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Trends in Health Savings Account Balances, Contributions, Distributions, and Investments, 2011–2017: Estimates From the EBRI HSA Database

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

AT A GLANCE

The Employee Benefit Research Institute (EBRI) developed the EBRI HSA Database to analyze the state of and individual behavior in Health Savings Accounts (HSAs). The HSA database contains 5.9 million accounts with total assets of $13.4 billion as of Dec. 31, 2017. This *Issue Brief* is the second longitudinal study from the HSA database and supplements the annual cross-sectional analyses. It examines trends of account balances, individual and employer contributions, distributions, invested assets, and account-owner demographics from 2011–2017. Plan sponsors who wish to introduce or continue offering HSA-eligible health plans as part of their workplace benefit program can leverage this long-term view of account-holder behaviors when developing strategies to increase employee financial wellness.

Key findings:

On average, account holders appear to be using HSAs as specialized checking accounts rather than investment accounts. HSAs offer a valuable tax incentive to set aside money on a tax-favored basis for current or future medical expenses. However, most account holders appear to be using the accounts to cover current expenses, such as deductibles, coinsurance, and copayments, rather than fully taking advantage of the tax preference by contributing the maximum.

- Average total contributions — combined individual and employer contributions — increased from $2,348 to $2,843 between 2011 and 2017. This average was just above the minimum allowable deductible amount for family coverage, but less than one-half the allowable contribution maximum for family coverage.
- Overall, 66 percent of account holders withdrew funds. The average annual amount distributed was $1,725 in 2017, implying an average rollover of $1,119.
- Very few account owners invested their HSA balance in investments other than cash despite the tax-saving possibilities. In 2017, 5 percent had investments other than cash.

Longer experience with HSAs improves account-holder prospects for financial security. The rollover feature of HSAs enables account holders to build up a balance for unexpected major medical expenses — in the near future and/or for retirement.

- Average end-of-year balances, by the year the account was opened, show that financial security increases over time. Accounts opened in 2007 had an average $8,384 year-end account balance, while accounts opened in 2017 had an average $1,093 year-end account balance.

- Annual 2017 contributions are higher the longer an account owner had an account. Individual contributions averaged $3,201 among those who opened their account in 2007 but only averaged $1,240 among those who opened their account in 2017.
- Older, larger accounts offer a stronger hedge against unexpected bills. Those accounts opened in 2007 had an average annual distribution of $2,568, while those only opened in 2017 took $1,005 in distributions.
- Over time, account owners appear to see the value in investing. In 2017, 10 percent of accounts opened in 2007 had investments other than cash, compared with only 2 percent among those opened in 2017. It is possible that rules requiring minimum balances may have prevented owners of relatively new accounts from investing as the accounts would not have reached the minimum balance requirement.

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 authors and should not be ascribed to the officers, trustees, or other sponsors of EBRI, Employee Benefit Research Institute-Education and Research Fund (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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Trends in Health Savings Account Balances, Contributions, Distributions, and Investments, 2011–2017: Estimates From the EBRI HSA Database

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

Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allows individuals enrolled in high-deductible health plans meeting certain requirements to open and fund health savings accounts (HSAs), a tax-exempt trust or custodial account that is funded with contributions and assets that an individual can use to pay for health care expenses. Individuals can contribute to an HSA only if they are enrolled in an HSA-eligible health plan. HSAs benefit from a triple tax advantage: Employee contributions to the account are deductible from taxable income,[1] any interest or other capital earnings on assets in the account build up tax free, and distributions for qualified medical expenses from the HSA are excluded from taxable income to the employee.[2] Contributions are limited to $3,450 for people with individual coverage and $6,900 for those with family coverage (Figure 1).

Enrollment in HSA-eligible health plans and the number of HSAs have increased since the plans first became available in 2004. In 2017, enrollment in HSA-eligible health plans was estimated to be between 21.4 and 33.7 million policyholders and their dependents (Fronstin 2018). As many as one-quarter of smaller employers (10–499 employees) and 61 percent of larger employers (500 or more employees) offered an HSA-eligible health plan or HRA in 2016, covering nearly 1 in 3 workers with health insurance, with most of those workers in HSA plans (Figure 2). It has also been estimated that there were about 22.2 million HSAs holding $45.2 billion in assets as of Dec. 31, 2017.[3]

Enrollment in HSA-eligible health plans is expected to continue to grow. According to Mercer's survey of employers, 25 percent of employers with 10–499 employees and 61 percent of employers with 500 or more employees offered an HSA-eligible health plan or HRA in 2016. By 2019, 34 percent of employers with 10–499 employees and 72 percent of employers with 500 or more employees said they would be very likely to offer such a health plan.

While there is growing literature around how individuals in HSA-eligible health plans use and pay for medical services,[4] there are very few sources of data on the HSAs themselves and the owners of such accounts. The most recent report by America's Health Insurance Plans (AHIP) includes data on account balances, contributions, distributions, and account-owner demographics, but the most recent data available is from 2012.[5] Devenir reports trend data going back to 2006 from a survey of HSA providers, but the data is aggregated and does not provide the kind of detail available in the AHIP report.[6] The EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey (CEHCS), conducted annually since 2005, collects self-reported demographic information on enrollees in HSA-eligible health plans and on their HSA balances, contributions, and distributions, but the survey is based on a relatively small sample, limiting the ability to do detailed analysis on balances, contributions, and distributions.[7]

To improve on data limitations, EBRI created the EBRI HSA Database to collect a large, representative repository of administrative information from record-keepers about HSAs and account owners.

This *Issue Brief* is the second longitudinal study to examine trends in cross-sectional data from the EBRI HSA Database. It examines account balances, individual and employer contributions, distributions, investments, and account-owner demographics from 2011–2017.

Figure 1

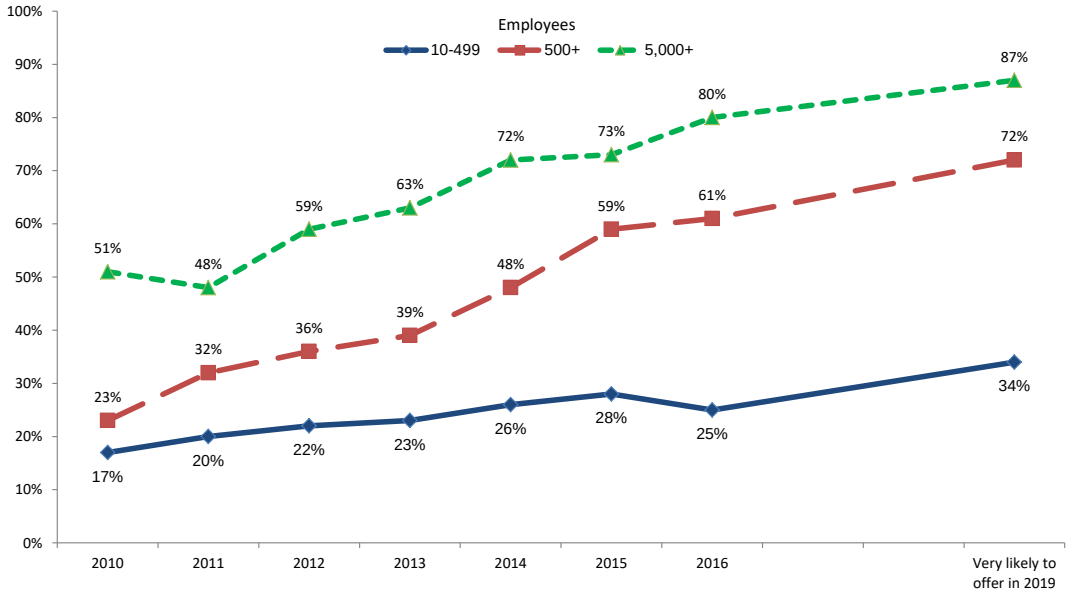
Statutory Health Savings Accounts Limits, 2004–2018

