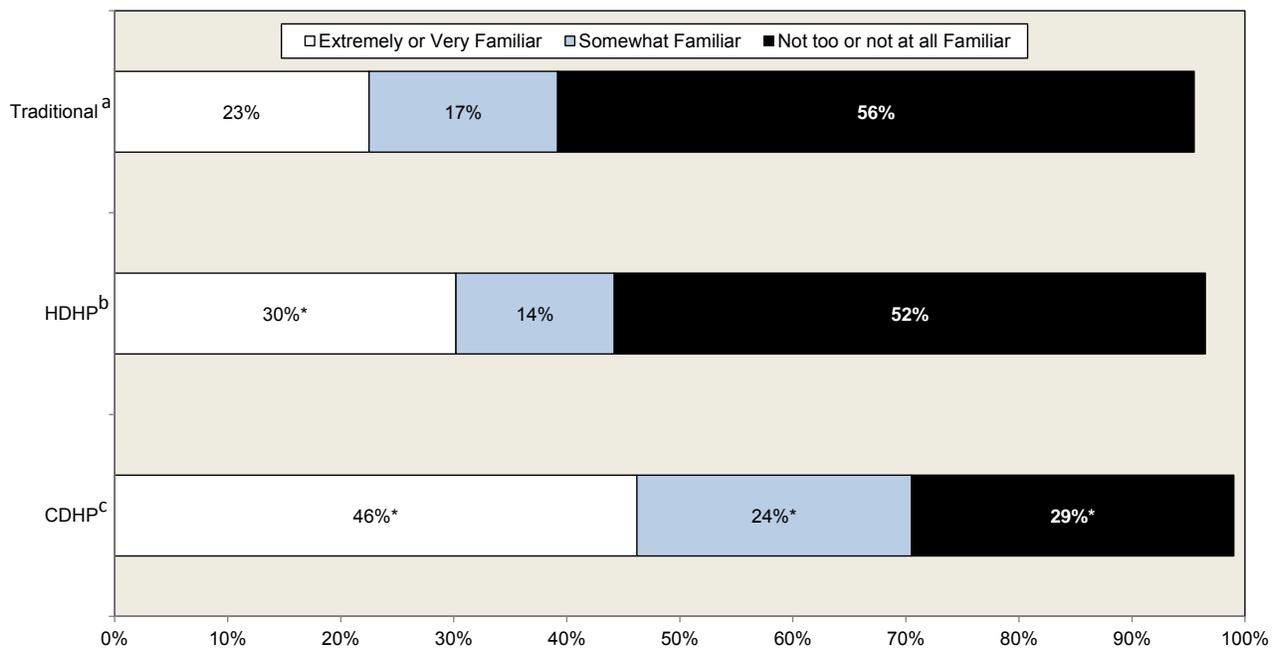
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014–2016.

Figure 9
Employer Contributions to Account, 2014–2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014–2016.

Figure 10
Familiarity With Consumer-driven Health Plans, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.
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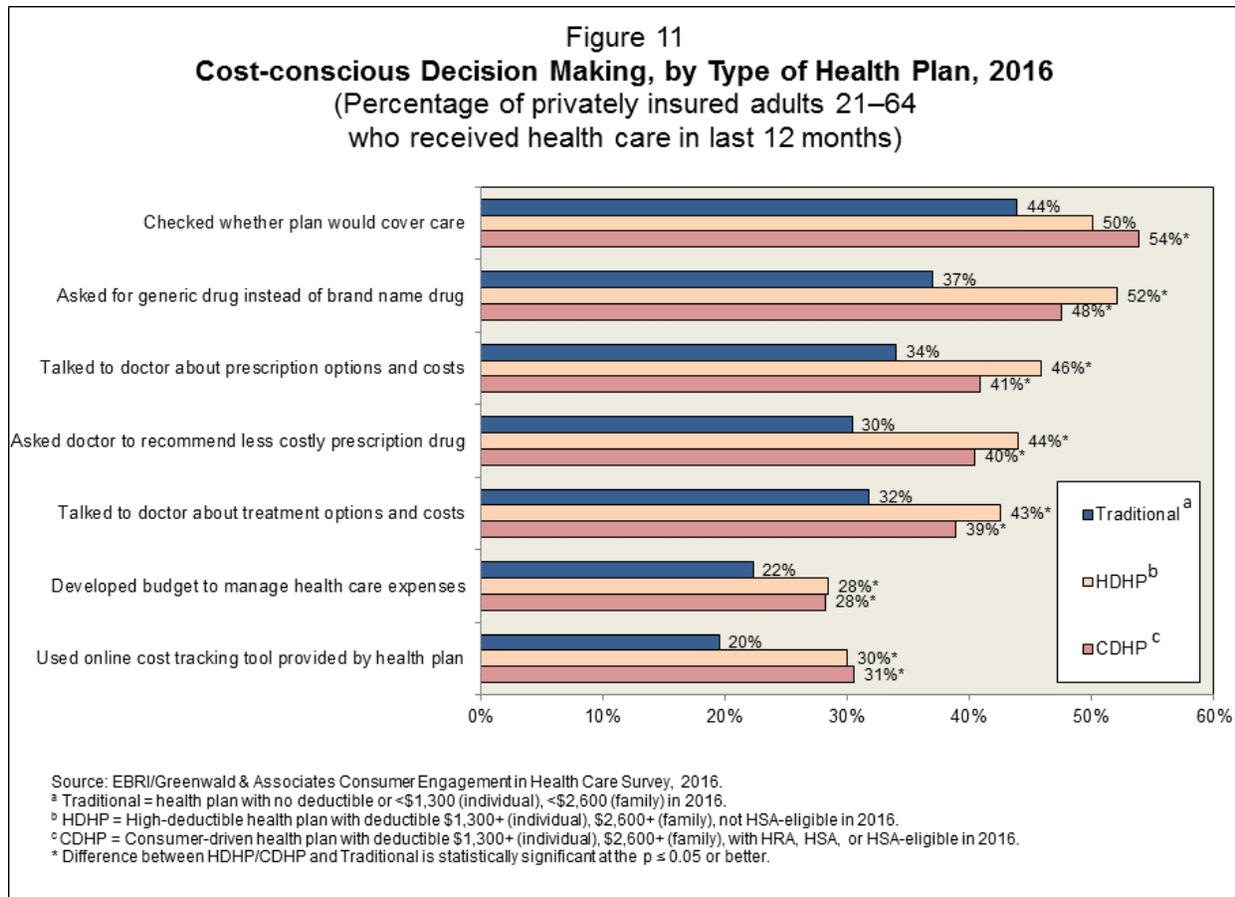
CDHP and HDHP Enrollees Have More Cost-Conscious Behaviors

