CHOICES FOR ALL PROJECT

Create Individual Health Accounts (IHAs)

Healthcare Reforms for the Future

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Patients—not employers, insurers, or the government—should be in control of their healthcare choices. Our current system fails to do that largely because of the tax preference for employer-sponsored insurance (ESI) premiums, which weakens incentives to think about the cost of healthcare purchases. Two decades ago, policymakers tried to fix these incentives with health savings accounts (HSAs), which allow people to save for future healthcare spending, secure a tax advantage, and reduce the incentive to buy high-premium plans. They suffer, however, from several shortcomings that make them unattractive—or unavailable—to many Americans.

To fix these shortcomings, we propose the creation of individual health accounts (IHAs). IHAs would be alternative tax-advantaged savings accounts that promote saving for healthcare expenses by allowing larger contributions when paired with low-premium plans. They would operate akin to a mix of traditional individual retirement accounts (IRAs) and HSAs. The new IHAs would empower and encourage individuals and families to save specifically for both routine and unexpected healthcare costs. They would promote price discovery and give families more control over their healthcare decisions.

KEY PLAN ELEMENTS

- Create new tax-advantaged accounts for future healthcare needs.
- Accounts would be available to all individuals with at least catastrophic coverage, from either a private or public plan.

- Annual contribution limits would be set much higher than current HSA limits, but allowable contributions would be reduced by the enrollee's premiums.

- Contributions would count as "above-the-line" deductions.

- Withdrawals would count as taxable income unless spending is on qualified medical expenses, but there would be no additional tax penalty for unqualified withdrawals.

THE PROBLEM: THE ESI TAX PREFERENCE AND THE INFLEXIBLE HSA

The US tax code gives a special tax break to employer-sponsored insurance (ESI) premiums. Unlike most other fringe benefits, premiums paid by an employer are not subject to federal income or payroll taxes.[1] The result is that workers have an incentive to buy insurance through their employer. And not just any type of insurance. Because premiums are tax-free while most out-of-pocket spending is not, workers have a tax incentive to purchase plans with high premiums and little cost sharing. While workers may be asked to shoulder higher premium payments by their employers for more generous coverage, they nonetheless receive more of a tax benefit for the purchase of plans with higher premiums. This ends up raising healthcare costs for all Americans.

Oddly, then, the ESI tax preference has undermined choice in our healthcare system. The outsize tax benefits have created a one-size-fits-all system where an employee's best—and sometimes only—options are high-premium plans.

There have been attempts to fix these perverse incentives. The Reagan and Obama administrations each tried to limit the tax value of expensive ESI premiums. But the tax preference is politically popular. President Reagan's proposal died in Congress, while President Obama's "Cadillac" tax on expensive ESI plans was repeatedly delayed and then repealed.

Since the ESI tax preference is politically favored, policymakers have sought other reforms to improve incentives when buying health insurance that do not directly threaten the existing tax treatment of ESI premiums. The most popular—and arguably successful reform—has been the advent of health savings accounts (HSAs).

HSAs allow consumers to use pretax dollars for out-of-pocket spending. Employers and employees may generally contribute to the accounts tax free, which can amount to thousands of dollars in reduced federal income and payroll taxes. Once accounts exceed specified balances, account holders may invest contributions in low-cost index funds or similar investments. Investment returns grow tax free. Individuals do not pay any taxes

on HSA withdrawals if they go to qualified medical spending for account holders, their spouses, or their dependents.

Despite the tax benefits, however, HSAs come with stringent rules that make them unattractive or simply unavailable options for millions of Americans. First, eligibility is limited to those who choose high-deductible health plans (HDHPs). These plans offer lower premiums but come with higher coinsurance and out-of-pocket payment requirements. Under current IRS rules, HDHP-compliant insurance plans must have a minimum annual deductible that covers most nonpreventive care.[2] In 2023, the minimum deductible was $1,500 for individual and $3,000 for family coverage.[3] High deductibles make these plans less desirable for anyone with a chronic health condition. If individuals switch from a high-deductible plan to a traditional health plan, they must stop contributing to their HSA, although they are permitted to continue to withdraw money from their account.

