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Health-Related Tax Expenditures: Overview and Analysis

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Summary

Public and private health care spending is growing due to increased enrollment in health insurance, demographic changes of an aging society, and the expansion of government programs, among other reasons. While much attention is being paid to the budgetary cost of outlays from the largest federally funded health programs (Medicare, Medicaid, and the Children's Health Insurance Program), the implicit subsidies in the Internal Revenue Code for the provision of private- and publicly-provided health insurance are sometimes less prominent in public debates. These subsidies are *tax expenditures*, or provisions that confer preferential tax status to certain forms of income, and result in revenue foregone.

This report primarily analyzes health-related tax expenditures, or tax expenditures associated with health and Medicare. As of FY2015, JCT identified 14 health tax expenditures. From FY1974 to FY2014, JCT had been identifying three Medicare-related tax expenditures based on the tax-excluded value of benefits in excess of insurance payments (not the total value of benefits).

The single largest tax expenditure is the tax exclusion for employer-sponsored insurance and health coverage (ESI). From FY2015 to FY2019, JCT estimates that the annual tax expenditure amount for the ESI tax exclusion will increase from $145.5 billion to $169.4 billion. The second largest health tax expenditure is for subsidies for insurance purchased in the exchanges (i.e., the advance premium tax credits, or APTCs). From FY2015 to FY2019, JCT estimates that the annual tax expenditure amount for APTCs will increase from $29.6 billion to $84.8 billion.

Congressional interest in health-related tax expenditures could be related to the value of health-related tax expenditures over time, their value relative to total revenue collected, and how they compare to the value of discretionary and mandatory outlays for health.

Health-related tax expenditures have increased in value over time, after adjusting for inflation in constant 2014 dollars. From FY1974 to FY2014, real health-related tax expenditures have increased, on average, at an annual rate of 7.5%. Looking forward, the nominal value of health tax expenditures is estimated to increase from $210.4 billion in FY2015 to $296.2 billion in FY2019.

Health-related tax expenditures have also increased in value relative to total revenue collected, from 1.9% in FY1974 to 8.4% in FY2014. In other words, health-related tax expenditures have generally increased at a rate greater than the growth of total revenue collections.

Over this FY1974 to FY2014 period, the value of health-related tax expenditures as a percent of GDP exceeded health discretionary outlays, but were still much less than health mandatory outlays according to analyses of Office and Management and Budget (OMB) data on health and Medicare spending.

This report analyzes these provisions at the level of a budget function, rather than focusing any single provision. For more information on individual health tax expenditures, see CRS Committee Print CP10001, Tax Expenditures: Compendium of Background Material on Individual Provisions—A Committee Print Prepared for the Senate Committee on the Budget, by Jane G. Gravelle et al. For broader analysis of tax expenditures and comparisons of different categories of tax expenditures, by budget function, see CRS Report R44012, *Tax Expenditures: Overview and Analysis*, by Donald J. Marples.

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Introduction

Public and private health care spending is growing due to increased enrollment in health insurance, demographic changes of an aging society, and the expansion of government programs, among other reasons. While much attention is being paid to the budgetary cost of outlays from the largest federally funded health programs (Medicare and Medicaid), the implicit subsidies in the Internal Revenue Code for the provision of private and publicly provided health care are sometimes overlooked in public debates. These subsidies come in the form of *tax expenditures*, or provisions that confer preferential tax status to certain forms of income, and result in revenue foregone.

Congressional attention to health-related tax expenditures could be related to a number of questions, such as the following:

- What is the value of health-related tax expenditures? How has it changed over time? Has the value of these tax expenditures increased since enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended)?
- How has the value of health-related tax expenditures changed relative to the value of total revenue collected?
- What was the size of health tax expenditures relative to discretionary and mandatory outlays on health programs in past years? Likewise, has federal support for health grown more in the form of direct outlays or indirectly through revenue losses attributable to tax expenditures?

To provide some insights into these questions, this report analyzes historical data on health-related tax expenditure estimates published by the Joint Committee on Taxation (JCT). This report analyzes these tax expenditures together at the budget function level, rather than focusing on the size of any single provision.

For more information on individual tax expenditures, see CRS Committee Print CP10001, *Tax Expenditures: Compendium of Background Material on Individual Provisions — A Committee Print Prepared for the Senate Committee on the Budget*, by Jane G. Gravelle et al. For broader analysis of tax expenditures and comparisons of different categories of tax expenditures, by budget function, see CRS Report R44012, *Tax Expenditures: Overview and Analysis*, by Donald J. Marples.

What Is a Tax Expenditure?

This report relies on the tax expenditure definition and estimation methodology used by the Joint Committee on Taxation (JCT). To define tax expenditures, JCT refers to the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93-344; Budget Act), which defines tax expenditures as

> revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of tax liability….

JCT uses a modified Haig-Simons baseline definition of income (consumption plus changes in net wealth in a given period).[1] Provisions considered "tax expenditures" cause a divergence from

[1] The Joint Committee on Taxation (JCT) baseline is larger than income as reported on tax returns (in part, because it

measured income under this baseline definition, and are considered as revenue forgone from this baseline. Certain tax provisions might also incur revenue losses under other forms of taxation (e.g., an exclusion might reduce income and payroll tax collection), but only the revenue forgone from the income tax system are included in JCT's tax expenditure estimates.[2] JCT generally publishes estimates of tax expenditures during each session of Congress.

