

**OVERVIEW AND ESTIMATED REVENUE EFFECTS
OF THE MANAGED COMPETITION ACT OF 1993
(H.R. 3222 AND S. 1579)**

**Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION**

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INTRODUCTION

This document,¹ prepared by the staff of the Joint Committee on Taxation, provides an overview and estimated revenue effects of H.R. 3222 and S. 1579, the "Managed Competition Act of 1993". H.R. 3222 was introduced by Mr. Cooper and others on October 6, 1993; and S. 1579 was introduced by Sen. Breaux and others on October 21, 1993.

Part I of the document is a brief overview of the bill; and Part II shows the estimated revenue effects of the tax provisions of the bill under two possible benefit packages.

¹ This document may be cited as follows: Joint Committee on Taxation: Overview and Estimated Revenue Effects of the Managed Competition Act of 1993 (H.R. 3222 and S. 1579) (JCX-7-94), May 6, 1994.

**I. OVERVIEW OF THE MANAGED COMPETITION ACT OF 1993
(H.R. 3222 AND S. 1579)**

A. In General

The Managed Competition Act of 1993 (H.R. 3222/S. 1579, "the bill") has as its stated goal "[t]o contain health care costs and improve access to health care through accountable health plans and managed competition." The bill would not require individuals to purchase health insurance nor employers to pay any portion of their employees' health care costs. It would require employers to provide employees the opportunity to acquire health insurance--in the case of small employers by participating in state-sponsored health plan purchasing cooperatives (HPPCs). The sponsors of the legislation contend that the availability of HPPCs together with a number of tax incentives and disincentives contained in the bill will increase price competition among health plans and providers, thereby reducing prices and making health care coverage available to more individuals. The bill would provide health-care subsidies to low-income individuals through premium and cost sharing assistance.

The bill would establish a Health Care Standards Commission (the "Commission") to implement various requirements under the bill.²

B. Health Plan Purchasing Cooperatives (HPPCs)

The bill would provide opportunities and incentives for eligible individuals and small businesses to purchase health care coverage through HPPCs. HPPCs would negotiate with accountable health plans (AHPs); enroll individuals in AHPs, charge, receive, and forward premiums; reconcile low-income assistance; coordinate with other HPPCs; and establish a complaint process. Each State would be required to establish HPPCs by July 1, 1994.

In general, all individuals other than full-time employees of large employers could purchase coverage through a HPPC.³ Members of the same family would not be required to enroll in the same AHP. Thus, members of the same family could enroll on an individual basis in different AHPs offered by a HPPC.

C. Employer Obligations

Small employers would be required to enter into agreements

² S. 1579 calls the entity that would perform these duties the National Health Care Board rather than the Commission.

³ A large employer generally would be one with more than 100 employees.

with HPPCs to facilitate the purchase of health coverage by employees through the HPPC. Small employers would be required to provide certain information to the HPPC with respect to those employees who purchase insurance through the HPPC, to deduct from employees' compensation the premium due, and to forward such amount to the HPPC. Small employers could, but would not be required to, pay for a portion of the cost of health care coverage for their employees. Failure on the part of a small employer to have a HPPC agreement in effect or to comply with the agreement would result in a civil penalty not to exceed \$500 for each day in which the violation continues.

Large employers would be required to make health care coverage available to employees through one or more AHPs but would not be permitted to do this through a HPPC. Large employers could, but would not be required to, pay for a portion of the cost of coverage for its employees. Large employers would be required, at the request of an employee, to deduct the cost of health care coverage under an AHP from employees' compensation and forward the premiums to the AHP. Failure on the part of a large employer to offer coverage under an AHP or provide for payroll deduction of premiums at the employee's request would result in a civil penalty not to exceed \$500 for each day in which the violation continues.

D. Accountable Health Plans (AHPs)

The bill would not require health plans or providers to meet any specific requirements. However, the bill would encourage providers and insurers to provide coverage through AHPs by conditioning certain tax incentives on the purchase of health care through an AHP. AHPs could be either "open" or "closed". In general, a closed AHP would be an AHP that is limited by structure or law to one or more large employers. An open plan would be a plan that is not closed.

