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Issue BRIEF

Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2009

By Paul Fronstin, Employee Benefit Research Institute

EXECUTIVE SUMMARY

ASSET LEVELS GROWING: In 2009, there was $7.1 billion in consumer-driven health plans (CDHPs), which include health savings accounts (or HSAs) and health reimbursement arrangements (or HRAs), spread across 5 million accounts. This is up from 2006, when there were 1.2 million accounts with $835.4 million in assets, and 2008, when 4.2 million accounts held $5.7 billion in assets.

AVERAGE ACCOUNT BALANCE LEVELING OFF: Increases in average account balances appear to have leveled off. 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.

TYPICAL ENROLLEE: The typical CDHP enrollee was more likely than traditional plan enrollees to be young, unmarried, higher-income, educated, and exhibit healthy behavior. No differences were found between CDHPs enrollees and traditional plan enrollees with respect to gender, race, and presence of children.

MORE ROLLOVERS: Overall, the number of people with a rollover, as well as the total level of assets being rolled over, have been increasing. The average rollover increased from $592 in 2006 to $1,295 in 2009.

DIFFERENCES IN ACCOUNT BALANCES: Men tend to have higher account balances than women, account balances increase with household income, education has a significant impact on account balances independent of income and other variables, and no statistically significant differences in account balances were found by smoking, obesity, or the presence of chronic health conditions. Individuals who developed a budget to manage their health care expenses had a higher account balance ($1,726) than those who did not ($1,428), but otherwise, no statistically significant differences in average account balances were found between individuals who exhibited various aspects of cost-conscious decision-making behaviors and those who did not.

DIFFERENCES IN ROLLOVER AMOUNTS: Men rolled over more money than women, whites have higher rollover amounts than minorities, and the youngest adults and the oldest adults had the largest rollover amounts in 2009. Rollover amounts increase with household income and education, and individuals with single coverage rolled over a slightly higher average amount than those with family coverage. There was no statistically significant difference in rollover amounts by health status, although individuals who smoke had higher rollover amounts than those who do not and obese individuals had lower average rollover amounts than nonobese individuals. Individuals who talked to their doctor about treatment options and costs, those who used an online cost-tracking tool provided by the health plan, and those who asked their doctor to recommend a less costly prescription drug had higher rollover amounts than those who did not take such actions.

Paul Fronstin is director of the Health Research and Education Program at EBRI. 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.

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Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2009

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Introduction

Employers first started offering account-based health plans in 2001, when a handful of plan sponsors began to offer health reimbursement arrangements (HRAs), a type of employer-funded health plan that reimburses workers for qualified medical expenses. In 2004, employers were able to start offering health plans with health savings accounts (HSAs), a type of tax-exempt trust or custodial account that an individual can use to pay for health care expenses. The theory behind these accounts is that when individuals are given 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 2009, 15 percent of employers with 10–499 workers and 20 percent of those with 500 or more workers offered either an HRA or HSA-eligible plan.[1] As a result, these plans covered 15–19 million people in 2009, representing 9–11 percent of the privately insured market (Fronstin, 2009b). As the number of people with account-based plans grows, total assets in these plans will grow as well.

HRAs and HSAs are relatively new, but a growing percentage of the population has had them for numerous years. In 2006, 15 percent of the population with an HRA or HSA had held the account for less than six months, 42 percent for six months to a year, and 30 percent for one–two years (Figure 1). By 2009, 8 percent had held an account for less than six months, 20 percent for six months to a year, and 36 percent for one–two years. And as the length of time individuals have these plans increases, average account balances should increase as well.

This *Issue Brief* examines HSA and HRA assets, account balances, and rollover amounts. It examines the types of individuals likely to have a consumer-driven health plan (CDHP). It then examines differences 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.

About the 2009 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 (CEHCS) to examine issues surrounding consumer-directed health care, including the cost of insurance, the cost of care, satisfaction with health care, satisfaction with the health care plan, reasons for choosing a plan, and sources of health information. The 2009 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 Survey and the 2008 EBRI/MGA Consumer Engagement in Health Care Survey.

The 2009 survey was conducted within the United States between August 8 and August 20, 2009, through a 14-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. Over 2,000 adults (n=2,007) 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 27.4 percent (21 percent for the base sample or national sample, and 38 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 94 individuals in a CDHP, an oversample of individuals with a CDHP was added. The oversample included 879 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.[2] The CDHP oversample was weighted by gender, age, income, and race/ethnicity. More information can be found in (Fronstin, 2009a).

While panel Internet surveys are nonrandom, studies have demonstrated that such surveys, when carefully designed, obtain results comparable to 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.

Assets and Account Balances

According to findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey, $7.1 billion was invested in HSAs and HRAs in 2009, spread across 5 million accounts (Figure 2). In 2006, there were 1. 2 million accounts with $835.4 million in assets, and by 2008, 4.2 million accounts held $5.7 billion in assets.[3]

While total assets in the accounts have increased each year, increases in average account balances appear to have leveled off. In 2006, account balances averaged $696 (Figure 3). They rose to $1,320 in 2007, a 90 percent increase. Account balances averaged $1,356 in 2008 and $1,419 in 2009, increasing 3 percent and 5 percent, respectively.

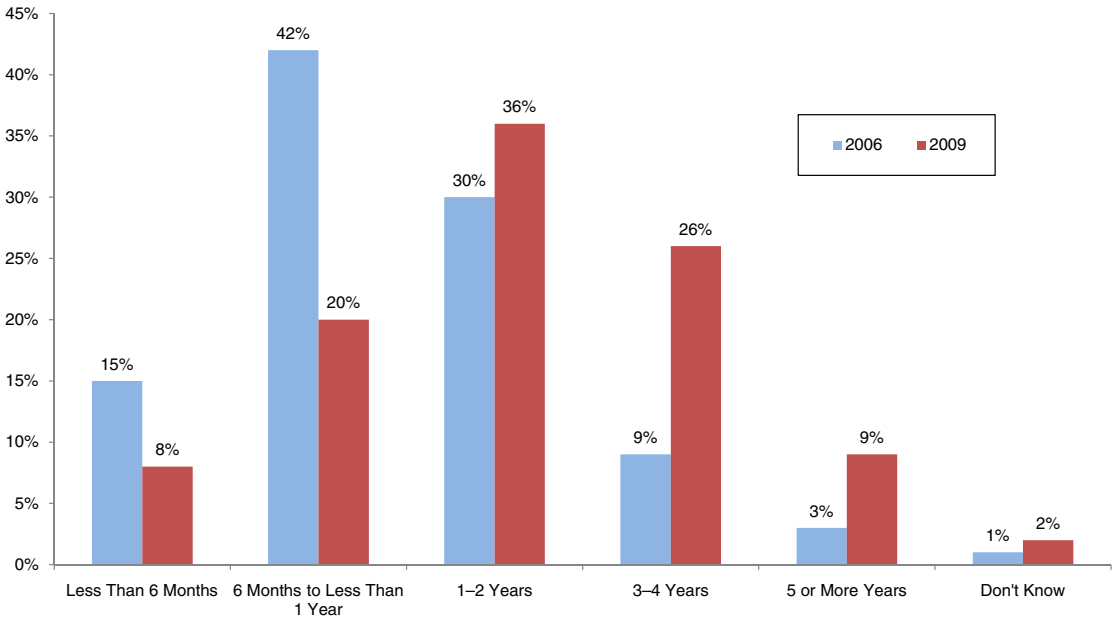
The Typical Account-Based Health Plan Enrollee

The typical CDHP enrollee was more likely than traditional plan enrollees to be young, unmarried, higher-income, educated, and exhibit healthy behavior. It is not known if the health behavior differences are due to the impact of the health plan or whether healthy people disproportionately gravitate to CDHPs. No difference was found between CDHP enrollees and traditional plan enrollees with respect to gender, race, and presence of children.

The data for age differences between CDHP enrollees and traditional plan enrollees can be seen in Figure 4. One-fifth (21 percent) of traditional plan enrollees were ages 55–64, while 16 percent of CDHP enrollees were ages 55–64. The difference was statistically significant.

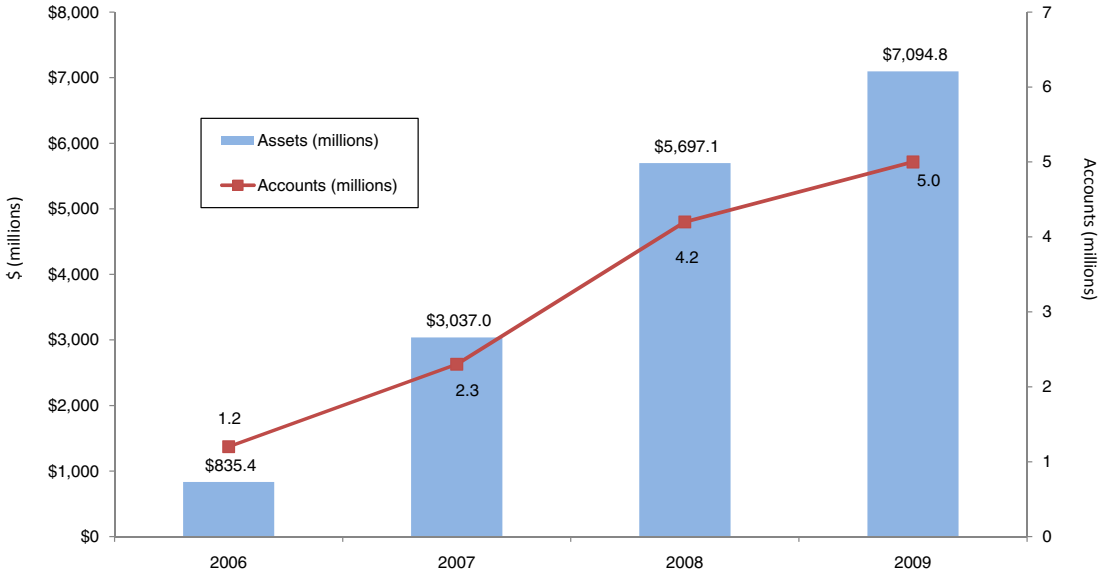
In terms of income, CDHP enrollees were more likely than traditional plan enrollees to be in households with $50,000 or more in income. Forty-five percent of CDHP enrollees had household income of $50,000–$99,999, compared with 38 percent of traditional plan enrollees (Figure 5). Similarly, 24 percent of CDHP enrollees had household income of $100,000–$149,999, compared with 17 percent of traditional plan enrollees. There was no difference in the percentages of those with income of at least $150,000.

Figure 1
Length of Time With HRA[a] or HSA,[b] 2006 and 2009



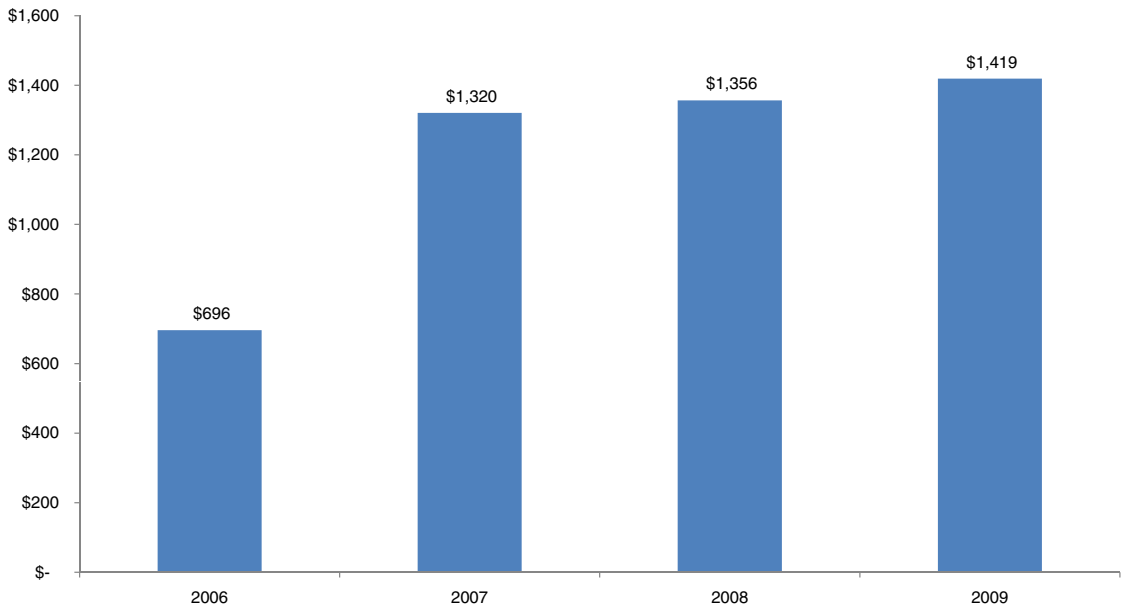
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006. EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 2
Total Assets and Number of Adults Ages 21–64 With an HRA[a] or HSA,[b] 2006–2009



