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Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation

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Summary

How tax policy affects health insurance and health care spending is a subject of increasing discussion in Washington. The issue is prompted both by the size of the tax subsidies, particularly the exclusion for employer-paid insurance, and by growing interest in comprehensive tax and health care reform. At the moment, however, attention is focused on narrower goals, such as improving health savings accounts and allowing carryovers of unused balances in flexible spending accounts.

Current law contains significant tax benefits for health insurance and expenses: (1) Employer-paid coverage is excluded from the determination of income and employment taxes. More than 60% of the noninstitutionalized population under age 65 is 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 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 those who purchase individual market policies or who have catastrophic costs. (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, Medicaid, SCHIP, and military and veterans health care programs 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, some of these tax benefits help extend coverage to more people; they also lead some people to obtain more coverage than they would otherwise. The incentives also 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. In addition, the tax benefits increase the demand for health care by enabling insured people to obtain services at discounted prices; this in turn contributes to rising health care costs. Because many people would likely obtain insurance without tax benefits, they can be an inefficient use of public dollars. When insurance is viewed as a form of personal consumption, the tax benefits appear inequitable because taxpayers' savings depend on marginal tax rates. When viewed as spreading catastrophic economic risk over multiple years, however, basing those savings on marginal rates might be justified as the proper treatment for losses under a progressive tax system. This report replaces CRS Issue Brief IB98037, *Tax Benefits for Health Insurance and Expenses: Current Legislation*, and it will be updated as warranted by legislative activities and other developments.

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Tax Benefits for Health Insurance and Expenses: Current Law and Legislation

Most Recent Developments

In his FY2007 budget, released on February 6, 2006, President Bush proposed tax incentives that would increase the availability and attractiveness of Health Savings Accounts. He also proposed minor changes to the health coverage tax credit.

The House Committee on Ways and Means held a hearing on Health Savings Accounts on June 28, 2006. There was discussion about whether the accounts will help reduce the number of people without health insurance and what effect they might have on health care costs.

Tax Benefits in Current Law

Current law provides significant tax benefits for health insurance and expenses. The tax subsidies (mostly 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.

This section of the report summarizes the current tax treatment of the principal ways that people obtain health insurance and pay their health care expenses. It describes general rules but does not discuss all limitations, qualifications, or 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 *omitted* from gross income, whereas 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.

This section also includes Joint Committee on Taxation (JCT) estimates of tax expenditures, where available. Tax expenditures measure the difference in tax liabilities for individuals and corporations due to provisions that are exceptions to a normative comprehensive income tax. Tax expenditures are not the same as revenue

losses to the government, the measurement of which reflects assumed behavioral responses, timing considerations, and changes in employment tax receipts.[1]

Most of the tax rules discussed here have also been adopted by states that have income taxes.

Employer-Paid Insurance

More than 60% of the noninstitutionalized population under age 65 is insured under an employment-based plan. On average, employers pay about 80% of the cost of this insurance, though some pay all and others pay none. Employers typically pay a higher percentage for single coverage and a lower percentage for families.[2]

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).[3] 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 may be subject to a premium conversion arrangement under a cafeteria plan or counted towards the itemized medical expense deduction (both of which are discussed below).

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 previously excluded from gross income. [4] Benefits are also taxable to the extent that taxpayers received a tax benefit from deducting expenses in a prior year (e.g., if taxpayers claimed a medical expense deduction for expenditures in 2005 and then received an insurance reimbursement in 2006). 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.

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[1] All JCT estimates are from *Estimates of Federal Tax Expenditures for Fiscal Years 2006-2010*, JCS-2-06 (Apr. 25, 2006). The JCT report discusses how tax expenditures are defined (pp. 2-3) and measured (pp. 26-27). Tax expenditures should not be added together since they do not take account of interaction effects among provisions.

[2] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2004*, by Chris L. Peterson; *Employer Health Benefits: 2005 Summary of Findings*, by the Kaiser Family Foundation and the Health Research and Educational Trust; and *Health Insurance Coverage in America: 2004 Data Update*, by the Kaiser Commission on Medicaid and the Uninsured. Much of the employers' cost for this insurance is probably passed on to employees through reductions in wages and other forms of compensation.

[3] Sections 106 and 3121, respectively.

[4] Sections 104 and 105.

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 FY2006 tax expenditure attributable to the exclusion for employer payments for health insurance and health care (for self-insured plans) will be $90.6 billion. The estimate does not include the effect of the exclusion on employment taxes.[5]

Unreimbursed Medical Expenses

Taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of adjusted gross income (AGI).[6] Medical expenses include health insurance premiums paid by the taxpayer, principally premiums for individual market policies and the employee's share of premiums for employment-based coverage (aside from those subject to a premium conversion arrangement). 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."[7] They also include certain transportation and lodging expenditures, qualified long-term care costs, and long-term care insurance premiums that do not exceed certain amounts.

The deduction is intended to help only people with catastrophic expenses, so by design, it is not widely used. For most taxpayers, the standard deduction is larger than the sum of their itemized deductions; moreover, most do not have unreimbursed expenses that exceed 7.5% AGI. In 2002, about 35% of all individual income tax returns had itemized deductions; of these returns, only about 19% (about 6.6% of all returns) claimed a medical expense deduction.[8]

The JCT estimates that the FY2006 tax expenditure attributable to the medical expense deduction (including long-term care expenses) will be about $7.3 billion.

