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Tax Benefits for Health Insurance: Current Legislation

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CONTENTS

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SUMMARY

At the start of the 107th Congress, a number of new or expanded tax benefits for health insurance are being discussed. Proponents generally argue that changes are needed to extend coverage to the uninsured and to address efficiency and equity problems; opponents generally doubt that the changes under consideration would make much difference. One overarching issue is whether new or expanded benefits would limit the reductions in general tax rates that President-elect Bush and others seek.

Current law contains significant tax benefits for health insurance. (1) Most important is the exclusion of employer-paid health insurance from the determination of income taxes. (Employer-paid health insurance is also excluded from employment taxes.) Nearly two-thirds of the noninstitutionalized population under age 65 is insured through employment-based insurance; on average, large employers pay about 80% of its cost, though some pay all and others none. The exclusion also applies to health insurance provided through cafeteria plans. (2) Self-employed taxpayers may deduct 60% of their health insurance payments, a proportion scheduled to rise to 100% in 2003. (3) Taxpayers who itemize deductions may deduct insurance payments to the extent they and other medical expenses exceed 7.5% of adjusted gross income. While not widely used, this deduction benefits some with employment-based insurance (for the employee share), some self-employed (the remaining 40% of their cost) and others who purchase individual market policies. (4) Coverage under Medicare and Medicaid is not considered taxable income. (5) With some exceptions, benefits actually received from private or public insurance are not taxable.

By lowering the after-tax cost of insurance, the tax benefits help extend coverage to more people; they also lead insured people to obtain more coverage than otherwise. The incentives influence the way in which coverage is acquired: the uncapped exclusion for employer-paid insurance, which can benefit nearly all workers and is easy to administer, is partly responsible for the predominance of employment-based insurance in the United States. Employment-based insurance has both advantages and disadvantages for the typical worker.

The tax benefits also increase the demand for health care by enabling insured people to obtain services at discounted prices. This is one reason why prices for health care have risen more rapidly than the general rate of inflation. Moreover, since many people would likely obtain some insurance without the tax benefits, they can be an inefficient use of public dollars. They also raise questions of equity, largely because the tax savings they generate depend upon the taxpayer's marginal tax rate. When viewed as a form of personal consumption, giving tax incentives for health insurance provides more benefits to higher income families who may not need them. Comprehensive reforms (e.g., capping the employer exclusion or replacing it with deductions and credits) might address some of these concerns, though they could be difficult to implement and may cause serious inequities of their own.

MOST RECENT DEVELOPMENTS

The final tax legislation for the 106th Congress (the Community Renewal Tax Relief Act of 2000, P.L. 106-554) included a two-year extension of eligibility for new medical savings account (MSA) participants. The 106th Congress had considered a number of other tax benefits for health insurance, including a new deduction not limited to itemizers and a new tax credit, but none became law.

BACKGROUND AND ANALYSIS

Tax Benefits in Current Law

Current law provides significant tax benefits for health insurance. The tax subsidies—for the most part federal income tax exclusions and deductions— are widely available, though not everyone can take advantage of them. They reward some people more than others, raising questions of equity. They influence the amount and type of coverage that people obtain, which affects their ability to choose doctors and other providers. In addition, the tax benefits affect the distribution and cost of health care.

Overview of Current Provisions

This section summarizes the current tax treatment of the principal ways that people obtain health insurance. It describes general rules but does not discuss all limitations, qualifications, and exceptions. To understand possible effects on tax liability, readers may want to refer to the Appendix for an outline of the federal income tax formula. (For example, exclusions are items that are omitted from gross income, while deductions are subtracted from gross income in order to arrive at taxable income.) Section number references are to the Internal Revenue Code of 1986 as amended.

The tax treatment of long-term care insurance is not discussed below. For information on this topic, see CRS Report RL30254, *Long-Term Care: The President's FY2001 Budget Proposals and Related Legislation*, by Carol O'Shaughnessy, Bob Lyke, and Carolyn Merck.

