Congressional Research Service
Informing the legislative debate since 1914

Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief

Updated March 24, 2016

Congressional Research Service
https://crsreports.congress.gov
R44147

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Archived CRS Report R44147

This report provides an overview of the Patient Protection and Affordable Care Act's (P.L. 111-148, as amended) excise tax on high-cost employer-sponsored health insurance coverage as of March 24, 2016. In 2019, the excise tax was repealed before it was implemented (P.L. 116-94). Therefore, this report has been archived and will not be updated. It may be used as a historical document.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) includes a 40% excise tax on high-cost employer-sponsored health coverage. This excise tax is often called the *Cadillac tax*. Under the ACA, the excise tax was to be implemented beginning in 2018; however, the Consolidated Appropriations Act of 2016 (P.L. 114-113) delays implementation until 2020.

The excise tax applies to the aggregate cost of an employee's applicable coverage that exceeds a dollar limit. Applicable coverage includes, but is not limited to, the employer's and the employee's contribution to health insurance premiums and certain contributions to tax-advantaged health accounts (e.g., health care flexible spending accounts, or FSAs).

In 2020, the Congressional Research Service (CRS) estimates the dollar limits will be about $10,800 for single coverage and $29,100 for non-single (e.g., family) coverage. The dollar limits may be adjusted based on growth in health insurance premiums and characteristics of an employer's workforce. Additionally, the dollar limits are to be adjusted for inflation in subsequent years.

The entity providing the coverage, the coverage provider, is responsible for paying its share of the excise tax. A coverage provider may be an employer, a health insurer, or another entity that sponsors the coverage. The employer is responsible for calculating the amount of tax owed by each coverage provider (if any).

All of this information is covered in more detail in this report, which provides an overview of how the excise tax is to be implemented. The information in the report is based on statute and guidance issued by the Department of the Treasury and the Internal Revenue Service.

Contents

The Excise Tax on High-Cost Employer-Sponsored Health Coverage....2
Applicable Coverage....2
Definition of Applicable Coverage....3
Determining the Cost of Applicable Coverage....4
Dollar Limits....5
Demographic Adjustment....6
Retiree and High-Risk Profession Adjustment....6
Coverage Providers....7
Cost Estimate....8
Relationship to the Tax Exclusion for Employer-Sponsored Insurance....8

Tables

Table 1. Applicable Coverage....3
Table 2. Not Considered Applicable Coverage....4
Table 3. Coverage Provider by Type of Coverage....7

Contacts

Author Information....9
Acknowledgments....9

Archived CRS Report R44147

This report provides an overview of the Patient Protection and Affordable Care Act's (P.L. 111-148, as amended) excise tax on high-cost employer-sponsored health insurance coverage as of March 24, 2016. In 2019, the excise tax was repealed before it was implemented (P.L. 116-94). Therefore, this report has been archived and will not be updated. It may be used as a historical document.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) includes a 40% excise tax on high-cost employer-sponsored health insurance coverage, often referred to as the *Cadillac tax*.[1] The 40% excise tax is assessed on the aggregate cost of employer-sponsored health coverage that exceeds a dollar limit. If a tax is owed, it is levied on the entity providing the coverage (e.g., the health insurance issuer or the employer). Under the ACA, the excise tax was to go into effect in 2018; however, the Consolidated Appropriations Act of 2016 (CAA of 2016; P.L. 114-113) delays implementation until 2020.

The excise tax is included in the ACA to raise revenue to offset the cost of other ACA provisions (e.g., the financial subsidies available through the health insurance exchanges). The most current publicly available cost estimate from the Congressional Budget Office (CBO) indicates that the excise tax was expected to increase federal revenues by $87 billion between 2016 and 2025, based on 2018 implementation.[2] The excise tax also is expected to limit the tax advantages for employer-sponsored health coverage. Many economists contend that the tax advantages lead to an overconsumption of coverage and health care services.

