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Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans

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AT A GLANCE

IRS Notice 2019-45 allows health savings account (HSA)-eligible health plans the flexibility to cover 14 medications and services used to prevent the exacerbation of chronic conditions prior to meeting the plan deductible.

In this *Issue Brief*, we report on the findings from a 2021 Employee Benefit Research Institute (EBRI) survey of employers that collected information on their response to the 2019 guidance. The survey examined not only whether employers added pre-deductible coverage as a result of Notice 2019-45, but also examined each of the allowed services individually; the type of cost sharing, if any, used in lieu of deductibles; and other relevant questions.

Key findings:

- Three in four employers (76 percent) say that they have added pre-deductible coverage as a result of IRS Notice 2019-45.
- Pre-deductible coverage was often added for health care services related to heart disease and diabetes care. Two-thirds added pre-deductible coverage for blood pressure monitors and insulin/glucose lowering agents, 61 percent added coverage for glucometers, and 54 percent added coverage for beta blockers. Health care services least likely to have pre-deductible coverage include peak flow meters and INR testing (25 percent each).
- Nearly two-thirds (64 percent) of employers covered six or fewer of the 14 health care services allowed per IRS Notice 2019-45. Only 8 percent added pre-deductible coverage for all 14 services.
- The percentage of employers that eliminated cost sharing for the pre-deductible services ranged from a low of 25 percent to a high of 40 percent. Between nearly one-half and two-thirds require a copayment from employees, depending on the health care service.
- Between 57 percent and 69 percent provide pre-deductible coverage for both brand and generic drugs in the specified drug classes.
- Most employers would add pre-deductible coverage for additional health care services if allowed by law.
- Employers offered several reasons for adding pre-deductible coverage: for the sake of their employees (74 percent), employee retention (64 percent), employee attraction (52 percent), and as a long-term cost-saving measure (48 percent).
- Nearly all (96 percent) employers adopted pre-deductible coverage for telehealth services under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Three-quarters (76 percent) prefer to make the provision permanent, while only 20 percent would like the provision to remain temporary.

- Among employers that did not add pre-deductible coverage as a result of IRS Rule 2019-45, most either plan to do so later (32 percent) or are exploring whether to do so (61 percent).

While a substantial amount of pre-deductible coverage has been added, there is an appetite among employers for adding more services if allowed by the IRS, and there is also an appetite among policymakers as evidenced by The Chronic Disease Management Act, which was reintroduced in the U.S. Congress as recently as May 2021. This bipartisan, bicameral legislation would provide HSA-eligible health plans additional flexibility to provide pre-deductible coverage for services that manage chronic conditions.

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Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans

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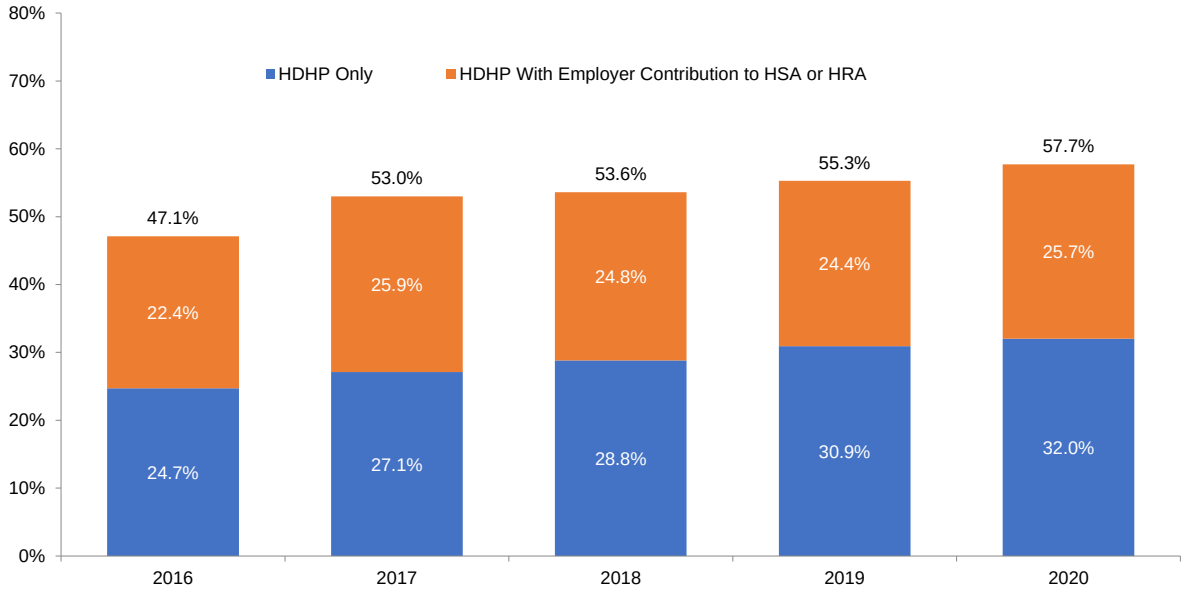
Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included a provision that created what are commonly known as high-deductible health plans (HDHPs). At the time, these plans had to have a deductible of at least $1,000 for individual coverage and $2,000 for family coverage (see Appendix Figure 1). As will be discussed in more detail below, HDHPs may provide coverage of certain preventive services prior to satisfaction of the health plan deductible. Enrollees in plans that met these and other requirements are allowed to open and contribute to a health savings account (HSA) on a tax-preferred basis. Thus, these plans are also commonly known as HSA-eligible health plans. In 2021, these plans must have a deductible of at least $1,400 for individual coverage and $2,800 for family coverage. Enrollment in HSA-eligible health plans may account for over one-half of those with private health coverage (Figure 1).[1]

Under the IRS guidance, until the deductible is met, coverage does not include "any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications."[2] This narrow definition of the "safe harbor" has likely caused harm to plan members as it is well established that increases in cost sharing for health care have been associated with deleterious consequences. Thus, the U.S. Department of Treasury issued guidance in 2019 via IRS Notice 2019-45 to further increase the flexibility of HSA-eligible health plans to cover specific low-cost preventive services to prevent the exacerbation of chronic conditions on a pre-deductible basis (Figure 2).[3]

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).

