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Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2012

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

AT A GLANCE

- ***Asset levels growing:*** In 2012, there was $17.8 billion in health savings accounts (HSAs) and health reimbursement arrangements (HRAs), spread across 11.6 million accounts, according to data from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey, sponsored by EBRI and Matthew Greenwald & Associates. This was up from 2006, when there were 1.3 million accounts with $873.4 million in assets, and 2011, when 8.5 million accounts held $12.4 billion in assets.

- ***After leveling off, average account balances increased:*** After average account balances leveled off in 2008 and 2009, and fell slightly in 2010, they increased in 2011 and 2012. In 2006, the average account balance was $696. It increased to $1,320 in 2007, a 90 percent increase. Account balances averaged $1,356 in 2008 and $1,419 in 2009, 3 percent and 5 percent increases, respectively. In 2010, average account balances fell to $1,355, down 4.5 percent from the previous year. In 2011, average account balances increased to $1,470, a 9 percent increase from 2010. It increased to $1,534 in 2012, a 4 percent increase.

- ***Total and average rollovers increase:*** After declining to $1,029 in 2010, average rollover amounts increased to $1,206 in 2011 and remained there in 2012. Total assets being rolled over increased: $9.7 billion was rolled over into HSAs and HRAs in 2012, up from $6.8 billion in 2011. The percentage of individuals without a rollover was 11 percent in 2012.

- ***Healthy behavior does not mean higher account balances and higher rollovers***: Individuals who smoke have more money in their accounts than those who do not smoke. In contrast, obese individuals have less money in their account than the nonobese. There was very little difference in account balances by level of exercise. Very small differences were found in account balances and rollover amounts for individuals who used cost or quality information, compared with those who did not use such information. However, next to no relationship was found between either account balance or rollover amounts and various cost-conscious behaviors.

- ***Differences in account balances:*** Men have higher account balances than women, older individuals have higher account balances, 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 in 2012. Rollover amounts increased with household income and education, and individuals with single coverage rolled over a slightly higher amount than those with family coverage in 2012.

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Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (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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Table of Contents

Figures

Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006–2012

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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 giving individuals more control over funds allocated for health care services will cause them to 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 2011, 32 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan, covering 13 percent of that population, up from 23 percent offering such a plan and 10 percent enrollment in 2010.[1] As a result, these plans covered about 25 million people in 2012, representing about 15 percent of the privately insured market (Fronstin 2012). As the number with account-based plans grows, total assets in these plans can be expected to grow.

While HRAs have been around for just over a decade and HSAs since 2004, a growing percentage of the population has held them for a number of years. In 2006, 9 percent of the population with an HRA or HSA had held that account for three to four years, and 3 percent for five years or more (Figure 1). By 2012, 29 percent had held an account for three to four years, and 16 percent for five years or more. As the length of time individuals have these plans increases, average account balances should increase as well.

This report examines HSA and HRA assets, account balances, and rollover amounts, using data from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey (CEHCS). It then examines differences and trends in account balances by demographics, income, contribution levels, and engagement in an individual's own health care using a regression equation. Rollover amounts are then examined.

Assets and Account Balances

According to the 2012 EBRI/MGA CEHCS, there was $17.8 billion in HSAs and HRAs in 2012, spread across 11.6 million accounts (Figure 2). In 2006, there were 1.3 million accounts with $873 million in assets, and by 2011, 8.5 million accounts held $12.4 billion in assets.[2] Growth rates in both assets and the number of accounts have been high, other than in 2010. In 2007, assets doubled (101 percent) and the number of accounts nearly tripled (282 percent) (Figure 3). While growth slowed in 2008–2010, it continued at relatively high rates, accelerated in 2011, and continued to increase at nearly 40 percent for both assets and the number of accounts in 2012.

Despite growth in total assets and in the number of accounts, average account balances have not increased at the same rate. Average account balances leveled off in 2008, dropped slightly in 2010, and then increased in 2011 and 2012. In 2006, the account balance average was $696 (Figure 4). 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, but in 2011, the average account balance increased to $1,470, a 9 percent increase. And in 2012, the average account balance increased to $1,534, a 4 percent increase.

Between 2007 and 2012, the percentage with at least $3,000 in their account increased from 16 percent in 2007 to 23 percent in 2012, while the percentage with a zero account balance fell from 10 percent in 2007 to 5 percent in 2012 (Figure 5).

About the 2012 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 a health care plan, reasons for choosing a plan, and sources of health information. The 2012 EBRI/MGA CEHCS is comparable with findings from the 2005, 2006, and 2007 EBRI/Commonwealth Fund Consumerism in Health Care Surveys, and the 2008−2011 EBRI/MGA Consumer Engagement in Health Care Surveys.

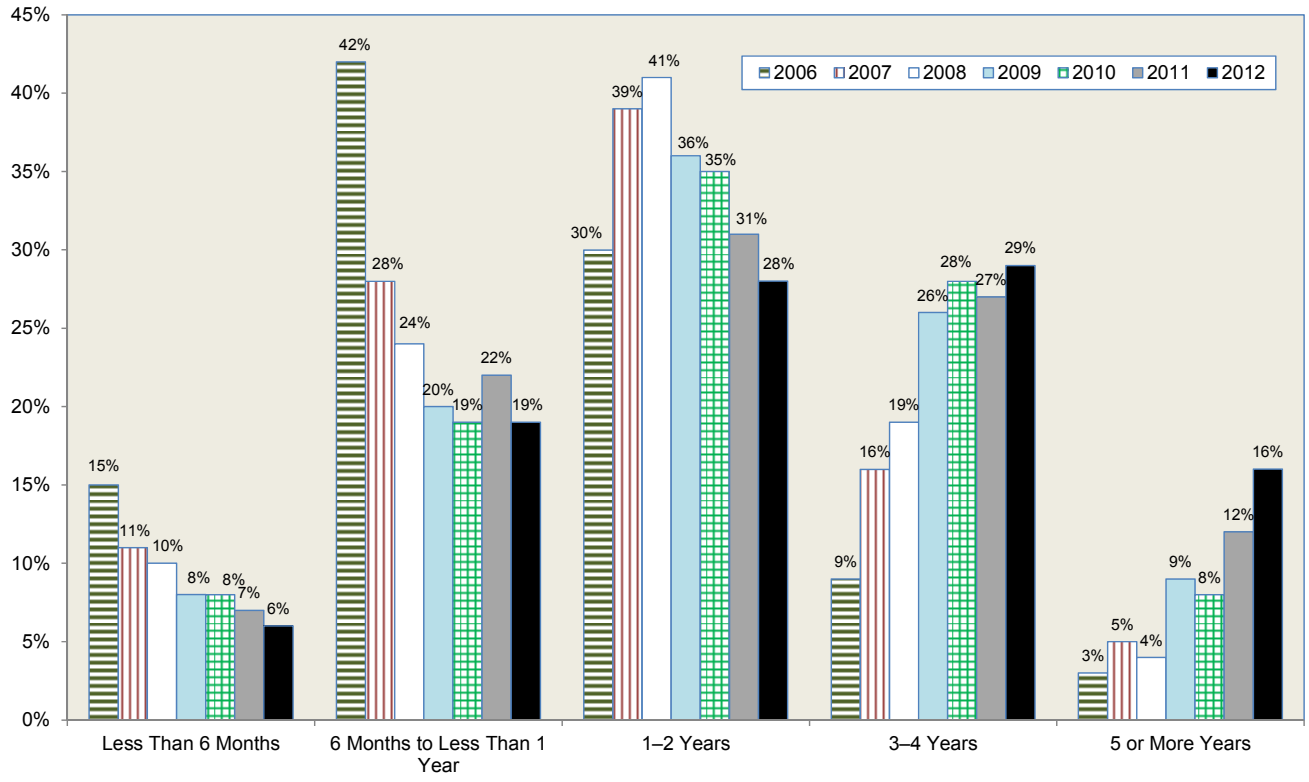
The 2012 survey was conducted within the United States between August 8 and August 17, 2012, through a 15-minute Internet survey. The national or base sample was drawn from Synovate's online panel of Internet users who have agreed to participate in research surveys.[3] About 2,000 adults (n=2,004) ages 21−64 who had health insurance through an employer or purchased directly from a carrier were drawn randomly from the Synovate sample for this base sample. This sample was stratified by gender, age, region, income, and race. The response rate was 37 percent (32 percent for the base sample or national sample, and 43 percent for the oversample). The margin of error for the national sample was ±2.2 percent.

The sample was divided into three groups: those with a consumer-driven health plan (CDHP), those with a high-deductible health plan (HDHP), and those with traditional health coverage. Individuals were assigned to the CDHP or HDHP group if they had a deductible of at least $1,000 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 198 individuals in a CDHP, an oversample of individuals with a CDHP was added. The oversample included 1,218 individuals with a CDHP. In addition to being stratified, the base sample was also weighted by gender, age, education, region, income, and race/ethnicity to reflect the actual proportions in the population ages 21–64 with private health insurance coverage.[4] The CDHP oversample was weighted by gender, age, income, and race/ethnicity. More information can be found in Fronstin (2012).

While panel Internet surveys are nonrandom, studies have demonstrated that such surveys, when carefully designed, obtain results comparable with random-digit-dial telephone surveys. Taylor (2003), for example, provides the results from a number of surveys that were conducted at the same time using the same questionnaires both via telephone and online. He found that the use of demographic weighting alone was sufficient to bring almost all of the results from the online survey close to the replies from the parallel telephone survey. He also found that in some cases, propensity weighting (meaning the propensity for a certain type of person to be online) reduced the remaining gaps, but in other cases it did not reduce the remaining gaps. Perhaps the most striking difference in demographics between telephone and online surveys was the under-representation of minorities in online samples.

Figure 1
Length of Time With HRA[a] or HSA,[b] 2006–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.
[a] Health reimbursement arrangement.
[b] Health savings account.

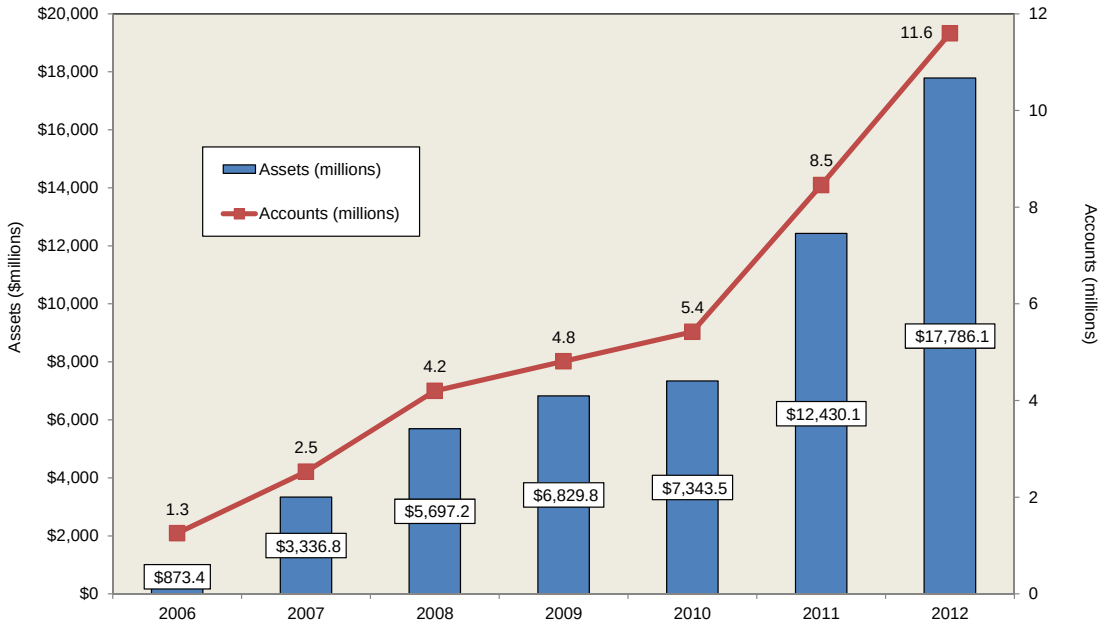
Account Balance Variation

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 held an HRA or HSA, employer contributions to the account, individual contributions to the account, and unused balance rollover amounts.[5] Unlike the overall data on account balances shown in Figure 4, 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 2012, men had an average of $1,772 in their HRA or HSA while women had $1,476 (Figure 6). Among both men and women, account balances increased between 2007 and 2009, fell in 2010, and then increased in 2011 and 2012.

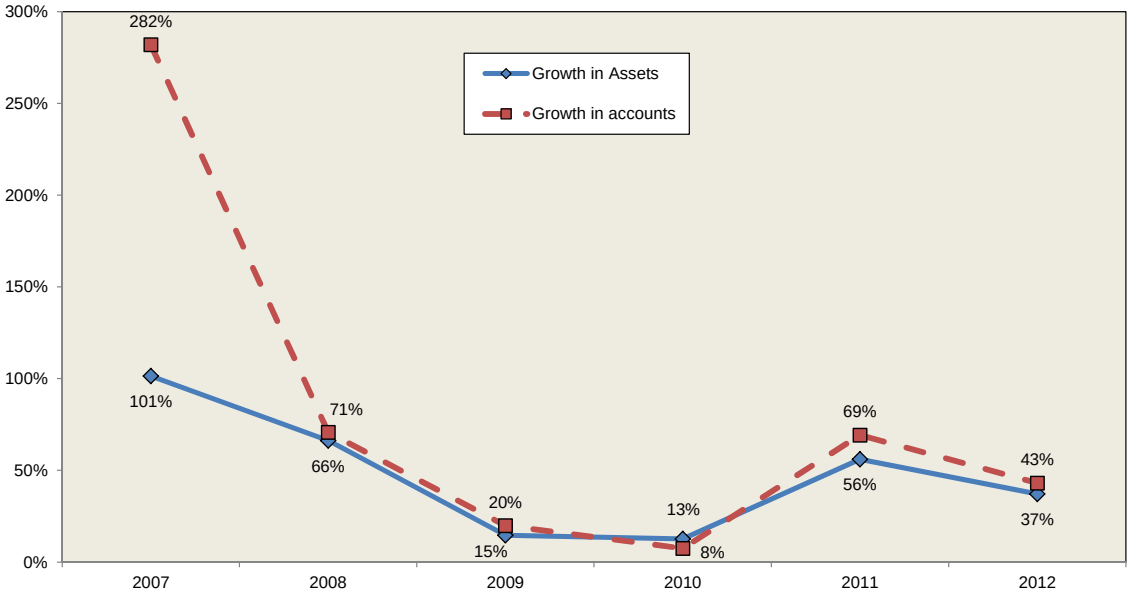
There is a general trend toward higher account balances with age. In 2012, individuals ages 55–64 had an average of $1,816 in their account, compared with between $1, 391 among those ages 21–34, $1,559 among those 35–44, and $1,639 for those 45–54 (Figure 7). This was found despite the fact that older individuals use more health care on average than younger ones. It is possible that older individuals were 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 2010).