To qualify as an AHP, a plan would be required to meet quality standards to be established by the Commission, to offer a uniform set of benefits to be established under the bill, to establish standard premiums for the uniform set of benefits, and to make adjustments in cost-sharing in the case of low-income individuals. An AHP could offer benefits in addition to the uniform set of benefits, but only if the additional benefits were offered and priced separately from the uniform benefits.

In offering the uniform set of benefits, an AHP could not discriminate with respect to enrollment or benefits based on an individual's health status, claims experience, receipt of health care, medical history, receipt of public subsidy, or any characteristic that may relate to the need for health care services. An AHP would be allowed to exclude coverage with respect to a pre-existing condition for no more than six months

beginning on the first date of coverage under the plan.

AHPs would be required to charge a standard premium for the uniform set of benefits within each HPPC in which the plan is offered. The premium could vary only by premium class. The Commission would establish premium classes based on four types of enrollment (i.e., individual, individual and spouse, individual and one child, individual and more than one family member) and the age of the principal enrollee. Closed AHPs would be permitted to set premiums based on type of enrollment only (i.e., closed AHPs could disregard the age adjustment).

As discussed below, premiums would be reduced for low-income individuals.

E. Tax Incentives Relating to the Purchase of Health Plans

1. Excise tax on employers with excess health plan expenses

The bill would impose a deductible excise tax on employers equal to 34 percent of their excess health plan expenses. For this purpose, excess health plan expenses would include all expenses for group health insurance except certain expenses attributable to coverage under an AHP. Expenses attributable to coverage under an AHP would also be excess health plan expenses (1) if the employer's contribution is not uniform for a premium class regardless of which plan is selected by the individual, (2) if, in the case of a small employer, the payment is not made through a HPPC, and (3) to the extent the expense attributable to any particular individual exceeds the reference premium rate pertaining to that individual. The reference premium rate would be the lowest premium offered by an open plan in the HPPC area to individuals in the relevant premium class.

The excise tax would not apply to employer-provided health care for Medicare-eligible retirees or to expenses for direct services that are determined by the Commission to be primarily aimed at workplace health care and health promotion or related population-based preventive health activities.

The excise tax generally would be effective for expenses incurred after December 31, 1994, with a delayed effective date for expenses incurred pursuant to a collective bargaining agreement.

2. Increase in deduction for health plan premium expenses of self-employed individuals

On and after January 1, 1995, the bill would provide a 100-percent deduction for amounts paid by a self-employed individual to a HPPC for health care coverage for the individual and his or her spouse or dependents under an AHP, to the extent

the amount paid does not exceed the reference premium rate for the self-employed individual's premium class. Under the bill as drafted, no deduction would be allowed for the health insurance expenses of self-employed individuals during 1994.

3. Deduction for health plan premium expenses of individuals

Individuals would be able to deduct from gross income the cost of health insurance under an AHP up to the reference premium rate for the individual's premium class. Premiums that do not qualify for this deduction would continue to be deductible as under present law, i.e., subject to the 7.5-percent floor on itemized medical deductions.

The provision would be effective for amounts paid after December 31, 1994.

4. Exclusion of health care expenses from gross income

The bill would not change the present-law rule that employer contributions to an accident or health plan are excludable from an employee's gross income. The bill would extend this exclusion to partners and more than 2-percent shareholders of S corporations by providing that such individuals can exclude from gross income amounts paid by the partnership or S corporation for health care coverage of the partner or shareholder. Under present law, S corporation shareholders that own 2 percent or less of the corporation are permitted to exclude employer-provided health care from gross income.

The provision would apply to taxable years beginning after December 31, 1994.

5. Other provisions

H.R. 3222 (but not S. 1579) would provide for a liberalization of the rules governing when a health plan can qualify for tax exemption as a voluntary employees' beneficiary association (VEBA). The liberalized rules would apply only to health plans which are AHPs. H.R. 3222 would also provide for a simplified annual reporting system for certain fully-insured multiple employer welfare arrangements devoted solely to health care. The bill also would repeal the health care continuation rules for employers ("the COBRA rules"), generally effective on January 1, 1995.