There are a number of ways tax expenditures can be categorized. JCT categorizes provisions by budget function, such as health, commerce and housing, energy, etc.[3] Budget functions serve as one way to identify provisions that operate in a common area of policy or share a similar purpose. The Department of the Treasury also has its own list of tax expenditures, by budget function, and a baseline that it estimates annually for the President's budget. The health budget function that JCT uses to organize tax expenditures are arguably broader than the "health" budget functions used for outlays by agencies such as the Office of Management and Budget (OMB). This is partly due to a difference in historical practices within JCT and OMB.[4] It is also due to the difficulty in trying to contain cross-cutting health provisions within a narrow category intended to simplify the understanding of tax expenditures or spending amounts. For example, some health tax expenditures for medical benefits for active-duty military dependents might be related to spending programs in OMB's national defense budget function.

In addition to categorizing tax expenditures by budget area, the Congressional Budget Office (CBO) typically analyzes tax expenditures by the forms outlined in the 1974 Budget Act: exclusions, exemptions, deductions, preferential tax rates, and tax credits.[5] Academic researchers also have other ways of categorizing tax expenditures, such as provisions that effectively substitute for social policy or economic spending programs.[6]

Economists typically evaluate tax expenditures based on the standard criteria of economic efficiency, equity, and administrative simplicity. These standard criteria can add value to

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includes units that do not file tax returns) but narrower than a comprehensive Haig-Simons definition, which would tax imputed income from homeownership, among other items.

[2] See JCT, *Background Information on Tax Expenditure Analysis and Historical Survey of Tax Expenditure Estimates*, JCX-18-15, February 6, 2015, p. 3, at https://www.jct.gov/publications.html?func=startdown&id=4705.

[3] The President's budget and congressional budget resolutions use budget functions to compare different categories of activities. The JCT groups tax expenditures in the same functional categories used for outlays in the federal budget. As of FY2015, these budget functions are: national defense; international affairs; general science, space, and technology; energy; natural resources and environment; agriculture; commerce and housing; financial institutions; transportation; community and regional development; education, training, employment, and social services; health; income security; Social Security and railroad retirement; veterans' benefits and services; general purpose fiscal assistance; and interest.

[4] See CRS Report 98-280, *Functional Categories of the Federal Budget*, by Bill Heniff Jr. Traditionally, budget function classifications are used to classify provisions that have an outlay effect, and connect these provisions to a particular budget account identification number. By statute, these budget classifications are to be made in consultation with the House and Senate Committees on Appropriations and on the Budget. See U.S. Government Accountability Office, *Budget Function Classifications: Origins, Trends, Implications for Current Uses*, GAO/AIMD-98-67, February 1998, at http://www.gao.gov/products/AIMD-98-67. GAO noted that there could even be a lack of consistency among executive branch agencies because "of the wide range of activities that can be associated with a given budget account and because of the discretion afforded agencies in how they treat certain common activities." Since many tax expenditures do not have an outlay effect, JCT might have more discretion in categorizing certain tax expenditures.

[5] For example, see Congressional Budget Office (CBO), *The Distribution of Major Tax Expenditures in the Individual Income Tax System*, May 23, 2013, at https://www.cbo.gov/publication/43768.

[6] The size of a tax expenditure is not necessarily proportional to the outlay costs if the program were structured as a spending program. On top of any additional administrative costs, a spending program could produce income that could be subject to taxation. See Leonard E. Burman, Christopher Geissler, and Eric J. Toder, "How Big Are Total Individual Income Tax Expenditures, and Who Benefits from Them?," *American Economic Review*, vol. 98 (May 2008), pp. 79-83.

Congressional decision-making by identifying ways that policies could increase or decrease economic distortions, and potential impacts on certain groups of people. Using health insurance as an example, some tax expenditures could correct some inefficiencies in the health care market while increasing others.[7] Regarding equity, tax expenditures in the form of exclusions and deductions could undermine tax progressivity, where the tax benefits of the provisions are based on the top marginal income tax rate faced by the filer.

With respect to administrative considerations, the tax code could have an advantage in administering social policy targeted towards lower-income households because information about income and family size is reported directly on tax forms. Administering social programs through the tax code could, however, increase tax filing complexity and increase tax administration costs. Depending on the provision, administering the tax expenditure as a direct spending or grant program could be comparatively easier for beneficiaries and could reduce administrative costs.

Brief Overview of Health-Related Tax Expenditures

JCT currently identifies 14 health tax expenditures as summarized in **Table 1**.[8] JCT previously identified three tax expenditures related to Medicare, but as of December 2015, JCT no longer includes these Medicare-related provisions in its tax expenditure estimates.[9] References to "health-related" tax provisions in this report include both health and Medicare tax expenditures before FY2015.

[7] For example, tax incentives to encourage employer-sponsored insurance coverage could increase efficiency by reducing premium costs by pooling risk among more workers and reducing administrative costs relative to the non-group market. On the other hand, tax incentives for employer-sponsored insurance could lead to some economic inefficiency if workers feel locked into a particular job because their employer provides a low-cost or comprehensive health plan. See the discussion in JCT, *Tax Expenditures for Health Care*, July 30, 2008, pp. 8-17, JCX-66-08, at https://www.jct.gov/publications.html?func=fileinfo&id=1273. ACA provisions, such as prohibitions to discriminating against individuals with pre-existing conditions and availability of insurance through the exchanges, have addressed some of the issues concerning job lock.

[8] The Treasury also provides a list of health-related tax expenditures, although provisions included in the Treasury's list differ from that of JCT. Treasury classifies 12 provisions as "health-related" tax expenditures, and does not classify the exclusion of Medicare benefits as a tax expenditure. Some provisions identified as "health-related," such as the exclusion of workers' compensation medical benefits, are grouped under the "income security" budget function in Treasury's estimates. Treasury also includes other provisions in its list of health-related tax expenditures, such as a deduction for Blue Cross/Blue Shield that has been in effect since 1986. For more information, see U.S. Department of the Treasury, "Tax Expenditures," at http://www.treasury.gov/resource-center/tax-policy/Pages/Tax-Expenditures.aspx. For general comparisons between JCT's and Treasury's tax expenditure estimation methodology, see JCT, *Estimates Of Federal Tax Expenditures For Fiscal Years 2015-2019*, JCX-141-15, December 7, 2015, p. 18, at https://www.jct.gov/publications.html?func=startdown&id=4855.

