[JOINT COMMITTEE PRINT]

DESCRIPTION AND ANALYSIS OF TITLE VII OF H.R. 3600, S. 1757, AND S. 1775 ("HEALTH SECURITY ACT")

PREPARED BY THE STAFF

OF THE

JOINT COMMITTEE ON TAXATION

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INTRODUCTION

This pamphlet,[1] prepared by the staff of the Joint Committee on Taxation, provides a description and analysis of the provisions contained in Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act"). A complete description of the Health Security Act is beyond the scope of this pamphlet. In addition, it is not intended that this pamphlet be considered a complete description of the revenue provisions of the Health Security Act. Other provisions in the Act (for example, the payments required to be made in connection with the mandates contained in the Act) could be viewed as revenue provisions. It is anticipated that some of these provisions will be analyzed at a later date.

President Clinton unveiled his comprehensive plan for providing universal access to health care and for controlling health care spending in a September 22, 1993, address to a joint session of Congress. The Administration delivered its health care reform plan to the Congress on October 27, 1993. The legislative language was subsequently introduced in the House by Mr. Gephardt (and others) on November 20, 1993, as H.R. 3600; it was introduced in the Senate by Senator Mitchell (and others) on November 20, 1993, as S. 1757; and it was also introduced in the Senate by Senator Moynihan on November 22, 1993, as S. 1775.

Part I of the pamphlet is a brief summary of the provisions of the Health Security Act; Part II is a discussion of tax issues involved in health care; and Part III is a description and analysis of Title VII of the Health Security Act.

[1] This pamphlet may be cited as follows: 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.

I. OVERVIEW OF THE HEALTH SECURITY ACT

Universal coverage and comprehensive benefit package

Under the Administration's proposed Health Security Act, all American citizens and residents would be guaranteed a comprehensive health benefit package. Individuals would generally be required to enroll in an applicable health plan providing the guaranteed benefit package through an appropriate health alliance. The comprehensive benefit package would be set forth in the statute initially, and would be subject to the cost sharing requirements of the bill, the exclusions in the bill, and the duties and authority of the National Health Board to be established by the bill. Individuals would be able to purchase supplemental health insurance to cover health services not included within the comprehensive benefit package.

Each health plan would be required to offer one, and only one, of 3 prescribed cost-sharing schedules: lower cost sharing; higher cost sharing; or combination cost sharing. Under a lower cost sharing plan, deductibles would be prohibited, and there would be relatively low out-of-pocket limits, low copayments[2], and no coinsurance[3] (except for an out-of-network item or service). A higher cost sharing plan would have deductibles, coinsurance instead of copayments, and certain other specified out-of-pocket expenses. A combination plan could have different cost sharing depending on whether the individual uses out-of-network providers.

National Health Board

The operation of the new health care system would be overseen by a National Health Board. The Board would consist of 7 members appointed by the President by and with the advice and consent of the Senate. The chair of the Board would serve a term concurrent with that of the President, and could serve a maximum of 3 terms. The other members of the Board would serve staggered, 4-year terms. A member other than the chair could serve a maximum of 2 terms.

Among other things, the Board would have the authority to establish requirements for State plans and monitor compliance with the bill's requirements, interpret and update the comprehensive benefit package, and recommend changes in the package to the President and the Congress. It would also establish a baseline budget for alliances and certify compliance with the budget.

Health alliances

In general

Individuals would generally obtain health insurance through regional health alliances established and overseen by States or corporate health alliances established by large employers or certain other entities. In general, if a family member is eligible to enroll in a corporate alliance, then the family would obtain insurance

[2] Copayments are amounts, expressed as a dollar amount, that an individual may be required to pay with respect to an item or service, such as $10 per office visit.

[3] Coinsurance is an amount, expressed as a percentage of an amount otherwise payable, that an individual may be required to pay with respect to an item or service, such as 20 percent of the total fee for a service.

through the corporate alliance. Otherwise, the family would obtain insurance through the regional health alliance for the alliance area in which the family resides. Special rules would apply in determining the appropriate alliance if more than one family member is employed. If an individual and his or her spouse are employed and eligible to participate in different corporate alliances or if one spouse is eligible to participate in a regional alliance and the other in a corporate alliance, they can choose in which alliance to participate.

In lieu of establishing a system of regional alliances, States would be permitted to establish single-payer systems.

Regional alliances

The bill would require States to establish regional alliances by January 1, 1997. Regional alliances could be organized as non-profit organizations, independent State agencies, or agencies of the State. Only one alliance could serve any geographic area. States would be required to certify health plans that can offer coverage through an alliance.

Regional alliances would be governed by a Board of Directors consisting of equal representation of employers whose employees purchase health coverage through the alliance, including self-employed individuals, and members who represent individual consumers. Each regional alliance would also be required to have a provider advisory board consisting of representatives of health care providers and professionals who provide covered services through health plans offered by the alliance.

Regional health alliances would negotiate with State-certified health plans and enter into contracts with health plans to provide health services to eligible individuals. Regional alliances would be required to offer at least one fee-for-service plan among the health plans offered to eligible individuals.[4]

Regional alliances would receive funds from the following sources: employer and individual premiums; State and Federal payments for recipients of Aid to Families with Dependent Children (AFDC) and supplemental security income (SSI); State maintenance of effort payments; payments from corporate alliances for dual earner families; and Federal payments for premium subsidies. Regional alliances would disburse funds for the following reasons: payments to health plans; administrative costs; payments to other alliances for dual earner families; and payments to the Federal Government for academic health centers.

Corporate alliances[5]

In general under the bill, employers with more than 5,000 full-time employees (large employers), certain multiemployer plans, rural electric cooperatives, rural telephone cooperatives, and the U.S. Postal Service could elect to provide health care coverage to their employees through corporate alliances rather than through regional alliances. The corporate alliance could provide health in-

[4] In general, a fee-for-service plan would be defined as a health plan that provides coverage for all items and services included in the comprehensive benefit package, subject to reasonable restrictions, and makes payments for such benefits to providers without regard to whether or not there is a contractual arrangement between the plan and the provider.

[5] Corporate alliances are discussed in more detail in Part III.2.a., below.

surance through self-insurance or through commercial insurance. The corporate alliance would be responsible for providing the comprehensive benefit package.

Employer mandate

All employers would be required to pay for a portion of the cost of the comprehensive benefit package for their employees.

Premiums

Regional alliances

In general.--Each regional health alliance would contract with the various health plans interested in providing health benefits to individuals residing in the alliance area. An individual who resides in the alliance area (and who is not eligible to participate in a corporate alliance) could choose coverage by any of the available plans.

Participating plans would submit a per capita bid for providing the comprehensive benefits package to all eligible individuals residing within the alliance area. Using set formulas, this per capita bid would be converted into premiums for each type of family class: individual; couple-only (i.e., a married couple without children); single parent; or dual parent (i.e., a married couple with children). For this purpose, marital status would be determined in accordance with state law.

Employer share of premiums.—An employer would be required to pay, for each employee, 80 percent of the weighted-average premium for all plans in the alliance for the employee's class of enrollment. This weighted-average premium would be computed for each family class on an alliance-wide basis according to a formula specified in the bill. Thus, employers would pay a fixed amount for each employee in a given family class, regardless of which plan actually is selected by the employee. The calculated averages would be based upon the number of wage earners expected to be making premium payments for a given class (rather than the number of families covered in the class), to reflect that some families may have more than one wage earner. Under the bill, a single weighted-average premium would be calculated and would apply both to the single parent and dual parent classes of enrollment.

In addition to the required employer premiums, employers could pay some or all of the family share of premiums on behalf of their employees, as long as all employees received the same dollar amount. For part-time employees (those whose monthly employment is at least 40 hours, but less than 120 hours), the required employer premium would be calculated on a pro rata basis, using 120 hours per month as a measure of full-time employment.

Employer premiums would be capped at 7.9 percent of an employer's total payroll. Small employers (those employing 75 or fewer employees) who paid average annual wages of $24,000 or less would be entitled to caps of 3.5 percent to 7.9 percent of total payroll, depending upon the average number of employees and their average annual wage. These caps would not apply to governmental employers before 2002.

Special rule for large employers.—A large employer who is eligible to form a corporate alliance, but who chooses not to do so, or who forms a corporate alliance that is later terminated would not be eligible for the percent of payroll caps for the first four years of regional alliance coverage. The benefit of the caps would be phased in ratably for such employers over the fifth through seventh years of regional alliance coverage, and would be fully available after seven years of regional alliance coverage. In addition, such employers would be required to make "excess risk" payments if the demographic risk of its employee pool exceeds the average demographic risk of all individuals eligible to participate in the regional alliance. (Demographic risk would be measured based on demographic characteristics such as age, gender, and socio-economic status.) The excess risk adjustment would be phased out ratably over the fifth through seventh years of regional alliance coverage.

Bad debt.—Employers would be required to make additional premium payments to compensate for 80 percent of the anticipated bad debt losses of the regional alliance. The regional alliance would estimate the total premiums unlikely to be collected, and divide it by the number of people covered by the alliance to obtain a per capita shortfall amount. The per capita shortfall amount would be converted into a premium amount for each family class using the same methodology as used to calculate base premiums. All employers would be required to make this payment regardless of any percent of payroll caps that would otherwise apply.

Self-employed individuals.—A self-employed individual (one whose earnings are subject to self-employment taxes under present law) would be treated as employing himself or herself for purposes of calculating the employer premium due. The individual's net self-employment earnings would be deemed wages paid. The amount of employer premium due for a self-employed individual would be reduced by the amount of any employer premiums paid by other employers of the individual. The bill would also provide an anti-abuse rule applicable to any individual who is both an employee and a substantial owner of a closely-held business.

Family share of premiums.—The premium due for a family living in an alliance area would depend upon the specific plan selected. Each family having a family member employed on a full-time basis would be entitled to a "credit" of 80 percent of the weighted-average premium for all plans in the alliance for its family class. (The credit would be reduced proportionately if family members were employed only on a part-time basis, or were unemployed.) The family premium due would be the difference between the total premium for the plan actually selected and this computed credit. The family premium could be less than 20 percent of the average premium if a low-cost plan is selected or more if a higher-priced plan is selected.

Families also would be required to make additional premium payments to compensate for 20 percent of the anticipated bad debt losses of the regional alliance, under a calculation similar to that described above for employers.

Certain low-income families would be entitled to a reduction in the family share of premiums owed. Such families include Aid to Families with Dependent Children (AFDC) or Supplemental Secu-

rity Income (SSI) recipients, those having family adjusted income below 150 percent of the poverty level, or those earning less than $40,000 and for whom the family obligation amount would otherwise exceed 3.9 percent of the family's adjusted income. Depending upon income, the reduction would be an amount up to 20 percent of the weighted-average premium for all plans in the alliance for its family class.

Corporate alliances

Each corporate alliance would determine its own weighted average premium. Premiums charged by a corporate alliance for health care coverage could vary only by class of family enrollment and by premium area. Corporate alliances would be required to designate premium areas, which are to reasonably reflect labor market areas or health care delivery areas and which are to be consistent with rules to be established by the Department of Labor. The employer premium for corporate alliance employers would be 80 percent of the weighted average monthly premium. In addition, corporate alliance employers would be required to subsidize the premiums of full-time workers who have wages of less than $15,000 on an annualized basis. The $15,000 threshold would be indexed annually for inflation after 1994. Individuals would be required to pay the difference between the employer share and the cost of the plan they select (subject to the low-wage subsidy). The 7.9-percent payroll cap on employer premiums would not apply to corporate alliance employers.

Cap on health care expenditures

The Administration expects that the Act will result in increased competition in the health care market, and that such competition would reduce the growth in health care expenses. In addition, the Act would impose limits on the payments made by alliances to health plans and providers.

Regional alliances

The amount that regional alliances would be allowed to pay health plans and providers would be subject to a budget. The Federal Government would be responsible for enforcing this budget, generally as follows.

No later than January 1, 1995, the National Health Board would be required to establish a national per capita baseline premium target based on current per capita health expenditures for the comprehensive benefit package based on 1993 expenditures, trended forward. This amount would be increased annually for inflation based on the "general health care inflation factor". For 1996, the inflation factor would be the percentage increase in the consumer price index (CPI), plus 1.5 percentage points; for 1997, the inflation factor would be the percentage increase in the CPI plus 1.0 percentage points; for 1998, the inflation factor would be the percentage increase in the CPI plus 0.5 percentage points; for 1999 and 2000, the inflation factor would be the percentage increase in the CPI. For later years, the Board would be required to submit to Congress recommendations of what the general health care inflation factor should be.

The Board would then set a per capita premium target for each alliance based on the national per capita target and the general health care inflation factor. In setting alliance targets, the inflation factor and the overall target would be adjusted for factors specific to each regional alliance, such as the variations in health care expenditures and the rate of uninsurance and underinsurance.

Regional alliances would be required to conduct a bidding and negotiation process with health plans. If the weighted-average premium exceeds the alliance target set by the Board, the alliance could renegotiate premiums. If the final bids submitted by the alliance exceed the alliance's premium target, the payments to noncomplying plans and providers and premium payments would be reduced.

Corporate alliances

The National Health Board would be required to develop a methodology for calculating an annual per capita equivalent for amounts paid for coverage for the comprehensive benefit package within a corporate alliance. If a corporate alliance exceeds the allowable increase in health care costs as determined by the Board in two years in a 3-year period, then the Secretary of Labor would terminate the corporate alliance.

Public sector spending

The Health Security Act would also limit public sector health spending by curtailing growth in Medicare and Medicaid outlays.

Effective date

In general, the provisions of the Health Security Act are intended to be fully effective by January 1, 1998.

II. GENERAL OVERVIEW OF FEDERAL TAX ISSUES RELATING TO HEALTH CARE REFORM

Role of the Internal Revenue Code in health care policy

When health reform proposals are considered, the Federal tax laws are often viewed simply as a revenue source. However, the tax laws not only raise revenues, but also are a significant tool in shaping health care policy. This role can be quantified by examining both the tax expenditure for health care and the number of health-related provisions contained in the Internal Revenue Code ("the Code"). The exclusion from gross income for employer-provided health coverage is the most often cited. It is the second largest Federal tax expenditure, estimated at $287 billion over 5 years (fiscal years 1994-1998).

Although significant tax expenditures are involved, the health care area is relatively unregulated. For example, tax-favored pension benefits are subject to nondiscrimination rules, minimum participation rules, vesting requirements, and funding rules. There are also limits on the possible tax benefits. In contrast, there is no comprehensive set of similar rules in the health area. Health insurance nondiscrimination rules were enacted in 1986, but then were repealed in 1989 before they took effect. In the case of an insured plan, there are no Federal restrictions on coverage--i.e., the plan can cover only the highest-paid executives and no one else. Self-insured plans are subject to a nondiscrimination requirement. There is no limit on the exclusion for employer-provided health care.

Similarly, the provisions in Title I of the Employee Retirement Income Security Act of 1974 (ERISA) contain extensive rules for pension benefits, but do not have rules regarding who must be offered coverage under an employer's health plan or what benefits must be provided. ERISA preempts State laws, other than insurance laws. The effect of the preemption provision is that health care purchased from an insurance company is subject to State regulation, but self-insured plans are not. Thus, self-insured plans are not subject to comprehensive regulation at either the State or Federal level.

Policies reflected in the tax provisions

The Code provisions relating to health care have evolved over a period of time. These provisions do not necessarily reflect a coherent policy toward health care, although there are some general trends.

In general, the Federal tax system contains an employment-based incentive system for the provision of health care. By providing an exclusion from income for accident and health benefits provided under an employer-maintained plan, employees may prefer to receive an increase in compensation in the form of health benefits rather than cash or other taxable fringe benefits. Employers generally can deduct compensation paid whether in the form of cash or taxable or nontaxable benefits. Many employers believe that the provision of health benefits to employees promotes worker productivity and, therefore, may prefer to pay some compensation in the form of health benefits.

Employer-provided health care receives the most favorable Federal tax treatment. The exclusion from income of employer-provided health benefits is unlimited and the area is generally unregulated. The exclusion applies not only to health insurance, but also to other expenses, such as out-of-pocket expenses, deductibles, and co-pays, or other items that are not covered by insurance. The exclusion also applies for employment tax purposes.

A separate incentive is provided under present law with respect to the health insurance expenses of self-employed individuals. Self-employed individuals may generally deduct health expenses relating to their employees. Until December 31, 1993, self-employed individuals may deduct 25 percent of the cost of health insurance for themselves and their families. The deduction is limited to insurance only, and not other health expenses. Thus, under present law, a self-employed individual is treated less favorably with respect to his or her own purchase of health insurance than the 100-percent shareholder of a closely held C corporation whose benefits are provided by the corporation, but is treated more favorably than an individual whose employer does not provide health insurance. S corporation shareholders are treated as self-employed for this purpose.

There is no comparable incentive for the purchase of health insurance by individuals. Rather, under present law, individuals who purchase health insurance on their own or have health expenditures not covered under a plan maintained by an employer can deduct the cost of medical expenses only to the extent their total medical expenses for a year exceed 7.5 percent of adjusted gross income. This deduction for extraordinary expenses is based on the notion that the amount of Federal income taxes imposed on a taxpayer should be based, in part, on the taxpayer's ability to pay. Excessive medical expenses reduce a taxpayer's ability to pay and, therefore, are taken into account in calculating taxable income.

Internal Revenue Code provisions relating to health care

Any fundamental health reform package will involve the issue of the tax treatment of health care for Federal tax purposes. The Internal Revenue Code contains numerous provisions which should be evaluated in the context of fundamental health care reform. Although it may not be necessary to change any of these provisions, a comprehensive review of the health care delivery system is not complete without at least a consideration of the Federal tax laws and how they interact with the health care policy being proposed.

Among the provisions relating to health care in the Internal Revenue Code are the following:

o Contributions to and benefits received under employer-provided health plans are excludable from employees' incomes without limit. The exclusion applies for income tax purposes as well as payroll tax (e.g., social security tax) purposes (secs. 105 and 106).

o For amounts paid before January 1, 1994, self-employed individuals may deduct 25 percent of the cost of health insurance for themselves and family members (sec. 162(l)).

o Taxpayers who itemize deductions can deduct their medical expenses (including the cost of health insurance and other medical expenses) to the extent the expenses exceed 7.5 percent of adjusted

gross income (sec. 213). The medical expense deduction threshold is 10 percent for minimum tax purposes.

o Employers can deduct the cost of health benefits provided to employees just as they can deduct other compensation (sec. 162(a)).

o Health benefits can be offered through a cafeteria plan which offers employees the choice of a variety of benefits, such as cash, health benefits, or dependent care benefits. This provision enables employees to pay for health benefits through salary reduction on a pre-tax basis. Many employers allow employees to have a flexible spending account as part of the cafeteria plan which the employee can use to pay noninsured expenses on a pre-tax basis (sec. 125).

o Within certain limits, employers can fund medical benefits (including retiree medical benefits) in advance on a tax-favored basis (secs. 419 and 419A).

o Medical benefits can be funded on a tax-favored basis by means of a voluntary employees' beneficiary association (VEBA) (secs. 501(c)(9) and 505).

o Retiree medical benefits can be funded in advance on a tax-favored basis in a pension plan maintained by the employer (sec. 401(h)).

o Excess pension plan assets can be used by the employer to pay retiree health liabilities (sec. 420).

o Persons who lose health insurance coverage by reason of a termination of employment or certain other events must be given the opportunity to continue to purchase comparable health insurance. This coverage is called continuation health coverage, and is generally referred to as "COBRA coverage," after the short title of the law which contains the requirements (sec. 4980B).

o Certain health care related organizations are exempt from Federal income tax. These include hospitals, HMOs, and certain organizations providing insurance at substantially below cost to a class of charitable recipients (sec. 501(c) and (m)).

o Tax-exempt financing is available for certain charitable organizations, including hospitals (sec. 145).

o Certain contributions to charitable organizations, including tax-exempt hospitals, are deductible from adjusted gross income (sec. 170).

o Certain health insurance companies receive special tax treatment, including the ability to claim a special deduction with respect to their health insurance business (sec. 833).

o Certain amounts received by an individual for personal injuries, sickness, and disability are excluded from income (sec. 104).

o Individuals are permitted to exclude from gross income the amount of certain qualified accelerated death benefits paid to an insured on account of terminal illness (Treasury Prop. Reg. sec. 1.101-8).

o There are no special provisions for long-term care, but to the extent long-term care expenses are medical or health expenses, they receive the same tax treatment applicable to such expenses. The extent to which long-term care expenses are medical or health expenses is unclear. Reserves set aside by a life insurance company for a policy providing long-term care in the event of the insured's chronic impairment qualify as life insurance reserves (Rev. Rul. 89-43).

o Individuals can use the tax provisions relating to pensions and individual retirement arrangements (IRAs) to save money on a tax-favored basis. The savings can be used for any purpose, including medical care. Thus, these provisions are an indirect way of funding medical (including retiree medical) care (secs. 401 and 408).

General issues with respect to tax provisions

Certain general issues will arise when the interaction of the present-law rules relating to health and medical care with any specific health reform proposal is considered. Some of these issues include the following:

(*1*) *To what extent does the present-law tax treatment of health care expenses contribute to any problems perceived with the current health care system?*

A fundamental issue for consideration of any health reform proposal is the extent to which it maintains the present-law employment-based incentive system for the provision of health care. The exclusion from gross income provided under present law for employer-provided health insurance is often cited as contributing to overutilization of health care because it makes health care cheaper for an employee than it would be in the absence of the exclusion. Thus, some economists believe that people tend to purchase more health care when it is subsidized under an employer plan than they would in the absence of the exclusion.

