DESCRIPTION AND ANALYSIS OF PROPOSALS RELATING TO THE TAX TREATMENT OF HEALTH CARE ORGANIZATIONS AND EXCISE TAXES ON TOBACCO PRODUCTS AND FIREARMS AND AMMUNITION

Scheduled for a Hearing

Before the

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INTRODUCTION

The Senate Committee on Finance has scheduled a public hearing on April 28, 1994, on the tax treatment of health care organizations and excise taxes on tobacco products and firearms and ammunition. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of present law and proposals and also a brief discussion of related issues.

Part I of the document relates to the tax treatment of health care organizations; Part II relates to excise taxes on tobacco products; and Part III relates to excise taxes on firearms and ammunition.

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[1] This document may be cited as follows: Joint Committee on Taxation, Tax Treatment of Health Care Organizations and Excise Taxes on Tobacco Products and Firearms and Ammunition (JCX-5-94), April 28, 1994.

I. TAX TREATMENT OF HEALTH CARE ORGANIZATIONS[2]

A. Background and Present Law

Tax-exempt organizations generally

Code section 501(a) provides that certain organizations listed in sections 501(c) and (d) are exempt from Federal income tax. Among the organizations listed in section 501(c) are those organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual (sec. 501(c)(3)), and civic leagues and organizations not organized for profit which are operated exclusively for the promotion of social welfare (section 501(c)(4)).

Charitable organizations described in section 501(c)(3) are classified either as public charities or private foundations. In general, an organization will be classified as a public charity if it (1) receives significant support (generally more than one third) in the form of contributions from the general public or (2) is a church, school or hospital. In addition, section 509(a)(3) provides that public charities include certain "support" organizations which are organized and operated exclusively to benefit one or more specified public or publicly supported charitable organizations. Public charities are not subject to the special rules applicable to private foundations, such as a prohibition against self-dealing and tax on net investment income, and contributions to public charities are subject to more liberal deduction rules than are contributions to private foundations.

Charitable organizations exempt under section 501(c)(3) receive four major tax benefits: (1) exemption from Federal income tax; (2) ability to accept tax-deductible contributions; (3) ability to benefit from tax-exempt financing; and (4) exemption from certain State and local taxes.[3] In contrast, social welfare organizations exempt from Federal income tax under

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[2] This description and discussion is principally derived from the previous Joint Committee pamphlet: Joint Committee on Taxation, Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act") (JCS-20-93), December 20, 1993.

[3] The extent to which an organization is eligible for exemption from State and local taxes depends on the laws of the local jurisdiction; while local exemption is frequently conditioned upon Federal exempt status, it does not flow automatically from such status.

section 501(c)(4) cannot accept tax-deductible contributions or use tax-exempt financing, and generally are not exempt from State and local taxes.

Hospitals as tax-exempt entities

Although Code section 501(c)(3) does not specifically mention furnishing medical care and operating a not-for-profit hospital, such activities have long been considered to further charitable purposes.[4] However, the mere provision of not-for-profit medical care is not, by itself, sufficient to allow an organization to qualify for exemption under section 501(c)(3). Rather, an organization must demonstrate that its activities are targeted to a charitable class. The precise nature of that charitable class has been and continues to be a source of controversy.

In 1956, the Internal Revenue Service (IRS) issued Revenue Ruling 56-185, 1956-1 C.B. 202, setting forth the conditions that a not-for-profit hospital must satisfy to qualify for recognition as a tax-exempt charitable organization under section 501(c)(3). The IRS ruled that a hospital would be exempt if it met the following four conditions: (1) it must be organized as a not-for-profit organization for the purpose of operating a hospital for the care of the sick; (2) it must be operated, to the extent of its financial ability, for those not able to pay for the services rendered and not exclusively for those able and expected to pay; (3) it must not restrict use of its facilities to a particular group of physicians; and (4) its earnings must not inure, directly or indirectly, to the benefit of any private shareholder or individual (this last requirement merely restated a restriction generally applicable to all organizations under section 501(c)(3)).

With respect to the "financial ability" requirement, the IRS noted that:

> The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept

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[4] Although not-for-profit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some may also qualify for exemption as "educational organizations" because they are organized and operated primarily for medical education purposes.

> patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

Three years after publication of Revenue Ruling 56-185, the Treasury Department significantly revised its regulations interpreting section 501(c)(3). The amended regulations provided that:

> The term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions.[5]

Relying upon the amended regulations, the IRS issued Revenue Ruling 69-545, 1969-2 C.B. 117, which considered whether two nonprofit hospitals qualified for Federal tax exemption. In establishing the so-called "community benefit" standard, the IRS noted that the promotion of health is "one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." The IRS specifically modified Revenue Ruling 56-185 to eliminate the requirement relating to caring for patients without charge or at rates below cost.

The "community benefit" standard, which remains the principal standard applied by the IRS today, focuses on a number of factors which indicate that the operation of a hospital benefits the community rather than serving private interests. In Revenue Ruling 69-545, the IRS determined that the standard was satisfied by a hospital that operated an emergency room open to all persons and provided hospital care in non-emergency situations for everyone able to pay the cost thereof, either themselves, or through third-party reimbursement.[6] The hospital

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[5] Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

[6] In Rev. Rul. 83-157, 1983-2 C.B. 94, the IRS clarified that the operation of an emergency room was not a prerequisite for hospital exemption, if a State health planning agency made an independent determination that the operation of an emergency room

also had a board of directors drawn from the community, an open medical staff policy, treated persons paying their bills with the aid of public programs (such as Medicare and Medicaid), and applied any surplus receipts to improving facilities, equipment, patient care, and medical training, education and research.

The community benefit standard was challenged in a class action by various health and welfare organizations and several private citizens on the grounds that it failed adequately to identify a charitable class. In Eastern Kentucky Welfare Rights Organization v. Simon, 370 F. Supp. 325, 338 (D.D.C. 1973), a Federal District Court sustained the challenge, and concluded that Congress intended to restrict the term charitable to its narrow sense of relief of the poor. The United States Court of Appeals reversed the District Court, however, and upheld the IRS' broader interpretation of "charitable" reflected in Revenue Ruling 69-545.[7] The Court of Appeals explained that the term "charitable" is "capable of a definition far broader than merely the relief of the poor." The Court also noted that the community benefit standard did not supplant the "financial ability" requirement of Revenue Ruling 56-185, but rather represented an alternative method whereby a not-for-profit hospital could qualify as a tax-exempt charitable organization.

Health maintenance organizations (HMOs) as tax-exempt entities

The same community benefit standard for determining whether a hospital is a tax-exempt charitable organization applies in determining whether a health maintenance organization ("HMO") qualifies for tax-exempt status under section 501(c)(3). In this context, the IRS has developed a fairly comprehensive list of characteristics that distinguish tax-exempt charitable HMOs from other HMOs. Although an HMO seeking exemption as a social welfare organization under section 501(c)(4) is not required to possess all of the same characteristics as an HMO that qualifies for exemption under section 501(c)(3), its activities must generally satisfy a community benefit standard similar to, but less exacting than, that imposed on charitable HMOs.[8]

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would be unnecessary and duplicative, and provided that other factors set forth in Rev. Rul. 69-545 were present indicating that the hospital promoted the health of a class of persons broad enough to benefit the community.

[7] Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1976).

[8] See GCM 39829 (August 30, 1990) which reviews the IRS' position regarding HMOs and considers the extent to which HMOs customarily act as providers of health services or insurance.

In general, HMOs represent one form of managed health care delivery organization. Although there is case law regarding the tax treatment of HMOs, the Code does not define an HMO.[9] In general, HMOs have structured their delivery of medical care in accordance with four basic models: (1) a "staff model" HMO employs its own doctors and staff and serves its members at its own central location; (2) a "group model" HMO contracts with an existing group of physicians to perform services at the HMO's central location; (3) an "IPA model" HMO contracts with physicians, often through an individual practice association ("IPA"), to provide care to HMO members at the physicians' own offices; and (4) a "network model" HMO provides care to its members through a network of independent medical groups.[10]

The IRS initially took the position that, while HMOs could qualify for tax-exempt status as social welfare organizations under section 501(c)(4), they could not qualify as charitable organizations under section 501(c)(3) because the preferential treatment provided to members/subscribers represented private, rather than public, benefit. However, the United States Tax Court rejected this position in Sound Health Association v. Commissioner, 71 T.C. 158 (1978). The Court held that the programs and facilities of the staff model HMO benefited the community because its membership class was so open as to be practically unlimited; where possible membership is so broad, benefit to the membership constitutes benefit to the community.

In response to the Sound Health Association decision, the IRS issued several GCMs identifying certain factors which differentiate HMOs exempt under section 501(c)(3) from other HMOs.[11] In GCM 39828 (August 30, 1990), for example, the IRS

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[9] Both State and Federal law regulate the operation of HMOs. For Federal purposes, the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, codified as amended at 42 U.S.C. 300e - 300e17, defines a health maintenance organization and prescribes the manner in which such organizations must be organized and provide health services to be qualified under the Act and eligible for certain Federal developmental loans, grants and guarantees. In GCM 39829, the IRS suggested that an HMO's qualification under the Act could be considered as evidence of community benefit, noting that the Act imposes requirements in the areas of quality assurance, community rating and continuation of coverage that tend to suggest that the HMO's operations would benefit the community.

[10] See GCM 39829 (August 30, 1990).

