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Tax Benefits for Health Insurance: Current Legislation

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SUMMARY

The 108th Congress is considering a number of new or expanded tax benefits for health insurance. Individual tax credits have been proposed to help people purchase and maintain coverage, as have tax credits for employers. Legislative activity has recently occurred on measures to expand insurance options qualifying for the existing tax credit for trade-displaced workers (H.R. 1528) and to authorize expanded tax-advantaged health savings accounts (H.R. 2596 and H.R. 1). Proponents of these measures generally argue that new tax benefits are needed to reduce the number of uninsured and to address efficiency and equity problems; opponents claim they would primarily benefit higher income taxpayers and do little for most without coverage.

Current law contains significant tax benefits for health insurance. (1) Most important is the exclusion of employer-paid coverage from the determination of income and employment taxes. About two-thirds of the noninstitutionalized population under age 65 are insured through employment-based plans; 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 100% of their health insurance payments, up from 70% in 2002. (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 who purchase individual market policies and others who pay for employment-based insurance with after-tax dollars. (4) Some workers eligible for Trade Adjustment Assistance or receiving a pension paid by the Pension Benefit Guarantee Corporation can receive an advanceable, refundable tax credit to purchase certain types of insurance. (5) Coverage under Medicare and Medicaid is not considered taxable income. (6) With some exceptions, benefits 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 how 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 health care prices have risen more rapidly than the general inflation rate. 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 these concerns, though they could be difficult to implement and may cause inequities of their own.

MOST RECENT DEVELOPMENTS

On June 19, 2003, the House passed an amended version of H.R. 1528, the Taxpayer Protection and IRS Accountability Act of 2003. One provision would allow certain insurance to qualify for the current-law tax credit for trade-displaced workers if the eligible taxpayer elects to waive requirements for guaranteed issue and no preexisting condition exclusion, provided the taxpayer does not reside in a state with state-sponsored or arranged coverage qualifying for the credit. The waiver provision would apply through December 31, 2004.

On June 26, the House approved H.R. 2596, which would authorize two forms of tax-advantaged savings accounts (health savings accounts and health security savings accounts) and allow limited rollovers for flexible spending accounts; the legislation was then appended to H.R. 1, the Medicare prescription drug bill that the House passed earlier that day.

H.R. 1 would also make the Medicare medical savings account demonstration a permanent program and remove the current enrollment limits and deadlines. S. 1, the comparable bill passed by the Senate on June 27, would extend the enrollment deadline for the current demonstration by one year, through 2003.

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. An outline of the tax provisions discussed in this section is provided in **Table 1**. 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.

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).

Over 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 2002 and then received an insurance reimbursement in 2003). 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) estimates the FY2003 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 will be $75.1 billion. The estimate does not include the effect of the exclusion on employment taxes.

Medical Expense Deduction. Taxpayers who itemize their deductions may deduct unreimbursed medical expenses, but only the amount of such expenses that exceeds 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.

Table 1. Summary of the Tax Treatment of Health Insurance

Plan type	Tax treatment for individual	Tax treatment for employer
Traditional employer-sponsored plan	— Premiums paid by employer are excluded for income and employment tax purposes — Insurance benefits used for health care are excluded from employee's gross income — Premiums paid by employee are deductible if (1) employee itemizes and (2) premiums plus other unreimbursed medical expenses exceed 7.5% of adjusted gross income (AGI). Payments are made through cafeteria plan ("premium conversion") are exempt from income and employment taxes	— Employer contributions deducted as a business expense, and they are not counted for employer's share of employment taxes
Individual market policies	— Premiums are deductible if (1) the individual itemizes and (2) premiums plus other unreimbursed medical expenses exceed 7.5% of AGI	— N/A
Policies purchased by self-employed individuals	— Individual can deduct 100% of premiums (up from 70% in 2002) in determining adjusted gross income; deduction does not have to exceed 7.5% of AGI	— Not exempt from employment taxes
Cafeteria plans	— Premiums and other health benefits are excluded for income and employment tax purposes	— Employer contributions deducted as a business expense, and they are not counted for employer's share of employment taxes
Flexible spending accounts	— All contributions excluded for income and employment tax purposes	— Employer contributions deducted as a business expense, and they are not counted for employer's share of employment taxes
Medical savings accounts	— Employer contributions excluded for income and employment tax purposes — Individual contributions deductible for income tax purposes — Only for self-employed individuals with high-deductible insurance or employees of a small business providing high deductible insurance	— Employer contributions deducted as a business expense, and they are not counted for employer's share of employment taxes
Military and veterans health care	— Benefits and coverage provided under military and veterans health care programs are not considered taxable income	— N/A
Medicare and Medicaid	— Benefits and coverage provided under the Medicare and Medicaid programs are not considered taxable income — Premiums paid for Medicare are deductible if (1) the individual itemizes and (2) premiums plus other unreimbursed medical expenses exceed 7.5% of AGI	— N/A

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 1998, about 31% of all individual income tax returns had itemized deductions, and of these only about 15% (i.e., about 4.5% of all returns) claimed a medical expense deduction.

