PRESENT LAW AND BACKGROUND ON FEDERAL TAX PROVISIONS RELATING TO HEALTH CARE

Scheduled for a Public Hearing

Before the

SUBCOMMITTEE ON OVERSIGHT

of the

HOUSE COMMITTEE ON WAYS AND MEANS

on April 23, 1998

Prepared by the staff

of the

JOINT COMMITTEE ON TAXATION

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CONTENTS

INTRODUCTION

The Subcommittee on Oversight of the House Committee on Ways and Means has scheduled a public hearing on Federal tax-related provisions affecting health care on April 23, 1998.

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description (Part I) of present-law rules and legislative background for certain Federal tax provisions affecting health care (other than tax-exempt organizations and tax-exempt bond provisions relating to hospitals and other health care organizations). In addition, Part II of this document discusses data on the utilization of certain of these tax provisions under present law.

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[1] This document may be cited as follows: Joint Committee on Taxation, *Present Law and Background on Federal Tax Provisions Relating to Health Care* (JCX-26-98), April 22, 1998.

I. PRESENT LAW AND BACKGROUND

A. Exclusion from Income and Wages for Employer-Provided Health Care

Present Law

In general, employer contributions to an accident or health plan are excludable from an employee's income (sec. 106 of the Code). This exclusion for employer-provided health coverage also generally applies to coverage provided to former employees. In the case of a self-insured medical reimbursement plan, the exclusion is conditioned on the coverage being provided under a plan meeting certain nondiscrimination requirements (sec. 105(h)). Insured health plans are generally not subject to nondiscrimination rules. Employer-provided accident or health coverage is generally excludable from wages for employment tax purposes as well without regard to whether the coverage is provided on a nondiscriminatory basis (sec. 3121(a)(2)).

Benefits paid under employer-provided accident or health plans are also generally excludable from income to the extent they are reimbursements for medical care (as defined in sec. 213) or to the extent the benefits constitute payments for the permanent loss of use of a member or function of the body or permanent disfigurement and are computed with reference to the nature of the injury and without regard to the period the employee is absent from work (sec. 105).[2]

Legislative Background

In 1943, the Internal Revenue Service ruled that employer contributions to group health insurance policies were not taxable to the employee. Employer contributions to individual health insurance policies, however, were declared to be taxable income in an IRS revenue ruling in 1953.

Section 106 of the Internal Revenue Code, enacted in 1954, reversed the 1953 IRS ruling. As a result, employer contributions to all accident or health plans generally are excluded from gross income and therefore are not subject to tax. In addition, section 105 of the Code provides that benefits received under an employer's accident or health plan generally are not included in the employee's income.

The provision relating to self-insured medical reimbursement plans was added by the Revenue Act of 1978.

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[2] The Code also provides an exclusion for amounts received under workmen's compensation acts for personal injuries or sickness and damages received on account of personal injuries or sickness (sec. 104).

B. Employer Deduction for Health Care for Employees

Present Law

Under present law, amounts paid or accrued by an employer within a taxable year for a sickness, accident, hospitalization, medical expense, or similar health plan for its employees are generally deductible as ordinary and necessary business expenses under section 162 of the Code. The deduction is available provided the amounts are used to pay accident and health insurance premiums or to pay or reimburse benefits directly. Amounts paid for premiums are not deductible if the proceeds of the policy are payable to the employer rather than the employee. The timing of the deduction is based on the employer's method of accounting. Under the cash method, the expenses are deductible for the taxable year for which they were paid. Under the accrual method, the expenses are deductible for the taxable year in which all events have occurred to determine the fact and amount of the expenses.

Contributions by an employer to a welfare benefit fund are not deductible under section 162 of the Code but are deductible under section 419 of the Code. A welfare benefit fund is, in general, any fund that is part of a plan of an employer, and through which the employer provides welfare benefits to employees or their beneficiaries.

The amount of the deduction otherwise available to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

A qualified asset account under a welfare benefit fund is an account consisting of assets set aside to provide for the payment of disability payments, medical benefits, supplemental unemployment compensation benefits or severance pay benefits, or life insurance benefits. Under present law, an account limit is provided for the amount in a qualified asset account for any year. The account limit for any taxable year may include a reserve to provide certain postretirement medical and life insurance benefits.

Legislative Background

The provisions relating to employer deductions for amounts contributed to welfare benefit plans were added by the Deficit Reduction Act of 1984.

C. Cafeteria Plans and Flexible Spending Accounts

Present Law

Cafeteria plans

In general

Under present law, compensation generally is includible in gross income when actually or constructively received. An amount is constructively received by an individual if it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, amounts are not included in the gross income of a participant in a cafeteria plan described in section 125 of the Code solely because the participant may elect among cash and certain employer-provided qualified benefits under the plan.

In general, a qualified benefit is a benefit that is excludable from an employee's gross income by reason of a specific provision of the Code. Thus, employer-provided accident or health coverage, group-term life insurance coverage (whether or not subject to tax by reason of being in excess of the dollar limit on the exclusion for such insurance), and benefits under dependent care assistance programs may be provided through a cafeteria plan. However, a cafeteria plan may not provide qualified scholarships or tuition reduction (sec. 117), educational assistance (sec. 127), or miscellaneous employer-provided fringe benefits (sec. 132). In addition, a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)).

A cafeteria plan must be in writing, must include only employees (including former employees) as participants, and must satisfy certain nondiscrimination requirements. An employer that maintains a cafeteria plan is required to file an annual return relating to such plan.

The cafeteria plan exception from the principle of constructive receipt generally also applies for employment tax (FICA and FUTA) purposes.[3]

Nondiscrimination rules

The exception to the constructive receipt principle provided for cafeteria plans does not apply to highly compensated individuals if the plan discriminates in favor of such individuals as to eligibility to participate or as to contributions or benefits under the plan. A plan is not discriminatory as to eligibility if the plan benefits a nondiscriminatory classification of

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[3] Elective contributions under a qualified cash or deferred arrangement that is part of a cafeteria plan are subject to employment taxes.

employees and requires no more than 3 years of employment as a condition of participation. Special rules apply for determining whether a plan that provides health coverage is discriminatory with respect to contributions and benefits. In addition, a plan is deemed not to be discriminatory if the plan is maintained pursuant to a collective bargaining agreement.

For purposes of these nondiscrimination requirements, a highly compensated individual is an officer, a shareholder owning more than 5 percent of the employing firm, a highly compensated individual (determined under the facts and circumstances of the case), or a spouse or dependent of the above individuals.

In the case of a key employee, the exception to the constructive receipt principle does not apply if the qualified benefits provided under the plan to such employees exceed 25 percent of the aggregate of such benefits provided for all employees under the plan. A key employee is defined under the top-heavy rules applicable to qualified pension plans (sec. 416).

Flexible spending accounts

A flexible spending account ("FSA") is a reimbursement account under which an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care. A flexible spending account may be part of a cafeteria plan and may be funded through salary reduction. Flexible spending accounts may also be provided by an employer outside a cafeteria plan. Such accounts are commonly used, for example, to reimburse employees for medical expenses not covered by insurance.

There is no special exclusion for benefits provided under an FSA. Thus, benefits provided under an FSA are excludable from income only if there is a specific exclusion for the benefits in the Code (e.g., the exclusion for employer-provided health or group-term life insurance coverage). FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)). According to proposed Treasury regulations, a cafeteria plan would permit the deferral of compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.[4] Thus, amounts in an employee's account that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the "use it or lose it" rule.

In addition, proposed Treasury regulations contain additional requirements with which health FSAs must comply in order for the coverage and benefits provided under the FSA to be excludable from income.[5] These rules apply with respect to a health FSA without regard to

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[4] Prop. Treas. Reg. 1.125-2 Q&A-5(a).

[5] Prop. Treas. Reg. 1-125-2 Q&A-7(b).

whether the health FSA is provided through a cafeteria plan (i.e., without regard to whether an employee has an election to take cash or benefits).

The proposed regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.[6]

Under the proposed regulations, the employer-provided health coverage under the FSA and the reimbursements and other benefits received under the health FSA will be excludable from an employee's income only if the health FSA satisfies certain additional requirements. According to the proposed regulations, health FSAs are required to (1) provide the maximum amount of reimbursement available under the FSA at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage), (2) offer coverage for 12 months or, in the case of a short plan year, the entire short plan year, (3) only reimburse medical expenses which meet the definition of medical care under section 213(d) of the Code, (4) reimburse medical expenses for which the participant provides a written statement from an independent third party stating the amount of the medical expense and that the medical expense has not been reimbursed or is not reimbursable under any other health plan, (5) reimburse medical expenses which are incurred during the participant's period of coverage, and (6) allocate experience gains with respect to a year of coverage among premium payers on a reasonable and uniform basis.[7]

Legislative Background

The Employee Retirement Income Security Act of 1974 ("ERISA") provided that an employer contribution made before January 1, 1977, to a cafeteria plan in existence on June 27, 1974, was required to be included in an employee's gross income only to the extent that the employee actually elected taxable benefits. If a plan did not exist on June 27, 1974, the employer contribution was to be included in income to the extent the employee could have elected taxable benefits. The Revenue Act of 1978 set up permanent rules for plans that offer an election between taxable and nontaxable benefits.

