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Health Savings Accounts (HSAs)

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SUMMARY

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Ryan J. Rosso
Analyst in Health Care Financing

Health Savings Accounts (HSAs)

A health savings account (HSA) is a tax-advantaged account that individuals can use to pay for unreimbursed medical expenses (e.g., deductibles, co-payments, coinsurance, and services not covered by insurance). Although eligibility to contribute to an HSA is associated with enrollment in high-deductible health insurance plans (HDHPs), HSAs are a trust/custodial account and are not health insurance.

HSAs have several tax advantages: individual contributions are tax deductible unless made through a cafeteria plan; employer contributions and individual contributions made through a cafeteria plan are excluded from taxable income and from Social Security, Medicare, and unemployment insurance taxes; account earnings are tax exempt; and withdrawals are not taxed if used for qualified medical expenses.

Individuals may establish and contribute to an HSA for each month that they are covered under an HSA-qualified HDHP, do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return. The account can be established with an insurer, bank, or other Internal Revenue Service (IRS)-approved trustee and is tied to the individual. Account holders retain access to their accounts if they change employers, insurers, or subsequently become ineligible to contribute to the HSA.

To be considered an HSA-qualified HDHP, a health plan must meet several tests: it must have a deductible above a certain minimum level, it must limit total annual out-of-pocket expenditures for covered benefits to no more than a certain maximum level, and it can provide only preventive care services and (for plan years beginning on or before December 31, 2021) telehealth services before the deductible is met. In 2020, HSA-qualified HDHPs must have a minimum deductible of $1,400 for self-only coverage and $2,800 for family coverage and an annual limit on out-of-pocket expenditures for covered benefits that does not exceed $6,900 and $13,800, respectively. In 2021, HSA-qualified HDHPs must have a minimum deductible of $1,400 for self-only coverage and $2,800 for family coverage and an annual limit on out-of-pocket expenditures for covered benefits that does not exceed $7,000 and $14,000, respectively. These amounts are adjusted for inflation (rounded to the nearest $50) annually.

If an individual is eligible to contribute to an HSA any time during a given tax year, the total amount that individual may contribute to his or her HSA is capped. Generally, the maximum amount an individual may contribute to his or her HSA in a tax year is based on the months during the year that he or she was considered HSA eligible; the type of HDHP coverage the individual had during those months (self-only or family); and the individual's age (those aged 55 or older are allowed additional catch-up contributions). For 2020, the maximum annual amount an individual with self-only coverage can contribute to his or her HSA is $3,550 and the maximum annual amount an individual with family coverage can contribute to his or her HSA is $7,100. For 2021, the maximum annual contribution limit amounts are $3,600 and $7,200 respectively. For those aged 55 or older, the maximum annual amount an individual can contribute to his or her HSA is increased by $1,000. Individuals may have lower contribution limits if they were not HSA eligible for the entire year.

Individuals may make tax-free HSA withdrawals to pay for the qualified medical expenses for the account holder, the account holder's spouse, or the account holder's dependents. Qualified medical expenses include the costs of diagnosis, cure, mitigation, treatment, or prevention of disease and the costs for treatments affecting any part of the body; the amounts paid for transportation to receive medical care; and qualified long-term care services. In general, health insurance premiums are not considered qualifying medical expenses for HSA purposes (except in limited circumstances). Withdrawals not used to pay for qualified medical expenses must be included in an individual's gross income when determining federal income taxes and generally are also subject to a 20% penalty. Individuals do not need to be enrolled in an HSA-qualified HDHP to make withdrawals from an HSA.

For tax year 2017, the IRS estimated that 9 million tax returns reported an HSA that received employer contributions (including pretax employee contributions) and 1.9 million tax returns reported an HSA that received individual contributions. These populations are not mutually exclusive. Furthermore, these data are at the tax return level (not individual) and do not account for individuals who were eligible to contribute to an HSA in 2017 but did not do so.

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Introduction

An HSA is a tax-advantaged account that individuals can use to pay and save for unreimbursed medical expenses (e.g., deductibles, co-payments, coinsurance, and services not covered by insurance). Eligibility to contribute to HSAs is associated with enrollment in high-deductible health insurance plans (HDHPs); however, HSAs are a trust/custodial account and are not health insurance.

HSAs were first authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) and are one type of health-related tax-advantaged account/arrangement that individuals can use to pay for unreimbursed medical expenses.[1]

HSAs have several tax advantages: individual contributions are tax deductible unless made through a cafeteria plan; employer contributions and individual contributions made through a cafeteria plan are excluded from taxable income and from Social Security, Medicare, and unemployment insurance taxes; account balances may be invested and any corresponding earnings are tax exempt; and withdrawals are not taxed if used for qualified medical expenses.[2]

This report summarizes the principal rules governing HSAs, covering such matters as eligibility, qualifying health insurance, contributions, withdrawals, and tax advantages. It incorporates changes made to HSAs as a result of the Coronavirus Disease 2019 (COVID-19) pandemic and corresponding recession. It concludes with a discussion of HSA data limitations and recent trends in HDHP enrollment and HSA utilization.

Eligibility to Establish and Contribute to an HSA

Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified HDHP, do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return.[3]

Whether someone qualifies for an HSA is determined as of the first of each month; thus, a person might be eligible to contribute to an HSA in some months of a given tax year but not in others. For example, if someone first enrolled in an HDHP on September 15, his or her HSA eligibility period would begin on October 1 of that year. Individuals may keep their HSAs and withdraw funds if they become ineligible but cannot make contributions until they become eligible once again.

Accounts may be established with banks, insurance companies, or other entities approved by the Internal Revenue Service (IRS) to hold individual retirement accounts (IRAs) or Archer medical savings accounts (Archer MSAs).[4] HSAs also may be established with additional nonbank

[1] Other categories of health-related tax-advantaged accounts/arrangements include health flexible spending arrangements (FSAs), Archer medical savings accounts (Archer MSAs), and health reimbursement arrangements (HRAs). For more information on these types of tax-advantaged accounts/arrangements, see IRS, Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans, January 30, 2020, at https://www.irs.gov/pub/irs-pdf/p969.pdf. Hereinafter IRS, Publication 969.

[2] *Cafeteria plans* are further discussed in "Allowable Contributors".

[3] Tax dependency is determined on a yearly basis and might not be known until the end of the year. IRS, *Publication 969*, p. 3.

[4] Archer MSAs are another type of health-related tax-advantaged account that individuals can use to set aside money to pay for unreimbursed medical care. Because Archer MSAs share many similarities to HSAs and existed before HSAs,

entities if such entities requested and received approval from the IRS.[5] All eligible individuals have the flexibility to establish an HSA with an institution other than their insurer or may choose not to establish an account.

HSA-Qualified High-Deductible Health Plans

To be HSA qualified, a health plan must meet several tests: it must have a deductible above a certain minimum level, it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level, and it can cover only preventive care services and (for plan years beginning on or before December 31, 2021) telehealth services before the deductible is met.[6] (See **Table 1** for the minimum deductibles and out-of-pocket limits for 2020 and **Table 2** for the minimum deductibles and out-of-pocket limits for 2021.)

In addition, the plan's coverage cannot be limited to a narrow set of services, such as coverage for a particular disease (e.g., cancer-only coverage) or vision-only coverage.[7] This rule is designed to prevent individuals from establishing and making HSA contributions when the only insurance they have is coverage for a narrow class of benefits.

Table 1. HSA-Qualified HDHP Deductible and Out-of-Pocket Limit Requirements for 2020

Requirement	Self-Only Plan	Family Plan
Minimum Deductible	$1,400	$2,800
Out-of-Pocket Limit	$6,900	$13,800

Source: Internal Revenue Service (IRS), *Internal Revenue Bulletin: 2019-22*, Revenue Procedure 2019-25, May 18, 2019, at https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25.

Notes: HSA = health savings account. HDHP = high-deductible health plan. Not all HDHPs are considered HSA-qualified HDHPs. As an example, plans may meet the deductible and out-of-pocket limits but may cover more than preventive care services and telehealth services before the deductible is met. Minimum deductible and out-of-pocket limits apply only to in-network payments for *usual, customary, and reasonable (UCR) charges*. UCR is defined as "the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service." Centers for Medicare & Medicaid, *Glossary*, at https://www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable/.

Archer MSAs can be thought of as an older, more restrictive version of HSAs.

[5] IRS, *Internal Revenue Bulletin: 2004-2*, Notice 2004-2, January 12, 2004, at https://www.irs.gov/irb/2004-02_IRB#NOT-2004-2. Hereinafter IRS, *Internal Revenue Bulletin: 2004-2*, Notice 2004-2.

[6] 26 U.S.C. §223(c)(2) and IRS, *Publication 969*, p. 3. Individuals should be able to find out from their insurer whether their high-deductible health plan (HDHP) is HSA qualified. They cannot apply to the IRS or another government agency for a determination.

[7] 26 U.S.C. §223(c)(2)(B).

Minimum Deductible

To be HSA qualified, a health plan's annual deductible in 2020 and 2021 must be at least $1,400 for self-only coverage; for family coverage, it must be at least $2,800.[8] These amounts are adjusted for inflation (rounded to the nearest $50) annually.[9]

In addition, a health plan is required to take into account only *usual, customary, and reasonable charges* for covered benefits that are provided in network when determining whether deductibles are met.[10] Premiums cannot be included in meeting the deductible.