Figure 2
Chronic Disease Management Services in the Expanded Safe Harbor

Preventive Care Service	For Individuals Diagnosed With
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Source: https://vbidcenter.org/initiatives/hsa-high-deductible-health-plans-2/

A 2020 survey from the Kaiser Family Foundation found that 29 percent of employers with 200 or more employees increased the number of drugs and services covered pre-deductible in HSA-eligible health plans as a result of IRS Notice 2019-45.[4] However, no details are available regarding the specific services that were included in these design changes. Furthermore, by the time the IRS released Notice 2019-45, it was too late for many employers to modify their health plan for 2020. A more recent survey[5] of insurers found that most modified their HSA-eligible health plans to cover more services on a pre-deductible basis, with 75 percent doing so in fully insured products and 80 percent doing so in self-insured products. The survey also found that most respondents reported either no premium increase or premium increases of less than 1 percent.

In this *Issue Brief*, we report on the findings from a 2021 survey of employers requesting information on their response to the 2019 guidance. The survey examined not only whether employers added pre-deductible coverage as a result of Notice 2019-45, but also examined each of the allowed services individually; the type of cost sharing, if any, used in lieu of deductibles; and other relevant questions. The next section provides more information on HSA-eligible health plans, the impact of deductibles on use of health care services, and the 2019 guidance. The section following contains information on the data and methods. We then present the findings and our conclusions.

Background

Until IRS Notice 2019-45 was released on July 17, 2019, when it came to providing pre-deductible coverage of health care services in HSA-eligible health plans, employers were guided by the Internal Revenue Service (IRS) safe harbor section 223(c)(2)(C) of the Internal Revenue Code (IRC). Employers could only provide coverage of the following services prior to satisfaction of the plan deductible:

- Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Future Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services (required by Section 2713 of the Patient Protection and Affordable Care Act of 2010 (ACA) and IRS Notice 2013-57).[6]
- Periodic health evaluations such as annual physicals and select preventive screenings not listed above (optional, per IRS Notice 2004-23).[7]
- Obesity weight-loss programs and tobacco cessation programs (option, per IRS Notice 2004-23).[8]
- Drugs taken by asymptomatic individuals to prevent the manifestation of disease (optional, per IRS Notice 2004-50).[9]

Increases in consumer out-of-pocket costs for health care have been associated with deleterious consequences. These include financial stress, worse disease control, increases in hospitalizations, and exacerbation of health disparities, particularly those with chronic medical conditions and lower household income.[10] In fact, there is a body of peer-reviewed literature demonstrating that selectively lowering cost-sharing for high-value chronic disease management medications can meaningfully improve adherence; reduce the risk of adverse health outcomes; and, in some cases, reduce expenditures.[11]

Now, with IRS Notice 2019-45 in place, all HSA-eligible health plans are now able to adopt a more flexible benefit design offering more protection for certain medical services through a value-based insurance design (V-BID) plan structure. As the market for HSA-eligible health plans grows, it is important that these plans use this flexibility to allow for effective health management for all beneficiaries. A targeted strategy exploring coverage for certain high-value, clinically indicated health services prior to meeting the deductible will produce more effective clinically nuanced designs, without fundamentally altering the original intent and spirit of these plans. Adoption of voluntary, clinically nuanced expanded HSA-eligible health plan benefit designs has the potential to mitigate cost-related non-adherence, enhance patient-centered outcomes, allow for lower premiums than most PPOs and HMOs, and substantially reduce aggregate health care expenditures.

According to Notice 2019-45, the list of preventive services that can be covered pre-deductible will be reviewed on a periodic basis. In fact, the guidance specifically states that the periodic review is expected to occur approximately every five to 10 years. For patients and employers alike, 10 years may be a long time to wait for such coverage decisions to be made given the pace of research on plan design and medical innovation. There are already examples of services that may meet the criteria for pre-deductible coverage that were omitted from Notice 2019-45. For example, the Notice identifies angiotensin converting enzyme (ACE) inhibitors to prevent exacerbations for individuals diagnosed with congestive heart failure (CHF), diabetes, and/or coronary artery disease. Patients who either do not respond or who have a reaction to ACE inhibitors are usually switched to what are known as angiotensin receptor blockers (ARBs) to prevent the same exacerbations. However, ARBs are not included in the list of 14 services in Notice 2019-45, thus they cannot be covered pre-deductible in HSA-eligible health plans.

Financial Impact of Expanded Drug Coverage

Implementation of pre-deductible drug coverage can change plan-paid expenditures in three respects:

(a) Volume: Lower patient out-of-pocket costs tends to increase utilization. An estimate of enrollees' responsiveness to changes in price (i.e., elasticity of demand) was used to determine increases in utilization and related expenditures.

(b) Shift: Independent of volume effects, lower consumer cost sharing shifts the cost burden from the patient to the plan. The prior analysis accounted for changes in the apportionment of expenditures.

(c) Offsets: In some clinical scenarios, greater utilization of high-value therapies can decrease spending on other services (e.g., hospitalizations). The prior analysis did not account for these offsets.

There is already an appetite for adding more services, as evidenced by The Chronic Disease Management Act, which was reintroduced in the U.S. Congress as recently as May 2021. This bipartisan, bicameral legislation would provide HSA-eligible health plans additional flexibility to provide pre-deductible coverage for services that prevent the exacerbation of chronic conditions.

Data and Methods

The data for this study come from an online survey of benefits decision makers.[12] A total of 354 large employers were surveyed, including 270 that made changes to pre-deductible coverage and 62 that did not. Not all respondents answered every question. The survey averaged 10 minutes. The research was conducted in July and August of 2021.

Respondents were screened to ensure that they had full- or part-time employees; have worked at their company for at least 6 months; have some familiarity with managing or making decisions about health insurance offerings at their firm; work for an organization with at least 200 employees; and work for an organization that currently offers employees an HSA-eligible health plan.

