PRESENT LAW AND ANALYSIS RELATING TO THE TAX TREATMENT OF HEALTH CARE EXPENSES

Scheduled for a Public Hearing
Before the
SENATE COMMITTEE ON FINANCE
on March 8, 2006

Prepared by the Staff
of the
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INTRODUCTION

The Senate Committee on Finance has scheduled a public hearing on March 8, 2006, on the taxation of health care coverage and related issues. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the individual income tax provisions relating to the taxation of health care expenses, discusses issues raised under present law, and provides a general analysis of possible proposals to modify present law.

[1] This document may be cited as follows: Joint Committee on Taxation, *Present Law and Analysis Relating to the Tax Treatment of Health Care Expenses*, (JCX-12-06), March 6, 2006.

I. PRESENT LAW

In general

Present law includes a variety of provisions that provide tax benefits for health expenses. The specific tax treatment of such expenses depends in part on whether the taxpayer is covered under a health plan paid for by an employer, whether the taxpayer has self-employment income, or whether an individual itemizes deductions and has medical expenses that exceed a certain threshold. Individuals who are covered by a high deductible health plan are able to contribute to a health savings account ("HSA"). Certain limited classes of individuals are eligible to receive a refundable tax credit of 65 percent of the cost of health insurance coverage. Table 1, below, provides a comparison of the various tax provisions of present law. Each provision is discussed in more detail, below.[2]

Exclusion for employer-provided accident and health coverage[3]

An employer's contribution to a plan providing health coverage for an employee, and his or her spouse and dependents, is excludable from the employee's income for both income and payroll tax purposes. In addition, active employees participating in a cafeteria plan may pay their share of premiums on a pre-tax basis through salary reduction. Such salary reduction contributions are treated as employer contributions and thus are also excluded from gross income and payroll taxes. Reimbursements under an employer plan for medical expenses are also excludable from gross income and wages. There is no limit on the amount of employer-provided health coverage that is excludable.

The exclusion for employer-provided health coverage applies to medical expenses not covered by insurance as well as health insurance expenses. Arrangements commonly used by employers to reimburse medical expenses of their employees (and their spouses and dependents) include health flexible spending arrangements ("FSAs") and health reimbursement accounts ("HRAs").

[2] Some of the tax provisions described below apply to long-term care as well as health care. For example, the deduction for health insurance expenses of self-employed individuals applies to qualified long-term care insurance. The tax treatment of long-term care is not addressed in this pamphlet.

[3] Secs. 104, 105, 106, 125, and 3121(a)(4). All section references are to the Internal Revenue Code of 1986 ("the Code") unless otherwise indicated.

Table 1.–Comparison of Present-Law Tax Benefits for Health Expenses

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
1. Employer contributions to an accident or health plan (sec. 106)	Exclusion from gross income and wages.	Employees (including former employees).	No limit on amount excludable.	Contributions to health plan for the taxpayer, spouse and dependents.
2. Employer reimbursement of medical expenses (sec. 105)	Exclusion from gross income and wages.	Employees (including former employees).	No limit on amount excludable.	Medical care expenses (as defined under section 213(d)) of the taxpayer, spouse and dependents.
3. Employer-provided health benefits offered under a cafeteria plan (sec. 125)	Exclusion from gross income and wages (for salary reduction contributions).	Employees.	No limit on amount excludable.	Coverage under an accident or health plan (secs. 105 and 106).
4. Health reimbursement arrangement (secs. 105 and 106)	Employer-maintained arrangement providing exclusion from gross income and wages for amounts used to reimburse employees for medical expenses. Amounts remaining at the end of the year can be carried forward to reimburse medical expenses in later years. There is no tax-free accumulation of earnings.	Employees (including former employees).	No limit on amount excludable.	Medical care expenses (as defined under section 213(d)) of the taxpayer, spouse and dependents.
5. Health flexible spending arrangements (secs. 105, 106, and 125)	Employee salary-reduction arrangement providing exclusion from gross income and wages for amounts used to reimburse employees for medical expenses.	Employees.	No limit on amount excludable.	Medical care expenses (as defined under section 213(d)) of the taxpayer, spouse and dependents (but not premium payments for other health coverage).
6. Deduction for health insurance expenses of self-employed individuals (sec. 162(l))	Income tax deduction for cost of health insurance expenses of self-employed individuals. Deduction does not apply for self-employment tax purposes.	Self-employed individuals.	No specific dollar limit; deduction limited by amount of taxpayer's earned income from the trade or business.	Insurance which constitutes medical care for the taxpayer, spouse and dependents.

