

## Consumer-Directed Health Care: The Employer Perspective



**National  
Business  
Group on  
Health**



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### Introduction

In 2008, the National Business Group on Health developed a Critical Issue Update on *consumer-directed health plans (CDHPs)*. At the time, they were a relatively new kind of plan, developed to encourage employees to become more active in their health care decision-making. Over the past few years, these plans have grown in prominence in the large group market. This *Critical Issue Update* identifies changes in plan design since CDHPs were first introduced.

### Plan Types/Accounts

**Consumer-Directed Health Plan (CDHP):** Typically, it is a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA). This type of plan can include many positive features of preventive care and personal care accounts as well as health information on costs and quality of treatment options. Network providers of CDHPs and high deductible health plans (HDHPs) continue to be mostly preferred provider organizations (PPO).<sup>1</sup>

**High Deductible Health Plan (HDHP):** A plan that has a deductible of at least \$1,250 for individual coverage and \$2,500 for family coverage. The annual deductible for individuals and families remain the same for 2014. The plan also encompasses annual out-of-pocket limits of \$6,250 for individual coverage and \$12,500 for family coverage. In 2014, the annual out-of-pocket limits are \$6,350 for individual coverage and \$12,700 for family coverage.

**Full Replacement CDHP:** Employers only offer CDHP options for employees. Often, a variety of plan designs are offered so employees have a choice between health account type and cost-sharing levels.

**Health Savings Account (HSA):** A tax-advantaged account that is used to pay for qualified medical expenses and must be offered alongside an HDHP. HSAs can be funded by employers and/or employees, and they are portable. Contributions may be made up to the 2013 statutory maximum of \$3,250 for an individual or \$6,450 for a family, and they are rolled over at the end of the year. In 2014, contributions may be made up to a maximum of \$3,300 for an individual or \$6,550 for a family.

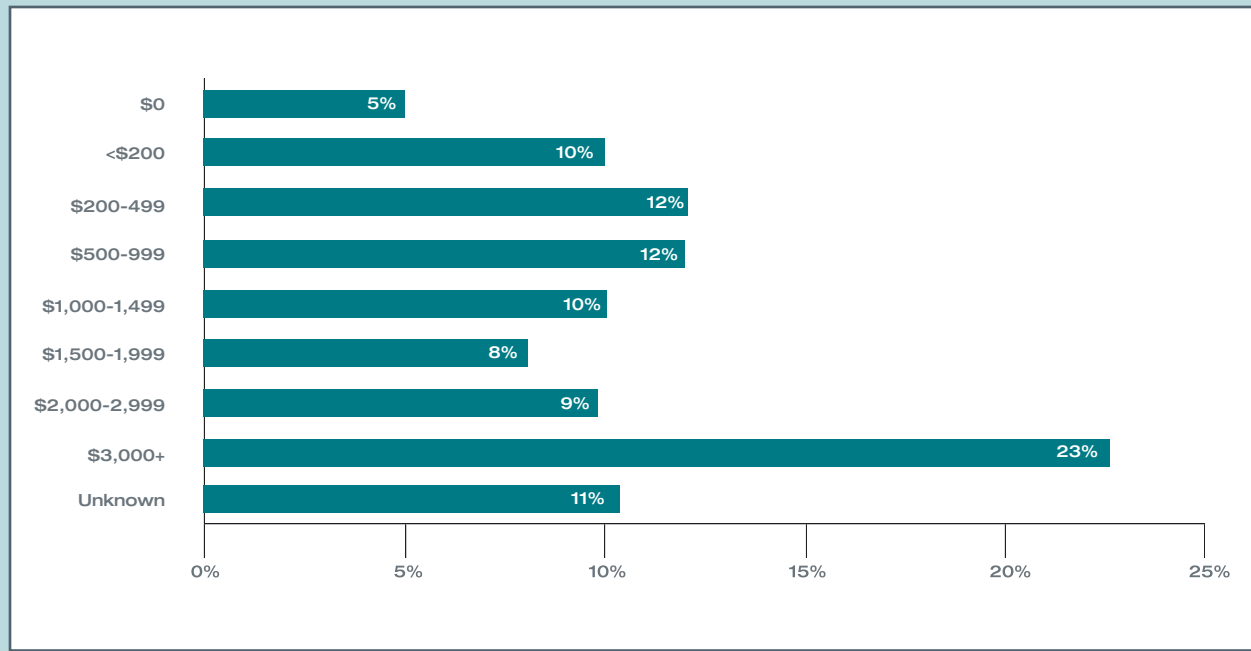
**Health Reimbursement Arrangement (HRA):** An employer-provided financial contribution to employees used to pay for qualified medical expenses, as defined in IRS section 213(d). The funds may also be used to pay for plan deductibles, copays or coinsurance. The employer determines the contribution amounts and whether the balance can roll over at the end of the year. Because this is not an actual account, the employee cannot take the money if he or she leaves the organization. An HRA may be coupled with any plan type.