The theory behind CDHPs and HDHPs is that the cost-sharing structure is a tool that will be more likely to engage individuals in their health care, compared with people enrolled in more traditional coverage. This study found evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors. Specifically, among privately insured adults ages 21–64 who received health care in the past 12 months, those in a CDHP were more likely than those with traditional coverage to say that they had checked whether the plan would cover care (54 percent CDHP vs. 44 percent traditional); asked for a generic drug instead of a brand name (48 percent CDHP and 52 percent HDHP vs. 37 percent traditional); talked to their doctors about prescription options and costs (41 percent CDHP and 46 percent HDHP vs. 34 percent traditional); asked a doctor to recommend less costly prescriptions (40 percent CDHP and 44 percent HDHP vs. 30 percent traditional); talked to their doctors about other treatment options and costs (39 percent CDHP and 43 percent HDHP vs. 32 percent traditional); developed a budget to manage health care expenses (28 percent CDHP and 28 percent HDHP vs. 22 percent traditional); and that they had used an online cost-tracking tool provided by the health plan (31 percent CDHP and 30 percent HDHP vs. 20 percent traditional) (Figure 11).

CDHP and HDHP Enrollment Associated With Higher Likelihood that Individuals Look for Cost Information

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

The survey asked if participants tried to find the cost of health care services before getting care and found that CDHP enrollees and HDHP enrollees were more likely than traditional-plan enrollees to report that they tried to find cost information (Figure 12). However, plan type had no impact on whether enrollees actually had found information from various sources: CDHP, HDHP and traditional-plan enrollees were equally likely to say they had found information from various sources.

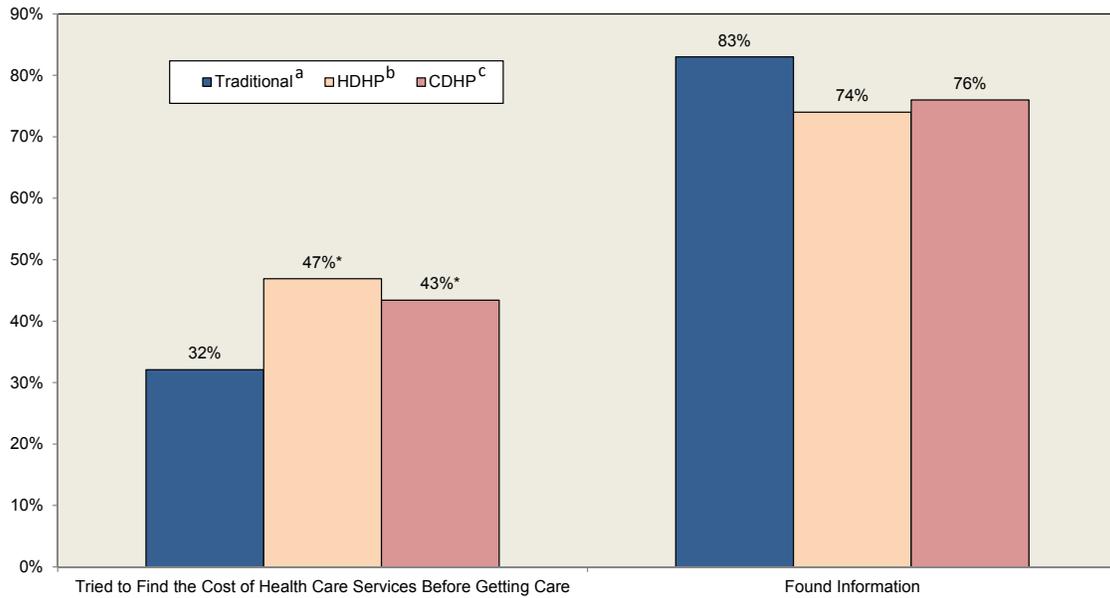


CDHP Enrollees Report Higher Rates of Wellness Program Availability and Participation

Employers offer a number of different types of wellness benefits—programs designed to promote health and to prevent disease. The 2016 CEHCS examined availability and participation in three types of wellness programs: a health-risk assessment, a health-promotion program to address a specific health issue, and a biometric screening. A health risk assessment is a questionnaire filled out by the enrollee and then examined by a medical professional to identify any conditions an enrollee may have or that they might be at risk for developing. Health promotion programs are used to improve enrollees’ health, through a combination of weight loss, walking or other exercise, nutrition, stress management, smoking cessation, and other programs. Biometric screenings collect blood work to determine an enrollee’s health status through blood pressure, cholesterol, weight, height, and other potential measures.

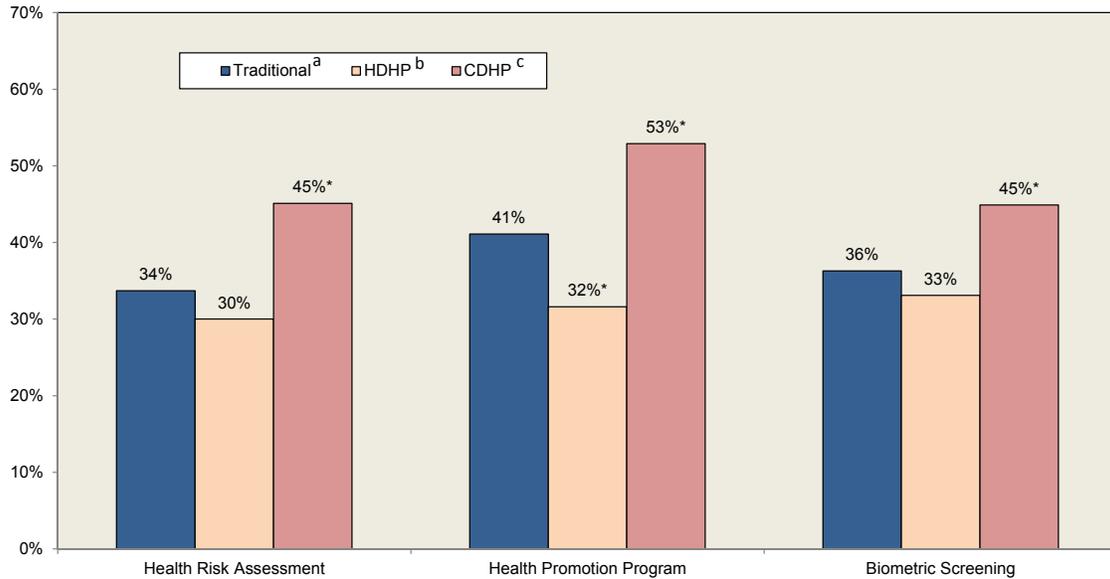
The survey found that CDHP enrollees were more likely than traditional-plan enrollees to report that they had the option to participate in all three types of wellness programs. Specifically, 45 percent of CDHP enrollees reported that their employer offered a health risk assessment, compared with 34 percent of traditional-plan enrollees and 30 percent of HDHP enrollees (Figure 13). When asked about the availability of health-promotion programs, 53 percent of CDHP enrollees, 32 percent of HDHP enrollees, and 41 percent of traditional-plan enrollees reported that their employer offered such a program. When asked about biometric-screening programs, 45 percent of CDHP enrollees reported that their employer offered such a program, compared with 36 percent among traditional-plan enrollees and 33 percent among HDHP enrollees.