[9] See JCT, *Estimates Of Federal Tax Expenditures For Fiscal Years 2015-2019*, JCX-141-15, December 7, 2015, p. 24, at https://www.jct.gov/publications.html?func=startdown&id=4855. According to JCT, "Historically, the Joint Committee staff has included in its report on tax expenditures some items for which no provision of the Federal tax law specifically allows an exclusion, but which are nonetheless excluded from income. Among these are the exclusion of all Medicare benefits from taxation, the exclusion of investment income on life insurance and annuity contracts, and the exclusion of cash public assistance. This report no longer includes tax expenditure estimates for these items." For arguments why Medicare and Medicaid benefits should be included into baseline calculations of income, see Stanley S. Surrey and Paul R. McDaniel, *Tax Expenditures* (Cambridge, MA: Harvard University Press, 1985), p. 205.

Table 1. Summary of Health-Related Tax Expenditures

Internal Revenue Code (IRC) Section	Provision	Tax Expenditure Estimate, in Billions of Dollars[a] FY2016	FY2015-FY2019
Health Care			
IRC §105, 106, 125	Exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums	$143.8	$769.8
IRC §36B	Credits and subsidies for insurance purchased through health benefit exchanges (advance premium tax credits)	$53.5	$322.5
IRC §213	Deduction for dental, medical, and long-term care expenses	$11.1	$58.5
IRC §170, 642(c)	Deduction for charitable contributions to health organizations	$5.2	$26.7
IRC §104(a)(1)	Exclusion of workers' compensation benefits (medical benefits)	$5.0	$25.6
IRC §162(l)	Deduction for health insurance premiums and long-term care insurance premiums by the self-employed	$5.1	$25.3
IRC §112, 134	Exclusion of medical care and TRICARE medical insurance for military dependents, retirees, and retiree dependents not enrolled in Medicare	$2.7	$13.9
IRC §103, 141, 145(b), 145(c), 146, 501(c)(3)	Exclusion of interest on state and local government qualified private activity bonds for private nonprofit hospital facilities	$2.5	$13.1
IRC §223	Health savings accounts	$2.1	$12.4
IRC §41(b), 45C, 280C	Credit for orphan drug research	$1.0	$5.3
IRC §45R	Tax credit for small businesses purchasing employer insurance	$1.1	$5.2
IRC §112, 134	Exclusion of health insurance benefits for military retirees and retiree dependents enrolled in Medicare	$0.9	$4.9
IRC §35	Credit for purchase of health insurance by certain displaced persons	NA[b]	$0.2
IRC §220	Archer savings accounts	*[de minimus]*	*[de minimus]*[c]
Medicare			
NA[d]	Exclusion of Medicare benefits in excess of contributions:		
	Hospital insurance (Part A)	Beginning with its 2015 tax expenditure estimates, JCT no longer classifies these provisions as tax expenditures.	
	Supplementary medical insurance (Part B)		
	Prescription drug insurance (Part D)		

Source: CRS compilation of information from U.S. Congress, Senate Committee on the Budget, *Tax Expenditures: Compendium of Background Materials on Individual Provisions*, committee print, prepared by the Congressional Research Service, 113th Cong., 2nd sess., December 2014, S. Prt. 113-32 (Washington: GPO,

2014); and Joint Committee on Taxation (JCT), *Estimates Of Federal Tax Expenditures For Fiscal Years 2015-2019*, JCX-141-15, December 7, 2015, at https://www.jct.gov/publications.html?func=startdown&id=4855.

Notes:

a. Includes both individual and corporate tax expenditure estimates.

b. Positive tax expenditure of less than $50 million annually.

c. JCT estimates that the total revenue loss from FY2015-FY2019 is less than $50 million.

d. Authorized by IRS Rev. Rul. 70-341, 1970-2 C.B. 31.

In FY2016, health tax expenditures are estimated to amount to $234.0 billion.[10] A short summary of each provision, including information about each provision's legislative origins, is provided in more detail in the **Appendix**.

The largest tax expenditure in **Table 1** is the tax exclusion for employer-sponsored insurance (ESI). This provision is also the largest tax expenditure in the federal tax code. From FY2015 to FY2019, JCT estimates that the annual tax expenditure amount for the ESI tax exclusion will increase from $145.5 billion to $169.4 billion.

The second largest health tax expenditure value is for subsidies for insurance purchased in the exchanges (the advance premium tax credits, or APTCs, not the cost-sharing subsidies).[11] From FY2015 to FY2019, JCT estimates that the annual tax expenditure amount for APTCs will increase from $29.6 billion to $84.8 billion.

Health-related tax expenditures serve various purposes and many have a long history in the tax code. Some of these tax provisions effectively subsidize the cost of private health insurance or supplemental benefits provided by government health programs. Other provisions reduce the cost of private activities that are intended to have positive spillover benefits to society (e.g., exclusion of interest on state and local government private activity bonds for nonprofit hospitals; itemized deduction for charitable giving to qualified nonprofit health organizations).

While some provisions are noted for particular policy effects and size today, it is important to note that some of these older, health tax provisions in the code have their origins in legal doctrine or thought about definitions of income at the time of adoption, and could have been indirectly affected by other policies. Some of these provisions (e.g., itemized deduction for charitable giving to nonprofit health organizations) are subcomponents of the tax treatment of larger categories of activity (e.g., itemized deduction for charitable giving). Given that earliest forms of the income tax had larger exemptions, it might also have been difficult to imagine the breadth of these older tax provisions during their time of enactment.

