Consumer-Driven Health Care: What Is It, and What Does It Mean for Employees and Employers?

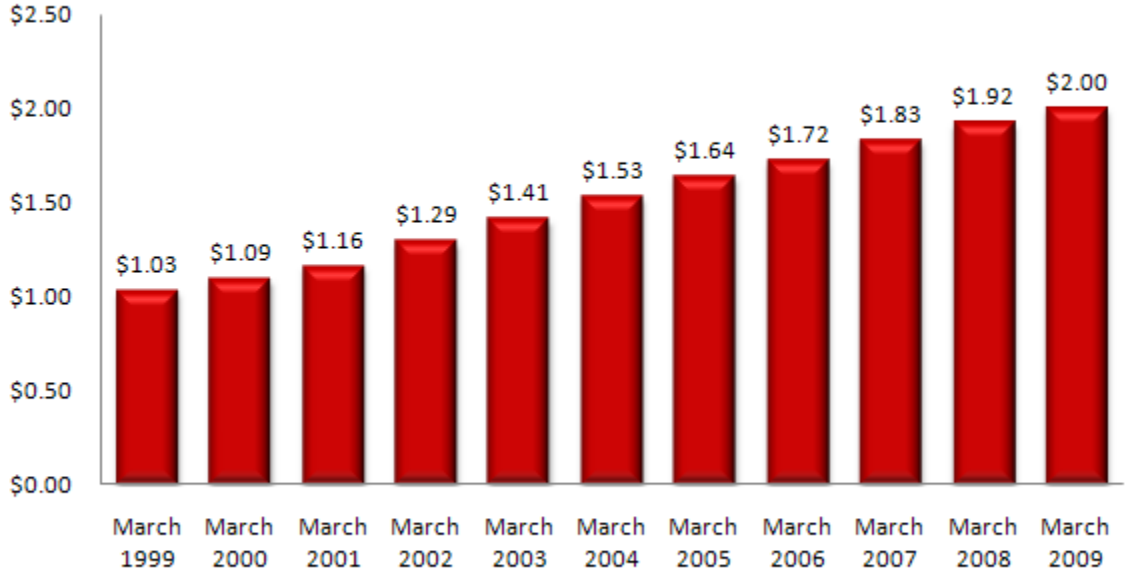
by Song G. Yi
Bureau of Labor Statistics

Originally Posted: October 25, 2010

Some employers are considering the switch to consumer-driven health plans (CDHPs) in order to reduce the cost of providing health insurance benefits to their employees. Because CDHPs generally have lower premiums, they might be a popular choice for some employees. Employers and employees will need to carefully weigh the costs and benefits of CDHPs compared with more traditional health insurance plans before deciding which type of plan to use.

The cost to employers of providing health insurance to their employees has been rising for decades.[1] Estimates from the National Compensation Survey (NCS) indicate that the average cost for the private employer to provide health care insurance has risen from $1.03 per hour worked in March 1999 to $2.00 per hour worked in March 2009, a change from 5.4 percent to 7.3 percent of total compensation.[2] Chart 1 displays the rising cost for the private employers.

Chart 1. Health benefit costs, dollars per hour worked, private industry, March 1999–March 2009



Source: U.S. Bureau of Labor Statistics, Employer Costs for Employee Compensation archives, 1999-2001, March 2002–03, and 2004–present, available on Employment Cost Trends page at http://www.bls.gov/ncs/ect/#tables.

Interestingly, the costs to employees have increased as well. NCS estimates indicate that the average medical plan monthly flat-rate premium paid by private industry workers in single and family coverage has increased from $67.57 (single) and $264.59 (family) in 2004 to $92.43 (single) and $349.36 (family) in 2009.[3] Even though the cost for both employer and employee has increased, the proportion of cost for the employer and employee has remained similar. In 2003, private employers share of the premium for single coverage reflected 82 percent of the total premium, whereas the employees were responsible for the remaining 18 percent. In 2009, the employers share for single coverage was 80 percent compared with 20 percent for the employees share. The share for family coverage was at 70 percent for the employer and 30 percent for the employee in 2003 and in 2009.[4]

With the rise in health care costs, what options are available for employers and employees to lower their costs each month? Some employers may have stopped offering health insurance as a benefit altogether. Some employees may have opted not to enroll in the health plan, and others might have lost coverage when their employers went out of business during the recent recession (although coverage rates have remained fairly steady in recent years).[5] These options are extreme, however, because they result in no coverage, which puts employees and their families in a position of financial risk should they need urgent medical care. Yet, there are some available alternatives for employers and employees that would help to trim their costs.[6] One of these alternatives is the consumer-driven health plan.

