

Health Savings Account Balances, Contributions, Distributions, and Other Vital Statistics, 2020: Evidence From the EBRI HSA Database

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

Health savings account (HSA)-eligible health plans are an important part of the health benefits landscape, yet there is little empirical research on how HSAs are used by employees. Based on its unique database of more than 11.4 million HSAs, the Employee Benefit Research Institute (EBRI) seeks to shed light on the ways HSA accountholders contribute to, withdraw from, and invest in their HSAs. Such analyses can help not only plan sponsors but also providers and policymakers better understand strategies that can help improve utilization of HSAs and, ultimately, overall employee financial wellness.

Key findings for 2020 are that:

- ***Despite the COVID-19 pandemic, HSA accountholders continue to build up savings in their HSAs.*** The average end-of-year balance was higher than the average beginning-of-year balance, and the average balance increase was even larger when analyzing only accounts that had received either an employee or employer contribution in 2020.
- ***Employer contributions can play a role in fostering accountholders' engagement with their HSAs.*** Accounts that received an employer contribution showed several signs of optimal usage, including higher total contributions and greater likelihood of investments other than cash. However, EBRI's analysis also reveals that these accountholders were more likely to take a distribution and, when they did, took larger distributions than accountholders who did not receive an employer contribution.
- ***The average HSA had a distribution.*** More than half of HSAs experienced a distribution in 2020. However, most accountholders who did take distributions from their HSAs withdrew small amounts.
- ***Few HSAs are invested.*** Along with the lack of a "use-it-or-lose-it" provision, one of the largest differentiators of HSAs from flexible savings accounts is the ability to invest assets within the account. However, relatively few accountholders took advantage of this ability, and those who did tended to have very large average balances.
- ***Age and tenure play a major role in HSA utilization.*** Older accountholders tended to have higher average contributions than younger accountholders and higher average balances as well. Similarly, accountholders who have had their HSAs for a longer period of time tended to have higher average contributions, higher average balances, and invested their balances in assets other than cash more frequently.

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Health Savings Account Balances, Contributions, Distributions, and Other Vital Statistics: Evidence From the EBRI HSA Database

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Introduction

While there is a growing body of literature on how individuals in health savings account (HSA)-eligible health plans use and pay for medical services,¹ there is still a general lack of data on HSAs as well as how accountholders use them. For instance, the Survey of Consumer Finances (SCF), a gold-standard, publicly available, and nationally representative survey updated every three years by the Federal Reserve, lumps HSAs in the same category as 529s and Coverdell education savings accounts (ESAs) for the purposes of protecting respondents' identification. Therefore, an enterprising analyst cannot rely on the SCF to examine how HSA balances have changed over the years, for instance, or if older accountholders use their HSAs differently than younger accountholders. The lack of widely available data on HSAs contributes to a blind spot for researchers, which keeps policymakers in the dark on how they are (or are not) used. EBRI's HSA database plays a critical role in filling in those gaps.

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 a health savings account (HSA), 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, 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 are limited to \$3,600 for people with individual coverage and \$7,200 for those with family coverage (Appendix Figure 1).

This blind spot is particularly troublesome given the proliferation of HSA-eligible health plans and HSA offerings in the workplace. HSAs are being positioned not only as a component of an employer's health benefit offerings but also as retirement savings vehicles to support an employee's overall financial wellbeing (Fronstin and Spiegel 2020). Thus, a complete understanding of how accountholders use HSAs is critical.

There are, for instance, some disconnects between "optimal" HSA usage and the behavior observed in EBRI's HSA Database. HSAs are well-positioned to fit in personal finances as long-term savings vehicles. Their triple tax advantage enables accountholders to accumulate large balances by leveraging the ability to invest HSA funds in the stock market, much like an employer-sponsored retirement plan. An optimal strategy, then — for those in a position to do so — is to invest HSA funds and pay for medical expenditures out of pocket. However, the percentage of accountholders who invest some portion of their HSAs remains stubbornly low; only about 7 percent of accountholders currently hold investments outside of cash in their HSAs. Even among those who invest, most take distributions from their HSAs, suggesting that even these accountholders might not be taking full advantage of the tax benefits HSAs offer, perhaps because they lack sufficient cash flow to pay for medical expenditures out of pocket. There is some encouraging evidence suggesting that as time passes, accountholders gain some clarity in how their HSAs fit into their personal finances, and a greater share of them begin investing, suggesting the importance of outreach and education efforts when it comes to HSAs (Spiegel 2020).

To better understand HSA accountholder behavior, this *Issue Brief* focuses on the 11.4 million HSAs in EBRI's HSA Database that were open for at least some part of 2020. EBRI's HSA Database grew to account for 11.4 million open HSAs in 2020, up from 10.5 million open accounts in 2019. The assets contained by accounts in EBRI's HSA Database continued the trend of significant growth that EBRI has observed in previous iterations of this paper. Assets contained

within accounts captured by EBRI's HSA Database grew to \$32.9 billion, up from \$28.1 billion in 2018. We exclude all accounts that were closed prior to 2020 from analysis in this *Issue Brief*.

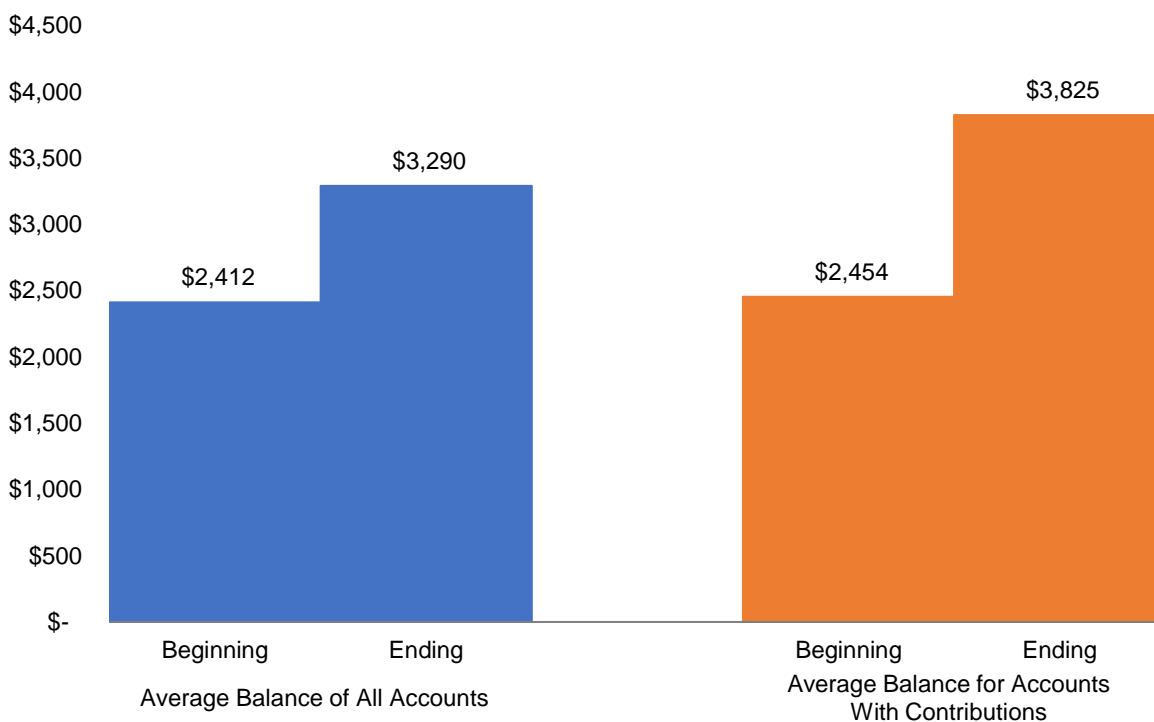
Data on the HSA market are incomplete, but based on outside estimates, EBRI's HSA Database contains about 40 percent of the whole market.² This robust database allows us to conduct rich analyses and strong inferences.³

Account Balances

Encouragingly, and continuing the trend from previous years, the average HSA balance increased over the course of 2020, rising more than a third from \$2,412 at the beginning of the year to \$3,290 by the end of the year. An increasing average balance indicates that many accountholders are better prepared to handle an unexpected medical emergency than they were at the beginning of the year. Encouragingly, this happened despite a pandemic in which the labor market experienced a significant disruption and despite slightly smaller average contributions than in previous years (Fronstin 2021).