If a health plan has a deductible requirement for prescription drugs that is different than requirements for other benefits, in order for the plan to be HSA qualified, the prescription drug deductible must also meet the same minimum requirements.[11]

Out-of-Pocket Limit

To be HSA qualified, a health plan's annual limit on out-of-pocket expenditures for covered benefits for self-only coverage must not exceed $6,900 in 2020 and $7,000 in 2021. For family policies, the limit must not exceed $13,800 in 2020 and $14,000 in 2021.[12] These amounts are adjusted for inflation (rounded to the nearest $50) annually.

Generally, enrollee cost sharing—deductibles, co-payments, and coinsurance—for in-network coverage provided under the HSA-qualified HDHP is taken into account in determining whether the out-of-pocket limits are exceeded. However, these limits should not be interpreted as ceilings on *all* out-of-pocket expenditures for health care. Enrollee payments to providers for services provided out of network that are in addition to any relevant cost sharing (i.e., balance bills) or payments for services that are not covered by the HSA-qualified HDHP do not count toward the out-of-pocket limit. Premiums for the HSA-qualified HDHP and any other insurance also do not count toward the out-of-pocket limit.

[8] IRS, *Internal Revenue Bulletin: 2019-22*, Revenue Procedure 2019-25, May 28, 2019, at https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25, and IRS, *Internal Revenue Bulletin: 2020-24*, Revenue Procedure 2020-32, June 8, 2020, at https://www.irs.gov/irb/2020-24_IRB#REV-PROC-2020-32. Hereinafter IRS, *Internal Revenue Bulletin: 2019-22*, Revenue Procedure 2019-25 and IRS, *Internal Revenue Bulletin: 2020-24*, Revenue Procedure 2020-32, respectively.

[9] This and other HSA inflation adjustments are based upon the Chained Consumer Price Index for All Urban Consumers published by the U.S. Department of Labor. 26 U.S.C. §223(g)(1)(B) provides that the measurement period for HSA inflation adjustments is the 12-month period ending on March 31 of the prior year.

[10] *Usual, customary, and reasonable* (UCR) is defined by the Centers for Medicare & Medicaid as "the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service." Centers for Medicare & Medicaid, *Glossary*, at https://www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable/. If an enrollee pays a provider an amount greater than the UCR, then any amount above the UCR does not count toward to the deductible.

[11] IRS, *Internal Revenue Bulletin: 2004-15*, Revenue Ruling 2004-38, April 12, 2004, at https://www.irs.gov/irb/2004-15_IRB#RR-2004-38.

[12] IRS, *Internal Revenue Bulletin: 2019-22*, Revenue Procedure 2019-25 and IRS, *Internal Revenue Bulletin: 2020-24*, Revenue Procedure 2020-32.

Table 2. HSA-Qualified HDHP Deductible and Out-of-Pocket Limit Requirements for 2021

Requirement	Self-Only Plan	Family Plan
Minimum Deductible	$1,400	$2,800
Out-of-Pocket Limit	$7,000	$14,000

Source: Internal Revenue Service (IRS), *Internal Revenue Bulletin: 2020-24*, Revenue Procedure 2020-32, June 8, 2020, at https://www.irs.gov/irb/2020-24_IRB#REV-PROC-2020-32.

Notes: HSA = health savings account. HDHP = high-deductible health plan. Not all HDHPs are considered HSA-qualified HDHPs. As an example, plans may meet the deductible and out-of-pocket limits but may cover more than preventive care services and telehealth services before the deductible is met. Minimum deductible and out-of-pocket limits apply only to in-network payments for *usual, customary, and reasonable (UCR) charges*. UCR is defined as "the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service." Centers for Medicare & Medicaid, *Glossary*, at https://www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable/.

Services Allowed to Be Provided Before the Deductible Has Been Met

Generally, HSA-qualified HDHPs are not allowed to provide any benefits before the deductible has been met; however, HSA-qualified HDHPs are allowed to provide preventive care benefits and (for plan years beginning on or before December 31, 2021) telehealth services without a deductible or with a deductible less than the aforementioned minimum annual deductible requirement.[13]

Preventive Care Services

IRS guidance provides that *preventive care* includes, but is not limited to, periodic health evaluations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and various screening services.[14] Drugs and medications can be considered preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent or to prevent a disease recurrence.[15]

Additionally, HSA-qualified HDHPs are required to comply with the federal private health insurance requirement to provide specified preventive care services without imposing cost sharing.[16] For this requirement, *preventive care* includes evidenced-based services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, routine immunizations, and other evidence-based preventive care and screenings for women and children.[17] Because this requirement provides that health plans,

[13] 26 U.S.C. §223(c)(2)(C), 26 U.S.C. §223(c)(2)(E).

[14] IRS, *Publication 969*, p. 3, and IRS, *Internal Revenue Bulletin: 2004-15*, Notice 2004-23, April 12, 2004, at https://www.irs.gov/irb/2004-15_IRB#NOT-2004-23. Hereinafter IRS, *Internal Revenue Bulletin: 2004-15*, Notice 2004-23.

[15] IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50, August 16, 2004, at https://www.irs.gov/irb/2004-33_IRB#NOT-2004-50. Hereinafter IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

[16] 42 U.S.C. §300gg-13.

[17] 42 U.S.C. §300gg-13. For more information about preventive care services, see Department of Health and Human Services, "Preventive Care," February 1, 2017, at https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html. The United States Preventive Services Task Force is an independent, volunteer panel of experts in prevention, evidence-based medicine, and primary care. The task force makes preventive care recommendations and

including HSA-qualified HDHPs, cannot impose any cost sharing for the specified preventive services, all such services must be covered by HSA-qualified HDHPs before the plan's deductible is met and such coverage does not disqualify the plan from being considered HSA qualified.[18]

In general, preventive care does not include services or benefits intended to treat existing illnesses, injuries, or conditions, although there are three exceptions to this rule. One exception allows pre-deductible coverage of treatments that are incidental to a preventive care service if it would have been unreasonable or impracticable to perform another procedure for such treatment.[19]

The second exception allows pre-deductible coverage of specified items and services prescribed both to treat an individual diagnosed with corresponding chronic conditions and to prevent the exacerbation of the chronic condition or the development of a secondary condition (see **Table 3**).[20]

Table 3. HSA-Qualified HDHP Preventive Care Services for Specified Chronic Conditions

Items and Service	Chronic Condition
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: Internal Revenue Service, *Internal Revenue Bulletin: 2019-32*, Notice 2019-45, August 5, 2019, at https://www.irs.gov/irb/2019-32_IRB#NOT-2019-45.

assigns each recommendation a letter grade based on the strength of the evidence supporting the recommendation. For more information about the task force, see U.S. Preventive Services Task Force, "About the USPSTF," https://www.uspreventiveservicestaskforce.org/.

[18] IRS, *Internal Revenue Bulletin: 2013-40*, Notice 2013-57, September 30, 2013, at https://www.irs.gov/irb/2013-40_IRB#NOT-2013-57.

[19] IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

[20] IRS, *Internal Revenue Bulletin: 2019-32*, Notice 2019-45, August 5, 2019, at https://www.irs.gov/irb/2019-32_IRB#NOT-2019-45.

Notes: HSA = health savings account. HDHP = high-deductible health plan. The items and services in this table are treated as preventive care for purposes of HSA-qualified HDHPs if prescribed both to treat an individual diagnosed with corresponding chronic conditions and to prevent the exacerbation of the chronic condition or the development of a secondary condition.

The third exception was developed by the IRS in response to the COVID-19 pandemic and corresponding recession.[21] Under this exception, HSA-qualified HDHPs are allowed to provide benefits related to the testing for and treatment of COVID-19 before the deductible has been met. Specifically, plans can provide benefits regarding the following (if incurred on or after January 1, 2020): diagnostic testing for influenza A & B, norovirus, and other coronaviruses, and respiratory syncytial virus, and any items or services required to be covered with zero cost sharing under Section 6001 of the Families First Coronavirus Response Act (P.L. 116-127, as amended by the Coronavirus Aid, Relief, and Economic Security Act [CARES Act], P.L. 116-136).[22] As such, HSA-qualified HDHPs are able to satisfy federal coverage requirements related to COVID-19 testing and still be considered HSA eligible.

Allowable Telehealth Services

HSA-qualified HDHPs with a plan year that begins on or before December 31, 2021, are allowed to provide telehealth and other remote care benefits without a deductible or with a deductible less than the aforementioned minimum annual deductible requirement. This requirement applies to telehealth and other remote care services provided on or after January 1, 2020.[23]

This provision was included in the CARES Act and was intended to increase health care access for HSA-qualified HDHP enrollees who may have COVID-19 while also protecting other patients from potential exposure.[24] As such, if an HSA-qualified HDHP plan administrator initially responded to the COVID-19 pandemic by providing telehealth services without a deductible, enrollees of that plan would not lose their HSA eligibility as a result of that decision.

Disqualifying Coverage

There are a number of ways in which an individual could be disqualified from establishing and contributing to an HSA, even if the individual has coverage under an HSA-qualified HDHP.