Figure 3
Firm Characteristics

	Total	Employers That Adopted Pre-Deductible Coverage	Employers That Did Not Adopt Pre-Deductible Coverage
Firm Size			
200 to 499	21%	22%	18%
500 to 999	17%	17%	18%
1,000 to 4,999	33%	34%	35%
5,000 to 9,999	12%	10%	16%
10,000 to 24,999	8%	8%	6%
25,000 or more	8%	9%	6%
Some or All Employees Unionized			
Yes	24%	24%	26%
No	69%	69%	69%
Don't know	6%	6%	5%
Plan Funding			
Self-insured (Administrative Services Only/ASO)	18%	21%	8%
Partially self-insured (level-funded)	41%	40%	44%
Fully insured	41%	39%	48%
Employer Contributes to HSA			
Yes	88%	91%	79%
No	10%	8%	18%
Don't know	1%	1%	3%
Industry			
Manufacturing	17%	17%	18%
Professional, scientific, or technical services	13%	14%	11%
Health care or social assistance (hospitals, non-insurance health services)	11%	11%	13%
Finance, insurance, or real estate	10%	11%	8%
Educational services (academic institutions/universities)	10%	9%	13%
Information (including publishing, telecommunications, broadcasting, and information technology)	9%	11%	3%
Retail trade	9%	9%	8%
Construction or utilities	6%	7%	5%
Wholesale trade, transportation or warehousing	5%	5%	5%
Public administration	4%	3%	5%
Accommodation or food services	1%	1%	5%
Arts, entertainment, or recreation	1%	1%	-
Administrative or support services	1%	0.4%	2%
Agriculture, forestry, fishing, hunting, or mining	1%	1%	2%
Management of companies and enterprises	1%	0.4%	2%
Waste management or remediation services	0.3%	0.4%	-
Other (please specify)	1%	1%	2%

Source: Employee Benefit Research Institute survey.

Findings

Firm Profile

Firm characteristics are shown in Figure 3. The firm size distribution between those employers adopting pre-deductible coverage and those not making such a change are very similar, with a few notable differences. Those employers that made a change were more likely to have 200–499 employees and less likely to have 5,000–9,999 employees.

There were differences by plan funding and whether the employer contributed to the HSA. Employers that adopted pre-deductible coverage were more likely to be self-insured. They were also more likely to contribute to the worker's HSA.

There are also a few notable differences by industry. Employers that adopted pre-deductible coverage were more likely to be in the information service sector and less likely to be in the education sector.

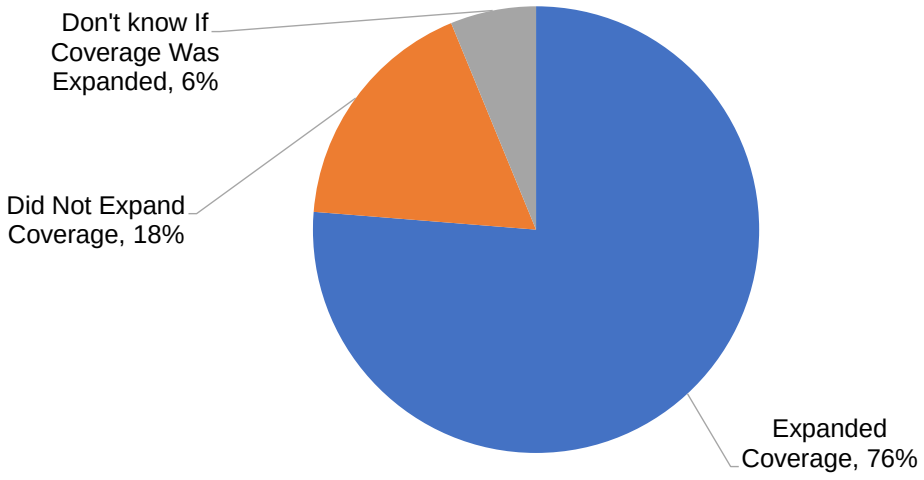
There were no differences by unionization.

Key Findings

Three in four employers (76 percent) say that they have added pre-deductible coverage because of IRS Notice 2019-45 (Figure 4). This is a substantial increase compared with data obtained by the Kaiser Family Foundation in early 2020, which found that only 29 percent had made such a change.[13] The likelihood of making such a change was not statistically different by firm size, industry, or the presence of unionized employees. However, self-insured employers are more likely to report having made changes — 90 percent added pre-deductible coverage, compared with 75 percent among those who were fully-insured or partially self-funded.

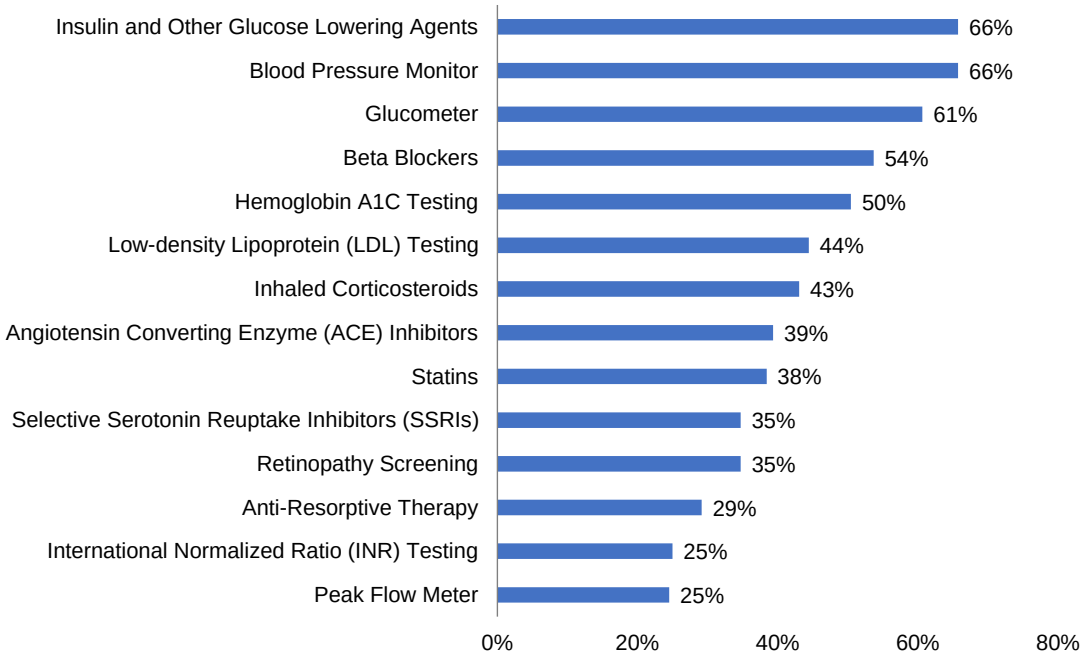
Pre-deductible coverage was often added for health care services related to heart disease and diabetes care. Two-thirds added pre-deductible coverage for blood pressure monitors and insulin/glucose lowering agents; 61 percent added coverage for glucometers; and 54 percent added coverage for beta blockers (Figure 5). Health care services least likely to have pre-deductible coverage include peak flow meters and INR testing (25 percent each). Nearly two-thirds (64 percent) added six or fewer types of coverage of the 14 health care services allowed per IRS Notice 2019-45 (Figure 6). Only 8 percent added pre-deductible coverage for all 14 services. On average, pre-deductible coverage was added for five services, and the median number of services added was six.