Next, we restrict our analysis to only accounts that received either employee or employer contributions in 2020, as their presence is a strong indicator that the account is being actively used. This analysis further reveals that HSAs may be increasingly used as longer-term savings vehicles. HSAs that received either employee or employer contributions in 2020 were systematically different from HSAs that received neither. Specifically, we find that there were nearly 7 million accounts that received either an employee contribution or an employer contribution and that the average balance of these accounts grew more than 50 percent in 2020: from \$2,454 at the beginning of 2020 to \$3,825 at the end of 2020 (Figure 1).

Figure 1
Average Account Balance, by Contribution Status

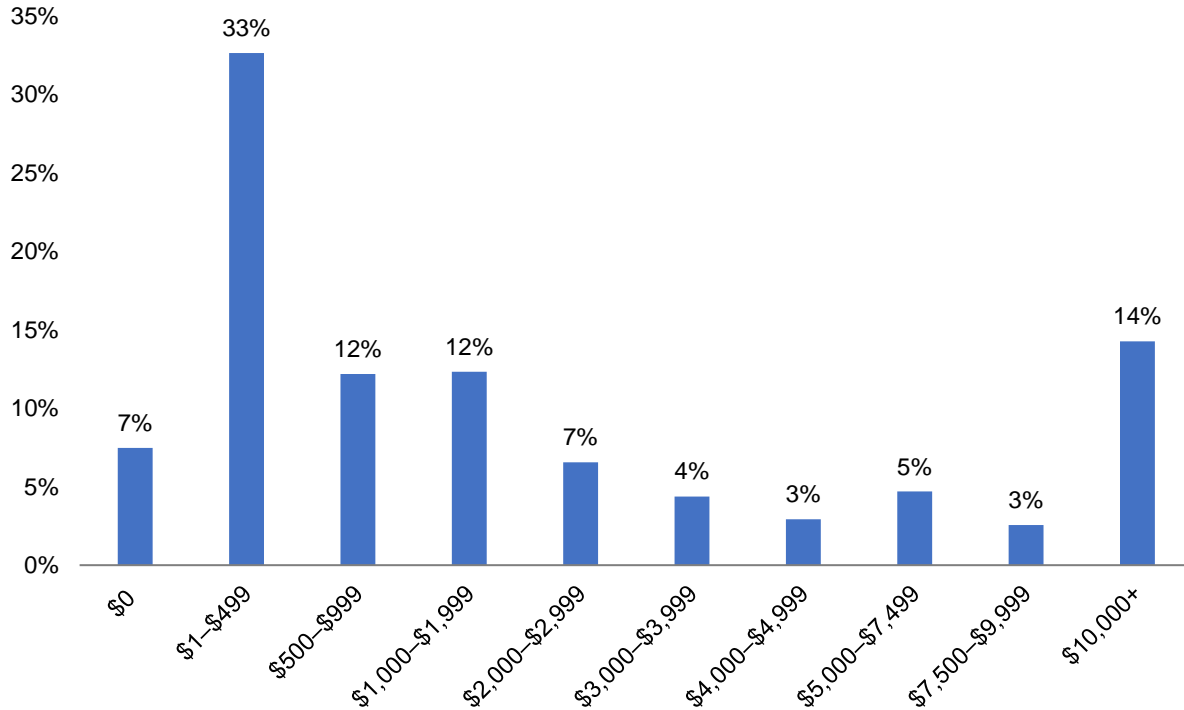


Source: EBRI HSA Database.

As with past years, and dovetailing with expectations given the recent proliferation of HSAs, the majority of accounts in EBRI's HSA Database contained relatively small balances by the end of 2020. Roughly 40 percent of accounts finished

the year with less than \$500 (Figure 2). Meanwhile, 14 percent of accounts finished the year with balances larger than \$10,000.

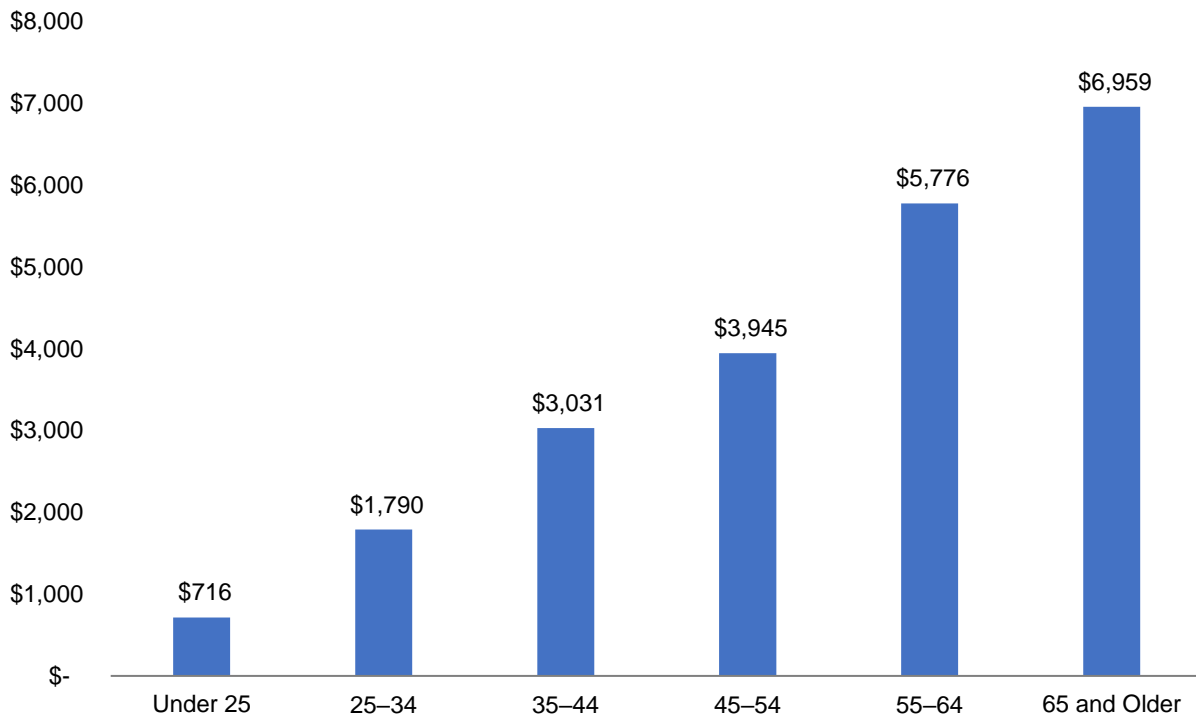
Figure 2
Year-End Account Balance for Accounts With Contributions



Source: EBRI HSA Database.

EBRI’s analysis reveals two predominant mechanisms that were strongly associated with higher average account balances. First, age is strongly associated with higher HSA balances: The older the accountholder, the higher the average balance. This result is not particularly surprising, as older workers tend to earn more than younger workers just starting their career. Additionally, older workers tend to have a higher account tenure, which helps them accumulate larger balances, and additional experience with HSAs helps them see the role they can play in their personal finances. Also, older workers are more likely to incur health care expenses than younger workers. We see this phenomenon reflected in plotting account balances by age group (Figure 3), where young accountholders under the age of 25 had an average balance of \$716, compared with middle-aged and mid-career accountholders aged 35–44, who had an average balance of \$3,031, and older accountholders aged 65 or older, who had an average balance of \$6,959. Older accountholders were also slightly more likely to make contributions to their accounts: 49 percent of accountholders under 25 made a contribution in 2020, compared with 54 percent of accountholders aged 55–64.