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
7. Itemized deduction for medical expenses (sec. 213)	Itemized deduction for unreimbursed medical expenses to extent expenses exceed 7.5 percent of adjusted gross income (10 percent for alternative minimum tax purposes).	Any individual who itemizes deductions and had unreimbursed medical expenses in excess of 7.5 percent of adjusted gross income.	No maximum limit.	Expenses for medical care (as defined under section 213(d)) of the taxpayer, spouse and dependents. Medicine or drugs must be prescribed or insulin.
8. Health Savings Accounts ("HSAs") (sec. 223)	Contributions are deductible if made by an eligible individual and excluded from gross income and wages if made by an employer (including contributions made through a cafeteria plan through salary reduction). Distributions used for qualified medical expenses excludable from gross income. Earnings on amounts in the HSA accumulate on a tax-free basis.	Individuals with a high deductible health plan and no other health plan other than a plan that provides certain permitted coverage. High deductible health plan is a plan with a deductible of at least $1,050 for self-only coverage and $2,100 for family coverage (for 2006). Out-of-pocket expense limit must be no more than $5,250 for self-only coverage and $10,500 for family coverage (for 2006).	Maximum annual contribution is the lesser of (1) 100 percent of the annual deductible, or (2) $2,700 for self-only coverage or $5,450 for family coverage (for 2006). Additional contributions permitted for individuals age 55 or older. No limit on the amount that can be accumulated in the HSA.	Qualified medical expenses include those for medical care (as defined under section 213(d)), but do not include expenses for insurance other than certain limited exceptions.
9. Archer Medical Savings Accounts ("Archer MSAs") (sec. 220)	Contributions are deductible if made by an eligible individual and excluded from gross income and wages if made by an employer. Distributions used for qualified medical expenses are excludable from gross income. Earnings on amounts in the Archer MSA accumulate on a tax-free basis.	Employees of small employers who are covered under an employer-sponsored high-deductible health plan (and no other health plan other than a plan that provides certain permitted coverage) and self-employed individuals covered under a high-deductible health plan. Definition of high-deductible health plan differs from that for HSAs. No new contributions may be made	Maximum annual contribution is 65 percent of the annual deductible under the high-deductible health plan in the case of self-only coverage, and 75 percent of the annual deductible in the case of family coverage. No limit on the amount that can be accumulated in the MSA.	Qualified medical expenses include those for medical care as defined under section 213(d), but do not include expenses for insurance other than certain limited exceptions.

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
		after 2005 except for individuals who previously had an MSA or work for an employer that made MSA contributions.		
10. Health Coverage Tax Credit (sec. 35)	Refundable tax credit of 65 percent of the cost of qualified health insurance coverage.	Individuals receiving trade adjustment assistance and certain individuals receiving benefits from the PBGC.	Limited to 65 percent of the cost of qualified health insurance. No specific dollar limit.	Qualified health insurance as defined in section 35(e).

Health FSAs are typically funded on a salary reduction basis, meaning that employees are given the option to reduce current compensation and instead have the compensation used to reimburse the employee for medical expenses. If the health FSA meets certain requirements, then the compensation that is forgone is not includible in gross income or wages and reimbursements for medical care from the health FSA are excludable from gross income and wages. Health FSAs are subject to the requirements relating to cafeteria plans generally, including a requirement that a cafeteria plan generally may not provide deferred compensation.[4] This requirement is often referred to as the "use-it-or-lose-it-rule." Until May of 2005, this requirement was interpreted to mean that amounts remaining in a health FSA as of the end of a plan year must be forfeited by the employee. In May 2005, the Treasury Department issued a notice that allows a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used.[5] Health FSAs are subject to certain other requirements, including rules that require that the FSA have certain characteristics similar to insurance.

HRAs operate in a manner similar to health FSAs, in that they are an employer-maintained arrangement that reimburses employees for medical expenses. Some of the rules applicable to HRAs and health FSAs are similar, e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes. Some of the rules are different. For example, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in the next year.[6]

Deduction for health insurance expenses of self-employed individuals[7]

Self-employed individuals may deduct the cost of health insurance for themselves and their spouse and dependents. The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. The deduction may not exceed the individual's self-employment income. The deduction applies to the cost of insurance, i.e., it does not apply to out-of-pocket expenses. The deduction does not apply for self-employment tax purposes. For purposes of the deduction, more than two-percent shareholder-employees of an S corporation are treated the same as self-employed individuals.[8] Thus, the exclusion for employer-provided health coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self employed.

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[4] Sec. 125(d)(2).

[5] Notice 2005-42, 2005-23 IRB 1204.

[6] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case an individual is covered under both, is provided in Notice 2002-45, 2002-2 CB 93.

[7] Sec. 162(l).

[8] Sec. 1372.

Itemized deduction for medical expenses[9]

Individuals may claim an itemized deduction for unreimbursed medical expenses, only to the extent that such expenses exceed 7.5 percent of adjusted gross income.[10] Thus, an individual (other than a self-employed individual) may deduct health insurance premiums only to the extent that aggregate unreimbursed medical expenses exceed 7.5 of adjusted gross income.

Refundable credit for health insurance expenses of certain classes of individuals[11]

Under the Trade Adjustment Assistance Reform Act of 2002,[12] certain individuals are eligible for the health coverage tax credit ("HCTC"). The HCTC is a refundable tax credit for 65 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals receiving a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they had not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 and receiving pension benefits from the Pension Benefit Guaranty Corporation. The credit is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market. The credit is available on an advance basis through a program established by the Secretary of the Treasury. Persons entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized plans, or with certain other specified coverage are not eligible for the credit.[13]

Health savings accounts[14]

Present law provides that individuals with a high deductible health plan (and no other health plan other than a plan that provides certain permitted coverage) may establish a health savings account ("HSA"). An HSA is a tax-exempt trust or custodial account. Subject to certain limitations, contributions to an HSA are deductible above-the-line if made by the individual and are excludable from income and wages if made by the employer (including contributions made through a cafeteria plan through salary reduction). Earnings on amounts in an HSA accumulate on a tax-free basis. Distributions from an HSA that are for qualified medical expenses are excludable from gross income. Distributions from an HSA that are not used for qualified

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[9] Sec. 213.

