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Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/ Commonwealth Fund Consumerism in Health Care Survey

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- ***The latest "big idea"—***Promoting consumerism in health care is the latest big idea in health insurance in the United States. One of the leading manifestations of this is the use of high-deductible health plans with savings accounts, such as health savings accounts (HSAs) and health reimbursement arrangements (HRAs), collectively known as consumer-driven health plans (CDHPs). The first EBRI/Commonwealth Fund Consumerism in Health Care Survey was conducted to provide reliable national data on the growth of high deductible plans and their impact on the behavior and attitudes of health care consumers. The study defines high-deductible plans as those that would qualify for federal HSA tax preferences: with deductibles of $1,000 or more for individual plans and $2,000 or more for family plans.
- ***Lower satisfaction with consumer-driven plans***—The EBRI/Commonwealth Fund Consumerism in Health Care Survey—the first national survey of its kind—found that individuals with more comprehensive health insurance were more satisfied with their health plan than individuals in high deductible plans, with or without accounts. Specifically, 63 percent of individuals with comprehensive health insurance were extremely or very satisfied with their health plan, compared with 42 percent of CDHP enrollees and 33 percent of HDHP participants. About 60 percent of individuals with comprehensive insurance reported they were extremely or very likely to stay with their current health plan if they had the opportunity to switch, compared with 46 percent of CDHP enrollees and 30 percent of HDHP enrollees.
- ***Higher out-of-pocket costs—***Despite similar rates of health care use, individuals with CDHPs and HDHPs are significantly more likely to spend a large share of their income on out-of-pocket health care expenses than those in comprehensive health plans. Two-fifths (42 percent) of those in HDHPs and 31 percent of those in CDHPs spent 5 percent or more of their income on out-of pocket costs and premiums in the last year, compared with 12 percent of those in more comprehensive health plans.
- ***More missed health care—***Individuals with CDHPs and HDHPs were significantly more likely to avoid, skip, or delay health care because of costs than were those with more comprehensive health insurance, with problems particularly pronounced among those with health problems or incomes under $50,000. About one-third of individuals in CHDPs (35 percent) and HDHPs (31 percent) reported delaying or avoiding care, compared with 17 percent of those in comprehensive health plans.
- ***More cost-conscious consumers—***Among people in the plans who did receive care, there is evidence that they are more cost-conscious than those in comprehensive health plans. People in the CDHPs and HDHPs were significantly more likely to say that the terms of their health plans made them consider costs when deciding to see a doctor when sick or fill a prescription, to report that they had checked whether their health plan would cover their costs as well as the price of a service prior to receiving care, and to discuss treatment options and the cost of care with their doctors. Nevertheless, they were also more likely to go without care.
- ***Lack of information—***Few health plans of any type provide cost and quality information about providers to help people make informed decisions about their health care. The study also found very low levels of trust in information provided by health plans.

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Introduction

While employment-based health benefits continue to be the most common form of health insurance in the United States, they are slowly becoming less common and less comprehensive. Between 2000 and 2005, overall premiums for health insurance increased a cumulative 73 percent, while worker income increased only 15 percent (calculated from Gabel, et al., 2005).[1] Because the cost of health benefits for workers is increasing much faster than worker income (Gilmer and Kronick, 2005), and because fewer employers are offering health benefits, fewer workers and dependents have employment-based health benefits.[2] When health benefits are offered, workers are noticing changes to their benefits package. Workers are not only contributing more to health insurance premiums but they are also contributing more to the cost of health care services. Deductibles are increasing,[3] copayments for physician office visits and prescription drugs are increasing, and health plans are increasingly more likely to provide incentives for beneficiaries to use generic drugs and/or mail order pharmacy services, and other forms of tiered benefits (Fronstin, 2003).[4]

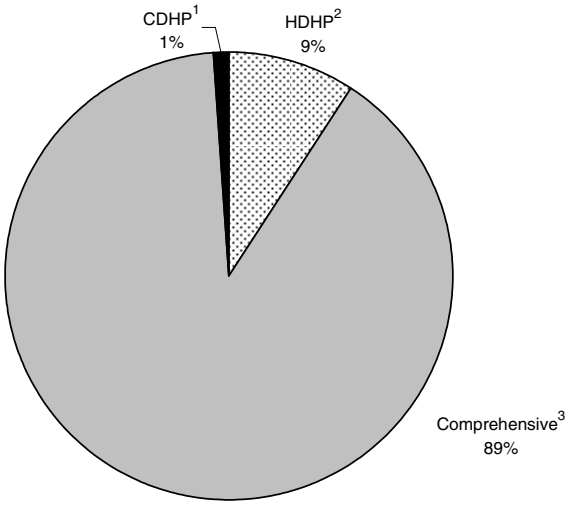
Recently, there has been growing interest among employers to offer health plans with very high deductibles (Fronstin, 2002 and 2004). Health plans with annual deductibles of $1,000 or more for individuals and $2,000 or more for families are becoming more common. These can be combined with one of two kinds of tax-exempt savings accounts: health reimbursement arrangements (HRAs) and health savings accounts (HSAs). Employers and employees can contribute pre-tax income to HSAs, while only employers can contribute to an HRA, and employees can use the balances to pay for medical expenses not covered by their health plans. Unused balances in both accounts can be rolled over at the end of the year, and HSA balances are portable from one employer to another. While some employers offer plans with an HSA, others offer only high deductible plans and allow individuals to contribute to their own HSA (HSA-qualified plans). Employers have been offering HRAs since 2001 and HSAs have been available to anyone with a high-deductible health plan since early 2004. Enrollment in HSA-qualified plans is expected to grow substantially in 2006.[5]

High-deductible health plans, with or without savings accounts, are controversial. Proponents of these plans think that they will encourage individuals to become more astute health care consumers, who make decisions about their health care on the basis of cost and quality information. Critics worry that the high out-of-pocket costs will discourage the use of needed health care services, especially among people with low incomes and/or chronic health conditions. And while most employers are interested in the long-term prospects for improved cost control that high-deductible health plans might provide, whether or not they adopt such a plan, they await evidence that the plans will succeed in controlling costs, and they are also concerned about potential adverse effects on the use of preventive care and other health care services (Davis, et al., 2005; Glied and Remler, 2005). They also fear that employees will consider a move to these plans as a cut in benefits, resulting in increased turnover or low morale.

Methods

This report presents findings from the first EBRI/Commonwealth Fund Consumerism in Health Care Survey. The online survey of privately insured adults ages 21–64 was conducted to provide national data regarding the growth of high-deductible health plans with and without savings accounts and their impact on the behavior and attitudes of health care consumers. The sample was randomly drawn from Harris Poll Online, Harris Interactive's online sample of Internet users who have agreed to participate in research surveys. The base sample was complemented with an over-sample of two groups of adults: 1) those with a high-deductible health plan with either an employer-funded HRA or an employer- and/or employee-funded HSA, and 2) those with a high-deductible health plan without an account but with deductibles high enough to meet the threshold that would qualify them 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. To draw a random sample for surveying, Harris initially stratified by gender, age, and region. The final sample of adults participating in the survey is skewed toward higher-income, more highly educated

Figure 1
Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] Consumer-Driven Health Plan = plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.
[2] High Deductible Health Plan = plan w/ deductible $1000+ (individual), $2000+ (family), no account.
[3] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).
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individuals and also under represents minorities. There was also a low response rate, as is typical of online surveys. (See Appendix for detail on the methodology.)

Despite its limitations, this is the first national survey of individuals with high-deductible health plans who also have savings accounts, or so-called consumer-driven health plans (CDHPs), and people with high-deductible health plans who are eligible to contribute to a health savings account but who currently do not have an account (HDHP). The survey enabled comparisons between people in these plans and adults enrolled in comprehensive health plans. This group includes 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 qualify for HSA tax preference.

Findings

Despite the widespread attention being given to consumerism in health care, the survey finds that as of October 2005, only 1 percent of the privately insured population ages 21–64 were enrolled in consumer-driven health plans—high-deductible health plans combined with an HRA or an HSA, or CDHPs. Another 9 percent were enrolled in high-deductible health plans that are eligible for an HSA, but have not yet opted to open an account. Nearly 90 percent of the privately insured population is in more comprehensive health plans (Figure 1).[6]

The study findings suggest that so far individuals in CDHPs and HDHPs are less satisfied than individuals with comprehensive health insurance with various aspects of their health plan, are less satisfied overall with their health plan, and are less likely to recommend the plan to a friend or work colleague. The survey also found that individuals enrolled in CDHPs and HDHPs are more likely than those with

comprehensive health insurance to avoid or delay needed care. When they do get care there are large financial burdens as compared with individuals in comprehensive health plans. However, it was also found that individuals in CDHPs and HDHPs exhibit more cost-conscious behavior in their health care decision making than individuals with comprehensive health insurance.

The remainder of this report compares and contrasts the findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey as they relate to differences and similarities among individuals enrolled in comprehensive health plans, CDHPs, and HDHPs. It examines health plan features, enrollee characteristics such as health status and demographics, attitudes and satisfaction toward health insurance, choice of health plan, use and spending, cost-related access problems, cost and quality information, and health care decision making.

Health Plan Features and Demographics

About half of all adults enrolled in more comprehensive health plans reported that they had a deductible and 13 percent said that they had a deductible that only applied to health care services obtained outside of the provider network. Among adults with individual coverage in comprehensive plans, 47 percent had no deductible, 29 percent had a deductible below $500 and 13 percent had a deductible between $500 and $999 (Figure 2). Among adults with family coverage, 48 percent had no deductible, 32 percent reported that the deductible was below $999, and 13 percent reported that it was between $1,000 and $1,999.

Among persons with individual coverage and enrolled in a HDHP, 64 percent reported a deductible of between $1,000 and $1,999, 23 percent had deductibles between $2,000 and $3,499, and 8 percent had deductibles of at least $3,500. Fifty percent of individuals in HDHPs with family coverage had a deductible of between $2,000 and $2,999, 22 percent had a deductible of between $3,000 and $4,999, and 20 percent were in a plan with a deductible of $5,000 or higher.