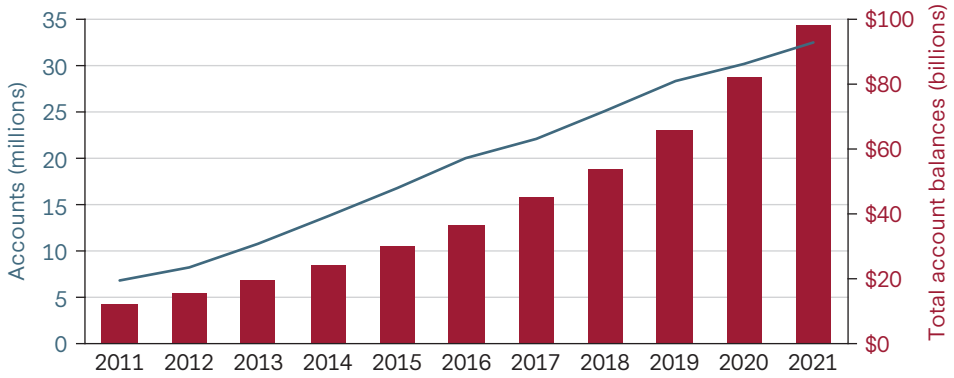
The underlying aim of pairing HSAs with HDHP-compliant insurance policies is worthwhile. The tax code's preference for high-premium plans distorts incentives, driving up healthcare consumption and ultimately health costs for all. The HSA architects believed that they could reduce these bad incentives by offering people access to HSAs while requiring them to choose HDHPs. The HDHP requirement, however, discourages many individuals from using HSAs in the first place. The approach doesn't work for those with chronic conditions or even those who are simply risk averse and prefer traditional coverage. It has particularly limited the take-up of HSAs among lower-income workers.

Second, there are strict caps on how much employers and employees may contribute to HSAs. In 2023, those with individual plans may only contribute $3,850 ($7,750 for family plans). These limits are indexed to inflation. The limits rise by $1,000 for individuals 55 and older, but that amount isn't indexed to inflation. The strict contribution limits mean some people with chronic conditions are often better off choosing high-premium plans with lower deductibles.

Third, most account holders pay income taxes on withdrawals for nonqualified spending plus a 20 percent penalty (those age sixty-five and older and/or with a disability are generally exempt from the penalty). The penalty ensures that individuals do not use HSAs as merely a tax avoidance strategy. It also encourages individuals to continue to save for future healthcare spending rather than drawing down their balances on nonhealth spending. Nevertheless, the penalty discourages some from choosing an HSA in the first place. The penalty also creates incentives for unnecessary health spending: a dollar spent on qualified medical spending is worth 70 cents or less if spent on other goods.

Finally, HSAs are largely unavailable to those not enrolled in an ESI plan. Most plans on the Affordable Care Act (ACA) exchanges are not HDHP compliant.[4] Likewise, Medicaid recipients can't use them. In short, saving for future healthcare expenses through an HSA generally requires ESI coverage.

FIGURE 1 HSA enrollment and aggregate account balances



Note: Data are as of December each year.

Source: Devenir Research, *2022 Midyear HSA Market Statistics & Trends* (September 20, 2022), https://www.devenir.com/wp-content/uploads/2022-Midyear-Devenir-HSA-Research-Report-Executive-Summary.pdf

Despite their limitations, HSAs have experienced rapid growth since their adoption in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. As figure 1 shows, there were over 30 million HSAs in 2021.[5]

HSAs have experienced success. Evidence suggests that those with HSAs and similar accounts are more price conscious than those with traditional health plans.[6] Account balances in HSAs have growth dramatically over the last two decades, meaning more Americans have savings available in the event of an adverse health shock. As shown in figure 1, aggregate account balances were nearly $100 billion, or $3,000 per account.