Individuals generally must not have any other health plan that is not an HSA-qualified HDHP or that provides coverage for any benefit that is covered under their HSA-qualified HDHP.[25] For

[21] IRS, *Internal Revenue Bulletin: 2020-14*, Notice 2020-15, March 30, 2020, at https://www.irs.gov/irb/2020-14_IRB#NOT-2020-15.

[22] IRS, *Internal Revenue Bulletin: 2020*-22, Notice 2020-29, May 26, 2020, at https://www.irs.gov/irb/2020-22_IRB#NOT-2020-29. Hereinafter IRS, *Internal Revenue Bulletin: 2020*-22, Notice 2020-29. For an overview of Section 6001 of the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, see CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127* and CRS Report R46334, *Selected Health Provisions in Title III of the CARES Act (P.L. 116-136)*, respectively.

[23] IRS, *Internal Revenue Bulletin: 2020*-22, Notice 2020-29.

[24] U.S. Congress, Senate Committee on Finance, *Coronavirus Aid, Relief, and Economic Security Act Subtitle D—Finance Committee Section-by-Section*, committee print, 116th Cong., at https://www.finance.senate.gov/imo/media/doc/CARES%20Act%20Section-by-Section%20(Finance%20Health).pdf.

[25] In this context, the term *health plan* is not limited to traditional health insurance-types of arrangements. For example, health flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs) would constitute a *health plan*. In addition, and as mentioned in a recent notice of proposed rulemaking, direct primary care arrangements that provide for a variety of primary care services (e.g., physical examinations, urgent care, laboratory testing, and treatment and diagnosis of sicknesses or injuries) would also constitute a health plan. 26 U.S.C. §223(c)(1)(A)(ii). IRS,

example, individuals with an HSA-qualified HDHP are not eligible to establish or contribute to an HSA if they also are covered under a spouse's policy for the same benefits and that spouse's policy is not an HSA-qualified HDHP.

Some types of health coverage are not considered disqualifying for purposes of being eligible to establish and contribute to an HSA.[26] Coverage for any benefit provided under permitted insurance,[27] and coverage (through insurance or otherwise) for accidents, disability, vision care, dental care, or long-term care are not considered disqualifying health coverage. In addition, for plan years beginning on or before December 31, 2021, telehealth and other remote care are not considered disqualifying health coverage.[28]

Individuals are not allowed to establish or contribute to an HSA if they are enrolled in Medicare, which generally first occurs at the age of 65.[29]

HSA-eligible individuals generally may not have employer-established flexible spending accounts (FSAs) or health reimbursement accounts (HRAs), which are two other types of health-related tax-advantaged accounts, unless these accounts (1) are for limited purposes (for example, dental services or preventive care), (2) provide reimbursement for services covered by the HSA-qualified HDHP only after the qualifying deductible is met, or (3) are used in retirement.[30]

Additional Guidelines

HSA-qualified HDHP enrollees who do not have disqualifying coverage still are considered HSA eligible even if they have access to and coverage under an employee assistance program, disease management program, or wellness program, provided the program does not provide "significant benefits in the nature of medical care or treatment."[31] HSA-qualified HDHP enrollees who receive treatment under the Veterans Health Administration, within the Department of Veterans Affairs, for service-connected disabilities also are still HSA eligible.[32]

Internal Revenue Bulletin: 2004-22, Revised Rule 2004-45, June 1, 2004, at https://www.irs.gov/irb/2004-22_IRB#RR-2004-45. Hereinafter IRS, *Internal Revenue Bulletin: 2004-22*, Revised Rule 2004-45. IRS, "Certain Medical Care Arrangements," 85 *Federal Register* 35398, June 10, 2020.

[26] Inversely, although individuals are allowed to have these additional types of coverage (in conjuncture with an HSA-qualified HDHP) and remain HSA eligible, a plan in which all of the coverage is through permitted insurance and/or coverage for accidents, disability, vision care, dental care or long-term care would not be considered an HSA-qualified HDHP and an individual would not be eligible for an HSA with only these types of insurance. IRS, *Publication 969*, p. 5.

[27] *Permitted insurance* is defined at 26 U.S.C. §223(c)(3) as insurance under which substantially all coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property (such as automobile insurance); insurance for a specified disease or illness; or insurance that pays a fixed amount per day or other period of hospitalization.

[28] This requirement applies to telehealth and other remote care coverage provided on or after January 1, 2020. IRS, *Internal Revenue Bulletin: 2020*-22, Notice 2020-29.

[29] Although the law states that eligible individuals are no longer able to establish and contribute to HSAs after becoming "entitled to benefits" under Medicare, the IRS interprets the phrase "entitled to benefits" as meaning "eligibility and enrollment" in either Medicare Part A or Medicare Part B. 26 U.S.C. §223(b)(7) and IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50. For more information on the relationship between HSAs and Medicare, see CRS In Focus IF11425, *Health Savings Accounts (HSAs) and Medicare*.

[30] IRS, *Internal Revenue Bulletin: 2004-22*, Revised Rule 2004-45.

[31] Screening and other preventive care services are not considered "significant benefits in the nature of medical care or treatment." IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

[32] 26 U.S.C. §223(c)(1)(C). *Service-connected disability* within the meaning of 38 U.S.C. §101(16).

HSA Contributions

Contribution Limits

If an individual is eligible to contribute to an HSA any time during a given tax year, the total amount that individual may contribute to his or her HSA is capped. Generally, the maximum amount an individual may contribute to his or her HSA in a tax year is based on the type of HDHP coverage the individual had during those months (self-only or family), the individual's age, and the months during the year that he or she was considered HSA eligible. Contributions to HSAs may be made at any time during a calendar year and until the federal income tax return filing date (without extensions), normally April 15 of the following year.[33] Thus, contributions could occur over a 15½-month time span (e.g., from January 1, 2020, through April 15, 2021), provided they do not exceed the allowable annual limit.

In 2020, the maximum annual contribution limit is $3,550 for self-only coverage and $7,100 for family coverage.[34] In 2021, the maximum annual contribution limit is $3,600 for self-only coverage and $7,200 for family coverage.[35] The applicable annual limits apply to total contributions to the HSA from all sources (i.e., from individuals and employers). These amounts are adjusted for inflation (rounded to the nearest $50) annually.

In addition, account holders who are at least 55 years of age may contribute an additional catch-up contribution of $1,000 each year, which is not annually indexed for inflation.

The annual limits are calculated on a monthly basis: for each month during the year when individuals are eligible, they may contribute (or others may contribute on their behalf) up to one-twelfth of the applicable annual limit. For example, an individual who is eligible from January through July could contribute seven-twelfths of the annual limit for that year.

As an exception to this rule, individuals who are eligible during the last month of the year are treated as if they had been eligible for that entire year and thus are allowed to contribute up to the annual limit so long as the contribution is before the tax filing date of the following year.[36] Individuals who make contributions under this exception must maintain their HSA eligibility for the entire following year, the *testing period*, except in cases of disability or death.[37] Otherwise, the additional contributions allowed under the exception are included in gross income when determining federal income taxes for the year in which an individual fails to be HSA eligible and, as shown in **Table 4**, are subject to a 10% penalty tax.

HSA Contribution Rules for Married Couples

Spouses are prevented from having joint HSA accounts (even if the spouses are covered by the same HSA-qualified HDHP). Only one spouse can be listed as the account holder for a given HSA, even though that spouse's HSA may be used to reimburse the medical expenses of either spouse. Nothing prevents each spouse from establishing his or her own HSA, assuming each is eligible.

If both spouses are HSA eligible and at least one spouse is covered by a family coverage HSA-qualified HDHP, then the maximum amount the couple can collectively contribute to its HSA(s) is associated with the family coverage

[33] IRS, *Internal Revenue Bulletin: 2004-2*, Notice 2004-2.

[34] IRS, *Internal Revenue Bulletin: 2019-22*, Revenue Procedure 2019-25.

[35] IRS, *Internal Revenue Bulletin: 2020-24*, Revenue Procedure 2020-32.

[36] 26 U.S.C. §223(b)(8).

[37] 26 U.S.C. §223(b)(8)(iii).

annual limit for that year ($7,100 in 2020 and $7,200 in 2021). The collective maximum amount is to be split evenly between the spouses' HSAs, unless both agree on a different division.[38] If both spouses are aged 55 or older and eligible to make catch-up contributions, each spouse must make such a contribution to his or her own account; one spouse cannot make catch-up contributions to his or her own HSA on behalf of the other spouse.[39]

Where applicable, HSA limits must be reduced by the amount of any direct contributions individuals make to their Archer MSAs during the same year or for any direct contributions to an HSA from traditional or Roth IRAs, the latter of which is discussed later in this section.

Any excess contributions to an HSA are not tax deductible and, if made by an employer, are treated as gross income for the tax year in which the contributions were earned. Excess contributions generally are subject to a 6% penalty tax (see **Table 4**), unless the excess amounts are withdrawn prior to the tax filing date of the year the excess contributions were made.[40] If not withdrawn, this penalty tax would apply to each tax year the excess contributions remain in the account.