Employment-Based Plans. Health insurance paid by employers generally is excluded from employees' gross income in determining their income tax liability; it also is not considered for either the employee's or the employer's share of employment taxes (i.e., social security, Medicare, and unemployment taxes). (Sections 106 and 3121, respectively) The income and employment tax exclusions apply to both single and family coverage, which includes the employee's spouse and dependents. Premiums paid by employees generally are not deductible, though they may be counted towards the itemized medical expense deduction or subject to a premium conversion arrangement under a cafeteria plan (both of which are discussed below).

Nearly two-thirds of the noninstitutionalized population under age 65 is insured under an employment-based plan. On average, large employers pay about 80% of the cost for employment-based insurance, though some pay all and others pay none. Employers typically pay a smaller percentage for family than for single coverage.

Insurance benefits paid from employment-based plans are excluded from gross income if they are reimbursements for medical expenses or payments for permanent physical injuries. Benefits not meeting these tests are taxable in proportion to the share of the insurance costs paid by the employer that were excluded from gross income. (Sections 104 and 105) Benefits are also taxable to the extent taxpayers received a tax benefit from claiming a deduction for the expenses in a prior year (for example, if taxpayers claimed a medical expense deduction for expenditures in 2000 and then received an insurance reimbursement in 2001). In addition, benefits received by highly-compensated employees under discriminatory self-insured plans are partly taxable. A self-insured plan is one in which the employer assumes the risk for a health care plan and does not shift it to a third party.

Employers may deduct their insurance payments as a business expense. The deduction is not a tax benefit but a calculation necessary for the proper measurement of the net income that is subject to taxation. Revenue loss attributable to this deduction is not considered a tax expenditure.

The Joint Committee on Taxation (JCT) estimated the FY2000 federal revenue loss attributable to the exclusion for employer contributions for health insurance, medical care (including that provided through cafeteria plans and flexible spending accounts, described below) and long-term care insurance to be $58 billion. The estimate did not include the effect of the exclusion on employment taxes.

Medical Expense Deduction. Taxpayers who itemize their deductions may deduct unreimbursed medical expenses to the extent they exceed 7.5% of adjusted gross income (AGI). (Section 213) Medical expenses include health insurance premiums paid by the taxpayer, such as the employee's share of premiums in employment-based plans, premiums for individual private market policies, and part of the premiums paid by self-employed taxpayers. More generally, medical expenses include amounts paid for the "diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." They also include certain transportation and lodging expenditures, qualified long-term care service costs, and long-term care premiums that do not exceed certain amounts. Currently, the deduction is intended to help only those with catastrophic expenses.

The medical expense deduction is not widely used. For most taxpayers, the standard deduction is larger than the sum of itemized deductions; moreover, most do not have unreimbursed expenses that exceed the 7.5% AGI floor. In 1996, about 27% of all individual income tax returns had itemized deductions, and of these only about 15% (i.e., about 4% of all returns) claimed a medical expense deduction.

The JCT estimated the FY2000 revenue loss attributable to the medical expense deduction (including long-term care expenses) to be $4.4 billion.

Individual Private Market Policies. Payments for private market health insurance purchased by individuals are a deductible medical expense, provided the taxpayer itemizes deductions and applies the 7.5% AGI floor as just described. Premiums for the following insurance, however, are not deductible: policies for loss of life, limb, sight, etc.; policies that pay guaranteed amounts each week for a stated number of weeks for hospitalization; and the part of car insurance that provides medical coverage for all persons injured in or by the

policyholder's car. Benefits paid under accident and health insurance policies purchased by individuals are excluded from gross income, even if they exceed medical expenses.

About 6% of the noninstitutionalized population under age 65 is insured through these private policies. Likely purchasers include early retirees, young adults, employees without access to employment-based insurance, and the self-employed.

