PRESENT LAW TAX TREATMENT OF THE COST OF HEALTH CARE

Scheduled for a Public Hearing
Before the
HOUSE COMMITTEE ON WAYS AND MEANS
on October 29, 2008

Prepared by the Staff
of the
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INTRODUCTION

The House Committee on Ways and Means has scheduled a public hearing for October 29, 2008, on economic recovery, job creation, and investment in America. Among the issues the Committee will consider is the increase in the cost of health care. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the rules relating to the taxation of health insurance and healthcare related expenses.

[1] This document may be cited as follows: Joint Committee on Taxation, *Present Law Tax Treatment of the Cost of Health Care* (JCX-81-08), October 24, 2008. This document is available at www.jct.gov.

I. OVERVIEW

The Internal Revenue Code (the "Code")[2] provides for a number of tax rules in the case of health insurance and healthcare-related expenses. Such rules include the following:

- The exclusion of employer-provided health insurance coverage and the benefits received pursuant to such coverage (for income and payroll tax purposes).
- The tax deduction for self-employed individuals for the cost of health insurance coverage (for income tax purposes).
- The itemized deduction for unreimbursed medical expenses to the extent that such expenses exceed 7.5 percent of adjusted gross income (for income tax purposes).
- The ability of a taxpayer covered under a high deductible health plan to maintain a tax-exempt savings account, funded with deductible (or excludable) contributions, for tax excludable reimbursement of health-related expenses (HSAs and Archer MSAs) (for income tax purposes and, in the case of employer contributions, for payroll tax purposes).
- A refundable tax credit equal to 65 percent of the cost of the qualified health coverage paid by certain displaced individuals (for income tax purposes).

Appendix A contains a table that compares the tax benefits described in this pamphlet by the taxpayers eligible for the benefit, the dollar limit on the benefit, and expenses that qualify for the benefit.

[2] Except as is otherwise noted, references in this document are to sections of the Code.

II. PRESENT LAW

A. Employer-Provided Health Care

1. General Rules

The Code generally provides that employees are not taxed on (that is, may "exclude" from gross income) the value of employer-provided health care. As with other compensation, the amount paid by employers 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 employees (and the employees' spouses and dependents), the contribution and all benefits (including reimbursements) for medical care under the plan are excludable from the employees' income for income tax purposes and are excludable from the employees' wages for payroll tax purposes.[3] The exclusion applies both in the case in which an employer absorbs the cost of 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 may be able to pay their share of premiums on a pre-tax basis through salary reduction.[4] Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income and wages for payroll tax purposes.

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[3] Secs. 104, 105, 106, 125, 3121(a)(2), and 3306(a)(2). 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 were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

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

The Employee Retirement Income Security Act of 1974 ("ERISA") preempts State law relating to certain employee benefit plans, including employer-sponsored health plans.[5] While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

Distinct from the exclusion, certain rules relating to coverage apply in the case of group health plans.[6] The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). In addition, in the case of group health coverage, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes a number of requirements that are designed to provide protections to health plan participants.[7] For example, HIPAA provides rules that prohibit discrimination with respect to eligibility and premium contributions on the basis of health status. HIPAA also provides rules relating to specific coverage (e.g., rules for minimum hospital stays following the birth of a child).

The Code imposes an excise tax on group health plans that fail to meet HIPPA and COBRA requirements.[8] The excise tax generally is equal to $100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan if the plan fails to meet the requirements.

2. Flexible Spending Accounts and Health Reimbursement Arrangements

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

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[5] ERISA sec. 514.

[6] 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.

[7] The COBRA and HIPPA requirements are enforced through the Code, ERISA, and the Public Health Service Act ("PHSA").

[8] Secs. 4980B, 4980D. ERISA also generally permits the Secretary of Labor and plan beneficiaries to enforce these requirements through a civil action.

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 requirements for cafeteria plans, including a requirement that amounts remaining in a health FSA at the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it rule").[9] If the health FSA meets certain requirements, the compensation that is forgone is not includible in gross income or wages for payroll tax purposes.