Those with high deductible plans and accounts (CDHPs) tended to have even higher deductibles. Nearly 3 in 5 (59 percent) of persons in a CDHP with individual coverage reported a deductible of $2,000 or higher. Among individuals with family coverage who were enrolled in a CDHP, two thirds (67 percent) reported that they were covered by a plan with a family deductible of $3,000 or higher; 24 percent reported a deductible of at least $5,000. The survey asked people with deductibles whether any services were excluded from their deductible. Those in CDHPs were the least likely to say that any services were excluded from their deductible: 37 percent of adults in CDHPs reported some deductible exclusions, 47 percent of those in HDHPs said some services were excluded, and 40 percent of adults in comprehensive health insurance reported that some services were excluded from their deductible,

Other differences with respect to health plan features were statistically significant by plan type. Individuals in comprehensive health plans and HDHPs were more likely than individuals enrolled in CDHPs to report that they were required to choose a primary care physician (PCP), and they were more likely to report that a referral from their PCP was required in order to see a specialist. However, there was no statistical difference in the health plan use of networks by plan type.

Health Status and Demographics

People with CDHPs or HDHPs are slightly more likely to be in excellent or very good health than those with comprehensive health insurance. About 57 percent of people with CDHPs and 47 percent of those with HDHPs, said their health status was excellent or very good compared with 45 percent of people with more comprehensive health insurance. People with lower incomes were much less likely than those with higher incomes to report being in excellent or very good health across all forms of coverage. Those in employment-based HDHPs were less likely to report being in excellent or very good health than were those who had purchased HDHPs in the individual market. Just over two-fifths (42 percent) of those with employment-based HDHPs were in excellent or very good health, compared with three-fifths (62 percent) of those with HDHPs purchased in the individual market (data not shown).

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 one of eight chronic health conditions (arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure, or stroke). The percentage of enrollees with health problems was similar across the three coverage groups.

Figure 2

Deductibles, Health Status, and Household Income, by Type of Health Plan

	Comprehensive[1]	HDHP[2]	CDHP[3]
Individual Deductible			
No deductible	47%	N/A	N/A
$1–$499	29	N/A	N/A
$500–$999	13	N/A	N/A
$1,000–$1,999	N/A	64%	39% (n=87)
$2,000–$3,499	N/A	23	49
$3,500 or higher	N/A	8	10
Family Deductible			
No deductible	48	N/A	N/A
$1–$499	17	N/A	N/A
$500–$999	14	N/A	N/A
$1,000–$1,999	13	N/A	N/A
$2,000–$2,999	N/A	50	31
$3,000–$4,999	N/A	22	43
$5,000 or higher	N/A	20	24
Self-Rated Health Status			
Excellent/very good	45	47	57*
Good	42	39	35
Fair/poor	13	14	8
At least one chronic health condition**	54	54	48
Health problem***	56	57	49
Obese	36	33	26*
Smokes cigarettes	23	14*	14*
No regular exercise	24	15*	16*
Household Income			
Less than $30,000	9	10	11
$30,000–$49,999	18	21	22
$50,000–$99,999	40	36	34
$100,000–$149,999	14	12	12
$150,000 or higher	4	3	9*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).

[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.

[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.

* Difference between HDHP/CDHP and Comprehensive 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 one of eight chronic health conditions.

People in CDHPs were slightly less likely to weigh in the range of what the Center for Disease Control considers obese. One-quarter of adults in CDHPs were obese compared with one-third (36 percent) of those in comprehensive health plans or HDHPs (33 percent). Those in CDHPs and HDHPs were also less likely to smoke and more likely to report that they exercised than those enrolled in more comprehensive plans.

Generally, there were very few statistically significant demographic differences among the three groups—those covered by comprehensive insurance, CDHP, and HDHP. There were no differences when comparing the groups by gender, marital status, number of children, or race/ethnicity. However, individuals in CDHPs and HDHPs were less likely than individuals in comprehensive health plans to be under age 35 (Figure 3). Almost 30 percent of persons in comprehensive health plans were under age 35, compared with 17 percent of those in HDHPs and 21 percent of those in CDHPs. Individuals in comprehensive plans were more likely than those in a CDHP or HDHP to have only a high school education, and they were less likely to have a college education. Also, individuals in a CDHP were more likely than those with comprehensive health insurance and those in a HDHP to have income at or above $150,000 (Figure 2).

Work Status

There were a number of statistically significant differences with respect to work status and job characteristics. Individuals in both CDHPs and HDHPs were more likely than individuals in comprehensive plans to be sole proprietors or to be employed in small firms than individuals in comprehensive health plans. Compared to the other two groups, individuals enrolled in CDHPs were the least likely to report that they were employed full time, but differences were narrow.

Figure 3

Selected Demographics, by Type of Health Plan

	Comprehensive[1]	HDHP[2]	CDHP[3]
Total Sample	1,061	463	185
Gender			
Male	49%	55%	58%
Female	51	45	42
Age			
21–34	29	17*	21*
35–44	25	24	31
45–54	26	33	33
55–64	19	26	15
Married	62	62	59
Has children	33	34	40
Race/Ethnicity			
White, non-Hispanic	91	93	92
Minority	6	3	5
Education			
High school graduate or less	32	8*	5*
Some college, trade or business school	33	37	29
College graduate or some graduate work	23	38*	46*
Graduate degree	11	17*	21*
Work Status			
Employed or self-employed	83	83	91*
Works 40 or more hours/week	82	79	75*
Works less than 40 hours/week (of those who are employed)	18	21	25*
Job Tenure			
Less than 2 years	26	21	13*
2–9 years	44	42	49
10 or more years	30	36*	38*
Firm Size			
Self-employed with no employees	2	9*	8*
2–49	15	31*	38*
50–199	9	9	8
200–499	10	7	5*
500 or more	55	37*	36*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).

[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.

[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.

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

Note: Percentages may not sum to totals due to rounding.

Attitudes and Satisfaction

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. In general, it was found that individuals with comprehensive health insurance were more satisfied and had a better opinion of their health care experience and health plan than individuals enrolled in CDHPs and HDHPs. Specifically, individuals with comprehensive health insurance were more satisfied than individuals enrolled in CDHPs and HDHPs with the quality of health care they received (Figure 4), and they were more satisfied with out-of-pocket costs (Figure 5). In addition, individuals in comprehensive health plans and CDHPs were more likely than individuals with HDHPs to be extremely or very satisfied with regard to access to doctors or choice of doctors (Figure 6).

Overall, individuals with comprehensive health insurance were more satisfied with their health plan than individuals with CDHPs and HDHPs. Specifically, 63 percent of individuals with comprehensive health insurance were extremely or very satisfied with their health plan, compared with 42 percent among CDHP enrollees and 33 percent of individuals with HDHPs (Figure 7).

Hence, it is not surprising that individuals with comprehensive health insurance were more likely than those with a CDHP or HDHP to report that they were extremely or very likely to recommend their health plan to a friend or coworker. One-half of individuals in the comprehensive plan were extremely or very likely to recommend their health plan, compared with 34 percent among those in CDHPs and 22 percent of those in HDHPs (Figure 8). In addition, individuals in CDHPs were more likely than those with HDHPs to report that they would recommend their health plan. It is also not surprising that individuals with comprehensive health insurance were more likely than those with a CDHP or HDHP to report that they were likely to stay with their current plan if they had the opportunity to change plans. About 60 percent of individuals with comprehensive health insurance reported that they were extremely or very likely to stay with their current health plan if they had the opportunity to switch, compared with 46 percent of CDHP enrollees and 30 percent of HDHP enrollees (Figure 9).

Some other findings from the survey regarding differences of opinion, or lack thereof, among individuals with comprehensive health plans, CDHPs, and HDHPs are worth highlighting (Figure 10). Individuals with comprehensive health insurance were more likely than those with CDHPs or HDHPs to strongly or somewhat agree with the statement that their health plan is easy to understand. Individuals with comprehensive health insurance and those in CDHPs were more likely than those with HDHPs to report that the plan would provide protection for them in the event of an expensive illness. Individuals with comprehensive health insurance were more likely than those enrolled in CDHPs and HDHPs to think that the health plan provided information to help choose a provider.

There were no differences in beliefs between those with comprehensive health insurance, CDHPs, and HDHPs with regard to the following series of questions:

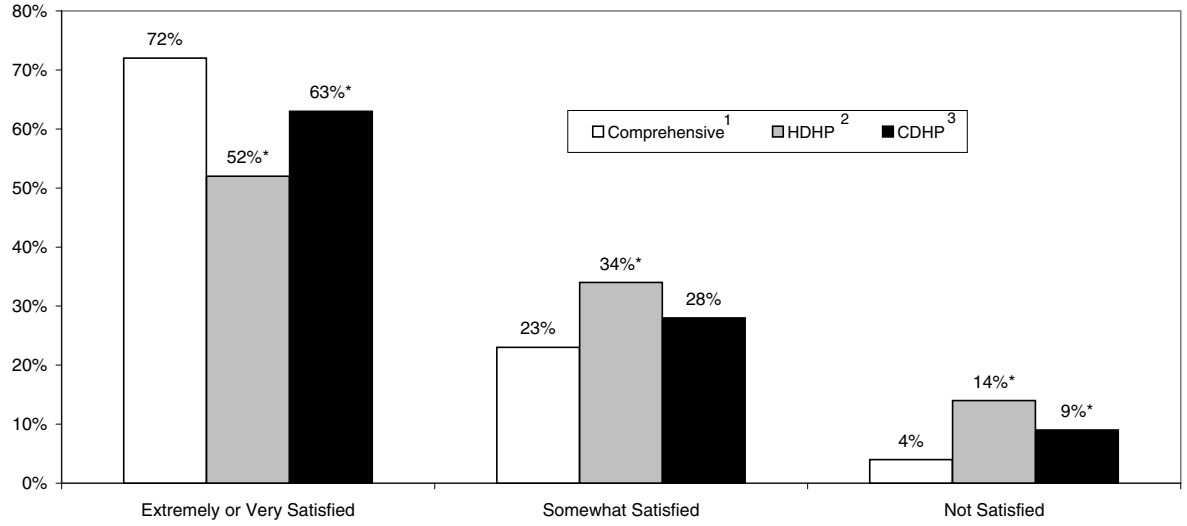
- In general, the choices made by the people who use health care services have a significant impact on the total cost of health care.
- In general, the choices made by the people who use health care services have a significant impact on the quality of health care they receive.
- In general, doctors who charge higher prices provide higher quality health care.