Consumer-driven Health Plans

The combination of a pretax payment account with a high-deductible health plan is what is commonly referred to as a *consumer-driven health plan* (CDHP).[7] In terms of payment methods, CDHPs are often referred to as three-tier payment systems, consisting of a savings account, out-of-pocket payments, and an insurance plan.[8] The first tier is a pretax account that allows employees to pay for services using pretax dollars. The account may be funded by the employer or the employee, depending on the type of account. The funds from this account can be used to satisfy the insurance plan deductible. The second tier is the difference, or the “coverage gap,” between the amount of money in the individuals pretax account and the deductible. The amount that is not covered by the pretax account must be covered by the insured. If health care expenses exceed the deductible amount, then the third tier, the high-deductible health insurance plan, kicks in.

Once this happens, everything behaves like a traditional health plan. The insured pays a coinsurance amount for benefits until an out-of-pocket maximum is reached. Once the out-of-pocket maximum is reached, the high-deductible health plan covers all costs for the remainder of the year. Subsequent sections of this article describe the various types of pretax accounts and how they are used, most of the time in conjunction with a high-deductible health plan, as a low-cost substitute for a traditional medical care plan.

High-deductible Health Plans

High-deductible health plans (HDHPs) are health plans with higher annual deductibles (the amount the insured must pay in medical costs before receiving coverage) and a higher annual out-of-pocket maximum (the amount that the insured pays before being fully covered for costs) than the typical traditional plan. One can view these plans as catastrophic coverage plans; HDHPs guard against major medical cost. Estimates from the National Compensation SurveyBenefits show that 15 percent of private sector workers participate in a high-deductible health plan. NCS benefits data also show that in 2009 the annual median deductible of a non-high-deductible health plan in the private sector was $400 per individual coverage, while it was $1,600 for HDHPs.[9] In turn, HDHPs have lower premiums compared with traditional health plans.[10] The lower premiums translate into lower costs for both the employer and the employee.

HDHPs share another important feature that distinguishes them from traditional healthcare plans; a person must be enrolled in an HDHP to open a health savings account (HSA) or an Archer medical savings account (MSA). The HDHP and the HSA or MSA work together to provide employees with tax-free savings earmarked for medical expenses. There are other types of pretax accounts that do not require enrollment in an HDHP that can be used to pay for medical care. There are various pretax accounts used to pay for medical care; however, each account has some feature that distinguishes it from the others. (See Exhibit 1.)

Health Savings Accounts

Health savings accounts (HSAs) allow various advantages for the account owners. For example, the employer or the employee may fund pretax dollars into this account up to the limit set by the Internal Revenue Service.[11] Any unused amount in this account will not be lost at the end of the year. Rather, the unused amounts will rollover to the next year without a penalty. Also, the rules for HSAs allow the money in these accounts to be used for retirement income, subject to regular income tax if the money is withdrawn after age 65. Before 65, there will be an additional 10-percent tax penalty. Participants may even elect to invest in stocks or other financial instruments using funds from this account. The same types of

investments permitted for IRAs are allowed for HSAs. And as long as the money is withdrawn to pay medical expenses and not for retirement income, the interest or other earnings in this account are tax and penalty free.[12]

There are stringent requirements for opening an HSA. An individual must be enrolled in a "qualified" HDHP to enroll in an HSA. The Internal Revenue Service (IRS) has placed rules and guidelines for HDHPs to be qualified. The HDHP must meet the following requirements: as of 2009, the IRS defines an HDHP as a health plan with a minimum yearly deductible of $1,150 for an individual and $2,300 for a family; and the annual maximum out-of-pocket expense cannot exceed $5,800 for an individual and $11,600 for a family.[13]

Archer Medical Savings Accounts Compared With Health Savings Accounts

An Archer medical savings account (MSA) is similar to an HSA in that it must be paired with an HDHP. An MSA is a tax-exempt trust or custodial account that is set up with a U.S. financial institution in which money is saved exclusively for future medical expenses. There are many similarities between MSAs and HSAs. Interest or other earnings generated by the assets of the MSAs and HSAs are tax free, the unused contributions are rolled over from year to year, and the accounts are portable, staying with the employee even if he or she changes employers or leaves the work force.