[11] Although general counsel memoranda may not be relied upon as precedent, these documents are made public under section 6110 of the Code and may be indicative of the IRS' position on

stated that the characteristics of an HMO eligible for tax-exemption under section 501(c)(3) include: actual provision of health care services and maintenance of facilities and staff; provision of services to nonmembers on a fee-for-service basis; care and reduced rates for the indigent; care for those covered by Medicare, Medicaid or other similar assistance programs; emergency room facilities available to the community without regard to their ability to pay (and communication of this fact to the community); a meaningful subsidized membership program; a board of directors broadly representative of the community; health research programs; health care providers who are paid on a fixed-fee basis; and the application of any surplus to improving facilities, equipment, patient care, or to any of the above programs. The IRS noted, however, that these factors are not all-inclusive, nor is the absence of any one determinative of the lack of a charitable operation.[12]

More recently, in Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir. 1993), the Court of Appeals for the Third Circuit applied the factors set forth in Sound Health Association and held that Geisinger Health Plan (GHP), a network model HMO, did not qualify for tax-exempt status under section 501(c)(3) because its activities did not primarily benefit the community. GHP did not provide any health services directly, but contracted to provide health services with other health care providers (which typically were other entities related to GHP). In addition, the Court noted that operating a subsidized dues program for 35 otherwise medically underserved individuals did not benefit the community sufficiently to overcome GHP's primary purpose of providing benefits only to its members.[13]

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particular issues.

[12] See, e.g., GCM 38735 (May 29, 1981) (concluding that staff model HMOs that have truly open membership, directly provide services to members and nonmembers, maintain an open emergency room, and treat patients regardless of ability to pay may be exempt under section 501(c)(3)); and GCM 39057 (Nov. 9, 1983) (ruling that an IPA model HMO which arranged for health care services through an affiliated, physician-owned IPA that controlled the HMO does not qualify for exemption under section 501(c)(3)). In GCM 39057, the IRS explicitly expressed no opinion as to whether the HMO in question could qualify for exemption under section 501(c)(4).

[13] The Court of Appeals remanded the case to the Tax Court for a determination of whether GHP could qualify for 501(c)(3) status as an "integral part" of an exempt organization. The integral part theory set forth in Treas. Reg. sec. 1.502-1(b) provides generally that an organization is entitled to exemption as an integral part of a tax-exempt affiliate if its activities

HMOs as taxable entities

In fact, the majority of HMOs are not organized as tax-exempt entities. At the beginning of 1990, there were 575 HMOs nationwide, approximately two-thirds of which were organized and operated as taxable, for-profit businesses.[14] The primary issue for such taxable HMOs concerns their ability to deduct additions to reserves established out of premium payments to cover accrued liabilities (so-called "incurred but not reported" or "IBNR" claims). In general, accrual method taxpayers are not entitled to deduct expenses until all events necessary to fix and determine the taxpayer's obligation have occurred (the "all events" test). In addition, section 461(h) imposes an economic performance requirement which, in general, postpones deductions until payment.

Property and casualty insurance companies are entitled to deduct IBNR reserves without regard to the "all events" test or the economic performance requirement. Such reserve deductions are, however, subject to certain limitations. For example, reserve deductions by an insurance company must be discounted on a pre-tax basis to take account partially of the time value of money, and unearned premium reserve deductions must be reduced by 20 percent.[15] Thus, the tax treatment of a taxable HMO depends largely on the extent to which it qualifies as an insurance

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are carried out under the supervision or control of an exempt organization and could be carried out by the exempt organization without constituting an unrelated trade or business. The Tax Court noted that a taxpayer may qualify for exemption under the integral part theory if the taxpayer performs an essential service directly to its affiliates, but not if it provides such services to unrelated organizations. Alternatively, the taxpayer may provide services on behalf of its exempt affiliates directly to the class of charitable beneficiaries of such affiliates. The Tax Court concluded GHP did not qualify for tax-exempt status under the integral part theory. Geisinger Health Plan v. Commissioner, 100 T.C. No. 26, filed May 3, 1993.

[14] See, T.J. Sullivan, "The Tax Status of Nonprofit HMOs After Section 501(m)", Tax Notes, January 7, 1991.

[15] Present law also provides that property and casualty insurance companies are eligible for exemption from Federal income tax if their net written premiums or direct written premiums (whichever is greater) do not exceed $350,000; and further provides that a company with such premiums in excess of $350,000 but less than $1.2 million may elect to be taxed only on taxable investment income (and thus, generally to exclude underwriting income from tax) (sec. 501(c)(15)).

company.[16]

Insurance activities of tax-exempt organizations

Under section 501(m), an organization described in section 501(c)(3) or 501(c)(4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance. Commercial-type insurance generally includes any insurance of a type provided by commercial insurance companies, subject to certain exceptions. For example, commercial-type insurance does not include insurance provided at substantially below cost to a class of charitable recipients. In addition, section 501(m)(3)(B) provides that commercial-type insurance does not include incidental health insurance provided by an HMO, of a kind customarily provided by an HMO.[17]

Special rules applicable to certain taxable insurance companies

When section 501(m) was enacted in 1986, special rules were added to benefit certain organizations that no longer qualified as tax-exempt organizations and became subject to tax as insurance companies under subchapter L. Section 833, enacted concurrently with section 501(m), provides special relief for Blue Cross and Blue Shield organizations existing on August 16, 1986, which were exempt from tax for their last taxable year beginning before January 1, 1987, and which have experienced no material change in their structure or operations since August 16, 1986. In addition, section 833 provides special relief for certain other organizations, substantially all of the activities of which involve the provision of health insurance, that meet certain community-service-related requirements.[18]

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[16] Under Treas. Reg. sec. 1.801-3(a), to constitute an "insurance company," a company must be one whose primary and predominant business activity is the issuing of insurance or annuity contracts or the reinsurance of risks underwritten by insurance companies.

[17] See GCM 39829 (August 30, 1990) for a discussion of the legislative history of the enactment of section 501(m) and the HMO exception in section 501(m)(3)(B).

[18] These community service requirements are: (1) substantially all the activities of the organization involve providing health insurance; (2) at least 10 percent of the health insurance is provided to individuals and small groups (not taking into account medicare supplemental coverage); (3) the organization provides continuous full-year open enrollment (including conversions) for individuals and small groups; (4) the policies covering individuals provide full coverage of pre-existing conditions of high-risk individuals without a price

Section 833 provides three special rules for organizations within its scope. First, eligible organizations are treated as stock insurance companies. Second, section 833 exempts eligible organizations from the rule (referred to above) that is generally applicable to property and casualty insurance companies, requiring a 20-percent reduction in the amount a company can deduct for any increase in unearned premium reserves.[19] Thus, eligible organizations are not required to reduce the deduction for increases in unearned premium reserves. Third, eligible organizations are entitled to claim a special deduction with respect to their health business in an amount equal to 25 percent of claims and expenses incurred during the taxable year, less adjusted surplus at the beginning of the year.

The transition rules in section 833 provide that no adjustment was to be made on account of a change in such an organization's method of accounting for its first taxable year beginning after that date. The transition rules also provide that, for purposes of determining gain or loss, the adjusted basis of any asset of such an organization held on the first day of the taxable year beginning after December 31, 1986, was treated as equal to its fair market value as of such day. Rules were also provided to limit adjustments to surplus that could affect the amount of the special deduction, and to treat reserve weakening after August 16, 1986, as occurring in the organization's first year as a taxable organization.[20]

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differential (with a reasonable waiting period), and coverage is without regard to age, income, or employment status of individuals under age 65; (5) at least 35 percent of its premiums are community rated; and (6) no part of its net earnings inures to the benefit of any private shareholder or individual.

[19] The 20-percent reduction requirement was added by the 1986 Act, effective for taxable years beginning after December 31, 1986. The 1986 Act also required the inclusion in income ratably, over the ensuing six-year period, of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1987. The inclusion was required at the rate of 3-1/3 percent of such outstanding unearned premium reserve in each of the first six taxable years beginning after December 31, 1986.

[20] Because increases in reserves are generally deductible by a taxable insurer, a reduction in reserves (so-called "reserve weakening") immediately prior to the time a tax-exempt organization becomes a taxable insurer could allow the organization to claim a bigger deduction than it would otherwise be entitled to after it becomes taxable.

B. Description of Bill (S. 1757--Sen. Mitchell and others and S. 1775--Sen. Moynihan (The "Health Security Act") (secs. 7601-7603 of bill)

<u>**Tax-exempt status of hospitals, HMOs, certain parent organizations and regional alliances**</u>

The bill would establish certain new requirements applicable to nonprofit health care providers (hospitals and HMOs) seeking to qualify as tax-exempt charitable organizations under section 501(c)(3).

In particular, the bill would amend the Code specifically to require that, in order for the provision of health care services to constitute a charitable activity for purposes of section 501(c)(3), the organization providing such services must periodically assess the health care needs of its community and develop a plan to meet those needs. Such assessment and plan development must take place at least annually and must include the participation of community representatives.

In addition, the bill would provide that an HMO seeking tax-exempt status under section 501(c)(3) must furnish health care services to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization.

The bill would further provide that organizations which serve as parent holding companies for hospitals or medical research organizations constitute public charities rather than private foundations. Thus, the bill would add to the list of organizations described in section 509(a) any organization which is organized and operated for the benefit of, and which directly or indirectly controls, (1) a hospital, the principal purpose or function of which is the provision of medical or hospital care or medical education or medical research; or (2) a medical research organization if such organization is directly engaged in the continuous active conduct of medical research in conjunction with a hospital and, during the calendar year in which the contribution is made, such organization is committed to spend such contribution for medical research not later than the beginning of the fifth calendar year beginning after the date such contribution is made.

