

## Trends in Health Savings Account Balances, Contributions, Distributions, and Investments and the Impact of COVID-19

By Paul Fronstin, Ph.D., Employee Benefit Research Institute, and Jake Spiegel, Employee Benefit Research Institute

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### AT A GLANCE

Plan sponsors that wish to introduce or continue offering health savings account (HSA)-eligible health plans as part of their workplace benefit program can benefit from a long-term view of HSA accountholder behaviors. As such, the Employee Benefit Research Institute has undertaken a series of longitudinal studies from its HSA Database, examining trends in account balances, individual and employer contributions, distributions, invested assets, and account-owner demographics from 2011–2020. Such analysis can help not only plan sponsors but providers and policymakers better understand strategies that can help improve employee financial wellness.

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 11.4 million accounts with total assets of \$32.9 billion as of Dec. 31, 2020.

#### Key findings:

HSAs offer a valuable tax incentive to set aside money on a tax-favored basis for current or future medical expenses. However, account owners often appear to be using the accounts primarily to cover current expenses, such as deductibles, coinsurance, and copayments, rather than fully taking advantage of the tax preference by contributing the maximum or maintaining HSA balances for retirement health care expenses. Further, use of investments other than cash within HSAs remains low.

From this study, we observe the following about HSA utilization:

- **Modest balances:** Between 2011 and 2020, end-of-year account balances increased but remained low.
- **Contributions below the maximum:** Average total contributions — combined individual and employer contributions — increased. However, the average was just above the minimum allowable deductible amount for family coverage and less than one-half of the allowable contribution maximum for family coverage.
- **High incidence of withdrawals:** Overall, just over half of accountholders withdrew funds.
- **Low use of investments:** Very few account owners invested their HSA balance despite the tax-saving possibilities.
- **Impact of the COVID-19 pandemic:** Between 2019 and 2020, average annual individual contributions fell. It is possible that as unemployment increased during the pandemic, HSA owners reduced contributions. Notably, average annual distributions fell as well, reaching an all-time low. The decline in both contributions and distributions may also be due to lower use of health care services during the pandemic.

One feature of HSAs is that accountholders can build up a balance for unexpected major medical expenses in the near future and/or for retirement — there is no use-it-or-lose feature. So while, on average, accountholders appear to be using HSAs as specialized checking accounts rather than investment accounts, this behavior appears to change the longer an HSA owner holds an account. In other words, longitudinal analysis shows that the longer individuals own HSAs, the greater the likelihood their usage becomes more investment-like. Over time we see increased size of balance, larger annual contributions, and greater use of investments.

Paul Fronstin is Director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). Jake Spiegel is a Research Associate at EBRI. This *Issue Brief* was written with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the authors, and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

**Suggested citation:** Fronstin, Paul, and Jake Spiegel, “Trends in Health Savings Account Balances, Contributions, Distributions, and Investments and the Impact of COVID-19,” *EBRI Issue Brief*, no. 538 (September 15, 2021).

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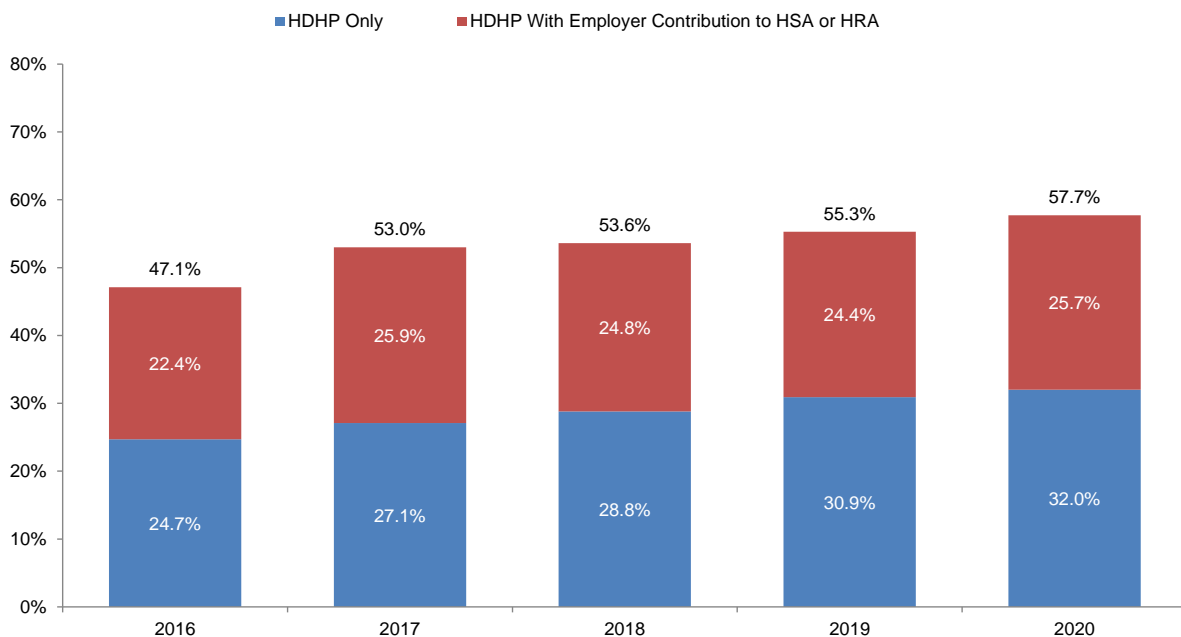
# Trends in Health Savings Account Balances, Contributions, Distributions, and Investments and the Impact of COVID-19

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## Introduction

Enrollment in health savings account (HSA)-eligible health plans and the number of HSAs has increased since the plans first became available in 2004. Today, more than one-half of enrollees in private-sector health plans are in a plan with a deductible large enough to qualify for HSA contributions (Figure 1). Nearly one-half of them, comprising 25.7 percent of enrollees in private-sector health plans, receive employer contributions to an HSA.<sup>1</sup> In fact, the adoption of high-deductible health plans (HDHPs) by employers is one of the strongest trends in employment-based health benefits and is driving the trends toward HSA-eligible health plans. It has also been estimated that there were 30.2 million HSAs holding \$82.2 billion in assets as of Dec. 31, 2020.<sup>2</sup>

Figure 1  
Percentage of Persons Enrolled in a High-Deductible Health Plan (HDHP), by Employer Contribution to HSA or HRA,\* Among Those With Private-Sector Health Coverage and Employee-Only Coverage, 2016–2020



\* HSA = health savings account, HRA = health reimbursement arrangement.  
Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

This *Issue Brief* is the fifth longitudinal study to examine trends in cross-sectional data from the EBRI HSA Database. It examines account balances, individual and employer contributions, distributions, and investments from 2011–2020.

## About the EBRI HSA Database

While there is growing literature around how individuals in health savings account (HSA)-eligible health plans use and pay for medical services,<sup>3</sup> 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 those data are from 2012.<sup>4</sup> Devenir reports trend data going back to 2004 from a survey of HSA providers, but the data are aggregated and do not provide the kind of detail available in the AHIP report.<sup>5</sup> 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.<sup>6</sup>

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

The EBRI HSA Database is a representative repository of information about individual health savings accounts (HSAs). The database is unique because it includes data provided by a wide variety of account recordkeepers and, therefore, represents the characteristics and activity of a broad range of HSA owners.<sup>7</sup>

As of Dec. 31, 2020, the EBRI Database includes:

- 11.4 million health savings accounts.
- \$32.9 billion in assets.

Since 2011, the database has grown from 800,000 to 11.4 million accounts, and assets have grown from \$1.5 billion to \$32.9 billion (Appendix Figure 2). Most HSAs in the EBRI HSA Database were initially opened within the past few years. Overall, 73 percent of the accounts were opened between 2016 and 2020 (Appendix Figure 3).

