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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 perennial subject of discussion in Washington. The issue is prompted by the size of the tax benefits, particularly the exclusion for employer-paid insurance; by their effect on the cost and allocation of health care resources; and by interest in comprehensive tax and health care reform. President Bush has proposed taxing the insurance that workers receive from employers and providing a new standard deduction for health insurance regardless of whether coverage is obtained through employment or in the individual or small group markets. Tax code changes also figure prominently in many comprehensive health care reform proposals.

Current law contains significant tax benefits for health insurance and expenses: (1) Employer-paid coverage is excluded from the determination of both income and employment taxes. This exclusion also applies to health benefits in 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) Voluntary Employees' Beneficiary Association (VEBA) plans, often called VEBAs, are vehicles for prefunding retiree health benefits on a tax-advantaged basis for certain groups of workers, particularly unionized workers. (7) Coverage under Medicare, Medicaid, SCHIP, and military and veterans health care programs is not considered taxable income. (8) With exceptions, benefits received from private or public insurance are not taxable.

By lowering the after-tax cost of insurance, these tax benefits generally help extend coverage to more people; they also lead some people to obtain more coverage than they otherwise would. The incentives influence how coverage is acquired: the uncapped exclusion for employer-paid insurance, which can benefit nearly all workers and is easy to administer, is partly responsible for the predominance of employment-based insurance in the United States. 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.

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Most Recent Developments

On April 15, 2008, the House approved the Taxpayer Assistance and Simplification Act of 2008 (H.R. 5719). Among other things, the legislation would require that amounts paid or distributed for qualified medical expenses out of a Health Savings Account after December 31, 2010, be substantiated in a manner similar to the substantiation required for flexible spending accounts.

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]

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[1] All JCT estimates are from *Estimates of Federal Tax Expenditures for Fiscal Years 2006-2010*, JCS-2-06 (April 25, 2006). Current estimates the JCT makes may be somewhat (continued...)

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. In the average plan, employers pay about 84% of the cost of single coverage and 73% of the cost of family coverage, though some pay all and others pay none.[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 deduction for medical expenditures in 2006 and then received an insurance reimbursement for them in 2007). 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.[5]

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.

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[1] (...continued)
different. 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 2005*, by Chris L. Peterson, and *Employer Health Benefits: 2006 Summary of Findings*, by the Kaiser Family Foundation and the Health Research and Educational Trust. 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.

[5] About 70% of these employers purchase stop-loss insurance to cover major liabilities.

The Joint Committee on Taxation (JCT) estimated that the FY2007 tax expenditure attributable to the exclusion for employer payments for health insurance and health care (for self-insured plans) will be $99.7 billion. The estimate does not include the effect of the exclusion on employment taxes.[6]

Unreimbursed Medical Expenses

Taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of adjusted gross income (AGI).[7] 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."[8] 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 2003, just under 34% of all individual income tax returns had itemized deductions; of these returns, less than 20% (about 6.7% of all returns) claimed a medical expense deduction.[9]

The JCT estimated that the FY2007 tax expenditure attributable to the medical expense deduction (including long-term care expenses) will be about $8.2 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 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.

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[6] The JCT estimate includes payments of premiums through cafeteria plans. The FY2007 tax expenditure estimate from the Administration is considerably higher, $146.8 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.

[7] Section 213. If the taxpayer is subject to the Alternative Minimum Tax (AMT), this is limited to expenses that exceed 10% of AGI. Section 56(b)1)(B).

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

[9] Michael Parisi and Scott Hollenbeck, "Individual Income Tax Returns, 2003," *Statistics of Income Bulletin*, vol. 25 no. 2 (fall 2005), U.S. Internal Revenue Service, table 3.

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.[10]

Self-employed taxpayers may deduct payments for health insurance in determining their AGI (i.e., as an "above-the-line" deduction).[11] 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.

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

In 2003, about 3.8 million tax returns (about 2.9% of all returns) claimed the self-employed health insurance deduction. For FY2007, the JCT estimated that the tax expenditure attributable to the deduction (including the self-employed deduction for long-term care insurance) will be $4.2 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

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[10] 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.

[11] Section 162(l).

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 reduces 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.

