

Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2011

By Paul Fronstin, Employee Benefit Research Institute

ASSET LEVELS GROWING: In 2011, there was \$12.4 billion in health savings accounts (HSAs) and health reimbursement arrangements (HRAs), spread across 8.4 million accounts, according to data from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey, sponsored by EBRI and Mathew Greenwald & Associates. This is up from 2006, when there were 1.3 million accounts with \$873.4 million in assets, and 2010, when 5.4 million accounts held \$7.3 billion in assets.

AFTER LEVELING OFF, AVERAGE ACCOUNT BALANCES INCREASED: After average account balances leveled off in 2008 and 2009, and fell slightly in 2010, they increased in 2011. In 2006, account balances averaged \$696. They increased to \$1,320 in 2007, a 90 percent increase. Account balances averaged \$1,356 in 2008 and \$1,419 in 2009, 3 percent and 5 percent increases, respectively. In 2010, average account balances fell to \$1,355, down 4.5 percent from the previous year. In 2011, average account balances increased to \$1,470, a 9 percent increase from 2010.

TOTAL AND AVERAGE ROLLOVERS INCREASE: After declining to \$1,029 in 2010, average rollover amounts increased to \$1,208 in 2011. Total assets being rolled over increased as well: \$6.7 billion was rolled over in 2011, up from \$3.7 billion in 2010. The percentage of individuals without a rollover remained at 13 percent in 2011.

HEALTHY BEHAVIOR DOES NOT MEAN HIGHER ACCOUNT BALANCES AND HIGHER ROLLOVERS: Individuals who smoke have more money in their accounts than those who do not smoke. In contrast, obese individuals have less money in their account than the nonobese. There is very little difference in account balances by level of exercise. Very small differences were found in account balances and rollover amounts between individuals who used cost or quality information, compared with those who did not use such information. However, next to no relationship was found between either account balance or rollover amounts and various cost-conscious behaviors. When a difference was found, those exhibiting the cost-conscious behavior were found to have lower account balances and rollover amounts.

DIFFERENCES IN ACCOUNT BALANCES: Men have higher account balances than women, older individuals have higher account balances than younger ones, account balances increase with household income, and education has a significant impact on account balances independent of income and other variables.

DIFFERENCES IN ROLLOVER AMOUNTS: Men rolled over more money than women, and older individuals had higher rollover amounts than younger individuals. Rollover amounts increase with household income and education, and individuals with single coverage rolled over a slightly higher amount than those with family coverage.

Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute. This *Issue Brief* was written with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the author, and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

Copyright Information: This report is copyrighted by the Employee Benefit Research Institute (EBRI). It may be used without permission but citation of the source is required.

Recommended Citation: Paul Fronstin, “Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2011,” *EBRI Issue Brief*, no. 367, January 2012.

Report availability: This report is available on the Internet at www.ebri.org

The 2011 EBRI/MGA Consumer Engagement in Health Care Survey was made possible with funding from American Express, Blue Cross Blue Shield Association, Deere & Co., Deseret Mutual, Metropolitan Life, National Rural Electric Cooperative Association, and The Commonwealth Fund.

Table of Contents

Introduction	4
Assets and Account Balances.....	4
About the 2011 EBRI/MGA Consumer Engagement in Health Care Survey.....	7
Account Balance Variation	7
Rollovers.....	16
Conclusion	20
References.....	28
Endnotes	28

Figures

Figure 1, Length of Time With HRA or HSA, 2006–2011	5
Figure 2, Total Assets and Number of Adults Ages 21–64 With an HRA or HSA, 2006–2011	5
Figure 3, Average HRA or HSA Account Balances, 2006–2011	6
Figure 4, Distribution of HRA or HSA Account Balances, 2007–2011	6
Figure 5, Average Account Balances, by Gender, 2007–2011	9
Figure 6, Average Account Balances, by Age, 2007–2011	9
Figure 7, Average Account Balances, by Gender and Age Combined, August 2011.....	10
Figure 8, Average Account Balances, by Race, 2007–2011.....	10
Figure 9, Average Account Balances, by Annual Household Income, 2007–2011.....	11
Figure 10, Average Account Balances, by Education, 2007–2011.....	11
Figure 11, Average Account Balances, by Plan Type, 2007–2011.....	13

Figure 12, Average Account Balances, by Health Behavior and Health Status, August 2011	13
Figure 13, Average Account Balances, by Use of Cost and Quality Information and Use of Wellness Program, August 2011	14
Figure 14, Average Account Balances, by Various Cost-Conscious Behaviors, August 2011	14
Figure 15, Average Account Balances, by Length of Time With Account, 2007–2011.....	15
Figure 16, Average Account Balances, by Level of Annual Employer Contribution, 2007–2011	15
Figure 17, Average Account Balances, by Level of Annual Individual Contribution, 2007–2011.....	17
Figure 18, Average Account Balances, by Rollover Level, 2007–2011.....	17
Figure 19, Rollover Amounts, Among Individuals With Account for More Than One Year, 2006–2011.....	18
Figure 20, Total Rollover Assets and Number of Adults Ages 21–64 With a Rollover, 2006–2011	18
Figure 21, Average HRA or HSA Rollover Amount, 2006–2011.....	19
Figure 22, Average Rollover Amount, by Gender, 2007–2011	19
Figure 23, Average Rollover Amount, by Age, 2007–2011.....	22
Figure 24, Average Rollover Amount, by Gender and Age Combined, 2011	22
Figure 25, Average Rollover Amount, by Race, 2007–2011	23
Figure 26, Average Rollover Amount, by Annual Household Income, 2007–2011	23
Figure 27, Average Rollover Amount, by Education, 2007–2011	24
Figure 28, Average Rollover Amount, by Plan Type, 2007–2011	24
Figure 29, Average Rollover Amount, by Health Behavior and Health Status, 2011	25
Figure 30, Average Rollover Amount, by Use of Cost and Quality Information and Use of Wellness Program, 2011	25
Figure 31, Average Rollover Amount, by Various Cost-Conscious Behaviors, 2011	26
Figure 32, Average Rollover Amount, by Length of Time With Account, 2007–2011	26
Figure 33, Average Rollover Amount, by Level of Annual Employer Contribution, 2007–2011.....	27
Figure 34, Average Rollover Amount, by Level of Annual Individual Contribution, 2007–2011.....	27

Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2011

By Paul Fronstin, Employee Benefit Research Institute

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 that individuals can use to pay for health care expenses. The theory behind these accounts is that by giving individuals more control over funds allocated for health care services, they will spend the money more responsibly, especially once they become more educated about the actual price of health services. Furthermore, these accounts can be used as tax-advantaged vehicles to save for health care expenses in retirement.

By 2010, 16 percent of employers with 10–499 workers and 23 percent of those with 500 or more workers offered either an HRA or HSA-eligible plan.¹ As a result, these plans covered about 21 million people in 2011, representing about 12 percent of the privately insured market (Fronstin, 2011). As the number of people with account-based plans grows, total assets in these plans can be expected to grow as well.

While HRAs and HSAs are still relatively new, a growing percentage of the population has held them for a number of years. In 2006, 9 percent of the population with an HRA or HSA had held an account for three–four years, and 3 percent for five years or more (Figure 1). By 2011, 27 percent had held an account for 3–4 years, and 12 percent for five years or more. As the length of time individuals have these plans increases, average account balances should increase as well.

This report examines HSA and HRA assets, account balances, and rollover amounts, using data from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey (CEHCS). It then examines differences and trends in account balances by demographics, income, contribution levels, and engagement in an individual's own health care using a regression equation. Rollover amounts are then examined.

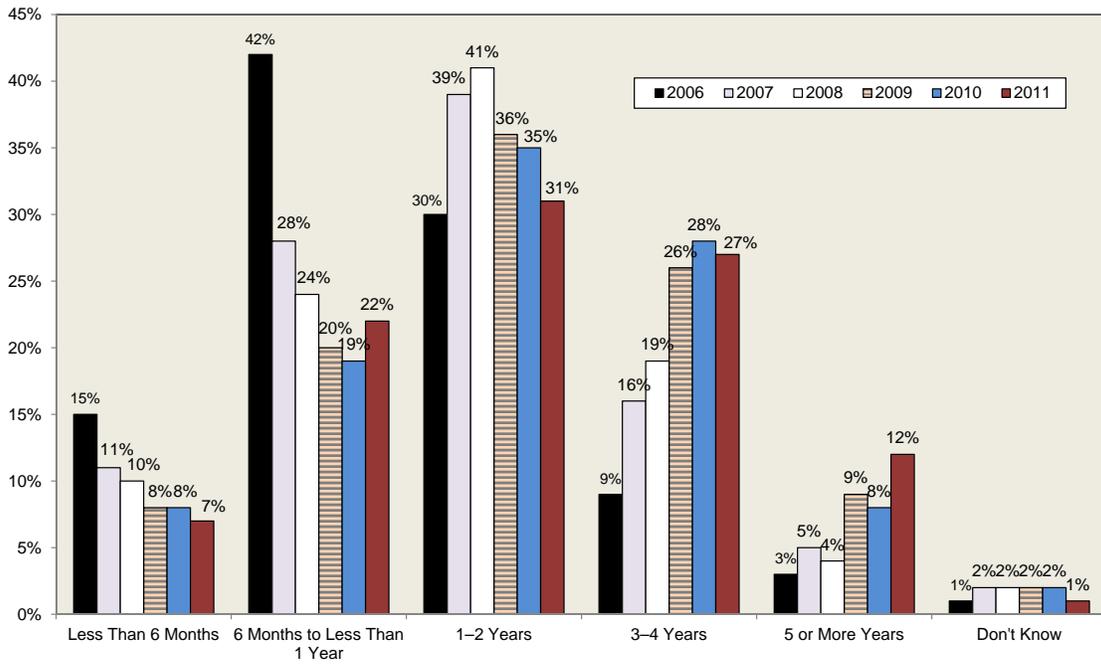
Assets and Account Balances

According to findings from the 2011 EBRI/MGA CEHCS, there was \$12.4 billion in HSAs and HRAs in 2011, spread across 8.4 million accounts (Figure 2). In 2006, there were 1.3 million accounts with \$873 million in assets, and by 2010, 5.4 million accounts held \$7.3 billion in assets.²

While total assets in the accounts have increased each year, average account balances have not increased at the same rate that the number of accounts and total assets in the accounts have increased. Average account balances leveled off in 2008, dropped slightly in 2010, and then increased in 2011. In 2006, account balances averaged \$696 (Figure 3). They increased to \$1,320 in 2007, a 90 percent increase. Account balances averaged \$1,356 in 2008 and \$1,419 in 2009, 3 percent and 5 percent increases, respectively. In 2010, the average account balance fell to \$1,355, down 4.5 percent from the previous year. In 2011, the average account balance increased to \$1,470, a 9 percent increase.

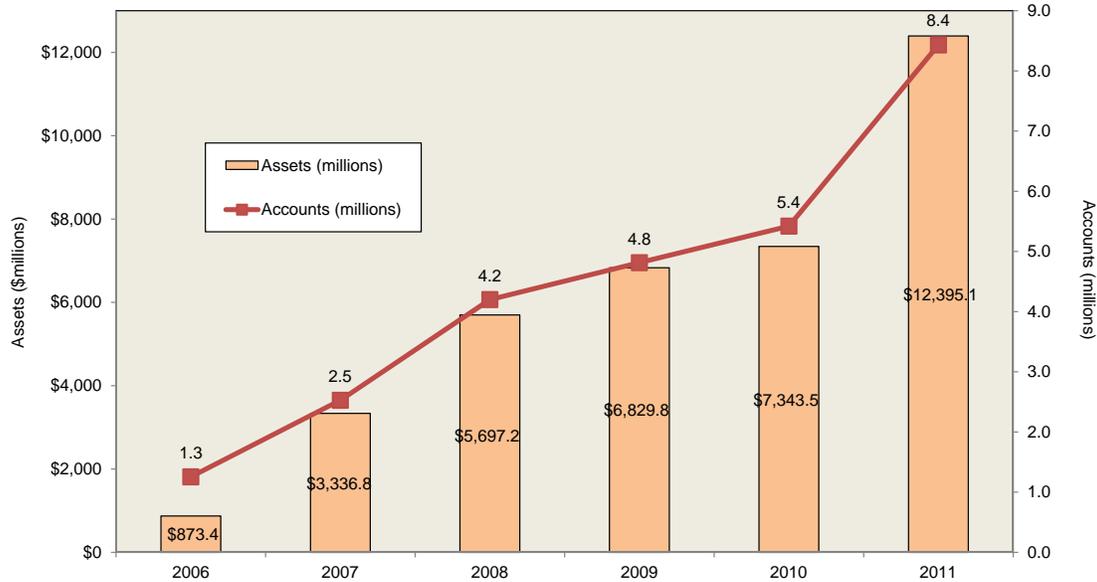
Between 2007 and 2011, there has been a decline in the percentage of individuals with a zero account balance and an increase in the percentage of those with an account balance of at least \$3,000. The percentage with at least \$3,000 in their account increased from 16 percent in 2007 to 22 percent in 2011 (Figure 4).

Figure 1
Length of Time With HRA^a or HSA,^b 2006–2011



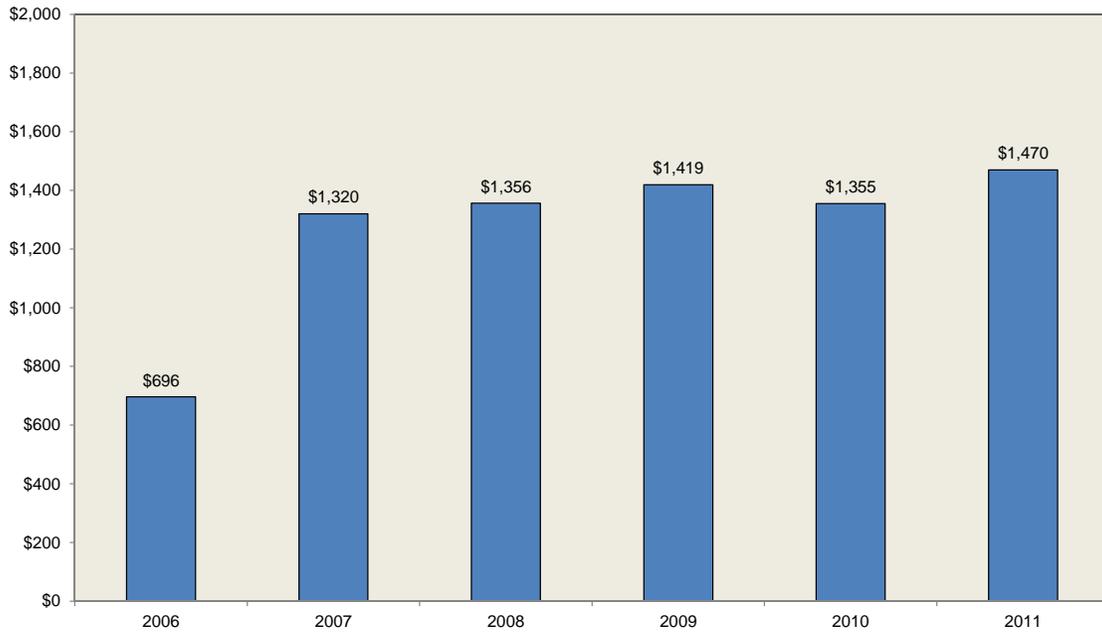
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Health reimbursement arrangement.
^b Health savings account.