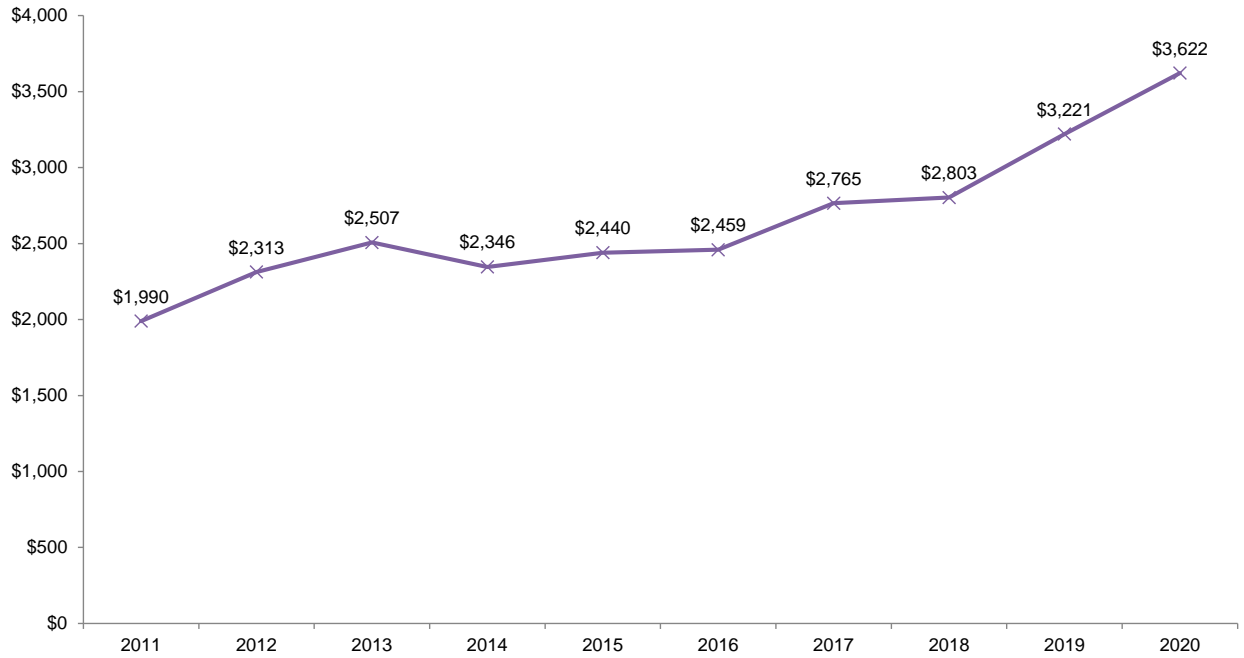
## Trends in HSA Balances

The EBRI HSA Database finds that end-of-year balances have been trending upward (with the exception of the dip between 2013 and 2014).<sup>8</sup> Between 2011 and 2020, end-of-year account balances increased from \$1,990 to \$3,622 (Figure 2). Between 2019 and 2020, account balances increased about \$400.

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 open for one year ended 2020 with an average balance of \$1,728, while those open for 10 years ended 2020 with an average balance of \$9,469 (Figure 3).

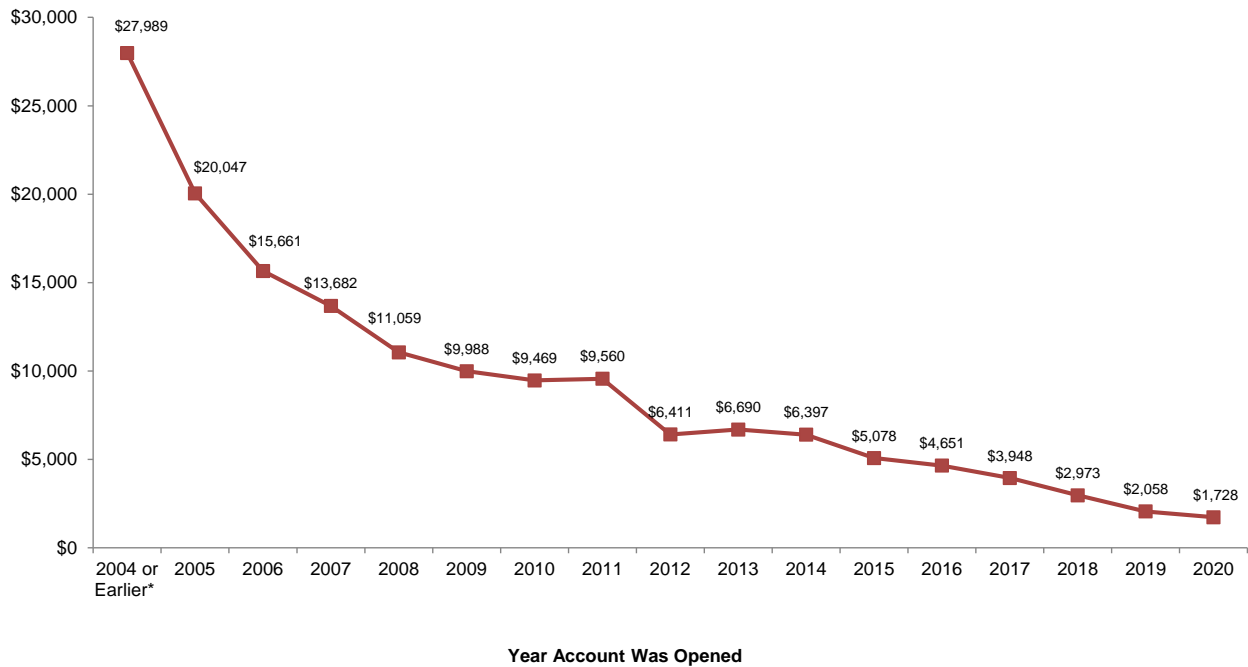
When examining end-of-year balances by age, balances for all age groups were greater in 2020 than in prior years — except for balances of those under age 25. Account owners ages 65 and older experienced the largest increase in average balance — from \$2,599 in 2011 to \$6,884 in 2020, or a 165 percent increase (Figure 4). However, this cohort also had the most variability in balance size. This may have had something to do with the fact that once these individuals were eligible for Medicare, they were no longer able to contribute to their account. Meanwhile, 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.

Figure 2  
Average End-of-Year Account Balance, by Year, 2011–2020



Source: EBRI HSA Database.

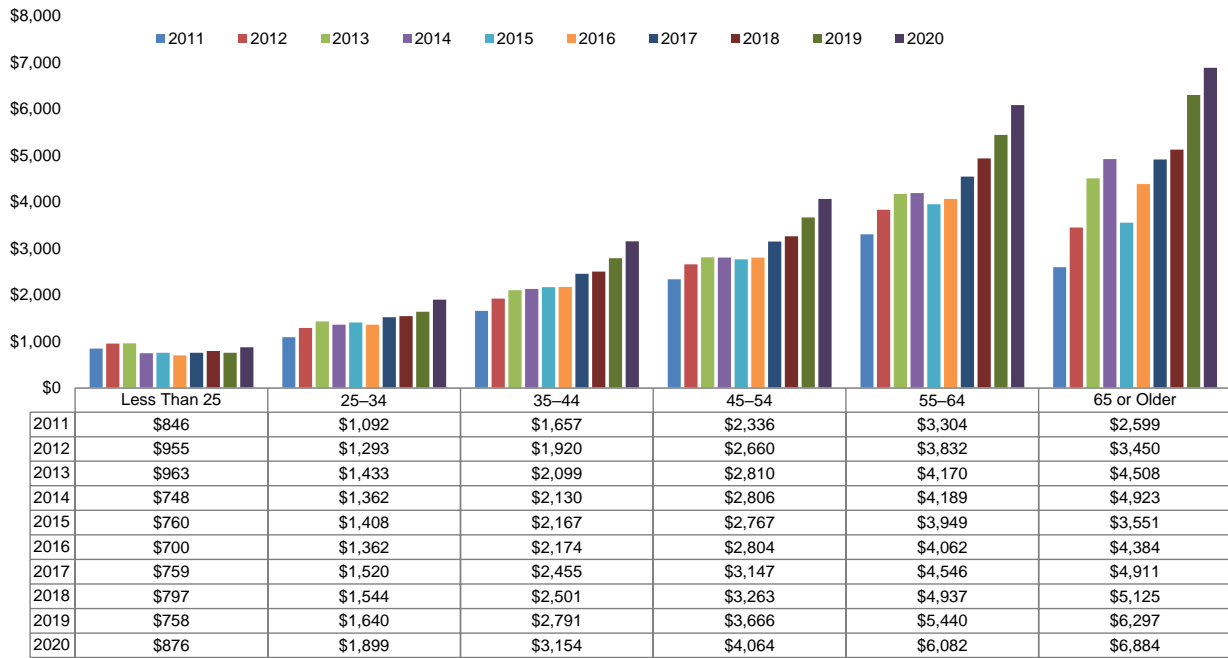
Figure 3  
Average End-of-Year Account Balance, by Year Account Was Opened, 2020



Source: EBRI HSA Database.

\*Includes Archer Medical Savings Account (MSA) rollovers.

