

TAX EXPENDITURES FOR HEALTH CARE

Scheduled for a Public Hearing
Before the
SENATE COMMITTEE ON FINANCE
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Prepared by the Staff
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I. OVERVIEW

The Senate Committee on Finance has scheduled a public hearing on July 31, 2008, titled “Health Benefits in the Tax Code: The Right Incentives.” This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a description of present law tax expenditures for health care.

The Internal Revenue Code² includes a number of significant tax expenditures for health expenses.³ The availability of these different benefits depends in part on:

1. Is the individual covered under an employer-provided health plan?
2. Does the individual have self-employment income?
3. Does the individual itemize deductions and have medical expenses that exceed a certain threshold?
4. Is the individual covered by a high-deductible health plan?

Table 1 shows estimates of the tax expenditures for the health care sector in 2007. The largest tax expenditure is for employer-provided health care benefits. The exclusion of Medicare benefits is the next largest tax expenditure, but at a total of \$39.3 billion, is only a fraction of the size of the expenditure for employer-provided health care benefits. The remaining tax expenditures, such as the self-employment exclusion and the deduction for medical expenses greater than 7.5 percent of adjusted gross income, were each less than \$10 billion, while the estimated tax expenditure for health savings accounts was less than \$500 million.

¹ This document may be cited as follows: Joint Committee on Taxation, *Tax Expenditures for Health Care* (JCX-66-08), July 30, 2008. This document is available at www.jct.gov.

² Unless otherwise indicated, all section references are to the Internal Revenue Code of 1986, as amended (the “Code”).

³ Appendix A compares in tabular form the various tax provisions that mitigate the costs of health care under present law.

Table 1.—Calendar Year Tax Expenditure for Health, 2007

Value of Tax Expenditures	Billions of Dollars
Exclusion of employer sponsored health care.....	246.1
Income	145.3
FICA	100.7
Exclusion of Medicare benefits from income	39.3
Hospital Insurance (Part A)	20.2
Supplementary Medical Insurance (Part B).....	13.3
Prescription Drug Insurance (Part D)	4.8
Exclusion of subsidies to employers who maintain prescription drug plans.....	1.0
Deduction for medical expenses above 7.5% of adjusted gross income.....	8.7
Self-employed health insurance deduction	4.8
Exclusion of medical care and TRICARE insurance for military dependents and retirees not enrolled in Medicare.....	2.1
Exclusion of health insurance benefits for military retirees enrolled in Medicare	1.0
Health savings accounts	0.3
Health coverage tax credit.....	0.1

Source: JCT Staff calculations.

The presentation in Table 1 differs from conventional estimates of tax expenditures in two respects. This presentation has been selected to provide a sense of the full scope of the amounts involved in the special tax treatment of the health tax items listed.

First, these estimates do not include the effects of “tax form behavior.” In particular, conventional expenditure estimates prepared by the Staff of the Joint Committee on Taxation (the “JCT Staff”) assume that when taxpayers are denied an exclusion for employer sponsored insurance, they can deduct premiums under section 213 to the extent that their expenses exceed 7.5 percent of adjusted gross income. By contrast, the figures in this Table 1 assume that, if the exclusion for employer sponsored health insurance were repealed, employees would not be permitted to take into account the insurance premiums towards the section 213 medical expense deduction. If tax form behavior were taken into account and insurance premiums paid by an employer remained eligible for section 213, the income tax expenditure would decline from \$145.3 billion to approximately \$105 billion.

In addition, conventional tax expenditures are calculated only with respect to their effect on income taxes, and thus do not include payroll tax (FICA) effects. The estimate for the FICA effects of the employer exclusion in Table 1 does not reflect the effects of changes in current FICA liability on the present value of taxpayers’ future social security benefits. Finally, unlike revenue estimates, neither the estimates in Table 1 nor conventional tax expenditure estimates assume other behavioral responses by taxpayers.

The most favorable tax treatment under present law generally is provided to individuals who are in an employer plan where the employer pays the premium.⁴ Such individuals may exclude from income and wages employer-provided health insurance; depending on the employer's plan, they may also exclude from income amounts expended for medical care not covered by insurance. Self-employed individuals receive the next most favorable treatment; they may deduct 100 percent of the cost of their health insurance from their income tax, but they may not deduct their health insurance premiums from their payroll tax base. In the case of the employer-provided exclusion and the self-employed deduction, there is no cap on the tax benefit that would limit the generosity of health plans that can be purchased with pre-tax dollars. Present law also provides additional, less significant, tax expenditures for health care benefits.

There are significant non-tax advantages to operating through the employer-provided system. Providing health insurance coverage through a large group provides significant savings because of risk mitigation and lower administrative costs. Employers typically have superior negotiating power, compared to individual consumers, in negotiating the terms of insurance coverage with insurers. In addition, a group system mitigates the problems of adverse selection and results in coverage of less healthy individuals who may be unable to obtain insurance outside of a pooled arrangement. The combination of tax and economic advantages of employer-provided health care have resulted in the employer-provided system providing the vast majority of health care coverage, resulting in the large tax expenditure seen in Table 1 for employer-provided health care.

Nevertheless, the current system of providing a generous tax subsidy for employer-provided health care with no or little subsidy in the case of insurance purchased outside of the employer market distorts taxpayer and market behavior. The existence of the subsidy reduces the price of the consumption of health care, leading to overconsumption of health care relative to other goods and services for those taxpayers with qualifying plans, and very expensive health care for taxpayers in the individual market. Unlike most tax expenditures, the large subsidy associated with employer-provided health care is subject to few statutory limitations.

⁴ The refundable HCTC provides a greater tax benefit than the exclusion. Fewer than one-half million taxpayers per year, however, are estimated to be eligible for the credit.

II. EMPLOYMENT RELATED TAX EXPENDITURES

A. Employer-Provided Health Care

In general

The Code generally provides that an employee is not taxed on (that is, may “exclude” from his or her gross income) the value of employer-provided health care. The exclusion for employer-provided health care is the largest tax expenditure under the current tax system. The tax expenditure for the exclusion for employer-provided health care is estimated to be \$246.1 billion for 2007, using the methodology described in connection with Table 1. This represents by far the largest portion of the total tax expenditures for health and is the third largest health expenditure if measured against direct Federal spending, exceeded only by direct expenditures for Medicare and Medicaid.

Income generally is defined to include compensation paid to a service provider in any form, whether in cash or in kind. The value of health insurance that an employer purchases for its employees unquestionably constitutes compensation to each covered employee in this general sense. The exclusion therefore represents a departure from the Code’s general tax principle that compensation should be included in income; for that reason, the JCT Staff treats employer-provided health insurance as a tax expenditure.⁵

⁵ For a discussion of the JCT Staff’s general approach to tax expenditures analysis, see Joint Committee on Taxation, *A Reconsideration of Tax Expenditure Analysis* (JCX-37-08), May 12, 2008.

Table 2.–Calendar Year Employer Exclusion Tax Savings¹, 2007

Adjusted Gross Income	Total Savings (millions)	Income Tax Savings (millions)	FICA Tax Savings (millions)	Total Tax Returns (thousands)	Average Savings Per Return (dollars)
< 10,000	4,185	-481 ²	4,666	6,692	625
10,000 – 29,999	38,860	20,095	18,765	19,355	2,008
30,000 – 49,999	45,696	24,451	21,245	18,261	2,502
50,000 – 74,999	49,075	26,471	22,604	15,798	3,106
75,000 – 99,999	39,713	24,343	15,370	9,998	3,972
100,000 – 199,999	51,984	36,999	14,985	11,543	4,504
200,000 – 499,999	13,104	10,685	2,419	2,828	4,634
> 500,000	3,455	2,785	670	788	4,385
Total	246,072	145,348	100,724	85,263	2,886

¹ See discussion immediately following Table 1 for the methodologies applied in calculating the value of this exclusion. Table 2 reflects both income tax and FICA distributional consequences.

² Negative amounts reflect the fact that the exclusion reduces earned income for purposes of the earned income credit, resulting in a decrease in refundable credits for some recipients.

Source: JCT Staff calculations.

Table 2 shows the total savings from the employer exclusion for eight income brackets. This table shows that those in the lower income brackets obtain cash savings from the exclusion for employer-provided health care valued at between \$600 and \$3,000, while those earning more than \$100,000 per year have average cash savings worth between \$4,000 and \$5,000.

As with other compensation, the amount paid by an employer for employer-provided health care of employees is deductible. Unlike other forms of compensation, however, if an employer contributes to a plan providing health coverage for an employee (and his or her spouse and dependents), the contribution and all benefits (including reimbursements) for medical care under the plan are excludable from the employee’s income for both income and payroll tax purposes.⁶ The exclusion applies both in the case in which employers absorb the cost of their employees’ medical expenses not covered by insurance (i.e., a self-insured plan) as well as employer payments to purchase health insurance. There is no limit on the amount of employer-provided health coverage that is excludable.

