CHOICES FOR ALL

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

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CHOICES FOR ALL PROJECT

Introduction to the Choices for All Project

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There is near-universal agreement that the US healthcare system currently fails to deliver affordable and high-quality care for all Americans. But the consensus ends there. Politicians and health-policy experts can't agree on how to improve the system.

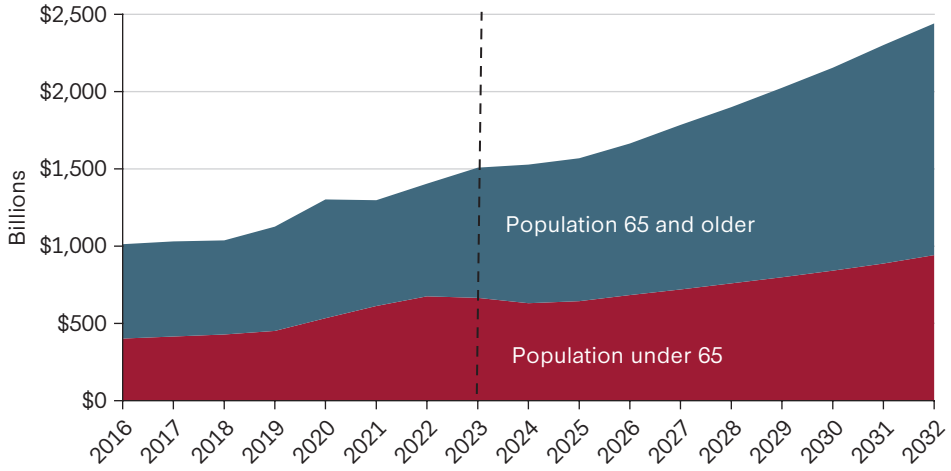
Why is our system so broken? Why have past reforms failed? Is there a better way forward?

THE PROBLEM: MISSING PRICES

Recent legislative remedies have embraced the notion that healthcare is *different* from other markets. Advocates of "Medicare for All" and the public option argue that providing up-front prices for health services is not useful because shopping is impossible when people are in pain, uninsured, or at the emergency room. Prices and competition are unnecessary, they argue, when providing a "human right" such as healthcare. Indeed, purchasing healthcare isn't like buying a car or a television. But the rules of supply and demand apply to healthcare just as they do in every other market. And centralized healthcare suffers from the same issues as all other centralized economic activity: it distorts prices so that they no longer convey useful information about value or cost. In the process, it takes choices away from patients and limits them to government-approved coverage.

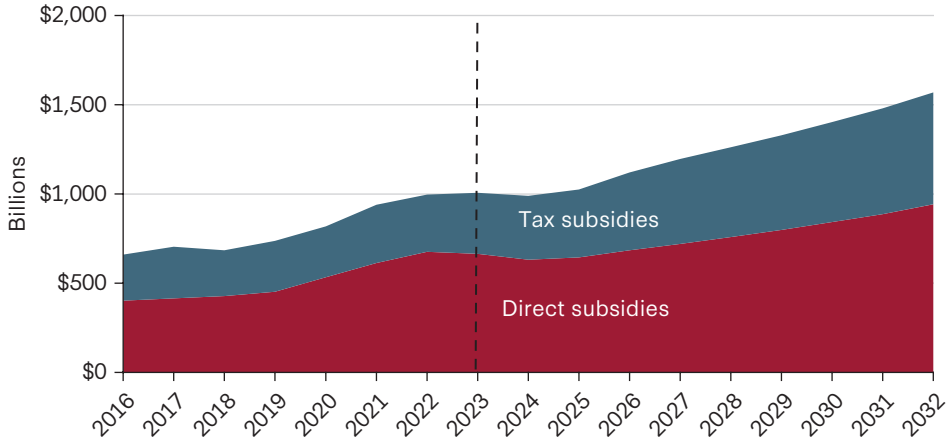
We can already see this fact in America's healthcare system. Myriad federal and state regulations affect medical care's price, quality, and availability. Nurses and physician assistants are prohibited from operating up to the scope of their training in many states. Insurers are limited in the way they can design and offer plans that would better meet the needs of consumers and expand their choices. Permissions to build and operate specialized facilities that would compete with existing institutions are denied or unnecessarily difficult to achieve.

FIGURE 1 Direct federal subsidies for healthcare (2016 to 2032)



Note: Data are derived from Congressional Budget Office data.

FIGURE 2 Healthcare subsidies for population under 65 (2016 to 2032)



Note: Data are derived from table 2 of Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under Age 65" (various years).

The regulations are paired with expensive government subsidies. As shown in figure 1, the federal government spends over $1.5 trillion a year in direct healthcare subsidies, largely through Medicare, Medicaid, and the Affordable Care Act (ACA).[1] Over the next decade, that total will rise by over 60 percent.[2]

Currently, almost half of the direct subsidies go to those under sixty-five years of age. As figure 2 shows, hundreds of billions more go to tax subsidies for employer-sponsored insurance (ESI)—but not for most out-of-pocket (OOP) spending. Much of that assistance is poorly targeted, going to households in the top half of the income distribution.

The long-term effects of these regulations and subsidies aren't immediately apparent, but they lead to enormous distortions of the healthcare market, which are erroneously blamed on a "free market" healthcare system that doesn't exist, because regulations prevent it from existing.

If the "free market" isn't the root cause, then what explains the system's failings?

There are, of course, many reasons, but none loom as large as the dominance of third-party payments for healthcare services. The government pays. Insurers pay. But patients are generally shielded from the full cost of their care. Consumers lack both the information and the incentives to make smart spending decisions. Providers often perform higher-cost or additional procedures because they know that patients are largely shielded from out-of-pocket costs, and they practice defensive medicine because of America's overactive litigation environment. And there is little demand for fixing the regulations reducing the supply of providers, hospitals, and medicines, which ultimately increases prices.

Prices, in fact, rarely make an appearance in conversations between providers and patients. And even then, the quoted prices rarely match what is actually paid by insurers or the government. That makes healthcare one of only a handful of markets in which prices are visible only after consumption—or not all.

Missing prices aren't a market phenomenon. They are, instead, a consequence of countless government interventions. The tax code rewards high-premium "Cadillac" workplace plans. Medicaid bans nearly all cost sharing among recipients. The ACA contains numerous rules and subsidies to limit out-of-pocket spending and prevent prices from conveying information, further distorting healthcare markets.

Those who call for single-payer systems tend to go even further. They think prices are the problem and argue that anyone who needs care has no choice but to accept whatever prices doctors or hospitals want to charge. As a result, only large purchasers like the federal government can put downward pressure on costs, through either price regulations or single-payer systems.

But single-payer care already exists in the United States in the form of Medicaid, care administered by the US Department of Veterans Affairs (VA), and, to some extent, Medicare. And these systems come with inevitable trade-offs among cost, quality, and access. Arbitrary cost ceilings lead to rationing, less access to new drugs or treatments, and longer wait times. The reality is that savings in single-payer systems are illusory: they can't achieve the same level of price savings and increases to quality that come from competition and prices driven by individual buying decisions.

In short, preventing patients from seeing meaningful prices—whether through regulations, tax subsidies, or single-payer systems—doesn't mean patients don't bear the costs of their medical decisions. Quite the opposite. The costs are just hidden in higher premiums and taxes, reduced quality, or limited access.

THE ANSWER: CHOICES FOR ALL

We believe the answer lies with patients. By providing patients with meaningful prices and genuine choices, they will make informed healthcare decisions that lower costs while preserving quality and access.

Healthcare is not fundamentally different from other markets. It has some difficult challenges, some unique and some not, but all can be solved in a way that puts downward pressure on existing prices using the same market forces that exist with every other good or service that people pay for. It is possible for everyday Americans to pay attention to prices and make informed decisions about most of the care they require. This is not hypothetical. This revolution is already happening across direct primary care, outpatient care facilities, health savings accounts, and more. These decisions represent enough of all medical spending to begin driving major changes to every aspect of the market.

The key is to put more decisions in the hands of patients. That means introducing meaningful prices into the system. It means fewer supply-side regulations that limit the supply of hospitals or providers. And it means finding new, innovative ways to deliver insurance and medical care that better meet the demands of patients.

PAST LESSONS: THE PROMISES AND FAILURES OF COMPREHENSIVE HEALTHCARE REFORMS

Our conclusion is not new. Countless healthcare proposals have begun with a similar premise of putting prices first. Guided by this conclusion, other plans have proposed radical, comprehensive changes to the American healthcare system. They featured good ideas that would have offered long-term improvements to this system.

Too often, however, the plans were narrowly focused on immediately reducing federal costs and failed to account for the short-term effects on coverage or care. Such solutions insisted on immediate, universal, and heavy-handed changes to the nation's healthcare system. Tax preferences for workplace plans would be reduced or eliminated. Existing federal subsidies—from Medicaid to the ACA—would be replaced with new programs that would ensure recipients had skin in the game. Health spending accounts paired with catastrophic health insurance plans would become the standard—and sometimes only—insurance that employers or others could offer.

Unsurprisingly, these past proposals failed to overcome significant political opposition. The result was that good ideas went unheeded, and America's healthcare system drifted further away from prices and toward more federal control.

The healthcare debate over the last decade reflects the danger in this approach. The focus from advocates of market-based healthcare has been almost exclusively on chipping or doing

away with the ACA at the expense of other dimensions of our healthcare system. There is no question that the ACA has fallen far short of its authors' objectives. It covers fewer people than projected, and it has increased premiums in the individual and small-group markets. But while these shortcomings demand changes, the ACA was never the primary culprit for our healthcare woes. As we have seen over the last decade, the repeated preoccupation with repealing the ACA is politically perilous and has made it more challenging to enact needed reforms in other parts of the system.

THE FUTURE: AN ALTERNATIVE APPROACH TO PATIENT-DRIVEN HEALTHCARE REFORM

Rather than offering comprehensive reforms that seek to upend the current system, policy-makers need commonsense proposals that give consumers incentives and the tools to make decisions based on prices.

These reforms should not eliminate existing options—politicians should be able to honestly promise that "if you like your healthcare plan, you can keep it." Instead, new choices should be created that offer clear benefits to consumers while improving their incentives to think deeply about the kind of medical care that they purchase. This does not mean that reforms can be costless or will not face political opposition. Inevitably, every reform will hurt someone's bottom line. But wherever possible, we need reforms that expand the choices available to consumers. In other words, successful healthcare reforms should offer consumers carrots, not cudgels.

The Choices for All Project seeks to do just that. The plan offers various healthcare reforms that would jump-start competition, help to furnish meaningful and transparent prices to patients, and bring consumer sovereignty to the healthcare market for many Americans under the age of sixty-five. We aim to improve incentives for consumers, providers, and payers. Over the long term, these reforms would lower overall costs, offer more choices in our healthcare system, and provide effective health coverage for those who cannot afford necessary medical care.

Our goals are as follows:

- Empower individuals to take more control of their healthcare decisions.
- Encourage personal saving for healthcare expenditures to protect against unexpected or catastrophic costs.
- Protect vulnerable populations while supporting individuals on their path toward self-sufficiency.
- Create competitive markets for healthcare services and insurance coverage that offer tailored products capable of meeting diverse preferences and needs.

- Reduce the growth of healthcare costs by promoting price transparency and reducing the reliance on third-party payment.
- Expand the supply of medical care.
- Promote long-term spending and deficit reductions (although not insisting on deficit neutrality in the first year of operation).
- Reduce long-term dependency on the government by providing better options for individuals and families.

To achieve these goals, we propose reforms that would put more control in the hands of those who currently have employer-based coverage; promote universal savings accounts specifically for healthcare expenses; encourage states to rescind regulations that reduce available coverage options and increase prices; and promote experimentation within state Medicaid policies to give recipients more control over their healthcare.

Brief summaries of our major reforms are below, with more details provided in the other essays in this series.

THE REFORMS

CREATE INDIVIDUAL HEALTH ACCOUNTS (IHAs)

We propose the creation of individual health accounts (IHAs), which are tax-advantaged savings accounts for healthcare expenses. IHAs would remove restrictive rules, giving consumers more opportunity to save for their future healthcare needs. They would be available to legal residents who have qualified health insurance (qualified plans would include traditional ESI, catastrophic insurance, ACA exchange plans, and Medicaid coverage). Annual tax-preferred contribution limits to IHAs would be based on family size, and to encourage consumers to choose lower-premium insurance plans, a family's contribution limit would be lowered by the amount of its tax-preferred premium payments. Those with low-premium catastrophic plans could contribute the most, while enrollees with higher-end "Cadillac" plans may not be able to contribute at all. Withdrawals for healthcare spending would not be taxed. All other withdrawals would be considered taxable income and taxed at ordinary rates, but there would be no additional penalty for nonqualified withdrawals.

EXPAND TAX DEDUCTIBILITY OF OUT-OF-POCKET PAYMENTS

Extending tax deductibility to all out-of-pocket (OOP) payments would reduce the backward incentives that are embedded in the nation's tax code. The deductibility would be "above the line," meaning OOP payments would reduce a tax filer's adjusted gross income. This would mirror the income tax treatment of ESI premiums and ensure taxpayers would

not need to itemize their deductions to receive the tax savings. This proposal would not perfectly level the tax treatment between premiums and OOP payments, as premiums are also excluded from payroll taxes, but the difference in tax treatments would be lessened.

ALLOW STATES TO REFORM ACA MARKETPLACE PLANS AND RELATED REGULATIONS

Our proposal would offer states additional flexibility in shaping their individual and small-group healthcare markets. Expanded waivers would be conditional upon states developing detailed plans that would guarantee coverage for individuals with high expected health costs. One particularly valuable option would allow states to create pilot programs that would allow ACA recipients to choose low-cost catastrophic plans—so-called copper plans—instead of the standard ACA plans, with the remaining subsidy balance deposited into an IHA. The total subsidy would remain unchanged, but this would give ACA recipients more control over their healthcare choices.

SUPPORT GREATER STATE EXPERIMENTATION WITHIN MEDICAID PROGRAMS

Like our proposed ACA reforms, this aspect of our plan would allow state policymakers additional flexibility in reforming their state Medicaid plans. The ultimate aims of this reform would be to give Medicaid recipients more control over their medical spending by providing them with partially funded IHAs and to use supply-side competitive pressure from managed care organizations to lower overall spending. This reform can likely be accomplished through existing authority granted by Section 1115 Medicaid demonstration waivers. Under this reform, states would be permitted to use Medicaid funds to contribute to state-administered IHA plans for low-income families. States that contribute funds would be permitted to increase cost-sharing requirements for Medicaid recipients on a dollar-for-dollar basis. Cost-sharing amounts would be limited to the funds contributed to IHA plans. State contributions to IHAs would ultimately belong to the recipients, but (unlike with private IHA plans) states could limit withdrawal options to prevent individuals from immediately withdrawing money after it has been deposited.

EXPAND THE SUPPLY OF HEALTHCARE PRACTITIONERS

Countless state and federal rules reduce the supply of doctors and nurses. Through scope-of-practice rules, about half of states prevent nurse practitioners and advanced registered nurse practitioners from practicing up to their level of competence and training. This often leads to longer wait times and more expensive medical care. Complicated federal and state rules regarding telemedicine make it difficult for doctors to see patients remotely from other states. Many of these rules were waived during the COVID-19 pandemic without negative consequences, demonstrating how unnecessary they are. Removing or liberalizing these rules would give patients more choice in choosing medical providers while driving down medical prices.

ELIMINATE LONG-TERM SHORTAGES IN PRIMARY-CARE PROVIDERS

The projected number of primary-care physicians in the United States falls far short of the amount needed for the foreseeable future. Increasing federal spending on residency programs will help alleviate some of the shortage. To further address this shortage, policymakers should lower burdensome requirements on foreign-trained doctors with appropriate credentials and work histories. A special visa status for healthcare providers going to underserved areas or population centers with large concentrations of immigrants would be an innovative way to handle the existing shortage. Similar visa expansions should be made for other medical providers, such as nurses or physician assistants.

REMOVE RESTRICTIONS ON NEW AND EXPANDED HEALTHCARE FACILITIES

Many states still have certificate-of-need (CON) laws that prevent entrepreneurs from building new hospitals or medical facilities. These rules were intended to prevent wasteful medical spending fifty years ago but are now used instead to shield existing facilities from competition. Similarly, ACA rules have banned the development of new physician-owned hospitals. The result of these rules is fewer healthcare facilities, particularly in rural areas. Eliminating these regulations would expand the supply of healthcare in underserved areas and promote competition that would drive down medical prices.

INCREASE AVAILABLE INSURANCE OPTIONS IN LARGE-GROUP MARKETS

Improving the number of available health insurance options available in the large-group market begins by allowing large-group coverage to be sold through association health plans at the state level. Association health plans are just like traditional health insurance plans, except instead of being tied to an employer, they are offered by and tailored to people within the same industry or profession. Multiple employers would be able to join together to offer medical benefits. In addition, self-employed workers in similar industries could participate. One can picture insurance for rideshare service employees, restaurant employees, or whole construction industries.

INCREASE DIRECT PRIMARY CARE ENROLLMENT

Direct primary care (DPC) agreements are a new model of providing primary care to patients with a low-cost monthly subscription cost. DPC can be thought of as "affordable" concierge care that expands choice and access for consumers. Unfortunately, federal tax rules make it difficult for patients to use pretax dollars to pay for the services. Allowing payments to DPC providers to count as deductible medical expenses would help to make them more widespread. They could also become a relatively cheap supplement to state Medicaid enrollment.

THE PATH FORWARD

The reforms presented above would lead to lower-cost, better-quality, more accessible healthcare and more choices for millions of Americans. They represent federal and state tax and regulatory options that could be implemented piecemeal or all together. Ultimately, they

would encourage healthcare prices to become much more visible, allowing patients to shop when they are able. Price competition leads to lower costs, better quality, and more choices in every industry. Healthcare is no different.

The other essays in this series handle each reform in turn, explaining how the current system works—and fails—before turning to more detailed solutions.

ACKNOWLEDGMENTS

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NOTES

1. This total doesn't include healthcare for veterans, the military, or federal civilian workers.

2. For more information, see Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under Age 65: CBO and JCT's May 2022 Baseline Projections" (May 2022), https://www.cbo.gov/system/files?file=2022-06/51298-2022-06-healthinsurance.pdf.

CHOICES FOR ALL PROJECT

Create Individual Health Accounts (IHAs)

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

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.