Choice of Health Plan

Among individuals covered by an employment-based health plan, those in CDHPs or HDHPs were more likely than those with comprehensive insurance not to have a choice of health plan. Only 34 percent of individuals with comprehensive insurance did not have a choice of health plan, compared with 52 percent of CDHP enrollees and 51 percent among HDHP enrollees (Figure 11).

When individuals have a choice of health plans, the premium affects their decision regarding which plan to choose. It was found that one-half of CDHP enrollees in individual and employment-based plans reported that their cost for insurance was less expensive than the other available options (data not shown). This

Figure 4
Satisfaction With Quality of Health Care Received, by Type of Health Plan



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
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* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 5
Satisfaction With Out-of-Pocket Costs for Health Care, by Type of Health Plan

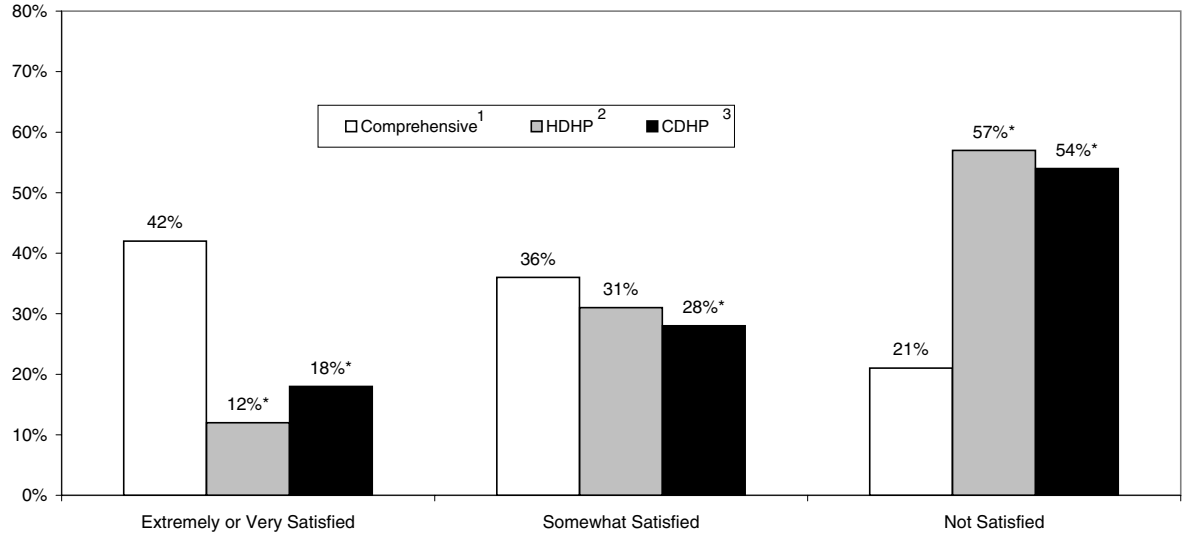

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Figure 6
Satisfaction With Choice of Doctors, by Type of Health Plan

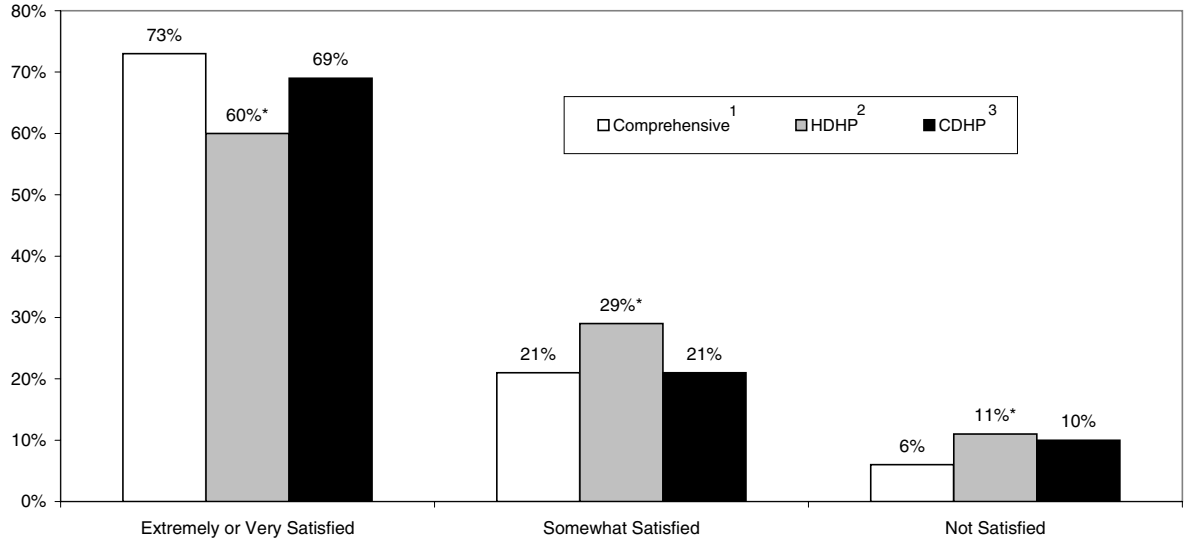

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Figure 7
Overall Satisfaction With Health Plan, by Type of Health Plan

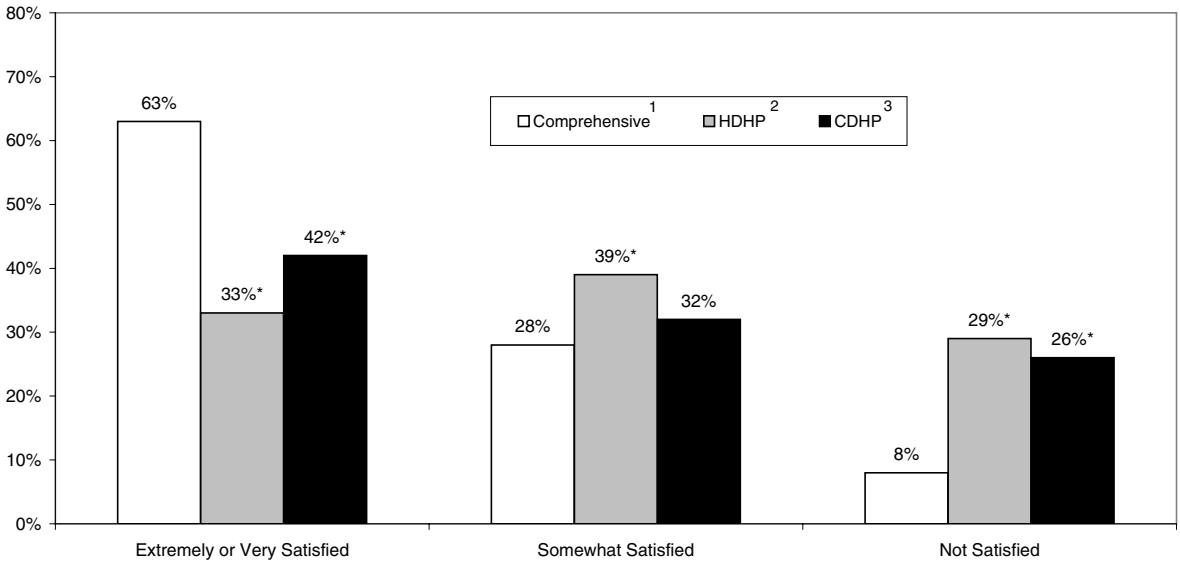

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Figure 8
Likelihood of Recommending Health Plan to Friend or Co-Worker, by Type of Health Plan

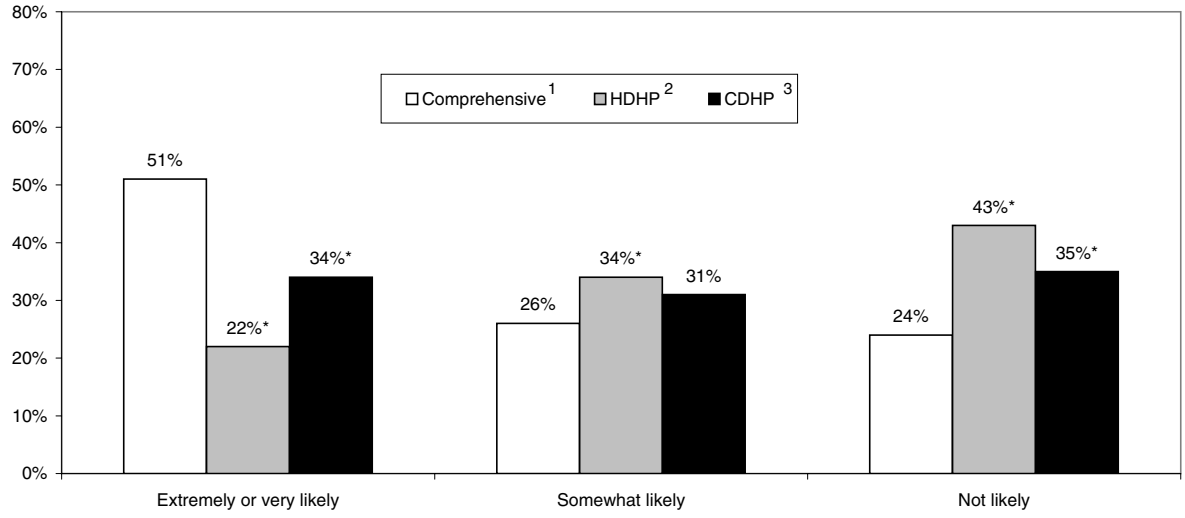

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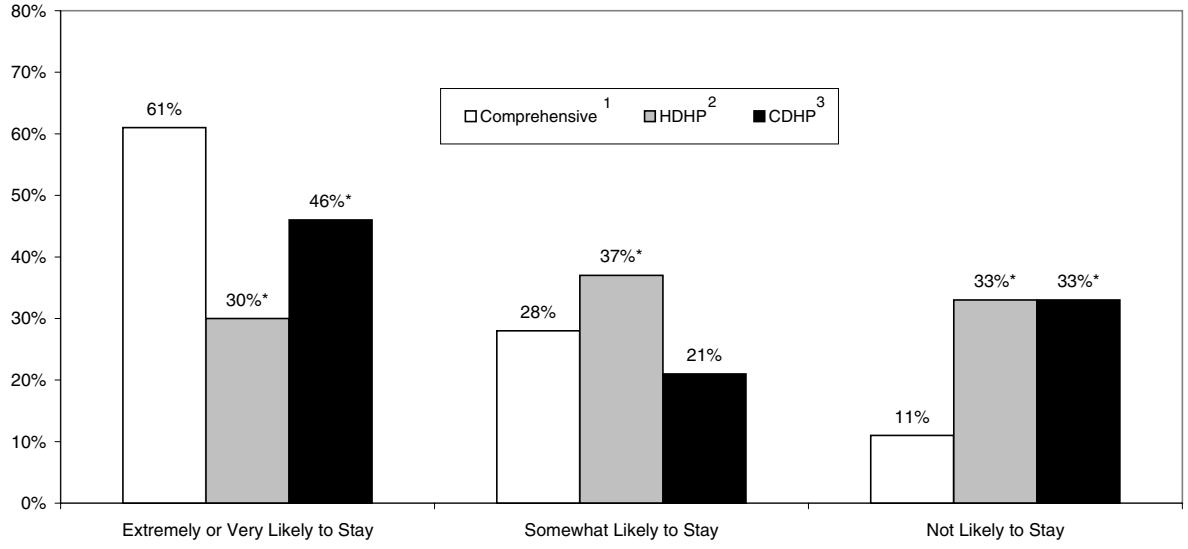
Figure 9
Likelihood of Staying With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan



