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1100 13th St. NW • Suite 878 • Washington, DC 20005
(202) 659-0670 • www.ebri.org • Fax: (202) 775-6312

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CONTACTS: Paul Fronstin, EBRI, (202) 775-6352, Fronstin@ebri.org
John MacDonald, EBRI, (202) 775-6349, macdonald@ebri.org

New Research from EBRI:

Consumer-Driven Health Plan Assets Show Three-Year Gain; Number of Accounts Also Increased from 2006–2009

WASHINGTON—Assets in health savings accounts (HSAs) and health reimbursement arrangements (HRAs), two relatively new employment-based health benefit plan options , have grown in recent years and totaled $7.1 billion in 2009, up from $835.4 million three years earlier, according to a study published today by the nonpartisan Employee Benefit Research Institute (EBRI).

In addition, the number of accounts in these plans, collectively known as consumer-driven health plans (CDHPs), also was up during the same period—totaling 5 million in 2009, up from 1.2 million in 2006.

The study, in the June 2010 *EBRI Issue Brief,* examines health savings account and health reimbursement arrangements assets, account balances, and rollovers from 2006 to 2009. It is available at www.ebri.org

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 he used as tax-advantaged vehicles to save for health care expenses in retirement.

Employers first began offering account-based health plans in 2001, when a handful of plan sponsors began to offer health reimbursement arrangements, 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, a type of tax-exempt trust or custodial account that an individual can use to pay for health care expenses.

With health reimbursement arrangements, 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, With health savings accounts, any money left in the account at the end of the year automatically rolls over and is available in the following year.

These plans covered 15–19 million people in 2009, representing 9–11 percent of the privately insured market. As the number of people with account-based plans grows, total assets in these plans will grow as well, the study says.

Here are some of the highlights from the study, which is based on findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey:

Account balances: 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 consumer-driven health plan enrollee was more likely than traditional plan enrollees to be young, unmarried, higher-income, educated, and exhibit healthy behavior. No differences were found between CDHP enrollees and traditional plan enrollees with respect to gender, race, and presence of children.

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.

Account balance differences: 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.

Rollover amount differences: Men rolled over more money than women, whites have higher rollover amounts than minorities, and the youngest adults and 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 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 average lower amounts than nonobese individuals.

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