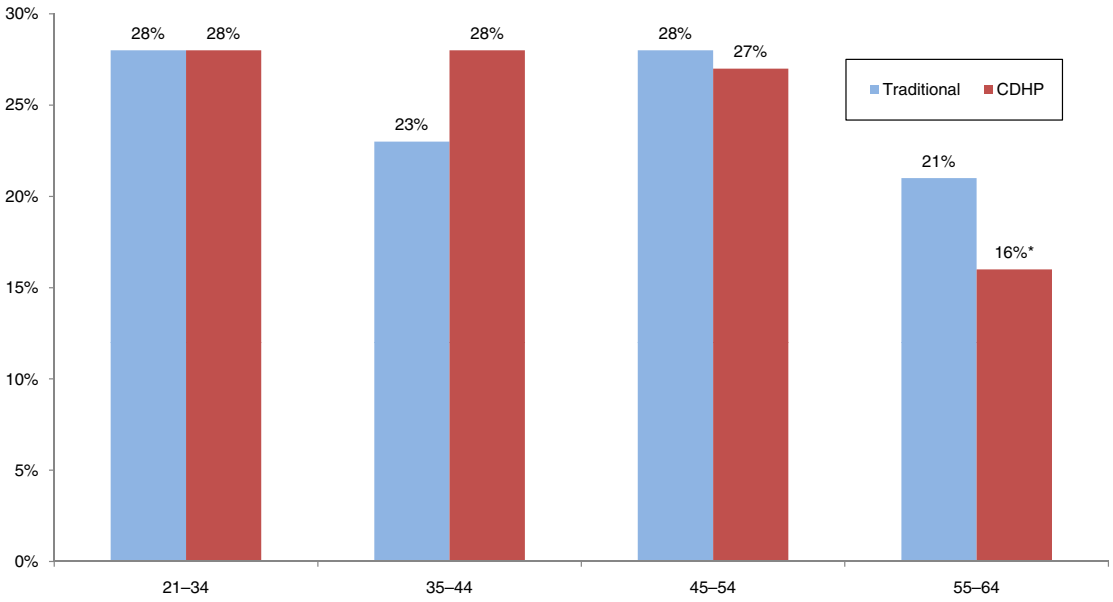
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 3
Average HRA[a] or HSA[b] Account Balances, 2006–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.
[a] Health reimbursement account.
[b] Health savings account.

Figure 4
Distribution of Traditional Plan Enrollees and CDHP[a] Enrollees, by Age, Adults Ages 21–64, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Consumer-driven health plan.
* Difference between traditional and CDHP is statistically significant at p ≤ 0.05 or better.

CDHP enrollees are much more likely to have a college or post-graduate education. Nearly one-half (46 percent) of CDHP enrollees had a college degree and another 21 percent had a graduate degree (Figure 6). In contrast, 23 percent of traditional plan enrollees had a college degree and 11 percent had a graduate degree. Traditional plan enrollees were much more likely than CDHP enrollees to have only a high school degree, 35 percent and 8 percent, respectively.

There are no statistically significant differences in self-reported health status between CDHP and traditional plan enrollees. However, CDHP enrollees are less likely than traditional plan enrollees to report that they had at least one of eight different chronic conditions. Just over one-half (52 percent) of traditional plan enrollees reported that they had at least one of eight different chronic conditions, while 46 percent of CDHPs reported at having at least one of the conditions (Figure 7).[4] Similarly, those in CDHPs were less likely than individuals enrolled in traditional plans to be obese. Nearly one-third (31 percent) of traditional plan enrollees were obese, compared with 23 percent among CDHP enrollees. Furthermore, CDHP enrollees were less likely than traditional plan enrollees to smoke cigarettes, and were more likely to exercise regularly.

With respect to firm size, the differences between CDHP and traditional plan enrollees are not large but there is one difference worth mentioning: CDHP enrollees are more likely than traditional plan enrollees to be employed in firms with 2–49 workers (Figure 8). Although large employers are much more likely than small employers to offer a CDHP, this finding may be explained by the fact that when large employers offer a CDHP they typically offer it as a choice along with other health plans, whereas when a small employer offers a CDHP it is typically the only available option.

Account Balance Variation

This section examines variation in account 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. The estimates 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]

Gender and Age

Men have higher account balances than women. By August 2009, men had an average of $1,620 in their HRA or HSA while women had $1,366 (Figure 9). 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, 2000).

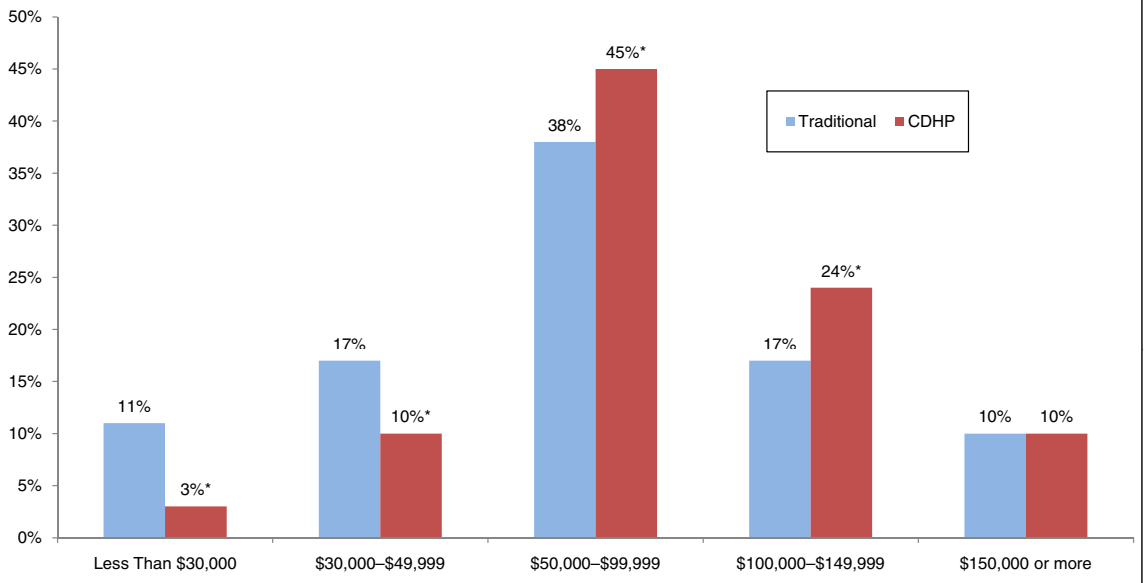
With respect to age, there is no difference in account balances by age for those below age 55. Individuals ages 55–64 had higher account balances than younger individuals (an average of $2,017 in their account, compared with roughly $1,400 for individuals under age 55). This occurred despite the fact 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 it was not possible to determine that 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 because of statutory constraints placed on contribution levels relative to expected health care spending in retirement (Fronstin 2010).

The higher account balance 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 would not be a factor in the observed differences.

There were differences in account balances between men and women when examined by age: Men ages 21–34 had a higher account balance than women of the same age. The average account balance for men was $1,679, while for women it was $1,050 (Figure 10). The difference between men and women can also be seen at ages 35–44, but it is smaller, as men have an average account balance of $1,487 while women have an average account balance of $1,301. The difference in account balances between men and women disappears for those ages 45–54 and 55–64.

Figure 5

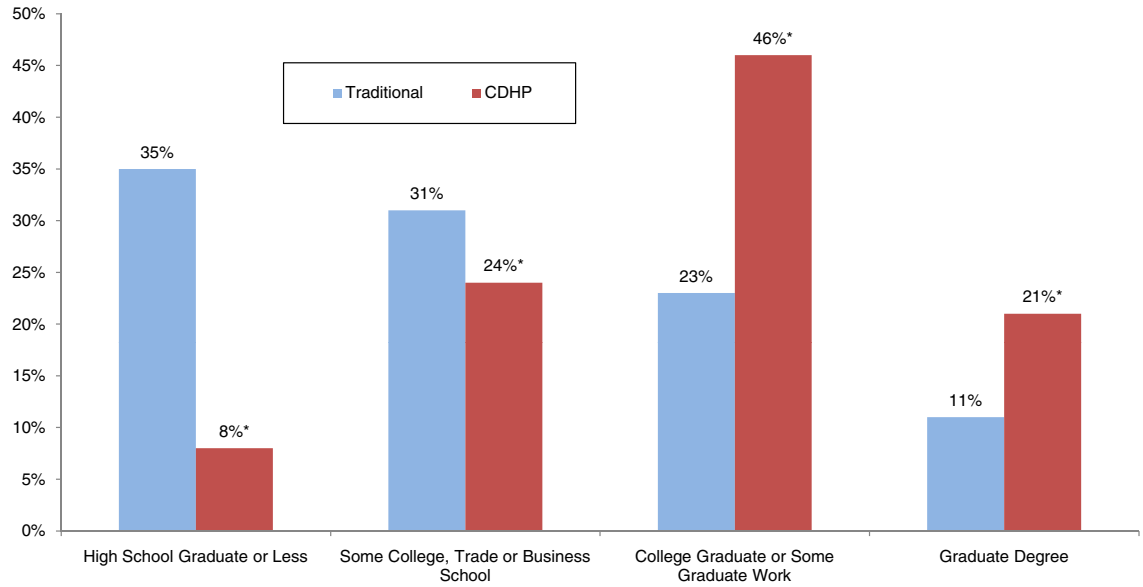
Distribution of Traditional Plan Enrollees and CDHP[a] Enrollees, by Household Income, Adults Ages 21–64, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Consumer-driven health plan.
* Difference between traditional and CDHP is statistically significant at p ≤ 0.05 or better.

Figure 6

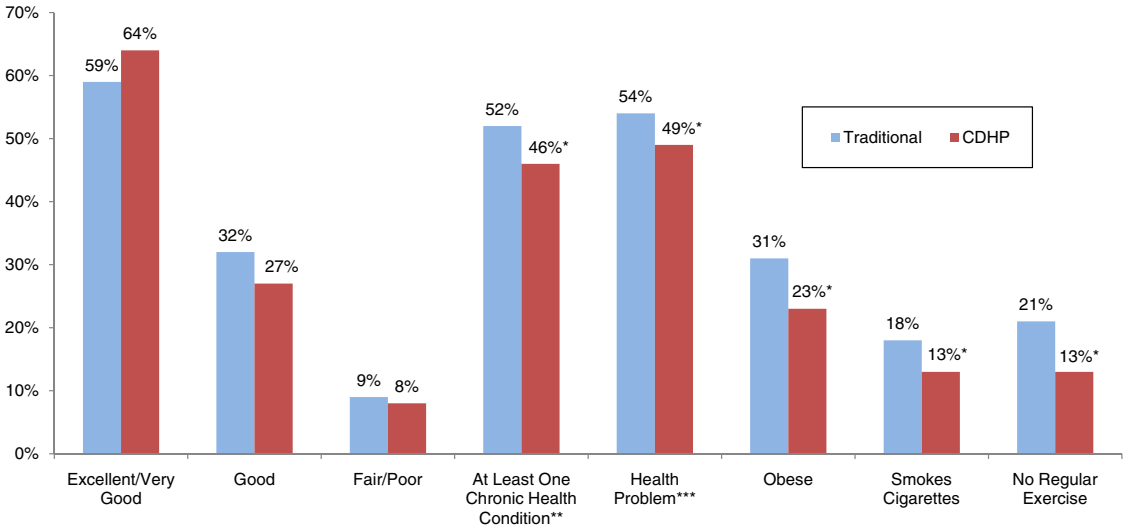
Distribution of Traditional Plan Enrollees and CDHP[a] Enrollees, by Education, Adults Ages 21–64, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Consumer-driven health plan.
* Difference between traditional and CDHP is statistically significant at p ≤ 0.05 or better.