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Note: Percentages may not sum to totals due to rounding.

compares with 31 percent of HDHP enrollees and 27 percent of individuals with comprehensive health insurance reporting that their health plan was the least costly option available.

Among the population with comprehensive insurance and a choice of plan, 33 percent were offered a CDHP, and 41 percent were not offered it, but 26 percent did not know if they were offered it (Figure 12).

Individuals with HDHPs reported that they had not opened an HSA for a number of reasons. Thirty percent reported that they did not have the money to fund the account, 19 percent reported that it was too much trouble to open and/or manage the account, 18 percent were more familiar with the plan that was already selected, 15 percent did not like the high out-of-pocket costs, and 10 percent reported that it was either too complicated or they did not understand the option.

Health Care Use

There was little significant variation in health care use between individuals with CDHPs or HDHPs and those with comprehensive insurance. The survey asked about health care use over the last year, including whether people had had a physical exam and the number of times they had filled a prescription, visited a doctor's office or clinic, been treated in an emergency room, been admitted to a hospital, had a diagnostic test or physical therapy, or visited an alternative medicine provider. While there were some significant differences in health care use by income and health status, those differences were consistent across source of health coverage (data not shown). For example, those with incomes of $50,000 or more were slightly more likely to have had a physical exam in the last 12 months and to be more frequent users of prescription drugs. Those with health problems were more likely to have had a physical exam in the last year, and to be more frequent users of prescription drugs, physician and hospital care, emergency rooms, diagnostic tests, and physical therapy. But there were no significant differences in reported use among people with health problems across plan type.

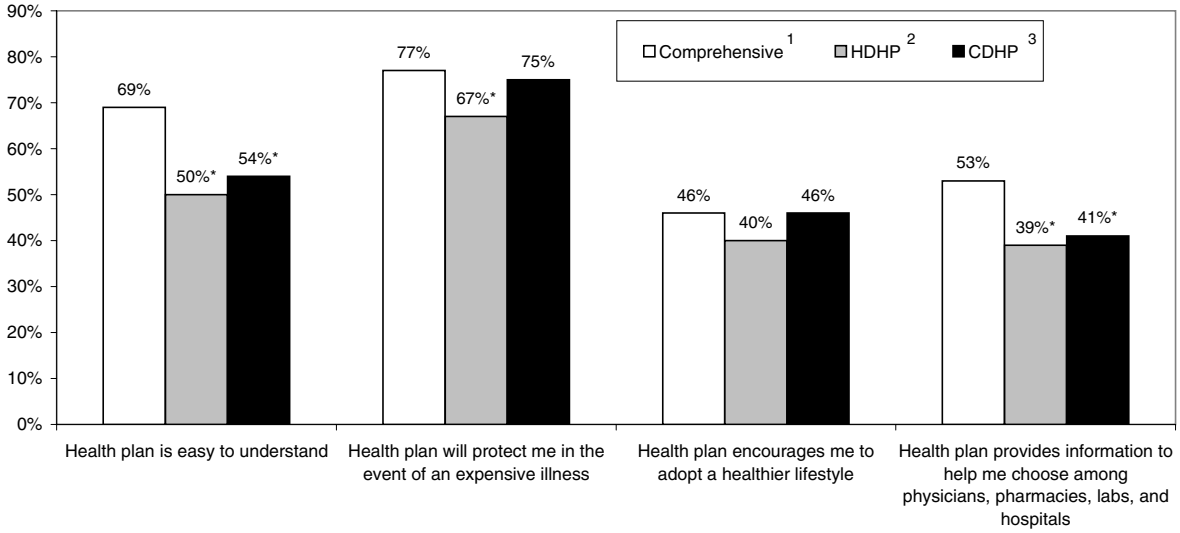
Health Care Spending

Despite similar rates of health care use, people with CDHPs and HDHPs were more likely to spend a large share of their income on out-of-pocket health care expenses than those in comprehensive plans. One-fifth (20 percent) of those in HDHPs and 11 percent of those in CDHPs spent 5 percent or more of their income on out-of-pocket costs in the last year, compared with 5 percent of those in comprehensive health plans (Figure 13). People with lower incomes or health problems were particularly vulnerable to spending large shares of their income on out-of-pocket costs. Forty-five percent of people in HDHPs with incomes under $50,000 spent 5 percent or more of their income on out-of-pocket costs and 15 percent spent 10 percent or more. In contrast, 14 percent of people in the same income group in comprehensive plans spent 5 percent or more and 3 percent spent 10 percent or greater. Among people with health problems, 29 percent of those in HDHPs spent 5 percent or more of their income on medical expenses, compared with 8 percent of those in comprehensive plans.

When combined with premiums, outlays on health care as a share of income rose substantially among those with HDHPs and CDHPs, particularly among those with low incomes or health problems. More than two-fifths (42 percent) of people with HDHPs and 31 percent of those in CDHPs spent 5 percent or more of their income on out-of-pocket costs and premiums, compared with 12 percent of people in comprehensive plans (Figures 13 and 14). Nearly everyone (92 percent) with HDHPs with incomes under $50,000 spent 5 percent or more of their income on out-of-pocket costs and premiums, and one-third spent 10 percent or more. This compares with 34 percent of people in that income group in comprehensive plans who spent 5 percent or more of their income and 10 percent who spent 10 percent or more. People with health problems in HDHPs were also vulnerable to spending large shares of their income on out-of-pocket costs and premiums: more than half (53 percent) of those in HDHPs with health problems spent 5 percent or more and 18 percent spent 10 percent or more. People with health problems in comprehensive plans were much better protected by comparison: 17 percent spent 5 percent or more of their income and 4 percent spent 10 percent or more.

Figure 10

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



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).

[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.

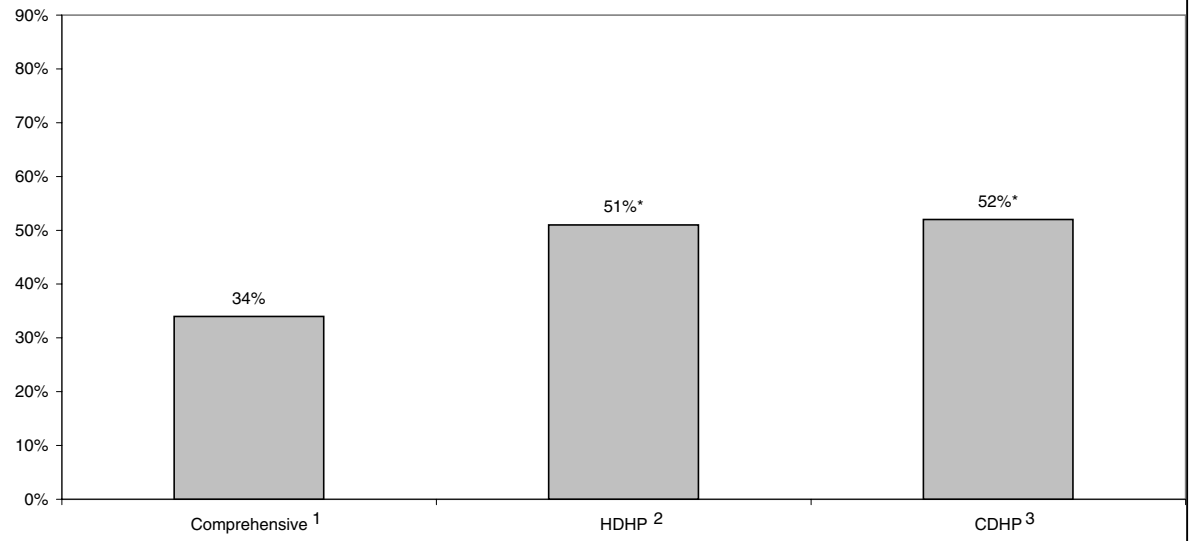
[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.

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

Note: Percentages may not sum to totals due to rounding.

Figure 11

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



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).

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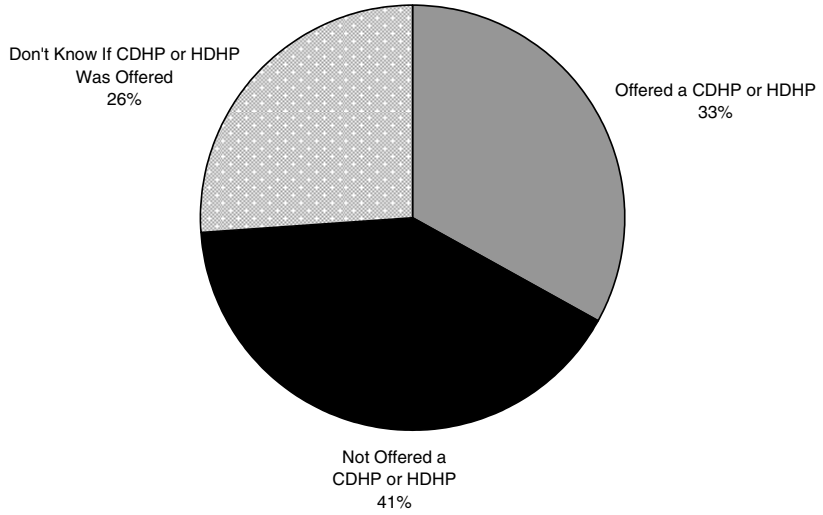
[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.