This report provides an overview of the excise tax. The report includes cost estimates for the excise tax and explores the excise tax's relationship with the tax advantages for employer-sponsored health coverage. The information in this report is based on statute and two notices issued by the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS). Notice 2015-16 was issued February 17, 2015, and the comment period for the notice closed May 15, 2015.[3] Notice 2015-52 was issued July 30, 2015. The comment period for the notice closed October 1, 2015.[4] As of the date of this report, regulations related to the excise tax have not been promulgated.

[1] 26 U.S.C. §4890I.

[2] Congressional Budget Office (CBO), *Insurance Coverage Provisions of the Affordable Care Act – CBO's March 2015 Baseline*, March 9, 2015. As of the date of this report, CBO has not issued a cost estimate that reflects the 2020 implementation date.

[3] Department of the Treasury (Treasury) and the Internal Revenue Service (IRS), Notice 2015-16, February 17, 2015.

[4] Treasury and IRS, Notice 2015-52, July 30, 2015.

The Excise Tax on High-Cost Employer-Sponsored Health Coverage

Many employers offer health insurance plans and other health-related benefits (e.g., health care flexible spending accounts, or FSAs). These benefits are one part of an employee's total compensation. Often employers pay for part or all of these benefits. To illustrate, 57% of employers offered health insurance plans to their employees in 2015, and on average employers covered 82% of the premiums for single coverage and 71% of the premiums for family coverage.[5]

Definition of *Employee*

Under Section 4980I(d)(3) of the Internal Revenue Code (IRC), "the term employee includes any former employee, surviving spouse, or other primary insured individual." The same definition is used in this report unless otherwise noted.

Beginning in 2020, a 40% excise tax is to be assessed on the aggregate cost of an employee's applicable coverage that exceeds a dollar limit during a taxable period.[6] Unlike some other ACA provisions, assessment of the excise tax is not dependent on an employer's characteristics (e.g., number of workers);[7] assessment is dependent on whether the aggregate cost of an employee's applicable coverage exceeds a dollar limit. The entity responsible for paying the excise tax to the IRS is the coverage provider. The terms *applicable coverage, dollar limit,* and *coverage provider* are defined and described in more detail below.

Applicable Coverage

The excise tax is assessed on the amount by which the aggregate cost of an employee's *applicable coverage* exceeds a dollar limit.[8] The amount is called the *excess benefit*. Determining the excess benefit requires knowing which types of coverage are considered applicable coverage and how the cost of such coverage is calculated. For example, consider an employee who has an employer-sponsored health plan, a separate vision-only plan, and a health care flexible spending account (FSA). To determine the excess benefit, if any, of the employee's coverage, it is necessary to know whether any of the coverage is considered applicable coverage and the methods for determining the cost of such coverage.

[5] The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits, 2015 Annual Survey*, September 22, 2015, at http://kff.org/health-costs/report/2015-employer-health-benefits-survey/.

[6] In statute, *taxable period* is defined as "the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes" (26 U.S.C. §4980I(f)(8)). In Notice 2015-52, Treasury and IRS say that they anticipate the taxable period will be a calendar year for all taxpayers.

[7] For instance, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) employer shared responsibility requirement (the employer mandate) only applies to large employers as measured by the size of the employer's workforce.

[8] In Notice 2015-16, Treasury and IRS indicate that the aggregate cost of applicable coverage is based on the coverage in which the employee enrolls, not the coverage that is made available to the employee.

Definition of Applicable Coverage

Applicable coverage is defined as

> coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106 [of the IRC], or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).[9]

Coverage that is excluded from an employee's gross income under Section 106 of the IRC includes, but is not limited to, employers' contributions to health insurance premiums, Archer Medical Savings Accounts (MSAs), and health savings accounts (HSAs).