Allowable Contributors

Eligible individuals may make direct contributions to their HSAs, and employers, family members, and other individuals may make contributions to an individual's HSA on the individual's behalf.[41] Contributions by one individual or entity do not preclude contributions by others, provided the total amount of contributions does not exceed annual contribution limits.[42]

Employed individuals may make HSA contributions through *cafeteria plans*—that is, benefit arrangements established by employers under which employees accept lower take-home pay in exchange for the difference being deposited in their HSA account.[43] Because these types of individual contributions are excluded from gross income, they are not tax deductible. The IRS has determined that salary reduction agreements must allow employees to stop, increase, or decrease their HSA contributions throughout the year as long as the changes are effective prospectively; however, employers may place restrictions on HSA contribution elections under this type of

[38] 26 U.S.C. §223(b)(5).

[39] IRS, *Internal Revenue Bulletin: 2008*-29, Notice 2008-59, July 21, 2008, at https://www.irs.gov/irb/2008-29_IRB#NOT-2008-59.

[40] 26 U.S.C. §4973(a) and (g). As an example, if individual who is HSA eligible from January through July contributes more than seven-twelfths of the annual limit for that year, then that individual has until that year's tax filing date to withdraw the excess contributions. If the funds are not withdrawn, the excess contributions would be subject to a 6% penalty tax. IRS, *Publication 969*, pp. 8-9.

[41] An employer's contributions to employees' HSAs are subject to 26 U.S.C. 4980G, which requires the employer to provide comparable HSA contributions to all comparable participating employees, unless the employer makes the HSA contributions through a cafeteria plan. If an employer contributes to employees' HSAs under a cafeteria plan, then the contributions are subject to the cafeteria plan nondiscrimination rules. For more details, see IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50 and 26 U.S.C. §223(b)(4).

[42] 26 U.S.C. §223(b)(4).

[43] In general, a cafeteria plan is a pretax salary reduction agreement that employers can offer their employees. Under a cafeteria plan, an employer allows employees to choose to forego a portion of their salary to instead receive a qualified benefit. The amount that goes toward the qualified benefit is then excluded from federal income and payroll taxes. Cafeteria plans must always offer employees a choice between at least one taxable benefit (e.g., cash) and at least one qualified (nontaxable) benefit but may also include additional benefit choices. HSAs can be considered a qualified benefit under a cafeteria plan. HSA contributions made in this manner are treated as employer contributions and are excluded from the employee's income for federal tax purposes (and are not tax deductible by the employee). 26 U.S.C. §125.

arrangement if the restrictions apply to all employees.[44] The IRS also has determined that these agreements allow employers to make an employee's annual expected HSA contribution available to the employee so that the employee may cover medical expenses that exceed his or her current HSA balances, provided the employee repays the accelerated contributions before the end of the year.[45]

HSA contributors cannot restrict how HSA funds are used. For example, employers may not limit HSAs to certain medical expenses (or medical expenses only), even for funds they contribute.[46] Therefore, account owners may make withdrawals from their HSA for any purpose, though nonqualified withdrawals are subject to taxation, as discussed in the section "Nonqualified Expenses."

Eligible individuals may use other tax-advantaged accounts to increase the amount of resources available in their HSAs. Specifically, individuals may make one rollover contribution to an HSA from an Archer MSA or another HSA during a one-year period.[47] Individuals also may make a once-in-a-lifetime distribution from their traditional or Roth IRA and deposit it into an HSA, which is factored into the annual contribution limits described in the "Contribution Limits" section.[48] These types of HSA contributions are subject to different tax rules than regular HSA contributions, as discussed in the "Tax Advantages of HSAs" section.

Eligibility to Withdraw HSA Funds

An account holder may withdraw HSA funds at any time, regardless of the account holder's eligibility to contribute to the HSA. Generally, withdrawals must be used for qualified medical expenses for the account holder, the account holder's spouse, or the account holder's dependents.[49] Any withdrawals for nonqualified expenses must be included in the account holder's gross income when determining federal income taxes and are generally subject to an additional 20% penalty (see **Table 4**).[50]

Neither the account holder nor the account holder's spouse or dependents need to be covered under the same or separate HSA-qualified HDHPs for the account holder to withdraw funds. Likewise, having disqualifying coverage would not prohibit an account holder from withdrawing HSA funds. For example, an account holder who enrolls in Medicare Parts A and B becomes ineligible to establish or contribute to an HSA, but the account holder may continue to withdraw funds from a previously established HSA.

[44] IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

[45] IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

[46] IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

[47] There is no limit on the number of HSA rollovers if they are sent directly from one trustee to another. Additionally, individuals do not need to be HSA eligible to roll over funds from an existing HSA to a new HSA. IRS, *Publication 969*, p. 8.

[48] 26 U.S.C. §408(d)(9). IRS, *Publication 969*, p. 7.

[49] In this context, the term *dependent* includes all dependents that the account holder claims on his or her tax return and any person the account holder could have claimed as a dependent on his or her tax return except that (a) the person filed a joint return, (b) the person had a gross income of $4,050 or more, or (c) the account holder could have been claimed as a dependent on someone else's return. IRS, *Publication 969*, p. 9.

[50] Nonmedical HSA distributions for those aged 65 and older are treated as ordinary income and are not subject to a penalty.

HSA Withdrawals

Qualified Medical Expenses

As noted above, HSA withdrawals are exempt from federal income taxes if used to cover *qualified medical expenses* for the account holder, the account holder's spouse, or the account holder's dependents. HSA withdrawals for these expenses remain exempt from federal income taxes even if the aforementioned individuals are not covered under an HSA-qualified HDHP or have disqualifying coverage.

For HSA purposes, *qualified medical expenses* are considered most medical care described in 26 U.S.C. §213(d) and further explained in IRS *Publication 502, Medical and Dental Expenses*.[51] More specifically, qualified medical expenses are defined as including the following: the costs of diagnosis, cure, mitigation, treatment, or prevention of disease and the costs for treatments affecting any part of the body; the amounts paid for transportation to receive medical care; and qualified long-term care services.[52] The CARES Act (P.L. 116-136) recently expanded the definition of HSA qualified medical expenses to include menstrual care products and over-the-counter medications and drugs (without a prescription).[53]

Of the medical expenses mentioned in 26 U.S.C. §213(d), health insurance premiums generally are not considered qualified medical expenses for HSA purposes. However, there are four exceptions to this rule, which are: (1) long-term care insurance, (2) health insurance premiums during periods of continuation coverage required by federal law (i.e., Consolidated Omnibus Budget Reconciliation Act coverage, or COBRA), (3) health insurance premiums during periods in which the individual is receiving unemployment compensation, and (4) for individuals aged 65 years and older, any health insurance premiums (including Medicare Part B premiums) other than a Medicare supplemental policy.[54]

There is no time limit on when HSA withdrawals need to be made to pay for (or reimburse payments for) qualified medical expenses, provided adequate records are kept.[55] However, HSAs may not be used to pay expenses incurred before the HSA was established. For example, an account holder may pay 2019 qualified medical expenses today using funds from an HSA established in 2018 but may not use the account to pay for qualified medical expenses incurred in 2017, since this was before the account was established.

Nonqualified Expenses

Withdrawals not used to pay for qualified medical expenses must be included in the account holder's gross income when determining federal income taxes and generally are subject to a 20% penalty, as shown in **Table 4**. The penalty is waived in cases of disability or death and for

[51] Qualified medical expenses that were paid for with an HSA withdrawal cannot be used for a medical and dental expenses deduction. IRS, *Publication 502 (2019), Medical and Dental Expenses*, January 21, 2020, at https://www.irs.gov/publications/p502. Hereinafter IRS, *Publication 502*.

[52] A nonexclusive list of qualified medical expenses can be found in IRS, *Publication 502*. Also see 26 U.S.C. §213(d).

[53] 26 U.S.C. § 223(d)(2)(A), as amended by Section 3702 of P.L. 116-136. Prior to the CARES Act, over-the-counter medicines and drugs (other than insulin) were not considered an HSA qualified medical expense unless an individual received a corresponding prescription for each over-the-counter expense.

[54] 26 U.S.C. § 223(d)(2)(C). IRS, *Publication 969*, p. 10.

[55] IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

individuals aged 65 and older; however, withdrawals for nonqualified expenses still may be treated as gross income.[56] There is no requirement, as there is for qualified retirement plans, that individuals begin to spend down account balances at a certain age.

Table 4. HSA Penalty Taxes

Penalty Tax	Tax Percentage	Tax Base	Authorizing Law
Withdrawal of Funds for Nonqualified Medical Expenses[a]	20%	Amount of Withdrawal	26 U.S.C. §223(f)(4)
Failure to Maintain HSA Eligibility During Testing Period[b]	10%	Contributions into HSA for Months Not Covered by HSA-Qualified HDHP	26 U.S.C. §223(b)(8)
Excess Contributions Above HSA Annual Limit	6%	Additional Contribution Amount	26 U.S.C. §4973(a) and (g)

Source: Congressional Research Service analysis of tax code.

Notes: HSA = health savings account.

a. The penalty is waived in cases of disability or death and for individuals aged 65 and older.

b. Individuals who are eligible during the last month of the year are treated as if they had been eligible for the entire year and thus are allowed to contribute up to the annual limit. Individuals who make additional contributions under this rule must maintain their HSA eligibility for the following year, the *testing period*, except in cases of disability or death.