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

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[5] The JCT estimate includes payments of premiums through cafeteria plans. The tax expenditure estimate from the Administration is considerably higher, $132.7 billion. *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007,* p. 289. The difference is attributable to several factors, the most important of which is the JCT assumption that without the exclusion the itemized deduction for medical care would be higher.

[6] Section 213.

[7] Section 213(d)(1)(A).

[8] Michael Parisi and Scott Hollenbeck, "Individual Income Tax Returns, 2002," *Statistics of Income Bulletin*, vol. 24 no. 2 (fall 2004), U.S. Internal Revenue Service, table 3.

the medical expense deduction just described, provided they qualify (i.e., they must itemize and then can deduct only unreimbursed expenses that exceed 7.5% AGI). Many self-employed taxpayers can claim a more generous deduction described below.

Premiums for certain types of individual market insurance are not deductible, including policies for loss of life, limb, and sight; policies that pay guaranteed amounts each week for a stated number of weeks for hospitalization; policies to provide payment for loss of earnings; and the part of car insurance that provides medical coverage for 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.

Self-Employed Individuals. 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.[9]

Self-employed taxpayers may deduct payments for health insurance in determining their AGI (i.e., as an "above-the-line" deduction).[10] The "above-the-line" deduction for the self-employed is not restricted to itemizers or subject to a floor, as is the medical expense deduction described above. Currently, 100% of the insurance cost may be taken into consideration. However, 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 (i.e., one in which the employer pays part of the cost). These restrictions prevent taxpayers with little net income from their business (which is not uncommon for a new business) from deducting much if any of their insurance payments. The portion not deductible under these rules may be treated as an itemized medical expense deduction.[11]

Self-employed individuals may not deduct their health insurance costs in determining the employment taxes they pay (the self-employment tax).

In 2002, about 3.6 million tax returns (about 2.7% of all returns) claimed the self-employed health insurance deduction. For FY2006, the JCT estimates the tax

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[9] Corporations may elect S-corporation status if they meet a number of Internal Revenue Code requirements. Among other things, they cannot have more than 100 shareholders or more than one class of stock. S-corporations are tax-reporting rather than tax-paying entities, in contrast to C-corporations, which are subject to the corporate income tax.

[10] Section 162(l).

[11] For more information, see CRS Report RL33311, *Federal Tax Treatment of Health Insurance Expenditures by the Self-Employed: Current Law and Issues for Congress*, by Gary Guenther.

expenditure attributable to the deduction (including the self-employed deduction for long-term care insurance) to be $3.8 billion.

Cafeteria Plans

Cafeteria plans are employer-established benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain normally nontaxable benefits (such as employer-paid health insurance) without being taxed on the value of the benefits if they select the latter. A general rule of taxation is that taxpayers given these options will be taxed on whichever they choose because they are deemed to be in constructive receipt of the cash. The cafeteria plan provisions of the Code provide an express exception to this rule when the plan meets various reporting and nondiscrimination requirements.[12] Nontaxable benefits received under a cafeteria plan are exempt from both income and employment taxes.

Cafeteria plans may be simple or complex. Simple plans might allow employees to choose between cash and one nontaxable benefit, such as additional health insurance. Complex plans might give employees a "pot of money" to allocate among health insurance and reimbursement accounts, dependent care assistance, group term life insurance, commuter benefits, and cash as they see fit.

Premium Conversion. Under a cafeteria plan option known as premium conversion, employees may elect to reduce their taxable wages in exchange for having their share of health insurance premiums paid on a pretax basis. The arrangement saves both income and employment taxes. Federal employees who participate in the Federal Employees Health Benefits Program (FEHBP) have been able to elect this option since October 2000. Private sector and state or local government employees may also elect premium conversion if their employers permit.

Premium conversion is not available to retirees. The barrier is not the cafeteria plan rules but an Internal Revenue Service (IRS) determination that distributions from qualified retirement plans are always subject to taxes, aside from several minor exceptions.[13] The IRS ruling precludes former employees from recasting pension payments as pretax income, as active workers can recast their wages. However, employer payments for retiree health insurance is excluded from taxes, just as they are for active workers. For many retirees, the employer pays much of the premium.

For FY2006, the JCT estimates the tax expenditure attributable to cafeteria plans to be $27.9 billion. The estimate pertains to all forms of nontaxable benefits, not just health insurance.[14]

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[12] Section 125. "Cash" in this context includes any taxable benefit.

[13] Rev. Rul. 2003-62.

[14] The JCT estimate for health insurance received through cafeteria plans is also included in the exclusion for employer-paid insurance (discussed above).

Flexible Spending Accounts

Flexible spending accounts (FSAs) are employer-established benefit plans that reimburse employees for specified expenses as they are incurred.[15] Accounts may be used for dependent care or for medical and dental expenses, though there must be separate accounts for these two purposes. FSAs and cafeteria plans are closely related, but not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans. FSA reimbursements funded through salary reduction agreements (the most common arrangement) are exempt from income and employment taxes under cafeteria plan provisions because employees have a choice between cash (their regular salary) and a nontaxable benefit. In contrast, FSA reimbursements funded by *nonelective* employer contributions are exempt from taxation directly under provisions applying to employer-paid dependent care or health insurance.[16]

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. Amounts unused at the end of the year must be forfeited to the employer (the "use it or lose it" rule), though employers may allow a 2½-month grace period. FSAs cannot be used to purchase insurance; however, they can be combined with premium conversion arrangements under cafeteria plans to achieve the same tax effect.