For example, the origins of the ESI tax exclusion can be traced back to 1918. Employer payments for individual health coverage were deductible as a cost of doing business. Regulatory rulings had

[10] All aggregated calculations of tax expenditures in this report assume no change in tax filer behavior in response to interactive changes to one or more provisions. JCT estimates each tax expenditure separately, under the assumption that all other tax expenditures remain, and does not sum multiple tax expenditures. If two or more tax expenditures were estimated simultaneously, the total change in tax liability could be smaller or larger than the sum of the amounts shown for each item separately, as a result of interactions among the tax expenditure provisions. See Leonard E. Burman, Christopher Geissler, and Eric J. Toder, "How Big Are Total Individual Income Tax Expenditures, and Who Benefits from Them?," *American Economic Review*, vol. 98 (May 2008), pp. 79-83. Preliminary research indicates that failing to take account of interactions among provisions understates the total cost of *all* individual tax expenditures, but by a relatively modest amount. See Leonard E. Burman et al., "Economic and Distributional Effects of Tax Expenditure Limits," in *The Economics of Tax Policy*, eds. Alan Auerbach and Kent Smetters (Oxford University Press, forthcoming).

[11] For more information, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*, by Bernadette Fernandez.

conflicting outcomes on the tax treatment of various forms of employer health contributions under a comprehensive revision of the Internal Revenue Code enacted in 1954.[12] The role of the ESI exclusion was significantly expanded during and after World War II by administrative decisions and policies that froze wages, but not employer-sponsored fringe benefits during wartime.[13] The Internal Revenue Code Act of 1954 (P.L. 83-591) explicitly excluded these contributions from income.

Data Analysis

This section analyzes JCT data on health-related tax expenditure estimates from FY1974 to FY2019 (with the most recent estimates covering the five-year period beginning in FY2015 and ending with projections for FY2019). The number of provisions within the health category of tax expenditures has changed over time, as provisions have expired or been added. The three Medicare-related tax provisions that JCT previously identified as tax expenditures are analyzed separately in the figures through FY2014 (since JCT stopped classifying these provisions as tax expenditures as of FY2015).

For the purposes of this report, multiple tax expenditure provisions are added together to give a sense of changes over time to tax expenditures in this budget function.[14] JCT does not typically add multiple tax expenditure values together, as interactions between multiple provisions could mean that the value of tax expenditures estimated as a group is not the same as the value of the sum of individual tax expenditure estimates. Provisions that JCT identifies as having a *de minimus* tax expenditure value are not included in the calculations in this report.

The Value of Health-Related Tax Expenditures Over Time

As shown in **Figure 1**, after adjusting for inflation, health-related tax expenditures have increased in value over time (as represented, in 2014 constant dollars, by the dotted line in **Figure 1**). From FY2004 to FY2014, health-related tax expenditures increased by 43.0% in real terms, compared with an increase of 110.5% from FY1994 to FY2004 and 83.2% from FY1984 to FY1994.[15]

From FY1974 to FY2014, the annual tax expenditure value for health-related provisions has increased by 11.5% (nominal dollars) and 7.5% (real dollars), on average.[16] In the years after enactment of the ACA in 2010, annual growth rates in health-related tax expenditures are all positive, but they fluctuate both above and below these historical averages.

In current, or nominal, dollars, the annual value of health tax expenditures are estimated to increase from $210.4 billion in FY2015 to $296.2 billion in FY2019. In FY2016, health tax expenditures are estimated to total $234.0 billion.

The net growth of health-related tax expenditures can be attributed to several factors, such as

[12] See the archived CRS Report RL34767, *The Tax Exclusion for Employer-Provided Health Insurance: Issues for Congress*, by Janemarie Mulvey.

[13] For more historical background, see the "Brief History of the ESI Tax Exclusion" section of CRS Report R44160, *The Excise Tax on High-Cost Employer-Sponsored Health Coverage: Background and Economic Analysis*, by Sean Lowry.

[14] See footnote 10.

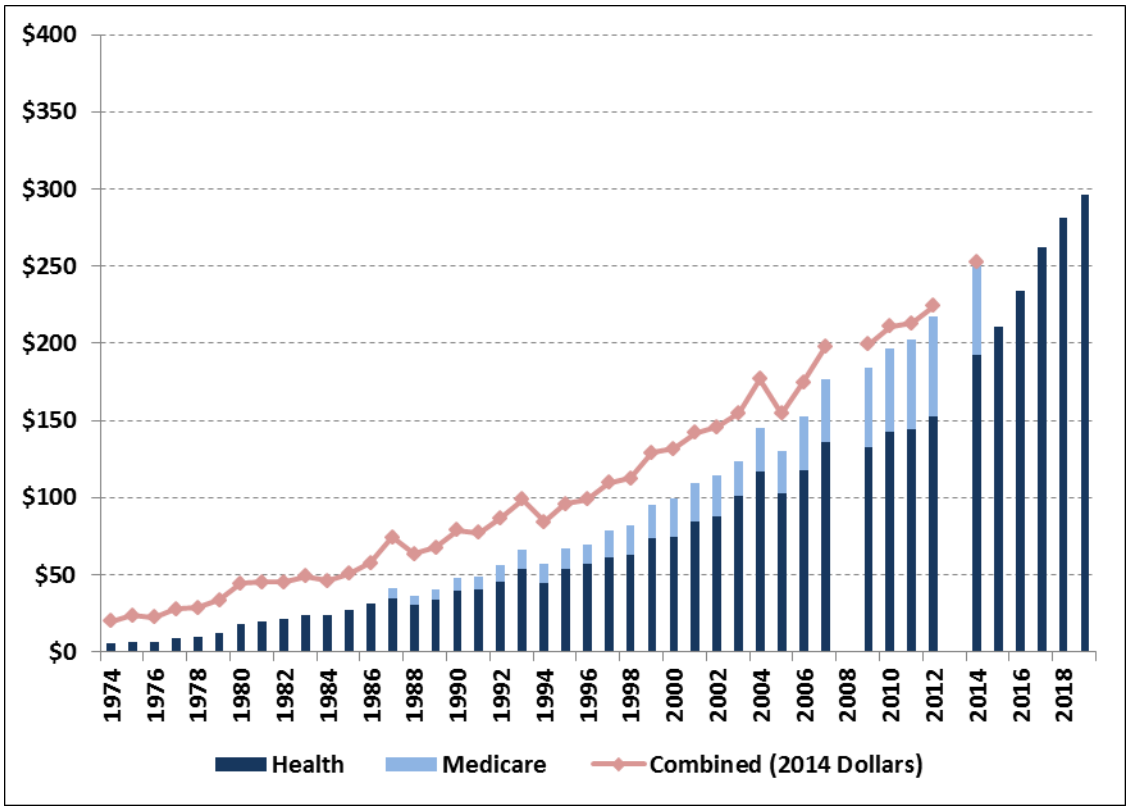
[15] CRS analysis of JCT data, various years, and deflators from Office of Management and Budget Historical Table 10.1.

