BACKGROUND MATERIALS FOR SENATE COMMITTEE ON FINANCE ROUNDTABLE ON HEALTH CARE FINANCING

Before the
SENATE COMMITTEE ON FINANCE
on May 12, 2009

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

May 8, 2009
JCX-27-09

CONTENTS

I. OVERVIEW

The Senate Committee on Finance has scheduled a roundtable on health care financing for May 12, 2009. As background for this roundtable, at the request of Chairman Baucus, the staff of the Joint Committee on Taxation has prepared background material relating to present-law tax expenditures related to health care and the Administration's fiscal year 2010 budget proposal to reduce the value of itemized deductions claimed by certain taxpayers. [1] The Administration's proposal is intended to offset the cost of health care reforms.

The Internal Revenue Code[2] includes a number of significant tax expenditures for health expenses.[3] The availability of these different benefits depends in part on the answers to the following questions:

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 2008. The largest tax expenditure is 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 $11 billion, while the estimated tax expenditure for health savings accounts was less than $1 billion.

---

[1] This document may be cited as follows: Joint Committee on Taxation, *Background Materials for Senate Committee on Finance Roundtable on Health Care Financing*, (JCX-27-09), May 7, 2009. 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.−Selected Tax Expenditures for Health, 2008

Value of Tax Expenditures	Billions of Dollars
Exclusion of employer sponsored health care	226.2
Income	132.7
FICA	93.5
Exclusion of Medicare benefits from income	41.8
Hospital Insurance (Part A)	21.3
Supplemental Medical Insurance (Part B)	14.9
Prescription Drug Insurance (Part D)	4.4
Exclusion of subsidies to employers who maintain prescription drug plans	1.1
Deduction for medical expenses above 7.5% of adjusted gross income	10.7
Self-employed health insurance deduction	5.2
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	1.2
Health savings accounts	0.5
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. 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 estimates in 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. In addition, conventional tax expenditure estimates are calculated only with respect to their effect on income taxes, and thus do not include payroll tax under the Federal Insurance Contribution Act ("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 expenditure for Health Coverage Tax Credit ("HCTC") is expected to increase in 2009 due to the enactment of the TAA Health Coverage Improvement Act of 2009 (Pub. L. No. 111-5) that increased the coverage per eligible individual and the number of individuals eligible for the credit.[4]

[4] Joint Committee on Taxation, *Tax Expenditures for Health Care* (JCX-66-08), July 31, 2008.

The exclusion of employer sponsored health care had a value of $226 billion with $133 billion coming from exclusion from the income tax and $93 billion from excluding the value of health insurance from both the employer and employee portions of the Federal Insurance Contribution Act FICA tax.

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.[5] Such individuals may exclude from income and wages employer-provided health insurance. Depending on the employer's plan, they may also exclude from income some 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.[6] 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. The tax benefit is only subject to the limitation that the health benefits covered must fall under the definition of medical care in section 213(d). Present law also provides additional, less significant, tax expenditures for other 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 because the formation of employer groups is not highly correlated with health status. This results in a relatively even distribution of individuals who are high-risk and may have trouble finding affordable health insurance in the individual market. The combination of tax and economic advantages of employer-provided health care has 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 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

[5] 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. Similarly, certain individuals are temporarily able to purchase health insurance at a reduced premium due to an employer tax credit for a portion of their COBRA eligibility period under the provision of the Consolidated Omnibus Reconciliation Act of 1985.

[6] In addition, where applicable, the deduction for self-employed individuals is taken after eligibility for the Earned Income Tax Credit ("EITC") has been calculated. In contrast, an employee's earned income for purposes of the EITC is determined after the exclusion of the value of employer provided health insurance.

and services for those taxpayers with qualifying plans, and a comparative disadvantage for those purchasing health insurance in the individual market.

II. EMPLOYMENT RELATED TAX EXPENDITURES

A. Employer-Provided Health Care

In general

The Code generally provides that an employee may exclude from his or her gross income the value of employer-provided health care. 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 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; 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 $226.2 billion for 2008, 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.

Table 2.–Calendar Year Tax Benefit from Employer Exclusion by AGI,[*] 2008

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	3,620	(269[**])	3,889	5,698	635
10,000 – 29,999	34,423	17,779	16,644	17,631	1,952
30,000 – 49,999	42,667	22,697	19,970	17,369	2,457
50,000 – 74,999	46,052	24,716	21,336	14,879	3,095
75,000 – 99,999	37,055	22,110	14,945	9,502	3,900
100,000 – 199,999	48,060	33,962	14,098	10,726	4,481
200,000 – 499,999	11,645	9,549	2,096	2,463	4,728
> 500,000	2,680	2,182	498	600	4,467
Total	**226,202**	**132,726**	**93,476**	**78,868**	**2,868**

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

[**] 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 taxpayers with adjusted gross income ("AGI") less than $50,000 obtain cash savings from the exclusion for employer-provided health care valued at between $600 and $2,500, 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.[7] 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.

Active employees participating in a cafeteria plan[8] 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.[9] 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

---

[7] 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.

[8] 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 the requirements of 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.

[9] ERISA sec. 514.

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.[10] In addition, the tax exclusion is not predicated on coverage of certain illnesses or conditions.

While there are certain restrictions with which group health plans must abide, the Code imposes an excise tax on group health plans that fail to meet these requirements.[11] 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 allow employees to fund (or fund themselves) employer sponsored accounts to reimburse some of the remaining 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").[12] If the health FSA under a cafeteria plan meets certain requirements, the compensation that is forgone is not includible in gross income or 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

---

[10] 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.

[11] Secs. 4980B; 4980D.

[12] 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.

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.[13] 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,[14] 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.

