Expanding Access to HSAs

A Path to More Healthcare Choices for ACA Enrollees

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EXPANDING ACCESS TO HEALTH SAVINGS ACCOUNTS FOR AMERICANS IN THE INDIVIDUAL MARKET

Health Savings Accounts (HSAs) have become an increasingly popular tool for Americans to manage their healthcare costs and save for future medical expenses. Since their introduction in 2004, HSAs have grown to cover more than 71 million individuals through over 35 million accounts.[1] These tax-advantaged accounts allow families to save for healthcare expenses while providing incentives for cost-conscious healthcare decisions.

Despite their widespread adoption in employer-sponsored insurance (ESI), HSAs remain largely unavailable to Americans who purchase coverage through the Affordable Care Act (ACA) marketplaces. Few ACA plans meet the requirements to be HSA-eligible. The result is that millions of Americans with high-deductible health plans (HDHPs) are unable to access the benefits of HSAs, simply because they purchase insurance through the individual market rather than through an employer.

ACA recipients deserve more choice, and like those with ESI coverage, they merit the opportunity to save for their healthcare futures. In this brief, we explore several methods to expand access to HSAs for those with individual coverage.

THE ACA'S BROKEN PROMISES

The ACA has been the law of the land for well over a decade but has failed to deliver on promises of low premiums and quality coverage. Democrats advocate for expanding subsidies, while some Republicans support extensions, fearing political costs.[2] However, ACA plans remain unattractive without subsidies due to high premiums, significant cost-sharing, and limited provider networks, thus shifting the financial burden to taxpayers.

Even with the expanded subsidies initially passed as a part of pandemic-era relief legislation, enrollment in the ACA remains far below what its creators promised. In 2010, the Congressional Budget Office (CBO) predicted 24 million Americans would purchase insurance on the exchanges by 2019.[3] Actual enrollment in that year was only 9 million.[4] And even after the

Biden administration temporarily expanded eligibility and subsidies, only 21 million enrolled in the exchanges in 2024.[5]

Cost-sharing requirements for enrollees are considerable. The average silver plan deductible was $4,900 in 2023 for those ineligible for cost-sharing reduction (CSR) subsidies.[6] In comparison, a private sector worker with ESI coverage faced an average deductible of $1,900.[7] Despite much higher deductibles, total premiums for ACA silver plans are not significantly lower than the average ESI premium.[8] Meanwhile, provider networks are becoming narrower: A recent Paragon Health Institute study found that only 11 percent of ACA exchange plans had "broad provider networks" in 2023, down from 36 percent in 2014.[9]

It is no wonder, then, that enrollment in the ACA is driven mostly by those eligible for premium and CSR subsidies. In 2023, over 75 percent of enrollees in the federal marketplace exchanges had incomes below 250 percent of the federal poverty line (FPL) (i.e., the qualifying threshold for CSR subsidies). In total, over 93 percent of those purchasing plans on the federal exchanges were eligible for premium or cost-sharing subsidies.[10]

The American Rescue Plan Act of 2021 temporarily reduced required premium contribution rates and made those with incomes above 400 percent of the FPL eligible for premium subsidies. The enhanced subsidies were then extended through 2025 in the Inflation Reduction Act. Former president Biden proposed making the changes permanent at a cost of $335 billion through 2034.[11] But expanding subsidies will do little to improve quality and choice within the ACA. In fact, adding enrollees to plans with narrow provider networks and few plan choices may very well reduce the quality of services.

Instead of expansion, policymakers should look to improve ACA plan offerings for current enrollees. That can be done in several ways.[12] One clear solution is to provide ACA recipients the same access to health savings accounts as those with employer-sponsored insurance.