Tax Advantages of HSAs

HSAs often are referred to as having a *triple tax advantage*: (1) contributions reduce taxable income, (2) earnings on the account grow tax free, and (3) withdrawals for qualified medical expenses are not subject to taxation.[57]

Qualified individuals who contribute to their HSAs (outside of a cafeteria plan) may claim a deduction on their federal income tax return and thus reduce their tax burden, as shown in **Table 5**.[58] The deduction is *above the line*; that is, it is made in determining adjusted gross income and may be taken by taxpayers regardless of whether they claim the standard deduction or the itemized deduction.

Table 5. Tax Advantages of Various Types of HSA Contributions

HSA Contribution Type	Can Be Used to Claim Federal HSA Tax Deduction	Counts as Federal Taxable Income	Counts Toward Annual HSA Contribution Limit
Individual Contribution[a]	Yes	No	Yes
Employer Contribution[b]	No	No	Yes

[56] 26 U.S.C. §223(f)(4). If the account holder dies and the account holder's spouse inherits the HSA, the spouse becomes the account holder. If someone other than the deceased account holder's spouse inherits the account, the account ceases to be an HSA and must be included as gross income by the inheritor. 26 U.S.C. §223(f)(8)(A).

[57] Employee Benefit Research Institute, *The Triple Tax Advantage of an HSA*, July 31, 2014, at https://www.ebri.org/docs/default-source/fast-facts/ff-292-hsa-tax-31july14.pdf?sfvrsn=2f38342f_2.

[58] Individuals who may be claimed as a dependent are not eligible to establish an HSA; therefore, they are not eligible for this deduction.

HSA Contribution Type	Can Be Used to Claim Federal HSA Tax Deduction	Counts as Federal Taxable Income	Counts Toward Annual HSA Contribution Limit
Traditional or Roth IRA Distribution to HSA[c]	No	No	Yes
Archer MSA and Other HSA Rollover	No	No	No
Investment Earnings	Not applicable	No	No

Source: IRS, *Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans*, March 1, 2018, at https://www.irs.gov/pub/irs-pdf/p969.pdf.

Notes: HSA = health savings account. Excess HSA contributions count toward gross income, cannot be used to claim the HSA tax deduction, and are subject to a 6% penalty tax.

a. Includes account holder contributions and other contributions made by individuals on behalf of the account holder (not including employer contributions).

b. Includes employee contributions made through a cafeteria plan.

c. A once-in-a-lifetime traditional or Roth individual retirement account (IRA) distribution to an HSA would not be subject to early IRA withdrawal penalties.

Individuals may claim the tax deduction for all amounts contributed to their HSAs that were made either by the individual or on behalf of the individual (not including employer amounts or contributions made through a cafeteria plan) over the course of the year through the subsequent tax filing deadline. For individuals claiming the deduction, the total tax effect of the eligible HSA contributions depends on an individual's marginal tax rate and the amount of nonemployer contributions to the individual's HSA.

No deduction may be claimed for a once-in-a-lifetime contribution from an IRA (though the IRA distribution is not penalized, as it otherwise might be) or for Archer MSA or other HSA rollovers.[59] These amounts do not count as gross income in determining income tax liability.[60]

An employer's contributions to an HSA cannot be deducted by employees as HSA contributions or as medical expense deductions; however, they are excluded from employees' gross income in determining their income tax liability.[61] In addition, the employer's contributions are excluded from Social Security and Medicare taxes for both employers and employees and are excluded from federal unemployment insurance taxes.[62] If an employee contributes to his or her HSA through a cafeteria plan, the contributions are considered to be made by the employer and are excluded from the employee's gross income in determining his or her income tax liability and are exempt from the three employment taxes (Social Security, Medicare, and unemployment insurance taxes). An employee cannot deduct amounts contributed to an HSA through a cafeteria plan.

HSA balances can be invested similar to IRAs (e.g., annuities, stocks, mutual funds, bonds, etc.), and any associated earnings can accumulate tax free.[63]

[59] 26 U.S.C. §223(d)(4)(A).

[60] IRS, *Publication 969*, pp. 7-8.

[61] IRS, *Internal Revenue Bulletin: 2004-2*, Notice 2004-2.

[62] If an individual is self-employed, the HSA deduction does not affect self-employment net earnings; as a consequence, HSA contributions are not exempt from Social Security and Medicare (Self-Employment Contribution Act or SECA) taxes. IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50.

[63] IRS, *Internal Revenue Bulletin: 2004-33*, Notice 2004-50, and IRS, *Publication 969*, p. 3.

State income taxes generally follow federal rules with respect to deductions and exclusions. However, some states may choose to provide different treatment. For example, California does not recognize HSAs as tax-advantaged accounts for state income tax purposes.[64] Therefore, a California taxpayer who contributed to an HSA is required to increase his or her California adjusted gross income by an amount equal to the sum of the taxpayer's HSA deduction on his or her federal return, the interest earned on the HSA, and the contributions made by the taxpayer's employer. This increase results in a larger state tax burden (or a smaller state tax refund) for the taxpayer.

HDHP Enrollment and HSA Utilization

Data Challenges

While it would be beneficial to study HSA statistics among the population that is eligible to establish and contribute to an HSA (i.e., those that are enrolled in an HSA-qualified HDHP and do not have any disqualifying coverage), there is limited information available on this population.

The lack of available data stems in part from the fact that HSAs and HSA-qualified HDHPs are two separate products and often can be administered by two separate institutions. For example, some individuals have their HSA established with their insurer, whereas others have their HSA administered by another type of institution, such as a bank. In the latter case, the insurer would have insights into individuals' potential eligibility to contribute to HSAs but would not have any information regarding the individuals' HSA activity (i.e., contributions, investments, or withdrawals). Inversely (and accounting for the fact that individuals can continue to have an HSA and withdraw HSA funds when they are no longer eligible to contribute to an HSA), the HSA holding institution likely would not be aware of the individuals' enrollment in or disenrollment from an HSA-qualified HDHP. Because of this, HSA holding institutions may not know about an individual's HSA eligibility and insurers may not know about an individual's HSA contributions.

As a result, there may be no single data source to answer key questions of interest, for example, how many individuals eligible to open an HSA or eligible to make an HSA contribution do so.[65] Instead, HSA research tends to focus on one of two populations, HSA-qualified HDHP enrollees or HSA holders. Although these two product populations overlap, they are not entirely identical. For example, not all HSA-qualified HDHP enrollees are eligible to or have established or contributed to an HSA, and not all HSA holders currently are enrolled in an HSA-qualified HDHP or are currently eligible to contribute to an HSA.

Within this research, other methodological limitations limit the extent to which available research can be generalized to the entire HSA and/or HSA-qualified HDHP populations. Specifically, many HSA holder/HSA-qualified HDHP enrollee studies rely on surveys of insurers, businesses, or HSA administrators. These data may not be nationally representative, may provide unadjusted results from a survey that does not use a random sample of the population being studied, or may use administrative data from a subsection of the population whose data are available. As such,

[64] California Assembly, *AB 2384 (Choi): Income Tax: Health Savings Accounts*, at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB2384.

[65] A recent study surveyed individuals to determine and evaluate HSA use amongst people enrolled in high-deductible health plans. For purposes of the study, "HSA" was defined to include HSAs and other accounts of funds that could be used to pay for medical care (e.g., health reimbursement arrangements [HRAs]). Jeffrey T. Kullgren, Elizabeth Q. Cliff, and Christopher Krenz, et al., "Use of Health Savings Accounts Among US Adults Enrolled," *JAMA Network Open*. 2020; 3(7):e2011014. doi:10.1001/jamanetworkopen.2020.11014.

data on the *entire* population of HSA-qualified HDHP enrollees or HSA holders are somewhat limited.

Current research can, however, highlight various trends with respect to HSA-qualified HDHP enrollment and HSA contributions.

Data Findings

HSA-Qualified HDHP Enrollment

For 2018 HSA-qualified HDHP enrollment estimates, an Employee Benefit Research Institute (EBRI) issue brief looked at four surveys produced by four different entities (two of which surveyed individuals and two of which surveyed employers) and found that HSA-qualified HDHP enrollment estimates ranged from 23 million individuals to 36.8 million individuals in 2018, though EBRI highlights methodological questions associated with these estimates.[66] For example, the two surveys of individuals indicated lower HSA-qualified HDHP estimates than the enrollment estimates indicated in the two surveys of employers. HSA-qualified HDHP estimates developed from surveys of individuals would generally be expected to be *higher* than the estimates developed from surveys of employers since the surveys of individuals would include those enrolled in HSA-qualified HDHPs in the individual market and the group market, whereas the surveys of employers would include only group market enrollment.