Self-Employed Deduction. Self-employed taxpayers may deduct payments for health insurance in determining their AGI. (Section 162) Their insurance typically is an individual private market policy. The self-employed deduction, an "above-the-line" deduction, is not restricted to itemizers, as is the medical expense deduction. Following enactment of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 (P.L. 105-277), the deduction is 60% of insurance payments in 1999 through 2001, 70% in 2002, and 100% in 2003 and thereafter. So limited, the deduction cannot exceed the net profit and any other earned income from the business under which the plan is established, less deductions taken for certain retirement plans and for one-half the self-employment tax. It is not available for any month in which the taxpayer or the taxpayer's spouse is eligible to participate in a subsidized employment-based health plan (that is, one in which the employer pays part of the cost). These restrictions prevent taxpayers with little net income from their business (which may not be uncommon in a new business, for example, or in a part-time business that grows out of a hobby) from deducting much if any of their insurance payments. However, the portion not deductible under these rules may be treated as an itemized medical expense deduction.

Self employed individuals include sole proprietors (single owners of unincorporated businesses), general partners, limited partners who receive guaranteed payments, and individuals who receive wages from S-corporations in which they are more than 2% shareholders. (S-corporation status may be elected by corporations that meet a number of Internal Revenue Code requirements. Among other things, they cannot have more than 75 shareholders or more than one class of stock. S-corporations are tax-reporting rather than tax-paying entities, in contrast to C-corporations that are subject to the corporate income tax.)

In 1995, about 3 million tax returns (about 2.5% of all returns) claimed the self-employed health insurance deduction. For FY2000, the JCT estimated the revenue loss attributable to the deduction (including the deduction for long-term care insurance) to be $1.2 billion.

Cafeteria Plans. Health benefits provided through a cafeteria plan are excludable for both income and employment tax purposes. A cafeteria plan is a written benefit plan under which employees may choose between receiving cash and certain nontaxable benefits such as health coverage or dependent care. (Cash here includes any taxable benefits.) Under an option known as a premium conversion plan, employees may elect to reduce their taxable wages in exchange for having their share of health insurance premiums paid on a pre-tax basis; the effect is the same as if employees could claim an above-the line deduction for their payments. Starting in October, 2000, federal executive branch employees who participate in the Federal Employees Health Benefits Program (FEHBP) could elect this option. Some legislative and judicial branch entities also have adopted it.

Nontaxable benefits provided through cafeteria plans are exempt from income and employment taxes under the Internal Revenue Code rules applicable to those benefits, such as employer-paid insurance. A separate statutory provision (Section 125) extends these exclusions to situations in which employees are given the option of receiving cash; were it not for this provision, the nontaxable benefit would be taxable since the employees had been in constructive receipt of the cash.

Flexible Spending Accounts. Benefits paid from flexible spending accounts (FSAs) are also excludable for income and employment tax purposes. FSAs and cafeteria plans are closely related, but not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans. FSAs funded through salary reductions are exempt from taxation through cafeteria plan provisions (since otherwise employees would be in constructive receipt of cash) while FSAs funded by nonelective employer contributions are exempt directly under provisions applying to employer-paid insurance. For additional information on FSAs, see CRS Report 96-500, *Flexible Spending Accounts and Medical Savings Accounts: A Comparison*, by Bob Lyke.

Health care FSAs must exhibit some of the risk-shifting and risk-distribution characteristics of insurance. Among other things, participants must elect a specific benefit amount prior to the start of a plan year; this election cannot be revoked except for changes in family status. The full benefit amount (less any benefits paid) must be made available throughout the entire year, even if employees spread their contributions throughout the year. Any amount unused at the end of the year must be forfeited to the employer (thus, "use it or lose it"). FSAs cannot be used to purchase insurance; however, they can be combined with premium conversion plans under cafeteria arrangements to achieve the same tax effect.

In 1997, about 40% of full-time employees in medium and large size private firms could have a health care FSA. Actual participation likely was far less.

Medical Savings Accounts. Medical savings accounts (MSAs) are personal savings accounts for unreimbursed medical expenses. They are used to pay for health care not covered by insurance, including deductibles and copayments. Currently, a limited number of MSAs may be established by individuals who have qualifying high deductible insurance (and none other, with some exceptions) and who either are self-employed or are employees covered by a high deductible insurance plan established by their small employer (50 or fewer employees on average).

