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Federal Tax Treatment of Health Insurance Expenditures by the Self-Employed: Current Law and Issues for Congress

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Gary Guenther
Analyst in Public Finance
Government and Finance Division

Congressional Research Service

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Summary

Current federal tax law allows self-employed individuals to deduct from their gross income the entire amount of their spending on health insurance for themselves and their spouses and dependents.

This report explains how these expenditures are treated under the federal tax code, reviews the legislative history of the deduction, assesses its effectiveness as a policy tool for expanding access to health care for the self-employed, describes proposals in the 110th Congress to modify the deduction, and discusses policy issues it raises. It will be updated to reflect significant legislative action.

Under section 162(l) of the Internal Revenue Code (IRC), self-employed individuals may deduct the entire amount of their payments for health insurance for themselves and immediate family members. A self-employed individual is defined as a sole proprietor, a working partner in a partnership, or an employee of a subchapter S corporation who owns over 2% of the firm's stock. Use of the deduction is governed by several rules. First, it may not exceed an eligible taxpayer's net earned income from the trade or business in which the health plan was established, less the deductions for 50% of the self-employment tax and contributions to certain pension plans. Second, the deduction may not be claimed for any period when a self-employed individual is eligible to participate in a health plan offered by an employer or by a spouse's employer. Third, the expenditures eligible for the deduction may not also be added to the medical expenses eligible for the itemized deduction under IRC section 213. Finally, self-employed individuals must include their expenditures eligible for the deduction in the income base for the self-employment tax.

The tax deduction for health insurance expenditures by the self-employed has advantages and disadvantages. On the one hand, it is relatively easy for the IRS to administer and for self-employed taxpayers to claim and establishes greater parity between the tax treatment of health insurance for the self-employed and the taxation of employer contributions to employee health plans. On the other hand, the deduction provides the greatest tax benefit for the same insurance policy to those who arguably need it the least: self-employed individuals with the highest incomes.

At least two bills in the 110th Congress (H.R. 3660 and S. 2239) would eliminate one of the remaining obstacles to the equal tax treatment of health insurance purchased by the self-employed and the taxation of health insurance obtained by employed individuals from their employers. The obstacle lies in a significant difference between the payroll taxes paid by wage earners and those paid by the self-employed: health insurance expenditures by the self-employed *are* included in the income base for the taxes, whereas employer contributions to employee health plans *are not*. H.R. 3660 and S. 2239 would allow the self-employed to treat these expenditures as a deductible business expense, exempting them from the self-employment tax.

Contents

List of Tables

Federal Tax Treatment of Health Insurance Expenditures by the Self-Employed: Current Law and Issues for Congress

Current federal tax law makes it possible for self-employed individuals to deduct the entire amount they spend on health insurance for themselves and their spouses and dependents. This treatment is similar to the exclusion for employer contributions to the health plans of wage earners, with one noteworthy exception: employer contributions are exempt from payroll taxes (e.g., Medicare and Social Security taxes), but health insurance expenditures by the self-employed are not deemed a deductible business expense and thus are subject to the self-employment payroll tax. Companion bills in the House and Senate in the 110th Congress would allow self-employed taxpayers to exclude those expenditures from the income base for the tax.

This report examines the current tax treatment of these expenditures, the legislative history of the deduction, its effectiveness as a policy tool for improving access to health care for the self-employed, proposals in the 110th Congress to alter the deduction, and the main policy issues it raises.

Current Law and Coverage

Under section 162(l) of the Internal Revenue Code (IRC), self-employed individuals are allowed to deduct the entire amount of their spending for health insurance for themselves and their immediate family members. A self-employed individual is defined as a sole proprietor, a working partner in a partnership, or an employee of a subchapter S corporation who owns over 2% of the firm's stock.[1] The deduction is claimed above-the-line, which means it may be claimed even if a self-employed individual does not itemize deductions on his or her income tax return.

Some self-employed individuals hire employees to assist with their trade or business. Any self-employed individual who offers health benefits to employees may deduct the cost of those benefits as an ordinary and necessary business expense. But

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[1] Subchapter S corporations pay no corporate income tax. Instead, their items of income and loss, deductions, and credits are passed on to shareholders, who must report them on their own income tax returns. To qualify for subchapter S status, a firm may have no more than 100 shareholders, all of whom must be citizens or residents of the United States; may issue only one class of stock; and must be a domestic corporation organized under the laws of any state or U.S. territory.

he or she may not include the cost of these benefits in any deduction claimed under IRC section 162(l).