(2) *Are the present-law tax provisions consistent with the goals of the reform proposal (whatever they may be)?*

Without modification, the present-law tax provisions could interfere with the goals of any specific reform proposal. Existing provisions should be examined to determine what changes are necessary to be sure the desired goals are accomplished.

(*3*) *Does the proposal create any new tax issues?*

For example, if the Federal tax laws are to be used to help make health care more affordable to lower-income individuals, the design of such subsidies and their interaction with other Federal tax laws must be considered.

(*4*) *If health care purchasing cooperatives are used, what is the tax status of the cooperatives?*

To the extent that any health reform proposal creates a new type of entity involved in the delivery of health care, the Federal tax status of the entity and its competitive effect must be considered.

(*5*) *Are the Federal tax laws or a model based on the Federal tax laws going to be used as an enforcement mechanism for any new requirements imposed on employers, individuals, insurers, or health care providers?*

A health reform proposal may contemplate a centralized system of premium collection and disbursement. The extent to which the existing money collection system of the Internal Revenue Service (IRS) will be utilized must be considered. Can existing forms and procedures be used to simplify the collection of money? To what extent will imposing a new collection burden on the IRS detract from

its primary mission (i.e., the collection of existing Federal income, excise, etc., taxes).

If the IRS is not used as a collection agency for premium money, then the extent to which existing IRS procedures will be used to develop a premium collection system must be considered.

If penalties are imposed on employers, individuals, or health care providers, then consideration should be given to whether the Federal tax laws are the most efficient means by which to enforce the penalties.

(*6*) *Are Federal tax provisions going to be used as incentives to encourage desired behavior?*

Any new incentives contained in a health reform proposal must be evaluated from a tax policy perspective and reviewed for administrability and interaction with existing incentives.

(*7*) *Are the Federal tax laws the best means of accomplishing the desired result?*

Depending on the nature of the proposal, the Federal tax system may not be the most efficient way to accomplish an intended goal. For example, a direct spending program or direct mandates or prohibitions in other laws may accomplish the same goals with more efficiency and less complexity.

(*8*) *Are the tax provisions (the present-law rules, any modifications, or any new provisions) consistent with the goal of simplification of the Code? Are the laws relatively easy to administer from the perspective of the IRS as well as taxpayers?*

Any fundamental overhaul of the Federal tax laws relating to health care will require taxpayers to adjust to the changes. The extent to which such changes complicate administration of the tax laws should be carefully considered.

Conclusion

Many health care reform proposals involve changes to the Internal Revenue Code. Federal tax issues are generally very complex, and require resolution of a variety of detailed and complicated questions. No analysis of a fundamental health reform proposal would be complete without a thorough review of the Federal tax issues.

III. DESCRIPTION AND ANALYSIS OF TITLE VII OF H.R. 3600, S. 1757, AND S. 1775

Subtitle A. Financing Provisions

1. Increase in tobacco products excise taxes (secs. 7111-7113 of the bill and secs. 5701-5704, 5761, and 7652 of the Code)

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:

Cigarettes:	
Small cigarettes (weighing no more than 3 pounds per thousand).[6]	$12 per thousand (i.e., 24 cents per pack of 20 cigarettes).
Large cigarettes (weighing more than 3 pounds per thousand).[7]	$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).
Cigarette papers and tubes:	
Cigarette papers[8]	0.75 cent per 50 papers.
Cigarette tubes[9]	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.

[6] Most taxable cigarettes are small cigarettes.

[7] 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.

[8] 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.

[9] 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.

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.

Description of Provisions

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

Cigarettes:	
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).
Cigarette 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.

Discussion of Issues

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.[10] Medical research has linked the use of tobacco products to a number of diseases--including cancer of the lungs, mouth and throat, emphysema, chronic bronchitis, and heart disease.[11] 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

[10] "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.*

[11] 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).

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	25.3
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.[12] The incidence of smoking among blacks is modestly greater than the incidence of smoking among whites.[13] 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 different from that of other developed countries,[14] 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

[12] *Statistical Abstract of the United States, 1992.*
[13] *Ibid.*
[14] See Table 2 below.

remain relatively low. Table 3 shows cigarette excise taxes as a percentage of retail prices in selected OECD countries for 1987.

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

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 products that can harm one's health. 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.[15]

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.[16] 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 has suggested that "second-hand smoke," that is, the smoke from smokers inhaled by nonsmokers, creates health risks and costs for nonsmokers.[17] 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 when he makes 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.[18] The idea is that if a tax is imposed on the product that creates the externality at a rate 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 a case of 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

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

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

[17] 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.

[18] 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.

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,[19] 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.[20] By reducing the incidence of tobacco use, increased tobacco taxes would reduce the magnitude of this problem but, 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.[21] While the life 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.[22] 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.[23]

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.[24] Tobacco excise

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

[20] 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.)

[21] 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, etc.).

[22] *Ibid.*

[23] 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.

[24] United States Congress, Congressional Budget Office, *Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels,* June 1990.

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. 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.

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 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.[25]

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.[26] 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.[27] 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.

Tobacco producers and consumers may also argue that increasing the tobacco tax unfairly singles out one activity that leads to health problems. For example, the consumption of alcohol or foods with

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[25] 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.

[26] 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.

[27] 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.

high fat content may lead to health problems, yet the taxation of these items is not affected by the bill.

2. Health-related assessments

a. Assessment on corporate alliance employers (sec. 7121(a) of the bill and new sec. 3461 of the Code)

Present Law

Under present law, employers are not required to maintain or to contribute to health plans on behalf of employees. In addition, if an employer elects to maintain a health plan on behalf of its employees, the employer generally may determine the level of contributions it will make to the plan and the level of contributions made by employees, as well as the options available to employees under the plan.

Description of Provision

Corporate alliances

In general under the bill, nonexcluded employers with more than 5,000 full-time employees (large employers), certain multiemployer plans,[28] rural electric cooperatives, rural telephone cooperatives,[29] and the U.S. Postal Service could elect to provide health care coverage through corporate alliances rather than purchasing coverage through regional alliances. The following employers would not be entitled to maintain a corporate alliance: an employer whose primary business is employee leasing; the Federal Government (other than the U.S. Postal Service); and a State government, a unit of local government, and an agency or instrumentality of government, including any special purpose unit of government.

Eligible full-time employees of a large employer that elected to form a corporate alliance would be eligible to enroll in a health plan offered by the alliance. Part-time employees would not be eligible to enroll in a corporate alliance, but would be eligible to enroll in a regional alliance. The following individuals also would not be eligible to enroll in a corporate alliance: recipients of Aid to Families with Dependent Children (AFDC); recipients of supplemental security income (SSI) benefits; certain military personnel and their families, veterans, and Indians who have coverage under another health plan; seasonal or temporary workers (as defined by the National Health Board), other than workers who are treated as eligible to enroll in a corporate alliance health plan pursuant to a collective bargaining agreement. In general, a full-time employee would be an employee who is employed for at least 120 hours in a month. An employee who is not so employed would also be a full-time employee for a month or for all months in a 12-month period, if the employee is employed by the employer on a continuing basis that, taking into account the structure or nature of the employment

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[28] A multiemployer plan may form a corporate alliance if (1) the plan offered health benefits as of September 1, 1993, and (2) as of both September 1, 1993, and January 1, 1996, the plan (a) has more than 5,000 active participants in the United States or (b) the plan is maintained by one or more affiliates of the same labor organization (or one or more affiliates of labor organizations representing employees in the same industry) covering more than 5,000 employees.

[29] Rural electric and telephone cooperatives may maintain a corporate alliance with respect to a group health plan maintained by such cooperative if (1) the plan offered health benefits as of September 1, 1993, and (2) as of both September 1, 1993, and January 1, 1996, the cooperative has more than 5,000 full-time employees in the United States entitled to benefits under the plan.

in the industry, represents full-time employment pursuant to rules established by the National Health Board.

In general, if an individual is eligible to participate in a corporate alliance, then the individual and his or her family would be required to participate in a health plan of the corporate alliance. Special rules would apply if both the individual and his or her spouse were employed by different employers. Thus, if an employee covered under a corporate alliance is married to a working individual covered under another corporate alliance or a regional alliance, then they may choose where to be covered.

An employer would have only one opportunity to elect to form a corporate alliance. If the employer did not elect to form a corporate alliance when first eligible to do so, it could never do so. The election to maintain a corporate alliance could be terminated voluntarily by the employer. In addition, the election would be terminated if the number of full-time employees falls below 4,800. The Department of Labor could terminate an election if it finds that the alliance has failed to fulfill its requirements or that it is in violation of the requirements relating to prohibition against excess increase in premium expenditure. If an election terminates for any reason, the employer could not again elect to form a corporate alliance.

The premium charged by a corporate alliance for health care coverage could vary only by class of family enrollment and by premium area. Corporate alliances would be required to designate premium areas, which would be required to reasonably reflect labor market areas or health care delivery areas and to be consistent with rules to be established by the Secretary of Labor. The employer premium for corporate alliance employers for a class of family enrollment for a family residing in a premium area would be 80 percent of the weighted average monthly premium of the corporate alliance health plans offered by the corporate alliance for that class of enrollment for families residing in that area. In addition, corporate alliance employers would be required to subsidize the premiums of full-time workers who have wages of less than $15,000 on an annualized basis. The $15,000 threshold would be indexed annually for inflation after 1994.

A transition period would apply with respect to employer premium payments of an employer that is eligible to form a corporate alliance but elects not to or forms an alliance that is later terminated. During the first 7 years after the employer participates in a regional alliance, if an eligible employer has high-risk workers (relative to the regional alliance community at large) and purchases health insurance through regional alliances, the employer would not be eligible to purchase health insurance at premiums reflecting community rating, but would be required to pay an additional excess risk amount. The amount that would be required to be paid for excess risk would be phased down over 7 years. In the first 4 years, the amount that would be required to be paid would be 100 percent of the excess risk amount; for the 5th year it would be 75 percent of such amount; for the 6th year it would be 50 percent of such amount; and for the 7th year, it would be 25 percent of such amount.

In general, the employer premium payment for a regional alliance would be capped at 7.9 percent of the employer's wages.[30] In the case of an employer that is eligible to participate in a corporate alliance but does not, or in the case of a terminated corporate alliance, the premium cap would be phased in over the first 7 years of regional alliance coverage. For the first 4 years, there would be no premium cap. For the 5th year, the premium would be reduced by 25 percent of the amount in excess of the cap. For the 6th year, the premium would be reduced by 50 percent of the amount in excess of the cap. For the 7th year, the premium would be reduced by 75 percent of the amount in excess of the cap. In later years, the cap would apply.

Assessment on corporate alliance employers

Under the bill, every corporate alliance employer would be required to pay an assessment of 1 percent of the employer's payroll for each calendar year. Payroll would mean the sum of: (1) wages (as defined for social security tax purposes, but without regard to the wage cap); (2) in the case of a sole proprietorship, the net earnings from self employment of the proprietor attributable to the trade or business; (3) in the case of a partnership, the aggregate of the net earnings from self employment of each partner which is attributable to such partnership; and (4) in the case of an S corporation, the aggregate of the net earnings from self employment (as defined under the bill) of each shareholder which is attributable to such corporation for the taxable year of such corporation. The tax would be imposed on total payroll, and thus would be imposed on all employees of the corporate alliance employer even if they do not obtain health coverage through the corporate alliance.

A corporate alliance employer would include any employer if any individual is provided with health coverage through any corporate alliance because the individual is employed by the employer. An employer would include any person for whom an individual performs services, of whatever nature, as an employee (as defined in Code sec. 3401(c)). For purposes of the bill, any individual who owns the entire interest in an unincorporated trade or business would be treated as the individual's own employer. In addition, a partnership would be treated as the employer of each partner and an S corporation would be treated as the employer of each shareholder of the corporation. All persons treated as a single employer under section 1901 of the Health Security Act would be treated as a single employer for purposes of the 1-percent assessment.

The 1-percent assessment would not apply to an employer that is a corporate alliance employer solely by reason of employees who are provided with health coverage through a corporate alliance sponsored by a multiemployer plan. In the case of an employer that is a corporate alliance employer in part (but not solely) by reason of such employees, the assessment on the employer would be determined without taking into account the payroll of such employees.

The 1-percent corporate assessment would be deductible by the employer. The assessment would be paid at the same time and in

[30] A lower premium cap would apply in the case of employers that have, on average, no more than 75 full-time equivalent employees and average wages of less than $24,000.

the same manner as employment taxes. For purposes of the provisions relating to the filing of tax returns and information reports and other rules relating to procedure and administration under subtitle F of the Internal Revenue Code, the 1-percent corporate assessment would be treated as an employment tax.

Effective Date

Every employer eligible to elect to be an eligible sponsor of a corporate alliance (other than an employer that is a corporate alliance employer solely by reason of employees who are provided with health coverage through a corporate alliance sponsored by a multiemployer plan) would be treated as a corporate alliance as of January 1, 1996, unless the employer irrevocably elects to waive its rights ever to be treated as such a sponsor. Thus, the assessment would be effective on January 1, 1996.

Discussion of Issues

The assessment on employers that choose to form a corporate alliance is equivalent to a 1-percent payroll tax. The proposal raises two fundamental questions: which employers will choose to be subject to the tax (i.e., by forming a corporate alliance) and who bears the tax?

Which employers will choose to be subject to the tax?

In general, an employer that has the option of providing health insurance through a corporate alliance will do so if the employer expects that, taking into account the corporate assessment, it will be cheaper to provide insurance through a corporate alliance rather than purchase it from a regional alliance. An employer might find it less costly to provide health insurance through a corporate alliance for a number of reasons. For example, the employer could have a younger, healthier labor force than is the norm for the region. As a consequence, average individual medical costs would be expected to be less for the firm's employees than for average employees covered under a regional alliance. If the firm's work force were healthier than the region's average, by not participating in the regional alliance the regional alliances' pool of insureds is made more risky. If a large number of "low risk" employees do not participate in a regional alliance, the regional alliance could experience greater outlays and greater costs. This potential problem is frequently referred to as "adverse selection." If adverse selection existed, it could confirm the firm's expectation that providing insurance through a corporate alliance would lower the firm's health insurance costs.

The payroll tax imposed on corporate alliances would increase the cost of providing insurance through a corporate alliance. As such it would make it less likely that firms would opt out of the regional alliances. To the extent that firms are discouraged from opting out, the risk pools of the regional alliances would be improved and adverse selection would be reduced, lowering the cost of health care to the regional alliances. However, the tax would not eliminate completely the incentive to opt out; rather, it would change the point at which the decision occurs. Those firms with the

very lowest risk employees still may find it in their interests to provide coverage through a corporate alliance.

Even if a firm did not have employees with lower than average health risks, in the absence of the assessment a firm might find it advantageous to establish a corporate alliance. This might occur because the insurance premiums charged by regional alliances might include costs not imposed on the corporate alliances. Such costs might include a portion of the cost of providing universal coverage or research and development expenses. To the extent that the cost of providing insurance through a corporate alliance is reduced by not having to pay such costs, the 1-percent payroll tax could be seen as extending some of these costs to corporate alliances.

Another reason that a firm may estimate that the costs of providing health insurance through a corporate alliance are less than the costs of joining a regional alliance could be that the firm is a more efficient manager of medical claims than the regional alliances or that it can negotiate better prices for care than the regional alliances.[31] If such cost savings do exist, by increasing the cost of maintaining a corporate alliance, the 1-percent payroll tax could have the effect of depriving an employer's employees of lower cost coverage.

There are other factors under the bill that also may affect whether it is less costly to provide health insurance through a corporate alliance or through a regional alliance. In general, regional alliance employers are subject to limits on premiums (i.e., the payroll caps) while corporate alliance employers are not. This would be expected to encourage employers to participate in regional alliances. However, a large employer is not fully eligible for the payroll cap until after it has been in a regional alliance for 7 years. In addition, during the first 7 years of regional alliance coverage, large employers must pay an excess risk premium if the employer has employees who are poorer than average health risks. This transition period reduces the attractiveness of purchasing insurance through a regional alliance. After the transition period, an eligible corporation may benefit from having elected to purchase health insurance through a regional alliance. An eligible employer must weigh the potential current costs of electing to purchase insurance through a regional alliance against potential future benefits.

Who bears the tax?

It is not clear who will ultimately bear the burden of the corporate assessment. It could be borne by employees, owners of the employer, or customers of the employer. Where the burden will fall depends on a variety of factors.

In a competitive labor market, firms must pay workers of a given productivity at least as much as they can earn elsewhere in the economy—otherwise they will switch jobs—but need not pay them more. From the firm's perspective, compensation includes all costs of hiring the worker, including cash compensation (e.g., wages and salary), noncash compensation (e.g., health care or other fringe

[31] Many large firms operate in many regions of the country. A firm could find that self insurance is more cost effective than purchasing insurance through multiple regional alliances because dealing with multiple regional alliances may increase administrative costs.

benefits), and payroll taxes. Employers are generally indifferent as to forms of compensation,[32] and labor markets generally do not respond to small changes in total compensation. Because of these factors, economists generally believe that payroll taxes are borne by employees. That is, if payroll taxes increase, then employers will generally respond by lowering some other form of compensation.[33]

To the extent the payroll tax would be borne by employees, it could be viewed as reducing the progressivity of the tax system because higher wage employees generally derive a greater proportion of their total income from nonwage income (e.g., interest and dividends) that would not be subject to the tax. In addition, the tax would not treat similarly situated individuals the same. The tax would not be applied to an employee's wages based on individual characteristics such as total income or family size, but rather on the nature of the employee's employer. Consequently, two otherwise identical individuals could bear different tax burdens because one works for a corporate alliance employer and the other works for a regional alliance employer.

It is not clear, however, that this payroll tax would be borne by employees. In part, this is because the tax is elective and would not be paid by all employers. It also depends on how many firms elect to form corporate alliances and what the health care costs of such firms are compared to other employers. Because these factors are not currently known, it is difficult to say what the ultimate result would be.

If the cost of health care (including the payroll tax) provided through a corporate alliance is greater than the cost of comparable health care provided by other employers, then the corporate alliance employer will not be able to pass the tax through to employees by lowering other compensation. If the employer attempted to do so, the employees could obtain greater compensation from another employer, and would change jobs. Therefore, to the extent that the corporate assessment increases the cost of providing health care above what it costs other employers, then it could be borne by the owners of the firm (in the form of lower profits) or the customers of the firm (if the firm is able to pass the increased cost along in the form of higher prices).

Note, however, that this analysis assumes that other employers' costs of providing health care remain the same. If there are enough other employers for whom the cost changes, then the change will be borne, at least in part, by employees as well. For example, if there is a sufficient number of corporate alliances with higher health care costs, then total compensation of employees may fall somewhat.

It is also possible that a corporate alliance employer could provide health care more cheaply than other employers. If that is the case, then the corporate alliance employer can provide the same compensation package as other employers but at a lower cost. In such a case, the owners of the firm are better off. That is, if the

[32] If some forms of compensation are not deductible to the employer as a business expense for tax purposes, then the employer may not be indifferent between forms of compensation.

[33] Employees paid the minimum wage present a somewhat different case because their cash compensation cannot be altered. The imposition of a payroll tax could result in eliminating minimum wage positions or it could be borne by employers to some extent depending upon the ability of employers to substitute other labor and capital for minimum wage employees.

firm can reduce the costs of providing health care, then the reduction adds to their profits and need not be passed on.

Additional issues

By relying on a similar tax base as the existing payroll taxes, the proposal would provide for relatively easy administration of and compliance with the tax. However, the proposed 1-percent payroll tax could create further incentives for erosion of that tax base. Employers and employees might find it in their interest to reduce payroll tax liability by compensating employees in forms that are not subject to the payroll tax or to seek additional exemptions from the payroll tax.

Under the bill, an employer in a corporate alliance would pay the 1-percent corporate assessment on part-time, seasonal, and other workers even though they are provided health insurance through a regional alliance. The assessment may create an incentive for the employer to eliminate such positions and contract for such labor services through an outside provider. Such an outcome would reduce total assessments paid by the employer without affecting the health benefits provided by the corporate alliance.[34]

The bill would provide that if a firm elects to purchase health insurance from a regional alliance it can never withdraw and form a corporate alliance. Thus, a firm could not elect to form a corporate alliance any time it perceives the health risks of its employees to be good and elect regional alliance coverage when it perceives the health risks of its employees to be poor. However, it also prohibits a firm from choosing to manage its own health insurance if it perceives that the administrative costs of the available regional alliances become inefficiently high over time. Because the election to participate in a regional alliance is irrevocable, an employer may form a corporate alliance when the Health Security Act is first enacted because it will not be able to analyze whether the regional alliance will be more cost effective. Thus, some employers may bear the burden of the corporate assessment even if it is not a cost-effective decision during the first years after the bill is effective until they determine whether it is beneficial in the long run.

b. Temporary assessment on employers with retiree health benefit costs (sec. 7121(b) of the bill and new sec. 3462 of the Code)

Present Law

Under present law, employers are not required to maintain or to contribute to health plans on behalf of former employees. In addition, if an employer elects to maintain a health plan on behalf of its former employees, the employer generally may determine the level of contributions it will make to the plan and the level of contributions made by former employees, as well as the options available to employees under the plan.

