



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

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January 10, 2012

Congressional Research Service

7-5700

www.crs.gov

RL33505

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, by their effect on the cost and allocation of health care resources, and by interest in comprehensive tax reform.

Current law contains significant tax benefits for health insurance and expenses. By far the largest is the exclusion for employer-paid coverage, which employees may omit from their individual income taxes. The exclusion also applies to employment taxes and to health benefits in cafeteria plans. (The exclusion should be distinguished from the deduction employers may take for the payments they make and other costs they incur.) Other important tax benefits include the following:

- Self-employed taxpayers may deduct 100% of their health insurance, even if they do not itemize deductions, and taxpayers who itemize may deduct insurance payments and other unreimbursed medical expenses to the extent they exceed 7.5% of adjusted gross income;
- Some workers eligible for Trade Adjustment Assistance or receiving a pension paid by the Pension Benefit Guarantee Corporation can receive the Health Coverage Tax Credit (HCTC) to purchase certain types of insurance;
- 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;
- Voluntary Employees' Beneficiary Association plans (VEBAs) are vehicles for prefunding retiree health benefits on a tax-advantaged basis for certain groups of workers, particularly unionized workers; and
- Coverage under Medicare, Medicaid, CHIP, and military and veterans health care programs is not considered taxable income.

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 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. When insurance is viewed as a form of personal consumption, most tax benefits appear to be inequitable because taxpayers' savings depend on marginal tax rates. When viewed as spreading catastrophic economic risk over multiple years, however, basing those savings on marginal rates might be justified as the proper treatment for losses under a progressive tax system.

This report details the current law for various tax benefits for health insurance coverage and identifies changes in certain provisions affected by the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) as amended.

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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 to the Internal Revenue Code (IRC) of 1986, as amended, are included.

This section also includes Joint Committee on Taxation (JCT) estimates of tax expenditures, where available.¹ 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.² Most of the tax rules discussed here have also been adopted by states that have income taxes.

Employer-Paid Insurance

Nearly 60% of the non-institutionalized population under the age of 65 is insured under an employment-based plan. In the average plan, employers pay about 83% of the cost of single coverage and 73% of the cost of family coverage, though some pay all and others pay none.³

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 employees' or the employer's share of employment taxes (i.e., Social Security, Medicare, and unemployment taxes).⁴ 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).⁵

¹ Estimates based on Joint Committee on Taxation, *Estimates of Federal Tax Expenditures For Fiscal Years 2010-2014*, JCS-3-10, December 15, 2010.

² Current estimates the JCT makes may be somewhat different. Tax expenditures should not be added together since they do not take account of interaction effects among provisions.

³ *Employer Health Benefits: 2011 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.

⁴ Internal Revenue Code (IRC) Sections 106 and 3121, respectively.

⁵ For more information about tax exclusion, see CRS Report RL34767, *The Tax Exclusion for Employer-Provided* (continued...)

The exclusion for employer-paid insurance should be distinguished from the tax deduction employers are allowed for the payments they make and other costs they incur. For income taxes, the exclusion applies to employees as individual taxpayers, while the deduction applies to employers. The employer 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.

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.⁶ 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 2009 and then received an insurance reimbursement for them in 2010). 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.⁷

The JCT estimates that the FY2011 tax expenditure attributable to the exclusion for employer payments for health insurance premiums, health care, and long-term care insurance premiums will be \$117.3 billion. The estimate does not include the effect of the exclusion on employment taxes.⁸

Starting in tax-year 2011, the ACA required employers to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2. However, to provide employers the time they need to make changes to their payroll systems or procedures, the IRS will defer the reporting requirement until January 2013 for large employers (those with more than 250 W-2 form employees), making the reporting optional in 2011 and 2012.⁹ IRS Notice 2011-28 provided further relief for smaller employers filing fewer than 250 W-2 forms by making the reporting requirement optional for them at least for 2012 and continuing this optional treatment for smaller employers until further guidance is issued. This reporting is for informational purposes only, and intended to show employees the value of their health care benefits so they can be more informed consumers. The amount reported does not affect tax liability, as the value of the employer contribution to health coverage continues to be excludible from an employee's income and it is not taxable.

COBRA Continuation Coverage

COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), which in general allows separated employees and their family members the right to continue employer-sponsored coverage for a limited time (generally 18 to 36 months, depending on the

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Health Insurance: Issues for Congress, by Janemarie Mulvey.

⁶ IRC Sections 104 and 105.

⁷ About 70% of these employers purchase stop-loss insurance to cover major liabilities.

⁸ The JCT estimate includes payments of premiums through cafeteria plans.

