March 2008

Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey

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- ***Third annual survey—***This *Issue Brief* presents findings from the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey. The online survey of 4,217 privately insured adults ages 21–64 was conducted to provide nationally representative data regarding the growth of account-based health plans and high-deductible health plans (HDHPs), and their impact on the behavior and attitudes of health care consumers.
- ***Enrollment remains low—***In 2007, 2 percent of the population was enrolled in a consumer-driven health plan (CDHP), up from 1 percent in 2006 and 2005. Enrollment in HDHPs increased from 9 percent in 2005 to 11 percent. The 2 percent of the population with a CDHP represents 2.3 million adults ages 21–64 with private insurance, while the 11 percent with a HDHP represents 12.5 million people. Among the 12.5 million individuals with an HDHP, 42 percent or 5.2 million reported that they were eligible for a health savings account (HSA) but did not have such an account. Thus, overall, 7.5 million adults ages 21–64 with private insurance, representing 6.6 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA, but had not opened the account.
- ***Income is higher—***Over 2005–2007, adults enrolled in CDHPs became increasingly more likely to earn higher incomes. In 2007, 31 percent were in households with incomes of $100,000 or more, up from 22 percent in 2005. Just 19 percent of adults with CDHPs were in households with incomes under $50,000, down from 33 percent in 2005. Among HDHP enrollees, 23 percent were in higher income households in 2007, up from 15 percent in 2005. In contrast, there was little change in the income distribution of people enrolled in more comprehensive plans.
- ***Health status is better—***Adults enrolled in CDHPs are in better health, are less likely to have chronic health conditions or to smoke, and are more likely to exercise than are people in more comprehensive health plans.
- ***No impact on the uninsured—***As in 2006, the survey finds that adults in CDHPs are no more likely to have been uninsured prior to enrolling in their plans than are those in more comprehensive plans. Seven percent of CDHP enrollees were uninsured prior to being covered by their current plan, compared with 15 percent among HDHP enrollees and 28 percent among individuals with comprehensive coverage.
- ***Lower satisfaction—***As in 2005 and 2006, individuals in CDHPs and HDHPs continue to be less satisfied with various aspects of their health plan than individuals in more comprehensive plans. However, individuals in CDHPs were somewhat more satisfied with their plans in 2007 than they were in 2006, and there was a significant increase in the share of CDHP enrollees who said that they would recommend their plan to a friend or co-worker and stay in their plan if they had the opportunity to change.
- ***More missed care—***Individuals in CDHPs and HDHPs reported using health services at rates similar to those in comprehensive plans, and there were no reported differences in the use of preventive screens or tests. However, as in prior years, the survey finds evidence that people in CDHPs and HDHPs are more likely to skimp on needed medical care or medications because of cost than are those in more comprehensive plans. Over 2005–2007, the reported rates of cost-related problems dropped among adults in CDHPs, although not among those in HDHPs.
- ***More cost-conscious behavior—***Adults in consumer-driven plans continue to be more cost-conscious in their health care decision-making. They are significantly more likely than those in comprehensive health plans, but not substantially so, to talk with their doctors about treatment options and costs or to ask for a generic drug or a less costly drug.
- ***Information still limited—***There have been no significant gains reported among plan enrollees in the provision of information on provider cost and quality by health plans over the three years of the survey.

Paul Fronstin of EBRI and Sara Collins of The Commonwealth Fund wrote this *Issue Brief* with assistance from their respective research and editorial staffs. The authors gratefully acknowledge the research assistance of Jennifer Kriss of the Commonwealth Fund.

This survey was made possible with major support from The Commonwealth Fund and additional support from IBM, Pfizer, and Proctor & Gamble. The views presented here are those of the authors and should not be ascribed to the survey sponsors or the directors, officers, trustees, or other sponsors of EBRI, EBRI-ERF, The Commonwealth Fund, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Introduction

Employment-based health benefits are the most common form of health insurance in the United States (Fronstin, 2007b). Because the cost of health benefits has been increasing faster than inflation and worker earnings, employers have been seeking ways to manage the cost increases. Recently, more workers have been subject to higher deductibles (Fronstin, 2007a), and there has been growing interest among employers in offering health plans with deductibles that are even higher than those workers are used to seeing. These health plans with high deductibles are often combined with a tax-preferred savings or spending accounts for health care expenses. Employers first started offering account-based health plans in 2001, when a handful of employers began to offer health reimbursement arrangements (HRAs). In 2004, employers were able to start offering health plans with health savings accounts (HSAs).[1] By 2007, 10 percent of employers offering health benefits were offering one or both of these options to their employees, covering an estimated 3.8 million workers (Claxton, et al., 2007).

High-deductible health plans, whether or not linked to a tax-preferred account, 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 use of needed health care services, especially among people with low incomes and/or chronic conditions. And while most employers are interested in the long-term prospects for improved cost control that high-deductible health plans might provide, they await evidence that the plan will succeed in sustaining cost control, and are concerned about the potential adverse effects on the use of preventive and chronic care conditions and other health care services that some researchers have found (Collins, et al., 2006; Davis, et al., 2005; Glied and Remler, 2005; Hsu, et al., 2006; Newhouse, 2004; Rice and Matsuoka, 2004; Schoen, et al., 2005; Tamblyn et al., 2001). 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 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey. Findings from the 2007 survey are compared with our findings from 2005 and 2006. For this study, we conducted an online survey of 4,217 privately insured adults ages 21–64 to provide nationally representative data regarding the growth of account-based health plans and high-deductible health plans, and their impact on the behavior and attitudes of health care consumers. The sample was randomly drawn from Synovate's online sample of more than 2 million Internet users who have agreed to participate in research surveys. We used a base sample of 2,182 to draw incidence rates for persons with account-based health plans and high-deductible health plans, and complemented the base sample with an additional random oversample of these two groups. More specifically, the oversamples were: 1) those with a high-deductible health plan and 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 that are generally high enough to meet the qualifying threshold to make tax-preferred contributions to such an account. High deductibles were defined as individual deductibles of at least $1,000 and family deductibles of at least $2,000.[2]

This survey, a nationally representative survey of individuals with high-deductible health plans who also have savings accounts—so-called consumer-driven health plans (CDHPs)—enables comparisons among individuals with these plans, individuals with deductibles generally high enough to meet the threshold that would qualify them to make tax-preferred contributions to an HSA but who currently do not have such an account, and adults enrolled in more comprehensive health plans or those with lower or no deductibles.[3] The final sample included 895 in high-deductible health plans with either an HSA or HRA (CDHPs), 1,404 in high-deductible health plans without accounts (HDHPs), and 1,918 in more comprehensive health plans.

Summary of Findings

This survey finds that, in 2007, 2 percent of the population was enrolled in a CDHP, up from 1 percent in 2006; and enrollment in HDHPs increased from 7 percent to 11 percent (Figure 1). The 2 percent of the population with a CDHP represents 2.3 million adults ages 21–64 with private insurance, while the 11 percent with a HDHP represents 12.5 million people. Among the 12.5 million individuals with an HDHP, 42 percent, or 5.2 million, reported that they were eligible for an HSA but did not have such an account. Thus, overall, 7.5 million adults ages 21–64 with private insurance, representing 6.6 percent of that market, were either in a CDHP or were in an HDHP that was eligible for an HSA, but had not opened the account. (See boxes on pgs. 46–47 for more information about other research that has estimated the size of the CDHP and/or HDHP market.)

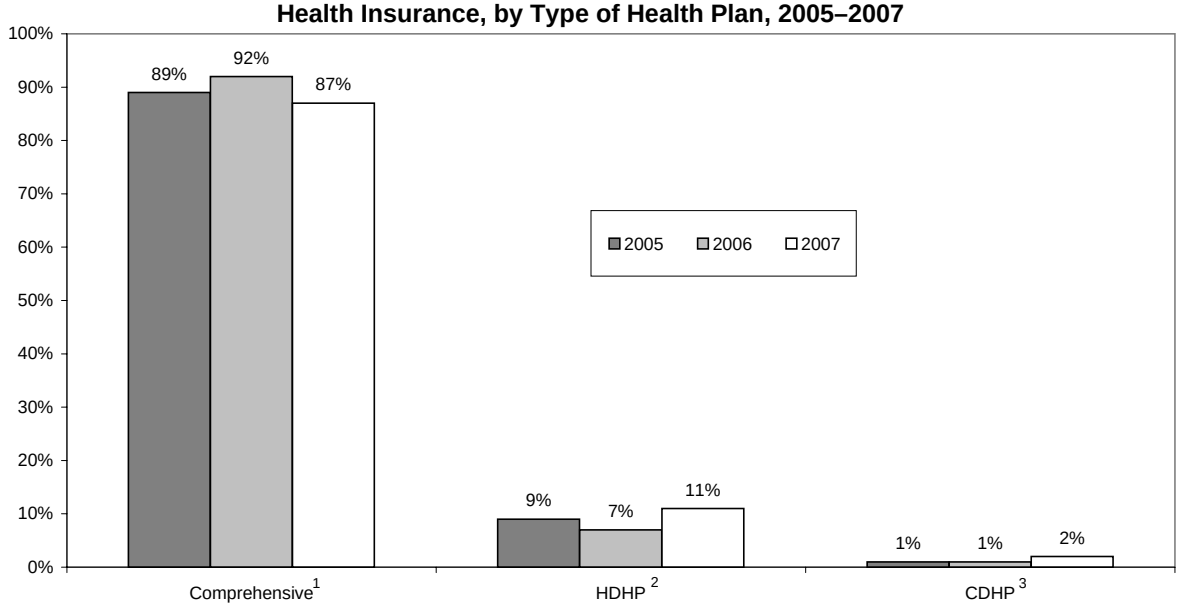
Although CDHPs have been around since 2001, the market penetration is small and the plans are still relatively new and unknown. Among persons with CDHPs, 34 percent had been covered by their health plan three years or longer in 2007 (Figure 2), up from 21 percent in 2006 (data not shown). Among comprehensive plan and HDHP enrollees, 60 percent and 52 percent, respectively, had been covered by their health plan three years or longer in 2007. With respect to familiarity with CDHPs, 61 percent of those with a CDHP were extremely or very familiar with CDHPs (Figure 3). In contrast, only 7 percent of individuals with comprehensive coverage were extremely or very familiar with CDHPs, and only 11 percent of individuals with an HDHP were extremely or very familiar with CDHPs.

The survey also finds that adults in CDHPs are no more likely to have been uninsured prior to enrolling in their plans than are those in more comprehensive plans. The survey asked respondents whether they had health insurance coverage prior to enrolling in their current health plan. Seven percent of CDHP enrollees were uninsured prior to being covered by their current plan, compared with 15 percent among HDHP enrollees and 28 percent among individuals with comprehensive coverage (Figure 4). In the individual insurance market, 11 percent of adults with CDHPs were uninsured just prior to enrolling in their health plan, compared with 39 percent of those in more comprehensive plans.[4]

The study also finds the following:

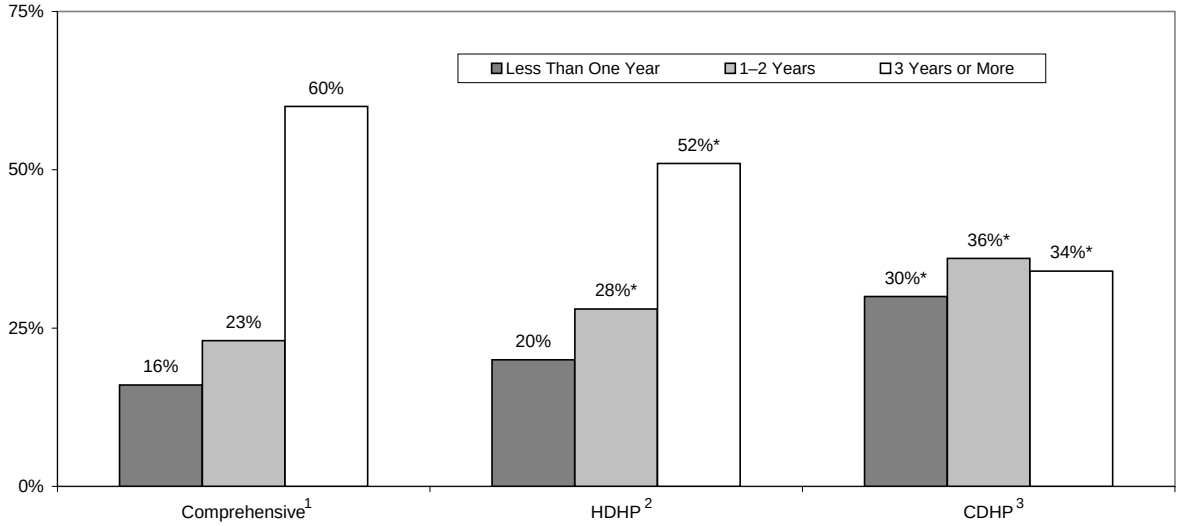
- Adults enrolled in CDHPs are in better health and are less likely to have chronic health conditions than are people in more comprehensive health plans. Adults in CDHPs were significantly less likely to smoke and more likely to exercise than were adults in more comprehensive plans. CDHP enrollees were more likely than those in comprehensive plans to have a high household income, were less likely to be between the ages of 21 and 34, and, along with those in HDHPs, more likely to be single, white, and college graduates, compared with those in comprehensive plans.
- While the legislation that created HSAs allows people to have high deductible health plans which cover the cost of preventive services (i.e., preventive services are excluded from the deductible), more than one-half of individuals in CDHPs report that their deductibles apply to all health care services—meaning preventive services are not carved out from the deductible.
- As in both 2005 and 2006, individuals in CDHPs and HDHPs continue to be 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. Changes to the trend in satisfaction among HDHP enrollees were not statistically significant, whereas the change among CDHP enrollees was less clear. The percentage of individuals extremely or very satisfied with the quality of their health plan increased between 2005 and 2007, with the increase between 2006 and 2007 being statistically significant. Increases in satisfaction rates with respect to out-of-pocket costs and choice of doctor were not statistically significant, but the increase in overall satisfaction was statistically significant between 2006 and 2007.
- The survey finds that individuals enrolled in CDHPs and HDHPs are more likely than those with comprehensive coverage to report that they delayed or avoided needed care because of the cost, with problems particularly pronounced among those with health problems and lower incomes. Yet the survey found little significant variation among adults in the three plan types in reported use of health services. Nor were there any significant differences among adults in the three plan types in their use of recommended preventive screening tests. The results were mixed with respect to following

Figure 1
Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan, 2005–2007



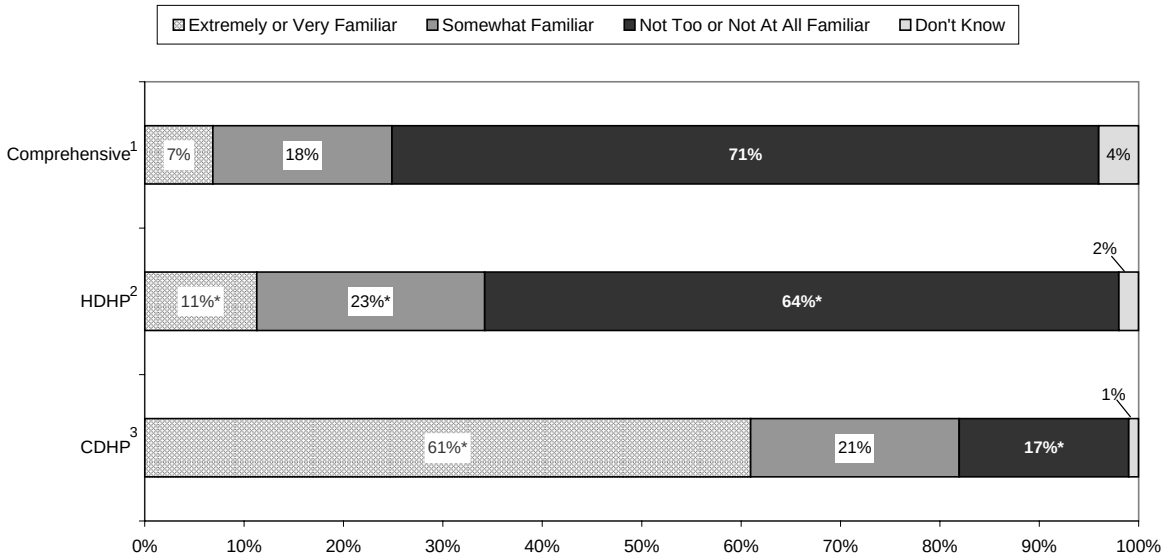
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 2
Number of Years Covered by Current Health Plan, by Type of Health Plan, 2007



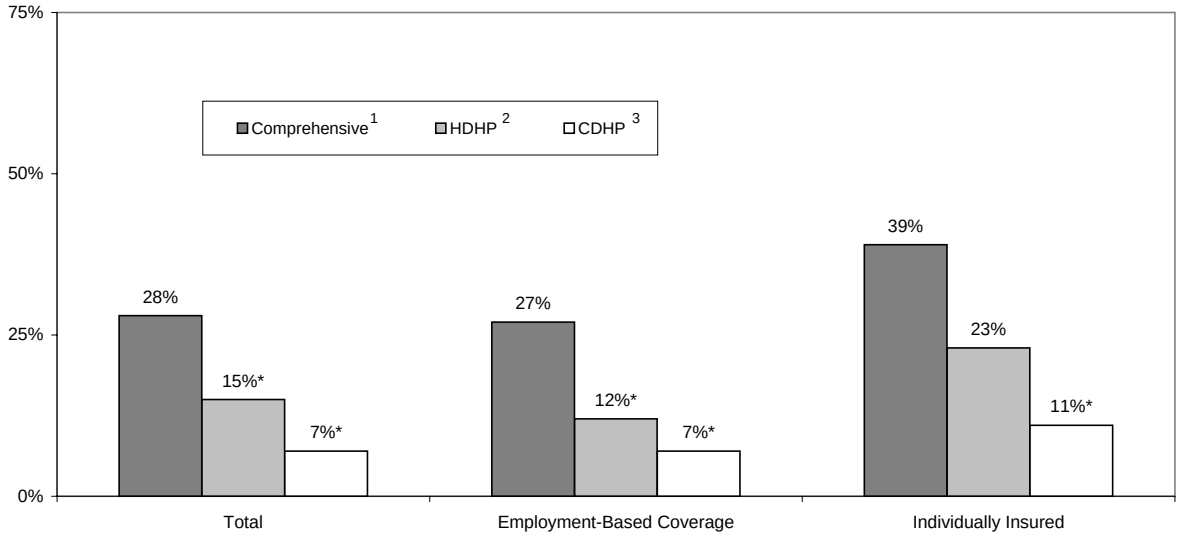
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 3
Familiarity With Consumer-Driven Health Plans, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 4
Percentage of Individuals With Health Insurance Coverage Who Were Uninsured Before Getting Coverage From Current Plan, by Type of Health Plan and Coverage Source, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.

recommended treatment regiments among persons with various diseases and conditions. Over time, adults in CDHPs were significantly less likely to report delaying or avoiding needed care, even among persons with health problems, although not among individuals in lower-income households. Adults in CDHPs also became significantly less likely over the three-year period to report that they had failed to fill a prescription because of cost or skipped doses of their medication.