Figure 12
Availability and Use of Cost Information, 2016



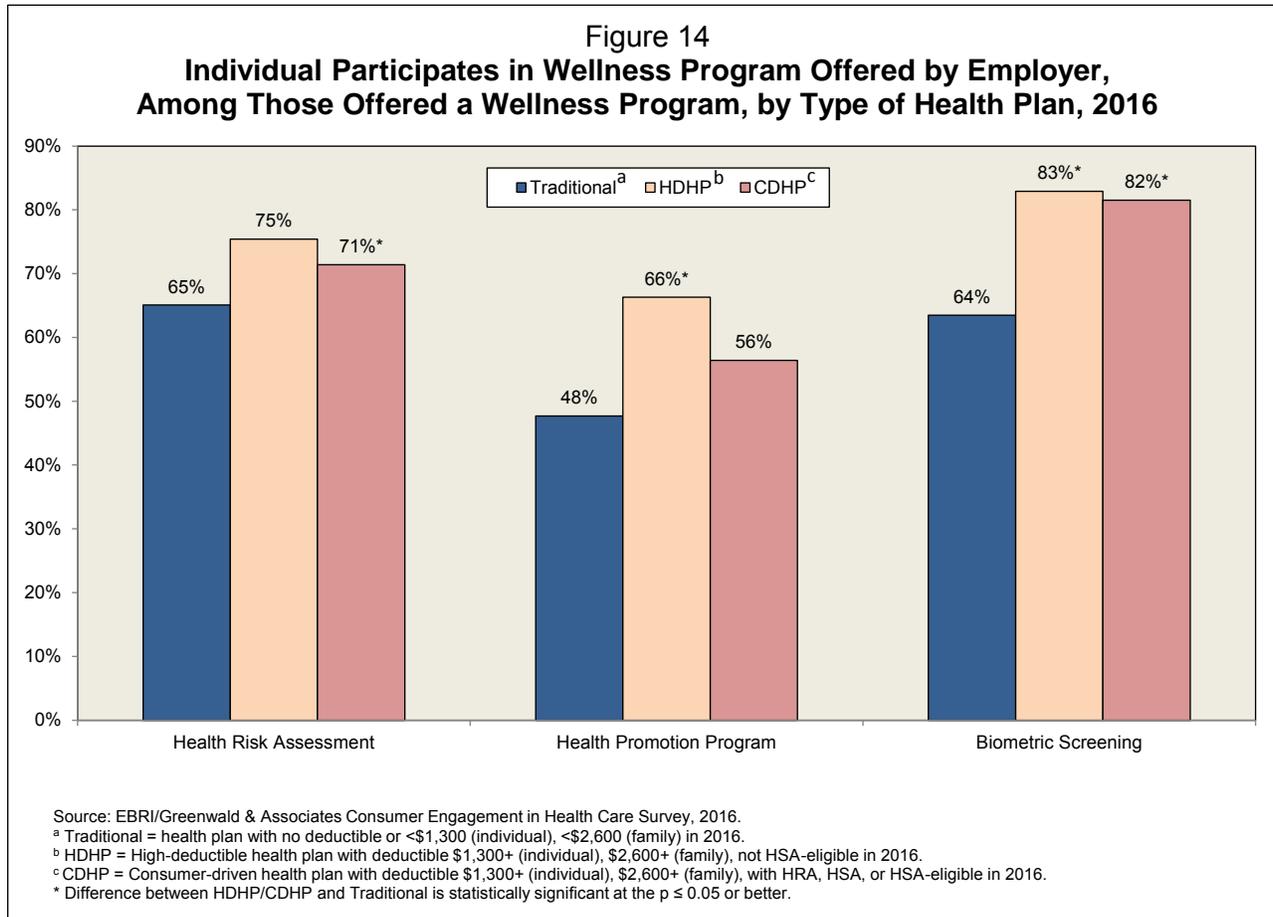
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 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 13
Employer Offers Wellness Program, by Type of Health Plan, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.
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 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

CDHP enrollees were more likely than traditional-plan enrollees to participate in biometric screenings. Just over 70 percent of CDHP enrollees said they participated in a health-risk assessment, compared with 65 percent of traditional-plan enrollees (Figure 14). Over 80 percent of CDHP enrollees reported they participated in a biometric screening, compared with 64 percent of traditional-plan enrollees. HDHP enrollees were also more likely than traditional-plan enrollees to report that they had participated in biometric screening program (83 percent HDHP vs. 64 percent traditional) or health promotion program (66 percent HDHP vs. 48 percent traditional).