	Minimum Deductible		Maximum Contribution		Maximum Out-of-Pocket Limit		Per-Person Catch-up Contribution
	Individual	Family	Individual	Family	Individual	Family	Limit
2004	$1,000	$2,000	$2,600	$5,150	$5,000	$10,000	$500
2005	1,000	2,000	2,600	5,150	5,000	10,000	600
2006	1,050	2,100	2,700	5,450	5,250	10,500	700
2007	1,100	2,200	2,850	5,650	5,500	11,000	800
2008	1,100	2,200	2,900	5,800	5,600	11,200	900
2009	1,150	2,300	3,000	5,950	5,800	11,600	1,000
2010	1,200	2,400	3,050	6,150	5,950	11,900	1,000
2011	1,200	2,400	3,050	6,150	5,950	11,900	1,000
2012	1,200	2,400	3,100	6,250	6,050	12,100	1,000
2013	1,250	2,500	3,250	6,450	6,250	12,500	1,000
2014	1,250	2,500	3,300	6,550	6,350	12,700	1,000
2015	1,300	2,600	3,350	6,650	6,450	12,900	1,000
2016	1,300	2,600	3,350	6,750	6,550	13,100	1,000
2017	1,300	2,600	3,400	6,750	6,550	13,100	1,000
2018	1,350	2,700	3,450	6,900	6,650	13,300	1,000

Source: https://www.treasury.gov/resource-center/faqs/taxes/pages/health-savings-accounts.aspx

Figure 2

Percentage of Employers Offering Health Savings Account-Eligible Health Plan/HRA, by Firm Size, 2010–2016, With Projections Through 2019



Source: Figure 5 in http://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html.

About the EBRI HSA Database

The EBRI HSA Database is a representative repository of information about individual HSAs. The database is unique because it includes data provided by a wide variety of account record-keepers and, therefore, represents the characteristics and activity of a broad range of HSA owners.[8]

As of Dec. 31, 2017, the EBRI Database includes:

- 5.9 million health savings accounts.
- $13.4 billion in assets.

Since 2011, the database has grown from 800,000 to 5.9 million accounts, and assets have grown from $1.5 billion to $13.4 billion (Figure 3). Most HSAs in the EBRI HSA Database were initially opened within the past few years. Overall, 73 percent of the accounts were opened between 2014 and 2017 (Figure 4).

Trends in HSA Balances

End-of-year balances have been trending upward (with the exception of the dip between 2013 and 2014). Between 2011 and 2017, end-of-year account balances increased from $1,990 to $2,765 (Figure 5).

Account balances are highly correlated with the length of time an account has been open. The longer an account has been open, the larger the account balance. Accounts opened in 2017 ended the year with an average balance of $1,093, while those opened in 2007 ended 2017 with an average balance of $8,384 (Figure 6).

When examining end-of-year balances by age, balances for all age groups experienced increases except for balances of those under age 25. While account balances generally have increased with age, those ages 35–44 have seen their average balances increase from $1,657 to $2,455, a 48 percent increase, while those ages 45–54 saw their average balances increase from $2,336 to $3,147, a 35 percent increase (Figure 7). Account owners ages 65 and older have experienced the largest increase in average balances, increasing from $2,599 in 2011 to $4,911 in 2017, an 89 percent increase, but also appear to have had the most variability in their balances. This may have had something to do with the fact that once they were eligible for Medicare, they were no longer able to contribute to their account, and they may have been more likely to take distributions as a result of their use of health care services and because the excise tax related to non-qualified distributions no longer applied.

The EBRI HSA Database does not contain employee or family earnings or income data. However, ZIP code data are available for most of the sample and were used to match to county-level data on median household income, as well as education and race data by county. It was found that, in all years, account owners in higher-income counties had higher average account balances than those in lower-income counties. Otherwise, account balances increased 12 percent between 2011 and 2017 among owners in counties where the median household income was less than $50,000, compared with an increase of 46 percent for those in counties with $50,000–$99,999 in median household income and an increase of 46 percent for those in counties with $100,000 or more in median household income.

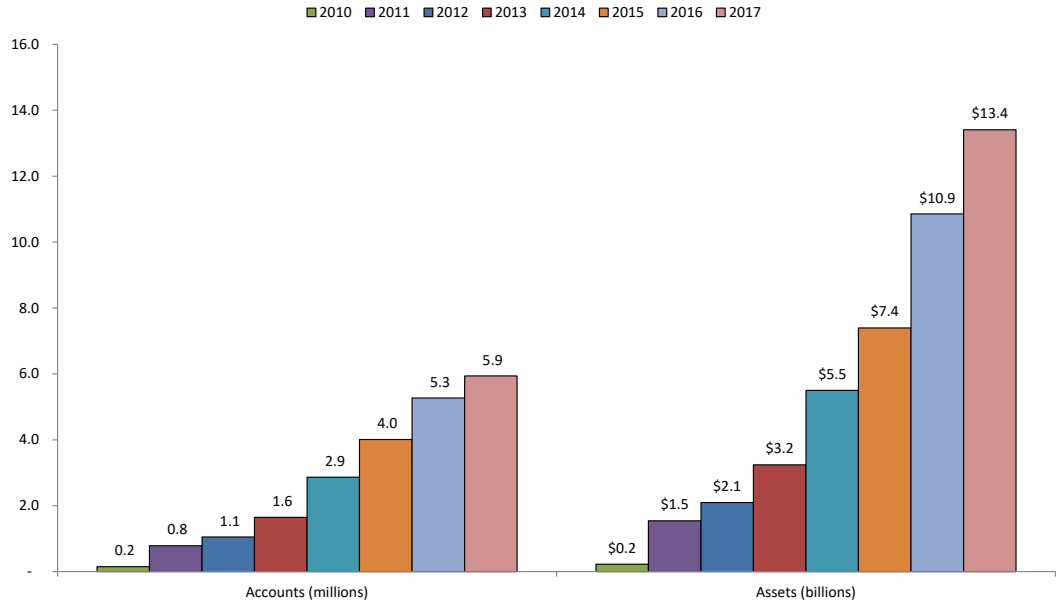
When examining differences by account-owner education level, education matters. In all years, account owners in counties where 50 percent or more of adults have a college education had higher account balances than account owners in counties with fewer adults who have a college education. There was no clear relationship between the percentage of minorities in a county and account balances.

Trends in Contributions to HSAs

The percentage of individuals making a contribution trended slightly upward between 2016 and 2017. The percentage with employer contributions also trended up. In 2017, 51 percent of account holders made a contribution to their account (Figure 8). The percentage of accounts with an employer contribution was 50 percent in 2017.