- Despite the emphasis on informed choice surrounding HDHPs and CDHPs, people in HDHPs were less likely than those in more comprehensive plans to report that their health plan provided information on the cost and quality of providers. There were no differences in plan-provided information between enrollees in CDHPs and comprehensive plans. CDHP enrollees were more likely than comprehensive plan enrollees to use the hospital cost information, and both HDHP and CDHP enrollees were more likely than comprehensive plan enrollees to seek information from sources other than their health plan on cost and quality of care provided by doctors.
- Individuals in CDHPs and HDHPs exhibit more cost-conscious behavior in their health care decision-making than individuals with more comprehensive health insurance.

The remainder of this report compares and contrasts the findings from the 2007 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. Findings from the 2007 survey are examined and compared with findings from both the 2005 and 2006 surveys, where relevant. The report examines health plan features, enrollee characteristics, attitudes and satisfaction, choice of health plan, health care use, cost-related access problems, cost and quality information, and health care decision-making.

Health Plan Features

The majority of privately insured adults have deductibles, regardless of plan type. More than three in five (61 percent) of adults enrolled in more comprehensive health plans reported that they had a deductible, and 9 percent said that they had a deductible that applied only to health care services obtained outside of the provider network (data not shown). Among adults with single-person coverage in more comprehensive plans, 29 percent had no deductible, 44 percent had a deductible below $500, 17 percent had a deductible between $500 and $999, and 9 percent either did not know if they had a deductible or did not know what their deductible was (Figure 5). Among adults with family coverage in more comprehensive plans, 44 percent had no deductible, 37 percent reported that the deductible was below $999, 10 percent reported that it was between $1,000 and $1,999, and 9 percent either did not know if they had one or what it was.

Among adults with single-person coverage and enrolled in a HDHP, 57 percent reported a deductible of between $1,000 and $1,999, 31 percent had deductibles between $2,000 and $4,999, and 9 percent had deductibles of $5,000 or more. Three-quarters (75 percent) of those in HDHPs with family coverage had a deductible of between $2,000 and $4,999, and 19 percent were in a plan with a deductible of $5,000 or higher.

Many people with CDHPs have deductibles substantially above the level required for HSA eligibility. Among CDHP enrollees with single person coverage, less than half (46 percent) had deductibles of under $2,000; 47 percent had deductibles between $2,000 and $4,999, and 5 percent had deductibles of $5,000 or more. Among people with family coverage who were enrolled in a CDHP, 70 percent reported that they were covered by a plan with a family deductible of $2,000 to 4,999 and 29 percent reported a deductible of $5,000 or more.

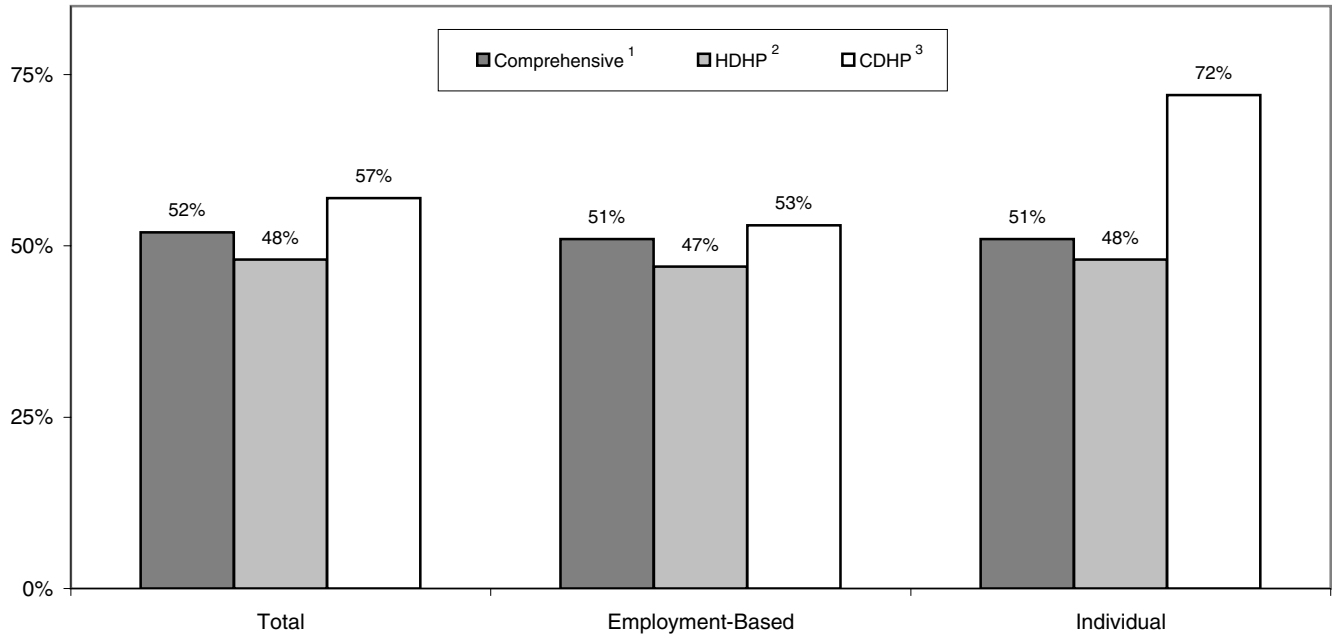
By law, people in high-deductible health plans can have the cost of preventive services excluded from their deductible and still be eligible for an HSA. This provision in the legislation was designed to encourage those with high deductibles to get regular screening tests like mammograms and colonoscopies. The survey asked people with deductibles whether their deductible applied to all medical care or whether some services were excluded. More than one-half (57 percent) of adults in CDHPs, including those with coverage through their employers (53 percent), said that their deductibles applied to all medical care (Figure 6). Seventy-two percent of those in CDHPs with coverage through the individual market said their deductibles applied to all their care.

Figure 5
Annual Deductibles and Premiums, by Type of Health Plan, 2007

	Comprehensive[1]	HDHP[2]	CDHP[3]
Total Sample	1,918	1,404	895
Single Person Deductible			
No deductible	29%	N/A	N/A
$1–$499	44	N/A	N/A
$500–$999	17	N/A	N/A
$1,000–$1,999	N/A	57	46
$2,000–$4,999	N/A	31	47
$5,000 or higher	N/A	9	5
Family Deductible			
No deductible	44	N/A	N/A
$1–$999	37	N/A	N/A
$1,000–$1,999	10	N/A	N/A
$2,000–$4,999	N/A	75	70
$5,000 or higher	N/A	19	29
Premium (Family)			
None	17	11*	10*
Less than $2,400	46	38*	42
$2,400–$3,599	12	17*	13
$3,600 or more	14	28*	28*
Don't know	11	4*	6*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Figure 6
Percentage of Adults Whose Deductibles Apply to All Medical Services, by Coverage Source, 2007
(Percentage of privately insured adults ages 21–64)



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.

Figure 7

Selected Demographics, by Type of Health Plan, 2005–2007

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

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005, 2006, 2007.

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

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

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

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

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

Difference between 2005 and 2007 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.

Health Status and Demographics

In 2007, adults in CDHPs were significantly more likely to be in excellent or very good health than those with HDHPs or comprehensive health insurance. Nearly two-thirds (65 percent) of adults with CDHPs said their health was excellent or very good, compared with just over half (54 percent) of those with HDHPs and 49 percent of those with comprehensive health insurance (Figure 7). Those in employment-based HDHPs and CDHPs were significantly less likely to report being in excellent or very good health than were those who had purchased either product in the individual market. About 3 in 5 (63 percent) adults with employment-based CDHPs said they were in excellent or very good health, compared with three-quarters (74 percent) of those with CDHPs purchased in the individual market (data not shown).

The survey asked respondents whether they had chronic health 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). People in CDHPs were significantly less likely to have a health problem than were adults in HDHPs or more comprehensive plans: 46 percent of those in CDHPs reported a health problem, compared with just over half (55–53 percent) of those in HDHPs and more comprehensive plans.

Adults in CDHPs were significantly less likely to smoke than were adults in more comprehensive plans: 15 percent of those in CDHPs smoked, compared with about one-quarter (24 percent) of those in more comprehensive plans (Figure 7). People in CDHPs were also slightly more likely to exercise but they were no less likely to be obese, compared with adults in other health plans.

Adults enrolled in CDHPs were significantly more likely than those in HDHPs and comprehensive plans to have a high household income: 31 percent of those in CDHPs had incomes of $100,000 or more, compared with 23 percent of those in HDHPs and 21 percent of those in comprehensive plans.

Those enrolled in CDHPs and HDHPs were also significantly less likely to be between the ages of 21 and 34, compared with those in comprehensive plans, and, more likely to be single, white, male, a college graduate, and to have a graduate degree.

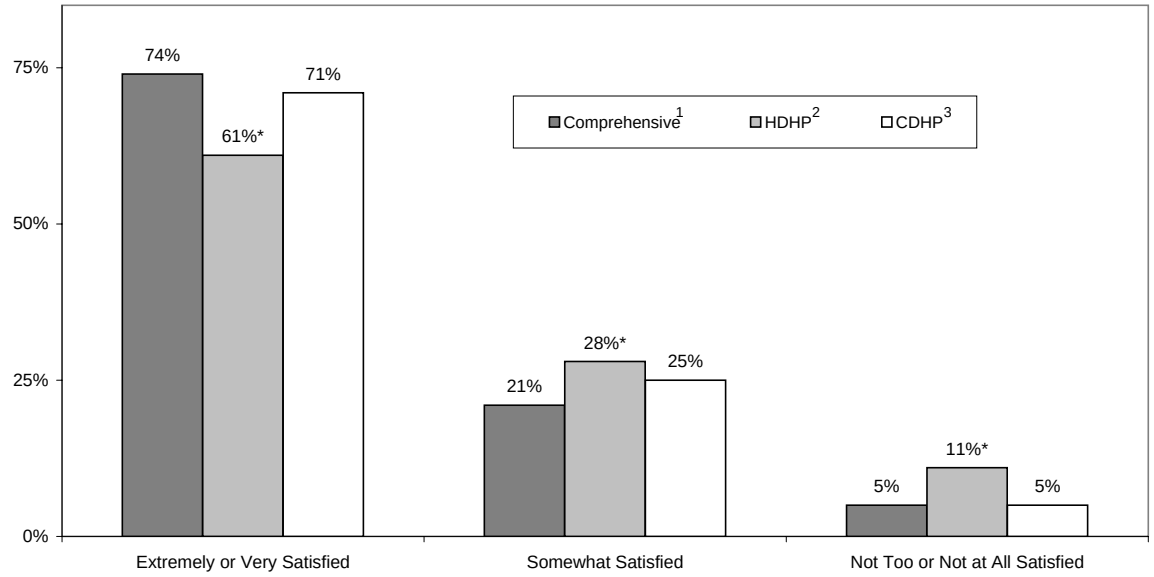
People in both CDHPs and HDHPs were more likely than those in more comprehensive plans to be sole proprietors or to be employed in small firms. Just over one-quarter (27–28 percent) of adults in HDHPs and CDHPs were employed in companies with fewer than 50 workers, compared with 19 percent of those in more comprehensive plans (Figure 7). There was little difference in the share of enrollees who worked for companies with 500 or more employees among the three plan types.

Trends

Over 2005–2007, adults enrolled in CDHPs became significantly higher income. In 2007, 31 percent were in households with incomes of $100,000 or more, up from 22 percent in 2005 (Figure 7). Just 19 percent of adults with CDHPs lived in households with incomes under $50,000, down from 33 percent in 2005. Among HDHP enrollees, 23 percent were in higher income households in 2007, up from 15 percent in 2005. In contrast, there was little change in the income distribution of people enrolled in more comprehensive plans.

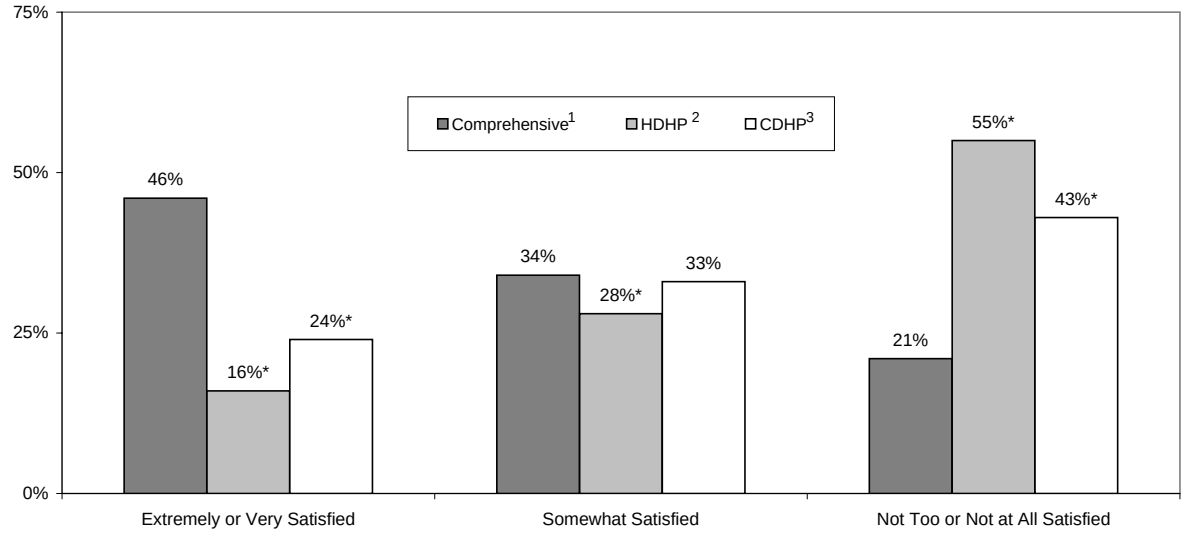
In addition, over the three years of the survey, people enrolled in CDHPs became significantly more likely to be employed in large firms and less likely to be sole proprietors or employees of small companies. In 2005, nearly half (47 percent) of CDHP enrollees were sole proprietors or worked in companies of fewer than 50 employees. By 2007, that percentage had fallen to one-third (34 percent). Employment of CDHP enrollees in companies of 500 or more workers climbed from 36 percent to 40 percent. A similar trend occurred among adults with HDHPs, but the changes were smaller.

