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Survey Summary

The Kaiser Family Foundation

National Survey of Enrollees in Consumer Directed Health Plans

November 2006

INTRODUCTION

Consumer directed health plans (CDHPs) are new health insurance arrangements designed to make consumers more active participants in decisions about their health care. In contrast with more traditional health insurance plans, CDHP enrollees take on substantial risk for the cost of their more routine health care expenses.

CDHPs are health plans with high deductibles (e.g., over $1050 for single coverage) that are combined with a savings account option that CDHP enrollees can use to pay for routine health expenses with tax-preferred funds. There are two primary types of saving accounts: health savings accounts, or HSAs, and health reimbursement arrangements, or HRAs. (See "Plan Definitions" for more complete descriptions). Before they reach their deductible, CDHP enrollees have to pay all of the costs of their routine care, either directly out-of-pocket or from their HRA or HSA. This design provides CDHP enrollees with a financial incentive to become aware of the actual costs of care and to explore less-costly alternatives.

To assist CDHP enrollees to be better health care consumers, insurers offering these arrangements often have web sites with health information and tools that enrollees can use to learn more about medical conditions and treatment options. These sites typically also have information about the relative quality and costs of medical services from different providers, although the amount and quality of the information varies across insurers.

We surveyed a random sample of CDHP enrollees to learn more about who is enrolling in CDHPs, their reasons for enrolling, their attitudes about health care, and their experiences with their health plans. Responses from CDHP enrollees are compared with those from a random sample of enrollees from more traditional private employer-sponsored health insurance plans. (See "Methodology" on page 7 for a more complete description of how the survey was conducted.)

PLAN DEFINITIONS

HRAs are medical care reimbursement plans established by employers that can be used by employees to pay for health care. HRAs are funded solely by employers. Employers typically commit to make up to a specified amount of money available in the HRA for premiums and medical expenses incurred by employees or their dependents. HRAs are accounting devices, and employers are not required to expend funds until an employee incurs expenses that would be covered by the HRA. Unspent funds in the HRA usually can be carried over to the next year (sometimes with a limit). Employees cannot take their HRA balances with them if they leave their job, although an employer can choose to make the remaining balance available to former employees to pay for health care.

HRAs often are offered along with a high deductible health plan, but it is not legally required. In such cases, the employee pays for health care first out of his or her HRA and then out-of-pocket until the health plan deductible is met. Sometimes certain preventive services are paid for by the plan before the employee meets the deductible.

HSAs are savings accounts created by individuals to pay for health care. An individual may establish an HSA if he or she is covered by a "qualified health plan" which is a plan with a high deductible (i.e., a deductible of at least $1,050 for single coverage and $2,100 for family coverage in 2006) that also meets other requirements.[1] Employers can encourage their employees to create HSAs by offering an HDHP that meets federal requirements. Employers in some cases also may assist their employees by identifying HSA options, facilitating applications, or negotiating favorable fees from HSA vendors.

Both employers and employees can contribute to an HSA, up to an annual limit equal to the lesser of the deductible in the HSA qualified health plan or a statutory cap. Employee contributions to the HSA are made on a pre-income tax basis, and some employers arrange for their employees to fund their HSAs through payroll deduction. Employers are not required to contribute to HSAs established by their employees, but if they elect to do so their contributions are not taxable to the employee. Interest and other earnings on amounts in an HSA are not taxable. Withdrawals from the HSA by the account owner to pay for qualified health care expenses are not taxed. The savings account is owned by the individual who creates the account, so employees retain their HSA balances if they leave their job.