Figure 2
Total Assets and Number of Adults Ages 21–64 With an HRA[a] or HSA,[b] 2006–2012



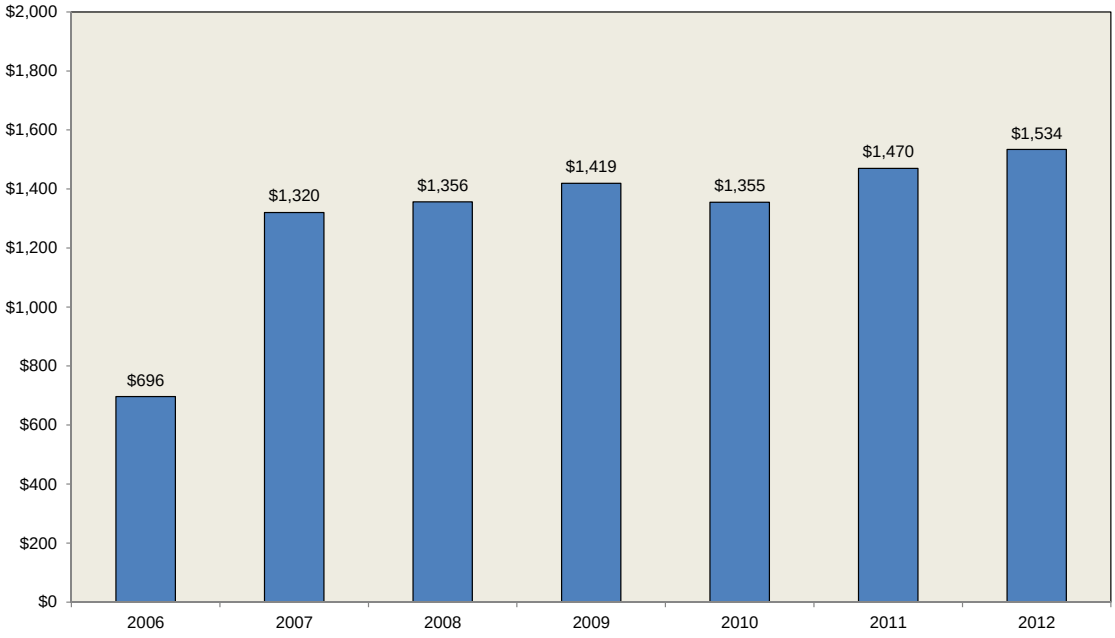
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.
[a] Health reimbursement arrangement.
[b] Health saving account.

Figure 3
Annual Growth Rate in HRA[a] or HSA[b] Assets and the Number of Accounts, 2007–2012



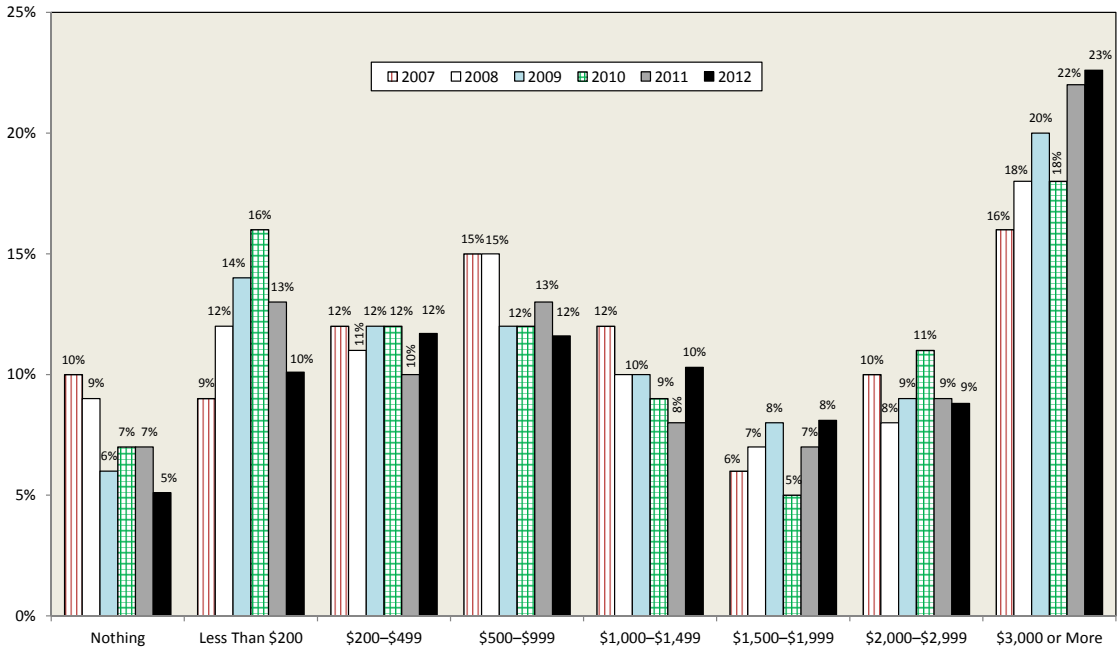
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.
[a] Health reimbursement arrangement.
[b] Health saving account.

Figure 4
Average HRA[a] or HSA[b] Account Balances, 2006–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 5
Distribution of HRA[a] or HSA[b] Account Balances, 2007–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.
[a] Health reimbusement arrangement.
[b] Health savings account.

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

When examining differences in account balances for men and women by age, men are still found to have higher account balances than women but the differences narrow with older ages (Figure 8).

Race—In 2009, 2010, and 2012, minorities with an HRA or HSA had higher account balances than whites with one of these accounts. However, in 2011, whites had higher account balances than minorities. On average, minorities had an account balance of $1,654 in 2012, while whites had an account balance of $1,600 in 2012 (Figure 9). Minorities experienced an increase in account balances in 2012, while whites saw their account balances decline.

Household Income—According to Figure 10, account balances for HSAs and HRAs increase with household income. In 2012, the average account balance was $1,246 among individuals with less than $50,000 in household income; $1,359 among individuals with $50,000–$99,999, and $1,957 among those with $100,000 or more. Account balances increased regardless of income level. While higher-income households may have contributed higher amounts to their HSAs than lower-income households, the regression equation controlled for contribution levels and educational attainment. The difference in account balances by household income *may* have been 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 were controlled for in the regression equation on which these estimates are based. In 2012, individuals with a high school degree or less had an average of $1,375 in their account, while those with a college degree had $1,627, and those with a graduate degree had $1,939 (Figure 11).

Type of Coverage—In formulating account balances for people with individual coverage and those with family coverage, a number of factors need to be considered. While individuals with family coverage often have higher cumulative deductibles than those with single coverage, and 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 both individuals with individual coverage and those with family coverage had an average account balance of $1,607 in 2012 (Figure 12). Those with individual coverage experienced an 11 percent increase in their account balance in 2012, while those with family coverage had only a 1 percent increase in their account balance average. In contrast, the average account balance of individuals with family coverage increased between 2010 and 2011, while it was unchanged for those with individual coverage.

Health Behaviors and Health Status—Individuals who smoke and those who exercise have more money in their accounts than those who do not smoke or exercise (Figure 13). In contrast, obese individuals were found to have less money in their account than the nonobese.

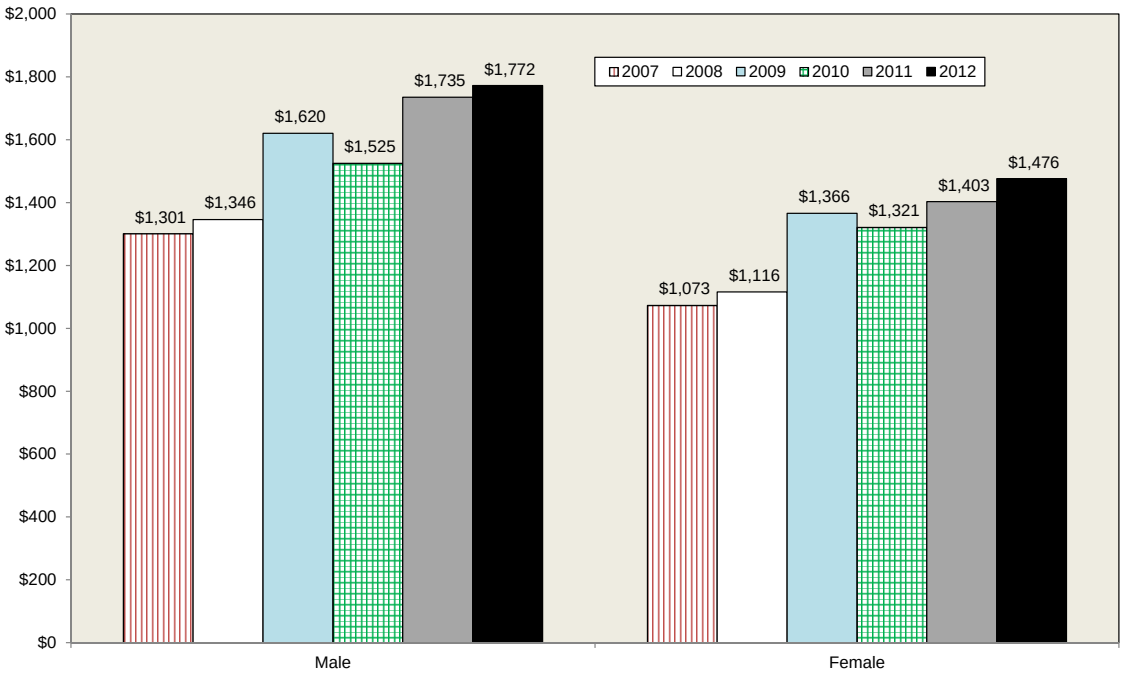
Use of Health Information and Programs—Account balances were examined using two variables to measure an individual's engagement in health care. One considered whether an individual used cost and quality information to choose a doctor. The other examined whether an individual participated in a wellness 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, or

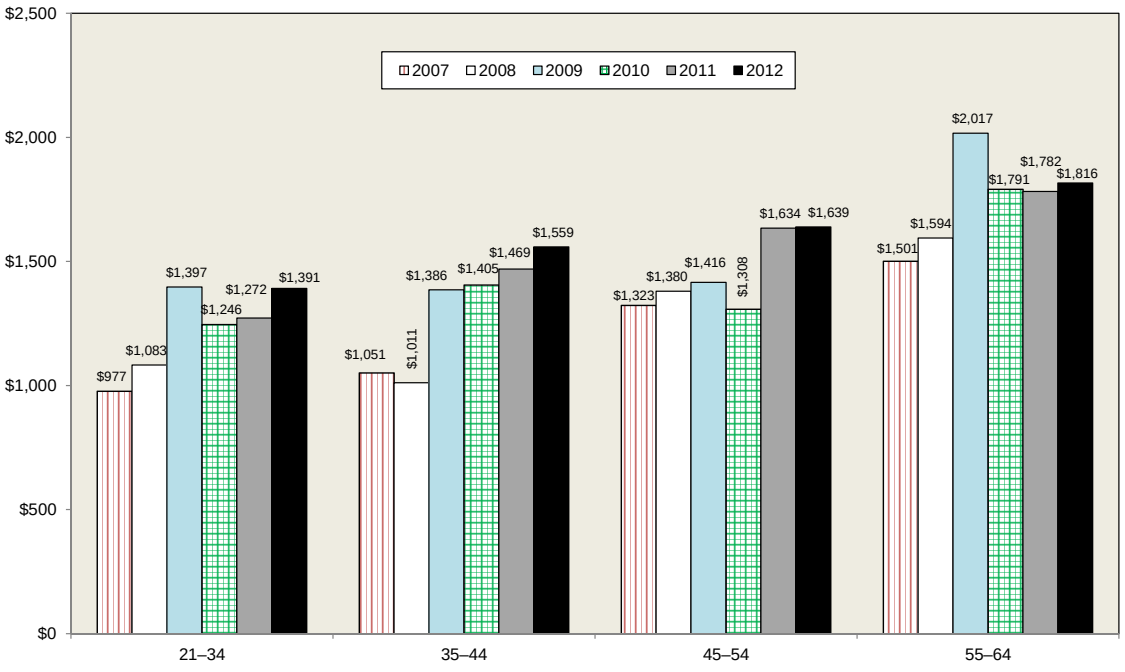
c) biometric screening, measurements or blood work to determine health status, such as blood pressure, cholesterol, weight, and height.