Figure 2
Total Assets and Number of Adults Ages 21–64 With an HRA^a or HSA,^b 2006–2011



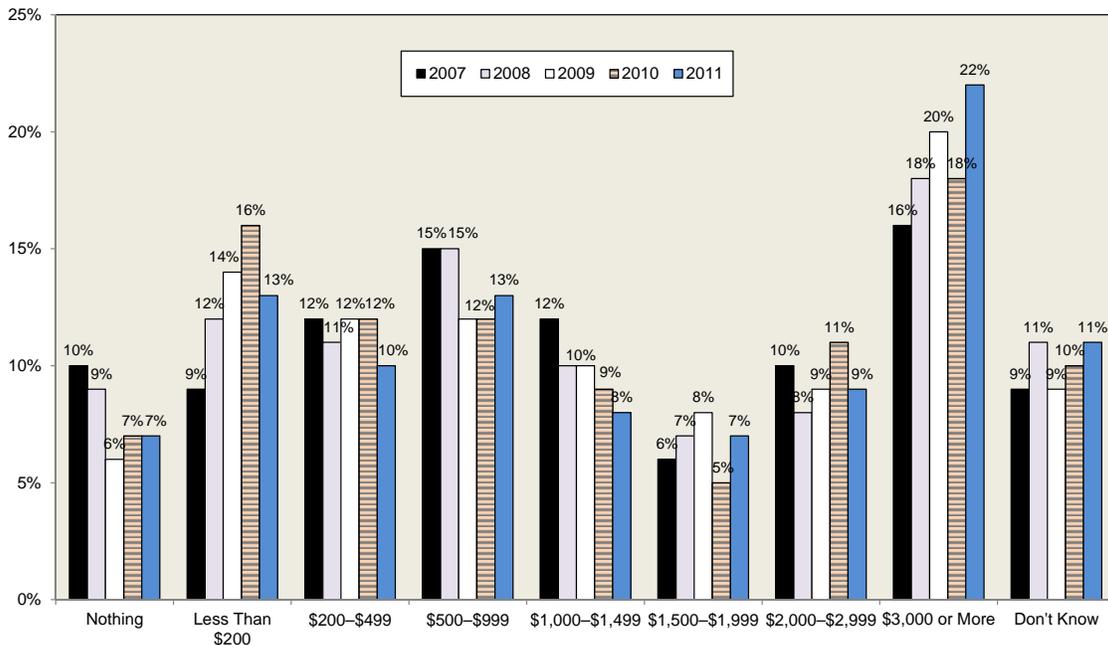
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Health reimbursement arrangement.
^b Health saving account.

Figure 3
Average HRA^a or HSA^b Account Balances, 2006–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Health reimbursement account.
^b Health savings account.

Figure 4
Distribution of HRA^a or HSA^b Account Balances, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Health reimbursement account.
^b Health savings account.

About the 2011 EBRI/MGA Consumer Engagement in Health Care Survey

The Employee Benefit Research Institute (EBRI) and Mathew Greenwald & Associates (MGA) created the Consumer Engagement in Health Care Survey 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. The 2011 EBRI/MGA Consumer Engagement in Health Care Survey is comparable with findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys, and the 2008, 2009, and 2010 EBRI/MGA Consumer Engagement in Health Care Survey.

The 2011 survey was conducted within the United States between August 8 and August 23, 2011, through a 15-minute Internet survey. The national or base sample was drawn from Synovate's online panel of Internet users who have agreed to participate in research surveys.³ About 2,000 adults (n=1,990) ages 21–64 who have health insurance through an employer or purchased directly from a carrier were drawn randomly from the Synovate sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 37 percent (30 percent for the base sample or national sample, and 44 percent for the oversample). The margin of error for the national sample was ± 2.2 percent.

The sample was divided into one of 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 and HDHP group if they had a deductible of at least \$1,000 for individual coverage or \$2,000 for family coverage. To be assigned to the CDHP group, they must also have an account, such as a health savings account (HSA) or health reimbursement arrangement (HRA), with a rollover provision that they can use to pay for medical expenses or the ability to take their account with them should they change jobs. Individuals with only a flexible spending account (FSA) were not included in the CDHP group.

Because the base sample (national sample) included only 151 individuals in a CDHP, an oversample of individuals with a CDHP was added. The oversample included 1,281 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.⁴ The CDHP oversample was weighted by gender, age, income, and race/ethnicity. More information can be found in Fronstin (2011).

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, provides 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.

Account Balance Variation

This section examines variation in account balances and trends in those balances by a number of different variables, such as demographics, income, health status, health behaviors, and various measures of cost-conscious decision making and health engagement. Both the account balance estimates and the statistical significance tests were generated from a regression equation that also controlled for how long an individual has had an HRA or HSA, employer contributions to the account, individual contributions to the account, and unused balance rollover amounts.⁵ Unlike the overall data on account balances shown in Figure 3, 2006 data are not shown for the different variables because of the small sample sizes.

Gender and Age—Men have higher account balances than women. By August 2011, men had an average of \$1,735 in their HRA or HSA while women had \$1,403 (Figure 5). This may be due to the fact that men use less health care than women, which allows them to maintain a higher account balance (Sandman, Simantov and An March 2000).

Among both men and women, account balances increased between 2007 and 2009, fell in 2010, and then increased in 2011.

There is a general trend toward higher account balances with age. In 2011, individuals ages 55–64 had an average of \$1,782 in their account, compared with between \$1,272 among those ages 21–34, \$1,469 among those 35–44, and \$1,634 for those 55–64 (Figure 6). This was found despite the fact that older individuals use more health care on average than younger ones. It is possible that older individuals are saving the money in the account to use to pay for health care expenses in retirement, but this could not be determined from the survey. Prior research has found that, while HSAs can be used to save for health care expenses in retirement, they are far from sufficient for that purpose because of statutory constraints placed on contribution levels relative to expected health care spending in retirement (Fronstin 2011).

The higher account balances among older individuals may also be due to the fact that they are allowed to make “catch-up” contributions that individuals under age 55 are not allowed to make. However, the regression equation controls for individual contributions, and thus older age would not be a factor in the observed differences.

When examining differences in account balances for men and women by age, men have higher account balances than women but the differences drop with higher ages (Figure 7).

Race—In 2009 and 2010, minorities with HRAs or HSAs had higher account balances than whites with these accounts. However, in 2011, whites had higher account balances than minorities. On average, minorities had an account balance of \$1,508 (a slight decrease from 2010), while whites had an account balance of \$1,802 (an increase from \$1,387 in 2010) (Figure 8).

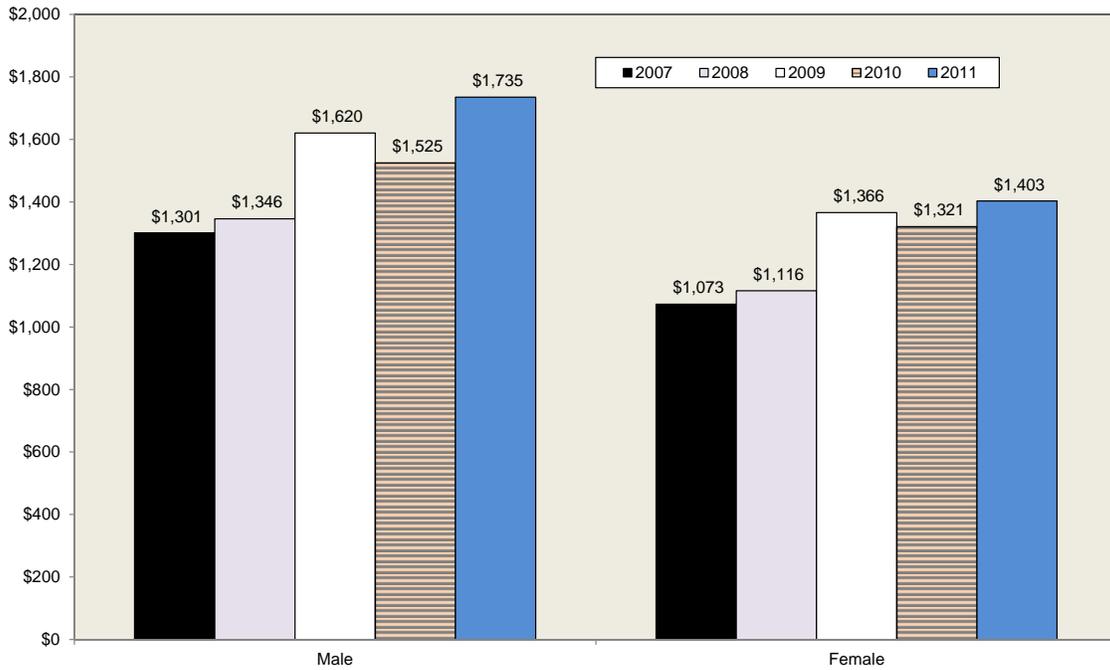
Household Income—According to Figure 9, account balances for HSAs and HRAs increase with household income. In 2011, the average account balance was \$1,103 among individuals with less than \$50,000 in household income; \$1,207 among individuals with \$50,000–\$99,999, and \$1,949 among those with \$100,000 or more. Account balances decreased slightly for those with less than \$50,000 in household income and those with \$50,000–\$99,999, and increased for those with \$100,000 or more. While higher-income households may contribute higher amounts to their HSAs than lower-income households, the regression equation controls for contribution levels and educational attainment. The difference in account balances by household income *may* be due to higher-income households being less likely to take distributions from the account. (This is an empirical question that is worth exploring as data become available.)

Education—Education has an impact on account balances independent of income and other variables, as they are controlled for in the regression equation that these estimates are based on. In 2011, individuals with a high school degree or less had an average of \$1,490 in their account, while those with a college degree had \$1,624, and those with a graduate degree had \$1,766 (Figure 10).

Type of Coverage—In formulating account balances for persons with individual coverage and persons with family coverage, a number of factors need to be considered. While individuals with family coverage often have higher deductibles than those with single coverage, and they are statutorily allowed to make higher contributions, they may also use more health care services and therefore have higher costs. This makes it difficult to predict whether families will have higher or lower account balances than individuals. It was found that individuals with family coverage had \$1,587 in their account in August 2011, while those with individual coverage had \$1,454 (Figure 11). The average account balance of individuals with family coverage increased between 2010 and 2011, while it was unchanged for those with individual coverage.

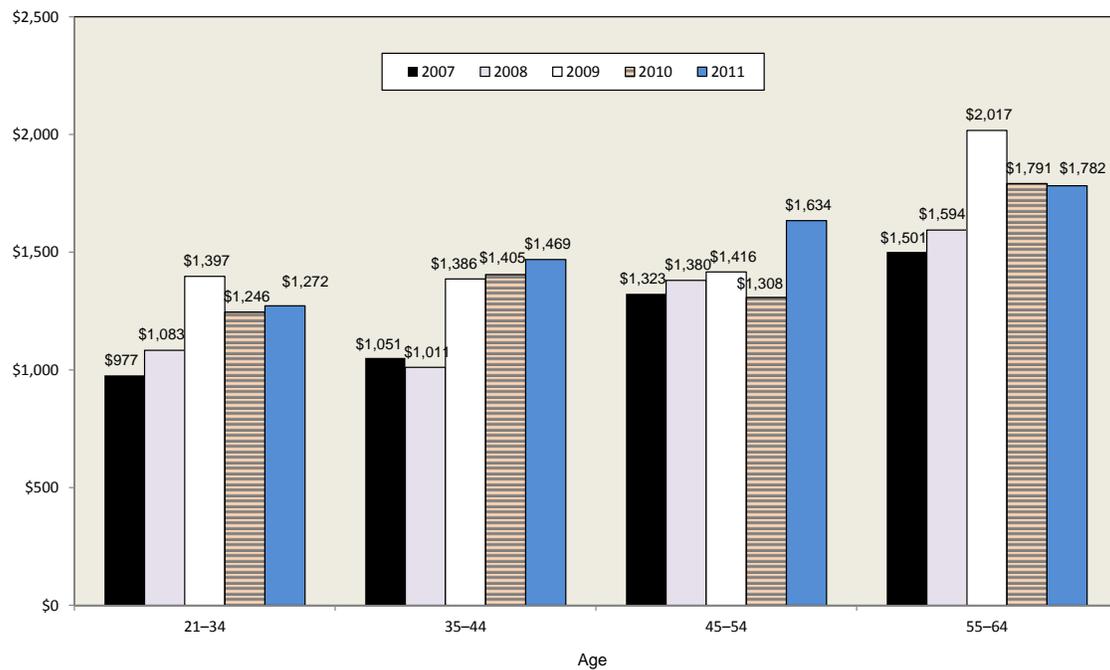
Health Behaviors and Health Status—Individuals who smoke have more money in their accounts than those who do not smoke (Figure 12). In contrast, obese individuals have less money in their account than the nonobese. There is very little difference in account balances by level of exercise.