[16] The median annual rates of growth over this period of time were 11.3% (nominal) and 7.3% (real).

- changes in demographics (e.g., an aging population with more health care costs),[17]
- changes in private and government-provided health costs (i.e., health care costs tend to grow at a rate faster than inflation),[18] and
- policy changes that affect the cost of health-related tax expenditures (e.g., enactment of new tax expenditures, changes in marginal income tax rates).

Figure 1. Health-Related Tax Expenditures, Nominal and Inflation-Adjusted, FY1974-FY2019

(In billions of dollars)



Source: CRS analysis of Joint Committee on Taxation (JCT) data, various years; and Office of Management and Budget Historical Table 10.1.

Notes: JCT did not produce tax expenditure estimates for FY2008 and FY2013. Previously, JCT only classified the net benefits received in excess of Medicare tax contributions as tax expenditures, not the total value of Medicare benefits, but it no longer classifies these provisions as tax expenditures as of FY2015.

[17] For more information, see Figure 3-2 in CBO, *The 2015 Long-Term Budget Outlook*, June 16, 2015, p. 52, at https://www.cbo.gov/publication/45308.

[18] For more analysis of the drivers of health care spending growth, see Michael E. Chernew and Joseph P. Newhouse, "Health Care Spending Growth," in *Handbook of Health Economics*, ed. Mark V. Pauly, Thomas G. McGuire, Pedro Pita Barros (Waltham, MA: Elsevier, 2012), vol. 2, pp. 1-44. For more discussion of recent and historical trends, see Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, "Is This Time Different? The Slowdown in Healthcare Spending" NBER Working Paper No. 19700, September 10, 2013; CBO, "Why Has Growth in Spending for Fee-for-Service Medicare Slowed?" Working Paper 2013-06, August 22, 2013, at http://www.cbo.gov/publication/44513; and Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," *Quarterly Journal of Economics*, vol. CXXII, no. 1 (February 2007), pp. 1-37.

Before FY2015, JCT identified Medicare-related tax expenditures as the value of benefits in excess of insurance payments, not the total value of Medicare benefits received.[19] All Medicare benefits are excluded from income tax, but JCT measured a positive tax expenditure only if the Medicare insurance benefits for a particular program (Part A, B, or D) were greater than what enrollees paid. For a contextual example, a positive tax expenditure for Medicare Part D (prescription drugs) indicated that the value of the insurance was greater than the premiums paid for coverage.

Medicare-related tax expenditures increased in both nominal and inflation-adjusted value over time. JCT estimated that tax expenditures for Medicare were virtually *de minimus* before FY1987, which would indicate that Medicare insurance benefits were roughly equal to payments. From FY1987 to FY2014, the annual tax expenditure value for the Medicare-related provisions increased by 10.2% (nominal) and 7.7% (real), on average.[20] Given JCT's past tax expenditure estimation methodology, these trends indicate that the annual value of Medicare insurance to beneficiaries increased at rates higher than payments over this period.

According to JCT's last estimate of Medicare-related tax expenditures in FY2014, these Medicare provisions were estimated to be 26.8% relative to the total value of health tax expenditures over five years.[21]

Health-Related Tax Expenditures Relative to Total Revenue

Health-related tax expenditures have also increased from a value relative to 1.9% of total revenue collected in FY1974 to 8.4% in FY2014, as shown in **Figure 2**.[22] In other words, the value of health-related tax expenditures has generally increased at a rate greater than the growth of total revenue collections.

Health tax expenditures are estimated to increase from a value relative to 6.4% of total revenue collected in FY2015 to 7.7% in FY2019. In FY2016, health tax expenditures are estimated to be valued at 6.6% of total revenue collected.

Tax expenditure values alone do not provide a complete picture of tax policies in health fields relative to total revenue. Several taxes imposed by the ACA raise revenue, such as the excise tax on high-cost employer-sponsored health coverage (also known as the "Cadillac tax"); the individual mandate; the employer mandate; and the medical device tax.[23] Additionally, the ACA imposed a 3.8% unearned income Medicare contribution tax on for higher-income taxpayers.[24] The annual revenue raised by these provisions is small compared to total value of health tax expenditures.

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[19] JCT, *Estimates Of Federal Tax Expenditures For Fiscal Years 2014-2018*, JCX-97-14, August 8, 2014, p. 4, at https://www.jct.gov/publications.html?func=startdown&id=4664.

[20] The median annual rates of growth over this period of time were 8.1% (nominal) and 5.6% (real).

