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Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2014

By Paul Fronstin, Ph.D., Employee Benefit Research Institute, and Anne Elmlinger, Greenwald & Associates

AT A GLANCE

- In 2014, there was $22.1 billion in health savings accounts (HSAs) and health reimbursement arrangements (HRAs), spread across 10.6 million accounts, according to data from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS). In 2008, there were only 4.2 million accounts with $5.7 billion in assets.
- The average account balance was $2,077 in 2014, up from $1,356 in 2008.
- An increasing number of individuals have held their account for three or more years. One-quarter (27 percent) had held their account for three to four years, up from 19 percent in 2008. Thirteen percent had held their account five or more years, up from 4 percent in 2008.
- Accounts with an employer contribution had a higher average balance than those without an employer contribution. Accounts with an employer contribution had an average balance of $2,403, whereas those without an employer contribution had an average balance of $2,056.
- Individuals who had held an HRA or HSA for five years or more had $3,092 in their account. Those who had held an account for less than a year had less than $1,500 in their account. In general, average account balances have grown over the longer term regardless of how long the account had been open.
- Average rollover amounts increased from $1,165 in 2013 to $1,244 in 2014.
- $8.9 billion was rolled over in 2014, down from $9.4 billion in 2013.
- Eleven percent of individuals had held an account for more than a year without a rollover in 2014.
- Rollover amounts increased with the length of time an individual had held an account. In 2014, those who had held an account one to two years rolled over an average of $982; those who had held an account three to four years rolled over an average of $1,421; and those who had held an account five or more years rolled over an average of $1,428.
- Accounts with an employer contribution had a higher amount rolled over than those without an employer contribution. Accounts with an employer contribution had an average rollover of $1,280, whereas those without an employer contribution had an average rollover of $1,069.

This survey was made possible with the funding support from the following organizations: Blue Cross and Blue Shield Association, HealthEquity, Healthways, Lincoln Financial Group,® National Rural Electric Cooperative Association, Optum, and Prudential.

Paul Fronstin is director of the Health Education and Research Program at the Employee Benefit Research Institute (EBRI). Anne Elmlinger is vice president, Healthcare Practice lead, with Greenwald & Associates. Any views expressed in this report are those of the authors and should not be ascribed to the officers, trustees, or other sponsors of EBRI, Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF), 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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Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2014

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Introduction

Employers first started offering account-based health plans in 2001, when a handful of employers began to offer health reimbursement arrangements (HRAs), employer-funded health plans that reimburse workers for qualified medical expenses. In 2004, employers were able to start offering health plans with health savings accounts (HSAs), tax-exempt trusts or custodial accounts used to pay for health care expenses. The theory was that these accounts would give individuals more control over funds allocated for health care services and would cause them to become more engaged in their health care, thereby using health care services more effectively, especially once they became more educated about the actual price of health services. Furthermore, these accounts could be used as tax-advantaged vehicles to save for future health care expenses.

By 2014, 27 percent of employers with 10–499 workers and 48 percent of employers with 500 or more workers offered either an HRA- or HSA-eligible plan.[1] As a result, these plans, collectively known as consumer-driven health plans (CDHPs), covered about 26 million people in 2014, representing about 15 percent of the privately insured market (Fronstin & Elmlinger, 2014). As the number of people with a CDHP grows, total assets associated with these plans can be expected to grow as well.

CDHPs are no longer a new type of health plan. HSAs have been around now for a decade and HRAs since 2001. Hence, a growing percentage of the population has had either an HRA or HSA for a number of years. In 2008, 19 percent of the population with an HRA or HSA had held an account for three to four years, and 4 percent for five years or more (Figure 1). By 2014, 27 percent had held an account for three to four years, and 13 percent for five years or more. As the length of time individuals have these plans increases, average account balances should increase as well.

This *Issue Brief* presents findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS). This study is based on an online survey of 3,887 privately insured adults ages 21–64. The survey was designed to provide nationally representative data regarding the growth of CDHPs and high-deductible health plans (HDHPs) and the impact of these plans and consumer engagement more generally on the behavior and attitudes of adults with private health insurance coverage.

The remainder of this report examines the findings from the 2014 CEHCS as they relate to the level of assets held in HSAs and HRAs, account balances, and rollover amounts. Findings from this survey are compared with findings from the 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008–2013 CEHCS.

Enrollment in CDHPs

Individuals with a deductible of at least $1,250 for individual coverage or $2,500 for family coverage who also have an HRA, or were enrolled in an HSA-eligible health plan (regardless of whether the HSA was opened) were assigned to the CDHP group in the CEHCS. Everyone else with a deductible of at least $1,250 for individual coverage or $2,500 for family coverage was assigned to the HDHP group. Individuals with no deductible or a deductible below $1,250 for individual coverage and $2,500 for family coverage were assigned to the "traditional" coverage category. More detail about the methodology is provided in Fronstin & Elmlinger (2014).

As reported in Fronstin & Elmlinger (2014), this survey finds that 14.7 percent of the population was enrolled in a CDHP in 2014, compared to 16.6 percent in 2013 (Figure 2). The difference between the 2013 and 2014 estimates is not

statistically significant. However, the lower 2014 enrollment estimate affects other trend data presented in this paper. As a result of the lower estimate, it appears that total assets held in HSAs and HRAs fell, and that the growth rate in assets was negative as well, when, in fact, this is simply a function of a lower estimate for HRA and HSA enrollment between 2013 and 2014 that is within the margin of error.

About the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey

The Employee Benefit Research Institute (EBRI) and Greenwald & Associates created the EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS) to examine issues surrounding consumer-directed health care, including the cost of insurance, the cost of care, satisfaction with health care, satisfaction with a health care plan, reasons for choosing a plan, and sources of health information. Findings from the 2014 CEHCS is comparable with findings from the 2005–2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey, and the 2008–2013 CEHCS.

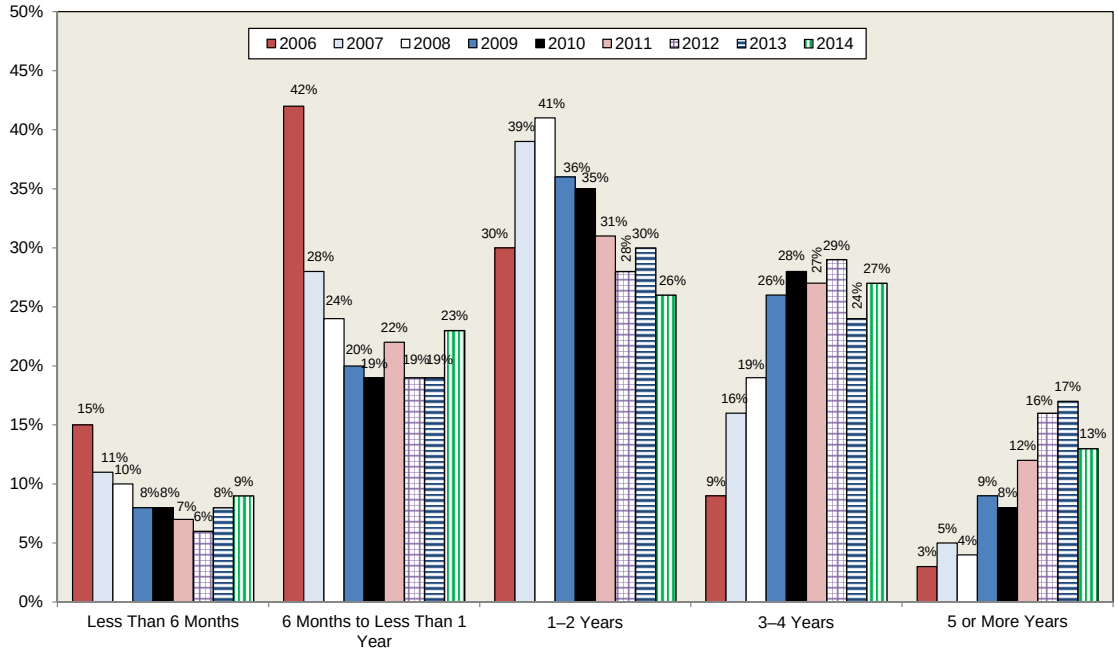
The 2014 survey was conducted within the United States between Aug. 7 and Aug. 27, through an 11-minute Internet survey. The national or base sample was drawn from Ipsos's online panel of Internet users who have agreed to participate in research surveys.[2] Nearly, 2,000 adults ages 21–64 who had health insurance through an employer, purchased directly from a carrier, or purchased through a government exchange were drawn randomly from the Ipsos sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 36.3 percent (26 percent for the base sample or national sample, and 48 percent for the oversample). Because a non-probability sample was used, traditional survey margin of error estimates did not apply. However, had the survey used a probability sample, the margin of error for the national sample would have been ±2.2 percent.