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[6] Prop. Treas. Reg. 1-125-2 Q&A-7(c).

[7] Prop. Treas. Reg. 1-125-2 Q&A-7(b).

The Deficit Reduction Act of 1984 clarified the types of employer-provided benefits that could be provided through a cafeteria plan, added a 25-percent concentration test, and required annual reporting to the IRS by employers.

The Tax Reform Act of 1986 also modified the rules relating to cafeteria plans in several respects.

D. Medical Savings Accounts

Present Law

In general

The Health Insurance Portability and Accountability Act of 1996 ("HIPA") included favorable tax treatment for medical savings accounts ("MSAs"), effective for taxable years beginning after December 31, 1996. Within limits, contributions to an MSA are deductible in determining adjusted gross income ("AGI") if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. Earnings on amounts in an MSA are not currently taxable. Distributions from an MSA for medical expenses are not taxable. Distributions not used for medical expenses are includible in income. In addition, distributions not used for medical expenses are subject to an additional 15-percent tax unless the distribution is made after age 65, death, or disability.[8]

Eligible individuals

MSAs are available to employees covered under an employer-sponsored high deductible plan of a small employer and self-employed individuals covered under a high deductible plan regardless of the size of the entity for which the individual performs services.[9]

An employer is a small employer if it employed, on average, no more than 50 employees on business days during either the preceding or the second preceding year. In determining whether an employer is a small employer, a preceding year is not taken into account unless the employer was in existence throughout such year. In the case of an employer that was not in existence throughout the first preceding year, the determination of whether the employer has no more than 50 employees is based on the average number of employees that the employer reasonably expects to employ on business days in the current year. In determining the number of employees of an employer, controlled groups of corporations (sec. 414(b)), unincorporated trades or businesses under common control (sec. 414(c)), affiliated service groups (sec. 414(m)), and certain businesses as provided in regulations (sec. 414(o)) are treated as a single employer.

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[8] HIPA (sec. 193) amends the Public Health Service Act to provide that health maintenance organizations may offer high deductible plans (as defined under the new Code provisions relating to MSAs). Thus, providing they are otherwise eligible, an individual with a high deductible plan through an HMO is eligible for an MSA.

[9] Self-employed individuals include more than 2-percent shareholders of S corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.

In order for an employee of a small employer to be eligible to make MSA contributions (or to have employer contributions made on his or her behalf), the employee must be covered under an employer-sponsored high deductible health plan (see the definition below) and must not be covered under any other health plan (other than a plan that provides certain permitted coverage, described below). In the case of an employee, contributions can be made to an MSA either by the individual or by the individual's employer. However, an individual is not eligible to make contributions to an MSA for a year if any employer contributions are made to an MSA on behalf of the individual for the year. Similarly, if the individual's spouse is covered under the high deductible plan covering such individual and the spouse's employer makes a contribution to an MSA for the spouse, the individual may not make MSA contributions for the year. For example, suppose individual a works for a small employer and is covered under a high deductible plan that covers a and her spouse, B. a's employer makes a contribution for a year to an MSA for a. B is not entitled to make contributions to an MSA for that year.

Similarly, in order to be eligible to make contributions to an MSA, a self-employed individual must be covered under a high deductible health plan and no other health plan (other than a plan that provides certain permitted coverage, described below). a self-employed individual is not an eligible individual (by reason of being self-employed) if the high deductible plan under which the individual is covered is established or maintained by an employer of the individual (or the individual's spouse).

An individual with other coverage in addition to a high deductible plan is still eligible for an MSA if such other coverage is certain permitted insurance or is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Permitted insurance is: (1) Medicare supplemental insurance; (2) 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; (3) insurance for a specified disease or illness; and (4) insurance that provides a fixed payment for hospitalization.

Individuals covered under Medicare are not eligible for an MSA. However, individuals covered under Medicare may have a Medicare+Choice MSA, described below.

If a small employer with an MSA plan (i.e., the employer or its employees made contributions to an MSA) ceases to become a small employer (i.e., exceeds the 50-employee limit), then the employer (and its employees) can continue to establish and make contributions to MSAs (including contributions for new employees and employees that did not previously have an MSA) until the year following the first year in which the employer has more than 200 employees. After that, those employees who had an MSA (to which individual or employer contributions were made in any year) can continue to make contributions (or have contributions made on their behalf) even if the employer has more than 200 employees.

Tax treatment of and limits on contributions

Individual contributions to an MSA are deductible (within limits) in determining AGI (i.e., "above the line"). In addition, employer contributions are excludable from gross income and wages for employment tax purposes (within the same limits), except that this exclusion does not apply to contributions made through a cafeteria plan. No deduction is allowed to any individual for MSA contributions if such individual is a dependent on another taxpayer's tax return.

In the case of a self-employed individual, the deduction cannot exceed the individual's earned income from the trade or business with respect to which the high deductible plan is established. In the case of an employee, the deduction cannot exceed the individual's compensation attributable to the employer sponsoring the high deductible plan in which the individual is enrolled.

The maximum annual contribution that can be made to an MSA for a year is 65 percent of the deductible under the high deductible plan in the case of individual coverage and 75 percent of the deductible in the case of family coverage. No other dollar limits on the maximum contribution apply. The annual contribution limit is the sum of the limits determined separately for each month, based on the individual's status and health plan coverage as of the first day of the month.

Contributions for a year can be made until the due date for the individual's tax return for the year (determined without regard to extensions).

In order to facilitate application of the cap on the number of MSA participants, described below, the employer is required to report employer MSA contributions, and the individual is required to report such employer MSA contributions on the individual's tax return.

Comparability rule for employer contributions

If an employer provides high deductible health plan coverage coupled with an MSA to employees and makes employer contributions to the MSAs during a calendar year, the employer must make available a comparable contribution on behalf of all employees with comparable coverage during the same coverage period in the calendar year. Contributions are considered comparable if they are either of the same dollar amount or the same percentage of the deductible under the high deductible plan. If an employee is employed for only a portion of the calendar year, a contribution to the MSA of such employee is treated as comparable if it is an amount which bears the same ratio to the comparable contribution as the portion of the year he or she is employed bears to the calendar year. The comparability rule is applied separately to part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week). No restrictions are placed on the ability of the employer to offer different plans to different groups of employees. The comparability rule does not restrict contributions that can be made to an MSA by a self-employed individual.

If employer contributions do not comply with the comparability rule during a calendar year, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to MSAs of the employer for the year. The excise tax is designed as a proxy for the denial of employer contributions. In the case of a failure to comply with the comparability rule which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed to the extent that the payment of the tax would be excessive relative to the failure involved.

For purposes of the comparability rule, employers under common control are aggregated in the same manner as in determining whether the employer is a small employer. The comparability rule does not fail to be satisfied in a year if the employer is precluded from making contributions for all employees with high deductible plan coverage because the employer has more than 200 employees or due to operation of the cap during the initial 4-year period.

Definition of high deductible plan

A high deductible plan is a health plan with an annual deductible of at least $1,500 and no more than $2,250 in the case of individual coverage and at least $3,000 and no more than $4,500 in the case of family coverage. In addition, the maximum out-of-pocket expenses with respect to allowed costs (including the deductible) must be no more than $3,000 in the case of individual coverage and no more than $5,500 in the case of family coverage. Beginning after 1998, the dollar amounts are indexed for inflation in $50 dollar increments based on the consumer price index. a plan does not fail to qualify as a high deductible plan merely because it does not have a deductible for preventive care as required by State law. a plan does not qualify as a high deductible health plan if substantially all of the coverage under the plan is for permitted coverage (as described above). In the case of a self-insured plan, the plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement.

As under present law, State insurance commissions would have oversight over the issuance of high deductible plans issued in conjunction with MSAs and could impose additional consumer protections. It is intended that the National Association of Insurance Commissioners ("NAIC") will develop model standards for high deductible plans that individual States could adopt.

Tax treatment of MSAs

Earnings on amounts in an MSA are not currently includible in income.

Taxation of distributions

Distributions from an MSA for the medical expenses of the individual and his or her spouse or dependents are generally excludable from income.[10] However, in any year for which a contribution is made to an MSA, withdrawals from an MSA maintained by that individual generally are excludable from income only if the individual for whom the expenses were incurred was covered under a high deductible plan for the month in which the expenses were incurred.[11] This rule is designed to ensure that MSAs are in fact used in conjunction with a high deductible plan, and that they are not primarily used by other individuals who have health plans that are not high deductible plans.

For this purpose, medical expenses are defined as under the itemized deduction for medical expenses, except that medical expenses do not include expenses for insurance other than long-term care insurance, premiums for health care continuation coverage, and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law.