Employer contributions to MSAs are excludable for both income and employment tax purposes, while individuals' contributions (allowed only if the employer does not contribute) are deductible for determining AGI. Contributions are limited to 65% of the insurance deductible for single coverage and 75% for family coverage. Account earnings are excludable as well, as are distributions used for unreimbursed medical expenses, with some exceptions. Non-qualified distributions are included in gross income and an additional 15% penalty is applied. For further information, see CRS Report 96-500, *Flexible Spending Accounts and Medical Savings Accounts: A Comparison*, by Bob Lyke..

Tax-advantaged MSAs, which first could be established in 1997, are not yet widespread. The Internal Revenue Service (IRS) has determined that 42,477 MSA returns were filed for 1998 and that 44,784 are likely to be filed for 1999. For additional information, see General

Accounting Office report HEHS-99-34, *Medical Savings Accounts: Results from Surveys of Insurers.*

MSAs should be distinguished from Medicare+Choice MSAs, which are discussed below under the tax treatment of Medicare and Medicaid.

Military and Veterans Health Care. Coverage under military and veterans health care programs is not taxable income, nor are the benefits these programs provide. The tax exclusion (Section 134) applies as well to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Tricare, which serve military dependents, retirees, and retiree dependents. In 1996, about 2.2% of the noninstitutionalized population under age 65 had military or veterans health care as their primary form of coverage. The FY1999 revenue loss attributable to CHAMPUS and Tricare was $1.5 billion. For more information, see CRS Issue Brief IB93103, *Military Medical Care Services: Questions and Answers*, by Richard A. Best.

Medicare and Medicaid. Coverage under Medicare or Medicaid is not taxable income. Similarly, benefits paid from either program are not subject to taxation. Medicare covers over 38 million people, including 96% of those ages 65 and older. Medicaid covers over 41 million people. The JCT estimated the revenue loss attributable to the exclusion of Medicare benefits to be $24.9 billion in FY2000. Medicaid beneficiaries, who must meet certain categorical requirements (aged, blind, or disabled, or specified members of families with dependent children) are generally poor and unlikely to have tax liability.

The employment tax individuals pay for Medicare Part A is not a deductible medical expense. However, premiums paid by individuals who voluntarily enroll in Part A are deductible, provided the taxpayer itemizes deductions and applies the 7.5 % AGI floor as described above. (Medicare Part A is insurance for hospitalization, skilled nursing facilities, home health and hospice care. Individuals age 65 and older may voluntarily enroll in Part A if they or their spouse do not have at least 10 years of Medicare-covered employment.) Medicare Part B premiums are also deductible subject to those same limitations, as are premiums for Medigap insurance. (Medicare Part B is supplementary insurance for doctors' fees and outpatient services. Medigap insurance is private insurance that covers Medicare deductibles, co-payments, and benefits not covered under Medicare.)

Beginning in 1999, legislation allowed a limited number of Medicare beneficiaries to elect Medicare+Choice medical savings accounts instead of traditional Medicare. Contributions to these accounts (made only by the Secretary of Health and Human Services) are exempt from taxes, as are account earnings. Withdrawals are likewise not taxed nor subject to penalties if used to pay unreimbursed medical expenses, with some exceptions. No Medicare+Choice MSA plans have ever been offered.

Some Consequences of the Tax Benefits

Increases in coverage. By lowering the after-tax cost of insurance, the tax benefits described above help extend coverage to more people. This of course is the intention: Congress has long been concerned about whether people have access to health care. The public subsidy implicit in the incentives (foregone tax revenues) usually is justified on grounds that people would otherwise under-insure, that is, delay purchasing coverage in the hope that

they will not become ill or have an accident. Uninsured people are an indication of market failure; they impose spill-over costs on society in the form of public health risks and uncompensated charity care (the free-rider problem). Moreover, if insurance were purchased only by people who most need health care, its cost would become prohibitive for others (the adverse selection problem).

However, the tax benefits also lead insured people to obtain more coverage than they would otherwise choose. They purchase insurance that covers more than hospitalization and other catastrophic expenses, such as routine doctor visits, prescription drugs, and dental care. They obtain coverage with smaller deductibles and copayments. On the other hand, comprehensive coverage and lower cost-sharing are thought to lead to better preventive care and possibly long-run savings for certain medical conditions.