[10] For alternative minimum tax purposes, the itemized deduction is calculated using a floor of 10 percent of adjusted gross income. Sec. 56(b)(1)(B).

[11] Sec. 35.

[12] Pub. L. No. 107-210, sec. 201(a), 202 and 203 (2002).

[13] Sec. 35(f).

[14] Sec. 223.

medical expenses are includible in gross income and are subject to an additional tax of 10 percent, unless the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65). HSAs provide the opportunity to pay for current out-of-pocket medical expenses on a tax-favored basis, as well as the ability to save for future medical and nonmedical expenses.

A high deductible health plan is a health plan that has a deductible that is at least $1,050 for self-only coverage or $2,100 for family coverage (for 2006) and that has an out-of-pocket expense limit that is no more than $5,250 in the case of self-only coverage and $10,500 in the case of family coverage (for 2006).

The maximum aggregate annual contribution that can be made to an HSA is the lesser of (1) 100 percent of the annual deductible under the high deductible health plan, or (2) for 2006, $2,700 in the case of self-only coverage and $5,450 in the case of family coverage.[15] The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year. In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and thereafter.

Archer medical savings accounts ("MSAs")[16]

Like HSAs, an Archer MSA is a tax-exempt trust or custodial account to which tax-deductible contributions may be made by individuals with a high deductible health plan. Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for certain individuals covered by high deductible health plans.

The rules relating to Archer MSAs and HSAs are similar. The main differences include: (1) only self-employed individuals and employees of small employers are eligible to have an Archer MSA; (2) for MSA purposes, a high deductible health plan is a health plan with (a) an annual deductible of at least $1,800 and no more than $2,700 in the case of self-only coverage and at least $3,650 and no more than $5,450 in the case of family coverage and (b) maximum out-of pocket expenses of no more than $3,650 in the case of self-only coverage and no more than $6,650 in the case of family coverage;[17] and (3) the additional tax on distributions not used for medical expenses is 15 percent rather than 10 percent.

After 2005, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had Archer MSA contributions and employees who are employed by a participating employer.

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[15] These amounts are the same as the maximum deductible amounts permitted under a high deductible plan for purposes of Archer medical savings accounts ("MSAs").

[16] Sec. 220.

[17] The deductible and out-of-pocket expenses dollar amounts are for 2006. These amounts are indexed for inflation in $50 increments.

Definition of medical care

For purposes of the itemized deduction for medical expenses, section 213(d) defines "medical care" to mean amounts paid for: (1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (2) transportation primarily for and essential to medical care referred to in (1); (3) qualified long-term care services; and (4) insurance covering medical care referred to in (1) or (2), or for eligible long-term care premiums for a qualified long-term care insurance contract.[18] Expenditures for items that are merely beneficial to the general health of an individual, such as expenditures for vacation or vitamins, are not medical care. Expenditures for "medicines and drugs" are medical care. Toiletries (e.g., toothpaste), cosmetics (e.g., face creams), and sundry items are not "medicines and drugs" and amounts expended for such items are not expenditures for "medical care." In general, cosmetic surgery and similar procedures do not constitute medical care.

For purposes of the exclusions for reimbursements under employer accident and health plans and distributions from HSAs, the limitation (applicable to the itemized deduction) that only prescription medicines or drugs and insulin are taken into account does not apply. Thus, for example, amounts paid from an FSA, HRA, or HSA to reimburse the employee for nonprescription medicines, such as sunscreen, nonprescription aspirin, allergy medicine, antacids, or pain relievers, are excludable from income; however, if the employee paid for such amounts directly (without such reimbursement), the expenses could not be taken into account in determining the itemized deduction for medical expenses.

[18] Sec. 213(d). The amount of long-term care premiums that may be taken into account for purposes of the itemized deduction is subject to a dollar limit based on the age of the covered individual.

II. ISSUES RAISED UNDER PRESENT LAW

The appropriateness of the present-law Federal tax treatment of health expenses has been the subject of discussion over time from a variety of perspectives, including as part of debates relating to health care reform and tax reform. The exclusion for employer-provided health care is typically a focal point of such discussions. The exclusion represents a departure from the normal income tax principle that compensation should be included in income, and has consistently been one of the three largest tax expenditure items.[19]

The present-law favorable tax treatment of employer-provided health coverage has generally been justified on the grounds that it encourages employees to prefer health coverage over taxable compensation, thereby increasing health insurance coverage and reducing the number of uninsured. Employees in employer-provided health plans not only receive a tax subsidy, but may also benefit from group rates which may make coverage more affordable. From this perspective, the exclusion may be said to be effective. For 2005, approximately 90 million policyholders are estimated to have employer-provided health coverage.[20]

Nevertheless, the present-law rules have been the subject of a number of criticisms. One criticism is that the present-law rules are inequitable because they do not provide a consistent tax benefit for health coverage. Some argue that this inequity provides the worst treatment in some cases for those who need the tax benefit the most, because many individuals who face the highest insurance rates also receive no tax subsidy for the purchase of such insurance (e.g., individuals who are not self employed and who purchase insurance in the individual market). Some argue that this may lead to some persons remaining uninsured.