The JCT estimates the FY2003 revenue loss attributable to the medical expense deduction (including long-term care expenses) will be $6 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 was 60% of insurance payments in 1999 through 2001, 70% in 2002, and 100% in 2003 and thereafter. 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. For additional information, see CRS Report 98-515, *Tax Treatment of Health Insurance Expenditures by the Self-Employed: Current Law and Selected Economic Effects,* by Gary Guenther.

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 1998, about 3.4 million tax returns (about 2.7% of all returns) claimed the self-employed health insurance deduction. For FY2003, the JCT estimates the revenue loss attributable to the deduction (including the deduction for long-term care insurance) to be $2.4 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. Federal employees who participate in the Federal Employees Health Benefits Program (FEHBP) have been able to elect this option since October, 2000; however, the option is not available to federal retirees.

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 and Chris L. Peterson.

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 1999, about 22% of private-sector firms could have a health care FSA, but actual participation 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). The formal name of MSAs is now Archer MSAs.

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 and Chris L. Peterson.

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 following a determination that the number of taxpayers with accounts exceeded certain thresholds (eventually, 750,000). 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 became active participants through a participating employer. The Community Renewal Tax Relief Act of 2000 (P.L. 106-554) included an extension of eligibility for new participants until December 31, 2002; it also changed the formal name to Archer MSAs for the retiring chairman of the House Ways and Means Committee. The Job Creation and Worker Assistance Act (P.L. 107-147) extended eligibility for new participants until December 31, 2003.

In October, 2002, the IRS estimated that there would be 78,913 MSA returns filed for tax year 2001; it also determined that 20,592 taxpayers who did not make contributions in 2001 established accounts in the first 6 months of 2002. These numbers are far less than the 750,000 statutory ceiling. (Not all MSAs are counted toward the ceiling; for example, accounts of taxpayers who previously were uninsured are not taken into consideration.) MSAs should be distinguished from Medicare+Choice MSAs, which are discussed below under the tax treatment of Medicare and Medicaid.

Tax Credit for Trade-Displaced Workers. On August 6, 2002, President Bush signed into law the Trade Act of 2002 (P.L. 107-210). The law allows workers displaced by trade to receive a tax credit for purchasing insurance. The amount of the credit is equal to 65% of the premiums paid by the worker for qualified health insurance. The credit is advanceable, meaning that workers can receive the credit when purchasing insurance rather than receiving it after filing their tax returns. The credit is also refundable; eligible workers can receive the credit even if they have zero tax liability for the year. To be eligible for the credit, a worker must be (1) a recipient of a trade readjustment allowance under the Trade Act of 1974; (2) an individual who is not eligible for a trade readjustment allowance because he or she has not exhausted all rights to unemployment insurance; (3) a displaced worker whose current job pays less than the job lost to trade and who is receiving a supplemental wage allowance; or (4) an individual who is over the age of 55 and is receiving a pension benefit from the Pension Benefit Guaranty Corporation (PBGC).

The tax credit for workers displaced by trade can be used for limited types of health insurance. The tax credit can be applied towards premiums paid to continue employer-sponsored health insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The credit can also be used to purchase an individual health insurance policy (if the worker was covered by an individual policy at least 30 days prior to becoming unemployed) or to purchase a group policy offered through a spouse's employer. An eligible worker can use the credit to purchase various types of state-based insurance coverage, such as coverage through a state-sponsored high-risk pool, coverage through a health insurance program offered to state employees, and coverage through an arrangement between private entities and the state. State-based coverage must be guaranteed issue, cannot limit coverage due to pre-existing conditions, cannot charge higher premiums than those charged to individuals who do not receive the tax credit, and must offer the same benefits as those provided to individuals who do not receive the tax credit.

Some Members of Congress have stated that the law was not intended to allow states to enter into agreements with private insurers offering individual coverage. However, others argue that the intent of the law was to allow states to enter into agreements with private insurers, even those offering individual coverage.