Similar to HSAs, but not exactly the same, are the deductible and annual out-of-pocket expenses requirements for the HDHP associated with an MSA. In 2009, the annual deductible limits were required to be between $2,000 and $3,000 for individual coverage and between $4,000 and $6,050 for family coverage. Also, the maximum annual out-of-pocket expenses could not be greater than $4,000 for individual coverage and $7,350 for family coverage. These restrictions had to be met for the HDHP to be qualified. Once enrolled in the qualified HDHP, the participant can enroll in an MSA. MSAs were designed specifically to meet the medical care cost needs of self-employed individuals and employees of small employers. Other tax-favorable accounts, such as a health reimbursement arrangement (HRA) or a flexible spending arrangement (FSA), are not allowed for self-employed individuals.[14]

Health Reimbursement Arrangements Compared With Health Savings Accounts

Health reimbursement arrangements (HRAs), or health reimbursement *accounts*, are not as flexible as HSAs. Only the employer is allowed to fund an HRA; the employee cannot contribute any pretax dollars to the account. This is in contrast to HSAs, which allow both the employer and the employee to contribute to the account. The funds in an HRA may only be used for medical expenses and cannot be invested. In both types of plans, any unused funds roll over from year to year without incurring a loss. An HRA has an advantage over an HSA in that the enrollee does not need to be covered under an HDHP or any other health care plan to participate.[15] Whether HSA or HRA, it is quite common for employers to provide a benefit such as contributing a dollar amount into one of these funds for their employees to effectively reduce the employees high out-of-pocket limits.

Flexible Spending Accounts Compared With Health Reimbursement Arrangements

Another tax-favorable account is the flexible spending account or flexible spending *arrangement* (FSA). This kind of account also allows employees to be reimbursed for qualified medical expenses. FSAs are funded through a voluntary salary reduction program with the employer, and Federal income taxes are not deducted from this contribution. Employers may also contribute to the FSA.

Similar to an HRA, the employee does not need to be enrolled in an HDHP to participate in an FSA. Employers may establish FSA accounts for their employees whether or not they are covered by any medical care plan. Unlike HRAs, FSAs allow contributions from the employee or the employer. One drawback of an FSA is that the remaining balance at the end of the year does not roll over to the next year. In other words, it is a "use-it-or-lose-it" account.

Conclusion

The underlying assumption of a consumer-driven health plan (CDHP) is that consumers will make more informed choices and forego unnecessary or excess medical care if they have to use more of their own money to pay for it. This assumption is

similar to that which underlies the “moral hazard” theory of health insurance, which posits that if one has zero-cost insurance, he or she is more likely to engage in risky and wasteful behavior.[16] Lower cost premiums may prove to make CDHPs a popular choice. According to a recent study published by the National Business Group on Health and Towers Watson, 2 percent of the companies with 1,000 or more employees offered CDHPs in 2002, whereas 54 percent of these companies are offering the choice in 2010.[17]

The recent economic downturn may help increase the participation of these plans even more.[18] In a recent Mercer survey of private employers, 46 percent of respondents stated that they would make more cost-saving changes to their health plans in 2010 because of the economic downturn. More interestingly, 22 percent of the respondents plan to institute a CDHP to curb the increase in cost.[19]

It seems as though a fair number of employers are considering the switch to CDHPs as a means of reducing their cost for providing health insurance benefits. At the same time, however, according to a study by the Employee Benefit Research Institute, CDHP enrollees report a lower satisfaction rating (52 percent) than traditional plan enrollees (66 percent). Furthermore, only 45 percent of enrollees in CDHPs state that they would recommend their plan to friends or coworkers, compared with 55 percent of those in traditional plans.[20] Therefore, surveys show that although CDHPs may help plan participants and employers lower costs, participants may not always get the quality they were accustomed to in a traditional plan. This suggests that employers and employees need to weigh their health care costs against employee satisfaction before they decide to make a switch to CDHPs.

Glossary

Coinsurance: The amount of a health benefits cost which will not be paid by a plan. For example, a health benefit plan may include a coinsurance rate of 10 percent for medical services. Plan participants are responsible for paying 10 percent of the costs for medical services with the health benefit plan paying 90 percent of the cost. Plans may have different coinsurance rates for different types of services, such as hospital room and board, outpatient surgery, etc.

Deductible: The amount of money a benefit plan participant must pay during a year before the plan begins to provide coverage and pay for all or a portion of the benefit. For example, a health benefits plan may include a $50 deductible per year per individual to receive reimbursement for prescription drugs.

Employer Costs for Employee Compensation (ECEC): A special tabulation of data used to publish cost levels data, which covers costs per hour worked of the various components of compensation. The ECEC is released on a quarterly basis. The cost levels are calculated with current employment weights, rather than the fixed weights used in computing the Employment Cost Index (ECI).

