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Tax Treatment of Health Insurance Expenditures by the Self-Employed: Current Law and Selected Economic Effects

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Summary

The federal tax code has offered a deduction for the health insurance expenditures of the self-employed since 1987. In 2001, self-employed individuals may deduct from their gross income 60% of the cost of health insurance for themselves and their immediate families, and the share is scheduled to rise to 70% in 2002 and 100% in 2003 and thereafter.

The deduction encourages the self-employed to purchase non-group health insurance by lowering its after-tax cost. While there is evidence that it has boosted health insurance coverage among the self-employed since it went into effect, the deduction in its present form raises some economic policy issues. Specifically, some are concerned that it is more valuable to high-income than low-income households, encourages the consumption of inefficient amounts of health care, and could worsen the problem of adverse selection in health insurance markets.

Tax Treatment of Health Insurance Expenditures by the Self-Employed

Under Section 162(1) of the Internal Revenue Code, self-employed persons are permitted to deduct from their gross income a portion of the cost of health insurance they purchase for themselves and their immediate families. The self-employed are defined as sole proprietors, working partners in a partnership, and employees of Subchapter S corporations who own more than 2% of their stock.[1] The deduction is taken above-the-line, which means that it is available regardless of whether a self-employed person itemizes.

[1] Subchapter S corporations are not subject to the corporate income tax but enjoy the non-tax benefits of regular corporations, especially limited liability under state laws. To qualify as an S corporation, a firm can have no more than 75 shareholders, the shareholders must be resident citizens of the United States, and the firm can issue only one class of stock.

It lowers a self-employed individual's after-tax cost of health insurance by a factor equal to her or his marginal tax rate. In 2001, 60% of health insurance premiums are deductible, and the deductible share is scheduled to rise to 70% in 2002 and 100% in 2003 and thereafter. Between now and 2003, the portion of premiums that cannot be deducted may be combined with other medical expenses, and the amount above 7.5% of adjusted gross income may be claimed as an itemized deduction.

Certain rules govern the use of the deduction. First, self-employed individuals are not allowed to deduct their health insurance expenditures in computing their self-employment taxes. Second, the deduction cannot exceed a self-employed individual's earned income from the trade or business for which the insurance plan was established, less the deductions for 50% of the self-employment tax and contributions to certain pension plans. Third, the deduction cannot be claimed for any month in which a self-employed individual is covered by a subsidized health insurance policy provided by a current or former employer or a spouse's employer.

Under a provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L.104-191), self-employed individuals (like all other taxpayers) may include long-term care insurance premiums in their health insurance expenditures eligible for the deduction. However, there are indexed annual limits on the amount of premiums that can be deducted, and the limits depend on the age of the insured individual: in 2000, these limits ranged from $210 for those 40 years and under to $2,660 for those over 70.

The self-employed (along with employees of firms with 50 or fewer employees) also have the option of opening medical savings accounts (MSAs) instead of buying conventional health insurance. This option stems from a pilot program established by HIPAA and begun in 1997 that is scheduled to last through 2002 and is limited to a total of 750,000 participants. A MSA resembles an individual retirement account in that it is a tax-exempt trust or custodial account established to pay unreimbursed medical expenses as part of a high-deductible health care plan. Individual contributions to MSAs are deductible from gross income up to an annual limit equal to 65% of the deductible (set at $1,550 to $2,350 in 2000) for insurance policies covering one person and 75% of the deductible (set at $3,100 to $4,650 in 2000) for policies covering two or more persons.

About 12.5 million workers were self-employed in 1998, up from 12.0 million in 1995, according to the latest estimates by the Employee Benefit Research Institute.[2] Of the 1998 self-employed population, 9.0 million had private health insurance, 0.6 million had public insurance – mainly Medicaid – and 3.1 million were uninsured. About 73% of the self-employed with private health insurance (or 6.6 million) were covered through a current or former employer or a spouse's employer. The remaining 2.4 million self-employed with private health insurance purchased it themselves. According to the U.S. Internal Revenue Service, 3.2 million claims for the deduction were filed in 1998, and the total amount claimed was $4.5 billion. The congressional Joint Committee on Taxation (JCT) estimates that the deduction cost the U.S. treasury $1.2 billion in forgone tax revenue in fiscal year 2000.

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[2] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey,* Issue Brief No. 192 (Washington: Employee Benefit Research Institute, January 2000), Table 4, p. 10.

Tax Treatment of Employment-Based Health Insurance

In analyzing the economic effects of the tax deduction for health insurance expenditures by the self-employed, a useful frame of reference is the tax treatment of employment-based health insurance. The majority of Americans under age 65 are covered by group health insurance policies provided by employers or labor unions. In 1998, an estimated 154.8 million Americans (or 65% of the non-elderly population) were covered by such policies. In general, employment-based group health insurance carries substantially lower premiums than comparable individual or non-group health insurance largely because large employers can pool the health risks among their workers and efficiently process the information required to calculate and collect premiums and submit claims.