The most favorable tax treatment under present law generally is provided to individuals who are in an employer plan.[21] Such individuals may exclude from income and wages employer-provided health insurance and, depending on the employer's plan, may also exclude from income amounts expended for medical care not covered by insurance. Self-employed individuals receive the next most favorable treatment, and may deduct 100 percent of the cost of their health insurance. Individuals who are not self employed and pay for their own health insurance receive the least favorable tax treatment; such individuals may deduct the cost of health insurance only to the extent that aggregate medical expenses exceed 7.5 percent of adjusted gross income and only if they itemize deductions. In the case of individuals covered by a high deductible health plan, the recently-enacted provisions relating to HSAs alter this

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[19] For Federal fiscal years 2005-2009, the tax expenditure for the exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums is estimated to be $493.7 billion. Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2005-2009* (JCS-1-05), January 12, 2005.

[20] The policy may cover more than one individual, e.g., the policyholder and his or her family.

[21] The refundable HCTC provides a greater tax benefit than the exclusion. However, the credit is available to only limited classes of taxpayers. Less than one-half million taxpayers per year are estimated to be eligible for the credit.

comparison to some extent; however, those with employer coverage still have the highest potential tax benefit.[22] Table 2, below, shows an example of the various tax treatments of medical expenses for an individual depending on the individual's circumstances. Table 3, below, shows an example of the various tax treatments of medical expenses for an individual with an HSA.

The present-law tax benefits for health coverage, particularly the exclusion for employer-provided health care, have been criticized as contributing to higher health care costs because individuals are not faced with the full cost of health care. That is, the cost of insurance or out-of-pocket expenses paid by the individual is reduced by the tax benefit received, effectively reducing the price of health care relative to other goods.[23] In addition, some argue that the unlimited exclusion for employer-provided coverage leads to very generous insurance coverage, which further contributes to increases in health costs because individuals are not as likely to question medical treatments to the extent the cost is paid by a third party through insurance. While some proponents of HSAs had a goal of reducing the tax benefit for health care and causing individuals to face more of their own expenses, HSAs allow individuals with a high deductible plan to receive tax-favored treatment for the first dollar of health care expenses. Thus, for example, expenses under the deductible amount are not reimbursed by an insurer, but do receive a tax subsidy.

Some argue that the present-law tax treatment of health coverage is inappropriate because it is not neutral. That is, the present-law rules create distinctions in both the way the coverage is purchased (e.g., through an employer or the individual market) and the type of insurance (e.g., high deductible policies or another type of policy).

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[22] With an HSA, both self-employed individuals and those with employer-provided coverage receive a tax benefit for the purchase of the health insurance as well as a tax benefit for out-of-pocket expenses (through the HSA). However, in some circumstances, an employee could, in addition, have an FSA or HRA that provides coverage for additional expenses on a tax-free basis. Thus, for example, an employer plan could provide that the cost of a high deductible plan is paid by the employer and could also allow an FSA that provides certain limited coverage, e.g., for dental or vision benefits. In addition, under Treasury guidance, the individual could also have an FSA or HRA in certain other situations, such as an FSA or HRA that pays expenses in excess of the deductible under the high deductible plan. In such cases, the individual could also have an HSA to which deductible contributions could be made. A self-employed individual, in contrast, would not have the opportunity to have an FSA or HRA. Individuals (other than self-employed individuals) who purchase a high deductible plan may make deductible contributions to an HSA, but would not receive a subsidy for the purchase of the insurance unless aggregate medical expenses exceed the adjusted gross income threshold. There is not always a clear distinction between out-of-pocket expenses and expenses covered by insurance, because insurance policies differ. That is, some insurance policies will cover expenses that are out-of-pocket expenses other policies.

[23] Specifically, because of the income tax exclusion, a dollar of consumption of tax favored health care actually costs the taxpayer only $(1-t), where t is the tax rate of the individual. In other words, the taxpayer is able to convert $(1-t) dollars of after-tax income into $1 of health consumption. The last column of Tables 2 and 3 reports the value of the tax subsidy as a percentage of the total health costs.

Discussions regarding inequities of the present-law rules typically do not include the itemized deduction for medical expenses that exceed 7.5 percent of adjusted gross income. This is because that deduction is generally viewed as having a different policy rationale than the other provisions relating to health care. While the other provisions are generally intended to provide subsidies in various ways for the purchase of health care, the policy behind the itemized deduction for medical expenses is that such expenses generally are not discretionary and that high levels of such expenses adversely impact the individual's ability to pay taxes.

Table 2.–Comparison of Value of Health Tax Benefits: Non-High-Deductible Health Plan

Assume that husband (H) has a health insurance plan that provides coverage for his wife (W) and dependents. The policy's premium is $850 per month ($10,200 annually) and has a $700 deductible. The family's out-of-pocket expenses are approximately $1,400 for the year. Thus, H's annual medical costs are $11,600. H and W file a joint income tax return and their annual adjusted gross income is $70,000.