⁶ Secs. 104, 105, 106, 125, and 3121(a)(4). Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludable under section 134. That section provides an exclusion for “qualified military benefits,” defined as benefits received by reason of status or service as a member of the uniformed services and which was excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

Active employees participating in a cafeteria plan⁷ 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 also are excluded from gross income and wages for payroll taxes.

The Employee Retirement Income Security Act of 1974 (“ERISA”) preempts State law relating to certain employee benefit plans, including employer-sponsored health plans.⁸ While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law. Further, self-insured employer plans are not subject to State insurance taxes or regulation, such as premium taxes imposed on insurance companies under State law.

Unlike tax-qualified pension plans, present law includes few requirements or limitations on the design of employer-provided health care plans. In particular, and in contrast to most other Federal tax benefits, there is no limitation on the amount of health benefits that an employer can provide on a tax-free basis. This effectively allows taxpayers to control the amount of their tax benefit. Employer-provided health plans are not required to cover all employees or to provide the same benefits to all employees.⁹ In addition, the tax exclusion is not predicated on coverage of certain illnesses or conditions.

⁷ If an employer offers employees a choice between taxable benefits (which include cash compensation) and qualified benefits (which include employer-provided accident and health coverage), the choice must generally be provided under a cafeteria plan that satisfies section 125. Otherwise providing this choice may result in income inclusion even if the employee chooses an excludable benefit. See sec. 125 and proposed Treas. Reg. secs. 1.125-1 through -7, published in the Federal Register on August 6, 2007, 72 FR 43938.

A cafeteria plan must be in writing and must not provide for deferred compensation except as specifically provided in section 125(d). Certain excludable benefits are not permitted to be provided in a cafeteria plan, including long-term care benefits, contributions to Archer MSAs, qualified scholarships under section 117, benefits under educational assistance programs under section 127, and certain fringe benefits under section 132. HSA contributions are allowed through a cafeteria plan. If benefits provided under a cafeteria plan discriminate in favor of highly compensated participants, any exclusion from income for benefits under the plan may not apply to such highly compensated participants. Any qualified benefit must also satisfy any specific requirements under the section that allows its exclusion.

⁸ ERISA sec. 514.

⁹ An exception to this general rule applies in the case of self-insured group health plans, which must satisfy certain nondiscrimination rules in order for the benefits of highly compensated individuals to be excludable. Sec. 105(h). As previously discussed, benefits provided under a cafeteria plan are subject to certain nondiscrimination requirements.

Distinct from the exclusion, certain rules relating to coverage apply in the case of group health plans.¹⁰ The Consolidated Omnibus Reconciliation Act of 1985 (“COBRA”) requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). In addition, in the case of group health coverage, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) imposes a number of requirements that are designed to provide protections to health plan participants.¹¹ For example, HIPAA provides rules on when a pre-existing condition exclusion may be imposed with respect to a participant or beneficiary and rules that prohibit discrimination with respect to eligibility and premium contributions on the basis of health status. HIPAA also provides rules relating to specific coverage (e.g., rules for minimum hospital stays following the birth of a child if such benefit is provided under the plan).

The employee income and wage exclusion for employer-provided health care is not dependent on satisfying the requirements of COBRA and HIPAA. Instead, the Code imposes an excise tax on group health plans that fail to meet these requirements.¹² The excise tax is generally equal to \$100 per day during the period of noncompliance and is imposed on the employer sponsoring the plan if the plan fails to meet the requirements.

In addition to offering health insurance (or self-insurance), employers often agree to reimburse medical expenses of their employees (and their spouses and dependents). These arrangements are commonly used by employers to pay or reimburse employees for medical expenses that are not covered by health insurance. These arrangements include health flexible spending arrangements (“FSAs”) and health reimbursement arrangements (“HRAs”).

Health FSAs typically are funded on a salary reduction basis under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses. Health FSAs that are funded on a salary reduction basis are subject to the Code’s requirements for cafeteria plans, including a requirement that amounts remaining in a health FSA under a cafeteria plan as of the end of a plan year must be forfeited by the employee (referred to as the “use-it-or-lose-it-rule”).¹³ If the health FSA under a cafeteria plan meets

¹⁰ A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

¹¹ The requirements are enforced through the Code, ERISA, and the Public Health Service Act (“PHSA”).

¹² Secs. 4980B; 4980D.

¹³ Sec. 125(d)(2). See proposed Treas. Reg. secs. 1.125-1 through -7. However, if a plan chooses, 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 is allowed. Notice 2005-42, 2005-1 C.B. 1204. Health FSAs are subject to certain other requirements, including rules that require that the FSA have certain characteristics similar to insurance.

certain requirements, the compensation that is forgone is not includible in gross income or wages. Reimbursements for medical care from the health FSA similarly are excludable from gross income and wages.

Health reimbursement arrangements (“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), but the rules are not identical. In particular, 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.¹⁴ Unlike a health FSA, an HRA is permitted to reimburse an employee for health insurance premiums.

Unlike the section 213 itemized deduction for medical expenses which (as discussed below), in the case of drugs, is limited to prescribed drugs,¹⁵ tax-free reimbursement for non-prescription drugs is permitted in the case of an employer-provided health plan. Thus, for example, amounts paid from an FSA, HRA, or health savings account (described later in the pamphlet) to reimburse the employee for nonprescription medicines, such as sunscreen, nonprescription aspirin, allergy medicine, antacids, or pain relievers, are excludable from income. This creates an even greater tax preference for employer-provided health care arrangements.

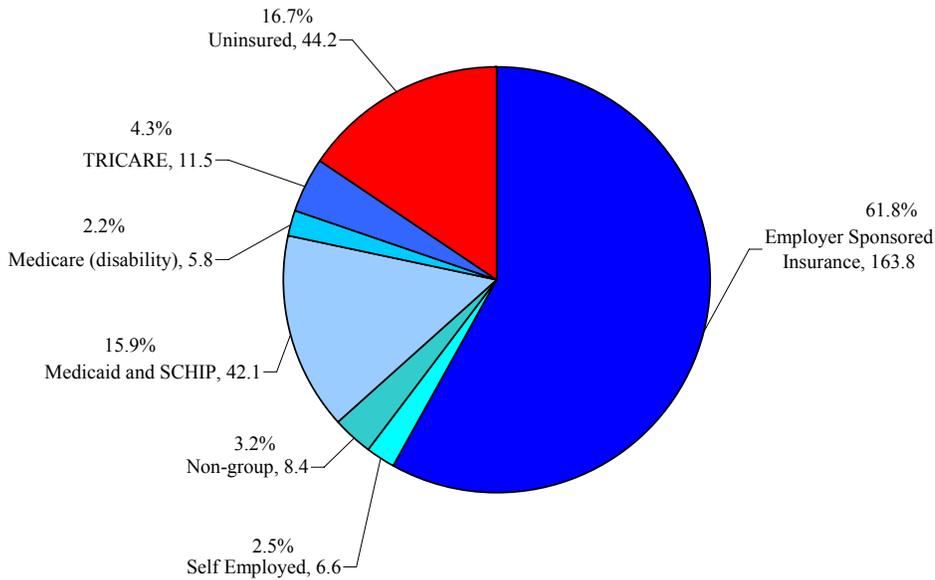
Coverage under employer-sponsored health care

The vast majority of Americans finance health care through employment-based insurance coverage.

¹⁴ Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

¹⁵ Under section 213(b), in the case of medicine or drugs, an expenditure is taken into account only if it is incurred for a prescribed drug or insulin.

Figure 1.—Health Insurance Coverage Source for the Nonelderly Population, 2008
[millions of persons]



* Total exceeds 100% because individuals may have multiple sources of health insurance coverage.

Source: JCT Staff calculations based on Medical Expenditure Panel Surveys (2001-3), and Internal Revenue Service Statistics of Income 2005 data; Congressional Budget Office March 2008 baseline.

All employers do not provide equal access to health insurance. Historically, small businesses are far less likely than large businesses to offer health insurance.¹⁶ Small businesses are more sensitive to price than are large businesses when considering offering health insurance. Therefore, if the price of health insurance changes due to a change in the tax treatment of health insurance, the greatest impact will be seen in the rates at which health insurance is offered by small businesses.