While HSAs have grown in popularity, they remain a poor fit for many Americans. While the number of HSAs has risen, survey estimates suggest that the number of individuals who are choosing HSA-eligible health plans has plateaued in recent years.[7] There are many potential explanations for this, but two likely culprits are the high penalties for unqualified withdrawals and the strict rules about the type of health plans (i.e., HDHPs) that may be paired with the tax-preferred accounts. The result is that while millions of Americans are benefiting from an additional healthcare choice, even more are still stuck with one-size-fits-all, high-premium ESI plans.

There have been several proposals to increase participation in HSAs. The most promising reforms would relax IRS rules governing required deductibles under HDHPs. The Chronic Disease Management Act of 2021, for example, would have exempted certain treatments for chronic conditions from the required deductibles.[8] Other promising proposals would expand eligibility for HSAs or raise the contribution caps.[9]

HSAs aren't the only tax-favored vehicle Americans can use to save for health spending. Flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs)

also offer opportunities to use pretax dollars for out-of-pocket spending. But they come with even more limitations and complicated rules than HSAs.

FSAs are offered through one's employer. Employees must select how much they will contribute over the next year, and they are generally prohibited from adjusting their annual contribution during the year. Those contributions are pretax, potentially saving workers hundreds of dollars that would otherwise go to income and payroll taxes.

FSAs, however, have a "use-it-or-lose-it" rule that forces workers to spend down their account balances each year or risk losing the remaining contributions. The rule produces bad incentives that encourage overspending. At the close of each year, FSA holders rush to buy extra medical supplies, engage in elective health procedures, or pick up new prescription eyeglasses. And even then, many workers are unable to reduce their balances below the maximum rollover amount ($610 in 2023). Data from the Employee Benefit Research Institute (EBRI) show that in 2019 and 2020 approximately 40 percent of workers with FSAs lost money at the end of the year. On average, these workers forfeited over $300. For some workers, this amount exceeds the tax benefits of their annual contributions.[10]

HRAs aren't much better. These plans allow employers to contribute funds to accounts for their workers' out-of-pocket (OOP) spending. Unlike an FSA, the account balances do not face a legal "use-it-or-lose-it" requirement, and there are no limits on how much an employer may contribute.[11] On the downside, HRAs belong to the employer, not the employee. Only the employer may contribute funds, and if the employee leaves, the funds remain with the employer. That means that, like HSAs and FSAs, HRAs give workers an incentive to increase their healthcare consumption even on medical care that doesn't offer much value.

Whether HSAs, FSAs, or HRAs, the nation's existing health savings options don't work for millions of Americans, particularly those with chronic conditions. And even among those who enroll, there are stringent and cumbersome rules that distort healthcare decisions.

THE FUTURE: A NEW TAX-ADVANTAGED SAVINGS VEHICLE FOR MEDICAL EXPENDITURES

Tax-advantaged savings vehicles are broadly available for retirement and education, two predictable lifetime expenses. Families should have a dedicated account set aside for medical care. Healthcare expenses are expected throughout life, but unpredictable in their timing. And yet no universal tax-advantaged health accounts exist.

We propose a new type of savings account that would give consumers more control over their healthcare decisions while removing barriers that discourage people from saving for their future healthcare needs. We call these accounts individual health accounts (IHAs). Akin to a mix of HSAs and individual retirement accounts, IHAs would offer more flexibility

over current options and would be available to any who have at least catastrophic health insurance coverage from either a private or public source.

The tax treatment of IHAs would be similar to HSAs. Contributions would constitute an "above-the-line" tax deduction and any investment gains would grow tax free. Balances would be wholly owned by the individual account holder, in the same manner as HSAs are today. And like HSAs, employers would be permitted to contribute to the accounts.