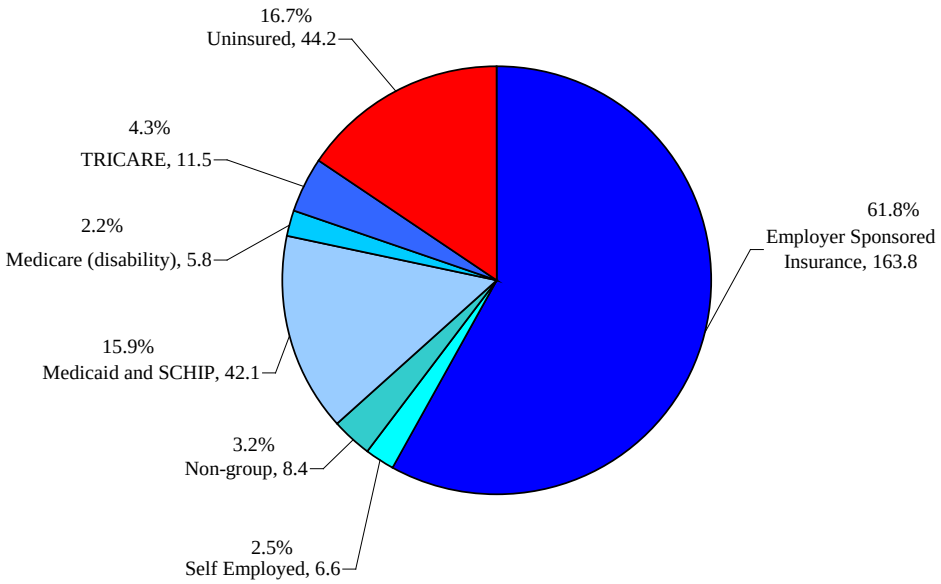
[13] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

[14] 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.

Coverage under employer-sponsored health care

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

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.[15] 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

[15] Forty-nine percent of workers in firms with fewer than 10 employees held employment-based health insurance while more than 77 percent of employees in firms with more than 100 employees held employment-based coverage. Based on Employee Benefit Research Institute analysis of Current Population Survey, March, 2008; Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey," Vol. 321; September, 2008. Subsidies for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs* Vol. 25 Issue 6, November/December, 2006 pp. 1568-1579.

insurance, the greatest impact will be seen in the rates at which health insurance is offered by small businesses.

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 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 fact that those who are most likely to use health care services are the most likely to purchase health insurance.) 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.[16] 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.

Finally, employers generally have superior negotiating power with an insurance company than does an individual consumer. Employers may 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.[17] 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

[16] 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.

[17] 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.

prescription drug benefits. There were reports that, with so many complicated options, many seniors had difficulty choosing a plan.[18]

Some have argued that employers are good agents for their employees and provide invaluable research into the appropriate health plans to offer. 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.

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.[19]

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 provided by the Health Insurance Portability and Accountability Act ("HIPAA") for pre-existing conditions,[20] 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 to maintain their current health insurance when their preference is to leave the workforce or find new work.[21] There are other examples of job lock. Job lock may prevent an individual from leaving a large employer

---

[18] John Leland, "73 Options for Medicare Plan Fuel Chaos, Not Prescriptions," *New York Times*, May 14, 2004. Jack Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries," The Commonwealth Fund: May, 2008.

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

[20] 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.

[21] 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.

that offers insurance and starting a new independent business due to increased health insurance premiums that may be charged with respect to an individual health insurance policy.[22] 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 by the Federal government to eligible consumers. 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, lower deductibles and expanded benefits. Because consumers are responsive to changes in the cost of health care,[23] 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. These market mechanisms affect the price for all health care services. The market inefficiency arising from the tax-induced spending on health care versus other goods generates a loss to the economy referred to as "dead weight loss,"[24] 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 overall societal 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

[22] 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 pre-existing 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. 300gg-41, 44.

[23] Joseph P. Newhouse, *Free For All?: Lessons From the RAND Health Insurance Experiment,* Harvard University Press, 1996.

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

considerable uncertainty among economists on the true size of the increase in the volume and price of health care due to the tax exclusion.[25]

On the other hand, some observers argue that tax subsidies for health insurance and other medical expenditures may correct an existing market failure where people have the tendency to spend below the optimal level of health insurance and health services due to underestimation of their likelihood of needing medical care in the future. Under this view, the tax subsidy might make the health care market more efficient and may improve welfare.[26]

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.[27] Generally, those who obtain their health insurance through their employer are afforded the most favorable tax treatment. Those 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 care 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 income 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 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.

---

[25] Joseph P. Newhouse, *Free For All?: Lessons From the RAND Health Insurance Experiment,* Harvard University Press, 1996.

[26] 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 only $1,855 per year, while 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 underutilized. 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.

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

Any exclusion from income or 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.[28] 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 progressivity of the tax code in the absence of the tax exclusion.

Geographic Variation In Health Spending

Markets for medical care are largely local and health spending varies greatly across regions even after controlling for both a health plan's benefits and the risk of the local population (a measure called actuarial value).[29] The higher costs are rooted in a combination of greater use of health care services and higher cost per service with little explicit evidence of greater resultant health outcomes in these regions. Because health insurance premiums are largely made up of health spending, health insurance premiums vary greatly by local markets. The person living in the low premium region pays a lower total cost (premium) for the same quality health care as the person in the high premium region.

Currently, both individuals may exclude their entire premium from all taxation regardless of premium cost because the tax exclusion for employer sponsored premiums is unlimited; every dollar of insurance purchased is subsidized through the tax code. Therefore, the greater the premium, the greater the tax subsidy. Currently, if two people purchase the same health plan benefits and one lives in a high premium region and one lives in a low premium region, the individual in the high premium region receives a greater tax benefit than a person living in the low premium region.

A uniform dollar cap on the tax exclusion would impact a greater portion of the population in regions with high premiums than in regions with low premiums. In regions with low premiums, a family could purchase a plan with greater actuarial value tax free than could the

[28] For related discussion, see William D. Andrews, "Personal Deductions in an Ideal Income Tax," 86 *Harvard Law Reveiw* 309, 1972.

[29] Peter Orszag, "Health Care and Behavioral Economics," Presentation to the National Academy of Social Insurance, May 28, 2008.

same family living in a high premium region. If there were no behavioral response to a cap on the exclusion, much of the incidence of the tax would be felt in high premium regions.

Generally, the tax code does not adjust for variation in cost of living between regions and some types of variation may be considered unconstitutional. In 2009 the marginal tax rate for a married couple filing jointly increases from 15 percent to 25 percent at $67,900 across the entire United States, even though $67,900 can purchase many more goods and services in a low cost region than it can in a high cost region. Economic theory holds that wages adjust in regions to account for these variations. In other words, even though cost of living is higher, pay is higher to appropriately compensate workers.