The Congressional Budget Office (CBO) estimates that a 10 percent increase in the cost of premiums to employees would cause a 7.2 percent reduction in the offer of health insurance for individuals working at firms with fewer than 100 employees. The same 10 percent price

¹⁶ Thirty-eight percent of workers in firms with fewer than ten employees are eligible for coverage, compared to 78 percent of workers in firms with more than 1,000 employees. When offered insurance, employee enrollment was 81 percent, ranging from 78 percent for small-moderate firms to 83 percent for very large firms. Thomas M. Selden and Bradley M. Gray, “Tax Subsidies For Employment-Related Health Insurance: Estimates For 2006” *Health Affairs*. Vol. 25 Issue 6, November/December, 2006 pp. 1568-1579.

increase would cause a 0.4 percent decrease in the health insurance offer for individuals working for firms with more than 100 employees.¹⁷

Employer involvement in the purchase of health insurance has both advantages and disadvantages in the market. The primary advantage is that health insurance costs less when purchased through an employer as compared with the non-group market; non-group insurance is fundamentally more expensive.

The principal reason for the price advantage of group over individual health insurance is that insuring a group has less per capita risk than insuring an individual; therefore, the risk premium paid to the insurance company is lower. Employer-sponsored health plans provide a pooling mechanism that is unrelated to the health status of the insured, which minimizes problems with adverse selection into health plans. (Adverse selection refers to the phenomenon that those most in need of insurance are the most likely to seek it out.)

Economies of scale also reduce the administrative costs for group plans, and therefore health insurance premiums are lower to this extent for employer plans relative to premiums in the non-group market.¹⁸ As a result, insurance purchased through the group market is less expensive, because it is less costly to sell to and maintain one group of several hundred people than to sell and maintain hundreds of groups of one to two people. CBO has estimated that 29 percent of the premium in the non-group market is spent on administration, while in the large group market administration costs only nine percent of the premium.¹⁹

Finally, employers generally have superior negotiating power with an insurance company than does an individual consumer. Employers have more experience and sophistication in evaluating insurance proposals, can offer much larger blocks of business by virtue of the group nature of employer-provided insurance, and may have other business relationships with the insurer.

There is some recent evidence from the financial services sector that shifting people into the individual market would increase the time and effort required to purchase health insurance. This may lead to procrastination in obtaining insurance and a temporary or even a permanent rise in the rate of uninsurance. Complexity of choice, paired with the absence of a deadline for acquiring insurance, will likely lead to delays in the purchase of insurance. For example, some have argued that employers are good agents for their employees and provide invaluable research

¹⁷ Congressional Budget Office, “CBO’s Health Insurance Simulation Model: A Technical Description,” October 2007.

¹⁸ A Congressional Research Service Report from 1988 found that insurance in small groups (fewer than five members) cost 40 percent more than in large groups (more than 10,000 members). Congressional Research Service, *Costs and Effects of Extending Health Insurance Coverage*, 1988.

¹⁹ Congressional Budget Office, “CBO’s Health Insurance Simulation Model: A Technical Description,” October 2007.

into the appropriate health plans to offer.²⁰ The employer acts as an agent to limit and guide choice. The open enrollment period, which is a limited time window when insurance can be chosen, prevents excessive procrastination before purchase. These complexity problems were seen by some American seniors after the release of the Medicare Part D plans in 2004, which required many seniors to choose a prescription drug plan in order to optimize prescription drug benefits. There were reports that, with so many complicated options, many seniors had difficulty choosing a plan.²¹

Although the individual market is at a cost disadvantage relative to the employer market for health insurance, it provides greater choice for health insurance coverage. This said, only one percent of those offered employer insurance decline it and purchase insurance in the individual market.²²

Some employees may feel locked into their current jobs because switching to a different employer could result in a loss of their current health coverage. Despite the protection of HIPAA for pre-existing conditions,²³ an employee who has insurance with a certain level of coverage for a specific condition through his or her current employer may nevertheless lose that level of coverage if the employee were to move to a new job because the new employer's health plan does not cover that condition or does not provide the same level of coverage for the condition. Even if the health plan is substantially identical, the employee might be concerned that the new job might not work out, and the employee might become unemployed resulting in a loss of coverage or the potential for significantly higher premium costs. The resulting labor market inefficiency is commonly referred to as "job lock", where individuals remain with employers in order to maintain their current health insurance when their preference is to leave

²⁰ Research on retirement plans finds that as the number of investment options increased by 10, participation declined by 1.5 to 2 percentage points. S.S. Iyengar, G. Huberman, and W. Jiang. "How Much Choice Is Too Much?: Contributions to 401(k) Retirement Plans," in Olivia Mitchell and Stephen Utkus, eds., *Pension Design and Structure: New Lessons from Behavioral Finance* (Oxford, UK: Oxford University Press, 2004): pp. 83-96.

²¹ John Leland, "73 Options for Medicare Plan Fuel Chaos, Not Prescriptions," *New York Times*, May 14, 2004.

²² Congressional Budget Office, "CBO's Health Insurance Simulation Model: A Technical Description." October 2007.

²³ Although a group health plan sponsored by an employer is limited by HIPAA in its ability to impose a pre-existing condition exclusion on a plan participant, a plan is permitted to exclude conditions diagnosed within the six-month period ending on enrollment in the plan, provided that the exclusion generally may not extend for longer than 12 months (18 months in the case of certain late enrollees in the plan) and the maximum exclusion period must be reduced by the participant's aggregate periods of "creditable coverage." Creditable coverage includes a participant's coverage under a group health of a prior employer provided that there is no more than a 63 day gap in coverage between the new plan and the old plan. Sec. 9801.

the workforce or find new work.²⁴ There are other examples of job lock. Job lock may prevent an individual from leaving a large employer that offers insurance and starting a new independent business due to extra health insurance premiums that may be charged with respect to an individual health insurance policy.²⁵ Job lock also may prevent an employee who is sick or has a sick dependent from switching to an employer with another health plan for fear of disrupting the patient-physician relationship.

Market distortions from employer-provided health care

The tax treatment of health care affects the health care market and can distort consumer choices. Reduced taxation of income spent on health insurance is an implicit subsidy to eligible consumers by the Federal government. This “discount” on the employer purchase of health insurance provides an incentive for the purchase of more generous health insurance benefits than would otherwise be purchased without the discount. Increased health insurance benefits generally include some combination of reduced copayments, deductibles and expanded benefits. Because consumers are responsive to changes in the cost of health care,²⁶ increased health insurance benefits lead to an increase in the use of health care services. Therefore, the tax exclusion for health insurance and other medical services increases the demand for health care services.

The distortion in the market caused by the tax preference afforded health insurance arises from a two-part market response: 1) demand for medical care increases, increasing the price of health care services; and 2) increased prices draw additional resources into the medical services sector, and away from other less tax-favored sectors. Moving resources from one sector where they are more productive to another sector may result in less efficient production of additional medical services, thus resulting in generally higher medical costs.

These market mechanisms affect all prices for health care services in the market, not only the extra services paid for through insurance. The market inefficiency arising from the tax-induced spending on health care versus other goods generates a loss to the economy referred to

²⁴ Evidence of job lock in the literature is mixed, with some papers finding health insurance decreasing mobility, some papers finding no effect and some papers finding an effect only under certain specifications. Brigitte C. Madrian, “The U.S. Health Care System and Labor Markets,” National Bureau of Economic Research, Working Paper # 11980, January 2006.

²⁵ While HIPAA contains rules that generally require that an individual who loses employer-provided health coverage have access to an individual health insurance policy without being subject to preexisting condition exclusions, such rules are subject to a number of exceptions (including rules that permit a State to implement alternative individual health insurance protections) and the rules do not provide protections with respect to the premium that may be charged for the policy. See 42 U.S.C. sec. 300gg-41, 44.

²⁶ Joseph P. Newhouse, “Free For All?: Lessons From the RAND Health Insurance Experiment.” Harvard University Press, 1996.

as “dead weight loss,”²⁷ because it results in a net loss of consumer welfare. Therefore, the impact on the economy materially exceeds the loss of tax revenues from subsidizing health care expenditures. The elimination of this distortion could lead the economy to function more efficiently and increase individuals’ collective welfare.

There is substantial evidence that the tax preference for health care does indeed increase demand; however, estimates of the size of the increase span an extremely wide range, indicating considerable uncertainty among economists on the true size of the increase in the volume and price of health care due to the tax exclusion.²⁸

On the other hand, some observers argue that tax subsidies for health insurance and other medical expenditures may correct a market failure, in the form of a tendency of many people to under-spend on health insurance and health services. Under this view, the tax subsidy might make the health care market more efficient and may improve welfare.²⁹

Equity issues relating to employer-provided health care

The current tax treatment of health care expenditures is criticized as inequitable because it provides an inconsistent tax benefit based on how health coverage is provided.³⁰ Generally, those who obtain their health insurance through their employer are afforded the most favorable tax treatment. Those who are employed but who must obtain health insurance in the individual market receive the worst tax treatment. Many observers believe that this inequity combined with the lack of group rates in the individual market may lead to some persons remaining uninsured.