Figure 3

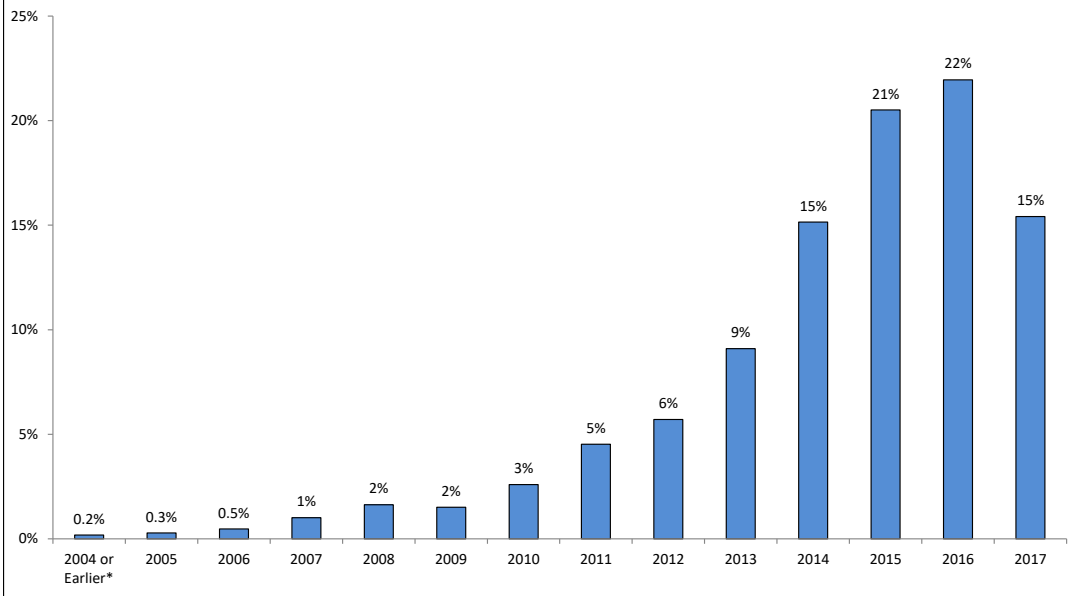
EBRI HSA Database: Accounts and Assets, 2011–2017



Source: EBRI HSA Database.

Figure 4

Health Savings Accounts, by Year Account Was Opened



Source: EBRI HSA Database.
*Includes Archer Medical Savings Account (MSA) rollovers.

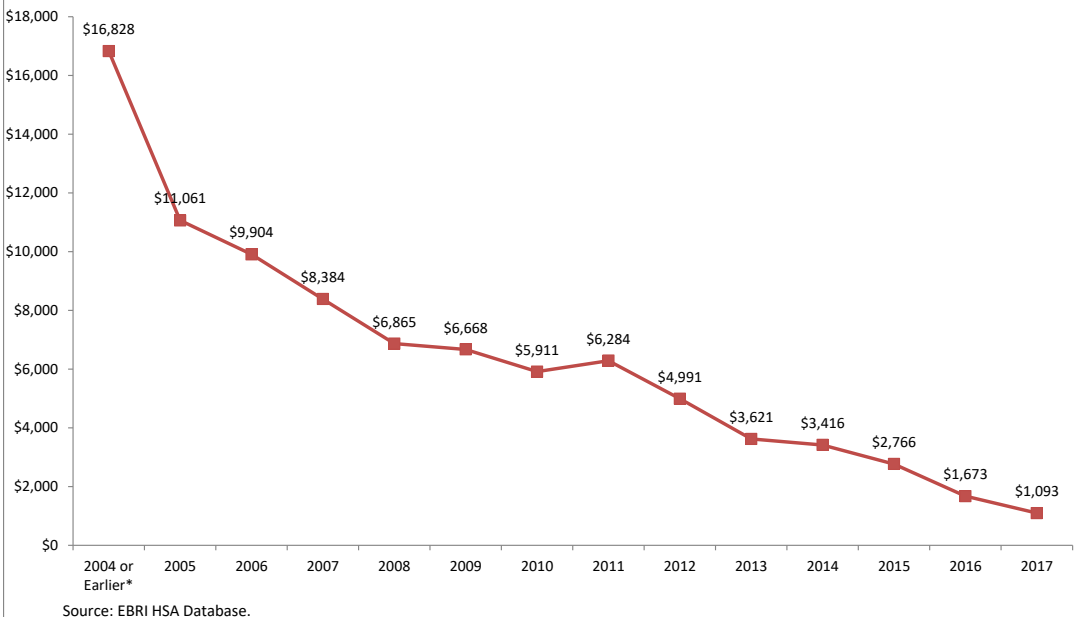
Figure 5

Average End-of-Year Account Balance, by Year, 2011–2017

Source: EBRI HSA Database.

Figure 6

Average End-of-Year Account Balance, by Year Account Was Opened, 2017



Source: EBRI HSA Database.

Figure 7

End-of-Year Average Account Balances by Account-Owner Demographics, 2011–2017

	End-of-Year Balance						
	2011	2012	2013	2014	2015	2016	2017
Age							
<25	846	955	963	748	760	700	759
25-34	1,092	1,293	1,433	1,362	1,408	1,362	1,520
35-44	1,657	1,920	2,099	2,130	2,167	2,174	2,455
45-54	2,336	2,660	2,810	2,806	2,767	2,804	3,147
55-64	3,304	3,832	4,170	4,189	3,949	4,062	4,546
65+	2,599	3,450	4,508	4,923	3,551	4,384	4,911
Median Household Income in County							
Less than $50,000	1,907	2,174	2,481	2,193	1,984	1,963	2,144
$50,000-$99,999	2,034	2,395	2,512	2,641	2,580	2,627	2,978
$100,000 or more	2,584	3,112	3,246	3,355	3,187	3,213	3,767
Percent With a College Degree in County							
Less than 30%	1,883	2,159	2,435	2,260	2,109	2,109	2,298
30%-49%	2,080	2,458	2,560	2,692	2,645	2,704	3,103
50% or more	2,413	2,811	2,965	3,137	2,970	2,928	3,344
Percent Minority in County							
Less than 15%	1,995	2,331	2,472	2,490	2,410	2,437	2,677
15%-29%	1,928	2,306	2,421	2,459	2,415	2,471	2,771
30% or more	2,033	2,306	2,570	2,556	2,453	2,467	2,835

Source: EBRI HSA Database.

Individual contributions have been increasing among those with contributions except in 2014 and in 2017. Average annual individual contributions have increased from $1,475 in 2011 to $1,949 in 2017 (Figure 9). Average annual employer contributions have been relatively flat and mostly in the $900–$1,000 range. As a result of higher individual contributions, total contributions increased from $2,348 to $2,843 between 2011 and 2017 (Figure 10).

Individual contributions in 2017 were higher the longer an account owner had an account. They averaged $3,201 among those who opened their account in 2007 but averaged only $1,240 among those who opened their account in 2017 (Figure 11).

Regardless of year, individual contributions increased with age. In 2017, account owners 25–34 contributed $1,134 on average, while those ages 55–64 contributed $2,636 on average (Figure 12). Employer contributions also increased with age, though the differences were less pronounced than for individual contributions, and the differences were limited to those below and above age 35.