Source of Coverage. Tax benefits influence the way in which insurance coverage is acquired. The uncapped exclusion for employer-paid insurance, for example, which can benefit nearly all workers and is easy to administer, is partly responsible for the predominance of employment-based insurance in the United States. In contrast, restrictions on the itemized deduction allowed for individual private market insurance may be one reason why that insurance covers only 6% of the population under age 65.

Employment-based insurance carries both advantages and disadvantages for the typical worker. Generally costs are lower, and usually individual premiums do not vary by age or risk. (Thus, young and healthy workers may pay more than their actuarial risk would cost, though they are protected as they get older or need additional health care.) However, plans chosen by employers may not meet individual workers' needs (particularly if there are limited options), and changing jobs may require both new insurance and doctors.

Increase in Health Care Use and Cost. The tax benefits increase the demand for health care by enabling insured people to obtain services at discounted prices. This induced demand can be beneficial to the extent it reflects needed health care (that which society deems everyone should have) that financial constraints otherwise would have prevented. It can be wasteful to the extent it results in less essential or ineffective care. In either case, many economists argue, the additional demand is one reason why prices for health care have risen more rapidly than the general rate of inflation.

Whether insurance coverage could be encouraged without increasing the cost of health care has been a matter of debate. Comprehensive reforms that might accomplish this goal include capping the exclusion for employer-paid insurance and replacing both the exclusion and the deduction with a limited tax credit. But these changes could be difficult to implement and may create serious inequities. A 1994 Congressional Budget Office study, *The Tax Treatment of Employment-Based Health Insurance,* provides an overview of the issues and questions these approaches raise.

Many people probably would obtain some health insurance even without the tax benefits. The cost of subsidizing people for what they would otherwise do is an inefficient use of public dollars. Ideally, the tax incentives should lead to insurance being purchased only to the extent it results in better health care for society as a whole. But how they could be revised to accomplish this goal is a difficult question given the different ways insurance is provided, the various ways it is regulated, and the voluntary nature of decisions to purchase it.

Equity. Questions might be raised about the distribution of the tax incentives. Since as a practical matter they are not available to everyone, problems of horizontal equity arise. Workers without employment-based insurance generally cannot benefit from them, nor can many early retirees (people under the age of 65). Even if these individuals itemized their deductions, they can deduct health insurance premiums only to the extent that they (and other health care expenditures) exceed 7.5% of AGI. In contrast, the exclusion for employer-paid insurance is unlimited.

Even if everyone could benefit from the tax incentives, there would be questions of vertical equity. Tax savings from the exclusions and deductions described above generally are determined by taxpayers' marginal tax rate. Thus, taxpayers in the 15% tax bracket would save $600 in income taxes from a $4,000 exclusion (i.e., $4,000 x 0.15) for an employer-paid premium, while taxpayers in the 36% bracket would save $1,440 (i.e., $4,000 x 0.36). If health insurance is considered a form of personal consumption (such as food or clothing), this pattern of benefits would strike many people as unfair. It is unlikely that a government grant program would be designed in this manner. However, to the extent that health insurance is considered a way of spreading an individual's catastrophic economic risk over multiple years, basing tax savings on marginal tax rates might be justified.

For additional information on the economics of health insurance, see CRS Report RL30762, *Tax Subsidies for Health Insurance for the Uninsured: An Economic Analysis of Selected Policy Issues for Congress*, by Gary Guenther.

Current Proposals

At the beginning of the 107th Congress, a number of new or expanded tax benefits for health insurance are being discussed: broadened eligibility for medical savings accounts, an immediate 100% deduction for health insurance by the self-employed, allowing carryovers and rollovers in flexible spending accounts, and authoring an expanded (above-the-line) tax deduction or tax credit for the purchase of insurance. Proponents generally argue that these changes are needed to extend coverage to the uninsured and to address efficiency and equity problems, while opponents generally argue that tax benefits are unlikely to make much difference for people who do not now purchase insurance.

An overarching issue is whether Congress should approve targeted tax benefits for health insurance (as well as education, child care, and so on) instead of larger reductions in general tax rates. While some targeted tax benefits would result in relatively little revenue loss, others, such as a refundable tax credit for health insurance, might involve significant costs (depending on specifications), as might collectively a number of benefits. For further discussion of these issues, see CRS Issue Brief IB10068, *Major Tax Issues in the 107th Congress*, by David L. Brumbaugh.