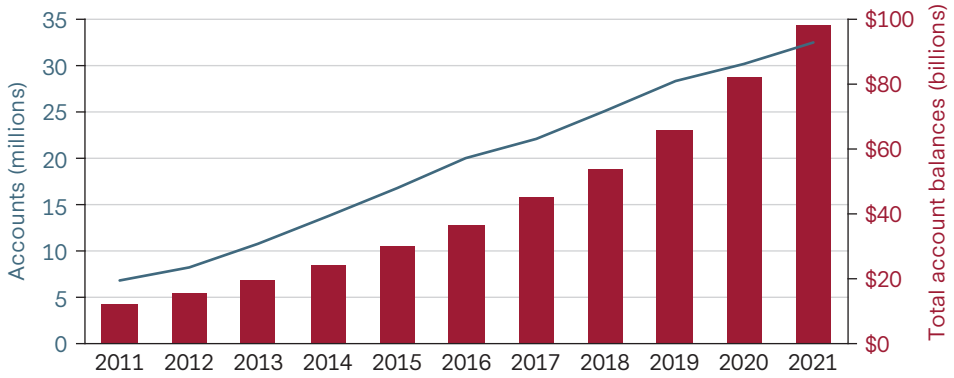
The underlying aim of pairing HSAs with HDHP-compliant insurance policies is worthwhile. The tax code's preference for high-premium plans distorts incentives, driving up healthcare consumption and ultimately health costs for all. The HSA architects believed that they could reduce these bad incentives 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

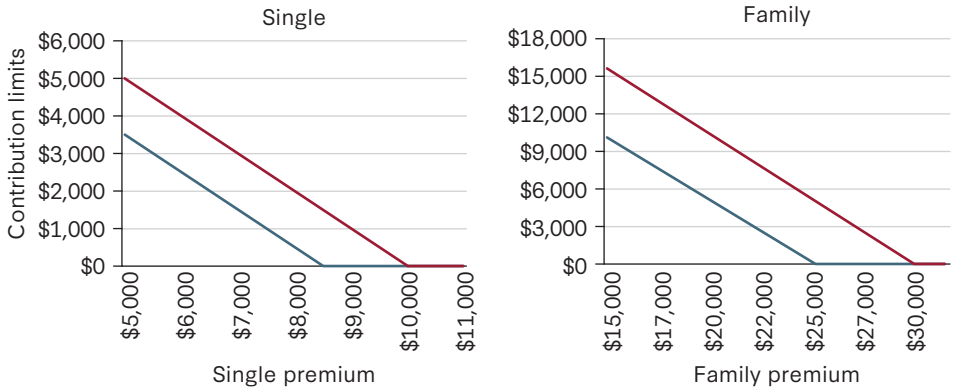
Notes: Calculations assume individual would face a 22 percent marginal income tax rate on all contributions and withdrawals. Contributions and OOP spending are assumed to grow at 5 percent annually with no investment income earned on savings.

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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CHOICES FOR ALL PROJECT

Expand the Tax Deductibility of Out-of-Pocket Payments

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

The "original sin" of healthcare policy—the federal tax preference for employer-sponsored insurance (ESI) premiums—produced the third-party payment system that wreaks havoc on consumer incentives. The tax preference for employer-sponsored plans extends to both federal income and payroll taxes, sheltering employees from viewing the full cost of their coverage. Tax-advantaged ESI plans with high premiums and low out-of-pocket (OOP) spending give people little reason to consider the marginal cost of their care. This drives up premiums as limited health resources go to medical procedures where the costs vastly exceed the benefits to patients. The tax break is the big reason why the market for healthcare doesn't look like it does for other goods or services. It also explains why patients see prices after they receive healthcare—not before. Finally, the tax break is regressive: individuals in higher tax brackets derive more savings than those in lower tax brackets.

But the ESI tax break isn't going anywhere. More than 150 million Americans benefit from it today, and any suggestion to change it carries significant bipartisan political opposition.

Rather than limiting the tax break, the Choices for All Project proposes extending tax deductibility to all out-of-pocket medical spending. The deduction would reduce a tax filer's adjusted gross income, mirroring the income tax treatment of ESI premiums. This change would curb incentives for purchasing high-premium ESI plans and give people more control over their healthcare spending. It would reduce the backward incentives embedded in the nation's tax code without raising anyone's taxes.

KEY PLAN ELEMENTS

- Replace the existing tax deduction for out-of-pocket spending with an "above-the-line" deduction.

- Make the deduction available to taxpayers regardless of income or whether they itemize their deductions.
- Reduce the bias in the tax code favoring the selection of high-premium ESI plans.
- Maintain existing ESI and self-employed premium tax preferences.
- Begin to level the income tax treatment between premiums and OOP payments (but maintain payroll tax exclusion only for premiums).

THE PROBLEM: EXISTING TAX PREFERENCES UNDERMINE CHOICE

Our tax system does the heavy lifting when it comes to subsidizing most Americans' healthcare. Since 1954, income spent on ESI premiums has not been subject to federal income or payroll taxes. Nearly 156 million individuals under sixty-five years of age receive their insurance through an employer-sponsored plan. The Congressional Budget Office (CBO) estimates that the tax value of the deduction for those under age sixty-five will total $326 billion in 2023, or over $2,000 per person covered by ESI plans.[1]

Table 1 shows how the tax preference works. In our simplified example, an unmarried worker has the option of a health insurance plan sponsored by her employer or a plan purchased

TABLE 1 THE BENEFITS OF THE ESI TAX PREFERENCE

	ESI coverage	Individual coverage
Total compensation	$75,000	$75,000
ESI HC premium	–$7,380	$0
Salary	$67,620	$75,000
Taxes		
OASDI	$4,328	$4,800
HI	$980	$1,088
Income taxes	$5,784	$7,408
Total taxes	**$11,092**	**$13,295**
Take-home pay	$56,528	$61,705
Individual HC premium	$0	–$7,380
Take-home pay after premiums	**$56,528**	**$54,325**

Notes: Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer. The estimated premium is based on MEPS-IC data for average total single premium in 2021. The estimates assume the individual does not receive any ACA subsidies for individual coverage.

FIGURE 1 Tax savings from ESI coverage

Notes: The tax savings are the difference in posttax/post-HC premium income for those with ESI coverage versus those purchasing individual policies. Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer. The estimated premium is based on MEPS-IC data for average total single or family premium in 2021. The estimates assume the taxpayer does not receive any ACA subsidies for individual coverage.

on the individual market. We assume the premiums are the same, but the only difference is where the plan is purchased. As the table shows, the worker would save over $2,000 by buying insurance through her employer.[2]

The size of the ESI tax benefit rises with income. America's progressive income tax system means those with higher incomes pay higher tax rates. Consequently, any tax preference that reduces taxable income reduces the taxes of high-income individuals the most. Figure 1 shows the size of the savings as total employee compensation rises. Single taxpayers with incomes of $50,000 save $1,465 by choosing ESI coverage over comparable individual coverage; single taxpayers with incomes at $250,000 save over $2,500. The savings are even larger for families. Moreover, because high-income families are more likely to have ESI coverage, they tend to benefit even more than the examples provided here. The US Treasury estimates that nearly half of the tax savings from ESI coverage go to families in the top 20 percent of incomes.[3]

Putting aside these distributional issues, the current ESI tax treatment affects the type of plans people buy and ultimately how much healthcare they consume. The favorable tax treatment for ESI plans only covers premiums; it doesn't include OOP medical spending. This encourages workers to buy high-premium plans that have lower coinsurance or copay requirements. The tax differences can be large.

TABLE 2 THE TAX BENEFITS OF HIGH-PREMIUM ESI PLANS

	High-premium ESI	High-deductible ESI
Total compensation	$75,000	$75,000
ESI HC premium	–$7,380	–$4,380
Salary	$67,620	$70,620
Taxes		
OASDI	$4,328	$4,520
HI	$980	$1,024
Income taxes	$5,784	$6,444
Total taxes	**$11,092**	**$11,988**
Take-home pay	$56,528	$58,632
Out-of-pocket spending	$0	–$3,000
Take-home pay after OOP	**$56,528**	**$55,632**

Notes: Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer. The estimated premium is based on MEPS-IC data for average total single premium in 2021. The estimates assume the individual does not receive any ACA subsidies for individual coverage.

Table 2 presents a stylized example where the same individual with ESI coverage shown in table 1 can purchase a high-premium plan with no cost sharing or a low-premium plan with a high deductible. For every $1 reduction in premiums in the example, deductibles rise by $1, so the only difference between the two plans is federal tax policy. In the example, picking a plan with a $3,000 deductible reduces income by $900 after accounting for taxes and OOP spending.

There are some significant assumptions underlining the example in table 2. The most important is that individuals consume the same amount of healthcare regardless of their health plans' cost-sharing requirements. One might think that healthcare consumption is fixed; medical care is a necessity, after all, so patients should consume the same amount regardless of the price. Since the 1970s, however, economists have found that individuals' medical consumption rises as the price they pay falls.[4] Relying on various studies, CBO estimates that a 10-percentage-point decrease in the share of total medical costs paid out of pocket will raise the quantity demanded for medical care by 11 to 17 percent, depending on the type of care.[5] Consequently, going from a plan that requires 20 percent cost sharing to one that requires no cost sharing will, on average, raise total medical spending by 22 percent or more.

In summary, the federal tax code encourages workers to choose high-premium ESI plans, which in turn give them more reason to increase their healthcare spending. That is a recipe for a costly, inefficient medical system.

Despite the distortions it creates in the healthcare market, the ESI tax exclusion is politically popular. Limiting the existing preference would amount to a tax increase for workers with ESI coverage. That group represents more than half of all nonseniors in the United States. Such a reform would inevitably be opposed by many workers, businesses, insurers, and labor unions. That's why past efforts to limit the deduction have failed. The Reagan administration sought to limit the deduction for employer contributions, but the efforts quickly died in Congress.[6] More recently, the Affordable Care Act (ACA) included the "Cadillac" tax for healthcare plans with particularly high premiums. The surtax's implementation was delayed twice before Congress permanently repealed it in 2019.

Right now, employees have few healthcare choices. The tax exclusion is so large and embedded in the system that we have ended up with a one-size-fits-all system, where the only effective option is to select a relatively high-premium ESI plan. It is no wonder that the prospect of removing the exclusion elicits such a visceral response.

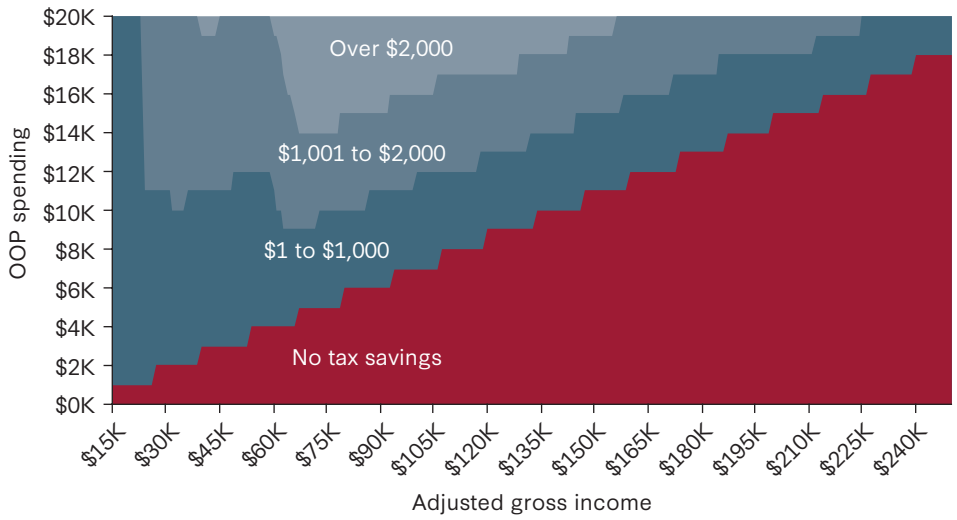
But while repealing or limiting the exclusion for ESI is unlikely to happen, there are still mechanisms to reduce the exclusion's distortions. Specifically, we can give patients new choices that give them more of an incentive to buy low-premium insurance plans with increased cost sharing. We can do this by equalizing the tax treatment of premium and OOP spending.

Current law allows individuals to deduct OOP spending under limited circumstances. Health savings accounts (HSAs) allow individuals who choose healthcare plans with high deductibles and lower premiums to save money in tax-preferred accounts. Employers and workers may contribute money to these accounts. If the money in an HSA is used for qualified healthcare spending, no taxes are paid; OOP spending therefore receives equivalent tax benefits as ESI premiums. If the money is withdrawn for nonqualified reasons, the person pays income taxes on the withdrawal, plus a 20 percent penalty.

HSAs are not the only tax-preferred vehicles for OOP spending. Flexible spending arrangements (FSAs) and health reimbursement arrangements offer tax savings as well, albeit with more limitations and complicated rules. Like HSAs, these savings vehicles improve the tax treatment of OOP spending, but as discussed in the essay in this series on individual health accounts, they have significant limitations that limit their appeal for many Americans. Worse, in some cases, they encourage patients to consume more medical care than they need. FSA plans, for example, have "use-it-or-lose-it" provisions that give consumers the choice between losing their money at the end of the calendar year or buying anything health related regardless of need.

Beyond tax-preferred accounts, individuals can deduct extraordinary medical expenses that exceed 7.5 percent of their adjusted gross income. That means the deduction isn't available for most Americans unless they have high medical expenses, and only if they itemize their

FIGURE 2 Tax savings from current OOP deduction (above 7.5 percent of AGI)



Notes: Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer with itemized deductions (excluding OOP spending) equal to the 2023 standard deduction. Tax savings are equal to the difference in income tax liability with and without OOP spending deduction. Calculations are done in $1,000 increments.

deductions. Figure 2 shows the potential tax savings from the current deduction for an unmarried taxpayer who itemizes. An unmarried taxpayer with an income of $75,000 would need $6,000 in OOP spending before receiving any tax benefit from the current deduction.

The nature of the current deduction produces seemingly arbitrary results. For example, individuals in high-tax states or with large mortgages are more likely to deduct their medical expenses merely because they are more likely to itemize. Given the complexity and limitations of the deductions, it is no wonder that few Americans take advantage of it; in 2023, Americans will spend over $450 billion out of pocket on medical expenses, and yet the existing deduction will only save taxpayers $11 billion.[7]

THE FUTURE: EXPAND THE TAX DEDUCTIBILITY OF OUT-OF-POCKET PAYMENTS

If we want to empower patients, we need to give them incentives to think about the costs and benefits of their medical decisions. That won't happen under current tax rules. We don't need to eliminate the ESI exclusion. Instead, we need to give people a new choice that offers similar tax benefits: we should extend the tax deductibility of OOP spending to all taxpayers.

What would that look like?

Rather than forcing filers to itemize their medical deductions, we should allow taxpayers to deduct their OOP spending when calculating their adjusted gross income. In tax parlance, this is called an "above-the-line" deduction.

TABLE 3 THE TAX BENEFITS OF HIGH-PREMIUM ESI PLANS WITH OOP DEDUCTIBILITY

	High-premium ESI	HDHP without OOP deductibility	HDHP with OOP deductibility
Total compensation	$75,000	$75,000	$75,000
ESI HC premium	–$7,380	–$4,380	–$4,380
Salary	$67,620	$70,620	$70,620
Deductible OOP spending	$0	$0	–$3,000
Taxes			
OASDI	$4,328	$4,520	$4,520
HI	$980	$1,024	$1,024
Income taxes	$5,784	$6,444	$5,784
Total taxes	**$11,092**	**$11,988**	**$11,328**
Take-home pay	$56,528	$58,632	$59,292
Nondeductible OOP spending	$0	–$3,000	$0
Take-home pay after OOP	**$56,528**	**$55,632**	**$56,292**

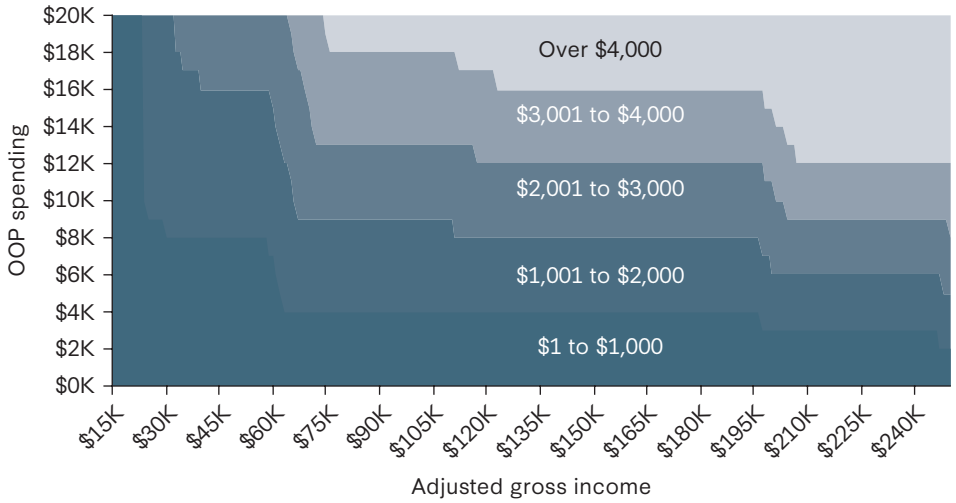
Notes: Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer. The estimated premium is based on MEPS-IC data for average total single premium in 2021. The estimates assume the individual does not receive any ACA subsidies for individual coverage.

Table 3 shows how this tax change affects our stylized example presented in table 2 above. Making all OOP spending deductible increases the take-home pay after OOP spending for people who purchase high-deductible health plans (HDHPs). The change only affects their income tax liability. With the new deduction, our taxpayer reduces her income taxes by $660. The most important takeaway from this table: the difference between a high-premium ESI plan and an HDHP is significantly reduced. In our example, the tax benefit from choosing the high-premium plan falls from $896 to $236.

When paired with our proposed universal individual health accounts (IHAs), the logistics of keeping track of OOP medical spending would mirror those used by owners of HSAs. HSA holders regularly pay for OOP spending with account-specific debit cards. The financial institutions that manage their HSAs are required to send end-of-year tax forms that report their clients' qualified medical spending. Expanding the deductibility of OOP spending would be much simpler than the existing system of only deducting when spending is above 7.5 percent of a filer's adjusted gross income.

Beyond reducing the relative tax preference for ESI premiums, moving the deduction "above the line" also avoids the need to itemize. This ensures that two taxpayers with similar incomes and medical expenses receive comparable tax savings from the deduction regardless of whether they itemize. This is significant, because more than 90 percent of taxpayers did not

FIGURE 3 Tax savings from hypothetical "above-the-line" OOP deduction



Notes: Tax savings are the difference in income tax liability with and without the OOP spending deduction. Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer who claims the standard deduction. Calculations are in $1,000 increments.

itemize their deductions in 2020.[8] Figure 3 shows the potential tax savings of the new deduction by income and OOP spending.

We estimate that after accounting for dynamic effects, expanding OOP deductibility would reduce federal tax revenues by $79 billion over ten years. Income tax revenues would fall by $167 billion, but payroll tax revenue would rise by $88 billion. For more information, see our cost estimate essay in this series.

CONCLUSION

The existing tax exclusion for ESI benefits offers significant tax benefits, but at a large cost. The exclusion has created incentives that undermine choice, pushing Americans into high-premium plans that distort their healthcare consumption. Americans deserve more choices in healthcare, but that will only happen if we level the tax treatment between premiums and OOP spending. Extending the deductibility of OOP spending will do just that.

NOTES

1. See table 2 in CBO (2022).
2. This example only applies to those with an offer of coverage from an employer. Self-employed individuals who do not have an offer of insurance from their employer (or their spouse) may deduct health insurance premiums from their net business income when paying income taxes; unlike ESI

coverage, however, the self-employed are not able to deduct their premiums when paying OASDI and HI payroll taxes.