Distributions that are not for medical expenses are includible in income. Such distributions are also subject to an additional 15-percent tax unless made after age 65, death, or disability.

The MSA trustee or custodian is responsible for reporting the amount of distributions in a year from an MSA. However, the MSA trustee or custodian is not responsible for determining whether or not a distribution is excludable from income or subject to the additional 15-percent tax (e.g., the trustee or custodian is not responsible for monitoring expenses or use of MSA funds). The account holder is responsible for properly reporting distributions as taxable or nontaxable on his or her tax return (and whether or not the additional 15-percent tax applies). The account holder is responsible for supporting a claim that distributions are not taxable (e.g., through maintenance of proper records of medical expenses), just as individuals are responsible for supporting deductions, e.g., the itemized deduction for medical expenses.[12]

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[10] This exclusion does not apply to expenses that are reimbursed by insurance or otherwise.

[11] The exclusion still applies to expenses for continuation coverage or coverage while the individual is receiving unemployment compensation, even if for an individual who is not an eligible individual.

[12] Similarly, although the MSA trustee or custodian is responsible for reporting the amount of MSA contributions, the trustee or custodian is not responsible for determining whether the contributions are in fact deductible.

Estate tax treatment

Upon death, any balance remaining in the decedent's MSA is includible in his or her gross estate.

If the account holder's surviving spouse is the named beneficiary of the MSA, then, after the death of the account holder, the MSA becomes the MSA of the surviving spouse and the amount of the MSA balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction provided in Code section 2056. The MSA qualifies for the marital deduction because the account holder has sole control over disposition of the assets in the MSA. The surviving spouse is not required to include any amount in income as a result of the death; the general rules applicable to MSAs apply to the surviving spouse's MSA (e.g., the surviving spouse is subject to income tax only on distributions from the MSA for nonmedical purposes). The surviving spouse can exclude from income amounts withdrawn from the MSA for expenses incurred by the decedent prior to death, to the extent they otherwise are qualified medical expenses.

If, upon death, the MSA passes to a named beneficiary other than the decedent's surviving spouse, the MSA ceases to be an MSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of MSA assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includible in income is reduced by the amount in the MSA used, within one year of the death, to pay qualified medical expenses incurred prior to the death. As is the case with other MSA distributions, whether the expenses are qualified medical expenses is determined as of the time the expenses were incurred. In computing taxable income, the beneficiary may claim a deduction for that portion of the Federal estate tax on the decedent's estate that was attributable to the amount of the MSA balance (calculated in accordance with the present-law rules relating to income in respect of a decedent set forth in sec. 691(c)).

If there is no named beneficiary for the decedent's MSA, the MSA ceases to be an MSA as of the date of death, and the fair market value of the assets in the MSA as of such date are includible in the decedent's gross income for the year of the death. This rule applies in all cases in which there is no named beneficiary, even if the surviving spouse ultimately obtains the right to MSA assets (e.g., if the surviving spouse is the sole beneficiary of the decedent's estate). Because of the significant tax consequences if a married individual fails to name his or her spouse as the MSA beneficiary, even if the rights to MSA assets are otherwise acquired by the surviving spouse, it is anticipated that the marketing materials describing other tax aspects of MSAs will explain the consequences of failure to name the spouse as the beneficiary.

Cap on taxpayers utilizing MSAs

The number of taxpayers benefiting annually from an MSA contribution is limited to a threshold level (generally 750,000 taxpayers). If it is determined in a year that the threshold level for that year has been exceeded (called a "cut-off" year) then, in general, for succeeding years

during the 4-year pilot period 1997-2000, only those individuals who (1) made an MSA contribution or had an employer MSA contribution for the year or a preceding year (i.e., are active MSA participants) or (2) are employed by a participating employer, would be eligible for an MSA contribution. In determining whether the threshold for any year has been exceeded, MSAs of individuals who were not covered under a health insurance plan for the six month period ending on the date on which coverage under a high deductible plan commences would not be taken into account.[13] However, if the threshold level is exceeded in a year, previously uninsured individuals would be subject to the same restriction on contributions in succeeding years as other individuals. That is, they would not be eligible for an MSA contribution for a year following a cut-off year unless they are an active MSA participant (i.e., had an MSA contribution for the year or a preceding year) or are employed by a participating employer.

In a year after a cut-off year, employees of a participating employer can establish new MSAs and make new contributions (even if the employee is a new employee or did not previously have an MSA). An employer is a participating employer if (1) the employer made any MSA contributions on behalf of employees in the cut-off year or any preceding year or (2) at least 20 percent of the employees covered under a high deductible plan made an MSA contribution of at least $100 in the cut-off year.

In the case of a cut-off year before 2000, an individual is not an eligible individual or an active MSA participant unless the individual was first covered under a high deductible plan on or before the cut-off date. The cut-off date is generally October 1 of the cut-off year. However, if the individual was enrolled in an employer-sponsored plan pursuant to a regularly scheduled enrollment period that occurs during the last 3 months of the year, then the cut-off date is December 31. Similarly, an employer is not considered a participating employer if it first offered coverage after October 1 of a cut-off year unless the high deductible plan is offered pursuant to a regularly scheduled enrollment period. In addition, a self-employed individual is not considered an eligible individual or an active MSA participant unless the individual was covered under a high deductible plan on or before November 1 of a cut-off year.

These rules are designed to prevent high deductible plans from being first offered just before the limitation on MSAs is effective in order to avoid application of the cap. They are not, however, intended to preclude individuals who first enroll in an employer-sponsored high deductible health plan or employees of employers that adopt a high deductible plan in a cut-off year due to normal health plan operation from having MSAs.

Under certain circumstances, MSA participation may be reopened after a cut-off year so that MSAs are again available to all individuals in the qualifying group of self-employed individuals and employees of small employers.

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[13] Permitted coverage, as described above, does not constitute coverage under a health insurance plan for this purpose.

End of pilot project

After December 31, 2000, no new contributions may be made to MSAs except by or on behalf of individuals who previously had MSA contributions and employees who are employed by a participating employer. An employer is a participating employer if (1) the employer made any MSA contributions for any year to an MSA on behalf of employees or (2) at least 20 percent of the employees covered under a high deductible plan made MSA contributions of at least $100 in the year 2000.

Self-employed individuals who made contributions to an MSA during the period 1997-2000 also may continue to make contributions after 2000.

Measuring the effects of MSAs

During 1997-2000, the Department of the Treasury will evaluate MSA participation and the reduction in Federal revenues due to such participation and make such reports of such evaluations to the Congress as the Secretary determines appropriate.

The General Accounting Office is directed to contract with an organization with expertise in health economics, health insurance markets and actuarial science to conduct a study regarding the effects of MSAs in the small group market on (1) selection (including adverse selection), (2) health costs, including the impact on premiums of individuals with comprehensive coverage, (3) use of preventive care, (4) consumer choice, (5) the scope of coverage of high deductible plans purchased in conjunction with an MSA and (6) other relevant issues, to be submitted to the Congress by January 1, 1999.

It is intended that the study be broad in scope, gather sufficient data to fully evaluate the relevant issues, and be adequately funded. It is expected that the study will utilize appropriate techniques to measure the impact of MSAs on the broader health care market, including in-depth analysis of local markets with high penetration. It is expected that the study will evaluate the impact of MSAs on individuals and families experience high health care costs, especially low- and middle-income families.

Medicare MSAs

In general

Beginning in 1999, individuals who are enrolled in Medicare will be eligible to elect an MSA option, called the Medicare+Choice MSA plan.[14] If an individual chooses such a plan, the Secretary of Health and Human Services makes a specified contribution directly into a

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[14] As under prior law, individuals who are eligible for Medicare are not eligible for an MSA that is not a Medicare+Choice MSA.

Medicare+Choice MSA designated by such individual. Only contributions by the Secretary of Health and Human Services can be made to a Medicare+Choice MSA and such contributions are not included in the taxable income of the Medicare+Choice MSA holder. Income earned on amounts held in a Medicare+Choice MSA are not currently includible in taxable income. Withdrawals from a Medicare+Choice MSA are excludable from taxable income if used for the qualified medical expenses of the Medicare+Choice MSA holder. Medical expenses of the account holder's spouse or dependents are not treated as qualified medical expenses. Withdrawals from a Medicare+Choice MSA that are not used for the qualified medical expenses of the account holder are includible in income and may be subject to an additional tax (described below).

Like the regular MSA program, the Medicare MSA program is a pilot--individuals are not eligible to enroll in a Medicare+Choice MSA plan after December 31, 2002, unless the enrollment is the continuation of enrollment in effect as of such date, or if the number of individuals in a Medicare MSA plan exceeds 390,000.

Definition of Medicare+Choice MSAs

In general, a Medicare+Choice MSA is an MSA that is designated as Medicare+Choice MSA and to which the only contributions that can be made are those by the Secretary of Health and Human Services.[15] Thus, a Medicare+Choice MSA is a tax-exempt trust (or a custodial account) created exclusively for the purpose of paying the qualified medical expenses of the account holder that meets requirements similar to those applicable to individual retirement arrangements ("IRAs").[16] The trustee of a Medicare+Choice MSA can be a bank, insurance company, or other person that demonstrates to the satisfaction of the Secretary of the Treasury that the manner in which such person will administer the trust will be consistent with applicable requirements.