**Figure 5
Average Account Balances, by Gender, 2007–2011**



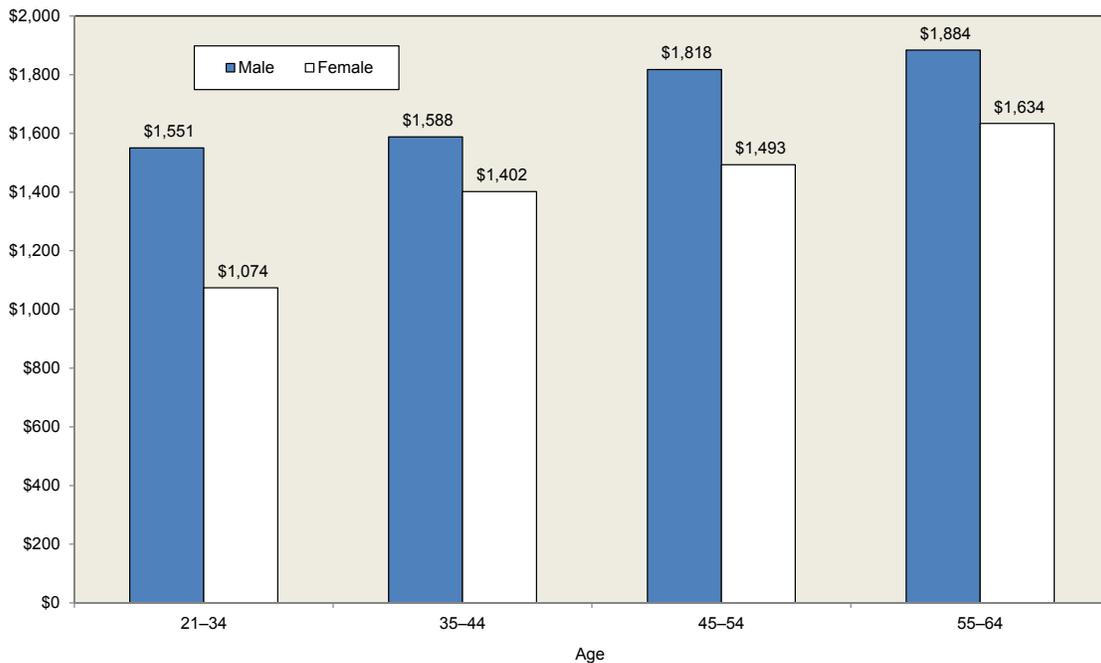
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

**Figure 6
Average Account Balances, by Age, 2007–2011**



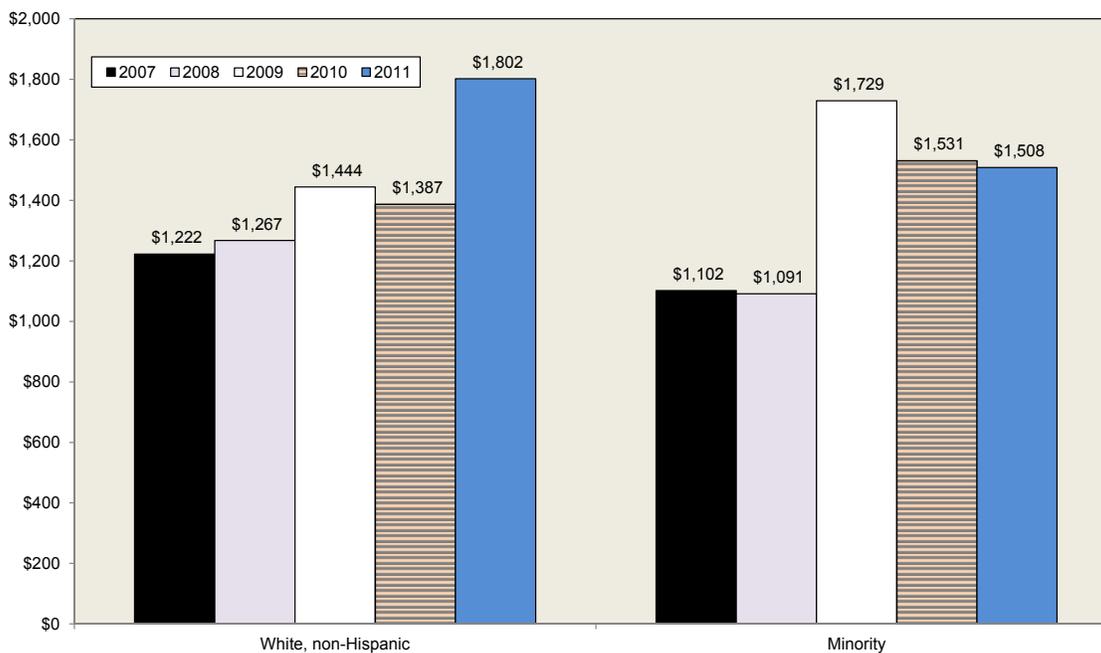
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 7
Average Account Balances, by Gender and Age Combined, August 2011



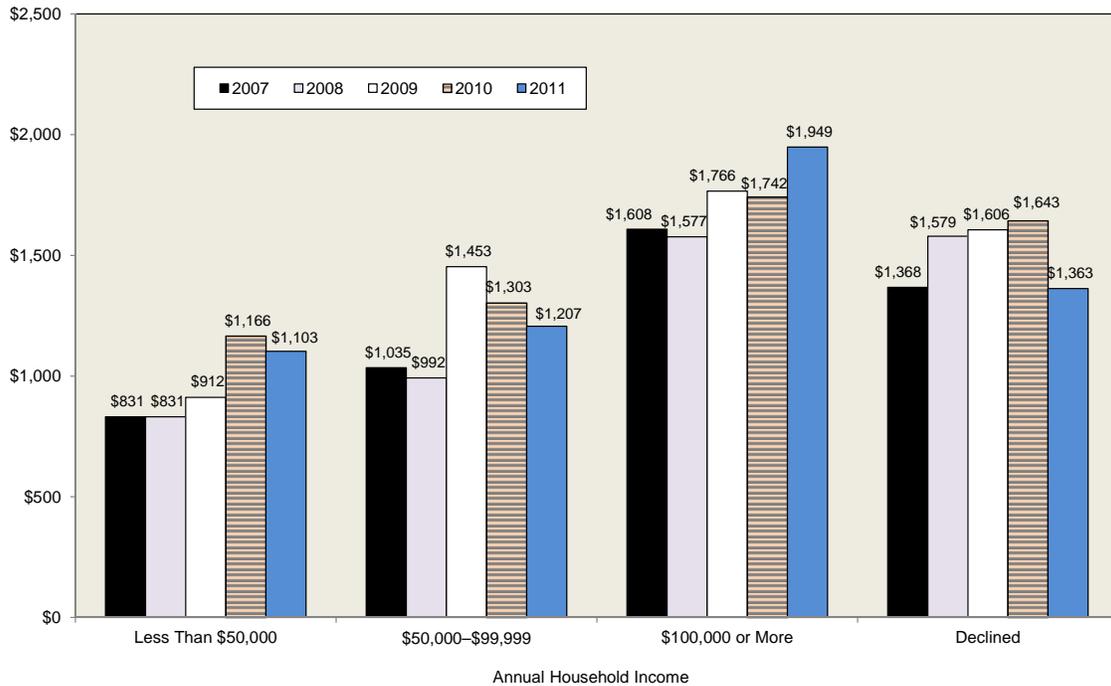
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

Figure 8
Average Account Balances, by Race, 2007-2011



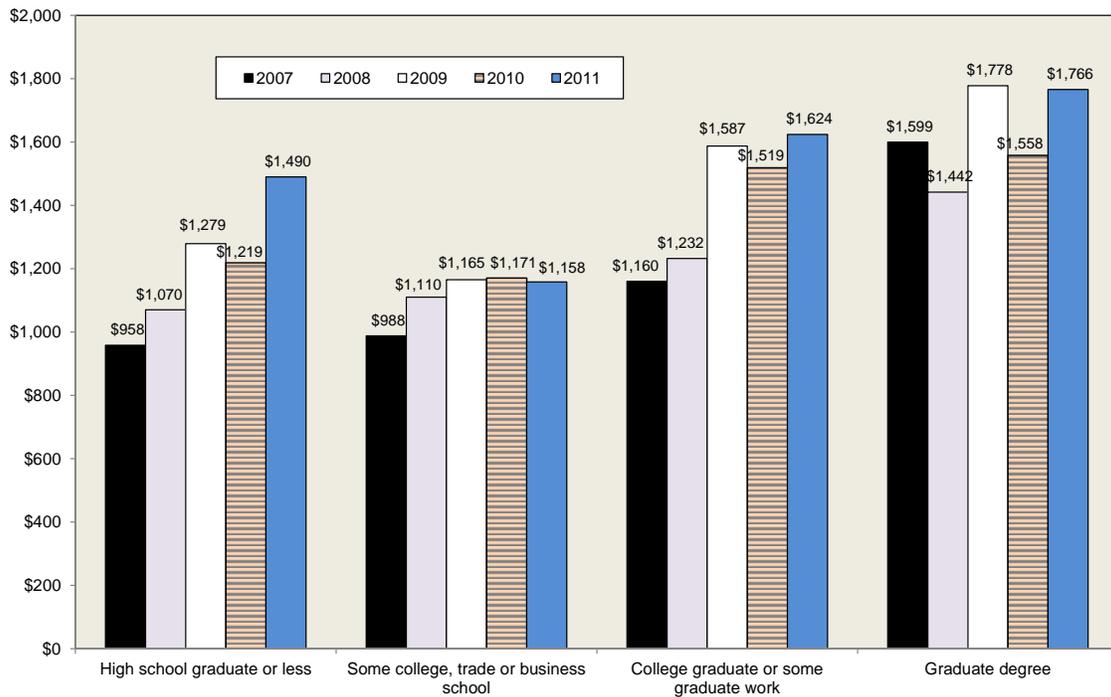
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2011.

Figure 9
Average Account Balances, by Annual Household Income, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 10
Average Account Balances, by Education, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

To measure health status, a measure of self-reported health status was combined with a measure indicating whether an individual had one of eight chronic conditions. Those with a health problem had lower account balances than those without a health problem.

Use of Health Information and Programs—Account balances were examined using two variables to measure an individual's engagement in health care. One examined whether an individual used cost and quality information to choose a doctor. The other examined whether an individual participated in a wellness program, such as (a) one designed to directly improve participants' health, i.e., a weight loss, nutrition, stress management, or smoking cessation program, or (b) a health risk assessment program, where an individual fills out a questionnaire and then, in consultation with a medical professional, examines his or her health history to identify any existing or potential medical conditions, in order to develop a program for early intervention. In both cases, very small differences in account balances were found. Individuals who participated in a wellness program had a higher average account balance than those who did not. The average account balance was \$1,611 among those who participated in a wellness program, and \$1,524 among those who did not participate (Figure 13).

Cost-Conscious Behaviors—A number of cost-conscious behaviors were examined to see if individuals who exhibit more cost-conscious decision making had higher account balances than those who did not exhibit such a decision-making process. The expectation was that individuals who exhibited cost-conscious behavior would have a higher average account balance than those who did not exhibit such behavior. The questions regarding cost-conscious decision making are as follows:

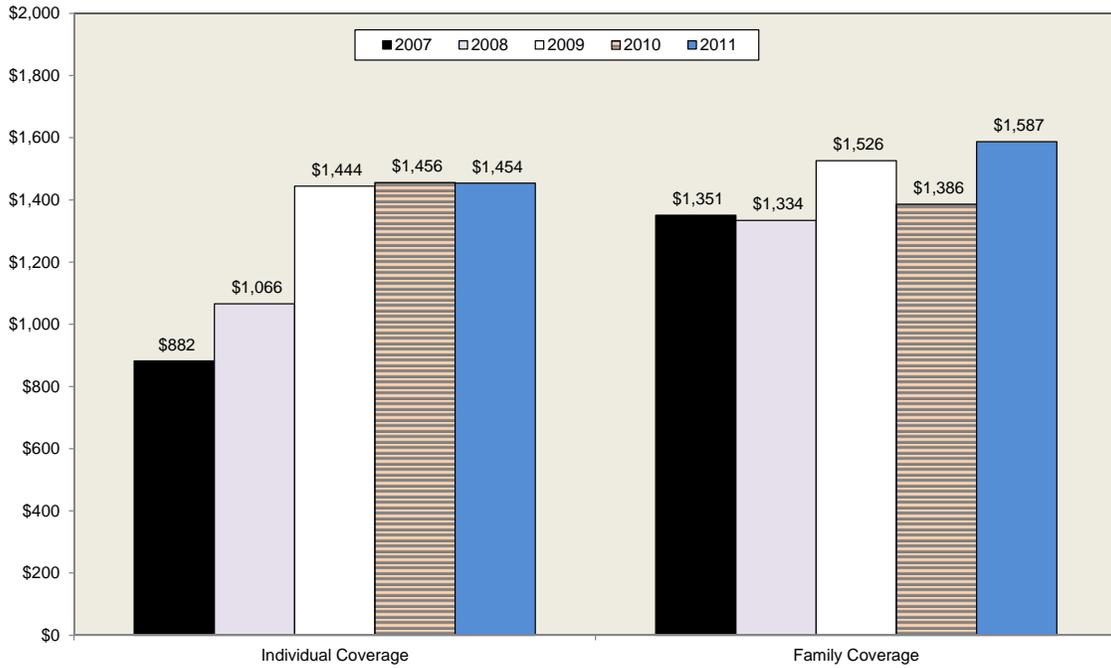
In the last 12 months or since you joined your current health plan, did you do any of the following:

- Checked whether my health plan would cover my care or medication?
- Checked the price of a doctor's visit, medication, or other health care service before I received care?
- Checked the quality rating of a doctor or hospital before I received care from them?
- Talked to my doctor about the prescription options and costs?
- Talked to my doctor about other treatment options and costs?
- Used an online cost-tracking tool provided by my health plan to manage my health expenses?
- Developed a budget to manage my health care expenses?
- Asked for a generic drug instead of a brand name drug?
- Asked my doctor to recommend a less costly prescription drug?

Differences in account balances by cost-conscious decision making were found with respect to only a few questions, but when differences were found those exhibiting a cost-conscious behavior had *lower* average account balances than those who did not (Figure 14). Hence, the expectation that cost-conscious decision making would lead to higher account balances was not borne out by the data.

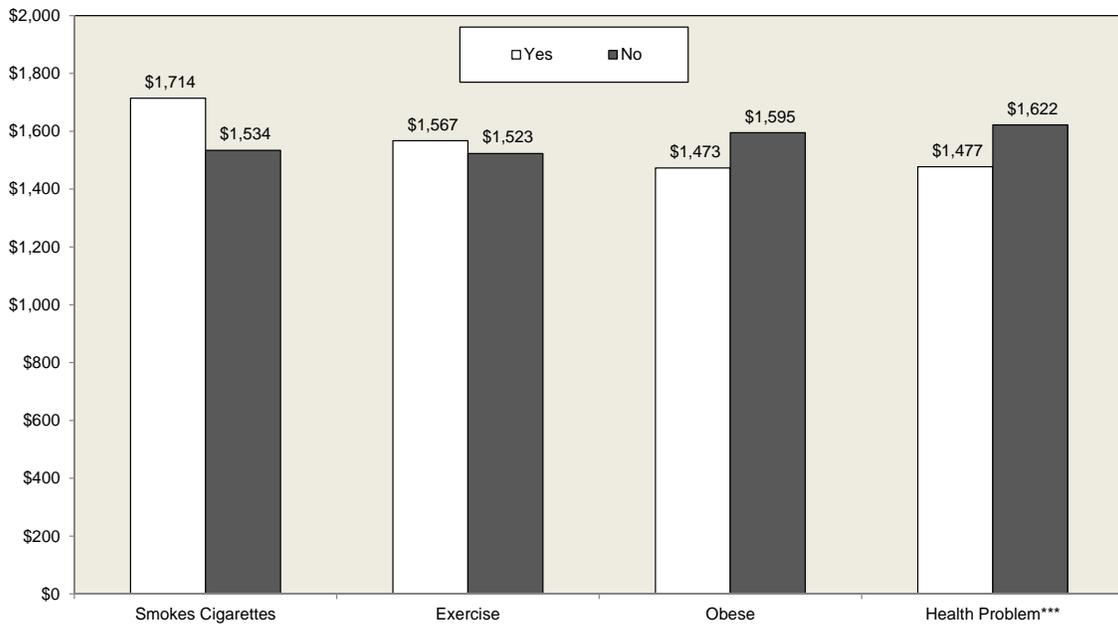
Length of Time With Account—Not surprisingly, the length of time that an individual has had an account has a major impact on the amount of money in the account. The analysis found that persons who held an account for less than six months had an average of \$740 in their account, and those who held an account at least six months but less than a year had \$1,081 (Figure 15). In comparison, individuals with an account for one to two years had an average of \$1,527. Those with an account for three to four years had an average of \$2,010. And those with an account for at least five years had an average account balance of \$1,968. In 2011, average account balances increased for each length-of-time group except for those with accounts for five years or more. Those with accounts for five years or more experienced a decline from \$2,563 to \$2,231 between 2009 and 2010, and experienced a decline to \$1,968 in 2011. The decline in account balances among this group could be because of pent-up demand due to having the account for a number of years as they tried to build up an account balance.