3. US Treasury (2016).

4. The RAND Health Insurance Experiment (HIE) is the most famous research. Importantly, while higher cost sharing reduces demand, the HIE found that the effects on health outcomes from higher cost sharing were minimal. See Brook et al. (2006) for more details.

5. Specifically, CBO estimates that the semielasticity of demand with respect to the percentage-point change in the OOP share for hospitals is –1.1, –1.5 for physician and clinical services, –1.7 for prescription drugs, and –1.3 for other services. See exhibit 5-1 in CBO (2020).

6. See Ronald Reagan, "Message to the Congress Transmitting Proposed Health Care Incentives Reform Legislation" (speech), February 28, 1983, Ronald Reagan Presidential Library & Museum, https://www.reaganlibrary.gov/archives/speech/message-congress-transmitting-proposed-health-care-incentives-reform-legislation.

7. Projections for total OOP expenditures are based on CMS (2022). The $11 billion estimate is the tax expenditure from the deductibility of medical expenses (US Treasury 2022).

8. In 2020, the IRS reported 15.5 million had itemized deductions out of 164 million total returns. Importantly, the Tax Cuts and Jobs Act of 2017 (TCJA) increased the standard deduction through 2025 so the share of itemizers will likely rise beginning in 2026. Nevertheless, even prior to the TCJA, a minority of taxpayers itemized their deductions. In 2017, for example, 46.8 million taxpayers itemized their deductions out of 153 million returns. See table A in IRS (2022).

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CHOICES FOR ALL PROJECT

Expand the Available Supply of Healthcare

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

Cumbersome federal and state regulations burden the supply of both medical care and health insurance. These regulations are intended to protect patients and restrain costs, but they often do the opposite. Government regulations have restricted the supply of medical care, depriving Americans of choice. These restrictions lead to longer wait times, reduced availability of services, and increased costs. Likewise, federal and state insurance regulations prevent innovative new insurance models that can lower costs and expand access.

Supply-side solutions should be aimed at increasing healthcare choices. That will require reducing federal and state regulatory burdens. To that end, the Choices for All Project proposes key incremental improvements that remove these barriers.

KEY PLAN ELEMENTS

HEALTHCARE PROVIDERS

- Standardize and expand on COVID-era telemedicine reforms.
- Expand scope of practice for nurse practitioners (NPs).
- Expand the recognition of medical licenses across states.
- Increase reciprocity of medical licenses for foreign-trained physicians to address the shortage of primary-care physicians.

- Repeal certificate-of-need laws to increase the supply of hospitals and specialized outpatient facilities.

- Reverse Affordable Care Act restrictions that prevent new physician-owned healthcare facilities.

HEALTH INSURANCE OPTIONS

- Allow payments to providers of direct primary care to count as qualified medical expenses.

- Expand access to association health plans.

- Allow "copper" plans to be sold on state exchanges.

THE PROBLEM: RULES AND REGULATIONS ARTIFICIALLY RESTRICT THE AVAILABLE SUPPLY OF MEDICAL CARE

Government rules and regulations affect the cost of healthcare by influencing the prices that providers can charge, the payments they receive, and the overall cost of delivering care. They also artificially restrict the supply of healthcare and health insurance options available to consumers.

Regulations that are overly burdensome or complex make it difficult for providers to deliver high-quality care and may even lead to unintended consequences such as reduced access to care. For example, regulations that limit the number of medical residency slots or restrict the scope of practice for certain healthcare providers limit available care, particularly in underserved communities. Restrictions on who can build and own hospitals, likewise, mean some areas are underserved. Similarly, regulations that restrict the types of insurance plans that can be offered limit access to affordable coverage for some patients.

Blame does not fall to the federal government alone. States have long held jurisdiction over public health and insurance markets more generally. The McCarran-Ferguson Act of 1945 gave states the authority to regulate insurance markets and exempted companies from certain antitrust provisions, allowing behavior that would have typically violated federal laws. As a result, offering insurance across state lines is next to impossible. It has led to a patchwork of insurance regulations, stifling competition, and increasing prices. The Competitive Health Insurance Reform Act, bipartisan legislation signed in 2019, walked back some of the McCarran-Ferguson antitrust protections for health and dental insurers.[1] The full impacts remain to be seen.

Today, we are told what types of health plans we can buy, what health services must be covered, which providers we may see, and which facilities we can access. The regulations may have originally been intended to protect patients, but many have devolved into mere barriers to entry or to a more competitive healthcare landscape. They now serve an anticompetitive purpose: protecting existing players in the healthcare economy, rather than improving patients' health.

THE IMPORTANCE OF EXPANDING SUPPLY

Rather than this one-size-fits-all approach, we need a regulatory system that embraces consensus without uniformity. Artificial restrictions on the provision of healthcare can lead to predictable outcomes: higher costs, less access, lower quality, and fewer choices. Progress toward our goals of lower costs, improved access, and better-quality medical care will come from removing restrictions so that patients have more choices in how they receive care.

Many of the solutions presented here are not novel, but they represent key incremental improvements that add to available choices rather than restrict them. Several other scholars and analysts have written extensively on many of them, and we encourage readers to examine the work that has been completed before us.

To be clear: these supply-side solutions aren't painless. Each reform will face opposition from incumbent players that benefit from the status quo.

We divide these reforms into two categories: reforms to regulations affecting the supply of healthcare providers and reforms affecting the types of health coverage available to Americans. In both cases, we identify reforms that could be championed by policymakers at the federal or state levels.

THE FUTURE: MORE HEALTHCARE PROVIDERS AND FACILITIES

There are only two effective ways to keep healthcare costs down while expanding access to care: reduce the demand for or increase the supply of healthcare services. In other essays in this series, we focus on the demand-side reforms that would improve patients' incentives to consider the cost of their healthcare consumption.

Fixing our healthcare system will also require increasing the supply of medical care. That means more physicians, nurses, and health facilities. But expanding the supply means more than just increasing the number of providers. Our economy is filled with examples of industries that have met a growing demand with fewer workers each year. From agriculture to automobiles, we have benefited from remarkable gains in worker productivity. Healthcare shouldn't be any different. Too often, however, regulations prevent the efficient use of our medical system and stifle innovations that can deliver better, more affordable care. The

reforms we highlight in this section are thus aimed at increasing the number and efficiency of medical providers.

PERMANENTLY EXPAND TELEMEDICINE AUTHORITY

The COVID-19 pandemic kick-started a wave in telemedicine across the United States. Waivers for existing rules surrounding telemedicine—including across state lines—were granted, and patients were able to access efficient and effective care.[2] Making these changes permanent should be a key goal for federal and state policymakers.

While states have broad jurisdiction over the regulation of health insurance within their borders, the federal government controls reimbursement rates and pricing decisions for a large part of medical care through Medicare. Moreover, Medicare policies set important benchmarks for state Medicaid programs and private plans. Consequently, changes in Medicare can reverberate throughout our healthcare system.

This was evident during the pandemic. The Centers for Medicare and Medicaid Services waived several regulations regarding telehealth services.[3] This included a March 2020 waiver that permitted states to allow out-of-state doctors to provide telehealth services to Medicare recipients. States quickly followed with similar waivers. During the pandemic, all fifty states and Washington, DC, enacted waivers allowing telehealth services across state lines.[4] Many of these waivers, however, were temporary; by December 2022, the waivers had expired in thirty-nine states and in Washington, DC.[5]

A handful of states, however, have permanently changed their rules allowing out-of-state providers to provide telehealth services. Meanwhile, the federal government has extended many of its telehealth waivers. The Consolidated Appropriations Act in 2023 included a two-year extension of COVID-related waivers for Medicare telehealth services, including the elimination of the geographic restriction on where telehealth services originate.[6] It also allowed federally qualified health centers and rural hospitals to provide telehealth services.[7] Flexible pay arrangements can be a boon for rural health clinics that struggle to remain open and that routinely receive higher federal payments.

The federal and state waivers should be made permanent to allow healthcare providers to provide services—at lower costs—to the patients who need them. States can do this by creating streamlined registration processes for out-of-state practitioners. For example, Florida in 2019 authorized providers not licensed in the state to "provide healthcare services to a patient located in this state using telehealth if the healthcare professional registers with the applicable board, or the department if there is no board, and provides healthcare services within the applicable scope of practice established by Florida law or rule."[8] Arizona enacted similar legislation in 2021.[9]

As we discuss below, states could also join the Interstate Medical Licensure Compact or the Nurse Licensure Compact if not party to either of them. These actions make it easier for out-of-state practitioners to provide services to a state's residents. That would remove

barriers for telemedicine to originate from other states to expand access to their own residents. Alternatively, Svorny (2020) suggests that Congress could establish the physician's state as "the site of care of a physician-patient interaction" in telehealth settings.

Removing unnecessary regulations in telehealth is a key step in extending access to cost-saving health treatments. But policymakers should exercise caution before implementing heavy-handed rules that may undermine the cost-saving features of telehealth. Specifically, some states have implemented pay parity requirements that require private insurers to pay the same rate for care provided in person versus via telemedicine. The idea behind the requirements is that healthcare providers will be less likely to offer telemedicine services if they are paid less. By enacting pay parity rules, lawmakers hope to encourage greater investment in telehealth services.

That line of thinking, however, restricts the choices available to consumers and raises their prices. Pay parity requirements should be avoided, as telemedicine that can offer the same quality care at lower costs should pass along savings to patients. If policymakers believe such requirements are necessary, they should insist on including legislative sunsets of pay parity requirements to ensure that the long-term cost savings from telehealth are realized.[10]

Increasing the supply of medical care means more than just adding more providers. It means ensuring that providers' time is used efficiently, and that geography is not a factor that prevents a patient from accessing a provider. Telemedicine accomplishes both goals. If patients receive the care they need from qualified medical professionals, they should not be prevented or disincentivized from using telemedicine options that work for them.

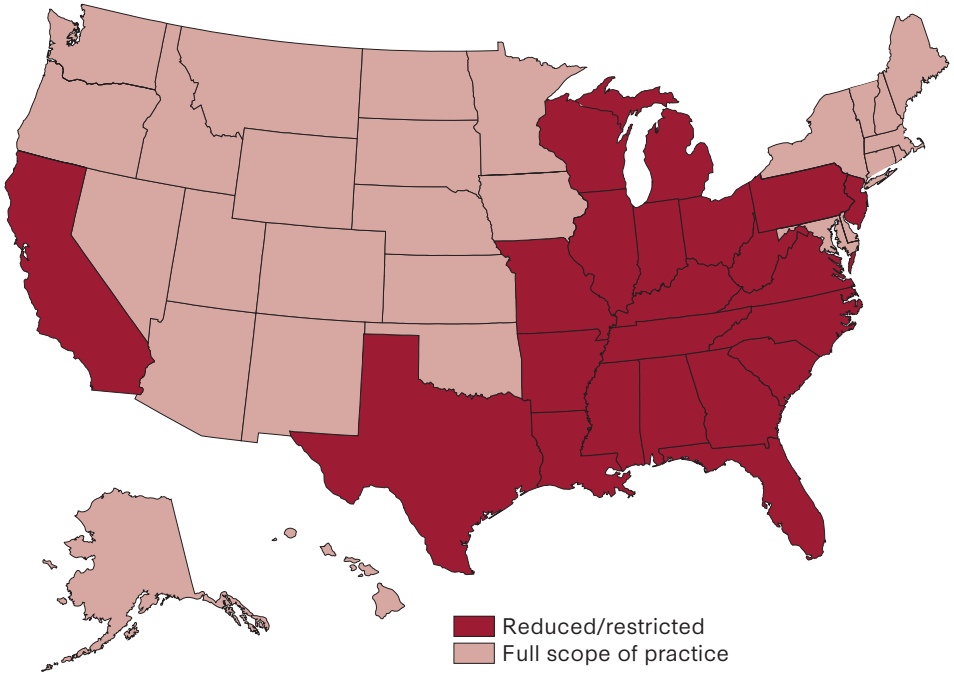
ELIMINATE SCOPE-OF-PRACTICE RULES

Currently, twenty-three states still restrict or reduce the "scope of practice" allowed to be performed by nurse practitioners (NPs), advanced registered nurse practitioners (ARNPs), and physician assistants (PAs).[11] Given the shortage of primary-care providers in the United States, restricting the allowable level of care that NPs, ARNPs, or PAs are allowed to provide to a level lower than that of their training is unwise. These scope-of-practice rules limit the available supply of healthcare workers and lead to longer wait times for nonemergency services.[12]

During the COVID-19 pandemic, many states with restrictions acknowledged the shortcomings of these rules.[13] They were quick to relax scope-of-practice rules to ensure an adequate supply of providers during the emergency. The guidance by then secretary of the Department of Health and Human Services (HHS) Alex Azar to states regarding state licensure and scope of practice is a model to follow. HHS recommended that states relax requirements to encourage retired or discouraged healthcare providers to reenter the workforce and recommended that state licensing fees be waived.[14]

Some defenders of scope-of-practice rules point to concerns over safety and the quality of care provided to the patient. But multiple studies conclude that there is no association between restrictions on scope of practice and an increase in the quality of primary care

FIGURE 1 States with reduced or restricted scope of practice



Note: Scope-of-practice rules are available at https://www.aanp.org/advocacy/state/state-practice-environment.

provided. Perloff et al. (2019) examine the quality of primary care provided to Medicare beneficiaries across states with varying levels of scope-of-practice rules. They find no consistent relationship between the quality of care and states with scope-of-practice rules, concluding that "state regulations restricting NP [scope of practice] do not improve the quality of care."[15]

Of course, there may be unobserved differences in the quality of care between providers with different credentials. Scope-of-practice rules, however, don't guarantee patients access to those with the highest credentials; instead, the rules often mean patients aren't able to see a provider when they need one. Studies have found that states with full-practice authority for NPs have a larger supply of NPs, and patients therefore benefit with shorter wait times, more access to primary care, and a fewer number of emergency room visits. In a summary of the research, Spetz (2019) concludes, "Numerous studies have found that state regulations requiring physician oversight of NPs and other restrictions on NP practice are associated with decreased access to care for patients, particularly in rural regions and for Medicaid enrollees."[16]

Removing scope-of-practice limits could produce large cost savings. NPs and ARNPs provide care at below the average cost associated with physicians and other primary-care providers. Spetz et al. (2013) estimate $1.3 billion in annual cost savings if states eliminated all restrictions preventing NPs from practicing and prescribing independently in retail clinic settings. Chattopadhyay and Zangaro (2019), meanwhile, find that removing scope-of-practice limits could save Medicare $44.5 billion annually.

The nation has been running an experiment for years regarding limits on the scope of practice of NPs, ARNPs, and PAs. Roughly half of states allow full-practice authority, and half do not—and there is no clear difference in health outcomes. The only meaningful difference is in the artificial restriction of supply and the price, quality, and access problems that come with it. States should thus consider permanently ending these unnecessary restrictions.

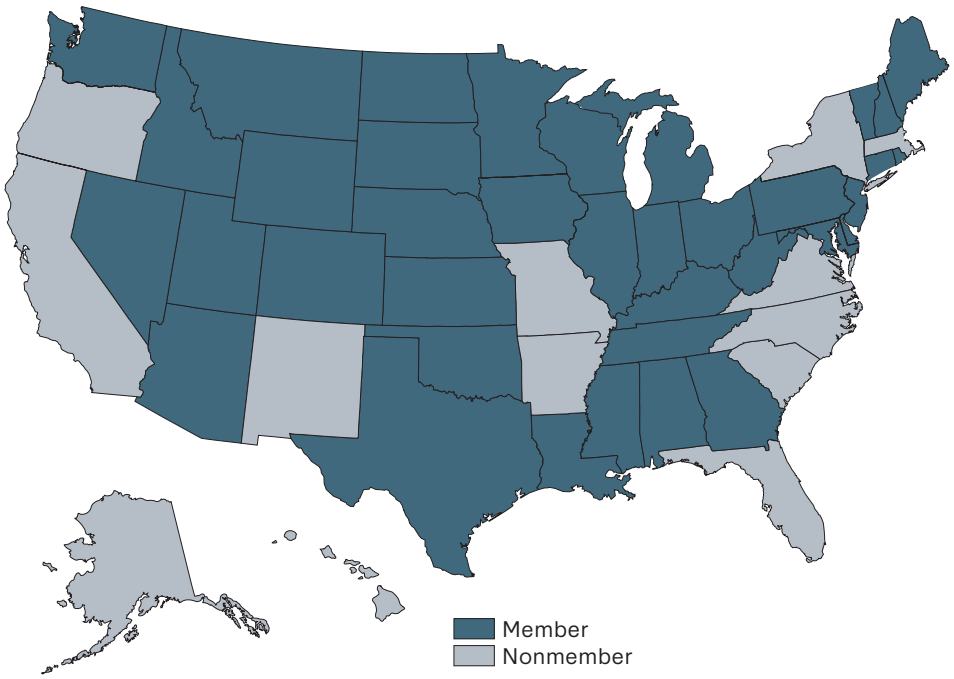
EXPAND RECOGNITION OF MEDICAL LICENSING ACROSS STATES

Medical licenses are issued by individual states, and there is currently no universal recognition of licenses across state lines. This can be a barrier to healthcare professionals who want to practice in multiple states, particularly for those living near state borders or providing telemedicine services to patients in other states.

The recognition of medical licenses across state lines promotes competition and expands the pool of available healthcare professionals, particularly in underserved areas. It also reduces administrative burdens and costs for healthcare professionals who practice in multiple states, allowing them to focus more on patient care.

Some progress has occurred through the Interstate Medical Licensure Compact. Under the compact, physicians can apply for a license in one state and have it recognized in other participating states if they meet certain eligibility requirements and pay a fee. Currently, thirty-seven states have joined the compact, with several additional states considering legislation that would allow them to join.[17] The Nurse Licensure Compact provides a similar interstate recognition

FIGURE 2 States that have joined the Interstate Medical Licensure Compact



Note: The current status of Compact states is from https://www.imlcc.org/participating-states/.

for nurses; thirty-nine states have joined the compact.[18] States that have yet to enter both of these compacts—large ones like California, Florida, and New York, particularly—should consider joining.

Beyond the compacts, Congress should look for opportunities to reduce the harmful effects of unnecessarily strict state licensing rules. The Center for American Progress has voiced support for national licensing.[19] There are legitimate concerns regarding whether such changes would undermine the principles of federalism. Nevertheless, Congress has a role in ensuring licensing rules do not undermine interstate commerce. Beyond national licensing, there are piecemeal reforms Congress should consider. For example, as we discuss in the telehealth section above, Congress could designate the "site of care" for telehealth visits as the physician's state rather than the patient's state.

REDUCE BARRIERS FOR FOREIGN-TRAINED MEDICAL LICENSE HOLDERS

America is not training and producing enough physicians. The Association of American Medical Colleges projects a shortage of up to 124,000 physicians by 2034.[20] As we discuss above, part of this gap could be filled by ending scope-of-practice rules on NPs and other practitioners.[21] The gap can be further narrowed by relying on foreign-trained doctors and other practitioners. Unfortunately, it is difficult and costly for foreign-trained physicians or nurse practitioners to move to the United States and help fill this gap.