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[34] Similarly, given the overall provisions of the bill, employers may find it advantageous to eliminate low-wage positions and contract for such labor services (e.g., custodial services) from independent firms that predominantly hire low-wage employees. These latter firms may qualify for subsidies for health costs for which the firm establishing the corporate alliance would not qualify.

In general, the extent to which an employer can terminate or amend a plan providing health benefits for former employees is determined by the contract consisting of the plan documents, insurance contracts, or other relevant documents. If the employer retains the right to amend or terminate the benefits, it generally may do so.

Description of Provision

In general, the bill would provide that the cost of providing the comprehensive benefit package to retirees between the ages of 55 and 65 is to be paid by the Federal Government. In some cases, employers may have had plans which obligated them to pay these retiree medical costs. To prevent a windfall to such employers, the bill would impose a temporary assessment on employers with base period retiree health costs. The assessment for a year would be equal to 50 percent of the greater of (1) the adjusted base period retiree health costs of the employer for the year, or (2) the amounts (determined in the manner to be prescribed by the Secretary) by which the employer's applicable retiree health costs for such calendar year were reduced by reason of the enactment of the Health Security Act.

"Base period retiree health costs" would mean the average of the applicable retiree health costs of the employer for calendar years 1991, 1992, and 1993. "Adjusted period retiree health costs" would mean the base period retiree health costs adjusted in the manner prescribed by the Secretary of the Treasury to reflect increases in the medical care component of the Consumer Price Index during the period after 1992 and before such calendar year. Rules similar to the rules of section 41(f)(3) (relating to adjustments to the research and development credit in the case of business transactions) would apply in determining adjusted base period retiree health costs in the case of acquisitions and dispositions after December 31, 1993. In general, these rules would increase the adjusted base period retiree health costs by costs attributable to acquisitions of the employer, and would decrease by dispositions of the portion of a business by the employer.

"Applicable retiree health costs" would mean, for any year, the aggregate cost (including administrative costs) of the health benefits or coverage provided during the year (whether directly by the employer or through a sec. 401(h) plan or a welfare benefit fund) to individuals who are entitled to receive such benefits or coverage by reason of being retired employees between ages 55 and 65 (or by reason of being a spouse or other beneficiary of such an employee).

The assessment applies to governmental and tax-exempt employers as well as otherwise taxable employers.

The assessment for each year would be paid on or before March 15 of the following year, but the Secretary of the Treasury would require quarterly estimated payments. Reporting requirements and interest and penalties for failure to make timely payment would apply in the same manner as in the case of Federal employment taxes.

Effective Date

The assessment would apply to calendar years 1998, 1999, and 2000.

Discussion of Issues

The Health Security Act would relieve employers from at least a portion of their retiree health benefit obligations and transfer such obligations to taxpayers as a whole. This results in a financial windfall to employers who were obligated to provide such benefits, and also may have the collateral effect of relieving employer obligations to disclose such retiree health liabilities on their financial statements. The temporary assessment can be viewed as a means of recapturing what would otherwise be a windfall to such employers.

The amount of the assessment does not match the amount of obligation shifted from the employer, but may be a more administrable alternative than determining the amount of reduced employer liability. The bill would only relieve employers of the liability for the comprehensive benefit package. In some cases, employers may be obligated contractually to provide greater benefits. Because the assessment is based on total cost, it will include an assessment for obligations for which the employer is still liable. In such cases, the assessment plus the amount the employer is still required to pay could be more than the employer would have paid in the absence of the bill. This will occur when the employer has supplemental coverage costs well in excess of the costs of the comprehensive benefit package. The assessment may also be less than the employer would otherwise have paid. In such a case, the Federal Government will subsidize more of the cost of the benefits than it does under present law.

Some would argue that the employer may not in all cases have a fixed obligation to pay retiree health benefits and that it might not have continued the plan or the same level of benefits. Thus, the imposition of the assessment could be viewed as unfair because it is based on an employer's obligations to pay retiree health benefits in 1991, 1992, and 1993, and does not adjust for changes in the employer's obligation that occur because of changes in plan design. However, the assessment operates to prevent employers from decreasing obligations merely to avoid the assessment. The temporary nature of the assessment may also be a recognition of the fact that employer retiree health obligations are not necessarily constant and, the more time passes, the more difficult it may be to say that the costs would have remained the same.

3. Recapture of certain health care subsidies received by high-income individuals (sec. 7131 of the bill, sec. 6050F of the Code, and new secs. 59B and 6050Q of the Code)

Present Law

Medicare

Medicare, authorized under Title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital in-

surance (Part A) program and the supplementary medical insurance (Part B) program.

Most Americans age 65 or older are automatically entitled to protection under Part A. Persons age 65 or older who are not "fully insured" (i.e., not eligible for monthly social security or railroad retirement cash benefits) may obtain coverage, providing they pay the full actuarial cost of such coverage. For those who are not automatically entitled to Part A benefits, the monthly premium, as of January 1, 1993, is $221. Also eligible, after a 2-year waiting period, are people under age 65 who are receiving monthly social security benefits on the basis of disability and disabled railroad retirement system annuitants. (Dependents of the disabled are not eligible.) Individuals who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under Part A regardless of age.

Part B of Medicare is voluntary. All persons age 65 or older (whether "insured" or not) may elect to enroll in the supplementary medical insurance program by paying the monthly premium. Persons eligible for Part A by virtue of disability or chronic kidney disease may also elect to enroll in Part B. The flat premium for 1993 is $36.60 per month. The premium rate is equal to 25 percent of estimated program costs for the coming year. Each individual who enrolls in Medicare Part B pays the same premium regardless of his or her income level. Benefits under Part A and Part B of Medicare are excludable from the gross income of the recipient.

Health coverage for early retirees

Retirees under the age of 65, often referred to as early retirees, generally are not eligible for Medicare benefits. Moreover, under present law, the Federal Government does not otherwise subsidize the cost of an early retiree's health coverage. Although employers are not required to provide health care coverage to former employees, many employers maintain health plans for retirees under the age of 65. Such plans pay for all or a portion of the medical costs of the retired employees of the employer (and possibly their dependents) either directly or through insurance. The employer may finance all or a portion of the cost of this benefit for the retiree. For retirees under the age of 65, the employer-sponsored health benefit normally represents the primary source of medical insurance. Some employers provide coverage to early retirees which terminates when the retiree attains age 65.

Under present law, the value of employer-provided coverage under a health plan that provides retiree health benefits to former employees, their spouses, or dependents is generally excludable from gross income (sec. 106). The exclusion applies whether the coverage is provided by insurance or otherwise. Thus, for example, the exclusion applies if the employer pays insurance premiums for retiree health coverage, or provides retiree health benefits through a trust.

In addition, present law generally excludes from gross income amounts that are paid directly or indirectly to a former employee to reimburse him or her for expenses incurred for the medical care of the former employee or his or her spouse or dependents. The ex-

clusion applies whether the benefits are paid for by employer contributions (sec. 105) or employee contributions (sec. 104).

Description of Provision

In general

Under the bill, taxpayers with modified adjusted gross income above a threshold amount would be required to pay additional premiums for coverage under Part B of Medicare. In addition, under the bill, eligible retirees and qualified spouses and children would be eligible to receive a Federal subsidy equal to the employer share of the health care premium for full-time employees under the comprehensive benefit package. Eligible retirees and qualified spouses and children with modified adjusted gross income above the threshold amount would be required to pay the employer share of their premium for health care under the nationally guaranteed comprehensive benefits package.

For the purpose of both of these additional payments, modified adjusted gross income would be adjusted gross income plus tax-exempt interest, certain foreign source income, and income from higher education U.S. savings bonds. The modified adjusted gross income of married taxpayers filing joint returns would be the combined modified adjusted gross income of both spouses.

For the purpose of both of these payments, the threshold amount would be $90,000 for unmarried taxpayers, $115,000 for married taxpayers filing joint returns, and $0 for married taxpayers filing separate returns. If a taxpayer's modified adjusted gross income for any taxable year exceeded the threshold amount by less than $15,000 ($30,000 for married taxpayers filing joint returns if each spouse were required to pay additional premiums), the amount of any additional payments imposed under this provision would be computed by multiplying the total amount due for the taxable year by a ratio, the numerator of which would be the amount of the taxpayer's modified adjusted gross income above the threshold amount and the denominator of which would be $15,000 ($30,000 for married taxpayers filing joint returns if each spouse is required to pay additional premiums).

Any additional premiums imposed under this provision would be treated as income taxes for purposes of subtitle F of the Code (relating to income tax procedure and administration) but would not be treated as income taxes for alternative minimum tax purposes (sec. 55) or for the purpose of determining the amount of other tax credits under the Code. Finally, additional premiums imposed under this provision would be considered deductible to the same extent as other health insurance premiums and would be excludable from the recipient's gross income if paid by a former employer.

Under the provision, penalties for failure to pay estimated income tax would not be imposed on a taxpayer for any period prior to April 16, 1997, to the extent that the underpayment resulted from the failure to pay additional Medicare Part B premiums. In addition, penalties for failure to pay estimated income tax would not be imposed on a taxpayer for any period prior to April 16, 1999, to the extent that the underpayment resulted from the failure to

pay additional premiums for health care coverage under this provision.

Additional Medicare Part B premiums

Under the bill, taxpayers with modified adjusted gross income above the threshold amount would be required to pay additional Medicare Part B premiums for each month of enrollment in Part B of Medicare. The additional monthly amount would be equal to the excess of 150 percent of the monthly actuarial rate for Medicare Part B enrollees age 65 or older over the monthly Medicare Part B premium.

Proceeds from the collection of additional Medicare Part B premiums would be credited at least quarterly to the Supplemental Medical Insurance Trust Fund.

Additional health care premiums

In general

Under the bill, eligible retirees and qualified spouses and children would be eligible to receive a Federal subsidy equal to the employer share of the health care premium for full-time employees under the comprehensive benefit package. For this purpose, the employer share of an individual's health care premium generally would be 80 percent of the average premium charged by health plans in the individual's health alliance for the individual's class of enrollment.[35] Under the recapture provision, eligible retirees and qualified spouses and children with modified adjusted gross income above the threshold amount would be required to pay the employer share of their premium for health care under the comprehensive benefits package. For purposes of the Federal subsidy and this provision, the determination of whether an individual is an eligible retiree or a qualified spouse or child would be made on a monthly basis. An individual would be required to establish his or her status as an eligible retiree or qualified spouse or child by filing an application with the regional alliance in the area in which the individual resides.[36]

Definition of eligible retiree

An individual would be considered an eligible retiree for a month if, as of the first day of the month, such individual (1) is between the ages of 55 and 65, (2) is not employed on a full-time basis,[37] (3) is not currently eligible for Medicare coverage, and (4) would have satisfied the employment requirements for Medicare Part A eligibility at age 65.

Definition of qualified spouse or child

An individual would be considered a qualified spouse for a month if the spouse is under age 65 and has been married to the eligible

[35] Sections 6121 and 6122 of the Health Security Act.

[36] Under the bill, if an individual makes any material misrepresentations relating to his or her status as an eligible retiree or qualified spouse or child to a regional alliance, he or she would be required to pay a penalty to the State in which the regional alliance is located equal to the greater of $2,000 or three times the excess payments made based on the misrepresentation (secs. 6114(d) and 1374(i)(2) of the Health Security Act).

[37] Eligible retirees who work at least 120 hours in a month would be considered full-time employees (secs. 6114(b)(2) and 1901(b)(2)(A) of the Health Security Act).

retiree for at least one year. An individual would be considered a qualified child for a month if the individual is a child of the eligible retiree.

Under the bill, the surviving spouse of an eligible retiree would also be considered a qualified spouse for a month if he or she (1) has not remarried, (2) was married to the eligible retiree at the time of his or her death, (3) is under age 65, (4) is not employed on a full-time basis,[38] and (5) the deceased spouse would still have been considered an eligible retiree for the month at issue if such spouse had not died. If a surviving spouse would be considered a qualified spouse for a month, his or her children also would be considered qualified children for the month.

Effective Date

The provisions relating to additional Medicare Part B premiums would be effective for taxable years beginning after December 31, 1995. The provisions relating to additional health care premiums would not become effective until January 1, 1998, which is when the Federal subsidy would first be provided.

Discussion of Issues

Additional Medicare Part B premiums

Under present law, the Federal Government subsidizes 75 percent of the cost of coverage under Part B of Medicare because the premium rate only covers 25 percent of estimated program costs for the coming year. The subsidy applies to all Medicare Part B enrollees regardless of their income levels. Supporters of the provision in the bill would argue that high income taxpayers should pay a greater share of the premiums for coverage under Medicare Part B because they can afford the additional premium.

On the other hand, many would argue that high-income taxpayers have the same need for health coverage as low-and middle-income taxpayers. If Medicare Part B benefits are not provided to them at the same cost as other enrollees, they may not enroll in Medicare Part B. In addition, some would argue that phasing in an additional premium payment as a taxpayer's income rises complicates the tax laws.

Additional health care premiums

Under the bill, the Federal Government would subsidize approximately 80 percent of the cost of the health coverage of early retirees and their dependents whose modified AGI does not exceed the threshold. Supporters of the provision would argue that the Federal Government should not subsidize the health care coverage of high-income early retirees and their dependents because they can afford to pay for their own health insurance. Some would argue that the provision would not effectively recapture the Federal subsidy because the income thresholds are too high.

Others would argue that the bill treats high-income early retirees and their dependents who would be entitled to coverage under

[38] Surviving spouses who work at least 120 hours in a month would be considered full-time employees (secs. 6114(c)(2)(C) and 1901(b)(2)(A) of the Health Security Act).

an employer-provided retiree health plan unfairly. Under the bill, former employers in effect would be relieved of at least a portion of their retiree health benefit plan liabilities regardless of whether the early retirees have vested contractual rights to employer-provided retiree health coverage.[39] Many would argue that it is unfair to require high-income early retirees to pay the full cost of their health care premium under the comprehensive benefit package while their former employers receive a subsidy from the Federal Government. Some argue that the subsidy results in a financial windfall to employers who were obligated to provide retiree medical benefits, and also has the collateral effect of relieving employer obligations to disclose such retiree health liabilities on their financial statements. They would also argue that it is unfair for the Federal Government to in effect rewrite the contractual agreement between an early retiree and his or her former employer especially where an early retiree retired in reliance on a promise to receive employer-provided health coverage at no cost or reduced costs.

Supporters of the provision would argue that the force of these arguments is not clear since former employers might reimburse their early retirees (on a tax-free basis) for the cost of the additional premiums, especially in the case of employees who have not yet retired and who may be able to negotiate such reimbursement prior to their retirement. Of course, unless there is a contract requiring such reimbursement, the employer is under no obligation to do so.

Others would argue that former employers may be unwilling to reimburse their early retirees for the cost of additional premiums in light of the temporary assessment on employers with retiree health benefit costs contained in the bill[40] and the requirement that certain employers pay 20 percent of the weighted-average premium for the health coverage of their early retirees under the comprehensive benefit package.[41] They point out that the determination of whether a former employer is contractually obligated to reimburse its early retirees for the cost of additional premiums is likely to provoke litigation in this area.

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[39] Employer-provided retiree health plans are subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and in the case of collectively-bargained plans, the Labor Management Relations Act ("LMRA"). Under present law, the determination of whether a retiree has vested rights to employer-provided health coverage depends on the contract between the employer and the retiree as evidenced by the official health plan documents required by ERISA and any applicable collective bargaining agreements. When the official plan documents are silent or ambiguous on the vesting issue, courts will also consider extrinsic evidence in order to determine the contractual intent of the parties. Many courts have held that retirees have vested rights to retiree health coverage at no cost or reduced cost and have prohibited employers from amending or terminating the retiree health benefits of employees after retirement. *Armistead* v. *Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991), *Schalk* v. *Teledyne*, 751 F. Supp. 1261 (W.D. Mich. 1990), *aff'd*, 948 F.2d 1290 (6th Cir. 1991), *Weimer* v. *Kurz-Kasch*, 773 F.2d (6th Cir. 1985), *Eardman* v. *Bethlehem Steel Corp.*, 607 F. Supp. 196 (W.D.N.Y. 1984), *UAW* v. *Yard-man, Inc.*, 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007, 104 S. Ct. 1002, 79 L.Ed. 2d 234 (1984).

[40] The temporary assessment on employers with retiree health benefit costs is described in Part III.A.2.b of the pamphlet.

[41] Under section 1608 of the Health Security Act, employers that as of October 1, 1993, had paid at least 20 percent of the premium (or premium equivalent) for the health coverage of their eligible retirees and qualified spouses and children (as those terms are defined in the bill) would be required to pay 20 percent of the weighted average premium for the health coverage of such individuals under the comprehensive benefit package. The weighted average premium would be based on the individual's class of enrollment and the regional alliance in which the individual resides. The requirement would not affect any employer obligations under collective bargaining agreements.

4. Modification of self-employment tax treatment of certain S corporation shareholders and partners (sec. 7141 of the bill and sec. 1402 of the Code)

Present Law

Employment taxes, in general

As part of the Federal Insurance Contributions Act (FICA), a tax is imposed on employees and employers up to a maximum amount of employee wages. The tax is composed of two parts: old-age, survivor, and disability insurance (OASDI) and Medicare hospital insurance (HI). For wages paid in 1993, to covered employees, the OASDI tax rate is 6.2 percent on both the employer and employee on the first $57,600 of wages and the HI tax rate is 1.45 percent on both the employer and employee on the first $135,000 of wages.

Similarly, under the Self-Employment Contributions Act (SECA), a tax is imposed on an individual's net earnings from self-employment (NESE). The SECA tax rate is the same as the total FICA rates for employers and employees (i.e., 12.4 percent for OASDI and 2.9 percent for HI) and, for 1993, is capped at the same levels. In general, the SECA tax is reduced to the extent the individual had wages for which FICA taxes were withheld during the year.

The cap on wages and NESE subject to the OASDI portion of FICA and SECA taxes is indexed to changes in the average wages in the economy. The cap on wages and NESE subject to the HI tax is repealed for wages and income received after December 31, 1993.

Treatment of partners and S corporation shareholders

The NESE of a partner in a partnership generally is the partner's distributive share of income or loss from any trade or business of the partnership, adjusted for certain items of income that are passive in nature (e.g., rentals of real estate, dividends, and interest are excluded from NESE unless such amounts are received in the course of a trade or business of a dealer in the related property). However, the distributive share of a limited partner generally is excluded from NESE except to the extent the distributive share is a guaranteed payment for services actually rendered to or on behalf of the partnership.

Similar rules are not provided for shareholders in S corporations.[42] Thus, shareholders are not required to include as NESE their pro rata share of the income of an S corporation.[43] Rather, shareholders who perform services for the S corporation are subject to FICA taxes on the wages paid to them.[44]

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[42] For some purposes, a shareholder that owns more than 2 percent of the stock of an S corporation is treated as a partner in a partnership (sec. 1372(a)). However, this rule does not apply for employment tax purposes.

[43] See, Rev. Rul. 59-221, 1959-1 C.B. 225.

[44] Furthermore, a shareholder of an S corporation may be subject to FICA tax even if the shareholder is not paid amounts denominated as "wages" by the corporation. In Rev. Rul. 74-44, 1974-1 C.B. 287, the IRS held that two shareholders who performed services for an S corporation but did not draw salaries were subject to FICA tax on dividend distributions from the corporation because the dividends represented reasonable compensation for the services performed. The present-law validity of this 1974 ruling following the substantial revision of the rules that apply to S corporations and their shareholders in 1982 is unclear. See also, *Radtke* v. *U.S.*, 895 F. 2d 1190 (7th Cir. 1990) and *Spicer Accounting, Inc.* v. *U.S.*, 918 F.2d 90 (9th Cir 1990), with respect to taxable years 1981 and 1982.

However, it is the present position of the IRS that if a shareholder is an officer of an S corporation and performs substantial services, such shareholder is an employee of the corporation

Description of Provision

The provision would: (1) amend the definition of NESE to include the pro rata share of certain S corporation income of certain shareholders and (2) modify the NESE rules applicable to limited partners in a partnership, for SECA tax and health insurance premium purposes.

Under the provision, in the case of a "2-percent shareholder" of an S corporation for any taxable year who materially participates in the activities of the corporation during the year, NESE would include the shareholder's pro rata share of taxable income or loss from "service-related businesses" carried on by the S corporation. A "2-percent shareholder" would be any shareholder that owns more than 2 percent of the stock of an S corporation at any time during the year (sec. 1372(b)). The shareholder's pro rata share of the income or loss of an S corporation would be determined pursuant to the general rules of subchapter S (sec. 1366). A "service-related business" would be any trade or business involving the performance of services in the fields of health, law, engineering, architecture, accounting, actuarial services, performing arts, consulting, athletics, financial services, brokerage services, or any trade or business where the principal asset is the reputation or skill of one or more of its employees. The present-law exclusions from NESE for certain passive income that apply to partnerships would also apply to S corporations.

The provision also would amend the treatment of limited partners in a partnership by providing that the distributive share of a limited partner would be excluded from NESE only if the partner does not materially participate in the activities of the partnership. The provision retains the present-law guaranteed payment rule for limited partners who provide services for the partnership.

The provision would make conforming amendments to the Social Security Act.

Effective Date

The provision would apply to taxable years of individuals beginning after December 31, 1995, and to taxable years of S corporations and partnerships ending with or within such taxable years of individuals.