Figure 7

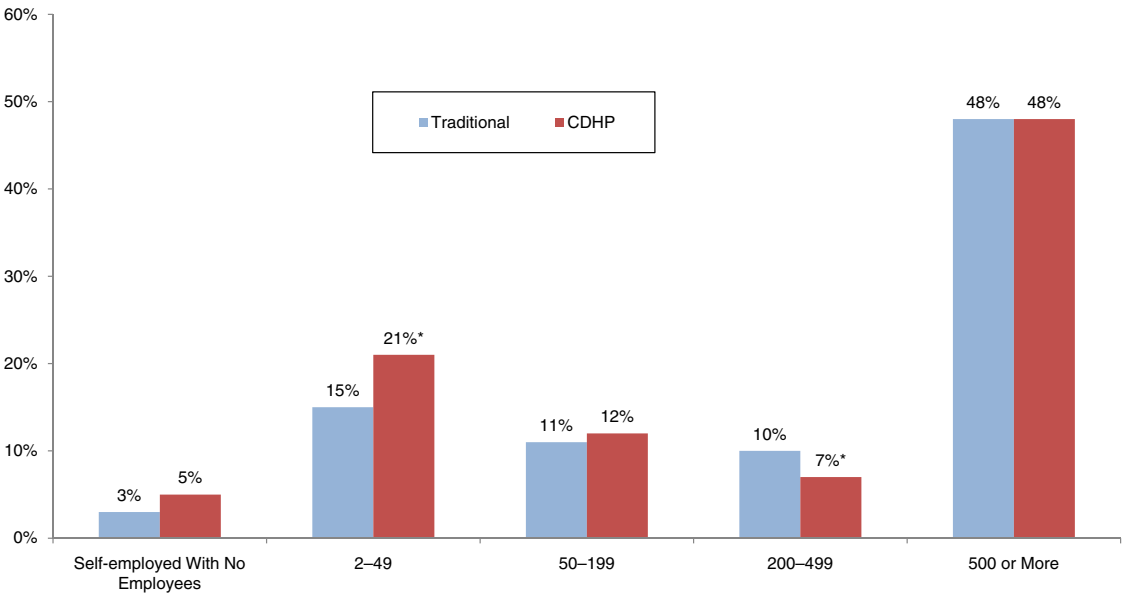
Distribution of Traditional Plan Enrollees and CDHP[a] Enrollees, by Self-Rated Health Status and Health Behavior, Adults Ages 21–64, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Consumer-driven health plan.
* Difference between traditional and CDHP is statistically significant at p ≤ 0.05 or better.
** Arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure or stroke.
*** Health problem defined as fair or poor health or one of eight chronic health conditions.

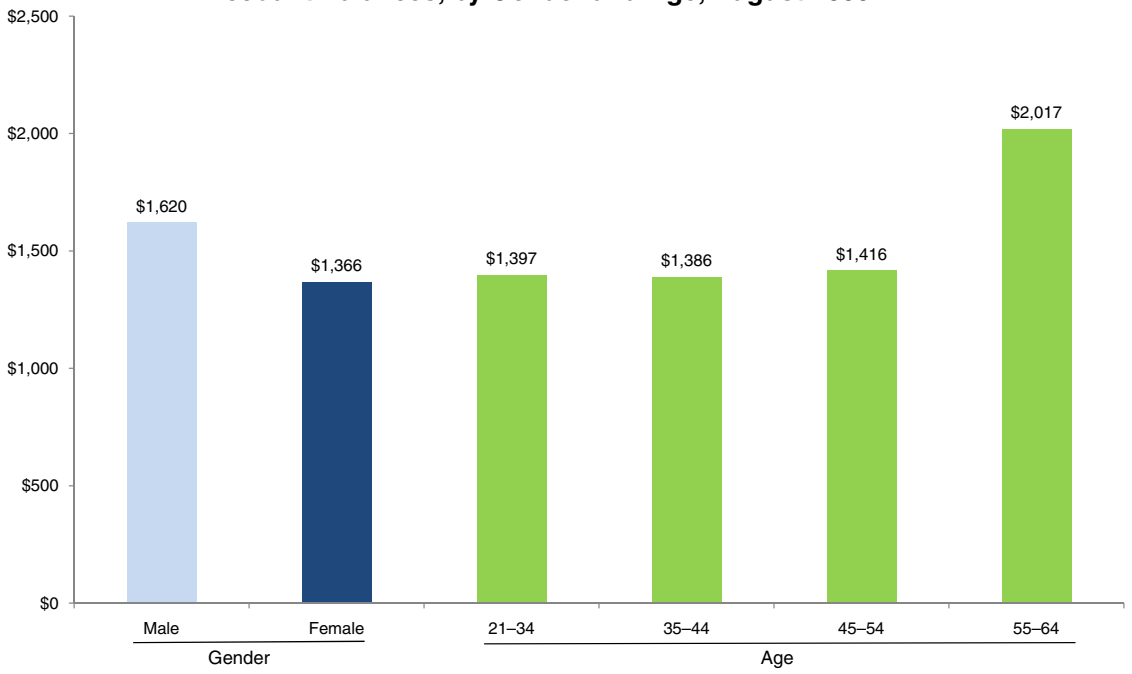
Figure 8

Distribution of Traditional Plan Enrollees and CDHP[a] Enrollees, by Firm Size, Working Adults Ages 21–64, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
[a] Consumer-driven health plan.
* Difference between traditional and CDHP is statistically significant at p ≤ 0.05 or better.

Figure 9
Account Balances, by Gender and Age, August 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 10
Account Balances, by Gender and Age Combined, August 2009

Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Race

Minorities with HRAs or HSAs have higher account balances that whites with these accounts. On average, minorities have an account balance of $1,729, while whites have an account balance of $1,444 (Figure 11).

Household Income

According to Figure 12, account balances for CDHPs increase with household income. The average account balance was $912 among individuals with less than $50,000 in household income; $1,452 among individuals with $50,000–$99,999, and $1,766 among individuals with $100,000 or more in household income. 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. Individuals with a high school degree or less have an average of $1,279 in their account, while those with a college degree have $1,587, and those with a graduate degree have $1,778 (Figure 13). It is possible that more highly educated individuals understand the value of saving money in the account and are therefore less likely to take distributions from the account.

Type of Coverage

In analyzing account balances for persons with individual coverage and those 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 make more use of health care services and therefore have higher costs. This makes it difficult to determine whether families will have higher or lower account balances than individuals. It was found that individuals with family coverage had $1,526 in their account in August 2009, while those with individual coverage had $1,444 (Figure 14); however, the difference was not statistically significant.

Health Behaviors and Health Status

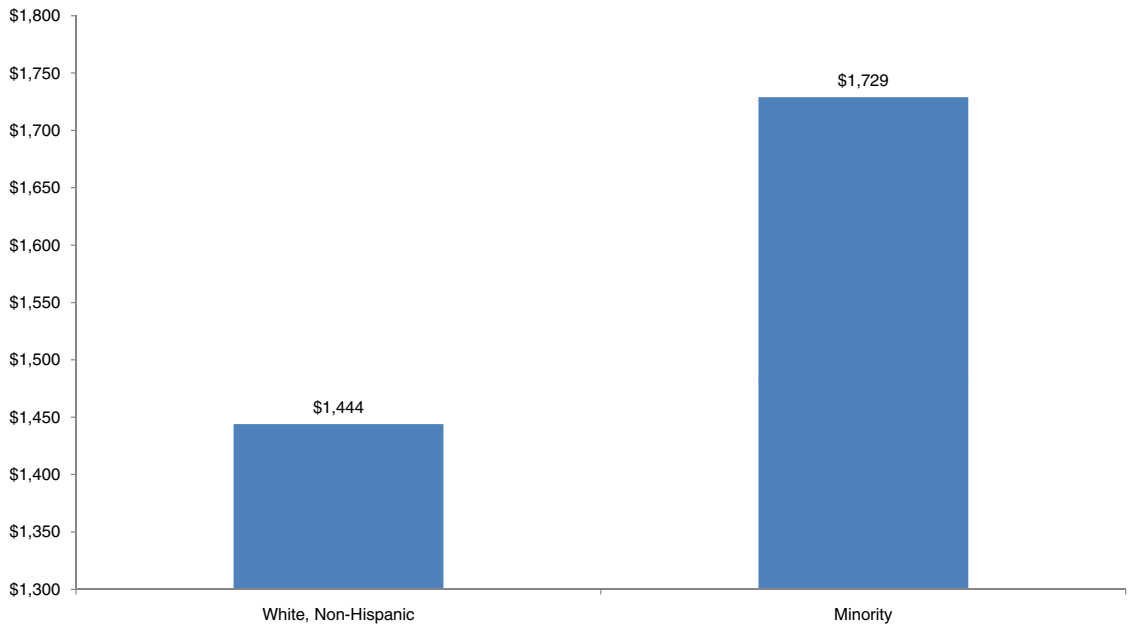
Individuals who smoke have more money in their accounts than individuals who do not, but the difference is not statistically significant (Figure 15). Similarly, obese individuals have less money in their account than nonobese individuals, but the difference is not statistically significant. There was a statistically significant difference in account balance by level of exercise: Individuals who exercise have an average of $1,647 in their account, while those who do not have $1,246.

To measure health status, self-reported health status was combined with whether an individual had one of eight chronic conditions. It was found that there was no statistically significant difference in account balances by health status.

Use of Health Information and Programs

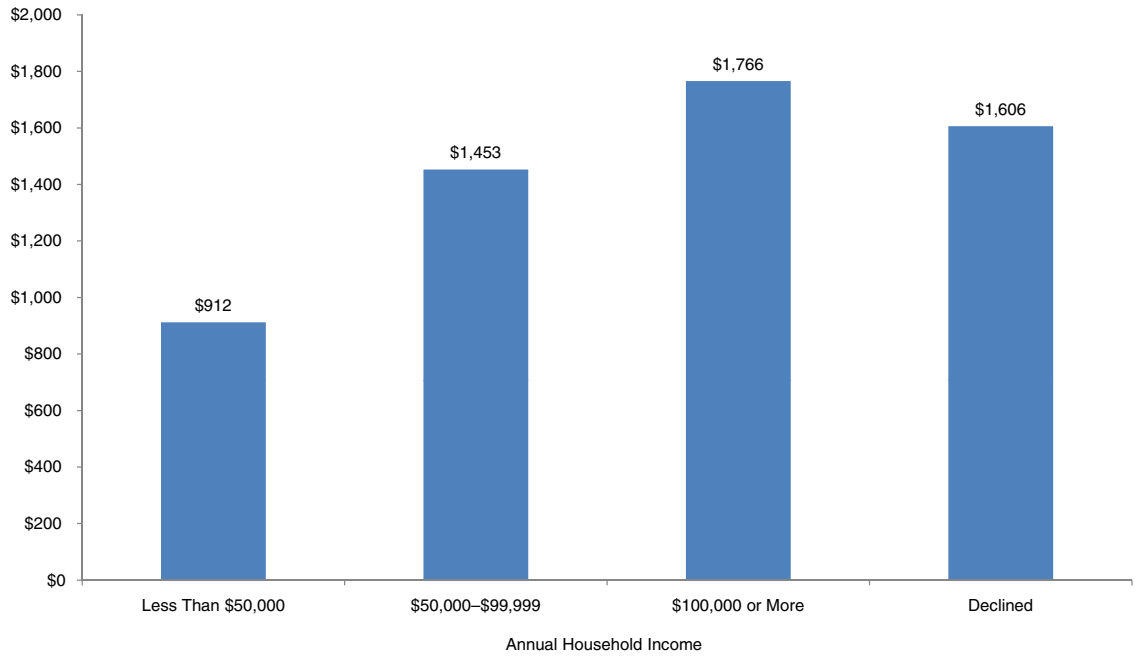
Account balances were examined by two variables to measure an individual's engagement in his or her health care: (1) whether an individual used cost and quality information to choose a doctor, and (2) whether he or she participated in a wellness program, such as one designed to directly improve health, like a weight loss, nutrition, stress management, or smoking cessation program, or a health risk assessment-type program that requires participants to fill out a questionnaire and then in consultation with a medical professional examine their health history to identify any conditions they may have or might be at risk of developing, in order to develop a program for early intervention. In both cases, it was found that individuals who participated in a wellness program had a higher average account balance

Figure 11
Account Balances, by Race, August 2009



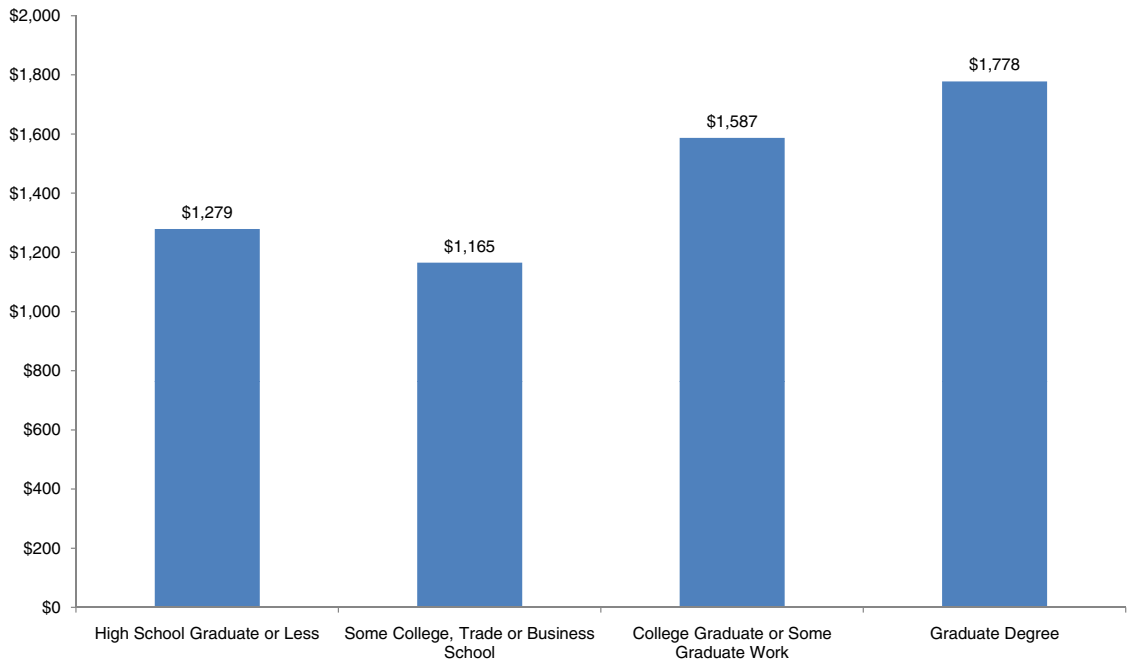
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 12
Account Balances, by Annual Household Income, August 2009