EXPANDING CHOICE FOR ACA RECIPIENTS BY EXPANDING ELIGIBILITY FOR HEALTH SAVINGS ACCOUNTS

Health savings accounts allow families to save for future health expenses in tax-preferred accounts. Up to certain limits, contributions and earnings within the account are tax-free so long as the money is eventually spent on qualified healthcare purchases. To contribute to an HSA, you must enroll in a qualified HDHP. Compared to low-deductible, high-premium plans, enrollees have an incentive to be more conscious of their healthcare purchases and reduce the use of low-value care. HSAs have proven popular with many Americans, offering an additional opportunity to save for the future and providing financial insurance from future health shocks.

Nearly all of the 35 million HSA accounts exist through ESI plans, and most ACA recipients are ineligible for HSAs, even if they choose high-deductible plans. That is because most plans offered on the ACA exchanges have cost-sharing rules that don't meet the requirements for HDHPs. Ironically, the ACA plans' maximum out-of-pocket (MOOP) cost sharing amounts are *too high* to qualify as a qualified HDHP.[13]

It wasn't always this way. When the ACA began offering coverage in 2014, the limit on MOOPs was set at the same level as required for HDHP compliance.[14] The growth rates of the MOOP limits, however, were linked to different prices. Beginning in 2015, ACA plan MOOPs have grown through premium increases in private health insurance.[15] Meanwhile, HDHP MOOPs increased by slower-growing consumer prices. As figure 1 shows, the result has been a widening gap between allowable MOOPs in the ACA and HDHP-compliant plans.

FIGURE 1 Maximum out-of-pocket limits: HDHP and ACA plans

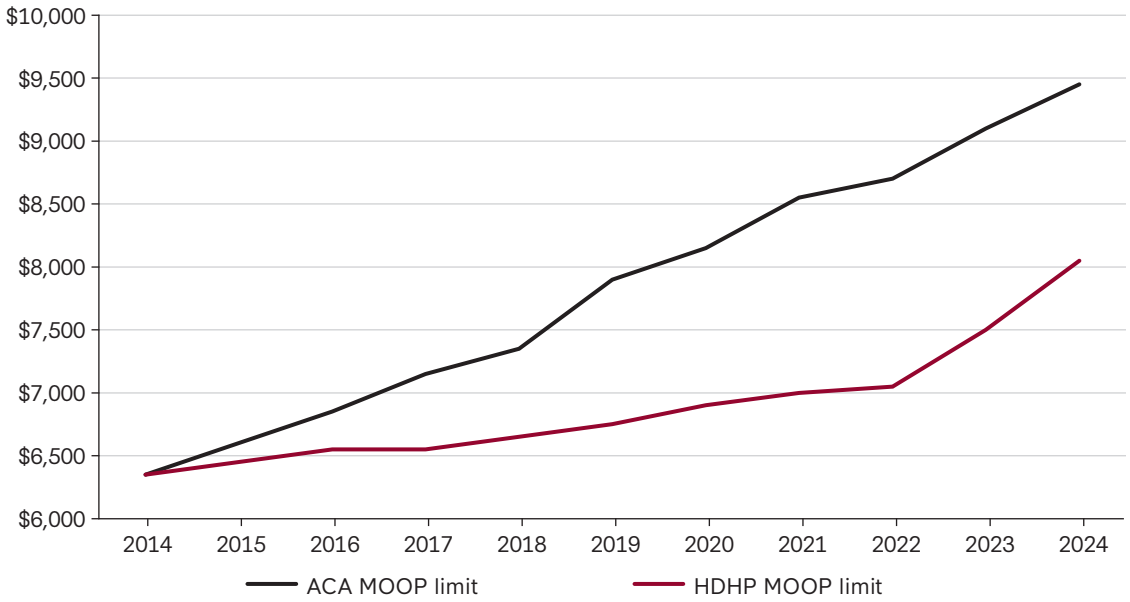
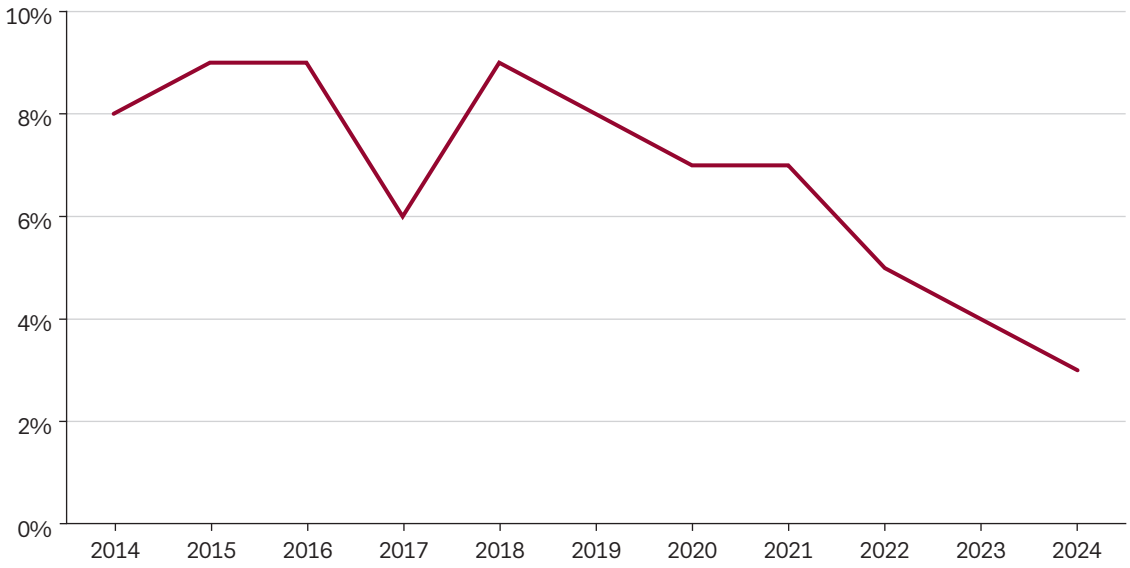