From a historical standpoint, multiple sources have demonstrated continued increases in HSA-qualified HDHP enrollment since the mid-2000s. An America's Health Insurance Plans report using survey data from insurers has shown a continued increase in enrollment in HSA-qualified HDHPs sold by commercial insurers in the individual and the small- and large-group markets from 2005 through 2017.[67]

The Kaiser Family Foundation (KFF) issued a report using survey data from employers with three or more workers that showed an increase in the percentage of covered employees in HSA-qualified HDHPs between 2006 and 2019.[68] The survey also revealed that in 2019, larger employers (i.e., those with 200 or more workers) were more likely than smaller employers (i.e., those with 3-199 workers) to offer HSA-qualified HDHPs to employees (among firms offering

[66] The issue brief discussed five surveys that were produced by five entities, however one entity did not have 2018 estimates. The sources included in the issue brief were produced by the Employee Benefit Research Institute (EBRI)/Greenwald & Associates, Kaiser Family Foundation (KFF), Mercer, National Center for Health Statistics (NCHS), and America's Health Insurance Plans (AHIP). Of these sources, AHIP did not have 2018 HSA-qualified HDHP estimates included in the issue brief. Paul Fronstin, *Enrollment in HSA-Eligible Health Plans: Slow Steady Growth Continued Into 2018*, Employee Benefit Research Institute, March 28, 2019, p. 5 at https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_478_hsaenrollment-28mar19.pdf?sfvrsn=e86b3f2f_4#:~:text=In%202017%2C%20both%20the%20EBRI,enrollment%20increased%20to%2023%20million. Hereinafter Fronstin, *Enrollment in HSA-Eligible Health Plans: Slow and Steady Growth Continued Into 2018*.

[67] More recent data from this source was not publically available at the time this report was published. America's Health Insurance Plans, *Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools*, April 12, 2018, p. 3, https://www.ahip.org/2017-survey-of-health-savings-accounts/.

[68] Gary Claxton, Matthew Rae, and Anthony Damico et al., *Employer Health Benefits 2019 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust, September 25, 2019, p. 142, at http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019. Hereinafter Claxton, Rae, and Damico et al., *Employer Health Benefits*.

health benefits).[69] Large employers also had a higher percentage of covered employees enrolled in such coverage in 2019, relative to small employers.[70]

The rate of growth in HSA-qualified HDHP enrollment has recently been slowing. The aforementioned EBRI issue brief looked at enrollment data from 2007 to 2018 and highlighted that most HSA-qualified HDHP enrollment sources indicated a recent slowing of enrollment growth in 2017-2018.[71] It is unclear whether or not this slow growth rate will be temporary, as the 2019 KFF report indicated a higher rate of growth in the percentage of covered workers enrolled in HSA-qualified HDHPs from 2018 to 2019 (relative to the 2017-2018 rate of growth demonstrated by any of the enrollment sources analyzed in the EBRI issue brief), and a 2019 Mercer report (which used survey data from employers that had 10 or more workers and offered health benefits) indicated a rate of growth in the percentage of covered workers enrolled in HSA-qualified HDHPs from 2018 to 2019 that was in line with the 2017-2018 rate of growth indicated in the EBRI issue brief.[72]

HSA Utilization

The IRS maintains data regarding the number of tax returns reporting HSA contributions and withdrawals. Because these IRS data are based on information provided by tax return, it is not possible to discern from the publicly available data how many individuals (as opposed to how many tax returns or filed forms) made HSA contributions or withdrawals in each tax year. Because each tax return is filed on behalf of at least one individual, the actual number of individuals making HSA contributions or withdrawals would be no fewer than the number of returns indicating such activity. Therefore, the figures reported here represent a minimum number of individuals who made HSA contributions or withdrawal in each tax year.

HSA Contribution Data

For tax year 2017, the IRS estimated that 1.9 million tax returns reported an HSA that received individual contributions (1.3% of filed tax returns) and 9 million tax returns reported an HSA that received employer contributions (5.9% of filed tax returns).[73] In this context, individual contributions are those non-employer contributions made by or on behalf of an individual. Employer contributions include contributions made by an employer and those contributions made by an employee through a cafeteria plan. The aforementioned tax return categories are not mutually exclusive (e.g., a tax return can have both individual and employer contributions).

Similar to historical increases in HSA-qualified HDHP enrollment, the IRS has estimated increases in both the number of tax returns reporting individual HSA contributions and the number of tax returns reporting employer HSA contributions from 2004 to 2017, though the

[69] Claxton, Rae, and Long et al., *Employer Health Benefits*, p. 141.

[70] Claxton, Rae, and Long et al., *Employer Health Benefits*, p. 143.

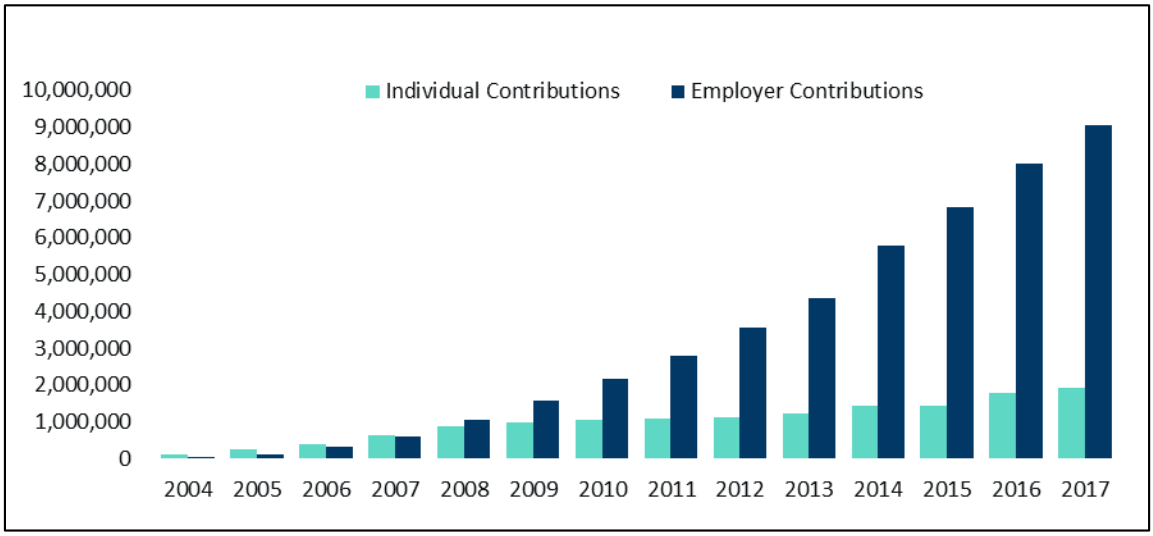
[71] This analysis included surveys produced by EBRI/Greenwald & Associates, KFF, Mercer, NCHS, and AHIP. Fronstin, *Enrollment in HSA-Eligible Health Plans: Slow and Steady Growth Continued Into 2018*, p. 8.

[72] Previous iterations of the KFF and Mercer sources were included in the EBRI issue brief analysis. Claxton, Rae, and Long et al., *Employer Health Benefits*, p. 142 and Mercer, *National Survey of Employer-Sponsored Health Plans 2019: Survey Tables*, 2020.

[73] Tax returns can represent contributions to more than one HSA account (e.g., spouses contributing to each of their own HSAs). The IRS estimates do not account for individuals who were HSA eligible but did not contribute to, or receive contributions for, an HSA. CRS analysis of Internal Revenue Service, *Statistics of Income—2017 Individual Income Tax Returns Line Item Estimates*, pp. 2, 196, https://www.irs.gov/pub/irs-pdf/p4801.pdf.

number of returns reporting employer contributions have grown at a faster rate than the number of returns reporting individual contributions (see **Figure 1**).[74]

Figure 1. Tax Returns Reporting HSA Contributions, TY2004-TY2017



Source: CRS analysis of Internal Revenue Service, *SOI Tax Stats – Individual Income Tax Returns, Line Item Estimates*, at https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-line-item-estimates.

Notes: TY = tax year. HSA = health savings account. Tax return categories are not mutually exclusive (e.g., a tax return can have both individual and employer contributions). Tax returns can represent more than one individual and therefore contributions to more than one HSA (e.g., spouses contributing to each of their own HSAs). *Employer contributions* include employer contributions and employee contributions made through a cafeteria plan. Data do not account for tax returns of individuals who were HSA eligible but did not contribute to, or receive contributions for, an HSA.

