

Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2010

By Paul Fronstin, Employee Benefit Research Institute

EXECUTIVE SUMMARY

ASSET LEVELS GROWING: In 2010, there was \$7.7 billion in health savings accounts (HSAs) and health reimbursement arrangements (HRAs), spread across 5.7 million accounts. This is up from 2006, when there were 1.2 million accounts with \$835.4 million in assets, and 2009, when 5 million accounts held \$7.1 billion in assets.

AFTER LEVELING OFF, AVERAGE ACCOUNT BALANCE DROPS SLIGHTLY: Increases in average account balances leveled off in 2008 and 2009, and fell slightly in 2010. 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.

AVERAGE ROLLOVER DECLINES, WHILE TOTAL ROLLOVERS INCREASE: Despite a decline in the average rollover amount in 2010, total assets being rolled over have been increasing. \$4.2 billion was rolled over in 2010, up from \$4 billion in 2009. The average rollover increased from \$592 in 2006 to \$1,295 in 2009, and fell to \$1,029 in 2010. The percentage of individuals without a rollover decreased from 23 percent in 2006 to 10 percent in 2009 and increased slightly to 13 percent in 2010.

HEALTHY BEHAVIOR MEANS HIGHER ACCOUNT BALANCES AND HIGHER ROLLOVERS: Individuals who exercised, those who did not smoke, and those who were not obese had higher account balances and higher rollovers than those with less healthy behaviors. It was also found that individuals who used cost or quality information had higher account balances and higher rollovers compared with those who did not use such information. However, no relationship was found between either account balance or rollover amounts and various cost-conscious behaviors such as checking pricing before getting services or asking for generic drugs instead of brand names, among other things.

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 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 authors, 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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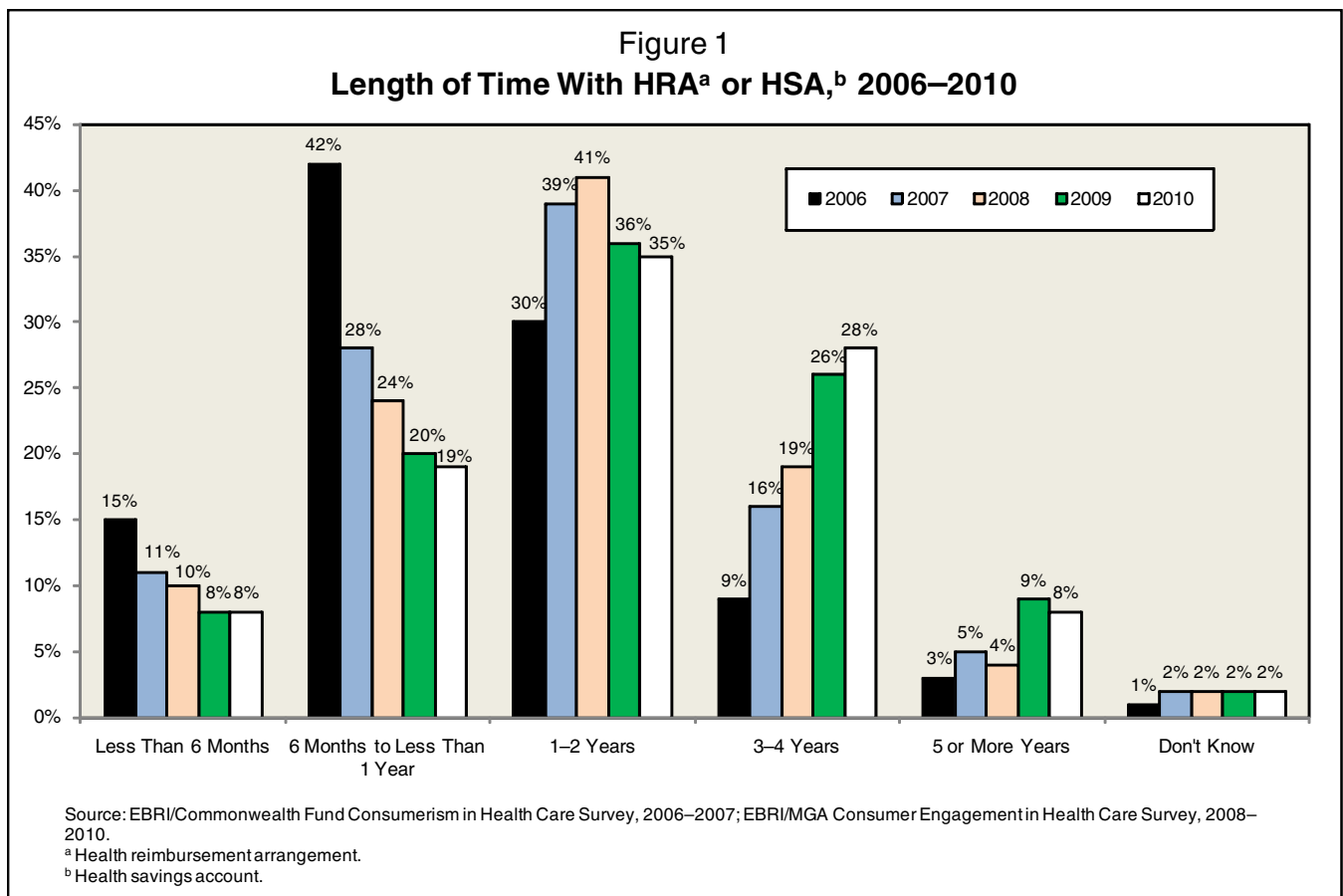
Introduction

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 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.¹ As a result, these plans covered about 21 million people in 2010, representing about 12 percent of the privately insured market (Fronstin 2010b). 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 held them for a number of years. In 2006, 15 percent of the population with an HRA or HSA had held an account for less than six months, 42 percent for six months to a year, and 30 percent for one to two years (Figure 1). By 2010, 8 percent had held them for less than six months, 19 percent for six months to a year, and 35 percent for one to two years. And 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. It examines the types of individuals likely to have an HSA or HRA. 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.



About the 2010 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 2010 EBRI/MGA Consumer Engagement in Health Care Survey is comparable to findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys, and the 2008 and 2009 EBRI/MGA Consumer Engagement in Health Care Survey.

The 2010 survey was conducted within the United States between August 8 and August 20, 2010, 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. A summary of sample characteristics is presented in Fronstin (2010b).

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 2010b).

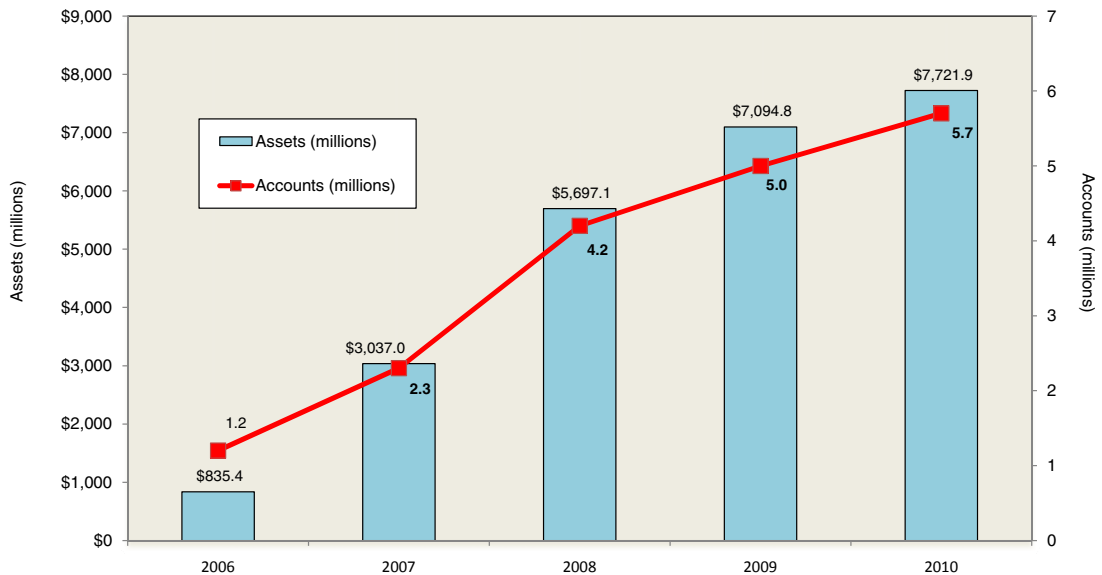
While panel Internet surveys are nonrandom, studies have demonstrated that such surveys, when carefully designed, obtain results comparable to random-digit-dial telephone surveys. Taylor (2003), for example, provides the results from a number of surveys that were conducted at the same time using the 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 2010 EBRI/MGA Consumer Engagement in Health Care Survey, there was \$7.7 billion in HSAs and HRAs in 2010, spread across 5.7 million accounts (Figure 2). In 2006, there were 1.2 million accounts with \$835.4 million in assets, and by 2009, 5 million accounts held \$7.1 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 2008, and dropped slightly in 2010. 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.

Figure 2
Total Assets and Number of Adults Ages 21–64
With an HRA^a or HSA,^b 2006–2010

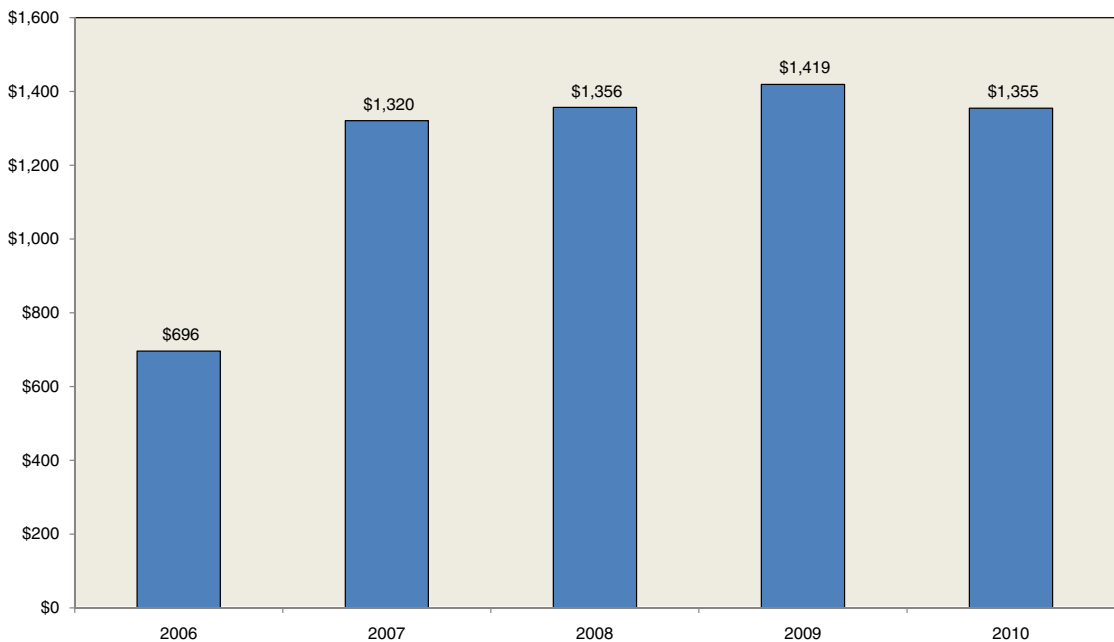


Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

^a Health reimbursement arrangement.