There are some important differences from HSAs. IHA contributions would be subject to payroll taxes—mirroring the tax treatment of retirement savings accounts like IRAs. All else constant, this makes them less attractive than existing HSA contributions, which are exempt from payroll and income taxes. But IHAs would have several advantages over HSAs that would make the trade-off worthwhile for many Americans.

Nonqualified withdrawals would be treated as ordinary income, but unlike HSAs, there would be no additional penalty. The current 20 percent penalty with HSAs is larger than the total payroll tax rate (a combined 15.3 percent for employer and employee taxes). This means that while HSAs would offer more up-front tax benefits than IHAs, those tax benefits are only realized if the money goes to qualified healthcare purchases or if the account holder waits until age sixty-five to withdraw the funds. Over time, the difference in the posttax value of IHA balances for unqualified withdrawals would grow relative to HSAs.

Table 1 compares the posttax values of IHAs and HSAs for a single individual who contributes the HSA-allowed maximum each year. We assume the individual pays a 22 percent income tax rate every year. For those with no OOP spending, the posttax value of their IHA would be nearly $4,000 more over ten years than their HSA. An individual with low OOP spending (set at half the current minimum deductible level for an HDHP), would have a posttax value of $2,000 over ten years. A person with high OOP spending (set at the current minimum deductible) would essentially break even between an IHA and HSA.

As discussed above, the architects of HSAs had good reasons to require HSA participants to enroll in HDHP-compliant plans. These high-deductible plans give HSA participants more incentive to think about the cost of their healthcare choices. But the requirement makes HSAs less desirable for those with chronic conditions, ultimately reducing take-up rates and keeping people in traditional high-premium plans.

Rather than this one-size-fits-all approach, individuals with at least catastrophic health coverage would be permitted to use an IHA. In contrast with existing law governing HSAs, IHA owners would not need to purchase plans that carry a minimum deductible

TABLE 1 POSTTAX VALUE OF IHA AND HSA FOR UNQUALIFIED WITHDRAWALS

	No OOP spending		Low OOP spending		High OOP spending	
	HSA	*IHA*	*HSA*	*IHA*	*HSA*	*IHA*
Annual pretax contribution	$3,750	$3,750	$3,750	$3,750	$3,750	$3,750
Payroll taxes	$0	$574	$0	$574	$0	$574
Annual OOP spending	$0	$0	$750	$750	$1,500	$1,500
Annual pretax savings	$3,750	$3,176	$3,000	$2,426	$2,250	$1,676
10-year pretax balance	$47,167	$39,951	$37,734	$30,517	$28,300	$21,084
Income taxes on unqualified withdrawals	$10,377	$8,789	$8,301	$6,714	$6,226	$4,638
Penalty for unqualified withdrawals	$9,433	$0	$7,547	$0	$5,660	$0
10-year posttax balance	$27,357	$31,161	$21,886	$23,803	$16,414	$16,445

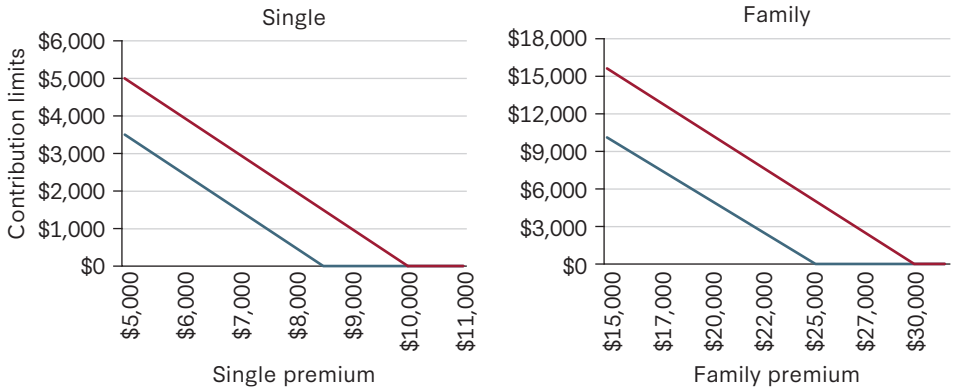
Notes: Calculations assume individual would face a 22 percent marginal income tax rate on all contributions and withdrawals. Contributions and OOP spending are assumed to grow at 5 percent annually with no investment income earned on savings.

amount. This means that those with chronic conditions could still save pretax dollars for their future healthcare needs. Likewise, those enrolled in ACA plans that are not HDHP compliant would be able to benefit.