In general, 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 are excluded from taxes, just as they are for active workers. For many retirees, the employer pays much of the premium.

The Pension Protection Act of 2006 (P.L. 109-280) allows certain retired public safety officers to pay up to $3,000 of qualified health insurance premiums from their pensions on a pretax basis. The premiums do not have to be for a plan sponsored by the former employer; however, the exclusion does not apply to premiums paid by the retiree and then reimbursed with pension distributions.

For FY2007, the JCT estimated that the tax expenditure attributable to cafeteria plans will be $30.6 billion. The estimate includes the tax expenditures attributable to dependent care flexible spending accounts.[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.[17] 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.

In 2004, about 20% of private-sector establishments offered a health care FSA to their workers.[18] They are more common in larger firms: 61.5% of establishments with 50 or more workers offered them, but only 6.5% of smaller establishments. Similarly, more employees had access to an FSA if they worked in larger firms: 68% of workers did in firms with 50 or more workers, but only 11% did in smaller firms. Overall, 52% of private-sector employees could establish a health care FSA.

Most people with access to an FSA do not use them. A 2006 survey by Mercer Human Resources Consulting showed that an average of 36% of eligible employees participated in health care FSAs offered by employers with 10 or more employees. The average amount contributed was $1,208.

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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 Bob Lyke.

[17] The Tax Relief and Health Care Act of 2006 (P.L. 109-432) allows individuals to make limited, one-time rollovers from balances in their health care FSAs to Health Savings Accounts. See IRS Notice 2007-22 for details.

[18] Data in this paragraph are from the 2004 Medical Expenditure Panel Survey.

Federal employees have had the opportunity to use FSAs since July 2003. In 2005, there were 157,991 federal health care FSAs.

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. 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.[19]

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).[20] Eligible individuals can establish and fund accounts when they have a qualifying high deductible health plan and no other health plan, with some exceptions. The high deductible plan may be through an employer-provided option or purchased individually. For 2008, the deductible for self-only coverage must be at least $1,100 with an annual out-of-pocket limit not exceeding $5,600; the deductible for family coverage must be at least $2,200 with an annual out-of-pocket limit not exceeding $11,200.

The annual HSA contribution limit in 2008 for individuals with self-only coverage is $2,900; for family coverage, it is $5,800. Individuals who are at least 55 years of age but not yet enrolled in Medicare may contribute an additional $900. Contributions may be made by employers, individuals, or both.[21]

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

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

[20] 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.

[21] Section 223. For more information, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2007*, by Bob Lyke.

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.

In January 2007, there were about 4.5 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.[22]

For FY2007, the JCT estimated that the tax expenditure attributable to HSAs will be about $300 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.[23]

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 legislative 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.

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

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[22] *January 2007 Census Shows 4.5 Million People Covered by HSA/High Deductible Health Plans*. America's Health Insurance Plans (AHIP) Center for Policy and Research (April 2007). (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.

[23] Section 220.

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 because they have not yet exhausted their state unemployment benefits;
- individuals 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.[24]

The HCTC equals 65% of the premiums the taxpayer pays for qualifying insurance for themselves and for their family. 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.

The Internal Revenue Services reports that approximately 28,000 taxpayers claimed the HCTC in tax year 2005. The average monthly premium for this group was $600, for an average credit of $429. Approximately 17,000 family members were covered under these plans; in total, 45,000 persons received some type of health insurance subsidized by the HCTC.[25]

For FY2007, the JCT estimated that the tax expenditure attributable to the HCTC will be about $200 million.

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[24] For additional information of the eligibility rules, see CRS Report RL32620, *Health Coverage Tax Credit Authorized by the Trade Act*, by Julie Stone and Bob Lyke.

[25] David R. Williams, Director of Electronic Tax Administration and Refundable Credits, Internal Revenue Service, Testimony Before the House Committee on Ways and Means, June 14, 2007, [http://waysandmeans.house.gov/hearings.asp?formmode=view&id=6131].