Figure 4  
End-of-Year Average Account Balances by  
Account-Owner Age, 2011–2020

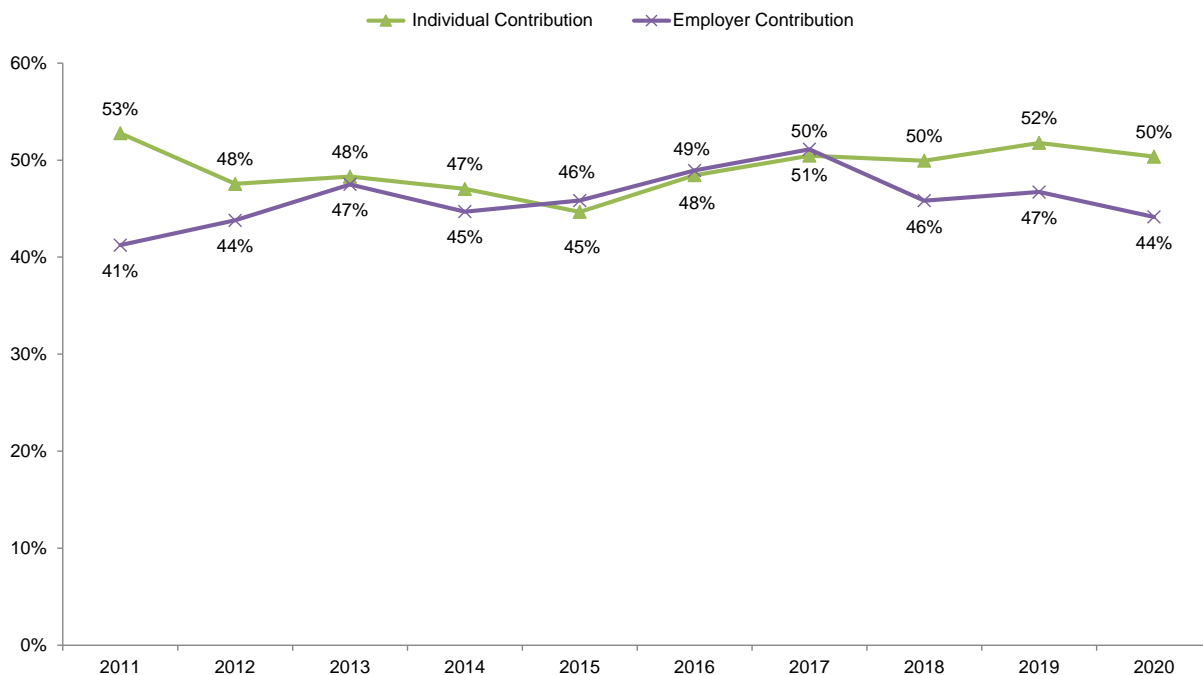


Source: EBRI HSA Database.

### Trends in Contributions to HSAs

The percentage of individuals making a contribution to their HSA was flat between 2017 and 2020, at 50 percent. (Figure 5). The percentage with employer contributions trended down over that time period, from 51 percent in 2017 to 44 percent in 2020.

Figure 5  
Percentage of Accounts With Individual and Employer  
Contributions to HSAs, by Year, 2011–2020

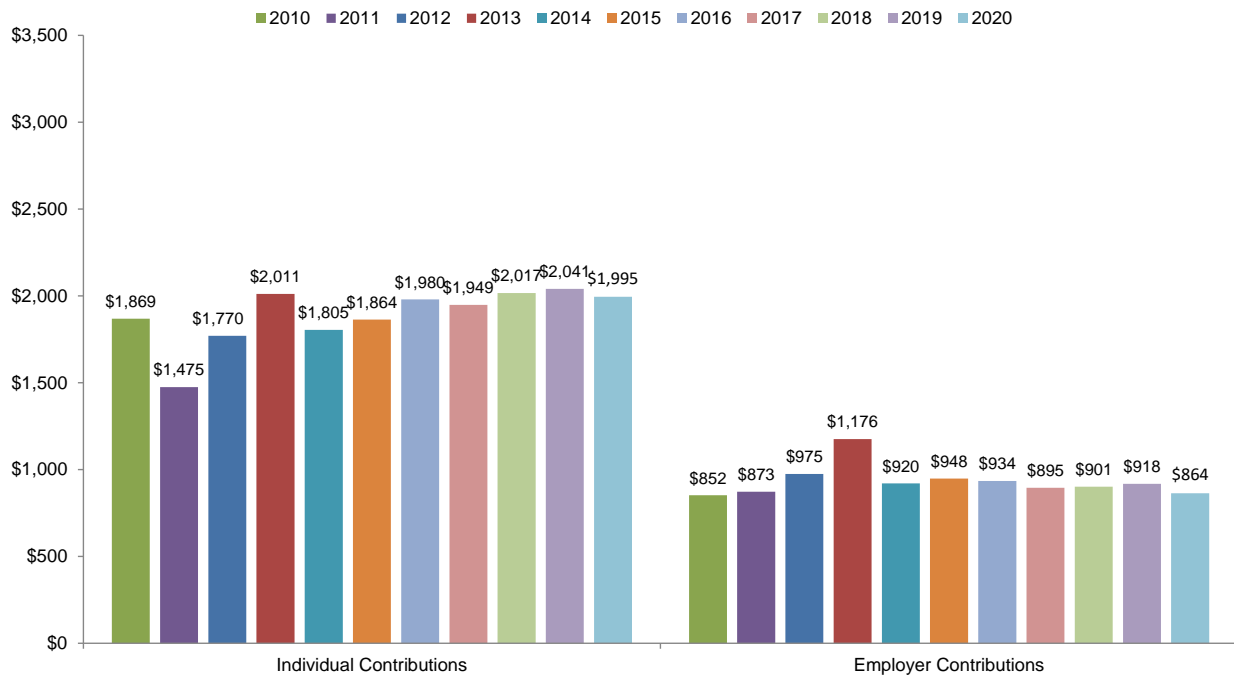


Source: EBRI HSA Database.



Average annual individual contributions fell in 2020 after reaching an all-time high in 2019, going from \$2,041 to \$1,995 (Figure 6). While the drop in contributions was relatively small — a 2 percent decline — it may have been related to COVID-19. It is possible that as unemployment increased, account owners reduced contributions. Furthermore, the decline in contributions may be correlated with the decline in use of health care services that was due to COVID-19.

Figure 6  
Annual Average Individual and Employer Contributions to HSAs, 2011–2020



Source: EBRI HSA Database.

Average annual employer contributions have been relatively flat and mostly in the \$900–\$1,000 range. However, they also fell between 2019 and 2020, declining from \$918 to \$864 on average, a 6 percent decline. As a result of declining individual contributions and employer contributions, total contributions decreased from \$2,959 to \$2,859 between 2019 and 2020, a 3 percent decline (Figure 7).

Individual contributions in 2020 were higher the longer an account owner had an account. They averaged \$1,144 among accounts opened in 2020 but averaged \$3,342 among accounts open for 10 years (since 2010), continuing to increase thereafter (Figure 8).

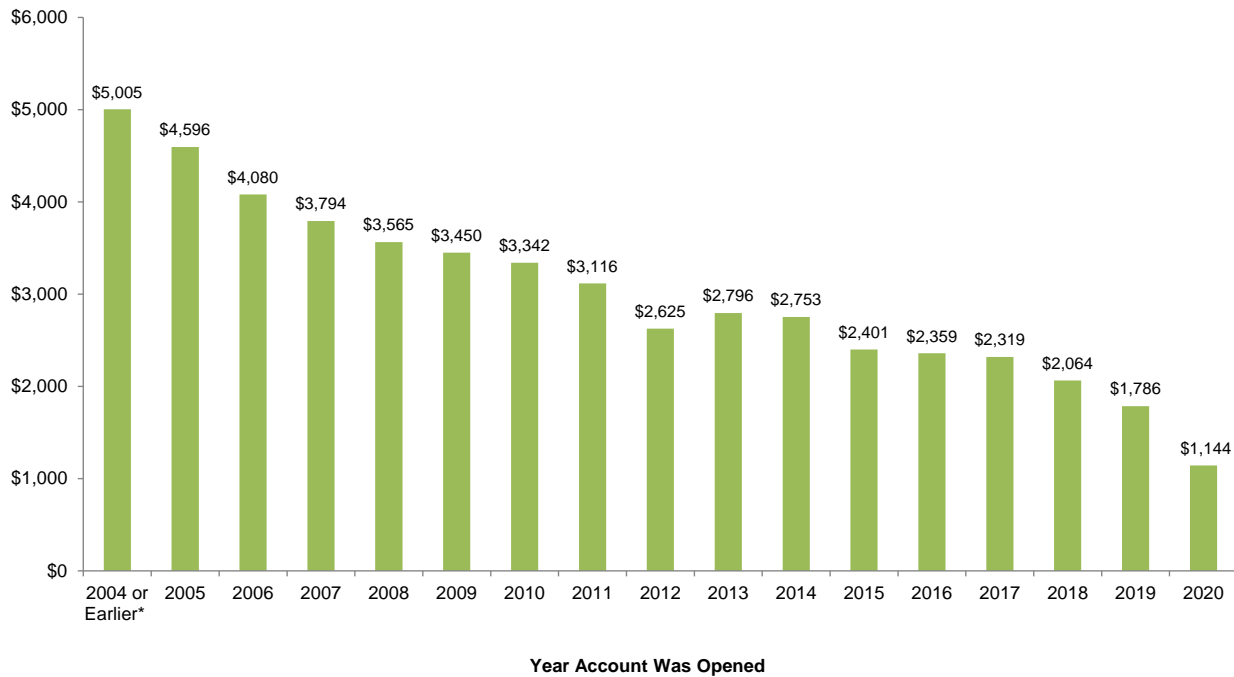
Regardless of the year the account was opened, individual contributions increased with age. In 2020, account owners 25–34 contributed \$1,167 on average, while those ages 55–64 contributed \$2,794 on average (Figure 9). Employer contributions increased through ages 45–54, but the increases were less pronounced than for individual contributions (Figure 10).