F. Treatment of Underserved Areas

The bill would provide special treatment to areas designated by the Governor of the relevant State (with the concurrence of the Commission) as underserved. Under the bill, a HPPC serving an underserved area could require AHPs offered by

the HPPC to include the underserved area as part of their service area. Special risk-adjustment factors could be used to increase the compensation available to AHPs serving individuals in an underserved area. The bill would authorize \$5 million in technical assistance funding for entities seeking to establish a network plan in an underserved area for each fiscal year 1995 through 1999. The bill would authorize \$75 million for each fiscal year 1995 through 1999 for financial assistance with respect to the development and implementation of AHPs in underserved rural areas. The bill would authorize \$11.5 million for each fiscal year 1995 through 1999 for migrant health centers and \$88.5 million for each such fiscal year for community health centers.

The bill would expand Medicare Part B coverage to include certain services provided by rural emergency access care hospitals. The bill would authorize \$50 million for each fiscal year 1995 through 1999 for transitional assistance to government-owned or private nonprofit safety net hospitals. The bill would establish a procedure whereby a State could identify an area as a chronically underserved area and arrange for it to be served by a single AHP.

G. Low-Income Assistance for Health Coverage

Low-income individuals could be eligible for some or all of the following subsidies under the bill: (1) premium assistance; (2) cost-sharing assistance; and (3) special assistance with respect to certain items and services (including prescription drugs, eyeglasses, and hearing aids). The types of subsidies available for any particular low-income individual would depend upon whether the individual is Medicare-eligible and whether the individual has very low income (family income below the poverty level) or moderately low income (family income below 200 percent of the poverty level).

Premium assistance would be available to all low-income individuals, whether Medicare-eligible or not. Cost-sharing assistance would be available to all low-income individuals who are not Medicare-eligible, and to very low-income individuals who are Medicare-eligible. Special assistance with respect to certain items and services would be available to all very low-income individuals, whether Medicare-eligible or not.

The total amount available for low-income premium assistance would be determined by the Commission for each year.

H. Medicare and Other Savings

The bill would make a number of changes relating to Medicare, including reducing certain provider payments under Medicare, requiring high-income individuals to pay an additional

premium for Part B of Medicare, and requiring certain agencies to prefund government health benefits. The bill would also repeal Medicaid.

I. Training and Education of Health Care Professionals

The bill would establish a National Medical Educational Fund to be used by the Commission to provide financing for certain medical residency training programs and physician retraining programs. Each AHP would be required to make a payment into the Fund of one percent of the gross premium receipts of the AHP. The bill would authorize appropriations for scholarship and loan repayment programs currently administered by the National Health Service Corps and funding for other grants.

J. Paperwork Reduction and Administrative Simplification

The bill would require the Commission to address certain issues relating to the use of health care information. Among other things, the Commission would be required to set goals and deadlines for the health care industry to take certain action regarding paperwork reduction and availability of information. A nondeductible penalty tax would be imposed on administrators of health plans for any failure to comply with the Commission's requirements.

K. Miscellaneous

The bill also contains provisions relating to the application of the antitrust laws to AHPs, preventive health and individual responsibility under public health plans, and malpractice reform.

II. ESTIMATED REVENUE EFFECTS OF TAX PROVISIONS IN THE MANAGED COMPETITION ACT (H.R. 3222 AND S. 1579)

The following tables show the estimated revenue effects of the various tax provisions in the Managed Competition Act for fiscal years 1995 through 2004. These revenue estimates were prepared by the staff of the Joint Committee on Taxation (Joint Committee staff) in cooperation with the Congressional Budget Office (CBO) as it prepared estimates of the outlay effects of the bill.

The major provisions of H.R. 3222 and S. 1579 would generally become effective on January 1, 1995. However, for purposes of estimation of the revenue and outlay effects of the bill, CBO and the Joint Committee staff have assumed that all effective dates would be postponed one year. Thus, the major provisions are not assumed to become effective until January 1, 1996.

The Joint Committee staff normally does not provide revenue estimates for fiscal years outside the standard five-year budget window (fiscal years 1995 through 1999), but an exception has been made for major health reform bills, for two reasons. First, the full impact of some of the provisions in the bills may not be apparent until the year 2000 or later. Second, the Congressional Budget Office has prepared baseline macroeconomic forecasts and baseline health expenditure forecasts through calendar year 2004 for the purpose of estimating the outlay effects of these bills. These macroeconomic forecasts are a necessary input for revenue estimation, and are not otherwise available for years outside the five-year budget window.