Finally, section 7603 of the bill would add the to-be-established regional alliances described in section 1301 of the bill to the list of tax-exempt organizations set forth in Code section 501(c).

<u>Effective date</u>.--The provisions regarding the definition of charitable activities of medical service providers and HMOs would be effective January 1, 1995. The provision regarding the exempt

status of regional alliances would apply to taxable years beginning after the date of enactment, and the provision regarding the treatment of parent organizations of health care providers would take effect on the date of enactment.

Insurance activities of tax-exempt organizations

Under the bill, health insurance provided by an HMO would be treated as commercial-type insurance if such insurance relates to care which is not provided pursuant to a pre-existing arrangement between the HMO and a health care provider (other than emergency care provided to a member of such organization at a location outside such member's area of residence). Under this rule, commercial-type insurance would include plans under which an HMO member can select any health-care provider, the HMO pays a portion of the costs of such provider, and the member is obligated to pay the remaining portion. Such arrangements are commonly referred to as providing "point of service" or "fee-for-service" benefits (i.e., the member decides which medical provider to use at the point at which service is required). However, the provision of emergency care, even if on a point of service basis, to HMO members outside their area of residence would not constitute commercial-type insurance.

The bill would specifically identify four types of health insurance provided by an HMO that would not be treated as commercial-type insurance and, thus, would not jeopardize the organization's tax-exempt status. Such non-commercial-type health insurance coverages generally address emergency situations and situations in which a health care provider has a pre-existing relationship with an HMO whereby the HMO exerts control over either the fee charged by the service provider or the member's use of such provider's services.

First, insurance relating to care provided by an HMO to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such HMO would not constitute commercial-type insurance. Such arrangements are characteristic of "staff model" or "group model" HMOs which hire health care providers (as employees or independent contractors) to provide services to members on an exclusive basis.

Second, insurance relating to primary care provided by a health care professional to a member of an HMO on a basis under which the amount paid to such professional does not vary with the amount of care provided to such member would not constitute commercial-type insurance. This rule addresses situations in which an HMO pays health care providers on a "fixed" or "capitated" basis for primary care services rendered to members. Although such fees may be based on the number of members served by such provider, they may not be based on the extent of services

provided to a member.

Third, insurance which relates to the provision of services other than primary care, if provided pursuant to a pre-existing arrangement with an HMO, would not be commercial-type insurance. This exception is intended to address situations in which an HMO member is referred by his or her primary care provider to a specialist who is a member of an HMO's so-called "provider network," even if the amount paid to the specialist varies with the amount of care provided. Unlike the "point of service" situation described above, the HMO in these cases, rather than the member, controls the decision regarding the appropriate health care provider.

Fourth, insurance relating to emergency care provided to a member of an HMO at a location outside such member's area of residence would not constitute commercial-type insurance. This exception would apply, for example, when an HMO reimburses health care providers for the provision of emergency care to HMO members, outside of their area of residence, irrespective of whether such providers have a pre-existing arrangement with the HMO.

Effective date.--These provisions would be effective on the date of enactment.

Definition of taxable property and casualty insurance companies

In general, the bill would redefine the scope of organizations treated as taxable property and casualty insurance companies. Under the bill, any organization that is not tax-exempt, is not a life insurance company, and whose primary and predominant business activity during the taxable year falls in one of three categories, would be treated as a property and casualty insurance company. The three categories of activities are: (1) issuing accident and health insurance contracts or reinsuring accident and health risks; (2) operating as an HMO; or (3) entering into arrangements to provide or arrange for the provision of health care services in exchange for fixed payments or premiums that do not vary depending on the amount of health care services provided. The bill would modify the "primary and predominant" requirement in the case of organizations that have, as a material business activity, the issuing or reinsurance of accident and health insurance contracts. For such organizations, the administering of accident and health insurance contracts would be treated as part of such business activity for purposes of determining whether the organization's activities fall within the scope of category (1) above.

Effective date.--This provision would be effective for taxable years beginning after December 31, 1996.

Special rules applicable to certain taxable insurance companies

The bill would repeal the special rules provided under section 833 to Blue Cross and Blue Shield organizations and other eligible organizations, and would provide transition rules for organizations that become subject to section 833 after the effective date (generally, taxable years beginning after December 31, 1996). The provision would treat such organizations as insurance companies, but would not specify that such organizations be treated as stock companies.

The bill would repeal the special exception to the 20-percent reduction with respect to unearned premium reserves. The bill would require inclusion in income ratably, over a six-year period following the effective date, of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1997. The inclusion would be required at the rate of 3-1/3 percent of such outstanding unearned premium reserve in each of the first six taxable years beginning after December 31, 1996.

The bill would also repeal the special deduction for 25 percent of claims. A special phase-out rule would apply to an organization that meets the community-service-related requirements of present law for each of its taxable years beginning in 1995 and 1996. For such organizations, the deduction would be phased out at a specified rate over the organization's first two years following the effective date; 67 percent of the otherwise allowable amount of the special deduction would be allowed for such an organization's taxable year beginning in 1997, and 33 percent would be allowed for its taxable year beginning in 1998. As under present law, the deduction would not be allowable during the phase-out period in determining the organization's alternative minimum taxable income.

The bill would provide transition rules for organizations that become subject to section 833, as amended, after the effective date (generally, taxable years beginning after December 31, 1996). For an organization that is not tax-exempt for its last taxable year beginning before January 1, 1997 (and is taxed other than under the property and casualty insurance company regime for taxable years beginning in 1992 through 1996), the amendments to section 833 would be treated as a change in method of accounting, and all adjustments required to be taken into account under section 481 would be taken into account in one taxable year, i.e., the company's first taxable year beginning after December 31, 1996. No special transition rule would apply to organizations that treat themselves as subject to tax under the property and casualty insurance company regime for taxable years beginning in 1992 through 1996.

For an organization that is tax-exempt for its last taxable year beginning before January 1, 1997, no adjustment would be taken into account under section 481 or any other provision for the company's first taxable year beginning after December 31, 1996, on account of a change in method of accounting required by the amendments to section 833. In addition, for purposes of determining gain or loss, the adjusted basis of any asset held by such an organization on the first day of its first taxable year beginning after December 31, 1996, would be deemed equal to the fair market value of the asset on that date.

The bill would also specify that the above amendments do not affect the adjusted basis of any asset determined under the transition rule provided for existing Blue Cross and Blue Shield organizations in the 1986 Act (i.e., generally, that basis equalled fair market value as of the first day of the organization's taxable year beginning after December 31, 1986). In addition, the bill would eliminate the requirement that existing Blue Cross and Blue Shield organizations not experience any material change in their operations or structure to be eligible for the basis adjustment, and would further provide that, on January 1, 1997, such basis adjustment is made permanent.

Effective date.--These provisions would generally be effective for taxable years beginning after December 31, 1996, subject to the special income inclusion rule (with respect to the repeal of the 20 percent reduction), the phase-out rule for certain organizations (with respect to the repeal of the special deduction for 25 percent of claims), and the transition rules described above.

C. Discussion of Issues

Tax-exempt status of certain organizations

In general, tax exemption is a form of subsidy administered through the tax system (sometimes referred to as a "tax expenditure"). It is granted to, among other organizations, certain private organizations that conduct activities which Congress deems to further worthy public objectives.

As a threshold matter, it is important to assess whether the subsidization of the operation of hospitals and HMOs, as well as regional health alliances, through tax expenditures, rather than through direct outlays or other means of finance, is appropriate. In general, such subsidization means that the true cost of such activities appears understated in relation to the cost of other goods and services because they do not appear as outlays in budget reporting. In addition, such tax expenditures are not subject to the annual appropriations process.

The desirability of tax exemption also must be evaluated in the context of the overall health care proposal. As described above, under present law, the provision of medical care and operation of a nonprofit hospital in a manner that satisfies the "community benefit" standard is considered to further "charitable" objectives. Although this community benefit standard evolved in response to the expanded Federal role in health care financing through programs such as Medicare and Medicaid, payment for medical care remained largely the province of the private sector.

The system of universal health care coverage envisioned under the bill represents a significant quantitative, and perhaps also qualitative, expansion of Federal participation in financing health care. Accordingly, it may be appropriate to reexamine the circumstances under which the provision of medical care would constitute a charitable function in such a system. Presumably, teaching institutions could continue to be eligible for tax exemption as educational organizations. However, if all Americans have access to health care, what other activities would distinguish a nonprofit from a for-profit health care provider? For example, would nonprofit hospitals provide charity care where gaps exist in the system of universal coverage?

These questions are particularly apt in light of the significant financial benefits for which charitable organizations are eligible. It is not clear, for example, that allowing such organizations continued access to tax-exempt financing is appropriate in a system in which the Federal Government provides considerable direct subsidies (for example, the Federal payments to alliances outlined in Title IX, Subtitle B of the bill). With respect to regional and corporate health alliances, section 7902 of the bill would provide that regional and corporate health alliances be treated as private businesses that are not eligible for tax-exempt financing. This raises the further question of why such alliances should be treated differently than other medical service providers exempt under section 501(c)(3).

Finally, it is not clear whether the community needs assessment and plan development requirements set forth in the bill are intended to replace or supplement present-law standards for exemption. In addition, the scope of organizations subject to the requirements is unclear. The bill states that the requirements apply to hospitals, HMOs and "other entities providing health care services." A wide variety of organizations exempt under section 501(c)(3) provide an equally wide range of health care services. For example, a half-way house for alcoholics, a blood bank, a childbirth education organization, a clinic to aid drug victims, an organization that provides home health care, homes for the elderly, and nursing homes all have qualified for exemption under section 501(c)(3). Do the community needs assessment and plan development requirements

apply to all of these organizations, as well as to hospitals and HMOs?