Discussion of Issues

Disparities created by present law

In general, partnerships and their partners and S corporations and their shareholders are treated similarly for Federal income tax purposes. The income of a partnership or S corporation is not subject to tax at the entity level, but rather is flowed-through to the partners or shareholders and reported on their individual income tax returns, regardless of whether or when the income is actually distributed to the individuals. In contrast, the income of a subchapter C corporation is subject to an entity-level income tax when

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whose income is subject to FICA (but not SECA) tax. See, Department of the Treasury, "Tax Guide for Small Businesses" (for use in preparing 1992 returns), Publication 334, p. 136.

it is earned and is subject to the individual income tax when it is distributed to the individual shareholders of the corporation.

The SECA tax on the earnings of self-employed individuals parallels the FICA tax on the wages of employees. Both taxes are intended to be imposed on remuneration received for one's own labor. Under this theory, income that is a return on capital investment should not be subject to SECA. Difficulties arise when an individual provides both investment capital and labor services to an enterprise and has control over whether the remuneration for such services is in the form of salary (subject to FICA) or a distribution of the net earnings of the enterprise (generally subject to neither FICA nor SECA when distributed). This issue is less problematic with respect to services provided by a shareholder-employee of a subchapter C corporation because there is an incentive to pay the individual a salary (subject to FICA) in order to claim a corporate income tax deduction for such amount. However, no such incentive generally applies with respect to flow-through entities. Thus, rules are needed to determine what portion, if any, of the income of a partnership or S corporation is subject to SECA at the partner or shareholder level.[45]

Present law treats all trade or business income earned by a partnership and allocated to *general* partners as NESE, regardless of whether such partners are material participants or mere investors. Thus, present law assumes that all partnership trade or business income that is allocated to a general partner is remuneration for services performed by the partner. Income allocated to *limited* partners is not NESE (unless in the form of a guaranteed payment for services rendered), on the theory that such partners have limited participation in the operation of the partnership and should not be entitled to social security benefits by virtue of their investment.[46]

Under present law, income allocated to a shareholder in an S corporation is not subject to NESE. This exclusion may be based on the theory that because S corporations are allowed to have only one class of stock, a shareholder that provides services to the corporation would draw a salary for such services, while a passive co-investor shareholder would not.[47] For example, assume two individuals form an S corporation by making equal capital contributions. One shareholder provides services to the venture while the other does not. Because the two shareholders have an equal number of shares in the corporation, a salary (subject to FICA) is needed in order to adequately compensate the service provider. Any income remaining after the payment of the salary would be deemed a re-

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[45] It should be noted that because the determination of NESE generally is based on income tax rules, the method by which a business is capitalized also affects the NESE of the owner. A business that is capitalized with debt generally will generate lower NESE than an a business that is capitalized with equity because the returns on debt (interest expense) are deductible while the returns on equity (dividends, distributive share, etc.) are not.

[46] Legislative history indicates that the definition of NESE was amended to exclude distributive shares of limited partners because of a concern that certain business organizations were soliciting investments in limited partnerships as a means for the investor to become insured for social security benefits. House Ways and Means Committee Report on P.L. 95-216 (1977).

[47] Conversely, partnerships are viewed as entities that allow greater flexibility with respect to the allocation among the partners of income or loss from partnership activities. Partnerships do not pay salaries for services rendered by the partners. Rather, the partnership agreement may provide special allocations of partnership income to those partners who provide services to or on behalf of the partnership. Such allocations of income may be respected for Federal income tax purposes if they have substantial economic effect.

turn on the capital investments of the shareholders and subject to neither SECA nor FICA taxes. However, the application of this theory may result in an under-inclusion of earnings for employment tax purposes in some cases. For instance, if both shareholders in the example above provide an equal amount of services to the corporation, there is no need to pay salaries to equalize their contributions, and each shareholder's pro rata share of the corporate earnings would not be subject to SECA (although the IRS may contend that the shareholders are subject to FICA on all or a portion of the S corporation's earnings).[48]

If the two individuals in the two examples above formed a general partnership rather than an S corporation, each partner's distributive share of partnership trade or business income would be NESE, regardless of the level of activities by the partners. Thus, present law treats general partners in a partnership differently than shareholders in an S corporation for employment tax purposes, despite the fact that a partnership and its partners and an S corporation and its shareholders are treated similarly for income tax purposes.

Treatment under the provision

The provision would broaden the SECA base and narrow the disparate SECA treatment between income earned by partnerships and S corporations by treating as NESE the pro rata share of income of certain S corporation shareholders. Under the provision, NESE would include the pro rata share of S corporation income: (1) of a 2-percent shareholder; (2) who materially participates in the activities of the corporation; (3) but only to the extent the income is from a service-related trade or business. Each of these three tests raises certain issues.

Two-percent shareholders.—Present law treats 2-percent shareholders as individuals in control of the corporation for fringe benefit purposes (sec. 1372(a)). Thus, the "2-percent shareholder" test of the provision appears consistent with the present-law treatment of 2-percent shareholders for employment related purposes. In addition, in practice, most S corporation shareholders that are not 2-percent shareholders likely are employees whose wages are subject to FICA or minority investors who are not involved in the operations of the corporation.

Material participation.—Under the provision, a 2-percent shareholder need not include his or her pro rata share of S corporation earnings as NESE unless the shareholder materially participates in the activities of the S corporation. This test may be appropriate under the theory that a shareholder's pro rata share of S corporation earnings is not remuneration for the services provided by the shareholder unless the shareholder materially participates in the activities of the corporation.

In many instances, the material participation test may be redundant with the 2-percent shareholder test (e.g., in the case of an S corporation owned by a sole shareholder-employee). However,

[48] The identical issue arises if the corporation is owned by a sole shareholder. It is reported that, based on 1990 data, approximately 80 percent of S corporations have only one or two shareholders. Susan C. Nelson, "S Corporations: The Record of Growth After Tax Reform", *Journal of S Corporation Taxation*, Vol. 5, No. 2, Fall 1993, p. 146.

where there are multiple shareholders with multiple duties, a determination as to the material participation of each shareholder would be required. These determinations may be difficult. The provision does not define "material participation." The term is used under SECA to include certain farm rental income as NESE (sec. 1402(a)(1)),[49] as well as elsewhere in the Code to determine whether an individual may deduct losses from certain activities in which he or she materially participates (the passive loss rules of sec. 469). Under the passive loss rules, "material participation" means involvement in the operations of an activity on a basis that is "regular, continuous, and substantial," a more rigorous test than under section 1402.[50] Treasury regulations under sections 469 and 1402 provide further guidance as to when a taxpayer's involvement constitutes material versus passive participation, for the respective purposes of the two provisions. Despite this guidance, however, the determination of "material participation" under either section is often thought to be a difficult and subjective process.

The provision also would apply a material participation test (but not the "2-percent shareholder" or "service-related trade or business" tests) to limited partners. Section 469 provides that, except as provided in regulations, the activities of limited partners do not constitute material participation. Treasury regulations provide instances in which the activities of a limited partner override this presumption. In general, it is more difficult for a limited partner to sustain material participation than it is for a general partner under section 469.

Although "material participation" may be an appropriate standard for determining when the activities of an S corporation shareholder or limited partner give rise to earnings that should be subject to SECA, the application of such a standard may be administratively difficult. Conversely, if the application of the standard proves to be administratively feasible, consideration should be given to applying the standard to general partners in partnerships as well.

Service-related trade or business.—Under the provision, only the portion of the pro rata share of the income or loss of a 2-percent shareholder who materially participates that is attributable to certain service-related trades or businesses is subject to NESE. This test would require an S corporation to determine if it is engaging in such activities and, if it is, to segregate the earnings from such activities from earnings of other activities. "Service-related trade or business" is defined with reference to a provision that was enacted with the Omnibus Budget Reconciliation Act of 1993 that allows for a partial capital gains exclusion for the gain on the sale of the stock of certain corporations engaged in active trades or businesses (sec. 13113 of the 1993 Act, adding sec. 1202 to the Code). "Service-

[49] Under present law, the NESE of a owner or lessee generally does not include rent paid in a share of agricultural or horticultural production pursuant to an arrangement unless the owner or lessee materially participates in the production or management of the commodity produced.

[50] It should be noted that "material participation" is used for different purposes under sections 469 and 1402. Under section 1402, the term is used to expand the SECA tax base to include the farm income of certain individuals. Under section 469, the term is used to determine whether certain losses incurred by individuals are deductible for income tax purposes. Thus, under present law, an individual generally would want to be a "material participant" for income tax purposes with respect to loss-generating activities, but would not want to be a "material participant" for SECA purposes with respect to certain farm income-generating activities.

related trade or business" generally means the activities of certain professions that are more dependent upon personnel skills than upon capital investment.

The "service-related trade or business" test may create some administrative difficulties. It may be difficult for an S corporation to determine if it is engaging in covered activities, due to the relative newness and subjectivity of the term.[51] Furthermore, if an S corporation engages in more than one business, it would be required to segregate the earnings from covered activities from other activities (e.g., an allocation may be necessary if an S corporation is involved in both architectural design and building construction). Income determinations for separate trades or businesses are particularly difficult (and manipulable) where the different trades or businesses share common costs such as overhead or interest expense. In addition, the use of a "service-related trade or business" test may provide an incentive for a service provider to break-up a single business into separate lines of business in order to minimize its NESE (e.g., an accounting firm that prepares computer-generated tax returns may claim to be in two businesses--the provision of income tax advice and the mechanical preparation of tax returns.)

The "service-related trade or business" test may be deemed appropriate for SECA purposes on the theory that passive investors are unlikely to invest where the success of the business is dependent upon the skills of another individual rather than the application of capital. As such, the "service-related trade or business" test may be redundant with the "2-percent shareholder" and "material participation" tests and may add little other than complexity to the employment tax rules. Conversely, if an entity-level activity test is appropriate as a separate standard for SECA purposes and is administrable, the question arises as to whether the test should be applied to partnerships as well. For example, under the provision, NESE would include income from manufacturing activities conducted through a general partnership, but not through an S corporation.

Other employment tax exceptions

In many instances, the bases of the FICA and SECA payroll taxes are broader than the base of the income tax with respect to the earned income of individuals. For example, several deductions and exclusions that are allowed for income tax purposes are not allowed for employment tax purposes.[52] The provision would further expand the SECA base to include additional trade or business income of self-employed individuals by eliminating present-law exceptions with respect to the incomes of certain S corporation shareholders and limited partners. If one of the goals of the provision is to expand the employment tax bases to include as much earned income as possible, consideration should perhaps be given as to whether there are any other present-law exceptions and whether these exceptions are warranted. One question to be kept in mind

[51] Present-law sections 401(c)(2) (relating to employee benefit plans) and 911(d)(2) (relating to an exclusion for foreign earned income) also provide distinctions between income earned from personal services and other income. Neither definition was adopted by the provision.

[52] For example, the net operating loss deduction of section 172, the personal exemptions of section 151, and the exclusion for income earned abroad of section 911 are not allowed for SECA purposes.

in determining whether an employment tax exception is warranted is whether the individual should be entitled to social security (or health care) benefits by virtue of the activity to which the exception applies.

5. Extending Medicare coverage of, and application of hospital insurance tax to, all State and local government employees (sec. 7142 of the bill and sec. 3121 of the Code)

Present Law

Under present law, State and local government employees hired before April 1, 1986, are not covered under Medicare unless a voluntary agreement is in effect. Although the hospital insurance payroll tax does not apply to such employees, they may receive Medicare benefits, for example, through their spouse. Medicare coverage (and the hospital insurance payroll tax) is mandatory for State and local government employees hired on or after April 1, 1986, and Federal employees.

For wages paid in 1993 to Medicare-covered employees, the total hospital insurance tax rate is 2.9 percent of the first $135,000 of wages. However, all wages paid after December 31, 1993, to Medicare-covered employees will be subject to hospital insurance taxes. One-half of the hospital insurance tax is imposed on the employee and one-half on the employer.

Description of Provision

The provision would extend Medicare coverage on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. These employees and their employers would become liable for the hospital insurance tax, and the employees would earn credit toward Medicare eligibility. In addition, the service of State and local government employees prior to October 1, 1995, would be considered covered employment for purposes of determining eligibility for Medicare coverage.

Under the provision, the Department of the Treasury would be required to reimburse the Federal Hospital Insurance Trust Fund for additional payments made, administrative expenses incurred, and any interest losses which occur as a result of the provision.

Effective Date

The provision would apply to services performed by State and local government employees after September 30, 1995.

Discussion of Issues

Under the provision, all State and local government employees would be treated similarly with regard to Medicare eligibility and the corresponding hospital insurance payroll tax. Proponents of the provision argue that it promotes sound tax and health care policy because there is no policy justification for treating State and local government employees differently for Medicare eligibility and hospital insurance tax purposes based on their date of hire. They also

argue that there is no policy justification for treating State and local government employees hired before April 1, 1986, differently than Federal or private sector employees for Medicare eligibility and hospital insurance tax purposes.

Proponents of the provision also point out that it is unfair for State and local government employees to receive Medicare benefits when they have not paid hospital insurance taxes to the same extent as all other employees. Under present law, State and local government employees hired before April 1, 1986, may receive Medicare benefits even though they have not paid any hospital insurance taxes while employed as State and government employees. The provision would resolve this problem.

Some would oppose the provision because governmental employers have relied on present law and the extension of hospital insurance coverage to State and local government employees hired before April 1, 1986 could impose a significant financial burden on such employers. In addition, the application of hospital insurance coverage to all State and local employees will occur over time as the class of employees hired before April 1, 1986, begins to retire. Thus, some would argue that the extension of hospital insurance coverage to such employees is unnecessary in light of the costs to governmental employers.

Subtitle B. Tax Treatment of Employer-Provided Health Care

1. Limitation on exclusion for employer-provided accident or health coverage (secs. 7201 and 7202 of the bill and secs. 106, 125, 3121(a), and 3231(e) of the Code)

Present Law

Exclusion for employer-provided accident or health coverage

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

Benefits paid under employer-provided accident or health plans are also generally excludable from income to the extent they are reimbursements for medical care (as defined in sec. 213) or to the extent the benefits constitute payments for the permanent loss of use of a member or function of the body or permanent disfigurement and are computed with reference to the nature of the injury and without regard to the period the employee is absent from work (sec. 105).[53]

Cafeteria plans

In general

Under present law, compensation generally is includible in gross income when actually or constructively received. An amount is constructively received by an individual if it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, no amount is included in the gross income of a participant in a cafeteria plan described in section 125 of the Code solely because, under the plan, the participant may elect among cash and certain employer-provided qualified benefits.

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

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

(sec. 117), educational assistance (sec. 127), or miscellaneous employer-provided fringe benefits (sec. 132). In addition, a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)).

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

The cafeteria plan exception from the principle of constructive receipt generally also applies for employment tax (FICA and FUTA) purposes.[54]

Nondiscrimination rules

The exception to the constructive receipt principle provided for cafeteria plans does not apply to highly compensated individuals if the plan discriminates in favor of such individuals as to eligibility to participate or as to contributions or benefits under the plan. A plan is not discriminatory as to eligibility if the plan benefits a nondiscriminatory classification of employees and requires no more than 3 years of employment as a condition of participation. Special rules apply for determining whether a plan that provides health coverage is discriminatory with respect to contributions and benefits. In addition, a plan is deemed not to be discriminatory if the plan is maintained pursuant to a collective bargaining agreement.

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

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

Flexible spending accounts

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

There is no special exclusion for benefits provided under an FSA. Thus, benefits provided under an FSA are excludable from income only if there is a specific exclusion for the benefits in the Code (e.g., the exclusion for employer-provided health or group-term life insurance coverage). FSAs that are part of a cafeteria plan must comply

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

with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)). According to proposed Treasury regulations, a cafeteria plan would permit the deferral of compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.[55] Thus, amounts in an employee's account that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the "use it or lose it" rule.

In addition, proposed Treasury regulations contain additional requirements that health FSAs must comply with in order for the coverage and benefits provided under the FSA to be excludable from income.[56] These rules apply with respect to a health FSA without regard to whether the health FSA is provided through a cafeteria plan (i.e., without regard to whether an employee has an election to take cash or benefits).

The proposed regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.[57]

Under the proposed regulations, the employer-provided health coverage under the FSA and the reimbursements and other benefits received under the health FSA will be excludable from an employee's income only if the health FSA satisfies certain additional requirements. According to the proposed regulations, health FSAs are required to (1) provide the maximum amount of reimbursement available under the FSA at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage), (2) offer coverage for 12 months or, in the case of a short plan year, the entire short plan year, (3) only reimburse medical expenses which meet the definition of medical care under section 213(d) of the Code, (4) reimburse medical expenses for which the participant provides a written statement from an independent third party stating the amount of the medical expense and that the medical expense has not been reimbursed or is not reimbursable under any other health plan, (5) reimburse medical expenses which are incurred during the participant's period of coverage, and (6) allocate experience gains with respect to a year of coverage among premium payers on a reasonable and uniform basis.[58]

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[55] Prop. Treas. Reg. 1.125-2 Q&A-5(a).
[56] Prop. Treas. Reg. 1.125-2 Q&A-7(b).
[57] Prop. Treas. Reg. 1.125-2 Q&A-7(c).
[58] Prop. Treas. Reg. 1.125-2 Q&A-7(b).

Description of Provisions

Exclusion for employer-provided accident or health coverage

In general

Under the bill, the present-law exclusion for employer contributions to an accident or health plan, including contributions to an FSA, would be limited to employer contributions for (1) comprehensive health coverage as described in section 1101 of the Health Security Act, (2) cost-sharing amounts under the comprehensive benefit package (including cost-sharing policies), or (3) permitted coverage. The value of employer-provided supplemental health coverage (as defined in sec. 1421(b) of the Health Security Act) would be includible in gross income and wages for income and employment tax purposes.

The bill would not affect the tax treatment of amounts received under an accident or health plan paid for by the employer. Such amounts would continue to be excludable from income to the extent excludable under present law.

Comprehensive health coverage

Under the bill, all employer contributions for coverage under the nationally guaranteed comprehensive benefit package, including employer contributions to an FSA would be excludable from income and wages.

Cost-sharing

Employer contributions for cost-sharing amounts (e.g., deductibles, copayments and coinsurance), including employer contributions for coverage under a cost-sharing policy, would also be excludable from income and wages. Under the bill, a cost-sharing policy would be defined to include a health insurance policy or health insurance plan which provides coverage for deductibles, coinsurance, and copayments imposed under the comprehensive benefit package, whether imposed under a higher cost-sharing plan or with respect to out-of-network providers.[59] The bill would also require cost-sharing policies to satisfy certain standards.[60]

Permitted coverage

Under the bill, permitted coverage would include (1) coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury, (2) coverage providing payment for permanent injuries of an employee, his or her spouse or a dependent that are computed with reference to the nature of the injury without regard to the period the employee is absent from work (i.e., coverage for payments described in sec. 105(c)), (3) coverage provided to an employee or former employee after such employee has attained age 65 unless such coverage is provided by reason of the current employment of the individual with the employer providing the coverage, (4) coverage under a qualified long-term care policy (as defined under the bill), (5) coverage provided under Federal law to veterans or any

[59] Section 1421(b)(2) of the Health Security Act.
[60] Section 1423 of the Health Security Act.

member of the Armed Forces of the United States and their spouses and dependents, and (6) any other employer-provided coverage which the Secretary of the Treasury determines should be excludable.

Flexible spending accounts

The bill's limits on the exclusion for employer-provided accident or health coverage would apply to coverage provided through an FSA just as it applies to other employer-provided accident or health coverage, except that the limits would have an earlier effective date. Thus, benefits provided through an FSA would be excludable from income only to the extent they are within the bill's limits. For this purpose, an FSA would be defined as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for such coverage is less than 200 percent of the value of such coverage. In the case of an insured plan, the maximum amount reasonably available would be determined on the basis of the underlying coverage.

Supplemental health coverage

In general, under the bill, any health benefits that are not provided under the comprehensive benefit package would be considered supplemental health benefits. Under the bill, a supplemental health benefit policy would be defined to include an insurance policy or health benefit plan that provides coverage for services and items not included in the comprehensive benefit package or coverage for items and services included in the package but not covered because of a limitation in amount, duration, or scope.[61] The bill would also require supplemental health benefit policies to satisfy certain standards.[62]

Valuation rules

Under the bill, the value of any employer-provided coverage would be based on the average cost of providing the coverage to those who receive it. The provision would permit cost determinations to be made on the basis of reasonable estimates to the extent provided by the Secretary of the Treasury.

Tax treatment of rebates

Under the bill, employers would be permitted to pay any portion of the employee's share of premiums for a health plan. If an employer pays part of an employee's premium, it must make the same dollar payment to all employees with the same family status in the same alliance. If the total employer contribution (mandatory and voluntary) for the employee's coverage exceeds the annual premium of the employee's health plan, the employee would be entitled to a

[61] Section 1421(b) of the Health Security Act.
[62] Section 1422 of the Health Security Act.

cash rebate equal to the excess amount.[63] The rebate would be taxable to the employee for both income and employment tax purposes. For example, suppose an employer pays for 100 percent of the total premium regardless of which plan the employee chooses. In such a case, because the bill would require the employer to make the same dollar payment to all employees, employees who do not choose the most expensive plan would receive a cash rebate equal to the difference between the employee premium for the most expensive plan selected by any employee and the employee premium for the plan selected by the employee. On the other hand, no rebates would occur if the employer pays the employee premium for the least expensive plan available to employees.