Use of the deduction is subject to several limitations. First, the deduction may not exceed a self-employed taxpayer's net earned income from the trade or business in which the health plan was purchased, less the deductions for 50% of the self-employment tax and contributions to certain pension plans (e.g., Keogh plans or simplified employee pension plans for the self-employed).[2] If a self-employed taxpayer earns income from more than one business or trade, he or she may not sum the profits and losses from those businesses to determine the net income ceiling for the deduction. Second, the deduction may not be claimed for any month when a self-employed individual is eligible to participate in a health plan offered by an employer or a spouse's employer. Third, the expenditures eligible for the deduction may not also be included in the medical expenses eligible for the itemized deduction under IRC section 213 — though health insurance expenditures that cannot be deducted under IRC section 162(l) may be included in these medical expenses.[3] Finally, health insurance spending by self-employed individuals is not deemed a business expense, which means that those expenditures are part of the income base for the self-employment tax of 15.3%.

In addition, self-employed individuals may add their payments for long-term care insurance to the health insurance expenditures eligible for the deduction. But the deductible amount of long-term care insurance premiums is limited by the age of the individual at the close of the tax year, and the limits are indexed for inflation. In 2008, the deductible amounts range from $310 for those age 40 and under to $3,850 for those age 71 and over.

Besides purchasing a health insurance policy in the non-group market and claiming the deduction, a self-employed individual has two options for obtaining health insurance coverage that offer more tax advantages than the deduction.

They may open a health savings account (HSA), which serves as a tax-exempt vehicle for paying medical and dental expenses not covered by insurance or not otherwise reimbursable.[4] An individual can open an HSA and make contributions to it only if he or she is covered by a qualified high-deductible health insurance plan and no other plan, including Medicare (with a few exceptions). In 2008, qualified plans must carry a deductible of at least $1,100 for individual coverage (with an out-of-pocket limit of $5600), and $2,200 for family coverage (with an out-of-pocket

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[2] All self-employed individuals must pay the self-employment (SECA) tax, whose purpose is to provide Social Security and Medicare benefits to such individuals. The tax, whose current rate is 15.3%, is assessed on self-employment income, which is defined as the net earnings from self-employment. In reality, it consists of two separate taxes: a 12.4% Social Security tax and a 2.9% Medicare tax. Employees pay the same taxes, but they split the tax evenly with their employers.

[3] Taxpayers claiming the itemized deduction for medical expenses may deduct all such expenses that exceed 7.5% of adjusted gross income.

[4] For more details on HSAs, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2008*, by Bob Lyke.

limit of $11,200). Total contributions to an HSA in 2008 are limited to the lesser of the deductible or $2,900 for individual plans, and the lesser of the deductible or $5,800 for family plans. Employer contributions are exempt from income and employment taxes, and account owners may claim a deduction for contributions they make. Self-employed individuals may not contribute to an HSA on a pre-tax basis (unlike employees who contribute to such an account through an employer's cafeteria plan), and they must include their contributions in the income base used to determine the self-employment tax. Withdrawals to pay for medical expenses are not subject to taxation. Unused balances may be carried over without limit to the following year with no tax penalty.

Self-employed individuals may also open Archer medical savings accounts (MSAs) — though the total number of such accounts nationwide is currently capped at 750,000. They are similar in design to HSAs but more restrictive in the rules for contributions. Holders of MSAs are allowed to own HSAs and transfer their MSA balances to the new accounts. It is not known how many self-employed individuals are covered by MSAs and HSAs.

An estimated 14.1 million non-elderly individuals were self-employed in 2006, the most recent year for which data on U.S. health insurance coverage by employment status are available. Of this total population, 9.7 million had private health insurance, 0.9 million received public health insurance (mainly Medicaid), and 3.8 million were uninsured.[5] About 72% of the self-employed with private health insurance (or 7.0 million) in 2006 were covered through plans offered by a current or former employer or a spouse's employer. The remaining 2.7 million (or 19% of the self-employed population) with private health insurance purchased it on their own.

According to the Internal Revenue Service (IRS), self-employed taxpayers filed 3.9 million claims for the deduction for a total amount of $19.6 billion in 2005 (see **Table 1**).[6] Individuals with adjusted gross incomes from $50,000 to under $500,000 accounted for 58% of those claims.

The revenue cost of the deduction was an estimated $4.3 billion in FY2007.[7] This cost represents the tax revenue that would have been collected if there were no deduction, and self-employed taxpayers instead had added their health insurance expenditures to the expenses eligible for the itemized deduction for medical expenditures.