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.[26]

Coverage under military health care programs and the benefits they provide are not considered taxable.[27]

For FY2007, the JCT estimated that the tax expenditure attributable to medical care and Tricare insurance for military dependents, retirees, and dependents of retirees will be approximately $2.0 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. Just over 5 million veterans receive services.[28]

Coverage under veterans health care programs and the benefits they provide are not considered taxable.[29]

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

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[26] For more information, see CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Richard A. Best, Jr.

[27] 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.

[28] For additional information, see CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, both by Sidath Viranga Panangala.

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

more of its parts. Coverage under Medicare and the benefits it pays for qualifying expenses are not considered taxable.[30]

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 for medical expenses.[31] 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.[32]

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, as may the Part D premiums themselves.[33]

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. In 2007, for the first time there are Medicare Medical Savings Account plans offered under Part C. The tax treatment of these plans is similar to that of Health Savings Accounts; contributions and account earnings are exempt from taxes, as are withdrawals used to pay medical expenses.[34] However, other specifications differ depending on the plan. Contributions to Medicare MSA plans are made by the

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[30] 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.

[31] Rev. Rul. 66-216.

[32] Rev. Rul 66-216.

[33] IRS Publication 502, *Medical and Dental Expenses*, p. 9.

[34] Section 138.

Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services.

For FY2007, the JCT estimated that the tax expenditure attributable to the exclusion of Medicare Part A benefits will be $20.7 billion. The tax expenditures attributable to Part B and Part D were estimated to be $14.2 billion and $6.2 billion, respectively.[35]

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 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 63 million people are covered by Medicaid each year.[36]

Coverage under Medicaid and the benefits it pays for qualifying expenses are not considered taxable.[37]

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.

VEBAs

Voluntary Employees' Beneficiary Association (VEBA) plans provide life insurance, medical, disability, accident and other welfare benefits to employee members and their dependents.[38] Most are organized as trusts to be legally separate

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[35] JCS-2-06.

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

[37] 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.

[38] Sections 501(a) and 501(c)(9). For a comprehensive summary of the tax treatment of VEBAs, see *Tax Expenditures: Compendium of Background Material on Individual*

(continued...)

from employers, which is important if the latter become bankrupt. Provided certain conditions are met, the investment earnings of VEBAs are exempt from taxation, as are the benefits paid out if the benefit would normally be exempt. For example, VEBA medical benefits would be tax exempt, but severance pay would not be.

VEBAs can be funded by employers or employees. Employer contributions are tax deductible as a business expense, but the deductions generally are limited to the sum of *qualified direct costs* (amounts employers could have deducted for the employee benefit for the year if they followed cash basis accounting) and additions to *qualified asset account*s (reserves for unpaid claims, some administrative costs, and certain post-retirement benefits), minus VEBA after-tax net income. Reserves for retiree health benefits normally must be funded over the working lives of covered individuals on a level basis, using actuarial assumptions incorporating current, but not projected, medical costs. These limitations reduce the utility of VEBAs for retiree health plans, but they do not apply to collectively-bargained plans or to multiple employer welfare arrangements (MEWAs) of ten or more employers.[39]

According to the 2005 Mercer National Survey of Employer-Sponsored Plans, 9% of employers with 500 or more employees use VEBAs for prefunding retiree health benefits. VEBAs are more common in heavy manufacturing, communication, transportation, and utility industries.

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

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[38] (...continued)
Provisions, U.S. Senate Committee on the Budget, December 2006 (S. Prt. 109-0720, p. 547-554.

[39] Sections 419 and 419A.

tax benefits are only one factor influencing the amount of insurance purchased. 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 substantial changes along these lines could be difficult to implement and might create serious inequities. 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. The Congressional Budget Office analyzed this approach

in a December 2006 publication, *Consumer-Directed Health Plans: Potential Effects on Health Care and Spending Outcomes.*

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.[40] 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.[41] 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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[40] 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.

[41] 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 them all. In a typical Congress, tax measures pertaining to health insurance and expenses have numbered in the hundreds, not all of which are easily tracked. In addition, not all bills are available in the Legislative Information System (LIS) as of the date of this report.

A list of all bills on a particular topic (e.g., tax credits for health insurance) is available to congressional staff through the 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 ostensibly has 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.