**Figure 7**  
**Annual Average Total Contributions to HSAs, 2011–2020**



Source: EBRI HSA Database.

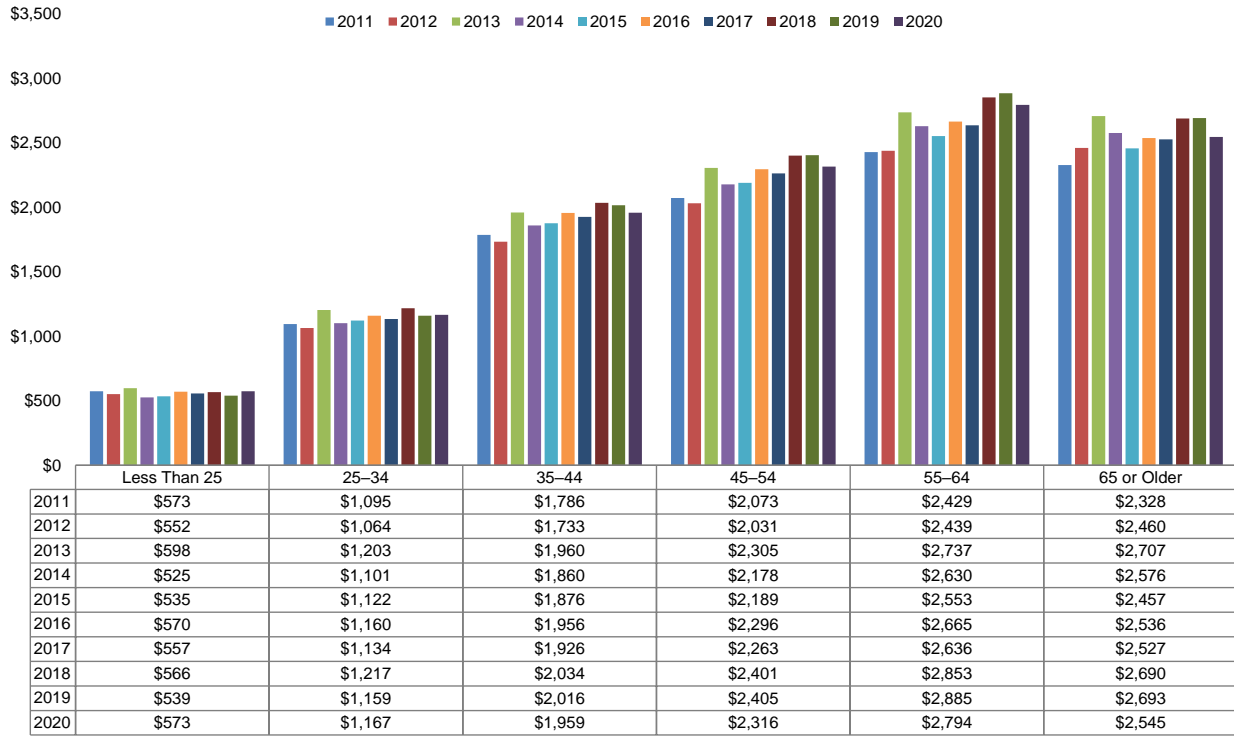
**Figure 8**  
**Annual Average Individual Contributions to HSA, by Year Account Was Opened, 2020**



Source: EBRI HSA Database.

\*Includes Archer Medical Savings Account (MSA) rollovers.

**Figure 9**  
**Average Annual Individual Contributions**  
**by Account-Owner Age, 2011–2020**



Source: EBRI HSA Database.

**Figure 10**  
**Average Annual Employer Contributions,**  
**by Account-Owner Age, 2011–2020**

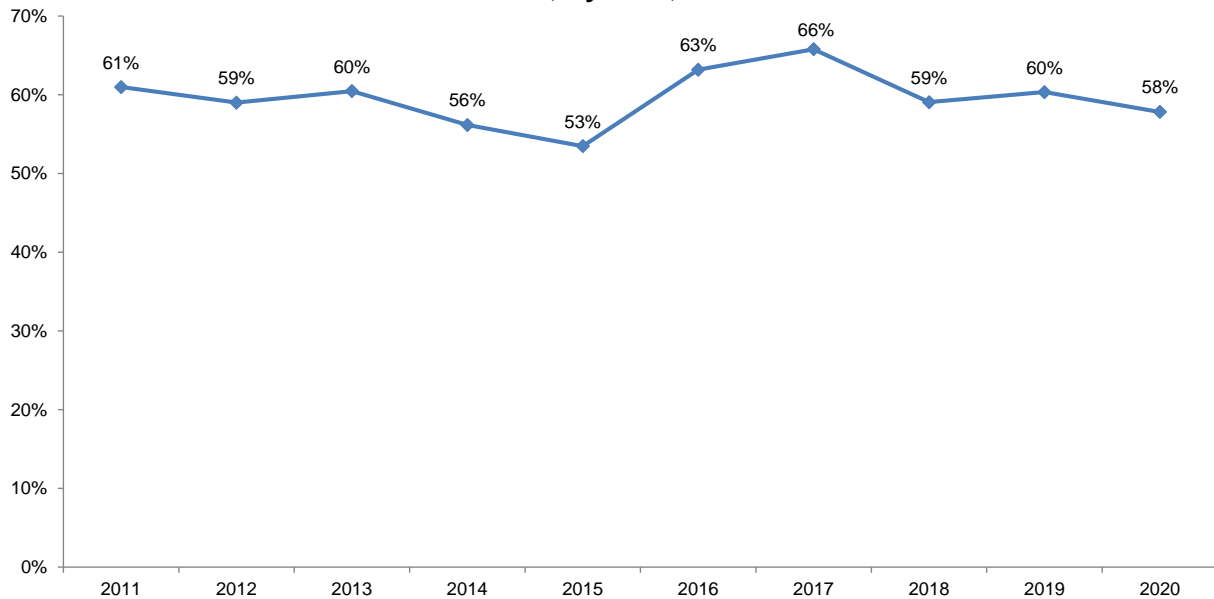


Source: EBRI HSA Database.