Figure 4
Percentage of Employers That Expanded Pre-Deductible Coverage in HSA-Eligible Health Plans for Preventive Services Allowed Under IRS Rule 2019-45



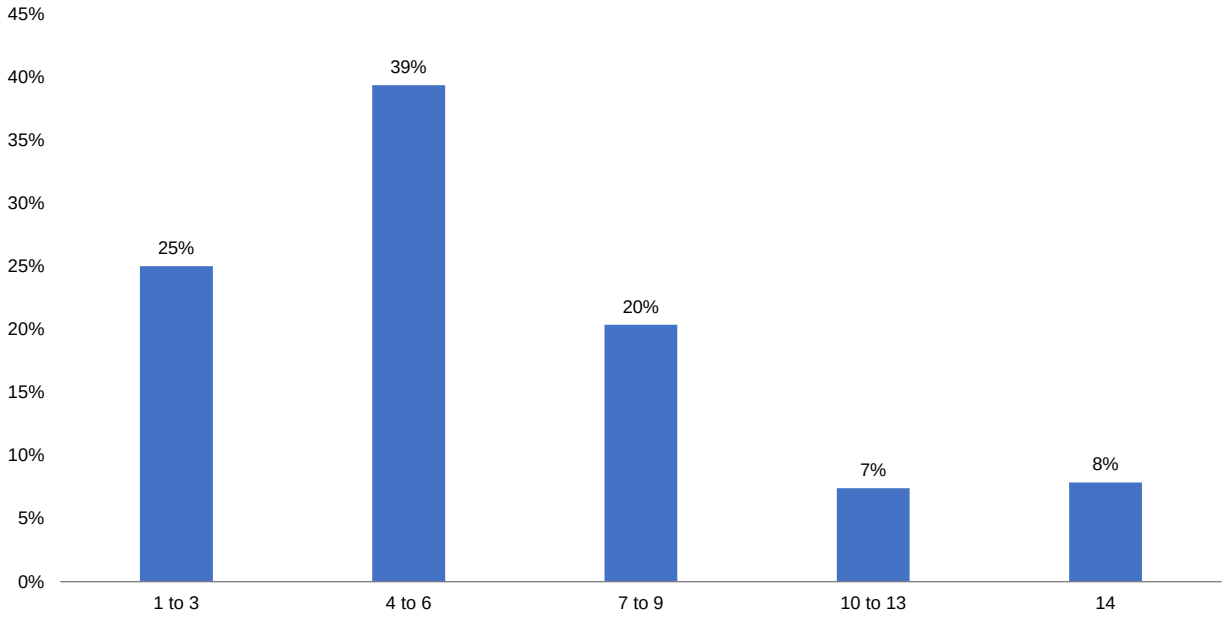
Source: Employee Benefit Research Institute survey.

Figure 5
Preventive Care Measures Covered on a Pre-Deductible Basis as a Result of IRS Notice 2019-45



Source: Employee Benefit Research Institute survey.

Figure 6
Number of Preventive Services Covered Pre-Deductible

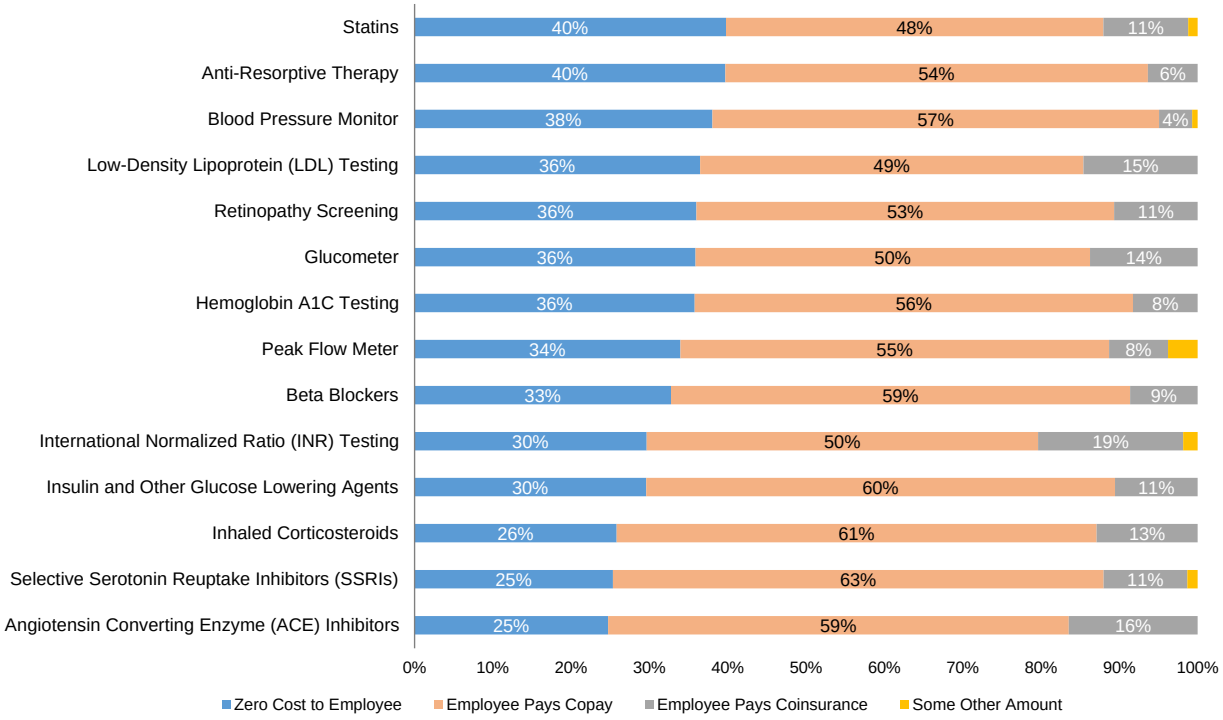


Source: Employee Benefit Research Institute survey.