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[5] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey*, Issue Brief No. 310, Employee Benefit Research Institute (Washington: October 2007), fig. 11, p. 14.

[6] Internal Revenue Service, *Statistics of Income Bulletin: Fall 2007* (Washington: 2007), table 1, p. 37.

[7] Office of Management and Budget, *Analytical Perspectives: Fiscal Year 2009* (Washington: GPO, 2008), p. 295.

Table 1. Deduction for Health Insurance Expenditures by the Self-Employed on Federal Income Tax Returns

Year	Tax Returns with the Deduction ($ millions)	Total Amount ($ billions)	Average Amount Per Return ($)	Percent of the Self-Employed Not Eligible for Medicare with Individually Purchased Health Insurance
1990	2.754	1.627	591	29[a]
1995	3.011	2.601	864	22
1999	3.492	6.755	1,934	20
2000	3.565	7.569	2,123	19
2001	3.560	8.177	2,297	19
2002	3.571	10.494	2,939	20
2003	3.802	16.454	4,328	19
2004	3.884	18.457	4,733	19
2005	3.901	19.646	5,037	18

Sources: Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured* (Washington: various years); Internal Revenue Service, *Statistics of Income Bulletin: Fall 2007* (Washington: 2007), table 1, p. 37.

a. 1991

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

The tax deduction for health insurance purchased by self-employed individuals entered the federal tax code as a temporary provision of the Tax Reform Act of 1986 (TRA86, P.L. 99-514). Initially, it was limited to 25% of qualified expenditures and was scheduled to expire at the end of 1989. Although the act specified that Congress was to assess the deduction's effectiveness before it expired, no such study was completed.

Congress made several significant changes in the rules governing the deduction's use before it considered legislation to extend the deduction beyond 1989. The Technical and Miscellaneous Revenue Act of 1988 (TAMRA, P.L. 100-647) added the limitation that the deduction cannot exceed a self-employed taxpayer's earned income from the trade or business in which the health insurance policy was established. TAMRA also added the requirement that the deduction be included in

a self-employed taxpayer's income base for the computation of the self-employment tax.

A string of laws enacted in the early 1990s extended the deduction for brief periods. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) extended the deduction through September 30, 1990 and made it available to certain subchapter S corporation shareholders; the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) extended the deduction through December 31, 1991; the Tax Extension Act of 1991 (P.L. 102-227) extended it through June 30, 1992; and the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) extended the deduction through December 31, 1993.

For reasons that evidently had nothing to do with the effects of the deduction, Congress allowed it to expire at the end of 1993 and did not extend it in 1994. But a bill adopted in April 1995 (P.L. 104-7) permanently extended the deduction, retroactive to January 1, 1994. It also increased the deductible share of health insurance expenditures by the self-employed to 30%, starting in 1995 and continuing thereafter.

The 104th Congress turned its attention to the deduction again in 1996, when it passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-91). Among other things, the act established a timetable for raising the deductible share of health insurance expenditures from 30% in 1996 to 80% in 2006 and thereafter. HIPAA also permitted self-employed taxpayers to include in the spending eligible for the deduction any payments they make for qualified long-term care insurance as of January 1, 1997; imposed annual limits on the amount of long-term care insurance premiums that could be deducted; and indexed these limits for inflation.

The Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105-277) accelerated the timetable for removing one of the differences between the tax treatment of employer-provided health insurance and the taxation of health insurance purchased by the self-employed by raising the deductible share of health insurance spending by the latter to 100%, beginning in 2003 and thereafter.

Effectiveness of the Deduction

One way to evaluate the effectiveness of the deduction is to determine whether it has achieved its intended purpose. Congress was seeking to achieve at least two policy objectives in enacting the deduction as part of TRA86. One was to provide the self-employed with a tax benefit for health insurance comparable to the exclusion for employee health benefits. The other objective was to foster a substantial expansion of health insurance coverage among self-employed individuals.[8] To what extent have these objectives been achieved?

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[8] U.S. Congress, Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986*, JCS-10-87 (Washington: GPO, 1987), p. 815.

The deduction reduces the after-tax cost of health insurance for a self-employed individual by a factor equal to his or her marginal income tax rate. For example, a self-employed individual in the 35% tax bracket realizes a 35% reduction in the after-tax cost of a health plan by claiming the deduction.