Some critics assert that the tax exclusion for employer-provided health is inherently regressive, and thus unfair – those with the greatest income are in the highest tax brackets, and therefore receive the greatest tax benefit from the exclusion from income. For example, a single individual with no dependents and \$100,000 of taxable income per year has a marginal tax rate of 28 percent, excluding the effects of Social Security and Medicare taxes. If that person purchases a health plan through an employer that costs \$5,000, the Federal income tax value of

²⁷ Martin S. Feldstein, “The Welfare Loss of Excess Health Insurance.” *Journal of Political Economy* Vol. 81 Issue 2, (Mar-April 1973): pp. 251-280.

²⁸ Joseph P. Newhouse, “Free For All?: Lessons From the RAND Health Insurance Experiment,” Harvard University Press, 1996.

²⁹ For example, one study found that 25 percent of patients took zero or one drug after a heart attack rather than two or more drugs due to the drugs’ copayment costs even though the extra drugs cost \$1,855, per year, they provided \$35,000 in health care benefits (not including savings from decreases in future medical costs). This study indicated that costs greatly impact the purchase of these drugs and they are often underused. Niteesh K. Choudhry, et. al., “Cost-Effectiveness of Providing Full Drug Coverage to Increase Medication Adherence in Post Myocardial Infarction Medicare Beneficiaries” *Circulation* Vol. 117 (2008) pp. 1261-1268.

³⁰ See Appendix B and Appendix C for illustrations of the tax benefits for an individual depending on the source and type of coverage.

the tax exclusion (the income tax not paid) is \$1,400. A single individual with no dependents and taxable income of \$30,000 is in the 15 percent bracket and would therefore receive a 15 percent, or \$750, subsidy for the same health plan.

The argument that the exclusion (or a similar deduction) for employer-provided health care is unfair because it is regressive is somewhat incomplete, in that the asserted unfairness of the exclusion follows directly from the tax rate structure being progressive. For example, under a single tax rate system (a flat tax), the tax benefit in the example above would be identical for the \$100,000 earner and the \$30,000 earner.

Any deduction will be regressive given a progressive rate structure, but the appropriateness of a deduction in defining the tax base arguably should be determined independently of the rate structure.³¹ If the tax base is intended to reflect ability to pay, then a deduction for an expenditure that reduces ability to pay may be appropriate, notwithstanding that the decision to have a progressive rate structure means that a given deduction will have more value the greater is the taxpayer's marginal tax rate.

Additionally, it must be recognized that policies with respect to permitted deductions and the marginal rate structure are set concomitantly to achieve the desired level of progressivity of the tax code overall. If a deduction were not permitted, the rate structure, including the bracket widths, might have evolved differently. That is, the same overall degree of progressivity of the tax code can be achieved with or without a given deduction, through the alteration of the rate structure. In the example above, it would be possible to permit the exclusions for employer-provided health care but alter the rate structure to raise taxes on the employee with \$100,000 of income by \$1,400, and the employee with \$30,000 of income by \$750, thus negating the tax advantage of the exclusion and preserving the overall progressivity of the tax code.

Alternative tax policies subsidizing insurance coverage

If a deduction or exclusion is merely intended to provide a Federal subsidy for a particular expenditure, and has no meritorious independent place in an income tax system other than as a means to deliver the subsidy, then a good case can be made that the deduction or exclusion should be altered to mitigate any distortionary effects it may have on economic behavior. Employer-provided health care has important nontax advantages compared to an entirely individual-consumer-based health care system,³² but also has some economic deadweight loss associated with it. Policy analysts have focused a great deal of attention on the trade-off between those advantages and economic deadweight loss.

³¹ For related discussion, see William D. Andrews, "Personal Deductions in an Ideal Income Tax", 86 Harv. L. Rev. 309, 1972.

³² See, for example, Melissa A. Thomasson, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," National Bureau of Economic Research, Working Paper 7543, February 2000.

Because of the efficiency and equity concerns associated with subsidizing health insurance through the exclusion for employer-sponsored health care, many health reform proposals begin with removing the employer exclusion. On the other hand, policy makers need to keep in mind the price sensitivity of the market. Removal or reduction of the exclusion of employer-provided health care from an employee's taxable income and wages could reduce the number of firms offering health insurance, possibly increasing the number of uninsured.

For example, one study estimated that the total number of employees offered health insurance would drop by 15.5 percent if all of the exclusions were repealed and by 9.7 percent if the income tax exclusion were repealed, but the payroll and state tax exclusions remained.³³ Thus, in practice most comprehensive health care proposals tend either to limit the exclusion, or replace it with some other form of Federal subsidy.

The unlimited exposure of the Federal budget created by the exclusion could be reduced by capping the dollar amount of the exclusion per person or per tax return. The cap would also reduce the incentive for individuals to over-consume health insurance, to the extent that the cap is lower than the policy an individual currently carries. If the cap is not indexed, or is indexed to a measure such as the consumer price index that typically grows more slowly than medical costs, the subsidy for employer-provided health care would decline relative to the cost of the care over time. Thus, the economic distortion effects of the exclusion would be reduced gradually over time.

Another approach to reforming the exclusion would be to replace it with a limited deduction. Under present law, if the employer exclusion for health insurance were removed, many individuals would still be able to deduct at least part of the cost of their premiums as itemized medical expenses under section 213.³⁴ As is discussed in more detail in Part III.B. below, there may be reasons to retain the section 213 deduction if the exclusion is eliminated and not replaced by some other tax subsidy for the purchase of health insurance. In brief, the section 213 deduction recognizes that many medical expenditures are not discretionary, and an income tax base that reflects ability to pay would allow a deduction of these expenses. In addition, the section 213 deduction is less regressive than the exclusion with respect to upper income taxpayers, because the 7.5 percent threshold for the deduction is difficult to overcome at higher income levels.

Replacing the exclusion with a deduction for expenditures over some threshold may link the tax subsidy more closely to ability to pay, but it does not address the efficiency issue that providing larger subsidies for larger insurance payments provides an incentive to over-consume health insurance. A different approach, which would reduce the incentives provided by the exclusion for individuals to over-consume employer-provided health insurance, would be to

³³ Jonathan Gruber and Michael Lettau, "How elastic is the firm's demand for health insurance?" *Journal of Public Economics*, Vol. 88 (2004), pp. 1273-1293.

³⁴ That deduction is only allowable to the extent that a taxpayer's medical expenses exceed 7.5 percent of his total adjusted gross income (see more detailed discussion of section 213 in Part III. B., below).

replace the exclusion with a deduction of a flat amount that is unrelated to the price of the insurance policy.³⁵ Under this approach, depending on the level set for this flat deduction, the tax subsidy would be large enough to enable people to continue insurance coverage, but there would be no tax advantage for a taxpayer to purchase more expensive insurance. If such a deduction were provided for the purchase of insurance in the individual market in addition to employer-provided insurance, individuals who do not have the option of obtaining employer-sponsored health insurance would be able to use the deduction to help purchase insurance in the individual market, thus reducing the number of uninsured. The advantage of obtaining insurance through one's employer would also be reduced, possibly leading to a reduction in the number of people who receive offers of health insurance coverage through their employers.

The net effect of this policy on the number of uninsured individuals would depend on the size of the fixed deduction relative to the cost of a typical insurance policy.³⁶ The amount of the deduction could be chosen to limit Federal budget exposure, and, like the cap, it could be indexed to grow more slowly than medical expenditures, thus reducing the Federal budget impact and the tax subsidy for health insurance over time.

An additional consideration in the setting of subsidy levels for employer and non-group insurance is the interaction of these changing subsidies with adverse selection. Non-group insurance is generally more attractive to individuals with low medical costs. To the extent that there is a substantial re-alignment between the attractiveness of employer insurance and non-group insurance, younger, healthier individuals may decline employer coverage to such an extent that the advantages of risk pooling by employers are lost, resulting in significant declines in the offer of employer insurance. To the extent that this occurs without some alternate risk pooling mechanism being made available, this could result in a significant increase in the number of uninsured individuals.

One problem with providing for a flat deduction (or exclusion) amount is that it could result in insurance products with minimal coverage being offered to individuals who are more interested in obtaining the deduction than in obtaining genuine health insurance coverage. The policy amounts could be set at amounts worth less than the tax value of the deduction. This would undermine the goal of promoting broader insurance coverage, at some cost to the taxpayer. In order to prevent such a result, the availability of the deduction could be linked to purchase of an insurance policy that met certain standards. However, this requirement would require additional administrative work by the IRS, in terms of determining whether an individual has health insurance that qualified for the deduction.

³⁵ See, for example, the proposal included in the Administration's Fiscal Year 2009 Revenue Proposals.