Currently, international medical graduates account for nearly one-quarter of practicing US physicians.[22] Graduates of medical schools outside of the United States or Canada are required to undergo a complicated licensing process overseen by the Educational Commission for Foreign Medical Graduates (ECFMG). The ECFMG requires these foreign-trained physicians to undergo at least one year of graduate medical education in the United States or Canada. This training is required regardless of the applicants' existing postgraduate education or experience.

While additional training may be necessary for some international graduates, the rules represent an unnecessary restriction for those educated in developed nations with medical education systems like the United States and Canada. For this reason, Canada exempts those with specific postgraduate schooling or specialty certifications from certain jurisdictions.[23]

Expanding the supply of foreign-trained practitioners would be especially effective in areas with large immigrant populations, where foreign medical professionals would be able to more effectively cross linguistic or cultural barriers that might exist in the current treatment of patients. Unfortunately, this policy idea has become part of the highly polarized and broader discussion over immigration reform in the United States; thus, little progress has been made.

Lawmakers should embrace the reciprocity of medical licenses, in conjunction with other requirements, to encourage foreign medical professionals in good standing to practice in the United States. The recognition of foreign medical licenses could be combined with a push to increase placements in rural or underserved areas. For example, Flier and Rhoads (2020)

highlight efforts by the Minnesota Department of Health to increase pathways for foreign graduates to practice in the state. Minnesota's International Medical Graduates Assistance Program, enacted in 2015, was intended "to increase access to primary care in rural and underserved areas of the state." Among other policies, the program relaxes residency program recency requirements for international medical graduates.[24]

ELIMINATE CERTIFICATE-OF-NEED LAWS

Certificate-of-need (CON) laws are state-level regulations requiring healthcare providers to obtain approval from a governing body before expanding, building new facilities, or offering certain services, based on demonstrated community need and financial viability. They gained popularity as a cost-saving measure when Medicare began and medical spending was rising rapidly. Congress soon passed the National Health Planning and Resources Development Act in 1974, which tied federal funding to states passing their own CON laws. Within years, nearly all states had adopted these rules.[25] Their aim was to restrict new spending by verifying there was a "need" for new medical facilities.

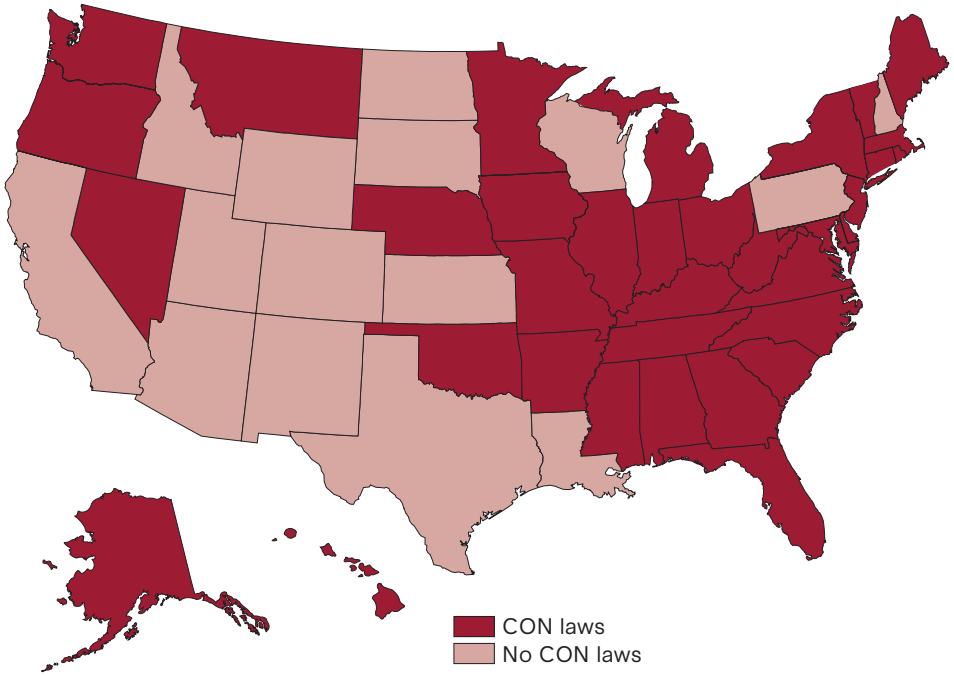
Over time, however, CON laws have been used primarily by existing medical providers to prevent new competition. By 1987, Congress repealed the federal mandates for CON laws.[26] Despite the decades-old repeal, as of May 2020, thirty-five states and the District of Columbia still had some form of rules that stifle the supply of medical facilities and specialized care that could otherwise be offered to patients.[27] In a review of the literature, Mitchell (2016) finds that projected cost savings from CON laws never materialize; instead, "the overwhelming weight of evidence suggests that CON laws are associated with both higher per unit costs and higher total expenditures." A separate review of the literature found that in 2008, the supposed benefits of CON laws were 8 percent lower than their estimated costs.[28]

An issue closely related to CON laws is the increased use of certificate-of-public-advantage (COPA) laws by states.[29] These laws shield hospital mergers from certain federal antitrust rules. Under COPA laws, states allow hospitals to merge but in exchange exercise increased regulatory oversight of their postmerger prices and policies. In evaluating COPA laws, the Federal Trade Commission (2022) has found that commercial inpatient prices rise after the introduction of COPA laws.

Competition is the only force that reliably leads to lower prices and better quality. Removing CON laws and avoiding the creation of new COPA laws would thus lead to lower costs through increased competition. The result would expand the quantity of healthcare facilities, including ambulatory surgery centers, imaging centers, dialysis centers, hospice facilities, and substance abuse centers. This idea is not new. The Federal Trade Commission (FTC) has long advocated for eliminating CON laws to improve competition. Former FTC commissioner Maureen Ohlhausen (2015) notes that "the FTC has tirelessly advocated for the repeal of these laws for many years, with strong support from Commissioners of both parties."

States should lift existing CON restrictions, a move that would drive healthcare costs down by removing the barriers to entry for new facilities. There are examples that can be followed.

FIGURE 3 States with certificate-of-need (CON) laws



Note: CON laws by state are available at https://nashp.org/50-state-scan-of-state-certificate-of-need-programs/.

Since the 1980s, fifteen states have fully repealed their CON laws. Even partial repeals can reduce the burden of CON laws. In 2019, Florida repealed the rules for general or long-term acute-care hospitals and for "tertiary services," including neonatal intensive care units, organ transplantation, and comprehensive rehabilitation.[30]

REMOVE LIMITS ON PHYSICIAN-OWNED HOSPITALS

Physician-owned hospitals (POHs) are healthcare facilities such as hospitals, clinics, and surgery centers that are owned, in part or whole, by physicians. In the United States, physician-owned medical facilities have been a source of controversy due to concerns that they may lead to self-dealing that would result in higher healthcare costs and unnecessary procedures.

In 2010, the Affordable Care Act (ACA) included provisions (Section 6001) that placed restrictions on physician-owned hospitals. This included a prohibition on the expansion of existing POHs and a requirement that new POHs meet certain criteria to be eligible for Medicare payments. These restrictions were intended to reduce the potential for conflicts of interest and to encourage the use of more cost-effective treatments. Instead, the result has been to limit competition by freezing the size of existing POHs and preventing the creation of new medical facilities. Miller et al. (2021) note that in light of the restrictions, forty-five hospital expansion projects were canceled, while an additional seventy-five planned new hospital projects were "terminated."

Opposition to new or existing POHs comes from non-physician-owned hospitals or existing trade associations representing those hospitals. But the bans constitute an anticompetitive regulation that limits the supply of new medical facilities. The arguments against POHs are that they will be more likely to employ cost-intensive treatments that drive up healthcare spending and potentially create conflicts of interest for referring physicians. Nevertheless, these worries should be balanced against the benefits from increased competition among medical providers, which would result from a larger supply of medical facilities available to patients.

One comprehensive literature review finds that physician-owned hospitals "generally provide higher-quality care at a lower or comparable cost than do non-POHs."[31] The authors find quality benefits within surgical specialty care facilities but no definitive evidence of differences in cost of care. They also note that POHs could be used to lower costs, improve quality of specialty care, expand access at community hospitals, and increase competition in hospital markets. The authors conclude that "in the absence of evidence that POHs provide services of lower quality or higher cost, Medicare's ban on new POH participation and expansion of preexisting POHs lacks justification."

New POHs can be built with waivers from the US secretary of the Department of Health and Human Services, but it is a political hurdle that is difficult to clear. Policymakers should instead reevaluate Section 6001's ban on physician-owned hospitals to increase choice and produce competition among healthcare providers, particularly in rural and other areas where healthcare facilities are limited. For example, the Patient Access to Higher Quality Health Care Act of 2023 would repeal Section 6001 of the ACA and related provisions that currently prevent physician self-referral in the Medicare program.[32]

THE FUTURE: PERSONALIZING HEALTH COVERAGE

Few sectors of our economy are as heavily regulated as healthcare is. Policymakers have enacted countless rules affecting what insurers may charge and the services they must provide. But insurance is complex, which makes rulemaking difficult. To simplify the process, lawmakers have often resorted to reducing plan options. They argue that simplification is good for consumers, who would otherwise be paralyzed with too many choices. But this one-size-fits-all or, more charitably, "few-sizes-fits-all" regulatory regime has left significant gaps in our system that deprive Americans of insurance coverage that works for them. Here, we propose reforms that would fill these gaps.

ENCOURAGE DIRECT PRIMARY CARE

Direct primary care (DPC) is a new and growing method of providing primary care to patients at a potentially much lower cost, with increased access and higher levels of satisfaction for both patients and physicians. Akin to "affordable concierge care," DPC patients pay a monthly fee (averaging around $80 a month) for expanded access to their personal physician. The monthly fee covers routine screenings, preventive care, chronic care services, and

care coordination. Prescription drugs are often included at cost, and DPC doctors regularly arrange discounted access to lab tests and imaging services.[33] More than two thousand practices currently exist, serving hundreds of thousands of Americans.[34] DPC is not insurance. There are typically no third-party payments allowed for services. Most patients are advised to pair a DPC arrangement with catastrophic or low-premium, high-deductible insurance to cover services and treatments not provided by one's primary-care physician.

Despite their popularity, DPC arrangements face significant barriers to expansion. One barrier is federal regulation. The IRS does not treat DPC membership fees as a qualified health expense. In fact, the IRS currently concludes that individuals or families that qualify for a health savings account (HSA) but participate in a DPC arrangement are ineligible to contribute to their HSA. In its proposed rule from June 2020, the IRS states that standard DPC arrangements "would constitute a health plan or insurance that provides coverage before the minimum annual deductible is met, and provides coverage that is not disregarded coverage or preventive care."[35] Notably, it did make room for employers to use health reimbursement arrangements (HRAs) to pay for employees' DPC membership payments.

Several attempts have been made to allow membership fees to be counted as qualified health expenses, including in the bipartisan Primary Care Enhancement Act of 2021.[36] Notably, the act only applied to HSA holders, ostensibly to codify that a DPC membership does not count as having a non-high-deductible health plan and therefore making purchasers ineligible for health savings accounts.

The regulatory obstacles facing DPCs serve as another example of how the cumbersome rules governing HSA and other existing health subsidy programs deprive many Americans of innovative healthcare solutions. In our essay in this series on individual health accounts (IHAs), we offer an alternative savings vehicle that would better fit the health needs of many Americans. IHAs would give more Americans an opportunity to save for their healthcare future while ensuring they can participate in DPCs and other healthcare delivery services that don't fit into the one-size-fits-all system we have today.

But even without enacting IHAs, policymakers can still improve access to DPCs. Expanding the recognition of DPC membership fees as qualified medical expenses for all taxpayers would help to increase the number of DPC practices available nationwide and help shift predictable and routine care to a more cost-efficient setting. Improving access to DPCs isn't just for those with employer coverage; in our essay on Medicaid and ACA reforms, we highlight how expanding access to DPC can be particularly useful for low-income Americans who currently face long waits and poor outcomes in their state Medicaid programs.

Congressman Dan Crenshaw's Direct Primary Care for America Act serves as a model of legislation to expand DPC access.[37] It proposes expressly allowing HSAs to be used to pay for DPC memberships, allows state waivers to provide Medicaid using DPC arrangements, and permits healthcare facilities to participate in various federal assistance programs if they offer direct primary care arrangements in officially designated areas with health professional shortages.

EXPAND ACCESS TO ASSOCIATION HEALTH PLANS

Association health plans (AHPs) are group health insurance arrangements allowing businesses, especially small and midsize enterprises, and self-employed individuals, to band together and purchase health coverage collectively. By pooling resources and spreading risk, AHPs aim to provide more affordable and accessible insurance options for enrollees. They also allow small businesses the ability to negotiate like a larger employer with insurers on cost and obtain medical claims data, too, if the AHP is self-funded.

However, AHPs are limited by numerous rules and regulations. The Employee Retirement Income Security Act of 1974 (ERISA) strictly limits the definition of an employer or association, making it difficult for multiple businesses to form AHPs. State insurance regulations prevent AHPs from forming across state lines or offering consistent coverage for mobile employees. In California, the Health and Human Services Agency imposed a 2019 rule preventing the sale of group coverage to individual subscribers directly or "indirectly through any arrangement," cutting off any new AHP associations.[38] Federally, the ACA's requirement of minimum essential health benefits limits possible AHP plan designs and raises costs.

In response, the US Department of Labor, under President Donald Trump, proposed a rule to expand the use of AHPs by small businesses and self-employed individuals.[39] That rule was finalized in June 2018 but was invalidated the following year by a federal district court, which argued it failed to set meaningful limits on AHPs. The court took issue with the provision that allowed AHPs to be formed based on geography but no other ties, and it ruled that self-employed individuals without employees were not supposed to be considered as employers under ERISA.[40]

Senator John Kennedy (R-LA) proposed the Association Health Plans Act of 2021 to remedy some of the objections of the district court. His bill would have permitted "groups or associations to sponsor fully insured group health plans as if they were employers."[41]

Expressly permitting association health plans to be formed by self-employed individuals or small businesses in similar industries would lower participants' costs while giving them more options for insurance coverage. Congress should go further by exercising its right to regulate interstate commerce and expressly allowing AHPs to form across state lines. In conjunction with expanded deductibility of out-of-pocket medical spending or individual health accounts (see our essays in this series on reforming the tax code for more details), more families and individuals would be able to get coverage that better matches their needs.

EXPAND ACCESS TO CATASTROPHIC ("COPPER") PLANS

Catastrophic insurance plans are rare in America, yet they make sense for many young and healthy Americans. As discussed in our essay in this series on Medicaid and the ACA, these plans are often labeled "copper" plans because insurance companies cover only 50 percent of expected health costs (as compared to 70 percent for "silver" plans). The ACA clamped down on the ability of consumers to choose catastrophic coverage. To be eligible, individuals need to be under age thirty or qualify for an exemption based on hardship or affordability. On top of that, tax credits for premiums are generally not eligible for the purchase of copper plans.

The result is that existing ACA marketplace plans are a bad deal for many healthy individuals, whose expected healthcare costs are far below the premiums they must pay. Many of these individuals opt to forego coverage—a prospect made easier since the ACA individual mandate penalties were eliminated in 2019. Expanding access to copper plans for more individuals would fill an important need. And as we discuss in our Medicaid and ACA essay, subsidized ACA enrollees who choose copper plans could have any excess subsidy directed to their individual health accounts, giving them more control over their healthcare needs.

CONCLUSION

Fixing the way we regulate healthcare will expand the number of providers, fill gaps in coverage, and allow for more healthcare innovations. Most policies are initially passed or created with good intentions but fall short in the real world. Too often, these rules have been abused to protect concentrated interests in the healthcare industry that benefit from these barriers to entry, while offering little protections or few choices to patients.

It is long past time that we consider the supply-side reforms articulated here to lower costs and improve access to care for more Americans. There are many other reforms that also merit consideration. While each reform requires deliberation, policymakers should focus on those that expand consumer choice. Conversely, they should be skeptical of reforms that undermine competition.

NOTES

1. P.L. 116-327. The text is available at https://www.congress.gov/bill/116th-congress/house-bill/1418.
2. Gajarawala and Pelkowski (2021).
3. See CMS (2020) for an overview of these waivers.
4. Andino et al. (2022).
5. See Alliance for Connected Care (2022) for an overview of the waivers as of December 16, 2022.
6. P.L. 117-328.
7. See HHS (2023) for an overview of current federal rules governing telehealth.
8. See Section 456.47, Florida Statutes. Available at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0456/Sections/0456.47.html.
9. Arizona House Bill 2454. Available at https://legiscan.com/AZ/text/HB2454/id/2391998/Arizona-2021-HB2454-Chaptered.html.
10. For a discussion on telehealth pay parity requirements and alternative reforms, see Dills (2021).
11. For a complete list, see American Association of Nurse Practitioners, "State Practice Environment," https://www.aanp.org/advocacy/state/state-practice-environment.
12. In a 2013 study, for example, Auerbach et al. find that potential shortages of primary-care physicians can be offset with additional NPs and PAs, but this would require "liberalization of scope-of-practice laws to allow nurse practitioners and physician assistants to perform expanding roles."

13. For an overview of these policies, see Poghosyan et al. (2022).

14. HHS (2020).

15. Similarly, Oliver et al. (2014) find improved health outcomes and lower hospitalization rates among Medicaid and Medicare recipients in states with full practice of NPs. Likewise, in a review of the literature, Newhouse et al. (2011) find "a high level of evidence that APRNs provide safe, effective, quality care to a number of specific populations in a variety of settings."

16. See table 2 in Spetz (2019) for a summary of the literature.

17. For a list of states in the compact and a summary of pending legislations, see https://www.imlcc.org/participating-states/.

18. The list of states is available at https://nursecompact.com/index.page#map.

19. Kocher (2014).

20. Association of American Medical Colleges (2021).

21. Auerbach et al. (2013).

22. Flier and Rhoads (2020).

23. For a list of the approved jurisdictions and specialties training, see https://www.royalcollege.ca/ca/en/credentials-exams/assessment-international-medical-graduates.html#jur.

24. For an overview of the program, see https://www.health.state.mn.us/facilities/ruralhealth/img/index.html.

25. Ohlhausen (2015) offers a summary of the history of CON laws.

26. P.L. 99-660, section 701.

27. For a summary of state laws, see Rakotoniaina and Butler (2020).

28. Conover and Bailey (2020).

29. COPA laws have been used for decades, but states increased their use after the 2013 Supreme Court decision in *FTC v. Phoebe Putney Health System*, which narrowed the state-action immunity doctrine that allows states to supersede federal antitrust rules.

30. Florida CS/HB 21. For an overview, see the Florida Senate 2019 Summary of Legislation Passed, Committee on Health Policy, https://www.flsenate.gov/PublishedContent/Session/2019/BillSummary/Health_HP0021hp_0021.pdf.