The sample was divided into three groups: those with a consumer-driven health plan (CDHP), those with a high-deductible health plan (HDHP), and those with traditional health coverage. Individuals were assigned to the CDHP or HDHP group if they had a deductible of at least $1,250 for individual coverage or $2,500 for family coverage. To be assigned to the CDHP group, they must also have been eligible to contribute to an HSA, or had a health reimbursement arrangement (HRA) with a rollover provision that they could have used to pay for medical expenses, or had the ability to take their account with them should they have changed jobs. Individuals with only a flexible spending account (FSA) were not included in the CDHP group.

Because the base sample (national sample) included only 294 individuals with a CDHP and 237 individuals with an HDHP, an oversample of individuals with a CDHP or HDHP was added. The oversample included 1,165 individuals with a CDHP. 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 21–64 with private health insurance coverage.[3] The CDHP oversample was weighted by gender, age, income, and race/ethnicity. More information can be found in Fronstin & Elmlinger (2014).

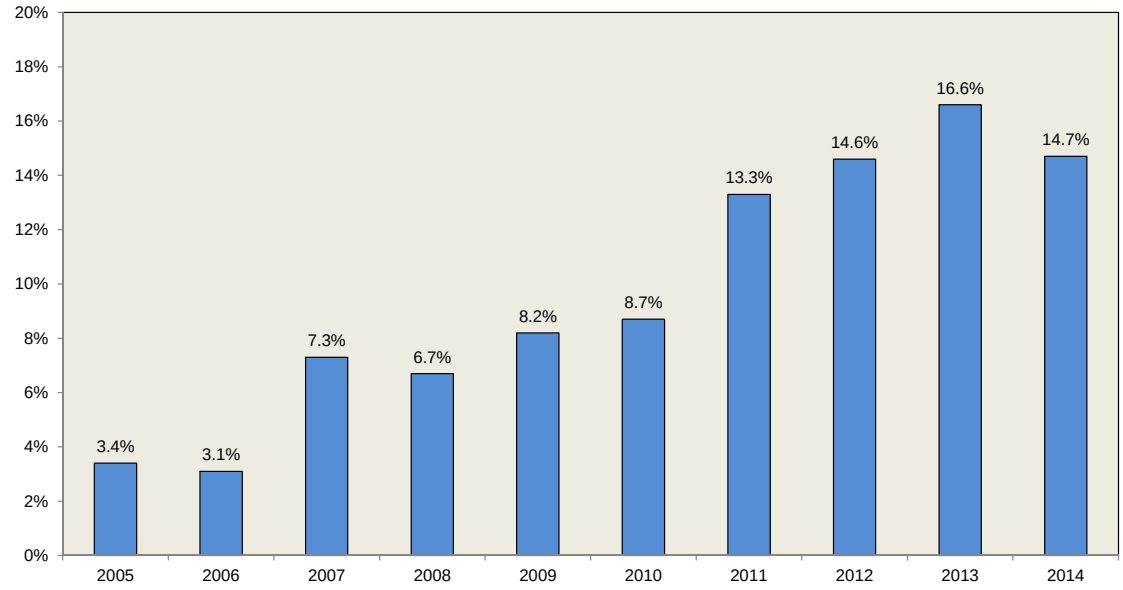
While panel Internet surveys are nonrandom, studies have demonstrated that such surveys, when carefully designed, obtain results comparable with random-digit-dial telephone surveys. Taylor (2003), for example, provided the results from a number of surveys that were conducted at the same time using the 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 under-representation of minorities in online samples.

Figure 1
Length of Time With HRA[a] or HSA,[b] 2006–2014



Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 2
Percentage of Adults Ages 21–64 With Private Health Insurance Covered by a CDHP,[a] 2005–2014



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
[a] CDHP = Consumer-driven health plan w/ deductible $1,250+ (individual), $2,500+ (family), with HRA, HSA, or HSA-eligible health plan in 2014.

Assets

According to findings from the 2014 CEHCS, there was $22.1 billion in HSAs and HRAs in 2014, spread across 10.6 million accounts (Figure 3).[4] In 2008, there were only 4.2 million accounts with $5.7 billion in assets.[5] In 2014, growth rates were negative for both assets and the number of accounts (Figure 4). As noted earlier, the decline between 2013 and 2014 was likely the result of the lower incidence rate of CDHPs in 2014 that was not statistically significant. Note that in 2013, the number of accounts grew 3 percent while assets grew 38 percent. Part of the reason for the difference in the growth of assets compared with the growth of accounts was due to a change in the survey. In prior years, "$3,000 or more" was the highest account balance category that a respondent could choose. Starting with the 2013 survey, respondents could report account balances in the "$5,000–$9,999" and "$10,000 or more" ranges.

Account Balances

In 2014, average account balances reached $2,077 (Figure 5). In 2008, average account balances were $1,356, and as recently as 2012 they were $1,534. Between 2008 and 2014, the percentage of accounts with a balance of $3,000 or more increased from 18 percent to 27 percent. At the same time, the percentage with a zero balance fell slightly from 9 percent to 7 percent (Figure 6).

Length of Time With Account—Not surprisingly, the length of time that an individual has held an account had a major impact on the amount of money in the account. In 2014, the average account balance was $796 among people who held an account for less than six months, while those with an account six months to less than a year had an average of $1,423 (Figure 7). In comparison, individuals who had held an account for one to two years had an average of $2,499. Those who had held an account for three to four years had an average of $3,225. And those who had held an account for at least five years had an average account balance of $3,092.

Employer and Individual Contributions—Annual contribution amounts, whether they came from the employer (in the case of both HRAs and HSAs), or from individuals (as they apply to HSAs only) had a strong impact on overall account balances. Not surprisingly, the more money that was contributed to an account, the higher the average account balance. In 2014, for instance, accounts with an employer contribution had a higher average balance than those without an employer contribution. Accounts with an employer contribution had an average balance of $2,403, whereas those without an employer contribution had an average balance of $2,056 (Figure 8).

When it came to the level of the employer contribution, individuals with an employer contribution of less than $1,000 had an average account balance of $2,183 in 2014, while those with an employer contribution of at least $1,000 had an average of $2,768 in their account (Figure 9). Similarly, individuals who contributed less than $1,000 had an average account balance of $1,548, while those who contributed at least $1,000 had an average balance of $3,151 (Figure 10).