The Managed Competition Act would create a Health Care Standards Commission that would be responsible for determining the standard package of health insurance benefits that would be provided through accountable health plans (AHPs). Revenue and outlay estimates for some of the major provisions in the bill are very sensitive to the level of benefits provided through AHPs. For estimation purposes, CBO and the Joint Committee staff have made two alternative assumptions concerning AHP benefits. The revenue estimates for Alternative 1 were prepared under the assumption that AHPs would contain the same benefits as the standard benefit plan in the Health Security Act (H.R. 3600, S. 1757, S. 1775). The revenue estimates for Alternative 2 were prepared under the assumption that AHPs would contain a reduced benefits package that is 20 percent less expensive than the Health Security Act's standard benefit plan.

The Managed Competition Act would limit the favorable tax treatment of employer-paid health insurance by imposing an excise tax on excess health plan expenses of employers. Excess health

plan expenses would be defined as employer contributions that exceed the premium for the lowest-cost accountable health plan in the employer's Health Plan Purchasing Cooperative area. Since all AHPs would provide the same package of benefits, the variation in premiums for AHPs would likely be small. Thus, it is assumed that employers could pay a large portion of the premium for AHPs for their employees without incurring any excise tax liability. However, employer contributions toward supplemental health insurance (beyond the basic AHP) would generally be subject to the excise tax on excess health plan expenses. If AHPs contained a generous package of benefits (comparable to the standard benefit plan in the Health Security Act), then it is unlikely that many employers would provide supplemental health insurance, and excise tax revenues would be small (about \$0.7 billion over the fiscal years 1996-2004), as shown in Alternative 1.

With a less generous benefits package (Alternative 2), it is likely that many employers would provide supplemental health insurance. Premiums for supplemental insurance could be paid by employees (through wage withholding) or by employers. If employers paid the premiums, there would most likely be a corresponding adjustment in the cash wages of the employees receiving the insurance. (Economists generally believe that all of the costs of employer-paid fringe benefits, including taxes imposed on employers, are borne by employees in the form of reduced cash wages.) Employer-paid premiums would be subject to the excise tax on excess health plan expenses, but employee-paid premiums would be paid out of cash wages that had been subjected to income and payroll taxation. In general, the excise tax would be less of a burden than the income and payroll taxes on cash wages, and it would be to the advantage of employees to have premiums for supplemental insurance paid by employers. Thus, with a less generous benefits package (Alternative 2), there would be larger excess health plan expenses by employers, and excise tax revenues would be much larger (\$65.5 billion over fiscal years 1996-2004).

Some employers who are now making generous contributions toward health insurance for employees would reduce their contributions by amounts sufficient to avoid the excise tax on excess health plan expenses. These reductions would most likely be accompanied by increases in cash wages and other fringe benefits to maintain the same level of total employee compensation. The increases in cash wages would generate additional income and payroll tax revenues. These additional revenues are included in the last lines of the two tables ("Other tax effects..."), along with other tax effects of the bill. (The other tax effects would include changes in tax-sheltered health spending through cafeteria plans and changes in itemized medical deductions.)

If the excise tax were deleted from the bill, the revenue losses would be significantly greater than the \$0.7 billion shown in Alternative 1 or the \$65.5 billion shown in Alternative 2 because there would no longer be a disincentive for employers to pay for supplemental insurance for employees. A larger share of employer-sponsored health insurance would be paid by employers, with corresponding adjustments in the cash wages of employees, which would lead to reductions in income and payroll tax revenues.

The Managed Competition Act would provide individual taxpayers with a deduction from gross income for their expenditures on accountable health plan premiums. The deduction would be limited to the premium for the lowest-cost accountable health plan in the individual's Health Plan Purchasing Cooperative area, less any amounts paid by the taxpayer's employer. In general, a more generous benefits package for AHPs would result in larger individual tax deductions for AHP premiums and a larger revenue loss from the deduction. If AHPs contained the Health Security Act's standard benefit package, the revenue loss from the deduction would total about \$165 billion over the fiscal years 1996-2004 (Alternative 1). With a less generous benefits package (Alternative 2), the estimated revenue loss from the deduction would fall to about \$86 billion.