FSAs are more common in large firms than small firms. 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.[17] Federal employees have had the opportunity to use FSAs since July 2003.

Health Reimbursement Accounts

Health Reimbursement Accounts (HRAs) are employer-established arrangements to reimburse employees for medical and dental expenses not covered by insurance or otherwise reimbursable. As with FSAs, reimbursements are not subject to either income or employment taxes. In contrast, however, contributions cannot be made through salary reduction agreements; only employers may contribute.

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[15] Some FSAs are linked to employers' health insurance plans so provider payments can be made directly from the accounts. These arrangements avoid the need for employees to pay first and then seek reimbursement.

[16] For additional information, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Chris L. Peterson and Bob Lyke.

[17] Tom Herman, "A Setback for a Popular Health Benefit: Treasury Rejects Effort to Ease 'Use-It-or-Lose-It' Provision of Flexible Spending Accounts," *Wall Street Journal*, Jan. 5, 2005, p. D1.

Employers need not actually fund HRAs until employees draw on 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 the Code provisions discussed above for the exclusion of benefits paid from employment-based plans and various IRS guidance.[18]

Health Savings Accounts

Health Savings Accounts (HSAs) are one way that people can pay on a tax-advantaged basis for unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance).[19] Eligible individuals can establish and fund accounts when they have a qualifying high deductible health plan and no other health plan, with some exceptions. For 2006, the deductible for self-only coverage must be at least $1,050 and the annual out-of-pocket limit must not exceed $5,250; the deductible for family coverage must be at least $2,100 and the annual out-of-pocket limit must not exceed $10,500.

The annual HSA contribution limit in 2006 for individuals with self-only coverage is $2,700 or 100% of the insurance deductible, whichever is lower. For family coverage, the annual contribution limit is $5,450, 100% of the overall deductible, or the embedded deductible (the deductible applying to one individual) multiplied by the number of covered family members, whichever of the three is lowest. Individuals who are at least 55 years old but not yet enrolled in Medicare may contribute an additional $700. Contributions may be made by employers, individuals, or both.[20]

In January 2006, there were about 3.2 million people covered by qualifying high deductible *insurance plans*; the number includes both policyholders and their family members. The number of people covered by HSAs is likely smaller because it is not necessary to establish an account along with the insurance. Moreover, some accounts may not be funded. Nonetheless, the number of HSAs appears to be growing rapidly.[21]

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[18] Section 105, Rev. Rul. 2002-41, and IRS Notice 2002-45.

[19] For an overview of HSAs and three other types of tax-advantaged accounts (Flexible Spending Accounts, Health Reimbursement Accounts, and Medical Savings Accounts) see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson.

[20] Section 223. For more information, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2006*, and CRS Report RS22437, *Health Savings Accounts: Some Current Policy Issues*, both by Bob Lyke.

[21] *January 2006 Census Shows 3.2 Million People Covered by HSA Plans*. America's Health Insurance Plans (AHIP) Center for Policy and Research (March 2006). (The Census was an AHIP Survey.) Also see CRS Report RS22417, *Data on Enrollment, Premiums, and Cost-Sharing in HSA-Qualified Health Plans*, by Chris L. Peterson.

HSA contributions are deductible as an above-the line deduction if made by individuals, and they are exempt from both income and employment taxes if made by employers. Contributions may be made through salary reduction agreements, in which case they are treated as if made by employers. Withdrawals are not taxed if used for qualified medical expenses; however, they are taxable and usually subject to a penalty if used for other expenses or to purchase health insurance, with some exceptions. Account earnings are tax-exempt. Unused balances may accumulate without limit.

For FY2006, the JCT estimates the tax expenditure attributable to HSAs to be about $100 million.

Medical Savings Accounts

Medical Savings Accounts (MSAs) are an older, more-restrictive version of HSAs. Begun as a demonstration program in 1997, they are limited to people who either are self-employed or are employees covered by a high deductible insurance plan established by a small employer (50 or fewer employees). Like HSAs, annual contributions are limited and can be made only when account owners have qualifying high deductible insurance, though the specific rules are different. Unlike HSAs, contributions can be made by individuals or employers, not both, and they cannot occur through salary-reduction agreements. The official name of MSAs is now Archer MSAs.[22]

MSA contributions are deductible (as an above-the-line deduction) if made by individuals, and they are exempt from both income and employment taxes if made by employers. Withdrawals are not taxed if used for qualified medical expenses under rules similar to those for HSAs. Account earnings are tax-exempt. Unused balances may accumulate without limit.

The upper limit on the number of MSAs is 750,000 (not counting accounts of owners who previously were uninsured, among others), though there never has been close to that many established. For tax year 2003, the IRS estimated that there were fewer than 80,000 accounts in total. Many of these have probably now been rolled into HSAs. Currently no new MSAs can be established, with some minor exceptions, though nearly everyone who would like to do so can set up an HSA.

MSAs should be distinguished from Medicare MSAs, which are discussed below under “Medicare.”