Figure 11
Average Account Balances, by Plan Type, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

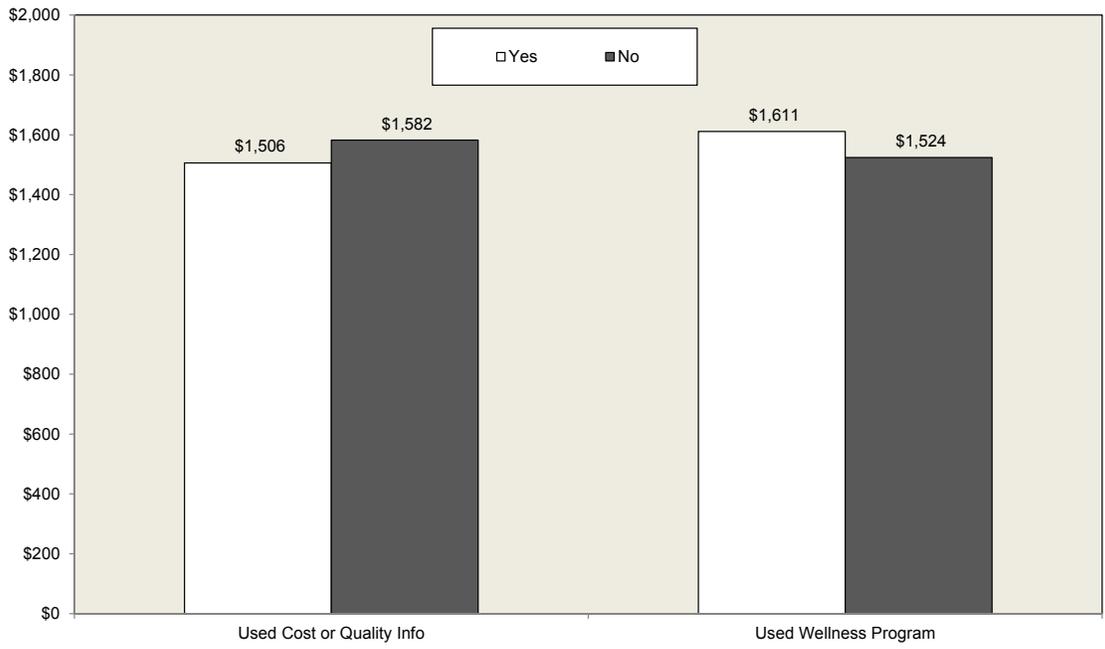
Figure 12
Average Account Balances, by Health Behavior and Health Status, August 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

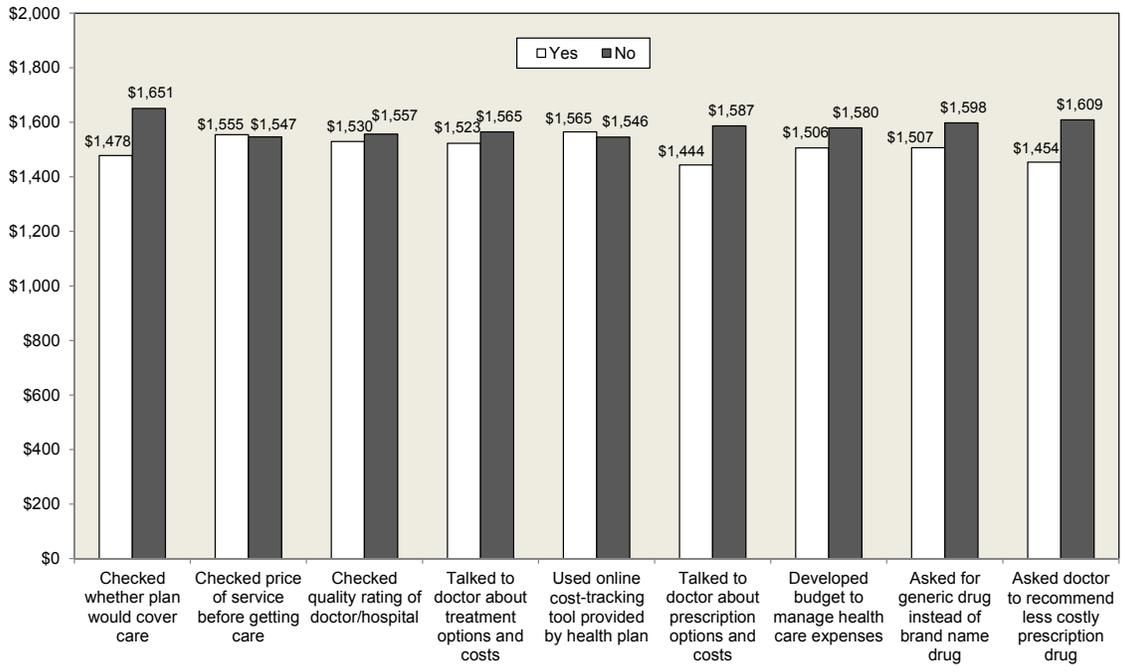
*** Health problem defined as fair or poor health or one of eight chronic health condition: arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure, or stroke.

Figure 13
Average Account Balances, by Use of Cost and Quality Information and Use of Wellness Program, August 2011



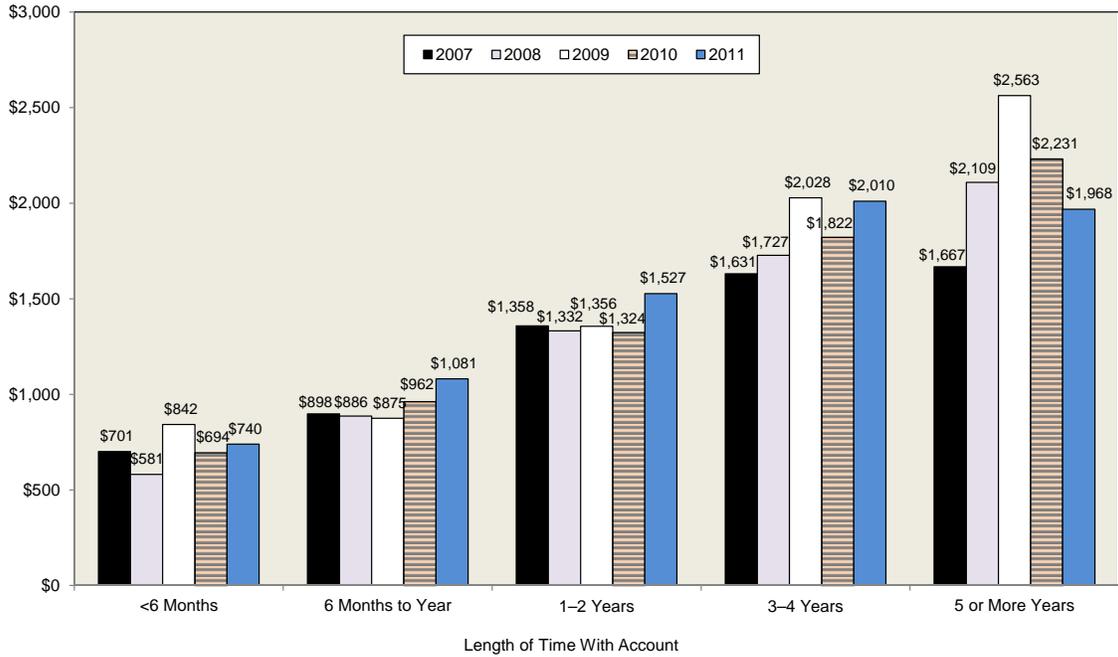
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

Figure 14
Average Account Balances, by Various Cost-Conscious Behaviors, August 2011



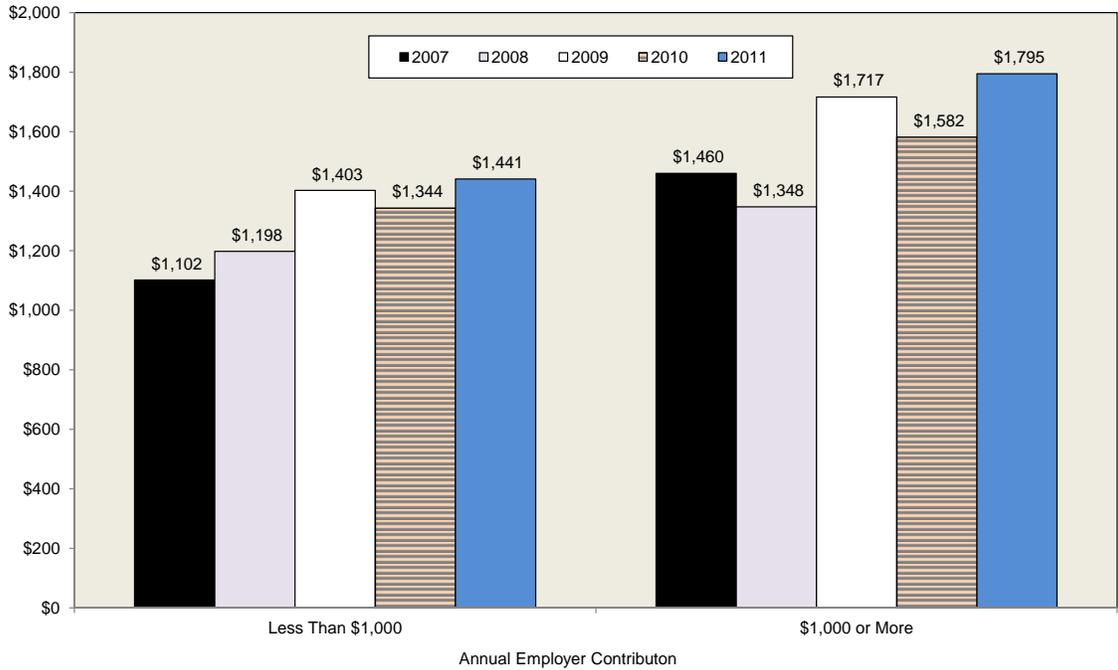
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

Figure 15
Average Account Balances, by Length
of Time With Account, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 16
Average Account Balances, by Level of
Annual Employer Contribution, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Employer and Individual Contributions—Annual contribution amounts, whether they come from the employer (in the case of both HRAs and HSAs), or from individuals (as they apply to HSAs only) have a strong impact on overall account balances. Not surprisingly, the more money that is contributed to an account, the higher the average account balance. In 2011, for instance, individuals with an employer contribution of less than \$1,000 had an average account balance of \$1,441, while those with an employer contribution of at least \$1,000 had an average of \$1,795 in their account (Figure 16). Similarly, individuals who contributed less than \$1,000 had an average account balance of \$1,178, while those who contributed at least \$1,000 had an average balance of \$1,915 (Figure 17).

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 increase but so do the opportunities for capital losses, even among individuals with high levels of employer and individual contributions.

Rollovers—Like contribution levels, annual rollover amounts are one of the biggest factors in average account balances. Individuals with less than a \$1,000 rollover had an average account balance of \$1,018 (Figure 18). In comparison, individuals with a rollover of at least \$1,000 had an average account balance of \$1,890. Among those with a rollover of at least \$1,000, average account balances fell from \$2,773 to \$1,890 between 2010 and 2011.

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

Overall, the percentage of individuals with a rollover has increased. In 2006, 23 percent of individuals with an HRA or HSA did not roll over any money (Figure 19). By 2011, 13 percent did not have a rollover.

The number of people with a rollover as well as the total level of assets being rolled over has been increasing. In 2006, 500,000 individuals rolled over \$274.8 million (Figure 20). By 2011, 5.6 million individuals rolled over \$6.7 billion. The average rollover increased from \$592 in 2006 to \$1,206 in 2011 (Figure 21). Average rollover amounts increased between 2010 and 2011 but are still below the 2009 average.

The remainder of this section examines variation in rollover amounts. The estimates in this section were generated from a regression equation that also controlled for how long an individual has had an HRA or HSA, employer contributions to the account, and individual contributions to the account.⁷ Like the detailed data on average account balances, 2006 data for rollovers are not shown for the different variables because of small sample sizes.

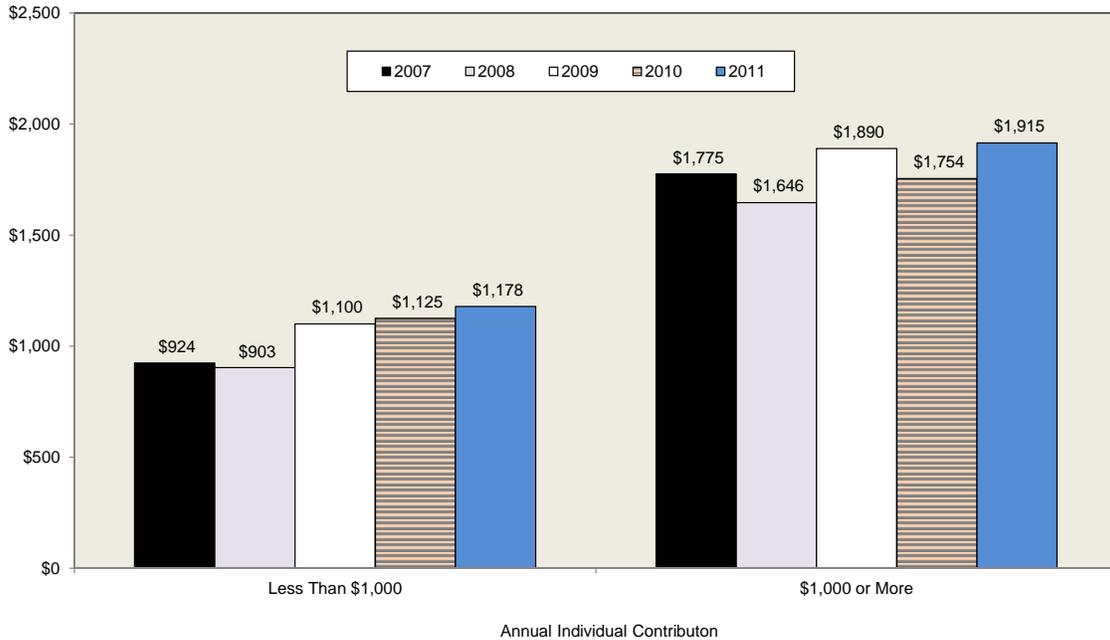
Gender and Age—Men rolled over more money than women. In 2011, men had an average rollover of \$1,201 while women had \$984 (Figure 22). Average rollover amounts increased for both men and women.