The President's Proposal

The President's FY2009 budget proposes replacing several long-standing tax benefits for health insurance and medical expenses with new standard deductions for health insurance. The new deductions, $7,500 for self-only coverage or $15,000 for family coverage, would be the same regardless of the cost of the insurance or whether it was obtained in the individual and small group markets or through the employer.[42]

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[42] For information about the proposal, see Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2009 Revenue Proposals*, February 2008, pp.19-22.

With some minor exceptions, the proposal is similar to what was proposed in the FY2008 budget. It would terminate these existing tax benefits:

- the exclusion for employer paid health insurance;
- the exclusion for employer paid health care;
- the exclusion for flexible spending accounts (FSAs) and health reimbursement accounts (HRAs);
- the exclusion for premium conversion arrangements;
- the health insurance deduction available to self-employed taxpayers; and
- the itemized deduction for medical expenses, except after 2013 for those who are not eligible for the new standard deduction.

The proposal would also affect employment taxes (i.e., Social Security and Medicare taxes). However, employers would be allowed to exclude a pro-rated portion of these taxes, and prior to 2013 employees could claim a refund of employer payments when they file their own returns. These rules are different from the FY2008 proposal.

The proposal would not affect the exclusion for employer contributions to Health Savings Accounts, nor the deduction individuals may take for their own HSA contributions.

Employers would be required to report the value of health insurance coverage to their employees on their annual W-2 forms; the amounts would be subject to regular withholding rules. Businesses would continue to deduct employer-paid health insurance as a business expense, just as they do other taxable forms of compensation.

JCT and CBO Estimates for the FY2008 Proposal. The Joint Committee on Taxation (JCT) estimated that repealing the provisions of existing law and providing the new standard health insurance deduction would reduce net revenue by $22.8 billion from FY2009 to FY2012. (The President proposed that the changes would be effective for tax years beginning after December 31, 2008.) However, for the FY2009-FY2017 period, there would be an estimated net revenue increase of $333.6 billion.[43]

The Congressional Budget Office (CBO) estimated that under current law there would be about 51 million people (both adults and children) without health insurance on any given day in 2010. If the President's proposal were enacted and individuals and firms had fully adjusted to the new policy, CBO estimated that the number of uninsured would decline by about 6.8 million.[44]

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[43] Joint Committee on Taxation, *Description of Revenue Provisions Contained in the President's Fiscal Year 2008 Budget Proposal* (JCS-2-07), p. 301. According to the JCT, the projected increase in net revenue is largely attributable to JCT assumptions regarding the growth of health insurance costs relative to the growth in the consumer price index.

[44] Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2008*, p. 62. CBO cautions that estimated effects on coverage are highly (continued...)

Some Observations. The President's proposal would increase tax equity for those who purchase health insurance outside of employer plans. In particular, the proposed standard deduction would allow individuals who buy coverage with their own funds to receive tax savings comparable to those who have the same amount of employer-paid insurance. The proposal would also increase the transparency of employee compensation by showing workers on their W-2 statements the nominal amounts employers were paying for their insurance.

However, the proposed standard deduction may unfairly limit tax savings for individuals who live where health care is expensive or who receive health insurance from an employer with an older, less healthy risk pool. The more favorable tax treatment of individual health insurance might spur some employers to drop coverage if the healthiest and youngest workers opt for individual insurance. The proposal would decrease the incentives for employers to build and maintain large risk pools, pushing some workers into the uncertain individual market.

The CBO estimates cited above show that the proposal might reduce the number of uninsured by about 13%, a not insubstantial amount. However, many analysts argue that larger reductions could be achieved by replacing the proposed standard deduction with a refundable tax credit.

Exclusion for Employer-Paid Insurance

The President's proposal to terminate the exclusion for employer-paid health insurance is discussed above.

S. 334 (Wyden), S. 1019 (Coburn), S. 1783 (Enzi), and S. 1875 (DeMint) would terminate the exclusion for employer-paid health insurance, with several exceptions as part of each of their respective comprehensive health care reform plans. H.R. 914 (Ryan) would limit the exclusion to $5,000 for self-only coverage and $11,500 for family coverage.

Bills introduced by Representative Cooper (H.R. 666 and H.R. 847) would require the amount that employers pay for health insurance be included on employees' W-2 statements. This would inform employees about how much of their compensation (at least in nominal terms) is received through that benefit.