Health Coverage Tax Credit

Three groups of taxpayers are potentially eligible for the health coverage tax credit (HCTC):

- individuals receiving a Trade Readjustment Assistance allowance, including those eligible for but not yet receiving the allowance

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[22] Section 220.

because they have not yet exhausted their state unemployment benefits;

- individuals aged 50 and older receiving an Alternative Trade Adjustment Assistance allowance; and

- individuals aged 55 and older receiving a Pension Benefit Guaranty Corporation pension payment, including those who received a lump sum payment after August 5, 2002.

Recipients cannot be enrolled in certain other health insurance, including Medicaid or employment-based insurance for which the employer pays at least half the cost, nor can they be entitled to Medicare.[23]

The HCTC equals 65% of the premiums the taxpayer pays for qualifying insurance. Up to 10 types of coverage are specified in the statute, though most require state action to become effective. The credit is payable in advance to insurers, allowing workers to benefit before they file their tax returns. It is also refundable: workers can receive the full credit even if they have no regular tax liability.

One study estimates that about 25,500 eligible taxpayers claimed the HCTC in 2004, or about 22% of all potentially eligible workers who did not have access to disqualifying insurance.[24]

For FY2006, the JCT estimates the tax expenditure attributable to the HCTC to be about $200 million.

Military Health Care

The U.S. Department of Defense (DOD) provides health care to active duty military personnel, military retirees, and their dependents. In general, active duty personnel receive care without cost (aside from small per diem charges), while the others may have deductibles, copayments, and premiums depending on where they are served and the particular insurance plan they are in. Military insurance plans currently are called Tricare plans. Nearly 9 million people are eligible for services and coverage by these arrangements.[25]

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[23] For additional information, see CRS Report RL32620, *Health Coverage Tax Credit Authorized by the Trade Act*, by Julie Stone-Axelrad and Bob Lyke.

[24] Stan Dorn et al., *Limited Take-Up of Health Coverage Tax Credits and the Design of Future Tax Credits for the Uninsured*, Economic and Social Research Institute, Nov. 3, 2005.

[25] For more information, see CRS Issue Brief IB93103, *Military Medical Care Services: Questions and Answers*, by Richard A. Best, Jr.

Coverage under military health care programs and the benefits they provide are not considered taxable.[26]

For FY2006, the JCT estimates that the tax expenditure attributable to medical care and Tricare insurance for military dependents, retirees, and dependents of retirees to be approximately $1.9 billion.

Veterans Health Care

The U.S. Department of Veterans Affairs provides health care directly to veterans through hospitals, nursing homes, residential rehabilitation treatment centers, and community-based outpatient clinics. In some cases, it pays for care provided by independent doctors and other health care professionals. Veterans health care is not an entitlement (unlike Medicare Part A, for example), and eligibility for services is prioritized according to several factors, including the severity of disabilities, whether disabilities occurred during or after military service, certain military events (e.g., having been a prisoner of war), the period of service, and means testing. Nearly 5 million veterans receive services.[27]

Coverage under veterans health care programs and the benefits they provide are not considered taxable.[28]

Medicare

Medicare is a national health insurance program for people aged 65 and older or who meet certain disability tests. Nearly 42 million people are covered by one or more of its parts. Coverage under Medicare and the benefits it pays for qualifying expenses are not considered taxable.[29]

Medicare Part A (insurance for hospitalization, skilled nursing facilities, post-hospitalization home health, and hospice care) is financed largely by employment taxes that workers and their employers both pay, currently 1.45% of covered wages. Individuals cannot take these tax payments into account for the itemized deduction

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[26] Section 134. The exemption of certain combat zone compensation under Section 112 might also apply, as might employer-provided health care and coverage under Sections 105 and 106.

[27] For additional information, see CRS Report RL32961, *Veterans' Health Care Issues in the 109th Congress*, and CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, both by Sidath Viranga Panangala.

[28] Section 134 of the Internal Revenue Code and 38 USC § 5301.

[29] Rev. Rul. 70-341. The ruling states that benefits received under Part A are not legally distinguishable from certain Social Security benefits and thus are excluded from taxation as disbursements made to further a social welfare function of the government. In contrast, benefits received under Part B are excluded from taxation as medical insurance proceeds under Section 104.

for medical expenses.[30] However, employers may deduct what they pay as a business expense.

Workers and their spouses become entitled to Part A once the workers have paid employment taxes on covered wages for certain periods of time. They pay no additional premium to be enrolled. People aged 65 and older who are not entitled to Part A may voluntarily enroll by paying a monthly premium. This premium may be taken into account for the itemized deduction for medical expenses, as may the deductibles and copayments associated with Part A.

Medicare Part B (insurance for doctors' fees, hospital outpatient services, most home health, and other medical services) is financed by general tax revenues and monthly premiums paid by those who enroll. Usually the premiums are withheld from Social Security benefits. These premiums may be taken into account for the itemized deduction for medical expenses, as may the deductibles and copayments associated with Part B.[31]

Medicare Part D (insurance for prescription drugs) is also financed by general tax revenues and monthly premiums paid by those who enroll. Deductibles and copayments associated with Medicare Part D may be taken into account for the itemized deduction for medical care. No official guidance has been issued regarding the tax treatment of Part D premiums.

Medicare Part C authorizes a number of alternative Medicare health plans, now called Medicare Advantage plans. Participants must be enrolled in both Medicare Part A and Part B. Some of these plans may charge an additional premium, which can be taken into account for the itemized deduction for medical expenses. The tax treatment of Medicare Advantage Medical Savings Accounts is similar to that of Health Savings Accounts. Contributions and account earnings are exempt from taxes, as are withdrawals used to pay medical expenses.[32] No Medicare Medical Savings Account plan has ever been offered.