Figure 8
Satisfaction With Quality of Health Care Received, by Type of Health Plan, 2007



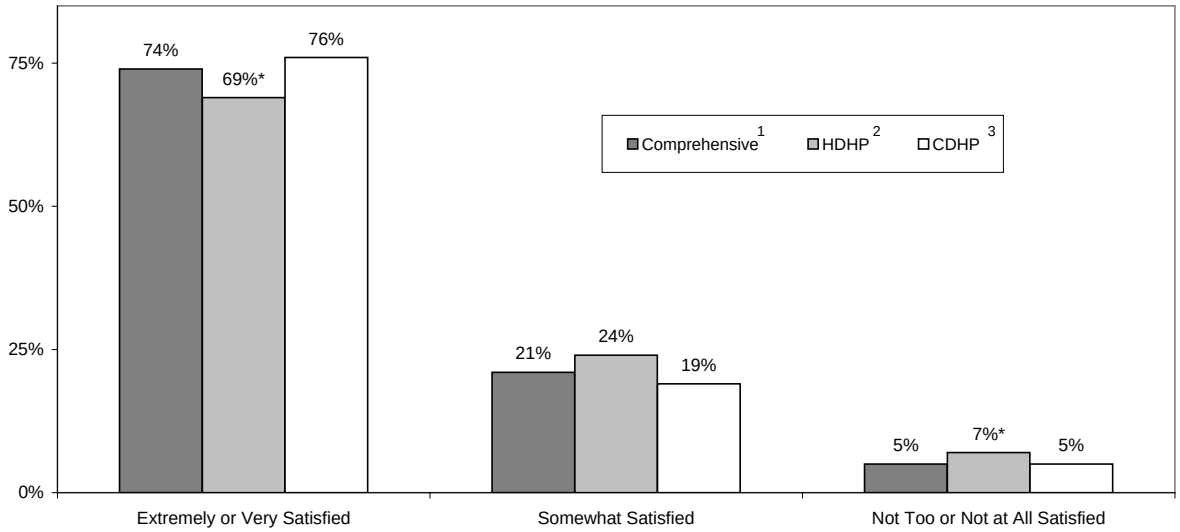
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 9
Satisfaction With Out-of-Pocket Costs for Health Care, by Type of Health Plan, 2007



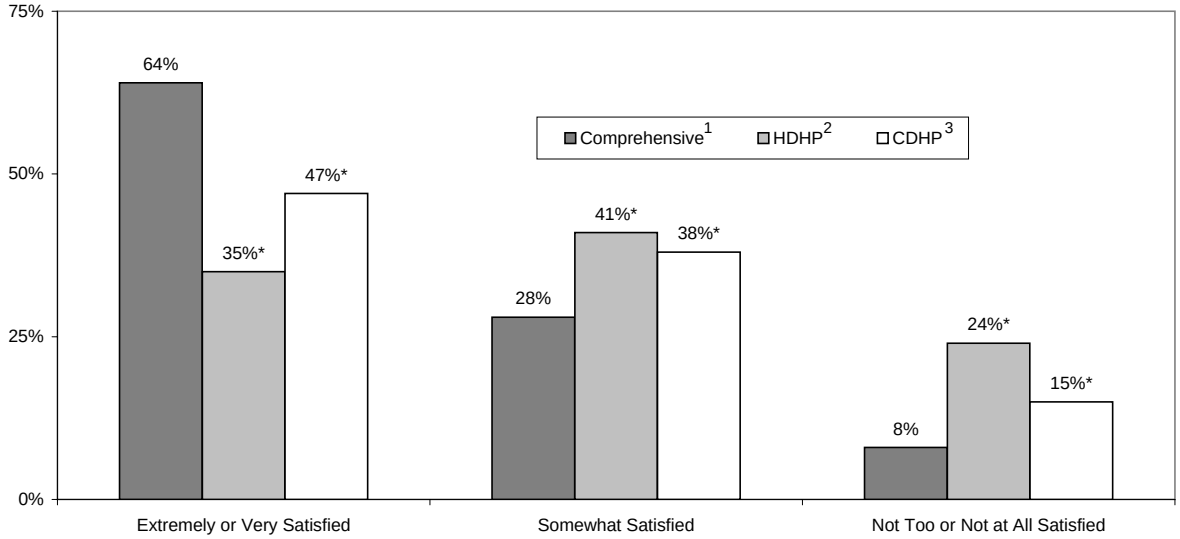
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 10
Satisfaction With Choice of Doctors, by Type of Health Plan, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 11
Overall Satisfaction With Health Plan, by Type of Health Plan, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the 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, the survey 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 insurance were more satisfied than individuals enrolled in HDHPs with the quality of health care they received (Figure 8) and they were more satisfied with out-of-pocket costs (Figure 9). In addition, individuals in comprehensive health plans were as likely as individuals with CDHPs to be extremely or very satisfied with regard to access to doctors or choice of doctors (Figure 10). They were more likely than individuals with HDHPs to be extremely or very satisfied with choice of doctors.

Overall, individuals with comprehensive health insurance were significantly more satisfied with their health plan than individuals with CDHPs and HDHPs. Specifically, 64 percent of individuals with comprehensive health insurance were extremely or very satisfied with their health plan, compared with 35 percent among HDHP enrollees and 47 percent among CDHP enrollees (Figure 11).

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. Slightly more than one-half of individuals in more comprehensive plans were extremely or very likely to recommend their health plan, compared with 39 percent among those in CDHPs and 27 percent among those in HDHPs (Figure 12).

Individuals in CDHPs and HDHPs were less likely than those with more comprehensive health insurance to report that they were likely to stay with their current plan if they had the opportunity to change plans. Just over one-third (34 percent) of HDHP enrollees and 45 percent of CDHP enrollees reported that they were extremely or very likely to stay with their current health plan if they had the opportunity to switch, compared with 64 percent of individuals with comprehensive health insurance (Figure 13).

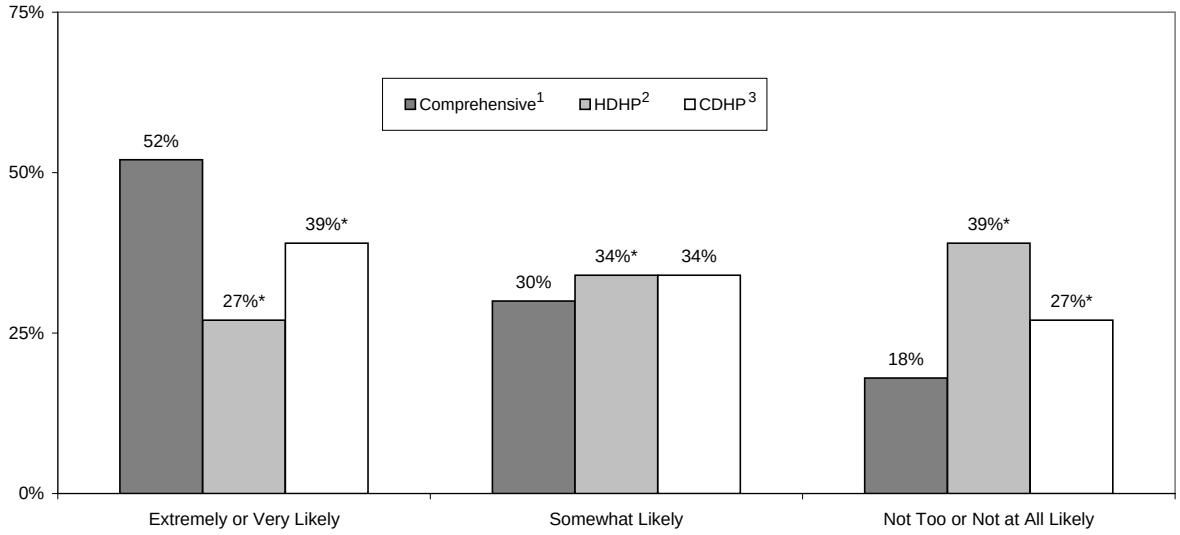
Trends

Figure 14 shows the 2005–2007 trends in the percentage of individuals either extremely or very satisfied regarding the various satisfaction questions presented in Figures 8–13. The figure shows that the percentage of individuals either extremely or very satisfied with the quality of health care received, out-of-pocket costs, choice of doctor, and overall with their plan was for the most part constant during the 2005–2007 period among individuals with comprehensive coverage. While there appears to be a general upward trend in satisfaction among individuals with HDHPs, the changes were not statistically significant. The percentage of individuals with a HDHP who were extremely or very satisfied with the quality of care received increased from 52 percent in 2005 to 61 percent in 2007, and the percentage satisfied with their choice of doctor increased from 60 percent in 2005 to 69 percent, but neither increase was statistically significant. Furthermore, the increase in satisfaction among HDHP enrollees with respect to out-of-pocket costs and their overall health plan was not statistically significant.

The trend in satisfaction levels for individuals with a CDHP is less clear. The percentage of individuals extremely or very satisfied with the quality of their health care received increased from 63 percent in 2005 and 2006 to 71 percent in 2007. The increase between 2006 and 2007 was statistically significant. In addition, the percentage satisfied with out-of-pocket costs increased from 18 percent in 2005 to 24 percent, and the percentage satisfied with choice of doctors increased from 69 percent to 76 percent, though neither of these changes was statistically significant. In contrast, the percentage of individuals who were extremely or very satisfied with their health plan decreased from 41 percent to 37 percent between 2005 and 2006 before increasing to 47 percent in 2007. While the decrease in satisfaction was not statistically significant between 2005 and 2006, the increase between 2006 and 2007 was statistically significant. Individuals in CDHPs continue to be less likely than individuals with more comprehensive coverage to be extremely or very satisfied with out-of-pocket costs and with their health plan overall; however, the difference in satisfaction levels with respect to the quality of health care received and choice of doctors that existed in 2006 no longer exists in 2007 because of increases in satisfaction levels among persons with CDHPs.

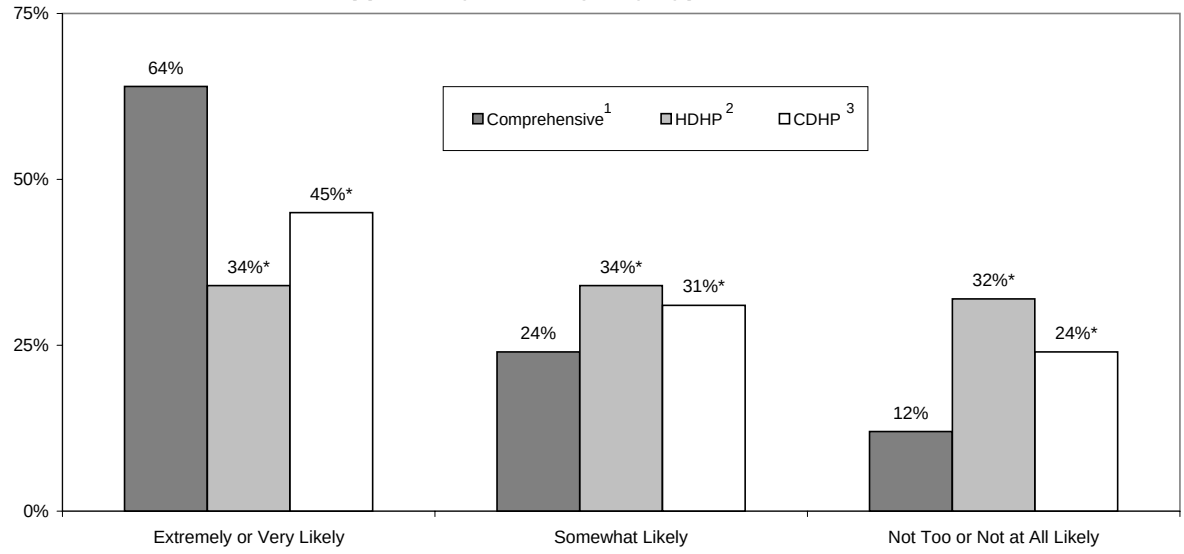
In terms of whether a person would recommend their plan to a friend or co-worker, there were no significant changes to the answers to this question between 2005 and 2007 for individuals in more

Figure 12
Likelihood of Recommending Health Plan to Friend or Co-Worker, by Type of Health Plan, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), 2000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 13
Likelihood of Staying With Current Health Plan If You Had the Opportunity to Change, by Type of Health Plan, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.
Note: Percentages may not sum to totals due to rounding.

Figure 14
Trends in Satisfaction, 2005–2007

	Comprehensive[1]			HDHP[2]			CDHP[3]		
	2005	2006	2007	2005	2006	2007	2005	2006	2007
Total Sample	1,061	1,506	1,918	463	930	1,404	185	722	895
Extremely or very satisfied with quality of health care received	70%	76%	74%	52%*	57%*	61%*	63%	63%*	71%^
Extremely or very satisfied with out-of-pocket costs for health care	45	46	46	13*	18*	16*	18*	20*	24*
Extremely or very satisfied with choice of doctors	72	77	74	60*	67*	69*	69	71*	76
Extremely or very satisfied with health plan	61	67	64	33*	37*	35*	41*	37*	47*^
Extremely or very likely to recommend health plan to friend or co-worker	49	53	52	23*	25*	27*	34*	30*	39*^
Extremely or very likely to stay with current health plan if had the opportunity to change	60	63	64	31*	30*	34*^	46*	36*	45*^

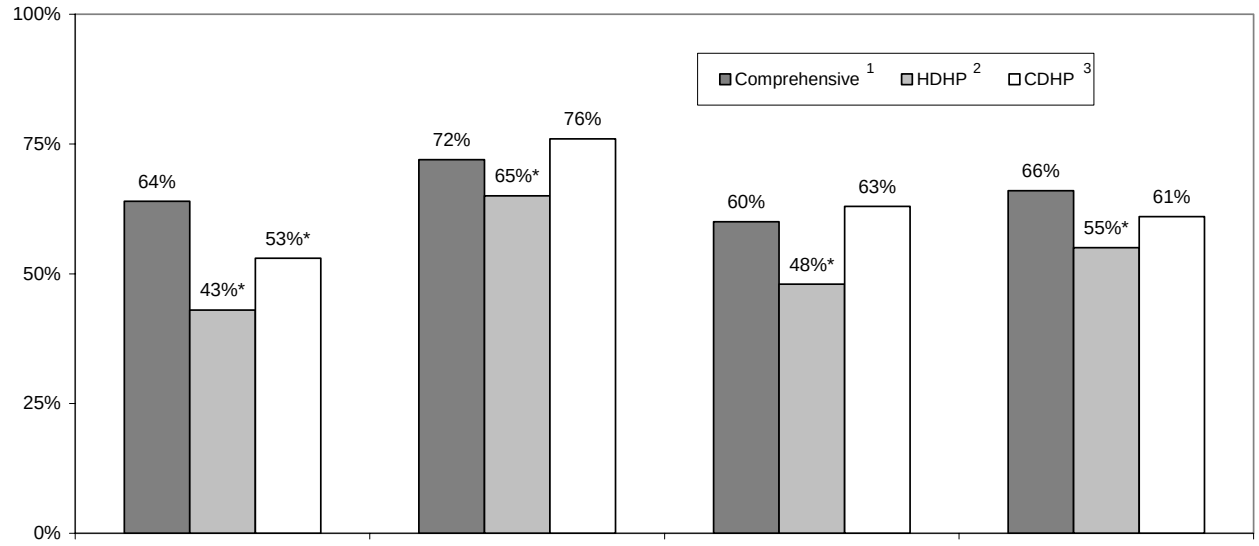
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005, 2006, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.
^ Difference from prior year shown is statistically significant at p ≤ 0.05 or better.
# Difference between 2005 and 2007 is statistically significant at p ≤ 0.05 or better.

comprehensive plans or those in HDHPs. Among individuals enrolled in CDHPs, 39 percent reported that they were extremely or very likely to recommend the plan to a friend or co-worker in 2007, up from 30 percent in 2006, but not statistically different than the 34 percent level in 2005 (Figure 14). Similarly, comprehensive plan enrollees did not report a change in the likelihood of staying with their plan during 2005–2007 if they had the opportunity to change plans. HDHP enrollees did not report a statistically significant change in the likelihood of staying with their plan during 2005–2006, but the increase from 30 percent to 34 percent between 2006 and 2007 was statistically significant. Similarly, there was a change in the likelihood of staying with their current health plan among CDHP enrollees, with 45 percent reporting they were extremely or very likely to stay with current health plan if had the opportunity to change, up from 36 percent in 2006. Neither 2006 nor 2007 were significantly different from the 46 percent reported in 2005.

Individuals with CDHPs and HDHPs were less likely than those with more comprehensive insurance to say that their health plan is easy to understand (Figure 15). Confusion about HDHPs may have increased. Between 2005 and 2007 the percentage of HDHP enrollees reporting that their health plan was easy to understand decreased from 51 percent to 43 percent, but the difference was not statistically significant (Figure 16). The percentage of enrollees in comprehensive health plans reporting that their health plan was easy understand was down slightly (though the change was not statistically significant), while the percentage of enrollees in CDHPs reporting that their health plan was easy to understand decreased from 54 percent to 45 percent between 2005 and 2006, and then increased back up to 53 percent in 2007. The change among CDHP enrollees was not statistically significant between 2005 and 2006, but was statistically significant between 2006 and 2007.

While HDHP enrollees were less likely than CDHP enrollees and individuals with more comprehensive coverage to report that their health plan encourages them to adopt a healthier lifestyle (Figure 15), there was also an across-the-board increase in these percentages between 2005 and 2007, with the increase occurring mainly between 2005 and 2006 for those with comprehensive coverage, while the increase occurred in both years for those with CDHPs.

Figure 15
Agreement With Statements About Health Plan: Percentage Reporting That They Strongly or Somewhat Agree, by Type of Health Plan, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.