31. Cho et al. (2021).

32. The legislation is cosponsored by senators Bill Cassidy (R-LA) and James Lankford (R-OK). The legislative text is available at https://www.lankford.senate.gov/imo/media/doc/lankford_colleagues_patient_access_to_higher_quality_health_care_act.pdf.

33. Busch, Grzeskowiak, and Huth (2020).

34. See DPC Frontier Mapper, https://mapper.dpcfrontier.com, for a map displaying the locations of all of them.

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CHOICES FOR ALL PROJECT

Empower Medicaid Recipients and ACA Participants

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

Federal healthcare subsidies for those under age sixty-five will total just over $1 trillion in 2023. Spending on Medicaid and on premium subsidies for the Affordable Care Act (ACA) will account for just over half that total. That spending is intended to ensure low- and middle-income families have access to medical care. Yet, while more is spent each year, the programs continue to underperform. Long wait times and uneven health outcomes are the norm for many Medicaid recipients, while narrow networks and limited plan options are standard for ACA participants. Rather than address these issues, policy-makers have opted to expand the rolls, exacerbating these problems.

Any reform should help ensure that both Medicaid and the ACA marketplaces work for beneficiaries and enrollees, but one-size-fits-all federal reforms are unlikely to help. Instead, the Choices for All Project proposes state-level reforms that would empower patients—not the government or third-party payers. This includes giving enrollees more control over the money that is spent on their behalf. Federal policymakers have a role to play. Existing waiver authority provides states with opportunities to experiment with their health subsidies, but their use relies on the whims of federal government officials who have plenary power to deny new waivers.

KEY PLAN ELEMENTS

- Ensure existing waiver authority is broadly available to facilitate innovative state-based health reforms.

- Strengthen waiver authority rules to ensure continuity across presidential administrations.

- Allow ACA recipients to select low-cost catastrophic plans with the remaining subsidy balance deposited into our newly proposed individual health accounts (IHAs).

- Provide Medicaid recipients with an option to receive partially funded IHAs—owned by the recipient—that can fully cover new cost-sharing requirements.

- Allow states to use waivers to pay for direct primary care (DPC) memberships for Medicaid enrollees.

THE PROBLEM: A ONE-SIZE-FITS-ALL APPROACH

Federal policy has long recognized that access to affordable healthcare is a critical component of overall well-being and quality of life. Since the 1950s, the federal government has subsidized healthcare for low-income Americans who meet certain demographic requirements or who are enrolled in other assistance programs.[1]

In 1966, the federal role in healthcare was expanded when Congress enacted Medicaid. The program is administered by the states, but the federal government covers most of the costs—anywhere from 50 to 90 percent depending on the state and enrollees' demographics. Initially, the program covered only families enrolled in state welfare programs and low-income seniors and individuals with disabilities. Over the decades, Congress has expanded Medicaid eligibility to include nearly all low-income individuals. Most recently, the ACA provided states with the option to expand Medicaid to able-bodied adults (under age sixty-five) without dependents. In fact, the majority of the ACA's coverage gains came from its Medicaid expansion.[2]

While Medicaid is administered by the states, there are strict federal regulations about what services Medicaid must offer. Generally, states may not charge any premiums for those with family incomes below 150 percent of the poverty line. Similar limitations apply to cost-sharing rules. States may not charge copays for emergency, preventive, or maternity services. They may charge small cost-sharing amounts for nonemergency services, but the maximum amounts are minimal for those with incomes below 100 percent of the federal poverty level.[3] In 2020, twenty-two states required some sort of cost sharing from their Medicaid adults. The most common type of cost sharing was copayments for prescription drugs. Only about one-fourth of states charged any copayments for outpatient or inpatient services.[4]

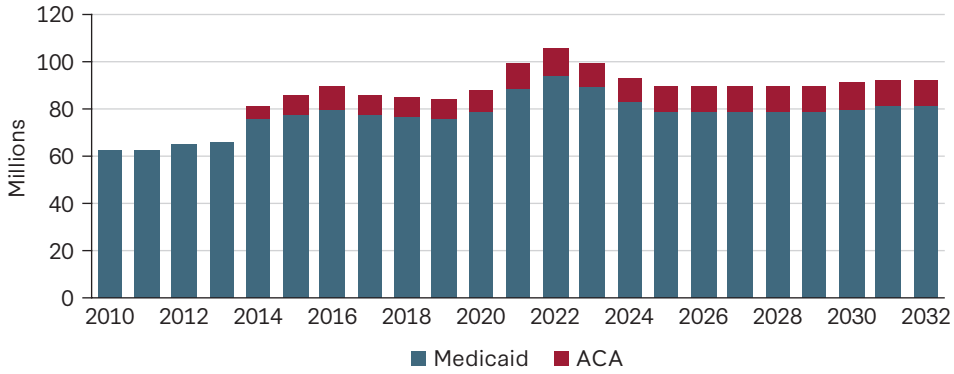
Historically, state Medicaid programs paid providers directly for services received by Medicaid enrollees. More recently, however, states have moved most Medicaid recipients to managed care organizations (MCOs). States contract with MCOs, which agree to provide comprehensive medical coverage to Medicaid recipients in exchange for a capitated payment (i.e., a set monthly payment) from the state Medicaid program. In 2022, forty-one states used MCOs for at least a portion of their Medicaid recipients, covering 72 percent of the nation's Medicaid beneficiaries.[5] MCOs must offer enrollees the same services and are bound by the same cost-sharing rules as traditional Medicaid.

The ACA did more than expand Medicaid eligibility. The 2010 law established subsidies for the purchase of private insurance for individuals with family incomes too high to qualify for Medicaid, but below 400 percent of the federal poverty level. To qualify for subsidies, individuals must not have an offer of coverage from their employer. Plans are purchased on the ACA's marketplace exchanges. The ACA requires participating insurers to include certain services and treatments with their plans (called essential health benefits). The law also requires insurers to offer plans to all who apply, regardless of any preexisting health condition (called a guaranteed issue requirement). And the law strictly limits what enrollee characteristics an insurer may use in setting premiums. Premiums may differ due only to age, geographical area, and whether an enrollee uses tobacco products—and even then, there are strict limits (called community rating rules) on how much more can be charged.

ACA plans are divided by metal tier: platinum, gold, silver, or bronze. The tiers are based on the plan's actuarial value, which is the average share of total covered health spending the plan will cover. Plans in the most generous tier, platinum, must cover approximately 90 percent of spending. Gold plans cover 80 percent, silver plans cover 70 percent, and bronze plans cover 60 percent. Of course, the more generous the plan, the higher the premium charged. Catastrophic plans—sometimes called "copper" plans—with coverage less generous than bronze plans are available to those under age thirty and to some individuals who qualify due to a hardship (e.g., one who is not eligible for premium subsidies but cannot afford a bronze plan).

ACA subsidies vary by a recipient's income. Enrollees are required to pay a share of their income for their premiums. The subsidy is the difference between an enrollee's second-cheapest silver plan (called the benchmark plan) and the required contribution. The subsidy amount is generally fixed regardless of which plan an enrollee chooses. Enrollees who choose a gold or platinum plan pay more than their required premium share. If they choose a bronze plan or the cheapest silver plan, they pay less; in some cases, a person may not have to pay any premiums if they select a particularly low-cost bronze plan.

FIGURE 1 Medicaid and ACA enrollment by year



Note: Authors' calculations from CBO's "Federal Subsidies for Health Insurance Coverage for People under Age 65" (various years)

Like Medicaid, states play a role in administering the ACA. States can add stricter rules on insurers regarding which services must be offered, how premiums are set, and how plans' cost-sharing rules are applied. But there is an asymmetry: states may add additional rules, but they cannot create rules that would weaken federal ACA regulations without a waiver.

Since the ACA's enactment, enrollment in the Medicaid program has grown dramatically.[6] As figure 1 shows, Medicaid enrollment among those age sixty-four or younger rose by over 50 percent from 2010 to 2022. Meanwhile, subsidized ACA enrollment reached a new peak in 2022 at twelve million. While COVID expansions have temporarily expanded enrollment, the Congressional Budget Office (CBO) expects the long-term trends to continue. By 2032, 29 percent of those under age sixty-five will receive assistance through Medicaid or the Affordable Care Act.

Medicaid and ACA enrollment rose particularly fast during the COVID-19 pandemic. This was in part due to congressional action that expanded eligibility for the programs. In 2020, the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act increased the share the federal government would pay for the program. In exchange, states agreed to not disenroll anyone from their Medicaid program during the public health emergency, regardless of current eligibility. As a result, enrollment exploded. CBO estimated in 2022 that an additional 13 million were enrolled in Medicaid due to the continuous eligibility enrollment.[7] In 2023, states were finally permitted to begin disenrolling recipients who had become ineligible.

Similarly, in 2021, Congress temporarily liberalized eligibility for increased ACA coverage subsidies. The American Rescue Plan Act of 2021 (ARPA) provided premium subsidies

to individuals with incomes above 400 percent of the federal poverty level. ARPA also reduced the required contribution from all enrollees. The ARPA expansions were due to expire in December 2022, but Congress extended the subsidies for an additional three years. This change added $64 billion in spending and tax subsidies to the federal budget over the next four years.[8]

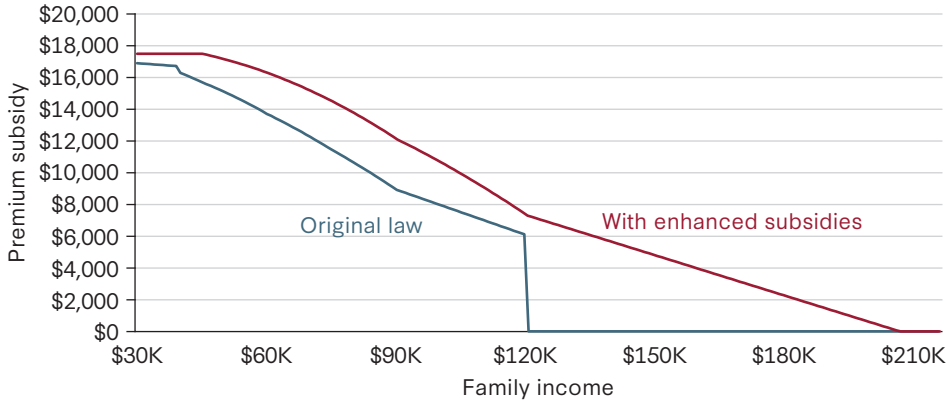
Booming enrollment and repeated liberalizations have exacerbated long-standing problems within Medicaid. Medicaid reimburses medical providers at lower rates than commercial insurers. Consequently, some doctors are leery of taking Medicaid patients. Survey data suggests that only 75 percent of doctors are willing to accept new Medicaid patients, while 95 percent are willing to accept private patients.[9] In a recent survey of fifteen metropolitan areas, the average acceptance rate was 54 percent.[10] The result is longer wait times to get an appointment.[11] Similarly, research suggests Medicaid patients are more likely to experience an extended time in waiting for a physician on the day of their appointment.[12]

Evidence is also mixed regarding whether Medicaid improves health outcomes relative to being uninsured. The Oregon Health Insurance Experiment was a randomized controlled trial that assigned a subset of low-income individuals without insurance to Medicaid. Baicker et al. (2013) found that those who enrolled in Medicaid saw their healthcare utilization rise, reported lower levels of depression, had less financial anxiety, and were more likely to be screened and treated for diabetes. Nevertheless, despite the additional health utilization, there were no statistical differences in health outcomes.

The Affordable Care Act's marketplace exchanges have also failed to live up to the aims of its proponents. Even with subsidies, ACA plans were far less popular than originally predicted. At the time of its passage, CBO (2010) estimated that in 2019, twenty-four million individuals would enroll in the marketplace exchanges, with nineteen million receiving subsidies. Instead, only nine million were enrolled in 2019 with eight million receiving subsidies.[13] There are likely several reasons why the ACA plans have proved unpopular. Without subsidies, premiums are high and cost-sharing rules are burdensome, making the plans unattractive to many. Moreover, to contain costs, insurers have developed relatively narrow provider networks that limit patient access.

The recent congressional action that dramatically liberalized eligibility has increased projected enrollment in the ACA. Nevertheless, the increased enrollment is not necessarily among low-income households. As noted above, the liberalizations expanded eligibility up the income ladder. The result is that a family of four with high incomes may qualify for health premium subsidies. Figure 2 shows the change in subsidies by

FIGURE 2 Estimated ACA subsidy for family of four before and after ARPA



Notes: Authors' calculations. We assume a family of four where parents are forty years old and children are under age fifteen. We use the estimated US average for the benchmark premiums from KFF (2023) for forty-year-olds ($5,472) and calculate children's premiums using HHS community rating age curves.

income level for a family of four with nationwide-average premiums. As the graph shows, a family of four with incomes above $200,000 may qualify for assistance. The increased subsidies have increased ACA enrollment but at a high cost: the Biden administration estimates that extending the expansions after 2026 would add $183 billion to federal deficits over the next ten years.[14]

Similarly, while the temporary Medicaid eligibility expansions offer new benefits to those who otherwise wouldn't qualify, they do little to help existing Medicaid patients. Instead, the expansions have strained the existing system, increased wait times, and exacerbated the provider shortages that have long plagued the program.[15]

As the COVID-era enrollment boom subsides, policymakers have an opportunity to rethink how Medicaid and the ACA work for remaining recipients. Real reform will require they shift their focus from expanding enrollment to ensuring the programs are working for the enrolled.

THE FUTURE: UNLEASH STATE INNOVATION

Despite the significant shortcomings of the ACA, repeal is neither politically likely nor necessary for advancing substantive health reforms in 2023.

Given the status quo, policymakers should instead focus on state-level reforms that will empower recipients and foster innovation in new pathways to coverage and cost containment. Existing waiver authority—combined with additional federal reforms—offers

the opportunity to give recipients more choices. Below we identify necessary changes in federal policy and several related reforms that states could champion.

EXPANDING STATE WAIVER AUTHORITY

To begin, states need more power to commit to reforms. That requires taking full advantage of waivers in existing laws. States are supposed to be the laboratories of democracy. Many federal policies began as reforms at the state level that succeeded and gained popularity. But today, state flexibility can be hampered by burdensome administrative requirements or simply the whims of presidential administrations and, more specifically, the leadership at the US Department of Health and Human Services.

Waiver provisions in laws governing Medicaid and private markets allow states to innovate and tailor their healthcare systems to better suit the unique needs of their populations. By granting states more flexibility in implementing healthcare reforms, these waivers can help improve efficiency, reduce costs, and promote choice and competition in healthcare.

State innovation waivers, authorized by Section 1332 of the ACA, provide a promising avenue for states to improve healthcare access and affordability in their own unique ways. These waivers allow states to deviate from certain ACA provisions, so long as they can demonstrate that their alternative approach still meets certain goals set out in the law. This flexibility gives states the ability to tailor their healthcare systems to their specific needs, which can lead to better outcomes for their residents.

Section 1332 waivers can be used by states to modify various aspects of their healthcare systems, such as the structure of health insurance marketplaces or premium subsidies. To be granted a Section 1332 waiver, a state's proposed plan must meet four essential criteria, referred to as "guardrails":

- Comprehensiveness: The plan must provide coverage that is at least as comprehensive as that mandated under the ACA.
- Affordability: The plan must ensure that coverage is as affordable as it would be under the ACA.
- Scope: The plan must cover at least as many residents as the ACA provisions would.
- Deficit neutrality: The plan must not increase the federal deficit within a ten-year window.

Similarly, waivers under Section 1115 of the Social Security Act allow states to request federal approval for experimental, pilot, or demonstration projects related to their Medicaid program and their Children's Health Insurance Program (CHIP). The primary objective of these waivers is to provide states with flexibility to design and implement innovative approaches that promote the objectives of Medicaid and CHIP. These waivers are widely used by states today and have been the source of some of the most significant innovations in the Medicaid program, such as the adoption of MCOs, the Oregon Health Insurance Experiment, and more recently the Healthy Indiana Plan.[16]

The most common uses of Section 1332 waivers are reinsurance policies that allow states to relax ACA rules about common risk pools. The result is that insurers can offer lower premiums that better reflect the expected health costs of healthy enrollees. But waivers offer states far more opportunities to deliver more healthcare choices to their residents. Expanding the use of these waivers could help address some of the challenges facing the US healthcare system. The current waiver process undermines this goal. To ensure that states can take full advantage of waivers, federal policymakers need to liberalize the process. Reforms include the following:

1. Streamlining the Waiver Application Process

Federal policymakers should simplify the waiver application process to make it more transparent while providing guidance and support to states seeking to implement innovative approaches to healthcare reform. Policymakers might also consider a provision that presumptively approves waivers that states certify will meet the existing Section 1332 guardrails. Finally, there should be a fast-track process for states that have already received a waiver and want to renew or modify it. This would allow states to bypass another lengthy application process and receive approvals more quickly.

2. Increasing Flexibility in Existing Waiver Requirements

The requirements for the approval of Section 1332 waivers should be loosened to give states more freedom to design their own healthcare systems if they meet the overall goals of the ACA. Under 2018 guidance from the Department of Health and Human Services (HHS), the Trump administration allowed states greater flexibility in interpreting the existing guardrails. Specifically, states could satisfy the scope guardrail by offering plans that were not as comprehensive as standard ACA plans.[17] Importantly, they were still required to offer other plans that met the comprehensiveness and affordability requirements.

The Biden administration repealed the 2018 guidance in its own 2021 rule. In repealing the additional flexibility, the administration argued that "the guardrails should be focused

on the types of coverage residents actually purchase such that individuals are enrolled in affordable, comprehensive coverage and not just that there is generalized access to such coverage."[18] In short, the Trump administration's guidance recognized that many individuals don't value any of the existing ACA plans. They want more choices. But the Biden administration took the Section 1332 waiver process in a different direction. It argued that mere choice was insufficient.

Returning to the 2018 guidance would thus increase choice in the individual market. For example, the ACA requires that insurance companies cover a set of essential health benefits (EHBs) in all plans sold in the individual and small-group markets. While EHBs have proved to be popular and important to many Americans, fully comprehensive plans may not be attractive to people who defer buying coverage because of the costs. Under the 2018 guidance, states could create health plans to target currently uninsured individuals who are forgoing coverage because they don't think the benefits provided by plans are worth the cost. Waivers could give states more flexibility to design insurance plans that meet the unique needs of these residents, if the states *also offer* alternative coverage that meets the comprehensiveness guardrails. This could be particularly beneficial for states with high healthcare costs, high numbers of voluntarily uninsured individuals, or for those that are struggling to attract insurers to their markets.

3. Strengthening Waiver Language to Ensure Continuity across Administrations

The Biden administration's effective repeal of the 2018 guidance reflects the often ideological nature of waiver approvals and denials. While policy changes are inevitable during new administrations, states need assurances that approved waivers will not be unilaterally suspended or altered by skeptical administrations.

