

Update

May 23, 2008



Encouraging CDHP enrollment and happier plan participants

Summary

According to Mercer's *National Survey of Employer-Sponsored Health Plans* – the largest, most comprehensive US employer benefit survey – 7 percent of all employers and 14 percent of employers with 500 or more employees offered a consumer-directed health plan (CDHP) in 2007. This includes CDHPs based on health savings accounts (HSAs) and those based on health reimbursement arrangements (HRAs). There are many CDHP design elements that can lead to positive results for sponsors seeking to hold down health care costs and satisfy employee needs. This *Update* looks at findings from Mercer's survey that identify some powerful predictors of CDHP success.

CDHP cost – and cost-savings potential

Now that CDHPs have been around for several years, we can start to evaluate the overall and relative performance of these plans. More than four-fifths of large CDHP sponsors say one reason for offering a CDHP is to save money. Clearly, these plans are less costly than other health insurance options: Among large employers, the average CDHP cost per employee was \$5,903 in 2007, about \$1,500 less than the average PPO cost of \$7,429 per employee. To date, very few large employers have been willing to limit their medical plan offerings to only a CDHP. While 13 percent offered a CDHP alongside another type of medical plan, only 1 percent offered it as a full replacement. Thus, the employer cost savings achieved with a CDHP depends on how many employees enroll and how well the plans meet participants' needs.

In these two areas, we see wide variation in performance from one plan sponsor to the next. Employers report very different levels of enrollment. This is partly a function of how long the plan has been offered: Among 77 survey respondents with CDHPs in place for three years, average enrollment rose

Study methods

While many factors influence both enrollment and employee satisfaction – including other plan choices available, administration and communication – plan design appears to have some impact. Using data from the 389 large CDHP sponsors responding to Mercer’s 2007 survey, we divided HRA and HSA sponsors into three roughly equal-sized groups based on enrollment levels (high, medium and low) and also divided them based on employee satisfaction. Key plan design features were compared between the groups, focusing on respondents with 500 or more employees.

High-enrollment groups

High-enrollment HRA plans had 30 percent or more of eligible employees enrolled in the plan. Low-enrollment plans had fewer than 10 percent of eligibles enrolled.

High-enrollment HSA-based plans had 10 percent or more of eligible employees enrolled in the plan. Low-enrollment plans had 2 percent or fewer eligible employees enrolled.

Employee satisfaction groups

Plan satisfaction was measured based on perceived employee acceptance of the CDHP. Plans with a “strongly positive” or “more positive than negative” employee response were considered high satisfaction. Plans with a neutral or negative employee response were considered low satisfaction.

from 21 percent in the first year to 29 percent in the third year. But even among plans that have been in place for three years, enrollment ranges from as low as 1 percent in some organizations to as high as 90 percent in others.

Still, plans with enrollment of over 50 percent are few and far between. For most HSA sponsors, enrollment ranges from 1 percent to 15 percent; most HRA sponsors enroll 1 percent to 34 percent of employees. Nonetheless, if employers save an average of \$1,500 when an employee moves from a PPO into a CDHP, even a few percentage points difference in enrollment can result in a substantial savings in overall health benefit spending.

Objectives for offering CDHP plans*

	HRA sponsors	HSA sponsors
To promote health care consumerism	91%	90%
To lower our organization’s health benefit cost over time	89%	82%
To improve our overall package of health plan offerings; add choice	68%	81%
To provide a savings vehicle for post-retirement medical coverage	25%	63%
To provide a tax-effective savings vehicle	N/A	62%

* Percent of employers reporting objective as “very important” or “important.”

Study results: How plan design influences enrollment and satisfaction

Many program design elements can lead to positive results, such as making employer contributions to health accounts; setting palatable financial protections with out-of-pocket maximums; and providing adequate tools, information and support for the CDHP. Equally important is helping employees understand and value the program they’re being offered. Multi-channel communication, done early and often, is a powerful tool, especially when supported by key stakeholder messaging from the top down and bottom up. Ideally, such initiatives will dovetail into longer-term education efforts to give the program substantial lift over time, increasing satisfaction and enrollment.

We divided the CDHP sponsors responding to the survey into groups based on enrollment and employee satisfaction levels and looked for variations in plan design among the groups. Features that appear to have the most significant effects are described on the next page.