The oldest adults had the largest rollover amounts in 2011. Individuals ages 55–64 had an average rollover of \$1,257, compared with \$938 for individuals 21–34, \$1,020 for those 35–44, and \$1,100 for those 45–54 (Figure 23).

When examining differences in rollovers for men and women by age, regardless of age men have higher average rollover amounts than women. (Figure 24).

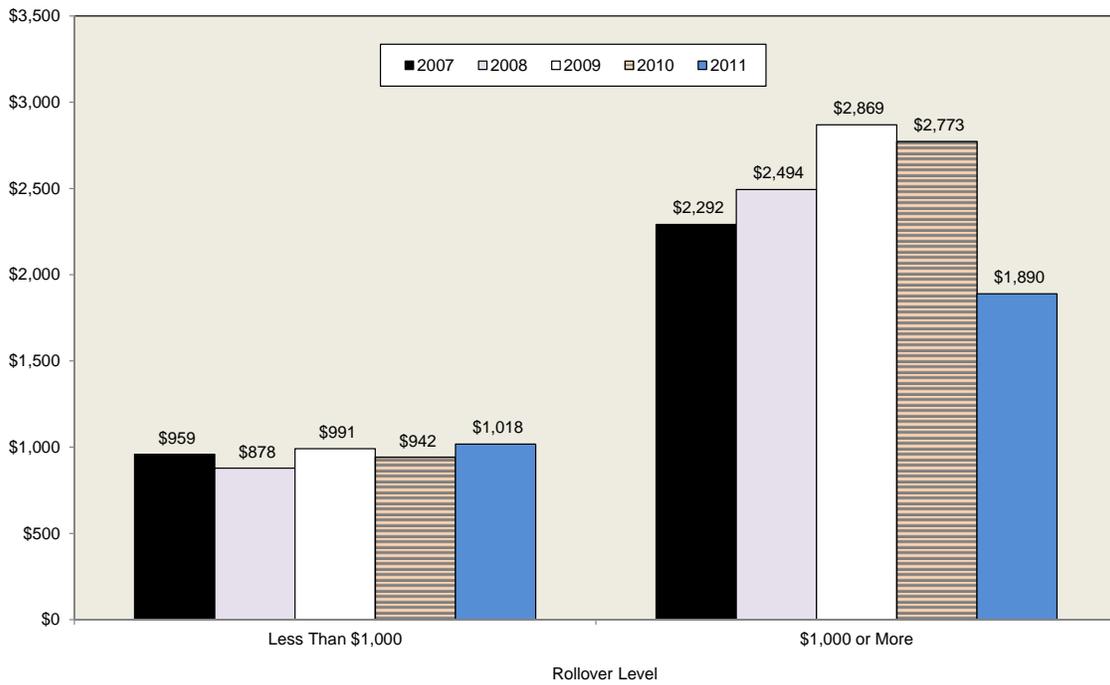
Race—Whites have lower rollover amounts than minorities. On average, minorities had a \$1,166 rollover in 2011, while whites had a \$1,066 rollover (Figure 25).

Figure 17
Average Account Balances, by Level of Annual Individual Contribution, 2007–2011



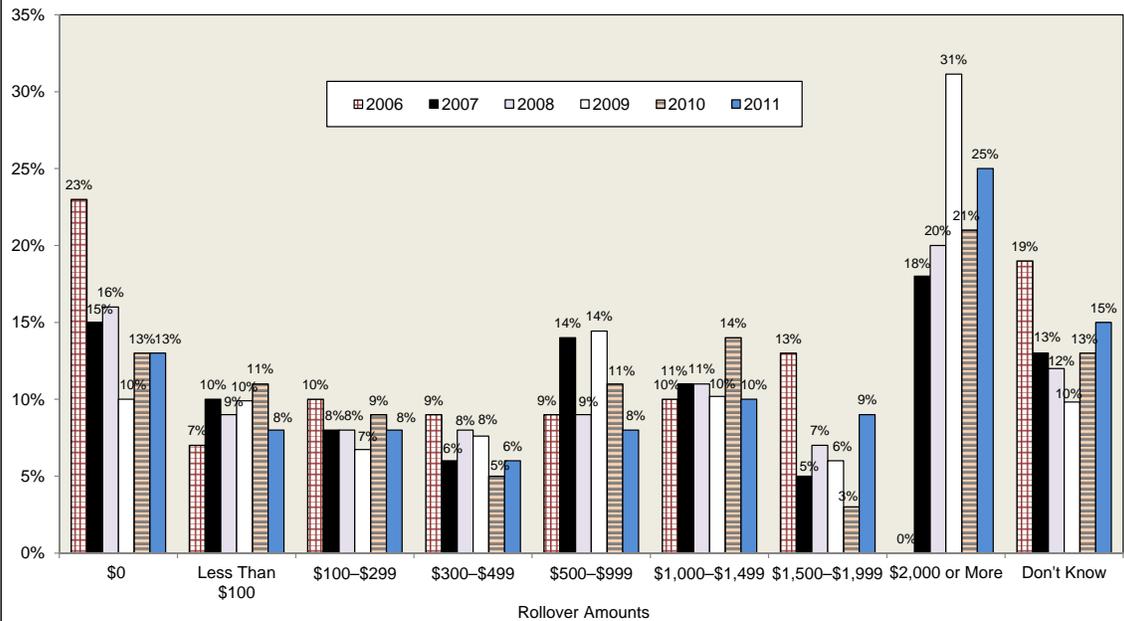
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 18
Average Account Balances, by Rollover Level, 2007–2011



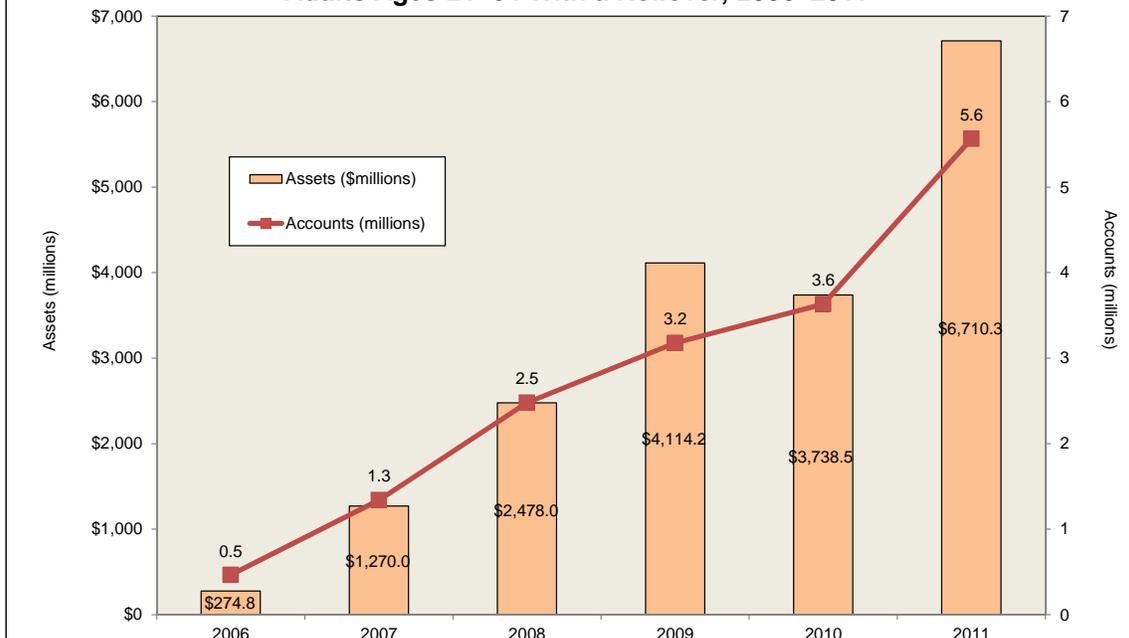
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 19
Rollover Amounts, Among Individuals With Account for More Than One Year, 2006–2011



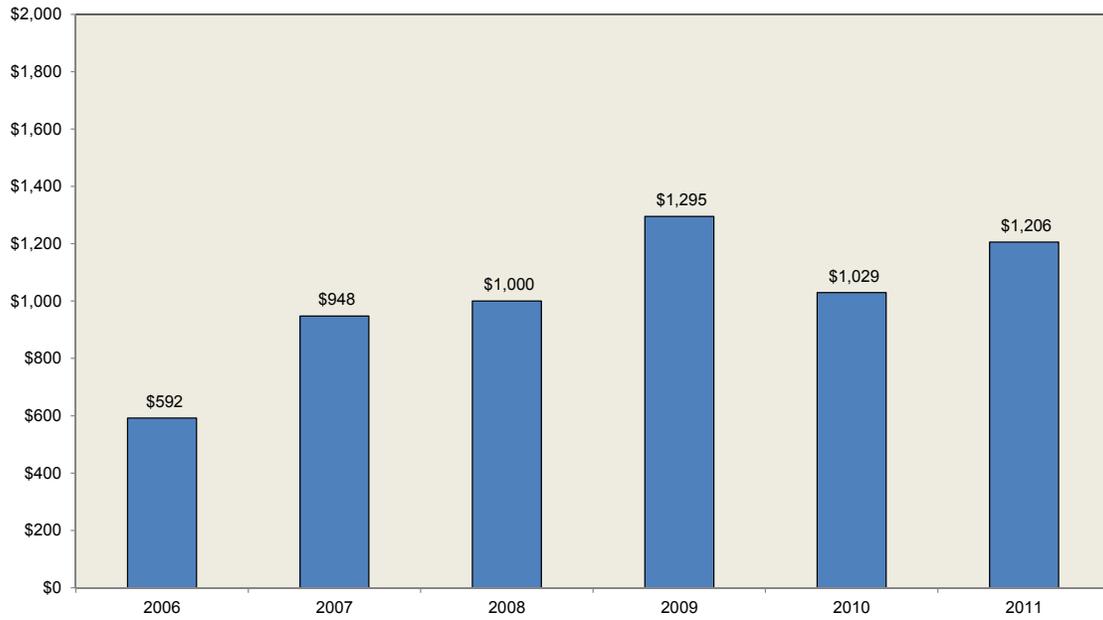
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
 Note: 2006 data were capped at \$1,500 or more.

Figure 20
Total Rollover Assets and Number of Adults Ages 21–64 With a Rollover, 2006–2011



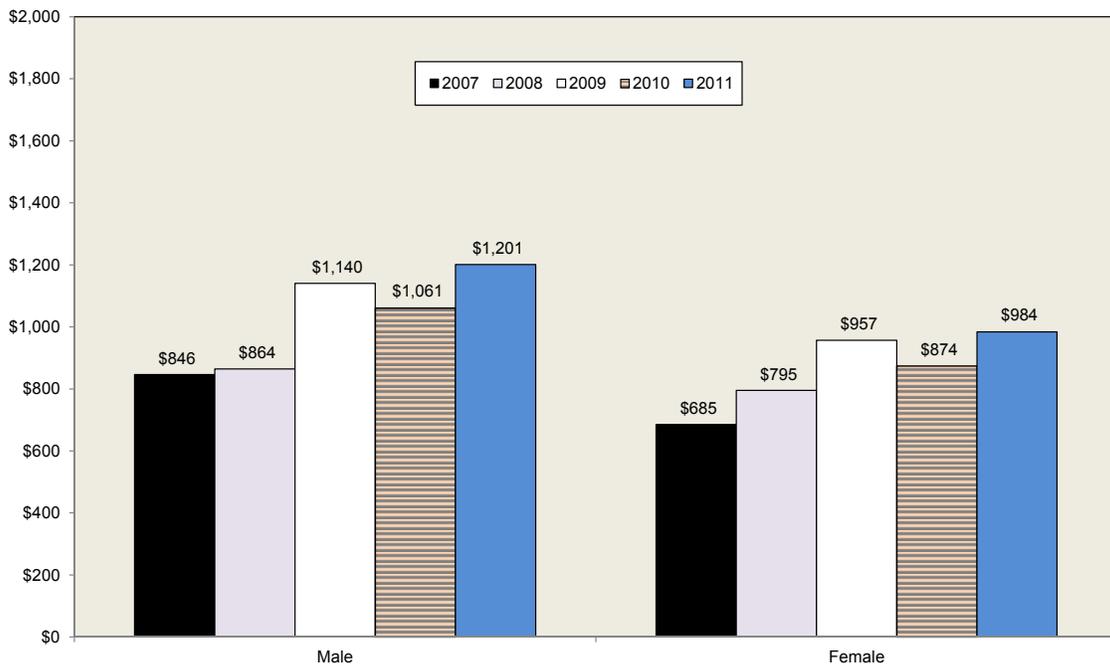
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 21
Average HRA^a or HSA^b Rollover Amount, 2006–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.
^a Health reimbursement account.
^b Health savings account.

Figure 22
Average Rollover Amount, by Gender, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Household Income—According to Figure 26, rollover amounts increase with household income. In 2011, the average rollover was \$795 among individuals with less than \$50,000 in household income, \$843 among those with \$50,000–\$99,999, and \$1,358 among those with \$100,000 or more in household income. Rollover amounts increased slightly for those with less than \$50,000 in household income, fell for those with \$50,000–\$99,999 in household income, and increased for those with \$100,000 or more in household income.

Education—Education has an impact on rollover amounts independent of income and other variables, as they are controlled for in the regression equation that these estimates are based on. Individuals with a high school degree or less had an average rollover of \$812, while those with a college degree had an average rollover of \$1,172, and those with a graduate degree had an average rollover of \$1,187 (Figure 27).

Type of Coverage—Individuals with single coverage had an average rollover of \$1,105, whereas those with family coverage had a \$1,071 average rollover (Figure 28).

Health Behaviors and Health Status—Individuals who smoke had higher rollover amounts than individuals who do not smoke (Figure 29). Those who exercise had slightly higher rollover amounts than those who did not. Obese individuals had lower average rollover amounts (\$1,027) than the nonobese (\$1,111). There was no difference in account balances by health status.