Although the tax code typically does not adjust for regional variation, the federal government often takes regional variation into account in other situations, particularly in health care. Most broadly, the Department of Labor calculates the Consumer Price Index by launching surveys in dozens of regions across the country to estimate cost of living in different regions. The Department of Health and Human Services uses Geographic Practice Cost Index ("GPCI") to vary Medicare payments to physicians by local practice conditions including wages of individuals who would make comparable earnings to physicians, as well as practice expenses, such as office rents and other labor costs of running a physicians' office. The Department of Health and Human Services also creates separate Federal poverty lines for Alaska and Hawaii due to a higher cost of living than in the contiguous states. The Federal Poverty Level for a family of four in the continental U.S. is $22,050, while it is $27,570 in Alaska and $25,360 in Hawaii.[30] This measure is often used to determine eligibility for Medicaid which although state run, is largely funded by the Federal government. Lastly, the Federal Medical Assistance Percentage legislation varies its funding of state Medicaid programs by state largely using an average measure of per capita income from the Bureau of Economic Analysis at the Department of Commerce. The share of Medicaid expenses paid for by the Federal government ranges from 50 percent in the states that have the highest per capita incomes to 75 percent in states with the lowest per capita incomes.[31]

Alternative tax policies subsidizing insurance coverage

Because of the efficiency and equity concerns associated with subsidizing health insurance through the exclusion for employer-sponsored health care, those considering options for financing health reform often consider capping the employer exclusion as a potential source of funding. On the other hand, 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

[30] Notice, 74 Fed. Reg. 4199, 4200 (Jan. 23, 2009).

[31] Christie Provost Peters, National Health Policy Forum, Issue Brief No. 828, Medicaid Financing: How the FMAP Formula Works and Why It Falls Short 4-5 (2008).

the income tax exclusion were repealed, but the payroll and State tax exclusions remained.[32] Proposals to eliminate the tax exclusion for health insurance would need to consider any increase in the total number of uninsured.

However, 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. A cap would also reduce the incentive for individuals to over-consume health insurance. To the extent that the cap is lower than the total cost of a policy the marginal cost of the policy would be paid with after-tax dollars. If the cap is not indexed, or is indexed to a measure that grows more slowly than medical costs, the subsidy for employer-provided health care would decline relative to the cost of care over time. In this event, the economic distortion effects of the exclusion would be reduced gradually over time.

One alternative to a tax exclusion for health insurance is a tax deduction available contingent on the purchase of health insurance. A set deduction would maintain the Federal subsidy for employer-sponsored health insurance, but would reduce the marginal incentive to purchase more expensive insurance because the deduction's value does not increase with the cost of insurance.[33] Under this approach, the tax subsidy would be large enough to enable people to continue insurance coverage, but there would be no tax advantage to purchase insurance that costs more than the cap. A tax credit would behave in much the same way, except its value would not vary with the marginal tax rate of the individual.

If such a deduction were provided for the purchase of insurance in the individual market in addition to employer-sponsored 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. However, the advantage of obtaining insurance through one's employer would also be reduced, possibly leading to a reduction in the number of firms offering health insurance benefits and therefore, the total number of individuals eligible to receive employer sponsored health insurance coverage.

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.[34] The amount of the deduction could be chosen to limit Federal budget exposure, and, like the cap, it could be

---

[32] 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.

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

[34] 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.

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-sponsored 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-sponsored 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 and/or the cost of employer-sponsored insurance.

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.[35] 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. While 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.[36] 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.[37]

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

---

[35] Lily L. Batchelder, Fred T. Goldberg Jr., Peter R. Orszag, "Efficiency and Tax Incentives: The Case for Refundable Tax Credits," 59 *Stanford. Law Review* Vol. 23 (2006).

[36] See, for example, the following papers regarding the administration of the earned income tax 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.

[37] 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.

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.

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

Under present law, self-employed individuals may deduct from self-employment the cost of health insurance for themselves and their spouses and dependents.[38] The tax expenditure for the deduction for health insurance premiums for self-employed individuals was $5.2 billion for 2008.

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 and is taken from earned income after the Earned Income Tax Credit "EITC" has been calculated. 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.[39] 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 a self-employed individual.[40] Thus, the exclusion for employer-provided health care 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 has 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.

---

[38] Sec. 162(l).

[39] 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).

[40] Sec. 1372.

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 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 because only some states will count self-employed individuals as an employer for health insurance purposes 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.[41]

Table 3 shows the tax savings by self-employed health deduction by income bracket for 2008.

Table 3.–Self Employed Deduction Tax Savings, 2008

Adjusted Gross Income	Total Income Tax Savings (millions)	Self Employed Deduction Number of Returns (thousands)	Average Savings Per Return (Dollars)
< 10,000	13	485	27
10,000 – 29,999	306	863	355
30,000 – 49,999	428	612	699
50,000 – 74,999	529	579	914
75,000 – 99,999	496	425	1,167
100,000 – 199,999	1,427	735	1,941
200,000 – 499,999	1,267	410	3,090
> 500,000	691	189	3,656
Total	5,157	4,298	1,200

Source: JCT Staff calculations.

[41] 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 PRESENT LAW HEALTH CARE TAX EXPENDITURES

A. 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 AGI.[42] 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 AGI 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 $10.7 billion for 2008.

Table 4 shows the medical expense deduction by income bracket for 2008. The greatest total tax expenditure is in the middle of the income distribution.

Table 4.–Calendar Year Medical Expense Deduction, 2008

Adjusted Gross Income	Total Income Tax Savings (millions)	Medical Expense Deduction Number of Returns (thousands)	Average Savings Per Return (Dollars)
< 10,000	7	987	7
10,000 – 29,999	754	3,272	230
30,000 – 49,999	1,853	3,135	591
50,000 – 74,999	2,612	2,606	1,002
75,000 – 99,999	1,958	1,340	1,461
100,000 – 199,999	2,658	1,022	2,601
200,000 – 499,999	680	86	7,907
> 500,000	162	7	23,143
Total	10,684	12,455	858

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 AGI 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.