For FY2006, the JCT estimates that the tax expenditure attributable to the exclusion of Medicare Part A benefits will be $18.5 billion. The tax expenditures attributable to Part B and Part D are estimated to be $12.5 billion and $3.4 billion, respectively.[33]

Medicaid

Medicaid is a form of health insurance for the elderly, people who have disabilities, pregnant women, families with dependent children, and children who have low income and few assets. It also pays for long-term care for people meeting similar needs tests. As each state designs and administers its own program, there is

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[30] Rev. Rul. 66-216.

[31] Rev. Rul 66-216.

[32] Section 138.

[33] JCS-2-06.

variation within broad federal guidelines with respect to who is served, benefits and delivery systems, and cost-sharing and other patient requirements. Medicaid waivers allow states even more flexibility for certain populations. Nearly 60 million people are covered by Medicaid.[34]

Coverage under Medicaid and the benefits it pays for qualifying expenses are not considered taxable.[35]

SCHIP

The State Children's Health Insurance Program (SCHIP) provides health insurance to children in families without coverage and with income above Medicaid eligibility levels. Some states expand their Medicaid programs to cover these children, whereas others have separate programs or a combination of both. SCHIP waivers allow states to cover adults as well. More than 6 million children are covered by SCHIP, as are about 650,000 adults.

As with Medicaid, coverage under SCHIP and the benefits it pays for qualifying expenses are not considered taxable.

Some Consequences of the Tax Benefits

Increases in Coverage

By lowering the after-tax cost of insurance, some of the tax benefits described above help extend coverage to more people. This is, of course, the intention: Congress has long been concerned about whether people have access to health care. The public subsidy implicit in the incentives (the foregone tax revenue) usually is justified on grounds that people would otherwise under-insure; that is, they would delay purchasing coverage in the hope that they will not become ill or have an accident. Uninsured people are an indication of what economists call market failure; they impose spill-over costs on society in the form of public health risks and uncompensated charity care. If insurance were purchased only by people who most need health care, its cost would become prohibitive for others.

Tax benefits also lead some people to obtain more coverage than they might 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 than are necessary. However, many people are risk-averse with respect to health care, so the tax benefits are only one factor influencing the amount of insurance purchased.

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[34] For an overview, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[35] There apparently is no statutory provision or revenue ruling that Medicaid coverage and benefits are exempt from taxation. The question would not often arise because Medicaid usually is for individuals and families with low income.

Some people contend that comprehensive coverage and lower cost-sharing lead to better preventive care and possibly long-term savings for certain medical conditions.

Tax benefits associated with Heath Savings Accounts are an attempt to encourage people to purchase less coverage by having higher deductibles. In this respect, they appear to differ from the tax benefits usually associated with health insurance. However, the accounts themselves might be viewed as a form of insurance, particularly as they grow in size, so it is not clear what their impact will be in reducing overall coverage.

The Source of Insurance Coverage

Tax benefits influence the way in which insurance 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. In contrast, restrictions on the itemized deduction allowed for individual private market insurance may be one reason this insurance covers only about 6% of the noninstitutionalized population under age 65.

Employment-based insurance carries both advantages and disadvantages for the typical worker. The principal advantage is that coverage is based on larger and often more stable risk pools; this generally lowers the cost for people who need more care. Usually, employee premiums do not vary by age or risk. Although young and healthy workers sometimes pay more than they would for identical individual market coverage, they are protected from cost increases as they get older or need additional care. However, plans chosen by employers may not meet individual workers' needs, particularly if there is only one available health plan, and changing jobs may require both new insurance and doctors.

Increases in Health Care Use and Cost

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 that 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 any case, increasing use of health care contributes to rising health care costs.

Whether insurance coverage could be encouraged without increasing the cost of health care has long 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 might 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. Consumer-driven health care (most commonly associated with high deductible insurance plans coupled with Health Reimbursement Accounts and Health Savings

Accounts) is a recent attempt to help people obtain coverage without driving up costs as much.

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. One important goal of the tax incentives is for insurance to be purchased only to the extent it results in better health care for society as a whole. But how the incentives 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. Because as a practical matter they are not available to everyone, problems of horizontal equity arise.[36] Workers without employment-based insurance generally cannot benefit from them, nor can many early retirees (people under 65, the age of Medicare eligibility). Even if these individuals itemize their deductions, they may 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.[37] 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, whereas 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. Under a progressive income tax system, economic losses ought to be deducted at applicable marginal rates, just as economic gains are taxed at those rates.

Assessing the equity of tax incentives for health insurance is complicated by uncertainty as to who pays for employer subsidies. In the long run, the cost of these subsidies presumably is passed on to the workers in the form of reductions to wages and other benefits. But whether these reductions are shared equally by all workers is unclear given differences in their preferences for insurance, their attachment to particular employers, and broader labor market forces.

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[36] Horizontal equity is a tax principle which in the case of an income tax holds that people who have essentially equal economic income should be treated the same.

[37] Vertical equity is a tax principle which in the case of an income tax holds that people who have higher economic income should have higher tax liabilities.

Current Proposals

This section focuses on bills that have received committee or floor action or that otherwise are the subject of discussion. It identifies other relevant bills but does not attempt to cite all of them. In a typical Congress, tax measures pertaining to health insurance and expenses number in the hundreds, not all of which are easily tracked.