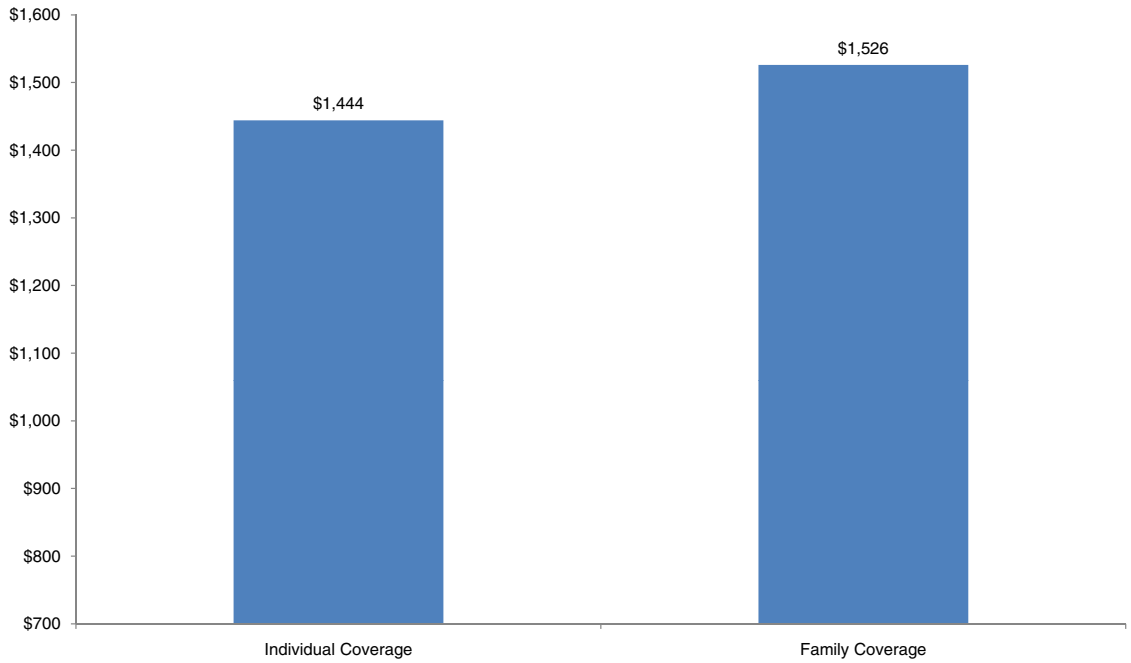
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 13
Account Balances, by Education, August 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 14
Account Balances, by Plan Type, August 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

than those who did not participate in such a program. The average account balance was $1,614 among those who used cost and quality information to choose a doctor, and $1,413 among those who did not do so (Figure 16). The account balances were similar by wellness program participation, with no statistically significant difference.

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. The expectation was that those 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:

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

Other than in questions 1, 3, and 7, there were no statistically significant differences in average account balances between individuals who exhibited the cost-conscious decision-making behaviors and those who did not. With respect to whether individuals checked their health plan to see if the plan would cover their care or medication and whether they checked the quality rating of a doctor or hospital before receiving care from them, it was found that those exhibiting such behavior had *lower* average account balances than those who did not exhibit such behavior. Also, individuals who developed a budget to manage their health care expenses had a higher account balance ($1,726) than those who did not develop such a budget ($1,428) (Figure 17). This was the only statistically significant difference that was identified where individuals exhibiting the cost-conscious behavior had a higher account balance than those not exhibiting such behavior.

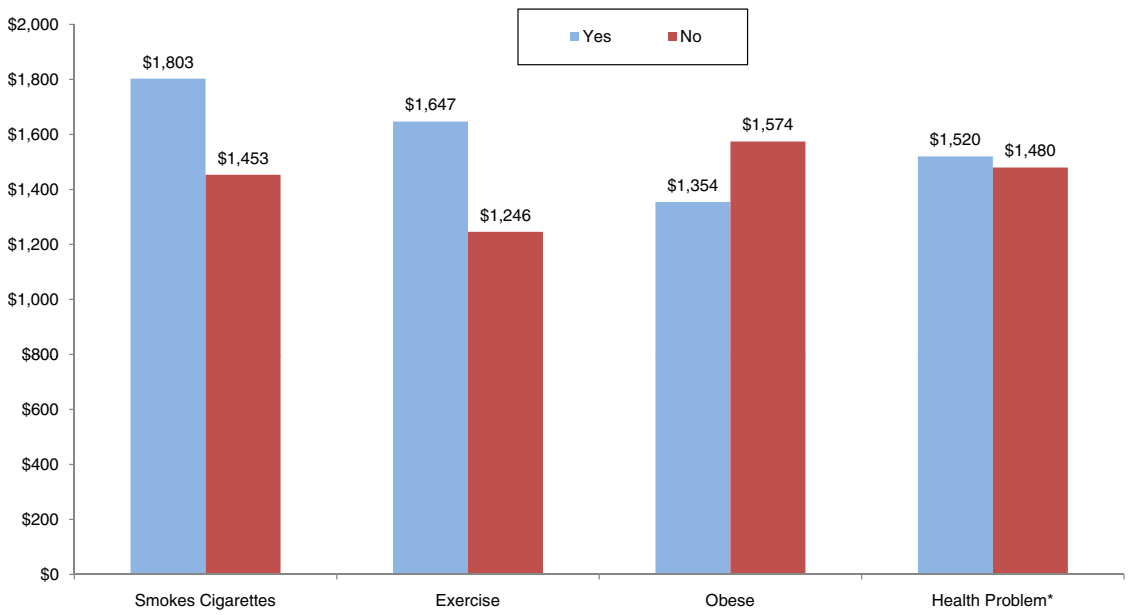
Length of Time With Account

Not surprisingly, the length of time that an individual has had the account has a major impact on the amount of money in the account. The analysis found that persons with an account for less than six months had an average of $842 in their account and those with the account at least six months but less than a year had $875 (Figure 18). In comparison, individuals with an account for one–two years had an average of $1,356. Those with an account three–four years had an average of $2,208. And those with the account at least five years had an average account balance of $2,563.

Employer and Individual Contributions

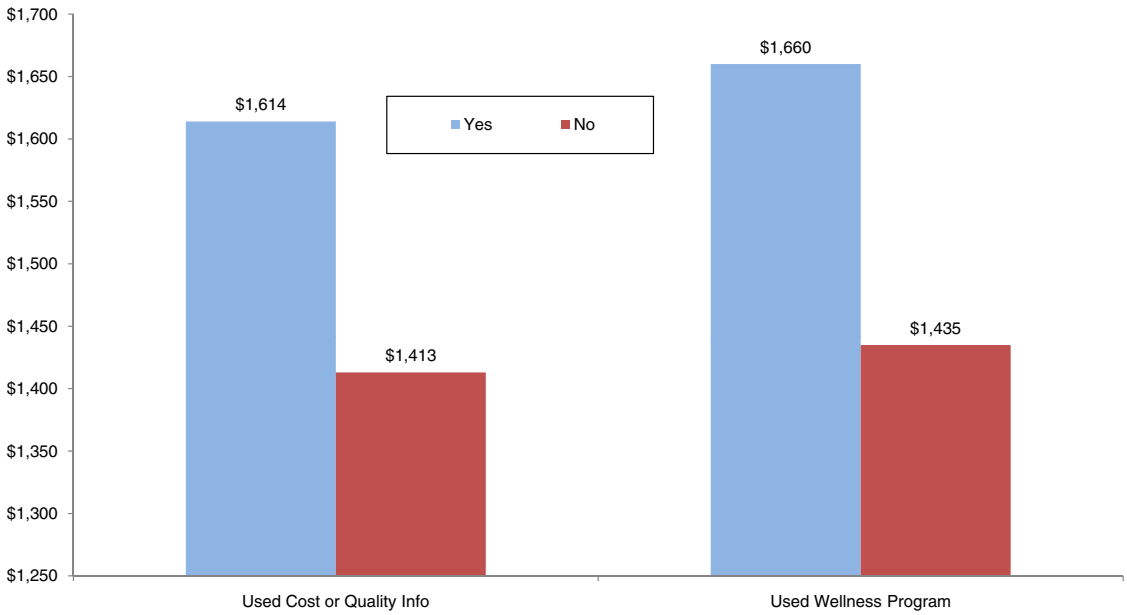
Annual contribution amounts, whether they come from the employer (in the case of both HRAs and HSAs), or from individuals (as they apply to HSAs only) have a strong impact on overall account balances. Not surprisingly, the more money that is contributed to the account, the higher the average account balance. For instance, individuals with an

Figure 15
Account Balances, by Health Behavior and Health Status, August 2009



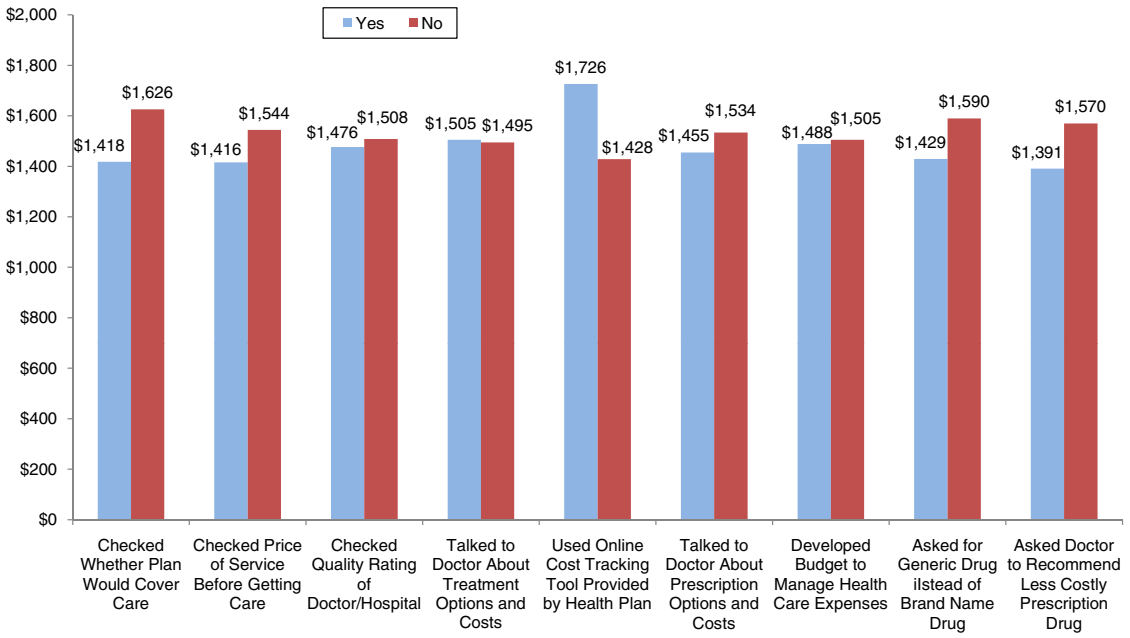
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
* Health problem defined as fair or poor health or one of eight chronic health condition: arthritis; asthma, emphysema, or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure, or stroke.