³⁶ For example, the Congressional Budget Office finds that removing the exclusion and replacing it with flat deductions of \$7,000 for single policies and \$15,000 for family policies would reduce the number of uninsured people by about five million in the first several years after enactment. Congressional Budget Office, "An Analysis of the Presidents Budgetary Proposals for Fiscal Year 2009," March 2008, p.10.

None of the approaches described above addresses the limitations of the exclusion or deduction in providing subsidies for the purchase of health insurance to those who are least able to afford it: to people who have little income and thus little or no tax liability. To address this problem, the exclusion or deduction could be converted to a refundable credit.³⁷ In contrast to an exclusion or deduction (even a deduction of a fixed amount), a refundable credit will provide the same benefit or subsidy to all taxpayers regardless of their income levels. A non-refundable credit for an expenditure would generally be as easy to administer as a deduction for the same expenditure. A refundable tax credit poses significant difficulties in administration for several reasons.³⁸ It brings into the income tax system people who otherwise would not be part of the tax system, and thus the IRS may not have easily verifiable information about their income and other information necessary to monitor compliance with the credit. Additionally, some have proposed that refundable tax credits be made available on an advance basis, so that they could be used directly to purchase health insurance. Such a system could require timely verification of insurance status and credit eligibility by the IRS. Some believe refundable credits, particularly advanceable refundable credits, may encourage fraud. Existing refundable credits in the Code that have been paid in error have proven difficult for the IRS to recoup.³⁹

Even the provision of a refundable tax credit to subsidize the costs of purchasing health insurance may not provide enough of an incentive to ensure that the estimated 44 million people who are currently uninsured obtain health insurance. For this reason, some have proposed making purchase of insurance mandatory for all citizens, and combining this requirement with a tax liability that would contribute to the payment of the premiums. Under such an arrangement, individuals would have a strong incentive to purchase insurance as they are paying for at least part of it through the tax system. However, because many individuals cannot afford to pay either the insurance or the tax liability, these proposals are often combined with subsidies in the form of deductions and refundable, or advance refundable tax credits. Such proposals are complex and far-reaching and face administrative and compliance challenges.

Exclusion from income, in contrast to either deductions or credits, has the administrative advantage of not requiring valuation or verification of the excluded item, at least when the exclusion is not capped. Providing a tax benefit through an exclusion has limited application however, as it requires that the subsidized item be provided to the taxpayer in the form of compensation, or other form of income.

³⁷ Lily L. Batchelder, Fred T. Goldberg Jr., Peter R. Orszag, "Efficiency and Tax Incentives: The Case for Refundable Tax Credits", 59 *Stan. L. Rev.* Vol. 23 (2006).

³⁸ See, for example, the following papers regarding the administration of the earned income credit: Janet McCubbin, "Non-compliance with the Earned Income Tax Credit" pp. 237-273; and Jennifer Romich and Thomas Weisner, "How Families View and Use the Earned Income Tax Credit: Advance Payments Versus Lump-Sum Delivery," pp. 366-391, in *Making Work Pay*, Bruce Meyr and Douglas Holtz-Eakin, eds, New York: Russell Sage Foundation, 2001.

³⁹ Government Accountability Office, "Advanced Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS's Efforts to Reduce High Noncompliance," Report to the Joint Committee on Taxation, GAO-07-1110, August 2007.

B. Deduction for Health Insurance Premiums of Self-Employed Individuals

Under present law, self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents.⁴⁰ The tax expenditure for the deduction for health insurance premiums for self-employed individuals was \$4.8 billion for 2007.

The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual's self-employment income. The deduction applies only to the cost of insurance, i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance.⁴¹ The deduction does not apply for self-employment tax purposes. For purposes of the deduction, a more than two percent shareholder-employee of an S corporation is treated the same as self-employed individual.⁴² Thus, the exclusion for employer-provided health care coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self employed.

This deduction can be claimed to have the effect of putting a self-employed individual in a similar position to an employee by allowing the self-employed individual to receive the equivalent of an income tax exclusion for health insurance coverage provided by the business for which the self-employed individual performs services. In fact, however, the two regimes differ in several important respects. First, as described above, a deduction from income for self-employment tax purposes is not provided in the case of a self-employed individual. For this reason, a self-employed individual receives less favorable tax treatment than does an employee with the same coverage provided by their employer. The employer-provided exclusion retains another significant advantage because the exclusion for self-employed individuals does not apply in the case of non-insurance arrangements, such as an HRA.

On the other hand, a self-employed individual, particularly a partner or a self-employed individual with a minority interest in a business, may be at an advantage over an employee because the self-employed individual may unilaterally decide to purchase health insurance

⁴⁰ Sec. 162(l).

⁴¹ Premiums for a self-insured plan are eligible for the deduction if the self-insured plan actually constitutes an insurance arrangement, which generally means that the arrangement must result in adequate risk-shifting and not merely reimburse the individual for health expenses. For example, the IRS has ruled that a self-insured health plan of a law firm covering 200 self-employed partners and 800 employees demonstrated adequate risk shifting where the plan charged premiums that were determined on the basis of the actuarial costs of the plan and each partner was liable for a pro-rata share of plan experience losses. Pvt. L. Rul. 200007025. Self-employed individuals are not eligible to participate in HRAs. See Notice 2002-45, 2002-2 C.B. 93. In addition, self-employed individuals are not eligible to participate in a cafeteria plan, including a health FSA funded by elective contributions, because cafeteria plan participation is limited to employees. See sec. 125(d)(1)(A).

⁴² Sec. 1372.

regardless of whether the business offers health coverage to its employees. A significant cost differential may exist, however, because the self-employed individual may have to purchase coverage on the individual market and thus not have the benefit of administrative savings and risk pooling from the group market unless the business has other self-employed individuals or common-law employees under the same plan.⁴³

⁴³ Even if a self-employed individual's business does not employ and cover enough employees to generate the advantage of risk pooling, state law may provide assistance. Under HIPAA, an employer with two to fifty employees is generally guaranteed access to insurance in the small group market, and States are permitted to allow sole proprietors with no employees to purchase health insurance on the small group market rather than being limited to the individual market. 42 U.S.C. sec. 300gg-11, 91(e). While HIPAA does not require the States to provide protections as to the amount of premiums charged in the small group market, many States do provide for premium protection rules for this market.

III. OTHER HEALTH CARE TAX EXPENDITURES

A. Medicare

Medicare benefits—that is, the dollar value of Medicare services received by participants in the Medicare system—are excluded from the recipient’s income.⁴⁴ The tax expenditure for the exclusion for Medicare is the second largest health tax expenditure at \$39.3 billion for 2007.⁴⁵

Medicare is a Federal program that provides medical insurance coverage to people age 65 and older and certain other individuals who are younger than age 65 (e.g., certain persons with disabilities and individuals with end-stage renal disease). In general, Medicare comprises three types of coverage: (1) Part A, which provides coverage for in-patient hospital care; (2) Part B, which provides coverage for doctor services and outpatient medical care; and (3) Part D, which provides coverage for prescription drugs.⁴⁶ In general, individuals are not required to pay any premium for Part A coverage, while premiums are charged for Part B and Part D coverage.

Under the Health Insurance (“HI”) tax component of FICA, workers and employers make contributions to pay for Medicare Part A coverage during the employee’s working years. The HI tax is imposed on both employers and employees at a rate of 1.45 percent of wages paid by employers (for a combined rate of 2.9 percent of wages). Total Medicare benefits for 2007 were \$425.2 billion and total HI receipts for 2007 were \$191.9 billion.⁴⁷

The value of Medicare Part A coverage generally is greater than the HI tax contributions that Medicare enrollees made during their working years. Similarly, the value of Medicare Part B coverage and Medicare Part D coverage is generally greater than the premiums that enrollees must pay. The exclusion of the value of Medicare Part A coverage in excess of HI tax

⁴⁴ The benefits, of course, also do not constitute taxable wages, because they are not paid in respect of an employment arrangement.

⁴⁵ The tax expenditures for the three types of coverage for 2007 are: (1) \$20.2 billion for Medicare Part A; (2) \$13.3 billion for Medicare Part B; and (3) \$4.8 billion for Medicare Part D. In addition, there is \$1.0 billion in tax expenditures for the exclusion of subsidies to employers who maintain prescription drug plans. Section 1860D-22 of the Social Security Act provides a subsidy for sponsors of retiree prescription drug plans that provide drug coverage that is at least actuarially equivalent to the Medicare Part D benefit. The subsidy is available only with respect to retirees who are eligible for, but do not enroll in, Medicare Part D and who are covered under the employer’s retiree prescription drug plan. Section 139A of the Code provides that gross income does not include any employer subsidy payment received under section 1860D-22 of the Social Security Act.