Situation	Tax-Subsidized Employer Premiums	Tax-Subsidized Employee Premiums	Tax-Subsidized Out-of-Pocket Expenses	Value of Employment Tax[1] (E) and Income Tax[2] (I) Subsidy	Value of Total Tax Subsidy as a Percentage of Total Health Costs
(a) H's health insurance is provided through his employer. The employer pays 75 percent of the premium for such coverage.	$7,650	$0	$0	$1,086 (E) $1,760 (I) $2,846 total	25%
(b) The employer also allows the employee's share of the annual premium to be paid on a tax-free basis (i.e., through a cafeteria plan).	$7,650	$2,550	$0	$1,448 (E) $2,346 (I) $3,794 total	33%
(c) The employer also offers a reimbursement account (i.e., either a health flexible spending arrangement or a health reimbursement arrangement).	$7,650	$2,550	$1,400	$1,647 (E) $2,668 (I) $4,315 total	37%
(d) H is self-employed.[3]	NA	$10,200	$0	$0 (E) $2,346 (I)	20%
(e) H does not have employer-provided coverage and is not self-employed.[3]	NA	Taken into account in determining itemized deduction of $6,350[4]	Taken into account in determining itemized deduction of $6,350[4]	$0 (E) $1,461 (I)	13%

[1] The employment tax subsidy includes both the employer and employee portions of old-age, survivors, and disability insurance ("OASDI") and hospital insurance ("HI"). The effective employment tax subsidy rate is the combined employer and employee tax rate divided by gross-of-tax compensation. The effective subsidy is thus 0.153 *(1 + .0765) = 14.2%

[2] This example assumes an effective income tax rate of 23 percent.

[3] This example ignores the fact that this policy in an individual market would either be more expensive or provide less comprehensive coverage.

[4] Medical expenses are deductible to the extent they exceed 7.5 percent of adjusted gross income ($70,000 X 7.5% = $5,250. $11,600 - $5,250 = $6,350). For alternative minimum tax purposes, medical expenses are deductible to the extent they exceed 10 percent of adjusted gross income.

Table 3.–Comparison of Value of Health Tax Benefits: High-Deductible Health Plan

Assume that H has a high-deductible health insurance plan that provides coverage for his wife (W) and dependents. The policy's premium is $765 per month ($9,180 annually) and has a $2,000 deductible. H is eligible to make contributions to a health savings account ("HSA"). The family's out-of-pocket expenses are approximately $2,420 for the year. Thus, H's annual medical costs are $11,600. H and W file a joint income tax return and their annual adjusted gross income is $70,000.

Situation	Tax-Subsidized Employer Premiums	Tax-Subsidized Employee Premiums	Tax-Subsidized Out-of-Pocket Expenses	Tax-Deductible HSA Contribution[1]	Value of Employment Tax[2] (E) and Income Tax[3] (I) Subsidy	Value of Total Tax Subsidy as a Percentage of Total Health Costs
(a) H's health insurance is provided through his employer. The employer pays 75 percent of the premium for such coverage.	$6,885	$0	$0	$2,000	$ 978 (E) $2,044 (I) $3,022 total	26%
(b) The employer also allows the employee's share of the annual premium to be paid on a tax-free basis (i.e., through a cafeteria plan).	$6,885	$2,295	$0	$2,000	$1,304 (E) $2,571 (I) $3,875 total	33%
(c) The employer also offers a reimbursement account (i.e., either a health flexible spending arrangement or a health reimbursement arrangement).	$6,885	$2,295	$2,420[4]	$2,000	$1,647 (E) $3,128 (I) $4,775 total	41%
(d) H is self-employed.[5]	NA	$9,180	$0	$2,000	$0 (E) $2,571 (I)	22%
(e) H does not have employer-provided coverage and is not self-employed.[5]	NA	Taken into account in determining itemized deduction of $6,350[6]	Taken into account in determining itemized deduction of $6,350[6]	$2,000	$0 (E) $1,921 (I)	17%

[1] Amounts contributed to a HSA can be used to pay qualified out-of-pocket expenses on a tax-free basis.

[2] The employment tax subsidy includes both the employer and employee portions of old-age, survivors, and disability insurance ("OASDI") and hospital insurance ("HI"). This example assumes that HSA contributions are made by the taxpayer. HSA contributions made by the employer would also be excluded from wages for employment tax purposes. See footnote 1 to table Table 2 for calculation of employment tax subsidy.

[3] This example assumes an effective income tax rate of 23 percent.

[4] Individuals eligible to make contributions to an HSA must have a high deductible health plan and no other health plan, other than certain permitted coverage. The reimbursement account is permitted if it allows reimbursements only for certain limited purposes (e.g., vision or dental) or in certain other limited situations.

[5] This example ignores the fact that this policy in an individual market would either be more expensive or provide less comprehensive coverage.

[6] Medical expenses are deductible to the extent they exceed 7.5 percent of adjusted gross income ($70,000 X 7.5% = $5,250. $11,600 - $5,250 = $6,350). For alternative minimum tax purposes, medical expenses are deductible to the extent they exceed 10 percent of adjusted gross income. Distributions from an HSA are not taken into account in determining the itemized deduction. If H used distributions of $2,000 from his HSA to pay qualified medical expenses, the itemized deduction would be limited to $4,350.

III. DISCUSSION OF POSSIBLE OPTIONS

A. General Description of Possible Options

A variety of proposals have been suggested that would modify the present-law tax treatment of health care expenses. Many such proposals have the common goals of providing more equitable tax treatment for the purchase of health care and reducing the number of uninsured individuals. Some proposals have other goals as well, such as reducing the tax expenditure associated with health care expenses or encouraging a particular type of health coverage delivery system or product. The details of such proposals, even those with the same objective, may differ substantially.

