



# The Budget Effects of Proposals in the Choices for All Project

## *Healthcare Reforms for the Future*

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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**

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- 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.
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## AN OVERVIEW OF PROPOSED TAX CHANGES

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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.<sup>1</sup> 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.<sup>2</sup>

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

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We use the Collection of Health Expenditures and Insurance (CHEI) database to estimate the effects of our policy changes.<sup>3</sup> 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.<sup>4</sup>

The dataset includes various tax variables including estimates of respondents' marginal tax rates by year.<sup>5</sup> 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.<sup>6</sup>

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.<sup>7</sup>

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.<sup>8</sup> 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.<sup>9</sup>

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.<sup>10</sup> 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	<b>\$10.9</b>
2024	\$4.4	\$1.3	\$2.7	\$3.0	<b>\$11.4</b>
2025	\$4.6	\$1.4	\$3.0	\$3.2	<b>\$12.2</b>
2026	\$6.9	\$1.9	\$4.6	\$5.0	<b>\$18.4</b>
2027	\$8.5	\$2.3	\$5.7	\$6.2	<b>\$22.8</b>
2028	\$9.2	\$2.5	\$6.1	\$6.8	<b>\$24.6</b>
2029	\$9.9	\$2.7	\$6.6	\$7.5	<b>\$26.6</b>
2030	\$10.6	\$2.9	\$7.1	\$8.1	<b>\$28.7</b>
2031	\$11.5	\$3.1	\$7.6	\$8.8	<b>\$30.9</b>
2032	\$12.3	\$3.3	\$8.2	\$9.5	<b>\$33.3</b>

**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.<sup>11</sup> 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.<sup>12</sup>

## 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.<sup>13</sup>

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
<b>Total</b>	<b>-\$22</b>	<b>-\$22</b>	<b>-\$23</b>	<b>-\$26</b>	<b>-\$25</b>	<b>-\$25</b>	<b>-\$26</b>	<b>-\$26</b>	<b>-\$28</b>	<b>-\$29</b>	<b>-\$252</b>

**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
<b>Total spending</b>	<b>\$552</b>	<b>\$532</b>	<b>-\$20</b>

**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
<b>Employment-based coverage</b>											
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
<b>Total</b>	<b>\$6</b>	<b>\$7</b>	<b>\$7</b>	<b>\$5</b>	<b>\$7</b>	<b>\$7</b>	<b>\$8</b>	<b>\$8</b>	<b>\$8</b>	<b>\$9</b>	<b>\$72</b>
<b>Uninsured: total</b>	<b>-\$8</b>	<b>-\$8</b>	<b>-\$9</b>	<b>-\$11</b>	<b>-\$10</b>	<b>-\$11</b>	<b>-\$11</b>	<b>-\$11</b>	<b>-\$12</b>	<b>-\$12</b>	<b>-\$104</b>
<b>Other coverage: total</b>	<b>-\$4</b>	<b>-\$4</b>	<b>-\$4</b>	<b>-\$5</b>	<b>-\$5</b>	<b>-\$5</b>	<b>-\$5</b>	<b>-\$5</b>	<b>-\$5</b>	<b>-\$5</b>	<b>-\$47</b>
<b>All coverage</b>											
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
<b>Total</b>	<b>-\$6</b>	<b>-\$6</b>	<b>-\$7</b>	<b>-\$10</b>	<b>-\$8</b>	<b>-\$8</b>	<b>-\$8</b>	<b>-\$8</b>	<b>-\$8</b>	<b>-\$9</b>	<b>-\$79</b>

**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.<sup>14</sup>

**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 health-care 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.<sup>15</sup> More recently, the Biden administration has proposed permanently extending expanded ACA subsidies, which would increase ten-year budget deficits by \$183 billion.<sup>16</sup>

**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
<b>Total change</b>	<b>-\$7</b>	<b>-\$7</b>	<b>-\$8</b>	<b>-\$11</b>	<b>-\$10</b>	<b>-\$10</b>	<b>-\$10</b>	<b>-\$10</b>	<b>-\$10</b>	<b>-\$11</b>	<b>-\$94</b>

**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

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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.<sup>17</sup> 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.<sup>18</sup> 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."<sup>19</sup>

### **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.<sup>20</sup> 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	<b>\$45</b>
Current policy baseline	\$22	\$20	\$19	\$22	\$23	\$24	\$23	\$23	\$25	\$26	<b>\$227</b>

**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.<sup>21</sup> The extension added \$64 billion in spending and tax subsidies to the federal budget over the next four years.<sup>22</sup> 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.”<sup>23</sup>

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.<sup>24</sup> Work requirements for Medicaid recipients were also a topic of discussion during the 2023 debt ceiling debates.<sup>25</sup>

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.<sup>26</sup>

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.<sup>27</sup> 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."<sup>28</sup>

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.<sup>29</sup> 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

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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

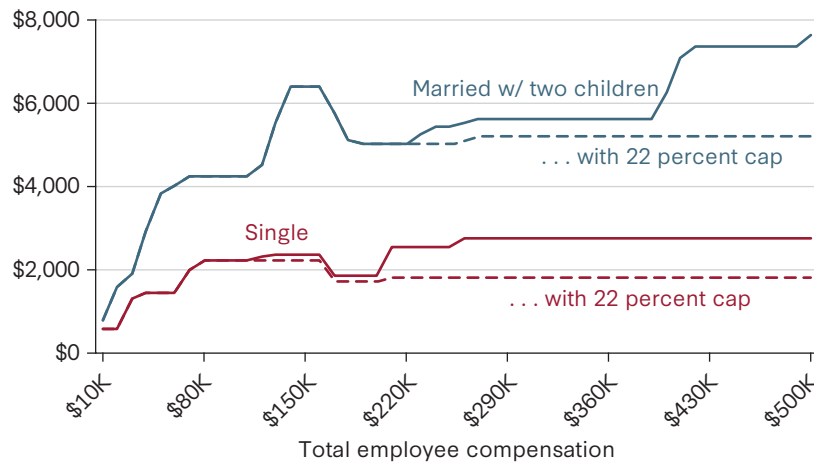
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The tax exclusion for employer-sponsored insurance (ESI) is currently unlimited. The size of the tax benefit is regressive because it is a function of a taxpayer's marginal tax rate: the higher the rate, the bigger the tax break. If a family in the 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.<sup>1</sup> 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.<sup>2</sup> 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
<b>Third statutory rate</b>											
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	<b>\$235</b>
<b>Fourth statutory rate</b>											
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	<b>\$144</b>
<b>Fifth statutory rate</b>											
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	<b>\$42</b>

**Note:** Authors' calculations

raise taxes for fourteen million taxpayers with ESI coverage in 2023.<sup>3</sup> 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).<sup>4</sup> 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	<b>\$237</b>

**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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### ***The Choices for All Project: Healthcare Reforms for the Future***

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

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