A Medicare+Choice MSA trustee is required to make such reports as may be required by the Secretary of the Treasury. a $50 penalty is imposed for each failure to file without reasonable cause.

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[15] Medicare+Choice MSAs are not taken into account for purposes of the cap on non-Medicare+Choice MSAs, nor are they subject to that cap.

[16] For example, no Medicare+Choice MSA assets could be invested in life insurance contracts, Medicare+Choice MSA assets can not be commingled with other property except in a common trust fund or common investment fund, and an account holder's interest in a Medicare+Choice MSA would be nonforfeitable. In addition, if an account holder engages in a prohibited transaction with respect to a Medicare+Choice MSA or pledges assets in a Medicare+Choice MSA, rules similar to those for IRAs would apply, and any amounts treated as distributed to the account holder under such rules would be treated as not used for qualified medical expenses.

Taxation of distributions from a Medicare+Choice MSA

Distributions from a Medicare+Choice MSA that are used to pay the qualified medical expenses of the account holder are excludable from taxable income regardless of whether the account holder is enrolled in the Medicare+Choice MSA plan at the time of the distribution.[17] Qualified medical expenses are defined as under the rules relating to the itemized deduction for medical expenses. However, for this purpose, qualified medical expenses do not include any insurance premiums other than premiums for long-term care insurance, continuation insurance (so-called "COBRA coverage"), or premium for coverage while an individual is receiving unemployment compensation. Distributions from a Medicare+Choice MSA that are excludable from gross income under the provision can not be taken into account for purposes of the itemized deduction for medical expenses.

Distributions for purposes other than qualified medical expenses are includible in taxable income. An additional tax of 50 percent applies to the extent the total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of the Medicare+Choice MSA as of December 31 of the preceding year exceeds 60 percent of the deductible of the plan under which the individual is covered on January 1 of the current year. The additional tax does not apply to distributions on account of the disability or death of the account holder.

Direct trustee-to-trustee transfers can be made from one Medicare+Choice MSA to another Medicare+Choice MSA without income inclusion.

The provision includes a correction mechanism so that if contributions for a year are erroneously made by the Secretary of Health and Human Services, such erroneous contributions can be returned to the Secretary of Health and Human Services (along with any attributable earnings) from the Medicare+Choice MSA without tax consequence to the account holder.

Treatment of Medicare+Choice MSA at death

Upon the death of the account holder, if the beneficiary of the Medicare+Choice MSA is the account holder's surviving spouse, the surviving spouse may continue the Medicare+Choice MSA, but no new contributions could be made. Distributions from the Medicare+Choice MSA are subject to the rules applicable to MSAs that are not Medicare+Choice MSAs. Thus, earnings on the account balance are not currently includible in income. Distributions from the account for the qualified medical expenses of the spouse or the spouse's dependents (or subsequent spouse) are not includible in income. Distributions not for such medical expenses are includible in income, and subject to a 15-percent excise tax unless the distribution is made after the surviving spouse attains age 65, dies, or becomes disabled.

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[17] Under the provision, medical expenses of the account holder's spouse or dependents are not treated as qualified medical expenses.

If the beneficiary of a Medicare+Choice MSA is not the account holder's spouse, the Medicare+Choice MSA is no longer treated as a Medicare+Choice MSA and the value of the Medicare+Choice MSA on the account holder's date of death is included in the taxable income of the beneficiary for the taxable year in which the death occurred (under the rules applicable to MSAs generally). If the account holder fails to name a beneficiary, the value of the Medicare+Choice MSA on the account holder's date of death is to be included in the taxable income of the account holder's final income tax return (under the rules applicable to MSAs generally).

In all cases, the value of the Medicare+Choice MSA is included in the account holder's gross estate for estate tax purposes.

Legislative Background

The provisions relating to regular MSAs were added by the Health Insurance Portability and Accountability Act of 1996. The provisions relating to Medicare+Choice MSAs were enacted as part of the Balanced Budget Act of 1997.

E. Deduction for Health Insurance Expenses of Self-Employed Individuals

Present Law

Under present and prior law, the tax treatment of health insurance expenses depends on whether the taxpayer is an employee and whether the taxpayer is covered under a health plan paid for by the employee's employer. An employer's contributions to a plan providing accident or health coverage for the employee and the employee's spouse and dependents contributions are excludable from an employee's income. The exclusion is generally available in the case of owners of a business who are also employees.

Under present law, self-employed individuals (i.e., sole proprietors or partners in a partnership), are entitled to deduct a portion of the amount paid for health insurance for the self-employed individual and the individual's spouse and dependents. Self-employed individuals may deduct the amount paid for health insurance as follows: 45 percent in 1998 and 1999, 50 percent in 2000 and 2001, 60 percent in 2002, 80 percent in 2003 through 2005, 90 percent in 2006, and 100 percent in 2007 and all years thereafter.

The deduction is available with respect to the cost of self insurance as well as commercial insurance. In the case of self insurance, the deduction is not available unless the self-insured plan is in fact insurance (e.g., there is adequate risk shifting) and not merely a reimbursement arrangement. The deduction is not available for any month in which the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse. In addition, no deduction is available to the extent that the deduction exceeds the taxpayer's earned income from self employment. Expenses for health insurance in excess of the deductible amount may be taken into account in determining whether the individual is entitled to an itemized deduction for medical expenses.

Payments for personal injury or sickness through an arrangement having the effect of accident or health insurance (and not merely a reimbursement arrangement) are excludable from income. In order for the exclusion to apply, the arrangement must be insurance (e.g., there must be adequate risk shifting). a self-employed individual who receives payments from such an arrangement can exclude the payments from income.

For purposes of these rules, more than 2-percent shareholders of S corporations are treated the same as self-employed individuals. Thus, they are entitled to the same health insurance deduction.

Legislative Background

The provision relating to the deduction for health insurance costs of self-employed individuals was added by the Tax Reform Act of 1986. Under that Act, the deduction was limited to 20 percent of health insurance costs. The Self-Employed Health Insurance Act of 1995 increased the level of deduction from 25 to 30 percent, beginning in 1995. The Health Insurance

Portability and Accountability Act of 1996 increased the level of deduction as follows: the deduction is 40 percent in 1997; 45 percent in 1998 through 2002; 50 percent in 2003; 60 percent in 2004; 70 percent in 2005; and 80 percent in 2006 and thereafter. The Taxpayer Relief Act of 1997 increased the level of deduction as described above under present law.

F. Itemized Deduction for Medical Expenses

Present Law

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, the taxpayer's spouse, and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income ("AGI").

Under a special rule, premiums paid during the taxable year by a taxpayer before the attainment of age 65 for insurance covering medical care for the taxpayer, his or her spouse, or a dependent after the taxpayer attains the age of 65 are treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for the insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains the age of 65 (but in no case for a period of less than 5 years).

Legislative Background

An itemized deduction for unreimbursed medical expenses above a specified floor has been allowed since 1942. From 1954 through 1982, the floor under the medical expense deduction was 3 percent of the taxpayer's AGI; a separate floor of 1 percent of AGI applied to expenditures for medicine and drugs.

In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the floor was increased to 5 percent of AGI (effective for 1983 and thereafter) and was applied to the total of all eligible medical expenses, including prescription drugs and insulin. TEFRA made nonprescription drugs ineligible for the deduction and eliminated the separate floor for drug costs.

The Tax Reform Act of 1986 increased the floor under the medical expense deduction to 7.5 percent of AGI, beginning in 1987.

Beginning in 1991, The Omnibus Budget Reconciliation Act of 1990 disallowed the medical expense deduction for cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

G. Provisions Relating to Long-Term Care

Present Law

In general

The Health Insurance Portability and Accountability Act of 1996 ("HIPA") clarified the Federal tax laws relating to qualified long-term care insurance contracts and expenses for qualified long-term care services, and provided for favorable tax treat for such contracts and services similar to the favorable tax treatment that applies to medical insurance and services and employer-provided accident or health plans.

In general, amounts received under a qualified long-term care insurance contract are excludable from income (subject to an annual dollar cap in the case of per diem contracts). Employer contributions for qualified long-term care insurance are excludable from income, except that this exclusion does not apply to long-term care insurance or services provided under a cafeteria plan. Up to certain dollar limits, premiums for long-term care insurance are treated as a medical expense for purposes of the itemized deduction for medical expenses, and are deductible under the rules relating to deduction of health insurance expenses for self-employed individuals. Expenses for qualified long-term care services are treated as medical expenses for purposes of the itemized deduction for medical expenses.

HIPA is silent with respect to the tax treatment of long-term care insurance and services that are not qualified. Thus, the tax treatment of such items is governed under prior law.