Additionally, three arrangements are identified in the statute as applicable coverage:[10] (1) the employee-paid portion of health insurance coverage (i.e., an employee's contribution to premiums); (2) a self-employed individual's health insurance coverage for which a deduction is allowable under Section 162(l) of the IRC;[11] and (3) coverage under a group health plan for civilian employees of federal, state, or local governments. See **Table 1** for a list of what is considered applicable coverage based on the statute and Notice 2015-16.

Table 1. Applicable Coverage

(for purposes of the excise tax on high-cost employer-sponsored health coverage)

Employer's and employee's contributions to the premium for a group health plan
Retiree coverage
Health care flexible spending account (FSA)
Archer medical savings account (MSA)[a]
Health savings account (HSA)[b]
Health reimbursement account (HRA)[c]
On-site medical clinics[d]
Coverage for a specified disease or illness if the coverage or insurance is purchased with pretax dollars or able to be deducted under Section 162(l) of the IRC[e]
Hospital indemnity or other fixed indemnity insurance if the coverage or insurance is purchased with pretax dollars or able to be deducted under Section 162(l) of the IRC
Coverage for a self-employed individual, provided a deduction is allowable under Section 162(l) of the IRC
Coverage under a group health plan offered to civilians by a federal, state, or local government
Executive physical programs[f]

Sources: 26 U.S.C. §4980I; Notice 2015-16.

a. In Notice 2015-16, Treasury and IRS indicate that they anticipate excluding employees' after-tax contributions to Archer MSAs from applicable coverage in future regulations.

b. In Notice 2015-16, Treasury and IRS indicate that they anticipate excluding employees' after-tax contributions to HSAs from applicable coverage in future regulations.

c. In Notice 2015-16, Treasury and IRS provide that they anticipate clarifying that HRAs are applicable coverage in future guidance.

[9] 26 U.S.C. §4980I(d)(1)(A).

[10] 26 U.S.C. §4980I(d)(1).

[11] IRC §162(l) allows self-employed individuals to deduct certain medical expenses, including premiums.

d. In Notice 2015-16, Treasury and IRS indicate that forthcoming proposed regulations will provide that on-site medical clinics that offer only de minimis medical care are not considered applicable coverage. Treasury and IRS requested comments on how to characterize the medical care provided by on-site medical clinics.

e. IRC §162(l) allows self-employed individuals to deduct certain medical expenses, including premiums.

f. In Notice 2015-16, Treasury and IRS provide that they anticipate clarifying that executive physical programs are applicable coverage in future guidance. A definition for an executive physical program is not provided.

Certain arrangements are excluded from the definition of applicable coverage (**Table 2**). Arrangements not considered applicable coverage are not included in the calculation for determining the aggregate cost of applicable coverage.

Table 2. Not Considered Applicable Coverage

(for purposes of the excise tax on high-cost employer-sponsored health coverage)

Coverage only for accident or disability income insurance
Coverage issued as a supplement to liability insurance
Liability insurance (including general liability and automobile liability)
Workers' compensation or similar insurance
Automobile medical payment insurance
Credit-only insurance
Other coverage, as specified in regulations, that is secondary or incidental to other health insurance benefits
Coverage, whether through insurance or otherwise, for long-term care
Coverage under a separate policy for dental and/or vision care
Coverage for a specified disease or illness if the coverage or insurance is not excludable from gross income or a deduction under Section 162(l) of the IRC is not allowed with respect to it[a]
Hospital indemnity or other fixed indemnity insurance if the coverage or insurance is not excludable from gross income or a deduction under Section 162(l) of the IRC is not allowed with respect to it
Coverage under a plan offered to members of the military and their families by a federal, state, or local government
Employee after-tax contributions to HSAs and Archer MSAs[b]

Sources: 26 U.S.C. §4980I; Notice 2015-16.

a. IRC §162(l) allows self-employed individuals to deduct certain medical expenses, including premiums.

b. In Notice 2015-16, Treasury and IRS indicate that they anticipate excluding employees' after-tax contributions to HSAs and Archer MSAs from applicable coverage in future regulations.