Figure 6
Account Balances, by Gender, 2007–2012



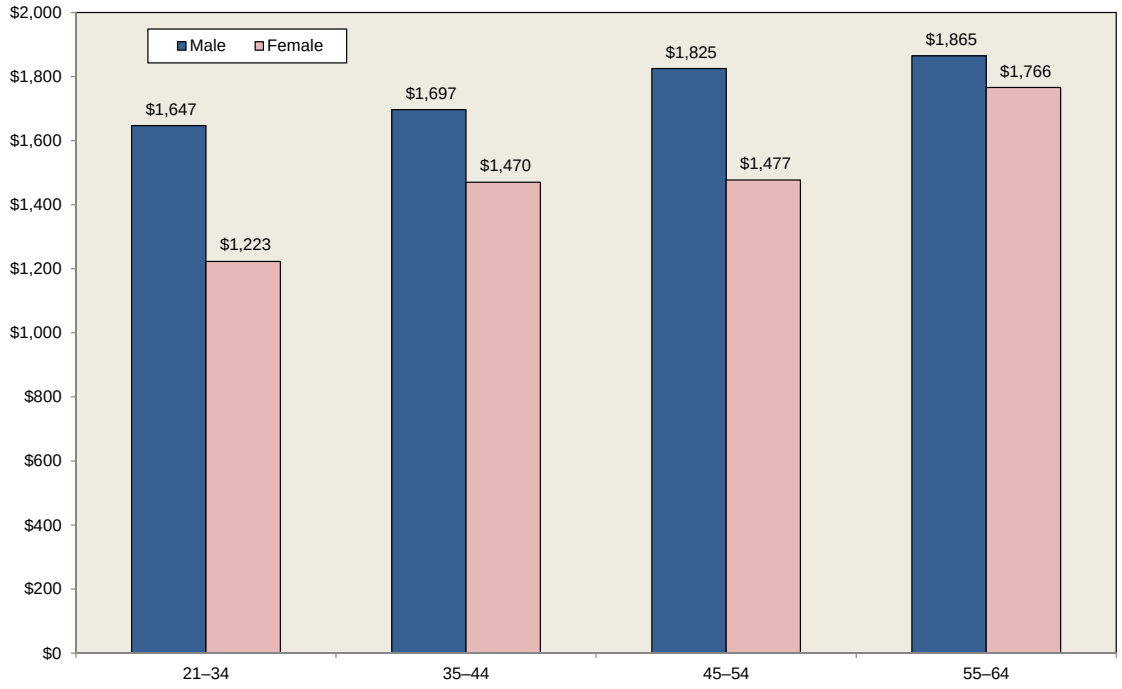
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 7
Account Balances, by Age, 2007–2012



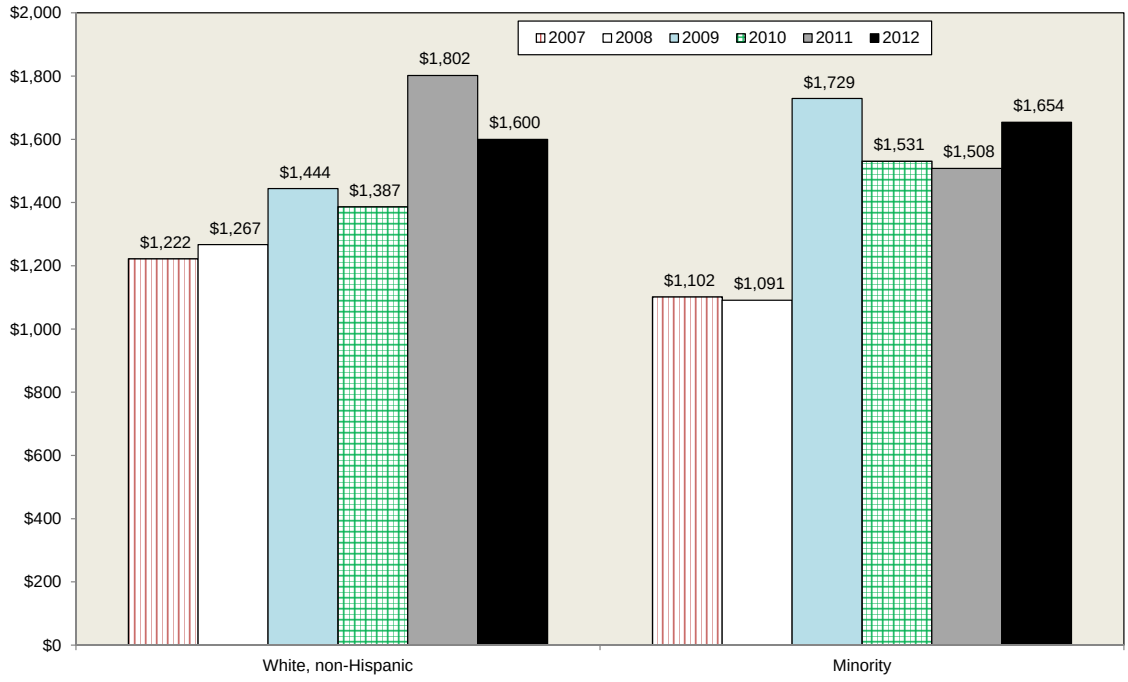
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 8
Account Balances, by Gender and Age Combined, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Figure 9
Account Balances, by Race, 2007–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008−2012.

With both variables, very small differences in account balances were found. Individuals who participated in a wellness program had a higher average account balance than those who did not. The average account balance was $1,670 among those who participated in a wellness program, and $1,573 among those who did not participate (Figure 14).

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 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?

Few differences in account balances by cost-conscious decision making were found (Figure 15).

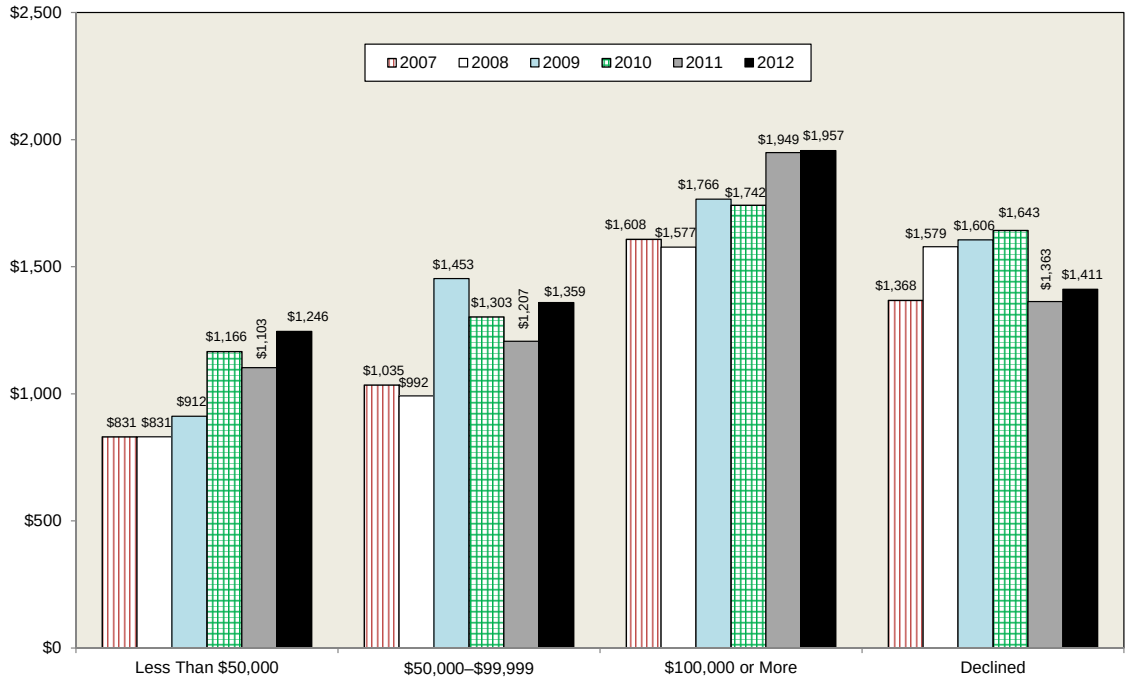
Length of Time With Account—Not surprisingly, the length of time that an individual has had an account has a major impact on the amount of money in the account. The analysis found that people who held an account in 2012 for less than six months had an average of $849 in their account, and those who held an account at least six months but less than a year had $967 (Figure 16). In comparison, individuals with an account for one to two years had an average of $1,528, those with an account for three to four years had an average of $1,896, and those with an account for at least five years had an average account balance of $2,320. In 2012, the average account balance increased most for those who held an account for five years or more. Those who held an account for five years or more experienced an increase from $1,968 to $2,320 between 2011 and 2012.

Employer and Individual Contributions—Annual contribution amounts, whether they come from the employer (in the case of HRAs and HSAs), or from individuals (HSAs only) have a strong impact on overall account balances. Not surprisingly, the more that is contributed to an account, the higher the average account balance. In 2012, for instance, individuals with an employer contribution of less than $1,000 had an average account balance of $1,563, while those with an employer contribution of at least $1,000 had an average of $1,697 in their account (Figure 17). Similarly, individuals who contributed less than $1,000 had an average account balance of $1,209, while those who contributed at least $1,000 had an average balance of $1,951 (Figure 18).

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

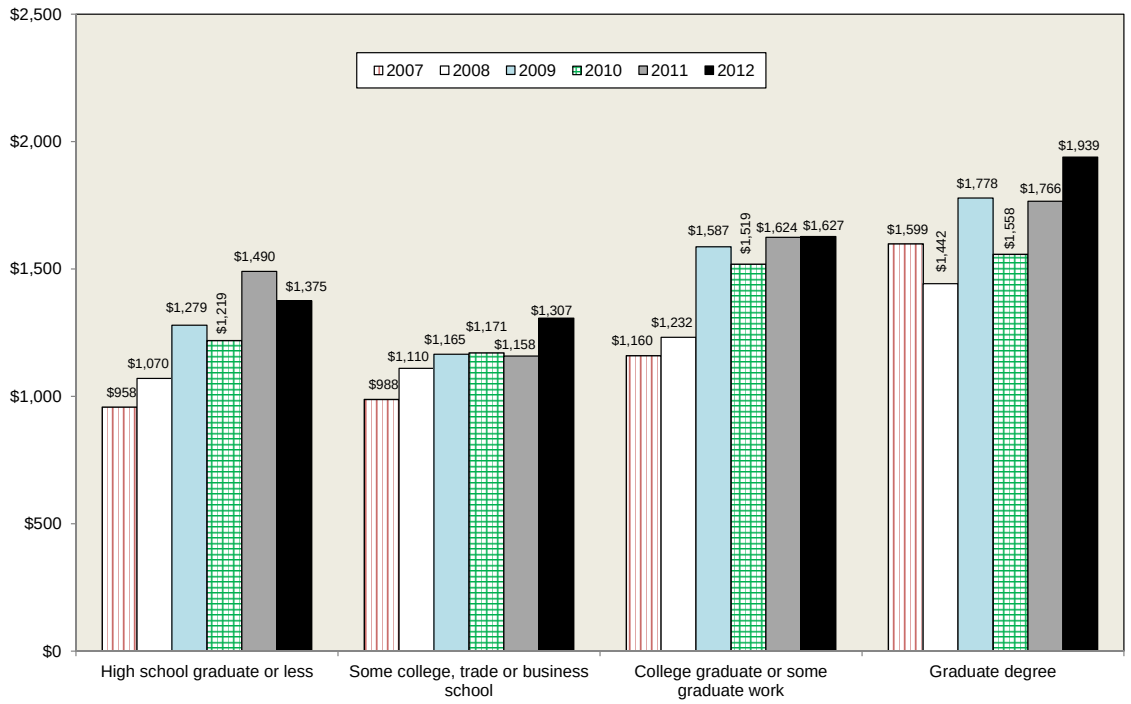
Rollovers—As with contribution levels, annual rollover amounts are one of the biggest factors in average account balances. Individuals with a rollover less than $1,000 had an average account balance of $1,083 (Figure 19). In comparison, individuals with a rollover of at least $1,000 had an average account balance of $2,778.