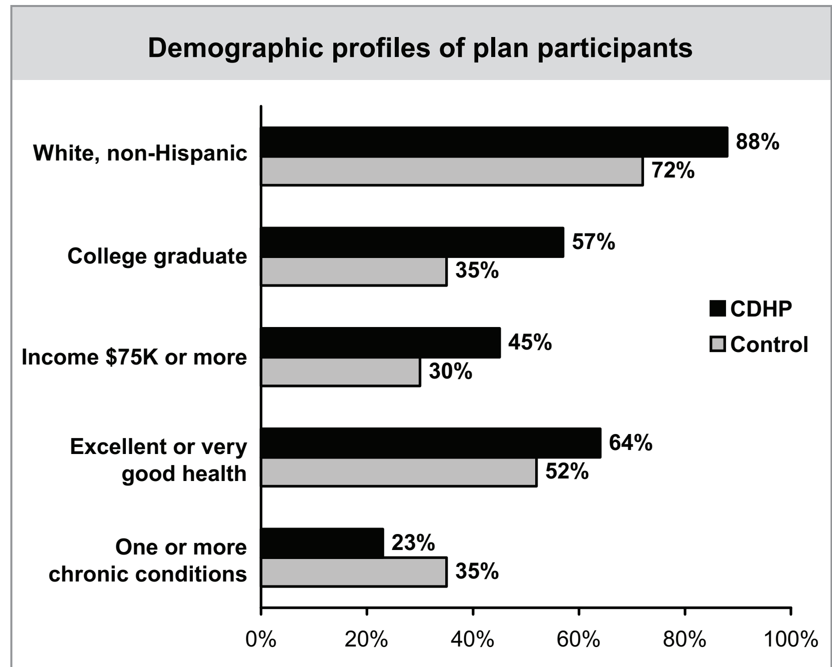
[1] See IRS Publication 969 (2005) ***Health Savings Accounts and Other Tax-Favored Health Plans***.

FINDINGS

1. Who reports being in a CDHP, and what draws people to these plans?

People in CDHPs are wealthier, more educated, more likely to be white, and report being in better health than their counterparts in other employer-sponsored plans. Lower premiums and tax-preferred savings are the main motivators people report for joining these plans.

Compared with people with more traditional employer-sponsored insurance, CDHP participants are more likely to be white, and less likely to be African American or Hispanic; they are also more educated, and have higher incomes than others with employer-sponsored insurance. Those in CDHP plans are also a somewhat healthier group – 64% (compared with 52% in the control group) say they are in excellent or very good health. They are less likely than the control group to report having a variety of conditions, including major selected chronic conditions (23% of CDHP vs. 35% of control have at least one major chronic condition, including arthritis, cancer, diabetes, hypertension, heart or lung disease).



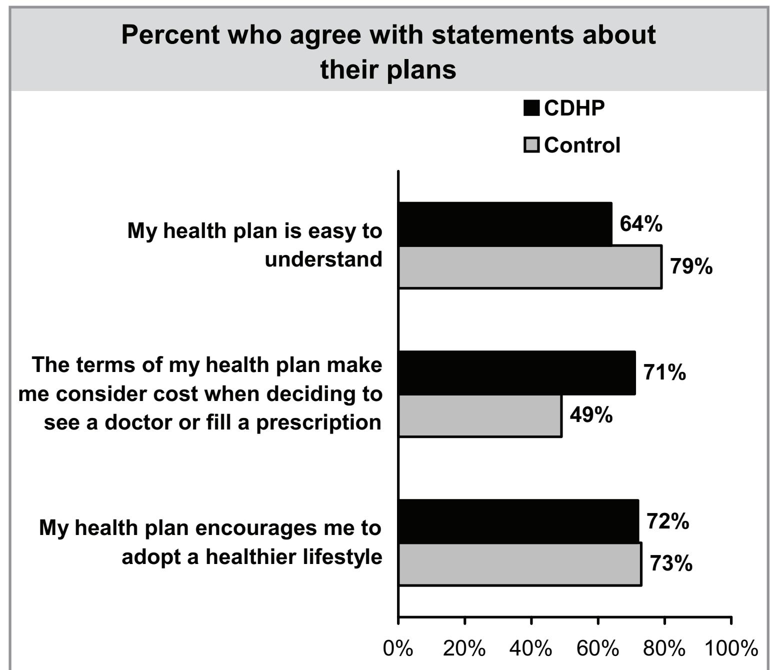
Lower premiums and tax-preferred savings appear to be the biggest motivators for most people in choosing CDHPs. Among those who had a choice of plans, 64% say the fact that the CDHP option had a lower premium than other options was a major reason for selecting their plan, and nearly four in ten (37%) say this was the most important reason they selected their plan. Ranking second as a reason was tax-preferred savings accounts, with six in ten saying this was a major reason for choosing their plan, and nearly two in ten saying it was the most important reason for their choice. In addition, 57% of CDHP participants agree (including 21% who strongly agree) that their plan will help them save money for future health expenses or for retirement.