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

Figure 12

Percentage of Individuals With Comprehensive[1] Employment-Based Health Benefits Offered HDHP[2] or CDHP[3]



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).

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[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.

Cost-Related Access Problems

While people reported using health services at similar rates across health plans, 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 comprehensive insurance, with problems particularly pronounced among those with health problems or incomes under $50,000. The survey asked whether in the last year respondents had delayed or avoided getting health care services when they were sick because of costs. About one-third of people in CDHPs (35 percent) and HDHPs (31 percent) reported delaying or avoiding care, twice the rate of those in comprehensive health plans (17 percent) (Figures 15 and 16). Having a health problem made it more likely that people avoided or delayed care. Among people who reported being in fair or poor health or having at least one chronic health condition, those in CDHPs or HDHPs reported delaying or avoiding care at higher rates than those in comprehensive plans: 40 percent of those in CDHPs and 31 percent of people in HDHPs, compared with 21 percent in comprehensive plans. People with HDHPs and CDHPs in households with incomes of under $50,000 were also more likely to avoid or delay care: nearly half of those in CDHPs and more than two in five in HDHPs reported delaying or avoiding care, compared with one-quarter (26 percent) of those in comprehensive plans in that income range.

In addition to delaying or avoiding health care, people in HDHPs were significantly more likely to skimp on their medications than were those in comprehensive plans. The survey asked respondents whether in the last 12 months they had not filled a prescription because of costs. More than one-quarter (26 percent) of those with HDHPs said they had not filled a prescription because of cost, compared with 16 percent of those in comprehensive health plans (Figure 17). Having a health problem made it more likely that people avoided filling prescriptions, particularly those with HDHPs: One-third of those in HDHPs with health problems had not filled a prescription because of cost, compared with one-fifth (21 percent) of people in comprehensive plans.

Similarly, members of HDHPs were significantly more likely to say they had skipped doses of medications to make them last longer. More than one-quarter (26 percent) of those in HDHPs said they had skipped a dose, compared with 15 percent in comprehensive plans (Figure 18). Skipping medications was more prevalent among people with health problems. Thirty-five percent of those with health problems in HDHPs had skipped doses, compared with one-fifth of those with health problems who were enrolled in comprehensive plans.

Figure 13
Out-of-Pocket Health Care Costs, by Type of Health Plan

	Comprehensive[1]	HDHP[2]	CDHP[3]
Total Sample	1,061	463	185
Total			
Total annual out-of-pocket medical expenses			
Spent annually 5% or more of income	5%	20%*	11%
Spent annually 10% or more of income	1	6*	3
Total annual out-of-pocket medical expenses plus premium			
Spent annually 5% or more of income	12	42*	31*
Spent annually 10% or more of income	3	13*	9*
Health Problem**			
Total annual out-of-pocket medical expenses			
Spent annually 5% or more of income	8	29*	16 (n = 90)
Spent annually 10% or more of income	1	8*	3
Total annual out-of-pocket medical expenses plus premium			
Spent annually 5% or more of income	17	53*	38*
Spent annually 10% or more of income	4	18*	12*
No Health Problem**			
Total annual out-of-pocket medical expenses			
Spent annually 5% or more of income	1	8	6 (n = 95)
Spent annually 10% or more of income	1	3	2
Total annual out-of-pocket medical expenses plus premium			
Spent annually 5% or more of income	6	28*	25
Spent annually 10% or more of income	2	7*	5
<$50,000 Yearly Household Income			
Total annual out-of-pocket medical expenses			
Spent annually 5% or more of income	14	45*	23 (n = 61)
Spent annually 10% or more of income	3	15*	7
Total annual out-of-pocket medical expenses plus premium			
Spent annually 5% or more of income	34	92*	66
Spent annually 10% or more of income	10	33*	21
$50,000+ Yearly Household Income			
Total annual out-of-pocket medical expenses			
Spent annually 5% or more of income	2	12	6
Spent annually 10% or more of income	<1	2	1
Total annual out-of-pocket medical expenses plus premium			
Spent annually 5% or more of income	4	28*	18
Spent annually 10% or more of income	<1	6*	3

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).

[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.

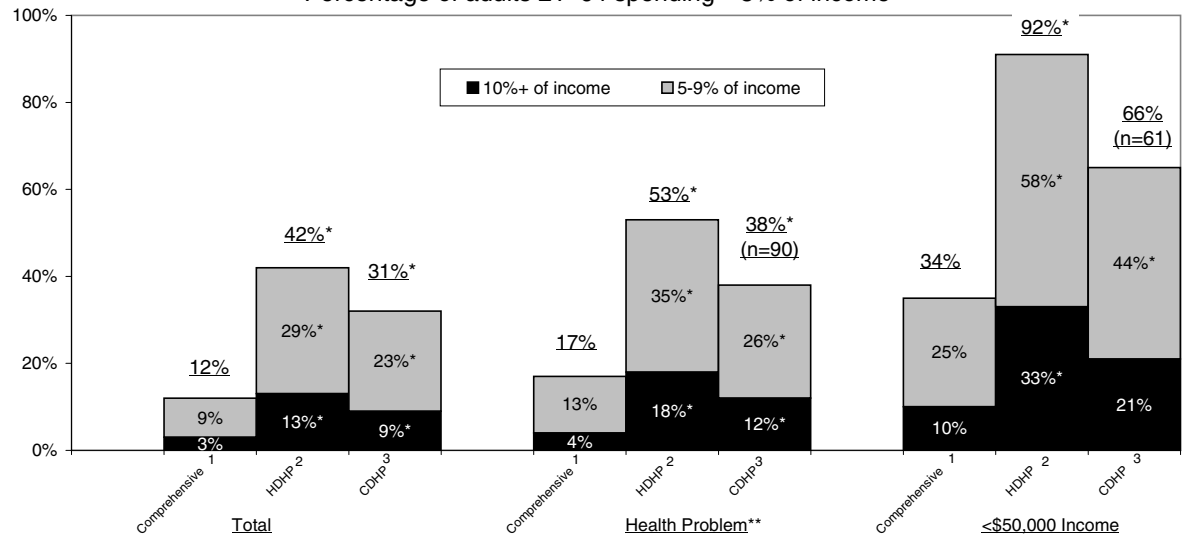
[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.

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

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

Note: Percentages may not sum to totals due to rounding.

Figure 14
Percentage of Income Spent Annually on Out-of-Pocket Medical Expenses Plus Premiums
Percentage of adults 21–64 spending ≥ 5% of income



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.
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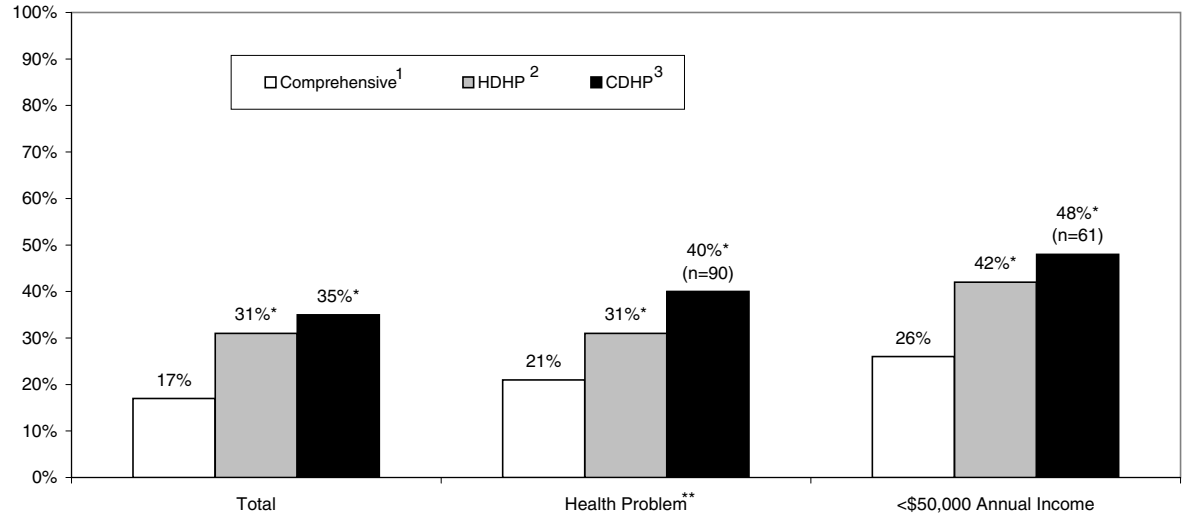
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
** Health problem defined as fair or poor health or one of eight chronic health conditions.
Note: Percentages may not sum to totals due to rounding.

Figure 15
Percentage of Adults Who Have Delayed or Avoided Getting Health Care Due to Cost
Percentage of adults 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).
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* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
** Health problem defined as fair or poor health or one of eight chronic health conditions.
Note: Percentages may not sum to totals due to rounding.

Figure 16

Access Issues, by Type of Health Plan

	Comprehensive[1]	HDHP[2]	CDHP[3]
Total			
Delayed or avoided getting health care due to cost	17%	31%*	35%*
Not filled a prescription due to cost	16	26*	20
Skipped doses to make medication last longer (of those who were given a prescription)	15	26*	20
Health Problem**			
Delayed or avoided getting health care due to cost	21	31*	40* (n = 90)
Not filled a prescription due to cost	21	33*	26 (n = 90)
Skipped doses to make medication last longer (of those who were given a prescription)	20	35*	29 (n = 85)
No Health Problem**			
Delayed or avoided getting health care due to cost	12	31*	31* (n = 95)
Not filled a prescription due to cost	11	17	15 (n = 95)
Skipped doses to make medication last longer (of those who were given a prescription)	8	13	10 (n = 81)
Less Than $50,000 Yearly Household Income			
Delayed or avoided getting health care due to cost	26	42*	48* (n = 61)
Not filled a prescription due to cost	27	32	25 (n = 61)
Skipped doses to make medication last longer (of those who were given a prescription)	21	32	28 (n = 50)
$50,000 or More Yearly Household Income			
Delayed or avoided getting health care due to cost	13	29*	29*
Not filled a prescription due to cost	11	26*	17
Skipped doses to make medication last longer (of those who were given a prescription)	13	25*	16 (n = 94)

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).