With respect to information made available by the health plan provided to individuals to help them choose from among different health care providers, enrollees in all three types of health plans have reported an increase in availability of such information. Between 2005 and 2007, the percentage of enrollees in comprehensive plans reporting that information was available to help them choose a health care provider increased from 55 percent to 66 percent, while it increased from 40 percent to 55 percent among HDHP enrollees, and 40 percent to 61 percent for CDHP enrollees (Figure 16). The changes for HDHP enrollees and enrollees in more comprehensive plans was not statistically significant, but the changes for CDHP were statistically significant over time.

CDHP and HDHP enrollees are much more likely than individuals in comprehensive plans to report the terms of their health plan makes them consider costs before seeking treatment from a physician or filling a prescription. Three-quarters (74 percent) of CDHP enrollees reported that the terms of their health plan made them consider costs before seeking treatment, compared with 60 percent among HDHP enrollees and 47 percent among individuals in comprehensive plans (Figure 16). The trend line for this question was unchanged between 2005 and 2007, with one exception—the percentage of enrollees in comprehensive plans reporting that the terms of their health plan made them consider costs before seeking treatment increased statistically, from 40 percent to 47 percent between 2005 and 2007.

The trend line was also unchanged for the question on whether the health plan will protect an individual in the event of an expensive illness for HDHP enrollees and comprehensive plan enrollees. Three-quarters (76 percent) of CDHP enrollees and 72 percent of individuals in comprehensive plans reported that their health plan would protect them in the event of an expensive illness, compared to 65 percent among individuals enrolled in HDHPs. Among CDHP enrollees, the increase from 69 percent in 2006 to 76 percent in 2007 was statistically significant.

Choice of Health Plan

Among individuals covered by an employment-based health plan, those in CDHPs were more likely than those with comprehensive insurance to have a choice of health plan, followed by those enrolled in HDHPs. Over 60 percent of CDHP enrollees had a choice of health plan, compared with 54 percent of individuals in more comprehensive plans, and 46 percent of those with a HDHP (Figure 17). These results are in contrast to findings from 2005 and 2006 when individuals with comprehensive health insurance were more likely to have a choice of health plan than individuals enrolled in CDHPs (Figure 18). We also find that fewer individuals enrolled in a comprehensive health plan have a choice of health plan while the percentage of individuals with a choice of health plan in a CDHP has grown from 47 percent to 63 percent. This may be due to the simple fact that an increasing percentage of the CDHP population works for an employer with 200 or more employees (Figure 7).

When individuals have a choice of health plan, the premium affects their decision regarding which plan to choose. The survey found that 52 percent of CDHP enrollees in individual and employment-based plans reported that their cost for insurance was less expensive than the other available options (Figure 19). This compares with 31 percent of HDHP enrollees and 28 percent of individuals with comprehensive health insurance reporting that their health plan was the least-costly option available. There are other reasons, however, why an individual may choose a particular health plan. When asked about the main reason for enrolling in a plan, 51 percent of CDHP enrollees reported that they enrolled because of the lower premium, while 46 percent reported that the opportunity to save money in the account for future years was a main reason for enrolling in that plan (Figure 20). Among individuals with comprehensive insurance, 46 percent cited the good network of providers and 41 percent report the low out-of-pocket costs as the main reason for enrolling in the plan.

Among the population with comprehensive insurance and a choice of plan, 37 percent were offered a CDHP or HDHP, and 28 percent were not offered either plan, but 34 percent did not know if they were offered either plan (Figure 21). Among the 37 percent who were offered either a CDHP or HDHP, 13 percent were offered a CDHP, 12 percent were offered a HDHP, and 12 percent were offered an HDHP and did not know if they were offered an account.

Figure 16
Trends in Satisfaction and Views of Health Plan, 2005–2007

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

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005, 2006, 2007.

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

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

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

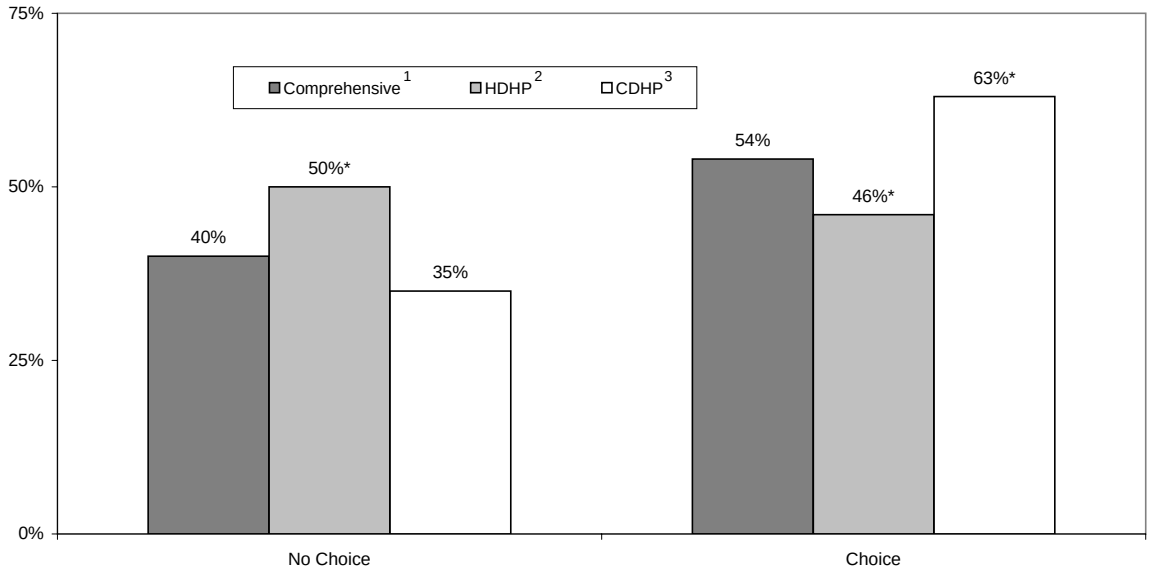
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

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

Difference between 2005 and 2007 is statistically significant at p ≤ 0.05 or better.

Figure 17

Percentage of Individuals Covered by Employment-Based Health Benefits With Choice and No Choice of Health Plan, by Type of Health Plan, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.

[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).

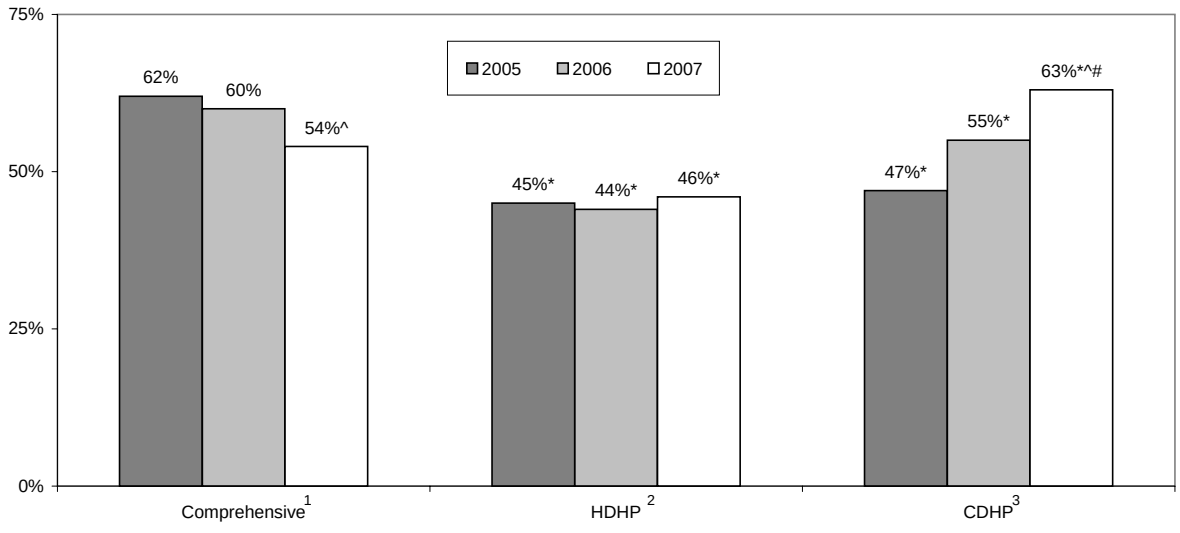
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.

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

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

Figure 18

Percentage of Individuals Covered by Employment-Based Health Benefits With a Choice of Health Plan, by Type of Health Plan, 2005–2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007.

[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).

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

[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.

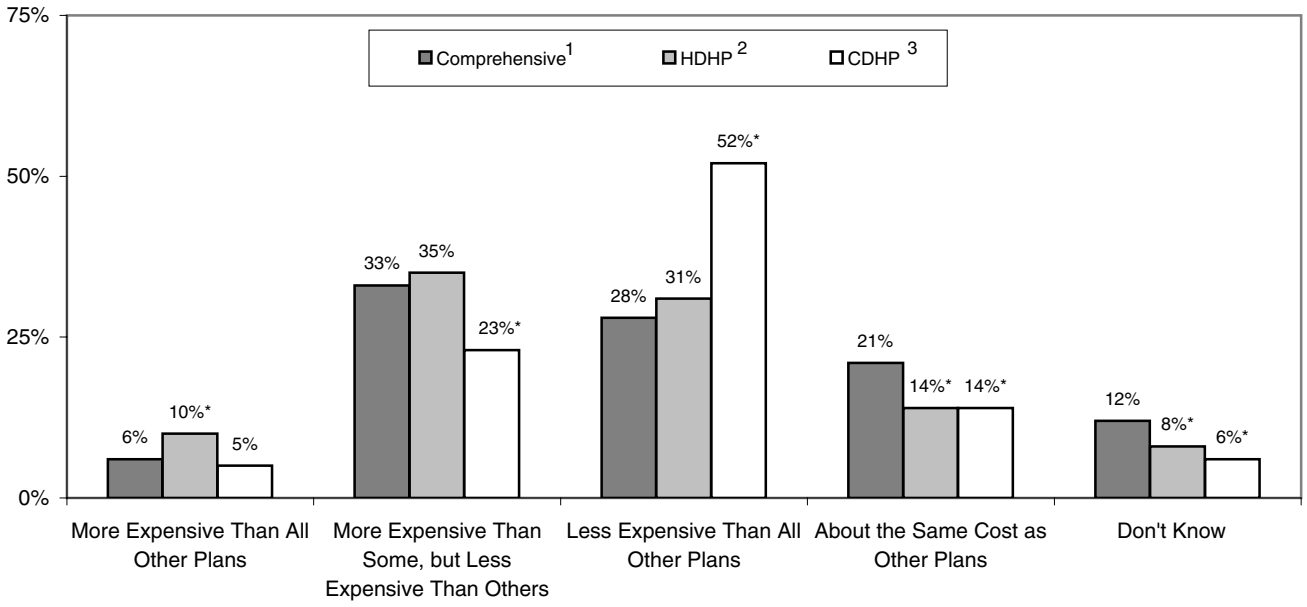
* Difference between HDHP/CDHP and Comprehensive is statistically significant at the p ≤ 0.05 or better.

^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.

[#] Difference between 2005 and 2007 is statistically significant at the p ≤ 0.05 or better.

Figure 19

Premium of Selected Plan Compared With Other Available Plans, Among Individuals With Choice of Plans and Those in the Non-group Market, by Type of Health Plan, 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.

[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).

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

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

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

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

Figure 20

Main Reason for Deciding to Enroll in Current Health Plan, Among Individuals With a Choice of Health Plans or in the Non-group Market, by Type of Health Plan, 2007

	Comprehensive[1]	HDHP[2]	CDHP[3]
Lower cost of the premium	29%	44%*	51%*
Low out-of-pocket costs for the doctor	41	13*	6*
Good network of physicians and hospitals/doctor in the network	46	43	26*
Prior experience with the plan	26	23	12
Plan's good reputation, recommended by others	18	15	8*
Famiar type of coverage, simple to understand	23	19	9*
Easy access to care	23	17*	12*
Opportunity to save money in the account, rollover funds for future years	2	1	46*
Puts you in control of your health care dollars, you make choices of how your account is spent	5	5	28*
Not much paperwork	16	16	7*
Tax benefits of the plan	4	3	24*

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.

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

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

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

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

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

- One-third (32 percent) reported that they did not have the money to fund the account.
- One-quarter (24 percent) reported that the tax benefits were not attractive enough.
- Sixteen percent reported that it was too much trouble to open and/or manage the account.
- Nine percent reported that it was either too complicated or they did not understand the option.

Contribution Behavior and Account Balances

Among individuals with a CDHP, some receive employer contributions to the account, while others do not. HRA enrollees will receive employer contributions but are unable to make their own contributions. Individuals with an HSA can contribute their own money to the account and may or may not also receive employer contributions. Six out of 10 individuals (61 percent) with an employment-based CDHP (including both those covered as an individual and those with family coverage) reported that the employer contributed to the account, while 34 percent reported that they did not receive employer contributions, and 4 percent did not know if the employer contributed (Figure 22).[5]

Among the 61 percent with an employer contribution, 13 percent received less than $500, 21 percent between $500 and $999, 22 percent received between $1,000 and $1,499, 13 percent received between $1,500 and $1,999, and 23 percent received $2,000 or more (Figure 23). Employer contributions vary, however, by whether an individual has employee-only or family coverage. Individuals with employee-only coverage are most likely to get an employer contribution between $500 and $750, while those with family coverage are most likely to get an employer contribution of at least $1,500 (Figure 24). In fact, 47 percent of individuals with family coverage get a contribution of at least $1,500, with 18 percent getting $1,500–$1,999 and 29 percent getting at least $2,000.

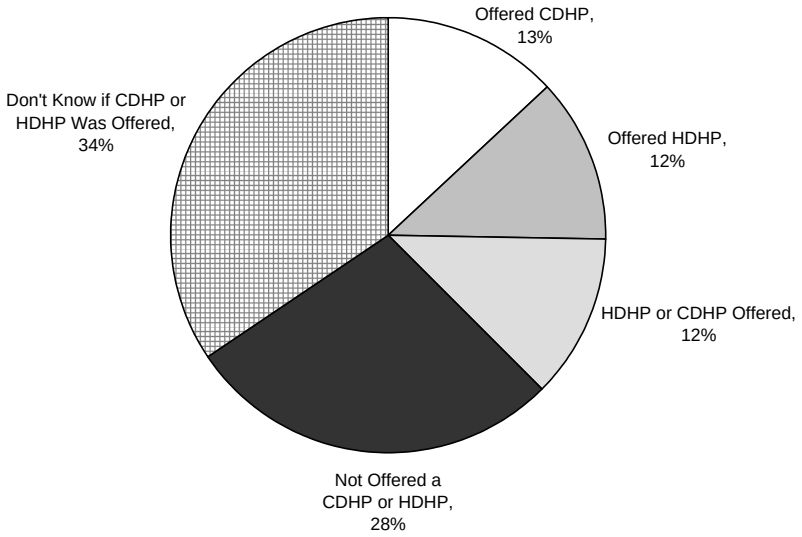
Overall, among persons eligible to contribute to an account, 16 percent of did not contribute anything, with 24 percent of those with household income below $50,000 and 15 percent of those with household income of at least $50,000 contributing nothing (Figure 25). The most significant difference in contributions by household income can be seen in the likelihood of contributing at least $1,500 to the account. One-half (48 percent) of individuals with household income of at least $50,000 contributed $1,500 or more to the account, whereas less than one-fifth (18 percent) of those with household income of less than $50,000 contributed $1,500 or more to the account.

Individual contributions to the account also vary by whether an individual has single coverage or family coverage. Specifically, individuals with single coverage are more likely than those with family coverage to contribute less than $500 to the account, whereas individuals with family coverage are more likely than those with single coverage to contribute at least $2,000 (Figure 26). Overall, 20 percent of individuals with single coverage contributed at least $2,000 while 42 percent of those with family coverage contributed at least $2,000 to the account.

The length of time that respondents to our survey have had a CDHP increased between 2006 and 2007. Between 2006 and 2007, the percentage of individuals with a CDHP for one to two years increased from 30 percent to 39 percent, and the percentage with a CDHP three to four years increased from 9 percent to 16 percent (Figure 27). This increased time with a CDHP may explain both the increased amount of money in accounts as well as the increased rollover amounts. Between 2006 and 2007, the percentage of individuals reporting $1,000 or more in their account increased from 25 percent to 44 percent (Figure 28), and the percentage of individuals reporting that they rolled over at least $1,500 increased from 13 percent to 23 percent (Figure 29). While we find that persons with a health problem are less likely to roll over $1,500 or more than persons without a health problem, the difference is not statistically significant (Figure 30).