Insurance activities of tax-exempt organizations

Similarly, it may be appropriate to reexamine the characterization of certain forms of insurance provided by HMOs as commercial- or non-commercial-type insurance. The bill generally appears to codify positions developed by the IRS with respect to various payment arrangements established by HMOs under a health care system very different from the one proposed in the bill.

In addition, the provisions regarding characterizing insurance arrangements as commercial or non-commercial appear somewhat inconsistent with other provisions of the proposed health plan. For example, the bill would characterize "point of service" or "fee-for-service" plans offered by HMOs as commercial-type insurance. However, section 1402(d) of the bill would require certain health plans (e.g., those that offer enrollees the lower cost sharing schedule described in section 1132 of the bill) to offer fee-for-service coverage. If participants elect such coverage to the extent that it constitutes a substantial portion of such HMO's activities, the HMO could lose its tax-exempt status.

Definition of taxable property and casualty insurance companies

The bill would expand the definition of taxable property and casualty insurance companies to include organizations that are not tax-exempt, are not life insurance companies, and that meet one of three tests. The first is insurance or reinsurance of accident and health risks (a traditional activity of insurance companies). The second is operation as an HMO, and the third appears to encompass arrangements similar to those which an HMO might enter into, whether or not it purports to be an HMO (i.e., arrangements to receive fixed payments as consideration for providing or arranging to provide health care services, regardless of the amount of health care services provided). Thus, the bill would treat taxable HMOs and taxable organizations that operate like HMOs as property and casualty insurance companies.

However, it is not self-evident that all taxable HMOs should be taxed as property and casualty insurance companies. The underlying presumption appears to be that if an HMO is not tax-exempt, its activities involve the provision of insurance services as opposed to medical services. This presumption is based on what traditionally has been a key distinction between HMOs and hospitals; HMOs deliver prepaid benefits whereas hospitals are paid on a fee-for-service basis.

Several issues are raised in determining whether a taxable HMO (for example, an HMO that is not tax-exempt because it is organized on a for-profit basis) sufficiently resembles a property and casualty insurance company to be taxed as one. One is whether deductions for reserves are appropriate to the operation of an organization that directly provides medical care.

A central issue in determining whether an HMO should be taxed as a property and casualty insurer is the method of accounting for premium payments received. In general, property and casualty insurance companies are entitled to deduct increases in reserves which affect premium income. Organizations that are not insurance companies, by contrast, are not entitled to deduct increases in reserves but rather, generally account for deductions in accordance with the all events test and the rules for determining when economic performance has occurred. The allowance of a deduction for Federal income tax purposes with respect to reserves of property and casualty insurance companies generally reflects the fact that payments (premium income) are generally received in a taxable year earlier than the year in which the loss is incurred or paid.

If an HMO receives payments that resemble the premiums received by insurance companies in these respects, it appears appropriate to tax them under the regime applicable to property and casualty insurance companies. On the other hand, if an HMO receives prepayments for medical services it directly provides, reserve deductions are arguably inappropriate, and the organization should not be treated as a property and casualty insurance company. Because the manner of organization and operation of HMOs varies and may change rapidly with business trends, consideration should be given to whether one rule is appropriate for all taxable HMOs. On the other hand, it may not be administratively feasible to distinguish among types of payments received by HMOs.

With respect to treatment of reserves, some taxable HMOs take the position that they are subject to taxation as property and casualty insurance companies. Others, however, may take the position that, although they may be subject to State regulation and financial reporting requirements as insurance companies, they are not taxable as property and casualty insurers. Such organizations nevertheless may claim tax deductions for reserves on the theory that the risk of loss has shifted to them. These organizations may argue that, because they are not taxable as property and casualty insurers, they are not subject to the limitations on reserve deductions imposed on property and casualty insurance companies. Thus, as a practical matter, the regime prescribed under the bill may represent a significant change only for taxable HMOs that take the position that they are not taxable as property and casualty companies.

An additional issue relates to the operation of the property and casualty company tax regime. Treating HMOs as property and casualty insurers could be criticized on the ground that the present-law regime for taxing such entities is flawed in certain respects. For example, present law provides for a pre-tax method of discounting loss reserves of property and casualty insurance companies which only partially takes account of the time value of money. It is arguable whether taxpayers not explicitly subject to this regime should be made explicitly subject to it without addressing its failure to take account fully of the time value of money. Further, some might assert that the regime of complete or partial tax exemption for small property and casualty companies may not be appropriate for HMOs that fail to qualify for tax-exempt status under 501(c)(3) or 501(c)(4).

As a technical drafting matter, the statutory structure set forth in the bill appears redundant in defining both criteria for tax-exempt status and criteria for taxable status. Rather than simply characterizing all organizations that are not tax-exempt as taxable, the bill would set forth one standard for tax exemption and another, different, standard for taxability. Conceivably, some organizations could fail to meet either set of criteria. In addition, the taxability standards themselves could be criticized as vague. Because neither present law nor the bill defines an HMO, the second standard ("operating as an HMO") is difficult to apply at best.

The bill would also require that the three enumerated activities constitute the primary and predominant business activity of an organization. This standard is similar to a rule set forth in Treasury regulations that describes an insurance company as one whose primary and predominant business activity is the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies, and has been variously interpreted in judicial decisions. While the bill does state that administering accident and health insurance contracts is treated as part of the activity of issuing accident and health insurance contracts or reinsuring accident and health risks (for an organization that has issuing such contracts or reinsuring such risks as a material business activity), the bill would not specify the nature and amount of other activities that a company may conduct and still be treated as a property and casualty insurance company. Because this standard does not provide a bright-line test, without further clarification, it could be criticized as an inadequate basis for determining the tax status of an organization.

Finally, because the effective date of this provision would be deferred until taxable years beginning after 1996, additional rules may be needed to forestall opportunities for manipulation of accounting items for organizations that become taxable under the bill (or whose accounting method is changed) and, thus,

become subject to the provision. For example, the bill does not contain a rule comparable to that provided in the Tax Reform Act of 1986 (the "1986 Act") to limit reserve weakening by organizations immediately prior to the point at which they become taxable.

Special rules applicable to certain taxable insurance companies

Some might argue that the present-law special rules under Code section 833 (enacted in 1986) for Blue Cross and Blue Shield organizations that became taxable was intended merely to ease the transition from tax-exempt to taxable status and should now be repealed. It could be argued that sufficient time has elapsed since the 1986 Act changed the tax status of these organizations for them to adjust to operation as taxable entities, and that repeal of the special deduction, as provided by the bill, is now appropriate. Others might assert that this purpose was not stated in the legislative history, and, in fact, the provision was not temporary when enacted.

II. EXCISE TAXES ON TOBACCO PRODUCTS

A. Present Law

Tax rates

Excise taxes are imposed on the manufacture or importation of cigarettes, cigarette papers and tubes, snuff, chewing tobacco, and pipe tobacco. The present-law tax rates are as follows:

Item	Rate
Cigarettes	
Small cigarettes (weighing no more than 3 pounds per thousand)[21]	$12 per thousand (i.e., 24 cents per pack of 20 cigarettes).
Large cigarettes (weighing more than 3 pounds per thousand)[22]	$25.20 per thousand.
Cigars	
Small cigars (weighing no more than 3 pounds per thousand)	$1.125 per thousand.
Large cigars (weighing more than 3 pounds per thousand)	12.75 percent of manufacturer's price (but not more than $30 per thousand).

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[21] Most taxable cigarettes are small cigarettes.

[22] Large cigarettes (measuring more than 6-1/2 inches in length) are taxed at the rate prescribed for small cigarettes, counting each 2-3/4 inches (or fraction thereof) as one cigarette.

Cigarette papers and tubes

Cigarette papers[23]..........	0.75 cent per 50 papers.
Cigarette tubes[24]...........	1.5 cents per 50 tubes.

Snuff, chewing tobacco, pipe tobacco

Snuff......................	36 cents per pound.
Chewing tobacco............	12 cents per pound.
Pipe tobacco...............	67.5 cents per pound.

Exemptions; use of revenues

No tax is imposed on tobacco products exported from the United States. Exemptions also are allowed for (1) tobacco products furnished by manufacturers for employee use or experimental purposes; and (2) tobacco products to be used by the United States. In addition, no tax is imposed on tobacco to be used in "roll-your-own" cigarettes.

Revenues from the tobacco products excise taxes are retained in the general fund of the Treasury. Revenues from taxes on tobacco products brought into the United States from Puerto Rico and the American Virgin Islands are transferred ("covered over") to those possessions if the products satisfy a domestic content requirement with respect to the possession from which they are received.

B. Description of Bill (S. 1757--Sen. Mitchell and others and S. 1775--Sen. Moynihan (The Health Security Act) (secs. 7111-7113 of the bill)

Rate increases; extension of coverage

The bill would increase the tax rate on all tobacco products by approximately $12.50 per pound of tobacco content, and would

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[23] Cigarette papers measuring more than 6-1/2 inches in length are taxed at the rate prescribed, counting each 2-3/4 inches (or fraction thereof) as one cigarette paper. No tax is imposed on a book or set of cigarette papers containing 25 or fewer papers.