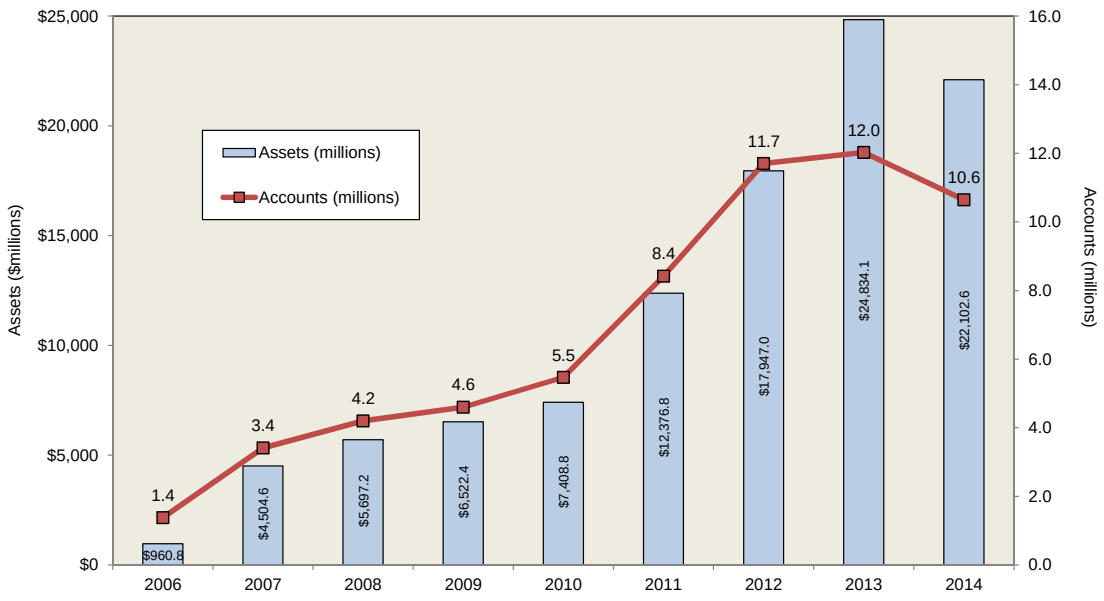
It will be important to track this trend over time. Currently, account balances are low and are therefore invested in relatively safe vehicles such as money market funds (currently, investments are usually restricted to a money market fund until the savings account reaches a minimum threshold, such as $2,000 or $3,000). As account balances grow, the potential to invest in more risky investment vehicles (such as mutual funds and stocks) will grow. The opportunities for capital appreciation will increase but so will the opportunities for capital losses, even among individuals with high levels of employer and individual contributions.

Rollovers—Like contribution levels, annual rollover amounts had a large impact on average account balances. Individuals with less than a $1,000 rollover had an average account balance of $1,452 (Figure 11). In comparison, individuals with a rollover of at least $1,000 had an average account balance of $4,792.

Rollovers

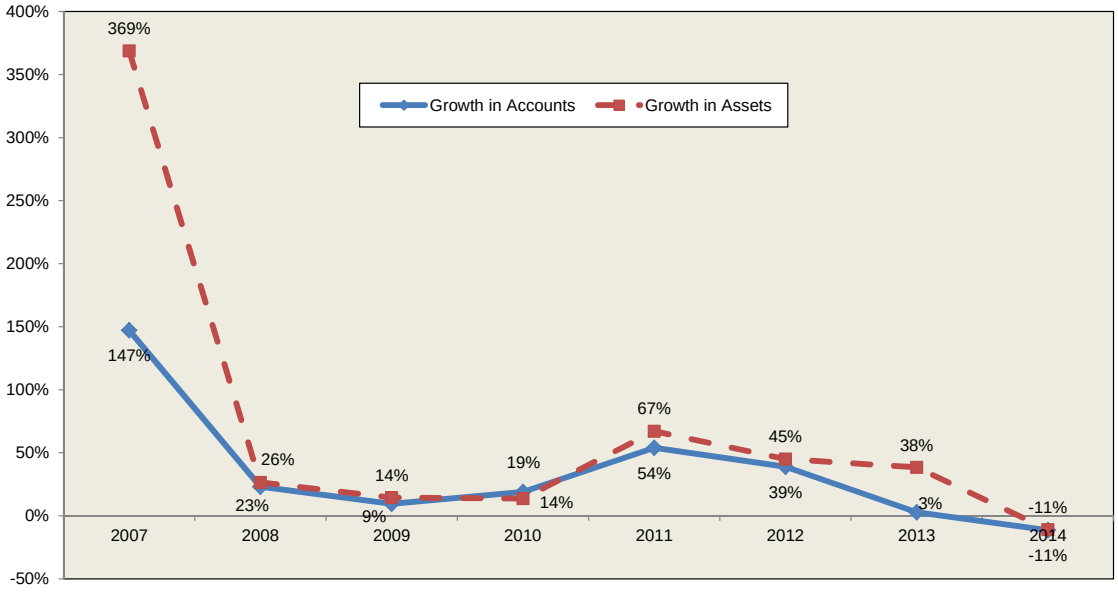
Employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. Leftover funds at the end of each year can be carried over to the following year (at the employer's discretion). Employers can, however,

Figure 3
Total Assets and Number of Adults Ages 21–64 With an HRA[a] or HSA,[b] 2006–2014



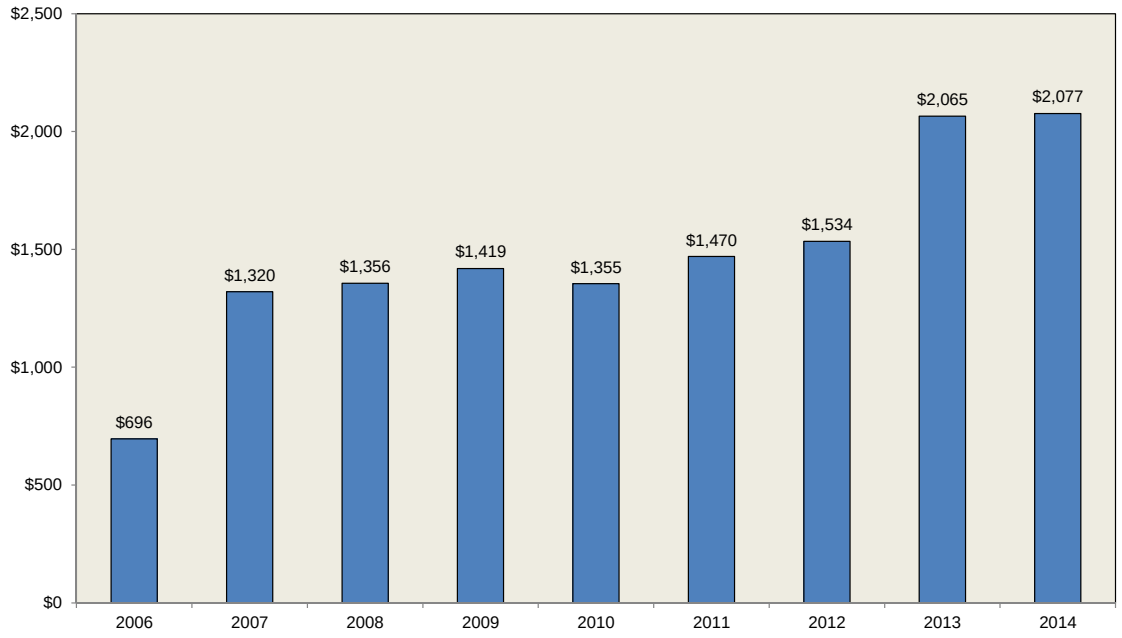
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 4
Annual Growth Rate in HRA[a] or HSA[b] Assets and the Number of Accounts, 2007–2014



