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

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Summary

Federal tax law allows self-employed individuals to deduct from their gross income the entire amount they spend 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 111th Congress to modify the deduction, and discusses the implications of leading health care reform proposals in Congress for health insurance coverage among the self-employed.

Under Section 162(l) of the Internal Revenue Code (IRC), qualified self-employed individuals may deduct the entire amount of their payments for health insurance for themselves and immediate family members. 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 qualified individual is eligible to participate in a health plan offered by an employer or by a spouse's employer. Third, the expenditures used to claim the deduction cannot be included in the medical expenses eligible for the itemized deduction under IRC Section 213. Finally, health insurance expenditures by self-employed individuals are subject to 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 the deduction comes close to establishing 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 delivers the largest tax benefit for the same insurance policy to those who arguably need it the least: self-employed individuals in the highest tax bracket. It also is uncapped, thus encouraging the purchase of generous plans.

Several bills in the 111th Congress (H.R. 533, H.R. 1470, H.R. 1763, H.R. 3067, and S. 275) would eliminate the final remaining obstacle to achieving equal tax treatment for the health insurance purchased by the self-employed and the health benefits employees receive through their employers. The obstacle lies in the difference between the income base for the payroll taxes paid by wage earners and the self-employment taxes paid by the self-employed: health insurance expenditures by the self-employed are subject to the self-employment tax, whereas employer contributions to employee health plans are not subject to the payroll tax. Each bill would allow the self-employed to deduct these expenditures as an ordinary and necessary business expense, thereby removing them from the income base for the self-employment tax.

Some of the health care reform legislation being considered in the House and Senate could affect health insurance coverage for the self-employed. Though it remains unclear whether either chamber will pass such a bill in the current Congress—and if so, what tax provisions it might contain—enough is known about the key issues in the congressional debate to sketch their implications for the self-employed. Proposals that would expand private health insurance coverage or simultaneously expand public and private coverage options (e.g., H.R. 3200) could lead to greater coverage among the self-employed through income-based tax subsidies for the purchase of insurance and an individual mandate.

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Current federal tax law allows 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 tax 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. Several bills in the 111th Congress would enable 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 111th Congress to alter the deduction, and the implications of the leading health care reform proposals in Congress for health insurance coverage among the self-employed.

Current Law

Under Section 162(l) of the Internal Revenue Code (IRC), self-employed individuals are allowed to deduct the entire amount of their spending on health insurance for themselves and their immediate family members. In this case, 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 he or she may not also include the cost of employee health 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] A self-employed taxpayer who earns income from more than one business or trade 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

[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.

[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. Wage earners pay the same taxes, but they split them evenly with their employers.

expenditures used to compute 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 an ordinary and necessary business expense, which means those expenditures must be added to the income base for the self-employment tax of 15.3%.

In addition, self-employed individuals may add any payments they make for long-term care insurance to the health insurance expenditures eligible for the deduction. But the amount of long-term care insurance premiums that may be deducted is limited, and the limits, which are indexed for inflation, vary with the age of a self-employed taxpayer at the close of a tax year. In 2009, the deductible amounts range from $320 for those age 40 and under to $3,980 for those over age 70.

A self-employed individual has two other options for obtaining health insurance coverage that offer significant tax benefits.

He or she 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. 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 2009, qualified plans must carry a deductible of at least $1,150 for individual coverage (with a cap of $5,800 on out-of-pocket expenses), and $2,300 for family coverage (with an out-of-pocket cap of $11,600). Total contributions to an HSA in 2009 are limited to the lesser of the deductible or $3,000 for individual plans, and the lesser of the deductible or $5,950 for family plans; the limits are $1,000 larger for individuals age 55 and older. 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. For example, annual contributions for individual coverage cannot exceed 65% of the deductible (not less than $2,000 but not greater than $3,000) for such coverage, and for family coverage the limit is 75% of the deductible (at least $4,000 but not greater than $6,050). 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.[4]

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

[4] For a comparison of the main features of HSAs and MSAs, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by (name redacted) and (name redacted).

Health Insurance Coverage for the Self-Employed

An estimated 14.0 million non-elderly individuals were self-employed in 2007, the most recent year for which reliable data on U.S. health insurance coverage by employment status are available. Of this total population, 9.7 million had private health insurance, 1.6 million received public health insurance (mainly Medicaid), and 3.7 million were uninsured.[5] Over 71% of the self-employed with private health insurance (or 6.9 million) in 2007 were covered through plans offered by a current or former employer, or by a spouse's employer. The remaining 2.8 million (or 20% of the self-employed population) with private health insurance purchased it on their own.

According to the Internal Revenue Service (IRS), individual taxpayers filed 3.8 million returns claiming the deduction in 2006; the amount claimed totaled $20.3 billion (see **Table 1**).[6] Individuals with adjusted gross incomes between $30,000 to under $500,000 accounted for 70% of the value of those claims and 67% of the volume.

The revenue cost of the deduction could total $4.8 billion in FY2009.[7] This cost represents the tax revenue that would be collected that year under two assumptions: (1) there were no deduction, and (2) self-employed taxpayers instead were to include their health insurance expenditures in the spending eligible for the itemized deduction for medical expenses.