Employment Cost Index (ECI): A measure of change in the cost of labor, free from the influence of employment shifts among occupations and industries. The compensation series includes changes in wages and salaries and employer costs for employee benefits. The survey is published quarterly. The survey covers the civilian economy, including State and local governments, but excludes farms, households, and the Federal government.

Out-of-pocket maximums: An out-of-pocket maximum is the maximum expenses an individual or family must pay, after any deductibles are met, in a given time period or for a given condition. After this maximum is reached, the plan pays 100 percent until the overall maximum is reached.

Individual Retirement Account (IRA): A financial vehicle for personal retirement that allows a person to make annual tax deductible or non-deductible contributions. This type of account must meet IRS Code 408 requirements, but is created and funded at the discretion of the individual. They are not employer-sponsored plans.

Exhibit

Exhibit 1. Comparison of various pretax savings accounts and relationship to high-deductible health plan (HDHP)

Type of account	Pretax employee contribution allowed	Employer contribution allowed	Rollover allowed	May the assets in the fund be used for investing purposes?		Must the account be linked with a HDHP?	
				Yes/ No	If yes, what investments are allowed?	Yes/ No	If yes, what plan limits constitute a Qualified HDHP?
Health savings account (HSA)	Yes	Yes	Yes	Yes	The individual may use the assets in the fund to invest in any IRA instruments.	Yes	Min. Deductible: (Self) $1,150 (Family) $2,300; Max. annual out-of-pocket: (Self) $5,800 (Family) $11,600 in 2009
Medical savings account (MSA)	Yes, only if employer does not contribute. None, if the employer contributes.	Yes	Yes	Yes	The individual may use the assets in the fund to invest in any IRA instruments.	Yes	Min. Deductible: (Self) $2,000 (Family) $4,000; Max. Deductible: (Self) $3,000 (Family) $6,050; Max. annual out-of-pocket: (Self) $4,000 (Family) $7,350 in 2009
Health reimbursement arrangement (HRA)	No contribution allowed from the employee.	Yes	Yes	No	The funds may only be used for qualified medical expenses.	No	---
Flexible spending account (FSA)	Yes	Yes	No	No	The funds may only be used for qualified medical expenses.	No	---

Song G. Yi
Economist, Division of Compensation Data Estimation, Office of Compensation and Working Conditions, Bureau of Labor Statistics.
Telephone: (202) 691-6270; E-mail: Yi.Song@bls.gov.

Notes

1 See "Employment Cost Index, private industry, 12-month percent change in employer costs per hour worked, total benefits and health benefits," on the Internet at http://www.bls.gov/ncs/ect/sp/echealth.pdf.

2 For 1999 data, see *Employer Costs for Employee Compensation — March 1999*, USDL 99–173 (U.S. Department of Labor), June 24, 1999, on the Internet at http://www.bls.gov/news.release/archives/ecec_031999.pdf. For 2009 data, see *Employer Costs for Employee Compensation — March 2009*, USDL-09-0634 (U.S. Department of Labor), June 10, 2009, on the Internet at http://www.bls.gov/news.release/archives/ecec_06102009.htm. The Employer Costs for Employee Compensation (ECEC) is a point-in-time, or cross-sectional, measurement of the economy; for the rate of wage and benefit costs over time, the Employment Cost Index (ECI) should be used.

3 For 2004 data, see *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2004*, Summary 04–04 (Bureau of Labor Statistics, November 2004), table 4, p. 8, on the Internet at http://www.bls.gov/ncs/ebs/sp/ebsm0002.pdf. For 2009 data, see *National Compensation Survey: Employee Benefits in the United States, March 2009*, Bulletin 2731 (Bureau of Labor Statistics, September 2009), table 11 (single coverage) and table 13 (family coverage), on the Internet at http://www.bls.gov/ncs/ebs/benefits/2009/ebbl0044.pdf.

4 For 2003 data, see *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2003*, Summary 04–02 (Bureau of Labor Statistics, April 2004), table 3, on the Internet at http://www.bls.gov/ncs/ebs/sp/ebsm0001.pdf. For 2009 data, see

Employee Benefits in Private Industry in the United States, March 2009, USDL 09–0872 (U.S. Department of Labor), July 28, 2009, table 3 (single coverage) and table 4 (family coverage), on the Internet at http://www.bls.gov/ncs/ebs/sp/ebnr0015.pdf.