Use of Health Information and Programs—Rollover amounts were also examined by whether an individual used cost and quality information to choose a doctor and whether he or she participated in a wellness program. It was found individuals who used cost and quality information to choose a doctor had a lower rollover amount than those who did not participate in such a program, although the differences were not statistically significant. The average rollover was \$1,017 among those who used cost and quality information to choose a doctor, and \$1,126 among those who did not (Figure 30).

Cost-Conscious Behaviors—A number of cost-conscious behaviors were examined to see if individuals who exhibit more cost-conscious decision making had higher rollover amounts than those who did not exhibit such a decision-making process. The expectation was that those who exhibited cost-conscious behavior would have a higher rollover amounts than those who did not. The questions regarding cost-conscious decision making were described above. In the series of questions, those exhibiting cost-conscious decision making had slightly lower rollover amounts (Figure 31).

Length of Time With Account—The length of time that an individual has had the account has an impact on rollover amounts. The analysis found that persons holding an account for one to two years had an average rollover of \$962 (Figure 32). In comparison, those holding an account for three to four years had an average rollover of \$1,318. And those with an account at least five years old had an average rollover of \$1,357. Average rollover amounts fell among those with accounts at least five years, from \$1,774 in 2009 to \$1,634 in 2010 and \$1,357 in 2011.

Employer and Individual Contributions—Annual contribution amounts from individuals have a strong impact on overall rollover amounts, whereas employer contributions do not have a statistically significant effect on rollover amounts. Individuals with an employer contribution of less than \$1,000 had an average rollover of \$1,020, while those with an employer contribution of at least \$1,000 had an average rollover of \$1,217 (Figure 33). In contrast, individuals who contributed less than \$1,000 had an average rollover of \$873, while those who contributed at least \$1,000 had an average rollover of \$1,284, a difference that is statistically significant (Figure 34).

Conclusion

Employers first started offering HRAs in 2001, and they were able to start offering health plans with HSAs in 2004. By 2010, 16 percent of employers with 10–499 workers and 23 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan. As a result, these plans covered about 21 million people in 2011, representing about 12 percent of the privately insured market (Fronstin, 2011).

According to findings from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey, there was \$12.4 billion in HSAs and HRAs in 2011, spread across 8.4 million accounts. In 2006, there were 1.3 million accounts with \$873.4 million in assets, and by 2009, 4.8 million accounts held \$7.3 billion in assets. Total assets in the accounts have increased each year, and growth in average account balances has slowed. Average account balances reached \$1,470 in 2011.

The number of people with a rollover as well as the total level of assets being rolled over have been increasing. In 2006, 23 percent of individuals with an HRA or HSA did not roll over any money. By 2011, 13 percent did not have a rollover. In 2006, 500,000 individuals rolled over \$274.8 million. By 2011, 5.6 million individuals rolled over \$6.7 billion. The average rollover increased from \$592 in 2006 to \$1,295 in 2009, fell to \$1,029 in 2010, and then increased to \$1,206 in 2011.

It might be expected that individuals who are given more control over funds allocated for health care services would become more cost conscious, especially once they become more educated about the actual price of health services. However, no evidence was found to support this. Nor was there evidence that healthy behaviors had any real correlation with account balance; individuals who smoke have more money in their accounts than those who do not smoke, while obese individuals have less money in their account than the nonobese. Additionally, there was very little difference in account balances by level of exercise.

Very small differences were found in account balances and rollover amounts between individuals who used cost or quality information compared with those who did not use such information. However, next to no relationship was found between either account balance or rollover amounts and various cost-conscious behaviors. When a difference was found, those exhibiting the cost-conscious behavior were found to have a lower account balance and rollover amount.

Future research should examine differences between individuals in HSAs and HRAs, and should also examine the impact that account balances have on the use of health care services as individuals continue to accumulate funds in their accounts.

Figure 23
Average Rollover Amount, by Age, 2007–2011

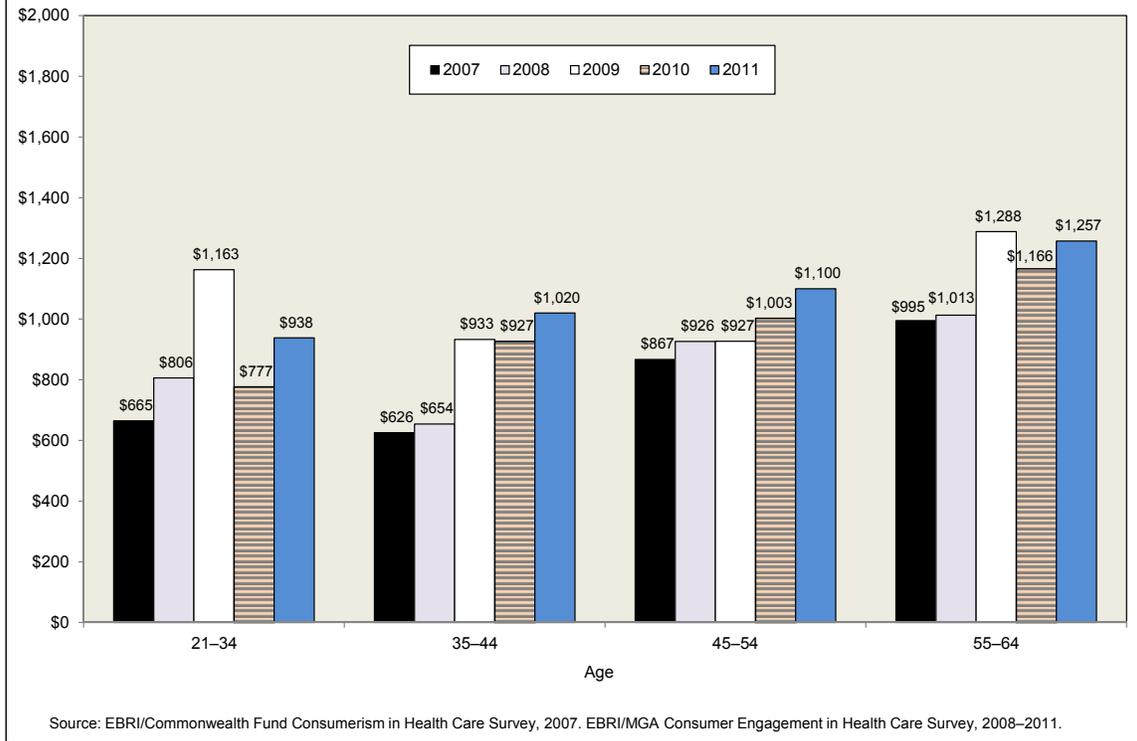


Figure 24
Average Rollover Amount, by Gender and Age Combined, 2011

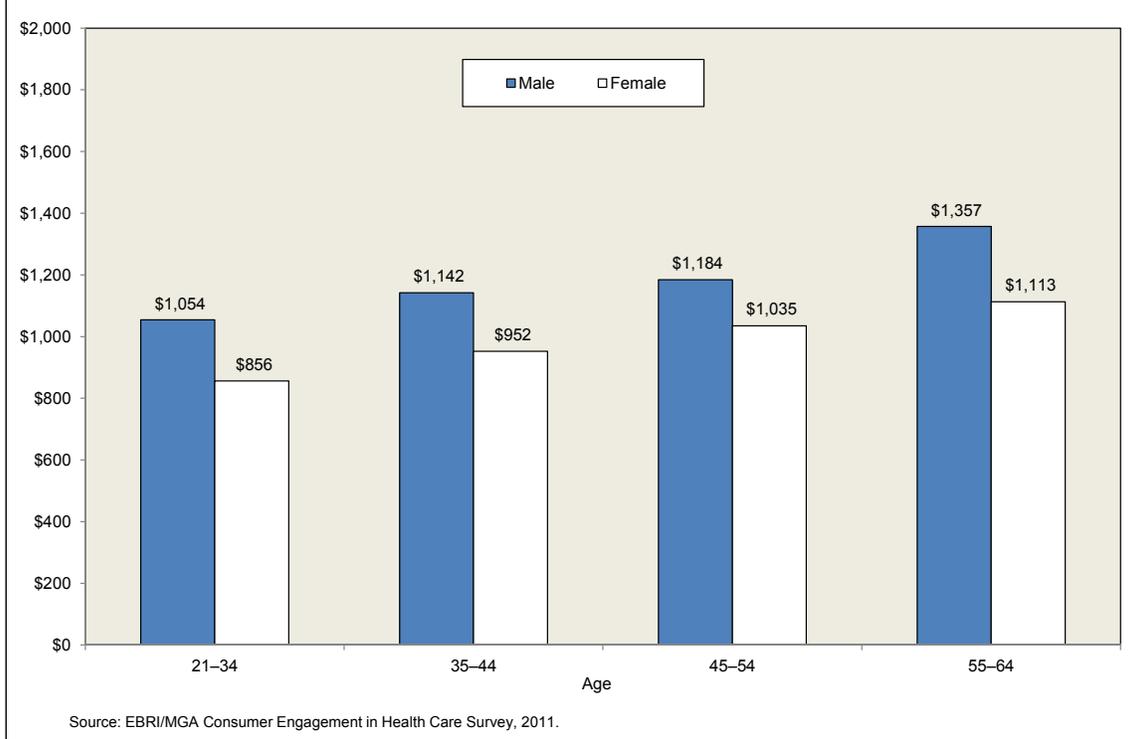
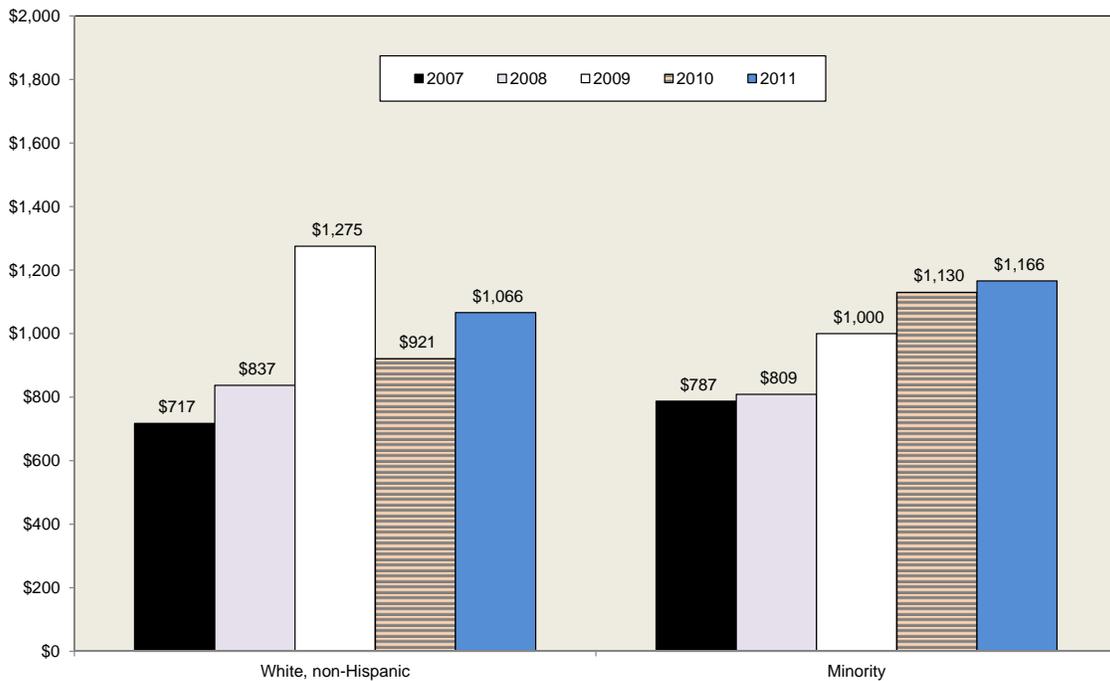
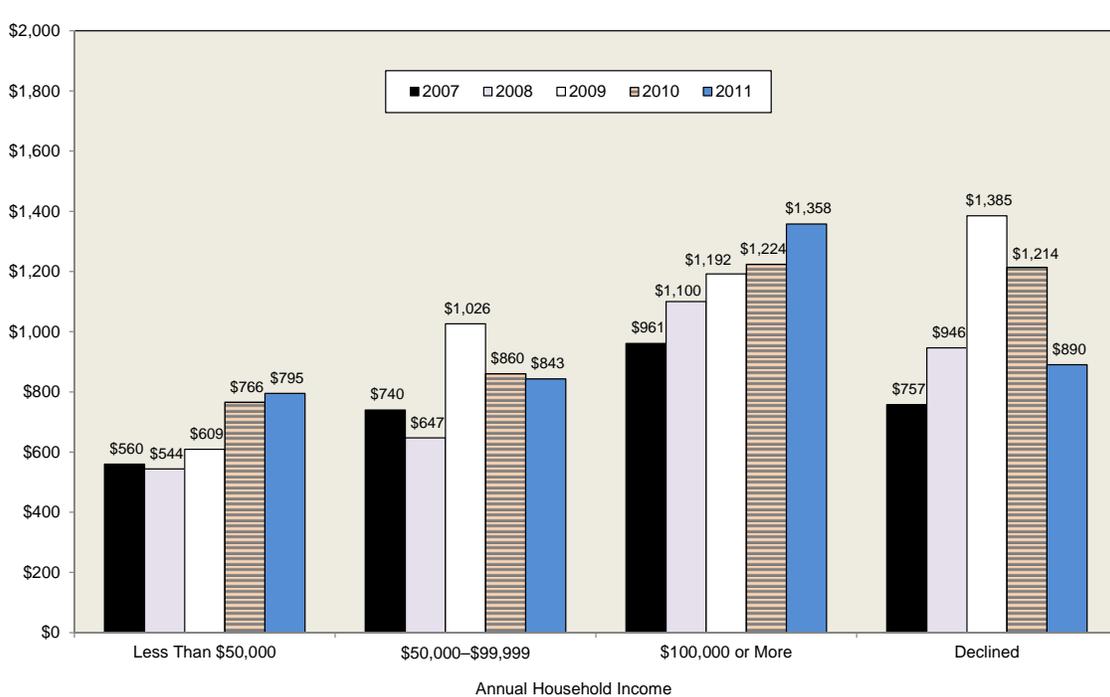


