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Tax Benefits for Health Insurance and Expenses: Current Legislation

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SUMMARY

While the 109th Congress has given little consideration to changing tax benefits for health insurance and medical expenses, fundamental changes might soon be proposed by the President's Advisory Panel on Federal Tax Reform. Smaller proposals on the table now include a generally available tax credit for lower middle income families to purchase insurance and additional incentives for individuals to establish Health Savings Accounts. Other proposals would help small businesses offer insurance to their employees. Proponents changes generally argue that new tax benefits would reduce the number of uninsured and address efficiency and equity problems; opponents claim they often would primarily benefit higher income taxpayers and do little for most without coverage. Some argue that expanding government programs such as Medicaid would be a more effective use of government money.

Current law contains significant tax benefits for health insurance and expenses: (1) Most important is the exclusion of employer-paid coverage from the determination of income and employment taxes. Two-thirds of the noninstitutionalized population under age 65 are insured through employment-based plans; on average, large employers pay about 80% of their 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, even if they do not itemize deductions. (3) Taxpayers who do itemize may deduct insurance payments and other unreimbursed medical expenses to the extent they 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 (the health coverage tax credit, HCTC) to purchase certain types of insurance. (5) Four tax-advantaged accounts are available to help taxpayers pay their health care expenses: Flexible Spending Accounts, Health Reimbursement Accounts, Health Savings Accounts; and Medical Savings Accounts. (6) Coverage under Medicare and Medicaid is not considered taxable income. (7) With exceptions, benefits received from private or public insurance are not taxable.

By lowering the after-tax cost of insurance, these 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. 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 general inflation. Since many people would likely obtain some insurance without tax benefits, they can be an inefficient use of public dollars. When insurance is viewed as a form of personal consumption, tax benefits appear inequitable since the savings they generate depend on taxpayers' marginal tax rates. When viewed as spreading catastrophic economic risk over multiple years, however, basing savings on marginal rates might be justified as the proper treatment for losses under a progressive tax system.

MOST RECENT DEVELOPMENTS

Some congressional offices are considering whether eligibility for the Health Coverage Tax Credit might be expanded to include Katrina survivors.

On June 16, 2005, the House Committee on Government Reform ordered H.R. 994 to be reported; among other things, the legislation would allow federal civilian and military retirees to pay their federal health insurance premiums to be paid on a pretax basis.

BACKGROUND AND ANALYSIS

Tax Benefits in Current Law

Current law provides significant tax benefits for health insurance and expenses. 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.

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 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 that the FY2005 tax expenditure (change in aggregate tax liability) 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 $78.6 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.

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 2001, about 34% of all individual income tax returns had itemized deductions, and of these only about 17% (i.e., about 5.8% of all returns) claimed a medical expense deduction.

The JCT estimates the FY2005 tax expenditure attributable to the medical expense deduction (including long-term care expenses) will be $7.7 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 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.

Under 7% 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 (typically individual private market coverage) in determining their AGI. (Section 162) Called an "above-the-line" deduction, this tax benefit is not restricted to itemizers or subject to a floor, as is the medical expense deduction described above. Starting in 2003, 100% of the cost may be taken into consideration. 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 1998, about 3.6 million tax returns (about 2.7% of all returns) claimed the self-employed health insurance deduction. For FY2005, the JCT estimates the tax expenditure attributable to the deduction (including the deduction for long-term care insurance) to be $3.2 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. 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.

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"), though employers may allow a 2 ½-month grace period. 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.

According to a 2004 survey by Mercer Human Resources Consulting, 81% of employers with 500 or more employees offered a health care FSA, and an average of 20% of eligible employees participated. Among employers with 10 or more employees, 25% offered a health care FSA, and an average of 36% of eligible employees participated. The average amount contributed was $1,295.

For additional information on FSAs, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Chris L. Peterson and Bob Lyke. Also see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke for a quick overview of FSAs and the three other accounts discussed below.

Health Reimbursement Accounts. HRAs are employer-established arrangements to reimburse employees for medical and dental expenses not covered by insurance or otherwise reimbursable. As is the case with FSAs, contributions are not subject to either income or employment taxes. In contrast, however, contributions cannot be made through salary reduction agreements; only employers may contribute. Employers need not actually fund HRAs until employees draw upon them; the accounts may be simply notional. Also unlike FSAs, reimbursements can be limited to amounts previously contributed. Unused balances may be carried over indefinitely, though employers may limit the aggregate carryovers.