## Trends in Distributions From HSAs

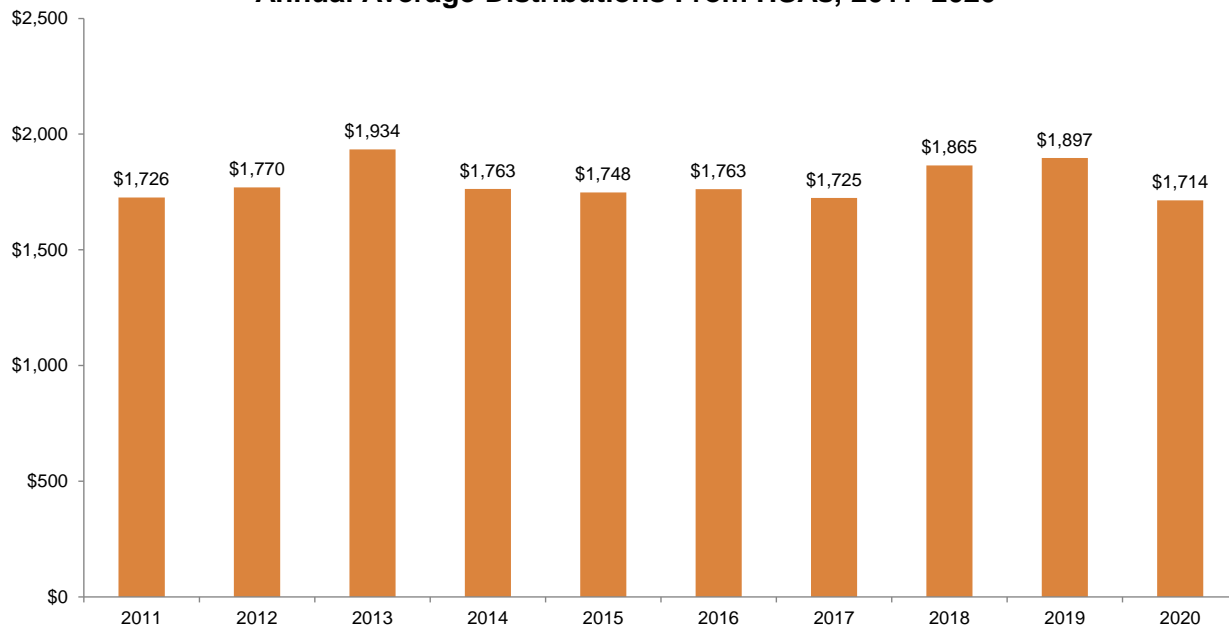
Until 2016, there had generally been a decline in the percentage of accounts taking a distribution. In 2015, 53 percent of accounts had a distribution, down from 61 percent in 2011, but between 2015 and 2016, the percentage of accounts with a distribution increased from 53 percent to 63 percent, and it increased again to 66 percent in 2017 (Figure 11). Since 2018, it has held steady at about 60 percent. Among those with a distribution, the average annual amount distributed has varied between around \$1,700 and \$1,900 (Figure 12). But in 2020, average annual distributions fell to an all-time low of \$1,714. This may be due to lower use of health care services during the COVID-19 pandemic.

Figure 11  
Percentage of Accounts With a Distribution  
From HSAs, by Year, 2011–2020



Source: EBRI HSA Database.

Figure 12  
Annual Average Distributions From HSAs, 2011–2020



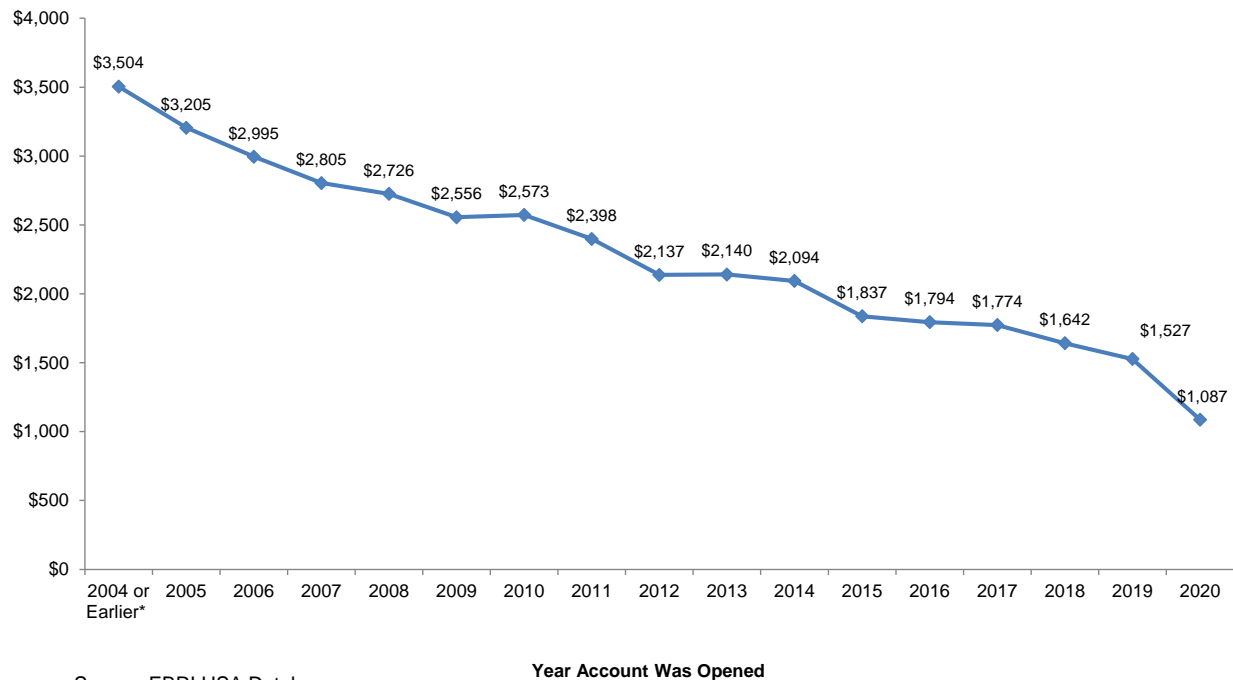
Source: EBRI HSA Database.

In 2020, distributions were higher in accounts that had been open the longest. Those accounts open for one year had an average annual distribution of \$1,087, while those open for 10 years took \$2,573 in distributions (Figure 13). 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 newer ones to have a distribution taken from them. Between 85 and 88 percent of the accounts open for six to 15 years had a distribution in 2020, whereas only 53 percent of accounts open for one year had a distribution that year (Figure 14). Newer accounts generally have lower levels of distributions because they have not had enough time to build up a balance and they are unable to be used to cover health care expenses incurred prior to the date on which the account was opened.

It is also possible that older accounts take larger distributions because older accounts are associated with older accountholders who are more likely to use health care services and thus take distributions. Among accounts opened in 2020, the average age of the account owner was 40.4 years (Figure 15). In contrast, among accounts opened in 2010, the average age of the account owner was 52.7 years.

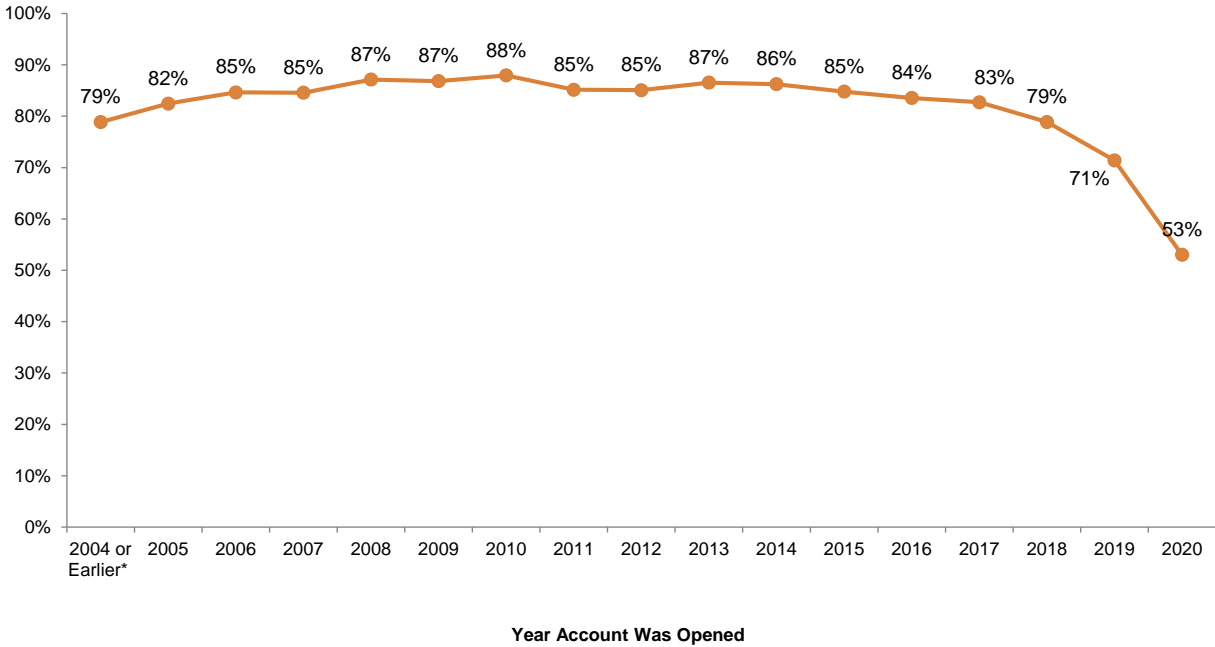
Average annual distributions increased with account-owner age in each year. They ranged from \$1,104 in 2020 for those ages 25–34 to \$2,085 for those ages 55–64 (Figure 16).