Sample proposals include the following very broad outlines of proposals. This is not intended as an exhaustive list of possible proposals.

(1) Impose a cap on the exclusion for employer-provided health care;

(2) Provide a tax credit (refundable or nonrefundable) or an above-the-line deduction for the purchase of health coverage;

(3) Provide a tax subsidy only for high deductible health insurance; and

(4) Impose a mandate on individuals to purchase (or employers to provide) health insurance.

These proposals are not necessarily mutually exclusive. For example, a cap on the exclusion for employer-provided health care could be combined with a credit for the purchase of health insurance.

B. Discussion of Issues

In general

Any proposal to substantially modify the present-law treatment of health coverage, while perhaps resolving some concerns under the present-law rules, will raise new (and sometimes conflicting) issues of health and Federal tax policy. The specific issues will, of course, depend on the details of any particular proposal. However, even with very broadly defined proposals, it is possible to identify a number of issues that would need to be addressed. The following discussion provides an overview of such issues.

Issues relating to limiting the exclusion for employer-provided health care

Potential effects on the group health market

Any proposal that seeks to cap or eliminate the exclusion for employer-provided health benefits must include a method of valuing such benefits. Under present law, the premium faced by individuals with employer-provided health coverage may vary based on the health plan and the type of coverage (e.g., self-only or family coverage) but may not vary based on age or health status. Thus, for example, if an employer pays for 80 percent of the cost of coverage under a health plan, a single employee age 25 with no adverse health history will pay the same amount for the coverage as an employee age 55 with high blood pressure and diabetes. By comparison, in the individual health market, these individuals would likely face very different premiums.

Proposals that seek to limit or repeal the exclusion for employer-provided health care typically value such coverage consistent with present law; that is, the cost of any particular health care plan generally is determined by dividing the total cost equally among all employees covered, with variations based on type of coverage (e.g., self-only vs. family coverage). Most employers are already familiar with this type of approach, as it is essentially that used for purposes of determining permissible premiums under the health care continuation rules.[24]

While this approach may appear to avoid issues of discrimination based on age or health status, it may have the potential to erode the group market through adverse selection with the result that individuals with higher expected health costs (e.g. the 55-year old with diabetes) pay more for health insurance. If the cost of health insurance were imputed uniformly without regard to health risk, higher risk individuals in the pool would benefit, because their premium would be less than their expected costs (which are higher than average).[25] Lower-risk individuals would

[24] Employers with 20 or more employees are subject to the COBRA health care continuation rules. While the statute provides the basic rule for determining premiums, many issues are left up to yet-to-be issued regulations. In the absence of regulations, a good faith interpretation of the statutory rules may result in inconsistent methods among employers. If such a result is not considered desirable under proposals to limit the exclusion for employer-provided health care, then additional statutory specification may be needed.

[25] A main argument against pricing goods without regard to risk is that individuals with expensive tastes would receive subsidies from those with more modest needs or tastes. In the context of

be disadvantaged because their premiums would be higher than their expected costs (which are lower than average). In effect, the lower risk individuals would be subsidizing the higher risk individuals. If individuals were allowed to choose whether or not to purchase the insurance, lower risk individuals might decide that it is better to forgo insurance at such a high price (relative to the value they place on it). When lower risk individuals leave the pool, however, the average cost of insurance increases for those remaining. As prices increase, more lower risk individuals will have an incentive to leave the pool. This process of attrition, known as adverse selection, could continue until only the very high risk individuals are left in the insurance pool. Of course, not all low risk individuals will necessarily leave the pool. Those with high incomes or less willingness to bear risk may be willing to pay a higher price for greater coverage. In addition, the extent of adverse selection may vary depending on any particular proposal. For example, a relatively high cap on the exclusion for employer-provided health care would likely produce less of an adverse selection effect than a lower cap. Some argue that any proposal that has the effect of shifting the purchase of insurance more toward the individual market should include market reforms that would help to counter balance effects of adverse selection and incorporate some of the consumer protections currently provided in the group market.

Those who support reducing reliance on the current employer-based system argue that such a reduction could have some positive effects. For example, the current reliance on employer-based coverage is sometimes cited as contributing to a "job lock" effect in that employees may stay at their current place of employment because of fear of an undesirable change in health care coverage. It is also argued that, even if employer groups are eroded, other group markets may arise, such as risk pools and purchasing cooperatives. The extent to which such cooperatives would result in true risk sharing and group rating that does not reflect health status would depend on a number of factors, including the regulatory environment in which they are established. It is also argued that, even if the tax subsidy for employer-provided health care were no longer available, employers could give employees the opportunity to purchase group coverage, thereby making group rates available.

Design of a cap on the exclusion for employer-provided health care

A variety of design issues would need to be addressed in developing a cap on the exclusion for employer-provided health coverage. Most proposals impose a dollar limit on such coverage, with different amounts based on whether the coverage is self-only coverage or family coverage. There are a number of different ways that a dollar cap could be set, all of which may have different policy implications. For example, a cap could be based on the average cost of health insurance. Some have suggested that a dollar cap should vary based on geographic locale because health care costs differ throughout the county. A cap could be indexed for medical cost inflation, so that the excludable share of the health insurance premium is not eroded over time.