FIGURE 2 Share of ACA enrollees in HSA-eligible plans



Notes: Data are from CMS 2024 Marketplace Open Enrollment Period PUF. The data exclude enrollees in state-based exchanges.

In 2024, HSA-eligible HDHPs were required to offer MOOPs less than or equal to $8,050.[16] ACA plans were permitted to have MOOPs up to $9,450.[17] That is one reason why most ACA bronze plans—84 percent in 2023—are not HSA eligible.[18] As shown in figure 2, only 3 percent of ACA enrollees are enrolled in an HSA-eligible plan in 2024—down from 8 percent in 2014.

There are few, if any, reasons why individuals with ESI coverage should have the opportunity to save for future health expenses, while ACA enrollees

with similar or higher cost-sharing requirements are precluded. Policymakers can improve access to HSAs for ACA enrollees in multiple ways.

GRANT AN EXCEPTION FOR HDHP ACA PLANS THAT WOULD OTHERWISE BE ELIGIBLE FOR AN HSA

Policymakers could grant an exception for ACA marketplace plans that would otherwise be eligible for HSAs if their MOOP limits were not above the level that would make them a qualifying HDHP.

This option would leave the MOOP cap in place for existing HDHPs but expand HSA eligibility to more high-deductible ACA health plans. Other HDHP requirements, such as minimum deductibles, could remain in place. ACA participants would then have the same opportunity to contribute to HSA plans as those with ESI. They could make tax-free contributions to their HSA up to the standard HSA maximum levels.