In a typical Congress, well more than 100 bills are introduced regarding tax benefits for health insurance. This issue brief does not attempt to identify let alone discuss all of them; rather, its focus is on bills that have been (or are likely to be) reported from committee or considered on the House and Senate floor. For summaries of these measures, see the Legislation section, below. However, a number of representative measures are identified in the discussion that follows.

Congressional offices can construct comprehensive lists of bills on particular proposals by using the Legislative Information System (LIS) available through the CRS home page. Under the Legislation heading, click on the LIS and then on Bill Text: Adv. In the Word/Phrase box, type either a term like "medical savings accounts" or a combination of words and connectors like "credit adj/5 health" or "deduction adj/5 health" and then click on Search. Depending on the terms and connectors used, search results may yield some irrelevant bills without identifying all relevant ones; thus, the lists should be reviewed carefully. For technical assistance with searches, congressional staff might call the La Follette Congressional Reading Room at 7-7100.

Medical Savings Accounts

The original medical savings account legislation (the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), authorized a limited number of MSAs under a demonstration beginning in 1997. Eligibility was to be restricted after the *earlier* of (1) December 31, 2000, or (2) specified dates in the years 1997-1999 following a determination that the number of taxpayers with accounts exceeded certain thresholds. Once eligibility was restricted under these tests, MSAs generally would have been limited to individuals who either were active participants (had contributions to their accounts) prior to the cut-off date or become active participants through a participating employer. The final tax legislation for the 106th Congress (the Community Renewal Tax Relief Act of 2000, P.L. 106-554) included a two-year extension of eligibility for new participants, i.e., until December 31, 2002

The IRS projected that fewer than 55,000 MSAs had been established by June 30, 1999, far lower than the 750,000 threshold that applied that year. (The IRS has not released more recent estimates. It should be noted that MSAs are not counted towards the threshold if the owners were previously uninsured; thus, not all of the 55,000 were considered in determining whether 1999 was a cut-off year.) The slow growth of MSAs can be attributed to many factors, including consumer unfamiliarity and the reluctance of insurance agents to sell lower-priced policies, but the statutory restrictions undoubtedly are playing some role. Thus, proponents are urging Congress to expand eligibility for MSAs and modify restrictions on the required high deductible insurance. In their view, MSAs ought to be encouraged since they can make insurance more affordable, allow a wider choice among doctors, and protect patient rights better than government regulation. Critics generally oppose expansion, arguing that MSAs will result in adverse selection among health plans, underutilization of preventive care, and unwarranted tax breaks for high income families. (For early analysis of these and other questions, see CRS Report 96-409, *Medical Savings Accounts: Background Issues*, by Bob Lyke.) The Clinton administration opposed expanding MSA eligibility.

In the 106th Congress, both the House-passed and Senate-passed patient protection bills (H.R. 2990 and S. 1344, no conference agreement) would have expanded eligibility for MSAs. Their provisions, which might serve as models for new legislation, would have:

- removed current law provisions restricting MSAs to employees of small employers and self-employed individuals, making them generally available to individuals with qualifying high deductible health plans;
- eliminated numerical limits on the number of taxpayers with MSAs;
- allowed contributions up to the amount of the insurance deductible (thus deleting the 65% and 75% ceilings); and

- lowered minimum insurance deductibles (prior to applying the cost-of-living adjustment) from $1,500 to $1,000 for single coverage and $3,000 to $2,000 for family coverage.

In addition, the House bill would have allowed MSAs to be offered under cafeteria plans and permited contributions to be made by both employers and employees. The Senate bill would have allowed rollovers to MSAs from cafeteria plans and flexible spending accounts, preempt state laws prohibiting health issues from offering high deductible plans, and modify the penalty for nonqualified distributions. The Senate bill also would have authorized a high deductible insurance/MSA plan for the Federal Employees Health Benefits Program (FEHBP).