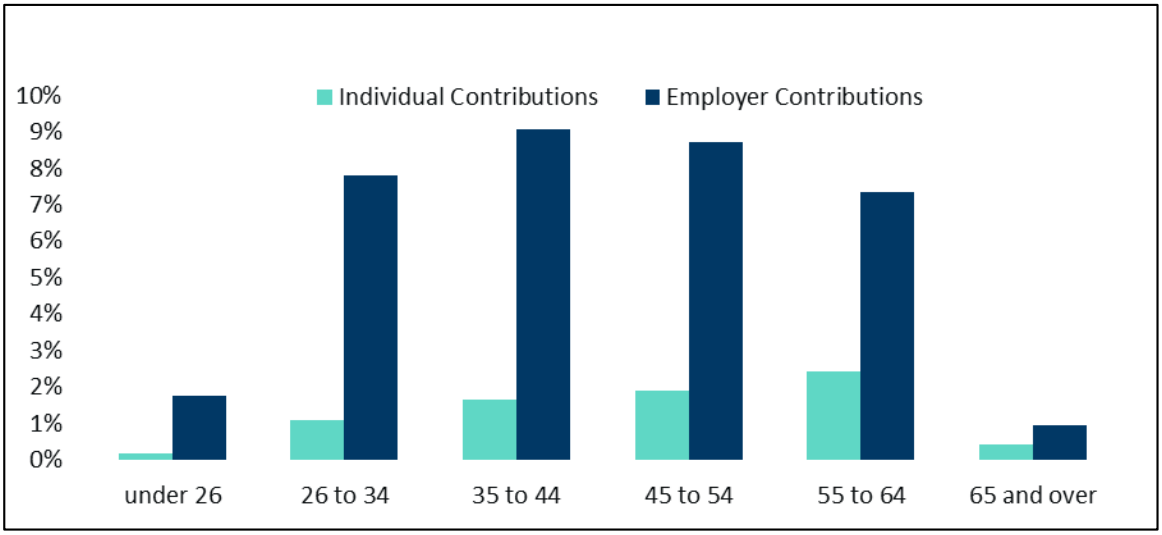
For tax year 2017, the percentage of tax returns within different age brackets that reported employer contributions is fairly consistent across all age groupings from 26 to 64. These percentages range from 7.3% to 9.1% and peak in the 35-44 age bracket (see **Figure 2**).[75]

The percentage of tax returns within different age brackets that reported individual contributions is also fairly consistent across all age groupings from 26 to 64. These percentages range from 1.1% to 2.4% and increase as individuals age. Regardless of age, the percentage of tax returns within an age bracket making individual contributions is lower than the percentage of returns making employer contributions, which suggests that fewer HSA-eligible individuals make contributions to an HSA outside of the employer-setting.

[74] Internal Revenue Service, *SOI Tax Stats – Individual Income Tax Returns, Line Item Estimates*, at https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-line-item-estimates.

[75] Age for joint returns was based on the primary taxpayer's age. CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

Figure 2. Percentage of Tax Returns Reporting HSA Contributions in TY2017, by Age



Source: CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

Notes: TY = tax year. HSA = health savings account. Y-Axis Maximum = 10%. Tax return categories are not mutually exclusive (e.g., a tax return can have both individual and employer contributions). Tax returns can represent more than one individual and therefore contributions to more than one HSA (e.g., spouses contributing to each of their own HSAs). Age for joint returns was based on the primary taxpayer's age. *Employer contributions* include employer contributions and employee contributions made through a cafeteria plan. Data do not account for tax returns of individuals who were HSA eligible but did not contribute to, or receive contributions for, an HSA.

Two age groupings have markedly lower HSA contribution rates: under 26, and 65 and over. Of the tax returns for those aged 25 and younger, 1.8% make employer contributions and 0.2% make individual contributions. Of the tax returns for those aged 65 and older, 0.9% make employer contributions and 0.4% make individual contributions.

Those aged 25 and younger are more likely to be considered a tax dependent of another taxpayer, which would preclude an otherwise eligible individuals from being HSA eligible.[76] In addition, those aged 19 and younger and aged 19-25 tend to have lower rates of private health insurance enrollment (relative to other age groupings), which reduces the population that may be HSA eligible.[77]

The drop-off in the number of returns reporting HSA contributions in the 65 and over age bracket is most likely associated with individuals enrolling in Medicare at the age of 65 and no longer being eligible to contribute to an HSA as a result of such enrollment.[78] The tax returns that indicate HSA contributions where the primary taxpayer is aged 65 and over may be the result of

[76] Tax dependency and private health insurance coverage dependency are made by separate determinations. For example, an individual may be considered a dependent on a parent's private health insurance policy while not being considered a tax dependent to such parent. Tax dependency is defined in statute at 26 U.S.C. §152 and private health insurance coverage dependency requirements can be found at 42 U.S.C. §300gg-14.

[77] Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, *Health Insurance Coverage in the United States: 2018*, U.S. Census Bureau, November 2019, p. 6, https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[78] For more information on the relationship between HSAs and Medicare, see CRS In Focus IF11425, *Health Savings Accounts (HSAs) and Medicare*.

the taxpayer delaying Medicare enrollment and retaining HSA eligibility and/or the primary tax payer having a spouse who is younger than the primary taxpayer and retains HSA eligibility.

When looking at contribution statistics by adjusted gross income (AGI) instead of age, the estimated percentage of returns that indicated employer contributions increased as AGI increased up to the $200,000 to $499,999 AGI bracket, before decreasing as AGI increased above such bracket (see **Figure 3**).[79] Of those tax returns with AGI between $200,000 and $499,999, roughly 1 in 6 tax returns (17.0%) indicated an employer contribution (and/or employee cafeteria plan contribution) to an HSA in 2017. The percentages of returns in each AGI bracket making employer contributions ranged from 0.2% to 17.0%, which is a wider variance than when looking at the data by age.

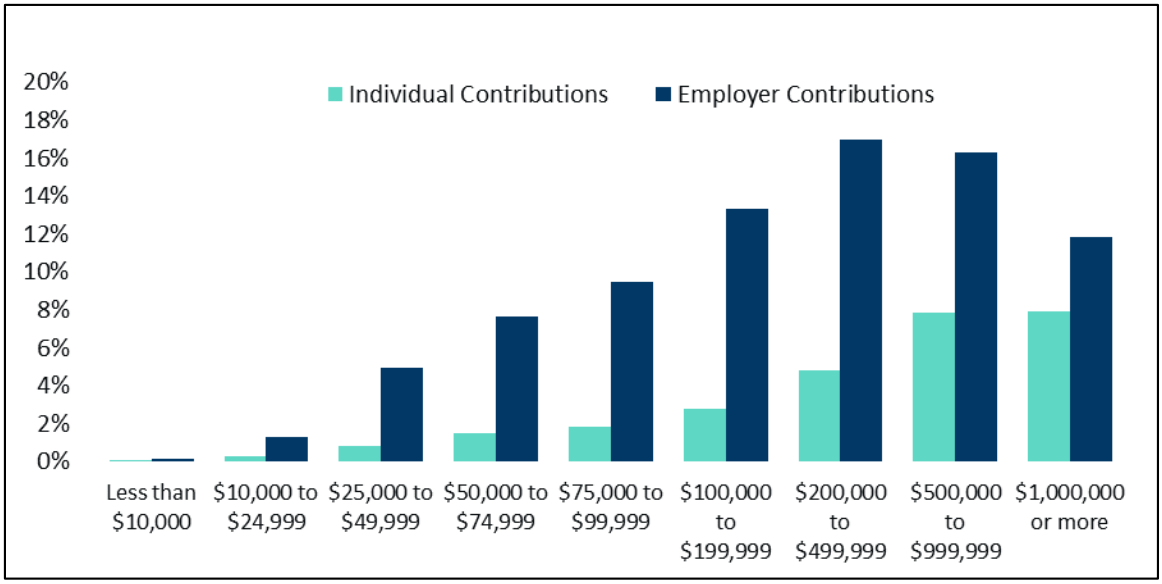
With respect to individual contributions, the estimated percentage of returns within an AGI bracket that indicated individual contributions to HSAs increased as AGI increased. These percentages ranged from 0.1% in the lowest AGI bracket and increased to 7.9% in the highest AGI bracket. Similar to when looking at tax returns by age, the percentage of returns within an AGI bracket that made individual contributions was lower than the percentage of returns making employer contributions across all AGI brackets.

The increased prevalence of HSA contributions among tax returns with higher AGIs is similar to the findings of previous research that looked at IRS data to evaluate the relationships between HSA utilization and income.[80]

[79] For more information on Adjusted Gross Income, see "Adjusted Gross Income (AGI)" in CRS Report RL30110, *Federal Individual Income Tax Terms: An Explanation*. CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

[80] One report by the U.S. Government Accountability Office looked at IRS data from 2005 and one study looked at IRS data from 2012. U.S. Government Accountability Office, *HEALTH SAVINGS ACCOUNTS: Participation Increased and Was More Common among Individuals with Higher Incomes*, GAO-08-474R, April 2008, https://www.gao.gov/products/GAO-08-474R and Lorens A. Helmchen, David W. Brown, and Ithai Z. Lurie, et al., "Health Savings Accounts: Growth Concentrated Among High-Income Households and Large Employers," Health Affairs Journal, vol. 34, no.9 (September 2015), p. 1594, at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0480.

Figure 3. Percentage of Tax Returns Reporting HSA Contributions in TY2017, by Adjusted Gross Income



Source: CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

Notes: TY = tax year. HSA = health savings account. Y-Axis Maximum = 20%. Tax return categories are not mutually exclusive (e.g., a tax return can have both individual and employer contributions). Tax returns can represent more than one individual and therefore contributions to more than one HSA (e.g., spouses contributing to each of their own HSAs). *Employer contributions* include employer contributions and employee contributions made through a cafeteria plan. Data do not account for tax returns of individuals who were HSA eligible but did not contribute to, or receive contributions for, an HSA.