**Figure 13**  
**Annual Average Distributions From HSAs,**  
**by Year Account Was Opened, 2020**



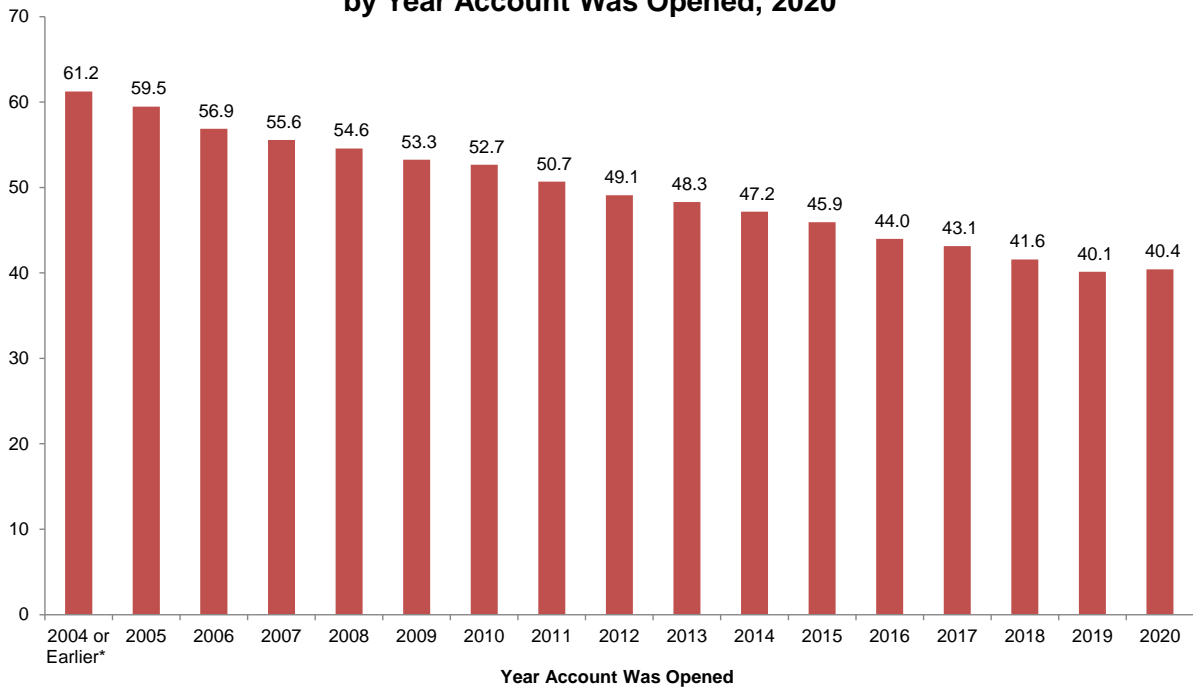
Source: EBRI HSA Database.  
 \*Includes Archer Medical Savings Account (MSA) rollovers.

Figure 14  
**Percentage of Accounts With Distributions From HSAs,  
 by Year Account Was Opened, 2020**



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

Figure 15  
**Average Age of Account Owner,  
 by Year Account Was Opened, 2020**



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

Figure 16  
Average Annual Distributions, by Account-Owner Age, 2011–2020



Source: EBRI HSA Database.

## Trends in Investing HSA Assets

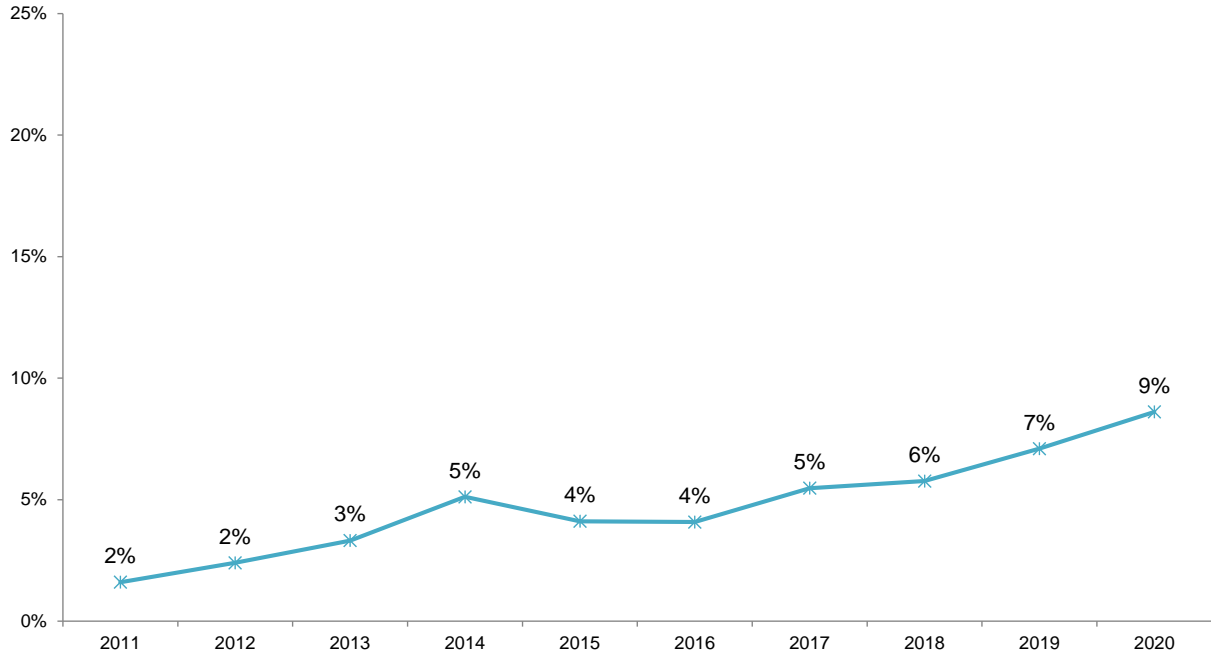
Very few account owners invest their HSA balance in investments other than cash. The percentage of accounts with investments may be low for a number of reasons. First, in order to invest, account owners often must have a minimum account balance. As reported above, most accounts are new, and, therefore, many will not have a large enough account balance to take advantage of investments. Second, account owners may not be aware of the option to invest. Third, 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. They may be trying to build up an account balance large enough to cover their deductible before investing.

In 2020, 9 percent of accounts were investing, up from 2 percent in 2011 (Figure 17). However, the longer an account had been open, the more likely it was to have investments. Only 4 percent of accounts open for one year had investments, compared with 13 percent in accounts open for 10 years (Figure 18). The initially low rate of investing may be due to the fact that most HSA providers require that account balances reach a minimum threshold, often \$1,000 to \$1,500, before a part of the account can be invested, and it may take more than one year for the average participant to reach that threshold. However, in prior research, we found only weak evidence that accountholders wait to accumulate a specific amount of money before investing (Spiegel 2020). Instead, most HSA investors began investing within the first three years of account ownership.

Because the percentage of account owners investing HSA balances was generally small, any differences by age were also small. However, there were some notable differences. Very young account owners were least likely to be investing (Figure 19).

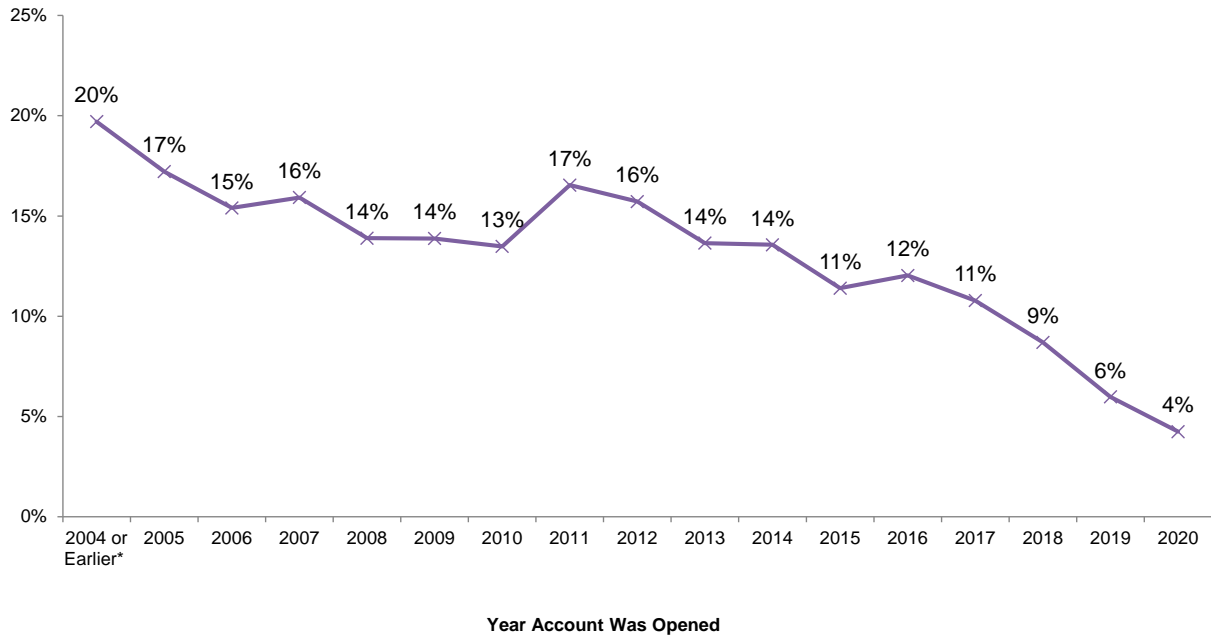
When accounts are invested, the majority of account assets are invested. Among accounts opened with investments, 74 percent of the balances were invested. Generally, the longer an account has been open, the larger the percentage of the account balance that is invested. Among accounts open for 10 years, 77 percent of the balances were invested (Figure 20).