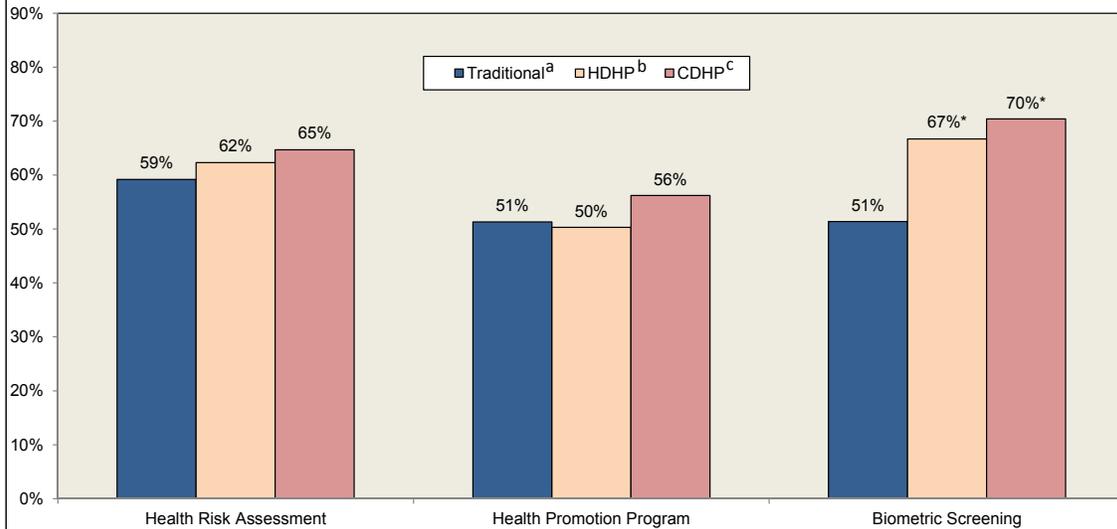
CDHP and HDHP enrollees were also more likely than traditional-plan enrollees to report that their employer offered a cash incentive or reward for participating in a biometric screening program. Seventy percent of CDHP and 67 percent of HDHP enrollees reported a cash incentive or reward for a biometric screening, compared with 51 percent among traditional-plan enrollees (Figure 15). Among the top reasons enrollees reported participating in an employer’s wellness program were because they were offered incentive prizes, to reduce premiums, and to maintain and improve health (Figure 16). There were few differences by type of health plan.

While these numbers represent self-reported awareness of available health and wellness programs and cannot be cross-referenced with objective data from employers and insurers, it is significant that, across the board, CDHP enrollees are aware and participate at higher rates in wellness programs. It would be helpful in future research to find the roots of this engagement, as plan sponsors experiment with financial, measurement and communication strategies to support wellness behaviors.

Use of Online Portals Increasing for Enrollees in All Plan Types

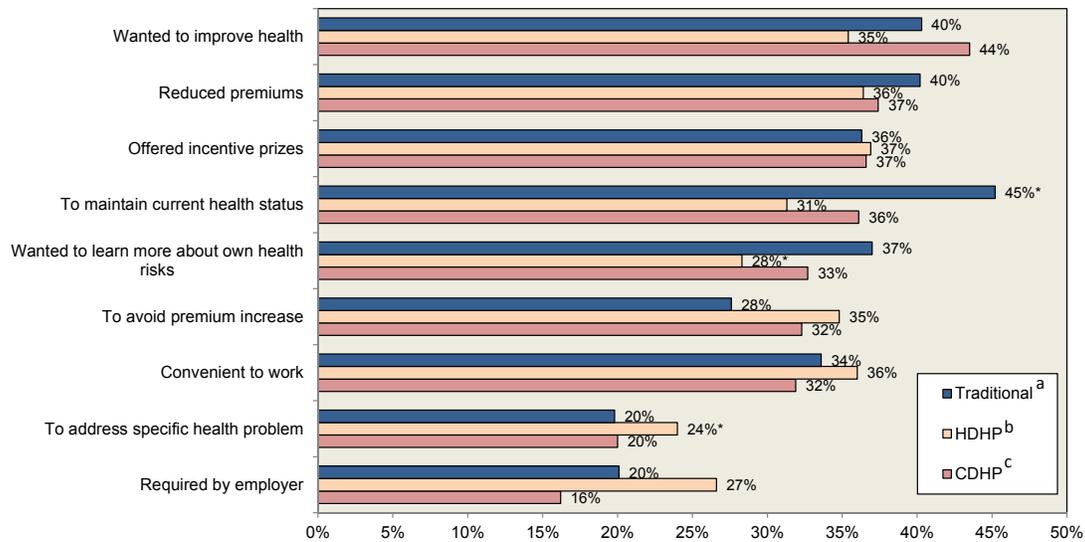
In 2016, the CEHCS added a series of questions about the use of online portals. The survey found that, regardless of plan type, most people used an online portal provided either by their primary care provider (Figure 17), their employer (Figure 18), or their health plans (Figure 19). CDHP enrollees were more likely than traditional plan enrollees to use a portal provided by their health plan.

Figure 15
Employer Offers Cash Incentive or Reward for Participating in Wellness Program, Among Workers Whose Employer Offers Wellness Program, by Type of Plan, 2016



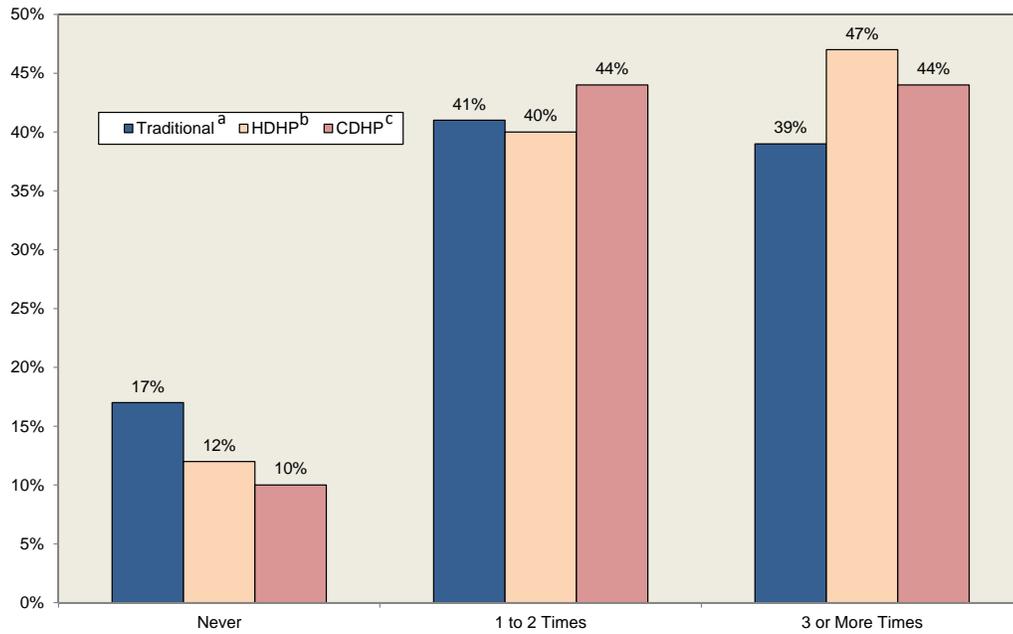
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.
^a Traditional = health plan with no deductible or <\$1,300 (individual), <\$2,600 (family) in 2016.
^b HDHP = High-deductible health plan with deductible \$1,300+ (individual), \$2,600+ (family), not HSA-eligible in 2016.
^c CDHP = Consumer-driven health plan with deductible \$1,300+ (individual), \$2,600+ (family), with HRA, HSA, or HSA-eligible in 2016.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 16
Reasons for Participating in Employer's Wellness Program, by Plan Type, 2016