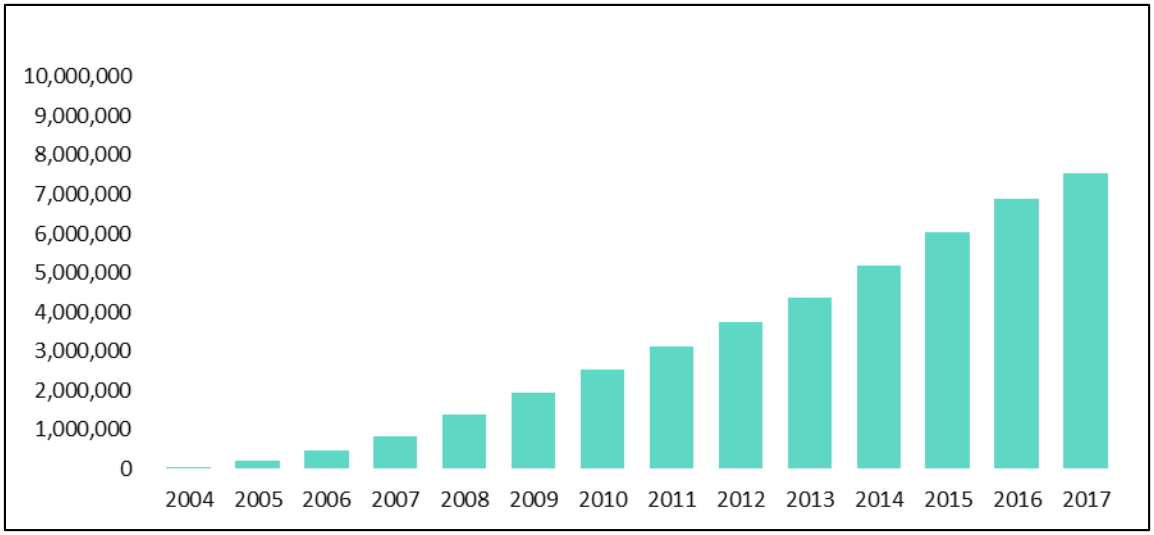
HSA Withdrawal Data

The IRS estimated increases in the number of tax returns indicating non-rollover HSA withdrawals from 2004 to 2017 (see **Figure 4**).[81] For tax year 2017, the IRS estimated that approximately 7.5 million tax returns reported a non-rollover HSA withdrawal (4.9% of filed tax returns).[82] Of the population indicating HSA withdrawals in 2017, few tax returns (approximately 4%) indicated taxable withdrawals (i.e., withdrawals for non-qualified medical expenses).

[81] Caution should be exercised in comparing contribution and withdrawal statistics since HSA withdrawals may be tied to contributions from a previous tax year. As such, the population of tax returns that indicated an HSA withdrawal is not the same as the population of tax returns that indicated an HSA contribution. Internal Revenue Service, *SOI Tax Stats – Individual Income Tax Returns, Line Item Estimates*, at https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-line-item-estimates.

[82] CRS analysis of Internal Revenue Service, *Statistics of Income—2017 Individual Income Tax Returns Line Item Estimates*, pp. 2, 196, https://www.irs.gov/pub/irs-pdf/p4801.pdf.

Figure 4. Tax Returns Reporting Non-rollover HSA Withdrawals, TY2004-TY2017



Source: CRS analysis of Internal Revenue Service, *SOI Tax Stats – Individual Income Tax Returns, Line Item Estimates*, at https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-line-item-estimates.

Notes: TY = tax year. HSA = health savings account. HSA withdrawal data include tax returns that made withdrawals for non-qualified medical expenses. Tax returns can represent more than one individual, and therefore tax returns can represent more than one HSA (e.g., spouses withdrawing from each of their own HSAs). Data do not account for tax returns of individuals who had an HSA but did not make a distribution from an HSA. Data do not correspond to HSA eligibility.

In 2017, the percentage of tax returns in the 26-34 age bracket that indicated a non-rollover HSA withdrawal was lowest amongst all age brackets from 26 to 64 (4.9%).[83] The percentage of tax returns in the age brackets between 35 and 64 were roughly similar (7.4%-7.6%), with slight increases as the age of the primary taxpayer increased (see **Figure 5**).

There are a couple of factors that could contribute to the lower withdrawal rate among those aged 26-34. Considering the age of the 26-34 population, these individuals are likely to have had less time to establish an HSA relative to those in other age brackets, especially when considering the impact of dependency status on HSA eligibility. Of those in this age bracket that did establish an HSA, the HSAs associated with these individuals may be more likely to be newer than the HSAs associated with individuals in older age brackets. HSA research has indicated that newer accounts generally have lower rates of HSA withdrawals.[84] This research has speculated that this may be because account holders have not had enough time to build up HSA balances and because HSAs are unable to cover health care expenses incurred prior to the opening date of the account.

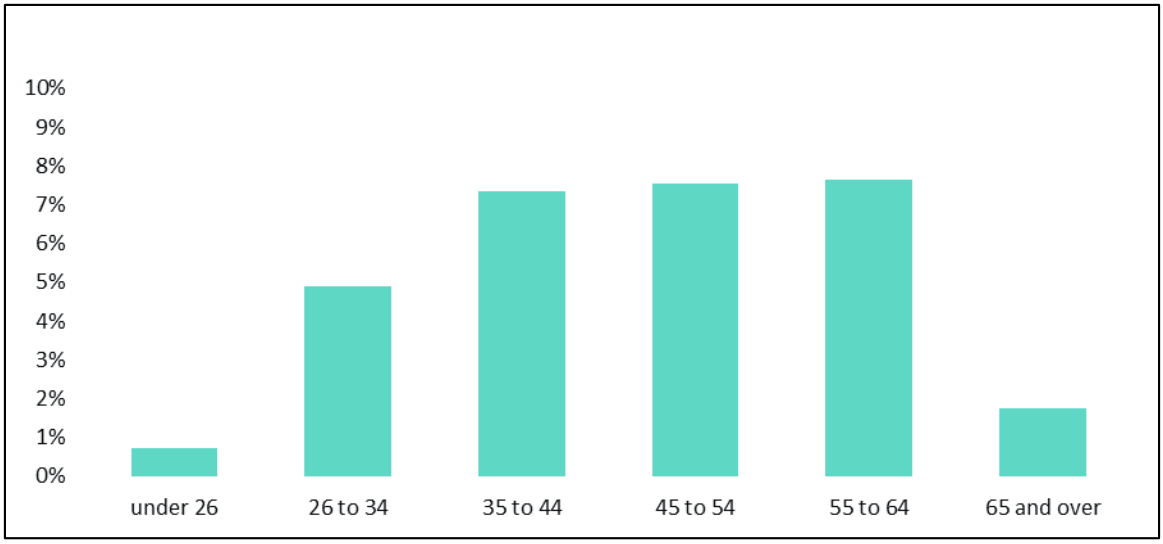
In addition, younger individuals are less likely to have health care expenditures in a given year and, when they do, such amounts tend to be lower (relative to older groups).[85] Because of this, individuals in the 26-34 age bracket may have been less likely to need to make withdrawals from their HSA (or may have paid for such expenditures from non-HSA sources).

[83] CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

[84] Paul Fronstin and Jake Spiegel, *Trends in Health Savings Account Balances, Contributions, Distributions, and Investments, 2011–2018: Estimates from the EBRI HSA Database*, Employee Benefit Research Institute, January 9, 2020, p. 13.

[85] Agency for Healthcare Research and Quality, *MEPS Summary Tables: Use, Expenditures, and Population*, https://www.meps.ahrq.gov/mepstrends/hc_use/.

Figure 5. Percentage of Tax Returns Reporting Non-rollover HSA Withdrawals in TY2017, by Age



Source: CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

Notes: TY = tax year. HSA = health savings account. Y-Axis Maximum = 10%. HSA withdrawal data include tax returns that made withdrawals for non-qualified medical expenses. Tax returns can represent more than one individual, and therefore tax returns can represent more than one HSA (e.g., spouses withdrawing from each of their own HSAs). Age for joint returns was based on the primary taxpayer's age. Data do not account for tax returns of individuals who had an HSA but did not make a distribution from an HSA. Data do not correspond to HSA eligibility.

When looking at the rates of non-rollover HSA withdrawals by AGI, the percentage of tax returns in each AGI bracket that indicated a non-rollover HSA withdrawal increased as AGI increased up to the $500,000 to $999,999 AGI bracket and decreased from the $500,000 to $999,999 AGI bracket to the $1 million or more AGI bracket (see **Figure 6**).[86] Of those tax returns with AGI between $500,000 and $999,999, approximately 1 in 5.5 tax returns (18.0%) indicated a non-rollover HSA withdrawal in 2017. The percentages of returns in each AGI bracket making non-rollover withdrawals ranged 0.3% to 18.0%, which is a wider variance than when looking at withdrawal data by age.

[86] CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

Figure 6. Percentage of Tax Returns Reporting Non-rollover HSA Withdrawals in TY2017, by Adjusted Gross Income

Source: CRS analysis of data provided by Internal Revenue Service (IRS), Statistics of Income (SOI) Division (provided December 2019) and IRS Publication 1304.

Notes: TY = tax year. HSA = health savings account. Y-Axis Maximum = 20%. HSA withdrawal data include tax returns that made withdrawals for non-qualified medical expenses. Tax returns can represent more than one individual, and therefore tax returns can represent more than one HSA (e.g., spouses withdrawing from each of their own HSAs). Data do not account for tax returns of individuals who had an HSA but did not make a distribution from an HSA. Data do not correspond to HSA eligibility.

Author Information

Ryan J. Rosso
Analyst in Health Care Financing

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