Figure 21

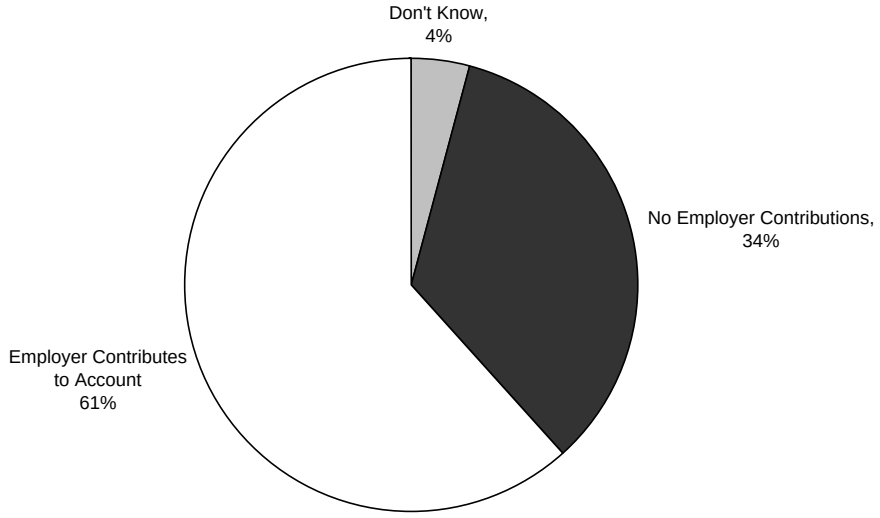
Percentage of Individuals With Comprehensive[1] Employment-Based Health Benefits Offered HDHP[2] or CDHP,[3] 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

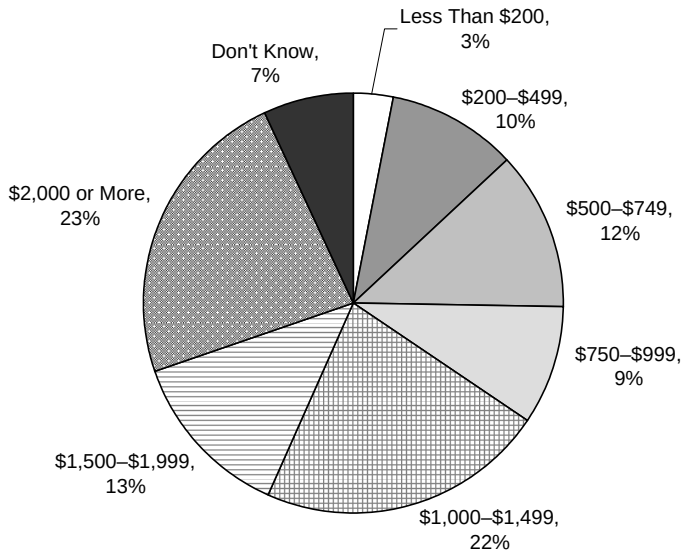
Figure 22

Percentage of Individuals With Employer Contribution to Account, Among Persons With Employment-Based Health Benefits and CDHP,[1] 2007



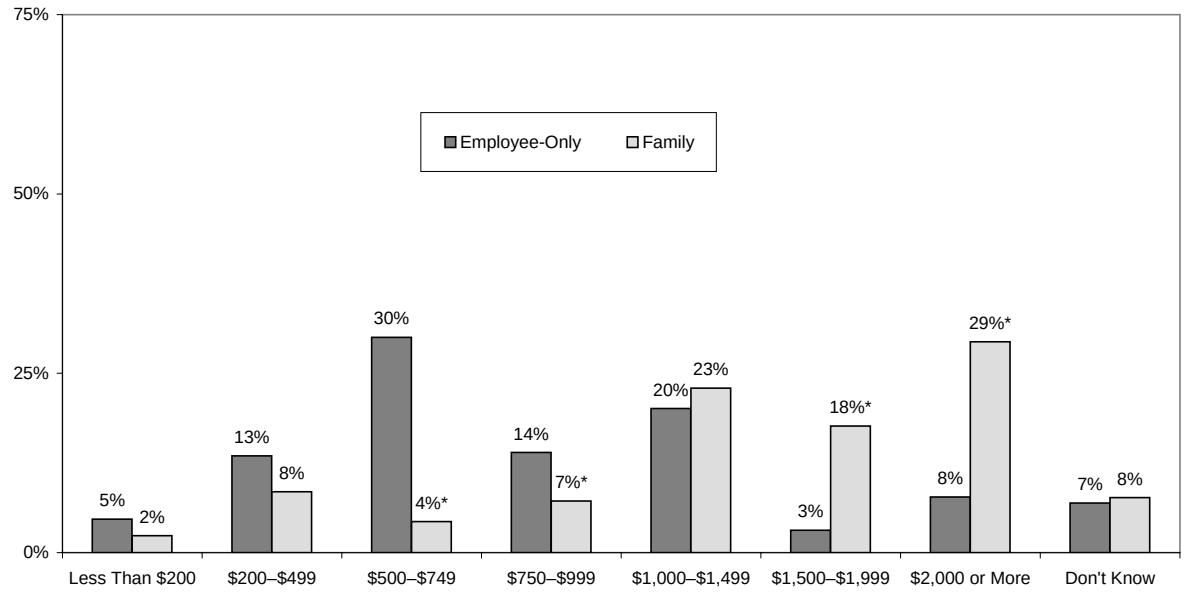
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 23
Annual Employer Contributions to the Account, Among Persons With CDHP,[1] 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.

Figure 24
Annual Employer Contributions to the Account, Among Persons With CDHP,[1] 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between employee-only coverage and family coverage is statistically significant at the p ≤ 0.05 or better.

Health Care Use

There was little significant variation in the frequency with which people in consumer-driven and high-deductible health plans used health care services, compared with adults in more comprehensive plans (Figure 31). The survey asked about health care use over the last year, including the number of times people had filled a prescription; visited a doctor's office or clinic; stayed overnight in a hospital; or had a diagnostic test such as an x-ray, MRI, blood test, cancer screening, or CAT scan. Adults in CDHPs were significantly more likely than those in more comprehensive plans to say they had not visited a physician's office in the past year, but there was no difference among people with health problems on this measure. There were no other significant differences in health care service use across the plan types.

Nor were there any significant differences among adults in the three plan types in their use of recommended preventive screening tests. The survey asked whether people had had their blood pressure checked or had a dental exam in the past year; if they had had their cholesterol checked in the last five years; if women had had a Pap test in the last three years; if women over age 50 had a mammogram in the past two years; and if adults over age 50 had had a colon cancer screening in the past five years. Plan type did not appear to make a difference in receiving preventive screening tests, even among people with health problems or in lower income households.

A concern that has been raised about consumer-driven or high-deductible health plans is that people with chronic health conditions might not take appropriate care of their conditions adequately when faced with high out-of-pocket costs. The survey asked respondents who had chronic conditions whether they agreed that they followed their treatment regimens for specific conditions carefully. The findings of the survey are somewhat mixed. People in CDHPs with arthritis and hypertension were significantly less likely than those in more comprehensive plans to say that they followed their treatment regimens for their conditions carefully (Figure 32). But people in CDHPs with depression were significantly more likely to say they followed their treatment regimens carefully than did those in comprehensive plans.

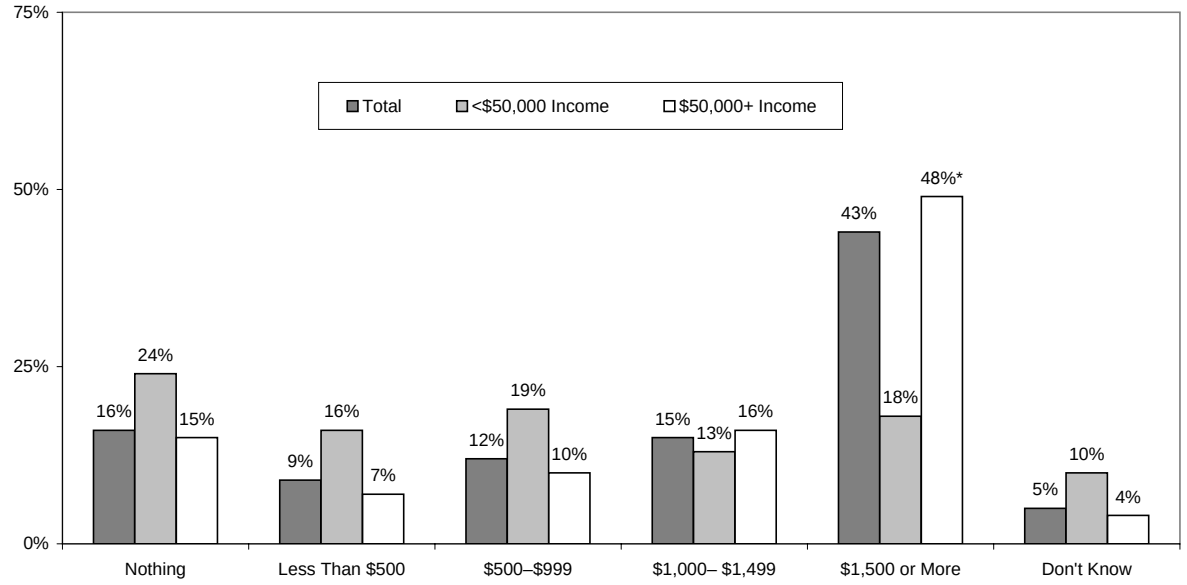
Cost-Related Access Problems

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 and lower incomes. The survey asked whether in the last year respondents had delayed or avoided getting any needed health care services because of costs. About 3 in 10 adults in HDHPs (31 percent) and CDHPs (29 percent) reported delaying or avoiding care, nearly two times the percentage of those in comprehensive health plans (16 percent) (Figure 33). 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, although the differences were not significant: 35 percent of those in HDHPs and 32 percent of adults in CDHPs, compared with 18 percent in comprehensive plans. People in all plan types with incomes of under $50,000 reported delaying or avoiding needed care at high rates: 26 percent of those in more comprehensive plans, 40 percent of those in HDHPs and 34 percent of those in CDHPs reported not getting health care when it was needed.

The survey also asked respondents about specific types of needed health care they delayed or avoided because of costs. About 1 in 5 of all adults with CDHPs (19 percent) and HDHPs (19 percent) said they had delayed or avoided a needed visit to a doctor, compared with 11 percent of those in more comprehensive plans (Figure 34). Just over 10 percent of adults with CDHPs (12 percent) and HDHPs (14 percent) had avoided needed visits to specialists and 9–10 percent had delayed or avoided lab or imaging tests.

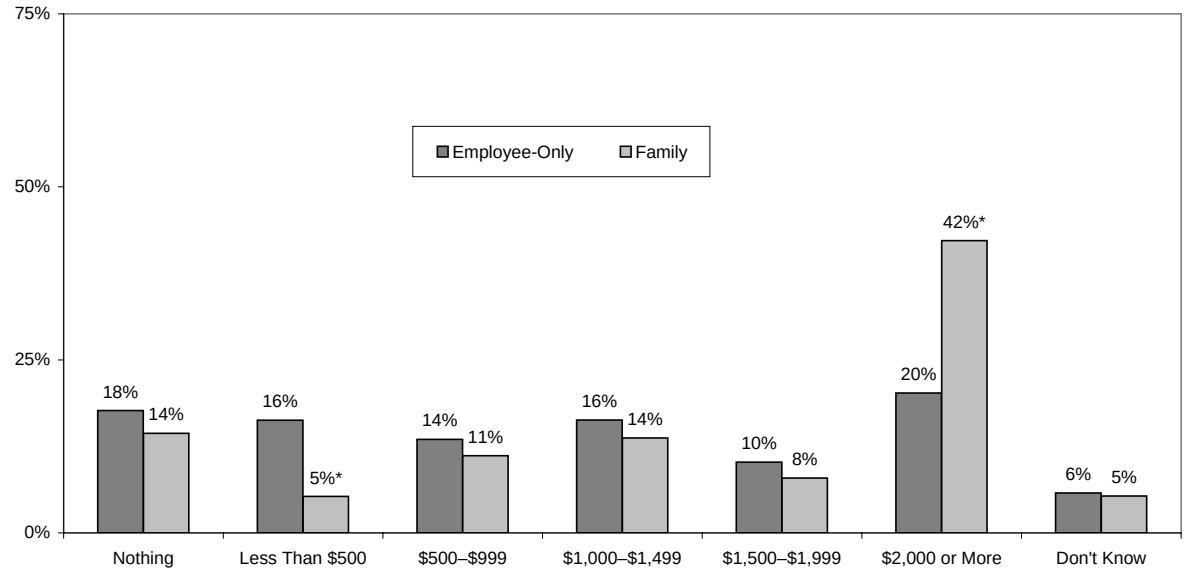
In addition to delaying or avoiding health care, people in HDHPs, but not CDHPs, were significantly more likely to skimp on their medications than were those in comprehensive plans. The survey asked respondents whether in the last 12 months they had not filled a prescription because of costs or if they had skipped doses of medications to make them last longer. About 29 percent of people with HDHPs and 24 percent of those in CDHPs said they had not filled a prescription because of cost or had skipped a dose of their medication, compared with 23 percent of those in comprehensive health plans (Figure 35). Among

Figure 25
Annual Individual Contributions to the Account, by Household Income, Among Persons With CDHP,[1] 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between <$50,000 and $50,000+ is statistically significant at the p ≤ 0.05 or better.

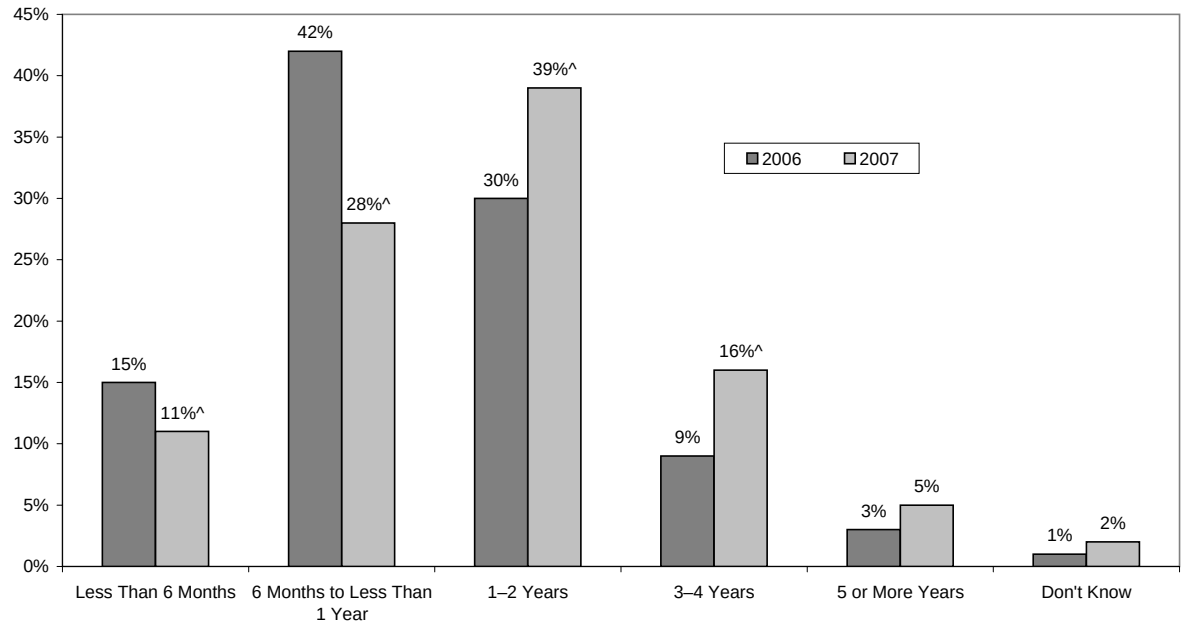
Figure 26
Annual Individual Contributions to the Account, by Type of Coverage, Among Persons With CDHP,[1] 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between employee-only coverage and family coverage is statistically significant at the p ≤ 0.05 or better.

Figure 27

Length of Time With CDHP[1] and Savings Account, 2006–2007



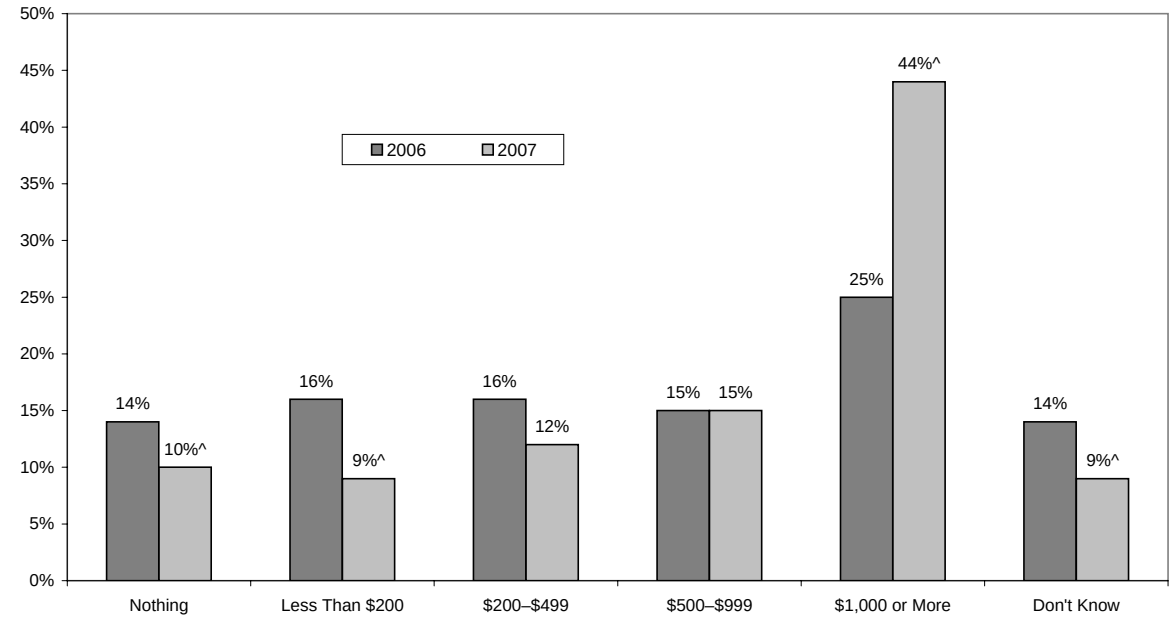
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006, 2007.