Reasons for choosing plan among CDHP participants who had a choice of plans:

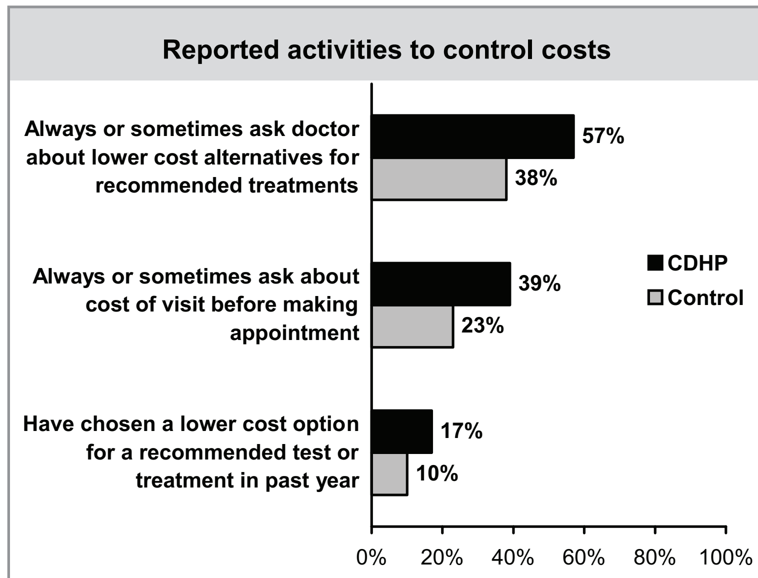
	Percent saying each was a "major reason"	When forced to choose, percent saying "most important reason"
Lower premium than other options	64%	37%
Savings account for future expenses	61%	18%
Broad provider network	58%	4%
Most hospital costs covered	53%	9%
More control of own health care	41%	5%
Most doctor and prescription costs covered	35%	9%
Wide range of benefits covered	35%	3%
Easy to understand/Minimal paperwork	31%	2%
Lower deductible than other options	16%	4%

2. Cost-conscious consumers?

One argument in favor of CDHPs is that they can lower health care costs by making consumers more conscious of the cost of care, and hence giving them an incentive to shop around for the best prices along with detailed information about price and quality. CDHP participants report higher levels of some cost-conscious attitudes and behaviors, which might be expected given that this is a group who say they chose their health plans primarily based on the low premiums. However, in general, CDHP participants do not report behaving as more informed, better shoppers than people in more traditional employer-sponsored health plans.

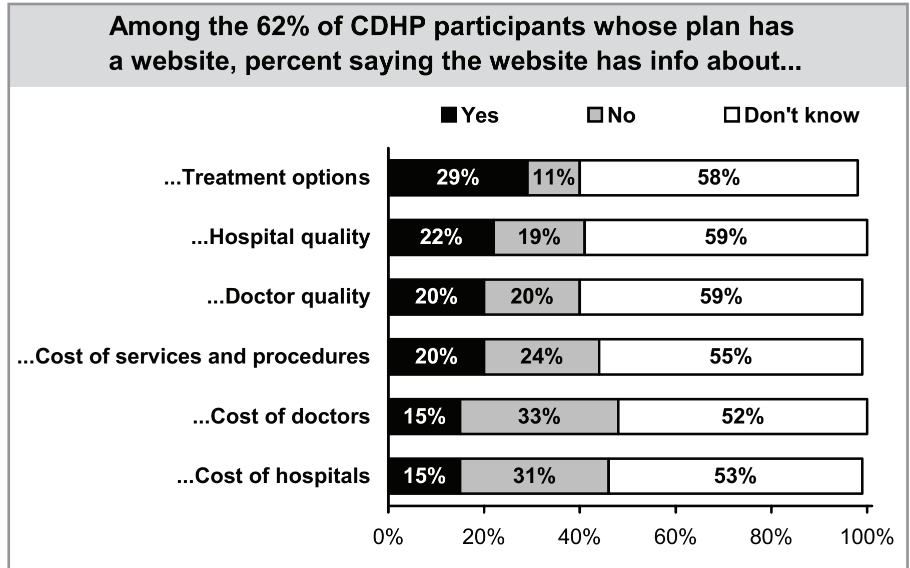


Seven in ten CDHP participants (71%) agree that the terms of their health plan make them consider cost when using health care services, compared with about half (49%) of those with non-CDHP employer coverage. In addition, people in CDHPs are more likely than people with more traditional employer-sponsored insurance to say that they usually ask about the cost of a visit before making a doctor's appointment (39% vs. 23% say they do this "almost always" or "sometimes") or talk to their doctor about whether lower-cost alternatives exist (57% vs. 38%). CDHP participants are also somewhat more likely than those in traditional employer-sponsored plans to say that in the past year they have chosen a lower-cost option for a recommended test or treatment, though it is still a relatively small share who report doing so (17% of CDHP compared with 10% of control group).