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 by an

[42] 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).

individual's insurance, often 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, the need for nursing home care, particularly in the elderly population, is another reason for the use of the medical deduction. While Medicare covers up to 100 days of nursing home care, 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 to cover the cost of nursing home care. Therefore, the cost of a nursing home frequently is paid directly by the taxpayers. In addition, someone in a nursing home is likely to be too sick to work and therefore, may have sufficiently limited income to more easily qualify for the deduction for medical expenses 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 AGI threshold, however, arguably distorts the decision whether to buy insurance or to 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 in the individual market every year, his or her annual medical expenses are below the threshold 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 such a large portion of their annual income.)

The deduction for medical expenses above 7.5 percent of AGI, 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.[43] 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 large medical expenses are generally involuntary nature, have a direct impact

[43] Moreover, not all medical expenses are involuntary. 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 subsidizes the cost of these discretionary 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 taxpayer's ability to pay tax.[44] 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.

However, a floor on such a deduction may be justified on economic grounds. Small health expenditures are predictable and part of consumption, however, very large medical expenditures are unpredictable and more likely impact the ability to pay taxes.

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 an FSA or HSA 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.

[44] See William D. Andrews, "Personal Deductions in an Ideal Income Tax," 86 *Harvard Law Review*, 309, 1972; William J. Turnier, "Personal Tax Deductions and Tax Reform: The High Road and the Low Road," 31 *Villanova Law Review*, 1703, 1986. Andrews argues that the main point of the Haig-Simons definition of income (Income = Consumption + 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.

B. 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)[45] may establish and make tax-deductible contributions to a health savings account ("HSA"). The tax expenditure for HSAs was $0.5 billion for 2008. HSAs are one of the lowest cost tax expenditure in the health care sector.

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 the condition 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 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 $1,150 for self-only coverage or $2,300 for family coverage (for 2009) 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 $5,800 in the case of self-only coverage and $11,600 in the case of family coverage (for 2009).[46]

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 contributions 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).

---

[45] 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.

[46] These amounts are indexed for inflation.

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 after age 65, nonmedical) 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,[47] including the same tax deferral of contributions and earnings 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 an FSA or HRA, 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 to be entitled to the exclusion.[48] Instead, the individual simply 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 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage.[49] 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 $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

---

[47] Other tax-favored vehicles may also be used to save for future medical expenses, but they are not specific to use for medical expenses and they do not provide the same tax benefits. For example, funds in a traditional IRA may be used to pay medical expenses, but distributions for medical expenses are includible in gross income in the same manner as are other traditional IRA distributions.

[48] 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.

[49] These amounts are the same as the maximum deductible amounts permitted under a high deductible plan for purposes of Archer Medical Savings Accounts ("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 exist based on the amount of the deductible under the high deductible health plan apply to years beginning before January 1, 2007.

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.[50] 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 (for 2009) (a) an annual deductible of at least $2,000 and no more than $3,000 in the case of self-only coverage and at least $4,000 and no more than $6,500 in the case of family coverage and (b) maximum out-of pocket expenses of no more than $4,000 in the case of self-only coverage and no more than $7,350 in the case of family coverage;[51] 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 distortion in the health insurance market caused by the exclusion for employer-sponsored health insurance. 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

[50] Sec. 220.

[51] These deductible and out-of-pocket expenses dollar amounts are for 2009. These amounts are indexed for inflation.

would result in lower volume of services and potentially consumer pressure to drive down prices of health care services.[52]

Prior to the introduction of HSAs, there was a clear tax advantage to structuring employer-sponsored 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 equalize health spending through premiums and through out of pocket spending while creating a financial incentive for individuals to be economical in their health expenditures. 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 premiums 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 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 a deductible IRA, in that HSAs allow tax-free compounding of earnings. 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 deductible 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.

[52] 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.

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

1. Health insurance tax credit

Under the Trade Adjustment Assistance Reform Act of 2002,[53] certain individuals are eligible for the Health Coverage Tax Credit ("HCTC").[54] The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. [55]

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 and administered by the Treasury Department. 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.[56]

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 significant in the first several years of implementation. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury. The Treasury pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.[57]

---

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

[54] Sec. 35.

[55] The amount of the credit was increased from 65 percent to 80 percent by the TAA Health Coverage Improvement Act of 2009, Pub. L. No. 111-5, effective May 2009. The credit returns to 65 percent for months after December 31, 2010.

[56] Sec. 35(f).

[57] See Internal Revenue Service Publication 4181.

2. COBRA continuation coverage premium reduction

The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") requires that a group health plan[58] must offer continuation coverage to qualified beneficiaries with respect to a covered employee[59] in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent[60] of the "applicable premium" [61]for such period and the premium must be payable, at the election of the payor, in monthly installments.

Section 3001 of the American Recovery and Investment Act of 2009[62] provides that, for a period not exceeding nine months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct). In addition, the qualifying event must occur during the period beginning September 1, 2008 and ending with December 31, 2009.

The premium subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program ("FEHBP") and to continuation health coverage

---

[58] 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.

[59] A "covered employee" is an individual who is (or was) provided coverage under the group health plan on account of the performance of services by the individual for one or more persons maintaining the plan and includes a self-employed individual. A "qualified beneficiary" means, with respect to a covered employee, any individual who on the day before the qualifying event for the employee is a beneficiary under the group health plan as the spouse or dependent child of the employee. The term qualified beneficiary also includes the covered employee in the case of a qualifying event that is a termination of employment or reduction in hours.

[60] In the case of a qualified beneficiary whose minimum coverage period is extended to 29 months on account of a disability determination, the premium for the period of the disability extension may not exceed 150 percent of the applicable premium for the period.

[61] The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred, and is determined without regard to whether the cost is paid by the employer or employee.

[62] Pub. L. No. 111-5.

under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the premium subsidy.[63] To the extent that the aggregate amount of subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on entitlement to the premium reduction and subsidy, and it is conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed on an individual's tax return.

[63] In the case of a multiemployer group health maintained by a multiemployer or a plan subject to a State program, the person to whom the reimbursement is payable is either the multiemployer group health plan or the insurer providing coverage under an insured plan.

IV. PRESIDENT'S FISCAL YEAR 2010 BUDGET PROPOSAL TO LIMIT THE RATES AT WHICH TAXPAYERS MAY BENEFIT FROM ITEMIZED DEDUCTIONS

As described in greater detail below, the President's Fiscal Year 2010 budget proposals contain a proposal to limit the tax rates at which taxpayers may benefit from itemized deductions, such as the charitable contribution deduction, the mortgage interest deduction, and the deduction for State and local income taxes. The proposal is designed in part to fund a new reserve fund for health care reform.