Figure 10
Account Balances, by Annual Household Income, 2007–2012



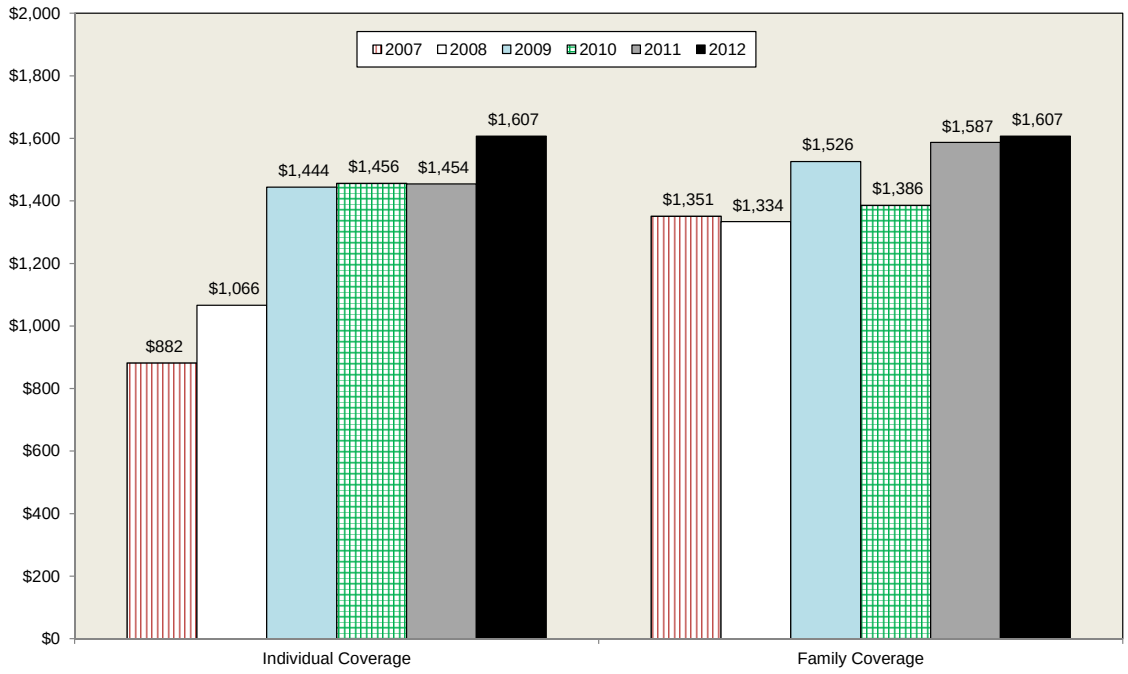
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 11
Account Balances, by Education, 2007–2012



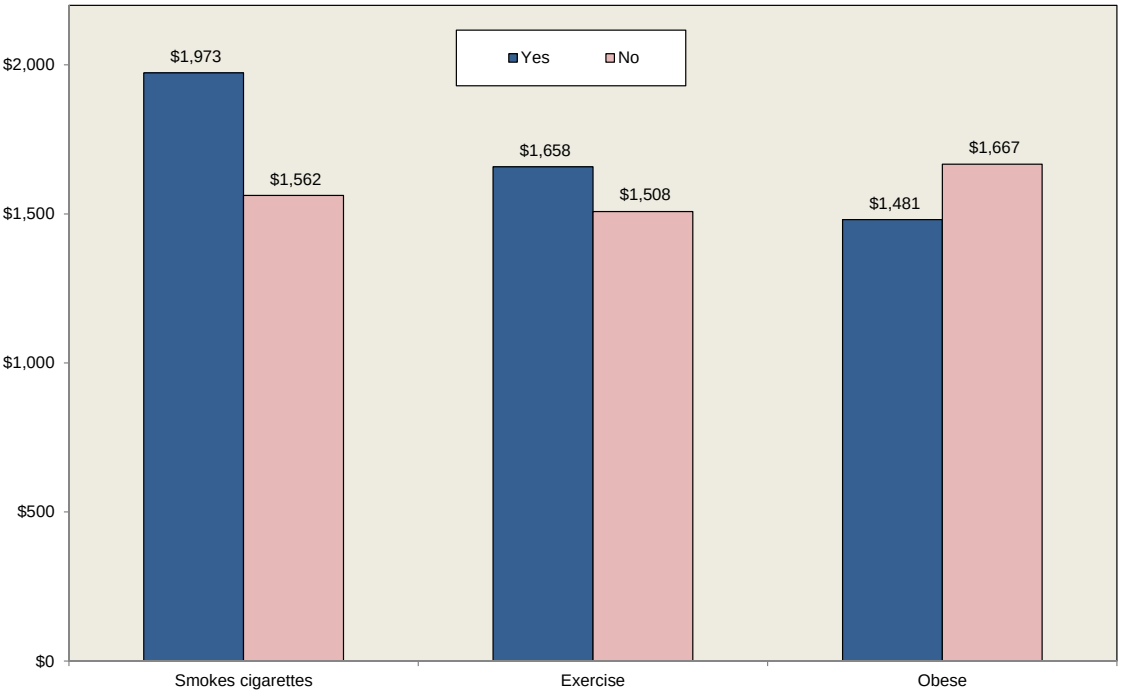
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 12
Account Balances, by Plan Type, 2007–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 13
Account Balances, by Health Behavior and Health Status, 2012



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Rollovers

Employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. Leftover funds at the end of each year can be carried over to the following year (at the employer's discretion). Employers can, however, place restrictions on the amount that can be carried over. When it comes to HSAs, any money left in an account at the end of the year automatically rolls over and is available in the following year because there is no use-it-or-lose-it rule, as is the case with flexible spending accounts.[6]

Over time, 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 20). By 2012, only 11 percent did not have a rollover.

The number of people with a rollover, as well as the total level of assets being rolled over, has been increasing. In 2006, 500,000 individuals rolled over $276.2 million (Figure 21). By 2012, 8.1 million individuals rolled over $9.7 billion. The average rollover increased from $592 in 2006 to $1,206 in 2012 (Figure 22). Average rollover amounts increased between 2010 and 2011 but remained at $1,206 in 2012.

The remainder of this section examines variation in rollover amounts. The estimates in this section were generated from a regression equation that also controlled for how long an individual has held an HRA or HSA, employer contributions to the account, and individual contributions to the account.[7] As with 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 2012, men had an average rollover of $1,224 while women had $1,036 (Figure 23). Average rollover amounts increased for both men and women between 2011 and 2012.

The oldest adults had the largest rollover amounts in 2012. Individuals ages 55–64 had an average rollover of $1,350, compared with $969 for individuals 21–34, $1,057 for those 35–44, and $1,105 for those 45–54 (Figure 24).

When examining differences in rollovers for men and women by age, men have higher average rollover amounts than women regardless of age. (Figure 25).

Race—In most years, whites had lower rollover amounts than minorities. However, in 2012, whites had slightly higher rollover amounts than minorities. On average, minorities had a $1,106 rollover in 2012, while whites had a $1,121 rollover (Figure 26).

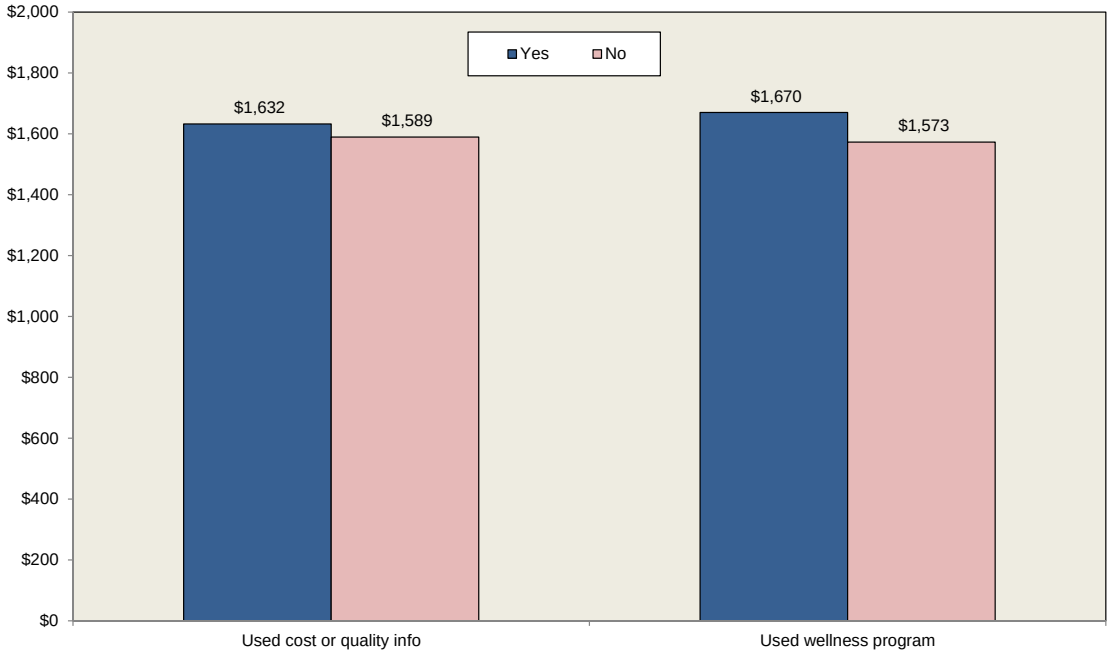
Household Income—According to Figure 27, rollover amounts generally increase with household income. In 2012, the average rollover was $951 among individuals with less than $50,000 in household income, $920 among those with $50,000–$99,999, and $1,353 among those with $100,000 or more in household income. In 2012, rollover amounts increased for those with less than $50,000 in household income, and for those with $50,000–$99,999 in household income, but decreased 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 on which these estimates are based. Individuals with a high school degree or less had an average rollover of $944, while those with a college degree had an average rollover of $1,173, and those with a graduate degree had an average rollover of $1,243 (Figure 28).

Type of Coverage—Individuals with single coverage had an average rollover of $1,137 in 2012, whereas those with family coverage had a $1,112 average rollover (Figure 29).

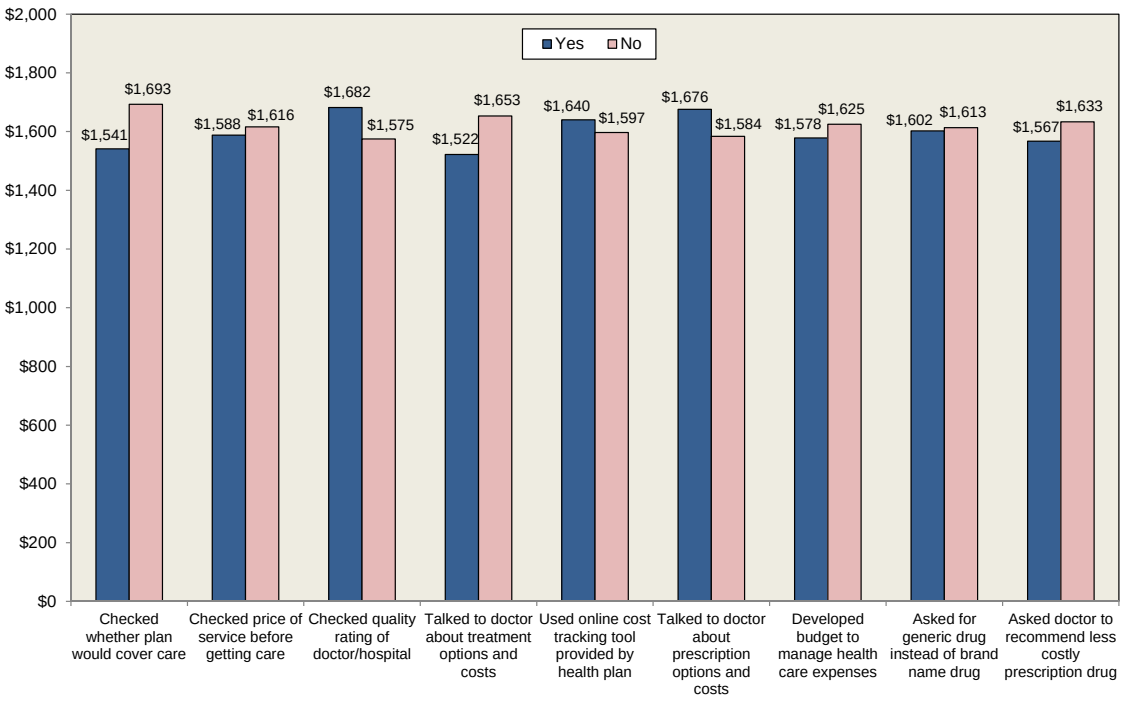
Health Behaviors and Health Status—Individuals who smoke had higher rollover amounts than individuals who do not smoke (Figure 30). Those who exercise had slightly higher rollover amounts than those who did not. Obese individuals had lower average rollover amounts ($979) than the nonobese ($1,185).

Figure 14
Account Balances, by Use of Cost and Quality Information and Use of Wellness Program, 2012



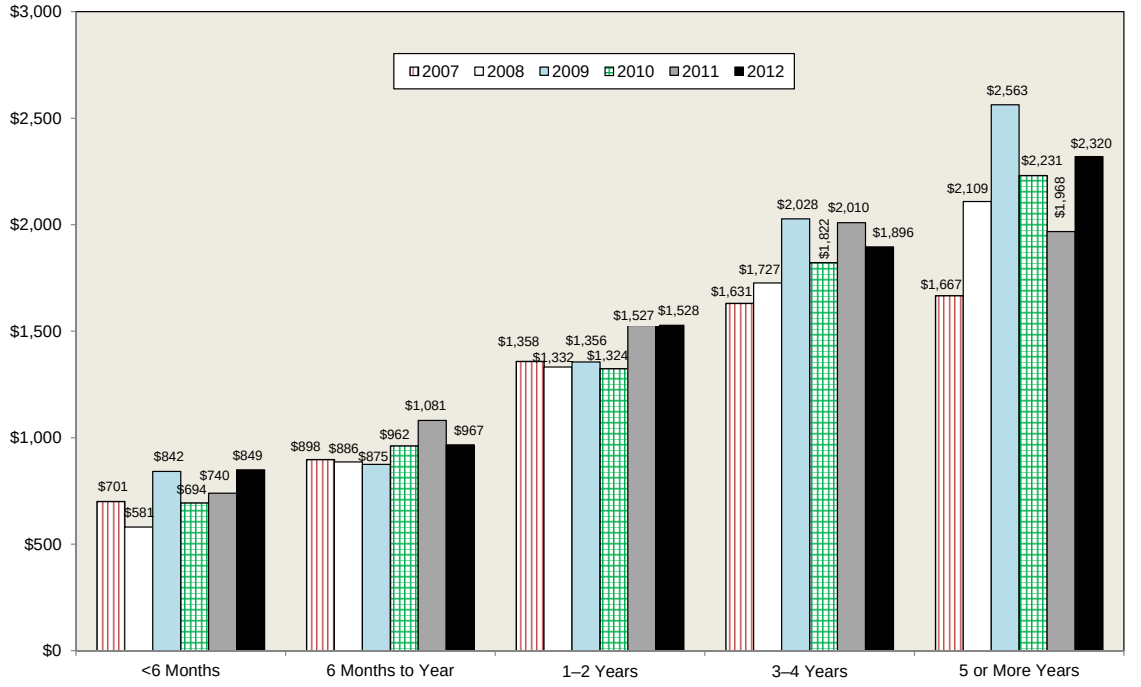
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Figure 15
Account Balances, by Various Cost Conscious Behaviors, 2012