## **Cost of CDHPs**

CDHPs are designed differently from many other more traditional health insurance plans. Usually, the premium cost to the employee is less (see Appendix 1). The employee is responsible for paying the initial annual cost of medical expenses, a finite amount referred to as the deductible. After the deductible has been paid, health coverage “kicks in,” and the employee pays a set dollar amount (copay) or a percent of the cost of care (coinsurance), up to the out-of-pocket maximum allowed.

Eighty-three percent of enrollees with an HSA make a contribution, with a majority contributing more than \$1,000.<sup>2</sup> Both employee and employer contributions are exempt from certain taxes, which makes contributing to an HSA a financially wise decision. Figure 1 shows the distribution of balances in HSAs among employees with CDHPs.

**Figure 1: Balances in HSA Accounts Among Privately Insured Adults with CDHPs**



Source: EBRI. *Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006-2012.*

## Enrollment

With each year of CDHP availability, enrollment has grown steadily.

- In 2012, an estimated 25 million individuals were covered by a CDHP:<sup>3</sup>
  - 11% of Americans are enrolled in a CDHP/HSA.
  - 8% of Americans are enrolled in a CDHP/HRA.<sup>4</sup>

Employers are more likely to offer HSAs than HRAs.

- Large employers are more likely to offer CDHPs than small employers:<sup>4</sup>
  - 22% of employers with 3 – 199 employees.
  - 35% of employers with 200 – 999 employees.
  - 54% of employers with 1,000+ employees.

## Demographics of CDHP Enrollees

- Distribution of CDHP enrollees, by age:<sup>5</sup>
  - 20% ages 21 – 34
  - 20% ages 35 – 44
  - 30% ages 45 – 54
  - 22% ages 55 – 64
- Gender:<sup>5</sup>
  - 44% of CDHP enrollees are male, 56% female.
  - Other plan enrollees are similarly split, with 44% male, 56% female.
- Income: 24% of CDHP enrollees earn over \$100,000, 20% of other plan enrollees earn over \$100,000.<sup>5</sup>
- Health Status: 69% of CDHP enrollees report excellent/very good health, 60% of other plan enrollees report excellent/very good health.<sup>5</sup>

## Evidence of Improved Quality

### Preventive Care

Even before the Affordable Care Act, tax-qualified HDHPs provided coverage for preventive care and medications before the deductible was met. Employees and their families received annual examinations, immunizations, screenings and, at times, treatment for chronic illness with no-to-low cost sharing. Most employers paid first dollar coverage, while others required a copay or coinsurance.

- An analysis conducted by Aetna found that CDHP enrollees used 12% more preventive care and accessed screenings for breast and cervical cancer at a higher rate than PPO members.<sup>6</sup>
- The effect of being in a CDHP appears to be greater for male enrollees: Although women use preventive services at a higher rate, in both CDHPs and non-CDHPs, male CDHP members had an 8.8% higher preventive utilization than those enrolled in non-CDHPs.<sup>7</sup>

### Wellness

Programs designed to help employees become healthier are used at a higher rate by CDHP enrollees, with greater effectiveness:<sup>8</sup>

- 53% of CDHP enrollees participated in health-promotion programs compared with 41% of traditional plan enrollees.
- 77% of CDHP enrollees participated in health assessments compared to 64% of traditional-plan enrollees.<sup>3</sup>

## Medication Adherence

CDHP enrollees' adherence to treatment regimens varies by drug class, according to Medco and researchers from the University of Oregon:

- There was an increase in the percent of employees enrolled in a CDHP discontinuing medications for high blood pressure, cholesterol and diabetes.<sup>9, 10</sup> Experts hypothesize that these medications are at risk for reduced adherence because not taking them may not have immediate symptomatic effects.
- Generic utilization is 6% higher for CDHP enrollees.<sup>11</sup>

## Urgent Care

Carriers, such as UnitedHealth Group, Aetna, and Blue Cross Blue Shield of Minnesota, and researchers from the Health Research & Educational Trust and Harvard Medical School have tracked the effects of CDHP enrollment on treatment-seeking behavior, specifically whether the enrollee avoids the emergency room (ER). This avoidance falls into two categories: 1) the enrollee seeks other means of medical care because the cause is not truly an emergency or 2) the enrollee avoids ER care altogether, regardless of injury or illness severity, due to potential out-of-pocket costs. UnitedHealth Group and Aetna examined their members' practices:

- CDHP enrollees had 20% lower non-urgent emergency room use than those in the control matched PPO group.<sup>6</sup> In a separate study, emergency room use dropped 17% in the first year and 14% in the second year among employees of large employers. Interestingly, full replacement plans saw a growth in hospital admissions but a slowing of emergency room visits over the same period.<sup>12</sup>

## Increased Use of Transparency Tools and Resources

CDHPs encourage enrollees to use available resources to help them make health care choices on the basis of quality and cost.<sup>13</sup>

- 33% of employers provide employees with health care service unit price information; an additional 10% plan to do so in the future.
- 12% of employers offer information on provider and/or hospital quality beyond what the health plan offers; 11% of employers are looking into this for 2014.