^b Health saving account.

Figure 3
Average HRA^a or HSA^b Account Balances, 2006–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

^a Health reimbursement account.

^b Health savings account.

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.⁴ 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 2010, men had an average of \$1,525 in their HRA or HSA while women had \$1,321 (Figure 4). 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 and then fell in 2010.

With respect to age, there is no difference in account balances for those below age 55; individuals ages 55–64 had a higher account balances than younger individuals. Individuals 55–64 had an average of \$1,791 in their account, compared with between \$1,250 and \$1,400 for those under age 55 (Figure 5). 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 2010a).

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 would not be a factor in the observed differences.

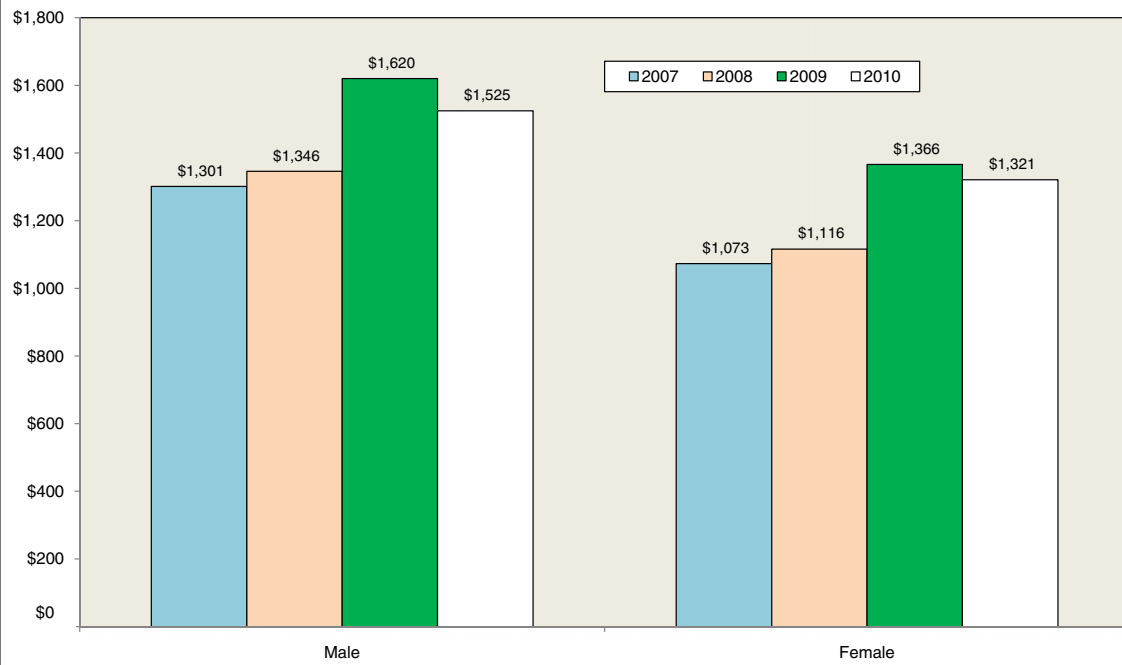
When examining differences in account balances for men and women by age, men ages 21–34 have a higher account balance than women ages 21–34. The average account balance for men was \$1,441, while for women it was \$1,103 (Figure 6). The difference between men and women can also be seen at ages 35–44, but it is smaller, as men have an average account balance of \$1,496, while women have an average account balance of \$1,334. The difference in account balances between men and women disappears for those ages 55–64.

Race—Minorities with HRAs or HSAs have higher account balances than whites with these accounts. On average, minorities have an account balance of \$1,531, while whites have an account balance of \$1,387 (Figure 7). Both experienced a decline between 2009 and 2010; however, the decline was larger among minorities.

Household Income—According to Figure 8, account balances increase with household income. The average account balance was \$1,166 among individuals with less than \$50,000 in household income; \$1,303 among individuals with \$50,000–\$99,999, and \$1,742 among individuals with \$100,000 or more. Account balances increased for those with less than \$50,000 in household income; fell for those with \$50,000–\$99,999, and stayed the same 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.)

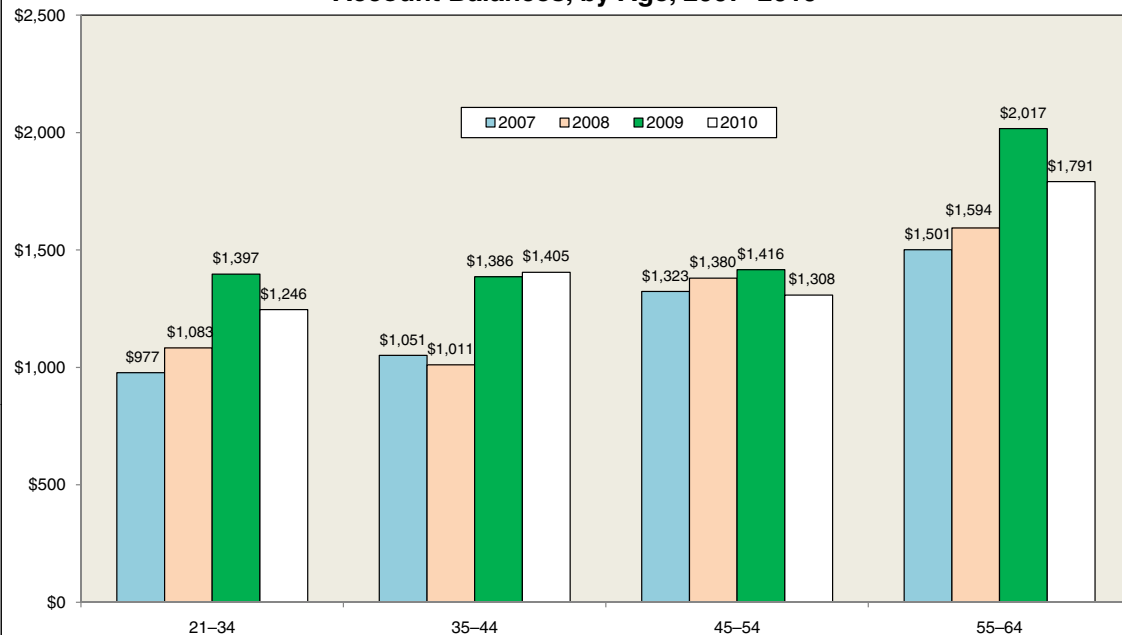
Education—Education has an impact on account balances independent of income and other variables, as they are controlled for in the regression equation that these estimates are based on. Individuals with a high school degree or less have an average of \$1,219 in their account, while those with a college degree have \$1,519, and those with a graduate degree have \$1,558 (Figure 9). Only individuals with a graduate degree experienced a decline in their average account balance in 2010.

Figure 4
Account Balances, by Gender, 2007–2010



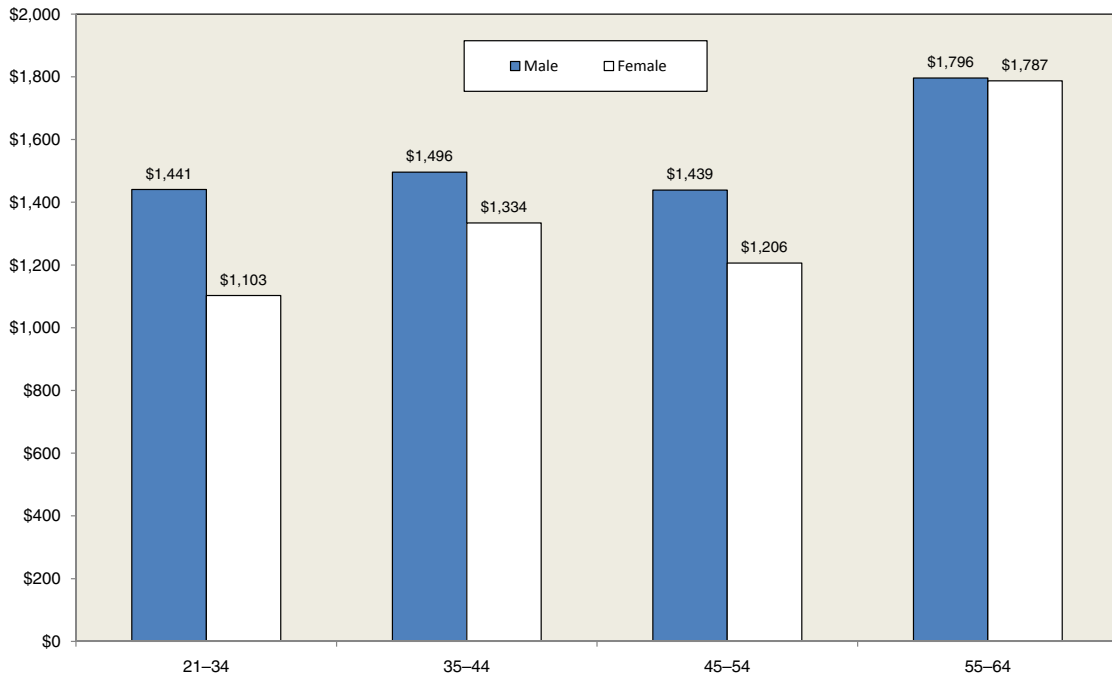
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 5
Account Balances, by Age, 2007–2010