⁹ See IRS Notice 2012-9 and 2011-28, which includes information on how to report, what coverage to include, and how to determine the cost of the coverage.

qualifying event). Private-sector firms with 20 or more employees are subject to COBRA, as are state and local governments; the federal government must provide continuation rights under other legislation.¹⁰ However, not all individuals who lose their jobs have access to COBRA. For example, firms with fewer than 20 employees are exempt from federal COBRA, but some states do have special programs for small employers. Additionally, firms that do not provide access to health insurance to current employees (including those that previously provided access but went out of business) are not required to provide access to COBRA coverage. Among those individuals with access to COBRA, the cost of the COBRA premiums may be prohibitive. Since most employers subsidize health insurance premiums for their workers, the 102% COBRA premium may not be affordable for the unemployed, especially when compared with unemployment compensation.

Unreimbursed Medical Expenses

Taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of AGI.¹¹ Beginning in 2013, the threshold will increase to 10% of AGI for taxpayers who are under the age of 65; this effectively further limits the amount of medical expenses that can be deducted. Taxpayers over the age of 65 will be temporarily excluded from this provision and still be subject to the 7.5% limit from 2013 through 2016.¹²

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."¹³ 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. About 7% of tax returns for tax year 2008 reported a deduction for medical expenses.¹⁴ Taxpayers with AGI below \$50,000 accounted for 41% of those taking this itemized deduction for medical expenses.¹⁵

The JCT estimates that the FY2011 tax expenditure attributable to the medical expense deduction (including long-term care expenses) will be about \$13.5 billion.

¹⁰ COBRA eligibility rules are complex. For additional information about basic COBRA rules, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by Janet Kinzer.

¹¹ IRC Section 213. If the taxpayer is subject to the Alternative Minimum Tax (AMT), the deduction is limited to expenses that exceed 10% of AGI. Section 56(b)(1)(B).

¹² §9013 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) as amended.

¹³ IRC Section 213(d)(1)(A).

¹⁴ Internal Revenue Service, Statistics of Income, *Table 1.3: All Returns: Source of Income, Adjustments, Deductions, Credits and Tax Items, by Marital Status, Tax Year 2008*.

¹⁵ Joint Committee on Taxation, JCS(3)-10, December 15, 2010.

Individual Market Policies

About 6% of the noninstitutionalized population under age 65 is insured through private individual market policies.¹⁶ 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.

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.¹⁷

Self-employed taxpayers may deduct payments for health insurance in determining their AGI (i.e., as an "above-the-line" deduction).¹⁸ 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 2008, about 2.4 million tax returns (about 2% of all returns) claimed the self-employed health insurance deduction. For FY2011, the JCT estimates that the tax expenditure attributable to the

¹⁶ P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey*, Issue Brief No. 362, Employee Benefit Research Institute, September 2011.

¹⁷ 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.

¹⁸ IRC Section 162(l).

deduction (including the self-employed deduction for long-term care insurance) will be \$5.1 billion.

Cafeteria Plans

Cafeteria plans are employer-established benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain normally nontaxable benefits (such as employer-paid health insurance) without being taxed on the value of the benefits if they select the latter. A general rule of taxation is that taxpayers given these options will be taxed on whichever they choose because they are deemed to be in constructive receipt of the cash. The cafeteria plan provisions of the Code provide an express exception to this rule when the plan meets various reporting and nondiscrimination requirements.¹⁹ 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.²⁰ 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.

Certain retired public safety officers are allowed to pay up to \$3,000 of qualified health insurance premiums from their pensions on a pretax basis each year. Technically, the amount is excluded from the retirees’ gross income. 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.²¹

¹⁹ IRC Section 125. “Cash” in this context includes any taxable benefit.

²⁰ Rev. Rul. 2003-62.

²¹ Pension Protection Act of 2006 (P.L. 109-280).

For FY2011, the JCT estimates that the tax expenditure attributable to cafeteria plans will be \$29.3 billion. The estimate includes the tax expenditures attributable to dependent care flexible spending accounts, though this is a minor portion.²²

Flexible Spending Accounts

Flexible spending accounts (FSAs) are employer-established benefit plans that reimburse employees for specified expenses as they are incurred.²³ 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.²⁴

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.²⁵ 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. Employers are permitted, but not required, to allow military reservists called to active duty to receive some or all of the remaining funds in their account.²⁶

Beginning in 2011, over-the-counter medications (except those prescribed by a physician) are no longer considered a qualified medical expense and therefore FSA funds cannot be used to purchase them.²⁷

According to the Bureau of Labor Statistics National Compensation Survey, 39% of all workers in 2010 had access to a health care flexible spending account. When viewed by firm size, 56% of workers in firms with more than 100 workers had access to a health care FSA. The accounts were not as common for workers in small businesses. In establishments with fewer than 100 employees, 20% of the workers could choose to participate in an FSA.²⁸ Not all employees

²² The JCT estimate for health insurance received through cafeteria plans is also included in the exclusion for employer-paid insurance (discussed above).