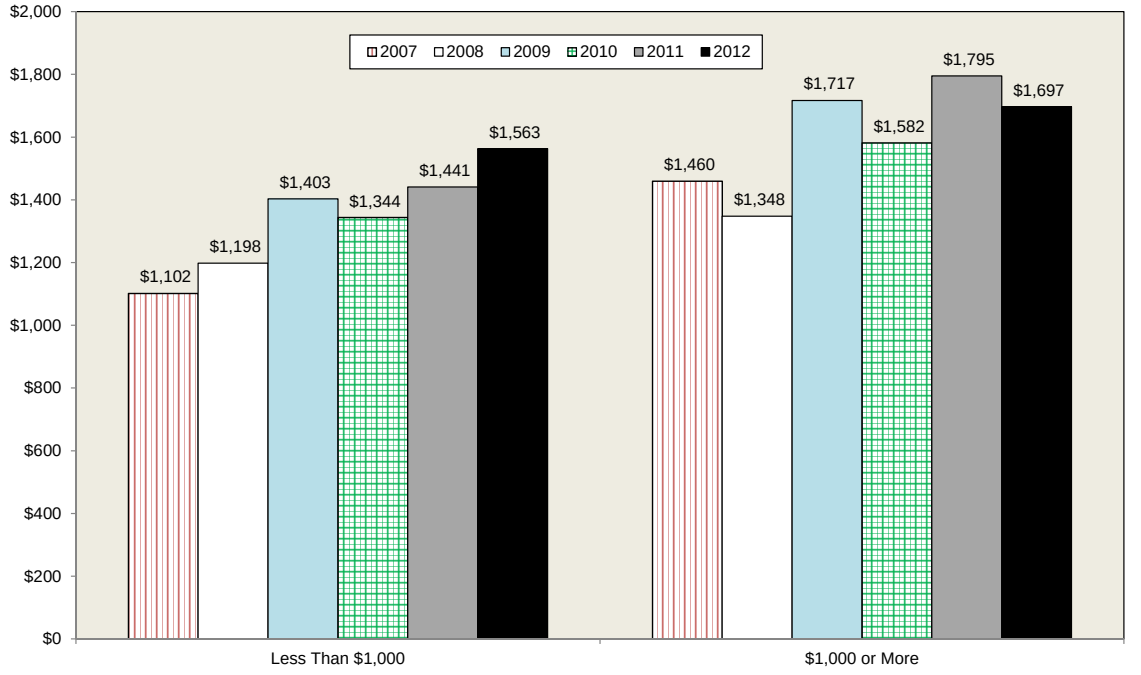
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Figure 16
Account Balances, by Length of Time With Account, 2007–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 17
Account Balances, by Level of Annual Employer Contribution, 2007–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

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 questions regarding cost-conscious decision making were described above. Differences in rollover amounts by various cost-conscious decision-making questions were relatively small (Figure 32).

Length of Time With Account—The length of time that an individual has held the account had an impact on rollover amounts. The analysis found that people holding an account for one to two years had an average rollover of $932 in 2012 (Figure 33). In comparison, those holding an account for three to four years had an average rollover of $1,214, and those with an account at least five years old had an average rollover of $1,627. Average rollover amounts in 2012 fell among those holding accounts less than five years and increased among those holding accounts at least five years.

Employer and Individual Contributions—Annual contribution amounts from individuals had a strong impact on overall rollover amounts, whereas employer contributions were not found to have a statistically significant effect on rollover amounts. Individuals with an employer contribution of less than $1,000 had an average rollover of $1,076 in 2012, while those with an employer contribution of at least $1,000 had an average rollover of $1,208 (Figure 34). In contrast, individuals who contributed less than $1,000 had an average rollover of $900, while those who contributed at least $1,000 had an average rollover of $1,308, a difference that is statistically significant (Figure 35).

Conclusion

Employers first started offering health reimbursement arrangements (HRAs) in 2001, and they were able to start offering health plans with health savings accounts (HSAs) in 2004. By 2011, 32 percent of employers with 500 or more workers offered either an HRA or HSA-eligible plan, covering 13 percent of that population, up from 23 percent offering such a plan and 10 percent enrollment in 2010. As a result, these plans covered about 25 million people in 2012, representing about 15 percent of the privately insured market.

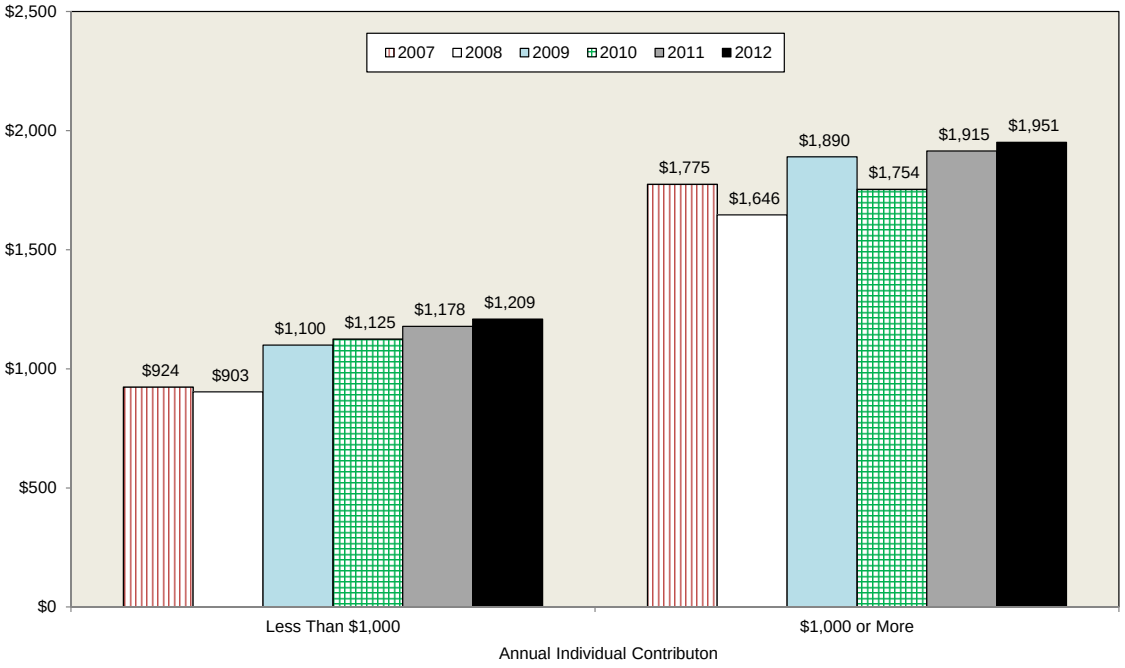
According to findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey, there was $17.8 billion in HSAs and HRAs in 2012, spread across 11.6 million accounts. In 2006, there were 1.3 million accounts with $873.4 million in assets, and by 2009, 4.8 million accounts held $6.8 billion in assets. Total assets in the accounts have increased each year, and average account balances are growing at a slower rate. The average account balance reached $1,534 in 2011.

The number of people with a rollover as well as the total level of assets being rolled over have been increasing. In 2006, 23 percent of individuals with an HRA or HSA did not roll over any money, but by 2012, only 11 percent did not have a rollover. In 2006, 500,000 individuals rolled over $276.2 million, but by 2012, 8.1 million individuals rolled over $9.7 billion. The average rollover increased from $592 in 2006 to $1,206 in 2012.

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

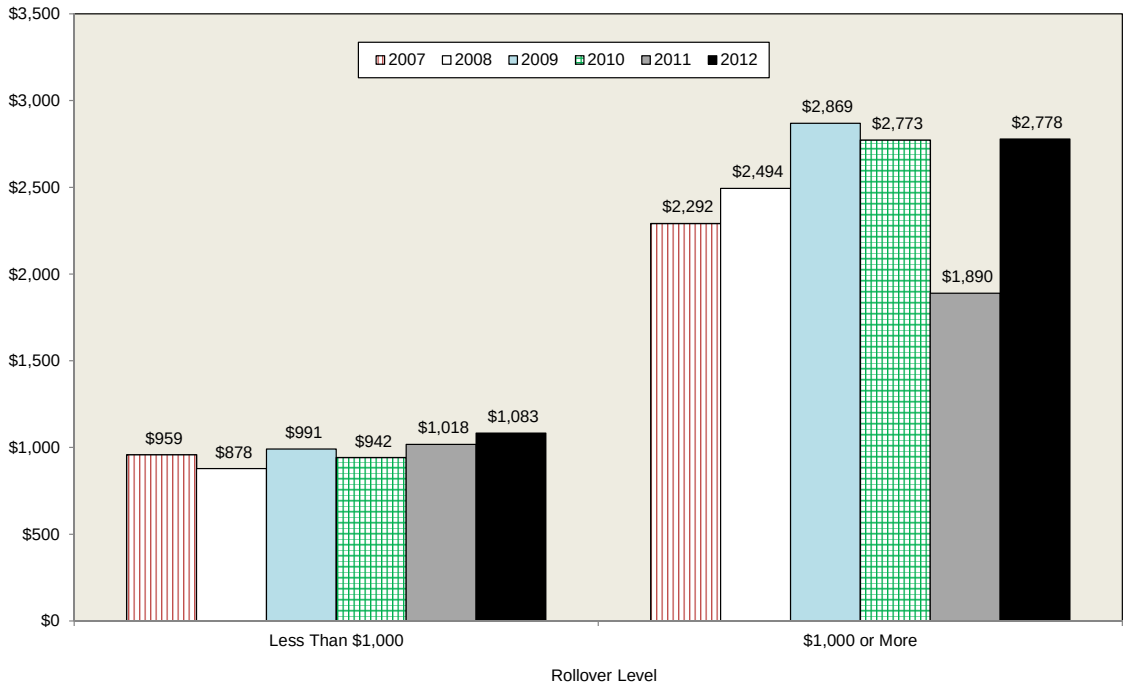
Very small differences were found in account balances and rollover amounts between individuals who used cost or quality information compared with those who did not use such information. However, next to no relationship was found between either account balance or rollover amounts and various cost-conscious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

Figure 18
Account Balances, by Level of Annual Individual Contribution, 2007–2012



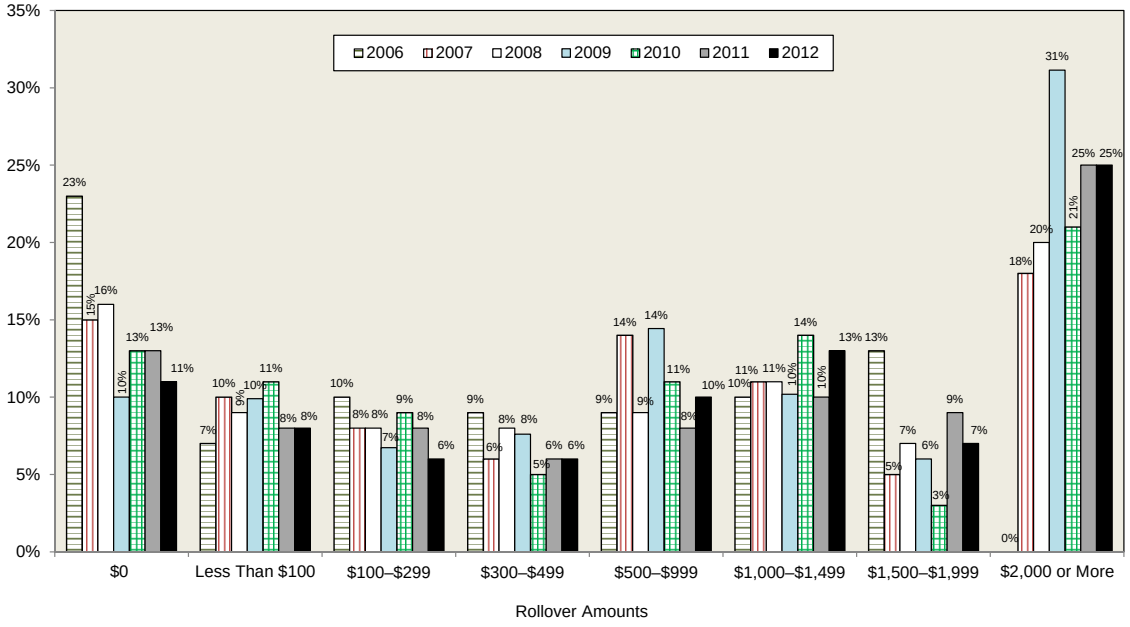
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 19
Account Balances, by Rollover Level, 2007–2012



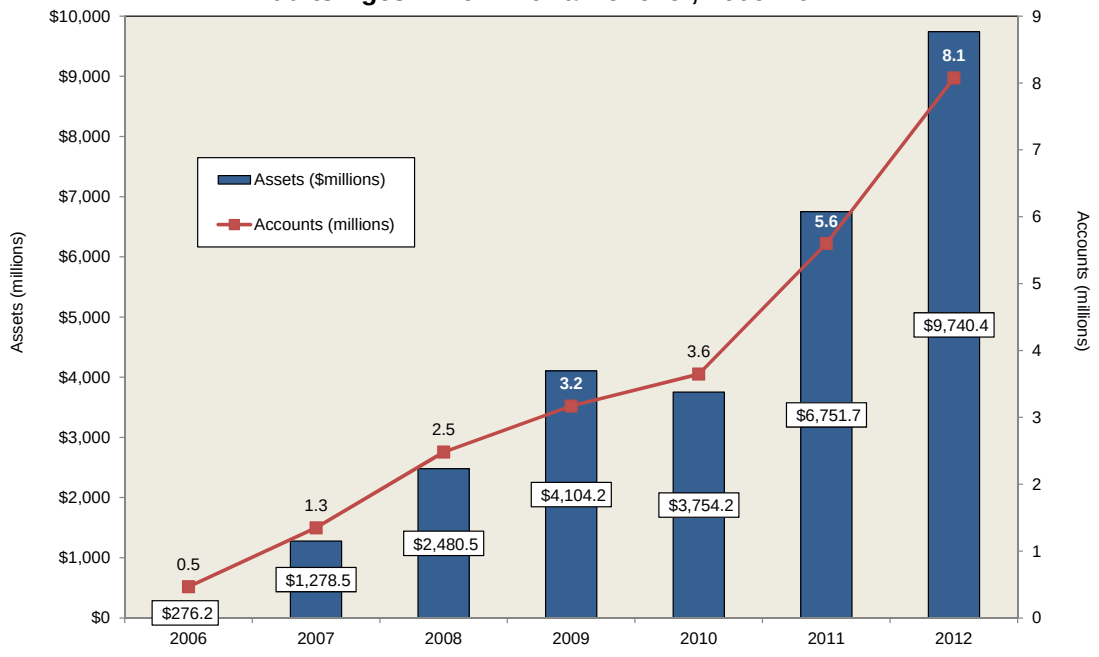
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 20
Rollover Amounts, Among Individuals With Account for More Than One Year, 2006–2012