[5] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey*, Issue Brief No. 321, Employee Benefit Research Institute (Washington: Sept. 2008), fig. 11, p. 12.

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

[7] U.S, Congress, Senate, Committee on the Budget, *Tax Expenditures: A Compendium of Background Material on Individual Provisions*, committee print, 110th Cong., 2nd Sess., S. Prt. 110-667 (Washington: Dec. 2008), p. 767.

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

Year	Tax Returns with the Deduction (millions)	Total Amount (billions of current dollars)	Average Amount Per Return (current dollars)	Percent of the Self-Employed Not Eligible for Medicare with Individually Purchased Health Insurance
1990	2.754	1.627	591	25
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
2006	3.804	20.302	5,343	20

Sources: Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured* (Washington: various years); Internal Revenue Service, *Statistics of Income Bulletin* (Washington: various years), available at www.irs.gov.

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 main 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 gauge of the effectiveness of the deduction is the extent to which it has accomplished its intended purpose. It can be argued that Congress added the deduction to TRA86 for two reasons. One was to provide the self-employed with a tax benefit for health insurance comparable to the tax exclusion for employee health benefits. The other reason was to foster a substantial expansion of health insurance coverage among self-employed individuals.[8] To what extent have these objectives been achieved?

Coverage Rate Among the Self-Employed

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 that cost 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 increase would hinge on how sensitive the demand for health insurance is to changes in its cost. There is some dated evidence that the demand for health insurance among single self-employed individuals is responsive to declines in this cost.[9]

[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.

[9] A 1994 study by the economists Jonathan Gruber and James Poterba of the impact of the deduction on the demand for (continued...)

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 someone 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 rises with household income, the deduction reinforces this linkage.

Is there any evidence that the deduction has spurred 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 1986. In 1985, 69% of the self-employed were covered through private health plans (both plans they purchased on their own 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 seems likely that much of that rise was due to the advent of the deduction. Still, coverage has gradually fallen ever since: it was 69% in 2007, 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 2007 (20%) than in 1991 (29%).

These declines raise the possibility that whatever initial stimulus 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 or retain health insurance. In the absence of the deduction, the health insurance coverage rate among the self-employed arguably would be lower.

Tax Subsidies for Health Insurance for the Self-Employed and Wage Earners

Does the deduction create a level playing field between wage earners and the self-employed in the tax subsidies 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

(...continued)

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.

[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.

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 expenditures 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 self-employed individual than for a wage earner. A truly level playing field would permit self-employed individuals to exclude their payments for health insurance from the income base for the self-employment tax.

The self-employed are not the only taxpayers for whom the federal tax code denies equal treatment in access to health insurance with wage earners. There is no deduction or exclusion for health insurance bought by the unemployed or by individuals whose employers do not offer health benefits. As a result, their only option for lowering the after-tax cost of health insurance is to claim the itemized deduction for medical expenditures, provided they qualify.

At the same time, there is some evidence that the use of health care by the self-employed is not as tied to health insurance coverage as one might expect. A 2001 study by Craig Perry and Harvey Rosen, using data from the 1996 Medical Expenditures Panel Survey, 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, their findings indicated that there were 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. Nor was there any evidence that the medical spending of the self-employed reduced their capacity to purchase other goods and services. Perry and Rosen 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. The study calls into question one of the main justifications for the deduction: that it is needed to increase the utilization of medical care among the self-employed. Rather, the findings suggest that access to medical care may have little to do with current tax subsidies for the purchase of health insurance.

Legislation in the 111th Congress That Could Affect Health Insurance Coverage for the Self-Employed

Numerous bills to create new tax subsidies for the purchase of health insurance have been introduced in the 111th Congress. Some of the subsidies would be of greater benefit to the self-employed than the current deduction under IRC Section 162.

A case in point is a proposal (H.R. 879) to establish a refundable tax credit for individuals who purchase health insurance on their own in the non-group market. 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

[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.

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 come to $2,550. Because the credit is refundable, the individual would receive the credit even if he or she has no federal income tax liability.

At least five bills in the current Congress would modify the deduction to equalize the tax treatment of health insurance purchased by the self-employed and the tax treatment of health benefits obtained by wage earners through their employers. Under current law, health insurance expenditures by the self-employed are subject to the self-employment tax, whereas employer contributions to employee health plans are not subject to payroll taxes. But the same provision in H.R. 533, H.R. 1470, H.R. 1763, H.R. 3067, and S. 725 would exempt these expenditures from the self-employment tax by allowing the self-employed to treat them as a deductible business expense. If enacted as proposed in these bills, the exemption would reduce the after-tax cost of health insurance to the self-employed by 15.3%, the self-employment tax rate. A decline of that size may be sufficient to spur an increase in the health insurance coverage rate for the self-employed. It is not clear what the revenue cost of the proposed exemption would be. Depending on the amount, the estimated cost could influence future congressional deliberations over whether to adopt such an exemption.