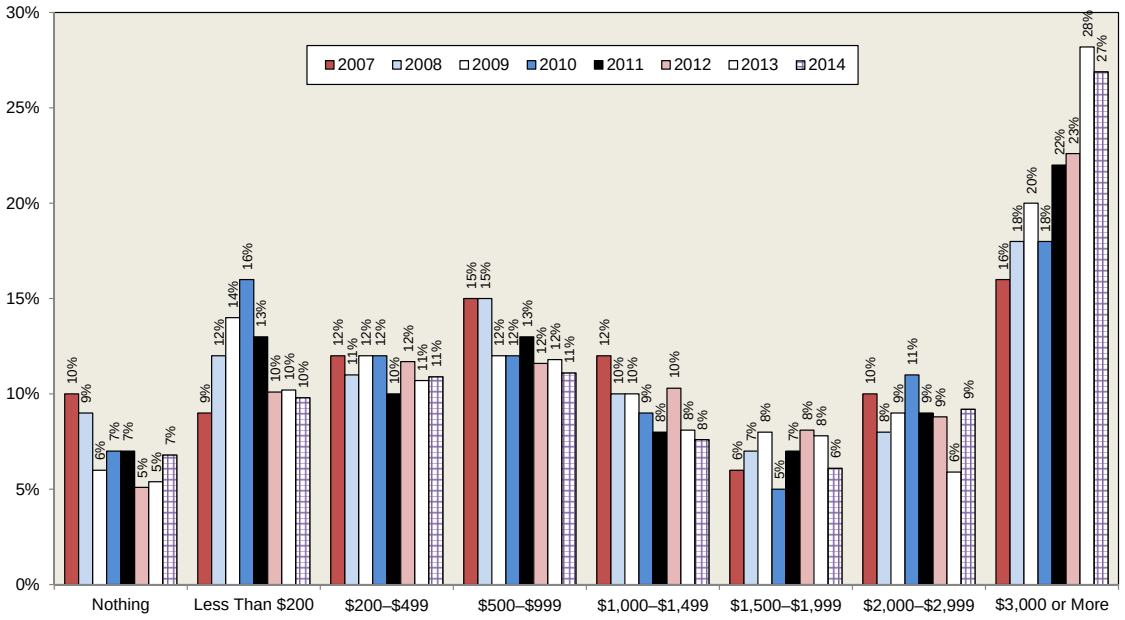
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 5
Average HRA[a] or HSA[b] Account Balances, 2006–2014



Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 6
Distribution of HRA[a] or HSA[b] Account Balances, 2007–2014



Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
[a] Health reimbusement arrangement.
[b] Health savings account.

place restrictions on the amount that can be carried over. When it comes to HSAs, any money left in an account at the end of the year automatically rolls over and is available in the following year because there is no use-it-or-lose-it rule.[6]

Overall, the percentage of individuals with a rollover has increased. In 2008, 16 percent of individuals with an HRA or HSA did not roll over any money (Figure 12). By 2014, 11 percent did not have a rollover.

The number of accounts with a rollover increased annually until 2013, and the total level of assets being rolled over has increased in all years except for 2010, 2013, and 2014. In 2008, 2.5 million accounts rolled over $2.5 billion (Figure 13). By 2014, 7.1 million accounts rolled over $8.9 billion. The average rollover increased from $1,000 in 2008 to $1,244 in 2014 (Figure 14).

Length of Time With Account—The length of time that an individual has held the account had an impact on rollover amounts. The analysis found that people holding an account for one to two years had an average rollover of $982 in 2014 (Figure 15). In comparison, those holding an account for three to four years had an average rollover of $1,421, and those with an account at least 5 years old had an average rollover of $1,428.

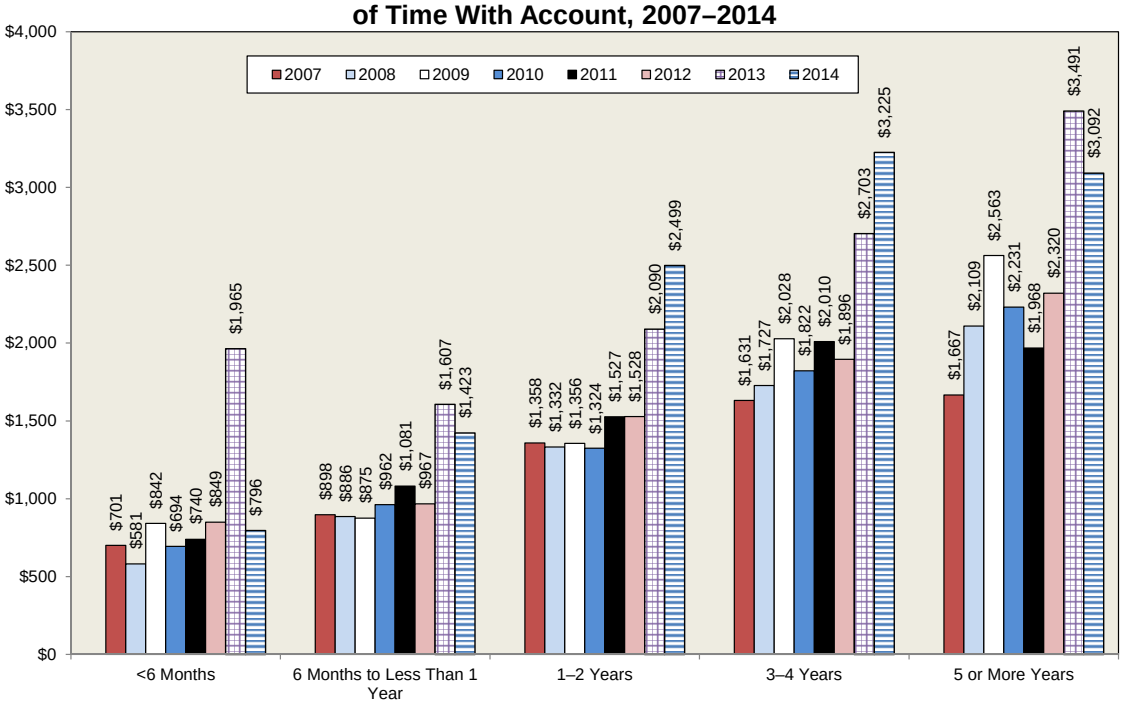
Employer and Individual Contributions— Accounts with an employer contribution had a higher amount rolled over than those without an employer contribution in 2014. Accounts with an employer contribution had an average rollover of $1,280 in 2014, whereas those without an employer contribution had an average rollover of $1,069 (Figure 16). Individuals with an employer contribution of less than $1,000 had an average rollover of $1,211 in 2014, while those with an employer contribution of at least $1,000 had an average rollover of $1,314 (Figure 17). In contrast, individuals who contributed less than $1,000 had an average rollover of $961, while those who contributed at least $1,000 had an average rollover of $1,444 (Figure 18).

Conclusion

Employers first started offering health reimbursement arrangements (HRAs) in 2001, and they were able to start offering health plans with health savings accounts (HSAs) in 2004. In 2014, 27 percent of employers with 10–499 workers and 48 percent of employers with 500 or more workers offered either an HRA- or HSA-eligible plan. As a result, these plans covered about 26 million people in 2014, representing about 15 percent of the privately insured market. According to findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS), there was $22.1 billion in HSAs and HRAs in 2014, spread across 10.6 million accounts. Overall account balances averaged $2,077 in 2014.