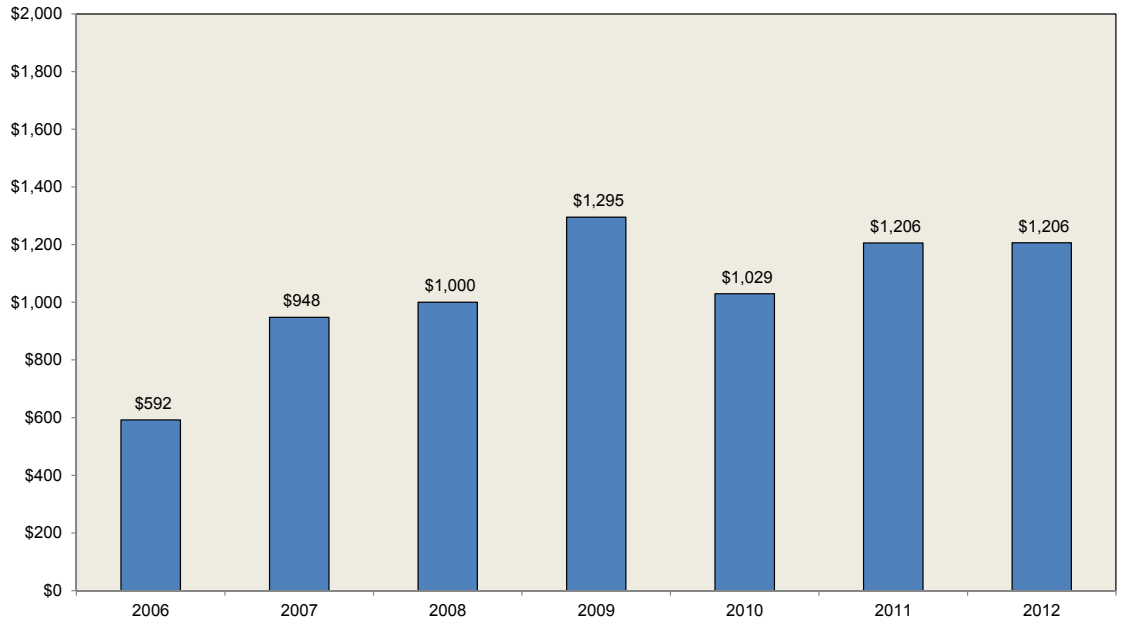
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.
Note: 2006 data was capped at $1,500 or more.

Figure 21
Total Rollover Assets and Number of Adults Ages 21–64 With a Rollover, 2006–2012



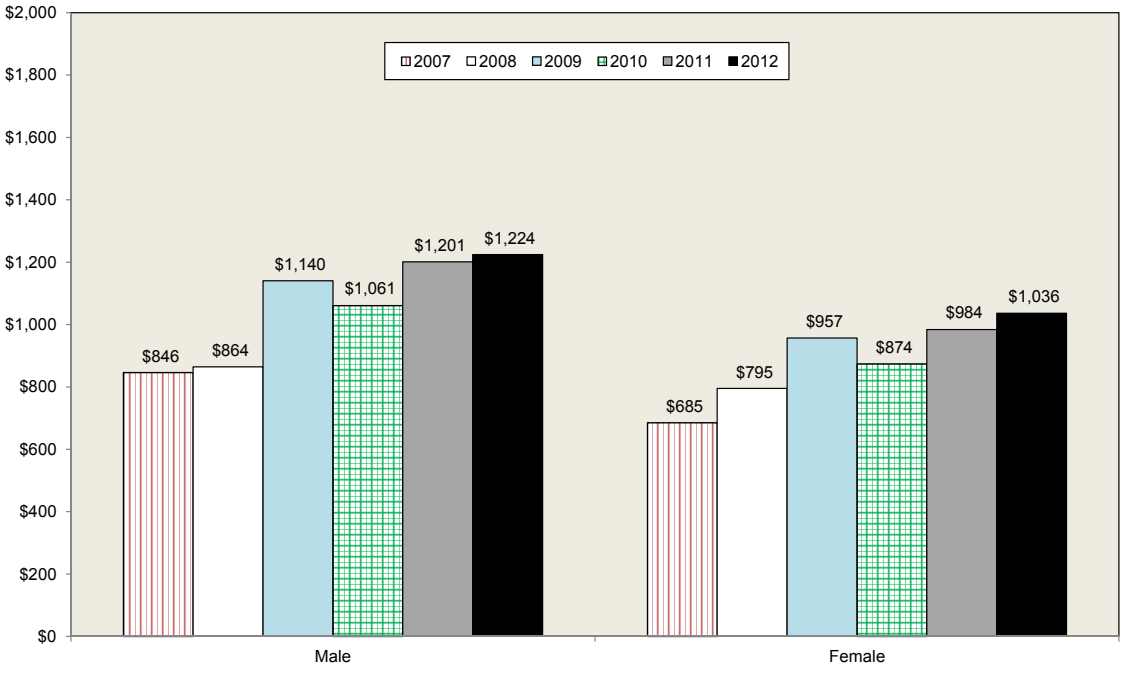
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 22
Average HRA[a] or HSA[b] Rollover Amount, 2006–2012



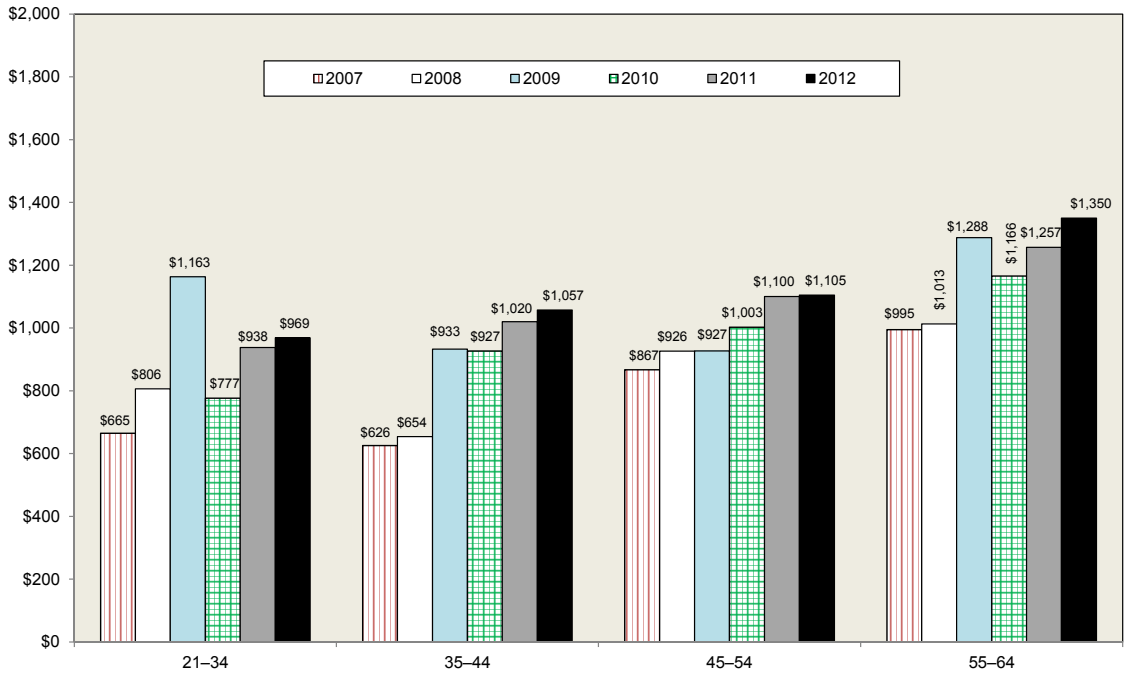
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006–2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.
[a] Health reimbursement arrangement.
[b] Health savings account.

Figure 23
Rollover Amount, by Gender, 2007–2012



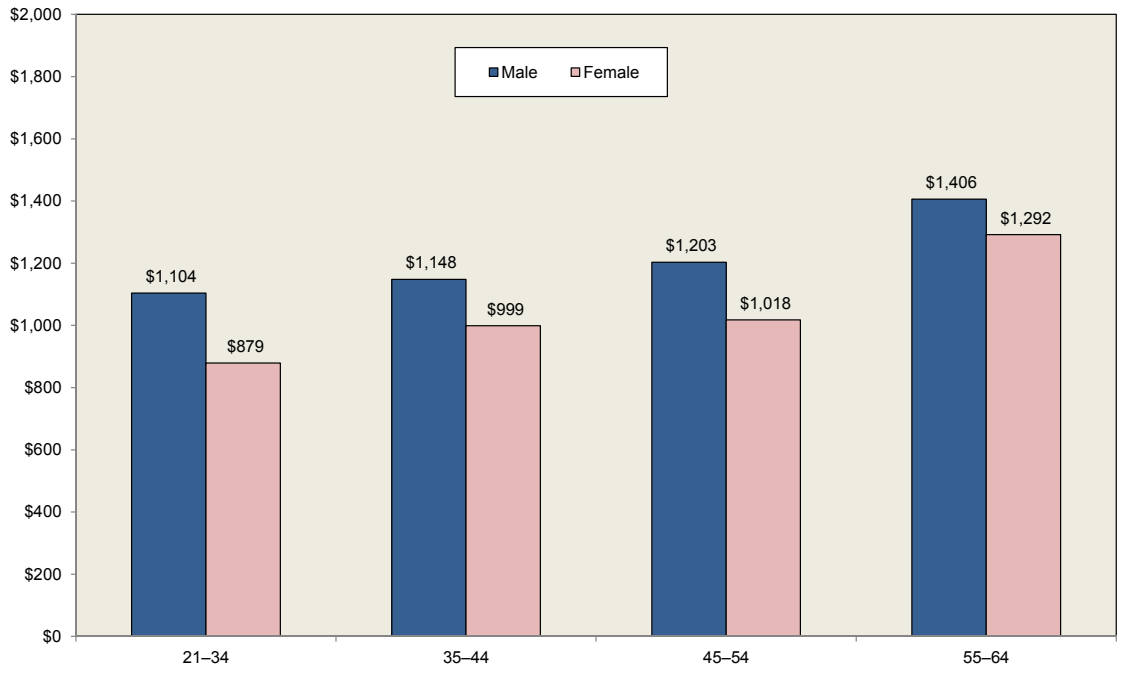
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 24
Rollover Amount, by Age, 2007–2012



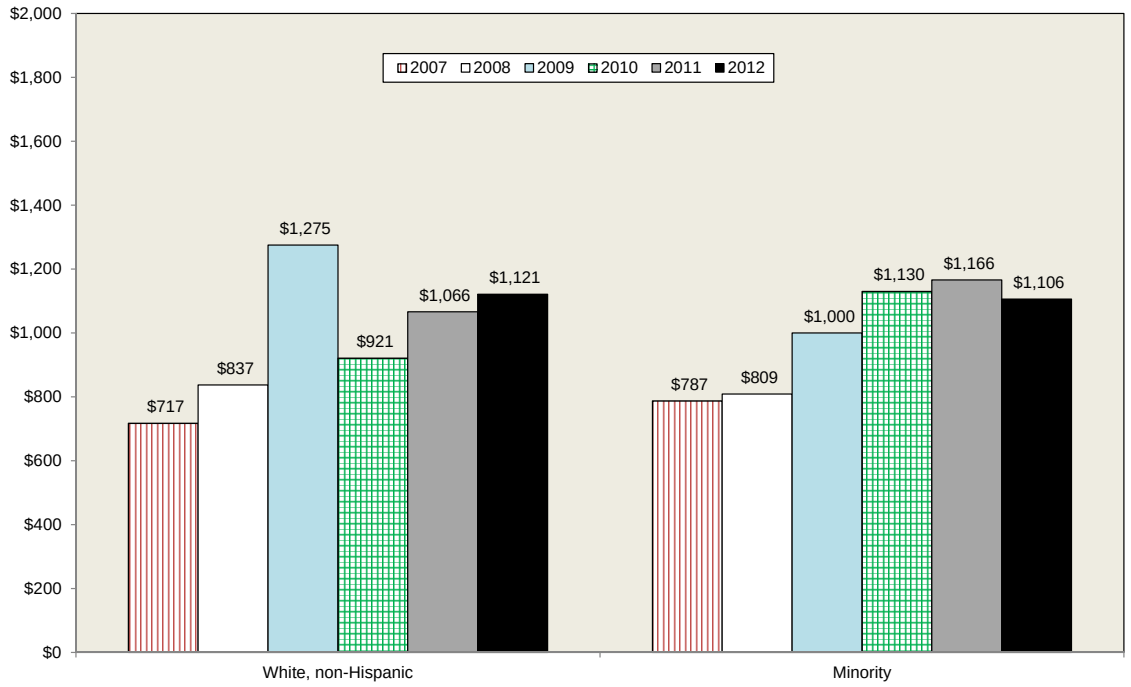
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 25
Rollover Amount, by Gender and Age Combined, 2012