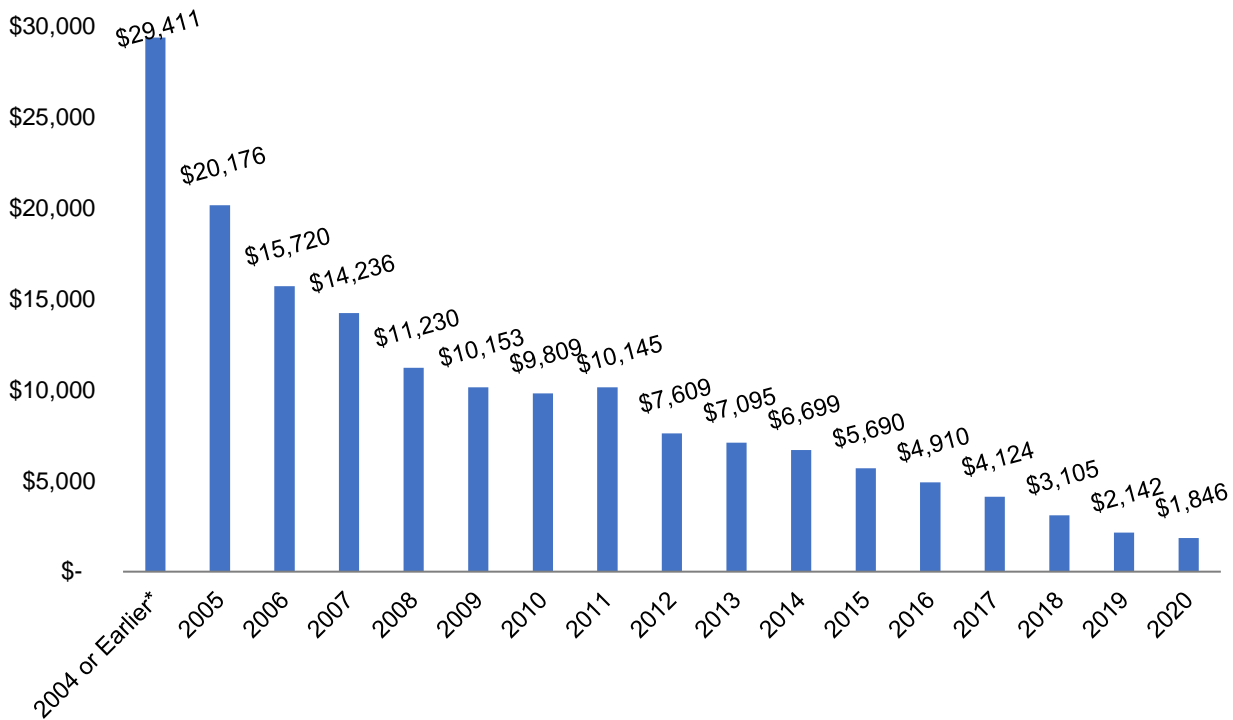
Figure 3
Year-End Account Balances for Accounts With Contributions, by Age



Source: EBRI HSA Database.

Second, EBRI's analysis indicates that account tenure is strongly associated with higher account balances. The longer someone has had their account, the more contributions they and their employer are likely to have made. While some accountholders spend down much of their balance each year, most do not, and as a result, accountholders build up progressively higher balances year after year. Unsurprisingly, HSAs that have been open for 15 years or more had, on average, a significantly higher balance than accounts open for only five years (\$20,176 and \$5,690, respectively), as shown below in Figure 4.

Figure 4
Year-End Account Balances for Accounts With Contributions, by Year Opened

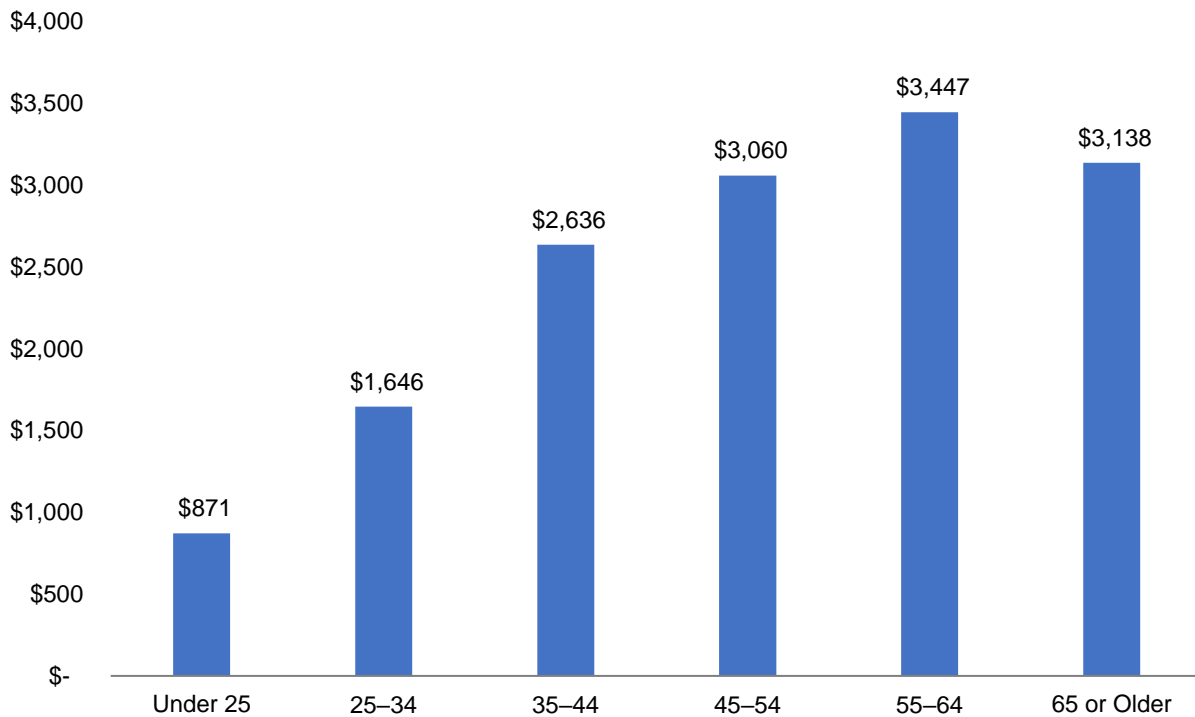


Source: EBRI HSA Database.

Contributions

Nearly 7 million accounts, representing roughly 60 percent of all accounts in EBRI’s HSA Database, received either an employee or an employer contribution in 2020.⁴ As with account balances, contributions tended to increase with age. Younger workers just starting their careers tend to have fewer discretionary dollars to divert to HSAs, and this results in lower average HSA contributions. Indeed, accountholders under the age of 25 contributed just an average of \$874. On the other hand, older accountholders tend to earn more and are therefore better positioned to contribute more to their HSAs. The average contribution increased as accountholder age increased, peaking in the 55–64 age group at \$3,447 before decreasing among accountholders 65 or older (Figure 5).⁵

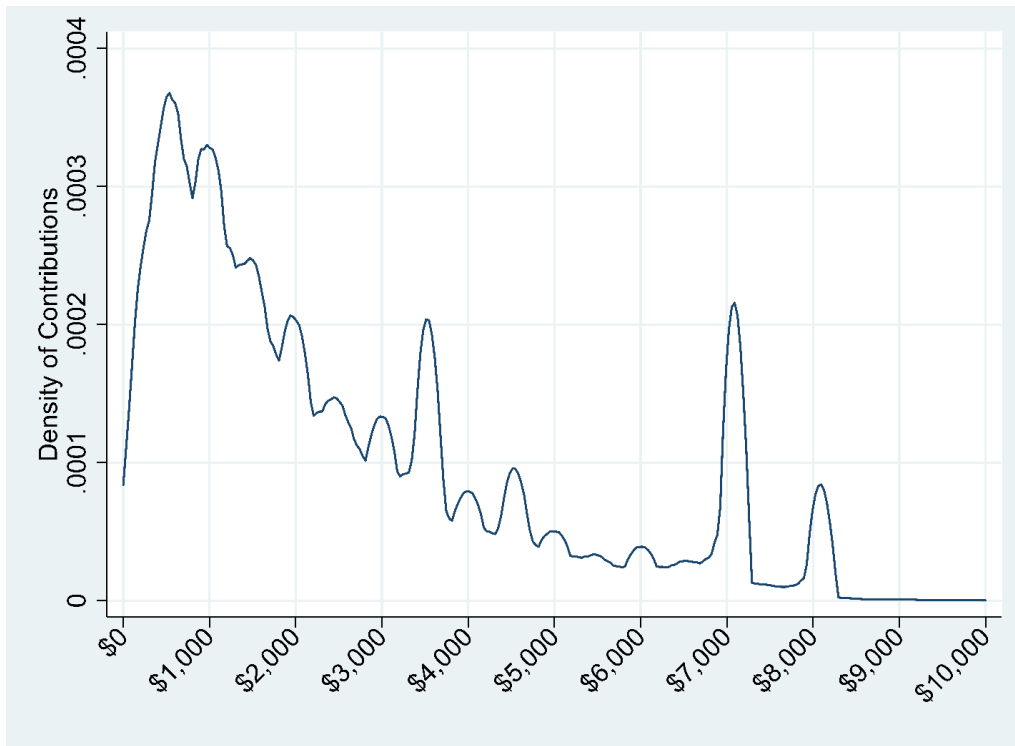
Figure 5
Average HSA Contributions, by Age



Source: EBRI HSA Database.