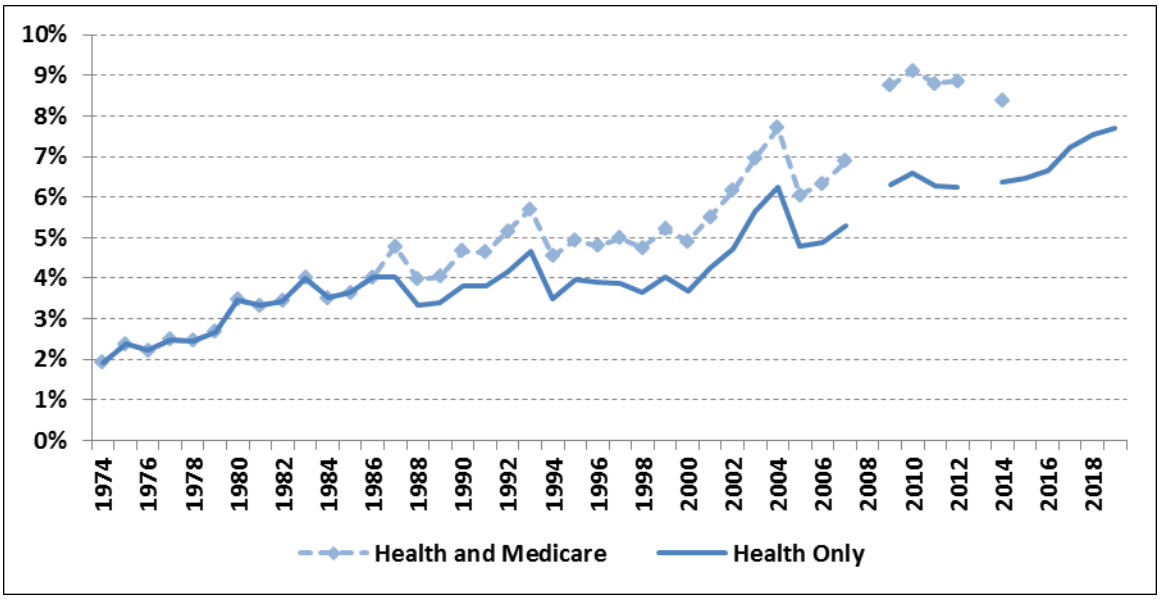
[21] CRS analysis of data in JCT, *Estimates Of Federal Tax Expenditures For Fiscal Years 2014-2018*, JCX-97-14, August 8, 2014, at https://www.jct.gov/publications.html?func=startdown&id=4664. Medicare-related tax expenditures were estimated at $350.2 billion from FY2014 through FY2018 while health tax expenditures were estimated at $1,302.6 billion.

[22] Total revenue is defined as revenue collected from: individual income taxes, payroll taxes, corporate income taxes, excise taxes, estate and gift taxes, customs duties, and miscellaneous receipts. See CBO, *An Update to the Budget and Economic Outlook: 2015 to 2025*, August 25, 2015, at https://www.cbo.gov/publication/50724.

[23] Presumably the effects of these policies are modeled into the baseline of income taxes for the purposes of estimating tax expenditures.

[24] See CRS Report R41413, *The 3.8% Medicare Contribution Tax on Unearned Income, Including Real Estate Transactions*, by Mark P. Keightley.

Figure 2. Health-Related Tax Expenditures, Relative to Total Revenue Collected, FY1974-FY2019



Source: CRS analysis of JCT data, various years, and Summary Table 1 (projections) and Table 1-5 (historical budget data) in CBO, *An Update to the Budget and Economic Outlook: 2015 to 2025*, August 25, 2015, at https://www.cbo.gov/publication/50724.

Notes: JCT did not produce tax expenditure estimates for FY2008 and FY2013. Previously, JCT only classified the net benefits received in excess of Medicare tax contributions as tax expenditures, not the total value of Medicare benefits, but it no longer classifies these provisions as tax expenditures as of FY2015.

Comparing Health-Related Tax Expenditures to Health Outlays

Figure 3 displays discretionary and mandatory outlays, as organized under OMB's health budget function, and health-related tax expenditures as a share of gross domestic product (GDP) from FY1974 to FY2014.

As mentioned in the "Brief Overview of Health-Related Tax Expenditures" section of this report, OMB classifies a more narrow set of activities under its health budget function than the categories that JCT uses to organize tax expenditures. Additionally, the base used to measure changes in expenditures is different from tax expenditures (e.g., increases in the level of total benefits issued under Medicare would have increased health outlays, but an increase in total Medicare benefits would only have increased Medicare-related tax expenditures to the extent that enrollee benefits exceed contributions). Still, this comparison between outlays and tax expenditures could be useful as one way to track federal support, direct or indirect, to the health sector or to assist with household health expenses over time.