While IHAs would not require a particular type of insurance coverage, the accounts would nevertheless maintain incentives for individuals to select lower-premium, higher-coinsurance plans. This would be accomplished by allowing people with lower premiums to contribute more to their IHAs than those with higher premiums. Specifically, an IHA's annual contribution limits would be set at a pre-premium threshold amount minus an individual or family's total premium contributions, inclusive of payments by both the employer and employee. As a result, individuals and families with lower-premium plans would be able to contribute more than individuals and families with higher-premium plans.

A natural target for contribution limits would equal the current median premiums paid for ESI plans. This includes both the employee and employer portions. In 2023, the estimated median premium will be approximately $8,500 for individual coverage and $25,000 for family plans. Figure 2 shows the maximum contributions people may make to their IHAs at various premium levels. We consider two contribution levels. The first is set at the median (50th percentile) of premiums paid for current ESI plans. The second is set at the 75th percentile.

FIGURE 2 Maximum annual IHA contribution under different contribution limits



Note: Contribution limit set at: 50th percentile or 75th percentile of ESI premiums

Setting the limit at the median would mean those who opt for plans with above-average premiums wouldn't be able to contribute to the plans at all. Because the allowable IHA contribution limit would be reduced by their premium contributions (either from an employer or individual), individuals would have more of an incentive to purchase low-premium, high-coinsurance plans. Unlike HSAs, though, individuals could choose plans that meet their individualized needs. These plans, for instance, could offer lower deductibles for certain services that are not considered preventive under IRS rules.

Holding all else constant, we estimate that setting the contribution limit at the 50th percentile would reduce ten-year income tax revenue by $82 billion with taxpayers setting aside $30 billion in their IHAs in the first year. Setting the contribution limit at the 75th percentile would reduce revenue by $176 billion and lead taxpayers to set aside $66 billion in the first year. For more information, see our cost estimate essay from this series.

Higher contribution limits could be selected if policymakers are willing to forego additional tax revenue. The higher limits would give more Americans the ability to save, but would reduce incentives to purchase low-premium plans. Over time, the limits could rise with inflation (as HSA contributions do now) or grow with the average health premium growth rate. Here too, indexing the IHA contribution maximum to a more aggressive growth rate will carry additional budgetary impacts.

Importantly, IHAs would not eliminate existing HSAs or otherwise alter existing tax preferences for healthcare. Instead, they would be an additional option.[12] Individuals contributing to an IHA wouldn't be permitted to contribute to an HSA or FSA or receive new employer contributions for HRAs in the same year.[13] Ideally, IHAs would be paired with the tax changes outlined in our essay on expanding out-of-pocket deductibility. And notably, local, state, or federal governments could also contribute to IHAs in lieu of other subsidies.

While they would be entirely voluntary, IHAs would likely become the dominant form of health savings for most Americans. Relative to current savings options, the accounts would offer a less cumbersome way to save for future health expenditures. Because the plans would not need to be directly linked to an existing type of health insurance plan, the number of financial institutions that could offer them would be far larger than the existing infrastructure for administering HSAs. And the flexibility granted to IHAs would give individuals more incentives to contribute than currently offered by HSAs. About thirty million Americans currently have savings set aside for healthcare in HSAs. IHAs can push that number to a hundred million, helping to prepare many more Americans for unexpected health shocks.

The lack of a penalty for nonqualified withdrawals would give individuals less of a reason to spend money on unnecessary medical treatments. Instead, nonqualified withdrawals would increase an individual's taxable income and raise their tax liability, leaving the decision of how best to use the money they have saved up to them.