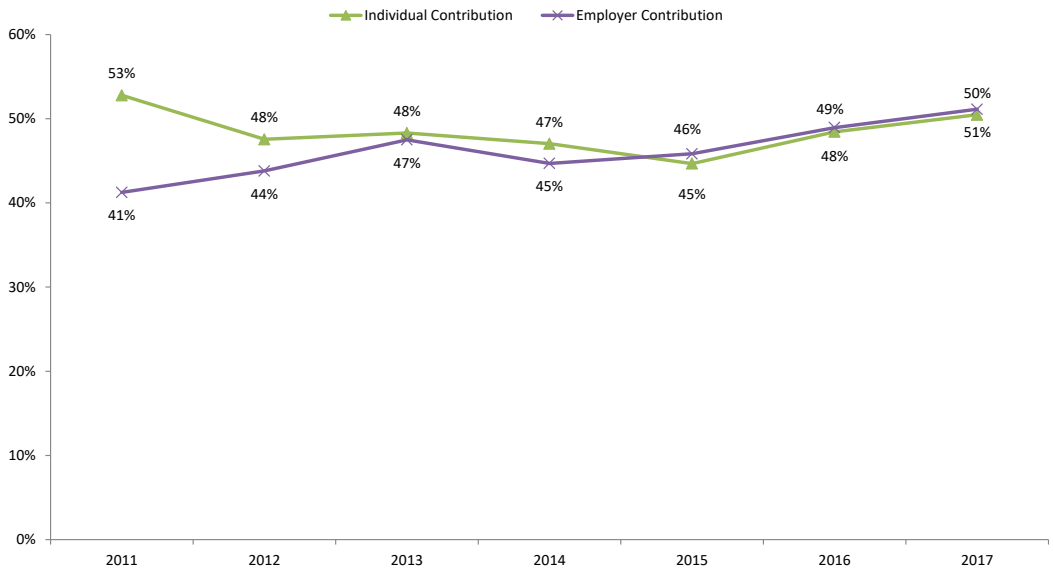
Similarly, in all years, individual contributions were higher among account owners residing in counties with higher median household income. Employer contributions also increased with median household income by county, which may have reflected higher overall compensation in higher-income areas of the country. Individual and employer contributions increased with educational levels by county but did not seem to vary by the county-wide racial mix.

Trends in Distributions from HSAs

Until 2016, there had been a decline in the percentage of accounts taking a distribution. In 2015, 53 percent of accounts had a distribution, down from 61 percent in 2011, but between 2015 and 2016, the percentage of accounts with a distribution increased from 53 percent to 63 percent and increased again to 66 percent in 2017 (Figure 13).

Among those with a

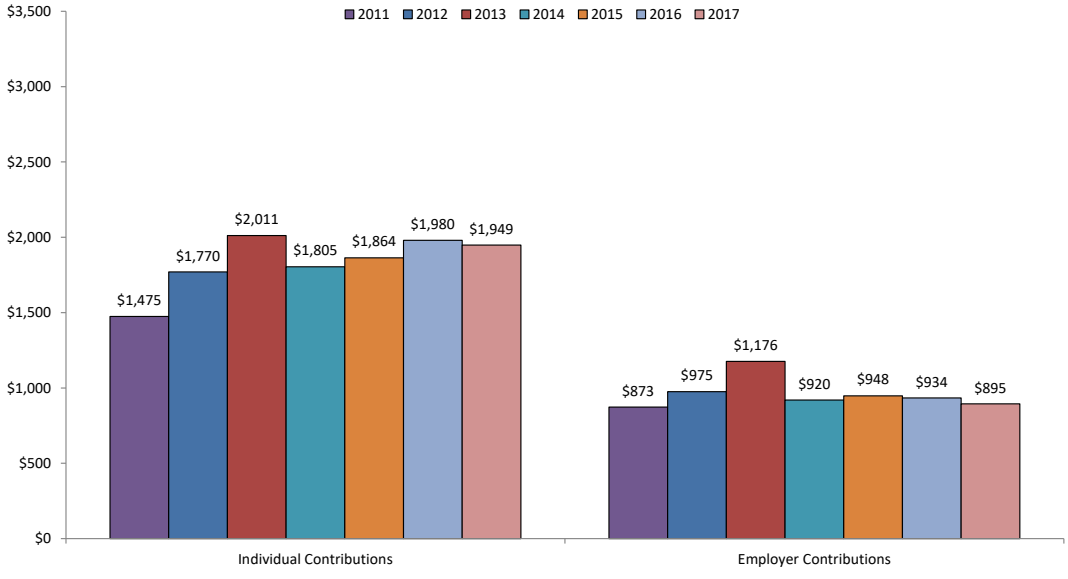
Figure 8
Percentage of Accounts With Individual and Employer Contributions to Health Savings Accounts, by Year, 2011–2017



Source: EBRI HSA Database.

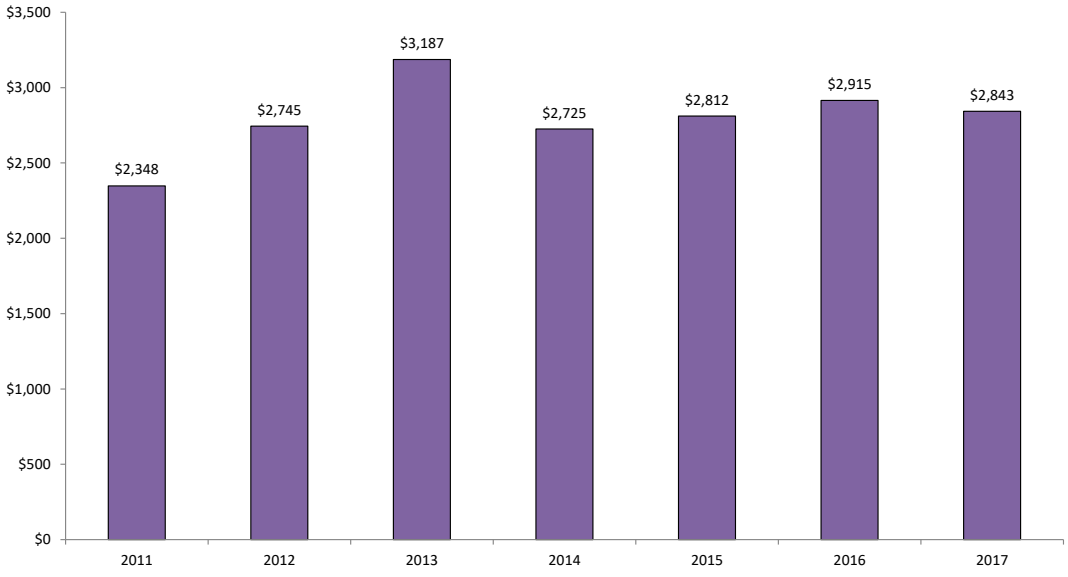
distribution, the average annual amount distributed has varied between $1,700 and $1,800 between 2011 and 2017, with 2013 being an exception at $1,934 (Figure 14).

Figure 9
Annual Average Individual and Employer Contributions to Health Savings Accounts, 2011–2017



Source: EBRI HSA Database.

Figure 10
Annual Average Total Contributions to Health Savings Accounts, 2011–2017



Source: EBRI HSA Database.

Figure 11
Annual Average Individual Contributions to Health Savings Account, by Year Account Was Opened, 2017

Source: EBRI HSA Database.
*Includes Archer Medical Savings Account (MSA) rollovers.