As EBRI's analyses have found in years past, there is some degree of lumpiness in HSA contributions, which we interpret as an indication that some accountholders target specific amounts to contribute to their HSAs. Plotting how frequently HSA contribution amounts appear in EBRI's HSA Database reveals a few interesting patterns (Figure 6). The largest cluster of contributions is at the \$500 level, with a slightly smaller cluster at the \$1,000 levels. Contributions then cluster at roughly \$500 increments thereafter. The spike in contributions around \$3,550 is consistent with the statutory maximum contribution amount for accountholders enrolled in a health care plan with individual coverage. There is also a spike in contributions at the \$7,100 level, which is the statutory maximum contribution amount for accountholders under the age of 55 with family coverage in 2020. Another spike in contributions is centered around \$8,100, which represents the maximum amount that accountholders over the age of 55 with family coverage can contribute.

Figure 6
Distribution of Contribution Amounts for HSAs With Contributions



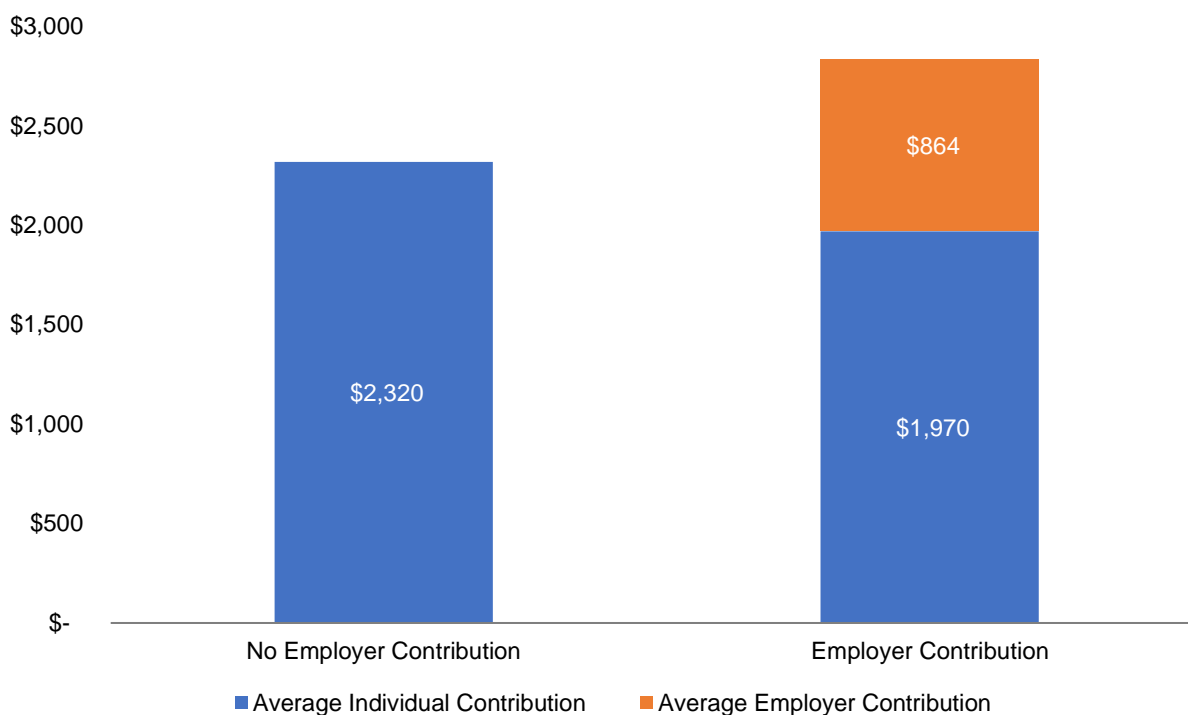
Source: EBRI HSA Database.

As Figure 6 above indicates, we find that a minority of accountholders contribute the statutory maximum to their HSAs.⁶ We find that only about 18 percent of accountholders contributed the statutory maximum in 2020. This share is smaller than the share who contributed the statutory maximum for other tax-advantaged savings vehicles. For instance, an analysis of EBRI’s IRA Database indicates that about 44 percent of individual retirement accounts (IRAs) with a contribution received the maximum allowable contribution in 2017 (Copeland 2020).

Additionally, we find evidence that accounts with an employer contribution differed systematically from accounts without an employer contribution. Employer contributions to HSAs can take several forms. Some employers may provide an initial seed contribution on the employee’s behalf to help them kickstart their accounts. Others may provide a recurring matching contribution, much like an employee contributing to a 401(k) plan, and others may provide a monthly contribution regardless of the employee’s contribution. While EBRI’s HSA Database does not allow us to conduct differential analyses based on employer contribution types, we can examine whether accountholders use their HSAs differently based on whether or not they receive employer contributions.

Accounts that had received employer contributions were systematically different from accounts that did not receive employer contributions in several important ways. The average account with an employer contribution received 22 percent more in total contributions — \$2,834 in 2020 vs. \$2,320 for the average account without the benefit of an employer contribution (Figure 7). Interestingly, accounts with an employer contribution had lower average individual contributions. Employer contributions may nudge employees to allocate their discretionary dollars elsewhere, such as emergency savings accounts or retirement savings accounts, knowing that they could count on their employer’s contribution to hit their HSA savings target. Another interesting phenomenon is that accounts that received employer contributions more frequently contained assets other than cash — 9 percent, compared with 7 percent of all accounts.

Figure 7
**Average 2020 Individual and Employer Contributions,
 by Presence of Employer Contribution**



Source: EBRI HSA Database.

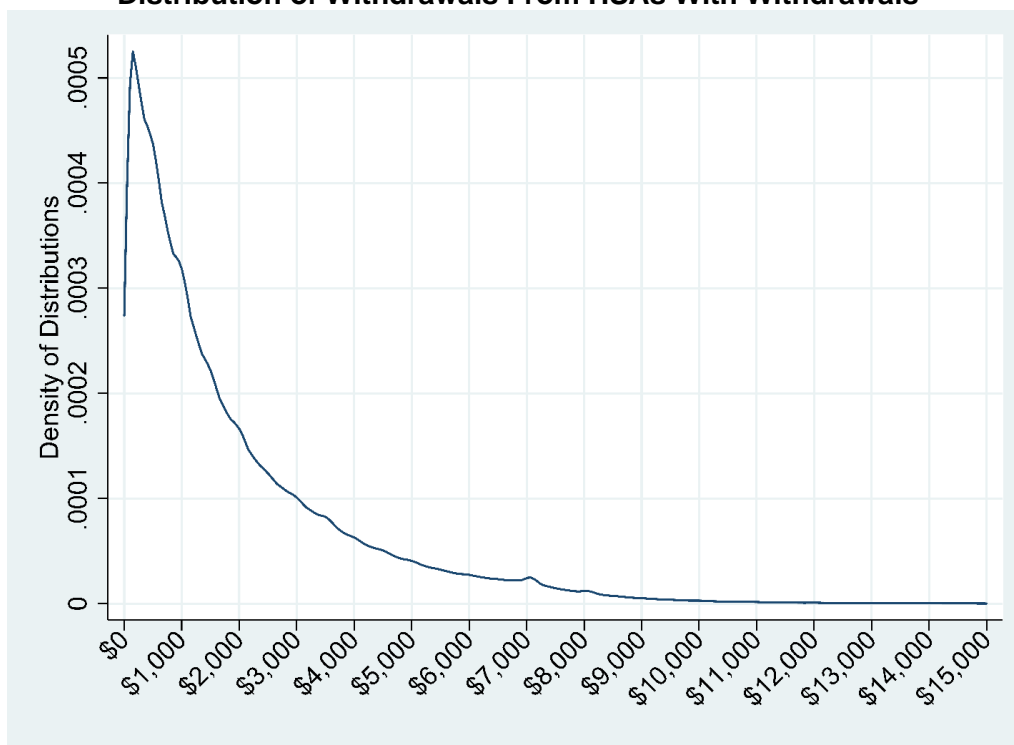
Perhaps as a result of their higher contributions and higher balances, accounts that had received contributions from an employer tended to see different distribution behavior. Accountholders who received an employer contribution were more likely to have taken a distribution than accountholders who did not receive an employer contribution (72 percent vs. 53 percent), and they took larger distributions on average (\$1,934 vs. \$1,445). Accountholders who received an employer contribution may have been emboldened to take larger distributions knowing that their employer’s contribution padded their account balances. Or this may be related to a phenomenon frequently observed in behavioral economics known as the endowment effect. Accountholders with a balance built solely from their own contributions may be less willing to take a distribution than accountholders who also receive an employer contribution.