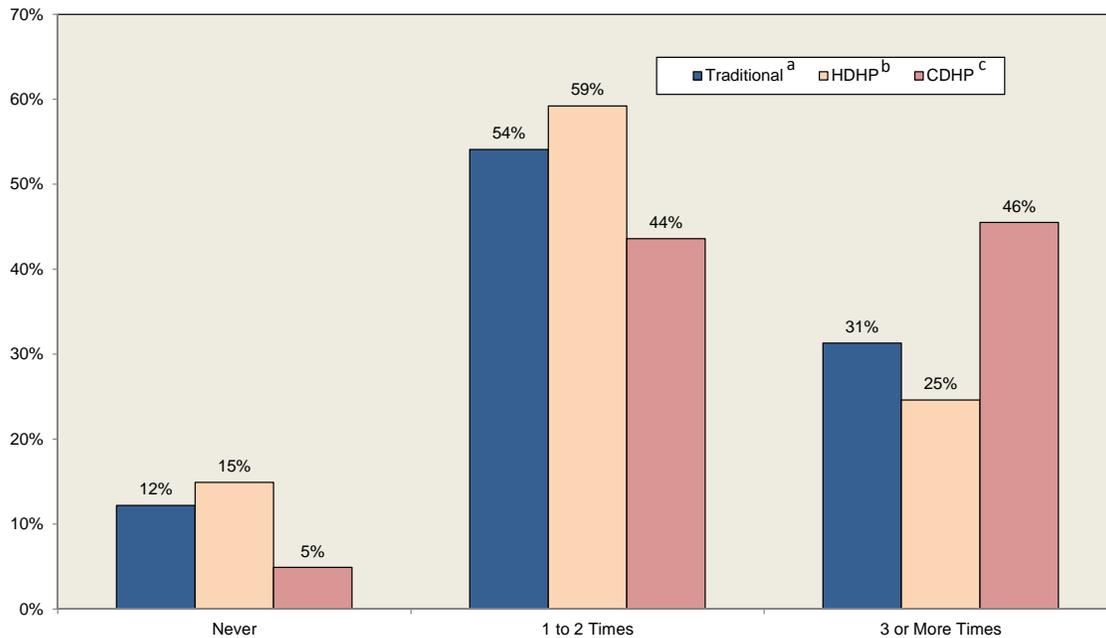
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.
^a Traditional = health plan with no deductible or <\$1,300 (individual), <\$2,600 (family) in 2016.
^b HDHP = High-deductible health plan with deductible \$1,300+ (individual), \$2,600+ (family), not HSA-eligible in 2016.
^c CDHP = Consumer-driven health plan with deductible \$1,300+ (individual), \$2,600+ (family), with HRA, HSA, or HSA-eligible in 2016.
 * Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

Figure 17
Use of Primary Care Provider's Health Care Portal, by Plan Type, 2016



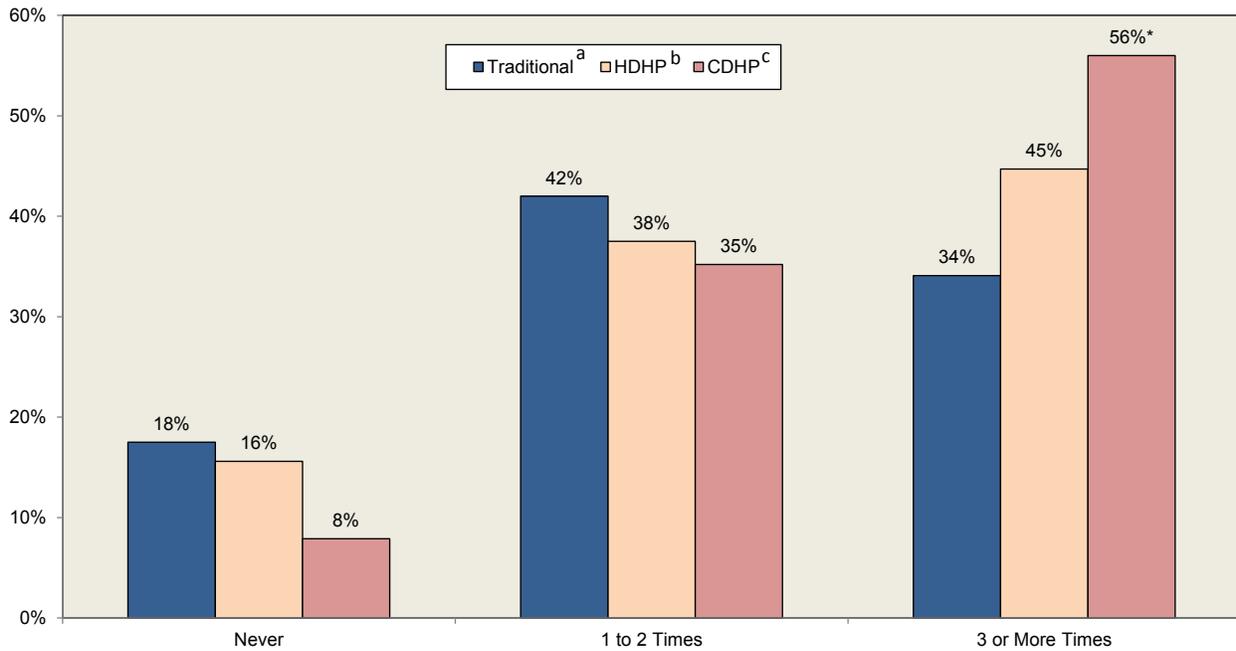
Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.
^a Traditional = health plan with no deductible or <\$1,300 (individual), <\$2,600 (family) in 2016.
^b HDHP = High-deductible health plan with deductible \$1,300+ (individual), \$2,600+ (family), not HSA-eligible in 2016.
^c CDHP = Consumer-driven health plan with deductible \$1,300+ (individual), \$2,600+ (family), with HRA, HSA, or HSA-eligible in 2016.