Cost Sharing for Pre-Deductible Coverage

When an employer offers pre-deductible coverage for any of the 14 health care services allowed in IRS Notice 2019-45 it does not necessarily mean that those services are not subject to any other cost sharing. We find that the percentage of employers that do not subject the health care service to any cost sharing ranges from a low of 25 percent to a high of 40 percent (Figure 7). Between nearly one-half (48 percent) and two-thirds (63 percent) require a copayment from employees, depending on the health care service. The percentage of employers requiring coinsurance for the 14 health care services ranges from 4 percent to 19 percent.

Figure 7
Cost-Sharing Arrangement as a Result of IRS Rule 2019-45

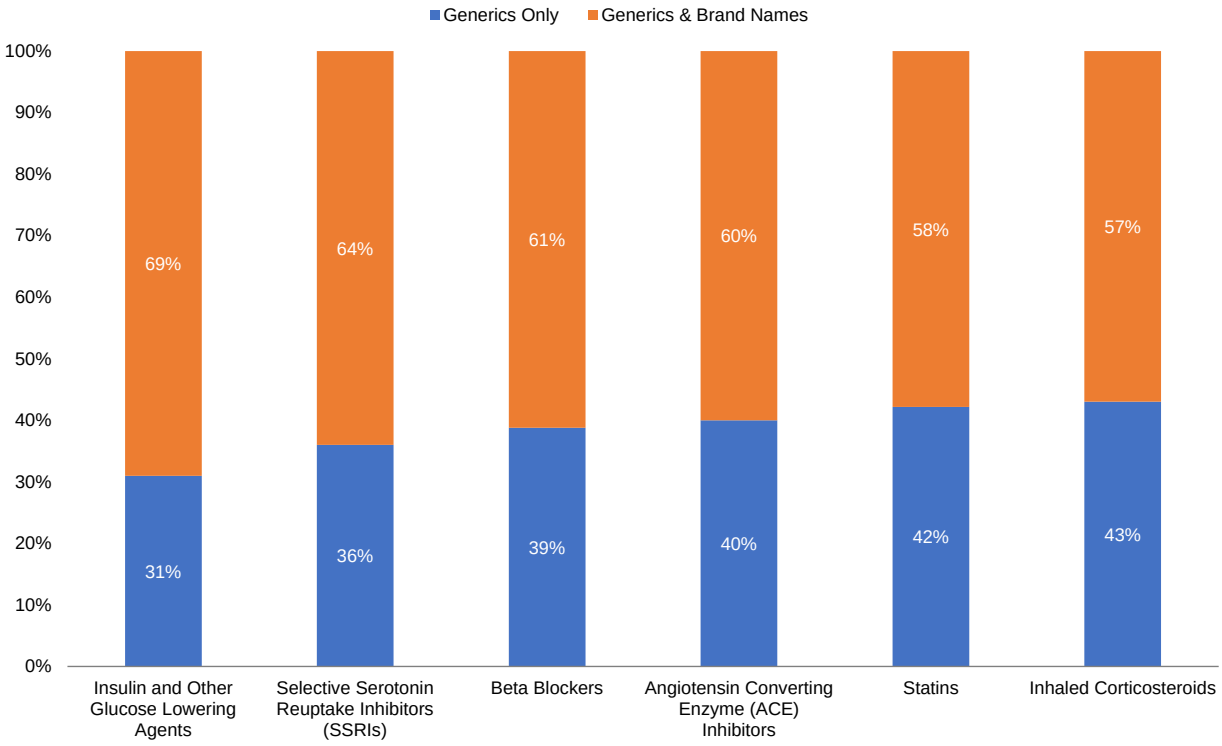


Source: Employee Benefit Research Institute survey.

For the six classes of prescription drugs, employers sometimes imposed other restrictions as well. For example, some employers adopted pre-deductible coverage only for generic drugs. More specifically, between 57 percent and 69 percent provide pre-deductible coverage only for generics (Figure 8).

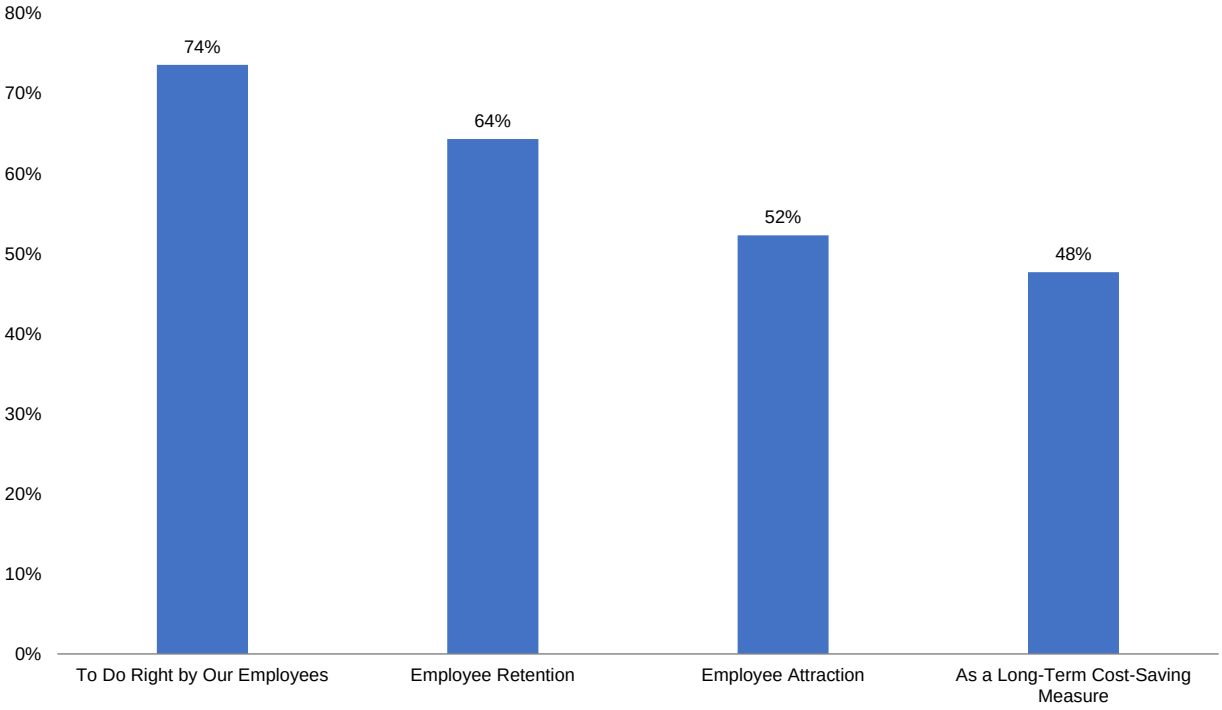
Employers offered several reasons for adding pre-deductible coverage for the 14 health care services allowed under IRS Notice 2019-45. Those who made changes did so primarily for the sake of their employees, but many had business considerations as well. Three-quarters (74 percent) reported that it was the right thing to do (Figure 9). Two-thirds reported that they added such coverage for employee retention, while one-half reported that they added it for employee attraction (52 percent) and as a long-term cost-saving measure (48 percent).