HRAs are governed by Section 105 of the Internal Revenue Code, which allows health plan benefits used for medical care to be exempt from taxes, and Section 106 of the Code, which allows employer contributions to those plans to be tax-exempt. Rules regarding HRAs are spelled out in IRS revenue rulings and notices issued in 2002.

Health Savings Accounts. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) authorized new heath savings accounts (HSAs) for unreimbursed medical expenses. HSAs are similar to medical savings accounts (MSAs), and it is thought in time HSAs will replace them. HSAs are available to taxpayers generally; individuals do not have to be either self-employed or employed by a small employer that provides high deductible insurance. There is not any limit on the number of accounts.

HSA contributions can be made when individuals have qualifying health insurance: for self-only insurance, the deductible must at least $1,000 and required out-of-pocket expenses for covered benefits cannot exceed $5,000; for family coverage, the deductible must be at least $2,000 and required out-of-pocket expenses for covered benefits cannot exceed $10,000. In 2005, contributions are limited to the lesser of $2,650 or 100% of the deductible for self-only coverage; for family coverage, they are limited to the least of $5,250, 100% of the overall deductible, or the embedded deductible (the deductible applying to one individual) multiplied by the number of covered family members. Individuals aged 55 and over bmay contribute an additional $600. Contributions may be made by employers, individuals, or both.

HSAs were first allowed as of January 1, 2004, and many insurers and employers have only recently begun offering products. According to America's Health Insurance Plans (AHIP), as of March, 2005, over 1 million individuals were covered by insurance plans that accompany HSAs, most of them in the private individual market. For additional information, see CRS Report RL32467, *Health Savings Accounts*, by Bob Lyke, Chris L. Peterson, and Neela Ranade.

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.

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 (extended by subsequent legislation to December 31, 2003) 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.

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 six 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 MSAs, which are discussed below under the tax treatment of Medicare and Medicaid.

Health Coverage Tax Credit. This tax credit equals 65% of the premiums paid by eligible individuals for qualifying insurance. The HCTC is payable in advance, meaning that workers can receive the credit when purchasing insurance rather than receiving it after filing their tax returns. It is also refundable; eligible workers can receive the credit even if they have zero tax liability for the year. Three groups of taxpayers are eligible for the HCTC: (1) individuals receiving a Trade Readjustment Assistance allowance, including those eligible for but not yet receiving the allowance because they have not yet exhausted their state unemployment benefits; (2) individuals age 50 and over receiving an Alternative Trade Adjustment Assistance allowance; and (3) individuals age 55 and over receiving a Pension Benefit Guaranty Corporation (PBGC) pension payment, including those who received a lump sum payment from the PBGC after August 5, 2002. Eligible individuals cannot be enrolled in certain other health insurance, including Medicaid employment-based insurance for which the employer pays 50% or more of the cost, or entitled to Medicare.

The HCTC can be claimed only for 10 types of insurance coverage specified in the statute, seven of which require state action to become effective. As of November 2004, 39 states and the District of Columbia made at least one of these seven forms of coverage available; in the remaining 11 states, only the three automatically qualified forms not requiring state action were available, though not to all who were eligible for the credit.

The HCTC is not widely used. As of November 2004, 13,369 of the estimated 223,307 taxpayers who were potentially eligible for the credit were receiving advance payments, or about 6%. Others might be claiming the credit without an advance payment, but their number is not likely to be large. For additional information, see CRS Report RL32620, *Health Coverage Tax Credit Authorized by the Trade Act* by Julie Stone-Axelrad and Bob Lyke

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. For 2005, the JCT estimates that the tax expenditure attributable to CHAMPUS and Tricare will be $1.6 billion. For more information, see CRS Issue Brief IB93103, *Military Medical Care Services: Questions and Answers*, by Richard A. Best, Jr.

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. For FY2005, the JCT estimates the tax expenditure attributable to the exclusion of Medicare benefits will be $27.3 billion. 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. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) renamed Medicare+Choice plans Medicare Advantage plans. No Medicare MSAs 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 Expanding Health Insurance Coverage: Selected Policy Issues for the 108th Congress*, by Gary Guenther.