Self-Employed Deduction

The Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 (P.L. 105-277) accelerated the schedule for full deductibility of health insurance costs by the self-employed. Limited to 45% of the amount paid in 1998, the deduction is limited to 60% in 1999 through 2001, 70% in 2002, and 100% in 2003 and thereafter.

Numerous 106th Congress bills would have allowed a 100% deduction starting in 2000 or 2001 (depending on when the bill was introduced), but none became law.

The principal argument for increasing the deduction is equity. People who have employment-based insurance—nearly two-thirds of those under age 65—may exclude from their gross income the amount of insurance paid by the employer. The exclusion, which is uncapped, also applies to employment taxes. (In contrast, self-employed taxpayers may not deduct their health insurance expenditures in calculating their self-employment tax.) Equitable treatment between corporate owners and owners of unincorporated businesses would remove an incentive to choose the form of business organization merely for tax reasons. Since Congress has already decided to allow the full deduction, advancing the date it becomes available may raise only budget, not policy issues.

Nonetheless, questions might still be raised about whether a 100% deduction would be equitable. As mentioned above, large employers on average pay about 80% of the cost of the insurance they offer, leaving employees to pay the other 20% with after-tax dollars. Perhaps capping the deduction at 80% would be the equivalent, though this would not offset the employment tax exclusion. Moreover, self-employed taxpayers are owners; for the most part, they can choose whatever insurance they want, even expensive coverage. A full deduction might not lead them to be as cost-conscious as corporate owners. Finally, it is debatable whether accelerating the deduction would make it more likely that the *employees* of self-employed owners will be provided health insurance. Some argue that the deduction should not be increased unless it is coupled with a nondiscrimination requirement. The original authorization for the deduction in 1986 had such a requirement, but it was repealed in 1989, leaving the owners with tax advantages their employees do not have.

Cafeteria Plans and Flexible Spending Accounts

Some 106th Congress legislation (such as the Senate-passed patient protection legislation, S. 1344), would have allowed up to $500 in unused balances in cafeteria plans and flexible spending accounts (FSAs) to be carried over to the following year without being

taxed. In the case of health care and dependent care FSAs, unused balances could also be distributed to participants (in which case they would be taxed) or rolled over into certain qualified deferred compensation plans (section 401(k), 403(b), and 457 plans) or a medical savings account (MSA). None of this legislation became law.

The principal argument for allowing these options is that taxpayers might be more willing to participate in cafeteria plans and FSAs if unused balances at the end of the year were not lost. Under current law, unused balances must be forfeited. Allowing carryovers or rollovers might also discourage participants from spending remaining balances carelessly, just to use them up. Cafeteria plans and FSAs generally do not restrict patients' choice of doctors; thus, some might favor them as a way around limitations of managed care.

However, the options might result in tax breaks that are unwarranted, particularly for higher income families. Some participants might increase their FSA contributions just to take advantage of them. The health care FSA carryover could become another form of MSA, though limited in size and without account earnings that accrue to the employee.

Expanded Tax Deduction

A number of 106th Congress bills would have allowed an above-the-line deduction (not limited to itemizers) for health insurance. Generally, the deduction would have been limited during a phase-in period and would not apply to months in which the taxpayer participates in a health plan maintained by employer if 50% or more of cost is paid or incurred by employer, or if taxpayer is enrolled in certain public programs. Among the more prominent bills with this provision were H.R. 2488, the Taxpayer Refund and Relief Act of 1999 (the omnibus tax bill that President Clinton vetoed on September 23, 1999) and the House-passed patient protection legislation (H.R. 2990). An expanded deduction did not become law.

An expanded tax deduction would improve horizontal equity since more taxpayers could receive tax benefits similar to those associated with employer-paid coverage. (An above-the-line deduction has the same income tax effect as the exclusion allowed that coverage.) As discussed above, the deduction allowed under current law is restricted to taxpayers who itemize and is further limited to insurance and medical costs that exceed 7.5% adjusted gross income; thus, most taxpayers cannot benefit from it.