The bill would provide an exception to the general principle of constructive receipt for cash rebates. Under the bill, no amount would be included in the gross income of an employee solely because the employee may select coverage under a health plan which results in a cash rebate.

Cafeteria plans

Under the bill, the cafeteria plan exception from the principle of constructive receipt would not apply to employer-provided accident or health coverage or health FSAs offered under a cafeteria plan unless the coverage constitutes wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

Effective Date

The provision limiting the exclusion for employer-provided health coverage would be effective on and after January 1, 2004, except that it would apply to flexible spending accounts on and after January 1, 1997. The provision relating to the tax treatment of employer-provided accident or health coverage provided through cafeteria plans would be effective on and after January 1, 1997.

Discussion of Issues

Exclusion for employer-provided accident or health coverage

In general

The proposed limit on the exclusion for employer-provided health coverage can be evaluated from both a tax policy perspective and a health policy perspective. As is often the case with tax incentives provided to encourage certain behavior, what may be viewed as undesirable from a tax policy perspective may be justified because of the social policy goals that the incentives are intended to encourage. However, in the case of the exclusion of employer-provided health coverage, the tax policy considerations and the health policy considerations may not conflict. The following discussion analyzes these issues and raises certain other issues with respect to the proposal to limit the exclusion for health coverage.

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[63] Section 1607(b) of the Health Security Act. The equal payment rule and the rebate requirement would not apply to "voluntary" employer premium payments made pursuant to a collective bargaining agreement.

Tax policy considerations

From a tax policy perspective, the present-law exclusion for employer-provided health coverage is not justified because it results in mismeasurement of income. On a theoretical basis, the value of employer-provided health coverage is compensation that should be included in taxable income. The failure to include such value in income understates the income of those who receive such coverage.

The exclusion of employer-provided health coverage creates inequities in the operation of the Federal income system. An exclusion is worth more, that is, an exclusion saves more in foregone tax payments, to a taxpayer in a higher marginal tax bracket than to a taxpayer in a lower marginal tax bracket. Because marginal tax rates generally rise with income, higher income taxpayers benefit more than lower income taxpayers from the exclusion from income for the same health insurance coverage. This type of inequity is referred to as a vertical inequity.

In addition, the present-law exclusion also creates horizontal inequities. Taxpayers who receive the same total compensation but receive different amounts of excludable health coverage and taxable wages will have different tax liabilities. Although the bill would reduce such horizontal inequities by guaranteeing employer-provided health coverage and limiting the extent to which employer-provided health coverage is excludable from income and wages, horizontal inequities would still exist. This is because the bill would permit but would not require employers to pay any portion of the employee share of premiums and cost-sharing amounts under the comprehensive benefit package and would exclude such employer contributions from income and wages. Thus, under the bill, horizontal equity among employees would depend upon the extent to which employers pay for the employee share of health premiums and cost-sharing amounts. Horizontal inequities among employees could be further reduced if the bill limited the exclusion for employer-provided health coverage to the mandatory premium contributions that all employers are required to make on behalf of their employees under the bill.

Those in favor of the exclusion's repeal also point out that the exclusion narrows the tax base, thereby contributing to higher tax rates or reducing needed revenues. However, imposing limits on the exclusion may have the immediate effect of raising taxes for those who had employer-provided health benefits in excess of the limits. If this is undesirable, for example, because it increases the tax burden on lower- and middle-income taxpayers, some other adjustments may need to be made to offset this increased burden.

On the other hand, there are a number of possible nontax justifications for the exclusion of employer-provided health coverage. Even assuming that some nontax justification for the exclusion exists, the present-law exclusion may be subject to criticism on tax or fiscal policy grounds because it is not well-targeted, but provides an unlimited exclusion for all employer-provided health benefits with very few restrictions. As discussed below, the unlimited exclusion may lead to undesirable results from a health policy perspective. This also has fiscal policy implications, because it means that Federal monies are being spent on a program that does not achieve the desired result, and the deficit may be increased unnecessarily.

The unlimited exclusion for employer-provided benefits is somewhat of an anomaly in the Code. Other fringe benefits (such as the exclusion for employer-provided dependent care assistance) are limited in amount and virtually all excludable fringe benefits (other than health) are subject to nondiscrimination requirements.

Some analysts argue that to the extent medical expenses are non-discretionary, they represent a reduction in resources available to an individual for general use. This would suggest that such expenses not be included in taxable income. For example, if two individuals each earn $50,000 in cash wages, but one has annual unavoidable medical expenses of $10,000, some would argue that it is unreasonable to assume that both individuals have the same ability to pay for income tax purposes. That is, while they both have the same cash income, it might be considered unfair to impose equal tax burdens on them, since one does not have to incur the $10,000 cost of keeping healthy. To the extent that some medical expenses are discretionary, this argument is less persuasive. Also, the applicability of the argument to insurance premium payments, as opposed to direct out-of-pocket expenses, is less clear.

Health care policy considerations

It is important to consider whether the proposed limits on the exclusion for employer-provided health coverage promote sound health care policy and achieve the goals of health care reform. Many would argue that limiting or even repealing the exclusion for employer-provided health coverage is sound health care policy. The exclusion makes health care less expensive to an employee than it would be if the employee had to buy the health insurance on an after-tax basis. Thus, the exclusion will lead employees to prefer wages in the form of health care rather than in the form of taxable compensation and may lead them to purchase more health care services than they otherwise would. This may lead to overutilization of health care and contribute to increases in health care costs. Limiting the exclusion would cause employees to bear more of their health care costs and thus lead them to make different decisions about health care. Some argue that the exclusion limitations in the bill would not effectively cause employees to bear more of their health care costs and thus reduce overutilization of health care services because employer contributions for up to 100 percent of an employee's coverage under the comprehensive benefit package and cost-sharing amounts remain excludable from income and wages. They argue that the bill could reduce overutilization of health care services more effectively if the exclusion did not apply to the employee share of the comprehensive benefit package premium and all other cost-sharing amounts incurred by employees under the comprehensive benefit package, i.e., deductibles, copayments and coinsurance.

Further, it may be appropriate to repeal the exclusion for employer-provided health coverage because many of the stated health policy justifications for the exclusion would no longer apply under the health care system set forth in the Health Security Act.

Historically, the tax law has been structured to give incentives to employers (through statutory exclusions from gross income for employees) to provide health benefits to their employees. The statu-

tory exclusion from income and wages of employer-provided health coverage has been justified as a means to encourage broad-based health coverage of workers. Since the Health Security Act would guarantee access to health coverage for all Americans and would require all employers to contribute towards the cost of their employees' health coverage, this justification would no longer apply. Under this view, an exclusion for employer-provided health coverage would not be necessary or efficient, because it would provide a Federal subsidy for benefits guaranteed by the Health Security Act. In addition, the statutory exclusion has been said to provide an efficient means by which the Federal Government can encourage employers to provide employees with health benefits at lower cost through group coverage than if the benefits were purchased separately by individual workers. This justification for the statutory exclusion arguably no longer would apply under the Health Security Act because the regional alliances would provide the benefits of group rates to individuals regardless of employment status.

On the other hand, some argue that many employees value health care coverage as part of their compensation package and have bargained for health benefits in reliance on the availability of the exclusion. They argue that complete repeal of the exclusion would interfere with existing bargaining agreements and employee expectations. The delayed effective date for the bill's limitations on the exclusion may respond to such concerns. Those who disagree with this view argue that there is no guarantee that the tax exclusion for employer-provided health coverage will continue. Also, they argue that, at most, a delayed effective date for existing bargaining agreements is warranted. While terms of bargaining agreements differ, a typical term is 3 years.

Another function the exclusion for employer-provided health coverage can serve is to discourage certain behavior rather than encourage it. From this perspective, the proposal makes it more expensive for employees to purchase health insurance in excess of the guaranteed benefit package because they must do so on an after-tax basis. Thus, the proposal may lead employees to limit their health insurance to the guaranteed benefit package unless they expect to need benefits not covered by the guaranteed package. This may be viewed as desirable from a health policy perspective.

Perhaps the best way to view the exclusion for employer-provided health care is as a Federal subsidy for the purchase of health care. Federal tax subsidies are really a substitute for direct Federal spending. From this perspective, the issue is whether or not the exclusion provides an appropriate subsidy. What is an appropriate subsidy level is a policy decision.

The Health Security Act would provide a subsidy for guaranteed benefits for employees.[64] One rationale for subsidizing the guaranteed benefit package is that the package is in the nature of an entitlement that all Americans should be able to afford. However, as under present law, the exclusion retained in the bill does not pro-

[64] There are several other ways to design a Federal tax subsidy for employer-provided health coverage. For instance, the exclusion for employer-provided health coverage could be capped at a flat dollar amount or employees could be required to include in income a percentage of the value of health coverage in excess of a stated cap. Another way to reduce the Federal tax subsidy for employer-provided health care would be to deny employers a deduction for contributions for health coverage. Each of these designs has its own health and tax policy issues.

vide a subsidy for everyone who purchases health care, but only for those who are employed. Thus, the level of the subsidy will vary based on whether or not an individual is employed and the extent to which the employer pays for health premiums. This will create inequities between individuals based solely on employment. This inequity could be avoided by providing the subsidy directly to individuals regardless of employment status, for example, in the form of a tax credit for a portion of premiums paid for health care. The inequity could be reduced, but not eliminated, by limiting the exclusion to a dollar amount.

Others would argue that health care is no different from any other good or service and that there should be no Federal subsidy for health care any more than any other good. From this perspective, the exclusion should be repealed.

Still others might argue that there should only be a Federal subsidy for health care for lower-income individuals. This argues for an exclusion only for lower-income employees or for a subsidy provided to all lower-income individuals regardless of employment status.

Valuation issues

Some argue that the implementation of the exclusion limitation under the bill would not present valuation difficulties for employers because the bill would retain the exclusion for employer contributions for coverage under the comprehensive benefit package, thereby making valuation of such coverage irrelevant. However, valuation issues would arise under the bill in the context of employer-provided supplemental health benefit policies.

Generally, compensation received in noncash forms (such as property) is includible in an employee's gross income and wages at its fair market value. Although in theory a fair-market value rule for employer-provided health coverage would be simpler because employers would treat all noncash compensation similarly, in practice, significant administrative complexity may be added if employers are required to attribute fair market value to employer-provided health coverage.

In order to avoid the complexities of determining the fair market value of supplemental health benefit policies for inclusion purposes, the bill would permit an employer to use its cost as a measure of income for employees. Under the bill, the value of any employer-provided coverage would be based on the average cost of providing the coverage to those who receive it. The provision would permit cost determinations to be made on the basis of reasonable estimates to the extent provided by the Secretary of the Treasury.

The valuation rules contained in the bill raise several questions. For example, it is not clear whether the average cost would be determined based on family status. If only one person has a particular type of coverage, it is not clear what "average cost" would mean. In addition, the valuation rules do not specify how a self-insured employer is to determine average cost. Use of average cost can also create inequities. Some persons will have more included in income than the cost of the insurance they actually have, and others will have less.

In addition, the bill does not contain administrative provisions relating to the operation of the tax cap. Presumably, employers would be required to report the value of employer-provided supplemental health coverage on the employee's W-2 form. Also, special valuation and administrative rules may be necessary in the case of multiemployer welfare plans because in that case the employer may not know the extent to which supplemental health benefits are being provided under the plan.

Cost-sharing issues

Under the bill, employers would not be permitted directly to reimburse employees who receive their coverage from a regional alliance health plan for cost-sharing expenses incurred under the comprehensive benefits package.[65] Employers would be permitted to pay the premiums for a cost-sharing health insurance policy for their employees covered by a regional alliance health plan and such payments would be excludable from gross income. The bill would not impose a similar restriction on the ability of corporate alliance employers directly to reimburse employees who receive their coverage from the corporate alliance health plan for cost-sharing expenses incurred under the comprehensive benefits package. However, the bill would prohibit cost-sharing policies from providing any benefits relating to copayments imposed under the comprehensive benefit package.[66] It is unclear whether this prohibition would apply to cost-sharing health insurance policies only or to the ability of corporate alliance employers to reimburse directly their employees for their copayments. The standards in the bill which would apply to cost-sharing policies appear to apply only to insured cost-sharing policies.

If the prohibition on copayments is intended to apply to both insured and self-funded employer-provided cost-sharing policies, the bill should be clarified to so provide. If the prohibition on copayments is intended to apply only to insured cost-sharing policies, whether an employer can reimburse employees for copayments and the availability of an exclusion from income and wages for copayments would depend on whether the employee receives health coverage through a corporate alliance health plan or a regional alliance health plan. There is no apparent justification for such disparate treatment under the bill.

Regulatory authority

Under the bill, the Secretary of the Treasury would have the authority to determine whether certain types of employer-provided coverage should be excluded from income and wages. Although some regulatory authority may be necessary to allow the Secretary to exclude, for example, expenses or coverage that are so small that the administrative burdens for valuing such amounts outweigh the benefits of inclusion in income, some would argue that the regulatory authority in the bill is too broad because it would allow the

[65] Section 1606(a) of the Health Security Act.

[66] Section 1423(b) of the Health Security Act. Under the bill, copayments would be defined to include dollar amounts that an employee may be required to pay with respect to a covered medical item or service (sec. 1131(c)(3) of the Health Security Act).

Secretary to determine the taxation of benefits, which is a broader policy question better left to the Congress.

Cafeteria plans and health FSAs

Tax policy considerations

Some argue that employers primarily offer cafeteria plans so that their employees may receive favorable tax treatment for their health costs. Thus, they argue that the provision in the Health Security Act which would repeal favorable tax treatment for employer-provided health coverage under a cafeteria plan would significantly reduce the number of cafeteria plans being offered by employers and could effectively eliminate cafeteria plans and the provision of other qualified benefits. One issue raised by the provision in the Health Security Act is whether the partial or total elimination of cafeteria plans would promote sound tax policy.

Cafeteria plans, including FSAs, create unfairness in the Federal tax system because they result in unequal treatment of similarly situated taxpayers. For example, medical expenses paid or reimbursed through a cafeteria plan are excludable from gross income, whereas if paid directly by the employee, are deductible only if the expenses, together with other medical expenses of the individual, exceed 7.5 percent of the individual's gross income.

In addition, cafeteria plans violate the rule of constructive receipt. This rule operates to prevent taxpayers from avoiding taxation by manipulating the timing of income that has already been earned.

Economic efficiency

Economists argue that cafeteria plans give employers more flexibility to deal with the rapidly changing socioeconomic and demographic composition of their workforces and, therefore, may promote an efficient use of resources. Such an approach permits each employee to structure his or her own employee benefit program to fit changing needs and eliminates the need for an employer to provide benefits that employees do not need or want.

For example, a cafeteria plan could offer employees a choice among cash, group-term life insurance, health insurance, and child care. A married employee with minor children may elect child care and health insurance. A married employee without children may elect health coverage and cash. Thus, the cafeteria plan provides a tailor-made employee benefit program for each employee.

Health care policy considerations

Another important issue to consider is whether cafeteria plans and, more specifically, health FSAs promote sound health policy. In particular, what impact would the provision in the Health Security Act have on health care spending?

Some argue that cafeteria plans increase total health care spending and undermine sound health policy. Cafeteria plans allow employees to choose whether to take compensation in the form of tax-free employee benefits or cash. By structuring a cafeteria plan with a salary reduction mechanism, employees can effectively convert after-tax dollars spent on employee benefits (such as health care)

into pre-tax dollars. Such a conversion, in effect, reduces the cost to the employee of the health care expenditure on account of the tax subsidies, and may operate as an incentive to employees for greater health care utilization. This is true of all tax-favored health plans but it is exacerbated in the case of FSAs because such arrangements provide a tax subsidy for the first dollar of health care costs.

The extent to which the provisions of the bill relating to cafeteria plans and FSAs would be effective in reducing health care expenditures is unclear. This is because the bill would only limit the ability to pay for first-dollar coverage or employee premiums through salary reduction. Employees would still be permitted to pay for employee premiums and out-of-pocket expenses under the comprehensive benefit package through arrangements outside of a cafeteria plan, such as an FSA funded with direct employer contributions.

Proponents of continuing favorable tax treatment for health coverage and FSAs provided under a cafeteria plan would maintain that the plans offer an effective means for employers to reduce health care expenditures. They point to surveys conducted by a number of organizations, which show that some employers have, in fact, experienced success in lowering their health care costs in conjunction with the use of cafeteria plans (particularly, flexible spending accounts).

Others point out that any evidence of reduced health costs coincident with the establishment of cafeteria plans may be attributable to shifts to greater employee cost sharing, which have been adopted at the same time. In addition, any evidence of reduced health costs coincident with the establishment of cafeteria plans may be attributable to the fact that the employer has shifted some of its costs for health care to other employers due to the fact that some of its employees have declined health coverage because they can obtain coverage through a spouse's health plan. Thus, it is not clear from these surveys that cafeteria plans promote lesser health care expenditures by employees.

2. Increase in deduction for health insurance costs of self-employed individuals (sec. 7203 of the bill and sec. 162(l) of the Code)

Present Law

Under present law, the tax treatment of health insurance expenses depends on whether the taxpayer is an employee and whether the taxpayer is covered under a health plan paid for by the employee's employer. An employer's contribution to a plan providing accident or health coverage for the employee and the employee's spouse and dependents is excludable from an employee's income. In addition, businesses can generally deduct, as an employee compensation expense, the full cost of any health insurance coverage provided for their employees. The exclusion and deduction are generally available in the case of owners of the business who are also employees.

In the case of self-employed individuals (i.e., sole proprietors or partners in a partnership) no equivalent exclusion applies. However, present law provides a deduction for 25 percent of the amount

paid for health insurance for a self-employed individual and the individual's spouse and dependents. The 25-percent deduction is also available to more than 2-percent shareholders of S corporations. The 25-percent deduction is not available for any month if the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse. In addition, no deduction is available to the extent that the deduction exceeds the taxpayer's earned income. The amount of expenses paid for health insurance in excess of the deductible amount can be taken into account in determining whether the individual is entitled to a medical expense deduction (sec. 213). Thus, such amounts are deductible to the extent that, when combined with other unreimbursed medical expenses, they exceed 7.5 percent of adjusted gross income.

Other individuals who purchase their own health insurance can deduct their insurance premiums only to the extent that the premiums, when combined with other unreimbursed medical expenses, exceed 7.5 percent of adjusted gross income.

The 25-percent deduction is scheduled to expire for taxable years beginning after December 31, 1993.

Description of Provision

In general

The bill would make the deduction for health insurance expenses of self-employed persons permanent, and would replace it with a deduction of up to 100 percent of such expenses. The 25-percent deduction would continue until the 100-percent deduction is effective.

Limits on 100-percent deduction

The bill would provide a deduction for up to 100 percent of the amount paid for health insurance for a self-employed individual and the individual's spouse and dependents, but only to the extent that the health insurance constitutes comprehensive health coverage as described in section 1101 of the Health Security Act and is purchased from a qualified alliance.[67] Section 1101 of the Health Security Act lists the health benefits and services which would be provided under the nationally guaranteed comprehensive benefit package.

Under the bill, the deductible percentage for self-employed individuals who do not pay 100 percent of the weighted average premium (as determined under the Health Security Act) for each of their employees would be reduced to the lowest percentage paid by the individual for the health coverage of any of its employees. Thus, the deduction would be at least 80 percent of health insurance costs, because all employers would be required to pay 80 percent of the weighted average premium for each of its employees under the bill.

Like present law, a self-employed individual would not be permitted to claim the 100-percent deduction on amounts paid to pur-

[67] The provision states that the 100-percent deduction is limited to the cost of comprehensive health coverage purchased from a qualified alliance described in section 1311 of the Health Security Act. Section 1311 defines and sets forth rules relating to corporate alliances and the term qualified alliance is not defined in section 1311 or any other section of the Act. Presumably this provision will be clarified.

chase comprehensive health coverage during any month in which the individual was employed on a full-time basis by an employer. For purposes of this provision, an individual would be considered employed on a full-time basis if employed by an employer for at least 120 hours in a month.[68] The bill would provide for the establishment of rules by the National Health Board for determining an employee's hours of employment including rules for determining the hours of employment of salaried and commissioned employees.[69]

Finally, as under present law, the 100-percent deduction would not be allowed to the extent that the amount of such deduction exceeds the taxpayer's earned income as defined in section 401(c) of the Code.

Effective Date

The provision relating to the 100-percent deduction would be effective on the earlier of January 1, 1997, or the first day on which the taxpayer could purchase comprehensive health coverage from a health alliance. The 25-percent deduction would be extended effective for taxable years beginning after December 31, 1993, and would expire on the date the 100-percent deduction becomes effective.

Discussion of Issues

Under present law, the Federal tax laws encourage the provision of health care in the employment context by providing the most favorable tax treatment for employer-provided health care. The next most favored group are self-employed individuals. Taxpayers who do not receive employer-provided health insurance and who are not self employed cannot deduct their health insurance expenses unless their medical expenses exceed 7.5 percent of their adjusted gross income (AGI). (The floor is 10 percent for alternative minimum tax purposes.) This generally means that the cost of purchasing health insurance is not subsidized unless the taxpayer also has significant uninsured medical expenses so that the AGI floor is exceeded. Compared with these taxpayers, the health insurance expenses of self-employed individuals are provided more favorable tax treatment.