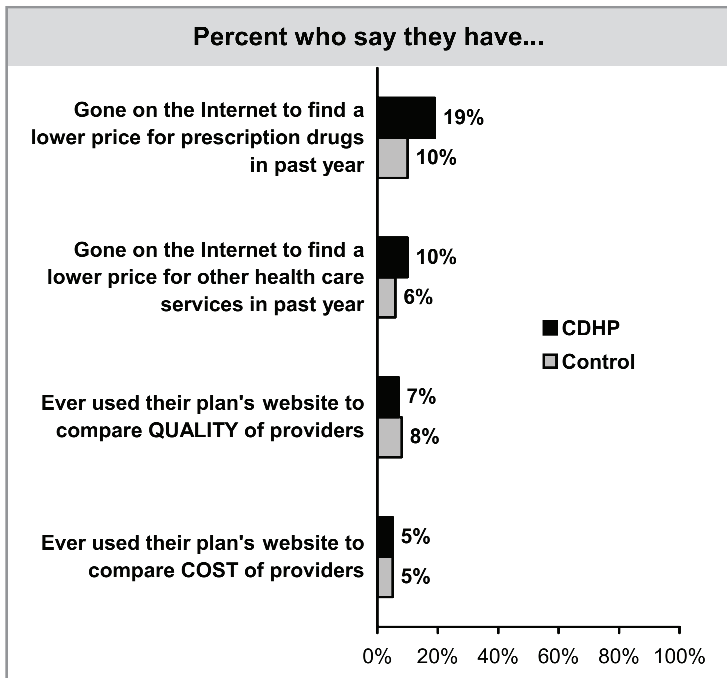
Among those who have used services under their plan, more than half (55%) say that having a CDHP has changed their approach to using health care. Nearly six in ten (57%) of those who say their approach has changed (or 32% of all CDHP participants who have used health care services) mentioned cost considerations in an open-ended question about how their approach has changed. This includes some people who say that it has made them more cost-conscious in general (e.g. "I'm more conscious of the cost of routine medical care because the cost is coming out of my own pocket. I think twice about going to the doctor or getting a prescription."). It also includes people who mentioned not getting services they needed because of the cost (e.g. "I try to conserve the amount in my account. I don't want to use it up before the end of the year. It makes me less likely to schedule follow up appointments as frequently as my doctor might like and I do not take my migraine medication as often as I should.").

One of the main arguments behind CDHPs is that they give people more control over their health care costs by providing them choices and information to become wise health care shoppers. The success of this idea requires that people have access to good information about the quality and cost of services provided by different doctors and institutions. However, most CDHP participants say it is difficult to find trustworthy information comparing quality and cost of care, and few have used their plan websites to access such information.



Most people in CDHPs say it is difficult for them to find information they can trust about the cost of health care provided by different doctors (61%) and hospitals (64%), and pluralities say the same about information on the quality of doctors (49%) and hospitals (49%).