⁴⁶ Medicare Part C contains rules under which private companies may contract with Medicare to provide coverage for Medicare beneficiaries who elect to enroll in the plans offered by such companies. The plans offered under Part C are generally referred to as Medicare Advantage Plans.

⁴⁷ 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, page 5.

contributions made during the taxpayer's earning years is classified as a tax expenditure, as is the exclusion of the value of Medicare Part B and Part D coverage in excess of the premiums paid by enrollees.

B. Itemized Deduction for Medical Expenses

Individuals may claim an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 7.5 percent of adjusted gross income.⁴⁸ As a result, the deduction is beneficial only if two conditions are met: the taxpayer's medical expenses must exceed the 7.5 percent of adjusted gross income threshold, and the taxpayer must have sufficient personal deductions in general to claim an itemized deduction.

The tax expenditure for the itemized deduction for medical expenses was \$8.7 billion for 2007. The deduction is classified as a tax expenditure because the Code generally denies deductions for personal consumption expenditures (that is, expenses not incurred directly in order to produce income).

Table 3 shows the medical expense deduction by income bracket for 2007. The greatest total tax expenditure is in the middle of the income distribution.

Table 3.—Calendar Year Medical Expense Deduction, 2007

Adjusted Gross Income	Medical Expense Deduction Number of Returns (thousands)	Income Tax Savings (millions)	Average Savings Per Return (Dollars)
< 10,000	853	8	9
10,000 – 29,999	2,762	711	257
30,000 – 49,999	2,571	1,508	587
50,000 – 74,999	2,296	2,054	895
75,000 – 99,999	1,204	1,605	1,333
100,000 – 199,999	923	2,060	2,232
200,000 – 499,999	86	586	6,814
> 500,000	7	138	19,714
Total	10,702	8,670	810

Source: JCT Staff calculations.

This deduction is available both to insured and uninsured individuals, thus, an individual with employer-provided health insurance (or another form of tax-subsidized health benefits, as summarized in this section) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5 percent adjusted gross income threshold is met. Moreover, an individual's nonsubsidized health insurance premiums can be counted towards the 7.5 percent threshold. In practice, however, it is very unusual for an individual who purchases insurance with after-tax dollars to meet the income threshold solely through the premiums that the individual has paid.

⁴⁸ 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).

There are a few common ways that individuals use this deduction. For those who are insured, it mainly consists of payments for expensive medical items that are not covered in an individual's insurance, including mental health care, dental care, and long-term care. Mental health care can consist of either frequent use of outpatient services, such as psychotherapy, or the use of inpatient services such as an inpatient rehabilitation facility for substance abuse or other mental illness. Dental care is only insured in a subset of those who have health insurance and frequently dental insurance is insufficient to cover expenses. People may reach the 7.5 percent limitation due to use of acute dental services such as root canal surgery. Lastly, need for nursing home care, particularly in the elderly population is a reason for the use of the medical deduction. Medicare covers up to 100 days, Medicaid coverage is only available once an individual can show he or she is impoverished, and long-term care insurance is rare and frequently insufficient. Therefore the cost of a nursing home frequently is paid directly by the user. Anyone in a nursing home is too sick to work, therefore, may have limited income and thus would likely qualify for the deduction for the entire cost of the nursing home in excess of 7.5 percent of income.

Health insurance is designed to spread the risk of expensive health care over time and across people through the payment of insurance premiums. The 7.5 percent of adjusted gross income threshold, however, arguably distorts the decision whether to buy insurance or self insure. Thus, if an individual without access to any tax-advantaged health insurance has a major medical event costing 50 percent of income every 10 years, that person can pay for 42.5 percent (50 - 7.5) of that event tax-free through the section 213 medical expense deduction if they self insure. If, however, that person pays an actuarially fair premium every year, his or her annual the medical expenses are below 7.5 percent and therefore, he or she cannot deduct any of it. (In practice, however, it is unlikely that those individuals who do not purchase health insurance will have the liquidity to pay medical expenses that are a large portion of their annual income.)

The deduction for medical expenses above 7.5 percent of adjusted gross income, like other deductions for expenses not directly incurred to earn income, might be criticized on the grounds that the deduction is inconsistent with the Code's general measure of taxable income, and (more importantly) might at the margin distort taxpayer behavior, by encouraging taxpayers to view the U.S. Treasury as a partial co-insurer of major medical expenses (through the tax benefits of the deduction), thereby crowding out the private insurance market.⁴⁹ Under this view, adverse selection would work against the interest of the Treasury (i.e., taxpayers in general), and in favor of those who rely on the existence of the deduction to mitigate the net cost of their major medical expenses.

⁴⁹ Moreover, not all medical expenses are involuntary, and to this extent the deduction for medical expenses creates additional efficiency costs in that it encourages excessive consumption of some medical services since the government becomes a partner in the cost of the services. Thus, while the deduction is not likely to encourage excess consumption of some services, such as critical need surgeries, it could cause excessive consumption of ancillary services, such as private hospital rooms, etc. Similarly, other medical expenditures have a strong personal consumption component, such as the quality or variety of one's eye glass frames, and a deduction or exclusion that includes these types of medical expenses is more likely to create economic distortions in consumption.

On the other hand, there is a longstanding consensus that a personal income tax should account for an individual's ability to pay tax, and that medical expenses, by their largely involuntary nature, have a direct impact on the taxpayer's ability to pay tax.⁵⁰ It therefore is argued that, for the income tax to be horizontally equitable—that is, to tax equally those with equal ability to pay—a deduction for medical expenses should be provided. Thus, a taxpayer with \$50,000 in income, but with \$10,000 in medical expenses, would, via the deduction for medical expenses, be taxed in the same amount as a taxpayer with \$40,000 of income and no medical expenses.

This argument would imply that individuals should be able to deduct all of their medical expenses if the tax system is premised on ability to pay. In response, a floor on the deductibility of medical expenses can be argued to be appropriate for administrative reasons, to eliminate the need for the Internal Revenue Service to audit millions of returns each claiming deductions for minor medical expenses.

Medical expenses that qualify for deduction are narrower than medical expenses for which a flexible spending arrangement or health savings account can be used. For example, non-prescription medicines such as aspirin are not deductible under the medical deduction, but could be purchased using dollars set aside in an HSA, HRA or an FSA.

⁵⁰ See William D. Andrews, "Personal Deductions in an Ideal Income Tax," 86 Harv. L. Rev. 309, 1972; William J. Turnier, "Personal Tax Deductions and Tax Reform: The High Road and the Low Road," 31 Vill. L. Rev. 1703, 1986. Andrews argues that the main point of the Haig-Simons definition of income ($\text{Income} = \text{Consumption} + \text{Change in Wealth}$) is to focus on the uses of income and not its sources, and that an ideal income tax would not treat income differently based on its source. He argues that an ideal income tax should focus on elaborating the notion of taxable consumption embodied in the Haig-Simons definition of income in order to arrive at a fairer definition of taxable income. He concludes that a medical expense deduction is necessary in an ideal income tax, i.e., that consumption of medical care should not be taxable consumption. Turnier rejects some of Andrews' reasoning, but ultimately arrives at the same conclusion that a deduction for medical expenses is necessary for an income tax to accurately base tax on ability to pay.

C. HSAs and Archer MSAs

Present law provides that individuals with a high deductible health plan (and no other health plan except for a plan that provides permitted coverage)⁵¹ may establish and make tax-deductible contributions to a health savings account (“HSA”). The tax expenditure for HSAs was \$334 million for 2007. HSAs are one of the lowest cost tax expenditure in the health care sector. However, HSAs are relatively new and utilization is expected to increase in the next several years.⁵²

Table 4.–Calendar Year Tax Expenditures for Health Savings Accounts, 2007

Adjusted Gross Income	Number of Returns (thousands)	Income Tax Savings (millions)	Average Savings Per Person (Dollars)
< 10,000	11	0	--
10,000 – 29,999	61	11	185
30,000 – 49,999	64	18	286
50,000 – 74,999	86	36	421
75,000 – 99,999	64	30	464
100,000 – 199,999	139	107	770
200,000 – 499,999	77	89	1,147
> 500,000	32	43	1,357
Total	534	334	626

Source: JCT Staff calculations.

Like opening an individual retirement account (“IRA”), the decision to create and fund an HSA is made on an individual-by-individual basis, but unlike the case of an IRA, an HSA is subject to a condition precedent that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). Subject to certain limitations, contributions made to an HSA by an individual are deductible for income tax purposes, regardless of whether the individual itemizes personal deductions. Moreover, the

⁵¹ An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is “permitted insurance” or “permitted coverage.” Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker’s compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Effective after December 20, 2006, with respect to coverage for years beginning after December 31, 2006, certain coverage under a health FSA is disregarded in determining eligibility for an HSA.