Under present law, self-employed individuals are disadvantaged when compared to individuals who organize their business in corporate form under subchapter C of the Code. In such a case, the individual could be the sole shareholder and employee of the company. Any employer contributions for health care would be fully excludable by the employee. Thus, some argue that the tax treatment of self-employed individuals should be the same as that of employees.

On the other hand, under present law, self-employed persons are treated more favorably than other individuals who do not receive employer-provided health care. Increasing the deduction for self-employed persons would merely exacerbate this inequity.

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[68] Section 1901(b)(2) of the Health Security Act.
[69] Sections 1901(b)(3) and (4) of the Health Security Act.

From a policy perspective, it may be difficult to justify different Federal tax subsidies for health care expenses based upon whether or not someone is an employee or the form in which an entity does business. For example, if the objective is to provide a certain level of subsidy for all Americans who purchase health care, or for persons with certain income levels, the subsidy should be independent of employment status. Thus, many argue that subsidies should be provided to individuals regardless of employment status.

Another issue to consider is whether the 100-percent deduction for self-employed individuals under the bill is fair when compared to the tax treatment of the health expenses of employees and unemployed individuals under the bill.

Under the bill, the present-law tax treatment of employer-provided health care would continue until January 1, 2004. On and after that date, the present-law exclusion for employer contributions to an accident or health plan would be limited to contributions for the comprehensive benefit package, including cost-sharing amounts. Any employer contributions for supplemental health coverage (as defined in the bill) would be taxable to employees. Employers would be required to pay approximately 80 percent of their employees' premiums but, would be permitted to pay up to 100 percent of their employees' premiums. Unemployed individuals would be required to pay 100 percent of the premium for coverage under the comprehensive benefit package unless eligible for additional income-related subsidies. The bill retains the present-law tax treatment of health expenses for unemployed individuals. That is, the cost of the guaranteed benefit package would be deductible subject to the 7.5 percent floor.

Under the bill, self-employed individuals would receive the same or a better tax subsidy for their health expenses than employees. If an employer voluntarily pays for 100 percent of an employee's coverage, self-employed individuals and employees would receive the same tax subsidy for health coverage under the comprehensive benefit package. If an employer pays 80 percent of an employee's premium, self-employed individuals would receive a greater tax subsidy. Thus, equity between self-employed individuals and employees would depend upon the extent to which employers pay for health premiums. Some would argue that the exclusion of employer-provided health coverage from the wages of employees for employment tax (FICA) purposes reduces the disparity between the tax treatment of the health expenses of self-employed individuals and employees under the bill because self-employed individuals cannot deduct their health insurance expenses when calculating Self-Employment Contributions Act (SECA) taxes.

Although the bill would treat self-employed individuals and employees more similarly than they are treated under present law, it would nevertheless retain different Federal subsidies for health care expenses based on employment status. In addition, the bill would establish different Federal subsidies for unemployed individuals based on their income. This inequity could be avoided by providing the subsidy directly to individuals regardless of employment status, for example, in the form of a tax credit for a portion of premiums paid for health care.

Many people would argue that the tax subsidies currently provided to health insurance are so large that they result in a higher level of health service utilization than is desirable. Some would argue that increasing the tax subsidy for self-employed individuals exacerbates this problem.

Finally, the bill would limit a self-employed individual's deduction to the lowest percentage paid by the individual for the health coverage of any of its employees. This limitation would encourage employers to pay for the health care expenses of their employees and would also remove any disparity between the tax treatment of the health care expenses of self-employed individuals and employees.

3. Limitation on prepayment of medical insurance premiums (sec. 7204 of the bill and sec. 213 of the Code)

Present Law

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

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

A series of revenue rulings has held that the portion of a lump-sum or other fee paid for life-time care that is properly allocable to medical expenses is deductible in the year paid, even though the medical services will not be performed in the future, if at all.[70] The Internal Revenue Service has recently issued a revenue ruling stating that those rulings should not be interpreted to allow a current deduction of payments for future medical care (including medical insurance) extending substantially beyond the close of the taxable year in situations where the future care is not purchased in connection with obtaining lifetime care of the type described in those rulings.[71] This revenue ruling states that it will not be applied to amounts paid before October 14, 1993, or to amounts paid on or after October 14, 1993, pursuant to the terms of a binding contract entered into before that date if such terms were in effect on that date.

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[70] Rev. Rul. 75-302, 1975-2 C.B. 86; Rev. Rul. 75-303, 1975-2 C.B. 87; Rev. Rul. 76-481, 1976-2 C.B. 82.

[71] Rev. Rul. 93-72, 1993-34 IRB 7 (Nov. 1, 1993).

Description of Provision

Under the bill, for purposes of the itemized deduction for medical expenses, amounts paid during a taxable year that are allocable to insurance coverage or medical care to be provided during periods more than 12 months after the month in which the payment is made would be treated as paid ratably over the period during which the coverage or care is to be provided. This limitation would not apply to any premium paid under a qualified long-term care insurance policy (as defined under the Health Security Act). The provision also would not amend the special rule under present law for post-age 65 medical insurance.

Effective Date

The provision would apply to amounts paid after December 31, 1996.

Discussion of Issues

The itemized deduction for medical expenses reflects Congressional recognition that medical expenses are essentially personal expenses and therefore no special tax treatment should be provided for them, except where the expenses for a year are so great that they absorb a substantial portion of the taxpayer's income and hence substantially affect the taxpayer's ability to pay taxes. In order to limit the deduction to extraordinary expenses, the tax law provides that medical expenses are deductible only to the extent that they exceed 7.5 percent of the taxpayer's AGI.

Permitting taxpayers to deduct the cost of medical care in advance of the period during which services are to be rendered undermines the purpose of the 7.5-percent floor. That is, by bunching expenses in a single year, taxpayers may be able to deduct the expenses even though if paid in the year the services were rendered they would be under the floor and therefore not deductible.

Allowing such manipulation of the timing of deductions based on cash expenditures (i.e., cash accounting) is contrary to general principles of tax policy. The cash method of accounting recognizes items of income and expense based on the taxable year in which funds are received or disbursed. This may result in the recognition of income and expense items without regard to the taxable year in which the economic events giving rise to the items occurred and a potential mismatching of income with related expenses. To the extent prepaid expenses are deductible in the current year by cash basis taxpayers, taxpayers could benefit significantly, for example, by borrowing funds and making prepayments to accelerate deductions into a year in which the value of the deductions is the greatest. The benefits could be significant even when the deduction is accelerated only for one year. For these reasons, the cash method generally is not in accord with generally accepted accounting principles, and is not the favored rule for measuring economic or taxable income. Rather, an accrual method of accounting, which generally tries to match items of income and expense periods during which such items are incurred (rather than paid) is generally considered a more accurate measure of income.

On the other hand, present law provides an exception to the accrual accounting principle for individual taxpayers. This exception exists primarily to provide administrative ease for taxpayers and also recognizes that many taxpayers in fact operate on a cash method. Some would argue that allowing a deduction in the current year for the cost of medical services to be rendered in the future is consistent with the reasons for treating individuals on a cash basis, and could result in significant hardship to individuals who find it convenient or necessary to prepay medical expenses.

A middle ground between the two views would be to permit the expenses to be taken into account in situations that are not felt to be abusive. The provision in the Health Security Act is an example of this approach, because it allows prepayment of some expenses. This approach would recognize, for example, that it is a normal transaction to pay medical expenses for a year in advance. For example, it would not be unusual for a taxpayer in December to make a premium payment for the next year. The present-law rule for post-age 65 insurance can also be viewed as an example of this middle ground. It permits taxpayers to spread the cost of such insurance evenly over a number of years and thus may make it easier for individuals to afford such insurance.

Some also argue that, if health care reform is successful in providing affordable medical care to all Americans, then an increased ability to deduct health care expenses is unnecessary. That is, if all taxpayers have access to an adequate level of health care, allowing prepayments of health care to be deducted could encourage taxpayers to purchase additional or more generous benefits. To provide an incentive to make those kinds of expenditures in the form of a tax deduction would undermine one of the objectives of the bill, to contain health care costs by making consumers more cost-conscious.

Subtitle C. Employment Status Provisions

1. Definition of employee and protection against retroactive employment tax reclassifications (secs. 7301 and 7303 of the bill and new secs. 3510 and 3511 of the Code)

Present Law

In general

In general, the determination of whether an employer-employee or independent contractor relationship exists for Federal tax purposes is made under a common-law test. Under this test, an employer-employee relationship generally exists if the person contracting for the services has the right to control not only the result of the services, but also the means by which that result is accomplished (Treas. Reg. sec. 31.3401(c)-(1)(b)). Whether the requisite control exists is determined based on the facts and circumstances.

The Internal Revenue Service (IRS) has developed a list of 20 factors that may be examined in determining whether an employer-employee relationship exists. Rev. Rul. 87-41, 1987-1 C.B. 296. The 20 factors were developed by the IRS based on an examination of cases and rulings considering whether a worker is an employee. The degree of importance of each factor varies depending on the occupation and the factual context in which the services are performed. The 20 factors are designed as guides; special scrutiny may be required in applying the factors to assure that formalistic aspects of an arrangement designed to achieve a particular status do not obscure the substance of the arrangement.[72]

In addition to the common-law test, there are statutory provisions classifying workers as employees or independent contractors. Thus, for example, full-time life insurance salesmen are treated as employees for certain purposes pursuant to statutory provisions (secs. 3121(d) and 7701(a)(20)). Similarly, certain real estate agents and direct sellers are not treated as employees (sec. 3508).

Section 530 of the Revenue Act of 1978

In the late 1960s, the IRS increased enforcement of the employment tax laws, and controversies developed between the IRS and taxpayers as to whether businesses had correctly classified certain workers as independent contractors rather than as employees. In response to this problem, Congress enacted section 530 of the Reve-

[72] The factors are as follows: (1) whether the worker is required to comply with instructions about when, where, and how to perform the work; (2) whether the service recipient trains the worker; (3) the extent to which the worker's services are integrated into the business operations of the service recipient; (4) whether the services must be rendered personally; (5) whether the service recipient supervises the worker; (6) whether there is a continuing relationship between the worker and the service recipient; (7) whether the service recipient sets the hours of work of the worker; (8) whether the worker is required to devote substantially full time to the business of the service recipient; (9) whether the work is done on the premises of the service recipient; (10) whether the worker must perform services in the order set by the service recipient; (11) whether reports by the worker to the service recipient are required; (12) whether payment is by the hour, week, or month; (13) whether the service recipient pays the worker's business and/or traveling expenses; (14) whether the worker is required to furnish his or her own tools; (15) whether the worker invests in facilities used to perform the work; (16) whether the worker can realize a profit or loss as a result of the performance of the services; (17) whether the worker performs services for more than one service recipient; (18) whether the worker makes his or her services available to the general public; (19) whether the service recipient has the right to discharge the worker; and (20) whether the worker has the right to terminate the relationship without incurring liability.

nue Act of 1978 ("section 530"), which generally permits a taxpayer to treat an individual as not being an employee for employment tax purposes regardless of the individual's actual status under the common-law test, unless the taxpayer has no reasonable basis for such treatment and if certain additional requirements are satisfied.[73] Section 530 does not apply in the case of an individual who, pursuant to an arrangement between the taxpayer and another person, provides services for such other person as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled worker engaged in a similar line of work.[74]

Under section 530, a reasonable basis is deemed to exist for a period if the taxpayer reasonably relied on any of the following: (1) judicial precedent, published rulings, technical advice with respect to the taxpayer, or a letter ruling to the taxpayer; (2) a past IRS audit of the taxpayer in which there was no assessment attributable to the treatment (for employment tax purposes) of the individuals holding positions substantially similar to the position held by the individual in question; or (3) long-standing recognized practice of a significant segment of the industry in which such individual was engaged. These factors are a safe harbor, not the exclusive means of meeting the reasonable basis requirement.

In order to qualify for section 530 relief, certain conditions must also be satisfied. In particular, section 530 does not apply if the taxpayer (or a predecessor) has treated any individual holding a substantially similar position as an employee for purposes of employment taxes for any period beginning after December 31, 1977. In addition, section 530 does not apply unless all Federal tax returns (including information returns) required to be filed by the taxpayer with respect to the individual are filed on a basis consistent with the taxpayer's treatment of such individual as not being an employee.

Section 530 also bars the Department of Treasury (including the IRS) from publishing any regulation or revenue ruling classifying individuals for purposes of employment taxes under interpretations of the common law. Taxpayers may, however, obtain private letter rulings from the IRS regarding the status of workers.

Section 530 does not apply for income tax purposes. Thus, the determination of whether an individual is an employee for income tax purposes is made without regard to section 530.

Description of Provisions

In general

The bill would (1) repeal section 530 of the Revenue Act of 1978, (2) codify a modified version of section 530 which protects taxpayers against retroactive reclassification of workers as employees, and (3) give the Secretary of the Treasury the authority to define the term "employee" by regulation. The modified rules would apply

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[73] The relief granted by section 530, initially scheduled to terminate at the end of 1979, was extended through the end of 1980 by P.L. 96-167 and through June 30, 1982, by P.L. 96-541. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248), the Congress extended the section 530 relief indefinitely, pending enactment of further statutory rules regarding the classification of workers as employees or independent contractors.

[74] This provision was contained in section 1706 of the Tax Reform Act of 1986, (P.L. 99-514), effective for remuneration paid and services rendered after December 31, 1986.

for income tax purposes, employment tax purposes, and the bill's health care provisions.

Codification and revision of section 530

The bill would repeal section 530 of the Revenue Act of 1978 and incorporate a modified version in the Internal Revenue Code. Under the bill, an individual would not be treated as an employee of a taxpayer for any period if, for that period:

(1) the taxpayer treats the individual as not being an employee;

(2) the taxpayer treats the individual (and all other individuals holding substantially similar positions) as not being an employee for employment tax purposes for such period and all prior periods;

(3) a return filing requirement is met;

(4) a safe harbor requirement is met; and

(5) the Secretary has not notified the taxpayer in writing before the beginning of such period that the Secretary has determined that the taxpayer should treat such individual (or any individual holding a substantially similar position) as an employee.

The return filing requirement would be met if all Federal tax returns (including information returns) required to be filed by the taxpayer for such period with respect to such individual (and all other individuals holding substantially similar positions) were timely filed on a basis consistent with the taxpayer's treatment of such individuals as not being employees. For purposes of this requirement, a return that was not timely filed would be considered to have been timely filed if the penalty for failure to file is reduced or waived because the failure was corrected or because it was a de minimis failure pursuant to section 6721(b) and (c). In addition, the taxpayer would not fail to satisfy the return filing requirement solely because the taxpayer failed to timely file accurate information returns with respect to individuals holding substantially similar positions if the taxpayer substantially complied with reporting requirements (as defined in new Code sec. 6721(a)(3)).

The safe harbor requirement would be met with respect to an individual for any period if treating such individual as not an employee was:

(1) in reasonable reliance on a written determination regarding the taxpayer that addressed the employment status of the individual or an individual holding a substantially similar position;

(2) in reasonable reliance on a concluded IRS audit which was for a period in which the rules for determining employment status were the same as for the period in question, and in which the employment status of the individual (or an individual holding a substantially similar position) was examined and accepted;

(3) in reasonable reliance on a long-standing recognized practice of a significant segment of the industry in which the individual is engaged; or

(4) supported by substantial authority (excluding for this purpose letter rulings regarding other taxpayers).

No other means could be used to demonstrate reasonable reliance.

The prior audit safe harbor would cease to apply to an individual for a period if the treatment of such individual as not being an employee is inconsistent with any regulation, revenue ruling, revenue procedure, or other authority published by the Secretary before the beginning of the period and after conclusion of the audit on which the taxpayer is relying.

The availability of the industry practices safe harbor would terminate for all workers for periods beginning after the date on which the Secretary prescribes regulations defining "employee" and could terminate with respect to particular workers for earlier periods if the treatment of such workers as not being employees was inconsistent with any other regulation, revenue ruling, revenue procedure, or other authority published by the Secretary before the beginning of such earlier period.

The bill would provide that if an individual was treated as not being an employee under the safe harbor rules for employment taxes, then the individual would be treated as self-employed for income tax purposes as well.

Treasury regulations defining employee

The bill would authorize the Secretary of the Treasury to prescribe rules for determining whether an individual is an employee. These rules would apply for employment tax purposes and, to the extent provided in the regulations, for income tax purposes. Such regulations could modify the rules otherwise applicable for determining whether someone is an employee, except for certain statutory rules. The regulations would be required to give significant weight to the common-law rules. The following statutory provisions could not be modified by the regulations: (1) the rules providing that the following persons are treated as employees (a) corporate officers (sec. 3121(d)(1)), (b) certain agent-drivers or commission-drivers, full-time life insurance salesmen, home workers, and traveling salesmen (sec. 3121(d)(3)); and (c) individuals who perform services that are included under an agreement entered into pursuant to section 218 of the Social Security Act (relating to voluntary coverage of certain State and local government employees)(sec. 3121(d)(4)); (2) the rule providing that for employment tax purposes a person who provides companion sitting services is not an employee of any person who places the individual with the service recipient (sec. 3506); (3) the rule providing that certain real estate agents and direct sellers are not employees (sec. 3508); and (4) the new safe harbor provisions described above (new Code sec. 3511). The regulations issued under this provision could not be effective earlier than 6 months after the regulations are promulgated as final regulations. When the regulations are issued, the Secretary of the Treasury is to submit a report to Congress relating to such regulations, including an explanation of their purposes and the issues they were designed to address.

Effective Date

The provision relating to section 530 would generally be effective for periods beginning after December 31, 1995, except that the repeal of the prohibition on the issuance of regulations and rulings would be effective on the date of enactment. The provision authorizing regulations defining "employee" would be effective on the date of enactment.

Discussion of Issues

Tax issues relating to the definition of employee

Under present law, significant tax consequences result from the classification of a worker as an employee or independent contractor.[75] Some of these differences relate to withholding and employment tax requirements, as well as the ability to exclude certain types of compensation from income or take tax deductions for certain expenses. They also relate to whether the service recipient has to include the worker for pension or other employee benefit plan purposes. Some of these consequences favor employee status, while others favor independent contractor status. For example, an employee may exclude from gross income employer-provided benefits such as pension, health, and group-term life insurance benefits. On the other hand, an independent contractor can establish his or her own pension plan and deduct contributions to the plan. An independent contractor also has greater ability to deduct work-related expenses.

The present-law rules for determining whether a worker is an employee or an independent contractor continue to result in misclassification of workers and uncertainty among taxpayers. While the section 530 safe harbor provides a relatively clear rule for determining worker status, the safe harbor does not apply in all cases, so many employers must rely on the common-law test.

Misclassification of workers can be either inadvertent or deliberate. At the extremes, it will be clear whether a worker is properly characterized as an employee or independent contractor. However, many work situations will involve the grey area in between—some of the 20 factors may support employee status, while some may indicate independent contractor status. Thus, it may be difficult to determine whether a particular case of misclassification was deliberate or inadvertent.

Inadvertent misclassifications can occur because the determination of proper classification is factual and reasonable people may differ as to the correct result given a certain set of facts. Thus, even though a taxpayer in good faith determines that a worker is an independent contractor, an IRS agent may reach a different conclusion by, for example, weighing some of the 20 factors differently than the taxpayer. Taxpayers wishing certainty can obtain a private letter ruling regarding the status of workers. However, not all taxpayers may wish to undertake the expense of obtaining a ruling or may not be able to wait for a ruling from the IRS. Thus, the prohibition on issuance of general guidance by the IRS may make the likelihood of such errors greater; the IRS is not permitted to pub-

[75] There may also be nontax consequences, such as applicability of wage and hour laws.

lish guidance stating which factors are more relevant than others. In the absence of such guidance, not only may taxpayers and the IRS differ, but different IRS agents may also reach different conclusions, resulting in inconsistent enforcement.

Misclassification of workers as independent contractors may also be deliberate. In some cases, workers and service recipients may prefer to classify workers as independent contractors, both for tax and nontax reasons. For example, the worker may wish to take advantage of the ability to contribute on a deductible basis to a pension plan or to deduct significant work-related expenses. A service recipient may wish to avoid the administrative burden associated with withholding income and employment taxes. The service recipient also may wish to avoid coverage and nondiscrimination requirements applicable to qualified retirement plans by classifying lower-paid workers as independent contractors.

The bill would place greater significance on the proper classification of a worker as an independent contractor or employee.[76] In addition to the consequences of present law, under the bill the classification of a worker would affect whether or not the service recipient is required to pay a health care premium for the worker. It could also affect the amount the employer is required to pay (because the aggregate amount is based on employee wages) and the Federal subsidy for health care premiums. Whether it is more beneficial to be an employee or independent contractor may be different under the bill than under present law. The increased significance of worker classification would mean that there would be even greater need for clarity of rules to help prevent worker misclassification.

Section 530 is supported by those who take advantage of it because it provides some certainty and protection to taxpayers in an area of law that is far from clear. However, section 530 has also been criticized. Not all taxpayers can use the section 530 safe harbors. For example, the consistency requirement may prevent some taxpayers from using section 530. Taxpayers who cannot take advantage of section 530 argue that it creates a competitive disadvantage that is particularly unfair because they are classifying their workers under the general rule. Section 530 has also been criticized because it may take very little to come within one of the safe harbors if section 530 is otherwise available to a taxpayer. For example, the prior audit rule has been criticized because the audit need not have been an employment tax audit. Thus, section 530 could apply even if worker status was not raised on the audit. The industry practice safe harbor has been criticized on the ground that it rewards people who have consistently misclassified workers. Limiting the scope of these provisions would be viewed as more fair to taxpayers who cannot take advantage of section 530, and would also be more consistent with tax policy concerns.