[24] Cigarette tubes measuring more than 6-1/2 inches in length are taxed at the rate prescribed, counting each 2-3/4 inches (or fraction thereof) as one cigarette tube.

extend the tax to tobacco to be used in "roll-your-own" cigarettes. The new tax rates would be:

Cigarettes	
Small cigarettes (weighing no more than 3 pounds per thousand)................	$49.50 per thousand (i.e., 99 cents per pack of 20 cigarettes).
Large cigarettes (weighing more than 3 pounds per thousand.................	$103.95 per thousand
Cigars	
Small cigars (weighing no more than 3 pounds per thousand.................	$38.625 per thousand
Large cigars (weighing more than 3 pounds per thousand.................	52.594 percent of manufacturer's price (but not more than $123.75 per thousand).
Cigarettes papers and tubes	
Cigarette papers..........	3.09 cents per 50 papers
Cigarette tubes...........	6.19 cents per 50 tubes
Snuff, chewing tobacco, pipe tobacco, "roll-your-own" tobacco	
Snuff.....................	$12.86 per pound
Chewing tobacco...........	$12.62 per pound
Pipe tobacco..............	$13.175 per pound
"Roll-your-own" tobacco...	$12.50 per pound

Exemptions; administrative provisions

The bill would repeal the present-law exemptions for tobacco products provided to employees of the manufacturer and for use by the United States.

The bill also includes several administrative and compliance provisions. First, the exemption for exports would be limited to products that are marked or labelled under Treasury Department rules designed to prevent the diversion of such products into the domestic market. Second, re-importation of tobacco products previously exported without payment of tax (other than for return to the manufacturer) would be prohibited and a new penalty, equal to the greater of $1,000 or five times the amount of tax imposed would be assessed against all parties involved in any prohibited re-importation. All tobacco products and cigarette papers and tubes, as well as all vessels, vehicles, and aircraft used in such re-importations, would be subject to seizure by the United States.

Third, the bill would extend current manufacturer inventory maintenance, reporting requirements, criminal penalties, and forfeiture rules to importers of tobacco products.

Fourth, the bill would repeal the present-law exemption for books or sets of cigarette papers containing 25 or fewer papers.

Fifth, the bill would limit the cover over of tobacco product revenues to Puerto Rico and the Virgin Islands to present-law tax levels.

Effective date

The provisions would be effective for tobacco products removed after September 30, 1994. A floor stocks tax would be imposed on taxed tobacco products held on the effective date.

C. Discussion of Issues[25]

Statistics relating to incidence of tobacco use

The United States National Institute on Drug Abuse estimates that, in 1991, 27 percent of the United States population currently smoked cigarettes and that 3.4 percent of the population currently used smokeless tobacco.[26] Medical research has linked the use of tobacco products to a number of

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[25] The following discussion draws substantially on the analysis presented in Joint Committee on Taxation, Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act") (JCS-20-93), December 20, 1993.

[26] "Current" use of cigarettes or other tobacco products is defined as use of the product within the last month. The estimate is based on a household survey. Bureau of the Census, United States Department of Commerce, Statistical Abstract of the United States, 1992.

diseases--including cancer of the lungs, mouth and throat, emphysema, chronic bronchitis, and heart disease.[27] In addition, smoking is believed to be a contributing factor to low birth weight babies. The public's increased awareness of these health hazards has led to substantial declines over the past 30 years in the percentage of the United States population that currently uses tobacco products. The incidence of smoking among males 20 years old or older has fallen from approximately 50 percent in 1965 to approximately 31 percent in 1988. Over the same period, the incidence of smoking among females 20 years old or older has shown a similar though smaller decline. Table 1 details the incidence of cigarette smoking for selected years between 1965 and 1988.

Table 1.--Incidence of Cigarette Smoking, by Male and Female, Selected Years 1965 to 1988

[Percentage of individuals 20 years old and older]

	1965	1970	1976	1980	1985	1988
Female...	31.9	30.8	31.3	29.0	28.0	23.3
Male.....	50.2	44.3	42.1	38.5	33.2	30.9

Source: Bureau of the Census, United States Department of Commerce, Statistical Abstract of the United States, 1992.

The incidence of smoking varies by age, gender, race, level of education, and other demographic factors. Individuals with more education tend to have a lower incidence of smoking than those with less education. For example, the incidence of smoking among individuals with college degrees was 15.6 percent in 1988, while the incidence of smoking among individuals with less than a high school diploma was 32.8 percent.[28] The incidence of smoking among blacks is modestly greater than the incidence of smoking among whites.[29] The incidence of smoking has fallen among all groups.

The incidence of smoking in developed countries, including the United States, has declined over the past 20 years. While the incidence of smoking in the United States is not substantially

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[27] Department of Health and Human Services, Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General, DHHS Publication No. (CDC) 89-8411 (prepublication version, January 11, 1989).

[28] Statistical Abstract of the United States, 1992.

[29] Ibid.

different from that of other developed countries,[30] it is generally conceded that health care costs in the United States exceed those abroad. Such aggregate data do not reveal the extent to which United States expenditures on health care are, or are not, attributable to tobacco-related health problems.

Table 2.--Incidence of Cigarette Smoking in Certain Foreign Countries, 1986

[Percentage of individuals 20 years old and older]

	Great Britain	Australia	Norway[1]	Sweden[2]
Female.....	31.0	30.6	32.4	30.0
Male.......	35.0	32.9	43.8	24.0

Notes: 1--Ages 20 to 70 only. 2--Ages 18 to 70 only.

Source: John P. Pierce, "International Comparisons of Trends in Cigarette Smoking Prevalence," American Journal of Public Health, 79, February 1989.

Many countries tax cigarettes at a higher total rate than does the United States. Some of this higher total tax is due to other countries' use of value-added taxes which generally tax all consumption items. However, when the effect of value-added or general sales taxes is removed, the cigarette taxes in the United States remain relatively low. Table 3 shows cigarette excise taxes as a percentage of retail prices in selected OECD countries for 1987.

[30] See Table 2 below.

Table 3.--Cigarette Excise Taxes (Excluding Value-Added and General Sales Taxes) as a Percentage of Retail Cigarette Prices in Selected OECD Countries, 1987

Country	Tax a percentage of price
United States	30.1
Australia	32.3
Belgium	64.4
France	49.2
Germany	59.8
Portugal	58.0
Spain	32.8
United Kingdom	61.3

Source: Congressional Budget Office, "Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels," June 1990.

Federal excise taxes on tobacco products are imposed in nominal terms, that is, they do not rise with inflation of the general price level. Cigarette taxes, imposed at eight cents per pack in 1951, remained unchanged until 1983. Subsequent increases under the Omnibus Budget Reconciliation Act of 1990 have increased the tax to 24 cents per pack, or three times the nominal 1951 level. The general price level today is more than five and one half times that prevailing in 1951, implying a substantial decline in the real (inflation-adjusted) burden of tobacco excise taxes. On the other hand, it may be inappropriate to compare tax rates prevailing today with those imposed during the Second World War or the Korean War.

Health policy and control of tobacco

In general

The medical research cited above has motivated many public health analysts to advocate greater governmental action to help reduce the use of tobacco among the population. Such non-tax action could range from increased expenditures on public service announcements detailing the risks associated with tobacco use to increased penalties for sales of tobacco products to minors. Some analysts advocate increasing tobacco taxes to provide a market incentive to individuals to reduce their consumption of unhealthy products. The higher prices of tobacco products resulting from increases in tobacco excises taxes would be expected to reduce consumption by consumers of tobacco products. Some consumers may cease using such products altogether, while others moderate their current level of consumption. Among smokers, some smokers may maintain their current rates of smoking by substituting discount

brands of cigarettes for more expensive brands.[31] Among smokers who crave nicotine, some may reduce the number of cigarettes they consume but switch to cigarettes with higher levels of nicotine.

Taxes on the consumption of specific products, as opposed to broadly imposed consumption taxes, distort consumer behavior by disfavoring certain goods in the economy relative to other goods. Generally, market price distortion through taxes reduces consumer well-being because the change in relative prices introduced by the tax causes consumers to choose a less preferred good than they would have in the absence of the tax. This general economic analysis is based on assumptions that consumers are fully informed about the product and that consumption of the product imposes no externalities, i.e., additional costs on society as a whole. Some public health analysts question the validity of these assumptions in the case of tobacco use.

In addition, some public health analysts observe that, as a major provider of health care, the Federal Government has an interest in controlling health costs, and that tobacco use may overly contribute to the Federal Government's health and welfare costs.

Informed versus uninformed choice

Some proponents of higher taxation of tobacco products argue that consumers are not fully informed about the true costs and benefits of the use of tobacco products, and that consumers do not fully account for the harm such products can have on their health. They argue that the higher prices that increased taxation will produce are necessary to help potential consumers see the true cost of tobacco products. They argue that this particularly may be the case among younger individuals who do not recognize the addictive power of nicotine or who otherwise might be expected to be less informed about the potential health dangers of tobacco use. There is evidence that younger individuals may be more likely than the population at large to reduce their consumption of tobacco products if the price rises.[32]

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[31] The market share of discount brands has grown in recent years and now accounts for nearly one third of the cigarette market. Michael Grossman, Jody L. Sindelar, John Mullahy, and Richard Anderson, "Policy Watch: Alcohol and Cigarette Taxes," Journal of Economic Perspectives, 7, Fall 1993.

[32] Department of Finance, Canada, Tobacco Taxes and Consumption, June 1993 ("Tobacco Taxes and Consumption"). Also see, Eugene M. Lewit, Douglas Coate, and Michael Grossman, "The Effects of Government Regulation on Teenage Smoking," The Journal of Law and Economics, 24, December 1981. Because nicotine is addictive, the price response of addicted consumers should be

There is some survey evidence, however, that both smokers and nonsmokers overestimate the probability of death and illness from tobacco use. Moreover, that survey suggested that teenagers attach a higher risk to smoking than do adults.[33] Opponents of higher tobacco taxes also argue that if the primary concern is to reduce the demand by young individuals who may be uninformed, a tax increase is inefficient because the tax also imposes large costs on older, informed individuals who derive pleasure from tobacco products. They argue that more targeted remedies such as greater penalties for sales to minors may be more efficient. Some argue for both higher tobacco taxes and greater penalties for sales to minors.