Exclusion of long-term care proceeds

Amounts (other than policyholder dividends or premium refunds) received under a qualified long-term care insurance contract generally are excludable from income as amounts received for personal injuries and sickness, subject to a cap of $175 per day, or $63,875 annually, as indexed, on per diem contracts only. The dollar cap is indexed by the medical care cost component of the consumer price index.

Employer-provided long-term care coverage

A plan of an employer providing coverage under a long-term care insurance contract generally is treated as an accident and health plan. Thus, employer contributions for long-term care insurance are deductible by the employer. Amounts received from long-term care insurance purchased by the employer are excludable from income (subject to the cap on per diem contracts).

Employer-provided coverage under a long-term care insurance contract is not excludable by an employee if provided through a cafeteria plan; similarly, expenses for long-term care services cannot be reimbursed under a flexible spending arrangement. Thus, employer

contributions (other than through a cafeteria plan) for long-term care insurance for the employee, his or her spouse, and his or her dependents (as defined for tax purposes) are excludable from income and wages for employment tax purposes.

Definition of long-term care insurance contract

A long-term care insurance contract is defined as any insurance contract that provides only coverage of qualified long-term care services and that meets other requirements. The other requirements are that (1) the contract is guaranteed renewable, (2) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed, (3) refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract may be used only to reduce future premiums or increase future benefits, and (4) the contract generally does not pay or reimburse expenses reimbursable under Medicare (except where Medicare is a secondary payor, or the contract makes per diem or other periodic payments without regard to expenses).

A contract does not fail to be treated as a long-term care insurance contract solely because it provides for payments on a per diem or other periodic basis without regard to expenses incurred during the period.

State-maintained plans

An arrangement is treated as a qualified long-term care insurance contract if an individual receives coverage for qualified long-term care services under a State long-term care plan, and the terms of the arrangement would satisfy the requirements for a long-term care insurance contract under the provision, were the arrangement an insurance contract. For this purpose, a State long-term care plan is any plan established and maintained by a State (or instrumentality of such State) under which only employees (and former employees, including retirees) of a State or of a political subdivision or instrumentality of the State, and their relatives, and their spouses and spouses' relatives, may receive coverage only for qualified long-term care services. "Relative" is defined as under section 152(a)(1)-(8). No inference was intended with respect to the tax consequences of such arrangements under prior law.

Definition of qualified long-term care services

Qualified long-term care services means 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. Maintenance and personal care services may include meal preparation, household cleaning, and other similar services which the chronically ill individual is unable to perform. It is anticipated that the scope of maintenance and personal care services will be defined in Treasury regulations.

A chronically ill individual is one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days[18] due to a loss of functional capacity, (2) having a similar level of disability as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.[19]

It was intended that an individual who is physically able but has a cognitive impairment such as Alzheimer's disease or another form of irreversible loss of mental capacity be treated similarly to an individual who is unable to perform (without substantial assistance) at least 2 activities of daily living. Because of the concern that eligibility for the medical expense deduction not be diagnosis-driven, the provision requires the cognitive impairment to be severe. It was intended that severe cognitive impairment mean a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in: (1) short- or long-term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning. In addition, it was intended that such deterioration or loss place the individual in jeopardy of harming self or others and therefore require substantial supervision by another individual.

A licensed health care practitioner is a physician (as defined in sec. 1861(r)(l) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. a licensed social worker includes any social worker who has been issued a license, certificate, or

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[18] The 90-day period is not a waiting period. Thus, for example, an individual can be certified as chronically ill if the licensed health care practitioner certifies that the individual will be unable to perform at least 2 activities of daily living for at least 90 days. The certification of an insured as a chronically ill individual may occur at any time, and is intended to take into account the sum of continuous prior days when the insured was chronically ill and future days when the insured is expected to remain chronically ill.

[19] For purposes of determining whether an individual is chronically ill, the number of activities of daily living that are taken into account under the contract may not be less than five. For example, a contract could require that an individual be unable to perform (without substantial assistance) two out of any five of the listed activities. By contrast, a contract does not meet this requirement if it required that an individual be unable to perform two out of any four of the listed activities. This requirement does not apply to the determination of whether an individual is a chronically ill individual either (1) by virtue of severe cognitive impairment, or (2) if the insured satisfies a standard (if any) that is not based upon activities of daily living, as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services.

authorization to act as a social worker by a State or a body authorized by a State to issue such authorizations.

Expenses for long-term care services treated as medical expenses

Unreimbursed expenses for qualified long-term care services provided to the taxpayer or the taxpayer's spouse or dependent are treated as medical expenses for purposes of the itemized deduction for medical expenses (subject to the present-law floor of 7.5 percent of adjusted gross income). For this purpose, amounts received under a qualified long-term care insurance contract (regardless of whether the contract reimburses expenses or pays benefits on a per diem or other periodic basis) are treated as reimbursement for expenses actually incurred for medical care.

For purposes of the deduction for medical expenses, qualified long-term care services do not include services provided to an individual by a relative or spouse (directly, or through a partnership, corporation, or other entity), unless the relative is a licensed professional with respect to such services, or by a related corporation (within the meaning of Code section 267(b) or 707(b)).[20]

Long-term care insurance premiums treated as medical expenses

Long-term care insurance premiums that do not exceed specified dollar limits are treated as medical expenses for purposes of the itemized deduction for medical expenses.[21] The limits are as follows:

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[20] The rule limiting such services provided by a relative or a related corporation does not apply for purposes of the exclusion for amounts received under a long-term care insurance contract, whether the contract is employer-provided or purchased by an individual. The limitation is unnecessary in such cases because it is anticipated that the insurer will monitor reimbursements to limit opportunities for fraud in connection with the performance of services by the taxpayer's relative or a related corporation.

[21] Similarly, within certain limits, in the case of a rider to a life insurance contract, charges against the life insurance contract's cash surrender value that are includible in income are treated as medical expenses (provided the rider constitutes a long-term care insurance contract).

In the case of an individual with an attained age before the close of the taxable year of:	*The limitation on premiums paid for such taxable years is:*
Not more than 40	$ 200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500

For taxable years beginning after 1997, these dollar limits are indexed for increases in the medical care component of the consumer price index. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, is directed to develop a more appropriate index to be applied in lieu of the foregoing. Such an alternative might appropriately be based on increases in skilled nursing facility and home health care costs. It is intended that the Treasury Secretary annually publish the indexed amount of the limits as early in the year as they can be calculated.

Deduction for long-term care insurance of self-employed individuals

The self-employed health insurance deduction applies to eligible long-term care insurance premiums.

The deduction for health insurance expenses of a self-employed individual is not available for a month for which the individual is eligible to participate in any subsidized health plan maintained by any employer of the individual or the individual's spouse. The fact that an individual is eligible for employer-subsidized health insurance is not intended to affect the ability of such an individual to deduct long-term care insurance premiums, so long as the individual is not eligible for employer-subsidized long-term care insurance.

Long-term care riders on life insurance contracts

In the case of long-term care insurance coverage provided by a rider on or as part of a life insurance contract, the requirements applicable to long-term care insurance contracts apply as if the portion of the contract providing such coverage were a separate contract. The term "portion" means only the terms and benefits that are in addition to the terms and benefits under the life insurance contract without regard to long-term care coverage. As a result, if the applicable requirements are met by the long-term care portion of the contract, amounts received under the contract as provided by the rider are treated in the same manner as long-term care insurance benefits, whether or not the payment of such amounts causes a reduction in the contract's death benefit or cash surrender value. The guideline premium limitation applicable under section 7702(c)(2) is increased by the sum of charges (but not premium payments) against the life insurance contract's cash surrender value, the imposition of which reduces premiums paid for the contract (within the meaning of sec. 7702(f)(1)). In addition, it is anticipated that Treasury

regulations will provide for appropriate reduction in premiums paid (within the meaning of sec. 7702(f)(1)) to reflect the payment of benefits under the rider that reduce the cash surrender value of the life insurance contract.

Inclusion of excess long-term care benefits

Long-term care benefits in excess of the annual dollar cap under per diem contracts are includible in gross income. The amount of the dollar cap with respect to any one chronically ill individual (who is not terminally ill) is $175 per day ($63,875 annually, as indexed), reduced by the amount of reimbursements and payments received by anyone for the cost of qualified long-term care services for the chronically ill individual.[22] If more than one payee receives payments with respect to any one chronically ill individual, then everyone receiving periodic payments with respect to the same insured is treated as one person for purposes of the dollar cap. The amount of the dollar cap is utilized first by the chronically ill person, and any remaining amount is allocated in accordance with Treasury regulations. 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) incurred for long-term care services. Amounts in excess of the dollar cap, with respect to which no actual costs were incurred for long-term care services, are fully includable in income.

The $175 per day limit is indexed for inflation after 1997 for increases in the medical care component of the consumer price index.