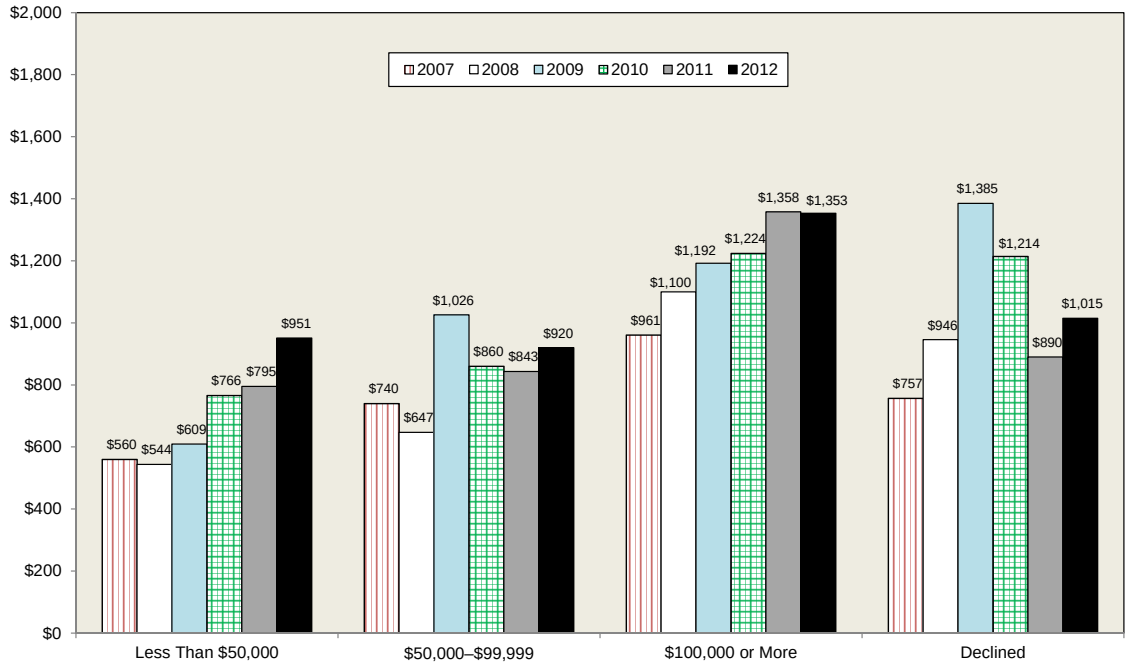
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Figure 26
Rollover Amount, by Race, 2007–2012



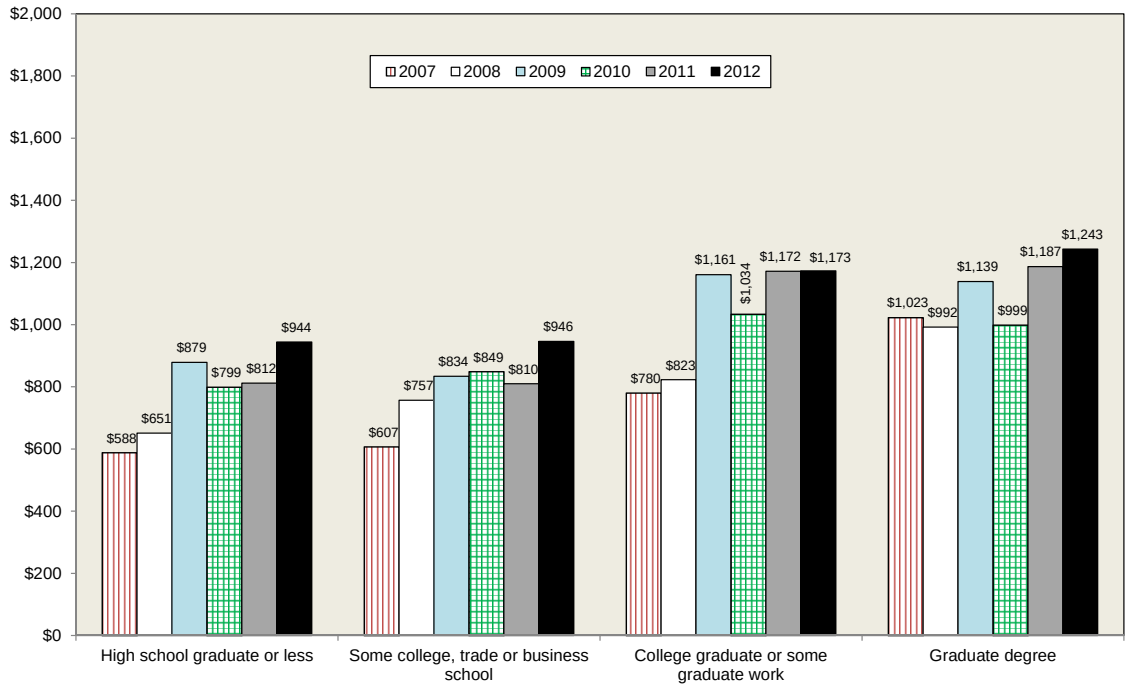
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 27
Rollover Amount, by Annual Household Income, 2007–2012



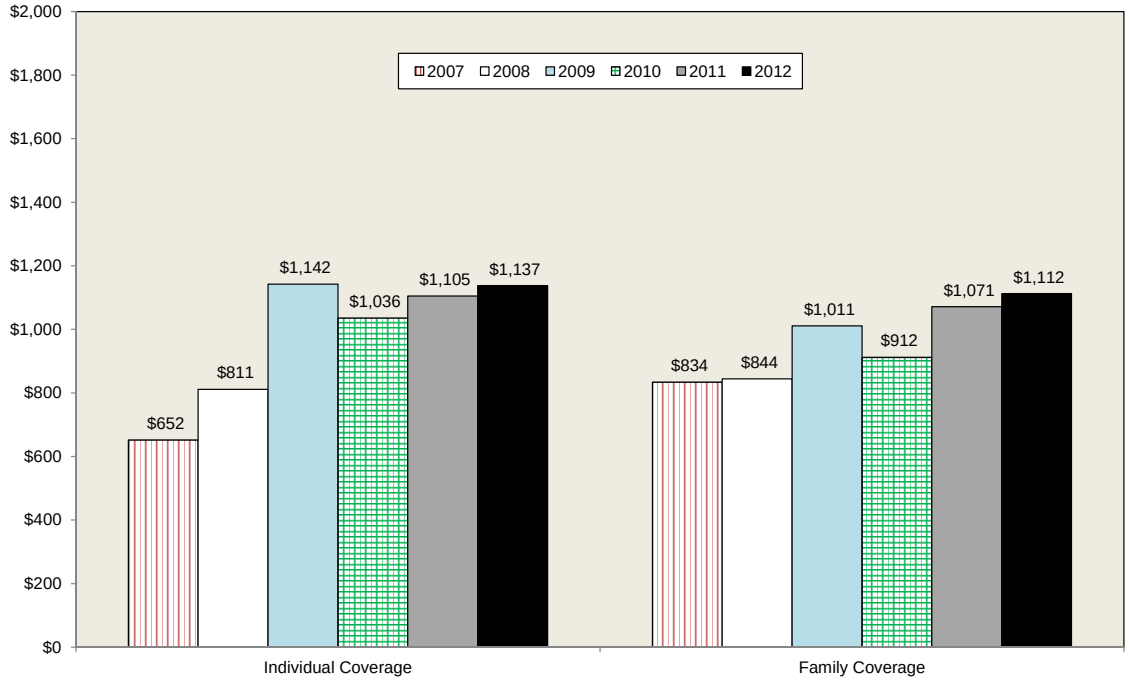
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 28
Rollover Amount, by Education, 2007–2012



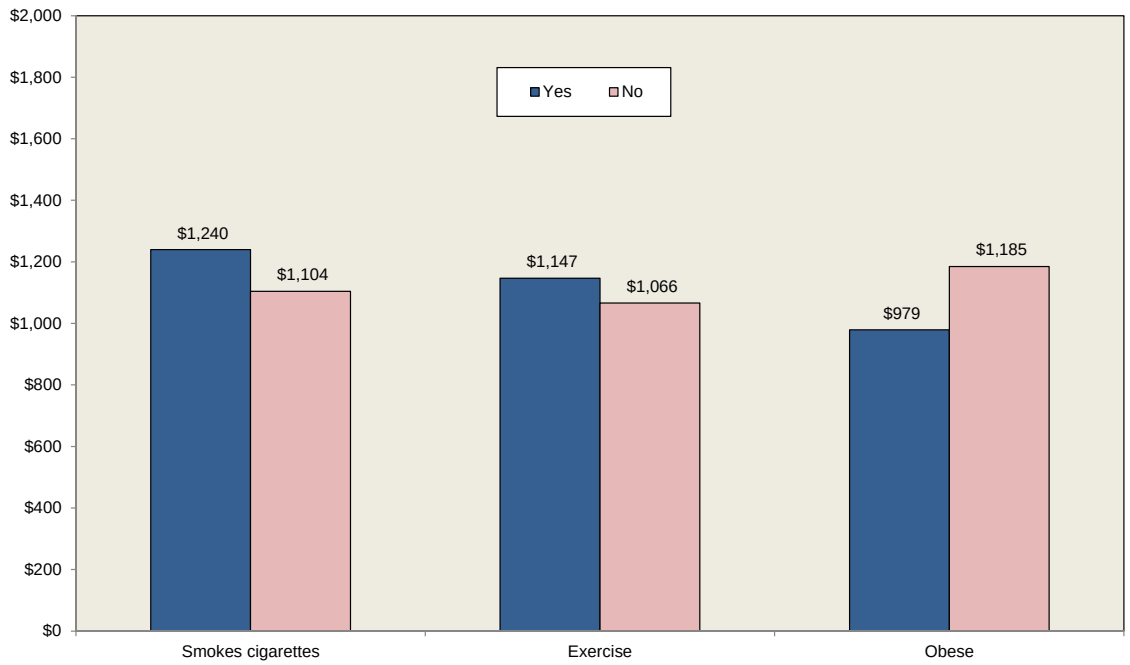
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 29
Rollover Amount, by Plan Type, 2007–2012



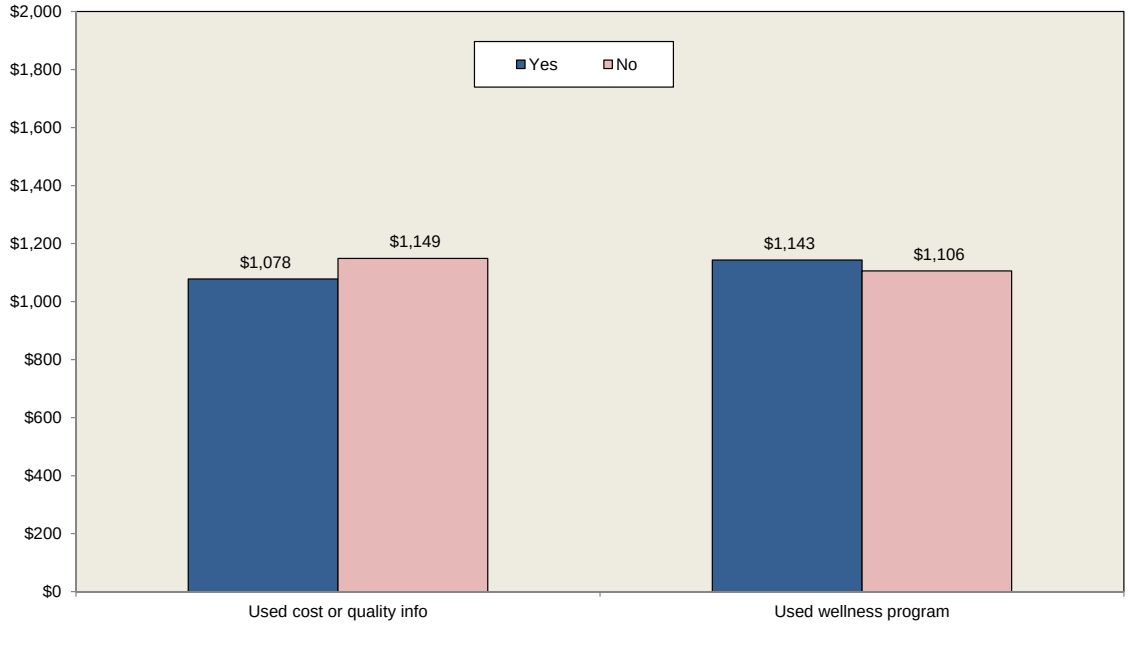
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 30
Rollover Amount, by Health Behavior and Health Status, 2012