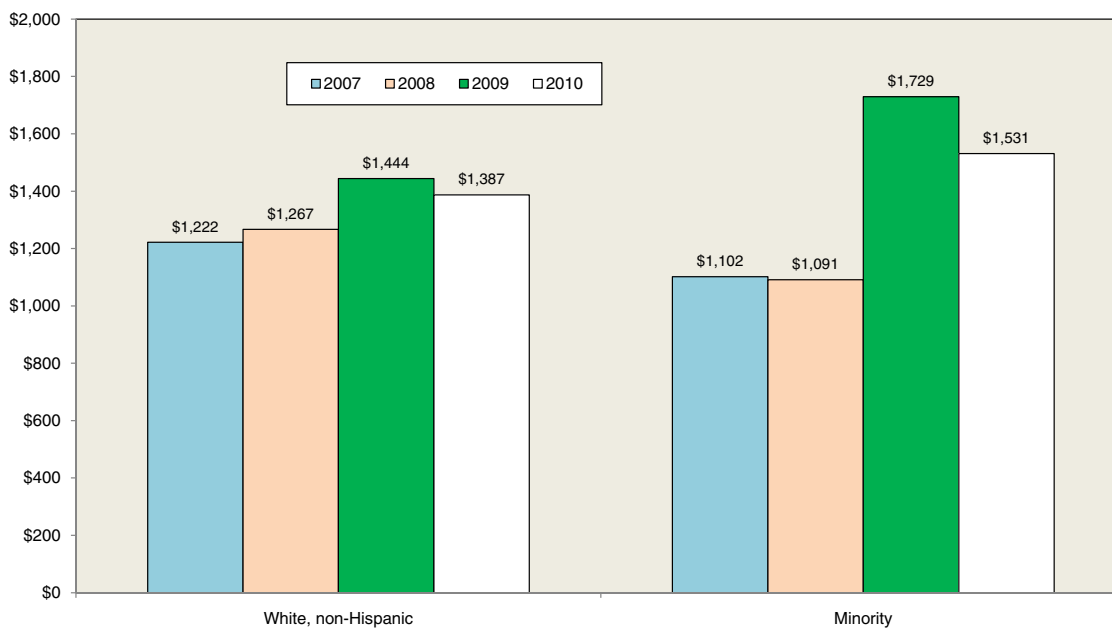
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 6
Account Balances, by Gender and Age Combined, August 2010



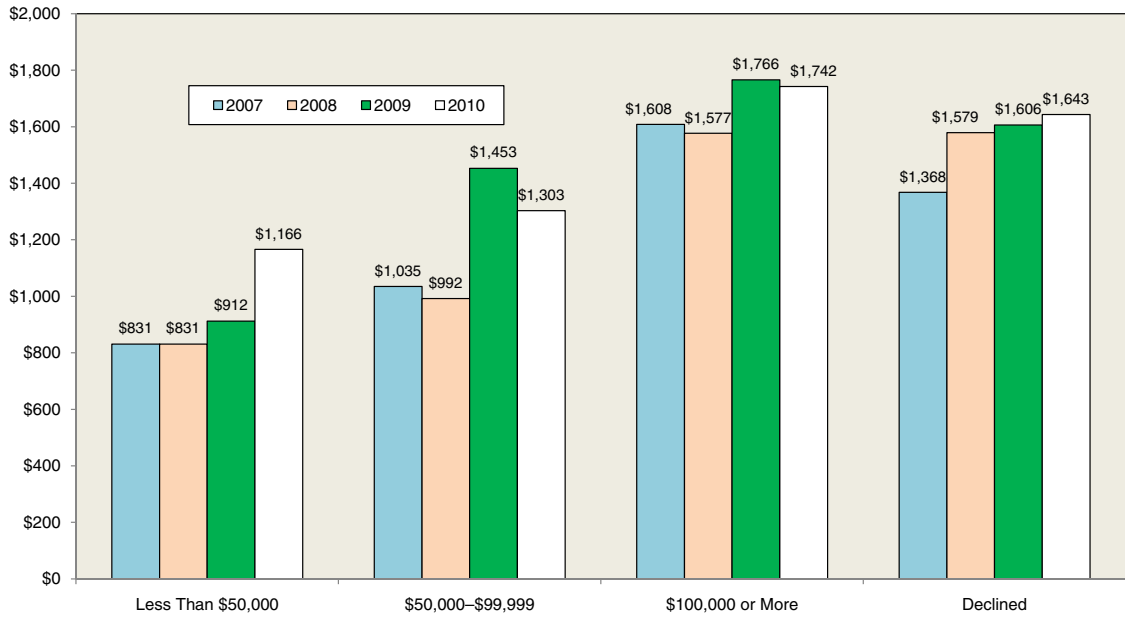
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

Figure 7
Account Balances, by Race, 2007-2010



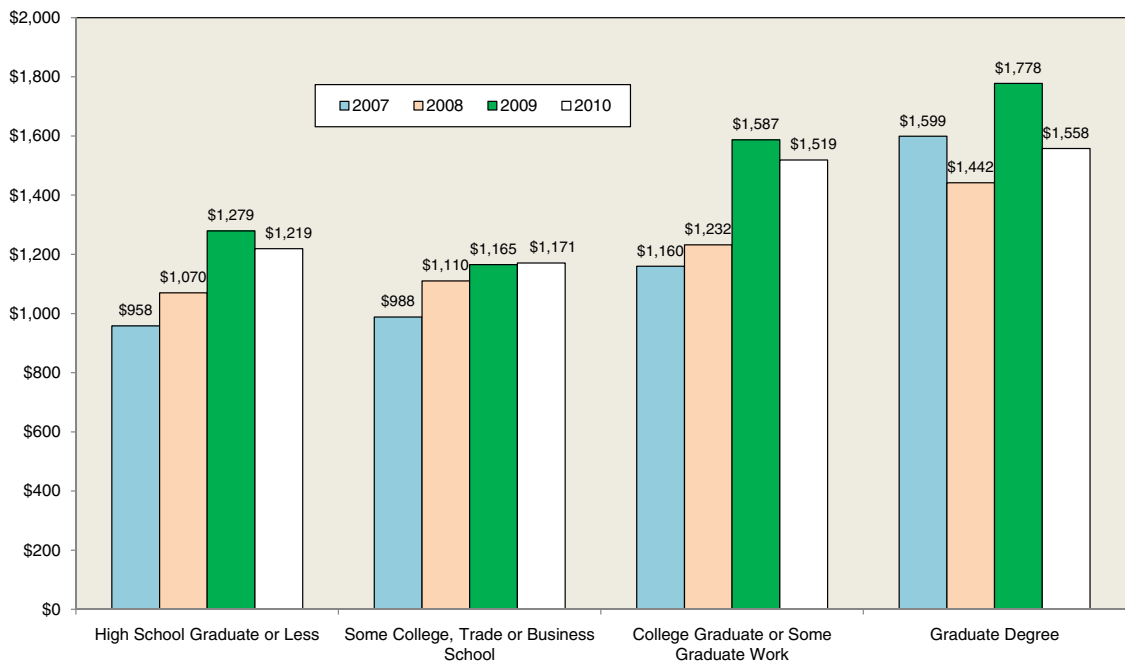
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008-2010.

Figure 8
Account Balances, by Annual Household Income, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 9
Account Balances, by Education, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

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 \$1,386 in their account in August 2010, while those with individual coverage had \$1,456 (Figure 10). However, the average account balance of individuals with family coverage declined between 2009 and 2010, while it was unchanged for those with individual coverage.

Health Behaviors and Health Status—Individuals who smoke have less money in their accounts than those who do not smoke, but the difference is not statistically significant (Figure 11). Similarly, obese individuals have less money in their account than the nonobese, but the difference is not statistically significant. No statistically significant difference was found in account balance by level of exercise. Individuals who exercise have an average of \$1,513 in their account, while those who do not exercise have \$1,239.

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. While the difference in account balances by this measure of health status was small, it was statistically significant.

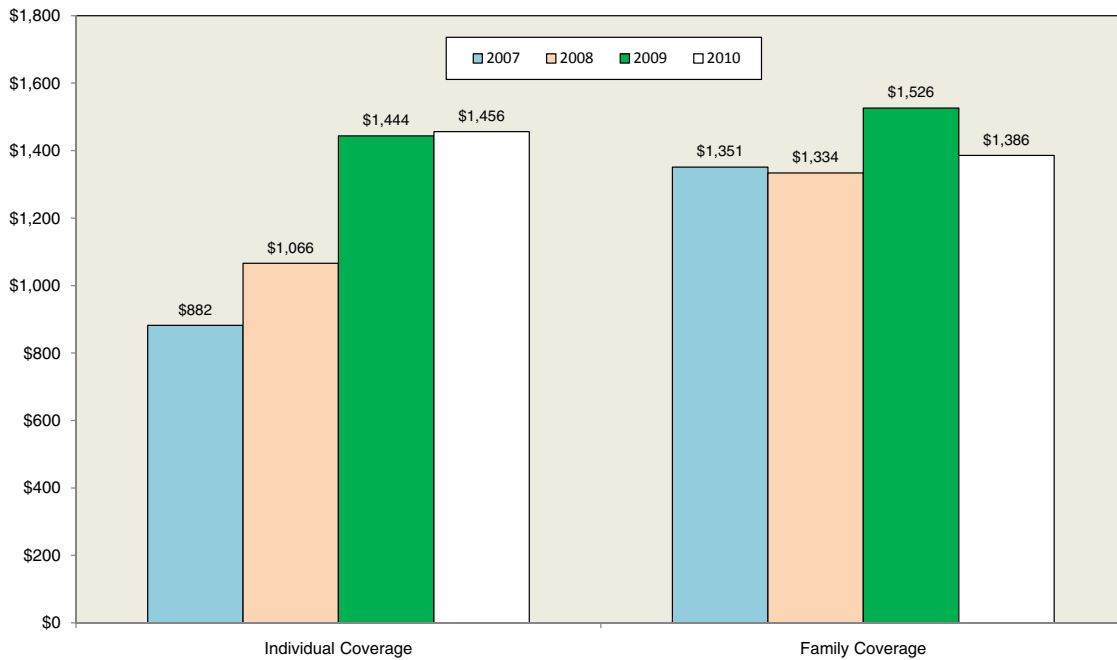
Use of Health Information and Programs—Account balances were examined using two variables to measure an individual's engagement in health care. One examined whether an individual used cost and quality information to choose a doctor. The other examined whether an individual participated in a wellness 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, it was found that individuals who participated in a wellness program had a higher average account balance than those who did not. The average account balance was \$1,536 among those who used cost and quality information to choose a doctor, and \$1,348 among those who did not use cost and quality information (Figure 12). Average account balances were similar by wellness program participation but the difference was not statistically significant.