Distributions

HSA help accountholders offset higher deductibles found in high-deductible health plans (HDHPs). This feature is particularly useful for households that lack the cashflow or emergency savings to pay for large, (and potentially unexpected) medical expenditures out of pocket. As a result, many accountholders in EBRI’s HSA Database withdraw money from their HSAs. Taking distributions could be counterproductive if an accountholder’s goal is to maximize wealth at retirement — assuming they have sufficient liquidity to pay for medical expenditures out of pocket. That said, roughly 58 percent of accountholders withdrew money from their HSAs at some point in 2020. Among those who took a distribution, the average amount withdrawn was \$1,713, and the median distribution — less sensitive to large outliers — was \$980.

Most accountholders who did take distributions from their HSAs withdrew small amounts. Of the accountholders who took a distribution, a plurality — about 32 percent — withdrew less than \$500. Meanwhile, a vanishingly small minority — only 0.5 percent — withdrew more than \$10,000. A graph of the distribution of withdrawals is strongly skewed toward zero, reflecting the most common amount withdrawn among accountholders with distributions was less than \$500 (Figure 8).

Figure 8
Distribution of Withdrawals From HSAs With Withdrawals

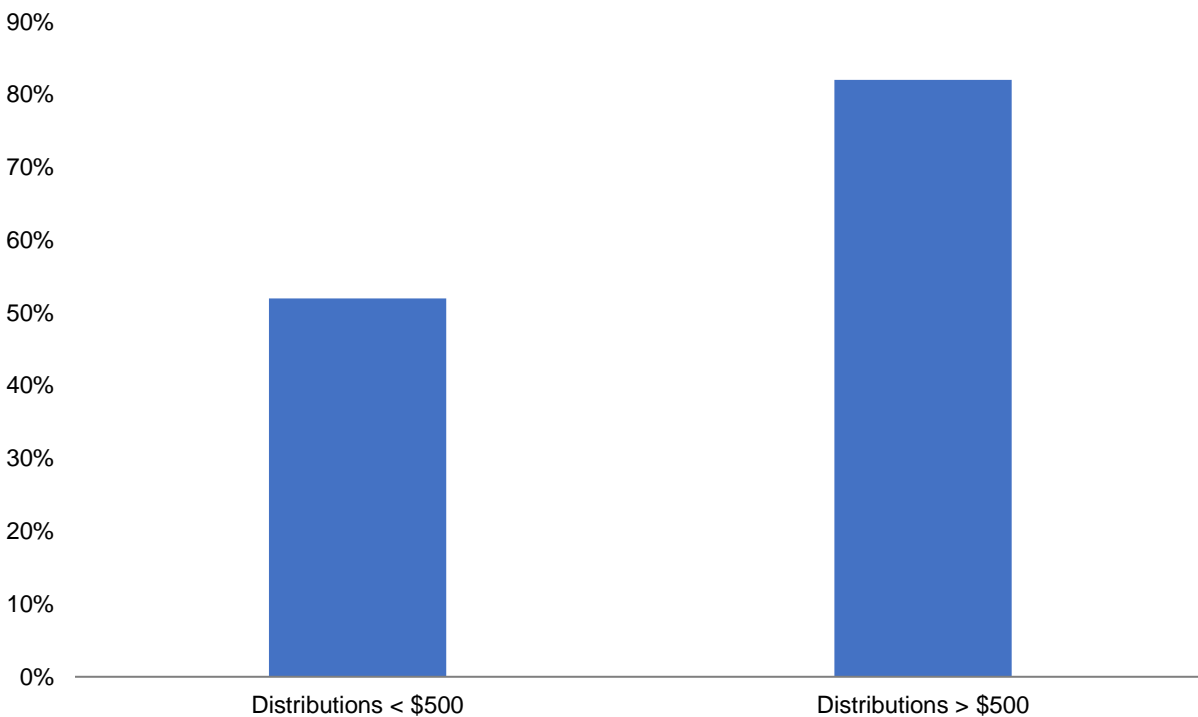


Source: EBRI HSA Database.

A majority of accountholders either did not take a distribution in 2020 or took a distribution smaller than \$500. Notably, accountholders' deductibles were at least \$1,400 in 2020 (and potentially higher). As such, the low amounts withdrawn could be an indication that healthier people who do not expect to have large medical expenditures are self-selecting into HDHPs or that most people do not incur large medical expenses (Fronstin and Roebuck 2019). This could also reflect that these accounts are owned by people who have multiple HSAs or are owned by people who have opted into a traditional health care plan and can no longer contribute to their HSA. Another possibility is that, as a result of the COVID-19 pandemic, the accountholder hesitated in seeking care in person and was either unwilling or unable to seek care via telemedicine.

Ultimately, we do find some evidence supporting the theory that many of the accounts that did not see distributions were held by accountholders who either have more than one HSA or opted into a traditional health care plan and could no longer contribute. Just over half (52 percent) of HSAs with either no or small distributions received either an employee or employer contribution, compared with 82 percent of HSAs that saw larger (i.e., over \$500) distributions (Figure 9).

Figure 9
Share of Accounts Receiving an Employee or Employer Contribution

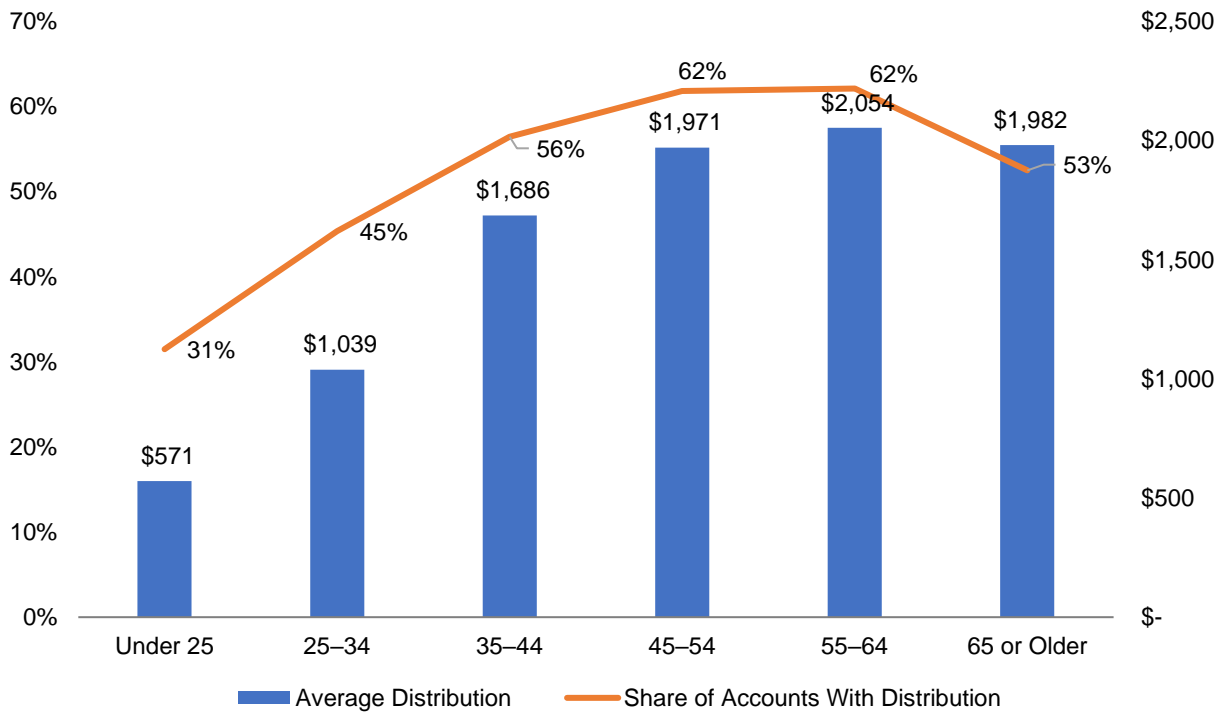


Source: EBRI HSA Database.