Expanded Tax Deduction

The President's proposal for new standard deductions for health insurance is discussed above.

S. 334 (Wyden) would also establish standard above-the-line deductions for health insurance. The deduction amounts would vary according to family status. It would not be available to people with incomes below the poverty line (who would receive other subsidies for their insurance), and it would phase out starting at

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[44] (...continued)
uncertain.

incomes of $62,500 ($125,000 for a joint return). The provision is part of his comprehensive health care reform plan.[45]

S. 1783 (Enzi) would establish standard above-the-line deductions for health insurance. These would be paired with refundable tax credits for those people with lower incomes. The provision is part of his comprehensive health care reform plan.

In recent Congresses, there have been a number of proposals allowing an above-the-line deduction for what taxpayers actually paid for their health insurance and sometimes other medical expenses. In the 110th Congress, H.R. 227 (Sterns) would allow this deduction for health insurance and unreimbursed prescription drug costs. H.R. 1110 (Tom Davis) and S. 773 (Warner) would allow this deduction for Tricare supplemental premiums or enrollment fees. H.R. 2626 (Price) would allow the costs of qualified health insurance to be deducted from income as part of his comprehensive health care proposal. H.R. 2302 (King) would allow deductions for premiums purchased on the individual market for high deductible plans associated with HSAs. H.R. 3516 (McHugh), H.R. 3975 (Chabot), and S. 2835 (DeMint) would allow the deduction of health insurance costs.

H.R. 636 (Bachman) would remove the AGI floor from the itemized deduction for health insurance and unreimbursed medical care costs.

Self-Employed Deduction

The President's FY2008 budget proposal to replace the tax exclusion for employer-paid coverage with a new standard deduction for health insurance would also terminate the tax deduction for self-employed taxpayers.

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.

H.R. 3660 (Kind) and S. 2239 (Bingaman) would allow self-employed taxpayers to subtract their health insurance costs in determining their self-employment taxes.

H.R. 2626 (Price) would limit the amount of self-employed tax payer's health care deduction as part of his comprehensive health care proposal.

Premium Conversion

H.R. 1110 (Tom Davis) and S. 773 (Warner) would allow retired military and civilian federal workers to pay their federal health insurance premiums (Tricare and FEHBP, respectively) on a pretax basis. The bills are similar to the 109th Congress measure (H.R. 994; Tom Davis), which was ordered to be reported by the House

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[45] In S. 1111, Wyden offers a standard health care deduction that is linked to the taxpayer's poverty level. This provision is part of a comprehensive tax reform plan.

Committee on Government Reform on June 16, 2005, but was never approved by the House Ways and Means Committee.

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.

President Bush's FY2008 budget proposal to replace the tax exclusion for employer-paid coverage with a new standard deduction for health insurance would terminate premium conversion arrangements.

Flexible Spending Accounts

President Bush's FY2008 budget proposal to replace the tax exclusion for employer-paid coverage with a new standard deduction for health insurance would also terminate tax-advantaged Flexible Spending Accounts. The accounts could continue without the tax advantage (i.e., employees could divert part of their taxable wages into an account to be used for health care expenses), but it is not obvious who would want these arrangements.

Under current IRS rules, FSA balances not used by the end of the year generally are forfeited to the employer, though the employer may allow a 2½-month grace period.[46] 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.

H.R. 298 (McCarthy) would allow a carryover of health care FSA funds, as would S. 555 (Snowe), H.R. 3306 (Royce), and H.R. 3947 (Larson). S. 555 would make other changes to FSAs as well, including allowing rollovers to qualified retirement accounts, 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. H.R. 3363 (Pomeroy) would allow long-term care insurance to be offered under cafeteria plans and FSAs.

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

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[46] The Tax Relief and Health Care Act of 2006 (P.L. 109-432) allows individuals to make limited, one-time rollovers from termination balances in their health care FSAs to Health Savings Accounts.

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.