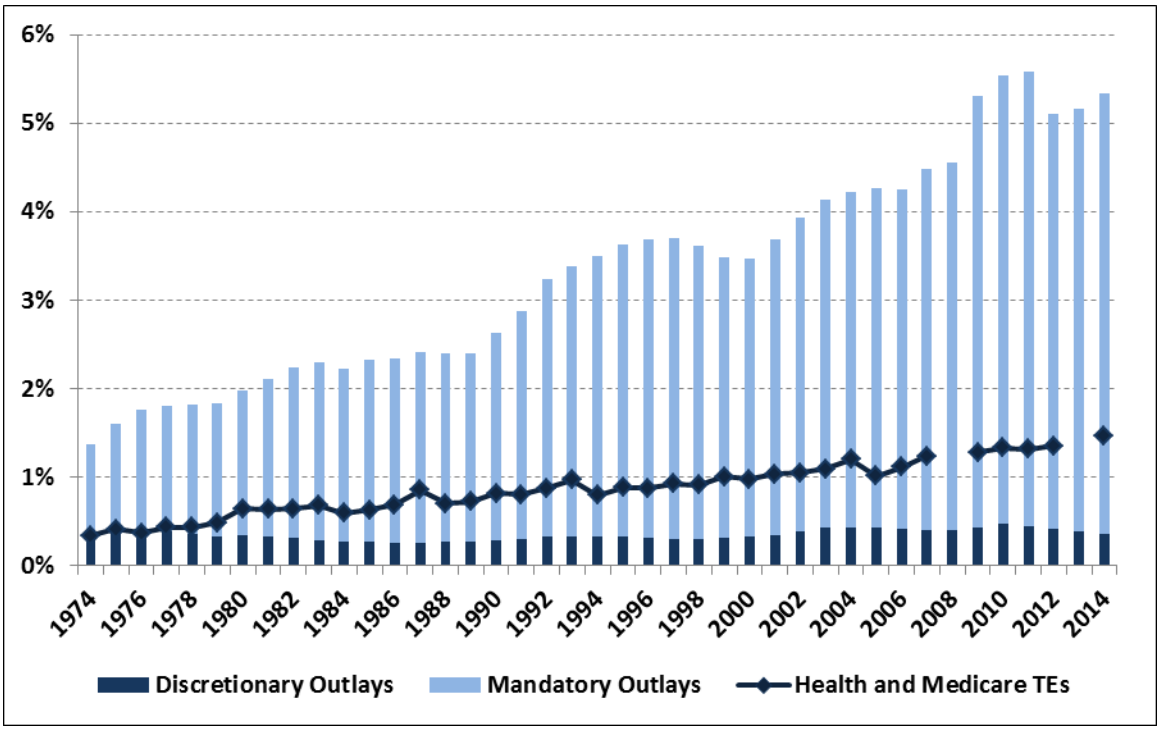
The costs of the largest federal health programs, Medicare and the federal portion of Medicaid costs, are nearly all mandatory outlays.[25] Administrative costs, which account for a small portion of those costs, are nearly all funded as discretionary spending. Federal health research (primarily through the National Institutes of Health) and veterans' health care is mostly funded through discretionary spending, as are certain public health clinics.

[25] For more information and analysis of historical trends, see CRS Report R41726, *Discretionary Budget Authority by Subfunction: An Overview*, by D. Andrew Austin.

As shown in **Figure 3**, the values of health-related tax expenditures historically exceeded health discretionary outlays, but were still much less than health mandatory outlays (which primarily consist of funding for Medicare, Medicaid, and the Children's Health Insurance Program). Specifically, as a percent of GDP:

- Mandatory outlays for health increased from 1.0% of GDP in FY1974, to 2.0% FY1984, to 3.2% in FY1994, to 3.8% in FY2004, to 5.0% of GDP in FY2014.[26]
- Health-related tax expenditures have also grown, but from a smaller base, from 0.3% of GDP in FY1974, to 0.6% in FY1984, to 0.8% in FY1994, to 1.2% in FY2004, to 1.5% in FY2014.
- Health discretionary outlays varied between 0.3% and 0.5% of GDP over the FY1974 to FY2014 period.

Figure 3. Health and Medicare, Tax Expenditures vs. Outlays, as a Share of Gross Domestic Product (GDP), FY1974-FY2014



Source: CRS analysis of JCT data, various years, and Historical Tables 8.5, 8.7, and 10.1 in Office of Management and Budget (OMB) at https://www.whitehouse.gov/omb/budget/Historicals.

Notes: With regard to the OMB's data, "mandatory outlays" include Medicare, Medicaid, refundable premium tax credit and cost sharing, Children's Health Insurance Program (CHIP), and other spending; "discretionary outlays" include health and Medicare.

[26] Mandatory outlays for health are calculated as the net amount after subtracting premiums.

Appendix. Description of Health Tax Expenditures

This appendix contains a brief description and legislative origins of each health tax expenditure provision, as identified by the Joint Committee on Taxation (JCT). As mentioned in the report, JCT stopped classifying Medicare-related tax expenditure provisions beginning with FY2015.

In some instances, health tax expenditures are among the longest-standing provisions in the Internal Revenue Code. Although some provisions might have certain policy effects today (such as encouraging employer-sponsored health insurance), the historical rationale for first creating these provisions could have been different. For example, some of these provisions could have had their origins in past legal definitions of taxable events or income, or were the result of administrative rulings to comply with previously enacted laws or policy traditions.

For more historical background on individual provisions, see their respective entries in CRS Committee Print CP10001, *Tax Expenditures: Compendium of Background Material on Individual Provisions — A Committee Print Prepared for the Senate Committee on the Budget*, by Jane G. Gravelle et al.

Table A-1. Brief Summary of Health-Related Tax Expenditures

Provision	Type of Tax Expenditure	Origins	Description
Health Care			
Exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums	Exclusion	Enacted by the Internal Revenue Code Act of 1954 (P.L. 83-591) as part of a comprehensive revision of the IRC. From the creation of the first permanent income tax code in 1918 until 1954, there had been decades of conflicting regulatory rulings and tax treatment of various employer-provided forms of insurance and health care.	Employers' contributions for employer-sponsored health insurance are exempt from federal income and payroll taxes.
Credits and subsidies for insurance purchased through health benefit exchanges	Credit	Enacted by the Patient Protection and Affordable Care Act (P.L. 111-148)	Tax credits apply toward premiums for private health plans offered through exchanges. The credits are credits established under the ACA are advanceable (able to be paid directly to insurance providers to lower premium payments) and refundable (for those with no federal income tax liability). The amounts received in premium credits are based on federal income tax returns and family size.