We estimate that 68 percent of ACA enrollees in 2023 (11 million) had plans with deductibles that met HDHP requirements (before accounting for cost-sharing reduction payments), but had MOOPs exceeding the HDHP limits.[19] Waiving the MOOP requirement wouldn't make all of these plans HSA-eligible, as some have reduced cost sharing for certain non-preventive care, even when the advertised deductibles align with HDHP requirements. It would, however, remove one obstacle to expanding choice for ACA recipients. If the reform raised the share of ACA enrollment in HSA-eligible plans to the 2014 rate—when MOOPs were the same as in traditional HSA plans (8 percent)—an additional 945,000 Americans would choose plans that provide access to HSAs.[20]

The reform would not be costless to the federal government, as HSA contributions would be tax-deductible for ACA recipients with sufficient income. The cost would be a tiny fraction of the $335 billion price tag for extending the pandemic-era ACA expansions. If enrollees' HSA contributions matched the average individual contribution of $1,962 in the employer-sponsored market, income tax revenue would fall by $207 million in 2026 and $1.7 billion over the ten-year budget window.[21] Notably, these estimates are likely to overstate the budget effects, as it is unlikely the typical ACA recipient's contribution would match the current average for all HSA contributors.[22]

LIFT OR WAIVE THE CAP ON MAXIMUM OUT-OF-POCKET COST SHARING AMOUNTS FOR HSA-ELIGIBLE PLANS

A secondary option for policymakers would be to increase the cap on allowable MOOP cost sharing for HDHP-compliant plans. This would affect all HDHPs, not just those in the ACA exchanges.

A natural concern with this option is that, absent a cap, HDHP-compliant plans would increase MOOPs in ways that would not be in consumers' best interests. But there is little evidence that the cap is binding for most plans. In 2023, more than 80 percent of ESI HDHP-compliant plans with a savings option had MOOP amounts less than $6,000—at least $1,500 below that year's maximum threshold.[23] Raising the MOOP limit would likely have little effect on existing HDHP plans.

ALLOW STATES AND THE FEDERAL GOVERNMENT TO CONTRIBUTE TO AN ENROLLEE'S HSA

For subsidized recipients of ACA plans, the tax benefits from making pretax HSA contributions would be minimal. Few recipients earn enough to pay income taxes, particularly after accounting for premium tax credits. To ensure that low-income Americans benefit, states should be able to experiment with models in which federal and state contributions are deposited into a recipient's HSA or similar health savings vehicle.[24]

Pairing ACA subsidies with tax-advantaged health account contributions is not a new idea. The Paragon Health Institute has proposed the *HSA Option*.[25] Its proposal would redirect money currently going to CSR subsidies into individual HSAs. Under current law, those with incomes below 250 percent of the FPL may purchase silver plans with reduced cost-sharing reductions. The federal government gives these subsidies directly to insurance companies. Paragon's proposed option would instead direct the money to individuals, giving them more control over their healthcare choices and providing better incentives for them to be price-conscious about their healthcare consumption.

There is an opportunity to expand access to HSAs for ACA recipients even further. Under current ACA rules, individuals are eligible for a premium subsidy equal to their benchmark premium (set to the second-lowest cost silver plan premium) less a required contribution, which is determined by family income. If recipients choose a plan with lower premiums than the benchmark plan—such as most bronze plans—their required contribution falls. In some cases, plans are available with premiums below the individual's potential premium subsidy. In that case, enrollees pay zero premiums and the government's subsidy is reduced. This gives enrollees little incentive to select less expensive plans. Why bother selecting a cheaper plan when the costs of a more generous plan are the same to the enrollee?

For example, the average 2024 benchmark annual premium was $5,700, while the lowest-cost bronze plan was $4,400.[26] Absent the Inflation Reduction Act's expanded subsidies, the required premium contribution for individuals with incomes at 100 percent of the FPL was about $300 for a benchmark plan. That is, the maximum ACA subsidy was $5,400. If a family opted for the lowest-cost bronze plan, it would owe nothing, but would be foregoing $1,000 in potential subsidies.