If the deduction were deleted from the bill, the revenue gain would be somewhat less than \$165 billion (Alternative 1) or \$86 billion (Alternative 2), for two reasons. First, some individuals would claim an itemized medical expense deduction for their insurance premiums (as allowed under present law, subject to a floor equal to 7.5 percent of adjusted gross income). Second, in the absence of the deduction, a larger number of employers would be willing to contribute toward health insurance for employees. These employers would make corresponding adjustments in the cash wages of their employees, which would lead to reductions in income and payroll tax revenues.

Bill Section	Provision	Effective	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-04
	Other income and payroll tax effects relating to excise tax on excess health plan expenses of employers, deduction for health plan premium expenses of individuals, and other changes in private health insurance.....	1/1/96	--	2.8	5.1	5.2	5.7	6.1	5.6	5.5	5.5	5.7	47.3
GRAND TOTALS.....			(6)	-2.9	-9.4	-9.5	-10.1	-10.5	-12.3	-14.0	-14.2	-14.1	-97.0

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NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column: eia = expenses incurred after
 ma/tyea = months after in taxable years ending after
 tyba = taxable years beginning after
 tbdHCSC = to be determined by Health Care Standards Commission

- (1) Revenue estimates in this table were prepared under the assumption that accountable health plans contain the same benefits as the standard benefit plan in the Health Security Act (H.R. 3600, S. 1757, and S. 1775).
- (2) If this provision were deleted from the bill, the revenue loss would be significantly greater than \$0.7 billion because a larger share of employer-sponsored health insurance would be paid by employers and thereby excluded from income and payroll taxation.
- (3) Gain of less than \$50 million.
- (4) Section 1002 would allow the self-employed to claim a deduction for their health insurance expenses, subject to the limits described in the text. Section 1003 would provide the same deduction to all individuals, including the self-employed. This line shows the revenue loss attributable to deductions that would be claimed by all individuals, including the self-employed. The omission of Section 1002 from the bill would have no revenue effect, because the self-employed would remain eligible for the deduction under Section 1003. If Sections 1002 and 1003 were deleted from the bill, the revenue gain would be somewhat less than \$164.7 billion because households would claim larger itemized deductions for health insurance premiums and a larger share of premiums would be paid by employers (which would result in the exclusion of a larger portion of employee compensation from income and payroll taxation).
- (5) This provision is not included in S. 1579.
- (6) Loss of less than \$10 million.
- (7) Loss of less than \$50 million.
- (8) Gain of less than \$1 million.

Bill Section	Provision	Effective	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-04
	Other income and payroll tax effects relating to excise tax on excess health plan expenses of employers, deduction for health plan premium expenses of individuals, and other changes in private health insurance.....	1/1/96	--	4.6	6.8	7.1	7.8	8.4	8.1	8.2	8.4	8.8	68.2
GRAND TOTALS.....			(5)	5.3	5.6	6.9	7.5	8.6	7.9	7.4	8.7	10.5	68.2

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NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column: eia = expenses incurred after
 ma/tyea = months after in taxable years ending after
 tyba = taxable years beginning after
 tbdHCSC = to be determined by Health Care Standards Commission

- (1) Revenue estimates in this table were prepared under the assumption that accountable health plans contain a benefits package that is 20 percent less expensive than the standard benefit plan in the Health Security Act (H.R. 3600, S. 1757, and S. 1775).
- (2) If this provision were deleted from the bill, the revenue loss would be greater than \$65.5 billion because a larger share of employer-sponsored health insurance would be paid by employers and thereby excluded from income and payroll taxation.
- (3) Section 1002 would allow the self-employed to claim a deduction for their health insurance expenses, subject to the limits described in the text. Section 1003 would provide the same deduction to all individuals, including the self-employed. This line shows the revenue loss attributable to deductions that would be claimed by all individuals, including the self-employed. The omission of Section 1002 from the bill would have no revenue effect, because the self-employed would remain eligible for the deduction under Section 1003. If Sections 1002 and 1003 were deleted from the bill, the revenue gain would be somewhat less than \$85.9 billion because households would claim larger itemized deductions for health insurance premiums and a larger share of premiums would be paid by employers (which would result in the exclusion of a larger portion of employee compensation from income and payroll taxation).
- (4) This provision is not included in S. 1579.
- (5) Loss of less than \$10 million.
- (6) Loss of less than \$50 million.
- (7) Gain of less than \$1 million.