Figure 16
Account Balances, by Use of Cost and Quality Information and Use of Wellness Program, August 2009



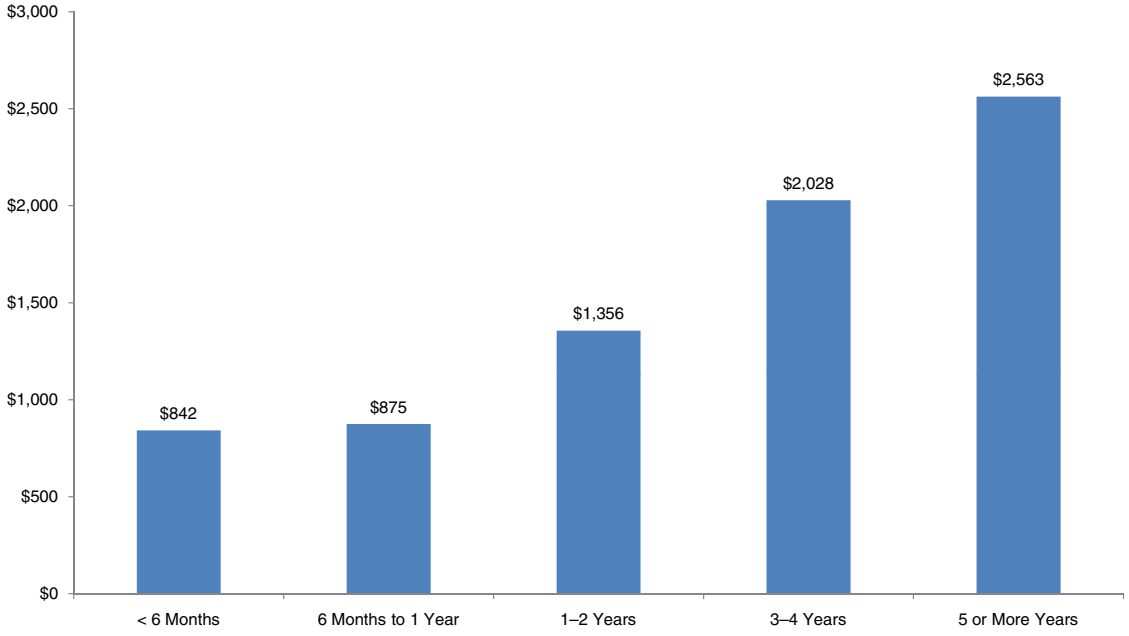
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 17
Account Balances, by Various Cost-Conscious Behaviors, August 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 18
Account Balances, by Length of Time With Account, August 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

employer contribution of less than $1,000 had an average account balance of $1,403, while those with an employer contribution of at least $1,000 had an average of $1,717 in their account (Figure 19). Similarly, individuals who contributed less than $1,000 had an average account balance of $1,100, while those who contributed at least $1,000 had an average balance of $1,890 (Figure 20).

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. 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 at the high end of the employer and individual contribution distribution.

Rollovers

Like contribution levels, rollover amounts have one of the largest impacts on average account balances. Individuals with less than a $1,000 rollover had an average account balance of $939 in 2009 (Figure 21). In comparison, individuals with a rollover of at least $1,000 had an average account balance of $2,474 (see next section).

Rollovers

There is no use-it-or-lose-it rule associated with HSAs, as any money left in the account at the end of the year automatically rolls over and is available in the following year.[6] But with HRAs, employers have a tremendous amount of flexibility in plan design: Leftover funds at the end of each year can be carried over to the following year or not, at the employer's discretion, and restrictions can be placed on the amount that can be carried over.

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 22). The number not rolling over any money fell to 15 percent in 2007, and was 16 percent in 2008. By 2009, 10 percent did not have a rollover. Some of the decrease in the percentage of individuals without a rollover between 2006 and 2007 may be due to the fact that the percentage of individuals who did not know whether they had a rollover or the amount decreased from 19 percent to 13 percent. In contrast, the decrease in the percentage of individuals without a rollover between 2008 and 2009 can be attributed to an increase in the percentage with a rollover of between $500 and $999, as well as an increase among those with a rollover of at least $2,000.

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 $302.9 million (Figure 23) in HSAs and HRAs. By 2009, 3.1 million individuals rolled over nearly $4 billion. The average rollover increased from $592 in 2006 to $1,295 (Figure 24).

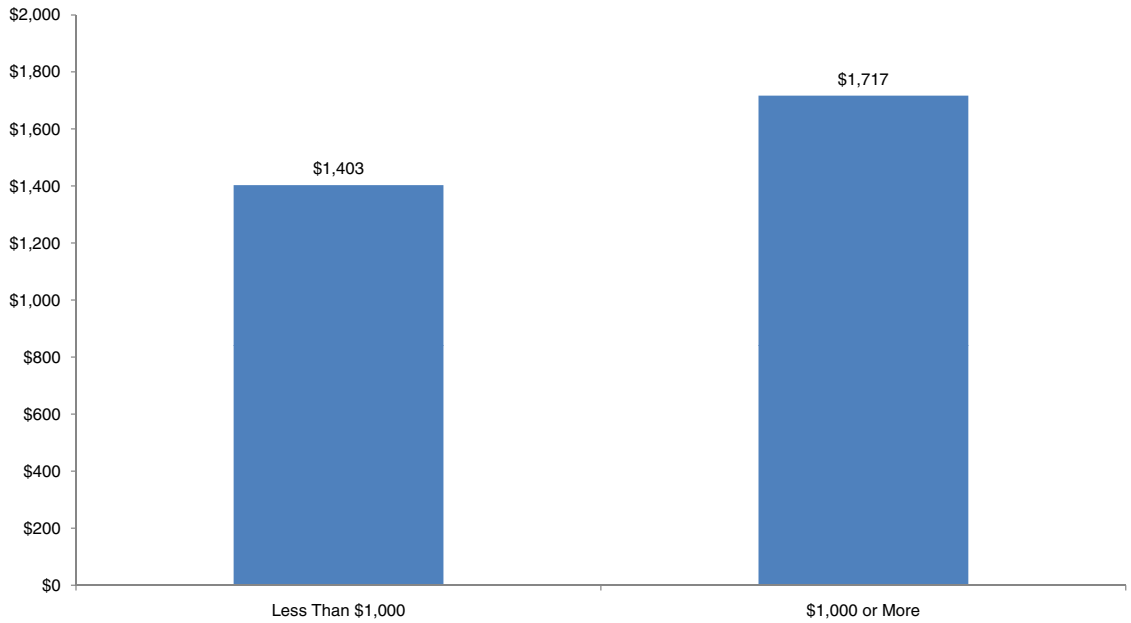
The remainder of this section examines variation in rollover amounts. The estimates in this section were also generated from a regression equation that also controlled for how long an individual has had an HRA or HSA, employer contributions to the account, individual contributions to the account.[7]

Gender and Age

Men rolled over more money than women. In 2009, men had an average rollover of $1,140 while women had $957 (Figure 25).

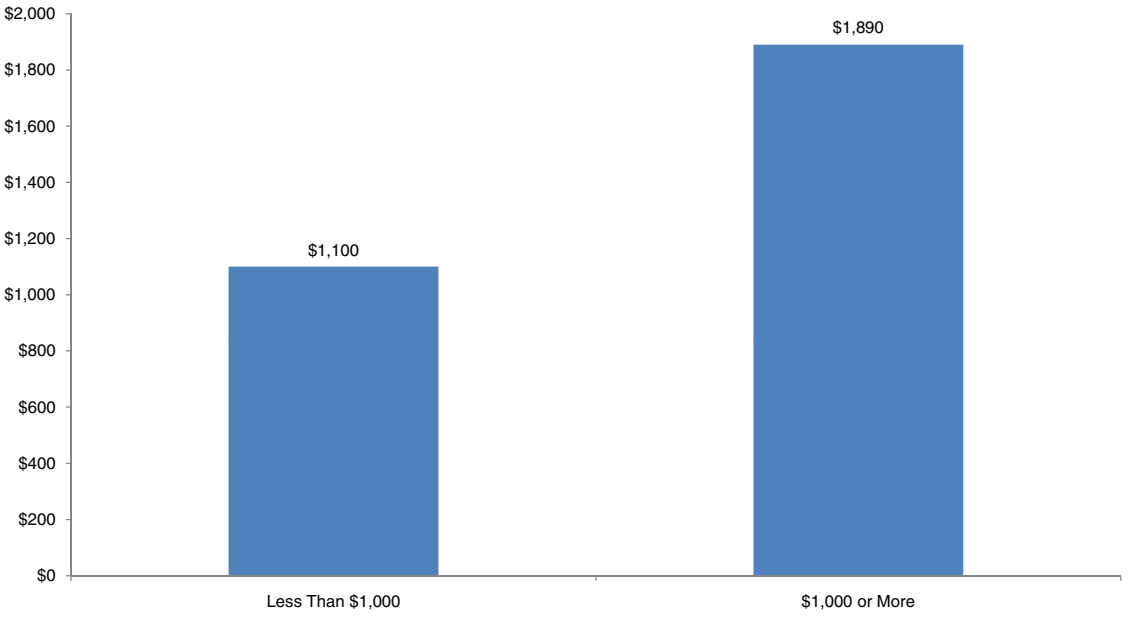
With respect to age, the youngest adults and the oldest adults had the largest rollover amounts in 2009. Individuals 55–64 had an average rollover of $1,288, compared with $1,163 for individuals 21–34, $933 for individuals 35–44, and $927 for individuals 45–54.

Figure 19
Account Balances, by Level of Annual Employer Contribution, August 2009



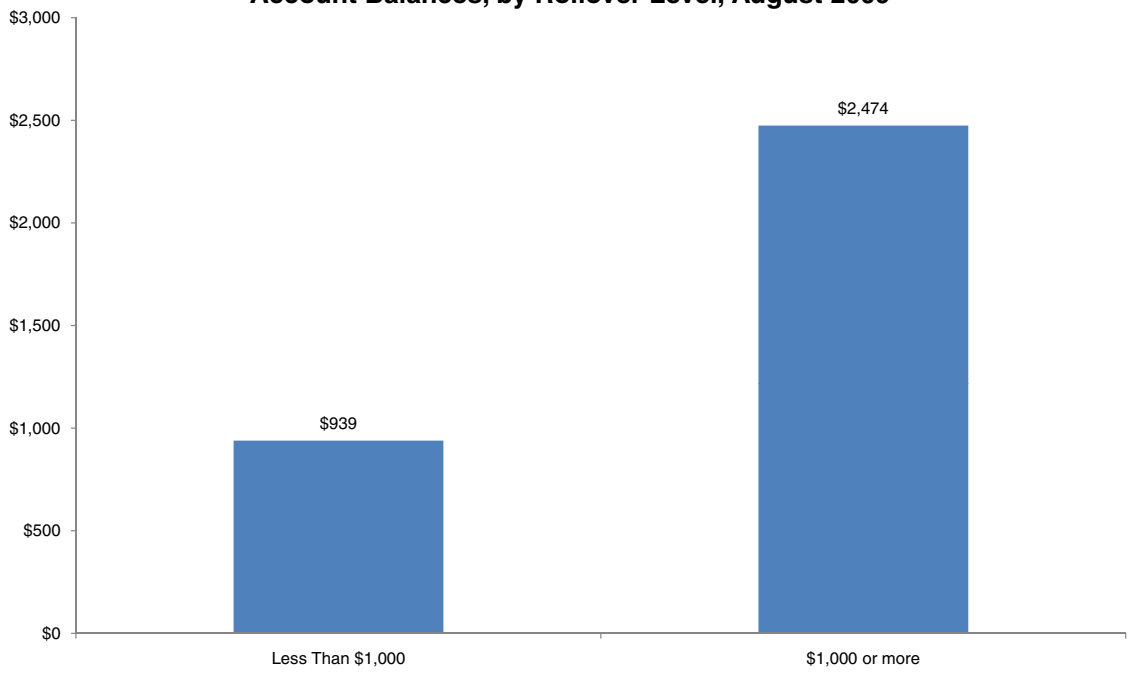
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 20
Account Balances, by Level of Annual Individual Contribution, August 2009