Determining the Cost of Applicable Coverage

The cost of applicable coverage is to be determined under rules "similar to" the rules in Section 4980B(f)(4) of the IRC.[12] These rules currently apply under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272). Under COBRA, an employer with 20 or more employees that provided health insurance benefits must provide qualified employees and their families the option of continuing their coverage under the employer's group health insurance plan in certain cases where the employee's coverage otherwise would end (e.g., the employee is terminated). For COBRA purposes, the rules in Section 4980B(f)(4) of the IRC are used to

[12] 26 U.S.C. §4980I(d)(2).

determine the cost of the premium for the health insurance plan in which the former employee can continue.

As of the date of this report, information is not available about how the rules in Section 4980B(f)(4) of the IRC will be applied in the context of the excise tax. In Notice 2015-16, Treasury and IRS describe potential approaches they are considering for applying the COBRA rules to determine the cost of applicable coverage.[13]

The statute also includes specific calculation rules for determining the cost of applicable coverage:

- Any portion of the cost of applicable coverage that is attributable to the excise tax will not be taken into account.
- The cost of applicable coverage will be calculated separately for single coverage and non-single coverage (e.g., family coverage).[14]
- In the case of applicable coverage provided to retired employees, the plan can choose to treat a retired employee who is under the age of 65 and a retired employee aged 65 or older as similarly situated beneficiaries.[15]
- With respect to a health care FSA, the cost of applicable coverage is the greater of an employee's salary reduction election or the total reimbursements under the FSA.[16]
- With respect to Archer MSAs, the cost of applicable coverage is equal to an employer's contributions to the Archer MSA.[17]
- With respect to HSAs, the cost of applicable coverage is equal to an employer's contributions, including salary reduction contributions, to the HSA.[18]
- If the cost of applicable coverage is not determined on a monthly basis, the cost of the coverage will be allocated to months on a basis prescribed by the Secretary of the Treasury.

Dollar Limits

The excise tax is assessed on the excess benefit—the portion of an employee's applicable coverage that exceeds a dollar limit. Under the ACA, the dollar limits for 2018 were to be $10,200 for single coverage and $27,500 for non-single coverage (e.g., family coverage),[19] as

[13] See the "Determination of Cost of Applicable Coverage" section of Notice 2015-16.

[14] See 26 U.S.C. §4980I(f)(1)(B) for the definition of non-single coverage.

[15] Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) rules, a former employee's premium is based on the cost of coverage for "similarly situated" non-COBRA beneficiaries. These similarly situated individuals are employees and their dependents who are receiving coverage from the employer and were most similarly situated to the COBRA beneficiary prior to the COBRA beneficiary becoming a former employee.

[16] Total reimbursements under a flexible spending account (FSA) may be greater than an employee's salary reduction election if an employer makes nonelective contributions (often referred to as *flex credits*) to the employee's FSA and the employee uses those funds.

[17] In Notice 2015-16, Treasury and IRS indicate that they anticipate excluding employees' after-tax contributions to Archer medical savings accounts (MSAs) from applicable coverage in future regulations.

[18] In Notice 2015-16, Treasury and IRS indicate that they anticipate excluding employees' after-tax contributions to health savings accounts (HSAs) from applicable coverage in future regulations.

[19] Any coverage provided under a multiemployer plan (as defined in IRC §414(f)) is treated as coverage other than single coverage. In other words, coverage provided under a multiemployer plan is always subject to the non-single

adjusted by the health cost adjustment percentage.[20] For 2019, the limits were to be the 2018 limits adjusted by the Consumer Price Index for all Urban Consumers (CPI-U), plus 1%.[21] For 2020 and beyond, the limits were to be the previous year's limits adjusted by the CPI-U.