The tax-credit for trade-displaced workers may serve as a model for a tax credit that is more generally available.

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 FY2003 revenue loss attributable to CHAMPUS and Tricare is estimated to be $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 estimates the revenue loss attributable to the exclusion of Medicare benefits will be $27.1 billion in FY2002. 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 35% bracket would save $1,400 (i.e., $4,000 x 0.35). If health insurance is considered a form of personal consumption like 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

In the 108th Congress, numerous proposals for new or expanded tax benefits for health insurance have been introduced. In general, proponents of new or expanded tax benefits argue that they are needed to extend coverage to the uninsured and to address efficiency and

equity problems. Opponents generally argue that tax benefits are unlikely to make much difference for most people who do not now have insurance.

This Issue Brief will not attempt to identify all bills relating to tax benefits for health insurance. For a comprehensive list of bills providing tax benefits for health insurance, Congressional offices can use the Legislative Information System (LIS) available through the CRS home page [http://www.crs.gov].

Tax Credit for Trade-Displaced Workers

Under current law, the tax credit for trade-displaced workers is available only for qualifying insurance, including coverage sponsored by state governments. State-sponsored or arranged coverage must meet certain requirements: it must be guaranteed issue, cannot have limits for pre-existing conditions, and must have the same benefits and no higher premiums as the coverage provided to individuals who do not receive the tax credit.

On June 19, 2003, the House passed an amended version of H.R. 1528, the Taxpayer Protection and IRS Accountability Act of 2003. One provision would allow certain insurance to qualify for the tax credit if the eligible taxpayer elects to waive requirements for guaranteed issue and no preexisting condition exclusion, provided the taxpayer does not reside in a state with state-sponsored or arranged coverage qualifying for the credit. The waiver would apply through December 31, 2004. The bill would not allow the waivers to supersede state laws relating to consumer insurance protections. (H.R. 1528 as introduced had different language regarding these waivers, as did the version reported by the Committee on Ways and Means.)

Proponents of the waiver contend that it is needed to give more options to trade-displaced workers who live in states without qualifying state-sponsored or arranged coverage. Opponents argue that it would allow insurance companies to "cherry-pick" workers whom they would like to cover, as well as the conditions they would cover.

H.R. 1528 would also provide that consumer protection provisions of the current tax credit law would not apply to insurance under state continuation coverage.

Tax-Advantaged Health Savings Accounts

As described above, relatively few tax-advantaged Archer **medical savings accounts** (MSAs) have been established since they first became available in 1997. The slow growth can be attributed to a number of factors including product unfamiliarity, consumer aversion to financial risk, and the reluctance of insurance agents to sell lower-priced policies; however, statutory restrictions undoubtedly have played some role. MSA proponents are urging Congress to expand eligibility 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.

President Bush's proposed FY2004 budget would expand and permanently extend the authorization for MSAs. (Under current law, the authorization for new MSAs is set to expire December 31, 2003.) Effective after December 31, 2003, the proposal would:

- repeal limits on the number of accounts;
- make active accounts generally available to anyone with qualifying high deductible insurance (thus repealing restrictions limiting them to employees of small employers and self-employed individuals);
- allow contributions up to the amount of the insurance deductible (thus deleting the 65% and 75% ceilings);
- allow contributions to be made both by employers and account owners;
- lower minimum insurance deductibles from $1,700 to $1,000 for single coverage and $3,350 to $2,000 for family coverage;
- allow MSAs to be offered through cafeteria plans;
- allow the qualifying insurance to provide, without counting against the deductible, up to $100 of preventive care per covered individual per year.