A payor of long-term care benefits (defined for this purpose to include any amount paid under a product advertised, marketed or offered as long-term care insurance) is required to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxpayer identification number of such individual. In addition, a payor is required to report the name, address, and taxpayer identification number of the chronically ill individual on account of whose condition such amounts are paid, and whether the contract under which the amount is paid is a per diem-type contract. a copy of the report must be provided to the payee by January 31 following the year of payment, showing the name of the payor and the aggregate amount of benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee is subject to the generally applicable penalties for failure to file similar information reports.

Life insurance company reserves

In determining reserves for insurance company tax purposes, the Federal income tax reserve method applicable for a long-term care insurance contract issued after December 31, 1996, is the method prescribed by the NAIC (or, if no reserve method has been so prescribed, a method consistent with the tax reserve method for life insurance, annuity or noncancellable

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[22] The dollar cap is also reduced by amounts received with respect to a chronically ill individual under a life insurance contract.

accident and health insurance contracts, whichever is most appropriate). The method currently prescribed by the NAIC for long-term care insurance contracts is the one-year full preliminary term method. As under prior and present law, however, in no event may the tax reserve for a contract as of any time exceed the amount which would be taken into account with respect to the contract as of such time in determining statutory reserves.

Consumer protection provisions

Long-term care insurance contracts, and issuers of contracts, are required to satisfy certain provisions of the long-term care insurance model Act and model regulations promulgated by the NAIC (as adopted as of January 1993).

The contract requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. Disclosure and nonforfeiture requirements also apply. The nonforfeiture provision gives consumers the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period in the event a policyholder who elects a nonforfeiture provision is unable to continue to pay premiums.[23] The requirement that insurers offer policyholders a nonforfeiture benefit does not preclude the imposition of a reasonable delay period. The consumer protection provisions that apply with respect to the terms of the contract apply only for purposes of determining whether a contract is a qualified long-term care insurance contract.

The requirements for issuers of long-term care insurance contracts relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, delivering a shopper's guide, right to return, outline of coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. a tax is imposed equal to $100 per insured per day for failure to satisfy these requirements. The consumer protection requirements for issuers of contracts apply with respect to contracts that are qualified long-term care insurance contracts.

An otherwise qualified long-term care insurance contract will not fail to be a qualified long-term care insurance contract solely because it satisfies a consumer protection standard

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[23] The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the appropriate State regulatory authority for the same contract form. a technical correction may be necessary so that the statute reflects this intent.

imposed under applicable State law that is more stringent than the analogous standard provided in the Code.

Legislative Background

The provisions relating to long-term care were added by the Health Insurance Portability and Accountability Act of 1996.

H. Group Health Plan Requirements

1. Health care continuation rules

Present Law

Under present law, the health care continuation rules (commonly referred to as "COBRA" rules, after the Consolidated Omnibus Budget Reconciliation Act of 1985 in which they were enacted) require that most employer-sponsored group health plans must offer certain employees and their dependents ("qualified beneficiaries") the option of purchasing continued health coverage in the case of certain qualifying events. These qualifying events include: termination or reduction in hours of employment, death, divorce or legal separation, enrollment in Medicare, the bankruptcy of the employer, or the end of a child's dependency under a parent's health plan. Under present law, the term qualified beneficiary includes individuals who were either the spouse or the dependent of the covered employee at the time of the qualifying event and includes a child born to or placed for adoption with the covered employee during the period of COBRA coverage

In general, the maximum period of COBRA coverage is 18 months. An employer is permitted to charge qualified beneficiaries 102 percent of the applicable premium for COBRA coverage. A tax equal to $100 per day may be assessed against employers (plans in the case of multiemployer plans) for failures to comply with the COBRA rules, subject to certain exceptions and limitations.

The 18-month maximum COBRA coverage period is extended to 29 months if the qualified beneficiary was determined under the Social Security Act to have been disabled at the time of the qualifying event and the qualified beneficiary provided notice of such determination to the employer before the end of the 18-month period. The Health Insurance Portability and Accountability Act of 1996 ("HIPA") clarified that this extended COBRA coverage applies if the disability exists at any time during the first 60 days of initial 18-month COBRA coverage as opposed to requiring the disability to exist at the time of the qualifying event. a qualified beneficiary has 60 days to notify the employer of a disability determination. During the 11-month period of extended COBRA coverage, the qualified beneficiary may be charged 150 percent of the applicable premium.

Under present law, COBRA coverage may be terminated before the 18-month maximum coverage period in the case of the following events: (1) the employer ceases to maintain any group health plan; (2) the qualified beneficiary fails to pay the premium; (3) the qualified beneficiary becomes covered under another group health plan even if such group health plan contains a preexisting condition limitation or exclusion, provided the preexisting condition limitation or exclusion does not apply to the qualified beneficiary by reason of requirements added by HIPA restricting the application of preexisting condition limitations and exclusions; or (4) the qualified beneficiary becomes entitled to Medicare.

Under present law, a group health plan is required to notify each covered employee and the covered employee's spouse of their COBRA rights upon commencement of participation in the plan. Further, the group health plan administrator must notify each qualified beneficiary of their COBRA rights within 14 days after the administrator is notified of the occurrence of a qualifying event.

Legislative Background

The COBRA rules were added by the Consolidated Omnibus Budget Reconciliation Act of 1985. Provisions modifying the COBRA rules were added by the Health Insurance Portability and Accountability Act of 1996.

2. Health Insurance Portability and Accountability Act ("HIPA") rules

Present Law

HIPA requirements--in general

Under HIPA, certain group health plans are subject to certain requirements regarding portability of coverage through limitations on preexisting condition exclusions, prohibitions on denial of coverage based on health status, and guaranteed renewability of health insurance coverage. An excise tax is imposed with respect to any failure of a group health plan to comply with the requirements.[24] The tax is generally imposed on the employer sponsoring the plan. However, the tax is imposed on the plan in the case of a multiemployer plan and, with respect to violations of the requirements relating to guaranteed renewability, on the arrangement in the case of a multiple employer welfare arrangement.

These group health plan requirements do not apply to governmental plans and plans which on the first day of the plan year cover fewer than 2 current employees. In addition, no tax may be imposed on a small employer (defined as an employer who employed an average of 50 or fewer employees on business days during the preceding calendar year) that provides health care benefits through a contract with an insurer or HMO if the violation is solely because of the coverage offered by the insurer or HMO.

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[24] HIPA also enforces these requirements through the Employee Retirement Income Security Act and the Public Health Service Act, and imposes similar and additional requirements on health insurance issuers.

Group health plan requirements

Limitations on preexisting condition exclusions

HIPA restricts the use of preexisting condition exclusions by group health plans. a preexisting condition exclusion is a limitation or exclusion of benefits relating to a condition, whether physical or mental, based on the fact that the condition was present before the enrollment date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information is not considered a condition in the absence of a diagnosis of the condition related to such information.

HIPA permits a group health plan to impose a preexisting condition exclusion if the exclusion relates to a condition (whether physical or mental), regardless of the cause of condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date. The exclusion can extend to not more than 12 months (18 months for late enrollees) after the enrollment date. The exclusion is reduced by the aggregate of the periods of creditable coverage. Enrollment date is defined as the date of enrollment in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

Any waiting period or affiliation period runs concurrently with any preexisting condition exclusion period. A preexisting condition exclusion period cannot be applied to a newborn, an adopted child, or a child placed for adoption under age 18, so long as the individual becomes covered under creditable coverage within 30 days of birth or adoption or placement for adoption. These exceptions for newborns and certain adopted children do not apply if the individual had a break in coverage longer than a 63-day period. Preexisting condition exclusions cannot apply to pregnancies.

A group health plan offering health insurance coverage through an HMO, or an HMO which offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if no preexisting condition exclusion is imposed, the period is imposed uniformly without regard to health status, and does not exceed 2 months for timely enrollment and 3 months for late enrollment. The affiliation period must apply to all new enrollees and beneficiaries. During the affiliation period, the HMO cannot be required to provide health care services or benefits and no premium can be charged to the participant or beneficiary. The affiliation period begins on the enrollment date and runs concurrently with any other applicable waiting period under the plan. An HMO may use alternative methods to address adverse selection as approved by state regulators.

Prohibiting exclusions based on health status

Except as specified below, a group health plan cannot establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on any of the following health-related factors in relation to the individual or a dependent of the

individual: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), or disability.

The inclusion of evidence of insurability in the definition of health status is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

A plan cannot knowingly be designed to exclude individuals and their dependents on the basis of health status. However, generally applicable terms of the plan may have a disparate impact on individual enrollees. For example, a plan may exclude all coverage of a specific condition, or may include a lifetime cap on all benefits, or a lifetime cap on specific benefits. Although individuals with the specific condition would be adversely affected by an exclusion of coverage for that condition, and individuals with serious illnesses may be adversely affected by a lifetime cap on all or specific benefits, such plan characteristics are permitted as long as they are not directed at individual sick employees or dependents.

HIPA does not require a group health plan to provide particular benefits other than those provided under the terms of the plan or coverage. Nor does it prevent any plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage. Rules defining any applicable waiting periods for enrollment may not be based on factors related to health status.

