



Expand the Tax Deductibility of Out-of-Pocket Payments

Healthcare Reforms for the Future

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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.
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- 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' health-care. 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

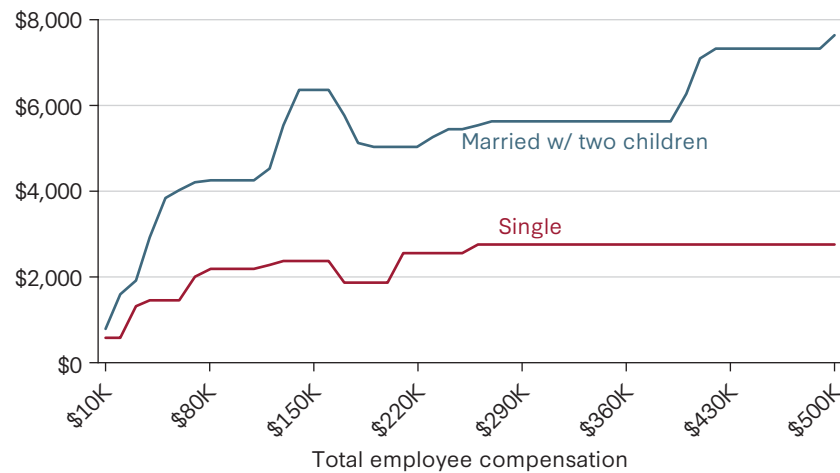
Table 1 shows how the tax preference works. In our simplified example, an unmarried worker has the option of a health insurance plan sponsored by her employer or a plan purchased

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.

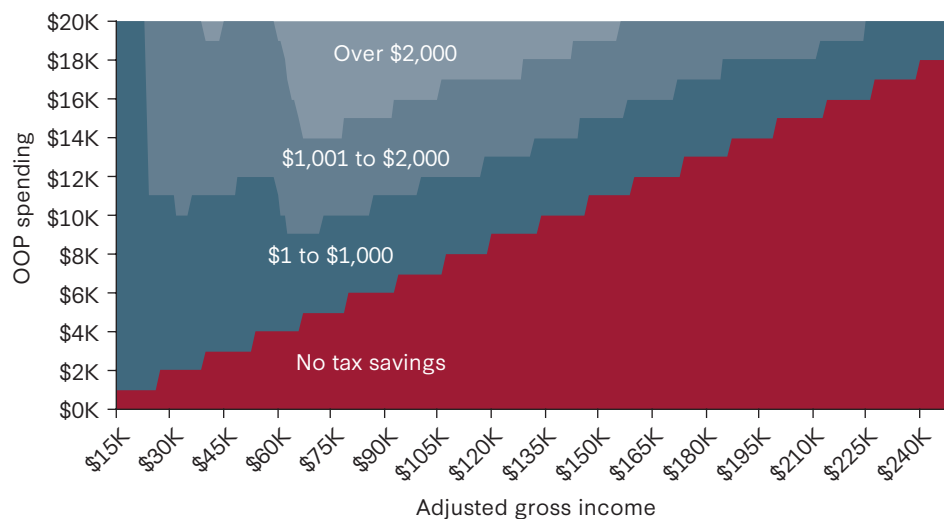
But while repealing or limiting the exclusion for ESI is unlikely to happen, there are still mechanisms to reduce the exclusion's distortions. Specifically, we can give patients new choices that give them more of an incentive to buy low-premium insurance plans with increased cost sharing. We can do this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

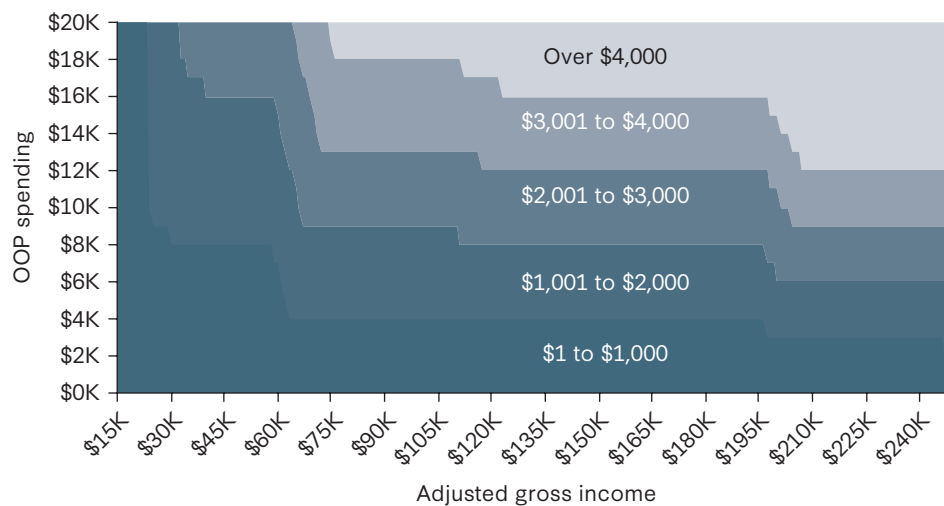
Notes: Tax estimates are based on the 2023 income tax brackets for an unmarried taxpayer. The estimated premium is based on MEPS-IC data for average total single premium in 2021. The estimates assume the individual does not receive any ACA subsidies for individual coverage.

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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