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:

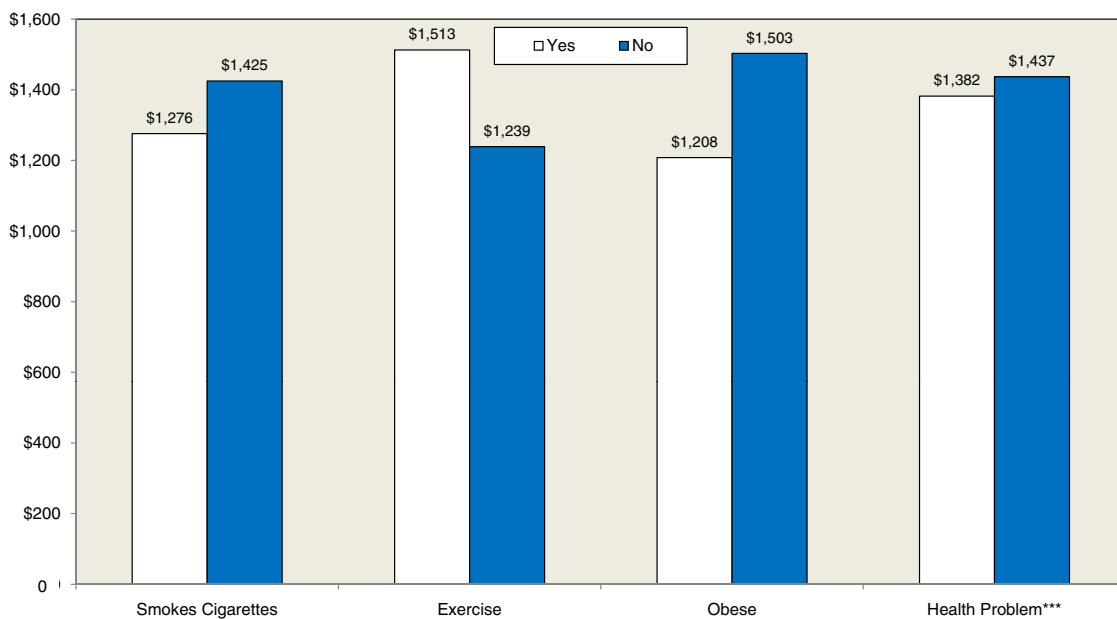
- Checked whether my health plan would cover my care or medication?
- Checked the price of a doctor's visit, medication, or other health care service before I received care?
- Checked the quality rating of a doctor or hospital before I received care from them?
- Talked to my doctor about the prescription 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?

Figure 10
Account Balances, by Plan Type, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

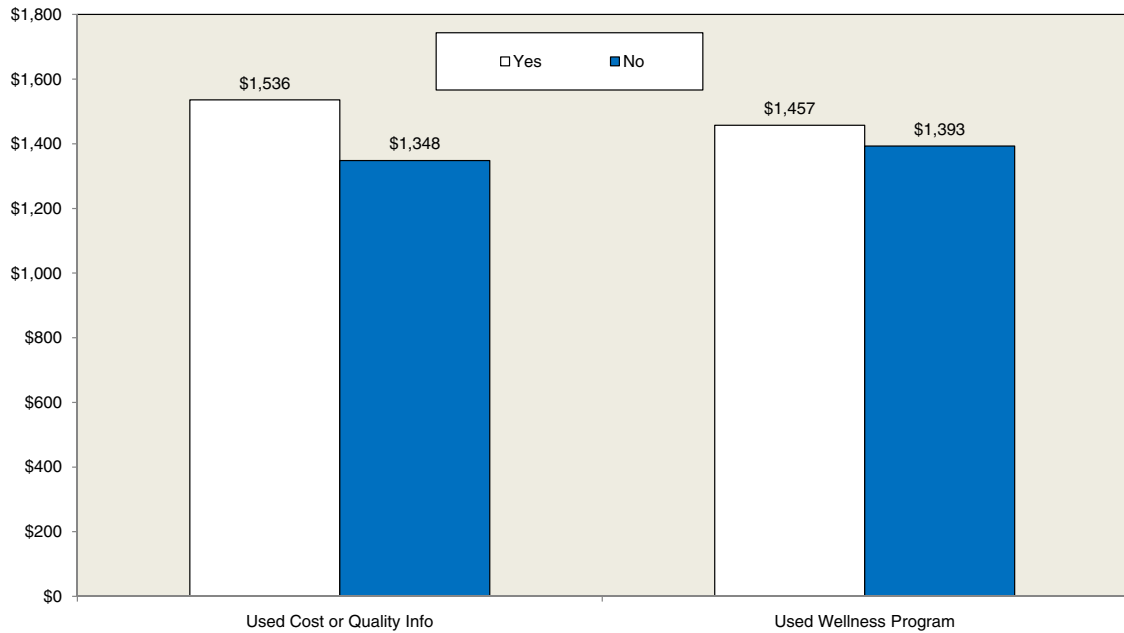
Figure 11
Account Balances, by Health Behavior and Health Status, August 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

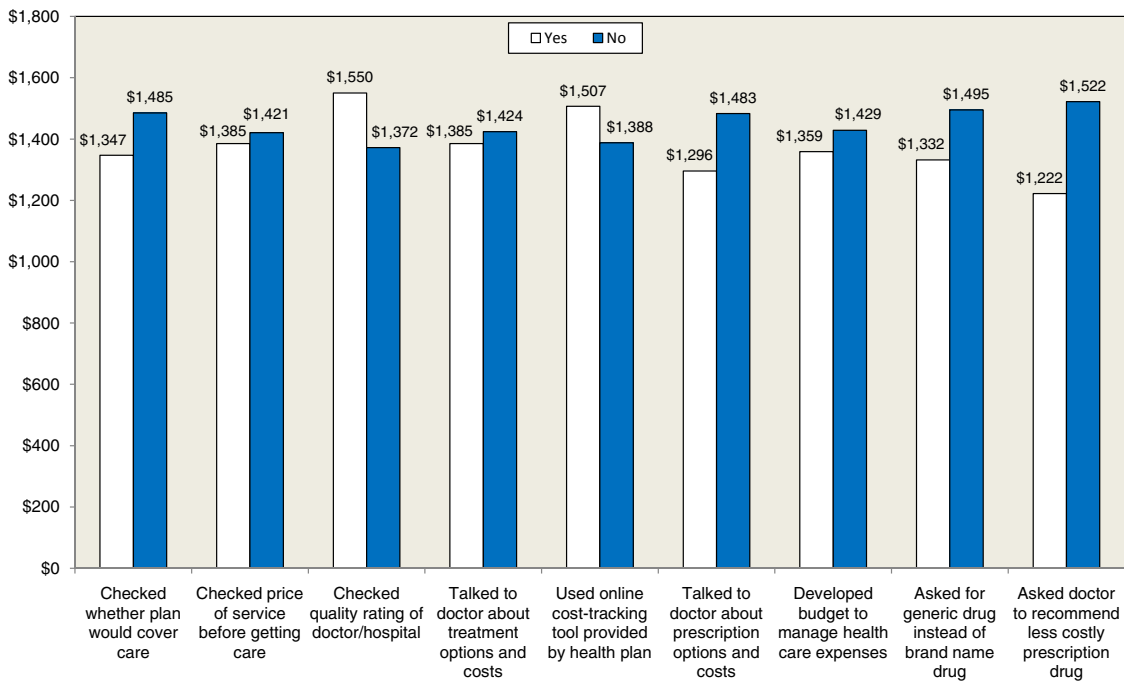
*** Health problem defined as fair or poor health or one of eight chronic health conditions: Arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; or hypertension, high blood pressure or stroke.

Figure 12
**Account Balances, by Use of Cost and Quality Information
 and Use of Wellness Program, August 2010**



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

Figure 13
Account Balances, by Various Cost-Conscious Behaviors, August 2010



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

Other than in response to the last question, no statistically significant differences were found in average account balances between individuals who exhibited the cost-conscious decision making behaviors and those who did not. Furthermore, with respect to whether an individual asked his or her doctor to recommend a less costly prescription drug, it was found that those asking for a recommendation had *lower* average account balances than those who did not (Figure 13).

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 \$694 in their account and those who held an account at least six months but less than a year had \$962 (Figure 14). In comparison, individuals with an account for one to two years had an average of \$1,324. Those with an account for three to four years had an average of \$1,822. And those with an account for at least five years had an average account balance of \$2,231. In 2009, average account balances fell by a much larger amount for individuals holding accounts for a longer period of time, as they had a much larger average account balances.

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. For instance, individuals with an employer contribution of less than \$1,000 had an average account balance of \$1,344, while those with an employer contribution of at least \$1,000 had an average of \$1,582 in their account (Figure 15). Similarly, individuals who contributed less than \$1,000 had an average account balance of \$1,125, while those who contributed at least \$1,000 had an average balance of \$1,754 (Figure 16).

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 with high levels of employer and individual contributions.

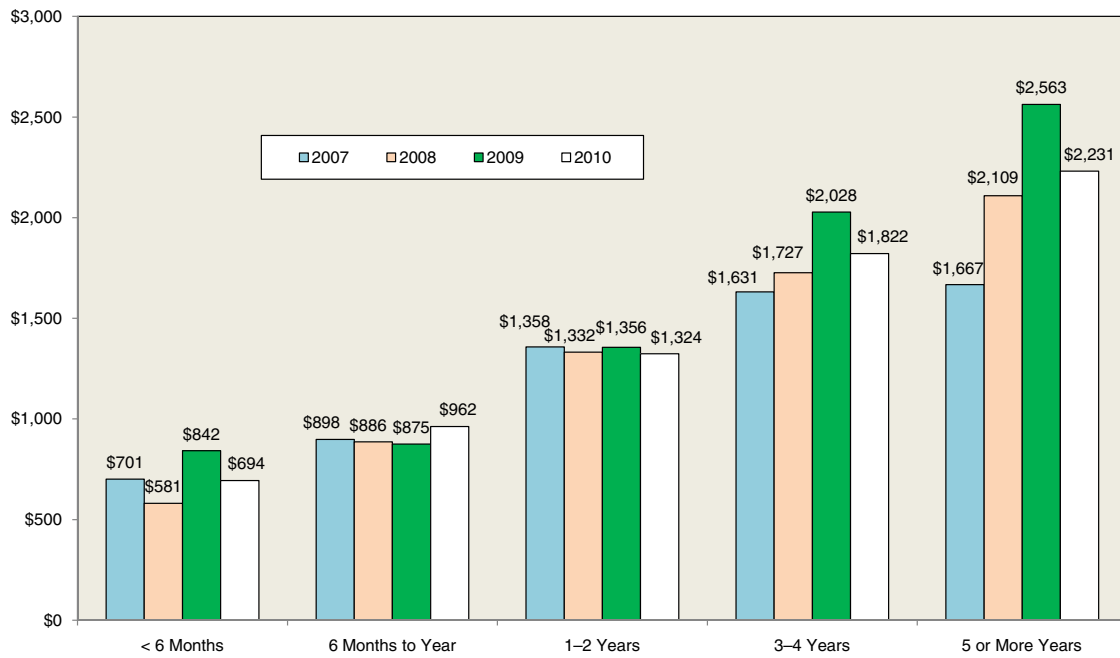
Rollovers—Like contribution levels, rollover amounts are one of the biggest factors in average account balances. Individuals with less than a \$1,000 rollover had an average account balance of \$942 (Figure 17). In comparison, individuals with a rollover of at least \$1,000 had an average account balance of \$2,773.

Rollovers

There is no use-it-or-lose-it rule associated with HSAs, as any money left in an account at the end of the year automatically rolls over and is available in the following year.⁵ 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.

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 18). 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, and that increased slightly to 13 percent in 2010. 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 associated with it 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 between \$500 and \$999, as well as an increase among those with a rollover of at least \$2,000. Between 2009 and 2010, the percentage with a rollover of \$1,500–\$1,999 fell from 6 percent to 3 percent, while the percentage with a rollover of at least \$2,000 fell from 31 percent to 21 percent.