Health Savings Accounts

On April 15, 2008, the House approved the Taxpayer Assistance and Simplification Act of 2008 (H.R. 5719). Among other things, the legislation would require that amounts paid or distributed for qualified medical expenses out of a Health Savings Account after December 31, 2010, be substantiated in a manner similar to the substantiation required for flexible spending accounts. Supporters of the HSA provision argue that it is needed to ensure accountability for withdrawals. Opponents claim that the provision would unreasonably increase administrative costs and inhibit the use of debit cards, which are both popular and convenient. The Administration opposes the provision.

The President's FY2009 budget includes several measures that would make them more attractive. These include

- allowing health plans with 50% coinsurance to qualify as high deductible health plans,
- allowing any medical expense incurred on or after the first day of HSA eligibility to be considered a qualified expense, even if incurred before the HSA is established,
- allowing larger contributions from employers for chronically ill persons,
- allowing family coverage to include coverage where each individual can receive benefits once they have reached the minimum deductible for an individual,
- allowing both spouses who are eligible individuals to contribute the catch-up contribution to a single HSA owned by one spouse, and
- allowing contributions to HSAs to be made by individuals covered by an FSA or HRA, but offset the maximum allowable HSA contribution by the level of FSA or HRA coverage.

In the 110th Congress, S. 46 (Ensign) and S. 2835 (DeMint) would allow HSA funds to be used (as a qualified distribution) to pay the premiums of individual market high deductible health plans. H.R. 3234 (Cantor) would allow HSA funds to be used to pay the premiums for most health insurance plans. H.R. 991 (Campbell) and H.R. 3234 would allow individuals eligible for veterans health benefits to contribute to HSAs.

S. 1019 (Coburn), H.R. 3234 (Cantor), and H.R. 3343 (Paul) would increase HSA contribution limits and would make other modifications that would make the accounts more attractive and effective.

H.R. 749 (Blackburn) and would allow people entitled to Medicare to instead receive a voucher to purchase high deductible insurance and contribute to HSAs. S.

173 (Inhofe) would establish a new Medicare Health Savings Account option. H.R. 2302 (King) would allow deductions for premiums purchased on the individual market for high deductible plans associated with HSAs. H.R. 2948 (Walberg) would repeal the general prohibition against the purchase of health insurance from a health savings account.

S. 2743 (Casey) would authorize new tax-exempt accounts for individuals with disabilities; contributions from family members would be deductible up to $2,000 each year. Medical care would be one type of qualified expense for which an account could be used.

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. The Trade Adjustment Assistance Reform Act of 2002 (P.L. 107-210) reauthorized the TAA and ATAA programs through FY2007. P.L. 110-89 (Herger, H.R. 3375) extended the program through CY2007.

The President's FY2008 budget includes a proposal that would allow state qualified plans to impose a pre-existing condition exclusion for a period of up to 12 months, provided the plan reduces the restriction period by the length of the eligible individual's creditable coverage as of the date of application for the state qualified plan.

The FY2008 budget also proposes allowing the spouse of an HCTC-eligible individual to claim the credit when the HCTC-eligible individual becomes entitled to Medicare. The spouse would have to be at least 55 years of age.

H.R. 3920 (Rangel) would extend potential TAA eligibility (and thus HCTC eligibility) to service and public sector workers and increase the credit rate from 65% to 85%, among other things. It would also terminate the credit after December 31, 2009, except for those who have been previously eligible. The comparable Senate bill (S. 1848), which is under consideration by the Committee on Finance, is similar in most respects, though it would not terminate the credit.

Several 110th Congress bills would extend eligibility to different classes of workers under certain circumstances, thus allowing them to get the tax credit; these bills include S. 1848 (Baucus), H.R. 910 (English), H.R. 3801 (Smith) which would extend the program to service and public agency workers; and H.R. 1729 (Hayes) and S. 1652 (Dole), which would include presumptive eligibility of textile and apparel workers.

S. 1739 (Rockefeller) and S. 1848 would allow family members to continue eligibility for the credit after the person through whom they had coverage became entitled to Medicare. S. 1739 would also have continued 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.

Some 110th Congress bills (S. 1652, S. 1739, H.R. 1729, H.R. 910, S. 1848, H.R. 3920, and H.R. 3801) would also increase the credit rate and expanded 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.

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.[47] 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.