²³ 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.

²⁴ For additional information, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

²⁵ 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.

²⁶ The Heroes Earnings Assistance and Tax Relief Act (P.L. 110-245).

²⁷ §9003 ACA (P.L. 111-148).

²⁸ Bureau of Labor Statistics, Table 39. Pretax benefits: Access, private industry workers, National Compensation (continued...)

offered an FSA chose to participate. According to a 2010 Mercer Survey, 37% of employees offered an FSA chose to participate and the average annual contribution was \$1,420.²⁹

Federal employees have had the opportunity to use FSAs since July 2003. In September 2008, there were 240,000 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.³⁰

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).³¹ 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 2012, the deductible for self-only coverage must be at least \$1,200 with an annual out-of-pocket limit not exceeding \$6,050; the deductible for family coverage must be at least \$2,400 with an annual out-of-pocket limit not exceeding \$12,100 for family coverage.

The annual HSA contribution limit in 2012 for individuals with self-only coverage is \$3,100; for family coverage, it is \$6,250. Individuals who are at least 55 years of age but not yet enrolled in Medicare may contribute an additional \$1,000. Contributions may be made by employers, individuals, or both.³²

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

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Survey, March 2010.

²⁹ Mercer LLC, National Survey of Employer-Sponsored Health Plans, Released July 2010.

³⁰ IRC Section 105, Rev. Rul. 2002-41, and IRS Notice 2002-45.

³¹ 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 Carol Rapaport.

³² IRC Section 223. See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2012*, by Janemarie Mulvey.

made through salary reduction agreements, in which case they are treated as if made by employers. Distributions from an HSA that are used for qualified medical expenses are not included in taxable income. However, distributions that are not used for qualified medical expenses are taxable as ordinary income and an additional 20% penalty tax is imposed for those under the age of 65.³³ In addition, beginning in 2011, the definition of qualified medical expenses is modified to exclude over-the-counter prescriptions (not prescribed by a physician).³⁴

As of January 2010, there were nearly 10 million people covered by qualifying high-deductible insurance plans; the number includes both policyholders and their family members.³⁵ The number of people covered by HSAs is smaller because it is not necessary to establish an account along with the insurance.³⁶

For FY2011, the JCT estimates that the tax expenditure attributable to HSAs will be about \$1.2 billion.

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.³⁷

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. Similar to FSAs and HSAs, beginning in 2011, the definition of qualified medical expenses excludes over-the-counter prescriptions (not prescribed by a physician).³⁸

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 (just before HSAs were authorized), the IRS estimated that there were fewer than 80,000 accounts in total. Many of these have subsequently been rolled into HSAs. The IRS estimated that 20,361 MSAs had contributions in 2005.³⁹

³³ §9004 of ACA (P.L. 111-148).

³⁴ §9003 of ACA (P.L. 111-148).

³⁵ *January 2010 Census Shows 10 Million People Covered by HSA/High Deductible Health Plans*. America's Health Insurance Plans (AHIP) Center for Policy and Research (May 2010). <http://www.ahipresearch.org/pdfs/2010hsacensus.pdf>.

³⁶ CRS Report RS22877, *Health Savings Accounts and High-Deductible Health Plans: A Data Primer*, by Carol Rapaport.

³⁷ IRC Section 220.

³⁸ §9003 of ACA (P.L. 111-148).

³⁹ IRS Announcement 2007-44.

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

Health Coverage Tax Credit

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

- individuals receiving a Trade Readjustment Allowance under the Trade Adjustment Assistance (TAA) program, including those eligible for but not yet receiving the allowance because they have not yet exhausted their state unemployment benefits;
- individuals receiving wage subsidies in the form of Re-employment Trade Adjustment Assistance (RTAA) benefits; and
- individuals aged 55 and older receiving a Pension Benefit Guaranty Corporation (PBGC) pension payment.

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.⁴⁰

The HCTC equals 72.5% of the premiums the taxpayer pays for qualifying insurance for themselves and for their family. Up to 11 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. Under current law, the HCTC will terminate on January 1, 2014, at which time the premium credits under ACA for enrollment in the health care exchanges will be available.

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. About 9 million people are eligible for services and coverage by these arrangements.⁴¹

Coverage under military health care programs and the benefits they provide are not considered taxable.⁴²

⁴⁰ For additional information of the eligibility rules, see CRS Report RL32620, *Health Coverage Tax Credit*, by Bernadette Fernandez.

⁴¹ For more information, see CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Don J. Jansen.

⁴² IRC 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.