A plan cannot single out an individual based on health status or related factors for denial of a benefit otherwise provided other individuals covered under the plan. For example, the plan may not deny coverage for prescription drugs to a particular beneficiary or dependent if such coverage is available to other similarly situated individuals covered under the plan. However, the plan could deny coverage for prescription drugs to all beneficiaries and dependents. The term "similarly situated" means that a plan is permitted to vary benefits available to different groups of employees, such as full-time versus part-time employees or employees in different geographic locations. In addition, a plan may have different benefit schedules for different collective bargaining units.

HIPA provides that a group health plan cannot require a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any factor relating to the health status of individual or any individual enrolled under the plan as a dependent of the individual. HIPA does not restrict the amount that an employee may be charged for coverage under a group health plan. The group health plan may establish premium discounts or rebates, or modify otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

These provisions preclude insurance companies from denying coverage to employees based on health status and related factors that they have traditionally used. In addition, this provision is

meant to prohibit insurers or employers from excluding employees in a group from coverage or charging them higher premiums based on their health status and other related factors that could lead to higher health costs. This does not mean that an entire group cannot be charged more. But it does preclude health plans from singling out individuals in the group for higher premiums or dropping them from coverage altogether.

Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements

HIPA provides that a group health plan which is a multiemployer plan or a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under the terms of such plan except: (1) for nonpayment of contributions; (2) for fraud; (3) for noncompliance with plan provisions; (4) because the plan is ceasing to offer any coverage in a geographic area; (5) in the case of a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan, and the plan applies this provision uniformly without regard to claims experience or health status-related factors; or (6) due to a failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining agreement or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

Excise tax on failure to satisfy group health plan requirements

The excise tax on the failure to satisfy the group health plan requirements is generally equal to $100 per day for each day during which a failure occurs until the failure is corrected. The tax applies separately with respect to each individual affected by the failure. In general, the tax is not imposed if the violation was unintentional and is corrected within 30 days.[25] The maximum tax for unintentional violations that can be imposed generally is the lesser of (1) 10 percent of the employer's payments during the taxable year in which the failure occurred under group health plans (or 10 percent of the amount paid by the multiemployer plan or multiple employer welfare arrangement during the plan year in which the failure occurred for medical care, if applicable), or (2) $500,000. The Secretary of the Treasury may waive all or part of the tax to the extent that payment of the tax would be excessive relative to the failure involved.

Legislative Background

The provisions relating to group health plan requirements were added by the Health Insurance Portability and Accountability Act of 1996.

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[25] In the case of a church plan, this correction is generally extended to 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to a failure to comply with the group health plan requirements.

3. Newborns' and mothers' health protection; mental health parity

Present Law

The Newborns' and Mothers' Health Protection Act of 1996 amended the Employee Retirement Income Security Act ("ERISA") and the Public Health Service Act to impose certain requirements on group health plans with respect to coverage of newborns and mothers, including a requirement that a group health plan cannot restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. These provisions are effective with respect to plan years beginning on or after January 1, 1998.

The Mental Health Parity Act of 1996 amended ERISA and the Public Health Service Act to Provide that group health plans that provide both medical and surgical benefits and mental health benefits cannot impose aggregate lifetime or annual dollar limits on mental health benefits that are not imposed on substantially all medical and surgical benefits. The provisions of the Mental Health Parity Act are effective with respect to plan years beginning on or after January 1, 1998, but do not apply to benefits for services furnished on or after September 30, 2001.

The Internal Revenue Code requires that group health plans meet certain requirements with respect to limitations on exclusions of preexisting conditions and that group health plans not discriminate against individuals based on health status. An excise tax of $100 per day during the period of noncompliance is imposed on the employer sponsoring the plan if the plan fails to meet these requirements. The maximum tax that can be imposed during a taxable year cannot exceed the lesser of 10 percent of the employer's group health plan expenses for the prior year or $500,000. No tax is imposed if the Secretary determines that the employer did not know, and exercising reasonable diligence would not have known, that the failure existed.

Failures to comply with the provisions of the Newborns' and Mothers' Health Protection Act and the Mental Health Parity Act are subject to the excise tax applicable to failures to comply with other group health plan requirements.

Legislative Background

The provision incorporating the provisions of the Newborns' and Mothers' Health Protection Act of 1996 and the Mental Health Parity Act of 1996 relating to group health plans into the Internal Revenue Code was added by the Taxpayer Relief Act of 1997.

I. Other Tax-Related Health Provisions

1. Prefunding of retiree health benefits

Present Law

Under present law, post-retirement medical benefit plans (i.e., retiree health plans) are plans maintained by employers to pay for all or a portion of the medical costs of retired or former employees of the employer (and possibly their dependents) either directly or by the purchase of insurance. Generally, the employer finances all or a significant portion of the cost of this benefit for the retiree. The costs for both the employer and the beneficiary of these retiree health benefits depends greatly on the age of the beneficiary.

Under present law, post-retirement medical benefits are generally excludable from the gross income of a plan participant or beneficiary. In addition, an employer may deduct contributions, within limits, made to a welfare benefit fund for retiree health and life insurance benefits of its employees. a welfare benefit fund is, in general, any fund that is part of a plan of an employer, and through which the employer provides welfare benefits to employees or their beneficiaries.

Contributions by an employer to a welfare benefit fund are not deductible under the usual income tax rules (sec. 162), but if they otherwise would be deductible under the usual rules (e.g., if they are ordinary and necessary business expenses), the contributions will be deductible within limits for the taxable year in which such contributions are made to the fund.

The amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

A qualified asset account under a welfare benefit fund is an account consisting of assets set aside to provide for the payment of disability payments, medical benefits, supplemental unemployment compensation benefits or severance pay benefits, or life insurance benefits. Under present law, an account limit is provided for the amount in a qualified asset account for any year.

The account limit for any taxable year may include a reserve to provide certain post-retirement medical and life insurance benefits. This limit allows amounts reasonably necessary to accumulate reserves under a welfare benefit plan so that the liabilities for post-retirement medical and life insurance benefits with respect to a group of employees can be prefunded.

Each year's computation of contributions with respect to post-retirement medical benefits is to be made under the assumption that the medical benefits provided to future retirees will have the same costs as medical benefits currently provided to retirees. Because the reserve is computed

on the basis of the current year's medical costs, neither future inflation nor future changes in the level of utilization may be taken into account until they occur.

In the case of an employee who is a "key employee" (as defined in sec. 416), a separate account is required to be established and maintained on a per-participant basis, and benefits provided to such employee (and his or her spouse and dependents) are payable only from the separate account. Contributions to the separate account of a key employee are considered annual additions to a defined contribution plan for purposes of the limits on contributions and benefits applicable to retirement plans (sec. 415), except that the 25-percent-of-compensation limits (sec. 415(c)(1)(B)) does not apply.

Under present law, if an employer maintains a welfare benefit fund that provides a disqualified benefit during any taxable year, the employer is subject to an excise tax equal to 100 percent of the disqualified benefit. a disqualified benefit includes (1) a benefit provided to a key employee other than from a separate account required to be established for such an employee, (2) any post-retirement medical or life insurance benefit that is provided in a discriminatory manner, and (3) any portion of a welfare benefit fund reverting to the employer.

Legislative Background

The provisions relating to welfare benefit funds were added by the Deficit Reduction Act of 1984.

2. Voluntary employees' beneficiary associations ("VEBAs")

Present Law

Under present law, a voluntary employees' beneficiary association ("VEBA") is a tax exempt welfare benefit fund that provides for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, and under which no part of the net earnings of such association may inure (other than through such payments) to the benefit of any private shareholder or individual. In addition the VEBA generally is required to satisfy certain rules prohibiting the provision of benefits on a basis that favors the employer's highly compensated employees.

Although a VEBA generally is exempt from tax, it is taxable on its unrelated business taxable income ("UBTI"). Income set aside to provide for post-retirement medical benefits is considered UBTI. This rule does not apply to a VEBA if substantially all of the contributions to it were made by employers who are exempt from income tax throughout the 5-taxable-year period ending with the taxable year in which the contributions were made. Further, VEBAs maintained pursuant to a collective bargaining agreement and certain employee pay all VEBAs are not subject to UBTI because no account limits apply to such VEBAs.

Legislative Background

The provisions relating to VEBAs were added by the Deficit Reduction Act of 1984.

3. Use of excess pension assets to fund retiree health benefits

Present Law

Under present law, a tax-qualified pension or annuity plan may provide for the payment of sickness, accident, hospitalization and medical expenses for retired employees, their spouses, and their dependents under a separate account method of prefunding post-retirement medical and life insurance benefits provided certain additional qualification requirements are satisfied with respect to the post-retirement medical benefits (sec. 401(h)). First, the medical benefits, when added to any life insurance protection provided under the plan, are required to be incidental to the retirement benefits provided by the plan. The medical benefits are considered incidental or subordinate to the retirement benefits if, at all times, the aggregate of employer contributions to provide such medical benefits and any life insurance protection does not exceed 25 percent of the aggregate contributions, other than contributions to fund past service credits.