Figure 8
Tiers of Drug Covered Pre-Deductible as a Result of IRS Rule 2019-45



Source: Employee Benefit Research Institute survey.

Figure 9
Reasons for Adding Pre-Deductible Coverage for Preventive Services

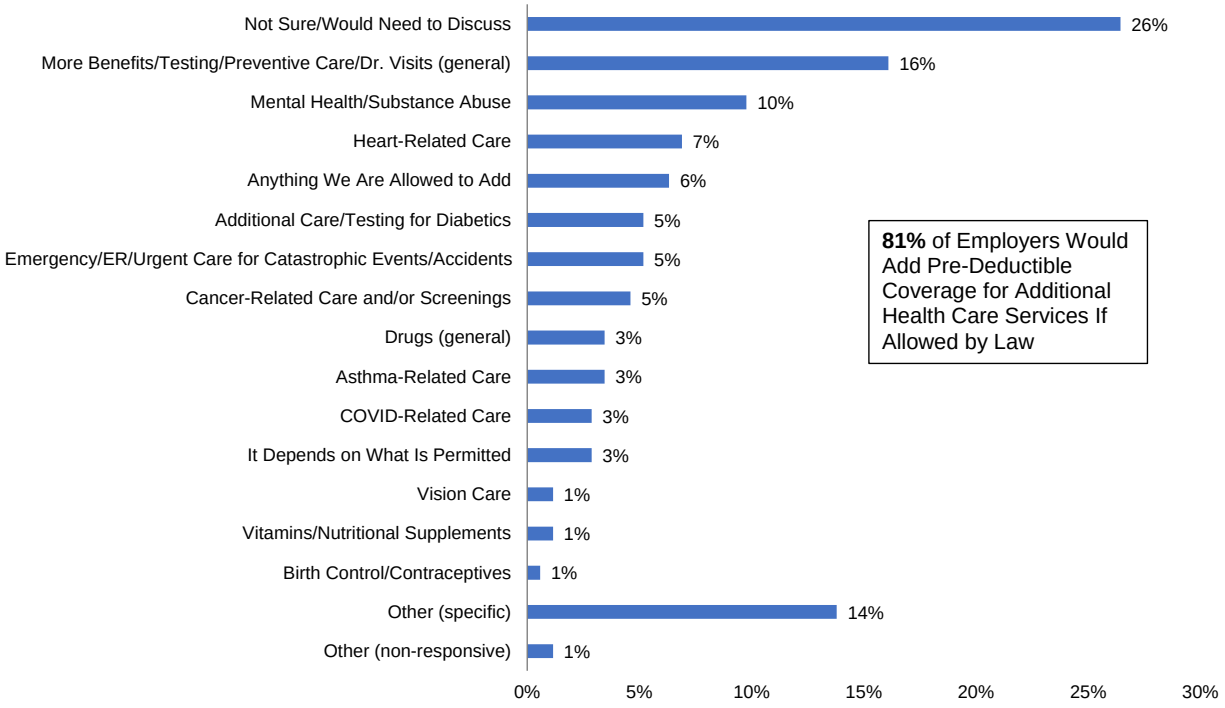


Source: Employee Benefit Research Institute survey.

Future Changes

Most (81 percent) employers would add pre-deductible coverage for additional health care services if allowed by law. However, based on an open-ended question, there was no clear health care service that stood out against the others. In fact, one-quarter of employers were not sure which service they would like to see added (Figure 10). Sixteen percent reported that they would like to add more testing and preventive services. Otherwise, 10 percent or less volunteered services such as mental health/substance abuse, heart-related care, and diabetes. Six percent reported that they would add anything they were allowed to add.

Figure 10
Additional Pre-Deductible Coverage That Employers Would Like to Add (based on open-ended question)



Source: Employee Benefit Research Institute survey.