Present Law

General structure of the individual income tax

Under the Code, gross income means "income from whatever source derived" except for certain items specifically exempt or excluded by statute. An individual's AGI is determined by subtracting certain "above-the-line" deductions from gross income. These deductions include, among other things, contributions to a tax-qualified retirement plan by a self-employed individual, contributions to certain IRAs, one-half of self-employment taxes, certain moving expenses, and alimony payments.

In order to determine taxable income, an individual reduces AGI by any personal exemption deductions and either the applicable standard deduction or his or her itemized deductions. Personal exemptions generally are allowed for the taxpayer, his or her spouse, and any dependents. For 2009, the amount deductible for each personal exemption is $3,650. This amount is indexed annually for inflation. The deduction for personal exemptions is reduced or eliminated for taxpayers with incomes over certain thresholds, which are indexed annually for inflation. The applicable thresholds for 2009 are $166,800 for single individuals, $250,200 for married individuals filing a joint return and surviving spouses, $199,950 for heads of households, and $125,100 for married individuals filing separate returns.

Standard and itemized deductions

A taxpayer also may reduce AGI by the amount of the applicable standard deduction. The basic standard deduction varies depending upon a taxpayer's filing status. For 2009, the amount of the standard deduction is $5,700 for single individuals and married individuals filing separate returns, $8,350 for heads of households, and $11,400 for married individuals filing a joint return and surviving spouses. An additional standard deduction is allowed with respect to any individual who is elderly or blind.[64] The amounts of the basic standard deduction and the additional standard deductions are indexed annually for inflation. Finally, a taxpayer may reduce

[64] For 2009, the additional amount is $1,100 for married taxpayers (for each spouse meeting the applicable criterion) and surviving spouses. The additional amount for single individuals and heads of households is $1,400. If an individual is both blind and aged, the individual is entitled to two additional standard deductions, for a total additional amount (for 2009) of $2,200 or $2,800, as applicable.

AGI by an additional standard deduction for State and local property taxes paid of $500 ($1,000 for joint filers) and for qualified motor vehicle taxes.

In lieu of taking the applicable standard deductions, an individual may elect to itemize deductions. The deductions that may be itemized include State and local income taxes (or, in lieu of income, sales taxes), real property and certain personal property taxes, home mortgage interest, charitable contributions, certain investment interest, medical expenses (in excess of 7.5 percent of AGI), casualty and theft losses (in excess of $500 per loss and in excess of 10 percent of AGI), and certain miscellaneous expenses (in excess of two percent of AGI).

Under present law, the total amount of otherwise allowable itemized deductions (other than medical expenses, investment interest, and casualty, theft, or wagering losses) is reduced by three percent of the amount of the taxpayer's 2009 adjusted gross income in excess of $166,800 ($83,400 for married couples filing separate returns). These amounts are adjusted annually for inflation. In computing this reduction of total itemized deductions, all present law limitations applicable to such deductions (such as the separate floors) are first applied and, then, the otherwise allowable total amount of itemized deductions is reduced in accordance with this provision. Under present law, the otherwise allowable itemized deductions may not be reduced by more than 80 percent.

Individual income tax rates

A taxpayer's net income tax liability is the greater of (1) regular individual income tax liability reduced by credits allowed against the regular tax, or (2) tentative minimum tax reduced by credits allowed against the minimum tax. The amount of income subject to tax is determined differently under the regular tax and the alternative minimum tax, and separate rate schedules apply. Lower rates apply for long-term capital gains; those rates apply for both the regular tax and the alternative minimum tax.

To determine regular tax liability, a taxpayer generally must apply the tax rate schedules (or the tax tables) to his or her regular taxable income. The rate schedules are broken into several ranges of income, known as income brackets, and the marginal tax rate increases as a taxpayer's income increases. Separate rate schedules apply based on an individual's filing status. For 2009, the regular individual income tax rate schedules are as follows in Table 5:

Table 5.–Federal Individual Income Tax Rates for 2009

If taxable income is:	Then income tax equals:
	Single Individuals
Not over $8,350	10% of the taxable income
Over $8,350 but not over $33,950	$835 plus 15% of the excess over $8,350
Over $33,950 but not over $82,250	$4,675 plus 25% of the excess over $33,950
Over $82,250 but not over $171,550	$16,750 plus 28% of the excess over $82,250
Over $171,550 but not over $372,950	$41,754 plus 33% of the excess over $171,550
Over $372,950	$108,216 plus 35% of the excess over $372,950
	Heads of Households
Not over $11,950	10% of the taxable income
Over $11,950 but not over $45,500	$1,195 plus 15% of the excess over $11,950
Over $45,500 but not over $117,450	$6,227.50 plus 25% of the excess over $45,500
Over $117,450 but not over $190,200	$24,215 plus 28% of the excess over $117,450
Over $190,200 but not over $372,950	$44,585 plus 33% of the excess over $190,200
Over $372,950	$104,892.5 plus 35% of the excess over $372,950
	Married Individuals Filing Joint Returns and Surviving Spouses
Not over $16,700	10% of the taxable income
Over $16,700 but not over $67,900	$1,670 plus 15% of the excess over $67,900
Over $67,900 but not over $137,050	$9,350 plus 25% of the excess over $67,900
Over $137,050 but not over $208,850	$26,637.50 plus 28% of the excess over $137,050
Over $208,850 but not over $372,950	$46,741.50 plus 33% of the excess over $208,850
Over $372,950	$100,894.50 plus 35% of the excess over $372,950
	Married Individuals Filing Separate Returns
Not over $8,350	10% of the taxable income
Over $8,350 but not over $33,950	$835 plus 15% of the excess over $8,350
Over $33,950 but not over $68,525	$4,675 plus 25% of the excess over $33,950
Over $68,525 but not over $104,425	$13,318.75 plus 28% of the excess over $68,525
Over $104,425 but not over $186,475	$23,310.75 plus 33% of the excess over $104,425
Over $186,475	$50,447.25 plus 35% of the excess over $186,475

Alternative minimum tax liability

An alternative minimum tax is imposed on an individual, estate, or trust in an amount by which the tentative minimum tax exceeds the regular income tax for the taxable year. The tentative minimum tax is the sum of (1) 26 percent of so much of the taxable excess as does not exceed $175,000 ($87,500 in the case of a married individual filing a separate return) and (2) 28 percent of the remaining taxable excess. The taxable excess is so much of the alternative minimum taxable income ("AMTI") as exceeds the exemption amount. The maximum tax rates on net capital gain and dividends used in computing the regular tax are also used in computing

the tentative minimum tax. AMTI is the taxpayer's taxable income increased by the taxpayer's "tax preference items" and adjusted by redetermining the tax treatment of certain items in a manner that negates the deferral of income resulting from the regular tax treatment of those items.