All other things being equal, a reduction in the after-tax cost of this insurance can be expected to lead to an increase in the coverage rate among the self-employed. The extent of the gain would hinge on how sensitive their demand for health insurance is to changes in its cost. There is some evidence that the demand for health insurance among single self-employed individuals is responsive to declines in this price.[9] Yet unlike a tax credit for the purchase of health insurance, which would be of equal value to everyone who claims it, the deduction is of lesser value to those with lower incomes and of greater value to those with higher incomes, for the same health insurance plan. This is because the tax benefit from a deduction depends on a taxpayer's marginal tax rate: for a taxpayer in the 35% bracket, a $100 deduction reduces his or her tax liability by $35; but for a taxpayer in the 10% bracket, the same deduction yields a reduction in tax liability of $10. To the extent that health insurance coverage among the self-employed varies with household income, the deduction reinforces this linkage.

Does the deduction create a level playing field between wage earners and the self-employed in the tax benefits they receive for the purchase of health insurance? Yes and no. On the one hand, the deduction has the same direct effect on the after-tax cost of health insurance as the exclusion for employer contributions to employee health plans: both lower that cost by a factor equal to an individual's marginal tax rate. On the other hand, the expenses eligible for the deduction are subject to the self-employment tax, whereas employer contributions to employee health plans are exempt from payroll taxes. This difference means that the after-tax cost of a health plan is 15.3% higher for a covered self-employed individual than for a covered wage earner. On a truly level playing field, self-employed individuals would be able to exclude their payments for health insurance from the income base used to determine the self-employment tax.

It should also be noted that the federal tax code does not provide a level playing for every taxpayer who purchases health insurance. There is no preferential treatment for health insurance bought by the unemployed or individuals whose employers do not offer health benefits — other than the itemized deduction for medical expenditures.

Is there any evidence that the deduction has caused an expansion in health insurance coverage among the self-employed? Such an effect seemed to materialize in the first few years after the deduction was enacted. In 1985, the year before the

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[9] A 1994 study by the economists Jonathan Gruber and James Poterba of the impact of the deduction on the demand for health insurance by the self-employed found that a 1% increase in the after-tax cost of this insurance lowered the likelihood that a single self-employed person will be insured by 1.8 percentage points. See Jonathan Gruber and James Poterba, "Tax Incentives and the Decision to Purchase Health Insurance: Evidence from the Self-Employed," *Quarterly Journal of Economics*, vol. 109, no. 3, August 1994, p. 727.

deduction was enacted, 69% of the self-employed were covered through private health plans (both plans they purchased individually and plans offered by former employers); but in 1987, the first full year in which the deduction could be claimed, the share climbed to 76%. It is possible that much of that rise in coverage was due to the advent of the deduction. Still, coverage has trended downward ever since: it was 69% in 2006, the most recent year for which data are available.[10] In addition, the share of the self-employed population with individually purchased private health insurance was significantly lower in 2006 (19%) than in 1991 (29%). These declines raise the possibility that whatever initial boost the deduction may have imparted to the demand for health insurance by the self-employed has been more than offset by certain other factors. A powerful countervailing force has been increases in the cost of health care, which is the main driver of trends in the cost of health insurance. In recent decades, the cost of health care has risen much faster than overall inflation.[11] This is not to suggest that the deduction no longer influences a self-employed individual's decision to purchase health insurance. Given that the deduction reduces the after-tax cost of health insurance, health insurance coverage among the self-employed since the late 1980s probably would have been notably lower if the deduction had not been available.

At the same time, there is some evidence that the use of health care by the self-employed is not as tethered to health insurance coverage as one might expect. A 2001 study by Craig Perry and Harvey Rosen of the role of health insurance in the use of medical services by the self-employed found that the "self-employed had the same utilization rates for medical services in 1996 as wage-earners, despite the fact that they (the self-employed) were substantially less likely to be insured."[12] More specifically, Perry and Rosen found no statistically significant differences between employees and the self-employed in hospital admissions, hospital stays, dental checkups, and optometrist visits, while the self-employed had higher utilization rates for alternative care and chiropractor visits. The authors concluded that the self-employed were able to "finance access to health care from sources other than insurance," such as their own assets or loans. Their findings call into question one of the justifications made for the deduction during the debate over adopting it:

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[10] The source for these figures is the Annual Social and Economic Supplement (ASES) to the Current Population Survey (CPS) conducted monthly by the Census Bureau for the Bureau of Labor Statistics. Although the CPS covers about 50,000 households, the ASES is a survey of about 78,000 households that is done in March of each year. Respondents to the ASES are asked to answer a variety of questions about the health insurance coverage in the previous year of every member of a household. See the bureau's website at [http://www.census.gov/hlthins/overview].