Figure 12

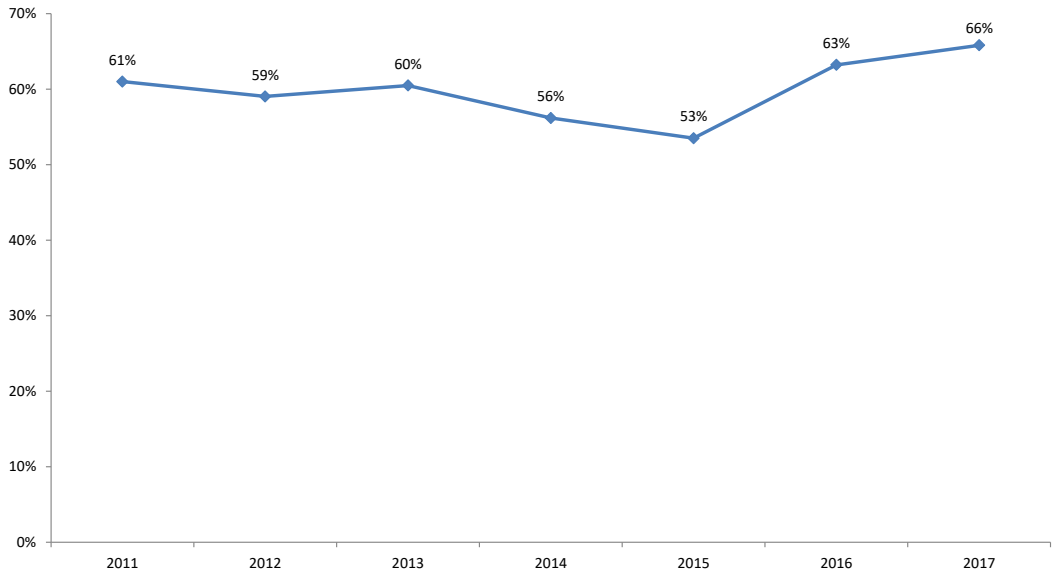
Average Annual Individual and Employer Contributions by Account-Owner Demographics, 2011–2017

	Individual Contributions							Employer Contributions						
	2011	2012	2013	2014	2015	2016	2017	2011	2012	2013	2014	2015	2016	2017
Age														
<25	573	552	598	525	535	570	557	465	552	622	524	526	534	498
25-34	1,095	1,064	1,203	1,101	1,122	1,160	1,134	710	803	966	769	783	772	728
35-44	1,786	1,733	1,960	1,860	1,876	1,956	1,926	947	1,041	1,350	1,033	1,036	1,016	974
45-54	2,073	2,031	2,305	2,178	2,189	2,296	2,263	983	1,090	1,291	1,048	1,056	1,040	1,002
55-64	2,429	2,439	2,737	2,630	2,553	2,665	2,636	982	1,102	1,203	1,029	1,028	1,006	964
65+	2,328	2,460	2,707	2,576	2,457	2,536	2,527	945	1,078	1,136	989	1,035	972	1,019
Median Household Income in County														
Less than $50,000	1,714	1,617	1,973	1,612	1,594	1,661	1,605	771	925	1,050	852	875	853	826
$50,000-$99,999	1,808	1,825	2,023	2,001	1,993	2,082	2,060	912	994	1,239	972	979	963	919
$100,000 or more	2,358	2,359	2,454	2,454	2,397	2,487	2,487	1,057	1,042	1,244	1,082	1,087	1,025	989
Percent With a College Degree in County														
Less than 30%	1,723	1,678	1,956	1,715	1,693	1,759	1,713	835	962	1,090	905	918	897	861
30%-49%	1,793	1,809	2,042	2,026	2,025	2,125	2,107	904	984	1,263	967	976	962	920
50% or more	2,252	2,194	2,289	2,302	2,246	2,323	2,286	853	990	1,114	1,001	1,019	960	923
Percent Minority in County														
Less than 15%	1,748	1,794	1,979	1,880	1,903	1,957	1,898	868	1,021	1,097	946	970	948	922
15%-29%	1,728	1,723	1,942	1,893	1,915	2,024	1,996	864	955	1,094	904	929	912	865
30% or more	1,894	1,796	2,084	1,952	1,861	1,959	1,948	887	946	1,289	974	958	943	898

Source: EBRI HSA Database.

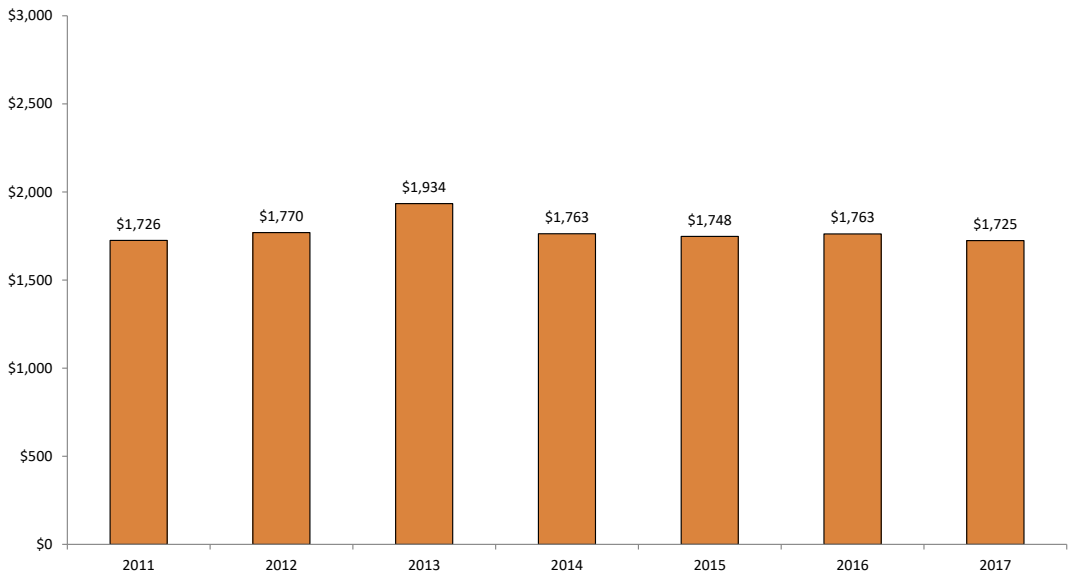
Figure 13

Percentage of Accounts With a Distribution From Health Savings Accounts, by Year, 2011–2017



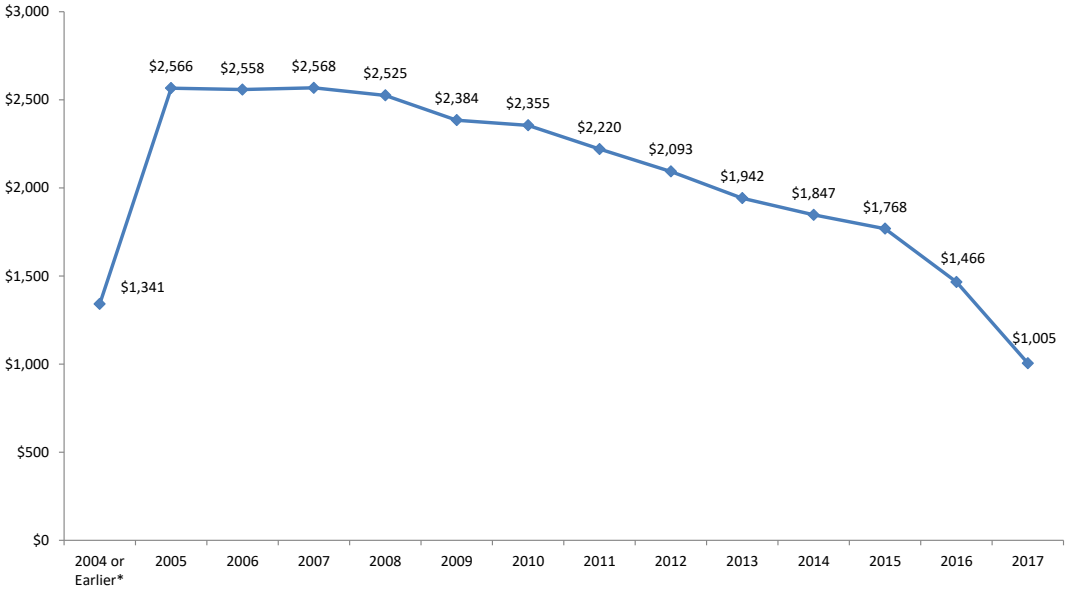
Source: EBRI HSA Database.