A list of all bills on a particular topic (e.g., tax credits for health insurance) is available to congressional staff through the Legislative Information System (LIS). The Advanced Search link in the middle of the screen enables users to search for terms such as "'Internal Revenue Code' AND 'health insurance' AND 'credit.'" Often it is helpful to restrict searches to terms that are likely to be in close proximity to each other in the bills. For example, the previous search might be modified to "'Internal Revenue Code' AND 'health insurance' adj/7 'credit'." Whatever the search terms, it is not unusual to miss relevant bills and turn up others that are irrelevant. For assistance, call the CRS inquiry number at 7-5700.

In considering bills on a particular topic, it is important to take account of whether the legislation would make other changes to health care financing (e.g., by authorizing the sale of insurance across state lines) or to the tax system (e.g., by changing the definition of dependents or reducing tax rates). The effect of one provision could differ substantially depending on the scope of these other changes.

Some changes might occur through legislation that has ostensibly little to do with a particular topic. For example, a tax credit for health insurance could increase the number of health savings accounts by enabling currently uninsured people to purchase qualifying high deductible insurance. Similarly, capping the exclusion for employer-paid insurance could increase the number of people who claim the medical expense deduction because they would have more unreimbursed expenses.

Premium Conversion

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, particularly since retirees generally have less income than workers. 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 coverage. Including the latter groups would substantially increase the cost of the legislation.

Flexible Spending Accounts

Under current IRS rules, unused FSA balances are forfeited to the employer at the end of the year, though employers may allow a 2½-month grace period. One rationale for this requirement is that cafeteria plans, under which most health care FSAs are funded, cannot include deferred compensation aside from one express exception. For the past several Congresses, efforts have been made to relax this requirement. The pension reform legislation that passed the House on December 15, 2005 (H.R. 2830, the Pension Protection Act of 2005) would allow up to $500 in unused health care FSA funds to be carried over to the following year or contributed to a health savings account. The comparable bill that passed the Senate on November 16, 2005 (S. 1783, the Pension Security and Transparency Act of 2005) does not include an FSA provision. These two bills are now before a conference committee.

Other bills introduced in the 109th Congress to allow a carryover or rollover of health care FSA funds include H.R. 1803 (Royce), H.R. 1998 (McCrery), H.R. 3075 (Paul), S. 309 (DeMint), S. 723 (Snowe), S. 1359 (Smith), and S. 2457 (Snowe). S. 723 and S. 2457would make other changes to FSAs as well, including making it easier for small employers to offer plans, setting a statutory limit on the amount that can be contributed to the accounts, limiting reimbursements to account balances, and permitting more modifications to the accounts within a plan year.

The principal argument for allowing rollovers 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 provide tax benefits for the first dollars of health care spending, which is just the opposite of the restriction limiting the medical expense deduction to catastrophic expenses (i.e., those exceeding 7.5% of AGI.). FSAs also conflict with the rationale for high deductible insurance, which is not to provide third-party assistance for expenditures that are customary and routine. Some argue that expansion of FSAs may inhibit the spread of health savings accounts. Allowing unused balances to be carried over or rolled over would also increase revenue losses associated with FSAs.

H.R. 4511 and H.R. 5262 (both by Cantor) would amend the health savings account provisions to allow greater combined use of FSAs and HSAs.

Health Savings Accounts

In his FY2007 budget, which was released on February 6, 2006, President Bush proposed measures that would increase the availability and attractiveness of Health Savings Accounts (HSAs). Such measures include the following:

- allow an above-the-line deduction and refundable income tax credits for the purchase of HSA-eligible individual market insurance;

- increase HSA contribution limits and allow a refundable income tax credit for HSA contributions not made by employers;
- allow HSAs to reimburse (as a qualified medical expense) medical expenses incurred earlier in the year, provided the individual had HSA-eligible insurance at the time;
- allow HSAs to reimburse (as a qualified medical expense) premiums for HSA-eligible individual market insurance; and
- allow employers to contribute additional sums to HSAs on behalf of employees or their spouse or dependents who are critically ill.

One bill that would carry out the President's proposals is H.R. 5262 (Cantor). Other bills that would authorize one or more of the proposals or something similar are listed below.

Increased Incentives to Purchase Qualifying Insurance. An expanded (above-the-line) deduction for HSA-qualified insurance would be allowed by H.R. 37 (King), H.R. 1872 (Johnson-TX), S. 4 (Frist), S. 160 (Murkowski), S. 978 (Santorum), S. 1503 (Frist), S. 2492 (Burns), and S. 3488 (Coburn).

Premiums for individual market high deductible health plans could be considered a qualified HSA distribution under H.R. 5586 (Johnson-TX), S. 2549 (DeMint), S. 2554 (Ensign), and S. 3488 (Coburn).

Individuals would receive a refundable tax credit for the premiums they paid for HSA-qualifying insurance under S. 2492 (Burns) and S. 3488 (Coburn).

To aid portability, qualified medical expenses would include amounts paid to insurers for the right to purchase insurance in the future under S. 3488 (Coburn).

Increased Incentives to Make Account Contributions. HSA contribution limits would be increased by H.R. 3075 (Paul), H.R. 4511 (Cantor), S. 2424 (Allen), and S. 3488 (Coburn).