In November 2020, Georgia secured approval for an innovation waiver to implement the Georgia Access Model. The plan called for the state to work with private brokers and insurance companies to directly sell qualified health plans through private channels rather than rely on the federally run HealthCare.gov.[19] In granting the waiver, HHS determined that Georgia had met the Section 1332 guardrails. Months later, however, the new Biden administration objected. They claimed the temporary changes to ACA eligibility in the American Rescue Plan Act of 2021 meant that the Georgia Access Model no longer met the guardrails. They demanded that Georgia redo its earlier analysis—within thirty days—to account for the effects of the temporary expansions. The state objected, claiming that the HHS request was effectively forcing the state to undergo reapproval for the same waiver.[20] After completing its own analysis of the Georgia Access Model, HHS suspended the state's waiver in August 2022.[21] Georgia authorities continue to contest

the HHS suspension, arguing it will cost the state millions of dollars and that HHS is violating the initial terms of the waiver.

The recent Georgia experience will ultimately discourage other states from seeking waivers. Applying for waivers is expensive. States must complete complex filing requirements and actuarial analyses. They must also regularly report the results of their waiver-initiated policies to HHS. These processes are intended to ensure the guardrails are met and federal tax dollars are spent wisely. But once given approval, states should have confidence that they can implement policies without having to relitigate the initial approval. Consequently, future waivers should include language that ensures states can commence approved policies without having to repeatedly show that their initial analyses remain true. HHS must still evaluate the efficacy of policies initiated by Section 1332 waivers; the department should terminate or modify experiments that are not meeting the agreed-upon benchmarks.

Regardless of partisan affiliation, offering states assurances that waivers will not be arbitrarily suspended is in the best interest of both the states and the federal government. Nevada has been issued a waiver to commence a public option experiment. The state plans to begin offering coverage in 2026, but the state has already committed significant resources in designing the plan. An incoming Republican administration in 2025 may object to the concept of a public option, but Nevada should not have to worry that the new administration will force it to recomplete its analysis before it can begin enrollment as scheduled.

Indeed, Section 1332 waivers can be used for more ambitious reforms like Nevada's public option or Georgia's attempt to redesign its marketplace for individual health insurance. The ACA gives broad latitude for states to consider a variety of coverage arrangements and, perhaps more importantly, a consolidated stream of federal funding to break down existing coverage silos among Medicaid beneficiaries, ACA-subsidized low- and middle-income individuals and families, and even Medicare beneficiaries. States should have the freedom and flexibility to pursue these reforms without regard to ideological, partisan, or other political restrictions at the federal level.

Liberalizing and expanding the use of waivers still requires finding policies that can improve state health programs. Below we identify potential reforms that states could champion.

EXPAND ACCESS TO CATASTROPHIC ("COPPER") PLANS

Catastrophic insurance plans are rare in America, yet they make sense for many young and healthy Americans. As discussed above, these plans are often labeled "copper"

plans because insurance companies are expected to cover only 50 percent of expected health costs (compared to 70 percent for silver plans). The ACA clamped down on consumers' freedom to choose catastrophic coverage. To be eligible, individuals need to be under age thirty or qualify for an exemption based on hardship or affordability. On top of that, tax credits for premiums generally cannot be used for the purchase of copper plans. Because of these issues, only about 1 percent of ACA enrollees choose a copper plan.[22]

The result is that the ACA is a bad deal for many healthy individuals, whose expected healthcare costs are far below the premiums they must pay. Many of these individuals opt to avoid coverage—a prospect made easier since the ACA individual mandate penalties were eliminated in 2019. Expanding access to copper plans to more individuals would fill an important need. As we discuss next, subsidized ACA enrollees who choose copper plans could have any excess subsidy directed to the individual health accounts we propose, giving them more control over their healthcare spending.

States that want to experiment with various copper plans are currently limited by ACA rules. Waivers would be needed to give states flexibility to design insurance products that fit the needs of their residents—many of whom are currently left with few affordable options. Unfortunately, the Biden administration's restrictive interpretation of ACA Section 1332 will impede states' ability to offer policies that consumers demand.

OFFER INDIVIDUAL HEALTH ACCOUNTS TO ACA RECIPIENTS

In another essay in this series, we propose a new healthcare savings account, the individual health account (IHA). IHAs would be akin to a mix of health savings accounts (HSAs) and individual retirement accounts. The aim of these accounts is twofold: First, the accounts will offer more Americans an opportunity to save for their future healthcare needs. Second, IHAs will give people an incentive to be more price conscious regarding their healthcare purchases.

As we noted in the IHA essay, HSAs are not available for most ACA recipients. Plans offered on the ACA exchanges have cost-sharing rules that don't meet the requirements of high-deductible health plans (HDHPs), which are required if individuals wish to contribute to an HSA. Since IHA participation wouldn't require HDHPs, ACA participants would be permitted to open and contribute to an IHA.

Unsubsidized ACA participants would face the same IHA contribution rules as employer-sponsored insurance (ESI) participants. They could make tax-free contributions to their

IHA up to a maximum level, less the premiums they pay. For subsidized recipients, however, the tax benefits from making pretax IHA contributions would be minimal; few recipients earn enough to pay income taxes, particularly after accounting for premium tax credits. To ensure low-income Americans can benefit, states should be able to experiment with models in which federal and state contributions are deposited into a recipient's IHA.

For example, recipients of subsidized coverage could select copper or bronze plans, with any remaining subsidy deposited into their IHA. Unlike those with ESI and unsubsidized plans, there would be limits on when they could withdraw their IHA funds for unqualified medical spending. Early withdrawal could be outright prohibited, or there could be a penalty attached to discourage individuals from immediately withdrawing their available IHA funds.

Pairing ACA subsidies with health account contributions is not a new idea. The Paragon Health Institute recently published one proposal in *The HSA Option*.[23] This option would redirect money currently going to cost-sharing reduction subsidies toward individual HSAs. Under current law, those with incomes below 250 percent of the poverty line may purchase silver plans with reduced cost-sharing requirements. 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.

INDIVIDUAL HEALTH ACCOUNTS FOR MEDICAID RECIPIENTS

Similarly, IHAs could be made available to Medicaid recipients through Section 1115 waivers. Currently, federal rules force most Medicaid recipients into a one-size-fits-all system of healthcare. Choice is minimal. IHAs offer an opportunity to empower these recipients. We propose that states pursue experiments that offer Medicaid recipients the option to have an IHA with contributions made to the account by the state's Medicaid program. In exchange, states would increase cost-sharing requirements one-for-one with the contributions made. Exemptions from cost sharing could be made for certain preventive services. Importantly, the requirements would include annual out-of-pocket maximums that match the annual contribution to the recipient's IHA. This ensures recipients would not be made worse off.

As with the ACA subsidies, rules would be needed to prevent withdrawals for nonqualified spending for a certain amount of time. Importantly, Medicaid participants with an IHA could spend their IHA funds on qualified medical expenses or even services not

broadly covered by Medicaid, such as dental benefits or access to direct primary care arrangements.

Why offer Medicaid recipients IHAs? First and most importantly, Medicaid recipients would be *better* off. As noted above, the current Medicaid program isn't working well for some Medicaid recipients, and their choices are generally limited. IHAs paired with Medicaid would maintain health coverage, but unlike with standard Medicaid, recipients would have an asset that offers value beyond their Medicaid coverage. The accounts would offer them more choice in the healthcare they consume along with the potential for greater financial security.

Second, IHAs are explicitly designed to discourage unnecessary health spending by consumers—not through heavy-handed rules, but through better incentives. IHAs would provide the same incentives to Medicaid recipients.

Seemingly similar reforms have been tried. The Healthy Indiana Plan (HIP) offers Medicaid recipients an alternative plan that includes contributions to a savings account.[24] But, as shown in table 1, there are important differences between Medicaid with IHAs and the Healthy Indiana Plan.

In the Healthy Indiana Plan, participating individuals are required to make contributions to the plan—anywhere from $1 to $20 per month. State and personal contributions to the accounts total $2,500 per year. In exchange, participants have an annual deductible

TABLE 1 A COMPARISON BETWEEN THE HEALTHY INDIANA PLAN AND MEDICAID WITH IHAs

	Healthy Indiana Plan	**Medicaid with individual health accounts**
Premiums	From $1 to $20 per month	No premiums
Government contributions	State makes $2,500 in contributions, less enrollee premiums	State contributions with no required individual contribution
Account ownership	Premiums belong to enrollee, but state contributions remain with state	All contributions belong to enrollee, with limits on non-qualified withdrawals
Qualified spending	Only services offered by state Medicaid program	Any IHA qualified medical spending
Cost sharing	Annual deductible of $2,500	Cost sharing limited to amount of state IHA contribution

of $2,500. In other words, the first $2,500 of Medicaid spending each year is financed through the accounts. Any spending above that amount is covered directly by the state's Medicaid program. The aim of HIP is to incentivize participants to think about their healthcare consumption. Nevertheless, HIP incudes many complex rules that limit its efficacy. Unlike IHAs with Medicaid, HIP account balances are never fully owned by the participants. Their contributions are generally returned to them if they leave the program in good standing. But the state contributions are returned to the state. This ultimately reduces incentives to contain costs.

In the short run, an IHA with Medicaid wouldn't be costless. Some individuals will receive more in contributions than Medicaid would have otherwise spent on them. Nevertheless, depending on the design, the long-term savings from improved incentives could be substantial.

DIRECT PRIMARY CARE FOR MEDICAID RECIPIENTS

Medicaid is now the fourth largest noninterest spending program in the federal budget. In most states, Medicaid spending reflects almost one-fifth of state budgets and is expected to grow over time.[25] With the rapid growth of Medicaid MCOs contracting with state governments to cover enrollees for a capitated cost, finding ways to reduce the growth of per capita Medicaid spending is in the federal and each state government's interest.

One idea is for states to obtain a Section 1115 waiver to experiment with offering direct primary care (DPC) coverage to Medicaid enrollees, either as a carve-out from existing per capita spending or on top of traditional coverage. The goal would be to lower long-term per capita Medicaid spending by having direct primary care needs covered at much lower cost than in existing arrangements.

Most annual DPC coverage costs are between $500 and $1,000 per year for adults. And the Society of Actuaries found that DPC coverage was associated with a statistically significant decrease in healthcare demands of 12 percent, including a 40 percent drop in emergency room services.[26] If states could get their Medicaid patients to first go through their DPC doctor and then through the existing Medicaid system, the savings could be significant.

The Medicaid Primary Care Improvement Act is one bipartisan proposal that would explicitly allow states to provide DPC coverage to their Medicaid enrollees.[27] The advantage would be to either simplify or skip the waiver process altogether. Access, quality, and satisfaction metrics among DPC enrollees suggest that supplementing traditional Medicaid coverage with DPC coverage could improve those metrics without adding new costs.

CONCLUSION

Low- and middle-income Americans deserve access to high-quality medical care that gives them genuine choices. There are many more ideas that states could champion that are worthwhile. While some of these reforms may prove unsuccessful, the long-term benefits to recipients from successful innovations are worth the short-term costs.

The success of the 1996 welfare reforms serve as a template. The ideas underpinning the act did not originate from the halls of Congress. Instead, the ideas came from state capitals where policymakers—aware of the challenges the federal programs were creating for recipients—were given opportunities to experiment with different welfare models.

The same opportunity could be available to states across America—for the benefit of the tens of millions of Americans who benefit from Medicaid or ACA subsidies today.

NOTES

1. The Social Security Act Amendments of 1950, for example, provided matching grants to states to provide health services to those enrolled in a state's welfare program. Even prior to 1950, the Social Security Act provided subsidies to states for certain health services. See Cogan (2017) for a history of federal healthcare subsidies.

2. See figure 7 in HHS (2022).

3. In 2013, individuals with family incomes below 100 percent of the federal poverty level could pay up to $4 for most noninpatient services, $8 for nonemergency use of emergency rooms, $75 for inpatient care copays, and $4 to $8 for prescription drugs. These amounts are indexed to inflation. States are permitted to charge coinsurance rates of 10 to 20 percent of total Medicaid costs to those with incomes above 100 percent. See https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs/index.html for an overview.

4. For an overview of Medicaid cost-sharing rules by state, see KFF (2020).

5. See KFF (2023) for an overview of MCOs.

6. Throughout this essay, when discussing Medicaid enrollment or spending, we include those who qualify through the Children's Health Insurance Program (CHIP).

7. See page 3 in CBO (2022a).

8. See table 1 in CBO (2022b).

9. See SHADAC (2022) for an overview of the survey results.

10. AMN Healthcare (2022).

11. For example, Gotlieb, Rhodes, and Candon (2020) find Medicaid patients wait a day longer to see their primary-care doctors than those with private coverage.

12. Oostram, Einav, and Finkelstein (2017) find Medicaid patients are 20 percent more likely to experience a wait time longer than 20 minutes. The longer Medicaid wait times were correlated with states with lower Medicaid reimbursement rates.

13. Some of the decline can be attributed to the effective elimination of the individual mandate in the Tax Cuts and Jobs Act of 2017 (TCJA). However, even prior to the passage of TCJA, CBO's

enrollment projections had fallen. In 2017, CBO (2017) estimated that 2019 ACA enrollment would be twelve million with ten million receiving subsidies—half of the number that CBO originally projected.

14. See page 140 in White House (2023).

15. Wang (2022) finds that the Medicaid expansion increased wait times in emergency departments, while Auty and Griffith (2022) find that the expansion increased physician appointment wait times in some cases.

16. For more on the history of Section 1115 waivers, see Guth et al. (2020).

17. See CMS (2018) for an overview of the 2018 guidance.

18. Page 53462 in the Federal Register, https://www.govinfo.gov/content/pkg/FR-2021-09-27/pdf/2021-20509.pdf.

19. HHS' original approval letter is here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Approval-Letter-STCs.pdf.

20. The state also noted that the temporary eligibility expansions were scheduled to end prior to the start of the Georgia Access Model. HHS, however, argued that even though the expansions were set to expire, there would be increased enrollment following the expansions, and thus the initial analysis was no longer applicable. Ultimately, Congress extended the expansions for an additional three years.

21. Correspondence between Georgia and HHS is available here: https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers.

22. See page 10 in CMS (2023).

23. See Blase et al. (2022) for a description of the proposal.

24. For an overview of the plan, see https://www.in.gov/fssa/hip/about-hip/frequently-asked-questions/.

25. See MACPAC (2017).

26. Society of Actuaries (2020).

27. For example, see Representative Dan Crenshaw's recent proposed bill discussed in Choi and Weixel (2023).

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CHOICES FOR ALL PROJECT

The Budget Effects of Proposals in the Choices for All Project

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

The Choices for All Project offers targeted, incentive-based improvements to our healthcare system rather than a one-size-fits-all fix. It attempts to improve incentives by creating more choices in how we pay for healthcare, what services we use, and which providers we see. The reforms, however, are not costless. They will require either short-term deficit spending or offsetting budget cuts. Here we estimate the budget effects of our proposed reforms, with particular focus on the ten-year effects of our proposals on the federal budget. We also offer options to pay for these plans if policymakers find it necessary.

SUMMARY

- Without individual health accounts (IHAs), extending out-of-pocket (OOP) deductibility of health expenses would reduce ten-year federal revenues by $79 billion.
- Separately, IHAs would reduce federal revenues by $82 billion over ten years if contribution limits were set at the 50th percentile of current employer-sponsored insurance (ESI) premiums.
- Combined, IHAs and full deductibility of OOP spending would reduce federal tax revenue by $94 billion over ten years.
- These policies can be paid for by ending the enhanced Affordable Care Act (ACA) subsidies from the Inflation Reduction Act or adding work requirements to Medicaid.

AN OVERVIEW OF PROPOSED TAX CHANGES

The Choices for All Project features two significant changes to the US tax code that, without offsetting changes, would increase federal deficits over the next ten years.

First, the project proposes a new tax savings vehicle for health spending: individual health accounts. These accounts are akin to a mix of health savings accounts (HSAs) and individual retirement accounts. IHAs would be available to all individuals and families with health coverage. Unlike HSAs, IHA contribution limits would vary depending on how much a person spends on their premiums. Those with low-premium plans could contribute more; those with high-premium plans may not be able to contribute at all. In addition, unlike HSAs, IHA contributions would not reduce a person's payroll tax liability, only their personal income tax liability.

Second, the Choices for All Project proposes improving the tax treatment of OOP medical spending. This spending would become an "above-the-line" tax deduction (i.e., it would reduce a taxpayer's adjusted gross income). It would replace the current medical expense deduction that allows taxpayers to deduct medical expenses totaling more than 7.5 percent of their adjusted gross income.

Extending OOP deductibility and offering IHAs would each affect individual healthcare spending, taxable compensation, and, ultimately, taxes owed. The budget effects of these changes depend crucially on the type of health insurance a taxpayer has.

While the proposals are distinct from one another, each would lower the posttax price of OOP spending. As the differential tax treatment between ESI premiums and OOP spending is reduced, more consumers with ESI coverage would opt for lower-premium plans with more cost sharing. Similarly, the incentives embedded in IHAs would encourage individuals to shift to plans with more cost sharing and lower premiums. These changes will reduce total health expenditures among those with current ESI coverage, raising their taxable income and, all else constant, increase tax revenue. The revenue gains would be at least partially offset by tax revenue losses from increased deductions for OOP spending and new tax-preferred contributions to IHAs. The combined magnitude and direction of these effects depend on consumers' responsiveness to changes in the posttax price of OOP spending, their income and payroll tax rates, and their saving behavior. The expected reduction in premiums would have a relatively larger effect on payroll tax revenue since the IHA contributions and the OOP deduction wouldn't reduce a taxpayer's payroll tax burden.

For those without ESI coverage, the budget effects are more straightforward but likely more costly. First, extending the tax deductibility of OOP spending will directly reduce income tax revenue as individuals take the "above-the-line" deduction or make contributions to their IHAs. Second, revenue will be further reduced as individuals respond to the improved tax treatment by selecting insurance plans with lower premiums and higher cost-sharing rates.

While it is possible that there are small offsetting effects to the revenue reductions among individuals without ESI, they are unlikely to have a material effect on our cost estimate. It might seem like the change could reduce ACA subsidies, but this is unlikely to be the case without further changes to ACA rules.[1] Under current ACA rules, enrollees' subsidies are based on their family's income relative to the federal poverty guidelines and their benchmark plan premium. Because the actuarial value of the benchmark plan is fixed at 70 percent, changes in plan selection will have a minimal effect on the premium for the benchmark plan. Thus, ACA subsidies wouldn't change even if ACA recipients responded to our tax changes by opting for plans with higher cost-sharing requirements.[2]

Below, we offer three distinct estimates for our proposed tax changes. First, we consider the individual effects of the tax deductibility of OOP spending. We then consider the effects of IHAs without expanding OOP deductibility. Finally, we consider the combined effects of both proposals. We consider both the static effects (i.e., before accounting for changes in plan selection) and then the dynamic effects (i.e., including likely changes in insurance plans). Finally, we consider potential "pay-fors" that could offset these budget effects if policymakers want deficit-neutral health reforms. We begin with an overview of our methodology and important limitations of our model.

METHODOLOGY

We use the Collection of Health Expenditures and Insurance (CHEI) database to estimate the effects of our policy changes.[3] This dataset imputes medical expenditures and premiums using data from the Medical Expenditure Panel Survey (MEPS) on respondents in the Current Population Survey (CPS). Health expenditures and premiums are a function of respondents' reported health insurance type (e.g., group coverage, individual coverage, Medicaid, Medicare), family income, various demographic and health variables, and state of residence.