The second requirement is that a separate account is to be maintained with respect to contributions to fund such medical benefits. This separate accounting generally is determined on an aggregate, rather than on a per-participant basis, and is solely for recordkeeping purposes. In addition, separate accounts are required to be maintained for each key employee in the same manner as under a welfare benefit fund.

The third requirement is that the employer's contributions to the separate account are to be reasonable and ascertainable. Fourth, the plan is required to preclude the use of amounts in the separate account for any other purposes at any time prior to the satisfaction of all liabilities with respect to the post-retirement medical benefits. Fifth, upon the satisfaction of all plan liabilities to provide post-retirement medical benefits, the remaining assets in the separate account are to revert to the employer and cannot be distributed to the retired employees.

If these requirements are satisfied, the income earned in the separate account (sec. 401(h) account) is not taxable. In addition, employer contributions to fund the benefits are deductible under the general rules relating to the timing of deductions for contributions to qualified pension plans. The deduction for such contributions are not taken into account in determining the amount deductible with respect to contributions for retirement benefits. The amount deductible may not exceed the total cost of providing the medical benefits, determined in accordance with any generally accepted actuarial method that is reasonable in view of the provisions and coverage of the plan and any other relevant considerations. In addition, the amount deductible for any taxable year may not exceed the greater of (1) an amount determined by allocating the remaining unfunded costs as a level amount or a level percentage of compensation over the remaining future service of each employee, or (2) the amount necessary to amortize the unfunded costs over a 10-

year period. Certain contributions in excess of the deductible limit may be carried over and deducted in succeeding taxable years.

Legislative Background

The provision relating to the transfer of excess assets to retiree health accounts was added by the Omnibus Budget Reconciliation Act of 1990.

II. UTILIZATION OF SELECTED FEDERAL TAX PROVISIONS RELATED TO HEALTH CARE

A. Exclusion from Income and Wages for Employer-Provided Health Care

Table 1 shows the Federal tax expenditures for selected health care related tax provisions. By far the most significant provision, both in terms of the number of taxpayers that benefit and the cost to the Federal Government, is the exclusion from income and wages for employer-provided health care. The staff of the Joint Committee on Taxation estimates that the revenue loss from the exclusion from income is $51.4 billion in fiscal year 1998 (see Table 1). This estimate includes employer-provided health insurance obtained through cafeteria plans. This estimate does not include the effects of the exclusion for employment tax purposes.

A majority of the population now receives health insurance as a consequence of their own employment or of a family member's employment. In 1996, for 58 percent of the population, employment based health insurance was the primary source of health coverage, while 5 percent purchased insurance privately, 13 percent received Medicare benefits, 9 percent received Medicaid benefits, and 15 percent had no health insurance.[26]

Cafeteria plans are a growing part of compensation plans, particularly for large employers. Benefits provided through cafeteria plans are excluded from income to the extent such benefits are eligible for an exclusion based on other provisions of the Code. Thus, employer-provided health care benefits that are provided through cafeteria plans are eligible for an income exclusion. The Bureau of Labor Statistics estimates that in 1995, 55 percent of employees at large and medium sized firms were eligible for flexible benefits and/or reimbursement accounts. Smaller firms generally do not offer cafeteria plans. In 1994, only 19 percent of workers in small, private establishments (nonfarm establishments with fewer than 100 employees) were eligible to participate in a cafeteria plan.

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[26] Congressional Budget Office analysis of 1996 Current Population Survey.

B. Itemized Deduction for Medical Expenses and Long-Term Care Expenses

The staff of the Joint Committee on Taxation estimates that 4,847,000 tax returns had itemized deductions for medical expenses in 1997, resulting in a loss of Federal revenues of $3.7 billion in 1997.[27] The itemized deduction for medical expenses is intended to apply only to extraordinary medical expenses, and hence only medical expenses in excess of 7.5 percent of AGI can be deducted. The utilization of this provision thus depends on both the extent of a taxpayer's medical expenses in a given year, and on the taxpayer's AGI. Additionally, to the extent that AGI is low, taxpayers may find it more advantageous to claim the standard deduction rather than itemize deductions, even if their medical expenses exceeded 7.5 percent of their AGI. The 7.5-percent floor for the medical expense deduction has a significant impact on the number of taxpayers who can claim the deduction. For example, when the medical deduction floor was increased from 3 percent of AGI to 5 percent of AGI, the number of tax returns claiming the deduction dropped from 22 million in 1982 to 9.7 million in 1983. Similarly, the increase from 5 percent of AGI to 7.5 percent saw a drop in the number of tax returns claiming the deduction from 10.5 million in 1986 to 5.4 million in 1987.[28] Table 2 shows the distribution by income class of the tax expenditure resulting from the deduction for medical expenses.

Unreimbursed expenses for qualified long-term care services provided to the taxpayer or the taxpayer's spouse or dependents are treated as medical expenses for purposes of the itemized deduction for medical expenses. Similarly, long-term care insurance premiums that do not exceed specified dollar limits are treated as medical expenses for purposes of the itemized deduction for medical expenses. The staff of the Joint Committee on Taxation estimates that the tax expenditure for the itemized deduction for medical expenses and long-term care expenses combined is $4.4 billion for fiscal year 1998 (see Table 1).

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[27] Figures do not include deductions for long-term care expenses.

[28] Internal Revenue Service figures.

C. Deduction for Health Insurance and Long-Term Care Insurance Expenses of Self-Employed Individuals

The Federal tax revenues forgone by the deduction for health insurance premiums and long-term care insurance premiums by the self-employed is estimated by the staff of the Joint Committee on Taxation to be $800 million in fiscal year 1998 (see Table 1). Currently, the self-employed may deduct 45 percent of their premiums; this amount will gradually increase until it reaches 100 percent for 2007 and subsequent years. The rise in the deductible fraction implies a greater subsidy to self-employed health and long-term care insurance, and thus it is likely that the increased subsidy will induce more self-employed to purchase such insurance.

D. Medical Savings Accounts

As described previously, eligibility for contributions to MSAs is limited by a number of statutory provisions relating to the size of the employer and the nature of the health insurance offered by that employer. There is also an overall limit on the total number of MSAs that may be established. The utilization of MSAs has been well below the applicable numerical limit to date. The Internal Revenue Service ("IRS") determined that only 7,383 MSAs had been established as of April 30, 1997, and that only 17,154 MSAs had been established as of June 30, 1997. The tax expenditure cost of MSAs is estimated to be less than $50 million in fiscal year 1998 (see Table 1).

Table 1.--Tax Expenditure Estimates for Selected Health Care Provisions, Fiscal Years 1998-2002

[Billions of Dollars]

Provision	1998	1999	2000	2001	2002	Total 1998-2002
1. Exclusion of employer contributions for medical care, health insurance premiums, and long-term care insurance premiums[1]	51.4	54.8	58.1	61.7	65.4	291.3
2. Deduction for medical expenses and long-term care expenses	4.4	4.9	5.3	5.9	6.5	27.1
3. Deduction for health insurance premiums and long-term care insurance premiums by the self-employed	0.8	0.9	1.0	1.1	1.4	5.2
4. Medical savings accounts	[2]	0.1	0.1	0.2	0.2	0.6

Source: Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 1998-2002* (JCS-22-97), December 15, 1997. Tax expenditure estimates are for Federal income taxes only and do not include any effects on Social Security payroll taxes.

[1] Estimate includes employer-provided health insurance purchased through cafeteria plans.

[2] Less than $50 million.

Table 2.--Distribution by Income Class of Medical Deduction Tax Expenditure at 1997 Rates and 1997 Income Levels[1]

[Money amounts in millions of dollars; returns in thousands]

Income class[2]	Medical deduction[3]	
	Returns	Amount
Below $10,000	13	$ 2
$10,000 to $20,000	203	61
$20,000 to $30,000	674	217
$30,000 to $40,000	961	456
$40,000 to $50,000	794	383
$50,000 to $75,000	1,424	1,087
$75,000 to $100,000	514	703
$100,000 to $200,000	245	657
$200,000 and over	20	181
Total	**4,847**	**$3,745**

Source: Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 1998-2002* (JCS-22-97), December 15, 1997. Tax expenditure estimates are for Federal income taxes only and do not include any effects on Social Security payroll taxes.

[1] Tax law as in effect on January 1, 1997. Excludes individuals who are dependents of other taxpayers.

[2] The income concept used to place tax returns into classes is adjusted gross income (AGI) plus: (a) tax-exempt interest, (b) employer contributions for health plans and life insurance, (c) employer share of FICA tax, (d) workers' compensation, (e) nontaxable Social Security benefits, (f) insurance value of Medicare benefits, (g) alternative minimum tax preference items, and (h) excluded income of U.S. citizens living abroad.

[3] Tax expenditures estimates does not include revenue losses attributable to deductions for long-term care and long-term care insurance premiums.