Figure 18
Use of Employer's Online Benefits Portal, by Type of Health Plan, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.
^a Traditional = health plan with no deductible or <\$1,300 (individual), <\$2,600 (family) in 2016.
^b HDHP = High-deductible health plan with deductible \$1,300+ (individual), \$2,600+ (family), not HSA-eligible in 2016.
^c CDHP = Consumer-driven health plan with deductible \$1,300+ (individual), \$2,600+ (family), with HRA, HSA, or HSA-eligible in 2016.

Figure 19
Use of Health Plan's Online Benefits Portal,
by Type of Health Plan, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.

^a Traditional = health plan with no deductible or <\$1,300 (individual), <\$2,600 (family) in 2016.

^b HDHP = High-deductible health plan with deductible \$1,300+ (individual), \$2,600+ (family), not HSA-eligible in 2016.

^c CDHP = Consumer-driven health plan with deductible \$1,300+ (individual), \$2,600+ (family), with HRA, HSA, or HSA-eligible in 2016.

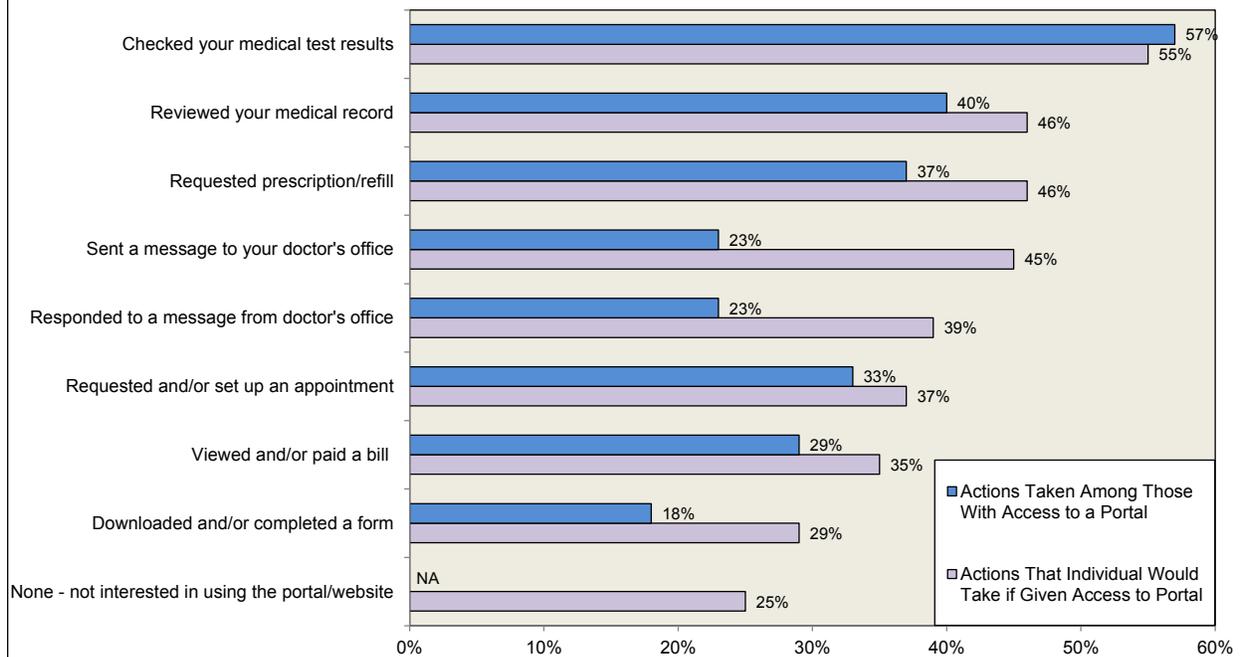
* Difference between HDHP/CDHP and Traditional is statistically significant at the $p \leq 0.05$ or better.

There are a number of things individuals are using or would use the various portals for. For the health care portal offered through a primary care physician, over one-half (57 percent) of those with a portal said they use it to check medical test results, while 55 percent without access to such a portal said they would use it to check medical test results if such a portal was available (Figure 20). Otherwise, the portal was being used to review medical records, request prescriptions, messaging with the doctor, and for appointment and billing by between 23 percent and 40 percent of portal users. Among those without access to such a portal, between 35 percent and 46 percent reported they were interested in using it for these activities.

Similarly, among individuals that have used their employer portal, the top reasons for using it included enrolling in benefits during open enrollment, looking for information about coverage, and updating personal information (Figure 21). Similarly, among individuals without access to an employer portal, the top reasons for using the portal also would be to enroll in benefits, look for information about health care coverage, and to update personal information as well as to view pay stubs.

When it came to a portal provided by the health plan, the top reasons for using the portal among those with access to one included looking for providers in the plan's network, looking for information about coverage, and checking the status of deductibles (Figure 22). These were the same top reasons individuals say they would use such a portal for if they had access to one. Note that 41 percent of individuals without access to such a portal reported that they were not interested in using such a portal; this may suggest that these individuals would prefer other vehicles of communications.

Figure 20
Actions Taken Among Individuals With Access to a Health Care Portal Through a Primary Care Physician and Actions that Individuals Would Take if Given Access to a Portal, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.