In the 110th Congress, H.R. 914 (Ryan), H.R. 2626 (Price), H.R. 2351 (Kaptur), H.R. 5784 (Granger), S. 158 (Collins), S. 397 (Martinez), S. 1019 (Coburn), S. 1783 (Enzi), S. 1875 (DeMint) S. 1886 (Burr), H.R. 3343 (Paul), and H.R. 3515 (McHugh) would all authorize a refundable individual income tax credit for health insurance. H.R. 2737 (Boswell) would allow the credit for taxpayers who previously were uninsured. H.R. 5348 (Langevin) would allow a credit as part of his comprehensive health care reform proposal, which also would include a general premium subsidy for certain coverage.

S. 95 (Kerry), H.R. 1111 (Waxman), H.R. 2147 (Emanuel), S. 2193 (Martinez), and H.R. 3888 (Musgrave) would authorize a refundable tax credit for health insurance coverage for children. In all bills, the credit is part of a more

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[47] 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.

comprehensive children's health insurance proposal. H.R. 2357 (Stark) and S. 2522 (Rockefeller) would authorize a refundable credit for catastrophic cost-sharing expenses under their proposed comprehensive Medikids program.

H.R. 343 (Emerson) would authorize a refundable tax credit for Medicare Part B premiums for military retirees.

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, 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.

Nonrefundable Tax Credit

H.R. 194 (Paul) would authorize a nonrefundable tax credit for 80% of the unreimbursed prescription drug costs paid by individuals who have obtained the Social Security retirement age.

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.

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.

A number of health insurance employer tax credit bills were introduced in the 110th Congress. Many were aimed at small employers, among them S. 99 (Kerry), S. 158 (Collins), S. 2795 (Durbin), and H.R. 1802 (Hooley). H.R. 2737 (Boswell) would authorize a tax credit for small business health expenses for previously uninsured workers.

H.R. 5907 (Gerlach) would authorize a tax credit equal to one percent of taxable income for employers designated as "Eagle Employers," i.e., employers whose compensation policies meet certain standards, including paying at least 60 percent of each employee's health care premiums.

Tax Penalties

Under current law, there are no tax penalties for individuals and families that do not have health insurance coverage. Proposals requiring coverage of everyone often include a tax penalty in order to encourage compliance. For example, in the Massachusetts health care reform plan, people who do not have insurance and are not exempt from the mandate will lose their state income tax personal exemption. Late enrollers will also face an additional premium-based penalty that will be collected through the state tax system.

S. 99 (Kerry) and H.R. 1111 (Waxman) would limit the dependent exemption that could be claimed with respect to a child to the same percentage that represents the proportion of the year that the child was covered by qualified health insurance. (These bills would also authorize a refundable tax credit for the purchase of children's coverage and expand both SCHIP and Medicaid.)

The comprehensive health care reform bill of Senator Wyden (S. 334) would also establish penalties for individuals who fail to purchase coverage, with some exceptions, but the penalties are not tax penalties.

S. 1899 (Cardin) would create new low-cost health insurance plans for the states for all individuals with incomes below 400% of the poverty level. It would require all individuals to be covered by qualified health coverage. It would also impose an excise tax for any individual who failed to have qualified health coverage.

Some Other Tax Measures

H.R. 15 (Dingell) would establish a national health insurance system with payments made from a National Health Care Trust Fund. The source of revenue for the fund would be a value added tax (a general sales tax on most goods and services).

H.R. 1200 (McDermott) would establish a new national health care system. It would be financed by specific increases in the individual income tax, payroll taxes, and excise taxes on tobacco products.

H.R. 1378 (Goode) would allow individuals to designate portions of their income tax refunds to a federal trust fund to provide catastrophic health coverage to uninsured individuals.

H.R. 2034 (Dingell) would create a comprehensive Medicare for all program that would be financed by employment taxes and taxes on employers.

H.R. 3000 (Lee) would establish a comprehensive system financed by an additional income tax levy on individuals and corporations. It would also modify or repeal a number of existing tax provisions relating to health insurance.

H.R. 4864 (Paul) would waive the employee portion of Social Security taxes on employees who have been diagnosed as having cancer or a terminal disease.

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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