Employees with a CDHP are more likely to adopt consumerism behaviors compared to their counterparts in other plans:<sup>3</sup>

- 56% checked to see if the plan covered care (other plans: 45%).
- 53% requested a generic drug (other plans: 41%).
- 35% discussed treatment options with their physician (other plans: 28%).
- 26% developed a health care budget (other plans: 16%).

- 23% used a tool to track health care costs (other plans: 11%).

Health care quality also plays a major role in employees' consumerism behavior. The Employee Benefit Research Institute (EBRI)<sup>2</sup> found that CDHP enrollees were more likely than those in other plans to search for information on quality of care of doctors and the cost of care provided by the health plan. Furthermore, CDHP enrollees were more likely to use information on quality and cost for medical decision-making.

### **Employee Satisfaction**

According to EBRI,<sup>14</sup> overall satisfaction is lower for those in CDHPs than for those in other plans: Fifty-seven percent of enrollees in other plans were extremely or very satisfied with the overall plan compared to 46% of CDHP enrollees and 37% of HDHP enrollees (those not offered an account but still have a high deductible). It is important to point out that the presence of a health account is shown to increase satisfaction rates based on the quality of the health plan by approximately 9%. The presence of account funding helps employees offset the higher deductible and gives them a sense that they "own" their health care dollars.

Employees are less likely to recommend CDHPs to their colleagues: Forty-one percent of CDHP enrollees would recommend their CDHP to a friend or co-worker compared to 49% enrolled in other plans.<sup>14</sup>

## Tips for Communicating to Employees About CDHPs

A key factor in employee satisfaction may be the company's ability to educate employees about the plan's strengths and weaknesses so that they have a better understanding of the plan's overall value. Comprehensive preenrollment communication to employees is extremely important. The following strategies have proven to be successful for Business Group members:

- ✓ Start communicating the plan change 12 – 18 months prior to implementation.
- ✓ Communicate plan design through a variety of channels, such as print, email, intranet/internet and face-to-face meetings, as frequently as possible.
- ✓ Emphasize the benefits of HSAs in saving for post-retirement health care.
- ✓ Provide common benefits terms in simple language.
- ✓ Use a variety of communication methods to accommodate all employees' learning styles. For example, some employees may prefer to absorb information through auditory channels; in those instances, the employer may want to offer podcasts. Other employees may prefer taking in information in "small bites"; therefore, sending information out in a series of emails may work best for those with this learning style.
- ✓ Clearly explain the benefits of decision support tools.
- ✓ Brand the consumerism campaign with the company logo, a tagline and a distinct look/feel.
- ✓ Send the same message repetitively – about seven different times in seven different ways.
- ✓ Use employee testimonials about the benefits of the program.
- ✓ Make communication actionable by asking employees to use suggested tools or review a document that pertains to their own health situation (e.g., information about maternal health for women of childbearing years).
- ✓ Provide your call center with accurate information to ensure consistency with branding and benefits language.

## **Outlook**

CDHPs will likely continue to increase in popularity, potentially under the private exchanges, where available, and for all consumers participating in the state-run or federally-run state exchanges, beginning in 2014. The exchanges should allow individuals to shop for a health plan that aligns with their health care needs and is affordable. CDHPs provide employers with a cost-effective solution to rising health care costs while promoting recommended preventive services and the use of cost and quality tools.

Employers must continue to educate employees about the value of these programs and to point out their benefits. Moving forward, the goal should be to increase employee satisfaction through targeted communications and in-depth education.