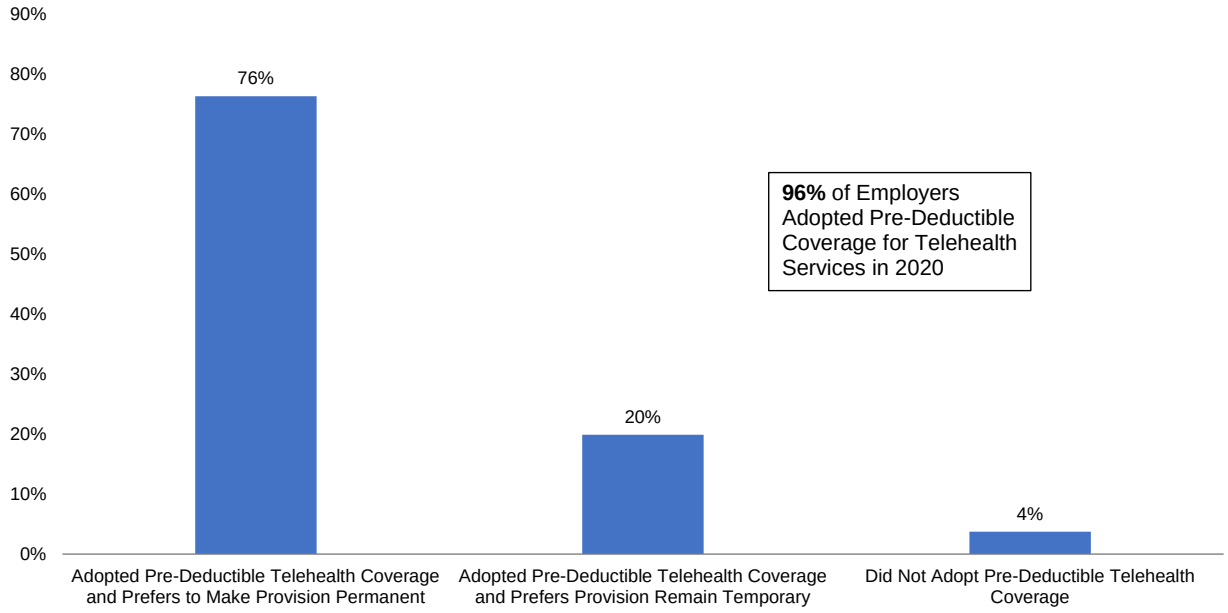
The CARES Act

The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 provided economic relief related to the COVID-19 pandemic. It included a provision that allowed HSA-eligible health plans to provide pre-deductible coverage for telehealth services. This provision is temporary, ending Dec. 31, 2021. Nearly all (96 percent) employers adopted pre-deductible coverage for telehealth services. Three-quarters (76 percent) prefer to make the provision permanent, while only 20 percent would like the provision to remain temporary (Figure 11).

Employers That Did Not Add Pre-Deductible Coverage

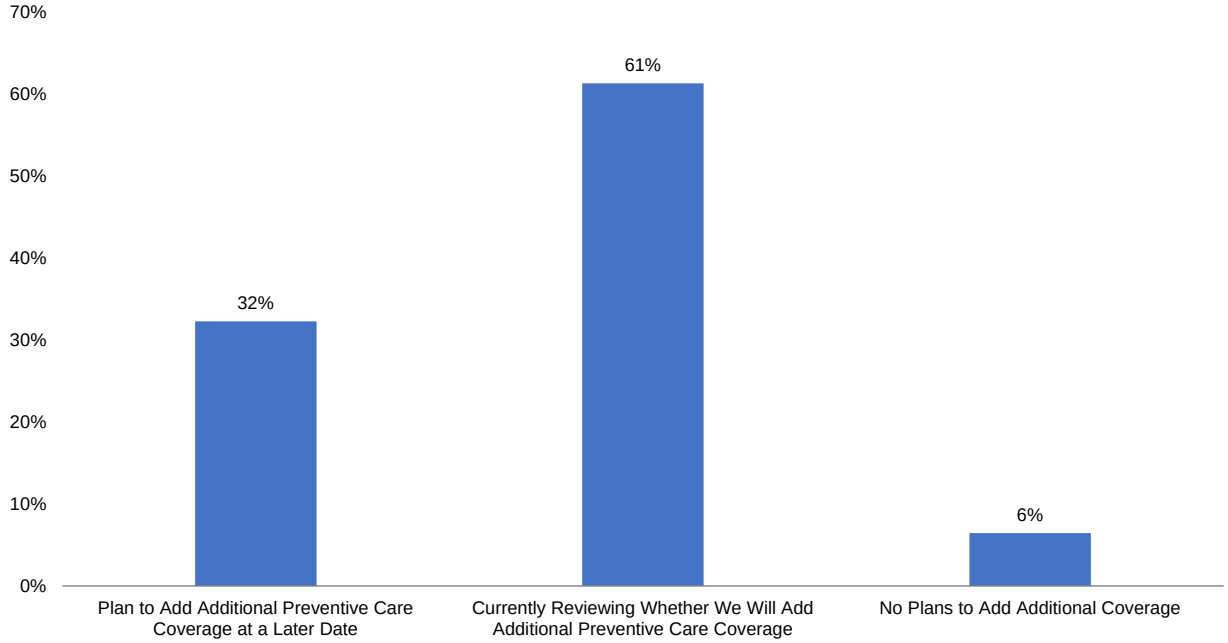
Eighteen percent of employers did not add pre-deductible coverage as a result of IRS Rule 2019-45. However, most either plan to do so later (32 percent) or are exploring whether to do so (61 percent) (Figure 12). Most have not yet made the change due to expense: 90 percent say this played at least a small role in the decision. But maintaining fairness in benefit offerings played a role for many as well (76 percent). Only 6 percent have no plans to add pre-deductible coverage.

Figure 11
Point of View on CARES Act Provision Allowing Pre-Deductible Telehealth Coverage on a Temporary Basis



Source: Employee Benefit Research Institute survey.

Figure 12
Plans to Add Pre-Deductible Preventive Coverage, Among Employers Who Have Not Added Such Coverage



Source: Employee Benefit Research Institute survey.

Congressional Efforts to Further Expand Pre-Deductible Coverage

Building on the momentum of Executive Order 13877 and IRS Notice 2019-45, Sens. John Thune (R-SD) and Tom Carper (D-DE) introduced the Chronic Disease Management Act of 2019 in the Senate (S. 1948), followed by the introduction of the companion bill in the House of Representatives (H.R. 3709) by Reps. Earl Blumenauer (D-OR) and Tom Reed (R-NY). This bipartisan, bicameral legislation would provide HSA-eligible health plans additional flexibility to provide coverage for services that manage chronic conditions prior to meeting the plan deductible. The bill was reintroduced in the Senate in January 2020 (S. 3200) and April 2021 (S. 1424) and in the House of Representatives in May 2021 (HR. 3563), building on the IRS guidance and previous versions to further increase pre-deductible coverage for chronic disease management.

Potential Financial Impact of Expanding Pre-Deductible Coverage

VBID Health has quantified the potential financial impact on patient out-of-pocket costs, plan expenditures and plan actuarial value of providing pre-deductible coverage for 57 drug classes used to treat 11 chronic conditions (Figure 13).[14]

An HSA-eligible health plan with a $2,000 deductible was used as a baseline for the analysis (actuarial value approximated 74 percent). Once the plan deductible was satisfied, this simulated plan imposed 10 percent coinsurance for all covered services (including drugs) until reaching the out-of-pocket maximum of $6,500. Conditions and drug classes were selected based on the disease prevalence and contribution to member- and plan-paid expenditures.

HSA-Eligible Health Plan With Pre-Deductible Drug Coverage

An HSA-eligible health plan with permitted pre-deductible drug coverage for the specified 57 drug classes was simulated. Consumer cost sharing was $5 for generic drugs, $40 for branded non-specialty drugs, and 10 percent coinsurance for specialty drugs.