[11] For U.S. urban consumers, this cost rose at an average annual rate of 5.4% between January 1987 and January 2006; by contrast, the overall rate of inflation for the same set of consumers in that period was 3.1%. The price index used to measure the rate of inflation for health care is the Consumer Price Index for medical care services used by all urban consumers (1982-84=100). Overall inflation is measured by the Consumer Price Index for all items used by these consumers.

[12] See Craig William Perry and Harvey S. Rosen, *Insurance and the Utilization of Medical Services Among the Self-Employed*, working paper 8490 (National Bureau of Economic Research: Cambridge, MA, September 2001), p. 26.

namely, that it was needed to raise health insurance coverage among the self-employed, thereby giving them the same access to health care as wage earners covered by employer health plans.

Legislation in the 110th Congress to Modify the Deduction

Many bills to create new tax subsidies for health insurance have been introduced in the 110th Congress. Some of them would benefit the self-employed. A case in point is the proposals (e.g., H.R. 914 and S. 1875) to establish a refundable tax credit for individuals who purchase health insurance on their own. Depending on its design, such a credit could lead to more extensive health insurance coverage among self-employed individuals, as well as the population at large. A key consideration is the effective rate of the credit. If it is large enough to lower the after-tax cost of health insurance more than the deduction does, then a self-employed individual would be better off claiming the credit. A simple example illustrates this point. Suppose a self-employed individual in the 15% tax bracket buys a health insurance policy for $3,000. Would he or she be better off with a 50% refundable tax credit for that purchase or a deduction of $3,000? With the credit, the after-tax cost of the policy would be $1,500, but with the deduction, the after-tax cost of the policy would rise to $2,550. And the individual would receive the credit even if he or she has no federal income tax liability.

At least two bills in the current Congress would modify the deduction to get rid of a remaining difference between the tax treatment of health insurance purchased by the self-employed and the tax treatment of employer contributions to employee health insurance. The difference lies in the disparate reach of the Medicare and Social Security taxes paid by wage earners on the one hand and by the self-employed on the other hand: health insurance expenditures by the self-employed are subject to the taxes, whereas employer contributions to employee health plans are not. Proposals by Senator Bingaman (S. 2239) and Representatives Herger, Kind, Schwartz, and a few others (H.R. 3660) would exempt these expenditures from the self-employment tax by allowing the self-employed to treat them as a deductible business expense. It is not known what the revenue cost of the proposed exemption would be. Nonetheless, this cost could be an important consideration in future congressional deliberations over whether to adopt such an exemption.

Policy Issues Related to the Deduction

The tax deduction for health insurance expenditures by the self-employed has several advantages. It is relatively simple for the IRS to administer and for self-employed individuals to claim. In addition, the deduction contributes to an expansion in health insurance coverage among the self-employed and their immediate families by lowering the after-tax cost of health insurance. Many economists regard a lack of health insurance as a market failure because of the negative externalities associated with being uninsured: the uninsured are more likely than the insured to spread communicable diseases, and the cost of uncompensated care received by the

uninsured is passed on to taxpayers through higher taxes and to insured patients through higher prices for medical care.[13] The deduction also establishes a substantial degree of parity between the tax treatment of health insurance purchased by the self-employed and the taxation of health benefits obtained by employees from their employers.

Yet the deduction also has some disadvantages, some of which have implications for the debate in the current Congress over the use of tax subsidies to shrink the size of the domestic uninsured population.

First, the deduction leads to insurance outcomes that many regard as unfair or unseemly. This is because its value to self-employed individuals who claim it depends on their marginal tax rates. Under the tax system's progressive rate structure, a deduction of $1 is of greater value to someone with a relatively high income (as much as $0.35) than to someone with a relatively low income (as little as nothing). Although disposable income plays a major role in decisions about whether to buy health insurance or how much coverage to buy, the deduction delivers the smallest marginal benefit to those who arguably are in greatest need of public assistance in order to be insured. One policy option for avoiding such a result is to enact a refundable tax credit for the purchase of health insurance that phases out over some range of relatively high incomes. Such a credit would deliver the largest marginal benefit to those most in need of assistance and the smallest (or no) marginal benefit to those least in need of assistance.