Figure 17  
**Presence of Investments Other Than Cash, 2011–2020**



Source: EBRI HSA Database.

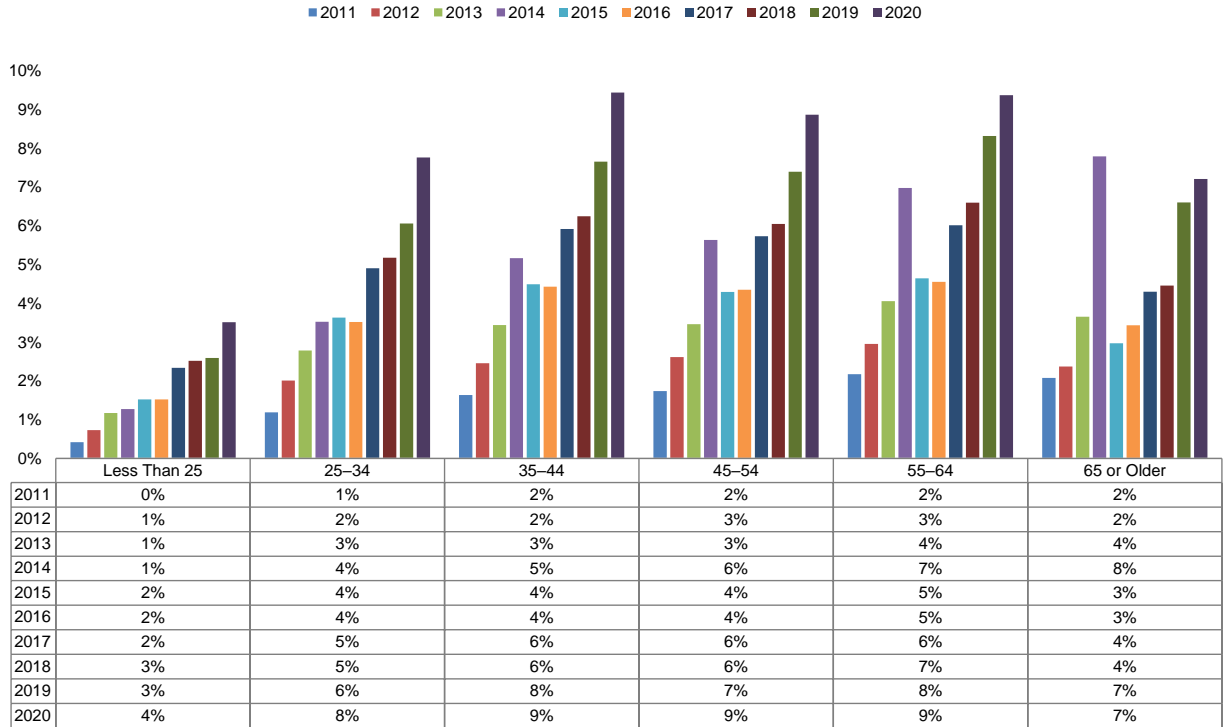
Figure 18  
**Presence of Investments Other Than Cash, by Year Account Was Opened, 2020**



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

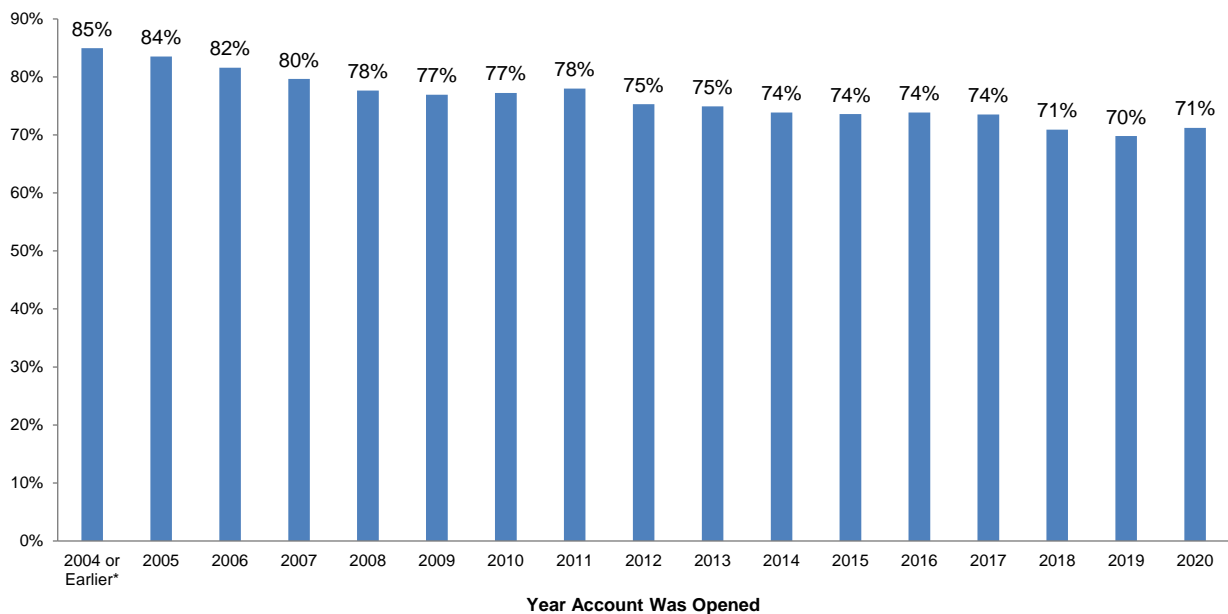


Figure 19  
**Percentage With Investments Other Than Cash,  
 by Account-Owner Age, 2011–2020**



Source: EBRI HSA Database.

Figure 20  
**Percentage of Total Assets Invested, Among Accounts With Invested  
 Assets, by Year Account Was Opened, 2020**



Source: EBRI HSA Database.

\*Includes Archer Medical Savings Account (MSA) rollovers.

## Conclusion

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 accountholders to withdraw larger sums when unexpected major health expenses occur. Plan sponsors that value employee financial wellness can work with administrators and advisors to better educate employees on use of HSAs, including available investments.

## Appendix — What Is an HSA?

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,<sup>9</sup> 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. Contributions in 2021 are limited to \$3,600 for people with individual coverage and \$7,200 for those with family coverage (Appendix Figure 1).

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.

	Minimum Deductible		Maximum Contribution		Maximum Out-of-Pocket Limit		Per-Person Catch-up Contribution Limit
	Individual	Family	Individual	Family	Individual	Family	
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
2019	1,350	2,700	3,500	7,000	6,750	13,500	1,000
2020	1,400	2,800	3,550	7,100	6,900	13,800	1,000
2021	1,400	2,800	3,600	7,200	7,000	14,000	1,000

## 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 2021, the plan must have had an annual deductible of at least \$1,400 for individual coverage and \$2,800 for family coverage, and the plan's out-of-pocket maximum may not have exceeded \$7,000 for individual coverage or \$14,000 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). Furthermore, IRS Notice 2019-45 now classifies certain health care services and items purchased for certain chronic conditions as preventive care for those people with those chronic conditions.<sup>10</sup> Otherwise, all health care services must be subject to the HSA's deductible, though there is an exemption for telemedicine services, as discussed below.