On June 19, 2003, the House Committee on Ways and Means approved an amended version of H.R. 2351 which would authorize tax-advantaged health savings accounts (HSAs) similar to MSAs. The bill was formally reported on June 25 (H.Rept. 108-177). On June 26, the House approved expanded tax-advantaged health savings accounts in H.R. 2596, which had been introduced the day before; the passed legislation was then appended to H.R. 1, the House-passed Medicare prescription drug bill, as provided in H.Res. 299. Under H.R. 2596 (and thus H.R. 1), two tax-advantaged accounts would be authorized, "health savings accounts" and "health savings security accounts." **Health savings accounts (HSAs)** would be for individuals covered by a health plan with an annual deductible of between $1,000 and $2,500 for self-only coverage and between $2,000 and $5,050 for family coverage; out-of-pocket limits could not exceed $3,350 for the former and $6,150 for the latter. Annual contributions equal to the deductible would be deductible by the taxpayer (or excluded by the taxpayer, if paid by the employer). The JCT estimates that HSAs would result in a revenue loss of $5.7 billion over the fiscal year 2004 through 2013 period. **Health savings security accounts (HSSAs)** would be for individuals who are uninsured or who are covered by a health plan with a deductible of at least $500 for self-only coverage and $1,000 for family coverage. Annual deductible contributions of up to $2,000 could be made by individuals with self-only coverage and uninsured individuals with no dependents; deductible contributions of up to $4,000 could be made by individuals with family coverage and uninsured individuals with dependents or who file a joint return. Allowable contributions would be reduced and then eliminated for the former individuals who have incomes between $75,000 and $85,000 and for the latter individuals who have incomes between $150,000 and $170,000. Individuals age 55 and over could make larger contributions. The JCT estimates that HSSAs would result in a revenue loss of $169 billion over the fiscal year 2004 through 2013 period.

Flexible Spending Accounts

President Bush's FY2004 budget would allow up to $500 in unused balances in health care flexible spending accounts (FSAs) to be carried over to the following year without being taxed. Under current law, unused balances must be forfeited to the employer. The proposal would also permit unused balances to 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). H.R. 176 (introduced by Representative Royce) and H.R. 1177 (introduced by Representative DeMint) would also allow limited amounts of unused balances to be carried forward to the following year.

On June 19, 2003, the House Committee on Ways and Means approved an amended version of H.R. 2351 which would allow up to $500 in unused health care FSA balances to be carried over, contributed to a qualified retirement or deferred compensation plan, or contributed to a health savings account (which that same legislation would allow). The provision was also included in H.R. 2596, which the House passed on June 26 (see the discussion above for tax-advantaged health savings accounts) and then was appended to H.R. 1, the House Medicare prescription drug bill, also passed that day.

The principal argument for allowing these options is that taxpayers might be more willing to participate in FSAs if unused balances at the end of the year were not lost. Allowing carryovers or rollovers might also discourage participants from spending remaining balances carelessly, just to use them up. 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. It is not clear in the President's proposal when rollovers to deferred compensation plans would occur; employers generally would need time to run nondiscrimination tests to see if additional contributions to these plans would be permissible.

Expanded Tax Deduction

In the 108th Congress, one bill has been introduced that would allow individuals to deduct 100% of their insurance premiums, regardless of whether they itemize (H.R. 198, introduced by Representative Stearns). Another bill would remove would allow itemizers to deduct all of their medical expenses (H.R. 53, introduced by Representative Cox). 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.

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.) 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 $700 for someone in the 35% bracket (i.e., $2,000 x 0.35) 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.

Expanded Tax Credit

President Bush's FY2004 budget includes a refundable tax credit for health insurance for individuals under age 65. Under the FY2004 budget proposal, the credit would equal 90% of the premium and would decrease for higher incomes; the credit would phase out at $30,000 for individuals and at $60,000 for families. The amount of the credit be limited to $1,000 for an adult covered by a policy and $500 for each child, up to two children. Individuals participating in public health plans (such as Medicaid or the State Children's Health Insurance Program) or employer health plans would not be eligible for the credit. The credit would be claimed through the normal tax-filing process. Alternatively, beginning July 1, 2005, an individual could use the credit in advance to reduce payments to the insurance company. The insurer would have then received the credit directly from the U.S. Treasury.

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.

Small Employer Tax Credit

The Economic Recovery Act of 2003 (S. 414, introduced by Senator Daschle) would provide a tax credit to small employers. The credit would equal a certain percentage of the amount spent by the employer for employee benefits. The percentage would equal 50% for employers with less than 26 qualified employees, 40% for employers with between 26 and 35 qualified employees, and 30% for employers with between 36 and 50 qualified employees. A qualified employee is a worker who is not covered under a spouse's health insurance or covered under a public insurance program.

In the 108th Congress, several other bills have been introduced that would provide a tax credit to small employers that offer health insurance to their employees (S. 10, introduced by Senator Daschle; S. 53, introduced by Senator Durbin; S. 86 introduced by Senator Clinton). In each bill, the credit would equal a percentage of the cost incurred by the employer for providing health insurance to qualified employees. Each bill has different

provisions for calculating the percentage of the credit. Factors determining the percentage include the number of qualified employees in the firm, the average wage of the firm's qualified employees, the share of insurance premiums paid by the firm, and whether a qualified employee is covered by a single or family policy.

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Appendix

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