Rather than have the government pocket this difference, the government could instead deposit the remainder into an enrollee's HSA. Recipients of subsidized coverage could select catastrophic (sometimes referred to as copper plans) or bronze plans, with any remaining subsidy deposited into their HSA.[27] Unlike those with ESI and unsubsidized plans, there could be limits on when they could withdraw their HSA funds for unqualified medical spending. Early withdrawal could be outright prohibited, or there could be a large penalty attached to discourage individuals from immediately withdrawing their available funds.

We estimate that, under the original premium credit formula (i.e., without the current expanded subsidies set to expire in 2025), enrollees with income up to 175 percent of the FPL would be eligible for an HSA contribution. As the example above shows, the size of the contribution would be as much as $1,050 annually for the typical enrollee who opts for the lowest-cost bronze plan. In some states, the difference between the benchmark silver premium and lowest-cost bronze premium is even greater. In New York, for example, the HSA contribution could be as much as $1,790 and individuals with incomes up to 210 percent of the FPL would qualify.

The costs to this reform would be minimal, since the maximum ACA subsidy wouldn't change. Meaningful budget costs would come from two sources. First, there could be additional outlays if the reform increased participation in the ACA. Second, there would be additional costs from enrollees who would otherwise leave money on the table when they select low-cost bronze plans.

The potential budget costs would be partially offset by individuals forgoing silver plans that include CSR subsidies. The costs could be further offset by reducing the HSA contribution by some fixed percentage. For example, the government's HSA contributions could be equal to 75 percent of the difference between the benchmark premium

and the selected plan premium. This method could potentially lead to cost reductions if individuals that would otherwise enroll in silver plans opt for lower-cost bronze plans with an HSA contribution.

CONCLUSION

Individuals and families deserve choices when they purchase health insurance. That is true whether they receive coverage through an employer or on the individual exchanges. But that is not the case today for those with ACA coverage. They face dwindling options in the number of insurers and the plans that are offered.

Fortunately, even without replacing the ACA, there are opportunities to provide consumer-friendly options that can benefit enrollees while improving their incentives to think more carefully about their healthcare consumption. Policymakers do not need to look far: HSAs have served many ESI enrollees well and offer the same prospect for those on the individual market.

NOTES

1. Devenir Research, *2022 Devenir & HSA Council Demographic Survey*, July 13, 2023, https://www.devenir.com/wp-content/uploads/2022-Devenir-and-HSA-Council-Demographic-Report.pdf.

2. Nathanial Weixel, "Murkowski Says She Supports Extending ObamaCare Premium Subsidies," *The Hill*, January 3, 2025, https://thehill.com/policy/healthcare/5066188-murkowski-obamacare-premium-subsidies/.

3. Congressional Budget Office, *H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)*, March 20, 2010, https://www.cbo.gov/publication/21351.

4. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's May 2019 Projections*, May 2, 2019, https://www.cbo.gov/system/files/2019-05/51298-2019-05-healthinsurance.pdf.

5. Congressional Budget Office, *Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections*, June 2024, https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.

Even these enrollment figures likely overstate current demand for exchange plans as "hundreds of thousands" of ACA recipients may have unknowingly been enrolled in a plan. See Joseph Walker, "Americans Clicked Ads to Get Free Cash. Their Health Insurance Changed Instead," *Wall Street Journal*, September 13, 2024, https://www.wsj.com/health/healthcare/social-media-ads-health-insurance-scams-37d1ecfa.

6. "Deductibles in the ACA Marketplace Plans, 2014–2024," Kaiser Family Foundation, December 22, 2023, https://www.kff.org/affordable-care-act/issue-brief/deductibles-in-aca-marketplace-plans/.

7. Data are from the MEPS-IC data dashboard: https://datatools.ahrq.gov/meps-ic/?tab=private-sector-national&dash=22.

8. In 2023, the average ACA silver plan in the federal marketplace was $7,600, while the average employer plan was $8,200. ESI premium data are from the MEPS-IC data dashboard. ACA premium data are limited to plans in the federal exchange. ACA premiums are from the 2023 OEP State, Metal Level, and Enrollment Status Public Use File, which can be found at "2023 Marketplace Open Enrollment Period Public Use Files," Centers for Medicare & Medicaid Services (CMS), https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2023-marketplace-open-enrollment-period-public-use-files.