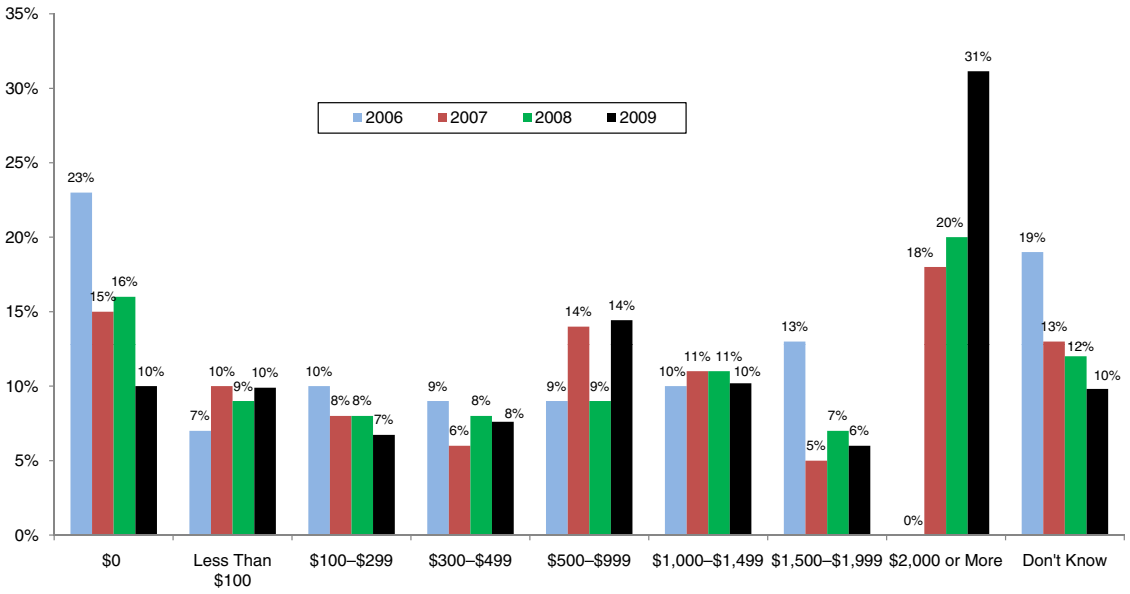
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 21
Account Balances, by Rollover Level, August 2009



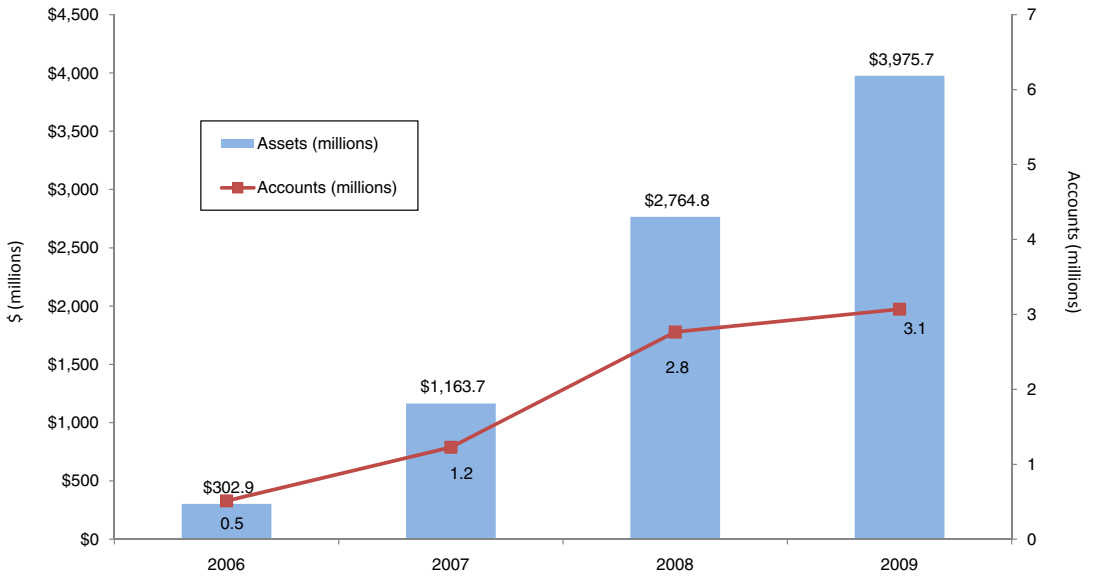
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 22
Rollover Amounts, Among Individuals With Account for More than One Year, 2006–2009



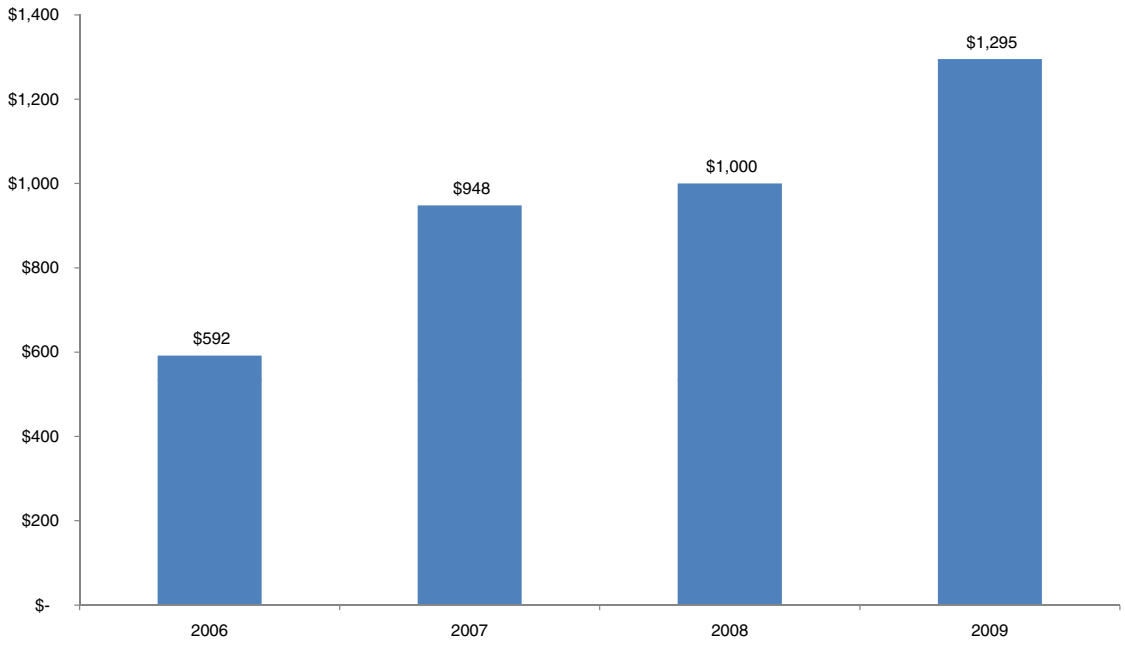
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.
Note: 2006 data were capped at $1,500 or more.

Figure 23
Total Rollover Assets and Number of Adults Ages 21–64 With a Rollover, 2006–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

Figure 24
Average HSA or HRA Rollover Amount, 2006–2009



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2009.

When examining differences in rollovers for men and women by age, men ages 21−34 have higher average rollover amounts than women in this age group. The average rollover for men was $1,320, while for women it was $970 (Figure 26). A smaller difference between men and women can also be seen at older ages.

Race

In contrast to the findings that minorities with HRAs or HSAs have higher account balances than whites, it was found that whites had higher rollover amounts than minorities. On average, minorities had a $1,000 rollover in 2009, while whites had a $1,275 rollover (Figure 27).

Household Income

According to Figure 28, rollover amounts increase with household income. In 2009, the average account balance was $609 among individuals with less than $50,000 in household income; $1,026 among individuals with $50,000−$99,999, and $1,192 among individuals 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 have an average rollover of $879, while those with a college degree had an average rollover of $1,161, and those with a graduate degree had an average rollover of $1,139 (Figure 29).

Type of Coverage

While it was found that individuals with *family* coverage had higher account balances than those with *individual* coverage, the opposite was true with respect to rollover amounts. Individuals with single coverage had an average rollover of $1,142, whereas those with family coverage had a $1,011 average rollover (Figure 30). Furthermore, unlike the difference in contribution amounts, which were not statistically significant, differences in rollover amounts by type of coverage were statistically significant.

Health Behaviors and Health Status

Individuals who smoke had higher rollover amounts than nonsmokers, and the difference is statistically significant (Figure 31). Those who exercise had higher rollover amounts than those who did not, but the difference was not statistically significant. Obese individuals had lower average rollover amounts than nonobese individuals, a statistically significant difference. There was no statistically significant difference in account balances by health status.

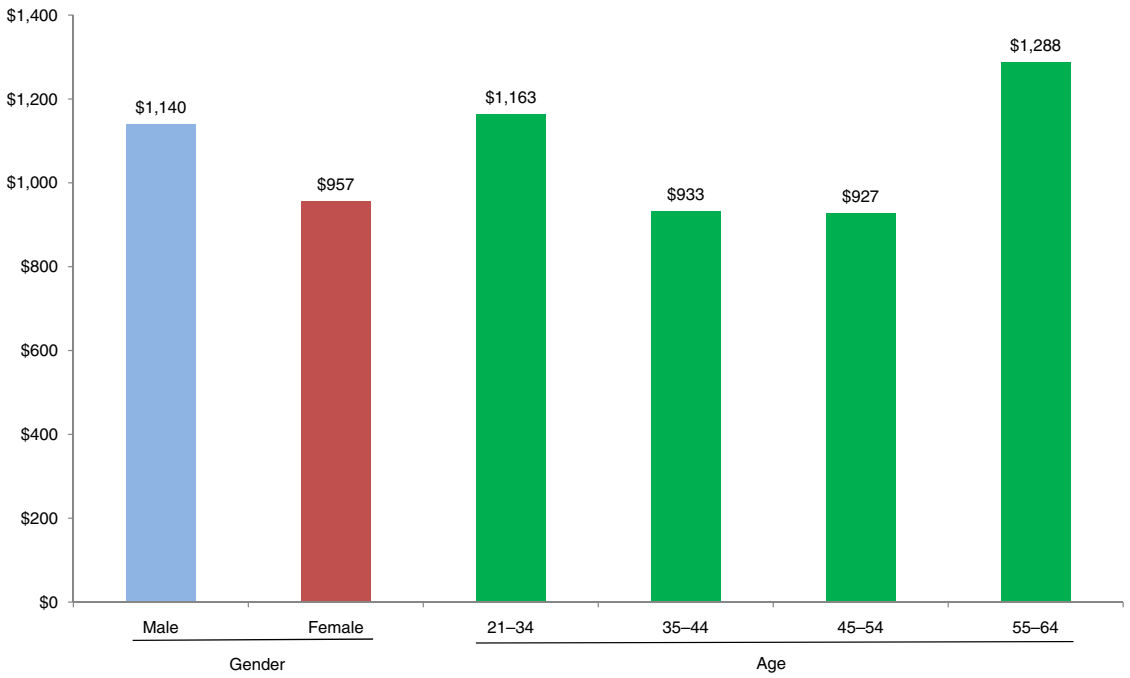
Use of Health Information and Programs

Rollover amounts were also examined by whether individuals used cost and quality information to choose a doctor and whether they participated in a wellness program. It was found that individuals who used cost and quality information to choose a doctor had a higher rollover amount than those who did not participate in such a program. The average rollover was $1,199 among those who used cost and quality information to choose a doctor, and $944 among those who did not use cost and quality information (Figure 32). The difference in rollover amounts was statistically significant. There was no statistically significant difference by participation in a wellness program.

Cost-Conscious Behaviors

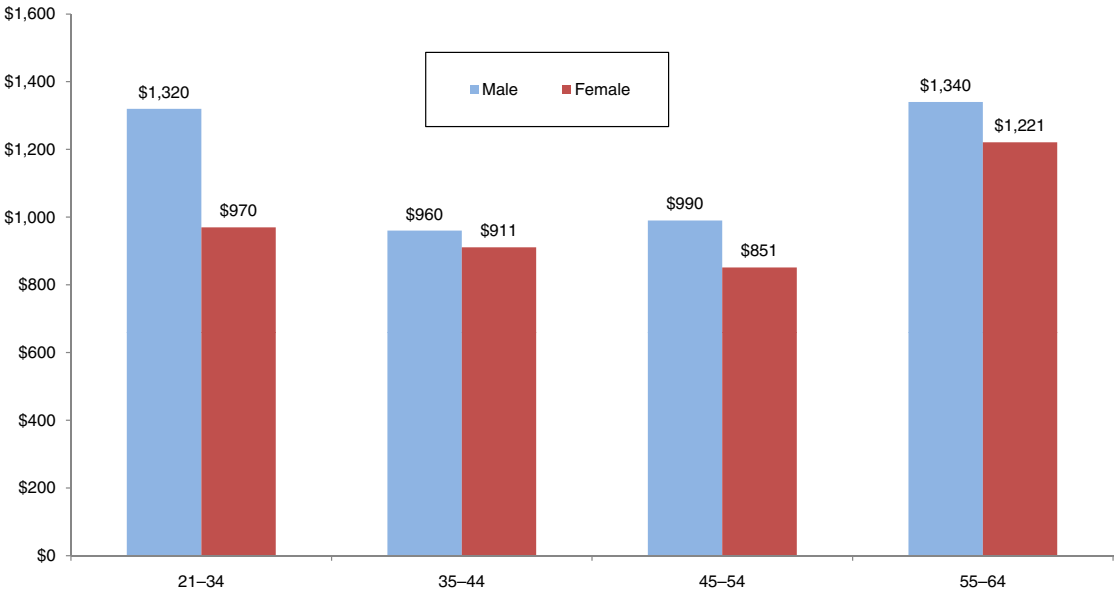
A number of cost-conscious behaviors were examined to see if individuals who exhibit more cost-conscious decision making had higher rollover amounts than those who did not exhibit such a decision-making process. The expectation was that those who exhibited cost-conscious behavior would have a higher rollover amounts than those who did not. The questions regarding cost-conscious decision making were described above.