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health services, this argument would take the form that individuals with low health needs should not be required to subsidize those with greater health needs. This argument is most frequently made with respect to health risks that are viewed as life-style choices, such as smoking, drinking, or eating habits. When health risks are looked at over an individual's lifetime, there is less of a difference between individuals with respect to health risk status.

Alternatively, a cap could be indexed based on the overall rate of inflation, in which case the excludable share would most likely fall over time.

Other limitations could be applied in addition to or in lieu of a dollar limit. For example, the exclusion could be limited to policies that provide a minimum package of specified benefits in order to ensure that some standard of comprehensive medical coverage is met. The exclusion could be made inapplicable to certain types of policies that provide only limited types of coverage, such as vision or dental care or coverage only for a specified disease. The exclusion could be made inapplicable to policies that fail to satisfy certain minimum standards with respect to copayments and deductibles, under the theory that policies that do not meet such requirements would provide excessively generous first-dollar coverage.

Employer-provided health coverage that is eligible for the exclusion can take many forms under present law. For example, health coverage may be provided through commercial insurance or through a self-insured plan (or some combination of both). Employers may provide for reimbursement of out-of-pocket expenses through an HRA or FSA or make contributions to an HSA. Contributions for health coverage may be made directly by the employer or on a salary reduction basis. In general, in order for a cap to be effective, all types of coverage to which the exclusion currently applies would need to be taken into account.

On-site health care coverage also presents issues. Some have argued that certain types of health benefits that are provided on a nondiscriminatory basis should be disregarded in applying a cap. For example, many employers have an on-site nurse or first aid facility, free health screenings, or programs relating to weight loss or smoking cessation. It is argued that such services typically are of minimal value and also may be difficult to value, e.g., issues arise as to whether value should be attributed to all eligible employees or only those that use the programs. On the other hand, some employers may provide more comprehensive on-site health care. Excluding on-site programs entirely may provide a means for avoiding application of the cap.

Issues arise as to how a cap would be applied in a variety of circumstances, including the cases of an individual with coverage from more than one employer and spouses with separate coverage under different plans (which may or may not be from the same employer).[26]

Definition of medical expenses

A far more limited proposal than imposing a cap on the exclusion for employer-provided health care is to conform the definition of medical expenses for purposes of the exclusion (as well as for HSA and MSA purposes) to that used for the itemized deduction. Thus, for example,

[26] For example, suppose there is a cap of a specified dollar amount per month for self-only coverage and a cap of twice that amount for family coverage and that a husband and wife have two children and that each spouse has employer-provided coverage covering the spouse and one child. May each spouse exclude the value of coverage up to the family cap (for a total exclusion for the couple of four times the single cap)? Does it matter if they file a joint return? Does it matter if they are employed by the same employer (but covered under different plans)? Similar issues are likely to arise with respect to other fact patterns.

nonprescription medicines, such as sunscreen, could not be reimbursed through an FSA. Such an approach would provide greater consistency in the tax treatment of medical expenses. It is also argued that such expenses are generally routine purchases made by most taxpayers and that, like other personal expenses, should not be deductible or excludable. In addition, providing a subsidy for over-the-counter medicines may result in noncompliance, as it may be more difficult to distinguish products that are deemed to be medical from those that are considered to promote general health (and therefore not eligible for the subsidy), such as toiletries.

There have also been proposals to expand the tax subsidies available for over-the-counter medicines. Supporters of such proposals argue that at least certain over-the-counter medicines are not routine for most taxpayers and can be expensive. Also, some over-the-counter products, such as certain allergy medicines and smoking cessation products, were recently available by prescription only. Some argue that it is appropriate to provide a subsidy for such products.

Issues relating to a credit or deduction for health care coverage

Proposals to provide a credit for health insurance generally have as a basic goal making health insurance more affordable and reducing the number of uninsured. As with other proposals, a credit for health insurance could take many forms. One alternative would be to replace the present-law tax provisions relating to health expenses with a credit available to everyone with health insurance. A credit could also be targeted to a more limited group, such as lower income individuals.

To the extent that making health insurance more affordable is a goal of a credit, the amount of the credit needs to be such that it adequately subsidizes the cost of coverage, particularly at lower income levels. A nonrefundable credit would provide a subsidy only for individuals with tax liability; a refundable credit would be needed to provide a subsidy for individuals with little or no tax liability.

Some have argued that, in order to make a credit more useful to lower income individuals, it should be refundable and provided on an advance basis. Experience with the earned income credit under present law indicates that refundable credits may increase the potential for fraud by taxpayers. For this reason, some have suggested that any credit (at least to the extend refundable) should be provided only to health care insurers or in the form of vouchers that can only be used to purchase health care coverage. The present-law HCTC provides some experience with respect to implementing such an approach. However, a broad-based advance refundable credit will raise different issues than those raised under the more limited HCTC.

Some proposals take the approach of providing an above-the-line deduction for health coverage rather than a credit. Like a nonrefundable credit, a deduction will not provide a subsidy for individuals with little or no tax liability and thus would not be as effective as a nonrefundable credit in lowering health coverage costs for low income individuals. A deduction may be more attractive than a credit for taxpayers with a higher marginal tax rate than the credit rate. In such cases, the deduction will offset more tax liability than would a credit. On the other hand, if the credit rate is higher than the taxpayer's marginal tax rate, the credit is more favorable than a deduction. For this reason, many credits are more attractive to lower-income individuals that a deduction.