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

^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.

Figure 28

Amount Currently in Account, Among Persons With CDHP,[1] 2006–2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006, 2007.

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

^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.

people who reported being in fair or poor health or having at least one chronic health condition, more than one-third of those in HDHPs (35 percent) and CDHPs (34 percent) had not filled a prescription because of cost or skipped a medication dose, compared to 29 percent of people with health problems in comprehensive plans who reported similar behavior (differences were not significant). About one-third of people with incomes under $50,000 across all health plans reported skimping on medications.

Trends

Although adults in CDHPs and HDHPs continue to be significantly more likely to report delaying or avoiding needed health care than those in more comprehensive plans, over 2005–2007, reported rates among those in CDHPs dropped significantly (Figure 36). In 2007, 29 percent of adults in CDHPs reported delaying or avoiding needed care because of cost, down from 37–38 percent in 2005 and 2006. However, adults in HDHPs were just as likely to report cost-related access problems in 2007 as they were in earlier years. Although people with health problems report cost-related access problems in CDHPs and HDHPs at higher rates than those in more comprehensive plans, those in CDHPs became significantly less likely to report problems over the three-year period: 32 percent reported problems in 2007, down from 44 percent in 2005. Again, there were no changes among adults with health problems in HDHPs reporting problems. There were no similar significant trends among adults in households with incomes under $50,000.

Adults in CDHPs also became significantly less likely over the three-year period to report that they had failed to fill a prescription because of cost or skipped doses of their medication. In 2007, 24 percent of adults in CDHPs reported either cost-related behavior, down from 30–31 percent in 2005 and 2006. There were no similar changes among adults with HDHPs or those in more comprehensive health plans.

Availability and Use of Cost and Quality Information

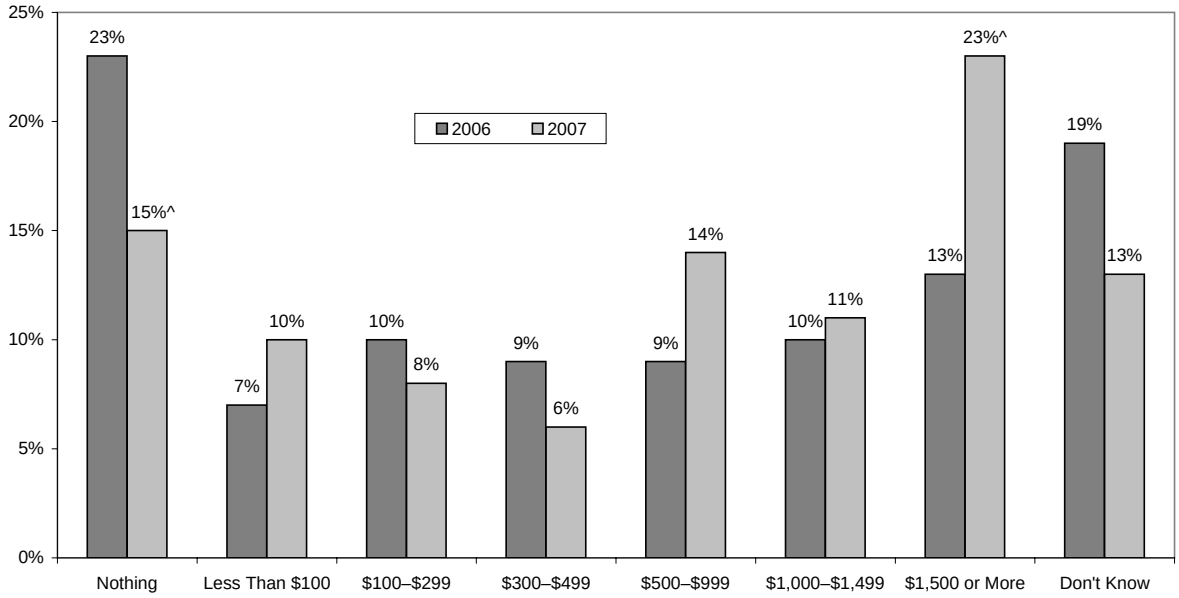
In theory, the incentives of consumer-driven health plans are designed to promote heightened sensitivity to cost and quality in people's decisions about their health care. Yet the ability of people to make informed decisions is highly dependent on the extent to which they have access to useful information.

The survey asked respondents whether their health plans provided any information regarding the cost and quality of providers. Less than one-third of adults in any plan type reported that their health plans provided them with information on either the quality or the cost of their doctors or their hospitals (among those who had either been admitted to a hospital or had a family member admitted in the past two years) (Figure 37). Adults in HDHPs were significantly less likely than those in more comprehensive plans to say that their health plans provided quality or cost information about either their doctors or hospitals. There were no differences in plan-provided information on provider cost and quality between CDHPs and comprehensive plans.

In terms of their use of information provided by their health plans, about half of respondents in all plan types indicated that they had made use of the information about quality and cost of their doctors. Of those who said they or a family member had been admitted to a hospital in the last two years, between 40 and 50 percent had tried to use information on the quality of hospitals. About one-third to two-thirds of respondents had tried to use information provided by their health plans on the cost of hospitals, with CDHPs significantly more likely that those in more comprehensive plans to try to use hospital cost information.

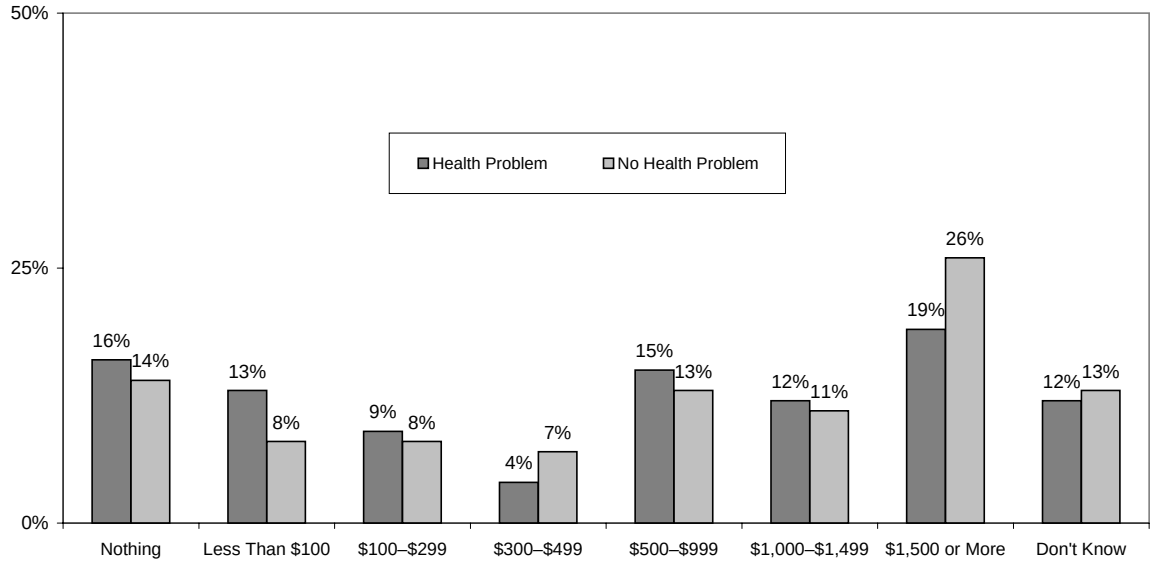
Some individuals reported that they had tried to find information from sources other than their health plans, with those in HDHPs and CDHPs somewhat more likely to say they had done so (Figure 38). About one-quarter of adults in HDHPs (23 percent) and CDHPs (25 percent) sought information from other sources on the cost and quality of care provided by doctors compared with 17 percent of those in more comprehensive plans. Among individuals who said they or a family member had been admitted to a hospital in the last two years, one-third (34 percent) of those enrolled in CDHPs sought information on hospital cost and quality compared with 22 percent in HDHPs and 18 percent in more comprehensive plans. Among those who tried to find information about the cost and quality of doctors, between one-half to two-thirds found useful information, with adults in HDHPs significantly less likely than those in more comprehensive plans to say that the information was useful. Larger shares of individuals in comprehensive plans and CDHPS who sought information about hospitals reported that they had found the information useful, although those in HDHPs were again significantly less likely to say it was useful.

Figure 29
Amount Rolled Over From Past Year, 2006–2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006, 2007.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
^ Estimate is statistically different from the prior year shown at the p ≤ 0.05 or better.

Figure 30
Amount of Money Rolled Over in the CDHP,[1] Among Individuals With CDHP One Year or Longer, by Health Status,[2] 2007



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
[2] Health problem defined as fair or poor health or one of eight chronic health conditions.
* Difference between health status categories is statistically significant at the p ≤ 0.05 or better.

Figure 31

Health Care Use and Preventive Care, by Type of Health Plan, 2007

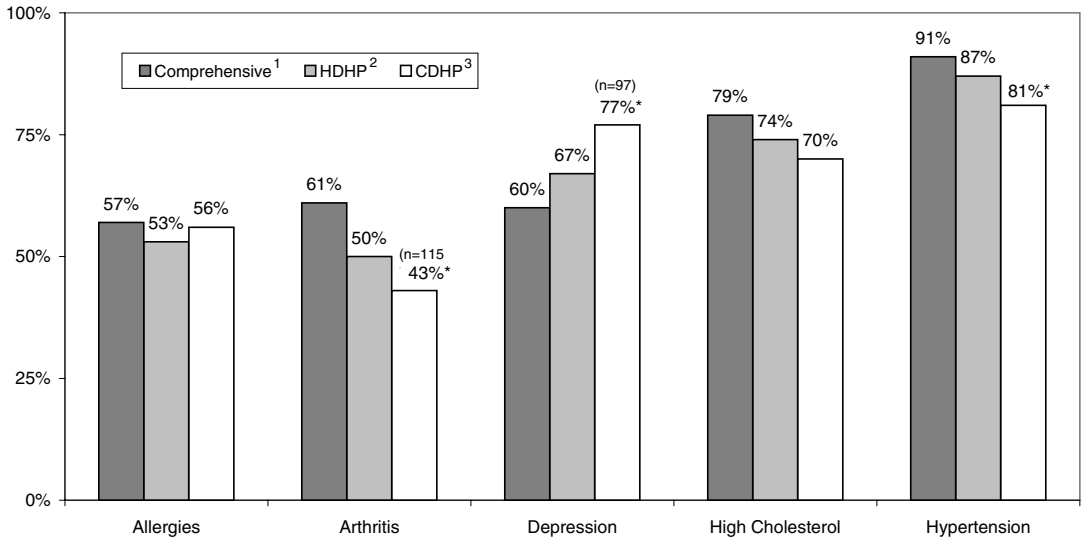
				Health Problem**			<$50,000 Annual Income		
	Comprehensive[1]	HDHP[2]	CDHP[3]	Comprehensive[1]	HDHP[2]	CDHP[3]	Comprehensive[1]	HDHP[2]	CDHP[3]
Total Sample	1,918	1,404	895	929	787	429	313	452	264
Medical Service Use (in past year)									
Filled a prescription									
Never	20%	21%	21%	12%	14%	11%	27%	25%	27%
Once	*7*	7	9	4	4	5	*7*	8	7
Two or more times	73	72	70	83	82	84	66	67	66
Visited doctor's office or medical clinic									
Never	10	11	16*	7	7	9	14	15	20
Once	15	16	17	10	12	13	16	16	19
Two or more times	75	73	67	83	82	78	69	69	62
Had a diagnostic test									
Never	33	37	38	23	27	26	38	41	48
Once	*27*	24	28	26	24	30	*27*	24	22
Two or more times	40	39	34	50	49	45	35	35	30
You or family member stayed overnight in hospital	25	23	21	28	26	24	23	25	19
Preventive Care									
Blood pressure checked (past year)	84	86	80	87	91	88	79	81	75
Dental exam (past year)	65	67	68	64	66	69	52	53	53
Received mammogram in past two years (females age 50+)	*76*	74	77	*77*	76	77	*64*	72	68
Received pap test in past three years (females)	77	81	82	75	79	84	71	74	80
Received colon cancer screening in past five years (age 50+)	54	49	57	55	52	62	*38*	41	40
Cholesterol checked in past five years	66	70*	70	72	77	79	52	55	62

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

Figure 32

Following Treatment Regimens for Chronic Disease, 2007

Percentage of privately insured adults ages 21–64 with chronic conditions who strongly/somewhat agree that they follow their treatment regimens very carefully



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.

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

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

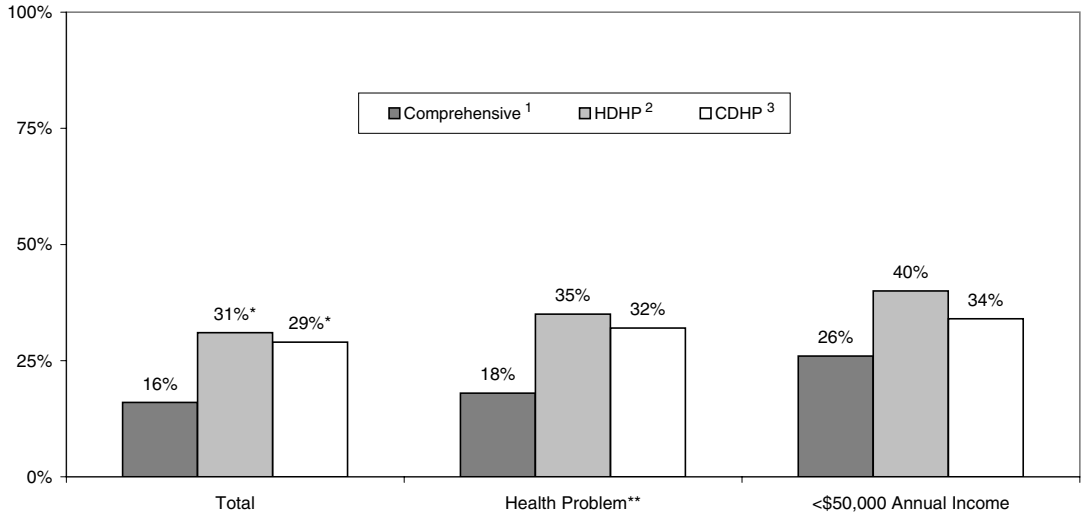
[3] CDHP = Consumer-driven health plan with deductible $1000+ (individual), $2000+ (family), with account.

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

Figure 33

Percentage of Adults Who Have Delayed or Avoided Getting Health Care Due to Cost, by Health Status and Income, 2007

Percentage of privately insured adults ages 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.

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

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

[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $,2000+ (family), with 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.

People looked to a wide variety of sources for health information. A majority consulted physicians frequently and many went online to explore health information Web sites, with adults in HDHPs and CDHPs more likely to say that they went online a lot or some (Figure 39). Friends or relatives were a commonly consulted source of health information among people in all plans. About three-quarters of individuals in all plan types consulted their health plans frequently for information. More than half of individuals in all plans frequently consulted magazines or books, with those in CDHPs the most likely to do so. Fewer than half of adults in all plan types frequently looked for health information in the newspaper and even smaller shares consulted a nurse advice or other help line.

But when it came down to whom they most trusted as a source of information about health care providers, adults in all health plans cited personal physicians by a substantial margin. More than half of adults said that they would most trust their doctor as a source of information about other providers, although those in more comprehensive plans were significantly more likely to cite their doctor than those in CDHPs (Figure 40). Fewer than 1 in 5 adults said they would most trust family members or friends. Between 4 percent and 6 percent of adults said they would most trust their health plans to provide information on providers, and less than 1 percent of respondents cited the government as their most trusted source.

People enrolled in CDHPs and HDHPs were somewhat more likely to consider costs in their decisions about their health care. Nearly three-quarters (74 percent) of adults in CDHPs and 3 in 5 (60 percent) of those in HDHPs strongly or somewhat agreed that the terms of their coverage made them consider cost when deciding to see a doctor when sick or fill a prescription; fewer than half (47 percent) of those in more comprehensive plans felt this way (Figure 41). Adults in high-deductible or consumer-driven plans were also more likely than those in more comprehensive plans to say that they had asked their doctor to recommend a less costly prescription drug: About 2 in 5 said they had done this, compared with 30 percent of those in more comprehensive plans (Figure 42). Adults in HDHPs and CDHPs were more likely to ask for a generic drug than those in more comprehensive plans and to talk with their doctor about treatment options and costs. More than one-quarter (27 percent) of adults in CDHPs and HDHPs said they had checked the price of a service prior to receiving care, compared to 21 percent of those in comprehensive plans. Few people participate in wellness programs offered by employers, but those in CDHPs were more likely to say they did so. Similarly, although only 1 in 5 adults in CDHPs used an online cost-tracking tool, their reported use is more than twice the rate reported by people in HDHPs or comprehensive plans.