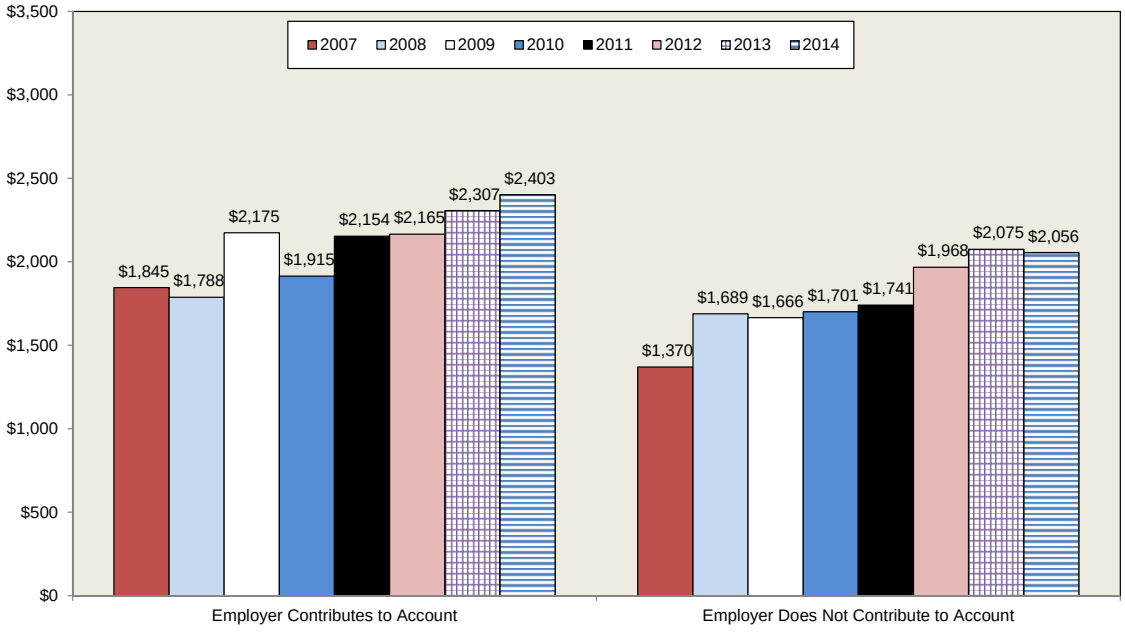
Over 7 million accounts rolled over money between 2013 and 2014, with $8.9 billion rolled over. The average amount rolled over was $1,244 in 2014.

Figure 7
Average Account Balances, by Length of Time With Account, 2007–2014



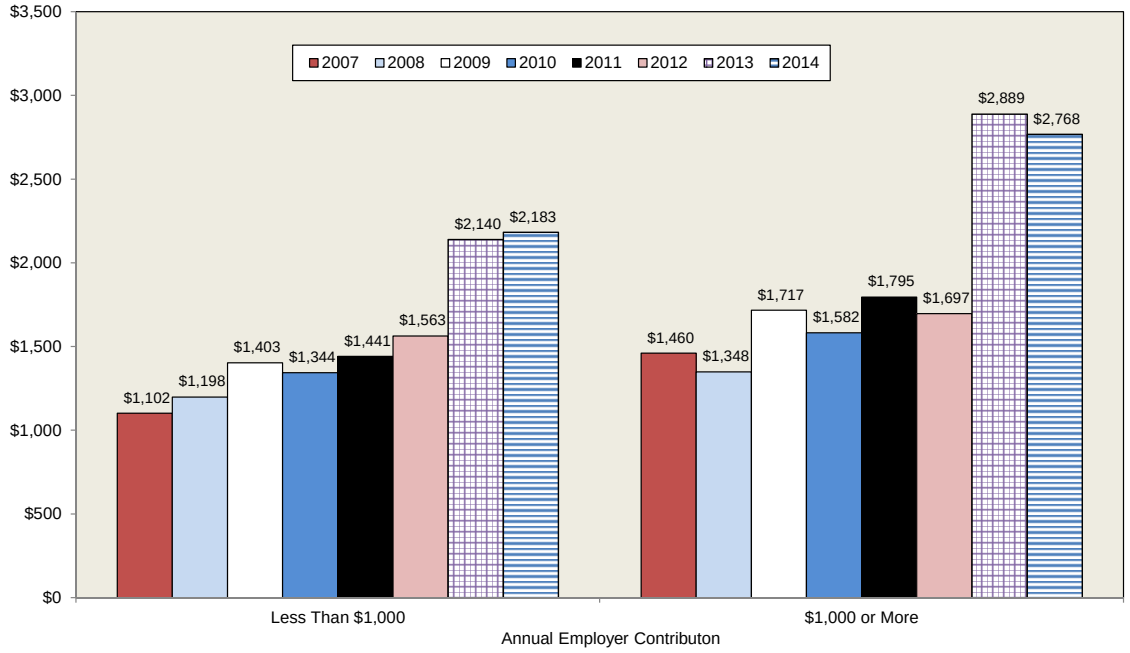
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 8
Average Account Balance, by Presence of Employer Contribution, 2007–2014



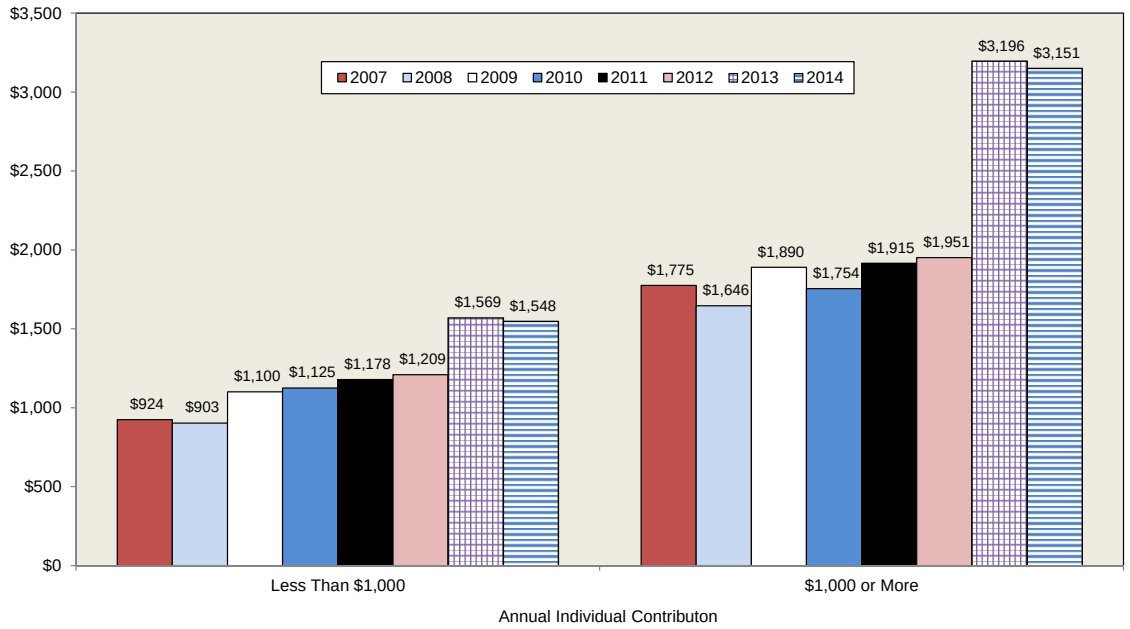
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 9
Average Account Balances, by Level of Annual Employer Contribution, 2007–2014



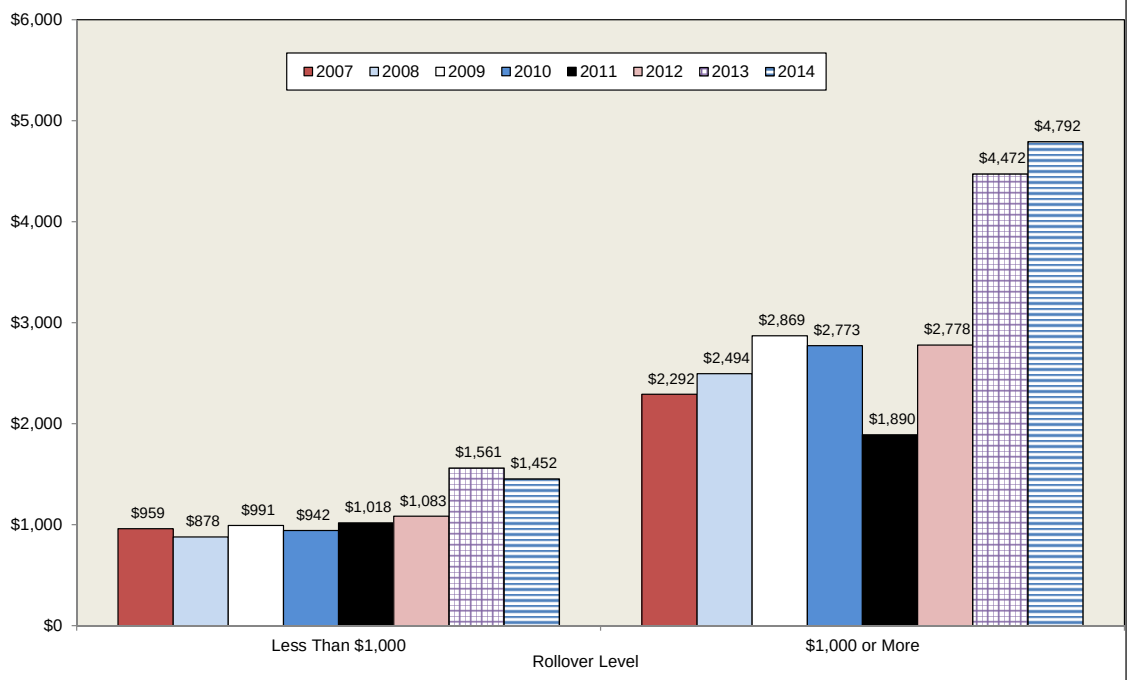
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 10
Average Account Balances, by Level of Annual Individual Contribution, 2007–2014