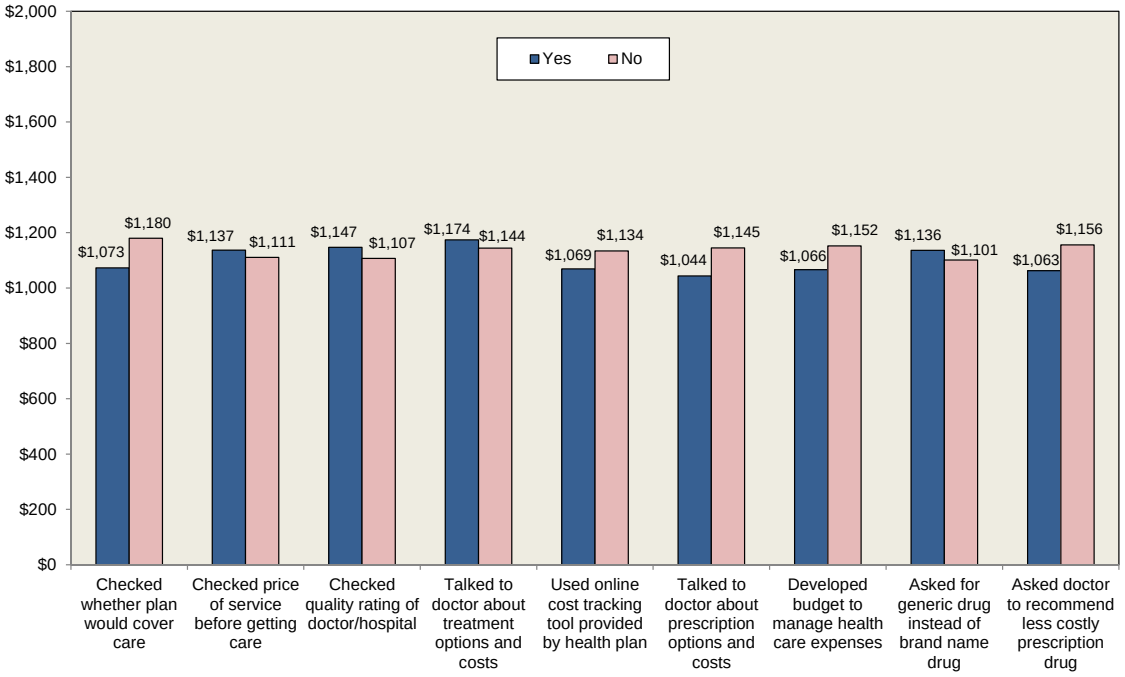
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Figure 31
Rollover Amount, by Use of Cost and Quality Information and Use of Wellness Program, 2012



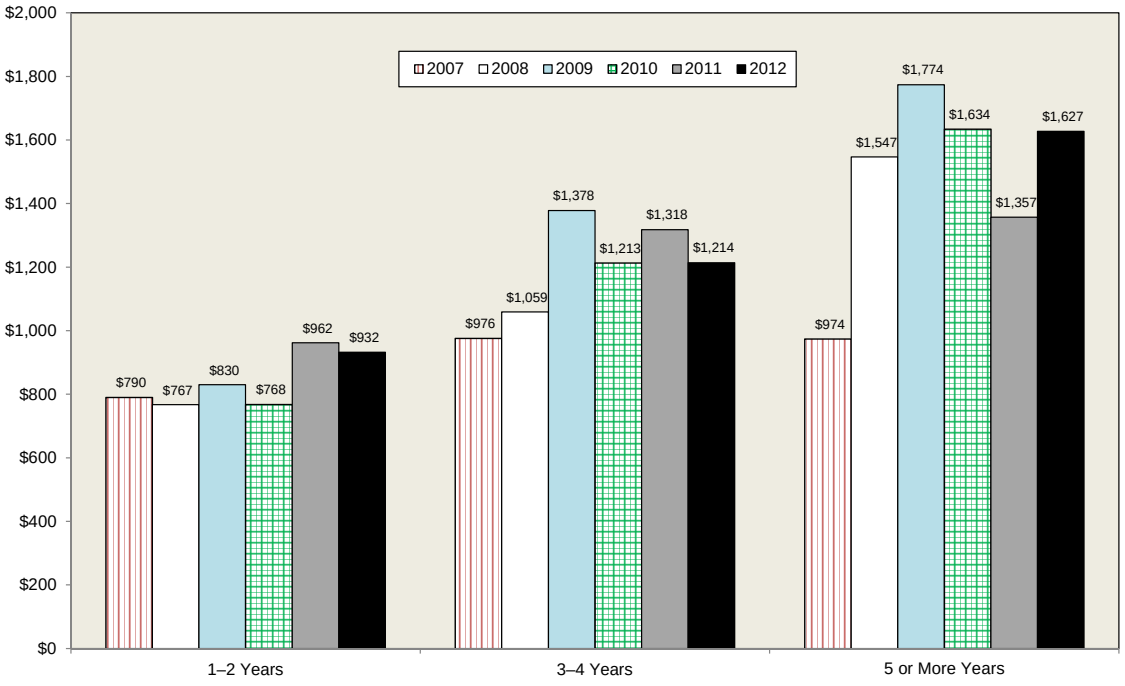
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Figure 32
Rollover Amount, by Various Cost Conscious Behaviors, 2012



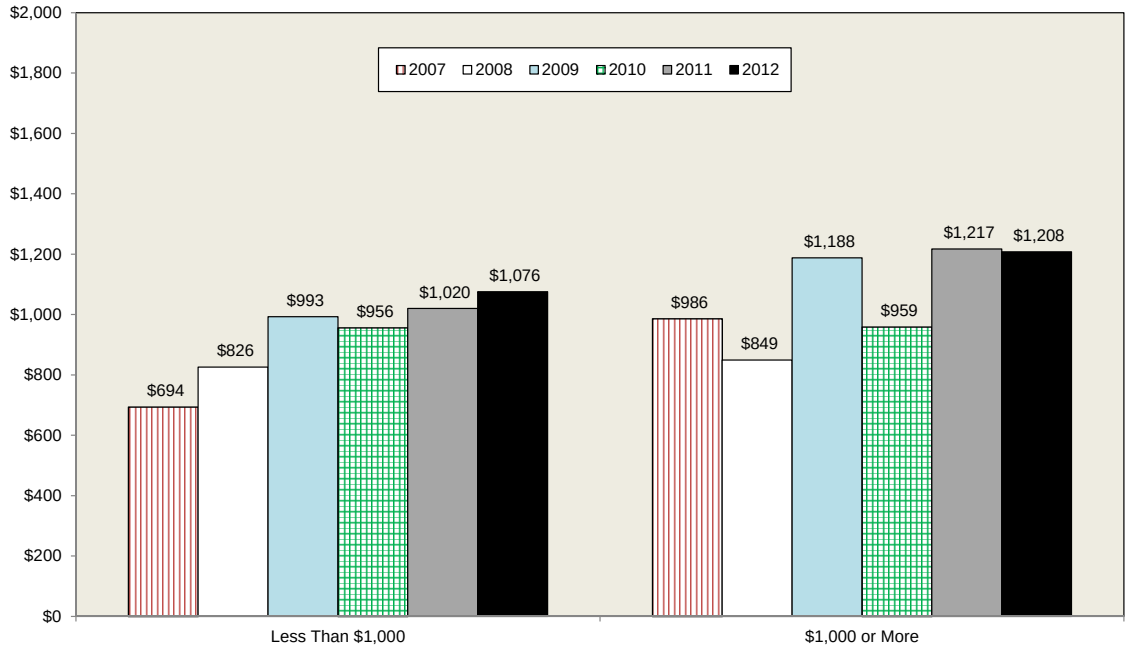
Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.

Figure 33
Rollover Amount, by Length of Time With Account, 2007–2012



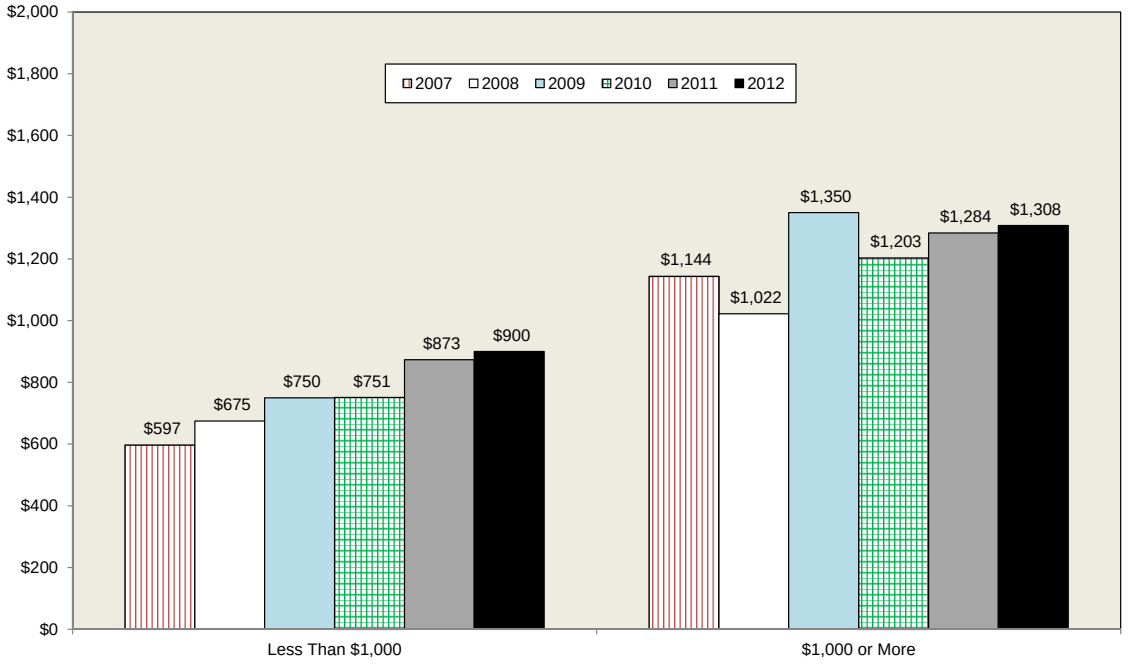
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 34
Rollover Amount, by Level of Annual Employer Contribution, 2007–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

Figure 35
Rollover Amount, by Level of Annual Individual Contribution, 2007–2012



Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007. EBRI/MGA Consumer Engagement in Health Care Survey, 2008–2012.

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Endnotes

[1] See www.mercer.com/pressrelease/details.htm?idContent=1491670

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

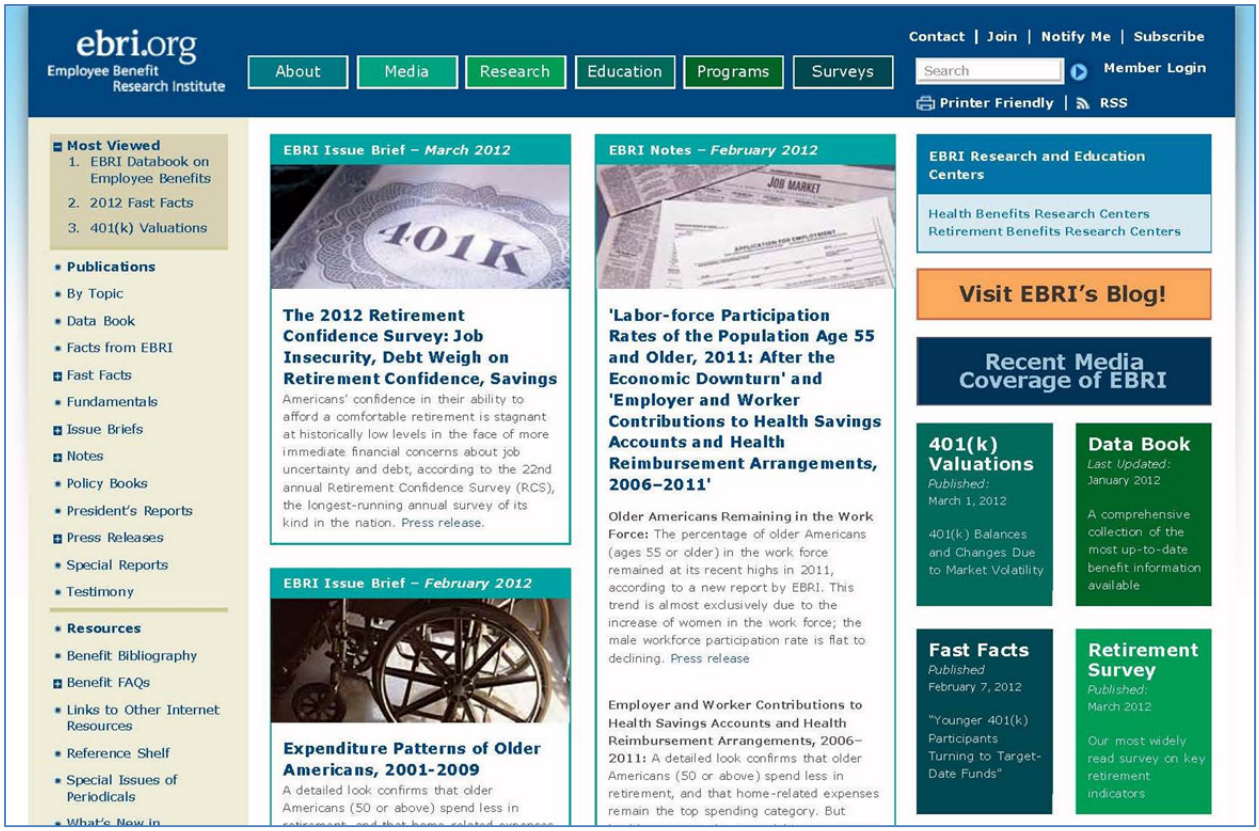
[3] See www.globalopinionpanels.com/home

[4] In theory, a random sample of 2,000 yields a statistical precision of plus or minus 2.2 percentage points (with 95 percent confidence) of what the results would be if the entire population ages 21–64 with private health insurance coverage were surveyed with complete accuracy. There are also other possible sources of error in all surveys that may be more serious than theoretical calculations of sampling error. These include refusals to be interviewed and other forms of nonresponse, the effects of question wording and question order, and screening. While attempts are made to minimize these factors, it is impossible to quantify the errors that may result from them.

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

[6] Individuals are also able to roll over funds from one HSA into another HSA without subjecting the distribution to income and penalty taxes as long as the rollover does not exceed 60 days. Rollover contributions from Archer Medical Savings Accounts (MSAs) are also permitted.

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



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