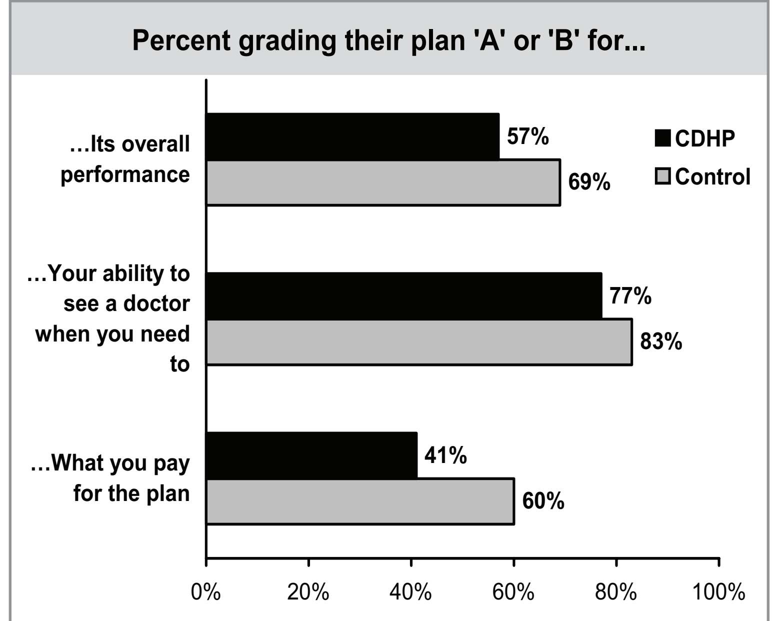
Six in ten CDHP participants (62%) say their health plan has a website that provides health care information (and most of the remainder say they don't know whether their plan has such a website). However, most of those who say their plan has a website say they don't know whether the site provides information about the quality of services offered by doctors and hospitals or the cost of different doctors and hospitals. Few say they have used their plan's website to compare physicians or hospitals based on quality (11% of those who say their plan has a website, or 7% of all CDHP participants) or costs (8% of those whose plan has a website, or 5% of all). It is interesting to note that the responses about ease of finding information and about plan websites are not statistically different between CDHP participants and those with non-CDHP employer coverage, indicating that at this point, CDHP participants are not more likely than others to use these information resources.



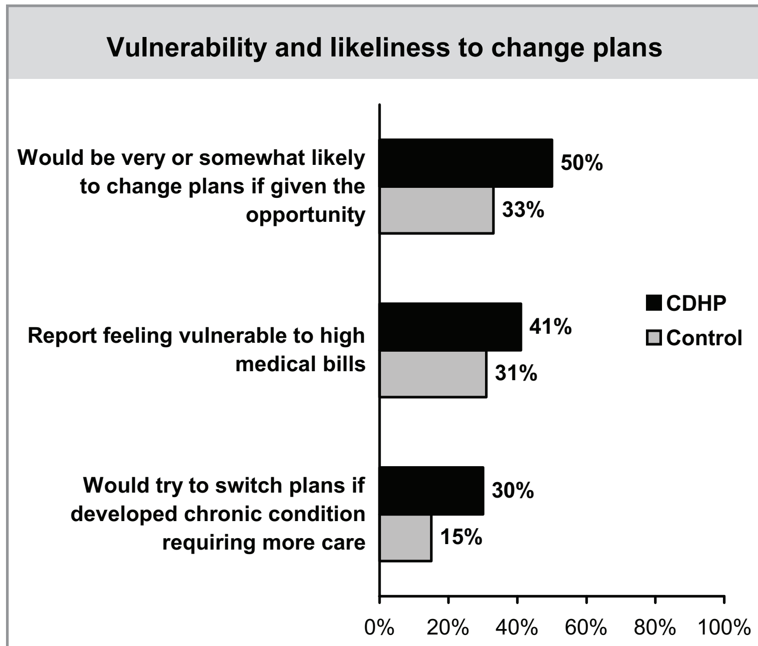
Further, when asked about shopping for lower prices on the Internet, relatively few CDHP participants (though more than those in other private plans) say that in the past year they have shopped on the Internet to get a lower price for prescription drugs (19% of CDHP compared with 10% of the control group). Even fewer (10%) say that in the past year they have shopped on the Internet to get a lower price for other types of health care services (not statistically different from the 6% of the control group who report doing so).

3. Vulnerable to high costs?

One argument often made against CDHPs is that they offer less protection and leave people vulnerable to potentially high health care costs. While people in CDHPs are generally satisfied with their plans, on a variety of measures they report feeling somewhat less protected and more vulnerable than people in more traditional employer-sponsored plans, and they report more problems accessing care due to cost.