Distributions from qualified retirement accounts would be tax-free if used to fund HSAs under H.R. 3873 (Fortenberry). H.R. 2063 (Shuster) would allow this exemption to occur only once.

Employers would receive a tax credit for HSA contributions under H.R. 1872 (Johnson-TX), S. 4 (Frist), S. 160 (Murkowsi), S. 978 (Santorum), S. 1503 (Frist), and S. 2457 (Snowe). and S. 2492 (Burns).

Employers would be allowed to make additional contributions to accounts of employees who are (or whose family member are) acutely or chronically ill under Coburn (S. 3488).

An individual tax credit for HSA contributions would be allowed under S. 2492 (Burns) and S. 3488 (Coburn).

Unused balances in flexible spending could be rolled over into HSAs under H.R. 1803 (Royce), H.R. 1998 (McCrery), H.R. 3075 (Paul), S. 309 (DeMint), S. 723 (Snowe), S. 1359 (Smith), and S. 2457 (Snowe).

Greater combined use of HSAs and FSAs would be allowed by H.R. 4511 (Cantor).

For all of the bills mentioned above, the principal issue is whether HSAs should be made more available and attractive. In general, people who favor HSAs would support the bills, whereas people who object to HSAs would oppose them. Some argue that further legislation should wait until more information is available. It would be useful to know the income and health status of the taxpayers who have HSAs and whether high deductible insurance reduces health care spending without increasing costs for others. However, it may be several years before any of these factors can be determined.[38]

The House Committee on Ways and Means held a hearing about HSAs on June 28, 2006.

Health Coverage Tax Credit

The HCTC is restricted to taxpayers who receive Trade Readjustment Assistance (or would once their state unemployment benefits end), Alternative Trade Adjustment Assistance, or a pension paid by the Pension Benefit Guaranty Corporation. Currently, only manufacturing workers are eligible for Trade Adjustment Assistance and Alternative Trade Adjustment Assistance, but several bills would extend eligibility to service workers, allowing them to get the tax credit: H.R. 1281 (King), H.R. 4156 (Smith of WA), and S. 1309 (Baucus).

Some bills would allow family members to continue eligibility for the credit after the person through whom they had coverage became entitled to Medicare; these include H.R. 4156 (Smith of WA), S. 4 and S. 1503 (both by Frist), S. 14 (Stabenow), and S. 1365 (Rockefeller). S. 4156 and S. 1365 would also continue their eligibility in other circumstances.

The narrow eligibility requirements are one reason why not many people use the HCTC. The requirements appear unfair with respect to people who are in similar circumstances, such as service workers whose jobs have been shifted overseas or lost due to foreign trade. Although the bills remove this inequity for the groups mentioned above, they are a small fraction of the many who now are ineligible.

H.R. 4156, S. 14, and S. 1365 would also increase the credit rate and expand insurance options. These steps would likely help cash-strapped families that now cannot afford to pay the remaining 35% of the insurance cost or that cannot find qualifying insurance. However, some might question whether additional subsidies should be provided to narrowly targeted groups while others get nothing.

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[38] See CRS Report RS22437, *Health Savings Accounts: Some Current Policy Issues*, by Bob Lyke.

President Bush proposed a number of clarifications and other minor changes to the HCTC in his FY2007 budget.

Refundable Individual Tax Credit

In recent years, there has been much discussion of a refundable income tax credit for health insurance. Refundability allows taxpayers to receive the full amount of a credit even if it exceeds their regular tax liability.[39] The HCTC (described above) is one example of a refundable tax credit. Unlike that credit, however, most of the recent proposals would not be restricted to narrow eligibility groups.

An individual tax credit for health insurance could be claimed through the normal tax-filing process. Taxpayers would include the credit when they file their tax returns (normally by April 15 of the following year) and then use it either to offset additional amounts they owe or to obtain a larger refund. It would also be possible for taxpayers to adjust their withholding in order to benefit from the credit earlier, but experience with the earned income tax credit suggests few would do so. Most proposals would allow taxpayers to claim a refundable health insurance tax credit in advance based on their prior year's income. In this case, the insurer would be reimbursed for the credit directly from the U.S. Treasury Department. Advance payments now occur for some who receive the HCTC.

Bills in the 109th Congress that would authorize a refundable individual income tax credit for health insurance include H.R. 765 (Kennedy-MN), H.R. 1399 (Kaptur), H.R. 1872 (Johnson-TX), H.R. 2089 (Granger), H.R. 2203 and H.R. 2732 (Shadegg), H.R. 3075 (Paul), H.R. 4219 (McHugh), H.R. 4527 (Boswell), S. 4 (Frist), S. 160 (Murkowski), S. 978 (Santorum), S. 1178 (Martinez), S. 1225 (Collins), S. 1503 (Frist), and S. 2701 (Santorum).

Several bills would authorize tax credits only with respect to coverage for dependent children; these include H.R. 1668 (Waxman), H.R. 3077 (Paul), S. 16 (Kennedy), and S. 114 (Kerry).

In his FY2007 budget, President Bush proposed a refundable tax credit for lower-income individuals who purchase HSA-eligible individual market insurance. Refundable credits would also be available for all individuals who claim above-the-line deductions for HSA-eligible individual market insurance or who make contributions to their HSAs; the latter credits generally would equal 15.3% of the premium or the contribution.