[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.

[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.

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

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

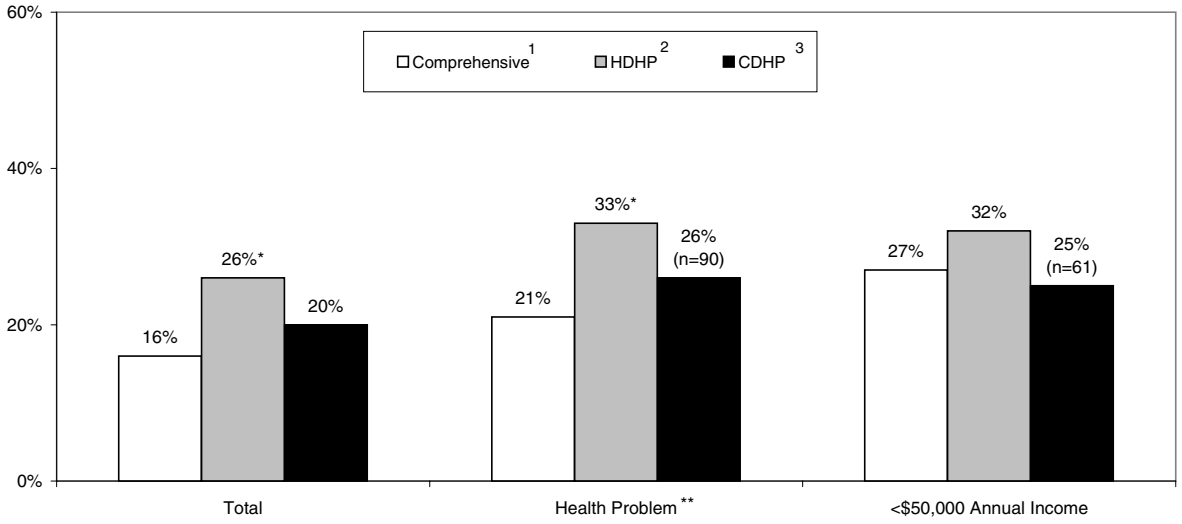
Note: Percentages may not sum to totals due to rounding.

Availability and Use of Cost and Quality Information

In theory, the incentives of consumer-driven health plans 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 respondents whether their health plans provided any information regarding the cost and quality of providers. Just 1 in 7 people (12–16 percent) in all plan types said that their plans provided either type of information on doctors and hospitals (Figure 19). Those in CDHPs and HDHPs whose plans provided quality or cost information were slightly more likely to say they had tried to use either type of information compared with those in comprehensive plans whose plans provided such information. Just over half (54 percent) of those enrolled in CDHPs or HDHPs who said their plan provided quality information on physicians said they had tried to use the information. Forty-five percent of adults in CDHPs or HDHPs whose plans provided quality information about hospitals had tried to use it, about twice the rate of those

Figure 17
Percentage of Adults Who Have Not Filled a Prescription Due to Cost
Percentage of adults 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
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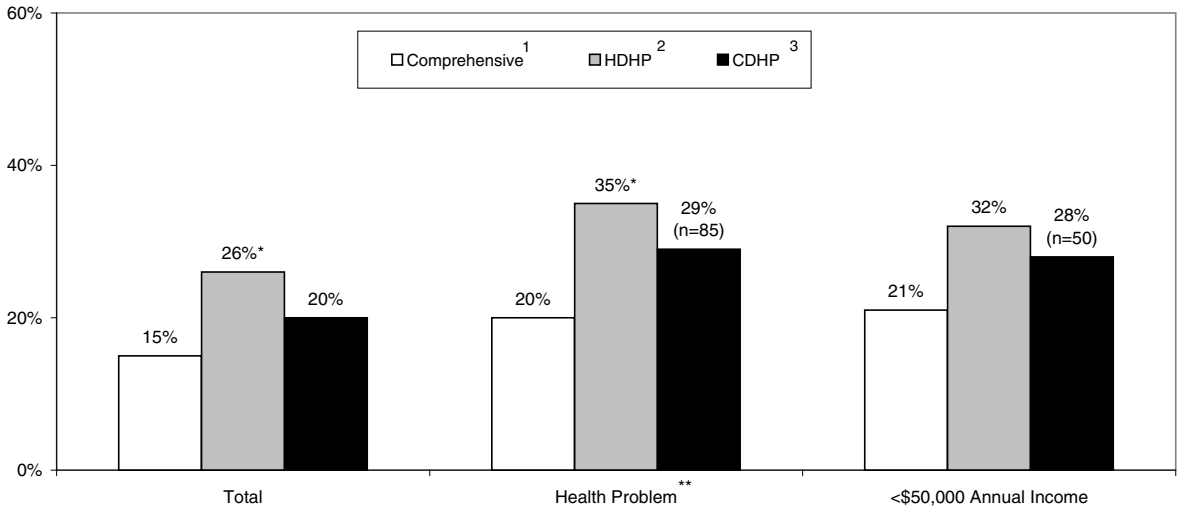
[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
** Health problem defined as fair or poor health or one of eight chronic health conditions.
Note: Percentages may not sum to totals due to rounding.

Figure 18
Percentage of Adults Who Have Skipped Doses to Make a Medication Last Longer
Percentage of adults 21–64 with prescriptions in the last 12 months



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* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
** Health problem defined as fair or poor health or one of eight chronic health conditions.

Figure 19

Availability and Use of Quality and Cost Information Provided, by Type of Health Plan

	Comprehensive[1]	HDHP[2]/CDHP[3]
Health plan provides information on quality of care provided by:		
Doctors	14%	16%
Hospitals	14	15
Health plan provides information on cost of care provided by:		
Doctors	16	12
Hospitals	15	12
Of those whose plans provide info on quality, how many tried to use it for:		
Doctors	42	54
Hospitals	25	45*
Of those whose plans provide info on cost, how many tried to use it for:		
Doctors	15	36* (n=76)
Hospitals	14	32* (n=76)

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

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Note: Percentages may not sum to totals due to rounding.

who had access to and tried to use information on hospitals in comprehensive plans. Fewer people attempted to use the cost information provided: About one-third of those in CDHPs and HDHPs and 15 percent of those in comprehensive plans had tried to use plan-provided cost information about doctors or hospitals.

People were asked about who they would most trust to provide information about health care providers. Across all plan types, personal physicians were most often cited as the most trusted source, with about 2 in 5 respondents (42–43 percent) saying that they would most trust their doctor (Figure 20). One in 5 (20–25 percent) said they would most trust consumer groups like *Consumer Reports* and about 1 in 7 (15–16 percent) would most trust a family member or friend. Just 1 in 20 (4–6 percent) said they would most trust their health plan.

Despite a clear deficit of information about providers, people enrolled in CDHPs and HDHPs were somewhat more likely to seek out information prior to receiving care and to consider costs in their decisions about their health care. More than 70 percent of people enrolled in CDHPs and 60 percent of those in HDHPs strongly or somewhat agreed that the terms of their health plans made them consider costs when deciding to see a doctor when sick or fill a prescription; less than 40 percent of those in comprehensive plans felt this way (Figure 21). Three in 5 (60 percent) of those enrolled in CDHPs or HDHPs said that they had checked whether their health plan would cover their costs prior to receiving care, and about one-third (32 percent) checked the price of a doctor's visit or other health service (Figure 22). In contrast, just under half (49 percent) of those in comprehensive plans had checked whether their plans would cover care and 23 percent had checked the price of a service. Many of these differences were narrower than might be expected, given the wide difference in deductibles across the three groups.

People in CDHPs and HDHPs appeared to be more willing than those in comprehensive plans to discuss the cost of their care with their doctors. Fifty-five percent of those in CDHPs or HDHPs reported that they had discussed treatment options and costs with their doctor, and 44 percent said that they had asked their doctor to recommend a less costly prescription drug. In contrast, 2 in 5 (43 percent) of those in comprehensive plans discussed options with their physician, and one-quarter (27 percent) had asked their doctor to recommend a cheaper drug.

Conclusion

Despite the substantial amount of attention that consumer-driven health plans have received recently, the EBRI/Commonwealth Fund Consumerism in Health Care Survey finds that as of October 2005 just 1 percent of the U.S. adult population had a high-deductible health plan with a health savings account or health reimbursement arrangement. An additional 9 percent had an HSA-eligible high-deductible health plan, but had not yet opted to open an account.

Among the small number of American adults who do have these plans, few are satisfied with them. The survey's over-sample of adults with CDHPs and HDHPs found that they are far more likely than people with comprehensive plans to report dissatisfaction with several aspects of their health care, including quality of care, out-of-pocket costs, and overall satisfaction with their plans. Moreover, one-third of those with the plans would change plans if they had the opportunity to do so, and only one-third or less would recommend the plan to a friend or co-worker.

The high rates of dissatisfaction with costs likely stem from the substantial shares of income that people in these plans are spending, particularly those with health problems or incomes of under $50,000. More than two-fifths of adults with HDHPs and 31 percent of those in CDHPs spent 5 percent or more of their income on out-of-pocket costs and premiums, compared with 12 percent in comprehensive plans. This is in spite of the fact that the survey sample has higher-than-average incomes than the U.S. population as a whole.

People in high-deductible plans reported using health services at rates similar to those in comprehensive plans. Yet, when people were asked if they avoided or delayed health care because of costs, those in high-deductible plans were significantly more likely to say yes—even those with savings accounts. About one-third of those in CDHPs and HDHPs reported delaying or avoiding care because of costs, twice the rate of those in comprehensive health plans. Again, people with health problems or incomes under $50,000 reported particularly high rates of avoiding care. Nearly half of adults with CDHPs in households earning less than $50,000 said they had avoided or delayed care, nearly twice the rate of people in that income class with comprehensive plans.