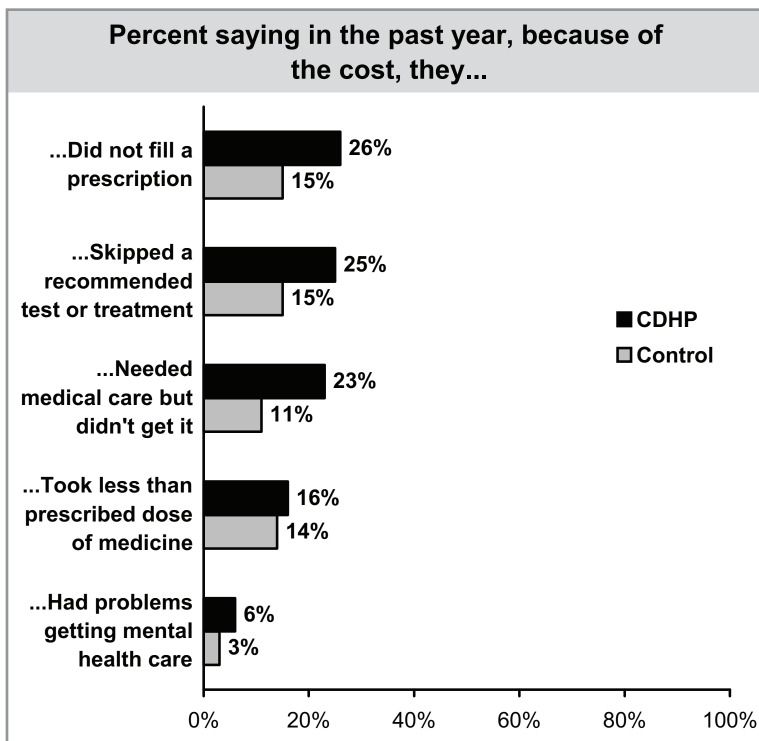


Most people in CDHPs give their plans good grades; however, they are somewhat less satisfied than others with private insurance. Nearly six in ten CDHP participants give their plan a grade of 'A' or 'B' for its overall performance, compared with about seven in ten people with non-CDHP employer coverage. Similarly, 10% of CDHP participants give their plan a grade of 'D' or 'F', compared with 4% of those in other employer-sponsored plans. Perhaps surprisingly, given the relatively lower premiums for CDHPs, participants in these plans also give them lower grades than people in other types of plans when it comes to what they pay for the plan.



People in CDHPs are more likely to say they would switch health plans if they could. Half of people in CDHPs say they would be very or somewhat likely to change health plans if given the opportunity, compared with a third of those with more traditional employer-sponsored insurance. Similarly, when asked what they would do if they developed a chronic medical condition requiring more frequent use of health care services, three in ten CDHP participants say they would try to switch plans, compared with 15% of the control group, while seven in ten (69%) say they would be comfortable staying in their current plan (compared with 84% of the control group).

When asked how they feel about their health plans in general, CDHP participants are somewhat more likely than those with non-CDHP employer-sponsored coverage to say they feel "vulnerable to high medical bills" (41% vs. 31%), and less likely to say they feel "well protected by my health plan" (59% vs. 68%). In addition, among those who were covered by another plan prior to their current coverage, people in CDHPs are more likely than those with traditional employer coverage to say their current plan offers *less* protection than their previous plan (37% vs. 19%), and less likely to say it offers *more* protection than their previous plan (14% vs. 33%).



In addition to feeling less secure, CDHP participants report more problems accessing care due to cost. They are twice as likely as others with more traditional employer-sponsored insurance to say there was a time in the past year when they needed medical care but didn't get it because of the cost. These difficulties accessing care resulted in problems for some CDHP participants; 14% say going without care seriously increased their level of stress; 9% say it caused a temporary disability; 5% say it caused a loss of time at work or school, and 2% say it caused a long-term disability. CDHP participants are also more likely to say that in the past year they have skipped a recommended test or medical treatment or not filled a prescription because of the cost.

However, despite being more likely to report problems accessing care due to cost, CDHP participants are no more likely to say that they have had problems paying medical bills in the past year (16% vs. 17%), and they are actually *less* likely than those with non-CDHP employer coverage to say that they currently have any medical bills that are overdue (11% vs. 17%).

4. Use of health care services?

CDHP participants report using fewer health care services than their counterparts in other private plans. There are several possible explanations for this, all of which may be supported by other data in the survey.

CDHP participants are less likely than those with non-CDHP employer-sponsored insurance to say that they have received *any* health care services since enrolling in their current plan (73% vs. 85%). They are also less likely than the control group to say they have visited a doctor in the past year for a specific problem (64% vs. 76%) and for a checkup (63% vs. 74%). However, CDHP participants and others report similar rates of dental check-ups (71% vs. 69%), emergency room visits (17% vs. 23%), outpatient surgeries and procedures (22% vs. 22%) and inpatient surgeries and procedures (6% vs. 9%).