Trends

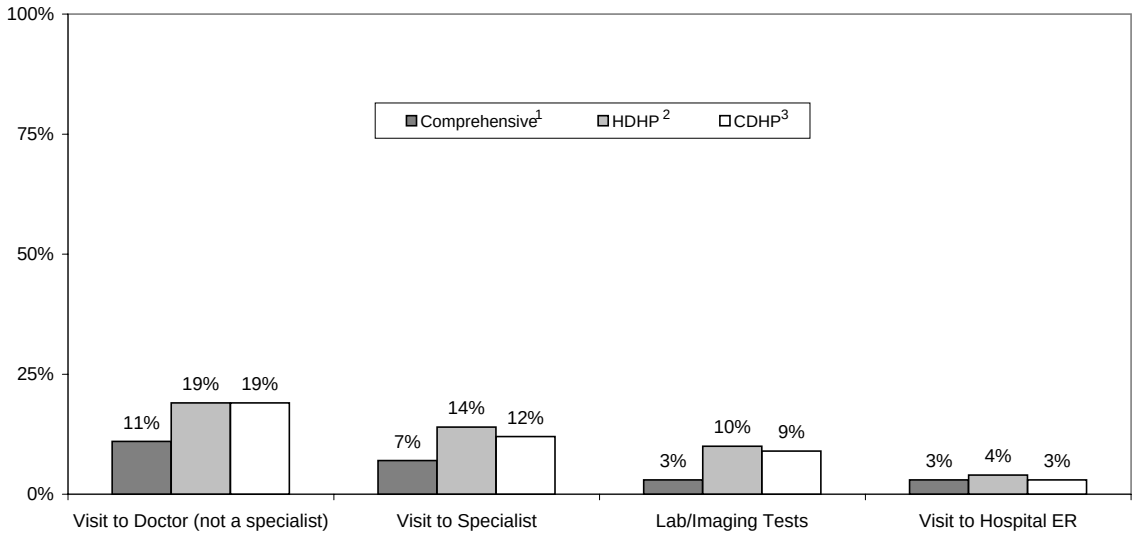
There have been no significant gains in the provision of information on provider cost and quality by any health plan type over the three years of the survey (data not shown). There has been no increase in the share of CDHP or HDHP enrollees who say their health plans provide them with quality and cost information about their providers, and they remain no more likely to receive such information than enrollees in more comprehensive plans.

Likely reflecting the lack of information available to help make informed decisions about health care, there has been no increase in the share of CDHP or HDHP enrollees who report cost-conscious decision making over the three years of the survey (Figure 43). Rates of reported behavior such as asking for generic drugs or talking to doctors about treatment options and costs have either remained static over time or declined.

Conclusion

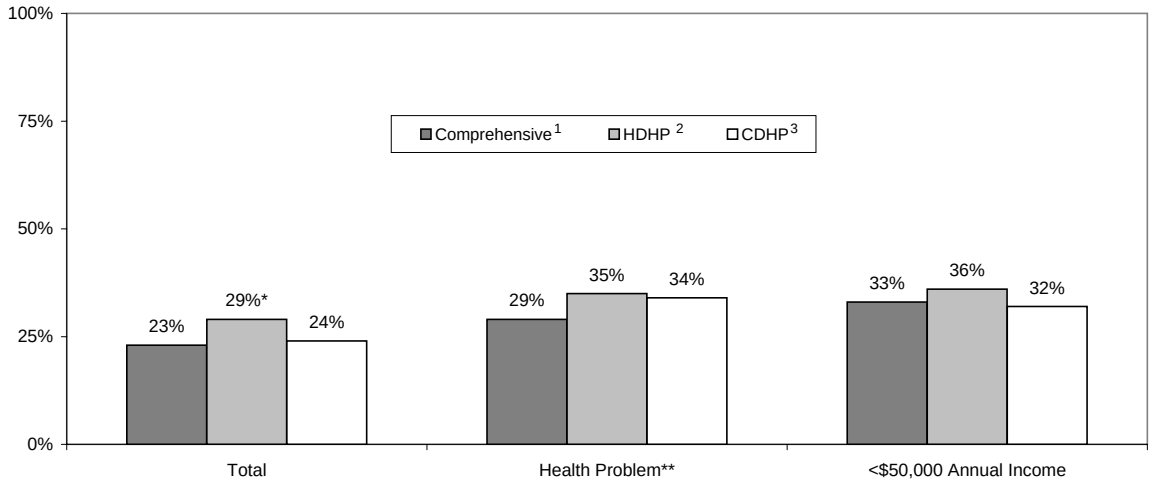
The 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey finds that enrollment in high-deductible health plans with a health savings account or health reimbursement arrangement remains a small percentage of the overall private insurance market. More people have high-deductible health plans without accounts. Enrollment in CDHPs rose from 1 percent of the U.S. privately insured population in 2006 to 2 percent in 2007. This represents an increase from 1.3 million people in 2006 to 2.3 million in 2007. An additional 11 percent, or 12.5 million adults, had a health plan with a deductible high enough to make them eligible for an HSA, of which 5.2 million said that they were eligible for an HSA but did not have

Figure 34
Percentage of Adults Who Have Delayed or Avoided Getting Health Care Due to Cost, by Type of Care Delayed, 2007
Percentage of privately insured adults ages 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Figure 35
Percentage of Adults Who Have Not Filled a Prescription Due to Cost or Who Have Skipped Doses to Make a Medication Last Longer, by Health Status and Income, 2007
Percentage of privately insured adults ages 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and 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 36

Access Issues, by Type of Health Plan, 2005–2007

	Comprehensive[1]			HDHP[2]			CDHP[3]		
	2005	2006	2007	2005	2006	2007	2005	2006	2007
Total Sample	1,061	1,506	1,918	463	930	1,404	186	722	895
Total									
Not filled a prescription due to cost (you or family members)	16%	16%	17%	26%*	21%*	21%*	21%	23%*	19%
Skipped doses to make medication last longer (of those who were given a prescription) (you or family members)	15	16	16	25*	22*	22*	20	23*	17^
Not filled a prescription due to cost or skipped doses to make medication last longer	22	22	23	32	29*	29*	30	31*	24^
Delayed or avoided getting health care due to cost (you or family members)	17	19	16	31*	33*	31*	37*	38*	29*^
Any of the above	29	30	28	44	44*	43*	48	49*	38*^
Health Problem**									
Not filled a prescription due to cost	21	18	21	30*	25*	24	26	25*	26
Skipped doses to make medication last longer (of those who were given a prescription)	21	21	23	32*	28*	28	30	29*	24
Not filled a prescription due to cost or skipped doses to make medication last longer	29	27	29	40	35*	35	39	38*	34
Delayed or avoided getting health care due to cost	20	23	18	31*	37*	35	44*	42*	32^
Any of the above	35	34	33	48	50*	49	58	55*	46^
No Health Problem**									
Not filled a prescription due to cost	11	13	12	48	17	17	15	22*	13^
Skipped doses to make medication last longer (of those who were given a prescription)	8	11	8	15	15	13	10	17	11^
Not filled a prescription due to cost or skipped doses to make medication last longer	14	18	16	22	22	21	20	25*	16^
Delayed or avoided getting health care due to cost	13	16	14	31*	28*	27	31*	35*	26^
Any of the above	20	25	23	39	38*	37	39	44*	32^
Less Than $50,000 Yearly Household Income									
Not filled a prescription due to cost	24	20	27	28	25	27	24	23	27
Skipped doses to make medication last longer (of those who were given a prescription)	21	21	25	31	23	28	30	26	23
Not filled a prescription due to cost or skipped doses to make medication last longer	31	29	33	38	31	36	36	33	32
Delayed or avoided getting health care due to cost	24	29	26	41	36	40	49*	40	34
Any of the above	39	42	41	53	48	53	56	53	48
$50,000 or More Yearly Household Income									
Not filled a prescription due to cost	12	13	12	24*	19*	19	19	23*	16^
Skipped doses to make medication last longer (of those who were given a prescription)	13	14	13	23*	20*	19	16	21*	16
Not filled a prescription due to cost or skipped doses to make medication last longer	18	19	18	30	27*	27	28	29*	22^
Delayed or avoided getting health care due to cost	13	14	12	28*	30*	29	31*	37*	29^
Any of the above	24	25	23	40	41*	40	45	47*	36^

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005, 2006, 2007.

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

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

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

* Difference between HDHP/CDHP and 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.

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

such an account. These findings are consistent with other recent estimates of enrollment in consumer-driven health plans (See box, pg. 47).

For the second year in a row, the survey found that adults in CDHPs are no more likely to have been uninsured prior to enrolling in their plans than were those in more comprehensive plans. This suggests that little of the growth in CDHPs was likely driven by people who were previously uninsured, despite the expectations of some policymakers that the lower premiums and tax benefits of consumer-driven health plans would help reduce the number of people without health insurance.

Indeed, the income profile of adults in consumer-driven health plans has trended up over the three years of the survey. In 2007, 31 percent of those enrolled in CDHPs were in households with incomes of $100,000 or more, up from 22 percent in 2005. Just 19 percent of adults with CDHPs had household incomes under $50,000, down from 33 percent in 2005. Among HDHP enrollees, 23 percent were in higher income households in 2007, up from 15 percent in 2005. In contrast, there was little change in the income distribution of people enrolled in more comprehensive plans—21 percent had household incomes of $100,000 or more in 2007 and 33 percent had incomes of under $50,000.

In addition, over the three years of the survey, people enrolled in CDHPs became significantly more likely to be employed in large firms and less likely to be sole proprietors or employees of small companies. A similar trend occurred among those with HDHPs, but the changes were much smaller. People enrolled in CDHPs also became much more likely over that time to have a choice of health plan. In 2005, people in CDHPs were less likely to have a choice of health plan than those in comprehensive plans. By 2007, CDHP enrollees were *more* likely to have a choice of plan than those in comprehensive plans. There was no change among adults with HDHPs in the share that said they had a choice of health plan, and in 2007 they were the least likely among adults in the three plan types to have a choice.

Consistent with these trends, people in CDHPs were somewhat more satisfied with their plans in 2007 than they were in 2006. In 2007, there was a significant increase in the share of adults in CDHPs who said they were extremely or very satisfied with the quality of care they received and with the quality of their health plan overall. In addition, there was a significant increase in the share of CDHP enrollees who said that they would be extremely or very likely to recommend their plan to a friend or co-worker and to stay in their plan if they had the opportunity to change. However, adults in CDHPs continue to give their health plans much lower marks on each of these measures than do those in more comprehensive plans. Those in HDHPs give their health plans the lowest marks of any plan types, and there was little improvement over the three-year period.

People in consumer-driven and high-deductible plans reported using health services at rates similar to those in comprehensive plans, and there were no reported differences in the use of preventive screens or tests. Among adults with chronic health conditions, those in CDHPs were less likely to say that they followed their treatment regimens for arthritis and hypertension very closely than were those in more comprehensive plans. But consumer-driven enrollees were more likely than those in comprehensive plans to say that they followed their treatment regimens carefully for depression.

As in prior years, the survey finds evidence that people in high-deductible and consumer-driven plans are more likely to skimp on needed medical care or medications because of cost than are those in more comprehensive plans. However, over 2005–2007, the reported rates of cost-related problems dropped among adults in CDHPs, although not among those in HDHPs. Similarly, although people with health problems in CDHPs report cost-related access problems at higher rates than those in more comprehensive plans, they became significantly less likely to report problems over the three-year period. Again, there were no changes among adults with health problems in HDHPs reporting problems.

There have been no significant gains in the provision of information on provider cost and quality by health plans over the three years of the survey. In 2007, no more than one-third of enrollees in any plan type said that their health plans provided information regarding the quality or the cost of health care providers in their networks. So far, the theory of many proponents of consumer-driven plans that consumer demand for information on cost and quality would lead health plans and providers to provide it has not materialized, according to respondents to our survey.

Despite a lack of key cost and quality measures, adults in consumer-driven plans continue to be more cost-conscious in their health care decision-making. Adults in CDHPs and HDHPs are significantly more

likely than those in more comprehensive plans to say that the terms of their coverage make them consider costs when deciding to seek health care services. They are significantly more likely than those in comprehensive health plans, but not substantially so, to talk with their doctors about treatment options and costs or to ask for a generic drug or a less costly drug.

The 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey suggests that the face of enrollees in consumer-driven health plans is gradually changing over time. On average, enrollees in CDHPs are significantly higher income and healthier than those in more comprehensive plans and HDHPs. They are just as likely to work for a large company as adults in more comprehensive plans, and more likely to have a choice of plan than either adults in comprehensive plans or those in HDHPs. Compared with one or two years ago, their savings account balances are higher, satisfaction with their plans is higher, and reported rates of cost-related access problems are lower. In contrast, there has been little improvement in health plan satisfaction or rates of cost-related access problems among adults in HDHPs. There is evidence that CDHP and HDHP enrollees are more cost-conscious in their decision-making than those in comprehensive plans, but the behavioral differences are not substantial on some measures. There is also evidence that consumer-driven health plans and high-deductible health plans do not provide their enrollees with any more information about provider cost and quality than other health plan types.

In these deficit-strapped times, when the nation faces critical health system challenges, the question for policymakers is whether the tax advantages that the federal government provides the enrollees of these health plans over those in other types of plans are achieving the broader health system goals that they were aimed at. So far there is little evidence that the tax benefits of consumer-driven health plans have the potential to help change the trajectory of health care cost growth, are leading health plans or providers to provide more information about the quality and price of services to patients, or are decreasing the number of people without health insurance. The tax benefits of the plans are greater for families in higher income tax brackets and the three years of the survey show a significant trend in enrollment towards wealthier families. Policy-makers should be concerned about the possibility suggested by the demographic trends in this survey that consumer-driven plans with health savings accounts could evolve into tax-preferred savings vehicles whose benefits ultimately will disproportionately accrue to wealthier individuals, rather than to the health system.

Figure 37
Availability and Use of Quality and Cost Information Provided by Health Plan, 2007

	Comprehensive[1]	HDHP[2]	CDHP[3]
Health plan provides information on quality of care provided by:			
Doctors	30%	22%*	27%
Hospitals (Base: self or family member admitted to hospital in past two years)	32	24*	34
Health plan provides information on cost of care provided by:			
Doctors	24	15*	23
Hospitals (Base: self or family member admitted to hospital in past two years)	29	19*	31
Of those whose plans provide info on quality, how many tried to use it for:			
Doctors	49	53	55
Hospitals	40	39	51
Of those whose plans provide info on cost, how many tried to use it for:			
Doctors	47	47	52
Hospitals	34	41	68*

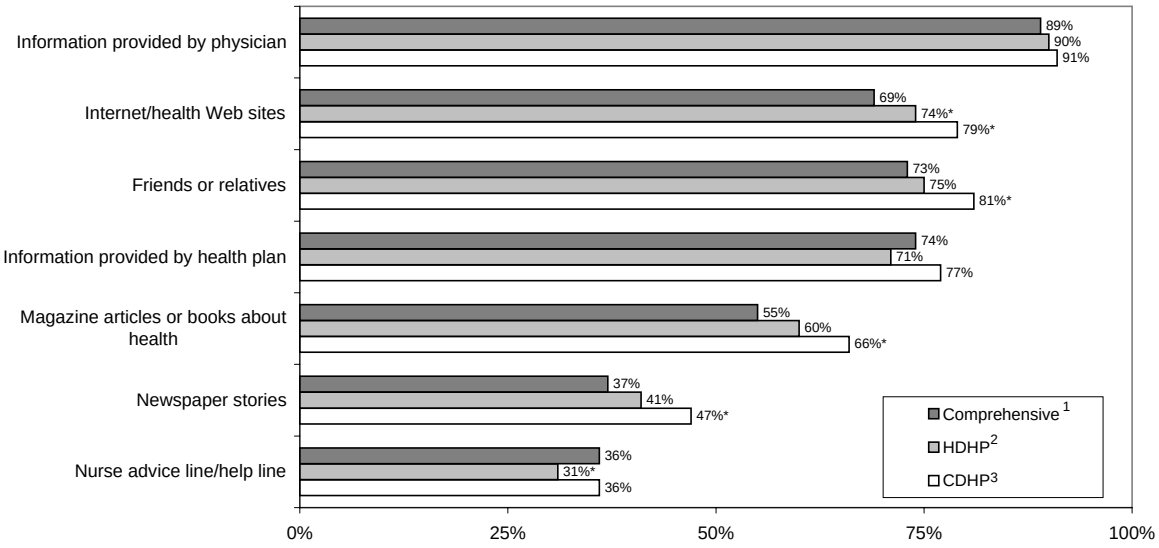
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Figure 38
Effort to Find Information on Quality and Cost From Sources Other Than Health Plans, 2007