A refundable tax credit for health insurance could be attractive. If it were generally available, a credit could aid taxpayers who do not have access to employment-based insurance but cannot claim the medical expense deduction. A credit could provide all taxpayers with the same dollar reduction in final tax liability,

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[39] It is also possible to place limits on refundability. For example, the credit might be limited to the taxpayer's regular tax liability plus payments for Social Security taxes. A credit might be refundable for purposes of the regular income tax but not the alternative minimum tax.

avoiding vertical equity problems associated with exclusions and deductions. A credit could also provide lower-income taxpayers with sufficient resources to purchase insurance, likely reducing the number of the uninsured.

The effects of tax credits, however, can vary widely depending on the legislation. One important question is whether a credit would supplement or replace existing tax benefits, particularly the exclusion for employer-paid insurance. If the credit replaced the exclusion, it probably would have to be made available to people with high as well as low income. A generous individual credit may lead employers to drop coverage (or to not start it in the first place), possibly increasing the number of the uninsured. A credit that is not generous would not enable lower-income families to purchase insurance. Advance payments would be essential for many families but might not work well on a large scale.

The most difficult questions about tax credits have to do with health policy. If a credit were generous enough to provide meaningful help to lower income people, it is likely that the legislation would have to specify what is qualifying insurance. Otherwise, there would be no assurance that public funds would be used efficiently and effectively. Defining qualifying insurance would involve decisions about minimum benefits, deductible and copayment limits, guaranteed issue and pre-existing condition exclusions, and other contentious issues.

Employer Tax Credit

Under current law, employers may deduct the expenses they incur for employees' health insurance and health care and the contributions they make to their tax-advantaged health care savings accounts. Depending on the employer's marginal tax rate, a tax credit might result in greater tax savings, thereby providing an additional incentive to start and maintain health insurance plans. Tax credits could also be useful for government and nonprofit employers that are not subject to income taxes; the credits would offset some of the employment taxes they pay.

In the 109th Congress, a number of bills have been introduced that would authorize an employer tax credit for health insurance. Typically these bills are aimed at small employers, usually defined as having fewer than 50 or 100 employees. Included among these bills are H.R. 118 (Hooley), H.R. 2001 (Moore-KS), H.R. 2002 (Moore-KS), H.R. 2073 (Barrow), H.R. 2259 (Dingell), H.R. 4527 (Boswell), S. 16 (Kennedy), S. 1012 (Kennedy), S. 1225 (Collins), S. 1329 (Bayh), and S. 2457 (Snowe). S. 2558 (Stabenow) would limit the credit to catastrophic costs.

Compared with the individual tax credits discussed above, an employer credit could be targeted to industries or localities that have greater need. They can be linked to employer contributions. An employer credit might not require advance payments, though if necessary these probably would be easier to provide than in the case of individual taxpayers. On the other hand, employer credits cannot be accurately varied by employee income (because employers know only what they pay workers, not their total income) and they would not be effective if employers do not want to provide health insurance.

Employers would receive a tax credit for HSA contributions under H.R. 1872 (Johnson-TX), S. 4 (Frist), S. 160 (Murkowsi), S. 978 (Santorum), S. 1503 (Frist), and S. 2457 (Snowe).

Expanded Tax Deduction

The current deduction for health insurance is restricted to taxpayers who itemize their deductions and whose payments for insurance and unreimbursed medical expenses exceed 7.5% adjusted gross income. 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 because there are also employment tax savings). This divergent treatment appears inequitable.

In recent Congresses, there have been several proposals to allow all taxpayers to deduct the full cost of their health insurance as an above-the-line deduction. Bills in the 109th Congress that would authorize this include H.R. 218 (Stearns), H.R. 2176 (Chabot), H.R. 4218 (McHugh), and S. 2379 (Burr). H.R. 4527 (Boswell) would limit the deduction to the first $2,000 of premiums.

Some bills would allow an above-the-line deduction for only HSA-qualified (high deductible) insurance; these include H.R. 37 (King), H.R. 1872 (Johnson-TX), S. 4 (Frist), S. 160 (Murkowski), S. 978 (Santorum), S. 1503 (Frist), and S. 2492 (Burns).

H.R. 994 (Davis-VA) and S. 484 (Warner) would allow an above-the-line deduction for Tricare supplemental premiums or enrollment fees.

H.R. 2599 (Rohrabacher) would allow an above-the-line deduction for all medical expenses, including contributions to new medical checking accounts.

H.R. 3075 (Paul) would repeal the 7.5% floor on the itemized deduction for medical expenses.

Self-Employed Deduction

Self-employed individuals may not deduct their health insurance costs in determining the employment taxes they pay (the self-employment tax). In contrast, employer-paid health insurance is excluded from employment taxes of both employees and the employer. Some people consider this treatment inequitable.

Several bills have been introduced in the 109th Congress that would allow self-employed taxpayers to subtract their health insurance costs in determining their self-employment taxes. Among these bills are H.R. 727 (Sanchez), H.R. 3841 (Manzullo), H.R. 4961 (Hart), and S. 663 (Bingaman).

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Appendix

The general formula for calculating federal income taxes appears below. 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 determining adjusted gross income (AGI) — "above the line deductions"
3. *Equals* AGI
4. *Minus* greater of standard or itemized deductions
5. *Minus* personal and dependency exemptions
6. *Equals* taxable income
7. *Times* tax rate
8. *Equals* tax on taxable income (i.e., "regular tax liability")
9. *Minus* credits
10. *Equals* final tax liability