Figure 14
Annual Average Distributions From Health Savings Accounts, 2011–2017



Source: EBRI HSA Database.

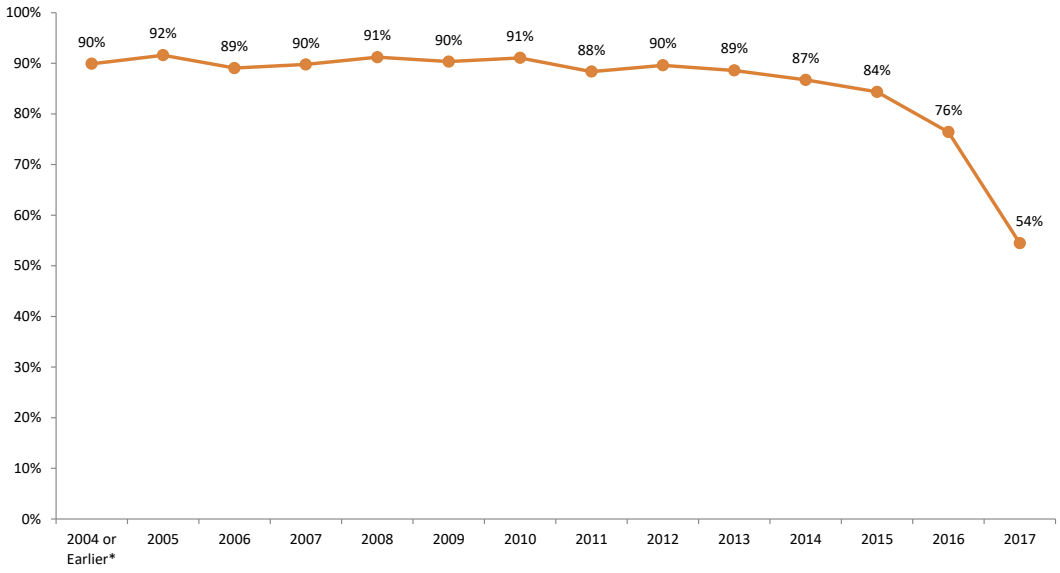
Figure 15
Annual Average Distributions From Health Savings Accounts, by Year Account Was Opened, 2017



Source: EBRI HSA Database.
*Includes Archer Medical Savings Account (MSA) rollovers.

Figure 16

Percentage of Accounts With Distributions From Health Savings Accounts, by Year Account Was Opened, 2017



Source: EBRI HSA Database.
*Includes Archer Medical Savings Account (MSA) rollovers.

Figure 17

Average Annual Distributions by Account-Owner Demographics, 2011–2017

	Distributions						
	2011	2012	2013	2014	2015	2016	2017
Age							
<25	637	643	671	596	588	548	561
25-34	1,148	1,178	1,277	1,165	1,155	1,122	1,087
35-44	1,772	1,806	2,011	1,857	1,856	1,816	1,772
45-54	1,989	2,052	2,239	2,086	2,091	2,088	2,044
55-64	2,085	2,157	2,316	2,178	2,135	2,152	2,097
65+	1,819	1,861	1,969	1,914	1,801	1,755	1,769
Median Household Income in County							
Less than $50,000	1,776	1,805	1,906	1,690	1,577	1,563	1,518
$50,000-$99,999	1,678	1,741	1,948	1,844	1,840	1,832	1,795
$100,000 or more	1,975	1,911	2,134	2,041	2,098	2,021	2,032
Percent With a College Degree in County							
Less than 30%	1,751	1,789	1,900	1,723	1,652	1,640	1,598
30%-49%	1,668	1,730	1,969	1,857	1,856	1,851	1,814
50% or more	1,945	1,928	1,988	1,949	1,947	1,912	1,909
Percent Minority in County							
Less than 15%	1,668	1,785	1,925	1,816	1,838	1,819	1,764
15%-29%	1,624	1,690	1,870	1,767	1,767	1,799	1,758
30% or more	1,825	1,812	1,966	1,806	1,719	1,678	1,658

Source: EBRI HSA Database.

In 2017, distributions were higher in accounts that had been open the longest, although accounts opened in 2004 (or earlier) are an exception. Those opened in 2007 had an average annual distribution of $2,568, while those opened in 2017 took $1,005 in distributions (Figure 15). The higher distributions associated with older accounts may suggest that individuals have been actively building up their account balances over time, and, as major health expenses have been incurred, account owners have been able to then take larger distributions. This is also supported by the fact that older accounts were more likely than younger ones to take a distribution. About 90 percent of the accounts opened before 2014 had a distribution, whereas only 54 percent of accounts opened in 2017 had a distribution (Figure 16).

Distributions increased with account-owner age in each year. They ranged from $1,087 in 2017 for those 25–34 to $2,097 for those 55–64 (Figure 17). Distributions also increased with income and education, but they did not vary by race. Higher-income accounts were slightly less likely to take a distribution (61 percent) than lower-income accounts (63 percent) in 2017 (data not shown in figure).

Trends in Investing HSA Assets

Very few account owners invest their HSA balance in investments other than cash. The percentage of accounts with investments may be low for a number of reasons. First, in order to invest, account owners often must have a minimum account balance. As reported above, most accounts are new, and, therefore, many will not have a large enough account balance to take advantage of investments. Second, not all HSA providers offer investments other than cash. Third, account owners may not be aware of the option to invest. Fourth, account owners may be using the account only to pay for out-of-pocket expenses and therefore may not want to take short-run risks with investment fluctuations.

In 2017, 5 percent of accounts had investments other than cash, up from 2 percent in 2011 (Figure 18). However, the longer an account had been open, the more likely it was to have investments other than cash. Only 2 percent of accounts opened in 2017 had investments other than cash, compared with 10 percent in accounts opened in 2007 (Figure 19).

Because the percentage of account owners investing HSA balances in something other than cash is generally small, any differences by age, income, education, and race are also small. However, there are some notable differences. Older account owners are more likely than younger ones to have non-cash investments (Figure 20). Account owners in higher-income counties are more likely than those in lower-income counties to invest, and those in more highly educated counties are more likely than those in lower-educated counties to invest.

When accounts are invested, only a portion of the account assets are in non-cash investments. Among accounts opened with non-cash investments, 59 percent of the balances were invested (Figure 21). Generally, the longer an account has been opened, the larger the percentage of the account balance that is in non-cash investments. Among accounts opened in 2007, 71 percent of the balances were in non-cash investments.