⁵² Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2007-2011*, (JCS-3-07), September 24, 2007.

individual can exclude from income (and from taxable wages) contributions that the individual's employer (including contributions made through a cafeteria plan through salary reduction) makes to the individual's HSA.

A high deductible health plan is a health plan that has an annual deductible that is at least \$1,100 for self-only coverage or \$2,200 for family coverage (for 2008) and that limits the sum of the annual deductible and other payments that the individual must make in respect of covered benefits to no more than \$5,600 in the case of self-only coverage and \$11,200 in the case of family coverage (for 2008).⁵³

Earnings on amounts in an HSA accumulate on a tax-free basis. Distributions from an HSA that are used for qualified medical expenses are excludable from gross income regardless of the taxpayer's age and regardless of whether treated as paid out of the account's corpus or its earnings.

Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 10 percent. The additional 10-percent tax does not apply, however, if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

In sum, 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 on a tax-favored basis. To the extent that amounts in an HSA are not used for qualified expenses, an HSA provides tax benefits similar to an IRA,⁵⁴ including the same tax deferral of contributions ultimately used to fund general living expenses after age 64 and the same 10 percent additional tax for nonqualified distributions before age 65.

In contrast to a flexible spending arrangement or health reimbursement arrangement, both of which require substantiation for tax-free reimbursement of a medical expense, an individual is not required to provide substantiation to the trustee or custodian of an HSA that a distribution is for a qualified expense in order to be entitled to the exclusion.⁵⁵ Instead, the individual simply

⁵³ These amounts are indexed for inflation.

⁵⁴ Other tax-favored vehicles may also be used to save for future medical expenses, but do not provide the same tax benefits. For example, funds in an IRA may be used to pay medical expenses, but distributions for medical expenses are includible in gross income (and subject to the same 10-percent additional tax for early withdrawal) in the same manner as are other IRA distributions.

⁵⁵ Qualified medical expenses include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for policies that provide supplemental coverage for individuals whose primary insurance is Medicare.

maintains his or her own books and records with respect to the expense and claims the exclusion for a distribution from the HSA on his or her return if it is used for a qualified expense. This may result in certain nonqualified distributions not being reported as subject to tax, including the 10-percent additional tax.

For 2008, the maximum aggregate annual contribution that can be made to an HSA is \$2,900 in the case of self-only coverage and \$5,800 in the case of family coverage.⁵⁶ The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). 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 \$900 in 2008, and \$1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

If an employer makes contributions to employees’ HSAs, the employer must make available comparable contributions on behalf of all employees who have comparable coverage during the same period. Employer contributions are not includable in employees’ incomes or taxable wages. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the plan. If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to HSAs for that period. The comparability rule does not apply to contributions made through a cafeteria plan.

A taxpayer may not combine the benefits of an HSA with those of an Archer MSA. Amounts can be rolled over, however, into an HSA from another HSA or from an Archer MSA. One-time rollovers are permitted from IRAs to HSAs.

Like an HSA, 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.⁵⁷ Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. The main differences include: (1) only self-employed individuals and employees of small employers are eligible to have an Archer MSA; (2) for Archer MSA purposes, a high deductible health plan is a health plan with (a) an annual deductible of at least \$1,950 and no more than \$2,900 in the case of self-only coverage and at least \$3,850 and no more than \$5,800 in the case of family coverage and (b) maximum out-of-pocket expenses of no more than \$3,850 in the case of self-only coverage and

⁵⁶ These amounts are the same as the maximum deductible amounts permitted under a high deductible plan for purposes of Archer MSAs and are indexed for inflation. In the case of individuals who are married to each other, if either spouse has family coverage, both spouses are treated as only having the family coverage with the lowest deductible and the contribution limit is divided equally between them unless they agree on a different division. Limitations based on the amount of the deductible under the high deductible plan applied to years beginning before January 1, 2007.

⁵⁷ Sec. 220.

no more than \$7,050 in the case of family coverage;⁵⁸ and (3) the additional tax on distributions not used for medical expenses is 15 percent rather than 10 percent.

After 2007, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had made Archer MSA contributions and employees who are employed by a participating employer. In light of this fact, the fact that HSAs are more generous than Archer MSAs, and the fact that an individual can roll over an Archer MSA into an HSA, one can expect Archer MSA to soon be replaced by HSAs.

Proponents of high deductible health plans believe that such plans help to alleviate the distortions caused by the exclusion for employer-provided health insurance and other tax-favored medical expenditures. Some proponents of HSAs believe that many current health insurance policies cover routine medical expenses and that the tax laws should provide a subsidy only for insurance for substantial and unpredictable medical expenses.

The creation of HSAs was intended to encourage high deductible health plans and to control the growth of health care spending. Proponents of HSAs believe that if consumers personally pay for a greater portion of their health care purchases (because of the large deductible) out of a fund that can be used for savings (and therefore ultimately is the consumer's money to use as they wish), they will be more prudent in their health spending. In theory, this would result in lower volume of services and potentially consumer pressure to drive down prices of health care services.⁵⁹

Prior to the introduction of HSAs, there was a clear tax advantage to structuring employer-provided health insurance to have a low deductible. The tax exclusion for premiums meant that purchasing a more generous plan with no deductible, essentially paying the deductible through the increased premium, was tax advantaged because any deductible had to be paid out of after-tax dollars, but the premium could be paid with pre-tax dollars. HSAs were meant to address this by tax subsidizing individuals who purchase high deductible health plans.

Concerns exist that HSAs and high deductible health plans are likely to be more attractive to healthier individuals, with the result that adverse selection will occur. If correct, this could erode the group market and result in higher insurance costs for individuals with greater health risks. When insurance is priced on a group basis, individuals with lower health risks in effect subsidize higher risk individuals. If the healthy, low risk individuals leave the pool to seek cheaper, high deductible insurance, the average cost will increase for those remaining. This in

⁵⁸ These deductible and out-of-pocket expenses dollar amounts are for 2008. These amounts are indexed for inflation.

⁵⁹ Evidence from the RAND Health Insurance experiment indicates that health expenditures are elastic; those who can access health care for free used 20 percent more hospital visits than those who paid a 25 percent coinsurance payment or higher for medical care. See Robert H. Brook, et. al. "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Reform Debate," RAND Corporation. 2006. http://www.rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf Accessed 24 July 2008.

turn may cause the next-lowest risk individuals to leave the pool, with a concomitant rise in cost for those still remaining, resulting in a spiral that could drive a plan with generous benefits to price itself out of the market.

To the extent that amounts in HSAs are not used for current medical expenses, HSAs provide a tax benefit similar to that of an IRA, in that HSAs allow tax-free compounding of earnings.⁶⁰ HSA proponents argue that this feature may help contribute to lowering medical costs by in effect rewarding lower spending on medical care. Because HSAs operate similarly to IRAs, there is concern that they will be used as an additional tax shelter for retirement income for wealthy individuals. Critics argue that HSAs are primarily attractive to higher income individuals who can afford to self-insure on a current basis for the higher deductible under the high deductible plan and who are primarily interested in a long-term tax-favored savings vehicle. In this regard, critics observe that a taxpayer can fund both an HSA and a deductible IRA, thereby substantially increasing the individual's annual contributions for tax-preferred savings. In response, proponents of HSAs argue that the additional tax of 10 percent for uses other than health care before age 65 (the age of Medicare eligibility) may mitigate this issue.

⁶⁰ For a discussion of the economic value of deferring tax on investment income, see Joint Committee on Taxation, *Economic Efficiency and Structural Analyses of Alternative U.S. Tax Policies for Foreign Direct Investment* (JCX-55-08), June 25, 2008 at pp.14-15.

D. Refundable Credit for Health Insurance Expenses of Certain Classes of Individuals

Under the Trade Adjustment Assistance Reform Act of 2002,⁶¹ certain individuals are eligible for the health coverage tax credit (“HCTC”).⁶² The HCTC is a refundable tax credit equal to 65 percent of the cost of qualified health coverage paid by an eligible individual.

In general, eligible individuals are individuals who receive 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 who receive 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.⁶³

The HCTC is often cited as an example of how a broad-based refundable tax credit for health insurance (or health expenses) could operate. However, the size of the population eligible for the HCTC is not representative of the population at large. In addition, the costs of administering the credit were very significant in the first several years of implementation.

⁶¹ Pub. L. No. 107-210, secs. 201(a), 202 and 203 (2002).

⁶² Sec. 35.

⁶³ Sec. 35(f).