Figure 14
Account Balances, by Length of Time With Account, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 15
Account Balances, by Level of Annual Employer Contribution, 2007–2010



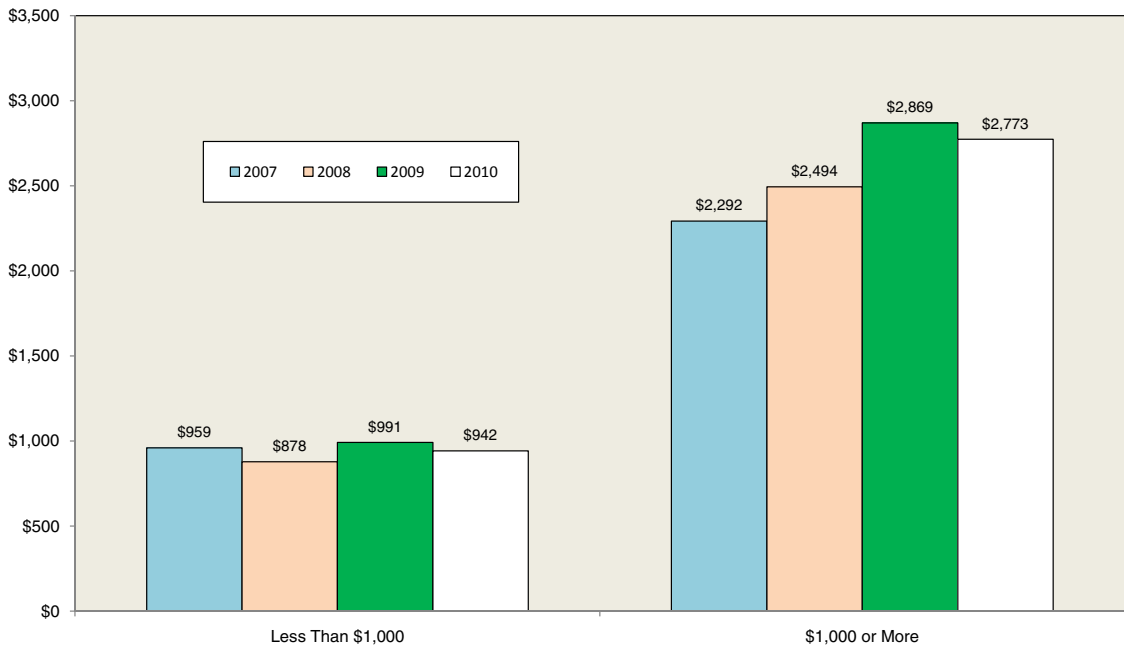
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 16
Account Balances, by Level of Annual Individual Contribution, 2007–2010



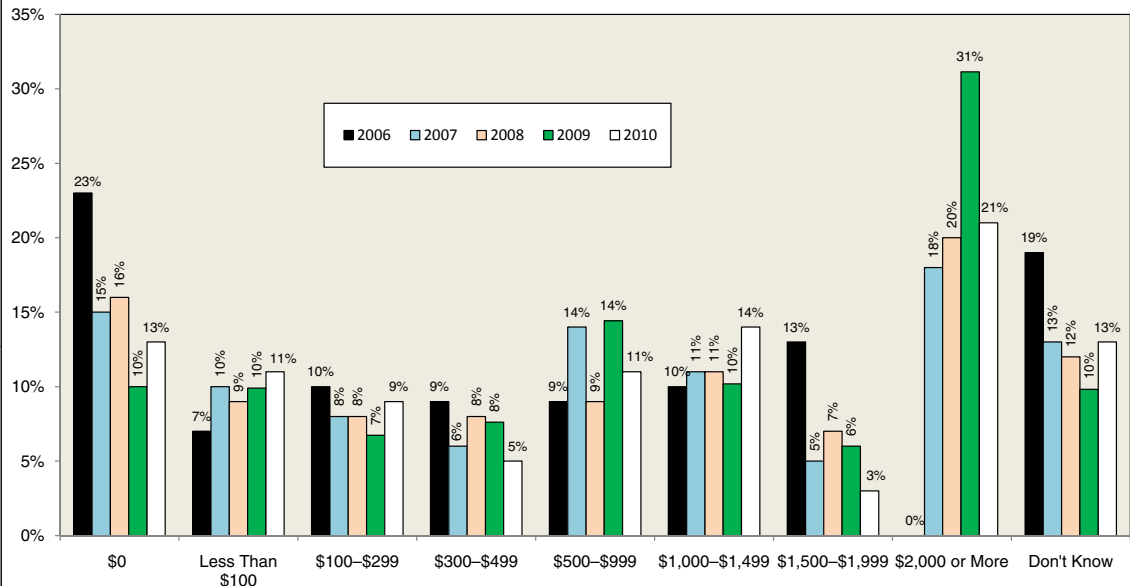
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 17
Account Balances, by Rollover Level, 2007–2010



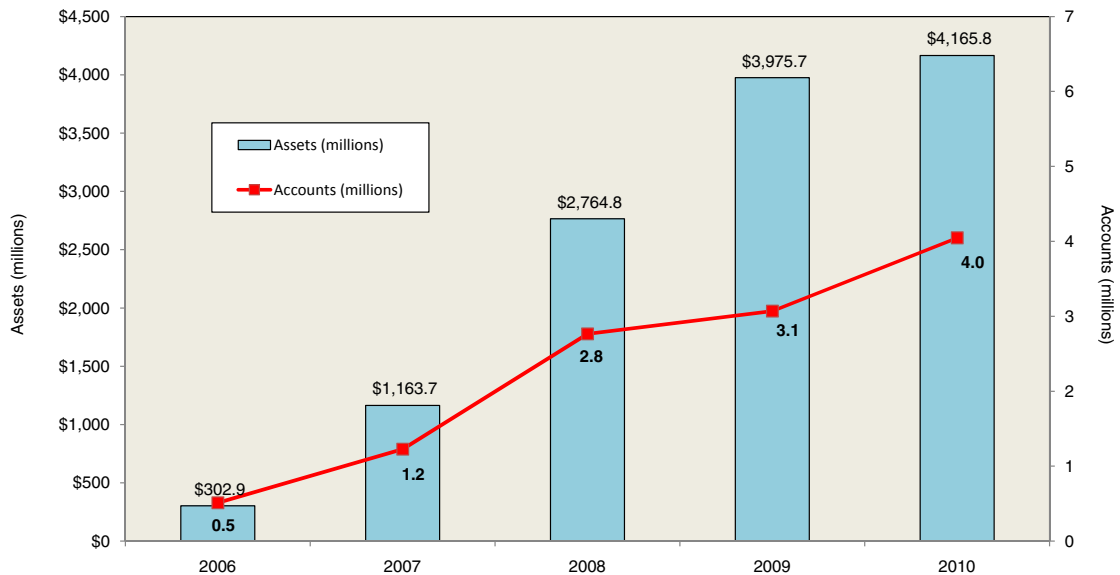
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 18
Rollover Amounts, Among Individuals with Account
for More than One Year, 2006–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.
 Note: 2006 data were capped at \$1,500 or more.

Figure 19
Total Rollover Assets and Number of Adults
Ages 21–64 With a Rollover, 2006–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

The number of people with a rollover as well as the total level of assets being rolled over has been increasing, although the growth slowed in 2010. In 2006, 500,000 individuals rolled over \$302.9 million (Figure 19). By 2009, 3.1 million individuals rolled over nearly \$4 billion. And by 2010, 4 million individuals rolled over nearly \$4.2 million. The average rollover increased from \$592 in 2006 to \$1,295 in 2009, and then fell to \$1,029 in 2010 (Figure 20).

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, and individual contributions to the account.⁶ 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 2010, men had an average rollover of \$1,061 while women had \$874 (Figure 21). Average rollover amounts declined for both men and women.

With respect to age, the oldest adults had the largest rollover amounts in 2010. Individuals ages 55–64 had an average rollover of \$1,166, compared with \$777 for individuals 21–34, \$927 for individuals 35–44, and \$1,003 for individuals 45–54 (Figure 22). Individuals ages 21–34 experienced the largest decline in rollover amounts, dropping from \$1,163 in 2009 to \$777 in 2010.

When examining differences in rollovers for men and women by age, men ages 45–54 have higher average rollover amounts than women—the same age. The average rollover for men was \$1,138, while for women it was \$898 (Figure 23). A smaller difference between men and women can also be seen at other ages, with a very small difference among those ages 55–64.

Race—In contrast to the findings from 2009, it was found that whites have lower rollover amounts than minorities. On average, minorities had a \$1,130 rollover in 2010, while whites had a \$921 rollover (Figure 24). Furthermore, whites experienced a decline in their average rollover amount, while minorities experienced an increase.

Household Income—According to Figure 25, rollover amounts increase with household income. The average account balance was \$766 among individuals with less than \$50,000 in household income, \$860 among individuals with \$50,000–\$99,999, and \$1,224 among individuals with \$100,000 or more in household income. Rollover amounts increased for those with less than \$50,000 in household income, fell for those with \$50,000–\$99,999 in household income, and increased slightly for those with \$100,000 or more in household income.

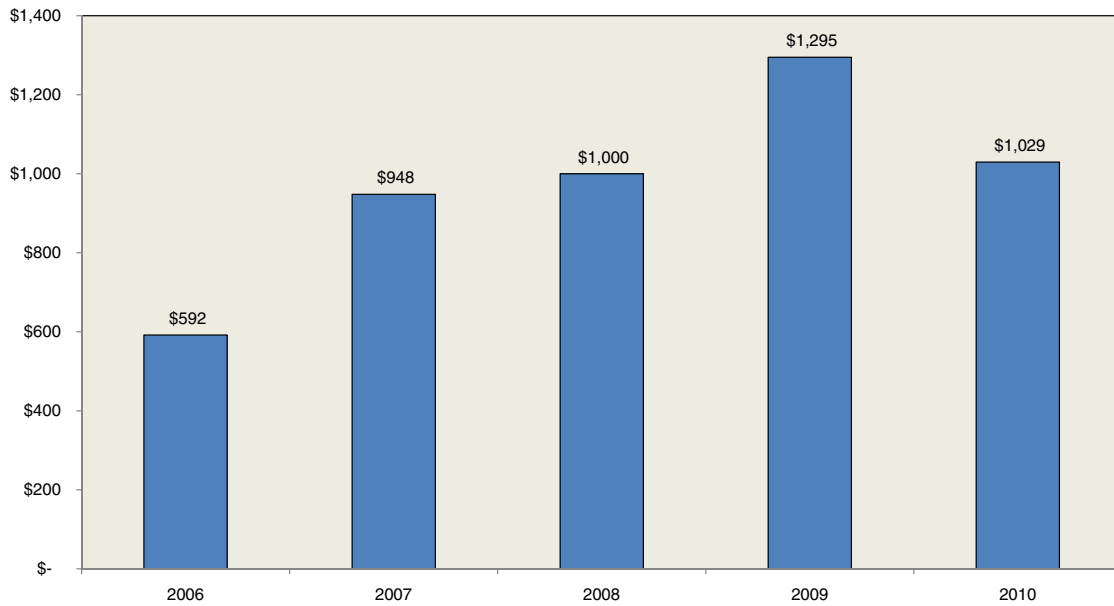
Education—Education has an impact on rollover amounts independent of income and other variables, as they are controlled for in the regression equation that these estimates are based on. Individuals with a high school degree or less have an average rollover of \$799, while those with a college degree had an average rollover of \$1,034, and those with a graduate degree had an average rollover of \$999 (Figure 26).