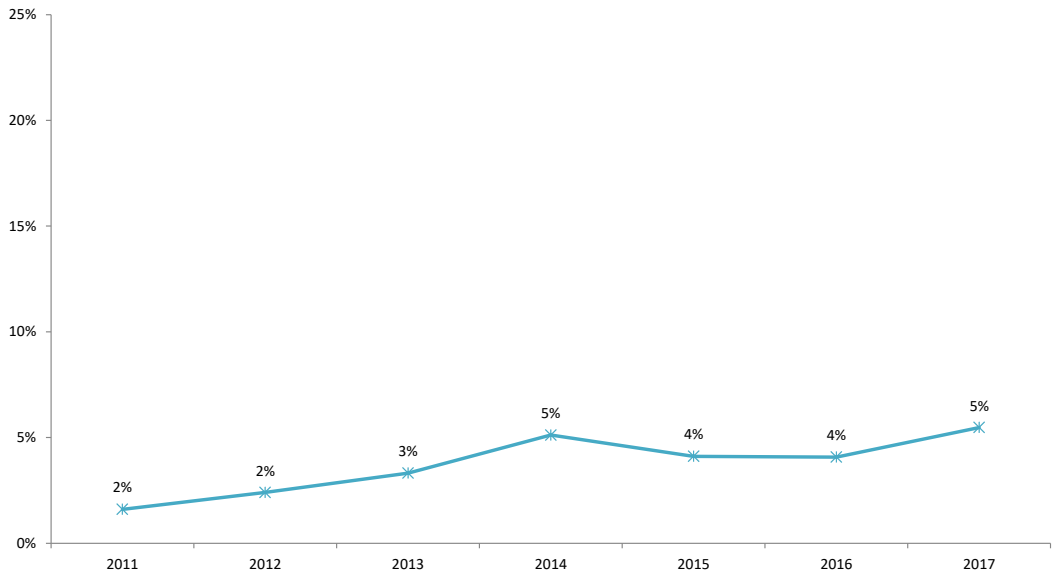
Conclusion

This study examines data from the EBRI HSA Database. It is the second longitudinal study to examine trends in cross-sectional data from the EBRI HSA Database. It examines account balances, individual and employer contributions, distributions, investments, and account-owner demographics from 2011–2017.

In 2017, enrollment in these HSA-eligible health plans was estimated to be between 21.4 and 33.7 million policyholders and their dependents. It was estimated that there were about 22.2 million HSAs holding $45.2 billion in assets as of Dec. 31, 2017.

The number of employers expected to offer an HSA-eligible health plan either as an option or as the only health plan option is expected to continue to increase both in the absence of public policy changes and possibly because Congress

Figure 18
Presence of Investments Other Than Cash, 2011–2017



Source: EBRI HSA Database.

Figure 19
Presence of Investments Other Than Cash, by Year Account Was Opened, 2017

Source: EBRI HSA Database.
*Includes Archer Medical Savings Account (MSA) rollovers.

Figure 20

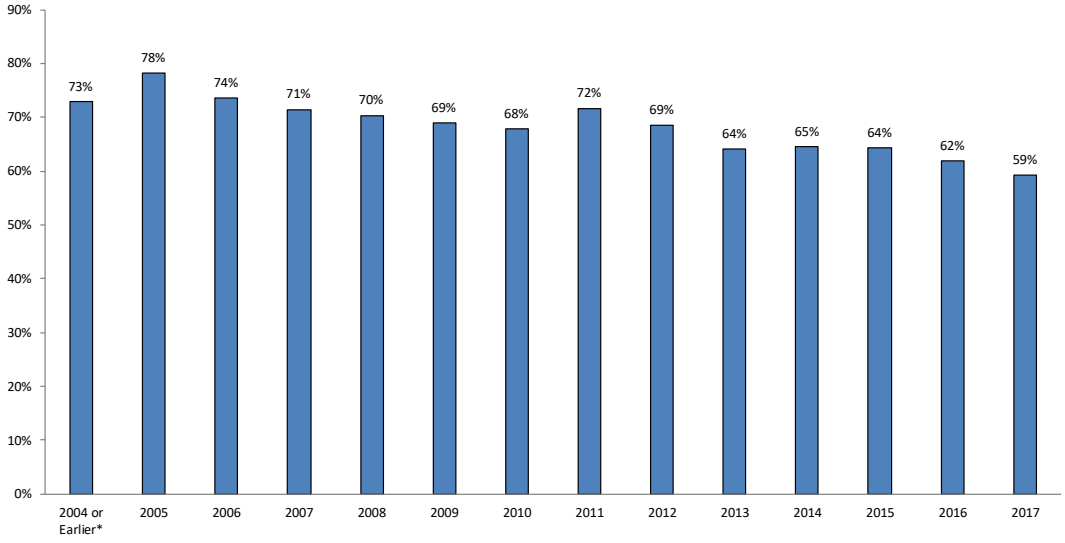
Percentage With Investments Other Than Cash by Account-Owner Demographics, 2011–2017

	Percentage With Investments						
	2011	2012	2013	2014	2015	2016	2017
Age							
<25	0%	1%	1%	1%	2%	2%	2%
25-34	1%	2%	3%	4%	4%	4%	5%
35-44	2%	2%	3%	5%	4%	4%	6%
45-54	2%	3%	3%	6%	4%	4%	6%
55-64	2%	3%	4%	7%	5%	5%	6%
65+	2%	2%	4%	8%	3%	3%	4%
Median Household Income in County							
Less than $50,000	1%	2%	3%	3%	2%	2%	3%
$50,000-$99,999	2%	3%	4%	6%	5%	5%	6%
$100,000 or more	3%	5%	6%	9%	7%	7%	9%
Percent With a College Degree in County							
Less than 30%	1%	2%	3%	4%	3%	3%	4%
30%-49%	2%	3%	4%	6%	5%	5%	7%
50% or more	3%	4%	6%	8%	7%	6%	8%
Percent Minority in County							
Less than 15%	1%	2%	3%	4%	3%	3%	4%
15%-29%	2%	2%	3%	5%	4%	4%	5%
30% or more	2%	3%	4%	6%	5%	5%	7%

Source: EBRI HSA Database.

Figure 21

Percentage of Total Assets Invested, Among Accounts With Invested Assets, by Year Account Was Opened, 2017



Source: EBRI HSA Database.
*Includes Archer Medical Savings Account (MSA) rollovers.

is interested in expanding HSAs. As a result, HSA-eligible health plans and HSAs are expected to grow as a vital component of employment-based health coverage in the United States.

Plan sponsors that wish to introduce or retain HSA-eligible health plans as part of their workplace benefit program can use past trends to inform future strategies. For instance, as individuals become more familiar with HSAs, they are using the accounts more as designed. Specifically, account balances are growing over time, enabling longtime account holders to withdraw larger sums when unexpected major health expenses occur. Plan sponsors that value employee financial wellness can work with administrators and advisors to take a long-term view of HSA account balance growth.

Appendix—What is an HSA?