Externality

Economists say that an externality arises when the consumption (or production) of a good by one individual imposes a cost (or benefit) on society as a whole. For example, emissions of volatile organic compounds from automobiles contribute to urban smog, which imposes health and other costs on society at large. When all such external costs (or benefits) are not accounted for by the individual purchaser/user, there is too much (or too little) of the good produced and consumed. Recent medical research suggests that "second-hand smoke," that is, the smoke from smokers inhaled by nonsmokers, creates health risks and costs for nonsmokers.[34] Thus, while potential health damage of smoking is a direct cost to the smoker, second-hand smoke creates a cost for nonsmokers for which the smoker does not account in making the decision to smoke. Such costs are referred to by economists as negative externalities.

Economists often propose corrective taxation as a remedy for existence of a negative externality.[35] The idea is that if a tax is imposed on the product that creates the externality at a rate

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less than that of nonaddicted consumers. It is probable that older smokers are more likely to be addicted than would younger smokers.

[33] W. Kip Viscusi, Smoking: Making the Risky Decision, (London: Oxford University Press), 1992.

[34] Department of Health and Human Services, The Health Consequences of Involuntary Smoking. A Report of the Surgeon General, DHHS Publication No. (CDC) 87-8398, 1986.

[35] These taxes often are called "Pigouvian taxes" after economist Alfred Pigou who first proposed such a policy. In the case of a beneficial externality, a subsidy would be provided instead of a tax to encourage the behavior producing the beneficial externality.

equal to the additional harm created by the externality, then the market price will fully reflect all benefits and costs to society from the production and consumption of the product. Assuming that second-hand smoke is an externality, a tax on smoking tobacco could improve economic efficiency. However, the difficulty is in choosing the correct level of the tax. Too great a tax could reduce economic efficiency by discouraging more tobacco use than the harm caused by second-hand smoke might justify. Critics of increases in tobacco taxes contend that there are no good measures of the value of possible external harms from tobacco products.

Some suggest that current pricing practices for medical insurance may create a negative externality. Whereas life insurance policy premium rates often vary based upon whether the consumer is a smoker or a nonsmoker, medical insurance premium rates typically are the same regardless of tobacco use by the consumer. If tobacco users have greater insured medical expenses than other consumers,[36] then some of the increased health costs of tobacco use may be borne, not by the tobacco user, but by all consumers in the form of higher insurance premiums.[37] By reducing the incidence of tobacco use, increased tobacco taxes would reduce the magnitude of this problem; however, given the current pricing practices for health insurance, the problem will exist as long as anyone uses tobacco.

Tobacco-related expenditures on health care

Researchers have found that smokers of all ages require more medical care than those who have never smoked.[38] While the life

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[36] See the discussion in the paragraph below titled "Tobacco-related expenditures on health care" for evidence relating to medical expenditures by smokers versus nonsmokers.

[37] The pricing of many employer-provided retirement annuities has an effect opposite that of the pricing of health insurance. When a retirement annuity is valued based on average life expectancy after retirement, on average, nonsmokers benefit at the expense of smokers, because smokers have a shorter life expectancy. In the case of retirement annuities, such pricing of annuities would overcharge smokers and undercharge nonsmokers. (See the discussion of social security below.)

[38] C. Stephen Redhead, "Mortality and Economic Costs Attributable to Smoking and Alcohol Abuse," Congressional Research Service (CRS) Report for Congress, 93-426 SPR, April 20, 1993. These findings do not necessarily mean that the smoking causes all the additional medical expenditures. Individuals predisposed to smoke may be predisposed to certain other unhealthy behavior, such as other drug use (alcohol, marijuana,

expectancy of smokers is less than that of nonsmokers, their cumulative lifetime medical expenditures exceed that of those who never smoke. One estimate places this excess at $2,500 over the smoker's lifetime.[39] Some advocates of higher taxes on tobacco products have argued that, by reducing the demand for tobacco products, the Federal Government will reap savings in its provision of health care. On the other hand, some have observed that when the Federal Government's entire budget is examined, tobacco use may not impose a net burden on the government. They observe that to the extent that tobacco users have shorter life expectancies than nonsmokers, the Federal Government has lower overall costs in the long run by making lower Social Security payments.[40]

It is difficult to measure the magnitude of such health costs and savings from reduced retirement expenditures across individuals' lifetimes. One study has attempted to measure the net external cost of smoking.[41] This study included costs of additional medical expenditures, the lost production from additional sick leave taken by employees who smoke, higher costs of group life insurance (from increased mortality rates), costs from fires attributable to smoking, and lost tax revenues from the earlier age of death of smokers. The study measured savings to society as reductions in pension payments and reduced use of nursing home care. The study concluded that the net costs of smoking were less than present combined Federal and State tobacco taxes. The study has been criticized for its failure to account for potential costs from second-hand smoke and other potential external costs such as increased litter from cigarettes or annoyance on the part of nonsmokers. With all such calculations, the results may be sensitive to the choice of the discount rate.[42]

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etc.).

[39] Ibid.

[40] John B. Shoven, Jeffrey O. Sundberg, and John P. Bunker, "The Social Security Cost of Smoking," National Bureau of Economic Research, Working Paper No. 2234, Cambridge, MA., May 1987.

[41] Willard G. Manning, Emmett B. Keeler, Joseph P. Newhouse, Elizabeth M. Sloss, and Jeffrey Wasserman, The Costs of Poor Health Habits, A RAND Study, (Cambridge, MA: Harvard University Press), 1991.

[42] A recent Congressional Research Service report reviews both the study and criticisms of its results in more detail. See, Jane G. Gravelle and Dennis Zimmerman, "Cigarette Taxes to Fund Health Care Reform: An Economic Analysis," CRS Report for

Other issues related to tobacco taxation

Excise taxes are perceived as imposing a larger burden on lower-income families (relative to income) than on middle- and higher-income families. Some economists argue that family expenditures may be a better measure of ability to pay than is annual family income. Measured against expenditures, tobacco taxes appear less regressive than when measured against income.[43] Tobacco excise taxes also have a varying impact on families with similar incomes, because the incidence of tobacco use varies across families.

If increases in tobacco excise taxes succeed in reducing consumption of tobacco products, the domestic tobacco industry may be expected to contract.[44] To the extent that the farming of tobacco and production of tobacco products is geographically specialized, reduction in demand may lead to at least short-term economic dislocations in these geographic areas. For example, unemployment may rise among those currently employed in tobacco farming and tobacco product manufacturing. The severity of this economic dislocation would depend in part on the ability of the affected individuals to gain employment in different industries. Finding new employment may require some individuals to relocate to another region and/or undergo substantial retraining. The major tobacco growing States are North Carolina, Kentucky, and South Carolina, followed by Virginia, Georgia, and Tennessee.[45]

In addition to possible economic dislocations in tobacco producing States, substantial reductions in tobacco consumption may be expected to reduce the revenues of all State governments, as all States impose tobacco taxes at the State level. At the present, tobacco taxes are a more important revenue source for States than for the Federal Government. In 1989, States collected $5 billion in tobacco tax revenues, representing 1.8 percent of

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Congress, 94-214E, March 8, 1994.

[43] United States Congress, Congressional Budget Office, <u>Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels</u>, June 1990.

[44] Some tobacco products are produced for export. Generally, exported tobacco products would be exempt from proposed increases in domestic excise taxes. The extent of production for export would mitigate the extent of contraction of the industry.

[45] Gravelle and Zimmerman, "Cigarette Taxes to Fund Health Care Reform" reviews recent estimates of potential employment effects that may result from increased taxation of tobacco products.

all State tax receipts. By contrast, the Federal Government collected $4.5 billion in tobacco tax revenues in 1989, representing less than one half of one percent of Federal tax receipts.[46]

Higher tobacco prices should induce fewer people to begin to use tobacco products. Thus, even if no existing tobacco users altered their behavior through time, a smaller percentage of the population would use tobacco products. Therefore, an increase in tobacco taxes could be expected to reduce the incidence of tobacco use in the long run, by a greater amount than any reduction achieved in the short run.[47] In the past, in the United States, population growth generally has made up for a reduced incidence of smoking such that the revenue yield of tobacco taxes has increased through time.[48] However, if higher prices induce substantial declines in the incidence of smoking, the short-run revenue yield may overstate the long-run revenue yield. If the tobacco taxes are earmarked for certain programs, the potential for lower revenue in the long run than in the short run may be an important consideration for Government policy.

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[46] Tax Foundation, Facts & Figures on Government Finance, (Baltimore: The Johns Hopkins University Press), 1991. Some local governments assess additional tobacco taxes which produced approximately $200 million in 1988. These revenues also would be expected to be reduced by reductions in tobacco consumption.

[47] The Canadian study finds that the price elasticity, that is the behavioral response to price changes, is greater in the short run than in the long run. The study attributes this to the habitual nature of tobacco and argues that at first smokers quit, but that they eventually start smoking again. (See, Tobacco Taxes and Consumption). This analysis does not appear to account for long-run aggregate behavior, such as fewer new-starting tobacco users.