E. Other Programs

1. Welfare benefit funds, VEBAs, and retiree medical accounts

Generally, an employer (including an employer that self insures) is not able to prefund employer-provided health care coverage for active employees, whether through a welfare benefit fund or otherwise.⁶⁴ In contrast, the Code permits an employer to deduct contributions to a welfare benefit fund for retiree medical benefits that generally are funded over the working lives of the covered employees.⁶⁵ For retirees, deductible contributions can be made to two types of tax exempt funding vehicles, either to a voluntary employees beneficiary association (VEBA)⁶⁶ or, if an employer sponsors a tax-qualified pension plan, to the tax-exempt trust that funds the pension plan (referred to as a “retiree medical account”).⁶⁷ In addition to direct deductible contributions, a retiree medical account under a defined benefit plan may be funded by transfers to the account of excess pension assets under the pension plan of which the account is a part.⁶⁸

2. Long-term care

Present law also provides tax subsidies for qualified long-term care insurance contracts and expenses for qualified long-term care services. A qualified long-term care insurance contract is defined as any insurance contract that provides only coverage for qualified long-term care services, and that meets additional requirements.⁶⁹ Per diem-type and reimbursement-type contracts are permitted. Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal

⁶⁴ Secs. 419(c)(3) and 419A(c)(1). The Code generally limits the deductions that may be taken with respect to contributions to a “welfare benefit fund” for active employees to (1) the amount which would have been allowable as a deduction for the benefits provided during the taxable year as if the employer had provided such benefits directly and (2) claims for benefits incurred but unpaid as of the close of the taxable year (and administrative costs with respect to such claims).

⁶⁵ Sec. 419A(c)(2) and Treas. Reg. sec. 1.404(a)-3(f)(2).

⁶⁶ Secs. 419(e) and 501(c)(9). Contributions also may be made to a VEBA to fund health coverage benefits for active employees.

⁶⁷ Sec. 401(h). Except for the exclusion for distributions from governmental retirement plans for health insurance premiums for public safety officers, excludable employer-provided health coverage generally may only be provided under a tax-qualified retirement plan through a retiree medical account under a tax-qualified pension plan. Rev. Rul. 2005-55, 2005-2 C.B. 284; Prop. Treas. Reg. sec. 1.401(a)-1(e), published in the Federal Register on April 20, 2007, 72 FR 46421.

⁶⁸ Sec. 420.

⁶⁹ Sec. 7702B(b). For example, the contract is not permitted to provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed (and any premium refunds must be applied as a reduction in future premiums or to increase future benefits).

care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.⁷⁰

A qualified long-term care insurance contract is treated as an accident and health insurance contract.⁷¹ Thus, amounts received under the contract generally are excludable from income as amounts received for personal injuries or sickness.⁷² In the case of per diem contracts, the excludable amount is subject to a dollar cap of \$270 per day (for 2008), as indexed. If payments under such contracts exceed the dollar cap, then the excess is excludable only to the extent of actual costs in excess of the dollar cap that are incurred for long-term care services.

An employer's plan that provides employees with coverage under a long-term care insurance contract generally is treated in the same manner as employer-provided health care. As a result, the employer's premium payments are generally excludable from income and wages, and benefits payable under the contract generally are excludable from the recipient's income.⁷³ This exclusion does not apply, however, to long-term care insurance provided under a cafeteria plan.⁷⁴ As a result, a cafeteria plan cannot offer long-term care coverage as a tax-favored option. (As noted earlier, an employee's share of employer-provided health care, by contrast, can be funded through a cafeteria plan.)

Long-term care insurance expenses of a self-employed individual are deductible under the self-employed health deduction.⁷⁵

Premiums paid for a qualified long-term care insurance contract⁷⁶ and unreimbursed expenses for qualified long-term care services are treated as medical expenses for purposes of the itemized deduction for medical care (subject to the floor of 7.5 percent of adjusted gross income). Unreimbursed expenses for qualified long-term care services provided to the taxpayer

⁷⁰ Sec. 7702B(c)(1). A chronically ill individual is generally one who has been certified within the previous 12 months by a licensed health care practitioner as being unable to perform (without substantial assistance) at least two activities of daily living (ADLs) for at least 90 days due to a loss of functional capacity (or meeting other definitional requirements). Sec. 7702B(c)(2).

⁷¹ Sec. 7702B(a)(1).

⁷² Secs. 104(a)(3), 105, and 106.

⁷³ Secs. 105, 106, and 3121(a)(2).

⁷⁴ Section 106(c) provides that gross income of an employee will include employer-provided coverage of qualified long-term care services (as defined in section 7702B(c)) to the extent such coverage is provided through a flexible spending or similar arrangement.

⁷⁵ Sec. 162(l).

⁷⁶ Premiums paid for long-term care coverage are deductible only to the extent that the premiums do not exceed a dollar cap measured by the insured's age at the end of the taxable year. Sec. 213(d)(10).

or the taxpayer's spouse or dependent also are treated as medical expenses for purposes of the itemized deduction.

3. Distributions for public safety officers

Present law provides an exclusion from income for distributions from governmental retirement plans that are used to pay for health insurance premiums for eligible retired public safety officers and their spouses and dependents.⁷⁷ The exclusion is limited to \$3,000 annually. An eligible retired safety officer is an individual who, by reason of disability or attainment of normal retirement age, is separated from service as a public safety officer with the employer that maintains the retirement plan from which the distributions are made. The premiums do not have to be for a plan sponsored by the employer; however, the exclusion does not apply to premiums paid by the employee and reimbursed with pension distributions. Amounts excluded under this provision are not taken into account in determining the itemized deduction for medical expenses or the deduction for health insurance expenses of self-employed individuals.

⁷⁷ Sec. 402(l). This rule is effective for taxable years beginning after December 31, 2006.

APPENDIX A
COMPARISON OF PRESENT-LAW TAX BENEFITS FOR HEALTH EXPENSES¹

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 arrangements (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)	Typically 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).

¹ The table describes the legal limits that apply under present law. Employers may establish rules and limitations consistent with those under present law. For example, it is common for employers to place a limit on the amount of expenses that may be reimbursed through an FSA or HRA.

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
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.
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 \$1,100 for self-only coverage and \$2,200 for family coverage (for 2008). Out-of-pocket expense limit must be no more than \$5,600 for self-only coverage and \$11,200 for family coverage (for 2008).	Maximum annual contribution is \$2,900 for self-only coverage or \$5,800 for family coverage (for 2008). 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	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	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	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
	are excludable from gross income. Earnings on amounts in the Archer MSA accumulate on a tax-free basis.	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 after 2007 except for individuals who previously had an MSA or work for an employer that made MSA contributions.	case of family coverage. No limit on the amount that can be accumulated in the MSA.	
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).

APPENDIX B
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 \$80,000.

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) \$1,913 (I) \$3,000 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).	\$7,650	\$2,550	\$0	\$1,448 (E) \$2,550 (I) \$3,998 total	34%
(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) \$2,900 (I) \$4,547 total	39%
(d) H is self-employed. ³	NA	\$10,200	\$0	\$0 (E) \$2,550 (I)	22%
(e) H does not have employer-provided coverage and is not self-employed. ³	NA	Taken into account in determining itemized deduction of \$5,600 ⁴	Taken into account in determining itemized deduction of \$5,600 ⁴	\$0 (E) \$1,400 (I)	12%

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 $0.153 / (1 + .0765) = 14.2\%$. The subsidy rate drops substantially for taxpayers with earnings above the Social Security earnings cap.

² This example assumes an effective marginal income tax rate of 25 percent. Subsidies to state and local income taxes are ignored here.

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 ($\$80,000 \times 7.5\% = \$6,000$. $\$11,600 - \$6,000 = \$5,600$). In addition, the taxpayer must claim itemized deductions on Schedule A. For most taxpayers, this means that total itemized deductions exceed the standard deduction. For alternative minimum tax purposes, medical expenses are deductible to the extent they exceed 10 percent of adjusted gross income.

APPENDIX C
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 makes contributions of \$2,000 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 \$80,000.

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) \$2,221 (I) \$3,199 total	28%
(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) \$2,795 (I) \$4,099 total	35%
(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) \$3,400 (I) \$5,047 total	44%
(d) H is self-employed. ⁵	NA	\$9,180	\$0	\$2,000	\$0 (E) \$2,795 (I)	24%
(e) H does not have employer-provided coverage and is not self-employed. ⁵	NA	Taken into account in determining itemized deduction of \$5,600 ⁶	Taken into account in determining itemized deduction of \$5,600 ⁶	\$2,000	\$0 (E) \$1,900 (I)	16%

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 Appendix B for calculation of employment tax subsidy.

³ This example assumes an effective marginal income tax rate of 25 percent. Subsidies to state and local income taxes are ignored here.

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 ($\$80,000 \times 7.5\% = \$6,000$. $\$11,600 - \$6,000 = \$5,600$). 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 \$3,600.