Among accountholders who took distributions, EBRI’s analysis finds several factors that are strongly associated with larger withdrawals. On average, older accountholders took higher distributions from their HSAs than younger accountholders. To illustrate, accountholders under 25 who took distributions withdrew \$571 on average, while their counterparts aged 55–64 withdrew an average of \$2,054 (Figure 10). They also took distributions less frequently (31 percent compared with 62 percent). This dovetails with expectations, as younger accountholders are likely healthier and therefore spend less on health care needs than older workers. Also, as indicated earlier, older accountholders tended to have higher account balances and contribute more to their HSAs and thus are better positioned to take larger distributions.

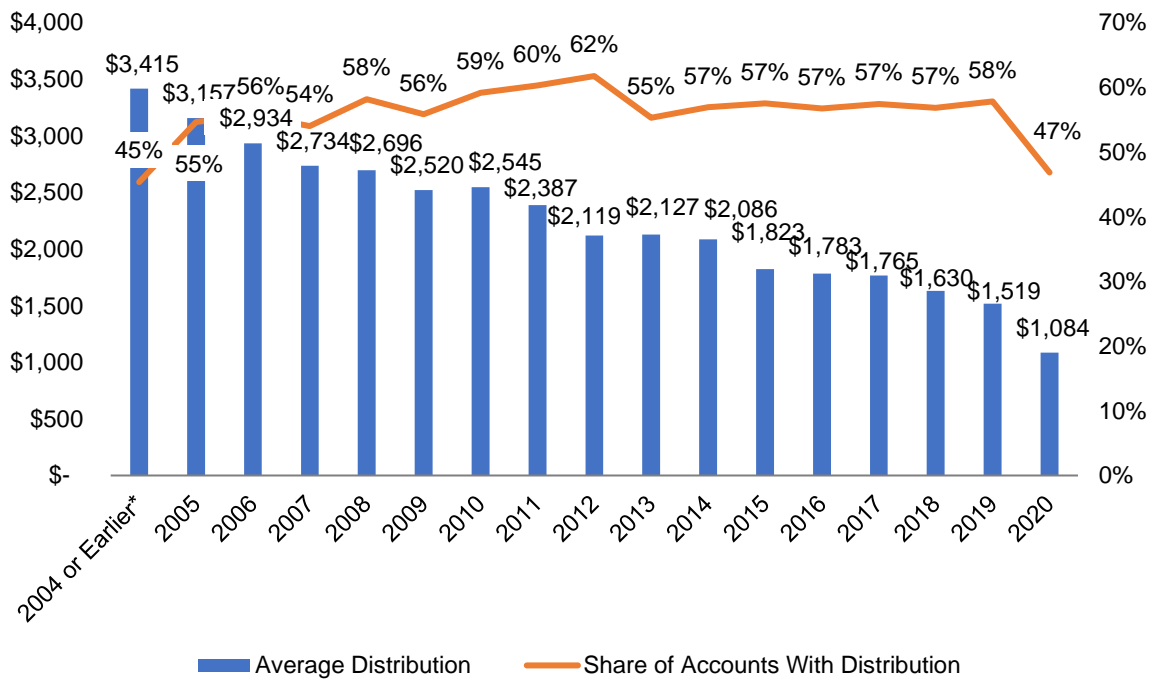
Accountholders with longer account tenure also took larger distributions. New accounts that were opened in 2020 were less likely to have a distribution taken from them than older accounts. For instance, 47 percent of new accounts took a distribution, compared with 57 percent for accounts three years old, shown below in Figure 11. Newer accounts took smaller distributions than accounts three years old as well (\$1,084 and \$1,765, respectively). As is the case with accountholder age, accountholders who have had their HSAs for a longer period of time build up larger balances over time and are therefore better positioned to take larger distributions when necessitated by their health care spending and personal finance situation.

Figure 10
Average HSA Distributions Among Accounts With Distributions, by Age of Owner



Source: EBRI HSA Database.

Figure 11
Average HSA Distributions Among Accounts With Distributions, by Year Account Was Opened



Source: EBRI HSA Database.

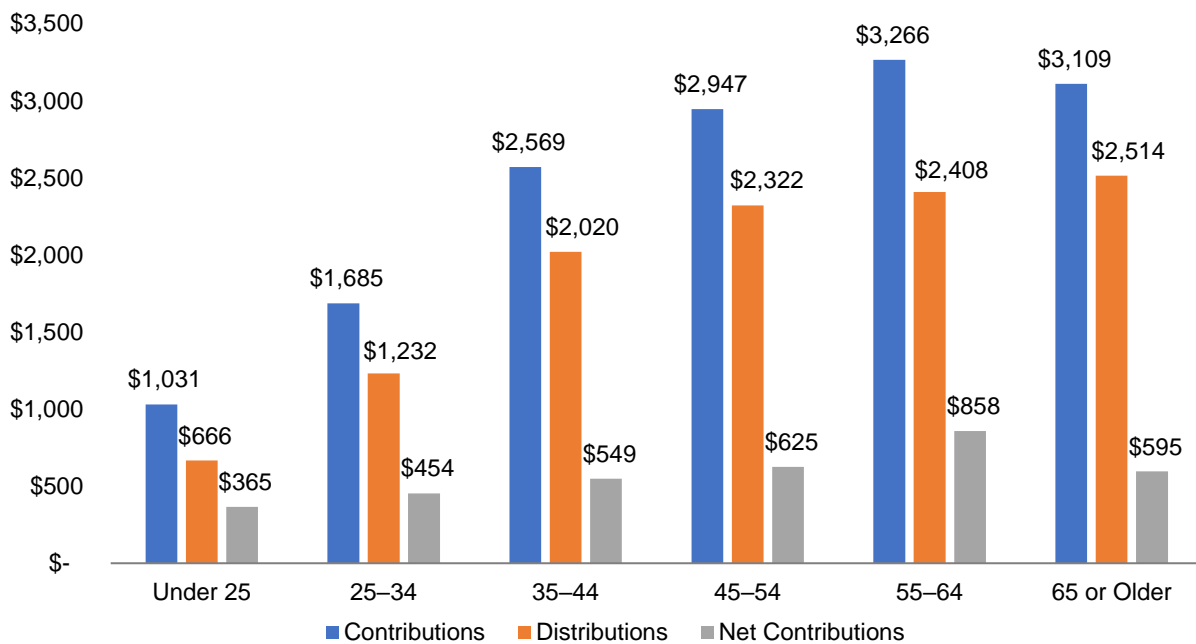
In an encouraging sign that most accountholders are willing and able to build up larger account balances, relatively few accountholders spent down the entirety of their HSA balances. Among accounts that had received either employee contributions or employer contributions, about 420,000 accounts, or about 3.5 percent of all accounts in EBRI’s HSA Database, finished the year with a balance of precisely zero. We restricted this analysis to accountholders with at least some contributions by either the employee or employer to isolate accounts that were actively used over the course of 2020. An additional 461,000 accounts — about 3.9 percent of the accounts in EBRI’s HSA Database — ended the year with very small balances (less than \$10), an indication that these accountholders functionally spent down their entire HSA balances.

That relatively few accountholders spent down their entire accounts — or close to it — is a positive sign that accountholders are reaping the tax advantages that HSAs offer. Since HDHPs feature higher deductibles by definition, HSA accountholders are well-served to keep a buffer that can cover their liabilities in case they incur unexpected health care expenses that they cannot cover with traditional checking or savings accounts. Also worth noting is that vanishingly few accountholders — about 0.2 percent — who drew down their balances at the end of the year had some portion of their accounts allocated to investments other than cash. The evidence suggests these accountholders treated their HSAs more as spending vehicles and less as long-term savings vehicles, but these accountholders comprise a small minority of the accounts in EBRI’s HSA Database.

Net Contributions

Our analysis finds that contributions and distributions alike tended to increase with accountholder age. Among accounts with both contributions and distributions, younger accountholders had the smallest average contributions and distributions, at \$1,031 and \$666, respectively (Figure 12). As accountholders age, both their contributions and withdrawals increased — although their net contributions tended to be higher. In fact, net contributions increased with owner age until the oldest age group. Net contributions were lowest for younger accountholders at \$365 and highest for accountholders aged 55–64 at \$858.