Amending IRS Safe Harbor to Include Chronic Disease Medications

Figure 14 shows expected changes in plan- and member-paid expenses between the baseline HSA-eligible health plan and an HSA-eligible health plan with expanded drug coverage, as well as impact on plan actuarial value. Estimated increases in premiums and deductibles needed to keep plan expenditures neutral are also presented. The modest increase in plan expenditures were split between increases in medication utilization and shifting allocation of drug expenditures. Covering all 57 targeted classes on a pre-deductible basis with $5/$40/10 percent cost sharing would require an increase in premium of less than 2 percent.[15]

Providing pre-deductible coverage for over 50 drug classes used to treat common chronic conditions would lower consumer out-of-pocket costs and increase utilization of essential medications. Such a change would lead to a small increase in plan actuarial value and would require a small increase in premium or deductible for payers interested in keeping the financial impact of the benefit change cost neutral. In addition to "blunt" approaches such as increasing premiums for all beneficiaries or raising deductibles on all services, plan sponsors could pursue a range of more nuanced cost-reducing strategies to create "headroom" for additional spending on high-value medications. For example, plans could steer patients to high-performing providers through centers of excellence programs or otherwise offer incentives for use of high-value sites of service. Plans could also target expenditures devoted to specific low-value clinical services such as non-recommended screenings, unneeded imaging, wasteful pre-surgical testing, and much more.[16]

Figure 13
Diseases Included

Diabetes
Hypertension
Attention deficit disorder
Asthma
Depression
Hyperlipidemia
Hypo-functioning thyroid gland
Inflammatory bowel disease
Adult rheumatoid arthritis
Breast cancer
Multiple sclerosis

Source: VBID Health, http://vbidhealth.com/docs/HSA-HDHP-Reform-Brief.pdf

Figure 14
Impact of Pre-Deductible Drug Coverage on Total Spending

	Plan Paid PMPM	Member Paid	Overall AV	Increase Needed to Offset Higher AV	
Baseline HSA-Eligible Health Plan	$319.77	$113.84	73.70%	**Premium or Deductible**	
HSA-Eligible Health Plan With Targeted Drugs Covered Pre-Deductible With $5/$40/10% Copay	$325.11 *Increase of $5.34*	$110.45 *Decrease of $3.38*	74.6% *Increase of 0.09%*	*Increase of 1.7%*	*Increase of $189*

Note: AV = actuarial value; PMPM = per member per month.
Source: VBID Health, http://vbidhealth.com/docs/HSA-HDHP-Reform-Brief.pdf

Conclusion

In response to IRS Notice 2019-45, three-quarters of large employers offering HSA-eligible health plans expanded pre-deductible coverage for medications and services that prevent the exacerbation of chronic conditions, up substantially from 2020. Employers would add additional services if allowed by the IRS, according to EBRI's survey results. Furthermore, there is bipartisan, bicameral legislation that has been introduced in the U.S. Congress which would provide additional flexibility to extend pre-deductible coverage to services that manage chronic conditions. Employers and policymakers have an appetite for more flexible plan designs or "smarter" deductibles because rising health care spending has created serious fiscal challenges.

Smarter deductibles accommodating services preventing the exacerbation of chronic conditions might be a natural evolution of health plans. Value-based reimbursement promotes the delivery of evidence-based, high-quality care that encourages use of — rather than creating barriers to —high-value services. Interventions that improve patient-centered outcomes while maintaining affordability may be found in the form of a clinically nuanced HSA-eligible health plan that better meets workers' clinical and financial needs.

Appendix

Appendix Figure 1
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

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Notes

[1] In 2020, 57.7 percent of individuals with health coverage through a private-sector establishment were in a plan with a deductible that met the deductible requirements to be HSA eligible. However, we do not know how many of these enrollees were in an HSA-eligible health plan. Some were enrolled in a health plan with a health reimbursement arrangement (HRA). Others were in health plans that met the deductible requirement but may have not met other requirements, such as the restriction on preventive services.

[2] See Internal Revenue Service, 2004.

[3] See https://www.irs.gov/pub/irs-drop/n-19-45.pdf

[4] See Figure 13.14 in https://www.kff.org/report-section/ehbs-2020-section-13-employer-practices-alternative-sites-of-care-and-provider-networks/.

[5] See https://www.ahip.org/wp-content/uploads/202109-AHIP_HDHP-Survey-v03.pdf.

[6] See Kaiser Family Foundation (2015) and Internal Revenue Service (2013).

[7] See Internal Revenue Service (2004).

[8] See Internal Revenue Service (2004).

[9] See Internal Revenue Service (2004).

[10] See the literature reviews in Bundorf (2012) and Agrawal, Mazurenko, and Menachemi (2017) as well as research in Brot-Goldberg, Chandra, Handel, and Kolstad (2017); Chandra, Gruber, and McKnight (2010); Chernew et al. (2008); Collins, Rasmussen, Beutel, and Doty (2015); Fronstin and Roebuck (2019); Fronstin and Roebuck (2013); Fronstin and Roebuck (2020); Fronstin and Roebuck (2014); Fronstin and Roebuck (2016); Fronstin, Sepulveda, and Roebuck (2013); Fronstin, Sepúlveda, and Roebuck (2013); Fronstin, Roebuck, Buxbaum, and Fendrick (2020); Goldman, Joyce, and Zheng (2007); Trivedi, Moloo, and Mor (2010); Wharam et al. (2017); and Wharam et al. (2018).

[11] See Lee, Maciejewski, Raju, Shrank, and Choudhry (2013).

[12] Fielding of the survey was conducted by independent research firm Greenwald Research. Respondents were sourced by OpinionRoute, an online panel aggregator.

[13] See Figure 13.14 in https://www.kff.org/report-section/ehbs-2020-section-13-employer-practices-alternative-sites-of-care-and-provider-networks/.

[14] See https://vbidhealth.com/docs/HSA-HDHP-Reform-Brief.pdf.

[15] These estimates should be considered "ballpark," as limitations tend to both overestimate and underestimate the effect. See http://vbidhealth.com/docs/HSA-HDHP-Reform-Brief.pdf for a summary of limitations.

[16] See Buxbaum, Mafi, and Fendrick (2017) for further detail on the magnitude of potential savings as well as practical strategies for waste avoidance.

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