The exemption amounts for 2009 are: (1) $70,950 in the case of married individuals filing a joint return and surviving spouses; (2) $46,700 in the case of other unmarried individuals; (3) $35,475 in the case of married individuals filing separate returns; and (4) $22,500 in the case of an estate or trust. The exemption amounts are phased out by an amount equal to 25 percent of the amount by which the individual's AMTI exceeds (1) $150,000 in the case of married individuals filing a joint return and surviving spouses, (2) $112,500 in the case of other unmarried individuals, and (3) $75,000 in the case of married individuals filing separate returns or an estate or a trust. These amounts are not indexed for inflation.

Among the preferences and adjustments applicable to the individual alternative minimum tax are accelerated depreciation on certain property used in a trade or business, circulation expenditures, research and experimental expenditures, certain expenses and allowances related to oil and gas and mining exploration and development, certain tax-exempt interest income, and a portion of the amount of gain excluded with respect to the sale or disposition of certain small business stock. In addition, personal exemptions, the standard deduction, and certain itemized deductions, such as State and local taxes and miscellaneous deductions items, are not allowed to reduce alternative minimum taxable income.

Description of President's Budget Proposal

The proposal limits the rate at which taxpayers with taxable income in excess of a threshold amount benefit from itemized deductions. In general, the proposal limits the benefit of itemized deductions for individuals with taxable income in excess of $200,000 and married couples with taxable income in excess of $250,000 to 28 percent.

For example, assume that a taxpayer in the 35-percent income tax bracket makes a $1,000 charitable contribution. Under present law, the $1,000 contribution would result in a $350 tax savings, or 35 percent of $1,000 (disregarding any other limitations that may apply to reduce the taxpayer's itemized deductions). Under the proposal, the same $1,000 contribution by the same 35-percent[65] bracket taxpayer would result in a tax savings of only $280 (28 percent of $1,000).

Effective date.−The proposal is effective for tax years beginning after December 31, 2010.

[65] Under a separate budget proposal, the President would increase the top marginal tax rates for higher-bracket taxpayers. For the sake of simplicity, however, the examples in this section assume a top marginal income tax rate of 35 percent, as under present law.

Analysis

The proposal has been the subject of considerable debate, much of which centers on the likely effect of the proposal on charitable giving and housing (discussed below), although the proposal applies more broadly to all itemized deductions. Some proponents have argued that limiting the benefit of itemized deductions in this manner will reduce the incentive to undertake certain activities. Some opponents have argued that such a limitation is inappropriate to the extent that the deductions, such as those for medical expenses, casualty or theft losses, or local taxes, are designed to reflect more accurately a taxpayer's ability to pay. If this is the case, then no adjustment should be made to the deductions, and any concern about fairness or progressivity should be addressed through the marginal tax rate structure. Furthermore the extent to which the proposal impacts progressivity is unclear given the interaction with other budget proposals such as the so-called Pease limitation on itemized deductions and provisions of the alternative minimum tax.

Charitable deduction

Some argue, for example, that the proposed limit on itemized deductions diminishes a taxpayer's incentive to make charitable contributions by increasing the cost of charitable giving[66]; such commentators argue that the proposal therefore will result in a decrease in charitable giving.[67] For example, disregarding any other limitations that may apply to limit itemized deductions, under present law a 35-percent bracket taxpayer who makes a $1,000 charitable contribution will save $350 (35 percent of $1,000). In other words, the after tax cost to the taxpayer is only $650 to give $1,000 to charity ($1,000 - $350 savings). Under the proposal, the same $1,000 charitable contribution would cost the same taxpayer $720 ($1,000 - (28 percent of $1,000)). This represents a cost increase of more than 10 percent.

Others, however, argue that the proposed limit will result in little if any reduction in overall charitable giving.[68] Some argue, for example, that charitable giving is motivated in

---

[66] For a recent literature review of the responsiveness of charitable giving to its price, see John Peloza and Piers Steele, "The Price Elasticities of Charitable Contributions: A Meta Analysis," Journal of Public Policy & Marketing 24(2): 260-272, 2005. See also Charles T. Clotfelter, *Federal Tax Policy and Charitable Giving* (Chicago: University of Chicago Press), 1985; and Jon Bakija and Bradley Heim "How Does Charitable Giving Respond To Incentives And Income? Dynamic Panel Estimates Accounting For Predictable Changes In Taxation," National Bureau of Economic Research Working Paper 14237, August 2008.

[67] *See* Independent Sector, Statement on Changes to Tax Incentives for Charitable Giving and Health Care Reform, *http://www.independentsector.org/media/20090326_giving_healthcare_statement.html* (March 26, 2009) (arguing that changing in tax benefits affect charitable giving levels and that the President's budget proposal will result in a decrease in charitable giving).

[68] For example, the Center on Philanthropy at Indiana University performed a study to determine how the President's proposal would affect charitable giving. *See* The Center on Philanthropy at Indiana University, white paper, "How Changes in Tax Rates Might Affect Itemized Charitable Deductions," *available at* http://www.philanthropy.iupui.edu/docs/2009/2009_TaxChangeProposal_WhitePaper.pdf

significant part by factors other than tax rules, such as altruism and the overall state of the economy;[69] most taxpayers, therefore would not eliminate or significantly reduce charitable giving under the proposal. Indeed, under the proposal, each additional dollar given to charity by a taxpayer subject to the proposal will continue to result in a tax savings, although at a rate of 28 percent rather than the higher 33- or 35-percent rates.