A health savings account (HSA) is a tax-exempt trust or custodial account that is funded with contributions and assets that an individual can use to pay for health care expenses. Individuals can contribute to an HSA only if they are enrolled in an HSA-eligible health plan. An employee's contributions to the account are deductible from taxable income, an employer's contributions to the account for an employee are excludable from the employee's gross income, and distributions for qualified medical expenses from the HSA are excluded from taxable income to the employee. Tax-free distributions are also allowed for certain premium payments. Any interest or other capital earnings on assets in the account build up tax free. Finally, HSAs are always funded, unlike similar types of health accounts known as health reimbursement arrangements (HRAs) and flexible spending accounts (FSAs), which can be and are typically set up as unfunded, notional arrangements.

Eligibility

An individual who is covered by an HSA-eligible health plan may (but is not required to) open and make contributions to an HSA. To be an HSA-eligible health plan for 2018, the plan must have an annual deductible of at least $1,350 for individual coverage and $2,700 for family coverage, and the plan's out-of-pocket maximum may not exceed $6,650 for individual coverage or $13,300 for family coverage with the deductible counting toward this limit. (These minimum allowable deductibles and maximum out-of-pocket limits are indexed to inflation.) Certain primary preventive services — typically those deemed to prevent the onset of disease — can be and often are exempt from the deductible and covered in full. (These preventive services are in addition to those preventive services that the Patient Protection and Affordable Care Act of 2010 (ACA) requires be covered in full.) Otherwise, all health care services must be subject to the HSA's deductible.

Additional HSA contribution requirements are that (1) an individual may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also an HSA-eligible health plan, (2) an individual may not be claimed as a dependent on another person's tax return, and (3) an individual may not be enrolled in Medicare. Notwithstanding these requirements, an individual is not precluded from making HSA contributions merely because he or she has supplemental coverage with deductibles below the statutory HSA-eligible health plan minimum for such things as vision care, dental care, certain specific diseases, and/or insurance that pays a fixed amount per day (or other stipulated period) for hospitalization.

Contributions

Individuals and employers are allowed to contribute to HSAs. As noted above, contributions are excluded from gross income if the employer makes them and deductible from taxable income if the individual account owner makes them.

For 2018, a worker with individual coverage is allowed to make an annual HSA contribution of $3,450, while a worker with family coverage can contribute as much as $6,900. These dollar limits are indexed for inflation. Additionally, individuals who have reached age 55 and are not yet enrolled in Medicare may make an additional $1,000 catch-up contribution. The catch-up contribution is not currently indexed to inflation.

If an employer does make contributions to an HSA, the contributions must be the same dollar amount or the same percentage of the deductible for all employees.[9]

Investments

HSAs can be invested in the same investment options that have been approved for individual retirement accounts (IRAs) — i.e., bank accounts, certificates of deposit (CDs), money market funds, stocks, bonds, and mutual funds. Many HSA custodians, however, require that an HSA have at least a minimum balance in order to invest HSA funds in options beyond cash or cash equivalents. And some HSA custodians do not offer investment options beyond cash. If an HSA owner is able to invest HSA funds in options beyond cash, the owners are responsible for making the investment decisions and bear the risks and rewards for investment losses or gains.

Distributions

An individual may take distributions from an HSA at any time. The individual need not be covered by an HSA-eligible health plan at the same time the individual withdraws money from the HSA. Distributions are generally treated as taxable income, but they are excluded from an individual's taxable income if they are used to pay for qualified medical expenses. Distributions for premiums for COBRA coverage, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare (other than for Medigap) are also tax free.

HSA distributions for nonqualified medical expenses are not excludable from gross income and, in addition to being taxable, are subject to a 20 percent penalty, which is waived if the HSA owner dies, becomes disabled, or is eligible for Medicare. Individuals are able to transfer funds from one HSA to another without subjecting the distribution to income and penalty taxes as long as the transfer occurs within 60 days of the date funds are received.

Archer Medical Savings Accounts

Prior to the availability of HSAs, Archer Medical Savings Accounts (MSAs) were authorized as a demonstration project under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Workers were eligible to set up an MSA if employed at a firm with 50 or fewer employees. The self-employed were also eligible. Both were required to be covered by a high-deductible health plan in order to be able to contribute to an MSA. When the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created HSAs, existing MSAs were grandfathered, but as of Dec. 31, 2007, no new MSAs could be opened. However, individuals with MSAs are allowed to transfer those account balances to HSAs. Amounts that continue to be held in grandfathered MSAs can be distributed tax free for qualified medical expenses.

ERISA Compliance

Unlike HSA-eligible health plans offered by an employer, when employer involvement in an HSA is limited, the HSA is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). Thus, for example, HSAs are not subject to ERISA when the employer does not contribute to the HSA or when the establishment of the HSA is completely voluntary on the part of the employee.[10] In addition, the employer may not limit the ability of employees to move their HSA funds to another HSA, impose conditions on using the HSA funds, or make or influence investment decisions. There are other considerations for employers as well when offering an HSA.[11]

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Endnotes

[1] Both employees and employers can contribute to an HSA. While employee contributions to the account are deductible from taxable income, employer contributions to the account for an employee are excludable from the employee's gross income.

[2] More detailed information about HSAs can be found in the appendix.

[3] See http://devenir.com/wp-content/uploads/2017-Year-End-Devenir-HSA-Market-Research-Report-Executive-Summary.pdf. The number of enrollees in HSA-eligible health plans differs from the number of HSAs for various reasons. The number of enrollees is composed of the policyholder and any covered dependents and generally is higher than the number of HSAs because one account is usually associated with a family. Hence, the number of individuals enrolled in an HSA-eligible health plan generally is higher than the number of accounts. However, over time, the number of accounts can grow relative to the number of enrollees because when an individual or family is no longer covered by an HSA-eligible health plan, they are allowed to keep the HSA open. Furthermore, individuals and families can have more than one account.

[4] See the literature review in Bundorf (2012) as well as more recent research in Brot-Goldberg, et al. (2015); Fronstin and Roebuck (2013); Fronstin, Sepulveda and Roebuck (2013a); Fronstin, Sepulveda and Roebuck (2013b); and Fronstin and Roebuck (2014).

[5] See AHIP (2014).

[6] See http://devenir.com/wp-content/uploads/2017-Year-End-Devenir-HSA-Market-Research-Report-Executive-Summary.pdf

[7] See Fronstin and Elmlinger (2017).

[8] Several recordkeeping organizations have provided de-identified data on HSA owners as of year-end 2017. Records are de-identified prior to inclusion in the database to conceal the identity of account owners, but the data are coded so that account owners can be tracked over time, a unique aspect of the EBRI HSA Database. At no time has any nonpublic personal information that is personally identifiable, such as Social Security number, been transferred to or shared with EBRI. A unique aspect of the de-identified coding is that the EBRI HSA Database can link the accounts of each individual with more than one account in the database while still preventing the identification of the individual, thus permitting the aggregation of the HSA balances of individuals with multiple accounts, within or across recordkeepers contributing to the database, providing a more complete picture of the number of individuals with accounts and their HSA balances. Moreover, the EBRI HSA Database contains information about the year of birth of account owners, individual and employer contributions, beginning- and end-of-year account balances, and the month and year the HSA was opened. A very small percentage (less than 0.5 percent) of accounts have an account-opening date prior to 2004. An HSA that was funded by amounts rolled over from an Archer Medical Savings Account (MSA) was considered established on the date the MSA was established.

[9] There are exceptions to the comparability rule. For instance, employers may make matching contributions that are conditional on a contribution by the employee if done through a cafeteria plan. Furthermore, employers may contribute more to the HSAs of non-highly compensated employees.

[10] See https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2004-01

[11] See https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2006-02

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