[48] This is absent an accounting of tax rate increases. However, if the downward trend in the incidence of smoking continues, lower rates of population growth in the future could cause tobacco revenues to fall in the absence of change in tobacco tax rates.

III. EXCISE TAXES ON FIREARMS AND AMMUNITION

A. Present Law

Ad valorem excise taxes

A 10-percent excise tax is imposed on the sale of pistols and revolvers by a manufacturer, producer or importer thereof. Other firearms and shells and cartridges are subject to an 11-percent excise tax (Code sec. 4181).[49]

An exemption is provided for sales of firearms and ammunition for use by the United States Department of Defense. In addition, no excise tax is imposed on sales by manufacturers, producers or importers: (1) for use by the purchaser in further manufacture, or for resale by the purchaser for use by the second purchaser in further manufacture; (2) for export, or for resale by the purchaser to a second purchaser for export; (3) for use by the purchaser as supplies for vessels or aircraft; (4) to a State or local government for their exclusive use; or (5) to a nonprofit educational organization for its exclusive use. In general, the effect of the State and local government exemption is to exempt sales to State and local police departments.

Amounts equivalent to revenues from these excise taxes fund the Federal Aid to Wildlife Program for use in making grants to support State wildlife programs.

Transfer and making taxes; special occupational taxes

Transfer and making taxes.--Present law also imposes making and transfer taxes on certain firearms and other destructive devices. A transfer tax of $200 is imposed on each "firearm" transferred, and a making tax at the rate of $200 is imposed on each firearm made (Code secs. 5811 and 5821).[50] The ad valorem excise taxes described above do not apply to firearms subject to these making and transfer taxes.

Firearms subject to the making and transfer taxes are machine guns, short-length or short-barrelled rifles or shotguns, pen guns, handguns with smooth bore barrels, firearms silencers,

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[49] A reloader of shells or cartridges is not considered a manufacturer for purposes of the ad valorem excise tax if, in return for a fee and expenses, the reloader reloads shells or cartridges submitted by customer and returns the reloaded shells or cartridges, with the identical casings provided by the customer, to that customer (Treas. Reg. sec. 53.11).

[50] A $5 transfer tax applies to articles defined as "any other weapon" under Code section 5845(e).

mufflers or suppressors, silencer parts, machine gun receivers and parts designed to convert a weapon into a machine gun (generally, firearms subject to regulation under the National Firearms Act ("NFA")).

In general, Federal, State and local governments are exempt from the making and transfer taxes. In addition, transfers between persons subject to the special occupational tax (described below) are exempt from the transfer tax, as are transfers of unserviceable firearms and exported firearms.

Special occupational tax.--All importers, manufacturers and dealers in NFA firearms are required to register with the Secretary of the Treasury. Importers and manufacturers are subject to a special occupational tax of $1,000 per year (small importers and manufacturers are eligible for a reduced rate of tax); dealers are subject to a special occupational tax of $500 per year (Code sec. 5801).

An exemption from the special occupational tax is available for persons who conduct business exclusively with or on behalf of the United States.

Other regulation of firearms and ammunition

Firearms and ammunition also are subject to regulation under the Gun Control Act of 1968 and the Arms Export Control Act of 1976, as amended. In general, the Bureau of Alcohol, Tobacco and Firearms ("BATF") administers the Gun Control Act of 1968 and the National Firearms Act (Code secs. 5801-5872). The United States Postal Service administers the prohibition against mailing firearms (18 U.S.C. 1715).

The Gun Control Act of 1968 ("GCA"), as amended, regulates interstate and foreign commerce in firearms. Under the GCA, manufacturers, importers, dealers and certain collectors are licensed and must maintain various records regarding manufacture, import, receipt, and disposition of firearms. Manufacturers and importers of ammunition are licensed under the GCA. The GCA also prohibits the disposition of firearms and ammunition to certain proscribed categories of persons, e.g., felons. The "Brady Law' is also contained in the GCA. The GCA sets forth various civil and criminal penalties and forfeiture provisions.

The Arms Export Control Act of 1976 ("AECA") regulates the importation and exportation of arms, ammunition and implements of war. The AECA contains registration and permit provisions, and provides civil and criminal penalties and forfeitures. The BATF administers the importation provisions and the Department of State and Customs Service administers the exportation provisions.

B. Description of Bills

None of the comprehensive health care proposals introduced in the 103rd Congress contain proposals for modifying the tax treatment of firearms and ammunition. However, several other bills have been introduced that would increase Federal taxes on firearms and ammunition.

The following is a brief description of the bills that provide for increases in the present-law excise and special occupational taxes. Many of these bills also contain extensive non-tax provisions amending the Federal regulation of firearms and ammunition through increased licensing fees, criminal penalties and other requirements. Some of these provisions may interact with the current excise and special occupational tax regimes contained in the Internal Revenue Code; however, a complete description of these bills is beyond the scope of this document.

1. S. 32 ("Violent Crime Control Act of 1993") and S. 179 ("Real Cost of Ammunition Act")--Senators Moynihan, Chafee, and Simon

The bills would increase the rate of the present ad valorem excise tax on certain ammunition--9 millimeter, .25 caliber and .32 caliber ammunition--to 1,000 percent.

2. S. 868 ("Firearm Victims Prevention Act")--Senators Murray, Bradley, Simon, Kerry, Moseley-Braun, Mathews, and Bingaman

The bill would increase the rate of the present ad valorem excise tax on handguns, assault weapons, large capacity magazines, and shells and cartridges used in handguns and assault weapons to 25 percent.

The bill also would impose a 25-percent retail excise tax on the sale, transfer, or other disposition of a handgun, assault weapon, large capacity magazine, or shells and cartridges used in handguns and assault weapons. Where the manufacturers' tax was paid, the retail tax would not be imposed until after the first retail sale of the article.

Revenues from the 25-percent excise taxes would be used to fund a new Health Care Trust Fund.

3. S. 1616 ("Real Cost of Handgun Ammunition Act")--Senator Moynihan

The bill would increase the ad valorem excise tax rate on certain handgun ammunition. Centerfire cartridges with a cartridge case of less than 1.3 inches in length and cartridge cases of less than 1.3 inches in length would be taxed at 50

percent. A 10,000-percent rate would apply to (1) jacketed, hollow point projectiles which may be used in a handgun and are designed to produce, upon impact, evenly-spaced sharp or barb-like projections that extend beyond the diameter of the unfired projectile; and (2) cartridges with a projectile measuring 0.500 inch or greater in diameter which may be used in a handgun.

The bill also would impose a special occupational tax on each importer and manufacturer of handgun ammunition of $10,000 per year.

4. S. 1798 ("Gun Violence Health Care Costs Prevention Act")--Senator Bradley

The bill would increase the ad valorem excise tax rate to 30 percent on handguns, semiautomatic assault weapons and shells and cartridges used in handguns and semiautomatic assault weapons.

In addition, the bill would impose a 30-percent transfer tax on any subsequent sale, transfer, or other disposition of a handgun, semiautomatic assault weapon or shells and cartridges used in handguns and semiautomatic assault weapons. The 30-percent tax would not be imposed on any such article taxed under the revised Federal manufacturer's level excise tax.

Revenues from the increased tax rates would be dedicated to a new Gun Violence Trauma Care Trust Fund.

5. S. 1878 ("Gun Violence Prevention Act of 1994")--Senators Metzenbaum, Bradley, Chafee, Kennedy, Lautenberg, Boxer, and Pell

The bill would increase the ad valorem excise tax rate on handguns to 30 percent and the tax rate on handgun ammunition to 50 percent.

Revenues derived from the excise tax on handguns and handgun ammunition would be used to fund a new Health Care Trust Fund.

C. Discussion of Issues

The taxation of firearms and ammunition

Rationale for increased taxation of firearms and ammunition

Some portion of health care expenditures is incurred to treat victims of gunshot wounds. Because public funds often are expended to treat gunshot wounds, it may be appropriate to charge those who purchase firearms and ammunition for the additional public expenditures resulting from such wounds. In this way, theoretically, these purchasers would bear a greater portion of

the costs of their behavior and the purchase and misuse of firearms would be discouraged.

On the other hand, taxes on the consumption of specific products, as opposed to broadly imposed consumption taxes, may distort consumer behavior by disfavoring certain goods in the economy relative to other goods. Generally, economists believe that market price distortion through taxes reduces consumer well-being because the change in relative prices introduced by the taxes causes consumers to choose a less preferred good than they would have in the absence of the tax. In addition, excise taxes applied to all purchases of firearms and ammunition for the purpose of accounting for the costs that arise from gunshot wounds arguably may be inefficient because such taxes impose costs on consumers whose use of firearms and ammunition does not lead to gunshot wounds or public expenditures. The majority of firearms and ammunition sales are to consumers who purchase these goods for sport (hunting, skeet, and target shooting) or for their personal protection.

Advocates of increased taxation argue that even firearms and ammunition purchased for sporting or personal protection purposes are the source of many suicide attempts and may result in accidental gunshot wounds, and some enter the supply of illegal weapons.[51] In addition, firearms increasingly are being used in homicides and other criminal activities. Advocates of higher taxes on firearms and ammunition argue that such taxes not only generate needed revenue to finance health care reforms or other policies, but also further the goal of firearms control.

The economic effects of increased taxation of firearms and ammunition

The higher prices of firearms and ammunition resulting from increases in excise taxes could be expected to reduce purchases by consumers of these products. To maximize this effect, it would be necessary to increase existing excise taxes applicable to the purchase of new firearms and ammunition, but also to tax subsequent transfers. Firearms are durable goods. There is a substantial market in used firearms, and sales of those firearms generally are beyond the application of current Federal excise taxes.