Health reimbursement arrangements ("HRAs") operate in a manner similar to health FSAs, in that they are an employer-maintained arrangement that reimburses employees for medical expenses. Some of the rules applicable to HRAs and health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[10] 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,[11] 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) may be used to reimburse the employee for nonprescription medicines.

[9] 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.

[10] 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.

[11] 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.

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

Under present law, self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents.[12] The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual's self-employment income. The deduction applies only to the cost of insurance (i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance).[13] 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.[14] Thus, the exclusion for employer-provided health care coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self- employed.

[12] Sec. 162(l).

[13] 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).

[14] Sec. 1372.

C. Itemized Deduction for Medical Expenses

Individuals may claim an itemized deduction for unreimbursed medical expenses to the extent that such expenses exceed 7.5 percent of adjusted gross income.[15] This deduction is available both to insured and uninsured individuals. Thus, an individual with employer-provided health insurance (or another form of tax-subsidized health benefits, as summarized in this section) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5 percent adjusted gross income threshold is met. Moreover, an individual's nonsubsidized health insurance premiums can be counted toward the 7.5 percent threshold.

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

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

D. HSAs and Archer MSAs

Present law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account ("HSA").[16] Like opening an individual retirement account ("IRA"), the decision to create and fund an HSA is made on an individual-by-individual basis. Unlike the case of an IRA, however, an HSA is subject to a 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 individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Moreover, individuals can exclude from income (and from wages for payroll tax purposes) contributions that their employer, including contributions made through a cafeteria plan through salary reduction, makes to the individuals' HSAs.

A high deductible health plan is a health plan that has an annual deductible that is at least $1,100 for self-only coverage or $2,200 for family coverage and that limits the sum of the annual deductible and other payments that the individual must make in respect of covered benefits to no more than $5,600 in the case of self-only coverage and $11,200 in the case of family coverage.[17]

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 individual's age.

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 ten percent. The additional ten-percent tax does not apply, however, if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

In contrast to a flexible spending arrangement or health reimbursement arrangement, both of which require substantiation for tax-free reimbursement of a medical expense, individuals are not required to provide substantiation to the trustee or custodian of an HSA that a distribution is

[16] 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. 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.

[17] These dollar amounts are for 2008 and are indexed for inflation.

for a qualified expense in order to be entitled to the exclusion.[18] Instead, the individuals simply maintain books and records with respect to the expense and claim the exclusion for a distribution from the HSA on their return if it is used for a qualified expense.

The maximum aggregate annual contribution that can be made to an HSA is $2,900 in the case of self-only coverage and $5,800 in the case of family coverage (even if the corresponding health plan deductible is lower than these amounts).[19] The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $900 in 2008, and $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

If an employer makes contributions to employees' HSAs, the employer must make available comparable contributions on behalf of all employees who have comparable coverage during the same period. Employer contributions are not includable in employees' incomes or as taxable wages for payroll tax purposes. 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.

Individuals 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.[20]

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[18] 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.

[19] These amounts are for 2008, are indexed for inflation, and are the same as the maximum deductible amounts permitted under a high deductible plan for purposes of Archer MSAs. In the case of individuals who are married to each other, if either spouse has family coverage, both spouses are treated as only having the family coverage with the lowest deductible and the contribution limit is divided equally between them unless they agree on a different division. Limitations based on the amount of the deductible under the high deductible plan applied to years beginning before January 1, 2007.

[20] Sec. 220.

Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. The main differences include: (1) only self-employed individuals and employees of small employers are eligible to have an Archer MSA; (2) for Archer MSA purposes, a high deductible health plan is a health plan with (a) an annual deductible of at least $1,950 and no more than $2,900 in the case of self-only coverage and at least $3,850 and no more than $5,800 in the case of family coverage and (b) maximum out-of pocket expenses of no more than $3,850 in the case of self-only coverage and no more than $7,050 in the case of family coverage;[21] 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.