At the same time, an expanded deduction would not improve vertical equity since the tax benefits generally would be proportional to the taxpayer's marginal tax rate. A $2,000 premium would result in tax savings of $720 for someone in the 36% bracket (i.e., $2,000 x 0.36) but only $300 for someone in the 15% bracket (i.e., $2,000 x 0.15). It might also be doubted whether tax savings of 15% would enable more lower income taxpayers to obtain insurance.

H.R. 2488 also would have allowed a new above-the-line deduction for prescription drug insurance coverage for Medicare beneficiaries (effective in 2003) if certain Medicare structural changes occur and low-income assistance is available. How to provide Medicare beneficiaries with a prescription drug benefit is an issue in the 107th Congress.

Tax Credit

Numerous bills for a generally available health insurance tax credit were introduced in the 106th Congress, but none was reported from committee or considered on the House or Senate floor. The principal objective of most bills was to extend coverage to people without insurance; other goals included improving tax equity and giving employees more health plan options.

A tax credit could be attractive in several respects. If it were generally available, a credit could aid taxpayers who do not have access to employment-based insurance (or who are dissatisfied with it) and who cannot claim the medical expense deduction. A credit could provide all taxpayers with the same dollar reduction in final tax liability; this would avoid problems of vertical equity associated with the tax exclusion and tax deduction. A credit might also provide lower income taxpayers with greater tax savings than either the exclusion or the deduction; this might reduce the number of the uninsured. If the credit were refundable, it could even help taxpayers with limited or no tax liability.

But the effects of tax credits can vary widely, depending on how they are designed. One important question is whether the credit would supplement or replace existing tax benefits, particularly the exclusion for employer-paid insurance. Another is whether the credit would be the same for all taxpayers or more generous for those with lower incomes. Ensuring that lower income families benefit from any credit may be difficult if they cannot afford to purchase insurance beforehand. Similarly, it might be asked whether the credit would vary with factors that affect the cost of health insurance, such as age, gender, place of residence, or health status. Whether the insurance must meet certain standards for benefits, coinsurance, and underwriting might also be a factor. For additional analysis, see CRS Report RL30762, *Tax Subsidies for Health Insurance for the Uninsured: An Economic Analysis of Selected Policy Issues for Congress*, by Gary Guenther.

Some tax credit bills were for more limited purposes, such as helping military retirees and certain senior citizens pay Medicare Part B premiums or helping Medicare beneficiaries pay for supplemental prescription drug coverage. President Clinton proposed a 25% credit in his last budgets for older individuals who buy into Medicare before age 65 (once that were authorized) or who pay COBRA continuation coverage premiums.

Employer Tax Credit

No employer tax credit legislation was enacted in the 106th Congress. In his last budgets, President Clinton proposed a 20% credit for small businesses that begin offering health insurance to their workers. The 1999 Senate omnibus tax bill (H.R. 2488, originally S. 1429) included a tax credit for small employers (9 or fewer employees, on average) for health insurance paid for certain lower income employees (individuals whose annual wages exceed $5,000 but not $16,000). The credit would equal 60% of the cost of individual coverage up to $1,000 and 70% of the cost of family coverage up to $1,715.

Appendix

The Federal Income Tax Formula

Listed below is the general formula for calculating federal income taxes. The list omits some steps, such as prepayments (from withholding and estimated payments) and the alternative minimum tax.

1. Gross income
2. *minus* Deductions (or adjustments) for AGI (i.e., "above the line")
3. = Adjusted gross income (AGI)
4. *minus* Greater of standard or itemized deductions
5. *minus* Personal and dependency exemptions
6. = Taxable income
7. *times* Tax rate
8. = Tax on taxable income ("regular tax liability")
9. *minus* Credits
10. = Final tax liability

LEGISLATION

This section will include bills that have been (or are likely to be) reported by committee or considered on the House or Senate floor. Congressional offices may obtain summaries of other bills and track their status by using the Legislative Information System (LIS) available through the CRS home page. Under the Legislation heading, click on "Bill Summary and Status for 107th Congress," search by bill number, and then click on either "CRS Summary" or "Bill Status." Some bills (particularly Senate bills) are also summarized in the *Congressional Record* when they are introduced. For guidance on searching for legislation addressing tax benefits for health insurance, see the introduction to Current Proposals, above.

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