For FY2011, the JCT estimates that the tax expenditure attributable to medical care and TRICARE insurance for military dependents, retirees, and dependents of retirees will be approximately \$4.2 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 5.5 million veterans receive services.⁴³

Coverage under veterans health care programs and the benefits they provide are not considered taxable.⁴⁴

Medicare

Medicare is a national health insurance program for people aged 65 and older or who meet certain disability tests. Nearly 48 million people are covered by one or more of its parts.⁴⁵ Coverage under Medicare and the benefits it pays for qualifying expenses are not considered taxable.⁴⁶

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.⁴⁷ Individuals cannot take these tax payments into account for the itemized deduction for medical expenses.⁴⁸ 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.

⁴³ For additional information, CRS Report R41944, *Veterans' Medical Care: FY2012 Appropriations*, by Sidath Viranga Panangala.

⁴⁴ Section 134 of the Internal Revenue Code and 38 USC § 5301.

⁴⁵ CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Paulette C. Morgan.

⁴⁶ 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.

⁴⁷ Beginning in 2013, there will be an additional payroll tax of 0.9% on high-income workers with wages over \$200,000 for single filers and \$250,000 for joint filers. The additional payroll tax applies only to wages above these thresholds. Thus, the hospital insurance portion of the payroll tax will increase from 1.45% to 2.35% for wage income over the threshold amounts.

⁴⁸ Rev. Rul. 66-216.

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.⁴⁹

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.⁵⁰

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.⁵¹ However, other specifications differ depending on the plan. Contributions to Medicare MSA plans are made by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services.

For FY2011, the JCT estimates that the tax expenditure attributable to the exclusion of Medicare Part A benefits will be \$33.6 billion. The tax expenditures attributable to Part B and Part D are estimated to be \$23.4 billion and \$6.6 billion, respectively.

Medicaid

Medicaid provides health care services 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 70 million people were covered by Medicaid in 2011.⁵²

Coverage under Medicaid and the benefits it pays for qualifying expenses are not considered taxable.⁵³

Beginning in 2014, Medicaid eligibility will be expanded to non-traditional groups⁵⁴ and will cover households with modified adjusted gross income less than 133% of the federal poverty level, or \$29,327 (in 2010 dollars) for a family of four.⁵⁵

⁴⁹ Rev. Rul 66-216.

⁵⁰ IRS Publication 502, *Medical and Dental Expenses*, p. 9.

⁵¹ IRC Section 138.

⁵² For an overview, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

⁵³ 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.

Children's Health Insurance Program

The State Children's Health Insurance Program (CHIP) 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. CHIP waivers allow states to cover adults as well. More than 7.4 million children were covered by CHIP in FY2008, as were about 335,000 adults.⁵⁶

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

Voluntary Employees' Beneficiary Associations

Voluntary Employees' Beneficiary Association (VEBA) plans provide life insurance, medical, disability, accident, and other welfare benefits to employee members and their dependents.⁵⁷ Most are organized as trusts to be legally separate 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 accounts* (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 10 or more employers.⁵⁸ VEBAs are considered qualified insurance for purposes of the Health Coverage Tax Credit.⁵⁹

According to the 2009 Mercer National Survey of Employer-Sponsored Plans, 8% 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.

(...continued)

⁵⁴ Prior to ACA there were categorical restrictions for Medicaid eligibility. These include the elderly, people with disabilities, members of families with dependent children, and certain other pregnant women and children.

⁵⁵ CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

⁵⁶ CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz and Evelyne P. Baumrucker.

⁵⁷ IRC 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 Provisions*, U.S. Senate Committee on the Budget, December 2008 (S. Prt. 110-667, p. 663-671).

⁵⁸ IRC Sections 419 and 419A.

⁵⁹ CRS Report RL32620, *Health Coverage Tax Credit*, by Bernadette Fernandez.

Some Consequences of the Tax Benefits⁶⁰

Increases in Coverage

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

Tax benefits also lead some people to obtain more coverage than they might otherwise choose. They purchase insurance that covers more than hospitalization and other catastrophic expenses, such as routine doctor visits, prescription drugs, and dental care. They obtain coverage with smaller deductibles and copayments than are necessary. However, many people are risk-averse with respect to health care, so the tax benefits are only one factor influencing the amount of insurance purchased. 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 Health 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.

Sources 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 the age of 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'

⁶⁰ The issues in this section are discussed in more detail in CRS Report RL34767, *The Tax Exclusion for Employer-Provided Health Insurance: Issues for Congress*, by Janemarie Mulvey.

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.⁶¹ Workers without employment-based insurance generally cannot benefit from them, nor can many early retirees (people under 65 years old, 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.⁶² 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

⁶¹ 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.

⁶² 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.

premium, whereas taxpayers in the 35% bracket would save \$1,400 (i.e., \$4,000 x 0.35). If health insurance were 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.

For Additional Reading

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Appendix. General Formula For Calculating Federal Income Taxes

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.

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