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

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

Under the Trade Adjustment Assistance Reform Act of 2002,[22] certain individuals are eligible for the health coverage tax credit ("HCTC").[23] The HCTC is a refundable tax credit equal to 65 percent of the cost of qualified health coverage paid by an eligible individual.

In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they had not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The credit is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market. The credit is available on an advance basis through a program established by the Secretary of the Treasury. Persons entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized plans, or with certain other specified coverage are not eligible for the credit.[24]

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

[23] Sec. 35.

[24] Sec. 35(f).

F. Other Tax Rules

1. Welfare Benefit Funds, VEBAs, and Retiree Medical Accounts

Generally, an employer (including an employer that self insures) is not able to prefund employer-provided health care coverage for active employees, whether through a welfare benefit fund or otherwise.[25] In contrast, the Code permits an employer to deduct contributions to a welfare benefit fund for retiree medical benefits that generally are funded over the working lives of the covered employees.[26] For retirees, deductible contributions can be made to two types of tax-exempt funding vehicles, either to a voluntary employees' beneficiary association (VEBA)[27] or, if an employer sponsors a tax-qualified pension plan, to the tax-exempt trust that funds the pension plan (referred to as a "retiree medical account").[28] In addition to direct deductible contributions, a retiree medical account under a defined benefit plan may be funded by transfers to the account of excess pension assets under the pension plan of which the account is a part.[29]

2. Long-term care

Present law also provides tax subsidies for qualified long-term care insurance contracts and expenses for qualified long-term care services. A qualified long-term care insurance contract is defined as any insurance contract that provides only coverage for qualified long-term care services, and that meets additional requirements.[30] Per diem-type and reimbursement-type

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[25] Secs. 419(c)(3) and 419A(c)(1). The Code generally limits the deductions that may be taken with respect to contributions to a "welfare benefit fund" for active employees to (1) the amount which would have been allowable as a deduction for the benefits provided during the taxable year as if the employer had provided such benefits directly and (2) claims for benefits incurred but unpaid as of the close of the taxable year (and administrative costs with respect to such claims). However, special rules apply for collectively bargained plans, employee pay-all plans, 10-or-more employer plans, and bona fide association plans.

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

[27] Secs. 419(e) and 501(c)(9). Contributions also may be made to a VEBA to fund health coverage benefits for active employees. Section 512 coordinates the tax-exemption for a VEBA with the section 419 limitations on contributions to a welfare benefit fund. This coordination limits the amount of a VEBA's income that is treated as tax-exempt.

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

[29] Sec. 420.

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

contracts are permitted. Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.[31]

A qualified long-term care insurance contract is treated as an accident and health insurance contract.[32] Thus, amounts received under the contract generally are excludable from income as amounts received for personal injuries or sickness.[33] In the case of per diem contracts, the excludable amount is subject to a dollar cap of $270 per day (for 2008), as indexed. If payments under such contracts exceed the dollar cap, then the excess is excludable only to the extent of actual costs in excess of the dollar cap that are incurred for long-term care services.

An employer's plan that provides employees with coverage under a long-term care insurance contract generally is treated in the same manner as employer-provided health care. As a result, the employer's premium payments are generally excludable from income and wages, and benefits payable under the contract generally are excludable from the recipient's income.[34] This exclusion does not apply, however, to long-term care insurance provided under a cafeteria plan.[35] As a result, a cafeteria plan cannot offer long-term care coverage as a tax-favored option. As noted earlier, an employee's share of employer-provided health care, by contrast, can be funded through a cafeteria plan.

Long-term care insurance expenses of a self-employed individual are deductible under the self-employed health deduction.[36]

Premiums paid for a qualified long-term care insurance contract[37] and unreimbursed expenses for qualified long-term care services are treated as medical expenses for purposes of the itemized deduction for medical care (subject to the floor of 7.5 percent of adjusted gross

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

[32] Sec. 7702B(a)(1).

[33] Secs. 104(a)(3), 105, and 106.

[34] Secs. 105, 106, and 3121(a)(2).

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

[36] Sec. 162(l).

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

income). Unreimbursed expenses for qualified long-term care services provided to the taxpayer or the taxpayer's spouse or dependent also are treated as medical expenses for purposes of the itemized deduction.