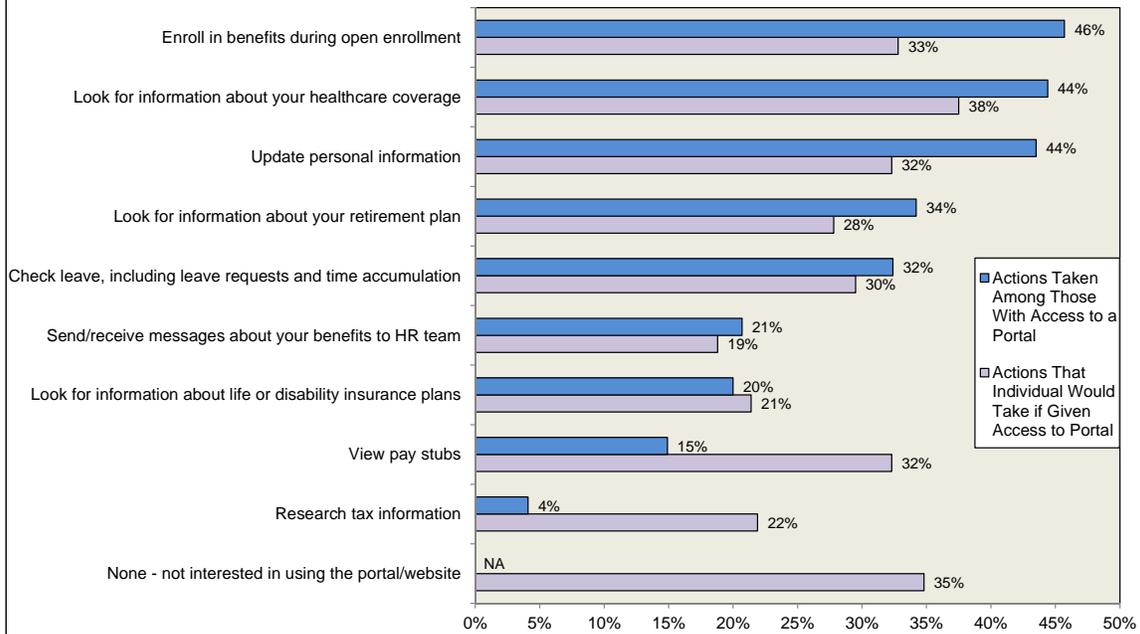
Conclusion

The 2016 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS) found 14 percent of the population was enrolled in a CDHP and 14 percent was enrolled in an HDHP, a slight increase for both since 2015. Availability of CDHPs also increased among individuals with traditional coverage.

The 2016 CEHCS found that CDHP enrollees were more likely than HDHP and traditional plan enrollees to have a choice of health plan. It also found that the percentage of individuals reporting that their employer contributed to either an HRA or HSA had increased and that the contribution amounts had increased as well. Employers may have determined that they needed to contribute to the account and that they needed to contribute more than they had in the past in order for CDHPs to be a viable choice for workers when they were offered a choice of health plan.

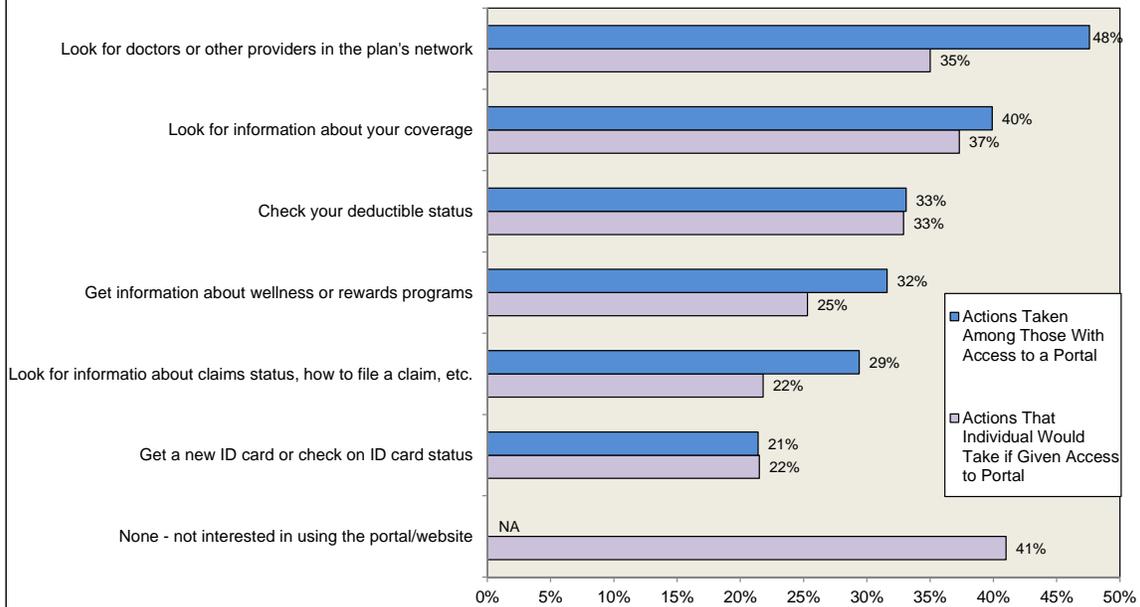
The 2016 CEHCS found that high deductibles were influencing new behaviors often encouraged by employers and insurers. CDHP enrollees and HDHP enrollees were more likely than traditional-plan enrollees to report that they tried to find cost information. They were also more likely to participate in wellness programs.

Figure 21
Actions Taken Among Individuals With Access to an Employer Portal and Actions that Individuals Would Take if Given Access to a Portal, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.

Figure 22
Actions Taken Among Individuals With Access to a Health Plan Portal and Actions that Individuals Would Take if Given Access to a Portal, 2016



Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2016.

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2016 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS), an online survey that examines issues surrounding consumer-driven health care, including the cost of insurance, the cost of care, satisfaction with health care, satisfaction with health care plans, reasons for choosing a plan, and sources of health information. This *Issue Brief* also presented findings from the 2014–2015 CEHCS. The 2016 CEHCS was conducted within the United States between Aug. 11 and Aug. 24, 2016, through a 13-minute internet survey. The national or base sample was drawn from Ipsos' online panel of internet users who have agreed to participate in research surveys. Over 2,000 adults ages 21–64 who had health insurance through an employer, purchased directly from a carrier, or purchased through a government exchange were drawn randomly from the Ipsos sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 56 percent. As a non-probability sample, traditional survey margin-of-error estimates do not apply. However, had the survey used a probability sample, the margin of error for the national sample would have been ± 2.2 percent.

To examine the issues mentioned above, the sample was divided into three groups: those with a consumer-driven health plan (CDHP), those with a high-deductible health plan (HDHP), and those with traditional health coverage. Individuals were assigned to the CDHP and HDHP groups if they had a deductible of at least \$1,300 for individual coverage or \$2,600 for family coverage. To be assigned to the CDHP group, they must also have been eligible to contribute to an HSA or had a health reimbursement arrangement (HRA) with a rollover provision that they could use to pay for medical expenses or the ability to take their account with them should they change jobs. Individuals with only a flexible spending account (FSA) were not included in the CDHP group.