Provision	Type of Tax Expenditure	Origins	Description
Deduction for dental, medical, and long-term care expenses	Itemized deduction	Enacted by the Revenue Act of 1942 (P.L. 77-753).	Taxfilers that itemize their deductions can deduct the cost of eligible expenses if the sum of the costs is at least 10% of adjust gross income (AGI) (7.5% if 65 or older for tax years 2013 through 2016).
Deduction for health insurance premiums and long-term care insurance premiums by the self-employed	Above-the-line deduction	Enacted as a temporary provision in the Tax Reform Act of 1986 (P.L. 99-514), and made permanent by P.L. 104-7.	A self-employed individual may deduct the premium costs of health insurance or long-term care insurance as long as he or she is not eligible to participate in a plan, in a given month, sponsored by his or her employer or the spouse's employer.
Deduction for charitable contributions to health organizations	Itemized deduction	Enacted by the War Revenue Act of 1917.	Taxfilers that choose to itemize their deductions rather than claim the standard deduction can deduct charitable contributions to tax-exempt health organizations
Exclusion of workers' compensation benefits (medical benefits)	Exclusion	Clarified by the Revenue Act of 1918 (whose reports suggested that these payments were already excludable from income).	Medical benefits from workers compensation are exempt from federal income and payroll taxes.
Exclusion of interest on state and local government qualified private activity bonds for private nonprofit hospital facilities	Exclusion	Enacted by the Internal Revenue Code Act of 1954 (P.L. 83-591)	Income earned from interest on qualified state and local government private activity bonds determined to generate a social benefit is exempt from federal income and payroll taxes.
Exclusion of medical care and TRICARE medical insurance for military dependents, retirees, and retiree dependents not enrolled in Medicare	Exclusion	Internal Revenue Code Sections 112 and 134, and certain court decisions (e.g., *Jones v. United States*, 60 Ct. Cl. 552 (1925)).	Medical benefits received from TRICARE insurance are exempt from federal income and payroll taxes.

Provision	Type of Tax Expenditure	Origins	Description
Health savings accounts (HSAs)	Exclusion of contributions, earnings, and distributions (when used for qualified medical expenses) Exclusion of contributions and deferral of tax liability on earnings (when used for non-medical expenses).	Enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).	Eligible individuals can establish Health Savings Accounts (HSAs) and fund these accounts when they have qualifying high deductible health insurance and no other health care coverage, with some exceptions. Withdrawals can be made for non-medical expenses, but are subject to a 20% penalty and income taxes.
Tax credit for small businesses purchasing employer insurance	Credit	Enacted by the Patient Protection and Affordable Care Act (P.L. 111-148).	A credit is allowed for employers with fewer than 25 full-time equivalent (FTE) employees, average annual wages that fall under a statutorily-specified cap, and that cover at least 50% of the cost of each of their employees' self-only health insurance coverage. The credit can be applied only to purchase coverage through a Small Business Health Options Program (SHOP) exchange. The credit is only available to an employer for two consecutive years.
Credit for orphan drug research	Credit	Enacted by the Orphan Drug Act of 1983 (ODA, P.L. 97-414), and made permanent by the Taxpayer Relief Act of 1997 (P.L. 105-34).	Qualified clinical testing expenses for drugs that either have no realistic prospect of earning a profit or are projected to treat less than 200,000 persons in the United States. The development of eligible drugs allows a company to claim a non-refundable tax credit equal to 50% of the qualified clinical testing expenses incurred during the development process. Qualified expenses for the orphan drug credit cannot also be used to claim the R&D tax credit.

Provision	Type of Tax Expenditure	Origins	Description
Exclusion of health insurance benefits for military retirees and retiree dependents enrolled in Medicare	Exclusion	Internal Revenue Code Sections 112 and 134, and certain court decisions (e.g., *Jones v. United States*, 60 Ct. Cl. 552 (1925)).	Medical benefits for those military and retiree dependents enrolled in Medicare are exempt from federal income and payroll taxes.
Credit for purchase of health insurance by certain displaced persons	Credit	Enacted by Trade Act of 2002 (P.L. 107-210).	A refundable credit is available for 72.5% of qualified premiums paid for those that were (1) eligible for Trade Adjustment Assistance allowances because they experienced job loss or (2) individuals whose defined benefit pension plans were taken over by the Pension Benefit Guaranty Corporation because of financial difficulties.
Archer savings accounts	Exclusion of contributions, earnings, and distributions (when used for qualified medical expenses) Exclusion of contributions and deferral of tax liability on earnings (when used for non-medical expenses).	Enacted by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).	Contributions toward Archer medical savings account (MSAs). Archer MSAs are tax-exempt trust or custodial accounts, established with a U.S. financial institution, used to save money exclusively for future medical expenses. Claimants must have a high deductible health plan (HDHP); have no other health or Medicare coverage; and be either a small employer or self-employed (or the spouse of a self-employed individual). Withdrawals can be made for non-medical expenses, but are subject to a 20% penalty and income taxes.
Medicare			
Exclusion of Medicare benefits:			
Hospital insurance (Part A)		Revenue Ruling 70-341, 1970-2 C.B. 31	Medical benefits for those enrolled in Medicare are exempt from federal income and payroll taxes.
Supplementary medical insurance (Part B)		Revenue Rulings 66-216 and 70-341, 1970-2 C.B. 31	

Provision	Type of Tax Expenditure	Origins	Description
Prescription drug insurance (Part D)		Part D was enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), and subject to tax exclusion in compliance with Revenue Ruling 70-341, 1970-2 C.B. 31.	From FY1974 to FY2014, JCT only classified the value of benefits in excess of insurance payments, not the total value of Medicare benefits. As of FY2015, JCT no longer identifies any Medicare-related tax benefits as tax expenditures.

Source: Various laws and CRS Committee Print CP10001, *Tax Expenditures: Compendium of Background Material on Individual Provisions — A Committee Print Prepared for the Senate Committee on the Budget*, by Jane G. Gravelle et al.

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