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.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was signed into law on March 27, 2020, to provide economic relief related to the COVID-19 pandemic and economic downturn affecting millions of families and businesses in the United States, contains two sections that are pertinent to HSAs. First, Sec. 3701 includes a provision that allows HSA-eligible health plans to provide access to telemedicine services prior to meeting the annual deductible. This provision is temporary and ends on Dec. 31, 2021. Second, Sec. 3702 allows HSAs to be used to purchase over-the-counter (OTC) medical products without a prescription from a physician including pain relievers, cold medicines, bandages, feminine hygiene products, and more. This provision is permanent and is retroactive to Jan. 1, 2020.

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 2021, a worker with individual coverage is allowed to make an annual HSA contribution of \$3,600, while a worker with family coverage can contribute as much as \$7,200. These dollar limits are indexed for inflation. Additionally, individuals who reach age 55 and are not yet enrolled in Medicare are able to 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.<sup>11</sup>

## 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 has 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 owner is responsible for making the investment decisions and bears 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.

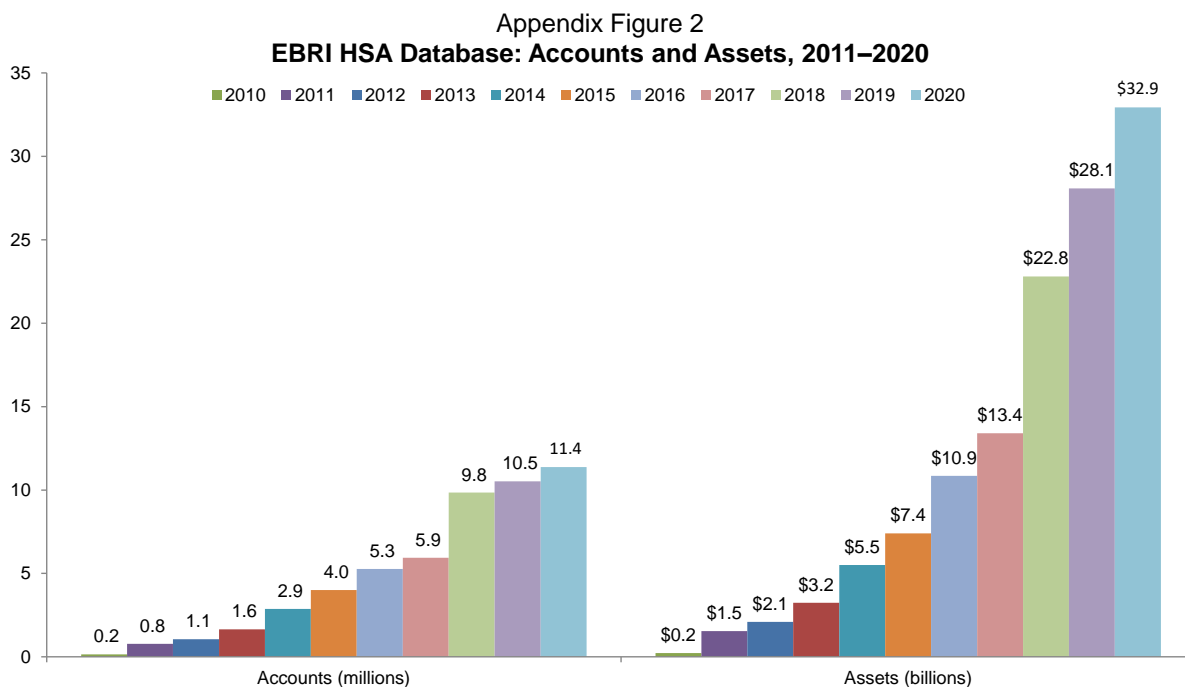
HSA distributions for nonqualified medical expenses are not excludable from gross income and, in addition to being taxable, are subject to a 20 percent penalty, which is waived if the HSA owner dies, becomes disabled, or is eligible for Medicare. Individuals are able to transfer funds from one HSA to 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 MMA created HSAs, existing MSAs were grandfathered in, 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.

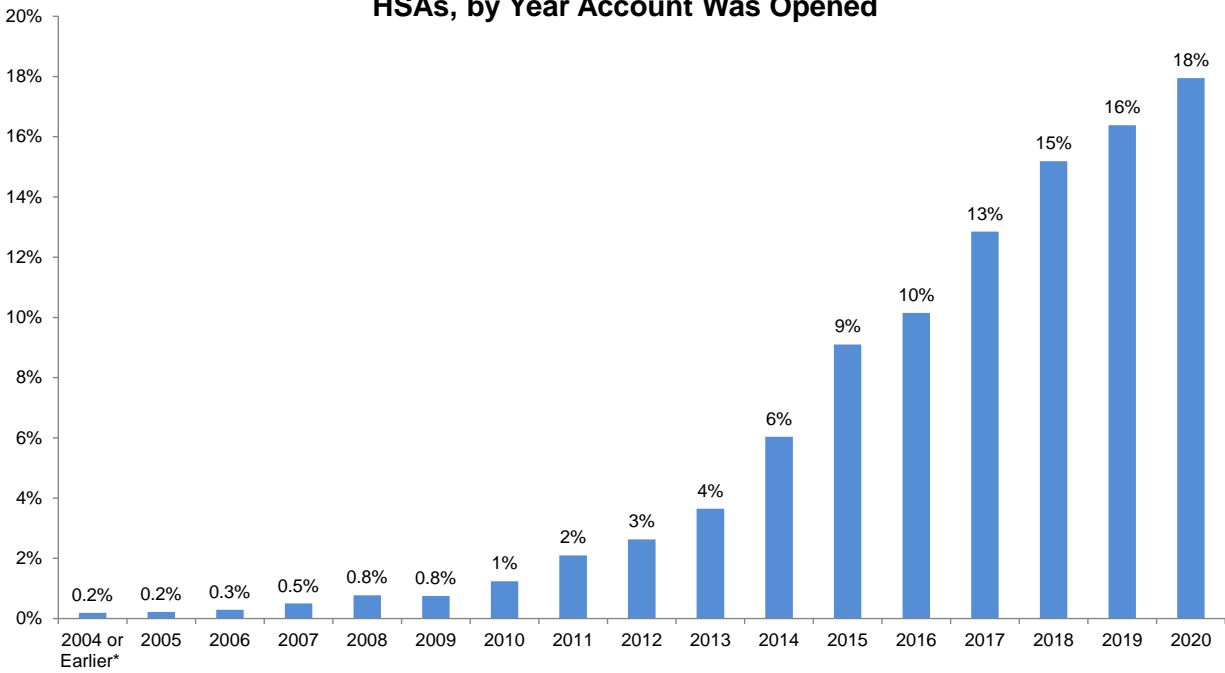
## ERISA Compliance

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.<sup>12</sup> 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.<sup>13</sup>



Source: EBRI HSA Database.

Appendix Figure 3  
**HSAs, by Year Account Was Opened**



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

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## Endnotes

<sup>1</sup> HRA enrollees are combined with HSA enrollees. According to a different survey, 77 percent of HDHP enrollees were in an HSA-eligible plan, and 23 percent were in an HRA plan. See Figure 8.5 in <https://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019>.

<sup>2</sup> See <https://www.devenir.com/wp-content/uploads/2020-Year-End-Devenir-HSA-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.

<sup>3</sup> See the literature review in Bundorf (2012) as well as subsequent research in Brot-Goldberg et al. (2015); Fronstin and Roebuck (2013); Fronstin, Sepúlveda, and Roebuck (2013a); Fronstin, Sepúlveda, and Roebuck (2013b); Fronstin and Roebuck (2014); Fronstin and Roebuck (2016); Fronstin and Roebuck (2019), Fronstin, Roebuck, Buxbaum and Fendrick (2020), and Fronstin and Roebuck (2020).

<sup>4</sup> See AHIP (2014).

<sup>5</sup> See <https://www.devenir.com/wp-content/uploads/2020-Year-End-Devenir-HSA-Research-Report-Executive-Summary.pdf>

<sup>6</sup> See [https://www.ebri.org/docs/default-source/cehcs/2019-cehcs-report.pdf?sfvrsn=b7293d2f\\_10](https://www.ebri.org/docs/default-source/cehcs/2019-cehcs-report.pdf?sfvrsn=b7293d2f_10)

<sup>7</sup> Several recordkeeping organizations have provided de-identified data on HSA owners. 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 numbers, 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

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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.

<sup>8</sup> Our findings from 2011–2014 might have been affected by the specific HSA providers that were able to provide data in those years.

<sup>9</sup> 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.

<sup>10</sup> See <https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions>

<sup>11</sup> 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.

<sup>12</sup> See <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2004-01>

<sup>13</sup> See <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2006-02>