The CAA of 2016, which delayed implementation of the excise tax until 2020, did not change the 2018 dollar limits or modify how the 2018 dollar limits were to be adjusted. The Department of the Treasury has not yet issued the 2020 limits, but the Congressional Research Service estimates they will be about $10,800 for single coverage and $29,100 for non-single coverage.[22]

The dollar limits also could be subject to two different adjustments, which are described below. The CAA of 2016 did not modify these adjustments.

Demographic Adjustment

For some employers, the dollar limits for each year could be increased based on their employees' demographic characteristics. The adjustment could occur if the age and gender characteristics of all employees of an employer are significantly different from the age and gender characteristics of the national workforce.[23] The adjustment uses the BCBS Standard plan offered through the FEHB program. The cost of the BCBS Standard plan is determined based on the age and gender characteristics of the employer's workforce and on the age and gender characteristics of the national workforce. The amount the dollar limits could be increased is equal to the excess cost of the BCBS Standard plan adjusted for the employer's workforce as compared to the BCBS Standard plan adjusted for the national workforce.

Retiree and High-Risk Profession Adjustment

The limits also may be adjusted for (1) individuals who are qualified retirees and (2) individuals who participate in an employer-sponsored plan that has a majority of its enrollees engaged in a high-risk profession or "employed to repair or install electrical or telecommunications lines."[24] For purposes of this adjustment, *qualified retirees* are retired individuals aged 55 and older who do not qualify for Medicare. Employees engaged in *high-risk professions* are

> law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as

coverage threshold.

[20] The health cost adjustment percentage is a one-time upward adjustment based on premium growth in the Blue Cross Blue Shield (BCBS) Standard plan under the Federal Employee Health Benefit (FEHB) program. The 2018 dollar limits will be adjusted upward if premium growth in the BCBS Standard plan is more than 55% between 2010 and 2018. Currently, it seems unlikely that premium growth in the BCBS Standard plan will exceed 55% between 2010 and 2018, as premium growth between 2010 and 2015 was about 20% for both the single and family coverage options. Premium growth for 2016 through 2018 would have to be significantly higher than in recent years for growth over the whole period to exceed 55%.

[21] The Consumer Price Index for All Urban Consumers (CPI-U) is a measure of inflation published by the U.S. Bureau of Labor Statistics.

[22] The estimates were created using CBO's projected annualized CPI-U of 2.3% for 2019 and 2020 from CBO's 10-Year Economic Projections from January 2016, at https://www.cbo.gov/about/products/budget_economic_data#4.

[23] The term *national workforce* is not defined in statute. Treasury and IRS explain an approach they are considering to determine the characteristics of the national workforce in Notice 2015-52.

[24] 26 U.S.C. §4980I(b)(3)(C)(iv).

> defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.[25]

Under this adjustment, the dollar limits are increased for these individuals by $1,650 for self-only coverage and $3,450 for coverage other than self-only.

Coverage Providers

The excise tax is not assessed on an employee; rather it is assessed on the entity providing the applicable coverage—the *coverage provider*. **Table 3** lists the coverage providers identified in statute.

Table 3. Coverage Provider by Type of Coverage

(for purposes of the excise tax on high-cost employer-sponsored health coverage)

Type of Coverage	Coverage Provider
Group health plan offered by a fully insured employer[a]	Health insurance issuer
Employer contributions to HSA	Employer
Employer contributions to Archer MSA	Employer
Other coverage (including coverage offered by a self-insured employer)[b]	Entity that administers the plan benefits[c]

Source: 26 U.S.C. §4980I(c)(2).

a. A fully insured employer is one that purchased a health plan offered by a state-licensed insurance carrier.

b. A self-insured employer sets aside funds to pay for health benefits directly and bears the risk for covering the medical expenses generated by the individuals covered under the self-insured plan.

c. This term is not defined in statute, except to indicate that the term includes a plan sponsor if the plan sponsor administers the plan's benefits. In Notice 2015-52, Treasury and IRS explain the various approaches they are considering to identify the entity that administers the plan benefits.