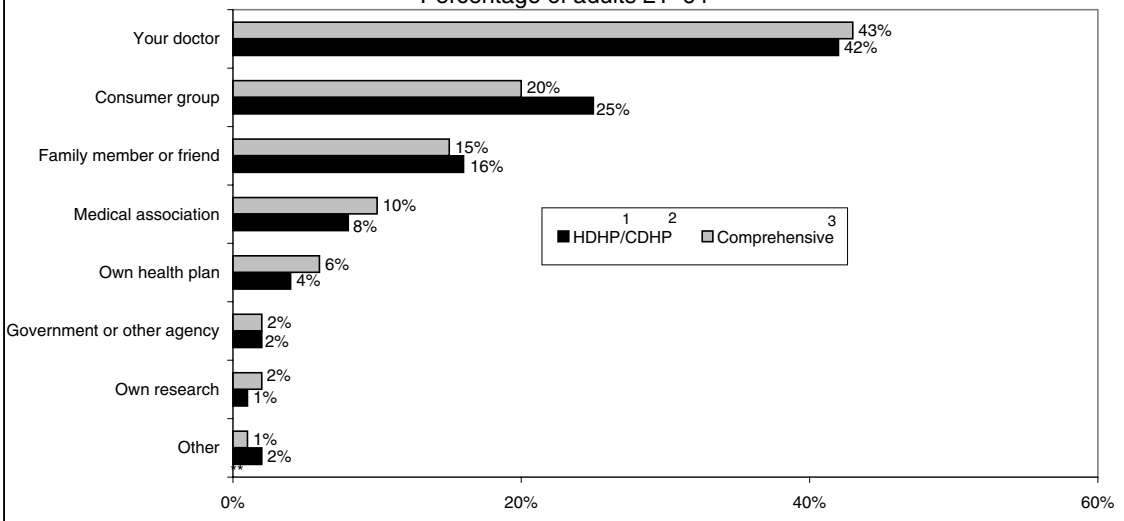
Among people in the CDHPs and HDHPs who did receive care, there is evidence that they are more cost-conscious than those in comprehensive plans. People in the plans are significantly more likely to say that the terms of their health plans made them consider costs when deciding to see a doctor when sick or fill a prescription, to report that they had checked whether their health plan would cover their costs as well as the price of a service prior to receiving care, and to discuss treatment options and the cost of care with their doctors.

Yet the survey also finds that Americans, regardless of the health plan they are in, continue to encounter a yawning gap between the quality and cost information they need to make decisions and what is available. Just 1 in 7 people in any type of health plan said that their plans provided information on the cost or quality of doctors, hospitals, and other medical services. This suggests that the nascent consumerism movement has so far failed to provide consumers with the basic tools they need to meet the challenges of participating in these plans. Indeed, practical and legal issues surrounding the release of price information by health plans and doctors suggest that people with these plans may never have access to actual prices (Hall and Havinghurst, 2005).

At its most fundamental level, consumerism in health care is an attempt to wrest control of the galloping increase in health care costs experienced by employers over the first half of this decade by addressing the incentives surrounding the *demand* for health care. This survey finds that consumer plans do, in fact, significantly raise consumer sensitivity to costs and reduce use.

But the survey also demonstrates that at least one factor crucial to the success of consumer-driven health plans—realistic, useful, accessible health-cost information—does not yet exist on a widespread basis. Further, the survey also demonstrates that cost-related reductions in demand are highest among individuals with the most to lose—those who are sick and those who have low incomes. To the extent that the health care cost problem is a problem owned by all of us, early evidence from the consumerism movement suggests that solving it through blunt, demand-side instruments like high deductibles gives disproportionate responsibility for the problem to the most vulnerable among us.

Figure 20
Most Trusted Sources for Information on Health Care Providers, by Type of Health Plan
Percentage of adults 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.
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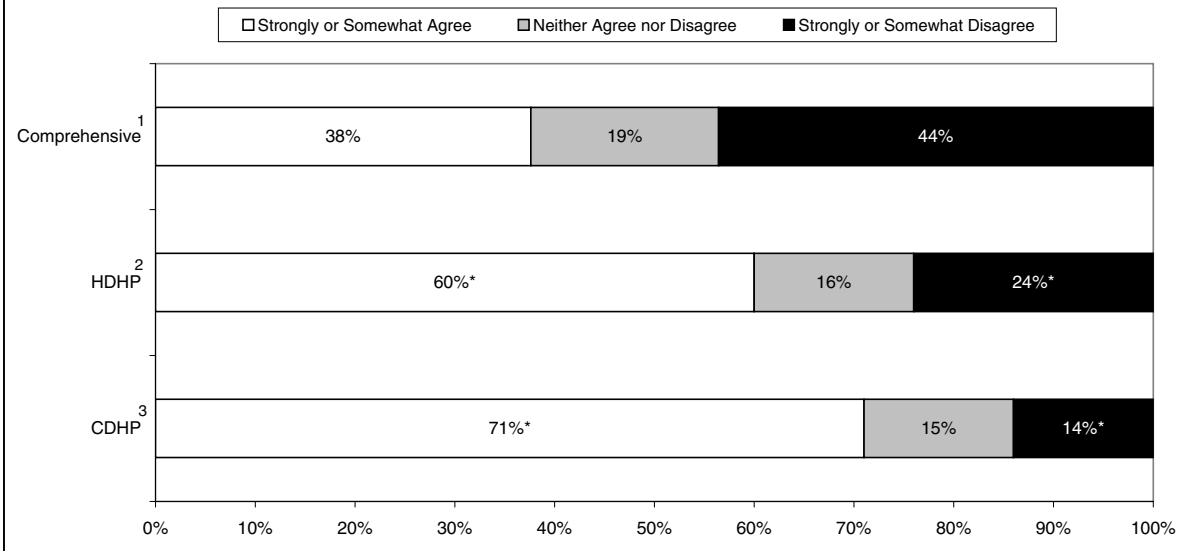
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Figure 21
Percentage of Individuals Who Agree That Terms of Coverage Make Them Consider Cost When Deciding to Seek Health Care Services



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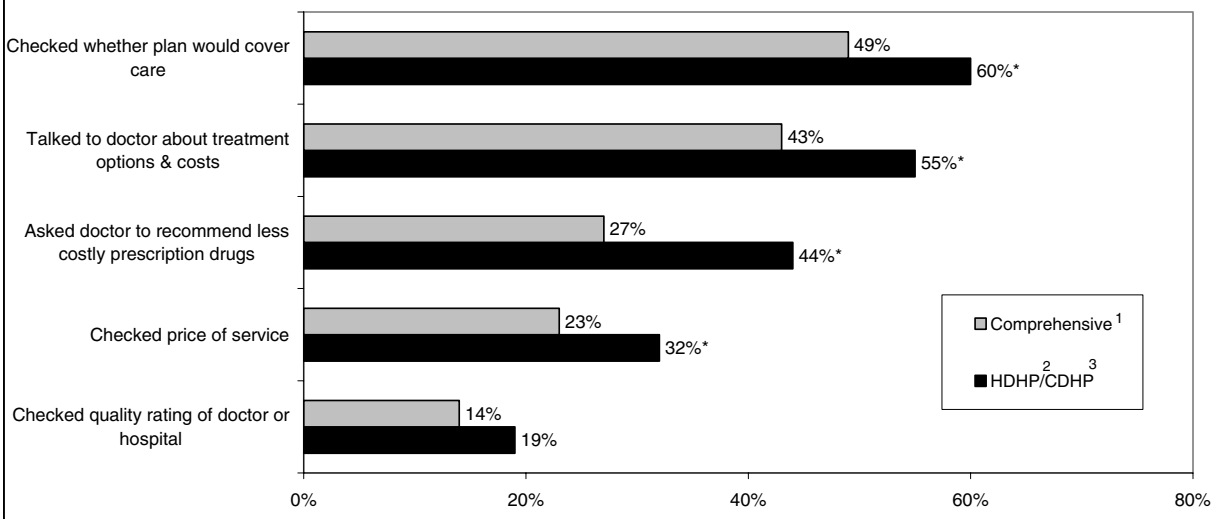
Note: Percentages may not sum to totals due to rounding.

Figure 22
Cost-Conscious Decision Making, by Type of Health Plan
Percentage of adults 21–64 who received health care in last 12 months



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Note: Percentages may not sum to totals due to rounding.

Appendix – Methodology

The findings presented in this *Issue Brief* were derived from the EBRI/Commonwealth Fund Consumerism in Health Care Survey (CHCS), an online survey that examines issues surrounding consumer-directed health care, including the cost of insurance, deductibles and the cost of care, satisfaction with health care, satisfaction with the health care plan, reasons for choosing a plan, cost-related access problems, availability and use of health information, and health care decision making. The survey was conducted within the United States between Sept. 28 and Oct. 19, 2005, through an 18-minute Internet survey. The base sample was randomly drawn from Harris Poll Online, Harris Interactive's online sample of Internet users who have agreed to participate in research surveys. Slightly more than 1,200 adults (n=1204) ages 21–64 who have health insurance through an employer or purchased directly from a carrier were drawn randomly from the Harris sample. To draw a random sample for surveying, Harris initially stratified by gender, age, and region. The final sample of adults participating in the survey is skewed toward higher income and more highly educated individuals, and also under-represents minorities. There is also a low response rate as is typical of online surveys.

To examine the issues mentioned above, the sample was sorted into three groups: those with a consumer-driven health plan (CDHP), those with a high-deductible health plan (HDHP), and those with comprehensive health insurance. 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. 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 such accounts. This group is the equivalent of individuals with HSA-eligible health plans. In other words, these individuals do not have an HSA, but could establish such an account on their own because their health plan includes a qualifying deductible of at least $1,000 for employee-only coverage or individual coverage, or $2,000 for family coverage.

Individuals with comprehensive health insurance 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 qualify for HSA tax preference.