Figure 25
Average Rollover Amount, by Race, 2007–2011



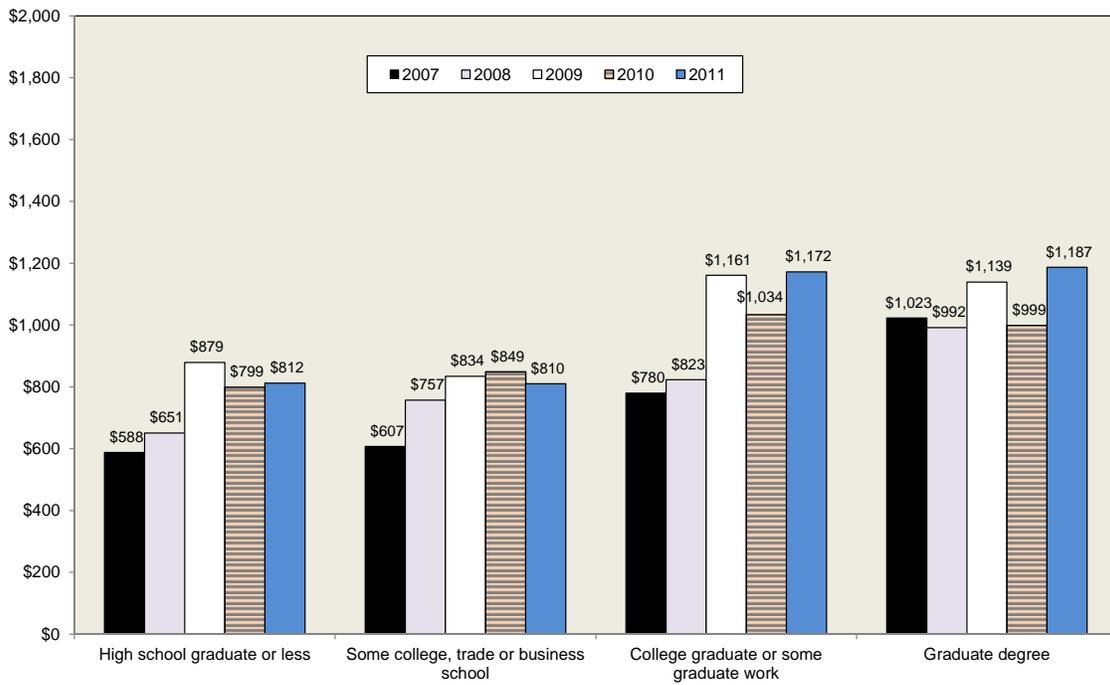
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 26
Average Rollover Amount, by Annual Household Income, 2007–2011



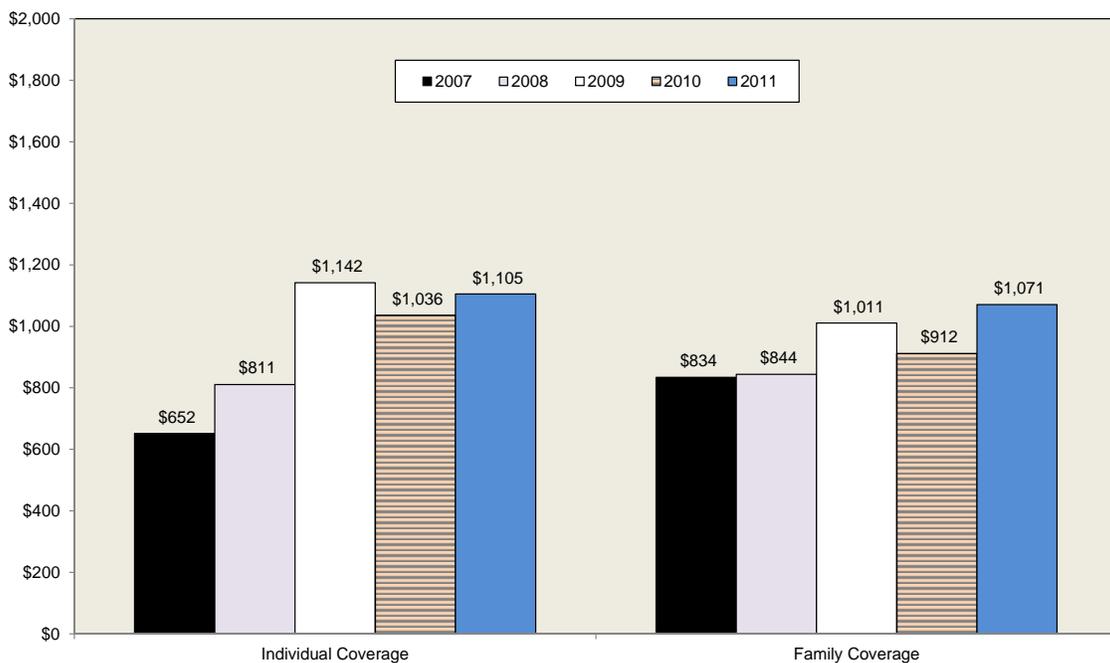
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 27
Average Rollover Amount, by Education, 2007–2011



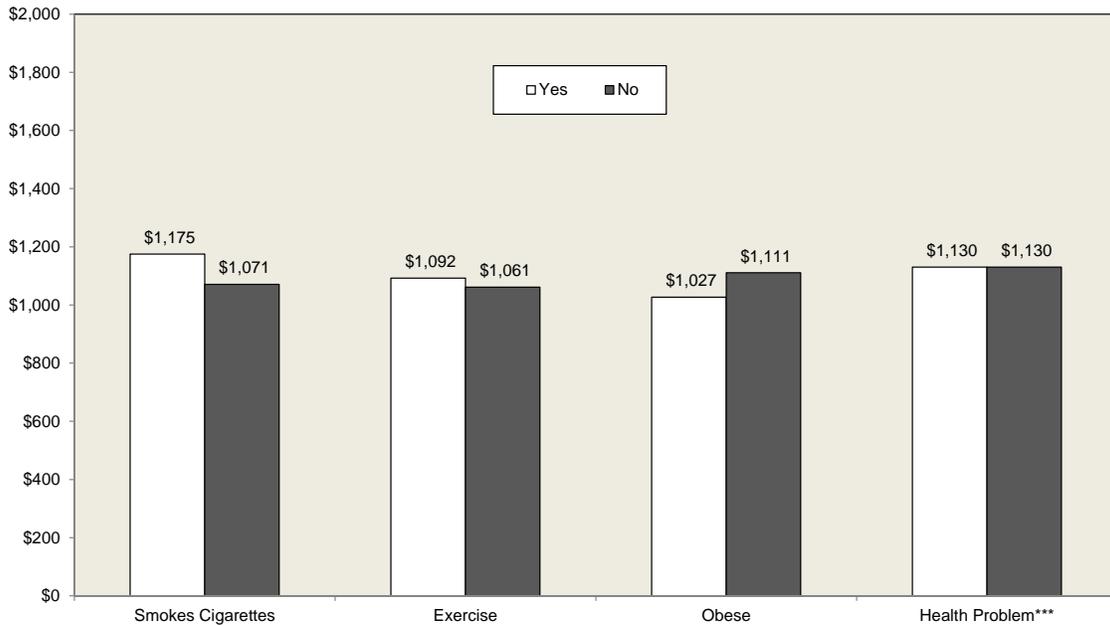
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 28
Average Rollover Amount, by Plan Type, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

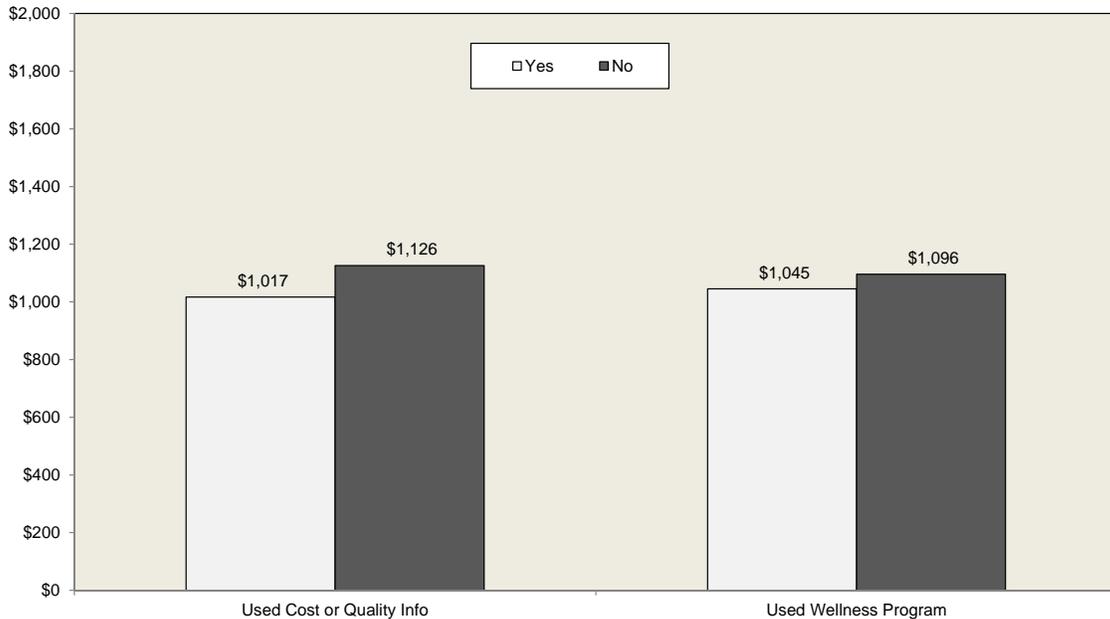
Figure 29
Average Rollover Amount, by Health Behavior and Health Status, 2011



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

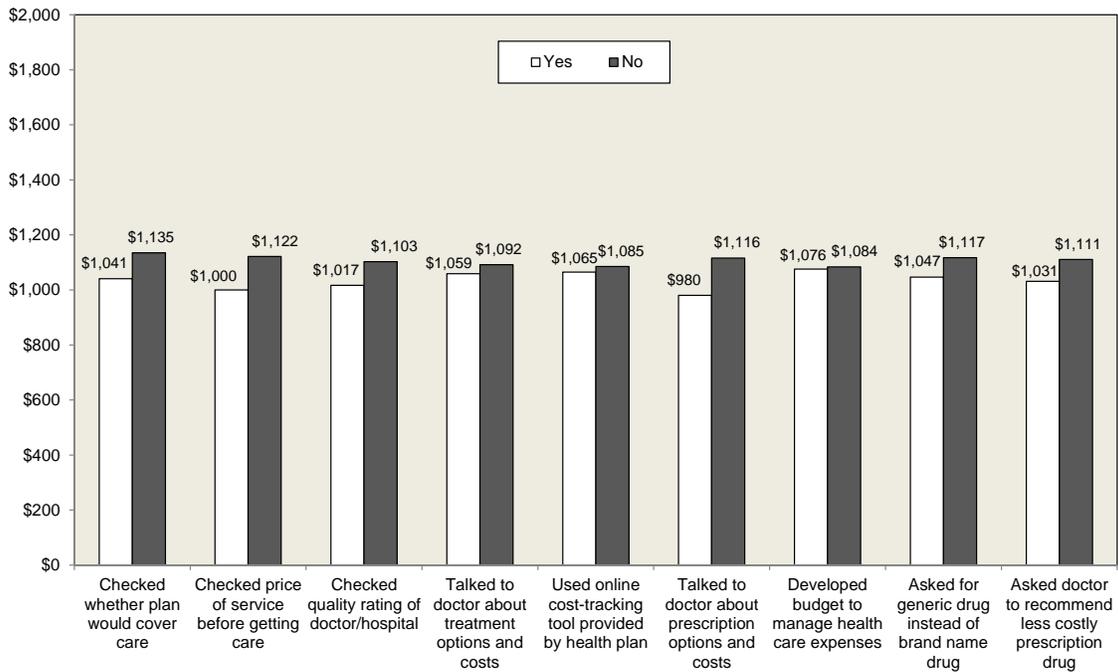
*** Health problem defined as fair or poor health or one of eight chronic health condition: arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure, or stroke.

Figure 30
Average Rollover Amount, by Use of Cost and Quality Information and Use of Wellness Program, 2011



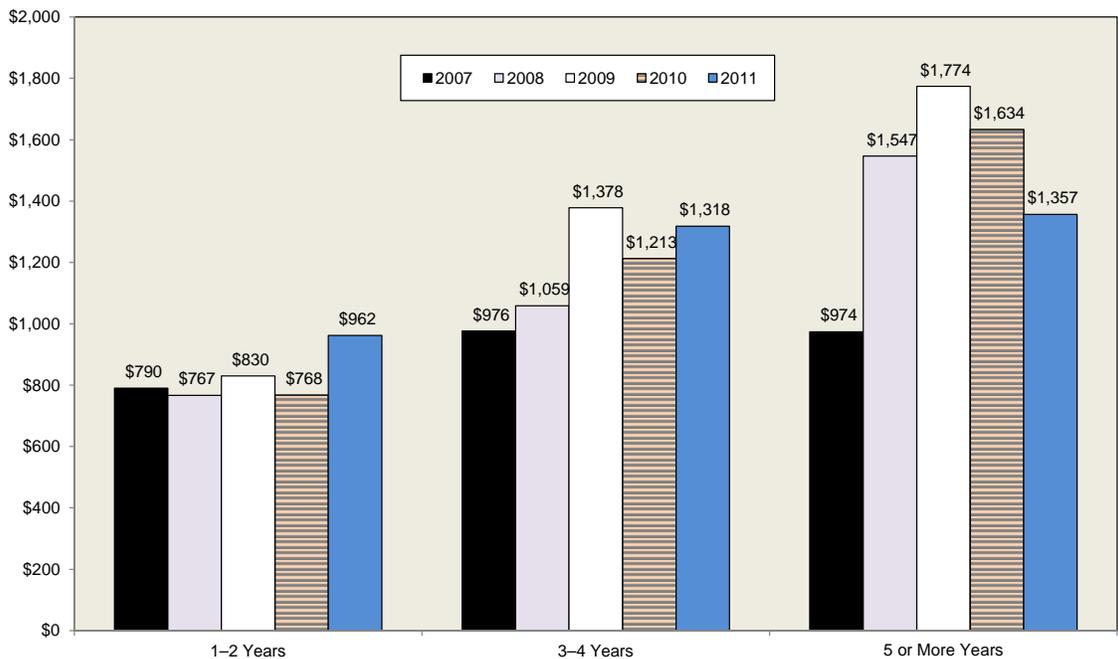
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

Figure 31
Average Rollover Amount, by Various Cost-Conscious Behaviors, 2011



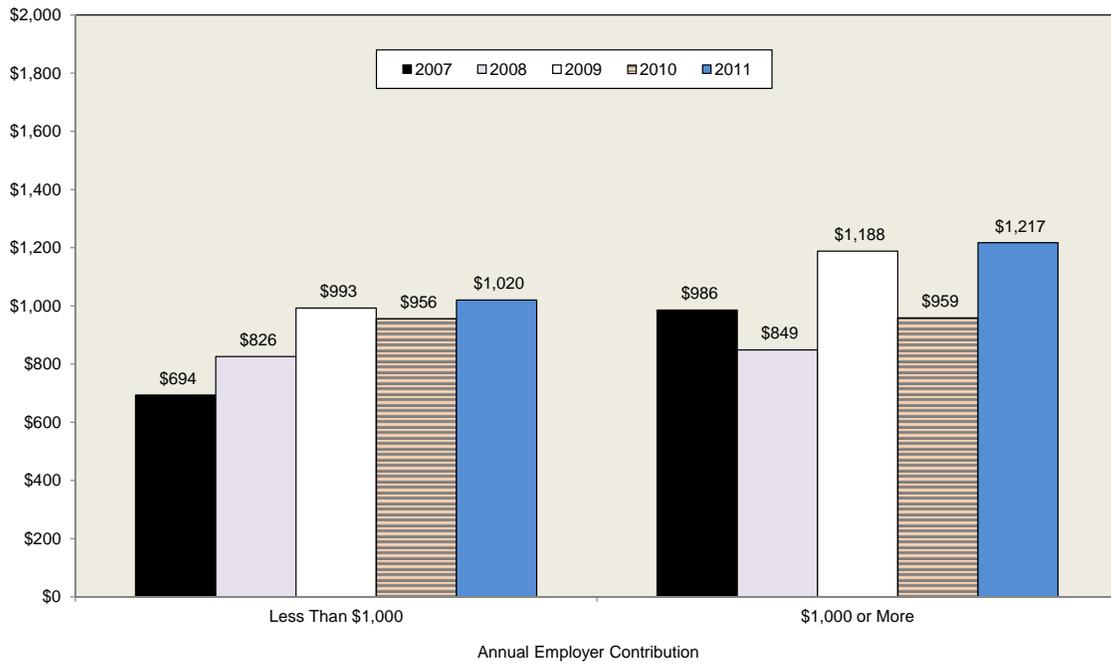
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2011.