	Comprehensive[1]	HDHP[2]	CDHP[3]
Tried to find information from sources other than health plan on cost and quality of care provided by:			
Doctors	17%	23%*	25%*
Hospitals (Base: self or family member admitted to hospital in past two years)	18	22	34*
Of those who tried to find info on cost and quality, how many found useful information for:			
Doctors	66	50*	59
Hospitals	74	51*	67

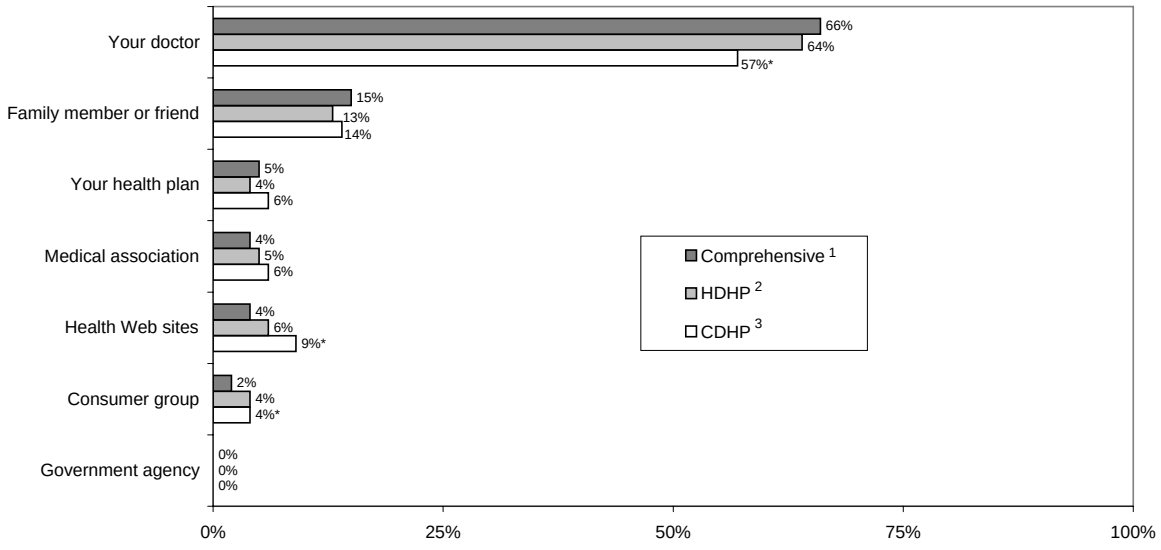
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Figure 39
Resources Used for Health Information, by Type of Health Plan, 2007
Percentage of privately insured adults ages 21–64
who use the following resources a lot/some



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Figure 40
Most Trusted Sources for Information on Health Care Providers, by Type of Health Plan, 2007
Percentage of privately insured adults ages 21–64

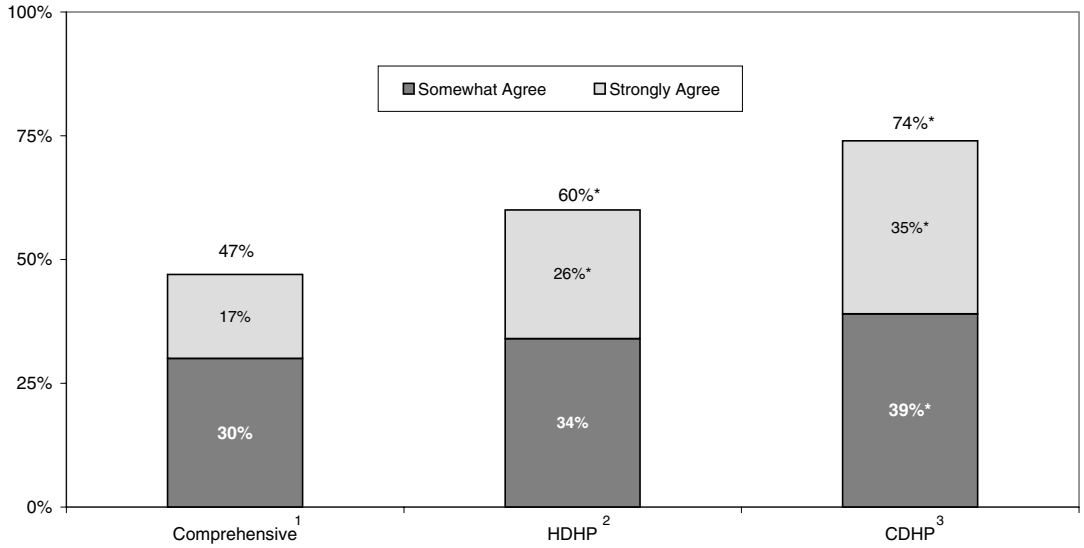


Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.
[1] Comprehensive = Health plan with no deductible or <$1,000 (individual), <$2,000 (family).
[2] HDHP = High-deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account.
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.
* Difference between HDHP/CDHP and Comprehensive is statistically significant at p ≤ 0.05 or better.

Figure 41

Percentage of Adults Who Agree That Terms of Coverage Make Them Consider Cost When Deciding to Seek Health Care Services, 2007

Percentage of privately insured adults ages 21–64



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.

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

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

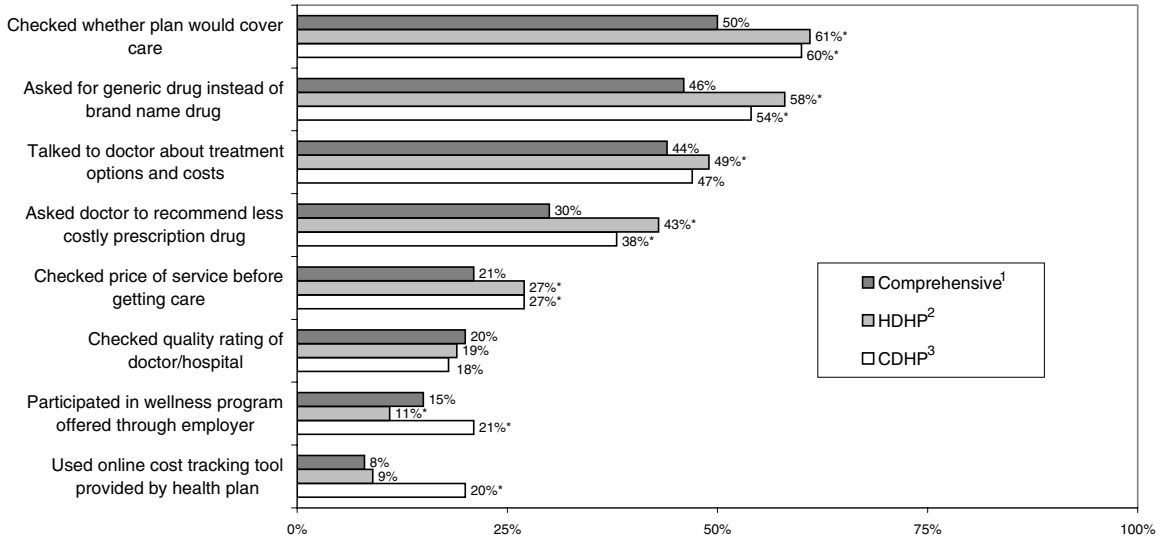
[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.

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

Figure 42

Cost-Conscious Decision Making, by Type of Health Plan, 2007

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



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007.

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

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

[3] CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2000+ (family), with account.

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

Figure 43
Trends in Cost-Conscious Decision Making, by Type of Health Plan, 2005–2007
Base: Adults ages 21–64 who received some health care in last 12 months

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

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005, 2006, 2007.

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

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

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

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

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

Appendix—Methodology

The findings presented in this *Issue Brief* were derived from the 2007 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, the cost of care, satisfaction with health care, satisfaction with their health care plan, reasons for choosing their plan, and sources of health information. The survey was conducted within the United States between August 22 and September 11, 2007, through a 19-minute Internet survey (fielding was extended to Oct. 10 for the CDHP oversample). The national or base sample was drawn from Synovate's online sample of Internet users who have agreed to participate in research surveys. Nearly 2,200 adults (n=2,182) ages 21 to 64 who have health insurance through an employer or purchased directly from a carrier were drawn randomly from the Synovate sample for this base sample. This sample was stratified by gender, age, region, income, education, and race. The response rate for the base sample (national sample) was 13 percent, while the response rate for the national sample was 21 percent).

To examine the issues mentioned above, we assigned our sample into one of 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 or the ability to take their account with them should they change jobs. Individuals with only a flexible spending account (FSA) were not included in the CDHP group.

Individuals were assigned to the HDHP group if they did not have an account used for medical expenses with a rollover provision or portability if they changed jobs. This group includes individuals with HSA-eligible health plans but may also include individuals with high deductibles who are not eligible to contribute to an HSA. Individuals with 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 quality for HSA tax preference, and they do not have an HRA-based plan.

The section below includes the questions and skip patterns that were used to assign our sample into the three analysis groups: those with comprehensive insurance, those with a CDHP, and those with a HDHP.

S5. Does your health plan have a <u>deductible</u> for medical care? [A <u>deductible</u> is the amount you have to pay before your insurance plan will start paying any part of your medical bills.]

Yes
Yes, but only when I go out of network
No
Don't know

S6a. [IF HAVE FAMILY COVERAGE ASK:] What is the amount of your <u>family deductible</u> 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

S6aa. [IF DEDUCTIBLE IS BETWEEN $2,000 AND $2,999, ASK:] Is your family deductible less than $2,200 or is it $2,200 to $2,999?

Less than $2,200
$2,200-$2,999
Don't know

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

S7aa. [IF DEDUCTIBLE IS BETWEEN $1,000 AND $1,499, ASK:] Is your family deductible less than $1,100 or is it $1,100 to $1,499?

Less than $1,100
$1,100-$1,499
Don't know

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
Don't know

S12c. Can you carry your account with you if you leave your job?

Yes
No
Don't know

Because the base sample only included 53 individuals in a CDHP and 211 individuals with a HDHP, we added an oversample of individuals with a CDHP or HDHP. The oversample included 842 individuals with a CDHP and 1,193 individuals with a HDHP, resulting in a total sample (base plus oversample) of 895 for the CDHP group and 1,404 for the HDHP group. After factoring out of the base sample the 53 individuals with a CDHP and the 211 individuals with a HDHP, there are 2,182 individuals in our sample with a comprehensive health plan.

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 to 64 with private health insurance coverage.[6] The CDHP and HDHP oversamples were weighted by gender, age, income and race/ethnicity, using the demographic profile of the CDHP and HDHP respondents to the omnibus survey described below.

To efficiently identify respondents who would qualify for the CDHP and HDHP oversamples, we used Synovate's omnibus survey of more than 102,000 online panel members who met the criteria for our study (having private insurance and age 21–64.) The following three questions were used in the May, June, July, and September Omnibus Surveys to identify likely CDHP and HDHP respondents:

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

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

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

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

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

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

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

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

Don't know if have deductible

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

   Yes
   No
   Not sure

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

Health Savings Accounts

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

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

In order for an individual to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than $1,100 for self-only coverage and $2,200 for family coverage. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $5,800 for self-only coverage and $11,000 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit will be indexed to inflation in the future. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services. An individual can have a health plan with a deductible and maximum out-of-pocket limit that qualifies them to make a tax-free contribution to an HSA, but the individual is not required to make a contribution nor open an account.

Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer, and deductible from adjusted gross income if made by the individual. The maximum annual contribution is $2,900 for self-only coverage and $5,800 for family coverage in 2008.

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.[7] Individuals enrolled in Medicare are not eligible to make HSA contributions, although they are able to withdraw money from the HSA for qualified medical expenses and certain premiums.[8] Individuals also may not make an HSA contribution if claimed as a dependent on another person's tax return.

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2004, a $500 catch-up contribution is allowed. A $1,000 catch-up contribution will be phased-in by 2009.[9]

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

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

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

Health Reimbursement Arrangements

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

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

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

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

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

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

Enrollment in CDHPs and HDHPs

According to the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey (CHCS), 7.5 mil-ion adults ages 21–64 with private health insurance were enrolled in either a CDHP (a plan with an HSA or HRA) or an HDHP that was eligible to contribute to an HSA (up from 3.6 million in 2006). This represents 6.6 percent of adults ages 21–64 with private insurance (up from 3.2 percent in 2006). The CHCS does not include children in the survey. Any children enrolled in CDHP or HDHP plans eligible for an HSA are *not* included in the 7.5 million adults with private health insurance. This enrollment number is comparable to estimates published by other sources. A summary of the other sources is below.

America's Health Insurance Plans (AHIP)—In 2007, America's Health Insurance Plans (AHIP) conducted a census of health plans to determine the number of people enrolled in plans with an HSA or eligible for one. AHIP determined that 4.5 million people were in an HSA-eligible plan in January 2007 (up

from 3.2 million in 2006). Nearly 3.4 million had coverage through the employment-based market, while an additional 1.1 million had it through the individual market. The report did not count HRA enrollees, but it does include workers, nonworking adults, and children. There is no methodology section in the report so it is unclear how many health plans reported data and how the data may have been weighted. The report includes data on HSA characteristics, but only for slightly more than 350,000 accounts. More information can be found at http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf.

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

Consumer Drive Market Report (CDMR)—According to enrollment estimates published by the Consumer Driven Market Report (CDMR), over 10 million people were enrolled in HRAs or HSA-eligible plans as of mid-year 2007 (up from 6 million in 2006). Specifically, 5.8 million were in HSA-eligible plans and 4.3 million were in HRA-based plans. The data reported here were obtained from http://www.chcchoices.org/publications/CPR%20--%2093.pdf, thus there is no information whatsoever about the methodology used to collect the data.

Inside Consumer-Directed Care (ICDC)—*Inside Consumer-Directed Care (ICDC)*, an industry newsletter published by Atlantic Information Services, has been following the movement to consumerism and growth in account-based plans for many years. The July 27, 2007 report contains enrollment data by insurer for 28 insurers, while the August 10, 2007 issue contains data from BlueCross BlueShield plans. According to the data from these two issues, nearly 8 million persons were enrolled in an HRA or HSA-eligible plan. The report should include workers, non-working adults, and children. While many insurers were not included in the analysis, Aetna, the Blues, Cigna, Humana, and United were included. Collectively, they account for about 140 million lives, and 7 million of the 8 million persons covered by an HRA or HSA-eligible. More information about ICDC can be found at http://www.aispub.com/Products/NewsICD.html.

Kaiser Family Foundation/Health Research and Educational Trust—In 2007, the Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) conducted a nationally representative survey of nearly 2,000 employers of all sizes. The 2007 survey found that 3.8 million workers enrolled in either an HRA (1.9 million) or an HSA-based plan (1.9 million) (up from 2.7 million in 2006). The KFF/HRET survey does not include nonworking adults or children in its estimates. More information can be found at http://www.kff.org/insurance/7672/index.cfm.

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

The survey also found that 7 percent of employers with fewer than 500 employees offered either an HRA or HSA (up from 5 percent in 2006), while 14 percent of employers with 500 or more employees offered one of the plans (up from 11 percent in 2006). Mercer notes that adoption of these plans slowed in 2008 and predicts adoption to be moderate in 2008. See http://www.mercer.com/pressrelease/details.jhtml?idContent=1287790 for more information.

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Endnotes

[1] More information about HRAs and HSAs can be found in the boxes on pgs. 46–47 and in Fronstin (2002 and 2004).

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

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

[4] In contrast to our 11 percent estimate in the individual market, AHIP reports that 27 percent of individuals with an HSA-qualified plan in the individual market were previously uninsured in 2007, down from 31 percent in 2006 (See www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf and www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf). This estimate is not comparable with our 11 percent estimate because our estimate for CDHPs includes individuals with HRAs, which was not covered by the AHIP study. Our overall estimates of 14 percent for CDHP enrollees and 28 percent for more comprehensive plan enrollees are closer to the findings of a 2006 Kaiser Family Foundation study which found that 14 percent of CDHP enrollees and 25 percent of comprehensive plan enrollees were previously uninsured (See www.kff.org/kaiserpolls/upload/7595.pdf).

[5] According to Claxton, et al. (2007) almost 66 percent of employers offering employee-only coverage through HSA-qualified HDHPs do not make contributions towards the HSAs that their workers establish. This accounts for 47 percent of covered workers enrolled in HSA-qualified HDHPs for employee-only coverage.

[6] In theory, a random sample of 2,182 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.

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

[8] Only Medicare enrollees age 65 and older are allowed to pay insurance premiums from an HSA. A Medicare enrollee under age 65 cannot use an HSA to pay insurance premiums.

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

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EBRI Employee Benefit Research Institute Issue Brief (ISSN 0887–137X) is published monthly by the Employee Benefit Research Institute, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, at $300 per year or is included as part of a membership subscription. Periodicals postage rate paid in Washington, DC, and additional mailing offices. POSTMASTER: Send address changes to: *EBRI Issue Brief,* 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051. No. 315.

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