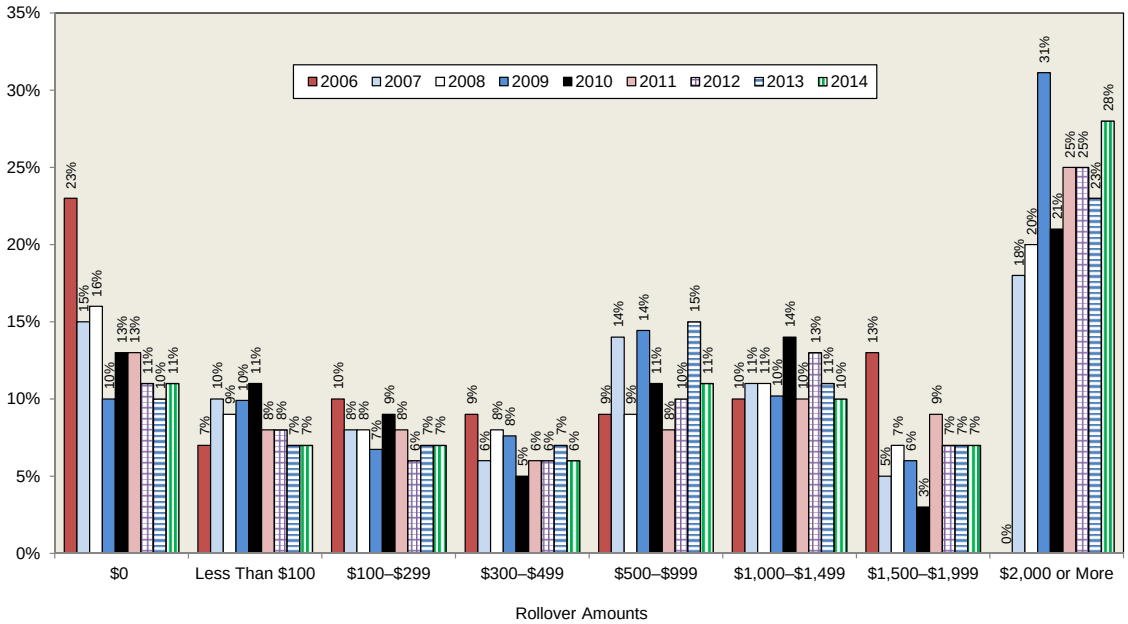
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 11
Average Account Balances, by Rollover Level, 2007–2014



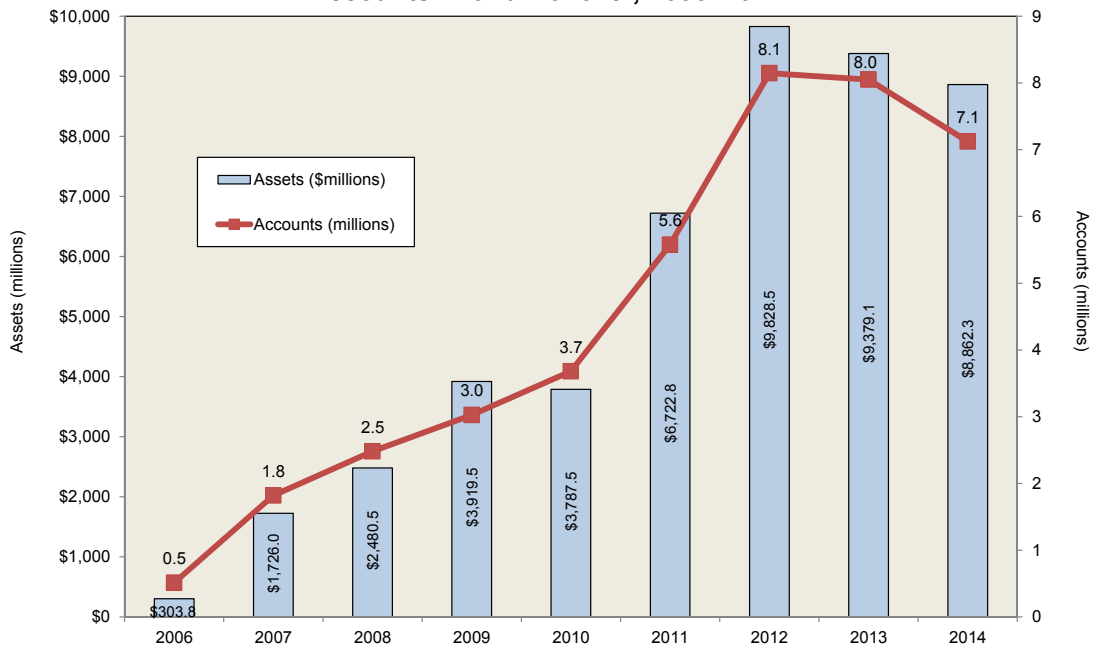
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014..

Figure 12
Rollover Amounts, Among Individuals Holding Account for More Than One Year, 2006–2014



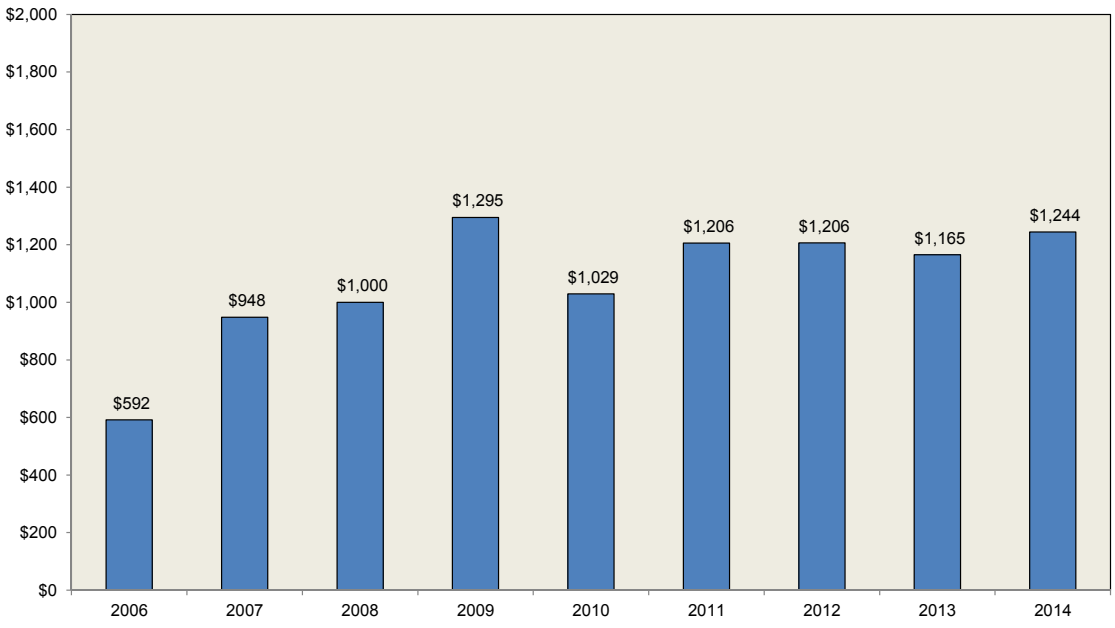
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
Note: 2006 data was capped at $1,500 or more.