Type of Coverage—Individuals with single coverage had an average rollover of \$1,036, whereas those with family coverage had a \$912 average rollover (Figure 27). Furthermore, both experienced a decline in average rollover amounts.

Health Behaviors and Health Status—Individuals who smoke had lower rollover amounts than individuals who do not smoke, but the difference is not statistically significant (Figure 28). 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 (\$804) than the nonobese (\$1,026), 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 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 higher rollover amount than those who did not participate in such a program, although statistically the differences were not significant. The average rollover was \$1,006 among those who used cost and quality information to choose a doctor, and was \$932 among those who did not use cost and quality information (Figure 29).

Figure 20
Average HSA^a or HRA^b Rollover Amount, 2006–2010

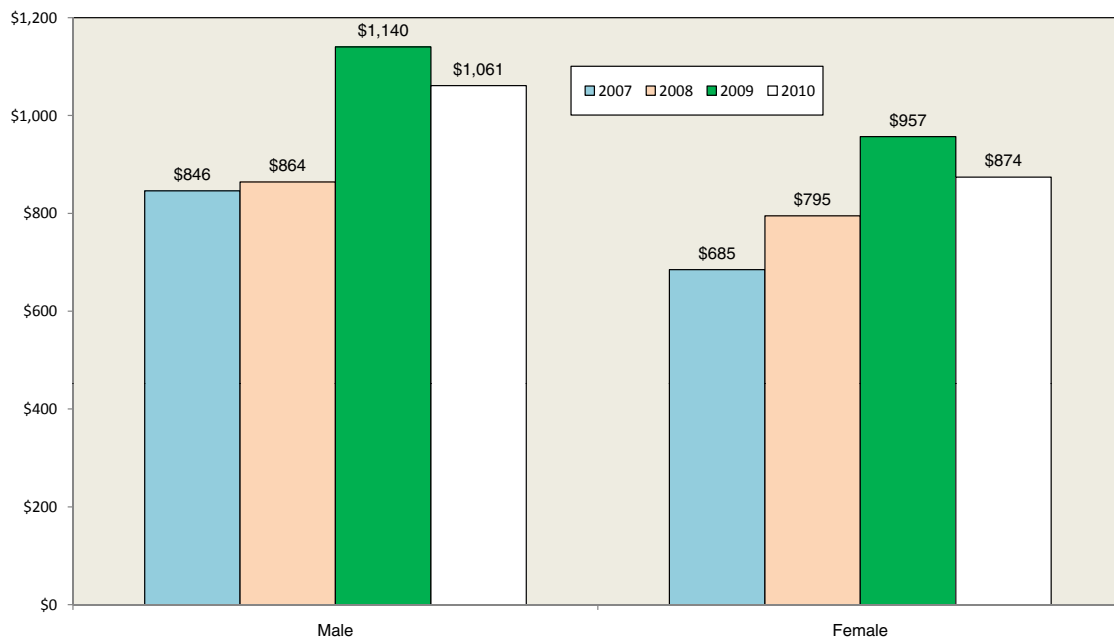


Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

^a Health reimbursement arrangement.

^b Health savings account.

Figure 21
Rollover Amount, by Gender, 2007–2010



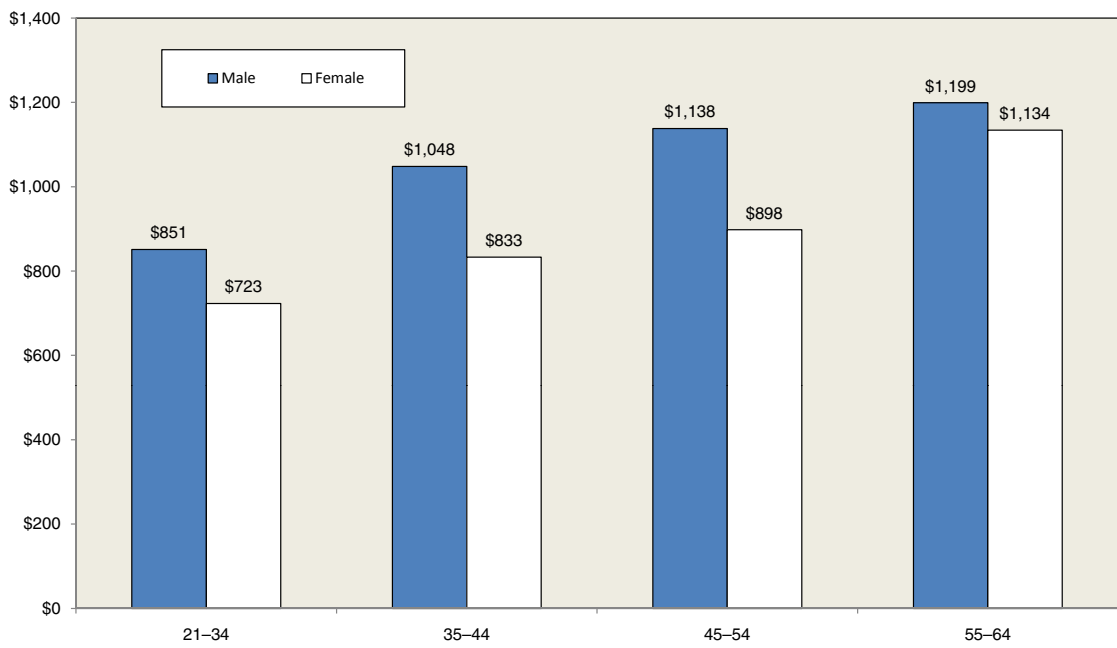
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 22
Rollover Amount, by Age, 2007–2010



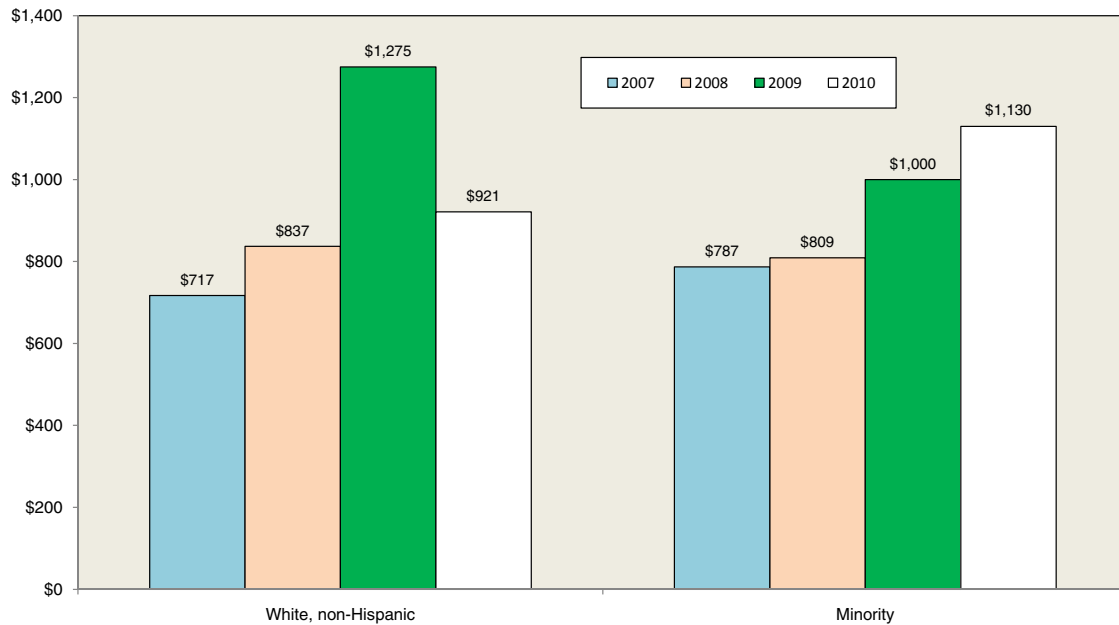
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2007–2010.

Figure 23
Rollover Amount, by Gender and Age Combined, 2010



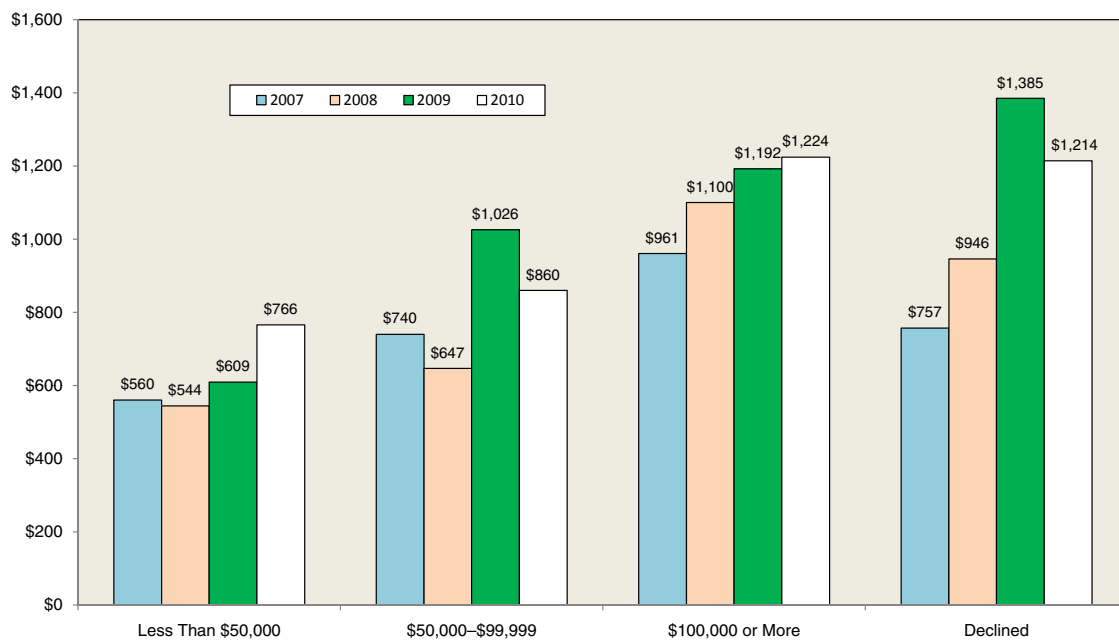
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

Figure 24
Rollover Amount, by Race, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 25
Rollover Amount, by Annual Household Income, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

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 amount than those who did not exhibit such behavior. The questions regarding cost-conscious decision making were described above. In the series of questions, no statistically significant differences were found (Figure 30).