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

Because the base sample (national sample) included only 288 individuals in a CDHP and 321 individuals with an HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 818 individuals with a CDHP and 482 individuals with an HDHP, resulting in a total sample (base plus oversample) of 1,106 for the CDHP group and 803 for the HDHP group. After factoring out the base sample—the 288 individuals with a CDHP and the 321 individuals with an HDHP—there were 1,386 individuals in the sample with traditional health coverage.

In addition to being stratified, the base sample was also weighted by gender, age, education, region, income, and race/ethnicity to reflect the actual proportions in the population ages 21–64 with private health-insurance coverage.¹¹ The CDHP and HDHP oversamples were weighted by gender, age, income and race/ethnicity, using the demographic profile of the CDHP and HDHP respondents to the omnibus survey described below.

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

Definitions

Consumer-Driven Health Plans (CDHPs)

CDHPs refer to health plans that have a deductible of at least \$1,300 for individual coverage and \$2,600 for family coverage in 2016, and include either a health savings account (HSA)-eligible health plan, with or without the HSA, or a health reimbursement arrangement (HRA), described in more detail below.

Health Savings Accounts

A health savings account (HSA) is a tax-exempt trust or custodial account that is funded with contributions and assets that an individual can use to pay for health care expenses. Individuals can contribute to an HSA only if they are enrolled in an HSA-eligible health plan. Contributions to the account are deductible from taxable income, an employer's contributions to the account are excludable from the employee's gross income, and distributions for qualified medical expenses from the HSA are excluded from taxable income to the employee. Tax-free distributions are also allowed for certain premium payments (see below). Any interest or other capital earnings on assets in the account build up tax free. Finally, HSAs are always funded.

Eligibility—An individual who is covered by an HSA-eligible health plan may (but is not required to) open and make contributions to an HSA. To be an HSA-eligible health plan for 2016, the plan must have had an annual deductible of at least \$1,300 for individual coverage and \$2,600 for family coverage, and the plan's out-of-pocket maximum may not exceed \$6,550 for individual coverage or \$13,100 for family coverage with the deductible counting toward this limit. (These minimum allowable deductibles and maximum out-of-pocket limits are indexed to inflation.) Certain primary preventive services—typically those deemed to prevent the onset of disease—can be and often are exempt from the deductible and covered in full. (These preventive services are in addition to those preventive services that the ACA requires be covered in full.) Otherwise, all health care services must be subject to the HSA's deductible.

Additional HSA contribution requirements are that (i) an individual may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also an HSA-eligible health plan, (ii) an individual may not be claimed as a dependent on another person's tax return, and (iii) an individual may not be enrolled in Medicare. Notwithstanding these requirements, an individual is not precluded from making HSA contributions merely because he or she has supplemental coverage with deductibles below the statutory HSA-eligible health plan minimum for such things as vision care, dental care, certain specific diseases, and insurance that pays a fixed amount per day (or other stipulated period) for hospitalization.

Contributions—Individuals and employers are allowed to contribute to HSAs. As noted above, contributions are excluded from gross income if the employer makes them, and deductible from taxable income if the individual account owner makes them.

For 2016, a worker with individual coverage is allowed to make an annual HSA contribution of \$3,350, while a worker with family coverage could contribute as much as \$6,750. These dollar limits are indexed for inflation. Additionally, individuals who have reached age 55 and are not yet enrolled in Medicare may make an additional \$1,000 catch-up contribution. The catch-up contribution is not currently indexed to inflation.

If an employer does make contributions to an HSA, the contributions must be the same dollar amount or the same percentage of the deductible for all employees.

Contributions and related assets can be invested in the same investment vehicles that have been approved for IRAs—i.e., bank accounts, stocks, bonds, and mutual funds. HSA custodians may require that the cash balance of the HSA meet and maintain a minimum balance in order to invest in equities.

Distributions—An individual may take distributions from an HSA at any time. The individual need not be covered by an HSA-eligible health plan at the same time the individual withdraws money from the HSA. Distributions are generally treated as taxable income, but they are excluded from an individual's taxable income if they are used to

pay for qualified medical expenses. Distributions for premiums for COBRA coverage, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare (other than for Medigap) are also tax free.

HSA distributions for nonqualified medical expenses are not excludable from gross income and, in addition, are subject to a 20 percent penalty, which is waived if the HSA owner dies, becomes disabled, or is eligible for Medicare.

Individuals are able to transfer funds from one HSA to another without subjecting the distribution to income and penalty taxes as long as the transfer occurs within 60 days of the date funds are received.

Health Reimbursement Arrangements

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

Employees are eligible for an HRA only when their employer offers such a health plan. Unlike HSAs, HRAs do not have to be funded and can be set up as notional accounts.

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.

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

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

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

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Endnotes

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- ¹ Unpublished EBRI estimates from the March 2016 Current Population Survey.
- ² Calculated from Figure 1.
- ³ More information about HRAs and HSAs can be found in the box on pg. 22 and in Fronstin (2002 and 2004).
- ⁴ See Figure 5 in <http://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html>
- ⁵ See Appendix for more detail on the methodology.
- ⁶ Traditional plans include a broad range of plan types, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), other managed care plans, and plans with a broad variety of cost-sharing arrangements. The shared characteristics of these plans are that they either have no deductibles or deductibles that are below current thresholds that would qualify for tax-preferred HSA contributions.
- ⁷ See Figure 3 in <http://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html>
- ⁸ See Exhibit 5.1 in <http://kff.org/report-section/ehbs-2016-section-five-market-shares-of-health-plans/>
- ⁹ See https://ahip.org/wp-content/uploads/2015/11/HSA_Report.pdf
- ¹⁰ See Figure 11 in <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>
- ¹¹ In theory, a random sample of 2,000 yields a statistical precision of plus or minus 2.2 percentage points (with 95-percent confidence) of what the results would be if the entire population ages 21–64 with private health insurance coverage were surveyed with complete accuracy. There are also other possible sources of error in all surveys that may be more serious than theoretical calculations of sampling error. These include refusals to be interviewed and other forms of nonresponse, the effects of question wording and question order, and screening. While attempts are made to minimize these factors, it is impossible to quantify the errors that may result from them.

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