Figure 25
Rollover Amount, by Gender and Age, 2009



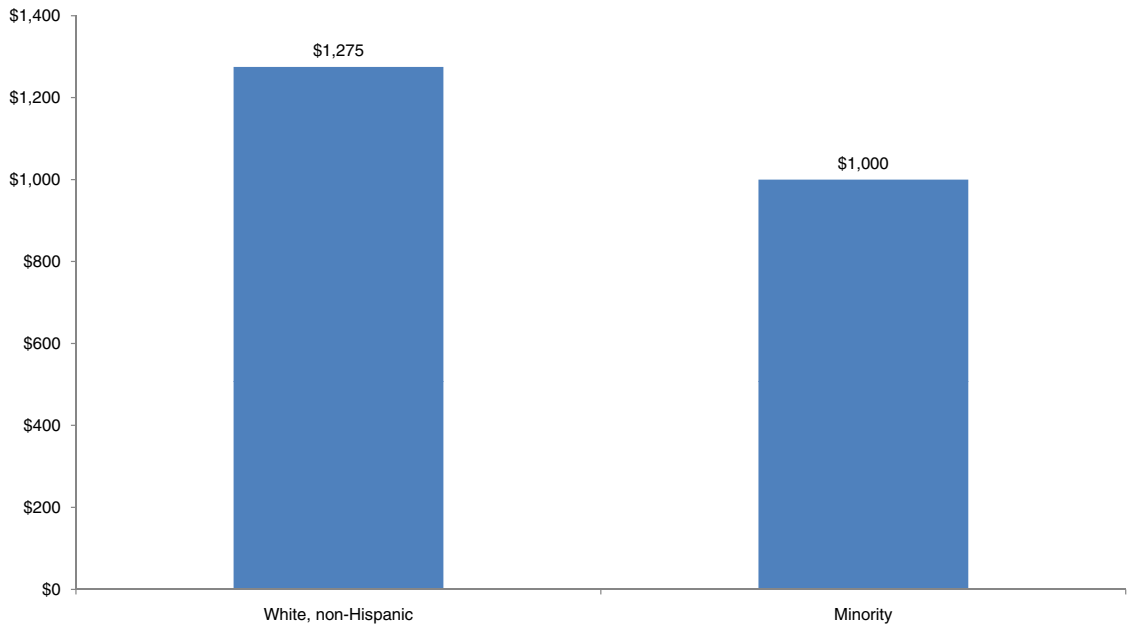
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 26
Rollover Amount, by Gender and Age Combined, 2009



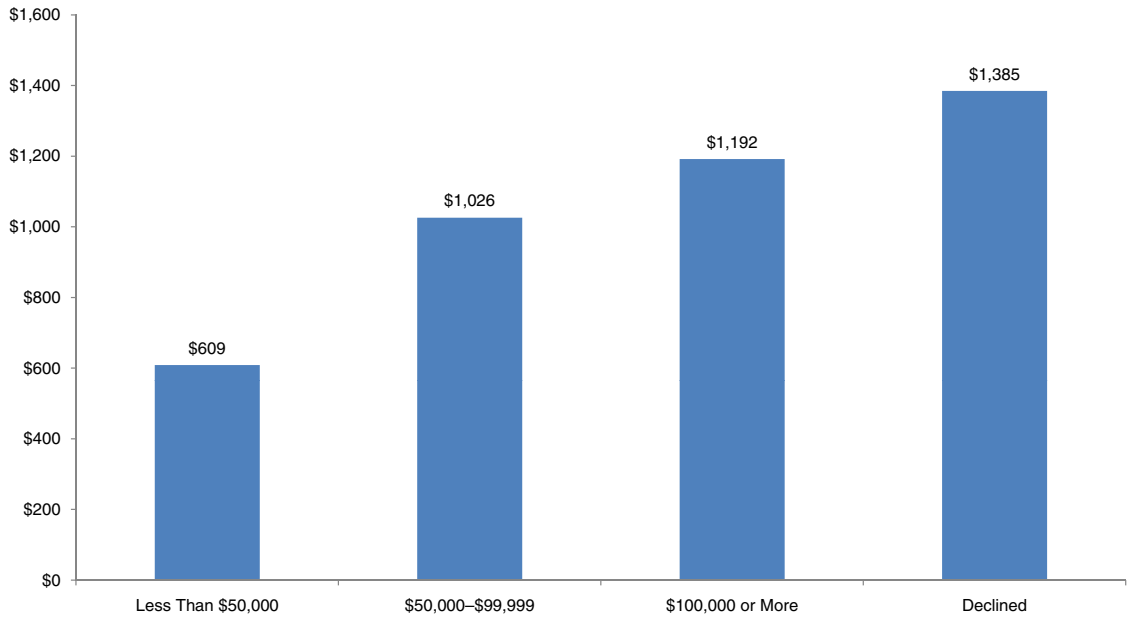
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 27
Rollover Amount, by Race, 2009



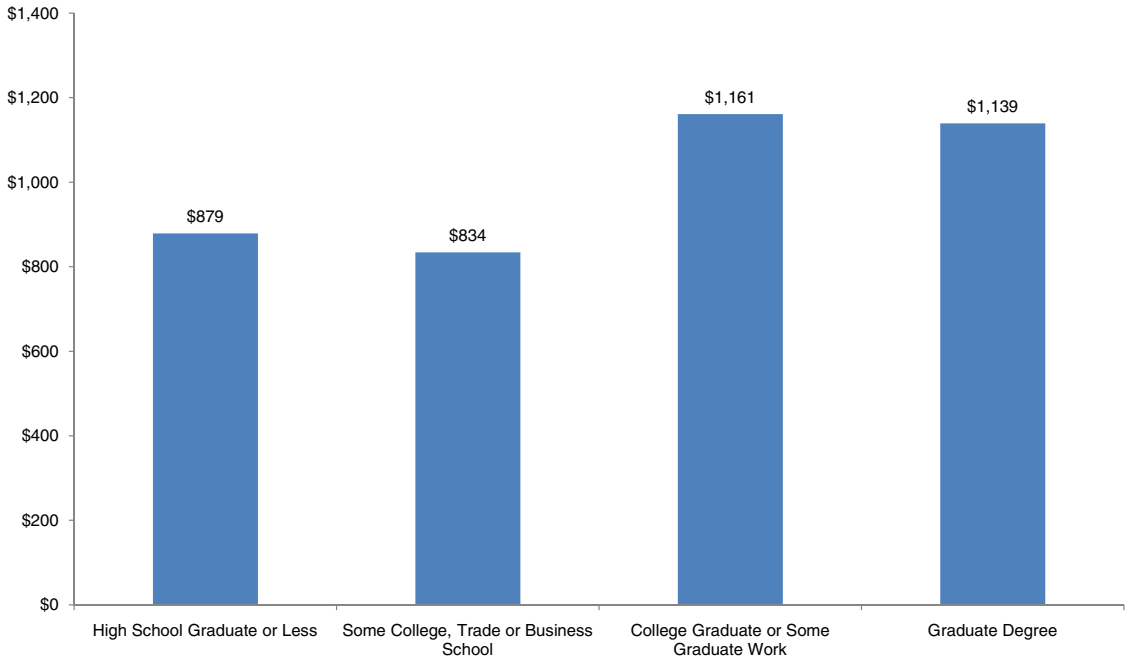
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 28
Rollover Amount, by Annual Household Income, 2009



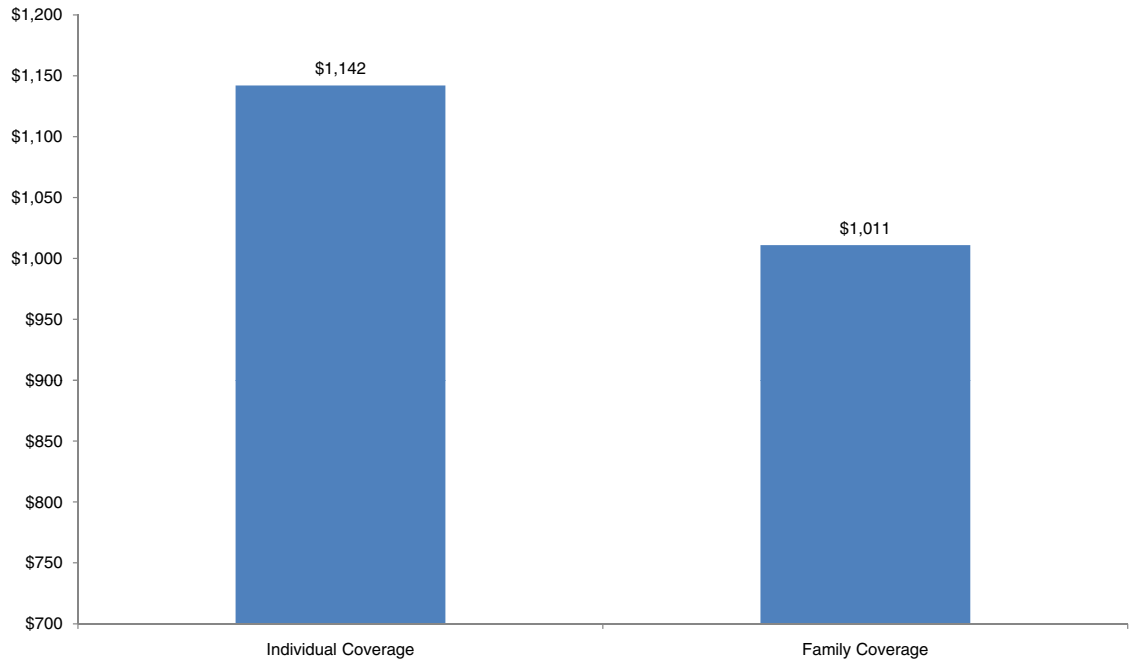
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 29
Rollover Amount, by Education, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 30
Rollover Amount, by Plan Type, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

It was found that individuals who talked to their doctor about treatment options and costs, those who used an online cost-tracking tool provided by the health plan, and those who asked their doctor to recommend a less costly prescription drug had higher rollover amounts than those who did not take such actions. In the series of questions, these were the only ones where the difference was found to be statistically significant (Figure 33).

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 with an account for one–two years had an average rollover of $830 (Figure 34). In comparison, individuals with an account for three–four years had an average rollover of $1,378. And those with the account at least five years had an average rollover of $1,774.

Employer and Individual Contributions

Annual contribution amounts from individuals have a strong impact on overall rollover amounts, whereas employer contributions do not. Individuals with an employer contribution of less than $1,000 had an average rollover of $993, while those with an employer contribution of at least $1,000 had an average rollover of $1,188, but the difference was not statistically significant (Figure 35). In contrast, individuals who contributed less than $1,000 had an average rollover of $750, while those who contributed at least $1,000 had an average rollover of $1,350, a difference that is statistically significant (Figure 36).

Conclusion

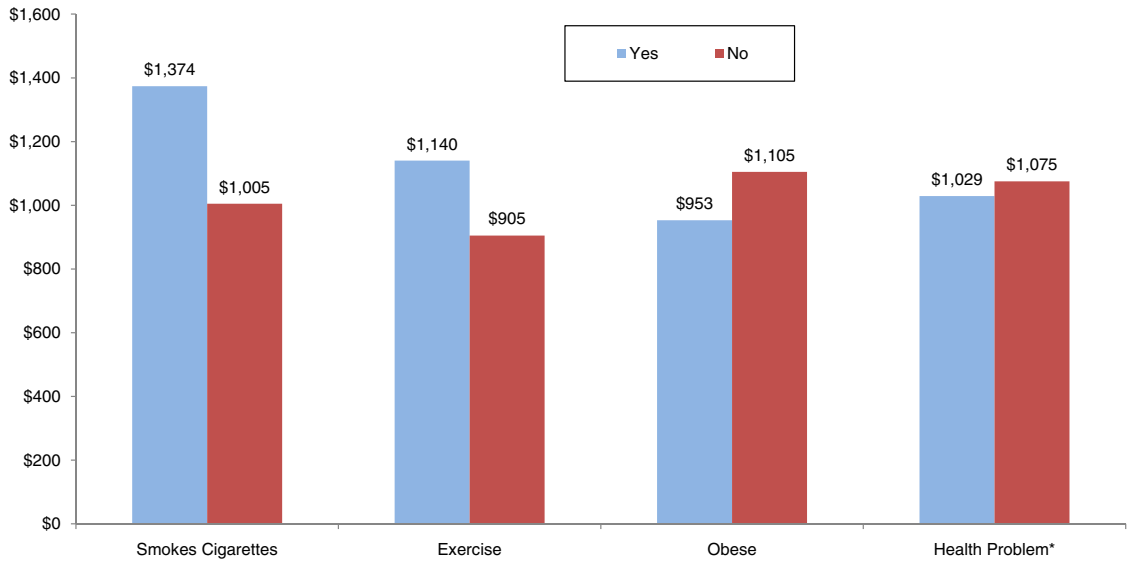
Employers first started offering HRAs in 2001, and they were able to start offering health plans with HSAs in 2004. By 2009, 15 percent of employers with 10–499 workers and 20 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan.[8] As a result, these plans covered 15–19 million people in 2009, representing 9–11 percent of the privately insured market (Fronstin, 2009b).