3. Distributions for public safety officers

Present law provides an exclusion from income for distributions from governmental retirement plans that are used to pay for health insurance premiums for eligible retired public safety officers and their spouses and dependents.[38] The exclusion is limited to $3,000 annually. An eligible retired safety officer is an individual who, by reason of disability or attainment of normal retirement age, is separated from service as a public safety officer with the employer that maintains the retirement plan from which the distributions are made. The premiums do not have to be for a plan sponsored by the employer; however, the exclusion does not apply to premiums paid by the employee and reimbursed with pension distributions. Amounts excluded under this provision are not taken into account in determining the itemized deduction for medical expenses or the deduction for health insurance expenses of self-employed individuals.

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

APPENDIX A
COMPARISON OF 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.	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).

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
6. Deduction for health insurance expenses of self-employed individuals (sec. 162(l))	Income tax deduction for cost of health insurance expenses of self-employed individuals. Deduction does not apply for self-employment tax purposes.	Self-employed individuals.	No specific dollar limit; deduction limited by amount of taxpayer's earned income from the trade or business.	Insurance which constitutes medical care for the taxpayer, spouse and dependents.
7. Itemized deduction for medical expenses (sec. 213)	Itemized deduction for unreimbursed medical expenses to extent expenses exceed 7.5 percent of adjusted gross income (10 percent for alternative minimum tax purposes).	Any individual who itemizes deductions and had unreimbursed medical expenses in excess of 7.5 percent of adjusted gross income.	No maximum limit.	Expenses for medical care (as defined under section 213(d)) of the taxpayer, spouse and dependents. Medicine or drugs must be prescribed or insulin.
8. Health Savings Accounts ("HSAs") (sec. 223)	Contributions are deductible if made by an eligible individual and excluded from gross income and wages if made by an employer (including contributions made through a cafeteria plan through salary reduction). Distributions used for qualified medical expenses excludable from gross income. Earnings on amounts in the HSA accumulate on a tax-free basis.	Individuals with a high deductible health plan and no other health plan other than a plan that provides certain permitted coverage. High deductible health plan is a plan with a deductible of at least $1,100 for self-only coverage and $2,200 for family coverage (for 2008). Out-of-pocket expense limit must be no more than $5,600 for self-only coverage and $11,200 for family coverage (for 2008).	Maximum annual contribution is $2,900 for self-only coverage or $5,800 for family coverage (for 2008). Additional contributions permitted for individuals age 55 or older. No limit on the amount that can be accumulated in the HSA.	Qualified medical expenses include those for medical care (as defined under section 213(d)) of the taxpayer, spouse and dependents, 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
9. Archer Medical Savings Accounts ("Archer MSAs") (sec. 220)	Contributions are deductible if made by an eligible individual and excluded from gross income and wages if made by an employer. Distributions used for qualified medical expenses are excludable from gross income. Earnings on amounts in the Archer MSA accumulate on a tax-free basis.	Employees of small employers who are covered under an employer-sponsored high-deductible health plan (and no other health plan other than a plan that provides certain permitted coverage) and self-employed individuals covered under a high-deductible health plan. Definition of high-deductible health plan differs from that for HSAs. No new contributions may be made after 2007 except for individuals who previously had an MSA or work for an employer that made MSA contributions.	Maximum annual contribution is 65 percent of the annual deductible under the high-deductible health plan in the case of self-only coverage, and 75 percent of the annual deductible in the case of family coverage. No limit on the amount that can be accumulated in the MSA.	Qualified medical expenses include those for medical care as defined under section 213(d), but do not include expenses for insurance other than certain limited exceptions.
10. Health Coverage Tax Credit (sec. 35)	Refundable tax credit of 65 percent of the cost of qualified health insurance coverage.	Individuals receiving trade adjustment assistance and certain individuals receiving benefits from the PBGC.	Limited to 65 percent of the cost of qualified health insurance. No specific dollar limit.	Qualified health insurance as defined in section 35(e).

[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.