Furthermore, some argue that the proposal improves fairness and equity to the tax treatment of itemized deductions by partially leveling the tax benefit to higher- and lower-income taxpayers resulting from identical gifts. For example, assume that a taxpayer in the 35-percent bracket and a taxpayer in the 25-percent bracket each make identical $1,000 contributions to charity. As a result of the $1,000 contribution, the higher-income taxpayer will have a tax savings of $350 (35 percent of $1,000), such that his cost of making the $1,000 contribution is $650 ($1,000 - $650). The taxpayer in the 25-percent bracket, however, will achieve a tax savings of only $250 (25 percent of $1,000), such that his cost of making the $1,000 contribution is $750 ($1,000 - $250). In other words, under present law, an identical charitable contribution results in a greater benefit (in this example, $100) to the higher-bracket taxpayer, even though the lower-bracket taxpayer arguably has been more generous by contributing a higher percentage of his taxable income to charity. The proposal limits (but does not eliminate) this disparate treatment by limiting the rate at which the higher-bracket taxpayer may benefit from itemized deductions to 28 percent.

On the other hand, such a fairness argument rests on an implicit assumption that, when a taxpayer makes a charitable contribution, he or she is buying something. If, however, one's initial view is that a gift to charity reduces a taxpayer's resources available for private consumption, then the proposed modification to the marginal rates at which taxpayers may benefit from deductions should not be undertaken, else taxpayers similarly situated with respect to resources available for private consumption would face differential tax burdens.

Mortgage interest and property tax deductions

The deductions for home mortgage interest and property taxes reduce the after-tax cost of financing and maintaining a home. The benefit generally rises as the marginal tax rate of the taxpayer rises. However, research suggests that the benefits of the home mortgage interest deduction, and thus the costs of any limitation, are distributed heterogeneously among taxpayers,

---

(March 2009) (hereafter "Indiana University White Paper). Using a simplified model and 2006 itemized deduction data, the Center estimated that, if the budget proposal had been in effect in 2006, "the impact on itemized giving would have been a relatively small reduction when measured as a percentage of total itemized charitable giving by individuals (a decrease of 2.1 percent)." Looking only at the highest income households, the Center estimated a slightly larger drop (approximately 4.8 percent). The Center concluded that "[t]he larger economy plays a more important role in changes in giving than do tax rate changes."

[69] *See, e.g.*, Indiana University White Paper, *supra*.

even among those with more than $250,000 in income.[70] Within this group, the largest benefits accrue to younger homeowners, who tend to have higher loan-to-value ratios, and to those taxpayers purchasing more expensive homes.

Limiting itemized deductions would raise the after-tax cost of financing and maintaining a home for affected taxpayers. One study estimates that completely repealing the mortgage interest deduction would raise the cost of capital for owner-occupied housing by seven percent.[71] Smaller cost increases would be associated with limiting the deduction. However, if taxpayers adjusted their portfolios to reduce their loan-to-value ratios, changing the tax treatment of mortgage interest might have little impact on the user cost.[72] As with the benefits of the deduction, the largest increases in the cost of housing would occur for younger, high-income homeowners with relatively higher loan-to-value ratios and relatively fewer non-housing assets with which to reduce those ratios. Demand for housing by affected taxpayers would be expected to decline in response to the increased cost.

Some argue that the proposal would have a detrimental effect on the U.S. economy, because it would lead to a decline in home prices at a time when many homeowners have seen the value of their residences decline to an amount below their mortgage balances. Areas with relatively large numbers of affected taxpayers and relatively inelastic housing supply would be expected to face the greatest price declines. This, they argue, could lead to deterioration in bank balance sheets as the value of their mortgage loans and mortgage-backed securities also decline.

Others argue that limiting the home mortgage interest deduction is unlikely to have a detrimental effect on the U.S. economy. They argue that the limitation will affect too few taxpayers to reduce incentives for the marginal homebuyer. Still others question whether the mortgage interest deduction does much to encourage homeownership and thus the positive spillover benefits that might entail.[73] On the contrary, to the extent that the mortgage interest deduction creates economic distortions−increasing the size and cost of housing, increasing the allocation of capital to owner-occupied housing away from potentially higher pre-tax return

---

[70] James Poterba and Todd Sinai, "Tax Expenditures for Owner-Occupied Housing: Deductions for Property Taxes and Mortgage Interest and the Exclusion of Imputed Rental Income" *American Economic Review Papers and Proceedings*, vol. 96, number 2 (May 2008).

[71] *Id.*

[72] *See* Martin Gervais and Manish Pandey, "Who Cares about Mortgage Interest Deductibility?" *Canadian Public Policy*, University of Toronto Press, vol. 34, number 1 (March 2008). Wealthier households are more likely to alter their balance sheets to reduce their loan-to-value ratios. To the extent that non-housing assets generate income derived subject to tax, such portfolio shifting will reduce taxable income for these households, partially offsetting the increase in tax due to limitation of the deduction. Indeed, the benefits of deductibility do not increase with income as fast as taxes paid. Accordingly, Gervais and Pandey (2008) find "mortgage interest deductibility makes the tax code less progressive at relatively low levels of income and more progressive for relatively high levels of income."

[73] Edward L. Glaeser and Jesse M. Shapiro, "The Benefits of the Home Mortgage Interest Deduction" Harvard Institute of Economic Research, Discussion Paper Number 1979, (October 2002).

investments in other sectors, increasing the amount of leverage used to purchase homes--limiting the deduction could be beneficial to the economy as a whole.

V. THE VALUE OF TAX EXEMPTION FOR TAX-EXEMPT HOSPITALS

Present Law

Tax exemption

Charitable organizations, i.e., organizations described in section 501(c)(3), generally are exempt from Federal income tax, are eligible to receive tax deductible contributions,[74] have access to tax-exempt financing through State and local governments (described in more detail below),[75] and generally are exempt from State and local taxes. A charitable organization must operate primarily in pursuance of one or more tax-exempt purposes constituting the basis of its tax exemption.[76] The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, or to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.[77]

The Code does not provide a per se exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and meets additional requirements of section 501(c)(3).[78] The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.[79] It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care.

Although section 501(c)(3) hospitals generally are exempt from Federal tax on their net income, such organizations are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions.[80] In general, interest, rents,

---

[74] Sec. 170.