5 Employer Health Benefits: 2009 Summary of Findings (Kaiser Family Foundation and Health Research & Educational Trust), p. 7, on the Internet at http://ehbs.kff.org/pdf/2009/7937.pdf (accessed October 18, 2010).

6 "Why is There Movement Toward Consumer Driven Health Care?" (ConsumerDrivenHealthCare.us, 2003–06), on the Internet at http://www.consumerdrivenhealthcare.us/MOVE.HTM?wwparam=1287412939 (accessed October 18, 2010).

7 Some surveys expand the definition to include regular deductible plans combined with a pretax payment account. For example, see "Raising the Bar on Health Care: Moving Beyond Incremental Change," 15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care, 2010, p. 15, on the Internet at http://www.towerswatson.com/assets/pdf/1345/TW_15565_NBGH.pdf (accessed October 18, 2010).

8 "What Are Common Features of Consumer Driven Health Plans?" (ConsumerDrivenHealthCare.us, 2003–06), on the Internet at http://www.consumerdrivenhealthcare.us/FEATURES.HTM (accessed October 18, 2010).

9 *National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009*, Bulletin 2749 (Bureau of Labor Statistics, July 2010), tables 3, 4, and 5, on the Internet at http://www.bls.gov/ncs/ebs/detailedprovisions/2009/ebbl0045.pdf.

10 Employer Health Benefits: 2009 Summary of Findings (Kaiser Family Foundation and Health Research & Educational Trust), p. 7, on the Internet at http://ehbs.kff.org/pdf/2009/7937.pdf (accessed October 18, 2010).

11 According to the Internal Revenue Service, "For 2009, if you have self-only HDHP coverage, you can contribute up to $3,000. If you have family HDHP coverage, you can contribute up to $5,950. For 2010, self-only increases to $3,050 and family increases to $6,150." See Health Savings Accounts and Other Tax-Favored Health Plans, Publication 969 (Internal Revenue Service, November 25, 2009), pp. 2–4, on the Internet at http://www.irs.gov/pub/irs-pdf/p969.pdf (accessed October 18, 2010).

12 For more information, see "HSA Frequently Asked Questions" (United States Department of the Treasury, March 14, 2006), on the Internet at http://www.ustreas.gov/offices/public-affairs/hsa/faq_using.shtml (accessed October 18, 2010).

13 Health Savings Accounts and Other Tax-Favored Health Plans, Publication 969 (Internal Revenue Service, November 25, 2009), pp. 2–3, on the Internet at http://www.irs.gov/pub/irs-pdf/p969.pdf (accessed October 18, 2010).

14 Ibid., pp. 10–17.

15 Ibid., pp. 17–19.

16 Mark Pauley, "The Economics of Moral Hazard: Comment," *The American Economic Review 58*, No.3, Part 1, June 1968, pp. 531–37; see p. 535.

17 "Raising the Bar on Health Care: Moving Beyond Incremental Change," 15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Health Care, 2010, p. 15, on the Internet at http://www.towerswatson.com/assets/pdf/1345/TW_15565_NBGH.pdf (accessed October 18, 2010).

18 See "Health benefit cost growth predicted to ease slightly in 2009 as employers shift cost," (Mercer, September 4, 2008), on the Internet at http://www.mercer.com/summary.htm?idContent=1319885 (accessed October 18, 2010).

19 Kathleen Koster, "Employers turn to CDHPs in anticipation of 2009 cost spike," (Employee Benefit News and SourceMedia, Inc., May 4, 2009), on the Internet at http://ebn.benefitnews.com/news/employers-turn-to-CDHPs-in-anticipation-of-2009-cost-spike-2672262-1.html (accessed October 18, 2010).

20 Paul Fronstin, "Findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey," Issue Brief No. 337 (Employee Benefit Research Institute, December 2009), p. 28, on the Internet at http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2009_No337_CEHCS.pdf (accessed October 18, 2010).

Data for Chart 1. Health benefit costs, dollars per hour worked, private industry, March 1999March 2009

	March 1999	March 2000	March 2001	March 2002	March 2003	March 2004	March 2005	March 2006	March 2007	March 2008	March 2009
Private Industry Health Benefit Cost	$1.03	$1.09	$1.16	$1.29	$1.41	$1.53	$1.64	$1.72	$1.83	$1.92	$2.00

U.S. Bureau of Labor Statistics | Division of Information and Marketing Services, PSB Suite 2850, 2 Massachusetts Avenue, NE Washington, DC 20212-0001 | www.bls.gov/OPUB | Telephone: 1-202-691-5200 | Contact Us