By increasing the price of new firearms, the market value of existing firearms could be expected to rise as well, as consumers substitute the purchase of old firearms for new firearms. For

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[51] Under this view, taxes on firearms and ammunition might be interpreted, in part, as insurance premiums to cover costs that arise from caring for gunshot wound victims (because any firearm may potentially lead to such wounds).

advocates of taxation as a means of firearms control, such an outcome would have the positive effect of making the existing stock of firearms more expensive to obtain,[52] as well as reducing the flow of new firearms into society. On the other hand, by increasing the price of firearms, self-manufacture and the smuggling of weapons, where possible, may become more attractive. The extent of any increase in such illegal activities would depend upon their cost compared to increased price of legal firearms.

In practice, some ammunition also is a durable good. Certain types of ammunition can be reloaded (the spent shell casings may be recovered and repacked with a bullet or pellets, powder, and primer); such reloading can occur several times, although not indefinitely. Reloaded ammunition is exempt from Federal excise taxes under certain conditions (as described above in "Present Law"). As with firearms, increasing the price of new ammunition through an increased excise tax would be expected to increase the price of reloaded ammunition as well, as consumers increase their use of tax-free reloaded ammunition. It would also be possible to tax reloading tools and materials. Higher prices also would make the illegal manufacture or importation of ammunition more attractive.

The overall effect of increased taxation of firearms and ammunition on health care expenditures will depend on the effect of higher firearm and ammunition prices on the use of firearms in legal activities (which can be the source of accidental gunshot wounds and suicide attempts) and illegal activities (which also can be the source of gunshot wounds). Increases in price should reduce the purchase of these goods for legal activities and reduce the flow of these goods to illegal activities. However, there is little evidence on how levels of legal and illegal activities would respond to changes in the price of firearms and ammunition.

The overall effect of increased taxation of firearms and ammunition on health care expenditures also depends on the extent to which firearms currently contribute to health care expenditures.

Issues in targeting the taxation of firearms and ammunition

The observation that the majority of uses of firearms and ammunition are legal and have little or no adverse medical consequences has led some analysts to explore ways to target the taxation of firearms and ammunition at firearms and ammunition

[52] Price increases also would be expected in "black market" sales of firearms as such weapons are substitutes for firearms purchased legally.

perceived to be most responsible for additional health care costs and most likely to be used in illegal activities. These types of firearms or ammunition, or both, could be singled out for increased taxation. Targeting certain firearms and ammunition may further health and law enforcement policy objectives. The effectiveness of any targeting efforts that rely on increased Federal taxes depends in large part, however, on whether the measures are administrable and enforceable. Certain issues in this regard are discussed further below.

Generally, there are four types of firearms: handguns; shotguns; rifles; and machine guns.[53] Firearms also can be characterized as non-automatic, semi-automatic, and fully automatic.[54] Ammunition generally is characterized by its caliber (diameter of the cartridge),[55] the length of the cartridge ("long," "short," or "intermediate"), and by whether it is rim-fire or center-fire.[56]

Targeting the taxation of firearms

Any proposal to increase the excise tax on a defined subset of firearms must address certain administrative and compliance issues. First, as discussed above in the case of increasing the excise tax on all firearms, increasing the tax on firearms may shift firearms transactions from licensed gun dealers to unlicensed or illegal sellers. Currently, a substantial number of the firearms used in criminal activities are illegally obtained. Although increased taxes on particular classes of firearms will increase the cost of such firearms, whether obtained legally or illegally, they also may encourage additional

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[53] Under present law, it is illegal to own machine guns unless one is a licensed collector.

[54] A weapon that fires each time one pulls the trigger and uses the force of the prior shot to automatically reload the chamber is characterized as "semi-automatic." A revolver technically is not semi-automatic because it requires mechanical force to bring the next round to the chamber after each shot. A machine gun, or fully automatic firearm, is a firearm that fires more than one round at the pull of the trigger.

[55] "Gauge" in the case of shotgun ammunition.

[56] A rim-fire cartridge is fired by crushing the rim of the shell casing to ignite the gunpowder inside the shell. A center-fire cartridge is fired by striking a center-mounted primer to ignite the gunpowder inside the shell. Rim-fire cartridges cannot be reloaded. Center-fire cartridges generally permit a more powerful charge and can be reloaded a limited number of times.

smuggling and illegal sale of these highly taxed items, further exacerbating law enforcement problems with unlicensed firearms dealers. To the extent this shift in purchases occurs, a disproportionate share of those who bear the burden of the tax arguably may be law-abiding consumers, rather than those involved in criminal activities.[57]

Second, restricting the tax to those firearms associated primarily with criminal activities and gunshot wounds, as opposed to those used in recreational endeavors, may raise difficult definitional issues. Some experts note that it is difficult to distinguish firearms used for sporting purposes from those that would be subject to an increased tax rate. For example, while handguns are not generally used in hunting, they are used in target shooting competitions; they are also often used in criminal activities. Similarly, rifles may be used in both hunting and target shooting, as well as in criminal activities. For instance, many hunting rifles are semi-automatic, a feature that makes them popular for criminal use.

One way to distinguish among firearms is their caliber. However, this method does not distinguish effectively firearms used for hunting from those used for other purposes by their caliber. Firearms of many caliber sizes are used for hunting. Generally, small caliber firearms are used for small game and larger caliber firearms are used for larger game. In addition, characteristics other than caliber are important in distinguishing firearms. The caliber of the popular .22 hunting rifle is essentially the same as that of the United States' military M-16. Further, as new weapons of different calibers are manufactured, it would be necessary to determine whether each weapon would be subject to tax.

Another way of distinguishing "street" weapons from sporting weapons is by their style or appearance, or by the size of the magazine the firearm accepts. However, differential tax rates for firearms (e.g., higher tax rates on assault rifles[58] or higher rates on firearms with larger magazines) may create enforceability questions, especially if the tax rate differentials are large. For example, while it may be possible to distinguish a handgun from a rifle, it is more problematic to

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[57] In addition, to the extent that the firearms targeted for taxation are substitutes for firearms not subject to taxation, one would expect the tax to increase the price of the untaxed firearms as would-be buyers substitute untaxed firearms for taxed firearms.

[58] In military parlance, an "assault weapon" is a shoulder-fired, select-fire (ability to choose single fire or fully automatic) weapon that fires an intermediate cartridge.

between semi-automatic and automatic rifles. Some experts state that it is a simple procedure to convert semi-automatic weapons to automatic-fire weapons. For instance, gun enthusiast magazines carry advertisements for kits to convert semi-automatic fire weapons to automatic fire.[59] As a result, what by outward appearances is a hunting rifle becomes the equivalent of an assault rifle.

Such convertibility may make it difficult to enforce a tax that imposes a higher tax rate on weapons capable of automatic fire than on semi-automatic fire weapons. This problem could be addressed by subjecting such "conversion kits" to tax; however, some experts state that, in many cases, conversions can be made with "off-the-shelf" parts. Similarly, small magazines often are easily replaced with larger magazines in a straightforward procedure. In general, defining the tax base by the outward appearance of firearms could create a secondary "conversion" market in which it is difficult to collect the tax, and may require repeated reactions to minor marketplace changes to ensure accurate administration of the tax. Although the tax base of any tax may change as the marketplace changes, the narrower the defined tax base, the more likely it is that revisions will be required.

<u>Targeting the taxation of ammunition</u>

As in the case of defining a subset of firearms to be subject to a higher rate of tax, defining a subset of ammunition to be subject to a higher rate of tax raises administrative and enforcement issues. In some cases, differential taxation of ammunition would be expected to lead to a substitution of lower tax ammunition for high tax ammunition. This would tend to increase the price of all ammunition, implying that part of the burden of the tax would fall on consumers of non-targeted ammunition.[60]

Typically the firing chamber of a firearm is designed to accept only one type of cartridge. Therefore, it is possible to

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[59] It is currently illegal to convert semi-automatic fire weapons to automatic fire.

[60] To the extent that firearms require specific ammunition, differential taxation of ammunition also would affect the demand for, and hence price of, different types of firearms. The demand for firearms using lightly taxed ammunition would increase relative to the demand for firearms using heavily taxed ammunition. Thus, purchasers of firearms may also bear some of the burden of the ammunition tax. However, because firearms purchasers are also ammunition purchasers, this potential shifting of the tax burden may not be deemed important.

impose a higher rate of tax on ammunition designed for a specific subset of firearms. For example, "short" ammunition generally is used only in handguns.[61] The Federal Bureau of Investigation reports that, in 1992, of the 15,377 murders due to firearms, 12,489 (81.2 percent) were due to handguns.[62] A tax targeted at handgun ammunition may reduce the use of such weapons.

However, just as firearms can be put to a variety of uses (i.e., handguns can be used for sport, personal protection, or crime), so too can a wide variety of firearms be put to the same use (i.e., both rifles and handguns can be used for sport or in illegal activities). This interchangeability means that it is difficult to identify types of ammunition that are used in all criminal activities or that are responsible for all gunshot wounds. Substitutability also may make it difficult to predict future patterns of ammunition use. On the other hand, if specific types of ammunition cause substantial public health expenditures because of the severity of the wounds inflicted or the frequency of occurrence of such wounds, an increased rate of tax on those types of ammunition could reduce public health expenditures by reducing demand for, and use of, the specified ammunition.

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[61] Some guns designed for long ammunition can accept short ammunition; the reverse is not true.

[62] U.S. Department of Justice, Federal Bureau of Investigation, Crime in the United States, Washington, D.C., 1992. Figures reported include data from all States except Maine.