[75] Sec. 145.

[76] Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

[77] Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

[78] Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some may qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

[79] Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

[80] Secs. 511-514.

royalties, and annuities are excluded from the unrelated business income of tax-exempt organizations.[81]

Charitable contributions

In general, a deduction is permitted for charitable contributions, including charitable contributions to tax-exempt hospitals, subject to certain limitations that depend on the type of taxpayer, the property contributed, and the donee organization. The amount of deduction generally equals the fair market value of the contributed property on the date of the contribution. Charitable deductions are provided for income, estate, and gift tax purposes.[82]

Tax-exempt financing

In addition to issuing tax-exempt bonds for government operations and services, State and local governments may issue tax-exempt bonds to finance the activities of charitable organizations described in section 501(c)(3). Because interest income on tax-exempt bonds is excluded from gross income, investors generally are willing to accept a lower rate on such bonds than they might otherwise accept on a taxable investment. This, in turn, lowers the cost of capital for the users of such financing. Both capital expenditures and limited working capital expenditures of charitable organizations described in section 501(c)(3) of the Code generally may be financed with tax-exempt bonds. Private, nonprofit hospitals frequently are the beneficiaries of this type of financing.

Bonds issued by State and local governments may be classified as either governmental bonds or private activity bonds. Governmental bonds are bonds the proceeds of which are primarily used to finance governmental functions or which are repaid with governmental funds. Private activity bonds are bonds in which the State or local government serves as a conduit providing financing to nongovernmental persons[83] (e.g., private businesses or individuals). For these purposes, section 501(c)(3) organizations are treated as nongovernmental persons. The exclusion from income for interest on State and local bonds does not apply to private activity bonds, unless the bonds are issued for certain permitted purposes ("qualified private activity bonds") and other Code requirements are met.

Analysis of Value of Tax Exemption for Section 501(c)(3) Hospitals

In 2006, the Joint Committee on Taxation analyzed the Federal cost associated with tax-exempt status for private nonprofit hospitals.[84] The analysis was not an estimate of the revenue

[81] Sec. 512(b).

[82] Secs. 170, 2055, and 2522, respectively.

[83] For these purposes, the term "nongovernmental person" generally includes the Federal Government and all other individuals and entities other than States or local governments.

[84] The analysis was performed at the request of the Congressional Budget Office ("CBO") and was incorporated into a CBO report regarding the community benefits provided by tax-exempt hospitals

effects of removing tax-exempt status from hospitals, but was an evaluation of the amount of tax savings generated by tax-exempt status, considering the then-current level of activity of such hospitals. The analysis was based on data from IRS Forms 990 ("Return of Organization Exempt from Income Tax") filed for 2002.

The total Federal tax cost associated with the tax exemption for section 501(c)(3) hospitals and their supporting organizations for calendar year 2002 was estimated to be approximately $6.1 billion, as follows in Table 6.

Table 6.−Federal Tax Cost Estimate for Tax Exempt Hospitals, 2002[85]

Tax Type	2002 Value (Billions of Dollars)
Corporate income tax (Federal)	2.5
Tax-exempt bond financing (Federal)	1.8
Charitable contributions (Federal)	1.8
Total	**6.1**[*]

[*] Details do not add to total due to rounding.

The value of tax exempt status for nonprofit hospitals is extremely difficult to quantify. The Form 990 that hospitals file with the IRS does not include all information that would be required to compute hypothetical Federal tax liability. The Form 990, for example: (1) does not provide information on State or local tax liability, which typically would be deductible by a business; (2) records book depreciation rather than tax depreciation; (3) does not reflect tax-exempt debt that has been issued by another entity on behalf of the filer; and (4) provides only limited information from which to determine possible relationships between the hospital and other tax-exempt and taxable filers. Because of these inherent limitations in the data and for various other reasons, the estimate carries substantial uncertainty.

---

that was published in December 2006. *See* Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits" (December 2006), at pp. 5-6.

[85] In 2008, the staff of the Joint Committee on Taxation published a tax expenditure estimate for the exclusion of interest on State and local government qualified private activity bonds for private nonprofit hospital facilities of $12.1 billion for the five-year period 2008 through 2012. *See* Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2008-2012* (JCS-02-08), October 31, 2008, at p. 56. As with the estimates derived from the above-described analysis, tax expenditure estimates are not revenue estimates and do not consider the behavioral effects of changes in tax laws. The 2008 tax expenditures publication also includes a tax expenditures estimate for health-related charitable contributions of $23.2 billion over the period 2008 through 2012; that figure, however, includes deductions for contributions not only to hospitals, but also to other health-related charitable organizations. The 2008 tax expenditure estimates are not directly comparable to the estimates from the 2006 study.

Also, as indicated above, the estimates are not revenue estimates, because they do not consider likely behavioral responses to proposed changes in tax laws. For example, such behavioral responses might include, corporate reorganizations, shifting of revenues between entities, changes in patterns of investment, or changes in charitable contributions.[86]

[86] In 2008, the staff of the Joint Committee on Taxation described certain tax subsidies intended to subsidize or induce behavior directly related to the production of business or investment income. *See* Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2008-2012* (JCS-02-08), October 31, 2008, at pp. 21-23. This description included tax-exempt status for certain organizations exempt from tax under section 501(a) that arguably have a direct business analog or compete with for-profit entities, such as small insurance companies, mutual or cooperative electric companies, State credit unions, and Federal credit unions. Along these lines, some argue that tax-exempt hospitals similarly operate much like for-profit hospitals and compete directly with such entities.

APPENDIX A
COMPARISON OF PRESENT-LAW TAX BENEFITS FOR HEALTH EXPENSES[1]

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 $1,150 for self-only coverage and $2,300 for family coverage (for 2009). Out-of-pocket expense limit must be no more than $5,800 for self-only coverage and $11,600 for family coverage (for 2009).	Maximum annual contribution is $3,000 for self-only coverage or $5,950 for family coverage (for 2009). 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 80 percent of the cost of qualified health insurance coverage.	Individuals receiving trade adjustment assistance and certain individuals receiving benefits from the PBGC.	Limited to 80 percent of the cost of qualified health insurance for months of coverage beginning April 2009. Limited to 65 percent of the same cost for months of coverage beginning after December 31, 2010. 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 X 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 X 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.