Codifying the safe harbors could provide more certainty to taxpayers. In addition, lifting the prohibition on issuance of guidance

[76] The health care provisions of the bill may also affect whether firms out-source some of their work or hire subcontractors to perform it because the amount of Federal subsidies and employer premiums may vary based on whether work is performed by subcontractors or through similar arrangements. While some of these arrangements may involve questions as to whether the worker is an employee of the service recipient, in many cases the question will not arise because the worker is the employee of the subcontractor.

would enable the IRS to issue clarifying rules. Overall, however, it is difficult to determine what effect the provisions of the bill would have on classification of workers. It is not clear to what extent modifying the safe harbors will actually reduce the number of taxpayers who take advantage of them. For example, a taxpayer that was relying on the prior audit safe harbor but could not do so under the bill might rely instead on the industry practice safe harbor. The bill would give the Treasury Department the authority to terminate the application of the industry practice safe harbor, but until actual rules are proposed, it is difficult to determine what effect they will have. The same issue arises in trying to determine what effect regulations defining "employee" would have. Clarifying the statutory rules would provide more certainty to both taxpayers and the IRS.

Another way to deal with the misclassification issue, other than clarifying the rules, would be to reduce the differences between the treatment of employees and independent contractors. The more the two groups of workers are treated the same, the less pressure there will be on the definition of employee. It has also been suggested that compliance problems could be addressed, such as requiring withholding on payments to independent contractors.[77]

Under present law, section 530 applies only for employment tax purposes. In general, the provision would apply the same definition of employee for income tax purposes and employment tax purposes. This would likely reduce taxpayer confusion and ease administration of the tax rules. Under present law, some individuals who are treated as not being employees under the safe harbor mistakenly use that status in filing their income tax returns. A single definition would avoid such mistakes.

Health care policy issues

The question of who is an employee is fundamental to the provisions of the bill because it has a mandated employer contribution. The question of whether there should be such a mandate and whether or not health care should be delivered through the employer is obviously a central issue in health care reform.[78] From an administrative perspective, if there is an employer mandate, a clear definition of employee would make the system easier to administer both for the private sector and government agencies involved. The greater differences there are between the consequences of being an employee and not being an employee, the more likely employers and individuals would take aggressive positions in order to achieve the outcome they desire.

Even if there is to be an employer mandate or employer-based system, it is not clear that the definition of employee for health care purposes should be the same as it is for other purposes. Different policies may underlie the health care rules and income and employment tax rules, and these policies could lead to different conclusions about proper classification. Thus, it may not be necessary to examine the question of worker status for income and em-

[77] See, U.S. General Accounting Office, *Approaches for Improving Independent Contractor Compliance*, GAO/GGD-92-108 (July 1992).

[78] A discussion of issues relating to employer mandates and use of an employer-based health care delivery system is beyond the scope of this pamphlet.

ployment tax purposes in the context of health care reform. On the other hand, overall administrative burdens on employers, individuals, the IRS, and those responsible for administering the health care system and the income and employment tax systems would be less if the rules are the same.

2. Increase in penalties for failure to file correct information returns with respect to non-employees (sec. 7302 of the bill and sec. 6721 of the Code)

Present Law

Information reporting requirements (secs. 6041(a) and 6041A(a))

The Code contains a number of information reporting requirements. One requires that a person engaged in a trade or business who makes payments during the calendar year of $600 or more to a person for rents, salaries, wages, premiums, annuities, compensations, remunerations, emoluments, or other fixed or determinable gains, profits, and income, must file an information return with the Internal Revenue Service ("IRS") reporting the amount of such payments, as well as the name, address and taxpayer identification number of the person to whom such payments were made.[79] A similar statement must also be furnished to the person to whom such payments were made.[80]

The Code contains an additional provision requiring that a service recipient (i.e., a person for whom services are performed) engaged in a trade or business who makes payments of remuneration in the course of that trade or business to any person for services performed must file with the IRS an information return reporting such payments (and the name, address, and taxpayer identification number of the recipient) if the remuneration paid to the person during the calendar year is $600 or more.[81] Also, the service-recipient must furnish to the person receiving such payments a statement setting forth the name, address, and taxpayer identification number of the service-recipient, and the aggregate amount of payments made to the payee during the year.[82]

Failure to file correct information returns (sec. 6721)

Any person that fails to file a correct information return[83] with the IRS on or before the prescribed filing date is subject to a penalty that varies based on when, if at all, the correct information return is filed. If a person files a correct information return after the prescribed filing date but on or before the date that is 30 days after the prescribed filing date, the penalty is $15 per return, with a maximum penalty of $75,000 per calendar year. If a person files a correct information return after the date that is after 30 days after

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[79] Sec. 6041(a). A number of exceptions to this requirement are provided in Treasury regulations. In addition, to the extent the general information reporting requirements of this provision overlap specific information reporting requirements elsewhere in the Code, taxpayers are generally required to report only once, under the more specific information reporting provision.

[80] Sec. 6041(d).

[81] Sec. 6041A(a).

[82] Sec. 6041A(e).

[83] This term is defined in sec. 6724(d)(1), and refers to 21 information reporting requirements in the Code, including secs. 6041(a) and 6041A(a).

the prescribed filing date but on or before August 1, the penalty is $30 per return, with a maximum penalty of $150,000 per calendar year. If a correct information return is not filed on or before August 1 of any year, the amount of the penalty is $50 per return, with a maximum penalty of $250,000 per calendar year.

There is a special rule for de minimis failures to include the required, correct information. This exception applies to incorrect information returns that are corrected on or before August 1. Under the exception, if an information return is originally filed without all the required information or with incorrect information and the return is corrected on or before August 1, then the original return is treated as having been filed with all of the correct required information. The number of information returns that may qualify for this exception for any calendar year is limited to the greater of (1) 10 returns or (2) one-half of one percent of the total number of information returns that are required to be filed by the person during the calendar year.

In addition, there are special, lower maximum levels for this penalty for small businesses. Small businesses are defined as firms having average annual gross receipts for the most recent 3 taxable years that do not exceed $5 million. The maximum penalties for small businesses are: $25,000 (instead of $75,000) if the failures are corrected on or before 30 days after the prescribed filing date; $50,000 (instead of $150,000) if the failures are corrected on or before August 1; and $100,000 (instead of $250,000) if the failures are not corrected on or before August 1.

Failure to furnish correct payee statements (sec. 6722)

Any person that fails to furnish a correct payee statement[84] to a taxpayer on or before the prescribed due date is subject to a penalty of $50 per statement, with a maximum penalty of $100,000 per calendar year. If the failure to furnish a correct payee statement to a taxpayer is due to intentional disregard of the requirement, there is a penalty of $100 per statement or, if greater, 10 percent[85] of the amount required to be shown on the statement, with no limitation on the maximum penalty per calendar year.

Failure to comply with other information reporting requirements (sec. 6723)

Any person that fails to comply with other specified information reporting requirements on or before the prescribed date is subject to a penalty of $50 for each failure, with a maximum penalty of $100,000 per calendar year. The information reporting requirements specified for this purpose include any requirement to include a correct taxpayer identification number on a return or a statement and any requirement to furnish a correct taxpayer identification number to another person.

Waiver, definitions, and special rules (sec. 6724)

Any of the information reporting penalties may be waived if it is shown that the failure to comply is due to reasonable cause and not

[84] This term is defined in sec. 6724(d)(2), and refers to 22 information reporting requirements in the Code, including secs. 6041(a) and 6041A(a).

[85] Five percent for several types of statements.

to willful neglect. For this purpose, reasonable cause exists if significant mitigating factors are present, such as the fact that a person has an established history of complying with the information reporting requirements.

Description of Provision

The bill would modify the penalty for failure to file correct information returns with respect to two types of information returns: (1) information returns under section 6041(a) which relate to payments to any person for services performed by such person (other than as an employee);[86] and (2) returns regarding remuneration for services under 6041A(a). In general, both of these sections of the Code relate to information returns with respect to payments made to non-employees, such as independent contractors.[87]

In general, the bill would increase the penalty for failure to file correct information returns on or before August 1 from $50 for each return to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

The bill would also provide for an exception to this increase where substantial compliance has occurred. The bill would provide that this exception would apply with respect to a calendar year if the aggregate amount that is timely and correctly reported under these two sections of the Code for that calendar year is at least 97 percent of the aggregate amount required to be reported under these two sections of the Code for that calendar year. If this exception applies, the penalty of $50 for each return would continue to apply.

The present-law reductions in the $50 penalty where correction is made within a specified period, the exception for de minimis failures, and the lower limitations for persons with gross receipts of not more than $5,000,000 would not be affected by the bill. Also, the penalty for failure to furnish correct payee statements, the penalty for failure to comply with other information reporting requirements, and the reasonable cause rules would not be affected by the bill.

Effective Date

The provision would apply to information returns the due date for which (without regard to extensions) is more than 30 days after the date of enactment.

Discussion of Issues

One issue to consider is whether the increase in the penalty for failure to file correct information returns will result in a penalty that is proportional to the offense of failing to report. Some might argue that the resulting penalty could be disproportionately high, particularly in light of the fact that intentional disregard or willful-

[86] It is intended that the modification to the penalty apply only to information returns reporting payments for services performed that are made to non-employees under section 6041(a), and not with respect to other types of information returns filed under section 6041(a). A technical correction to the statutory language may be necessary to effect this result.

[87] Employers are required to provide information with respect to wages paid to their employees on Form W-2 under section 6051; consequently, those information returns would not be affected by the bill.

ness are not required to be asserted or proven in order to impose the higher penalty. Others might argue that the penalty is not disproportionate to the offense because information returns filed by companies with respect to the independent contractors they engage are the principal means by which the IRS learns from someone other than the taxpayer of the existence and amounts of these payments. This is important under the bill because some self-employed individuals will be entitled to discounts on their health insurance premiums based upon their income, so that correct reporting of payments will be necessary to determine entitlement to these discounts. In addition, some might argue that the increased penalty is not disproportionate because the increase does not apply where correction is made within a specified period, within certain de minimis guidelines, or where there is reasonable cause.

An additional issue to consider is how well the increased penalty fits into the current information reporting penalty structure. For example, the increased penalty is parallel in structure to the penalty for intentional disregard of the information reporting requirements (sec. 6721(d)). The difference is the rate: the increased penalty would be 5 percent of the amount required to be reported, while the penalty for intentional disregard is 10 percent. Consideration might be given as to whether the differential between the two penalties should be adjusted. Another aspect of how the increased penalty fits into the current information reporting penalty structure is whether the increased penalty should also apply to failures to furnish correct payee statements (sec. 6722). Under the bill, the increased penalty applies only with respect to the failure to file a correct information return with the IRS, and it does not apply to the failure to provide a correct copy of the information return to the individual with respect to whom the information is reported. Another aspect of how the increased penalty fits into the current information reporting penalty structure is whether, in light of this increased penalty, the overall annual caps on the total amount of penalty that may be imposed should remain the same (as they do under the bill) or should be adjusted.

Subtitle D. Tax Treatment of Funding of Retiree Health Benefits (secs. 7401 and 7402 of the bill and secs. 401(h), 419A, and 420 of the Code)

Present Law

Post-retirement medical and life insurance reserves

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

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

If a welfare benefit fund satisfies certain requirements, it generally will be exempt from income tax. To be tax exempt, the fund generally is required to be a voluntary employees' beneficiary association (VEBA) providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, and no part of the net earnings of such association may inure (other than through such payments) to the benefit of any private shareholder or individual. In addition, the VEBA generally is required to satisfy certain rules prohibiting the provision of benefits on a basis that favors the employer's highly compensated employees.

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

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

The amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1)

the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

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

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

Each year's computation of contributions with respect to post-retirement medical benefits is to be made under the assumption that the medical benefits provided to future retirees will have the same costs as medical benefits currently provided to retirees. Because the reserve is computed on the basis of the current year's medical costs, neither future inflation nor future changes in the level of utilization may be taken into account until they occur.

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

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

Health benefits account maintained by qualified pension plans

A tax-qualified pension or annuity plan may provide for the payment of sickness, accident, hospitalization and medical expenses for retired employees, their spouses, and their dependents under a separate account method of prefunding post-retirement medical and life insurance benefits provided certain additional qualification requirements are satisfied with respect to the post-retirement medical benefits (sec. 401(h)). First, the medical benefits, when added to any life insurance protection provided under the plan, are required to be incidental to the retirement benefits provided by the plan. The medical benefits are considered incidental or subordinate

to the retirement benefits if, at all times, the aggregate of employer contributions to provide such medical benefits and any life insurance protection does not exceed 25 percent of the aggregate contributions, other than contributions to fund past service credits.

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

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

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

Description of Provisions

Post-retirement medical and life insurance reserves

Under the bill, the minimum period during which the cost of post-retirement medical and life insurance coverage could be funded under a welfare benefit fund would be at least 10 years. Thus, an employer would be permitted to deduct the costs of funding such coverage on a level basis over the working lives of covered employees, but not over a period of less than 10 years. Further, the bill would provide that the reserves for post-retirement medical and life insurance benefits cannot be maintained with respect to benefits that it is reasonably anticipated will be includible in income when provided. Thus, benefits that are not excludable from income under section 106 may not be prefunded.

The bill would clarify that a reserve to provide post-retirement medical and life insurance benefits under a welfare benefit plan would be maintained as a separate account. In addition, the bill would include any payment from the separate account required to be maintained for post-retirement medical and life insurance benefits that is not used to provide a post-retirement medical or life insurance benefit in the list of disqualified benefits for which the employer is subject to a 100-percent excise tax.

Health benefits accounts maintained by qualified pension plans

The bill would eliminate the use of section 401(h) accounts under qualified pension plans for the funding of post-retirement medical benefits. Thus, contributions would be permitted to be made to such accounts only before January 1, 1995, or if made as part of a qualified transfer under section 420. A qualified transfer would include certain transfers of excess pension assets to a health benefits account under section 401(h) to the extent such transfers are made in a taxable year beginning before January 1, 1996. The bill would modify the minimum cost requirements for purposes of determining the amount of excess pension assets that may be transferred to a health benefits account. The bill would provide that, to the extent provided by the Secretary of the Treasury, a plan would not be treated as failing to meet the minimum cost requirements of section 420 to the extent such failure is attributable to a reduction in qualified current retiree health liabilities by reason of the enactment of the Health Security Act.

Effective Dates

The provisions relating to reserves for post-retirement medical and life insurance benefits under welfare benefits plans would be effective for contributions paid or accrued after December 31, 1994, in taxable years ending after that date. The provision that requires that the reserve for post-retirement medical and life insurance benefits be maintained as a separate account would be effective for contributions paid or accrued after the date of enactment, in taxable years ending after that date.

Contributions generally would not be permitted to be made to health benefits accounts maintained by qualified pension plans after December 31, 1994. In the case of a plan maintained pursuant to a collective bargaining agreement (ratified on or before October 29, 1993), contributions would only be permitted until the earlier of (1) the date on which the last of the collective bargaining agreements (determined without regard to any extension after October 29, 1993) or, if later, January 1, 1995, or (2) January 1, 1998.

Discussion of Issues

In general, from a tax policy perspective, employers should not be permitted a current deduction for welfare benefits that may be provided in the future (i.e., for liabilities that are not accrued). This treatment is consistent with income tax rules in other areas, which generally match the time a payor deducts a payment and the time the payee includes the amount in income.

However, the Congress has found it appropriate to permit a reasonable level of reserves for the funding of post-retirement medical and life insurance benefits. Thus, employers have been permitted to take deductions for contributions to a welfare benefit fund to fund such benefits over the working lives of employees. The proposals in the bill relating to the funding of such post-retirement benefits can be viewed as incremental changes that do not alter the general rule permitting current deductions for future liabilities.

Some believe that any incentive provided to employers for the funding of retiree medical and life insurance benefits should be structured in a manner that encourages the funding to occur in a manner that provides the greatest protection to employees. Some employers have utilized the present-law rules to fund retiree medical and life insurance benefits over a fairly short period of time. Such an approach may undermine the benefit security of the covered employees and may permit the employer to take the deductions for prefunding at a time when the employer has the most taxable income. The proposal to require that contributions to a welfare benefit fund be made over a period of at least 10 years reduces the potential for abuse that the present-law funding rules might encourage.

The proposal to require that contributions to fund post-retirement medical and life insurance benefits be made to a separate account and that no other benefits can be paid from such separate account will discourage employer overfunding of post-retirement medical and life insurance liabilities.

The proposal to eliminate the funding of post-retirement medical benefits through sec. 401(h) accounts can be viewed as an attempt to simplify and rationalize the rules relating to the funding of post-retirement medical and life insurance benefits. Because there are existing rules that permit the funding of such benefits through welfare benefit funds, it can be argued that the continued existence of sec. 401(h) accounts is unnecessary. Further, the elimination of such accounts reduces the risk that employers will utilize multiple funding arrangements for post-retirement benefits in order to contribute more in the aggregate than would be permitted if only one such arrangement were used.

Subtitle E. Coordination with COBRA Health Care Continuation Provisions (sec. 7501 of the bill and sec. 4980B of the Code)

Present Law

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added provisions to the Internal Revenue Code, title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Public Health Services Act under which most employer-sponsored health plans are required to satisfy health care continuation rules.[88] In general, these rules require that an employer provide qualified beneficiaries with the opportunity to participate for a specified period in the employer's health plan after the occurrence of a qualifying event that otherwise would have terminated such participation.

The qualifying events that may trigger rights to continuation coverage are (1) the death of the employee, (2) the voluntary or involuntary termination of the employee's employment (other than by reason of gross misconduct), (3) a reduction of the employee's hours, (4) the divorce or legal separation of the employee, (5) the employee becoming entitled to benefits under Medicare, (6) a dependent child of the employee ceasing to be a dependent under the employer's plan, and (7) in certain cases the commencement of bankruptcy proceedings with respect to an employer. The maximum period of continuation coverage that may be elected is 36 months, except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. The 18-month period is extended to 29 months in certain cases involving the disability of the qualified beneficiary. Certain events, such as the failure by the qualified beneficiary to pay the required premium, may trigger an earlier cessation of the continuation coverage.

A qualified beneficiary has a prescribed period of time after a qualifying event in which to elect continuation coverage. This period does not end until the later of 60 days after coverage terminates or 60 days after the qualified beneficiary receives notice from the plan administrator of the right to continuation coverage.

If a plan subject to the health care continuation rules fails to satisfy the rules, an excise tax is imposed on the employer. In certain circumstances, persons other than the employer may be liable for the excise tax.

Description of Provision

Under the bill, the health care continuation rules would be repealed.

Effective Date

The repeal of the health care continuation rules would be effective on the earlier of January 1, 1998, or the first day of the calendar year following the calendar year in which each State has in effect health plans under which individuals are eligible to receive

[88] The health care continuation rules are commonly referred to as the COBRA rules.

comprehensive health coverage as described in section 1101 of the Health Security Act. Section 1101 of the Health Security Act lists the items and services which would be provided under the guaranteed comprehensive benefit package.

The bill also contains transition rules which would apply to individuals who become eligible to receive comprehensive health coverage prior to the repeal of the health care continuation rules. Prior to the repeal of the health care continuation rules, an individual will not be considered eligible for continuation coverage if he or she is eligible to receive comprehensive health coverage through a health alliance on the date of the qualifying event that would otherwise trigger the individual's rights to continuation coverage. In addition, the continuation coverage of an individual would terminate as of the date he or she becomes eligible for comprehensive health coverage through a health alliance.[89]

Discussion of Issues

Congress enacted the health care continuation rules to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in or entire loss of health coverage. One of the purposes of the Health Security Act is to guarantee all Americans comprehensive and secure health care coverage.[90] Under the Health Security Act, all individuals would be eligible to receive a guaranteed package of health benefits. Because the Health Security Act would guarantee access to the guaranteed benefit package to all individuals, there would no longer be a need for employers to provide continuation coverage to qualified beneficiaries for the benefits provided in the guaranteed benefit package.

Some would argue that the health care continuation rules should not be repealed as they relate to employer-provided health benefits which are not guaranteed under the national benefits package because to do so could result in a significant gap in or entire loss of such coverage. The guaranteed benefit package described in the bill limits and excludes certain types of health services and benefits. For example, the national benefits package provides limited vision and dental coverage. Eyeglasses and contact lenses for individuals less than 18 years of age would not be covered items.[91] In addition, prior to January 1, 2001, dental treatment for individuals less than 18 years of age other than emergency dental treatment would not be covered.[92] Additional limitations apply to orthodontic treatment.

Under the bill, any health benefits which are not provided under the guaranteed package would be considered supplemental health benefits. Under present law, employer-provided supplemental health benefits generally would be subject to the health care continuation rules.

The bill would impose several standards on supplemental health benefit policies. For instance, entities which offer supplemental

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[89] The bill makes conforming changes to the health care continuation coverage provisions of the Public Health Services Act and ERISA. (See sections 3801 and 8403 of the Health Security Act, respectively.)

[90] Section 3(1) of the Health Security Act.

[91] Section 1125 of the Health Security Act.