Current Proposals

In the 109th Congress, there are likely to be numerous proposals for new or expanded tax benefits for health insurance and medical expenses. Consideration may also be given to more comprehensive changes, such as limiting or eliminating the exclusion for employer-paid insurance; these might be included in recommendations for general tax reform to be made by the President's Advisory Panel on Federal Tax Reform.

This issue brief focuses on bills that would change tax benefits for health insurance and medical expenses that have received committee or floor action or that otherwise are the subject of discussion. This issue brief does not identify all bills on this topic, because these have numbered in the hundreds in a typical Congress. Congressional staff who are interested in other bills might search for them through the Legislative Information System (LIS); in particular, they might use the Advanced Search link (in the middle of the screen) and search for terms such as "health insurance" AND "credit" AND "Internal Revenue Code." For assistance, telephone CRS at 7-5700.

Flexible Spending Accounts

Under current IRS rules, unused FSA balances are forfeited to the employer at the end of the year (though starting at the end of 2005 employers may allow a 2½-month grace period each year). During the past several Congresses, legislation was introduced to allow up to $500 (or more) in unused health care FSA balances to be carried over to the following year without being taxed. Most proposals would also have permitted unused balances to be distributed to participants (in which case they would be taxed) or rolled over into qualified deferred compensation plans. While some proposals were passed by a single chamber, none was enacted. As a consequence, similar measures have been introduced in the 109th Congress, including H.R. 1803 (Royce), H.R. 1998 (McCrery), H.R. 3075 (Paul), and S. 309 (DeMint).

On August 23, 2004, Senator Grassley, chairman of the Senate Committee on Finance, requested the Treasury Department to assess whether it has the authority to modify the "use-it-or-lose-it" rule without a directive from the legislative branch. On December 23, 2004, Treasury Secretary John W. Snow responded that Congress had effectively ratified the rule and that changes would require legislative action. Nonetheless, on May 18, 2005, the Treasury Department announced that employers may offer a two and one-half month grace period in which taxpayers may continue to use their account balances (IRS Notice 2005-42).

The principal argument for these proposals 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.

However, FSAs sometimes conflict with HSAs. FSAs cannot be used to pay deductibles and copayments associated with the high deductible insurance that allows individuals to make HSA contributions; while individuals may have both types of accounts, they must cover different categories of expenses. Thus, rule changes that might make FSAs more popular may inhibit the spread of HSAs. Allowing unused balance to be carried over or rolled over would also increase revenue losses associated with FSAs.

Cafeteria Plans

As mentioned above, federal retirees who participate in the Federal Employees Health Benefits Program (FEHBP) do not have the option of paying their premiums on a pretax basis. One measure that would allow them to do so (H.R. 994; Davis-VA) was ordered to be reported by the House Committee on Government Reform on June 16, 2005. The bill has also been referred to the House Committee on Armed Services and the Committee on Ways and Means. S. 484 (Warner) is similar.

Paying FEHBP premiums on a pretax basis is currently available to federal workers, and it would appear equitable to allow federal retirees the same option. However, it would not seem equitable to allow this tax treatment for federal retirees but not retirees with private sector or state and local governmental insurance coverage. Including the latter groups would substantially increase the cost of the legislation.

Health Savings Accounts

The Administration strongly supports HSAs as a way of helping people acquire affordable insurance (since the deductibles are higher) and build reserves that can be used for health care expenses in later years. In his FY2006 budget, the President proposed two tax incentives associated with these accounts: (1) an above-the-line deduction (not limited to itemizers) for the cost of qualifying high deductible insurance for taxpayers who contribute to health savings accounts, and (2) a refundable tax credit for small for-profit employers that contribute to their employees' health savings accounts. Among the bills that would authorize these provisions are H.R. 37 (King), H.R. 1872 (Johnson-TX), S. 978 (Santorum), and S. 1503 (Frist).

H.R. 3075 (Paul) would increase the deduction allowed for contributions to HSAs.

Health Coverage Tax Credit

Though first available only in December 2002, the HCTC has been the subject of much controversy and proposals for change. One issue is eligibility: under current law, taxpayers must be in one of three groups discussed above, that is, recipients of Trade Readjustment Assistance (or eligible individuals still receiving state unemployment compensation), Alternative Trade Adjustment Assistance, or a pension paid by the Pension Benefit Guaranty

Corporation. Some argue that eligibility should be expanded to include other groups, such as service industry workers displaced by foreign trade (Trade Adjustment Assistance is now limited to manufacturing workers), the spouse of someone who is no longer eligible (perhaps because they enrolled in Medicare), or even Katrina survivors.