Under current law, workers who obtain health insurance through their employers as a fringe benefit pay no federal or state income and federal payroll taxes on their employers' contributions for the insurance. For employers, the contributions are considered a deductible business expense, like wages and salaries. There is no limit on the amount of employer contributions per employee that can be excluded from taxation. If an employer's contribution is less than the full premium, then covered employees typically pay for the difference out of their after-tax incomes.

The exclusion for employment-based health insurance represents a significant and costly subsidy for the purchase of this insurance. In effect, it reduces the after-tax cost of health insurance to employees by a factor equal to their combined marginal income and employment tax rates. This means for an employee covered by employment-based health insurance that the tax exclusion reduces the price of that insurance in after-tax dollars relative to the prices of other goods and services he or she may consume.[3] As a result, it gives employees a robust incentive to prefer compensation in the form of health insurance rather than wages and salaries. Wages are subject to income and payroll taxes, unlike fringe benefits such as employment-based health insurance. Moreover, because the tax exclusion is not capped, employees have an added incentive to prefer comprehensive health insurance with little or no cost sharing. With over 60 million workers taking advantage of the tax exclusion, it has a sizable impact on the federal budget.[4] The JCT estimates that the exclusion lowered federal income tax revenue by $61.3 billion in FY 2000.

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[3] In an analysis of the potential effects of various fundamental tax reform proposals on employer-provided health insurance, economists Jonathan Gruber and James Poterba estimated that the after-tax price of $1.00 of this insurance in 1994 was $0.62 in wages because of the tax exclusion for employment-based health insurance. See: Jonathan Gruber and James Poterba, "Fundamental Tax Reform and Employer-Provided Health Insurance," in *Economic Effects of Fundamental Tax Reform*, Henry J. Aaron and William G. Gale, eds. (Washington: Brookings Institution Press, 1996), pp. 135-136.

[4] See Thomas M. Selden and John F. Moeller, "Estimates of the Tax Subsidy for Employment-Related Health Insurance," *National Tax Journal*, vol. 53, no. 4, December 2000, p. 880.

Legislative History of the Health Insurance Deduction for the Self-Employed

The tax deduction for health insurance expenditures by the self-employed was first enacted as a temporary provision of the Tax Reform Act of 1986 (TRA, P.L. 99-514). It was equal to 25% of health insurance premiums and scheduled to expire at the end of 1989. Although the TRA specified that Congress was to assess the effectiveness of the deduction before it expired, no such study was completed. Nonetheless, with strong bipartisan support, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) extended the deduction through September 30, 1990. The deduction was further extended by the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) through December 31, 1991, the Tax Extension Act of 1991 (P.L. 102-227) through June 30, 1992, and the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) through December 31, 1993. No measure renewing the deduction was enacted in 1994.

Under legislation enacted in April 1995 (P.L. 104-7), the deduction was reinstated retroactively for 1994, made permanent, and increased to 30% of eligible premiums starting in 1995. The 104th Congress further modified the deduction by passing the Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), which included a gradual rise in the deduction from 30% in 1996 to 80% in 2006.

With the urging of small business owners, the 105th Congress twice liberalized the deduction. The Taxpayer Relief Act of 1997 (P.L. 105-34) accelerated the scheduled increase in the deduction and made health insurance expenditures by the self-employed fully deductible in 2007. And the Omnibus Consolidated and Emergency Supplemental Appropriations Act for FY 1999 (P.L. 105-277) made health insurance expenditures by the self-employed fully deductible beginning in 2003.

Selected Economic Effects of the Tax Deduction for the Self-Employed

Economists tend to evaluate subsidies like the tax deduction for health insurance expenditures by the self-employed largely on the basis of their effects on economic equity and efficiency. In general, depending on their design, tax subsidies can transfer resources from taxpayers as a whole to the intended beneficiaries, altering the distribution of income. Tax subsidies can also increase the expected benefits from engaging in the targeted activities, altering the allocation of economic resources.

Equity Effects. The fairness of the health insurance tax deduction for the self-employed can be assessed from two different but complementary perspectives. One is the federal tax treatment of health insurance as a whole, and the other is the deduction's impact on different income groups among the self-employed.

Before the enactment of the deduction in 1986, the federal tax code subsidized the purchase of health insurance through the exclusion for employer contributions for employment-based health insurance and the deductibility of medical expenses (including health insurance premiums) beyond a certain level of taxable income for individuals who itemized (including the self-employed). On the eve of the enactment, the tax subsidy per

dollar of health insurance expenditure was much greater for individuals with employer-provided health insurance than for self-employed individuals who purchased their own health insurance, and the gap was greatest for individuals in the highest tax brackets. Thus it can be argued that the deduction for the self-employed has made the tax treatment of health insurance more equitable by reducing the disparity between the tax subsidy for employment-based health insurance and that for health insurance bought by the self-employed.