Issues relating to providing a tax subsidy for high deductible health insurance

Recent attention has focused on high deductible insurance and HSAs. Some have proposed providing additional tax subsidies for the purchase of high deductible health insurance in conjunction with an HSA. Under present law, purchase of high deductible health plans is subsidized indirectly by the requirement that HSAs are permitted only to those covered by such plans. HSAs provide a tax benefit that is, at minimum, equivalent to an above-the-line deduction for medical expenses, up to the annual cap on contributions to an HSA. To see this, note that because the contribution to an HSA is deductible, the act of contributing to the HSA and immediately withdrawing the funds to pay for medical expense is equivalent, economically, to providing an above-the-line deduction for the medical expense itself. To the extent that the taxpayer is able to fund the HSA well in advance of the medical expense, the HSA additionally provides the ability to save for medical expenses on a pre-tax basis. The combined tax benefit can be thought of as providing the ability to take a current deduction for a future expense.

If the funds in the HSA are not used for qualified medical expenses, they may be withdrawn subject to income tax and a 10-percent early withdrawal tax. The early withdrawal tax ceases to apply after the age of Medicare eligibility, currently 65. Thus, funds that accumulate and are withdrawn for purposes other than to pay qualified expenses receive a tax benefit equivalent to the benefit provided to a deductible IRA.

Proposals in this area include providing a direct subsidy for the purchase of high deductible health plans by permitting a deduction or credit for premiums for such plans in situations where a tax subsidy is not currently provided (e.g., in the case of someone who is not self employed and who does not have employer-provided health insurance). Other proposals enhance the indirect subsidy provided to high deductible health plans by increasing the amounts that may be contributed to HSAs.

Proponents of such proposals believe that the use of high deductible plans promotes responsible health policy by making individuals more conscious of their health care costs because fewer expenses are paid by a third party insurer. Some proponents of such proposals believe that many current health insurance policies cover routine medical expenses and that the tax laws should provide a subsidy only for insurance for unpredictable medical expenses. However, the HSA itself may undermine that goal to some extent because, as noted above, it provides a subsidy for the first dollar of medical expenses. Others argue that it is inappropriate to favor any kind of health care product and that if only high deductible plans receive a tax subsidy (or a greater subsidy than other types of plans) then market decisions will be distorted.

Those who do not favor providing additional tax benefits for high deductible plans are concerned that such plans are likely to be more attractive to healthier individuals, with the result that adverse selection will occur and result in higher insurance costs for individuals with greater health risks. This issue is discussed in detail, above. It is also argued that increasing the contribution limits for HSAs makes it more likely that they will be used by higher income individuals as an additional tax-favored savings vehicle.

Issues relating to mandated health care coverage

The desire to have universal health coverage and avoid issues relating to adverse selection are sometimes advanced as arguments in favor of requiring individuals to purchase insurance. Another argument offered as a rationale for mandated coverage is that the government may not be able to commit to denying health care services to those needing them, in which case some individuals will have an incentive to "free ride," that is, to obtain services that others pay for. It is also argued that individuals may not be sufficiently informed regarding health care choices and may therefore choose a level of coverage (including no coverage) that is lower than what society in general views as appropriate. While mandates need not involve the tax laws, past proposals relating to mandates have often included a tax component.

Implementing an individual mandate would raise a variety of issues. A mandate could be enforced through the tax law, for example, by imposing a "premium tax" or denying certain tax benefits unless an individual provides proof of coverage. Proposals including mandates typically include specifications as to the minimum services and benefits the coverage must provide, and may also include provisions relating to risk pools or purchasing cooperatives, rules relating to community rating, and allowing certain individuals to pay for coverage under Medicare.

Mandates that employers provide health insurance coverage for their employees have been proposed both in lieu of and in addition to an individual mandate. From an economic perspective, the arguments for an employer mandate are less well established in economic theory than those for an individual mandate. Some of the more compelling arguments are premised on the idea that many individuals currently receive health coverage through their employer and that health care reforms should result in little disruption in current practices. The employer-provided health care system is also sometimes proposed to be used as part of an enforcement mechanism for an individual mandate, e.g., by requiring employers to withhold premiums. Economists generally argue that independent of whether a payment on behalf of an employee is made by the employer or the employee, the true economic impact of the requirement is the same--it is borne by the employee.

Complexity

Proposals to significantly modify the present-law tax treatment of health care are likely to involve increased complexity in many cases compared to present law. While the present law regime may raise a variety of issues, in many cases it is relatively simple to apply. For example, the exclusion for employer-provided health insurance is simple for both employers and employees because there is no limit on the exclusion and, in many cases, few requirements to be met for the exclusion to apply. Additional requirements apply in some cases. For example, under HRAs and FSAs, employers need to comply with rules to ensure that expenses submitted for reimbursement qualify for the exclusion. Proposals that impose a cap on the exclusion for employer-provided health care are likely to impose additional administrative burdens on employers. Proposals that place the burden on individuals to demonstrate compliance, such as a tax credit or a deduction for health coverage, will increase burdens for many individuals compared to present law.

On the other hand, complexity may be reduced in some cases. For example, under present law, FSAs, HRAs, and HSAs provide similar tax treatment for out-of-pocket health expenses but are subject to very different rules. A proposal that provides uniform treatment for such expenses could reduce complexity compared with present law.