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 \$768 (Figure 31). In comparison, those holding an account for three to four years had an average rollover of \$1,213. And those with an account at least five years old had an average rollover of \$1,634.

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 \$956, while those with an employer contribution of at least \$1,000 had an average rollover of \$959 (Figure 32). In contrast, individuals who contributed less than \$1,000 had an average rollover of \$751, while those who contributed at least \$1,000 had an average rollover of \$1,203, a difference that is statistically significant (Figure 33).

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 those with 500 or more workers offered either an HRA or HSA-eligible plan.⁷ As a result, these plans covered about 21 million people in 2010, representing about 12 percent of the privately insured market (Fronstin 2010b).

According to findings from the 2010 EBRI/MGA Consumer Engagement in Health Care Survey, there was \$7.7 billion in HSAs and HRAs in 2010, spread across 5.7 million accounts. In 2006, there were 1.2 million accounts with \$835.4 million in assets, and by 2009, 5 million accounts held \$7.1 billion in assets. Total assets in the accounts have increased each year, and increases in average account balances appear to have leveled off in 2008 and 2009, and dropped slightly in 2010. In 2006, account balances averaged \$696. They increased to \$1,320 in 2007, and then averaged \$1,356 in 2008 and \$1,419 in 2009. In 2010, average account balances fell to \$1,355.

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 2010, 13 percent did not have a rollover. In 2006, 500,000 individuals rolled over \$302.9 million. Furthermore, by 2010, 4 million individuals rolled over \$4.2 billion. The average rollover increased from \$592 in 2006 to \$1,295 in 2009 and then fell to \$1,029 in 2010.

It is expected that individuals who are given more control over funds allocated for health care services will 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 with respect to some of the measures used in this study of cost-conscious behavior. Individuals who exercised, those who did not smoke, and those who were not obese had higher account balances and higher rollovers than those with less healthy behaviors. It was also found that individuals who used cost or quality information had higher account balances and higher rollovers, compared with those who did not use such information. However, no relationship was found between either account balance or rollover amounts and various cost-conscious behaviors such as checking prices before getting services, or asking for generic drugs instead of brand names, among other things. 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 26
Rollover Amount, by Education, 2007–2010

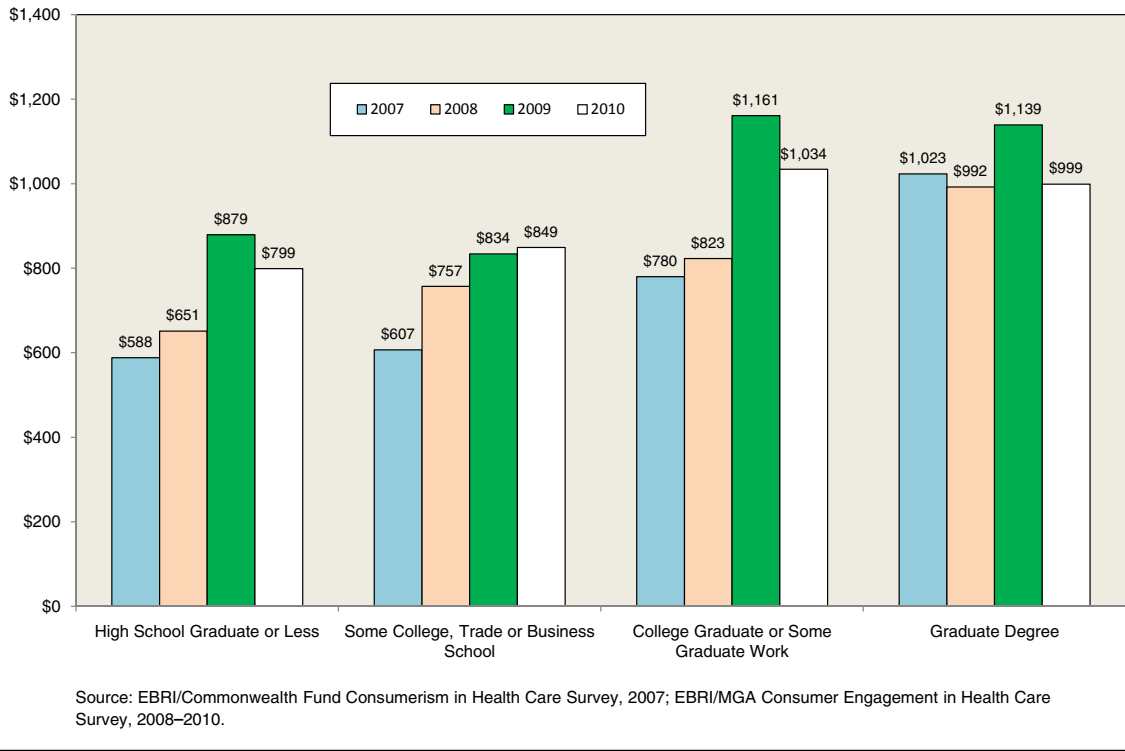


Figure 27
Rollover Amount, by Plan Type, 2007–2010

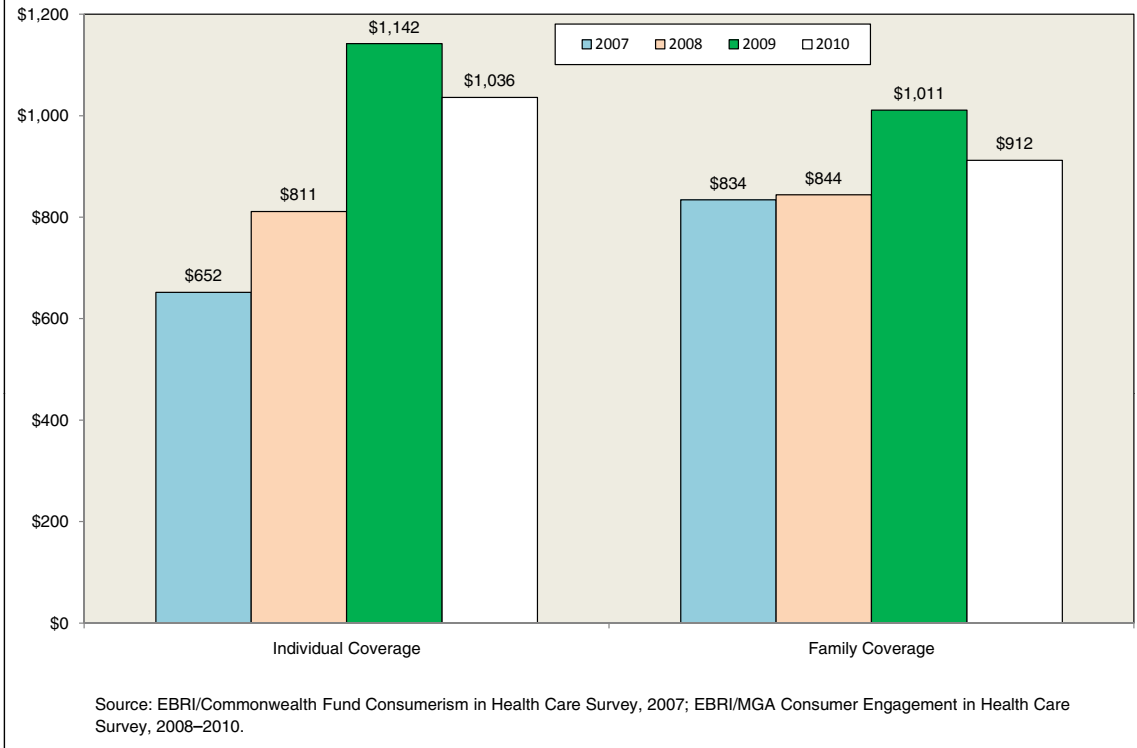


Figure 28
Rollover Amount, by Health Behavior and Health Status, 2010

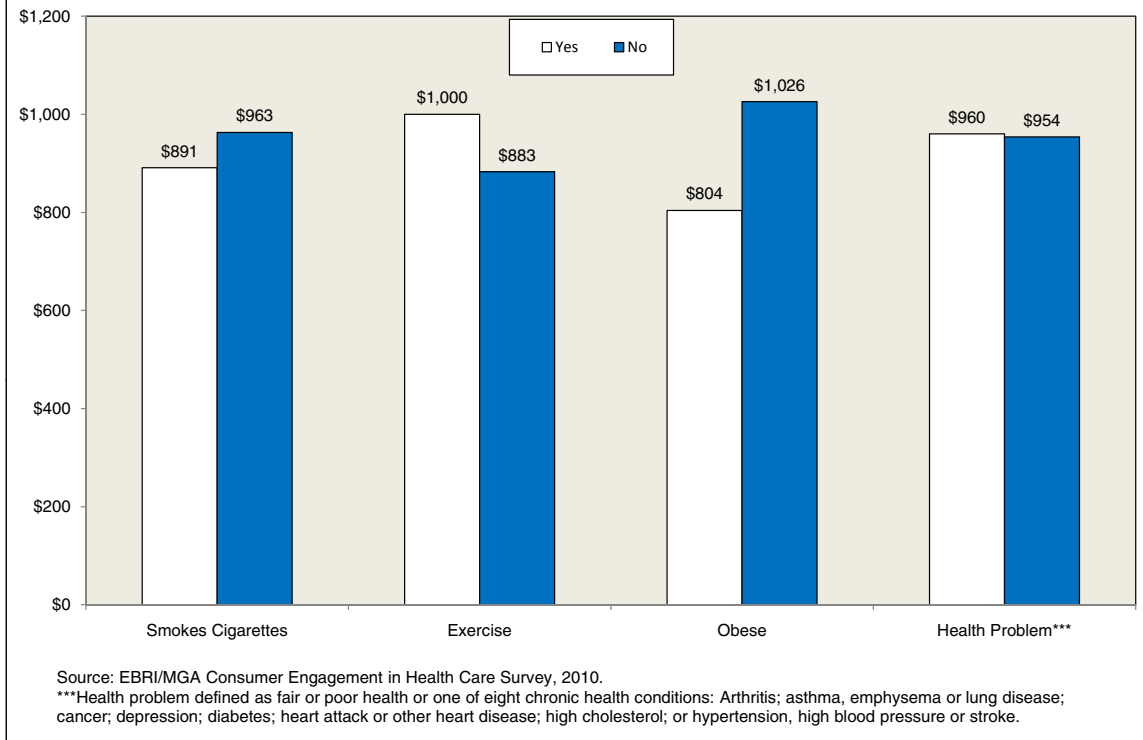


Figure 29
Rollover Amount, by Use of Cost and Quality Information and Use of Wellness Program, 2010