The equity effects of the tax deduction take on a different appearance when the frame of analysis shifts to its impact across income groups. As the tax subsidy for health insurance expenditures by the self-employed is a deduction, its value depends on a self-employed individual's marginal tax rate. The higher the rate, the larger the subsidy per dollar of health insurance. Since high-income households are more likely to be covered by health insurance than low-income ones, the deduction is likely to amplify this difference in coverages rates. A 1994 study by economists Jonathan Gruber and James Poterba supports this view. They found that between 1985-86 and 1988-89 health insurance coverage rose much more among self-employed households with over $50,000 (1985 dollars) in income than among self-employed households with less than $20,000 (1985 dollars) in income.[5]

Efficiency Effects. In essence, the tax deduction for health insurance expenditures by the self-employed affects economic efficiency in two ways. One is through its impact on the decision by self-employed individuals to purchase health insurance. The second avenue is through the deduction's impact on the amount of health care consumed by individuals who become insured in response to the price effects of the deduction. It is unclear from available evidence what the net efficiency effect of the deduction has been. Nevertheless, its magnitude is likely to be small; the self-employed with private health insurance accounted for only about 5% of privately insured nonelderly Americans in 1998.

On the one hand, consumers generally are better off when they have the opportunity to protect themselves against the risk of catastrophic financial losses caused by unexpected events like severe illness or injury. This principle implies that the presence of a market for health insurance enhances economic efficiency.

Yet this market and the related market for health care are subject to certain problems that may elevate the price of heath insurance to the point where too few consumers have it. Prices might reach such levels partly because a share of health insurance premiums is used to pay for some of the cost of providing uncompensated health care to the uninsured. Putting additional upward pressure on premiums is the presence of adverse selection in the private health insurance market. Adverse selection arises when individuals with relatively high risks of developing costly health problems who know more about their health status than insurers subscribe to insurance plans composed mostly of lower-risk individuals. Once high-risk individuals become insured, insurers have no choice but to raise premiums on all plan subscribers in the next period to cover higher-than-expected claims. As premiums rise, more and more lower-risk individuals leave the plans for less costly ones

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[5] Jonathan Gruber and James Poterba, "Tax Incentives and the Decision to Purchase Health Insurance: Evidence From the Self-Employed," *The Quarterly Journal of Economics*, vol. 109, no. 3, August 1994, pp.724-725.

or drop out of insurance risk pools altogether and self-insure. Over time, adverse selection, if unchecked by policy measures such as mandatory community rating could result in too few individuals covered by health insurance. In addition, because health insurance lowers the price of health care paid by individuals, it can encourage the consumption of inefficient amounts of health care, further driving up health insurance premiums. These market failures imply that the level of health insurance coverage may be less than socially optimal in the absence of government intervention.

For these reasons, it can be argued that the deduction for the self-employed improves economic efficiency to the extent that it increases health insurance coverage among the self-employed. Indeed, it appears that the deduction has increased the health insurance coverage rate among the self-employed by reducing the after-tax cost of this insurance. Gruber and Poterba have estimated that because of the decline in the after-tax price of health insurance induced by the deduction for 25% of health insurance expenditures that took effect in 1987, the coverage rate for the self-employed went up by 6.8% between 1985-86 and 1988-89.[6]

On the other hand, health insurance may reduce economic efficiency through its encouragement of the consumption of inefficient amounts of health care. Health insurance substantially lowers the out-of-pocket cost of covered health services to insured individuals, and this price reduction increases utilization of health care. The magnitude of the increase depends on the price sensitivity of the demand for health care. Such an outcome is likely to entail efficiency losses because it violates another prerequisite of economic efficiency – namely, that the marginal benefits of consuming a good or service should equal its marginal costs. In other words, health insurance leads insured individuals to consume additional health care whose actual marginal benefits may be less than its actual marginal costs.

The deduction for the self-employed also does not remedy the problem of adverse selection in the health insurance market — although it may offset some of the price effects of this problem. One significant advantage of employment-based health insurance is that it reduces the scope for adverse selection by fostering the growth of group health insurance policies priced on the basis of the average risk of a large pool of workers, typically with varying health problems and risk preferences. Under such a risk-pooling arrangement, it is likely that the insurer's assessment of the average risk for the group would come close to the group's actual average risk. By contrast, the deduction for the self-employed encourages the purchase of individual or non-group policies priced on the basis of what information an insurer can obtain about the health status and history of the persons to be covered by them. The scope for adverse selection is greatest when the purchase of health insurance is voluntary and health insurance is priced on the basis of narrow rather than wide risk pools.

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[6] *Ibid.*, p. 720.