Figure 13
Total Rollover Assets and Number of Accounts With a Rollover, 2006–2014



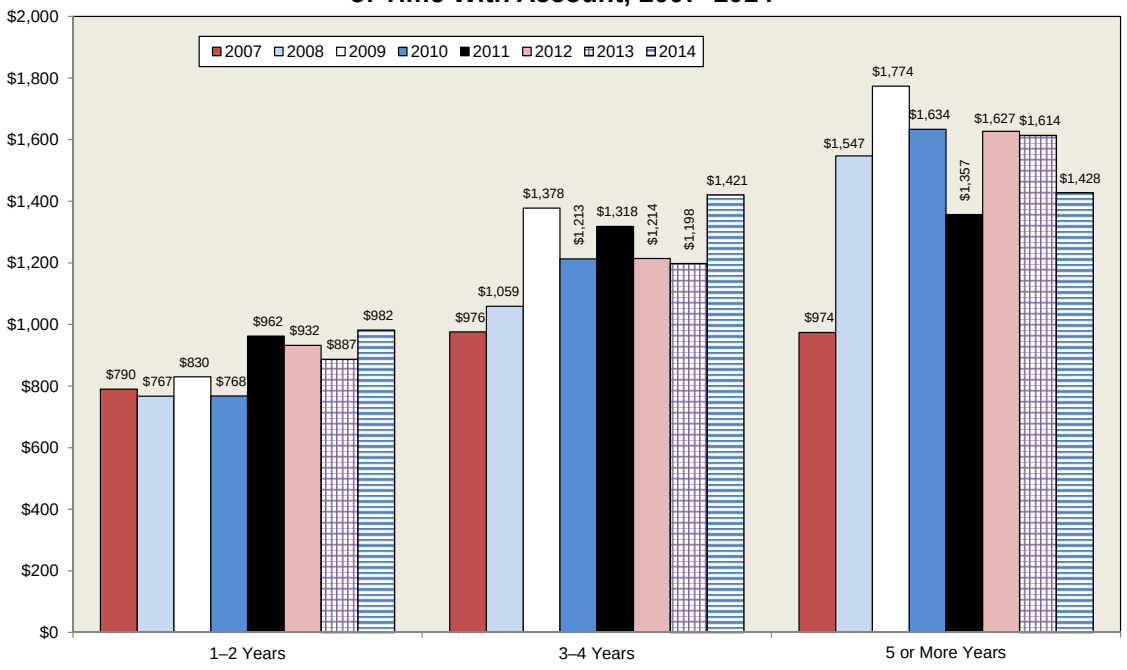
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 14
Average HRA[a] or HSA[b] Rollover Amounts, 2006–2014



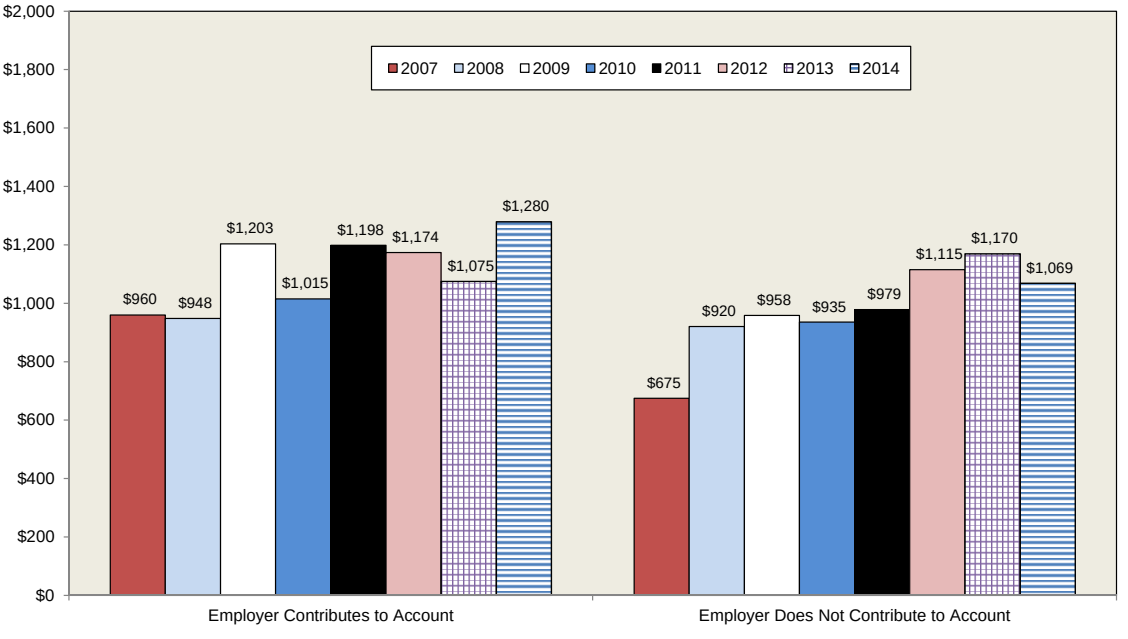
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 15
Average Rollover Amounts, by Length of Time With Account, 2007–2014



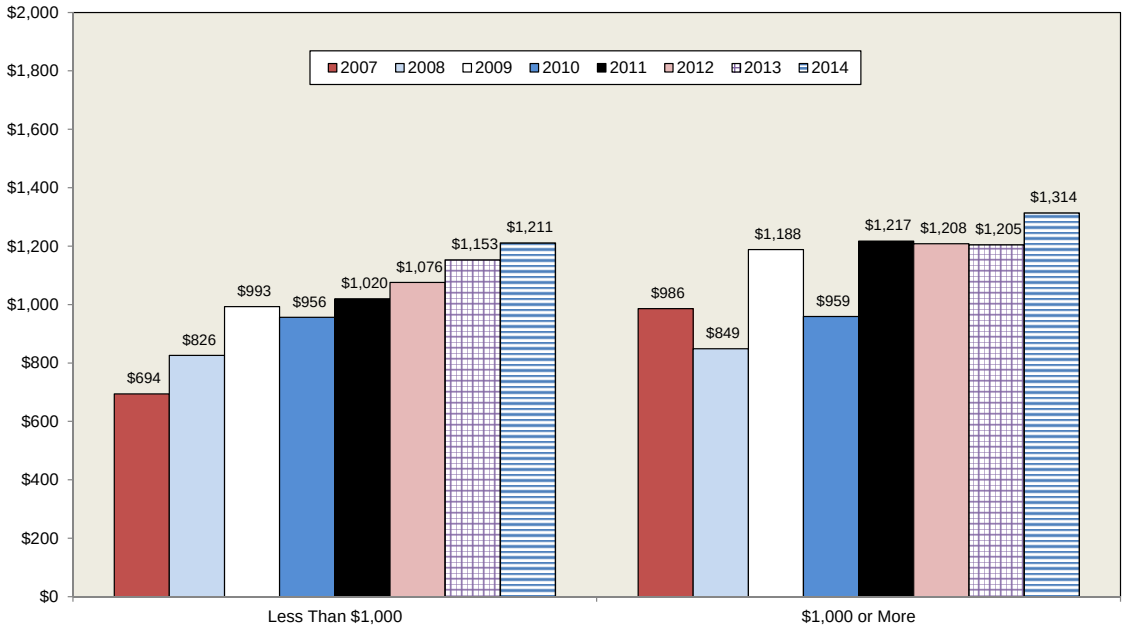
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 16
Average Rollover Amounts, by Presence of Employer Contribution, 2007–2014