A second issue involves the consumer protection standards (guaranteed issue, no preexisting condition exclusion, nondiscriminatory premiums, and substantially the same benefits for eligibles and noneligibles) required of state qualified insurance plans. While some argue that these provisions make access to insurance more equitable and guarantee premiums and benefit packages like those offered others in a particular state, others claim the provisions limit the availability of state qualified plans and raise costs. In the 108th Congress, the House passed legislation which would allow individuals to temporarily waive some of these provisions, but it was not enacted.

In his FY2006 budget, the President proposed a number of clarifications and other minor changes to the HCTC.

109th Congress bills that would amend the HCTC include S. 4 and S. 1503 (both by Frist), S. 14 (Stabenow), and S. 1365 (Rockefeller).

Expanded Individual Tax Credit

President Bush's FY2006 budget includes a refundable tax credit for health insurance for individuals under age 65. Congress took no action on a similar proposal in the FY2005 budget. The credit in the FY2006 budget would equal 90% of the cost of health insurance, up to a maximum of $1,000 for each adult and $500 for each of two children; the credit would be reduced and eventually phased out for incomes above $15,000 for single tax filers with no dependents and above $25,000 for other tax filers. If the premium were for qualifying high deductible insurance, individuals could elect to have 30% of the credit deposited in their health savings account. The credit would be claimed through the normal tax-filing process in the following tax year; alternatively, it could be claimed in advance (based on the individual's prior year tax return), allowing reduced premium payments. In the latter case, the insurer would be reimbursed for the credit directly from the U.S. Treasury.

In general, an expanded 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, as in the President's FY2006 proposal, 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.

A number of bills have been introduced that would authorize refundable individual tax credits for health insurance; these include H.R. 765 (Representative Kennedy), H.R. 2089 (Representative Granger), H.R. 2033 (Representative Shadegg), H.R. 3075 (Representative Paul), S. 4 (Senator Frist), S. 160 (Senator Murkowski), S. 1178 (Senator Martinez), S. 1225 (Senator Collins), and S. 1503 (Senator Frist). Several bills would authorize tax credits only with respect to coverage for dependent children; these include H.H. 3077 (Representative Paul), S. 16 (Senator Kennedy), and S. 114 (Senator Kerry.

Employer Tax Credit

In his FY2006 budget, the President has proposed a tax credit for small employers that make contributions to their employees' health savings accounts. Small employers are defined as having fewer than 100 employees on a typical business day. The credit could reimburse employers for HSA contributions of up to $200 for single coverage and $500 for family coverage.

A number of bills have been introduced that would authorize tax credits for small employers to help them start or maintain health insurance for their workers; these include H.R. 118 (Hooley), H.R. 2001 (Moore-KS), H.R. 2002 (Moore-KS), H.R. 2073 (Barrow), H.R. 2259 (Dingell), S. 1012 (Kennedy), S. 1225 (Collins), and S. 1329 (Bayh).

Expanded Tax Deduction

The current law deduction for health insurance is restricted to taxpayers who itemize and is further limited to payments for insurance and unreimbursed medical expenses that exceed 7.5% adjusted gross income; thus, most taxpayers cannot benefit from it. At the same time, taxpayers who have employment-based insurance can exclude the value of employer payments, and if they have a premium conversion plan, they can pay their share of the premiums on a pretax basis as well. The tax savings from the exclusion and premium conversion are roughly equivalent to a full deduction (actually, they are greater since there are also employment tax savings).

In recent Congresses there have been several proposals to allow all taxpayers to deduct the full cost of their health insurance premiums as an above-the-line deduction (i.e., a deduction not limited to itemizers). 109th Congress bills that would authorize an expanded tax deduction include H.R. 218 (Stearns) and H.R. 2176 (Chabot).

In his FY2006 budget, President Bush proposed allowing individuals with HSAs to deduct the cost of their health insurance. See the discussion above about legislation that would carry out his proposal.

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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 (everything counted for tax purposes)
2. *minus* Deductions (or adjustments) for AGI (i.e., "above the line deduction")
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 (i.e., "regular tax liability")
9. *minus* Credits
10. = Final tax liability