Figure 12
2020 HSA Activity, by Age, Among Accounts With Both Contributions and Distributions

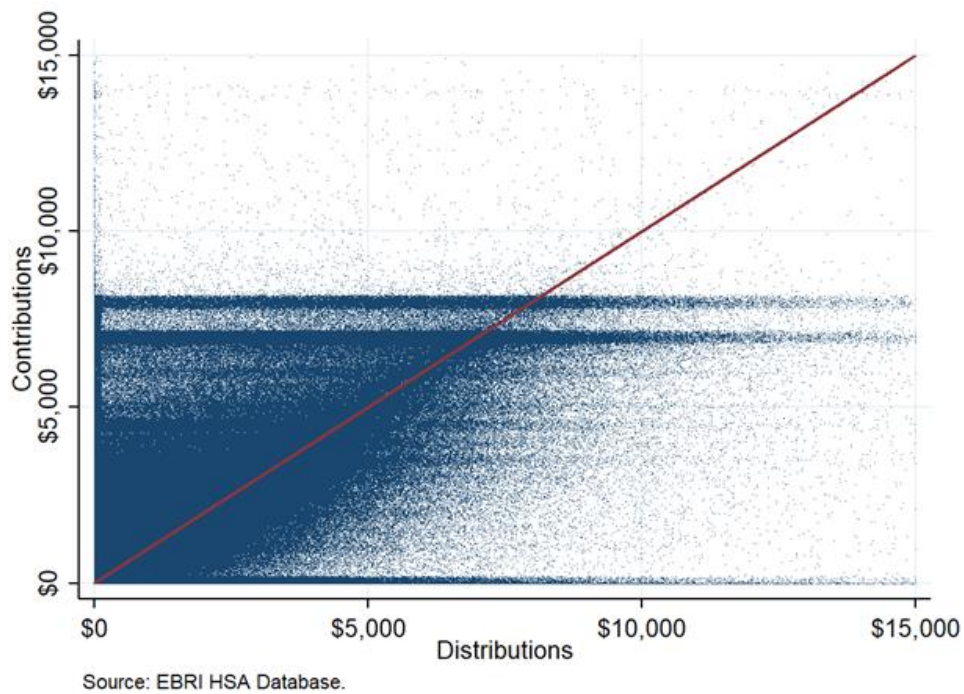


Source: EBRI HSA Database.

The average account balance at the end of 2020 was higher than at the start of the year, owing to the fact that the majority of accounts saw more money deposited than withdrawn. Our analysis finds that for 60.2 percent of the HSAs in EBRI’s HSA Database, accountholders contributed more than they withdrew. The average net contribution for accountholders who contributed more than they withdrew was nearly \$1,250. Meanwhile, the average net contribution for accountholders who withdrew more than they contributed was -\$839. Accounts with negative net contributions were also less likely to have invested assets; only 4 percent of these accounts contained assets other than cash, compared with 8 percent of accounts that received more contributions than withdrawals.

That most accountholders contributed more than they withdrew becomes clearer when plotting HSA contributions against distributions. The red line in Figure 13 is drawn at a 45-degree angle and represents a 1-to-1 ratio between contributions and distributions. Points above that line represent an accountholder who contributed more than they withdrew in 2020, and points below that line represent an accountholder who withdrew more money than they contributed in 2020. There are more outliers below the 45-degree angle, owing to the statutory limitation on HSA contributions but not withdrawals.

Figure 13
Plot of Contributions Against Distributions

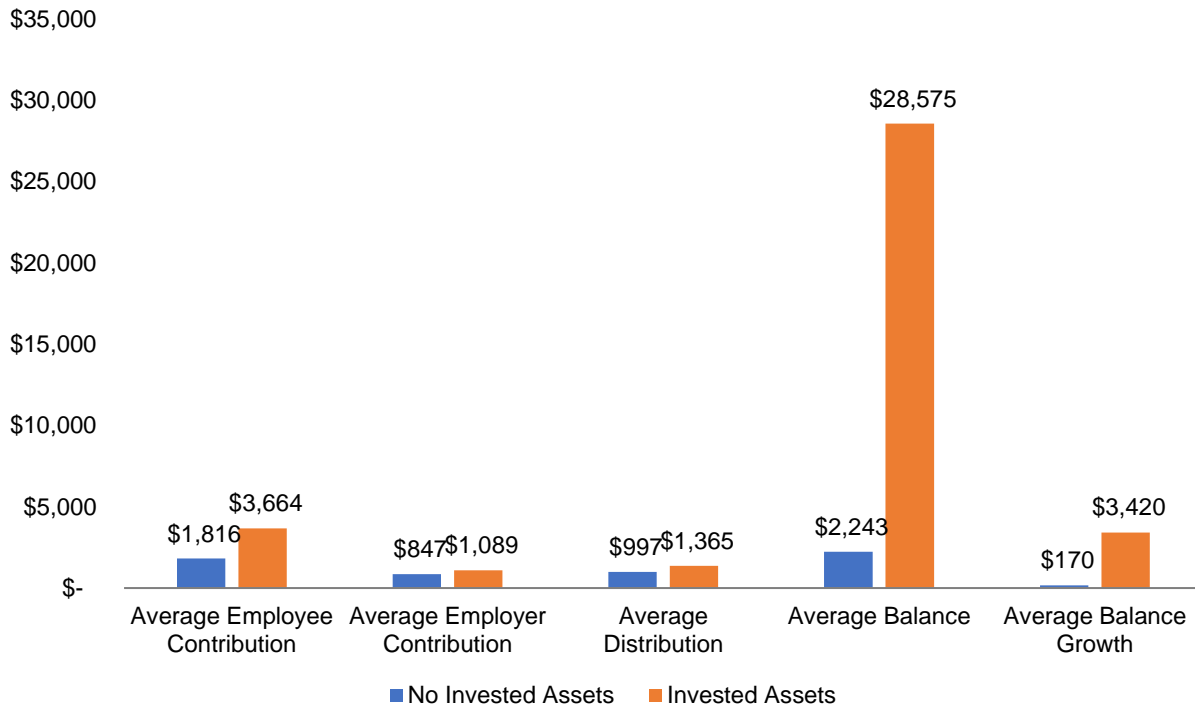


Investments

Continuing the trend observed in years past, relatively few accountholders hold investments other than cash in their HSAs. Only about 9 percent of accountholders invested at least some portion of their balance in 2020. Of course, there are valid reasons to not invest assets in an HSA: Accountholders should not invest their HSA balances in risky asset classes if they expect to use them in the short term, for instance. However, if accountholders have a large enough buffer in liquid accounts to weather a large, unexpected health care expense, then they could be better off at retirement by investing some portion of their HSAs.

Accounts with invested assets looked very different than accounts without invested assets. Accountholders with invested assets tended to have much higher employee contributions than accounts without invested assets. Among accounts that received either an employee or employer contribution in 2020, accounts with invested assets saw an average employee contribution of \$3,664, compared with \$1,816 for accounts without invested assets (Figure 14). That accountholders who invest contribute more than accountholders who do not invest is not entirely surprising; accountholders with invested assets may be in a better position to invest precisely because they are able to contribute more, and so the correlation between employee contributions and investing likely does not indicate causality.

Figure 14
**Selected Attributes of Accounts With
 Invested Assets and Without Invested Assets**



Source: EBRI HSA Database.

Interestingly, accounts with invested assets also had higher employer contributions. Unlike employee contributions, where employees who are motivated to invest are also likely to contribute more to their HSAs, employer contribution levels should be, in theory, exogenous to the employee’s decision to invest. We find that accounts with invested assets had an average employer contribution of \$1,089, compared with accounts without invested assets, which had an average employer contribution of \$847. This result suggests that having an employer contribution could make accountholders feel more comfortable investing at least some portion of their HSAs or that account owners with higher balances are more engaged because they have more at stake. This could also indicate that these employers are more engaged with helping employees see the value of using HSAs as longer-term savings vehicles.

Accountholders with invested assets saw their balances rise faster than accounts without invested assets. Despite the pandemic, many asset classes enjoyed a bull market in 2020 — the S&P 500 returned over 18 percent, for instance — which further fueled the growth of accounts with invested assets.⁷ The average account containing investments other than cash grew by \$3,420, compared with the average account without, which grew by \$170. Not all accounts were invested as aggressively as a 100 percent allocation to an S&P 500 index fund, and accounts that invested tended to have higher contribution amounts. However, the average balance growth — and average total balance — of accounts with invested assets demonstrates the benefit of investing HSA funds.