Second, the deduction cannot compensate for or replicate the significant advantages of receiving health insurance through an employer. Those advantages stem from certain critical differences between the group and non-group (or individual) health insurance markets. On the whole, wage earners who receive health benefits through their employers participate in the group market, while self-employed individuals who purchase health insurance from private insurers participate in the non-group market. Group health plans generally cater to the health care needs of relatively large groups of people who are drawn together for purposes other than obtaining insurance, such as employment. The plans are managed by sponsors (e.g., an employer) who negotiate directly with insurers on behalf of the insured members. By contrast, individual health plans generally are tailored to the health care needs of the individuals seeking coverage. Insurers set premiums and benefits in the group market mainly on the basis of key characteristics of the particular groups seeking coverage, especially their recent claims history, demographic composition, and geographic location; premiums tend to reflect an insurer's assessment of the expected cost of claims for medical services by the average member of a group (or risk pool). By contrast, insurers set premiums and benefits in the individual market mainly through a practice known as medical underwriting. Each applicant usually undergoes a thorough medical examination to assess his or her risk for developing a variety of serious health problems. Once the assessment is completed, an insurer then decides whether or not to offer a policy, what coverage to provide if it offers a policy, and the cost of that coverage, within the requirements imposed by state law.

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[13] Jonathan Gruber, *Public Finance and Public Policy* (New York: Worth Publishers, 2005), p. 401.

The differences between the two markets translate into more stable pricing and lower premiums in the group market than in the non-group market.[14] Premiums tend to be lower for comparable coverage in the group market for several reasons. Group insurance offers economies of scale in administrative functions such as billing, marketing, and claims processing that cannot be duplicated in individual insurance. In addition, relatively large employers can use their employment size to negotiate deals with insurers that provide more generous benefits with lower cost-sharing requirements than individuals could obtain on their own.

There is no simple or easy way to modify the deduction so that self-employed individuals could enjoy the advantages of employer-sponsored health plans to the same extent as wage earners. Such an outcome would require an overhaul of the U.S. health insurance market that would allow any adult not eligible for public health insurance (e.g., Medicare or Medicaid), regardless of his or her employment and health status, to join any group health plan on the same terms as those available through similar plans offered by large employers.

Third, like the exclusion for employer contributions to employee health plans, the deduction has the potential to foster inefficient uses of medical care. Such an outcome is the result of a market failure peculiar to insurance markets known as moral hazard. In the case of health insurance, moral hazard refers to the impact of insurance on the demand for medical services. Health insurance gives covered individuals a powerful incentive to consume too much health care because the insurance allows them to pay only a fraction of its cost through deductibles or co-payments. As a result, they could use medical services until their marginal benefit equals their out-of-pocket cost, and for someone with comprehensive first-dollar coverage, that cost can be nothing. Widespread use of health care whose marginal benefit is less than its true marginal cost entails a social welfare loss.

Neither the exclusion nor the deduction are capped. Without an upper limit on coverage, wage earners and the self-employed are more likely to purchase generous health insurance coverage than they would if they were required to pay in after-tax dollars for coverage beyond the cost of a typical individual or family policy in the regions where they reside. Indeed, conventional economic theory predicts that offering substantial subsidies for health insurance coverage will result in the purchase of more insurance than individuals would choose without the subsidies.[15] This extra coverage is more likely to activate the substantial costs of moral hazard than coverage that requires individuals to pay for most of the cost of routine medical procedures and fully insures only large medical expenses.[16] Capping the deduction at an amount tied to average premiums in the non-group market for individual or family plans is one way to curtail whatever welfare loss arises from overly generous health insurance coverage. For example, the President's Advisory Panel on Federal Tax Reform recommended in its final report that the exclusion for employer-

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[14] CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez.

[15] Kathleen McGarry, "Public Policy and the U.S. Health Insurance Market: Direct and Indirect Provision of Insurance," *National Tax Journal*, December 2002, p. 795.

[16] Gruber, *Public Finance and Public Policy*, p. 409.

provided health insurance be limited to $11,500 for families and $5,000 for individuals in 2006; these amounts were the projected average health insurance premiums that year.[17]

And fourth, the deduction does nothing to remedy a lack of horizontal equity in the tax treatment of spending on health insurance. Under current tax law, the unemployed and those whose employers do not provide health benefits receive no above-the-line deduction for their expenditures on health insurance. Several proposals in the 110th Congress (e.g., H.R. 227) would eliminate this inequity.

[17] President's Advisory Panel on Federal Tax Reform, *Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System* (Washington: November 2005), p. 81.