We construct separate datasets for each year through the next thirty years. We use economic assumptions by the Congressional Budget Office (CBO) and the National Health Expenditure data to grow incomes and health-related variables. Population changes reflect recent US Census Bureau projections.[4]

The dataset includes various tax variables including estimates of respondents' marginal tax rates by year.[5] The tax simulation has important limitations that affect our current analysis. Due to data limitations, we assume all taxpayers claim the standard deduction rather than itemize. This will result in overstated tax liabilities and marginal tax rates. The effect of this limitation grows after 2025, when the individual provisions of the Tax Cuts and Jobs Act expire. In addition, our dataset does not include tax credits; this will, again, lead us to overstate tax liabilities and affect our estimated tax rates.[6]

In calculating the static effects of OOP deductibility, we calculate the product of the respondents' estimated marginal income tax rates and their imputed OOP spending. To

calculate the dynamic effects of OOP deductibility, we follow the methodology outlined in the appendices of Cogan, Hubbard, and Kessler (2011). Their method yields the change in total health spending and the increase in coinsurance rates after the reduction in the post-tax price of OOP spending. We then estimate changes in payroll and income taxes using respondents' adjusted health spending estimates.[7]

To estimate the budgetary cost of IHAs (without any changes in OOP deductibility), we estimate potential contribution limits for IHAs based on estimated ESI premiums each year for individual and family plans. Below, we consider two contribution limits: the 50th percentile of ESI premiums and the 75th percentile of ESI premiums. We then estimate the maximum a person could contribute given their current ESI premium amount. Of course, it is unlikely that all individuals would save the maximum amount. To account for this, we use HSA contribution rates for current HSA enrollees by age as a proxy for how much individuals are likely to contribute relative to their allowable maximum amount.[8] Importantly, we do not calculate changes in insurance plan selection due to IHAs. This omission will mean we will overstate the cost of IHAs insofar as the proposal leads individuals to choose lower-premium plans.

There is a significant interaction between extending OOP deductibility and offering IHAs. If enacted jointly, an individual's annual IHA contribution limit should be reduced by the amount of their OOP spending. Otherwise, higher-income taxpayers could use IHAs as merely a tax-preferred savings vehicle with little incentive to use the account for qualified withdrawals. In this case, a person's allowable IHA contributions would be based on the person's net contribution over the year, that is, the difference between one's annual IHA contributions and one's qualified IHA withdrawals. Further, to ensure individuals do not deduct their OOP spending twice, tax rules would be required to tax all withdrawals that went to deducted OOP spending.[9]

After accounting for these interactions, the added cost of IHAs with extended OOP deductibility is small. This is particularly true over the long term, since all IHA contributions will eventually be spent on deductible health spending or be taxed.[10] In our joint calculations, we rely on our dynamic budget estimates of OOP deductibility and then simulate net IHA contributions using the method outlined above. This method will overstate the long-term cost of IHAs as it does not account for IHA withdrawals in subsequent years.

We make several other simplifying assumptions to our budget estimates. Generally, our aim in making these assumptions is to ensure our cost estimates represent an upper bound of the proposals' budgetary costs.

First, we exclude those with existing high-deductible health plans (HDHPs) covered by HSAs or health reimbursement arrangements (HRAs). Generally, the tax treatments of these accounts would be more favorable than IHAs or extended OOP deductibility. In particular, the accounts lower taxpayers' payroll tax liabilities while IHAs and OOP deductibility wouldn't. As discussed in the essay in this series on IHAs, these new accounts would come with certain advantages over existing health savings vehicles (e.g., additional insurance options, no tax penalties for

TABLE 1 TAX EXPENDITURES FOR EXTRAORDINARY OOP DEDUCTION BY INSURANCE TYPE (BILLIONS)

	Group coverage	Individual/other	Uninsured	Medicare	Total
2023	$4.2	$1.2	$2.6	$2.9	**$10.9**
2024	$4.4	$1.3	$2.7	$3.0	**$11.4**
2025	$4.6	$1.4	$3.0	$3.2	**$12.2**
2026	$6.9	$1.9	$4.6	$5.0	**$18.4**
2027	$8.5	$2.3	$5.7	$6.2	**$22.8**
2028	$9.2	$2.5	$6.1	$6.8	**$24.6**
2029	$9.9	$2.7	$6.6	$7.5	**$26.6**
2030	$10.6	$2.9	$7.1	$8.1	**$28.7**
2031	$11.5	$3.1	$7.6	$8.8	**$30.9**
2032	$12.3	$3.3	$8.2	$9.5	**$33.3**

Notes: Authors' estimates. We estimate aggregate OOP spending by insurance type in the CHEI database, weighted by the respondents' marginal tax rate. We then apply these shares to the aggregate tax expenditure estimates provided by the US Treasury (December 2023).

unqualified withdrawals). This might lead some individuals to opt for IHAs in lieu of HSAs or HRAs. Tax revenue would likely rise with these changes, but to be conservative we omit these effects from our analysis.

Second, we exclude Medicare recipients. Extending OOP deductibility or offering IHAs to Medicare recipients would significantly raise the cost of either proposal. Since the Choices for All Project is focused on fixing health insurance for nonseniors, we do not propose specific changes to the Medicare program. While improving incentives among Medicare recipients is a worthwhile goal, any changes in tax treatment would need to be paired with significant reforms to Medicare's structure.

Finally, as mentioned above, we do not impute itemized deductions in the CHEI data. This means our estimates will overstate individuals' tax rates, which will consequently lead us to overstate the static revenue losses from IHAs or extending OOP deductibility.[11] A related issue is the existing extraordinary medical expense deduction. Since we do not directly model the deduction in the CHEI dataset, our estimates will overstate the budget costs of our changes. To account for this, our aggregate estimates deduct the estimated amount of the tax expenditure for the existing extraordinary medical spending deduction, excluding the share attributed to Medicare recipients. Table 1 shows our estimate of this tax expenditure by insurance type.[12]

BUDGET COSTS OF TAX DEDUCTIBILITY OF OUT-OF-POCKET SPENDING (WITHOUT INDIVIDUAL HEALTH ACCOUNTS)

While it might seem like a small change to our healthcare system, extending deductibility would have important effects on total health spending and the federal budget.

Before accounting for changes in plan selection, extending OOP deductibility would reduce income tax revenue by $22 billion in 2023 and $252 billion over the next ten years. Table 2 reports the change in income taxes by insurance type.

However, the static estimates significantly overstate the likely effects of OOP deductibility. As the differential tax treatment between ESI premiums and OOP spending is reduced, more consumers would opt for lower-premium plans with more cost sharing. This would reduce total health expenditures among those with current ESI coverage. We estimate that the behavioral changes would reduce total health spending among those with ESI coverage by about $20 billion annually, or about 3.7 percent of health spending among those with ESI coverage (or self-employed) and enrolled in plans without HSAs or HRAs. The shift to higher cost sharing would reduce premiums by as much as 10 percent among this group. Table 3 shows the estimated change in total spending among the ESI group.

After accounting for these behavioral effects, we estimate that OOP deductibility would reduce federal tax revenue by $6 billion in 2023 and $79 billion over the ten-year budget window. We estimate income tax revenue would fall by $167 billion over ten years, but this would be offset by $88 billion in additional payroll tax revenue from reduced ESI premiums. Table 4 offers a breakdown of the ten-year revenue effects.[13]

The $79 billion revenue loss over ten years is significant, but as noted above, it would mean a $20 billion initial reduction in health spending with larger savings in future years.

TABLE 2 STATIC CHANGE IN INCOME TAX REVENUE FROM EXTENDING OOP DEDUCTIBILITY (BILLIONS)

Insurance type	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
Employment-based coverage	–$12	–$12	–$12	–$13	–$13	–$13	–$13	–$14	–$14	–$15	**–$131**
Uninsured	–$7	–$7	–$8	–$9	–$8	–$9	–$9	–$9	–$9	–$10	**–$85**
Individual/other coverage	–$3	–$3	–$4	–$4	–$3	–$4	–$4	–$4	–$4	–$4	**–$36**
Total	**–$22**	**–$22**	**–$23**	**–$26**	**–$25**	**–$25**	**–$26**	**–$26**	**–$28**	**–$29**	**–$252**

Notes: Authors' calculations. Change in income tax revenue is net of existing tax expenditures for OOP spending deductions.

TABLE 3 CHANGE IN 2023 HEALTH SPENDING BY ESI PARTICIPANTS WITH OOP DEDUCTIBILITY (BILLIONS)

	Current law	With OOP deductibility	Change
OOP spending	$92	$119	$27
Premiums	$460	$413	–$47
Total spending	**$552**	**$532**	**–$20**

Notes: Authors' calculations. Estimates exclude those with HDHPs with HSAs or HRAs.

TABLE 4 DYNAMIC CHANGE IN FEDERAL TAX REVENUE FROM OOP TAX DEDUCTIBILITY (BILLIONS)

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
Employment-based coverage											
Income taxes	–$1	–$1	–$1	–$3	–$2	–$2	–$2	–$1	–$2	–$2	–$16
Payroll taxes	$7	$8	$8	$8	$8	$9	$9	$9	$10	$11	$88
Total	**$6**	**$7**	**$7**	**$5**	**$7**	**$7**	**$8**	**$8**	**$8**	**$9**	**$72**
Uninsured: total	**–$8**	**–$8**	**–$9**	**–$11**	**–$10**	**–$11**	**–$11**	**–$11**	**–$12**	**–$12**	**–$104**
Other coverage: total	**–$4**	**–$4**	**–$4**	**–$5**	**–$5**	**–$5**	**–$5**	**–$5**	**–$5**	**–$5**	**–$47**
All coverage											
Income taxes	–$14	–$14	–$15	–$18	–$17	–$17	–$17	–$18	–$18	–$20	–$167
Payroll taxes	$7	$8	$8	$8	$8	$9	$9	$9	$10	$11	$88
Total	**–$6**	**–$6**	**–$7**	**–$10**	**–$8**	**–$8**	**–$8**	**–$8**	**–$8**	**–$9**	**–$79**

Notes: Authors' calculations. The revenue changes account for changes in total health spending and cost-sharing rates from the policy. Estimates exclude revenue changes from Medicare recipients. ESI coverage changes include self-employed.

BUDGET COSTS OF TAX DEDUCTIBILITY OF INDIVIDUAL HEALTH ACCOUNTS (WITHOUT EXTENDING DEDUCTION FOR OOP SPENDING)

All else constant, IHAs would reduce income tax revenue, particularly in the near term. While IHAs would be available to all non-Medicare recipients with public or private health insurance, changes in tax revenue would largely be due to tax-preferred contributions by those with ESI coverage who currently don't use HSAs or HRAs. Consequently, our analysis here focuses on this subgroup.[14]

TABLE 5 STATIC EFFECTS OF IHAs AT VARIOUS CONTRIBUTION LEVELS (BILLIONS)

IHA contribution limit	2023 IHA savings	Change in 2023 income tax revenue	Change in 10-year income tax revenue
50th percentile of ESI premiums	$30	–$6	–$82
75th percentile of ESI premiums	$66	–$12	–$176

Notes: Authors' calculations. Estimates assume no change in the ESI plan selection (i.e., policyholders choose plans with identical premiums and cost sharing as they would without IHAs).

We consider two contribution limits for IHAs: the 50th percentile of current premiums and the 75th percentile of current premiums. The 50th percentile of premiums corresponds to approximately $25,000 for family plans and $8,600 for self-only plans (the 75th percentile thresholds would be $29,800 and $10,100). We assume the thresholds would grow with overall healthcare premium growth. Estimated revenue losses could be lower if the thresholds grew only at the rate of medical inflation.

Table 5 reports the static ten-year expected contributions and associated revenue losses from IHAs.

As shown in table 5, we estimate that if the maximum contribution limit is set at the 50th percentile of ESI premiums, taxpayers would save approximately $30 billion in their IHAs in 2023. This would reduce federal income taxes by $6 billion in 2023. Over ten years, the federal government would lose $82 billion in revenue. If, instead, the maximum contribution limit was set at the 75th percentile of ESI premiums, taxpayers would save $66 billion in their IHAs in 2023. The loss in income tax revenue would be $12 billion in 2023 and $176 billion over the ten-year budget window.

The static estimates provided here overstate the budgetary cost of IHAs for several reasons. First, the explicit trade-off between premiums and IHA contribution limits is intended to encourage individuals to select plans with lower premiums that we do not model here. Because IHA contributions would not lower one's payroll tax liability, any reduction in ESI premium contributions would increase payroll tax revenue. For most ESI enrollees, substituting a dollar of premiums for an additional dollar of IHA savings would raise about 15 cents of payroll tax revenue. Second, the shift to lower-premium plans would raise coinsurance rates, which would reduce total medical spending, further reducing ESI premiums and the related tax expenditure. Finally, our analysis excludes those who have HSAs. If would-be HSA participants trend toward IHAs instead (as we expect), the budgetary costs would fall as HSA recipients would pay payroll taxes on their IHA contributions.

Meanwhile, the absence of any tax penalty for unqualified withdrawals could increase or decrease total revenue. Tax revenue would fall among those who take unqualified withdrawals

from their IHAs if they would have otherwise taken unqualified withdrawals from their HSAs and paid the penalty. Tax revenue could rise, however, if individuals who would otherwise have spent pretax HSA dollars on healthcare choose to make unqualified withdrawals from IHAs instead.

BUDGET EFFECTS OF INDIVIDUAL HEALTH ACCOUNTS PAIRED WITH OOP DEDUCTIBILITY

There are significant interactions between extending OOP deductibility and IHAs. Over the long term, all IHA contributions would either be taxed or go to qualified OOP spending. The additional budget effects from adding IHAs to our extended OOP deductibility proposal are thus relatively small. Nevertheless, here we estimate short-run effects from both proposals. As noted above, our method likely overstates the long-term cost of IHAs as it does not account for IHA withdrawals in subsequent years or changes in plan selection due to the availability of IHAs.

We estimate the combined revenue losses from IHAs and extending OOP deductibility would be $7 billion in 2023 and $94 billion over the ten-year budget window. While these costs should be viewed as an upper bound, they are nevertheless minor compared to recent healthcare reforms. The ACA's coverage provisions, for example, were initially scored as costing $938 billion over its first ten years—with nearly $900 billion in the second half of the budget window.[15] More recently, the Biden administration has proposed permanently extending expanded ACA subsidies, which would increase ten-year budget deficits by $183 billion.[16]

TABLE 6 CHANGE IN FEDERAL TAX REVENUE FROM OOP TAX DEDUCTIBILITY AND IHAs (BILLIONS)

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
Change from extending OOP deductibility	–$6	–$6	–$7	–$10	–$8	–$8	–$8	–$8	–$8	–$9	**–$79**
Change from IHAs (contribution limit set to 50th percentile of ESI premiums)	–$1	–$1	–$1	–$1	–$1	–$2	–$2	–$2	–$2	–$2	**–$15**
Total change	**–$7**	**–$7**	**–$8**	**–$11**	**–$10**	**–$10**	**–$10**	**–$10**	**–$10**	**–$11**	**–$94**

Notes: Authors' calculations. IHA contribution limits are set at the 50th percentile of estimated premium levels after accounting for the behavioral changes from extending OOP deductibility.

POTENTIAL "PAY-FOR" OPTIONS

To reduce health cost growth, policymakers should not resort to politically damning budget cuts or hidden costs through regulatory provisions or budget gimmicks. Instead, they should coalesce around healthcare reforms that lower the rate of healthcare inflation and produce budget savings over the long term. That requires better incentives that empower individuals to think more deeply about their healthcare choices. Our plan focuses on ways to improve these incentives through more choices in how we pay for healthcare, what services we use, and which providers we see.

These changes won't be costless, particularly in the short run. Nevertheless, weighed against the long-term benefits of the proposals, we believe the trade-offs to be worthwhile.

Importantly, as we show above, the combined federal budget costs for our reforms would be minimal relative to current federal health spending. We estimate that the two most costly provisions we propose, individual health accounts and extending deductibility for out-of-pocket medical spending, would reduce federal revenues by less than $100 billion over ten years. In comparison, the US Treasury (2023) estimates that the tax expenditure for ESI premiums will be $3.4 trillion over the next ten years. Federal outlays for Medicaid and the ACA will total $7.7 trillion.[17] Even compared to recent reforms, the budget costs of our proposals are modest.

Despite the relatively small costs, the state of the federal budget will make many policymakers leery of creating any additional deficits. For these policymakers, we offer potential budget changes that could offset the costs of our proposals while further improving incentives in our healthcare system. Importantly, the proposed pay-fors are not politically painless; policymakers may find their inclusion necessary for budget purposes, but their inclusion could weaken support for the remaining proposals.

Here we propose two potential pay-fors that will reduce federal healthcare costs while improving the system's incentives.[18] While we do not explicitly endorse either policy alternative, we present them here to illustrate possible policy alternatives that could produce necessary savings to compensate for the costs of instituting our own proposals. We offer additional alternatives in the appendix. Other policy alternatives are available to offset the relatively modest costs of the tax policy changes we propose and may be found in CBO's "Options for Reducing the Deficit."[19]

POTENTIAL PAY-FOR: END TEMPORARY EXPANSIONS OF THE ACA PREMIUM TAX CREDITS

When the ACA was created, premium tax credits were available to purchasers on the individual market if their family income was under 400 percent of the federal poverty line. In 2021, Congress temporarily liberalized eligibility for higher ACA coverage subsidies. The American Rescue Plan Act of 2021 (ARPA) provided premium subsidies to individuals with incomes above 400 percent of the federal poverty level.[20] ARPA also reduced the required contribution share for all enrollees.

TABLE 7 ESTIMATED OUTLAY CHANGE FROM ENDING TEMPORARY ACA EXPANSIONS (BILLIONS)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Total
Current law baseline	$22	$20	$3	$0	$0	$0	$0	$0	$0	$0	**$45**
Current policy baseline	$22	$20	$19	$22	$23	$24	$23	$23	$25	$26	**$227**

Notes: The current law baseline is based on CBO (2022b) beginning with its 2024 estimated effects of the ACA expansion. The current policy baseline combines CBO (2022b) with the estimated deficit effects of making the ACA expansions permanent per President Biden's FY2024 budget proposal (see table S-6 in White House 2023).

The ARPA expansions were due to expire in December 2022, but Congress extended the subsidies for an additional three years in the Inflation Reduction Act of 2022.[21] The extension added $64 billion in spending and tax subsidies to the federal budget over the next four years.[22] While the extensions are now due to expire in January 2026, the Biden administration is proposing to make these changes permanent. The president's FY2024 budget request proposed $183 billion over ten years to "make the enhanced premium tax credits previously extended under the Inflation Reduction Act permanent."[23]

The recent liberalizations have increased projected enrollment in the ACA. Nevertheless, the increased enrollment is not necessarily among low-income households. As noted above, the liberalizations expanded eligibility up the income ladder. The result is that a family of four with an income over $200,000 may qualify for premium subsidies.