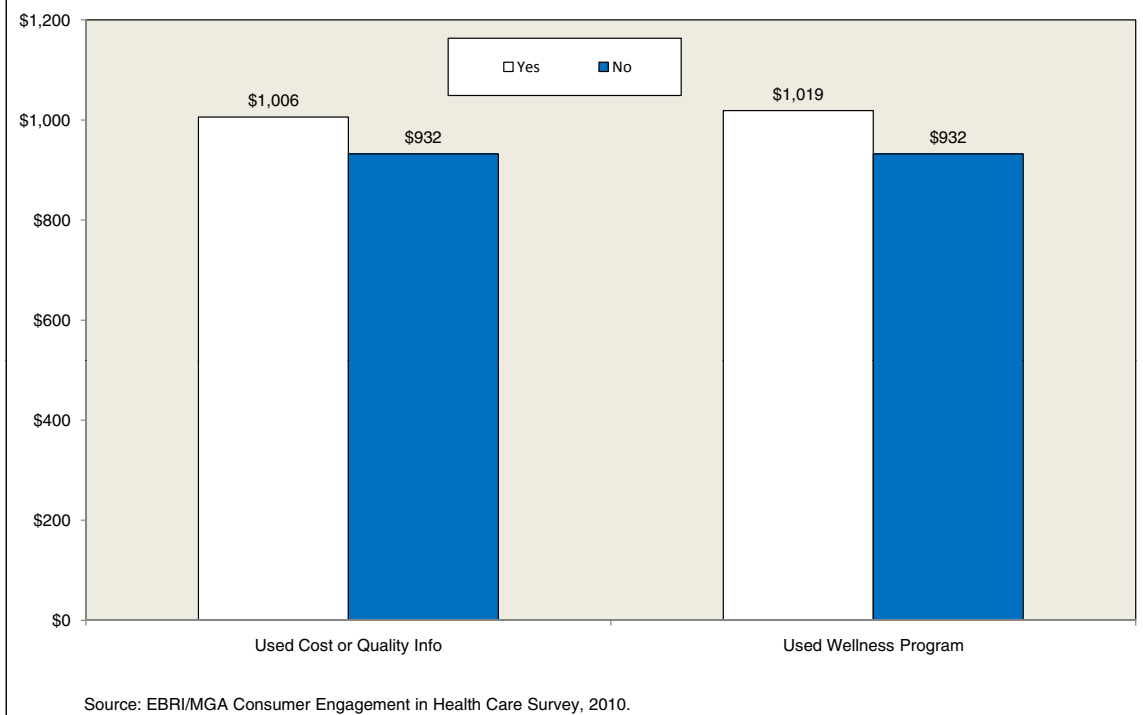
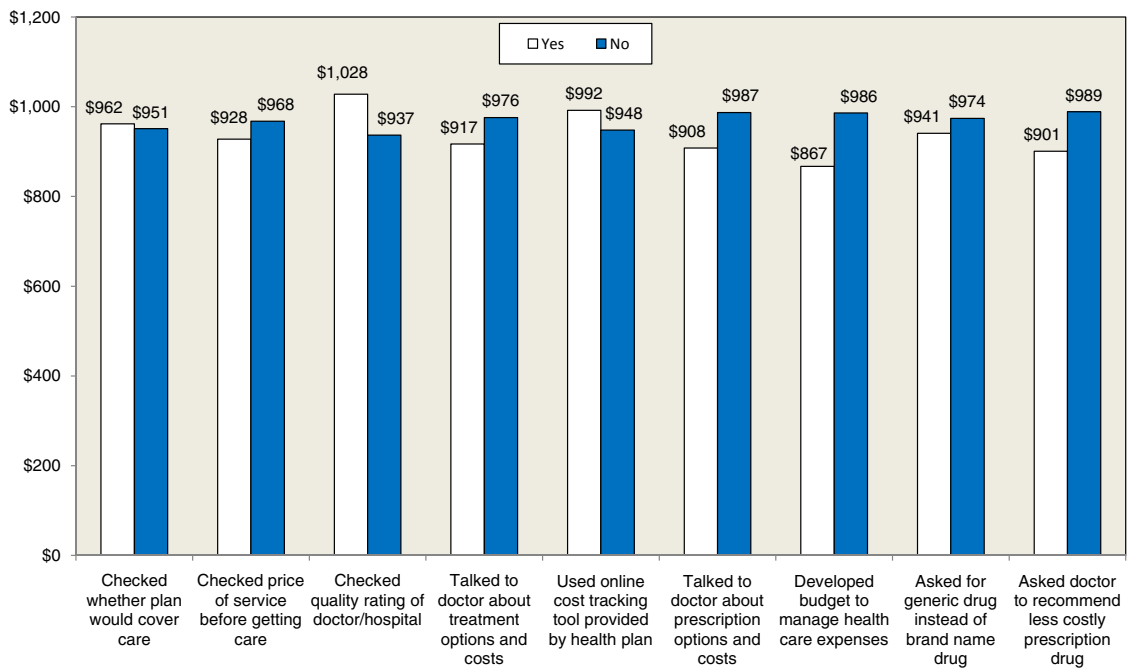
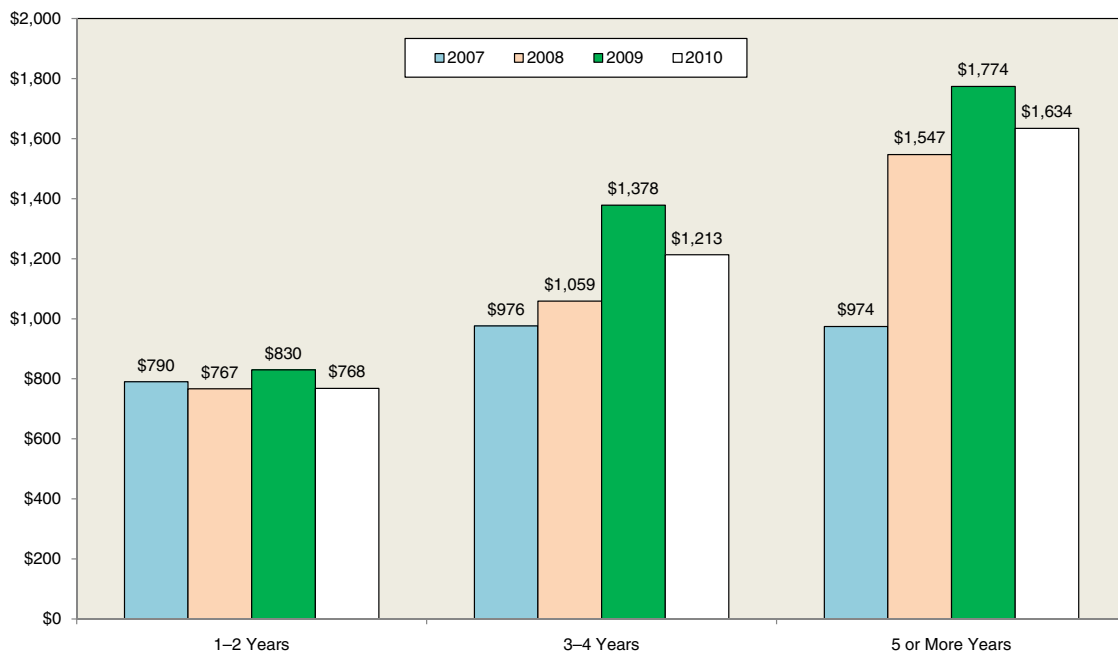


Figure 30
Rollover Amount, by Various Cost-Conscious Behaviors, 2010



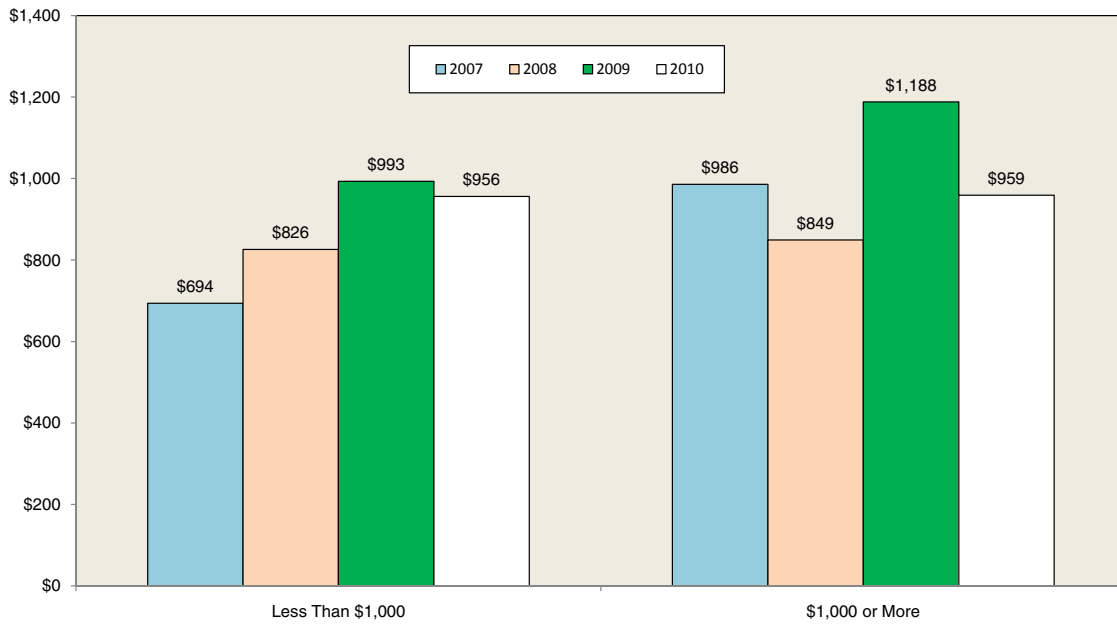
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2010.

Figure 31
Rollover Amount, by Length of Time With Account, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 32
Rollover Amount, by Level of Annual Employer Contribution, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

Figure 33
Rollover Amount, by Level of Annual Individual Contribution, 2007–2010



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007; EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2010.

References

Fronstin, Paul. "The Use of Health Savings Accounts for Health Care in Retirement." *EBRI Notes*, no. 3 (Employee Benefit Research Institute, April 2010a): 2–6.

_____. "Findings from the 2010 EBRI/MGA Consumer Engagement in Health Care Survey." *EBRI Issue Brief*, no. 350 (Employee Benefit Research Institute, December 2010b).

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).

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 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, but employers do not incur expenses associated with the arrangement until an employee incurs a claim.

⁴ 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.

⁵ 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.

⁶ More information about the regression equation is available upon request from the author.

⁷ See www.mercer.com/summary.htm?idContent=1364345

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