Account contributions. Although HSAs do not require an employer contribution (HRA accounts are solely employer-funded and -controlled), employees are more likely to enroll when plans include an employer contribution. More than three-fourths (78 percent) of respondents with high-enrollment HSAs contribute to employee accounts, compared with just 47 percent of respondents with low-enrollment HSAs. Among respondents making a contribution, however, the average contribution amounts are virtually identical for high- and low-enrollment plans (\$577 for individual coverage and \$1,150 for family coverage for high-enrollment plans; \$580 for individual and \$1,040 for family for low-enrollment plans). It may be that overt financial support is more important to the success of the plan than the actual amount of the contribution itself. It seems that making even a small contribution encourages more employees to establish HSAs than otherwise would, which improves perception of the plan among the general employee population.

Out-of-pocket maximums. Employee-only and family out-of-pocket maximums are higher for low-satisfaction and low-enrollment HSA-based CDHPs. Average individual maximums for high-enrollment plans are almost \$1,000 lower than low-enrollment plans, and average family maximums are about \$1,400 lower. This makes sense, since participants' first considerations when choosing a new plan are "What will happen if I get seriously injured or sick?" and "How will this plan protect me financially compared to other plans?" Respondents with high-satisfaction and high-enrollment CDHPs were also more likely to offer a debit card to their employees – tangible assurance that they'll have easy access to funds.

Decision-support tools and information resources. CDHP sponsors are generally more likely to provide decision-support information to employees than those offering only traditional medical plans. But the study found that respondents with high enrollment in or high satisfaction with their HRA-based CDHPs are more likely to offer information on health conditions to their employees and tools to help members select the most appropriate plan.

Will offer CDHP as the only medical plan within five years		
	HRA sponsors	HSA sponsors
High-enrollment plans	47%	32%
Low-enrollment plans	16%	10%
High-satisfaction plans	30%	21%
Low-satisfaction plans	18%	15%

Measuring success

Employer objectives for CDHPs include controlling costs, promoting consumerism and providing employees with a savings vehicle for post-retirement medical coverage. Those in the high-enrollment, high-satisfaction groups were more likely to say the CDHP is meeting objectives. For example, nearly two-thirds of high-satisfaction HRA sponsors and more than three-fourths of high-enrollment HRA sponsors agreed their most important program objectives had been met. Just two-fifths of sponsors with low-satisfaction HRAs and 29 percent of those with low-enrollment HRAs made this assertion. Respondents with high-satisfaction and high-enrollment HSAs were much more likely to rank promoting health care consumerism as an important or very important objective of their CDHP.

Plan satisfaction and enrollment affects sponsors' decisions about future plan offerings. Respondents with high-satisfaction or high-enrollment HRA- or HSA-based CDHPs were much more likely to say they will offer only an account-based CDHP in five years. Most with low-satisfaction or low-enrollment plans said they will offer a CDHP in five years alongside other plans.

Likewise, nearly one-third (32 percent) of respondents with high-enrollment HSA-based plans said they will offer only an account-based plan in the next five years, compared with just 10 percent of respondents with low-enrollment plans.



For more information

For additional information, please contact your Mercer consultant.

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Conclusion

CDHPs can be a useful and influential tool, helping to break the inertia around health care and leading to more sustainable costs and healthier populations over time. Achieving meaningful enrollment and positive employee satisfaction with the program are central to the success of CDHPs in meeting health care cost management objectives.

Authors

Sander Domaszewicz is Mercer's National Practice Leader for Consumerism, specializing in emerging benefits and informing and involving consumers around health care cost and quality. He can be reached at sander.domaszewicz@mercer.com

Beth Umland leads the Health & Benefits Research Group, which conducts Mercer's flagship *National Survey of Employer-Sponsored Health Plans* and other employer surveys. She can be reached at beth.umland@mercer.com

Kara Koss, MPH, is an analyst in the Health & Benefits Research Group. She can be reached at kara.koss@mercer.com.

Editorial Board

Amy Bergner
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amy.bergner@mercer.com
susan.lemaster@mercer.com
mark.major@mercer.com
kathleen.murray@mercer.com
chad.nicholl@mercer.com
henry.saveth@mercer.com
wade.symons@mercer.com
jennifer.wiseman@mercer.com