It is possible that an employee's applicable coverage may not be provided by just one coverage provider. In the case of multiple coverage providers, each coverage provider is responsible for paying the excise tax on its *applicable share* of the excess benefit.[26] A coverage provider's applicable share is based on the cost of the coverage provider's applicable coverage in relation to the aggregate cost of all of the employee's applicable coverage.

In general, the employer is responsible for calculating the aggregate amount of applicable coverage that is in excess of the threshold and determining each coverage provider's applicable share of the tax.[27] The employer is required to notify the Secretary of the Treasury and each coverage provider about the amount determined. A penalty may be imposed on the employer if the excess benefit is not calculated correctly. Under the ACA, the excise tax was nondeductible—coverage providers could not deduct the excise tax as a business expense. However, the CAA of 2016 includes a modification to allow coverage providers to deduct the tax.

[25] 26 U.S.C. §4980I(f)(3).

[26] 26 U.S.C. §4980I(c).

[27] For multiemployer plans, the plan sponsor has this responsibility.

Cost Estimate

The excise tax is one of several taxes and fees included in the ACA to raise revenue to offset the cost of other ACA provisions (e.g., the financial subsidies available through the health insurance exchanges). In March 2015, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated the excise tax would increase federal revenues by $87 billion between 2016 and 2025, based on the tax's implementation beginning in 2018.[28]

CBO and JCT indicate that the revenue raised by the excise tax will come from both collection of the excise tax and increases in taxable income, with most of the revenue raised a result of increases in taxable income.[29] The relationship between the excise tax and taxable income is discussed in the following section.

Relationship to the Tax Exclusion for Employer-Sponsored Insurance

Employer-sponsored health insurance and benefits generally are excluded from employees' gross income for purposes of determining employees' income tax liability.[30] Additionally, these amounts generally also qualify for exclusion from Social Security and Medicare (FICA) taxes and unemployment (FUTA) taxes.[31] These exclusions often are collectively referred to as the tax exclusion for employer-sponsored health insurance and benefits.

Modifying or repealing the tax exclusion has been discussed for many years. One reason federal policymakers are interested in the tax exclusion is that the exclusion results in considerable revenue loss to the federal government. JCT estimates the income tax exclusion will result in $785 billion in foregone revenue for the federal government between 2014 and 2018.[32] Ending or modifying the tax exclusion could raise a significant amount of revenue, depending on how it would be modified or repealed and how employers and workers would adjust.

The excise tax does not directly modify or end the tax exclusion; however, the excise tax is seen as an indirect method for limiting the tax exclusion. As discussed above, official scores indicate that the revenue raised by the excise tax will come both from collection of the excise tax and from increases in taxable income. The increases in taxable income are a result of the expectation that employers will reduce the amount of health coverage they offer to employees to avoid paying the excise tax. Provided employers do this but keep total compensation for employees constant (i.e., shift the compensation from health benefits to taxable wages), the result will be generally higher taxable wages for affected employees. CBO and JCT have estimated that about one-quarter of the revenue raised will come from collection of the excise tax, while about three-quarters of the revenue raised will stem from employers' responses to the tax.[33]

---

[28] CBO, *Insurance Coverage Provisions of the Affordable Care Act - CBO's March 2015 Baseline*, March 9, 2015. As of the date of this report, CBO has not issued an updated cost estimate based on the tax's 2020 implementation.

[29] CBO, Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014, April 14, 2014, at http://www.cbo.gov/publication/45231.

[30] 26 U.S.C. §§105(b) and 106.

[31] 26 U.S.C. §§3121(a)(2), 3306(b)(2).

[32] Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2014-2018*, August 5, 2014. This estimate does not include the effect of the exclusion for employment taxes.

[33] CBO, Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014, April 14, 2014, at http://www.cbo.gov/publication/45231.

Author Information

Ryan J. Rosso
Analyst in Health Care Financing

Acknowledgments

Annie Mach, former Specialist in Health Care Financing, authored this report.

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.