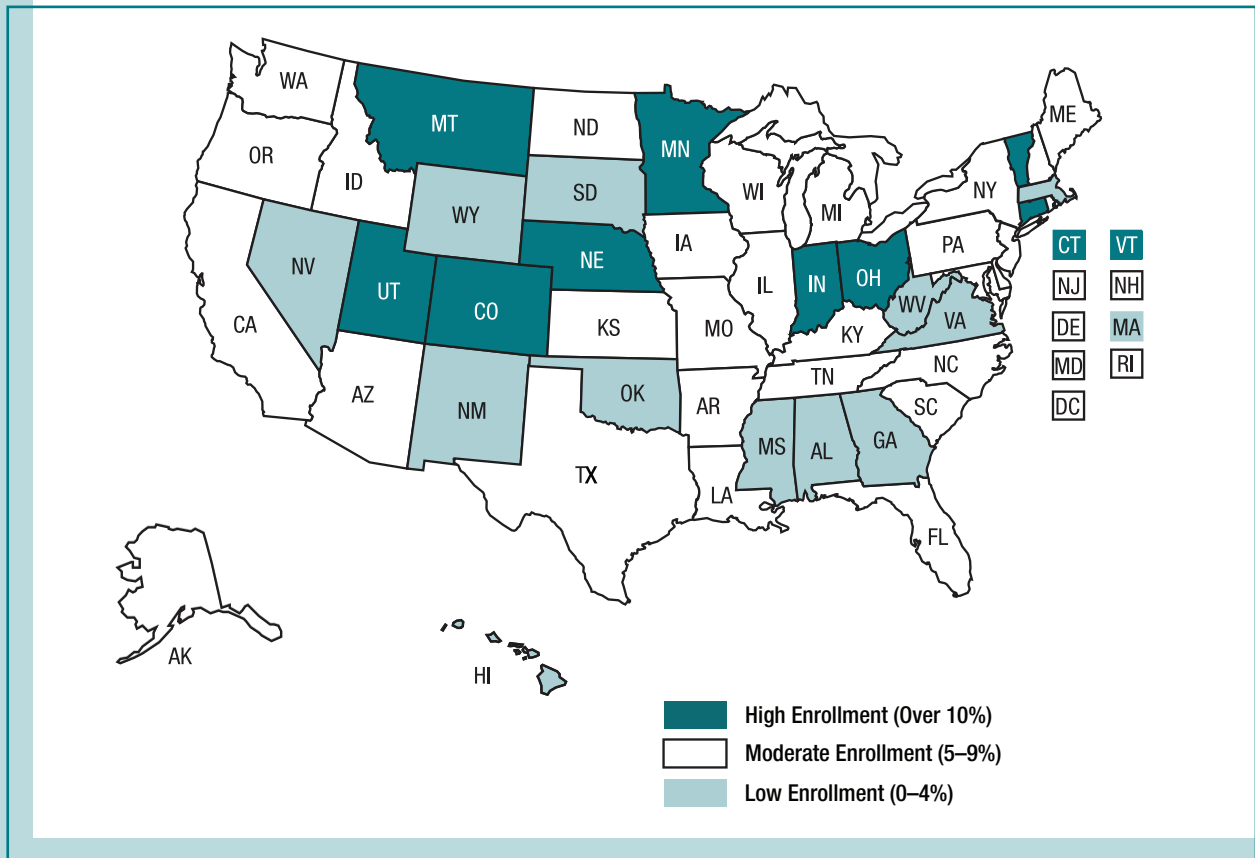
## Appendices

### Appendix 1: How Do CDHPs Compare to Other Health Plans?

Plan Type	Definition	2012 Enrollment	Average Deductible (Single)	Average Monthly Premium Employees (Single)	Average Monthly Premium Employer (Single)	% of Employees Subject to Out-of-Pocket Maximum Over \$3,000
PPO	Preferred Provider Organization: Managed care plan that contracts with employers and other third party administrators to provide comprehensive medical services. Providers negotiate discounted rates in exchange for volume and prompt payment.	63%	\$563	\$88	\$484	34%
POS	Point-of-Service: Plan that allows members, when they are seeking care, to choose to get services outside the network with some coverage, although there is a financial incentive to stay in network.	4%	\$664	\$76	\$483	42%
HMO	Health Maintenance Organization: A group model contracts with a single multispecialty group to provide care for its members. The medical group usually negotiates a per capita rate with the HMO.	16%	\$475	\$84	\$475	30%
CDHP	Consumer-Directed Health Plan: Typically, a plan with a high deductible benefit design with a health reimbursement arrangement (HRA) or a health savings account (HSA).	17%	\$1,881	\$68	\$406	72%

Source: Kaiser Family Foundation/HRET Employer Health Benefits Survey (2012)

Note: Based on large employers' (200+ employees) plan designs.

**Appendix 2: HSA Enrollment by State**

*Adapted from: America's Health Insurance Plans, Center for Policy and Research. January 2012 Census Shows 13.5 Million People Covered by HSA/High-Deductible Health Plans. May 2012.*

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The National Leadership Committee on Consumerism and Engagement is an initiative of the National Business Group on Health's Institute on Health Care Costs and Solutions. The committee was established in April 2006 and provides a leadership forum to focus on finding and evaluating effective solutions to the health care benefits and employee engagement challenges of large employers.

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The Business Group is the only non-profit organization devoted exclusively to representing large employers' perspectives on national health issues and providing solutions to its members' most important health care and health benefits challenges. The Business Group fosters the development of a safe health care delivery system and treatments based on scientific evidence. Members share strategies for controlling costs, improving patient safety and quality of care, increasing productivity and supporting healthy lifestyles.

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