Figure 32
Average Rollover Amount, by Length of Time With Account, 2007–2011



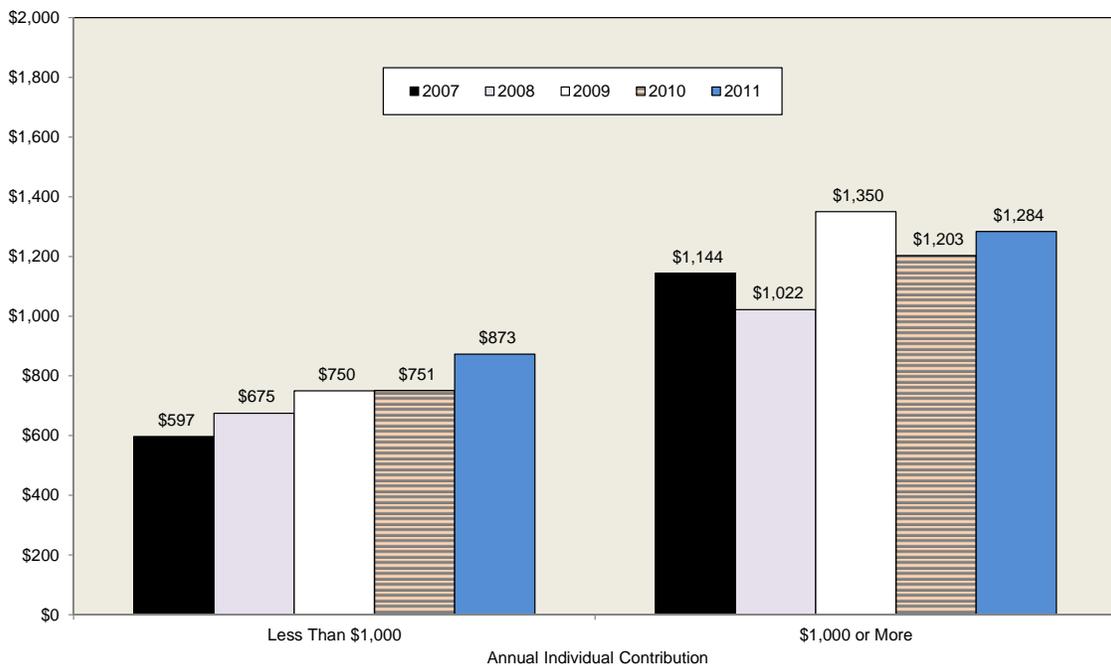
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 33
Average Rollover Amount, by Level of
Annual Employer Contribution, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

Figure 34
Average Rollover Amount, by Level of
Annual Individual Contribution, 2007–2011



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2011.

References

- Fronstin, Paul. "Findings from the 2011 EBRI/MGA Consumer Engagement in Health Care Survey." *EBRI Issue Brief*, no. 365 (Employee Benefit Research Institute, December 2011).
- _____. "The Use of Health Savings Accounts for Health Care in Retirement." *EBRI Notes*, no. 3 (Employee Benefit Research Institute, April 2010): 2–6.
- Sandman, David, Elisabeth Simantov, and Christina An. "Out of Touch: American Men and the Health Care System" (March 2000):
www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2000/Mar/Out%20of%20Touch%20%20American%20Men%20and%20the%20Health%20Care%20System/sandman_outoftouch_374%20pdf.pdf
(accessed December 2010).
- Taylor, Humphrey. "Does Internet Research 'Work'? Comparing Online Survey Results With Telephone Surveys." *International Journal of Market Research*. Vol. 42, no. 1 (August 2003).

Endnotes

¹ See www.mercer.com/press-releases/1400235?siteLanguage=100

² The term "assets" is used loosely as it relates to health reimbursement arrangements (HRAs). HRAs are typically set up as notional arrangements and exist only on paper. Employees may view the account 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.

³ See www.globalopinionpanels.com/home

⁴ In theory, a random sample of 1,990 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 were 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.

⁵ A regression equation is a statistical model that allows researchers to determine the effect of an independent variable on a dependent variable while holding the effect of all other independent variables constant. For this analysis, the amount of money an individual has in an HRA or HSA is determined by a number of factors. The regression equation allows researchers to determine the strength of each factor independently. More information about the regression equation is available upon request from the author.

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 MSAs are also permitted.

⁷ More information about the regression equation is available upon request from the author.

Established in 1978, the Employee Benefit Research Institute (EBRI) is the only independent nonprofit, nonpartisan organization committed exclusively to data dissemination, research, and education on economic security and employee benefits.

The Institute seeks to advance the public's, the media's and policymakers' knowledge and understanding of employee benefits and their importance to our nation's economy.

EBRI's mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

EBRI has earned widespread regard as an organization that "tells it like it is," based on the facts. As the Bylaws state: "In all its activities, the Institute shall function strictly in an objective and unbiased manner and not as an advocate or opponent of any position."

ebri.org
Employee Benefit Research Institute

Contact | Join | Notify Me | Subscribe

About | Media | Research | Education | Programs | Surveys

Search Member Login

Printer Friendly | RSS

Most Viewed

1. EBRI Databook on Employee Benefits
2. 2009 Fast Facts
3. 401(k) Valuations

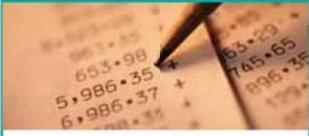
Publications

- By Topic
- Data Book
- Facts from EBRI
- Fast Facts
- Fundamentals
- Issue Briefs
- Notes
- Policy Books
- President's Reports
- Press Releases
- Special Reports
- Testimony

Resources

- Benefit Bibliography
- Benefit FAQs
- Links to Other Internet Resources
- Reference Shelf
- Special Issues of Periodicals
- What's New in Employee Benefits

EBRI Notes – December 2011



'Retirement Age Expectations of Older Americans Between 2006 and 2010,' and 'Variation in Public Opinion on the Future of Employment-Based Health Benefits: Findings from the 2011 Health Confidence Survey'

Retirement Age Expectations: Not only are older American workers (age 50 and over) expecting to work longer, but many now say they expect to never retire, according to EBRI. Data suggest the trend may be tied to the recent economic recession. Press release

Variation in Public Opinion on the Future of Employment-Based Health Benefits: Findings from the 2011 Health Confidence Survey-- The public remains in large part confident that employers and unions will continue to offer health coverage following enactment of the federal health reform law. According to results from the 2011 Health Confidence Survey, 57 percent of individuals with employment-based coverage are extremely or very confident that their employer or union would continue to offer health coverage. Press release

EBRI Notes – November 2011



'Public Opinion on the Future of Employment-Based Health Benefits: Findings From the 2011 Health Confidence Survey,' and 'How Do Financial Literacy and Financial Behavior Vary by State?'

Health Benefits: Even though employment-based health coverage is the primary source of health insurance coverage in the United States, long-term public confidence that employers and unions will continue to offer health coverage has fallen, according to findings by EBRI. Press release

Financial Literacy: New research by EBRI finds that the residents of New Hampshire and Alaska rank at the top of financial literacy and financial behavior, while residents of Louisiana and West Virginia rank at the bottom. Press release

EBRI Notes – October 2011



EBRI Research and Education Centers

Health Benefits Research Centers
Retirement Benefits Research Centers

Visit EBRI's Blog!

Recent Media Coverage of EBRI

401(k) Valuations
Published: December 1, 2011
401(k) Balances and Changes Due to Market Volatility

Data Book
Last Updated: November 2011
A comprehensive collection of the most up-to-date benefit information available

Fast Facts
Published: December 1, 2011
"Retirement Plan Participation Lowest in South, West"

Retirement Survey
Published: March 2011
Our most widely read survey on key retirement indicators

CHECK OUT EBRI'S WEB SITE!

EBRI's website is easy to use and packed with useful information! Look for these special features:

- EBRI's entire library of research publications starts at the main Web page. Click on *EBRI Issue Briefs* and *EBRI Notes* for our in-depth and nonpartisan periodicals.
- Visit EBRI's blog.
- EBRI's reliable health and retirement surveys are just a click away through the topic boxes at the top of the page.
- Need a number? Check out the *EBRI Databook on Employee Benefits*.
- Instantly get e-mail notifications of the latest EBRI data, surveys, publications, and meetings and seminars by clicking on the "Notify Me" or "RSS" buttons at the top of our home page.

There's lots more!

Visit EBRI on-line today: www.ebri.org

Where the world turns for the facts on U.S. employee benefits.

Retirement and health benefits are at the heart of workers', employers', and our nation's economic security. Founded in 1978, EBRI is the most authoritative and objective source of information on these critical, complex issues.

EBRI focuses solely on employee benefits research — no lobbying or advocacy

EBRI stands alone in employee benefits research as an independent, nonprofit, and nonpartisan organization. It analyzes and reports research data without spin or underlying agenda. All findings, whether on financial data, options, or trends, are revealing and reliable — the reason EBRI information is the gold standard for private analysts and decision makers, government policymakers, the media, and the public.

EBRI explores the breadth of employee benefits and related issues

EBRI studies the world of health and retirement benefits — issues such as 401(k)s, IRAs, retirement income adequacy, consumer-driven benefits, Social Security, tax treatment of both retirement and health benefits, cost management, worker and employer attitudes, policy reform proposals, and pension assets and funding. There is widespread recognition that if employee benefits data exist, EBRI knows it.

EBRI delivers a steady stream of invaluable research and analysis

- EBRI publications include in-depth coverage of key issues and trends; summaries of research findings and policy developments; timely factsheets on hot topics; regular updates on legislative and regulatory developments; comprehensive reference resources on benefit programs and workforce issues; and major surveys of public attitudes.
- EBRI meetings present and explore issues with thought leaders from all sectors.
- EBRI regularly provides congressional testimony, and briefs policymakers, member organizations, and the media on employer benefits.
- EBRI issues press releases on newsworthy developments, and is among the most widely quoted sources on employee benefits by all media.
- EBRI directs members and other constituencies to the information they need, and undertakes new research on an ongoing basis.
- EBRI maintains and analyzes the most comprehensive database of 401(k)-type programs in the world. Its computer simulation analyses on Social Security reform and retirement income adequacy are unique.

EBRI makes information freely available to all

EBRI assumes a public service responsibility to make its findings completely accessible at www.ebri.org — so that all decisions that relate to employee benefits, whether made in Congress or board rooms or families' homes, are based on the highest quality, most dependable information. EBRI's Web site posts all research findings, publications, and news alerts. EBRI also extends its education and public service role to improving Americans' financial knowledge through its award-winning public service campaign *ChoosetoSave*® and the companion site www.choosetosave.org

EBRI is supported by organizations from all industries and sectors that appreciate the value of unbiased, reliable information on employee benefits. Visit www.ebri.org/about/join/ for more.

EBRI Employee Benefit Research Institute Issue Brief (ISSN 0887-137X) is published monthly by the Employee Benefit Research Institute, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, at \$300 per year or is included as part of a membership subscription. Periodicals postage rate paid in Washington, DC, and additional mailing offices. POSTMASTER: Send address changes to: *EBRI Issue Brief*, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051. Copyright 2012 by Employee Benefit Research Institute. All rights reserved. No. 367.

Who we are

The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI's membership includes a cross-section of pension funds; businesses; trade associations; labor unions; health care providers and insurers; government organizations; and service firms.

What we do

EBRI's work advances knowledge and understanding of employee benefits and their importance to the nation's economy among policymakers, the news media, and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. **EBRI's Education and Research Fund** (EBRI-ERF) performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants.

Our publications

EBRI Issue Briefs is a monthly periodical with in-depth evaluation of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. *EBRI Notes* is a monthly periodical providing current information on a variety of employee benefit topics. *EBRI Fundamentals of Employee Benefit Programs* offers a straightforward, basic explanation of employee benefit programs in the private and public sectors. The *EBRI Databook on Employee Benefits* is a statistical reference work on employee benefit programs and work force-related issues.

Orders/ Subscriptions

Contact EBRI Publications, (202) 659-0670; fax publication orders to (202) 775-6312. Subscriptions to *EBRI Issue Briefs* are included as part of EBRI membership, or as part of a \$199 annual subscription to *EBRI Notes* and *EBRI Issue Briefs*. **Change of Address:** EBRI, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, (202) 659-0670; fax number, (202) 775-6312; e-mail: subscriptions@ebri.org **Membership Information:** Inquiries regarding EBRI membership and/or contributions to EBRI-ERF should be directed to EBRI President Dallas Salisbury at the above address, (202) 659-0670; e-mail: salisbury@ebri.org

Editorial Board: Dallas L. Salisbury, publisher; Stephen Blakely, editor. Any views expressed in this publication and those of the authors should not be ascribed to the officers, trustees, members, or other sponsors of the Employee Benefit Research Institute, the EBRI Education and Research Fund, or their staffs. Nothing herein is to be construed as an attempt to aid or hinder the adoption of any pending legislation, regulation, or interpretative rule, or as legal, accounting, actuarial, or other such professional advice. www.ebri.org

EBRI Issue Brief is registered in the U.S. Patent and Trademark Office. ISSN: 0887-137X/90 0887-137X/90 \$.50+.50