Conclusion

Since HSA-eligible health plans are continuing to proliferate, it is imperative for policymakers, HSA providers, and employers alike to understand how HSAs are used and misused. However, there is a dearth of data — such as large, nationally representative government surveys — for researchers to analyze the ways in which accountholders use HSAs. Identifying trends and patterns of utilization through analysis of empirical data, such as EBRI’s HSA Database, can help plan sponsors and providers tweak outreach and educational efforts and can inform policymaking.

There are some disconnects between what personal finance experts might consider optimal behavior and the accountholder utilization we observe in EBRI’s HSA Database. “Optimal” usage of an HSA, from the standpoint of maximizing wealth at retirement, dictates that accountholders maximize their contributions, hold investments other than cash, and avoid withdrawing money from their HSAs unless they cannot pay for health care out of pocket.

However, many accountholders in EBRI’s HSA Database do not appear to be following that strategy. Nearly 30 percent of accountholders in EBRI’s HSA Database withdrew more than they contributed, for instance, which may be an indication that some accountholders are encountering problems with cash flow — which may have been exacerbated by the COVID-19 pandemic — and need to tap their HSAs to pay for medical expenses. Very few accountholders contributed the statutory maximum in 2020, and only 9 percent of accountholders held assets other than cash in their HSAs. Furthermore, while a plurality of accounts did not see any money withdrawn in 2020, most of these accounts did not receive an employer or an employee contribution, which could be a sign that they are dormant and not actually an indication that the accountholder is using their HSA as a long-term savings vehicle. These behaviors could result in accountholders having a smaller buffer in the case of an unexpected health care expenditure as well as having a potentially less secure retirement.

At the same time, the average account balance increased over the course of 2020, despite the pandemic. Further, the majority of accountholders contributed more than they withdrew. These trends may improve workers’ financial wellness and help to prepare workers to shoulder unexpected medical costs, achieve a more secure retirement, or both. And even among accountholders who withdrew more than they contributed, their HSAs may very well have been a lifeline that helped cover medical expenses incurred while experiencing a high-unprecedented labor market dislocation.

Our analysis of EBRI’s HSA Database also sheds light on opportunities to improve accountholder engagement with HSAs. Our analysis finds, for instance, evidence that accounts with employer contributions tended to have higher total contributions and more frequently contained investments other than cash. This evidence suggests that employers can play a crucial role in fostering employee engagement with their HSAs. One clear avenue is for employers to contribute to an employee’s HSA on their behalf.

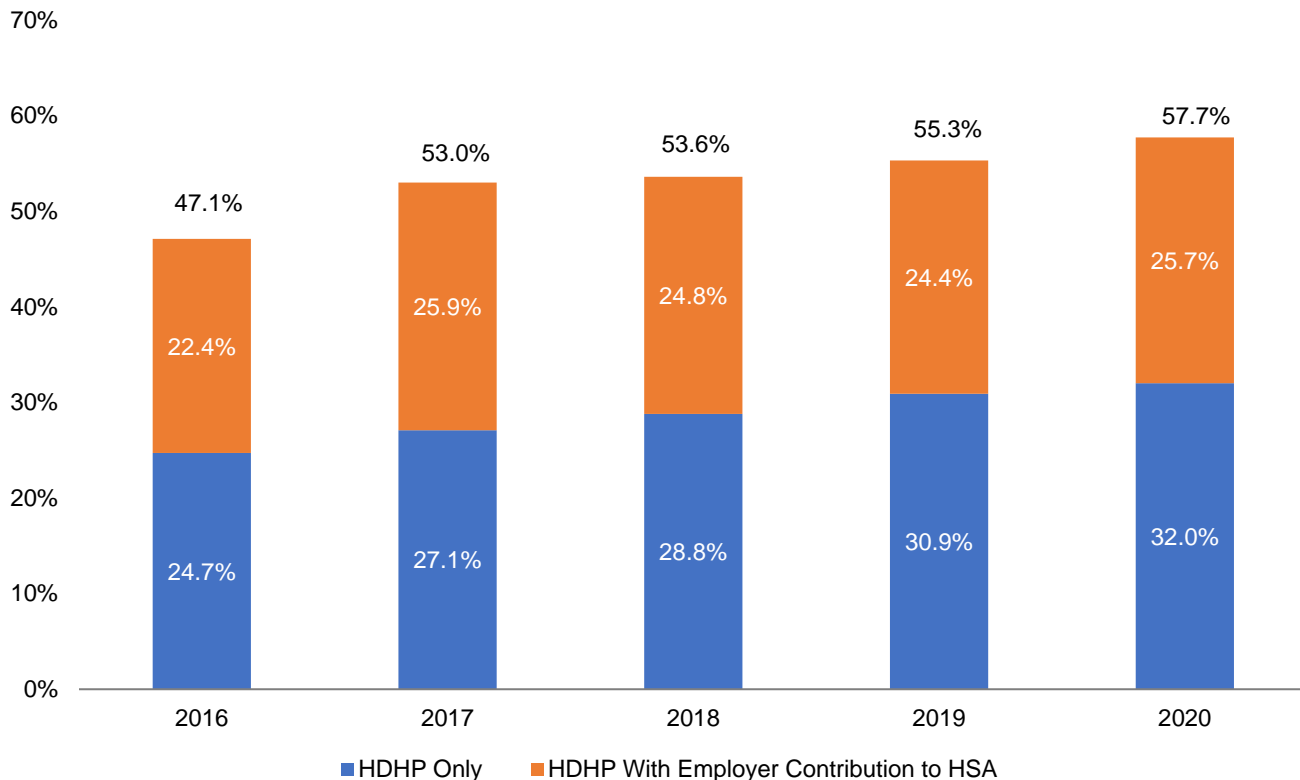
Of course, there is no magic bullet. Providing an employer contribution to an HSA will not automatically turn that accountholder into an investor who uses their HSA as a long-term savings vehicle instead of a short-term spending vehicle. Indeed, accountholders with employer contributions still take larger distributions than their counterparts who did not receive an employer contribution. However, it is clear that plan sponsors and administrators play a critical role in helping accountholders take a longer-term view of HSAs and the role they can play in their financial wellness.

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.

Appendix 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



* Note: HSA = health savings account; HRA = health reimbursement arrangement.

Source: Medical Expenditure Panel Survey – Insurance Component (MEPS-IC).

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. See Appendix Figure 2 for historical deductibles and maximum out-of-pocket limits). 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.⁸ 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 was 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.

Appendix Figure 2
Statutory HSA Limits, 2004–2021

	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

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 was allowed to make an annual HSA contribution of \$3,600, while a worker with family coverage could contribute as much as \$7,200. These dollar limits are indexed for inflation. Additionally, individuals who reached age 55 and were not yet enrolled in Medicare were 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.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 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 Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (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.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 For examples, see the literature review in Bundorf (2012) as well as more recent 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); and Fronstin and Roebuck (2019).

² See <https://www.devenir.com/wp-content/uploads/2020-Year-End-Devenir-HSA-Research-Report-Executive-Summary-1.pdf>.

³ As with any data that is not randomly drawn from a nationally representative sample, there is always a chance that the HSAs contained in EBRI's HSA Database are not representative of the market as a whole. However, since the database is comprised of such a large percentage of the HSA universe, we believe this likelihood is quite low.

⁴ There are several valid reasons for accountholders to not contribute to an HSA recorded by EBRI's HSA Database. For instance, the accountholder may have more than one HSA as a result of leaving a job and joining another firm that uses a different HSA provider, the accountholder lacking the liquidity to contribute to an HSA and choosing to spend down their accumulated balance, or the accountholder switching away from an HDHP and no longer being able to contribute to their HSA (HSAs can remain open after an accountholder switches out of an HSA-eligible health plan, and the accountholder can still take distributions, but the accountholder can no longer make contributions to the HSA). For that reason, HSAs that received employee or employer contributions are more likely to be representative of a typical accountholder who is engaged with their HSA, as these capture HSAs that receive regular payroll contributions. Accordingly, we focus the bulk of our analyses on these accounts.

⁵ The average may decrease among older accountholders since some may no longer be eligible to contribute to an HSA.

⁶ It is difficult to distinguish accountholders with family plans, so this analysis assumes that any account with a \$3,550 contribution or \$7,100 contribution, if the accountholder is under 55 (\$8,100 if the accountholder is over 55), is contributing the maximum.

⁷ See <https://markets.businessinsider.com/news/stocks/sp-500-2019-annual-return-for-year-best-since-2013-2019-12-1028790061>

⁸ See <https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions>

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>