The primary shortcoming of IHAs is their likely effect on the federal budget. The budget impact would depend on the amount of the maximum contribution allowed. See our essay on budget effects for estimates of IHAs and expanding out-of-pocket deductibility. In addition, the distributional effects may favor high-income taxpayers who would receive more benefits from tax-deferred savings vehicles. This would be offset by the fact that high-income taxpayers already receive generous ESI coverage and thus may not see much in the way of new benefits from IHAs.

In addition, IHAs may cannibalize current contributions for IRAs and other retirement savings vehicles depending on allowable contribution amounts. Since there would be no penalty for early withdrawals, taxpayers would likely choose to contribute to IHAs first before contributing to IRAs, which have more stringent withdrawal requirements for those under age fifty-nine-and-a-half.

Price consciousness is key to controlling health costs and prices. While expanded educational outreach efforts to teach people how to pay attention to prices are well meaning, they are inherently limited. Harnessing the power of the market and providing individuals with a financial incentive to pay attention to prices, negotiate for better deals, and spur suppliers to innovate and compete for their services would have salutary system-wide effects.

CONCLUSION

Too many Americans are stuck with a one-size-fits-all health insurance. Our tax code strongly encourages high-premium, low out-of-pocket types of insurance. And efforts to offer consumers more choice have come with stringent rules that make them no choice at all for millions of Americans. A more flexible savings vehicle is needed to encourage

tens of millions of Americans to save for future healthcare expenses. Individual health accounts would maintain the incentives in HSAs that encourage price consciousness, while becoming a viable choice for many more Americans.

NOTES

1. Self-employed workers also benefit from an income tax break on premiums paid for health coverage.

2. An overview of the IRS rules for HSAs is available at https://www.irs.gov/publications/p969#en_US_2022_publink1000204030.

3. For the current minimum deductibles and contribution limits, see https://www.irs.gov/pub/irs-drop/rp-22-24.pdf.

4. See Haislmaier (2018).

5. We use data from MEPS to estimate the share of private employees with insurance coverage who are enrolled in an HDHP. There are significant data challenges in estimating the number of HSAs and the number of individuals covered by these plans. See page 14 in CRS (2022) for a discussion of these data issues.

6. A review of the scholarly literature by Bundorf (2016) finds that those with HSAs are more price conscious particularly when choosing outpatient procedures and buying pharmaceuticals.

7. EBRI (2022) examines six different surveys and finds that all surveys "show enrollment in HSA-eligible health plans has slowed or even declined."

8. For the text of the proposed legislation, see https://www.congress.gov/bill/117th-congress/senate-bill/1424.

9. See Pipes (2023) for an overview of recent reforms.

10. See Hardy (2022) for an overview of the EBRI data.

11. Employers may have their own rules regarding the amount that can be rolled over.

12. Policymakers may also consider policies that would allow HSA holders to roll over HSA balances into an IHA. The policies would likely require rules preventing HSA holders from rolling over money simply to avoid paying penalties. These rules could include assessing a fee on transferred balances or limiting unqualified withdrawals on transferred money for a set amount of time.

13. This is broadly like how FSAs and HSAs interact now. HSA enrollees may not contribute to a standard FSA (although they may contribute to a limited-purpose FSA that can go to pay for dental and vision expenses).

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The Choices for All Project: Healthcare Reforms for the Future

There is near-universal agreement that the US healthcare system fails to deliver affordable, accessible, and high-quality care for many Americans. Fixing our system requires putting more decisions in the hands of patients. That means introducing meaningful prices into the system, reducing supply-side regulations that limit the supply of medical care, and finding innovative ways to deliver insurance and medical care that better meet the demands of patients. The Choices for All Project offers healthcare reforms that would jump-start competition, encourage meaningful and transparent prices to patients, and bring consumer sovereignty to the healthcare market for millions of working-age Americans.

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