There are several possible reasons that might explain why people in CDHPs use fewer services than their counterparts in other private plans. First, as noted above, CDHP participants report being somewhat healthier than others with private plans. These healthier people may need fewer health care services to begin with, perhaps explaining in part why their use of services is lower. A second possible explanation is that CDHP participants may be more cost-conscious, and are using care more wisely and avoiding care that they don't need. This explanation is supported by the findings indicating that CDHP participants are more likely to take costs into consideration when making decisions about whether to seek care. A third possible explanation is that CDHP participants may be delaying or not getting care that they need because of the cost. As noted above, people in CDHPs are indeed more likely to report skipping needed health care because of the cost.

METHODOLOGY

The *National Survey of Enrollees in Consumer Directed Health Plans* was designed, analyzed, and conducted by researchers at the Kaiser Family Foundation. In order to identify consumer directed health plan (CDHP) participants, we did screening interviews with a nationally representative sample of 22,560 people ages 18-64. Of these, 272 (1.2%) met the following criteria for belonging to a consumer directed plan with an accompanying savings account:

1. Currently covered by private insurance, either through an employer or purchased themselves
2. Have a deductible of at least $1050 for individual coverage or $2100 for family coverage
3. Say that their health insurance coverage is coupled with a personal savings account that they can use for health expenses
4. Say that the money in the account does NOT have to be used by the end of the year
5. Answer yes to at least one of the following questions:
    a. Does your health insurer or employer refer to this coverage as an "HSA Plan?"
    b. Health Savings Accounts or HSAs are tax-advantaged saving accounts that individuals and employers can fund and can be used to pay for qualified medical expenses. By law, HSAs must be paired with health coverage having a deductible between $1050 and $5100 for individuals, and from $2100 to $10200 for family coverage. These accounts belong to the individual consumer and may be taken with them to a different job, as well as rolled over into the next year. An HSA is NOT the same thing as a flexible spending account (FSA). Do you believe that this statement describes the type of health care coverage that you have?
    c. Does your health insurer or employer refer to this coverage as an "HRA Plan?"
    d. Health Reimbursement Arrangements or HRAs are tax-advantaged savings accounts funded ONLY by an employer, not the worker. By law, HRAs must be paired with health coverage having a deductible between $1050 and $5100 for individuals, and from $2100 to $10200 for family coverage. These accounts may be rolled over into the next year, but the funds are NOT portable from job to job. An HRA is NOT the same thing as a flexible spending account (FSA). Do you believe that this statement describes the type of health care coverage that you have?*

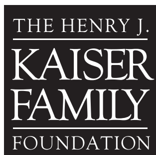
**Note: It is not a legal requirement that HRAs be paired with high-deductible health plans, and this was a mistake in our question wording. The second sentence of the question should have been worded "HRAs are often paired with health coverage having a high deductible." Of the 41 respondents in our final CDHP sample who answered yes to this question (item d in above list), 29 also answered yes to one or more of the other questions defining HSAs/HRAs (items a through c). There were 12 respondents included in the final analysis who answered yes to item d and did not answer yes to either a, b, or c (these respondents also met criteria 1 through 4 above).*

An additional 402 people (1.8%) met all of the above criteria EXCEPT they said the money in their account has to be used by the end of the year. These people were NOT included in our group of CDHP participants, because their accounts do not meet the definition of an HSA or HRA, which requires that money roll over from year to year.

Other surveys have identified groups closer to 3% of the population who are covered by "HSA-eligible" or "HRA-eligible" plans. Unlike our survey, these surveys do not necessarily require that participants actually open an HSA account to be included in the plan definition.

For comparison purposes, we also interviewed a "control" group, which was made up of 715 respondents who have employer-sponsored health insurance. People in the control group do not have a high-deductible plan coupled with a savings account, however they may have said yes to EITHER the high deductible question OR the savings account question.

A web-based survey among the 1,389 randomly selected individuals was conducted between June 21 and July 10, 2006. Fieldwork was conducted by Knowledge Networks. Respondents are members of the Knowledge Networks Panel, a large, randomly drawn, representative national panel of households. Knowledge Networks employs a random digit dialing (RDD) telephone methodology to develop a representative sample of households for participation in its panel. Every participating household receives free hardware (WebTV), free Internet access, free email accounts, and ongoing technical support, and participants receive surveys by email on the same standardized hardware.



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The Henry J. Kaiser Family Foundation
Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone: 650.854.9400
Fax: 650.854.4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street N.W.
Washington, DC 20005
Phone: 202.347.5270
Fax: 202.347.5274