9. Daniel Cruz and Greg Fann, "It's Not Just the Prices: ACA Plans Have Declined in Quality over the Past Decade" (paper, Paragon Health Institute, September 2024), https://paragoninstitute.org/wp-content/uploads/2024/09/Its-Not-Just-the-Prices_Dan-Cruz_Greg_Fann_FOR-RELEASE_V1.pdf.

10. Data from CMS's "2023 Marketplace Open Enrollment Period Public Use Files."

11. Congressional Budget Office, *Budgetary Outcomes Under Alternative Assumptions About Spending and Revenues*, May 2024, https://www.cbo.gov/system/files/2024-05/60114-Budgetary-Outcomes.pdf.

12. We highlight several ways to improve ACA plans in Lanhee Chen, Tom Church, and Daniel Heil, *Choices for All, Healthcare Reforms for the Future*, July 2023, https://www.hoover.org/sites/default/files/2023-07/Choices%20for%20All.pdf.

13. 26 U.S.C. § 223(c)(2)(A)(ii).

14. Section 1302(c)(1)(A) of the Patient Protection and Affordable Care Act.

15. Section 1302(c)(1)(B) of the Patient Protection and Affordable Care Act.

16. "26 CFR 601.602: Tax forms and instructions," Internal Revenue Service, https://www.irs.gov/pub/irs-drop/rp-23-23.pdf.

17. Notably, the 2025 ACA maximum out-of-pocket amount was *decreased* from $9,450 to $9,200. Centers for Medicare & Medicaid Services, *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2025 Benefit Year*, November 15, 2023, https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf.

18. Authors' calculations using CMS Health Insurance Exchange Public Use Files (Exchange PUFs). This is the average share of bronze plans that are ineligible for HSAs by county.

19. Calculations use CMS ACA Public Use Files for enrollment and plan information. The calculations do not account for the effects of CSR on deductibles and MOOP limits.

20. In 2014, 8 percent of ACA enrollees chose an HSA-eligible plan, five percentage points more than in 2024. CBO expects 18.9 million Americans will enroll in an ACA plan in 2026: CBO, *Health Insurance and Its Federal Subsidies*.

21. Consistent with the relatively low incomes of ACA recipients, we assume a 10 percent marginal tax rate. In 2023, the average individual contribution to HSAs was $1,962. We grow this at the CBO's projected growth of the CPI-U. Contribution data is from Jake Spiegel and Paul Fronstin, "Trends in Health Savings Account Balances, Contributions, Distributions, and Investments, 2011–2022," EBRI, March 21, 2024, https://www.ebri.org/content/trends-in-health-savings-account-balances--contributions--distributions--and-investments--2011-2022.

22. The reform could also affect the federal budget if the reform increases take-up in ACA plans. We do not model these effects.

23. See figure 7.46 in Kaiser Family Foundation, *Employer Health Benefits, 2023 Annual Survey*, https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf.

24. Chen, Church, and Heil, *Choices for All*.

25. Brian Blase, Dean Clancy, Andrew Lautz, and Roy Ramthun, "The HSA Option" (paper, Paragon Health Institute, November 2022), https://paragoninstitute.org/wp-content/uploads/2023/12/The-HSA-Option.pdf/.

26. "Average Marketplace Premiums by Metal Tier, 2018–2025," Kaiser Family Foundation, October 2024, https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/.

27. Currently, catastrophic plans are generally limited to individuals under thirty years old, and the plans are ineligible for subsidies. Lawmakers would need to waive these limits to allow individuals to select these plans.

31 30 29 28 27 26 25 7 6 5 4 3 2 1

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