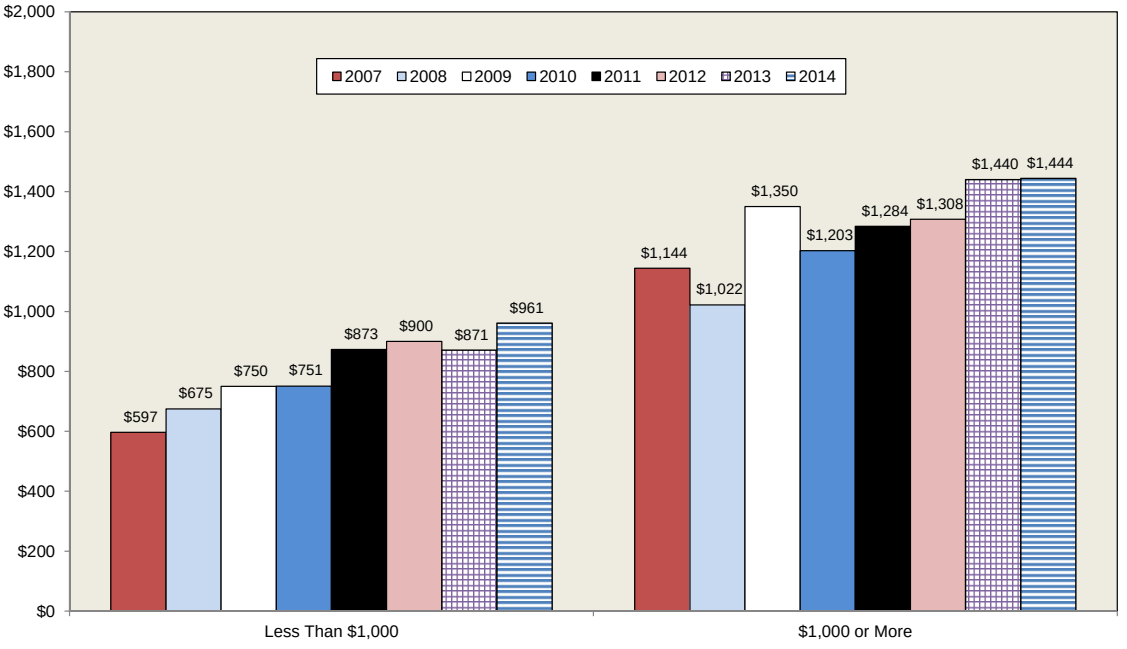
Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 17
Average Rollover Amounts, by Level of Annual Employer Contribution, 2007–2014



Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

Figure 18
Average Rollover Amounts, by Level of Annual Individual Contribution, 2007–2014



Sources: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2008–2014.

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Endnotes

[1] See http://www.mercer.com/content/mercer/global/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html

[2] See http://www.i-say.com/

[3] In theory, a random sample of 2,000 yields a statistical precision of plus or minus 2.2 percentage points (with 95 percent confidence) of what the results would be if the entire population ages 21–64 with private health insurance coverage was 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.

[4] The CEHCS undercounts the number of HSAs and total HSA assets because the survey only examines HSAs among people with an HSA-eligible health plan. Individuals who have an HSA but not an HSA-eligible health plan are not examined in the survey.

[5] The term "assets" is used loosely as it relates to HRAs. An HRA is typically set up as a notional arrangement and exists only on paper. Employees may view the HRA as if money was actually being deposited into an account, and they may carry a debit card that can be used to pay for health care services at the point of service, but employers do not incur expenses associated with the arrangement until an employee incurs a claim.

[6] Individuals are also 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 Medical Savings Accounts (MSAs) are also permitted.

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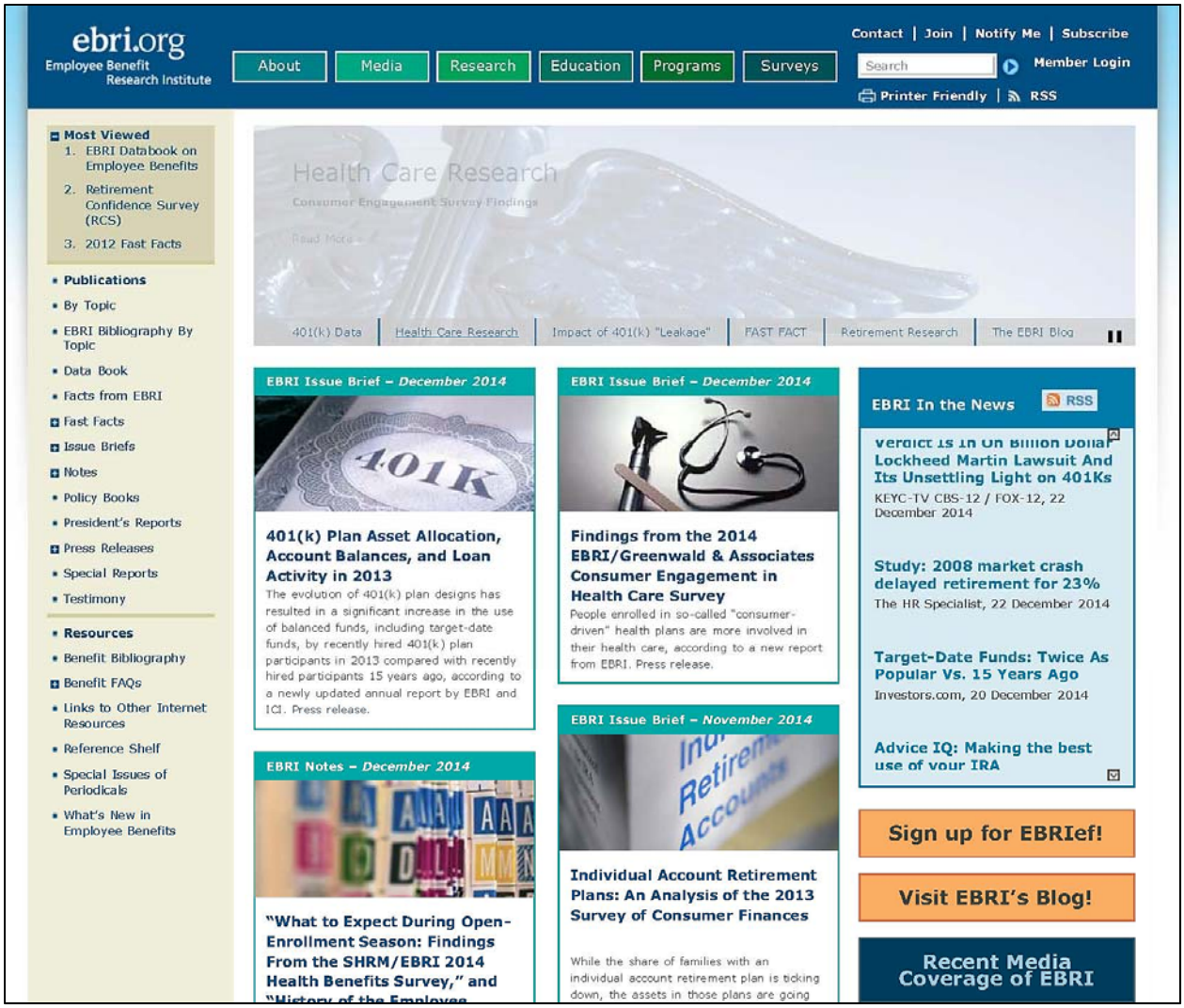

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