Health insurance coverage among the self-employed could also be affected by any major health care reform legislation Congress passes. The 111th Congress is considering a variety of proposals to expand health insurance coverage and curb the rate of growth in health care spending. In essence, they incorporate one or more of the following approaches: (1) replacing the current system of private health insurance with some kind of national health insurance plan; (2) expanding coverage under current public health insurance programs (such as Medicaid) by including certain groups of uninsured individuals; (3) expanding coverage under private health insurance plans; (4) encouraging reforms in state health insurance regulations to compel private insurers to offer insurance to all applicants, regardless of any pre-existing health problems they may have; and (5) expanding current public and private options for health insurance coverage.[13]

A prominent example of the fifth approach is H.R. 3200, which the three committees in the House with jurisdiction over health care have passed. As the bill now stands, H.R. 3200 would do more to expand coverage than to control future growth in per-capita health care spending. More specifically, it would make the following notable changes in the current health care system:

- require all individuals to have health insurance or pay a penalty,
- create a health insurance exchange where individuals and smaller companies can purchase health insurance,
- provide subsidies for the purchase of health insurance for individuals and families with incomes at or below 400% of the federal poverty level,
- require employers to provide health insurance to all employees or pay into a health insurance exchange trust fund,

[13] For more details on these approaches, see CRS Report R40581, *Health Reform and the 111th Congress*, by (name redacted), pp. 5-14.

- offer exceptions to the employer mandate to certain small firms and provide a tax credit to small employers that do provide coverage,
- impose new regulations on health plans participating in the health insurance exchange and in the small-group health insurance market aimed at improving access to affordable health insurance, and
- expand Medicaid coverage to eligible households with incomes up to 133% of the federal poverty level.

Such a measure could spark a significant rise in health insurance coverage among the self-employed. In 2007, the most recent year for which data are available, the self-employed accounted for 14% of the estimated U.S. non-elderly uninsured population, and 26% of all self-employed individuals under age 65 had no health insurance.[14] The coverage rate that year for the self-employed was lower than that for non-elderly wage and salary workers: 74% compared to 83%. Though there are no publicly available data on the distribution of uninsured self-employed individuals by income class, a majority of the uninsured self-employed are likely to have relatively low incomes. This is because a major share of the uninsured have relatively low incomes. In 2007, for example, 63% of the uninsured population had family incomes of less than $40,000.[15] So the enactment of a measure similar to H.R. 3200—with its individual mandate, income-based subsidies for the purchase of health insurance through exchanges, and health insurance market reforms—would be likely to boost the coverage rate among the self-employed.

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 seems to contribute 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.[16] 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 employees receive from their employers.

But the deduction also has some disadvantages, some of which have implications for the debate in the current Congress over expanding access to health care through the use of tax subsidies for health insurance.

First, the deduction fosters insurance outcomes that could be regarded as unfair or unjustified. This is because its value to self-employed individuals who take it depends critically on their

[14] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey*, EBRI Issue Brief N. 321 (Washington: Employee Benefit Research Institute, Sept. 2008), p. 12.

[15] Ibid., p. 15.

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

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 adequately 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 income above the federal poverty threshold. 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. Generally, wage earners who receive health benefits from 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 typically cater to the health care needs of 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 the terms of coverage directly with insurers on behalf of the insured members. By contrast, individual health plans are tailored to the health care needs of the individuals seeking coverage on their own. 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. Many applicants are required to have a thorough medical examination to assess their risk for developing a variety of costly 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.

The differences between the two markets result in more stable pricing, greater coverage, and lower premiums in the group market than in the non-group market.[17] Premiums tend to be lower for comparable coverage in the group market for several reasons. Group insurance offers economies of scale in key 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 can obtain on their own.

There is no easy way to modify the deduction so that self-employed individuals could enjoy the advantages of employer-sponsored health plans. 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 organized through some kind of exchange.

[17] CRS Report RL32237, *Health Insurance: A Primer*, by (name redacted).

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 tied to 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 more health care than is needed because the insurance allows them to pay only a fraction of its cost through deductibles or co-payments. As a result, they are likely to use medical services until the marginal benefit of the care equals their out-of-pocket cost; 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 is likely to give rise to a significant social welfare loss.

Neither the exclusion nor the deduction are capped. As a result, 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. 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.[18] This extra coverage is more likely to summon 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.[19] Capping the deduction at an amount tied to average premiums in the non-group market for individual or family plans is sometimes proposed as a way to curtail any welfare loss arising from overly generous health insurance coverage for the self-employed.

Finally, the current deduction points to a fundamental inequity in the tax treatment of health insurance expenditures. Under current law, only the self-employed and wage earners whose employers provide health benefits receive a tax subsidy for their purchase of health insurance. No comparable subsidy is available for the unemployed and those workers whose employers provide no health benefits. Their only option for lowering the after-tax cost of health insurance is to claim the itemized deduction for medical expenses, but it is doubtful that many of them could do so. Only about one-third of individual taxpayers itemize on their tax returns rather than take the standard deduction, and someone who itemizes may deduct only qualified medical expenses that exceed 7.5% of his or her adjusted gross income. Some of the health care reform proposals being considered in the 111th Congress would address the lack of tax subsidies for the purchase of health insurance by those who are not self-employed and have no access to employer-provided health benefits.

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

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