According to findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey, there was $7.1 billion in HSAs and HRAs in 2009, spread across five million accounts. In 2006, there were 1.2 million accounts with $835.4 million in assets, and by 2008, 4.2 million accounts held $5.7 billion in assets. While total assets in the accounts have increased each year, increases in average account balances appear to have leveled off. In 2006, account balances averaged $696. This increased to $1,320 in 2007, and then averaged $1,356 in 2008 and $1,419 in 2009.

The number of people with a rollover as well as the total level of assets being rolled over has been increasing. In 2006, 23 percent of individuals with an HRA or HSA did not roll over any money. By 2009, 10 percent did not have a rollover. In 2006, 500,000 individuals rolled over $302.9 million. Furthermore, by 2009, 3.1 million individuals rolled over nearly $4 billion. The average rollover increased from $592 in 2006 to $1,295 in 2009.

It is expected 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 care services. However, limited evidence was found to support this. Individuals who developed a budget to manage their health care expenses had a higher account balance than those who did not develop such a budget. Otherwise, there were no statistically significant differences in average account balances between individuals who exhibited various aspects of cost-conscious decision-making behaviors and those who did not exhibit such behavior. However, it was found that individuals who talked to their doctor about treatment options and costs, those who used an online cost-tracking tool provided by the health plan, and those who asked their doctor to recommend a less costly prescription drug had higher rollover amounts than those who did not take such actions. Future research should examine differences between individuals in HSAs and HRAs, and should also examine the impact that account balances have on use of health care services as individuals continue to accumulate funds in their accounts.

Figure 31
Rollover Amount, by Health Behavior and Health Status, 2009

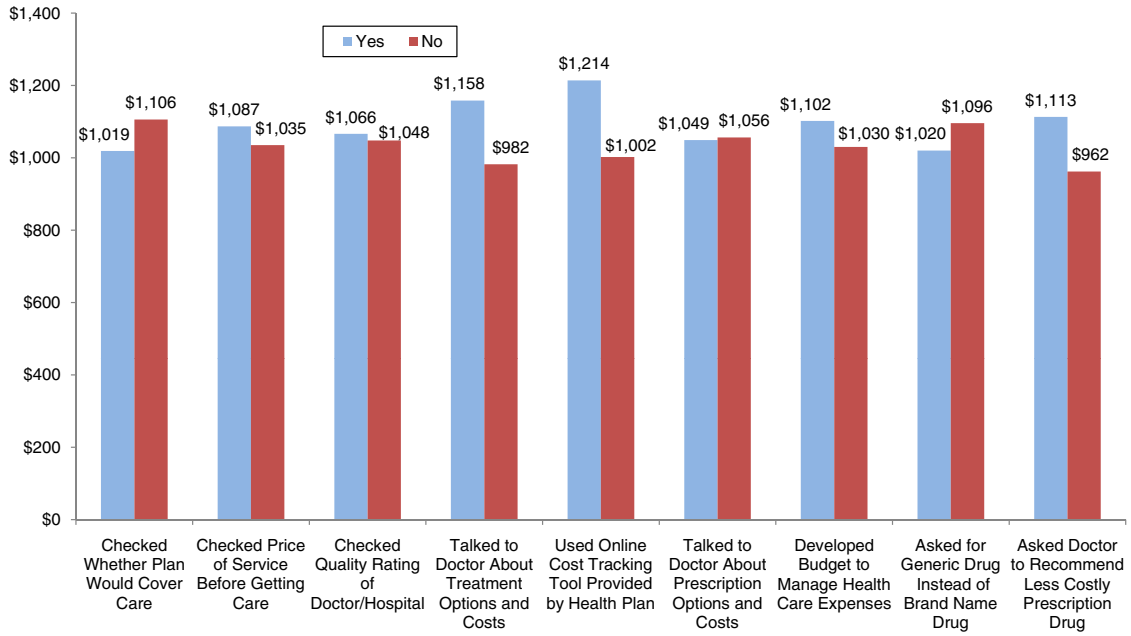


Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.
* Health problem defined as fair or poor health or one of eight chronic health condition: arthritis; asthma, emphysema, or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure, or stroke.

Figure 32
Rollover Amount, by Use of Cost and Quality Information and Use of Wellness Program, 2009

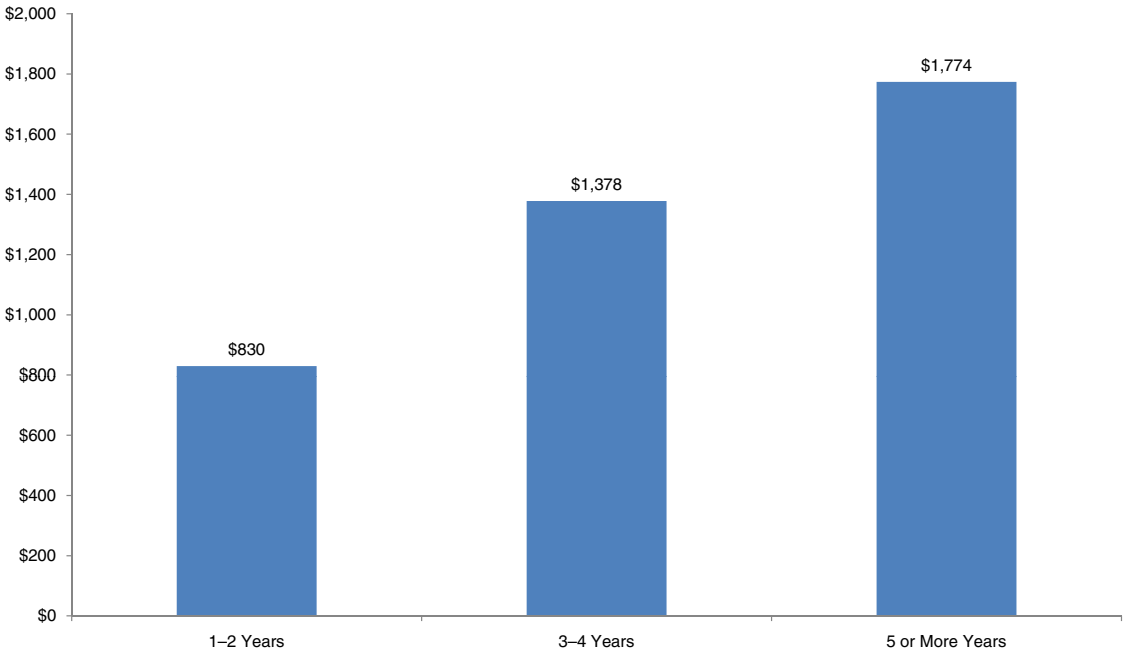
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 33
Rollover Amount, by Various Cost-Conscious Behaviors, 2009



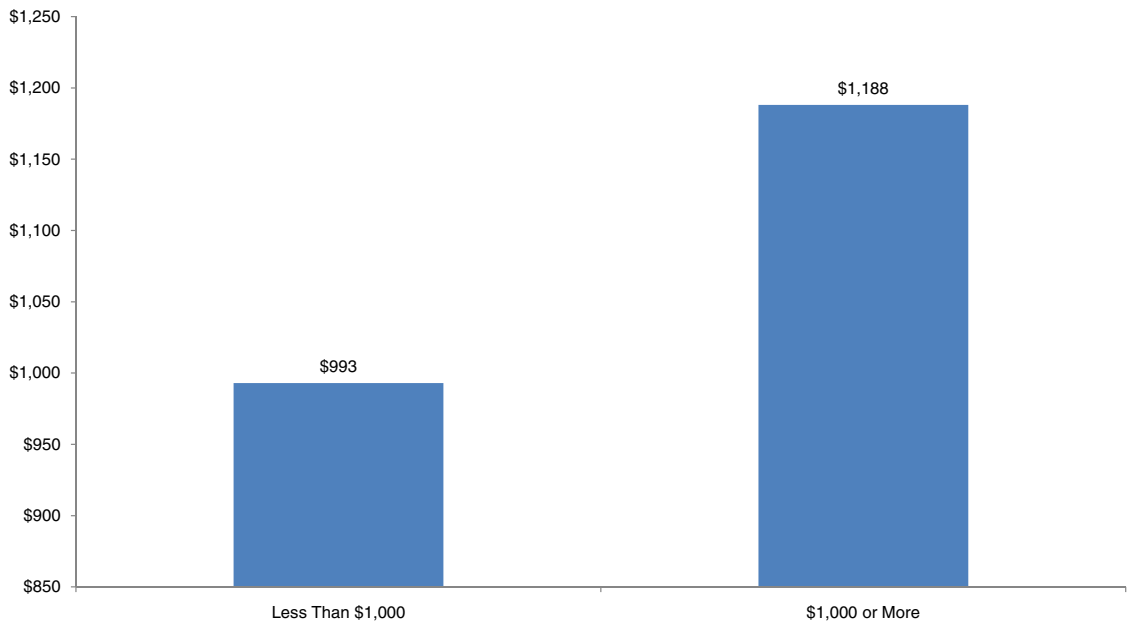
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 34
Rollover Amount, by Length of Time With Account, 2009



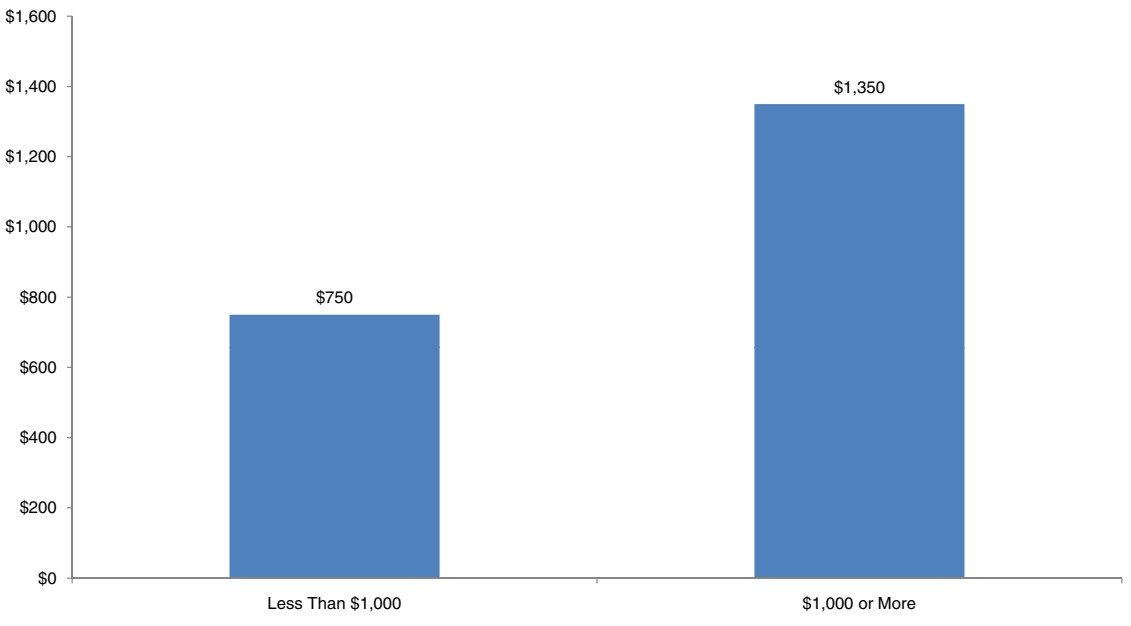
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 35
Rollover Amount, by Level of Annual Employer Contribution, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

Figure 36
Rollover Amount, by Level of Annual Individual Contribution, 2009



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2009.

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Endnotes

[1] See www.mercer.com/summary.htm?idContent=1364345

[2] In theory, a random sample of 2,007 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.

[3] The term *assets* is used loosely as they relate 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, but employers do not incur expenses associated with the arrangement until an employee incurs a claim.

[4] The conditions are arthritis; asthma, emphysema, or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure or stroke.

[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 medical savings accounts (MSAs) are also permitted.

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

[8] See www.mercer.com/summary.htm?idContent=1364345

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