QUESTIONS AND SKIP PATTERNS

S5. Does your health plan have a deductible for medical care? [A deductible is the amount you have to pay before your insurance plan will start paying any part of your medical bills.]
Yes
No
Yes, but only when I go out of network
Don't know

S6a. [IF HAVE FAMILY COVERAGE, ASK:] What is the amount of your family deductible for medical care? (If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.)
Less than $2,000
$2,000 or more
Don't know
Have a separate deductible for each family member

S6b. [IF DON'T KNOW AMOUNT OF DEDUCTIBLE, ASK:] Is the family deductible less than $2,000 or $2,000 or more?
Less than $2,000
$2,000 or more
Don't know

S7a. [IF HAVE INDIVIDUAL COVERAGE OR HAVE SEPARATE DEDUCTIBLES FOR FAMILY COVERAGE, ASK:] What is the amount of your annual per person deductible for medical care? (If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.)
Less than $1,000
$1,000 or more
Don't know

(continued next page)

The box (left) includes the questions and skip patterns that pertain to sorting the sample into the three analysis groups and identifying the over-samples: those with comprehensive insurance, those with a CDHP, and those with a HDHP.

Because the base sample included only 17 individuals in a CDHP and 126 individuals with a HDHP, an over-sample was conducted of 505 individuals with a CDHP or HDHP. The over-sample added 168 individuals with a CDHP and 337 individuals with a HDHP to derive a total sample (base plus over-sample) of 185 for the CDHP group and 463 for the HDHP group. After factoring out of the base sample the 17 individuals with a CDHP and the 126 individuals with a HDHP, there are 1,061 individuals in the sample with a comprehensive health plan.

The base sample was also weighted by gender, age, education, and region to reflect the actual proportions in the population ages 21–64 with private health insurance coverage.[7] The CDHP and HDHP samples were not weighted because population data for these groups do not exist.

The length of time with the plan and familiarity with the plan were examined. In the sample of CDHP individuals, 76 percent have been covered by their plan for two years or less (Figure A1). While 11 percent report that they have been covered by their current health plan for five years or more, it is possible that these individuals are reporting how long they have had insurance with their current employer, and are not defining the length of time of their health plan by when the features of their health plan were implemented.[8]

QUESTIONS AND SKIP PATTERNS
(continued)

S7b. [IF DON'T KNOW AMOUNT OF DEDUCTIBLE, ASK:]
Is the deductible less than $1,000 or $1,000 or more?
Less than $1,000
$1,000 or more
Don't know

S12a. 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
Don't know

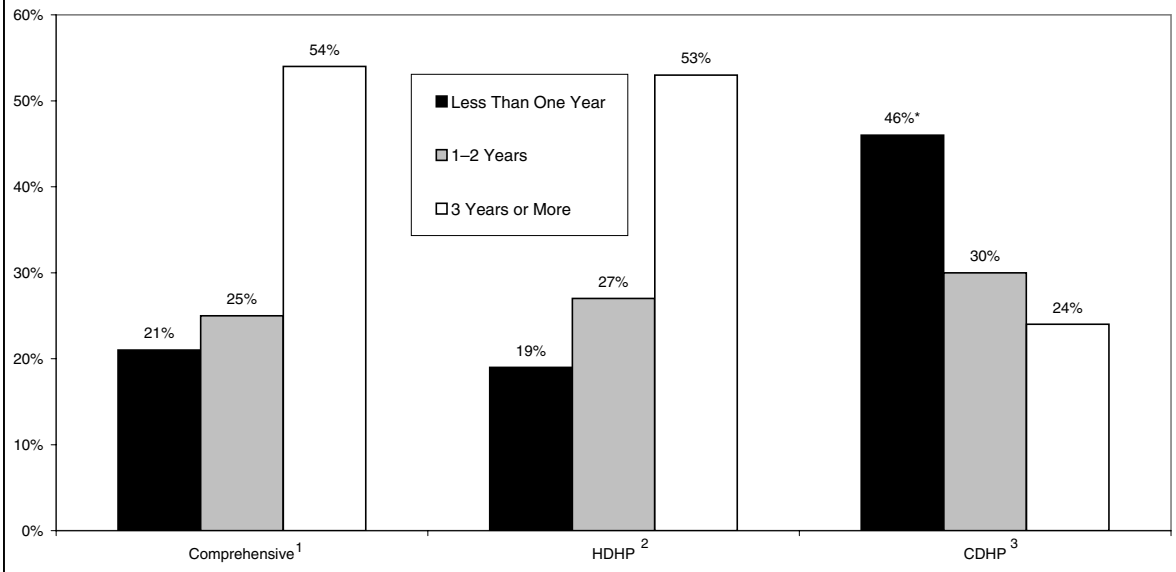
S12b. Are you allowed to roll over unspent money for your use in the following year?
Yes
No
Other (describe) _____
Don't know

Similarly, more than one-half of the HDHP sample reported that they had been in their health plan for three or more years. This group is comprised of 72 percent covered by an employment-based health plan and 28 percent covered by a nongroup health plan. Those covered in the employment-based market may have been with their employer for many years, but it is only recently that the employer moved to a HDHP HSA-qualified health plan. For those in the nongroup market, it is possible that they have been with the same insurer for many years, but only after the enactment of the Medicare Modernization Act of 2003 (MMA), switched to a HDHP, or were switched to a HDHP by their insurer.

With respect to familiarity with a CDHP, 65 percent of those with a CDHP were either extremely or very familiar with the plan, and another 22 percent were somewhat familiar with it (Figure A2). In contrast, only 4 percent of individuals with comprehensive coverage were extremely or very familiar with a CDHP, and 10 percent of individuals with an HDHP were extremely or very familiar with a CDHP.

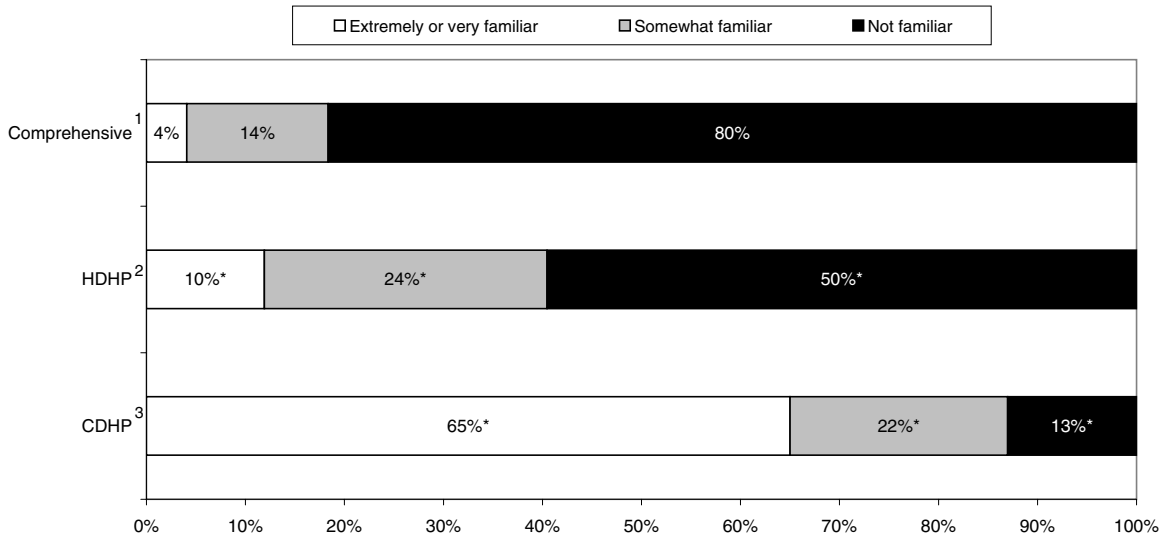
Studies have demonstrated that panel Internet surveys, when carefully designed, obtain results comparable with random-digit-dial telephone surveys. Taylor (2003), for example, provides the results from a number of surveys that were conducted at the same time using the same questionnaires both via telephone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

Figure A1
Number of Years Covered by Current Health Plan, by Type of Health Plan



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.
[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure A2
Familiarity With Consumer-Driven Health Plans



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.
[1] Comprehensive = health plan w/ no deductible or <$1000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan w/ deductible $1000+ (individual), $2000+ (family), no account.
[3] CDHP = Consumer-driven health plan w/ deductible $1000+ (individual), $2000+ (family), w/ account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

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Endnotes

[1] In 1999, workers paid an average of $27 per month for employee-only coverage and $129 per month for family coverage. By 2005, workers were paying $51 per month for employee-only coverage and $226 per month for family coverage. (See www.kff.org/insurance/7315/index.cfm).

[2] In 2004, 62.4 percent of the population under age 65, accounting for 159 million nonelderly individuals, had some form of employment-based health benefits, down from 66.8 percent in 2000 (Fronstin, 2005).

[3] In 1996, the average PPO deductible for in-network providers was $180 and the average POS plan deductible for in-network providers was $71. By 2005, those deductibles had reached $323 and $220, respectively. Deductibles for use

of out-of-network providers have been increasing as well and are considerably higher than deductibles for in-network providers.

[4] Currently, 19 percent of large employers use a tiered network for some combination of physician and hospital services, up from 11 percent in 2003 (Mercer Human Resources Consulting, 2004a).

[5] By the time the Treasury Department and Internal Revenue Service (IRS) released the bulk of the regulatory guidance for HSAs on July 23, 2004, it was too late for most large employers to offer an HSA by Jan. 1, 2005. The timing of the release of the guidance may explain why in spring 2004, 43 percent of large employers were very or somewhat likely to offer an HSA by 2005, but 73 percent were very or somewhat likely to offer them by 2006 (Mercer Human Resources Consulting, 2004b).

[6] In March 2005, it was reported that slightly more than 1 million individuals were covered by HSA-qualified plans, and 54 percent of them were covered in the individual market (www.ahip.org/content/pressrelease.aspx?docid=9771). More recently, based upon a national study of employers, it was estimated that 4 percent of employers offered a high-deductible health plan (HDHP) either with an HRA or one that was HSA-qualified, and that 2.4 million workers were enrolled in one of these plans, with 1.6 million in an HRA-based plan and 0.8 million in the HSA-qualified plan (Claxton, et al., 2005). The study also found that among employers offering health benefits, 20 percent were offering a HDHP.

[7] In theory, a random sample of 1,204 yields a statistical precision of plus or minus 3 percentage points (with 95 percent confidence) of what the results would be if the entire population ages 21 to 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.

[8] Employers started offering health plans with health reimbursement arrangements (HRAs) in 2001. The Treasury Department and the IRS provided initial guidance on the legality of these plans in June 2002 and how they fit into then current law on the tax treatment of health benefits. Health savings accounts (HSAs) were first codified into law as part of the Medicare Modernization Act (MMA) of 2003, and have only been available since 2004.

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