The money has increased ACA enrollment, but at a high cost. As shown in table 7, ending these expansions beginning in 2024 would reduce current law baseline deficits by approximately $45 billion during the ten-year budget window.

Moreover, while current law calls for the expansions to sunset in 2025, the provision's temporary design is not for substantive reasons. Instead, the included sunset exists because a permanent extension would have undermined the Inflation Reduction Act's deficit-reduction promises. As evidenced by President Biden's recent budget, proponents of the expansion intend for it to be a permanent policy, even if the budget baseline doesn't reflect it.

This reality means a reasonable argument could be made that substantive health reforms should be scored against a current *policy* baseline rather than under current *law* baseline. The ten-year cost (2023–34) of a permanent ACA expansion would be $227 billion. As shown in table 7, repealing the expansion beginning in 2024 would thus reduce the current policy baseline by an equivalent amount.

POTENTIAL PAY-FOR: CREATE WORK REQUIREMENTS FOR ABLE-BODIED MEDICAID RECIPIENTS WITHOUT DEPENDENTS

An additional method to reduce health budget costs would be to implement Medicaid work requirements for able-bodied adults ages nineteen to fifty-five without dependents.[24] Work requirements for Medicaid recipients were also a topic of discussion during the 2023 debt ceiling debates.[25]

Work requirements are not a new concept. In fact, they were used to great effect through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 when the Aid to Families with Dependent Children program was replaced by the Temporary Assistance for Needy Families program. It stands as one of the most successful welfare reforms in American history. Dependency fell and employment increased.

In 2018, the Trump administration granted waivers to thirteen states to experiment with work requirements for their Medicaid recipients. Ultimately, only Arkansas implemented a program with consequences for those who failed to meet the requirements. Other states either paused their implementation because of lawsuits or abandoned them due to the COVID-19 pandemic. The Biden administration has since revoked all the waivers that were granted.[26]

Since Arkansas was the only state that implemented a work requirement and went through with removing individuals who were in noncompliance, recent estimates of Medicaid work requirements' effectiveness come from that state's experience.[27] The program ran from June 2018 to March 2019. Sommers et al. (2020) estimate that insurance coverage fell without corresponding changes in employment. There are limitations in using the Arkansas experiment to measure the efficacy of work requirements. The period covering enrollees was only a few months long. Telephone interviews with those required to fulfill work requirements revealed many were unsure if the requirements applied to them. More time would allow more complete information to be conveyed to covered individuals. The CBO calls the evidence "scant."[28]

CBO (2023b) estimates that Medicaid work requirements would lower federal costs, increase the number of people without health insurance coverage, have no effect on the hours worked by Medicaid recipients, and raise budget costs for states who choose to maintain coverage for affected recipients. CBO estimates that a federal law imposing Medicaid work requirements would affect fifteen million people, although many would qualify for exemptions. About 1.5 million adults would lose federal funding for their Medicaid coverage. CBO also estimates that 60 percent would continue to be covered by states while the remaining 40 percent would become uninsured.

Table 8 shows CBO's (2023a) ten-year estimated cost savings from Medicaid work requirements. With a phase-in period, the requirements would reduce federal Medicaid outlays by $109 billion over the ten-year budget window.

TABLE 8 ESTIMATED OUTLAY CHANGE FROM MEDICAID WORK REQUIREMENTS (BILLIONS)

2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Total
$0	$0	–$4	–$7	–$11	–$12	–$13	–$14	–$15	–$16	–$17	**–$109**

Note: See table 3 in CBO (2023a).

CONCLUSION

Healthcare reform presents unavoidable trade-offs among cost, quality, and coverage, particularly in the short run. Our proposed reforms are no exception.

We estimate that extending the deductibility of out-of-pocket spending while offering individual health accounts to American families would raise federal deficits by $94 billion over the ten-year budget window. These budget changes represent a small change relative to the trillions of dollars spent on existing federal subsidies for healthcare. And, importantly, they represent a dramatic improvement in incentives that would lower total medical spending, particularly among those with ESI coverage.

Nevertheless, at a time of trillion-dollar deficits, fiscal responsibility may be an important objective for many reformers. If policymakers demand pay-fors that offset the deficit effects of our reforms, they could end the enhanced subsidies for the Affordable Care Act (which poorly target those in need) or add work requirements for some able-bodied Medicaid recipients. Either of these reforms would offset the cost of our proposed reforms.[29] These proposed changes, however, would impact existing coverage arrangements and therefore present some risk. Policymakers must determine whether the benefits of these tradeoffs outweigh the costs. But experience has shown that a focus on immediate deficit reductions have doomed good health policy ideas. The result is a healthcare system that ultimately costs even more.

Policymakers should not lose sight of the larger goal of our reforms. The aim should not be to achieve short-term budget savings. Instead, it should be to improve incentives that will fix our healthcare system over the long term, leading to lower costs, better quality coverage, and more access for those who need it most.

NOTES

1. Over the long term, there is the potential that premium growth will be reduced as our combined policy changes will reduce healthcare demand and raise supply. To be conservative, however, we do not consider these effects in any of our cost estimates.

2. The exception would be if ACA enrollees opt for low-cost bronze plans featuring premiums that are less than their maximum subsidy. These savings would be even larger if ACA recipients were permitted to choose "copper" plans, as proposed in our work.

3. See Church and Heil (2019) for details. The CHEI database aims to mirror the Congressional Budget Office's HISIM2 model, with important differences due to data limitations. These limitations are primarily related to firm behavior and ESI options, which are derived from the heavily censored MEPS Insurance Component (MEPS-IC).

4. To introduce changes in population, we adjust CPS weights using a raking technique to match Census projections. We subsequently perform an additional raking technique that adjusts population weights so insurance totals match CBO's ten-year insurance projections for nonseniors.

5. Marginal tax rates (MTRs) are based on discrete $1,000 increases in a filer's taxable income. To simplify our computations in all of our subsequent calculations, we assume the MTR is fixed at this estimated rate regardless of the change in a filer's taxable income.

6. We do not directly estimate state tax rates; instead, we use the National Bureau of Economic Research's TAXSIM model (Feenberg and Coutts 1993) to impute state tax rates as of 2019. We then assume these rates are fixed in subsequent years.

7. We assume no changes in marginal tax rates from any of our proposed changes.

8. Contribution rates for HSA plans are calculated as the ratio of average contributions (including employer contributions) by specified age group to the average contribution limit of each age group. For average contribution amounts, we use estimates from the Employee Benefit Research Institute (EBRI) (Fronstin and Spiegel 2021). Average contribution limits are based on a weighted average of self and family contribution limits where the weights are the estimated share of policyholders with group coverage who have self-only or family coverage. We use the CHEI dataset described in Church and Heil (2019) to estimate these shares. From 2011 to 2020, the average contribution rate for HSA respondents under age 25 was 29 percent, 45 percent for those ages 25 to 34, 58 percent for those ages 35 to 44, and 65 percent for those ages 45 and above.

9. The simplest way to achieve this result would be to add all IHA withdrawals to a tax filer's adjusted gross income (AGI) and then have them deduct their OOP spending. Note, these issues are present in the existing tax code: individuals are prohibited from including HSA-covered spending in the extraordinary medical expense deduction.

10. The long-term changes in nominal revenue collections, however, will likely not be zero for several reasons. First, since a filer's tax rates vary over time, taxed withdrawals may face a different tax rate than the taxpayer faced when making the IHA contribution. Second, there could be long-term changes to tax revenue because IHA investment gains would be taxed differently than post-tax investment contributions. Behavioral changes could also affect long-term revenue collections. Taxpayers who would have otherwise chosen HSAs may opt for IHAs, or IHAs might induce greater OOP spending if the accounts make individuals feel wealthier over time.

11. The effects on our dynamic estimates are more complicated. Overstating tax rates will mean we also overstate the behavioral response to our proposed tax changes. Thus, we may overestimate the reported increases in payroll taxes.

12. While we account for the extraordinary medical expense deduction, data limitations preclude a similar estimate for tax-preferred spending through flexible spending accounts.

13. Expanded deductibility may also affect outlays for ACA recipients that increase their healthcare spending in response to the new tax benefit. These outlays may be offset somewhat by savings in the federal employee healthcare plan if federal employees opt for higher cost-sharing plans.

14. We include the self-employed with health insurance as well.

15. See table 4 in CBO (2010).

16. See table S-6 in White House (2023).

17. See Swagel (2023), table 1-4.

18. There are many ways that politicians could attempt to offset increases in outlays or decreases in revenues so that healthcare reform remains deficit neutral. See the appendix for additional options.

19. See Swagel (2023).

20. P.L. 117-2, Section 9661.

21. P.L. 117-169, Section 12001.

22. See table 1 in CBO (2022b).

23. See table S-6 in White House (2023). For more, see the HHS press release: https://www.hhs.gov/about/news/2023/03/09/hhs-releases-presidents-fiscal-year-2024-proposed-budget.html.

24. H.R. 2811. For the legislative text, see https://www.congress.gov/bill/118th-congress/house-bill/2811.

25. See Luhby (2023) for an overview of the recent debate.

26. For more, see Guth and Musumeci (2022).

27. See CBO (2022a).

28. See page 2 in CBO (2022a).

29. In the appendix, we explore other opportunities to offset these costs with other changes in our healthcare system, largely through changes in existing ESI tax exclusions.

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APPENDIX: ADDITIONAL PAY-FOR OPTIONS FOR THE CHOICES FOR ALL PROJECT

Reducing the growth in healthcare costs must be a goal for all health reform proposals. It is an important objective for American families. And it is an important outcome for a federal budget that is increasingly strained by trillions of dollars in health-related spending.

A fixation on reducing federal health spending today, however, won't deliver politically viable reforms. In the short term, health reforms face trade-offs among cost, quality, and coverage. If the aim is immediate budget savings, it likely means shifting costs to individuals, increasing the number of uninsured, or rationing care. Past proposals for comprehensive reforms that promised immediate deficit reductions failed once the public was made aware of these trade-offs. It didn't matter that these reforms would have delivered long-term improvements to our healthcare system; the short-term disruptions made them political dead ends.

The Choices for All Project aims to offer politically viable reforms that will improve our healthcare system. The reforms, however, are not costless; they will require either short-term deficit spending or offsetting budget cuts. Here, we consider potential changes to the ESI tax exclusion that could offset the budget costs of our proposals while still improving incentives for the healthcare system. Importantly, we do not specifically endorse including any of these measures as offsets for our proposed reforms; the political and substantive shortcomings of each proposed offset are significant. We nevertheless offer them as potential reforms to policymakers who believe that deficit-reducing policies must be included in any significant health reform proposal.

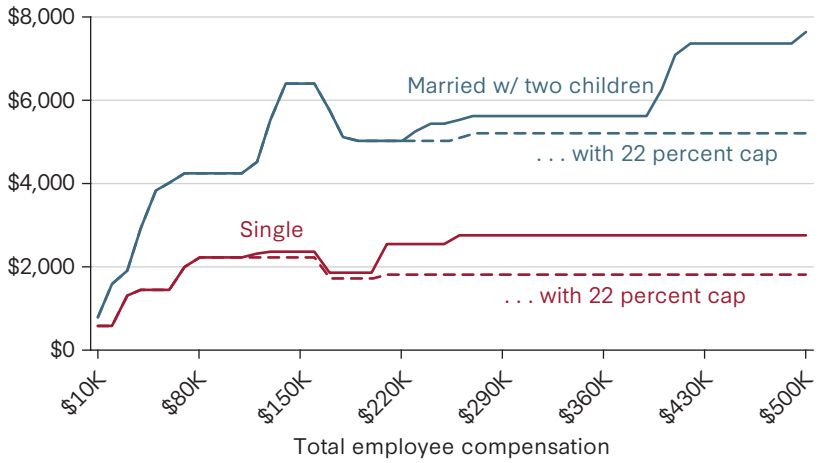
CAP THE ESI TAX EXCLUSION FOR HIGH-INCOME EARNERS

The tax exclusion for employer-sponsored insurance (ESI) is currently unlimited. The size of the tax benefit is regressive because it is a function of a taxpayer's marginal tax rate: the higher the rate, the bigger the tax break. If a family in the 22 percent tax bracket pays $20,000 in ESI premiums (between their and their employer's contributions), they would reduce their income tax liability by $4,400. Meanwhile, someone in the top tax bracket would reduce their tax liability by $7,400—a full $3,000 *more*.

Removing the tax exclusion, however, is politically untenable. Several legislative efforts have attempted to limit the tax value of expensive ESI premiums. Most notably, the ACA's "Cadillac" tax levied a surtax on insurance plans with particularly high premiums. Political opposition, however, meant the tax was never implemented.

Beyond its regressivity, the exclusion also favors high-premium plans over those with lower premiums and higher cost-sharing requirements. These bad incentives make health consumers less price conscious, ultimately driving up healthcare costs for all Americans. We

FIGURE A.1 Tax savings from ESI coverage with and without deduction cap



Notes: The tax savings are the difference in posttax/post-HC premium income for those with ESI coverage versus those purchasing individual policies. Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer. The estimated premium is based on MEPS-IC data for average total single or family premiums in 2021. The estimates assume the taxpayer does not receive any ACA subsidies for individual coverage.

discussed these issues in our essay in this series on extending deductibility for out-of-pocket (OOP) medical spending. We showed how we can improve the incentives in our healthcare system by rebalancing the tax code to reduce the differential tax treatments between ESI premiums and OOP spending. Extending tax deductibility of OOP spending would make the tax code marginally more progressive because lower income individuals tend to have larger OOP spending relative to their health costs. Nevertheless, any subsidy linked to income tax rates will inevitably return larger tax benefits to higher-income tax filers.

Policymakers could go further. A more politically viable method for achieving a similar goal as the "Cadillac" tax is to limit the maximum tax rate that the exclusion can be applied to. If the maximum tax subsidy were capped at the 22 percent tax bracket—the third statutory rate—the higher-income couple in the above example would receive the same $4,400 income tax break that middle-income Americans receive. Figure A.1 shows the combined individual savings (including payroll tax reductions) from the ESI tax exclusion with and without a 22 percent cap on the deductions.

This change would affect a small share of all taxpayers. In 2020, 92 percent of federal tax filers paid a marginal tax rate of 22 percent or lower.[1] The change would nevertheless represent a tax increase for high-income filers. In 2023, capping the deduction at 22 percent would affect married filers with total compensation greater than $220,000; single filers would be affected if their compensation exceeds $120,000.

We estimate that, before accounting for behavioral changes, capping the deduction at the third-highest statutory marginal rate (22 percent from 2023 to 2025 and 25 percent after the individual provisions in the Tax Cuts and Jobs Act expires) would save $15 billion in 2023, or about 6 percent of the estimated tax expenditure value for the year.[2] The cap would effectively

TABLE A.1 ESTIMATED REVENUE FROM CAPPED ESI TAX EXPENDITURE (BILLIONS)

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
Third statutory rate											
Capped rate	22%	22%	22%	25%	25%	25%	25%	25%	25%	25%	
Change in revenue	$15	$15	$16	$21	$23	$25	$27	$29	$31	$34	**$235**
Fourth statutory rate											
Capped rate	24%	24%	24%	28%	28%	28%	28%	28%	28%	28%	
Change in revenue	$11	$10	$11	$13	$14	$15	$16	$17	$18	$20	**$144**
Fifth statutory rate											
Capped rate	32%	32%	32%	33%	33%	33%	33%	33%	33%	33%	
Change in revenue	$2	$2	$2	$4	$4	$5	$5	$5	$6	$7	**$42**

Note: Authors' calculations

raise taxes for fourteen million taxpayers with ESI coverage in 2023.[3] Over ten years, capping the deduction would increase tax revenue by $235 billion.

Policymakers could opt for a higher cap to reduce the number of affected taxpayers. Setting the maximum exclusion rate at the second-highest statutory marginal tax rate (24 percent from 2023 to 2025 and 28 percent for 2026 and later) would raise $144 billion over the ten-year budget window. The cap would affect ten million taxpayers in 2023.

Capping the exclusion at the highest statutory marginal tax rate (32 percent from 2023 to 2025 and 33 percent for 2026 and later) would raise $42 billion in revenue over ten years, but affect only four million taxpayers. Table A.1 shows the annual estimated revenue changes at the different statutory brackets.

REMOVE HOSPITAL INSURANCE PAYROLL TAX EXEMPTION FROM ESI PREMIUMS

The tax exclusion for ESI premiums applies not only to federal income taxes but to payroll taxes as well. This includes the 12.4 percent payroll tax for the Social Security trust funds (the OASDI [Old Age, Survivors, and Disability Insurance] tax) and the 2.9 percent tax for Medicare's Hospital Insurance Trust Fund (the HI tax).[4] In 2023, the OASDI tax applies to

TABLE A.2 ESTIMATED REVENUE FROM REMOVING HALF OF THE HI TAX EXCLUSION FOR ESI PREMIUMS (BILLIONS)

2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
$18	$19	$20	$21	$23	$24	$25	$27	$29	$30	**$237**

Notes: Authors' calculations. We assume half of total HI tax (1.45 percent) and all of the additional Medicare tax would apply to ESI premiums.

wages below $160,200 (called the "taxable maximum"). The HI tax, meanwhile, is levied on all wages. In addition, the ACA added the additional Medicare tax, a 0.9 percent tax on the wages of high-income individuals (fixed at $200,000 for single filers and $250,000 for married filers).

As discussed above, eliminating the tax exclusion is a political dead end. Reducing its tax value, however, may be politically possible, particularly if it is paired with popular health reforms like expanded OOP deductibility or individual health accounts. A relatively minor change to the exclusion would be to end the tax break for the HI tax. Here, we examine the effects of ending half of the HI tax exclusion as well as removing the entire exclusion for the additional Medicare tax.

A single individual with an $8,000 premium ESI plan would pay $116 more in HI taxes; a family with $20,000 in ESI premiums would pay $290 more in HI taxes annually. Taxpayers subject to the additional Medicare tax would see their HI tax rise by about 60 percent more than lower-income taxpayers with the same premiums.

The revenue gains from this change would be substantial. Table A.2 shows the change in HI revenue by year before accounting for any behavioral changes. We estimate that over ten years (from 2023 to 2032), HI tax revenue would rise by $237 billion. To put that figure in perspective, CBO (February 2023) estimates that Medicare's HI Trust Fund will run a combined deficit of $238 billion from 2024 to 2033. In short, the change would extend the life of the HI Trust Fund, while improving incentives.

Importantly, because the reform would apply to the Additional Medicare Tax, the proposal is more progressive than other limits on the ESI tax exclusion.

NOTES

1. Authors' calculations derived from table 3.4 in IRS (2022).
2. The estimates provided here are derived from the Collection of Health Expenditures and Insurance (CHEI) database. For details on its construction, see Church and Heil (2019).

3. Beginning in 2026, the individual provisions in the Tax Cuts and Jobs Act expire, including the current bracket structure. We assume that beginning in that year the deduction would be capped at the 25 percent tax rate.

4. The legal incidence of each tax is split equally between employers and employees, but economists generally believe that, over the long term, employees pay their employers' share in the form of lower compensation.

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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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