[92] Section 1126 of the Health Security Act.

health benefits are required to enroll every individual who seeks enrollment.[93] This requirement does not apply to employers and fraternal, religious, or other similar organizations. Even though most entities which offer supplemental health coverage cannot restrict their enrollment, it is possible that an individual who was formerly receiving supplemental health coverage from an employer, such as dental or vision coverage, would be unable to obtain comparable coverage through a regional alliance. Another potential problem is that even if comparable coverage is available through a regional alliance, it may be more expensive to purchase on an individual basis.

Others argue, however, that the loss of supplemental health coverage does not constitute a significant gap in or entire loss of health coverage with which Congress was concerned when it enacted the health care continuation rules. Some would also argue that the financial and administrative burdens on employers attributable to compliance with the health care continuation rules would not be justified in a health care system where continuation coverage would only apply to supplemental health coverage.

[93] Section 1422(b) of the Health Security Act.

Subtitle F. Tax Treatment of Organizations Providing Health Care Services and Related Organizations (secs. 7601-7603 of the bill and secs. 501, 509 and 833 of the Code)

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.[94] In contrast, social welfare organizations exempt from Federal income tax under 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.[95] 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.

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[94] 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.

[95] 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.

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 described in 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 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.[96]

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.

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

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.[97] The hospital 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.[98] 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.[99]

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[97] 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 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.

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

[99] 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.[100] 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.[101]

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.[102] In GCM 39828 (August 30, 1990), for example, the IRS 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-

[100] 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.

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

[102] 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 particular issues.

inclusive, nor is the absence of any one determinative of the lack of a charitable operation.[103]

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.[104]

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.[105] 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 partially to take account of the time value of money, and unearned premium reserve deductions must be reduced by 20 percent.[106]

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[103] 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).

[104] 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 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.

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

[106] 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

Thus, the tax treatment of a taxable HMO depends largely on the extent to which it qualifies as an insurance company.[107]

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.[108]

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.[109]

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.[110] Thus, eligible organizations are not

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(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)).

[107] 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.

[108] 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).

[109] 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 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.

[110] 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

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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 for section 833 provided 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 December 31, 1986. The transition rules also provided 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.[111]

Description of Provisions

Tax-exempt status of hospitals, HMOs, certain parent organizations and regional alliances

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 would have taken place at least annually and 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 further would 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;

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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.

[111] 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.

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).

Effective date.—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 specifically identifies four types of health insurance provided by an HMO that would not be treated as commercial-type insurance and, thus, would not jeopardize an organization's tax-exempt status. Such non-commercial-type health insurance coverages would 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 would be: (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 does not specify that such organizations would 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 also would repeal the special deduction for 25 percent of claims. A special phase-out rule would apply to organizations that meet 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 Decem-

ber 31, 1996, would be deemed equal to the fair market value of the asset on that date.

The bill also would 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 further would provide that, on January 1, 1997, such basis adjustment is made permanent.

Effective date.—These provisions generally would 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.

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 qualify for tax exemption as educational organizations. However, if all Americans have access to

health care, what other, if any, activities 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?

This question is 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 treat such organizations 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.

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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 it 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. Nevertheless, 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 sets 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 also would 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 does 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 is 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, are 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, that the provision was not temporary when enacted.

Subtitle G. Tax Treatment of Long-Term Care Insurance and Services

1. Treatment of long-term care insurance and services (secs. 7701 and 7702 of the bill, and sec. 213 and new sec. 7702B of the Code)

Present Law

Deduction for medical expenses

In determining taxable income for Federal income tax purposes, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during any taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year (sec. 213). For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); or (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

Exclusion for amounts received under accident or health insurance

Amounts received by a taxpayer under accident or health insurance for personal injuries or sickness generally are excluded from gross income to the extent that the amounts received are not attributable to medical expenses that were allowed as a deduction for a prior taxable year (sec. 104).

Treatment of accident or health plans maintained by employers

Contributions of an employer to an accident or health plan that provides compensation (through insurance or otherwise) to an employee for personal injuries or sickness of the employee, the employee's spouse, or a dependent of the employee, are excluded from the gross income of the employee (sec. 106). In addition, amounts received by an employee under such a plan generally are excluded from gross income to the extent that the amounts received are paid, directly or indirectly, to reimburse the employee for expenses incurred by the employee for the medical care of the employee, the employee's spouse, or a dependent of the employee (sec. 105). For this purpose, expenses incurred for medical care are defined in the same manner as under the rules regarding the deduction for medical expenses.

Description of Provisions

In general

The bill would provide a safe harbor with respect to the deductibility of certain expenses for long-term care services. Services that

satisfy the requirements of the bill would be deductible as medical expenses. Services that do not satisfy such requirements would continue to be subject to present law.

Insurance contracts that meet the requirements of the bill ("qualified long-term care insurance policies") would be subject to the tax treatment set forth in the bill. Any amount received or coverage provided under a long-term care insurance policy that does not meet the requirements of the bill would not be treated as an amount received for personal injuries or sickness or provided under an accident and health plan and would not be excludable from gross income.

Tax treatment of long-term care services

In general

The bill would provide that certain services that are provided to an incapacitated individual (defined as "qualified long-term care services") are to be treated as medical care for purposes of the deduction for medical expenses. Thus, under the bill, a taxpayer would be allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during any taxable year for qualified long-term care services that are provided to the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses and other eligible medical expenses of the taxpayer exceed 7.5 percent of the adjusted gross income of the taxpayer for such year. In addition, under the bill, eligible medical expenses for purposes of the medical expense deduction would include premiums paid for insurance that provides coverage for qualified long-term care services, but only if such insurance is provided under a qualified long-term care insurance policy (as defined below).

Definition of qualified long-term care services

In general

The term "qualified long-term care services" would be defined as the necessary diagnostic, curing, mitigation, treating, preventive, therapeutic, rehabilitative, maintenance, and personal care services (whether performed in a residential or nonresidential setting) that are required by an individual during any period that such individual is an incapacitated individual, but only if (1) the primary purpose of the services is to provide needed assistance with any activity of daily living or protection from threats to health and safety due to severe cognitive impairment, and (2) the services are provided pursuant to a continuing plan of care that is prescribed by a licensed professional. In addition, in order to constitute qualified long-term care services, the services could not be provided by any relative (directly or through a partnership, corporation, or other entity) of the incapacitated individual unless the relative is a licensed professional with respect to the services provided.[112]

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[112] For this purpose, a relative of an incapacitated individual would include: (1) a son or daughter, or a descendant of either; (2) a stepson or stepdaughter; (3) a brother, sister, stepbrother, or stepsister; (4) the individual's father or mother, or an ancestor of either; (5) a stepfather or stepmother; (6) a son or daughter of a brother or sister; (7) a brother or sister of the individual's father or mother; and (8) a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law.

Definition of incapacitated individual

An incapacitated individual generally would be defined as any individual who is certified by a licensed professional within the preceding 12-month period as (1) being unable to perform, without substantial assistance from another individual, at least two activities of daily living, or (2) having severe cognitive impairment as defined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services. For purposes of determining whether an individual is an incapacitated individual, substantial assistance would include cueing or substantial supervision.

For purposes of the definition of an incapacitated individual, the activities of daily living (ADLs) would be (1) eating, (2) toileting, (3) transferring, (4) bathing, and (5) dressing. A licensed professional is (1) a physician or registered professional nurse, or (2) any other individual who satisfies such requirements as may be prescribed by the Secretary of the Treasury after consultation with the Secretary of Health and Human Services.

Tax treatment of qualified long-term care insurance policies

The bill would provide that for purposes of the Internal Revenue Code (1) a qualified long-term care insurance policy is to be treated as an accident or health insurance contract, (2) any plan of an employer that provides coverage under a qualified long-term care insurance policy is to be treated as an accident or health plan with respect to such coverage, (3) amounts (other than policyholder dividends or premium refunds) received under such a contract or plan with respect to qualified long-term care services are to be treated as amounts received for personal injuries or sickness and as reimbursement for expenses actually incurred for purposes of the medical expense deduction, (4) amounts paid for a qualified long-term care insurance policy are treated as amounts paid for insurance for purposes of the medical expense deduction, and (5) a qualified long-term care insurance policy is treated as a guaranteed renewable contract subject to the rules of Code section 816(e).

Thus, under the bill, amounts received under a qualified long-term care insurance contract would be excluded from the gross income of the recipient to the extent that the amounts are not attributable to expenses (i.e., medical expenses or expenses for qualified long-term care services) that were allowed as a deduction for a prior taxable year.

In addition, under the bill, contributions by an employer to a plan that provides coverage under a qualified long-term care insurance policy for an employee, the spouse of the employee, or a dependent of the employee, would be excluded from the gross income of the employee. However, this exclusion would not apply unless the plan allows all nonexcludable employees to participate and the benefits provided under the plan are identical for all employees that choose to participate. Excludable employees for this purpose would be (1) employees who have not completed 3 years of service, (2) employees who have not attained age 25, (3) part-time or seasonal employees, and (4) employees who are nonresident aliens.

Definition of qualified long-term care insurance policy

In general

An insurance policy would be a "qualified long-term care insurance policy" if: (1) the policy is a long-term care insurance policy as defined in section 4 of the Long-Term Care Insurance Model Act published by the National Association of Insurance Commissioners, as amended through January 1993 (NAIC Model Act); (2) it satisfies the requirements of subpart B of part 3 of subtitle B of title II of the Health Security Act (secs. 2321 to 2326 of the Health Security Act), relating to Federal standards and requirements for private long-term care insurance; (3) benefits under the policy are limited to individuals who are certified by a licensed professional within the preceding 12-month period as being unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision) two or more activities of daily living or who have a severe cognitive impairment; and (4) the policy satisfies the requirements specified below relating to (a) the payment of premiums, (b) cash value and the borrowing of money, (c) refunds of premiums and dividends, (d) the coverage of expenses reimbursable under Medicare or covered under comprehensive health coverage, and (e) the maximum benefit.

NAIC Model Act

Section 4 of the NAIC Model Act defines a long-term care insurance contract as any insurance policy or rider designed to provide coverage for not less than 12 consecutive months for a covered person for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. The term also includes a policy or rider that pays benefits based upon cognitive impairment or the loss of functional capacity. The term does not include life insurance policies that pay accelerated death benefits specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement.

Requirements of Health Security Act

Sections 2321 through 2326 of the Health Security Act set forth Federal standards with respect to long-term care policies. In general, these standards are to be established by the Secretary of Health and Human Services after considering (where appropriate) recommendations of the National Long-Term Care Insurance Advisory Council to be established under the bill.[113] These standards are to relate to the following areas: (1) information required to be provided to customers and beneficiaries about particular policies

[113] The National Long-Term Care Insurance Advisory Council is to be established by the Secretary of Health and Human Services (HHS) pursuant to section 2302 of the Health Security Act. The general purpose of the Advisory Council is to be: to provide advice, recommendations and assistance to the Secretary of HHS on matters relating to long-term care insurance; collect, analyze, and disseminate information relating to long-term care insurance in order to increase the understanding of insurers, providers, consumers, and regulatory bodies relating to such insurance; develop proposed models, standards, requirements, and procedures relating to such insurance for the consideration of the Secretary of HHS; and monitor the developments of the long-term care insurance market.

and the availability of different types of policies and the use of standardized formats and terminology; (2) coverage requirements (including requirements as to preexisting conditions, inflation coverage, premiums, conditions on eligibility for benefits, and prohibition of discrimination by diagnosis; (3) sales practices; (4) continuation, renewal, replacement, conversion, and cancellation of policies (including nonforfeiture rights); and (5) claims for and payment of benefits.

Payment of premiums

In order for an insurance policy to constitute a qualified long-term care insurance policy, the policy would be required to provide that the premium payments under the policy may not be made earlier than the date that such payments would have been made if the policy provided for level annual premium payments over the life expectancy of the insured or, if shorter, 20 years. A policy would not fail to meet this requirement merely because the policy provides for a waiver of premiums if the insured becomes eligible for benefits under the qualified policy.

Refunds of premiums and dividends

In order for an insurance contract to be a qualified long-term care insurance policy, it would have to provide that policyholder dividends are to be applied as a reduction in future premiums or to increase future benefits (to the extent consistent with the limit on maximum benefits). The policy would have to provide that refunds of premiums upon a partial surrender or cancellation of the policy are required to be applied as a reduction in future premiums. Further, the policy would have to provide that any refund that occurs by reason of the death of the insured or upon the complete surrender or cancellation of the policy cannot exceed the aggregate premiums previously paid under the contract. If an amount is refunded under a qualified long-term care insurance policy by reason of the death of the insured or upon complete surrender or cancellation of the policy, the amount received would be included in the gross income of the recipient to the extent that a deduction or exclusion was allowed with respect to the premiums.

Prohibition on cash value and borrowing

An insurance contract would constitute a qualified long-term care insurance policy only if the policy does not provide for a cash value or other money (other than refunds of premiums and dividends described above) that can be paid, assigned, pledged as collateral for a loan, or borrowed.

Coverage of expenses reimbursable under Medicare or other coverage

In addition, in order for an insurance policy to constitute a qualified long-term care insurance policy, the policy could not cover any expense incurred to the extent that the expense is reimbursable under Medicare or covered under comprehensive health coverage described in section 1101 of the Health Security Act.

Maximum permitted benefits

Benefits under a qualified long-term care insurance policy could be paid on a reimbursement basis or without regard to the expenses incurred during the period to which the payments relate. In either case, such payments would be treated as compensation for expenses paid for medical care for purposes of the deduction for medical expenses.

A qualified long-term care insurance policy could not provide for benefits in excess of $150 per day (or the equivalent amount within the calendar year in the case of payments on other than a per diem basis). For 1997, the $150 limit would be increased by the percentage increase in the consumer price index for calendar year 1996 plus 1-1/2 percent. For subsequent years, the dollar limit would be adjusted annually for inflation in accordance with a cost index to be developed by the Secretary of HHS to measure increases in costs of nursing homes and similar facilities. For purposes of applying the maximum benefit limit, all policies issued with respect to the same insured would be treated as one policy.

Treatment of life insurance contracts that provide coverage of qualified long-term care services

Except as provided in Treasury regulations, in the case of long-term care insurance coverage provided by rider on a life insurance contract, the requirements for a policy to constitute a qualified long-term care insurance policy would apply as if the portion of the contract that provides long-term care insurance were a separate contract. In addition, premium payments for long-term care coverage and charges against the life insurance contract's cash surrender value for such coverage would be treated as premiums for purposes of the premium payment rule described above. The guideline premium limitation (sec. 7702(c)) for a contract would be increased, as of any date, by the sum of any charges to the cash surrender value to pay for long-term care insurance coverage, less any such charges the imposition of which reduces the premiums paid for the contract. Finally, no medical expense deduction would be allowed for charges against the life insurance contract's cash surrender value used to reduce premiums, unless such charges are includible in income and the coverage provided by the rider is a qualified long-term care insurance policy.

Treasury regulations

The bill would direct the Treasury Department to prescribe such regulations as may be necessary to carry out the requirements of the provisions of the bill relating to long-term care, including regulations to prevent the avoidance of such provisions by providing long-term care insurance under a life insurance contract and to provide for the proper allocation of amounts between the long-term care and life insurance portions of a contract.

Effective Dates

The provision of the bill relating to the deductibility of expenses paid for qualified long-term care services would apply to taxable years beginning after December 31, 1995. The other provisions of

the bill relating to long-term care would apply to policies issued after December 31, 1995. A policy issued before January 1, 1996, that satisfies the requirements of a qualified long-term care insurance policy on and after January 1, 1996, would be treated as being issued after December 31, 1995.

A special transitional rule would be provided for any long-term care policy insurance issued on or before January 1, 1996. Under this rule, if, after the date of enactment of the bill and before January 1, 1996, the contract is exchanged for a qualified long-term care insurance policy, no gain or loss would be recognized upon the exchange. If any money or other property is received in the exchange, then any gain would be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this transition rule, the cancellation of a policy providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance policy within 60 days would be treated as an exchange.

The issuance of a rider on a life insurance contract providing long-term care insurance coverage would not be treated as a modification or material change of such contract for purposes of determining whether Code section 7702 (relating to the definition of life insurance contract) or section 7702A (relating to the definition of modified endowment contract) applies.

Discussion of Issues

In general

In determining whether special tax rules for long-term care services and expenses are necessary or desirable a number of questions need to be addressed. These include who is likely to need long-term care, what type of services are likely to be necessary, how much does the care cost, how much does the insurance cost, and are retirement benefits and private savings sufficient to pay for the care and/or insurance? If it is determined that special incentives for long-term care are necessary, additional issues need to be addressed, including who should be responsible for providing long-term care services and insurance and how best to ensure that those who need it will purchase it. This includes an examination of the role of employers, individuals, insurance companies, and the Federal and State governments (including spending and tax programs as well as programs regulating long-term care services and insurance). The use of tax incentives involves significant additional issues, including tax abuse potential (including administrability) and the effect on the market for other, similar products.

Issues involved in tax incentives for long-term care

Under present law, the tax treatment of long-term care expenses and insurance is unclear. For example, the extent to which payments for long-term care services are deductible as medical expenses is unclear. Specifying the tax treatment of long-term care services and expenses will further administration of the tax laws and provide greater certainty for employers and individuals. Some issues would remain under the bill. For example, the tax treatment provided in the bill for qualified long-term care expenses is a safe

harbor; expenses that do not qualify may still be deductible under the present-law rules. Thus, issues will still arise as to what is deductible under present law. The extent to which taxpayers will face these issues will be diminished, but not eliminated, by the bill.

There will also be compliance and administrative issues as to whether expenses and insurance meet the requirements set forth in the bill. For example, will the IRS be responsible for verifying whether or not an individual cannot perform the requisite number of activities of daily living? The IRS currently does not get involved in such issues, and verifying whether the tax treatment claimed by the individual is justified could present administrative problems. The more difficult verification is, the more likely there will be compliance problems. Determination of proper tax treatment may also be difficult under the bill because whether or not a policy is a qualified long-term care policy depends on factors outside of the Internal Revenue Code. The tax treatment of a policy will depend on HHS regulations.

The tax treatment provided in the bill for long-term care insurance is very favorable. Both the premiums and the benefits are excludable from income. This means that long-term care insurance would receive more favorable tax treatment than other, similar types of products and arrangements that could also be used to fund long-term care benefits. For example, contributions (and earnings thereon) to employer-provided pension plans are not taxed when made (or earned) but are includible in income when actually received by the plan participant.[114] Individual retirement arrangements (IRAs) receive similar treatment.[115] Thus, in the case of employer pension plans and IRAs, individuals receive the benefit of tax deferral rather than avoiding tax altogether, as would be the case with long-term care insurance under the bill.

Similarly, individuals can purchase deferred annuities. Contributions to such annuities are not tax deductible. Amounts received under the annuity are includible in income except to the extent of contributions. Again, under the bill, long-term care insurance would receive more favorable tax treatment. Further, the bill would permit payments to be made under a long-term care insurance policy on a per-diem basis without regard to whether the payments bear any relation to expenses incurred. Under the bill, almost $55,000 a year could be received, tax free, under a long-term care contract. It is likely that there will be some shifting of deferred annuity money into long-term care contracts under the bill.

Because the tax treatment of long-term care insurance under the bill is so much more favorable than the treatment of other arrangements that could be used by an individual to fund long-term care expenses, people who currently use (or would use) these alternatives will want to purchase long-term care insurance instead. Thus, the easier it is to meet the requirements for long-term care

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[114] Contributions that are made by an employee to an employer pension plan on an after-tax basis are not taxed again when distributed. Only earnings on such contributions are subject to tax.

[115] Contributions to an IRA can be either deductible or nondeductible. In the case of deductible contributions, the individual gets a tax deduction in the year the contributions are made, and contributions (and earnings thereon) are not includible in income until received. Nondeductible contributions are taxed in the same way as after-tax contributions to employer pension plans. Thus, earnings on the contributions are includible in gross income when received, but the contributions are not.

insurance and the more difficult it is for the IRS to monitor compliance, the more shifting away from other arrangements and the more growth in the sale of long-term care insurance will occur.

2. Tax treatment of accelerated death benefits under life insurance contracts (secs. 7703 and 7704 of the bill and secs. 101, 807, 816, and 7702 of the Code)

Present Law

The Federal income tax treatment of an insurance contract to the policyholder, beneficiaries and the issuing company depends upon whether the contract qualifies as a life insurance contract under section 7702 of the Code.

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. Thus, neither the beneficiary nor the owner of the contract is ever taxed on the inside buildup if the proceeds are paid to the beneficiary by reason of the death of the insured.

The exclusion under section 101 applies regardless of whether the death benefits are paid as a lump sum or otherwise. The interest component of amounts paid after the death of the insured is generally subject to tax.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includible in the gross income of the recipient to the extent that the amount received exceeds the taxpayer's investment in the contract (generally, the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

Treatment under a failed life insurance contract

In contrast, if a contract fails to be treated as a life insurance contract under section 7702(a), inside build-up on the contract is generally subject to tax. Under section 7702(g), income on the contract for the year in which a contract fails to meet the definition of life insurance (and for all prior years of the contract) generally is treated as ordinary income received or accrued by the holder during that year. For this purpose, income on the contract is the excess of the increase in the net surrender value of the contract during the tax year and the cost of the life insurance protection provided during the year minus the premiums paid (sec. 7702(g)(1)(B)). In addition, a portion of the amount paid by reason of the death of the insured may be includible in income; that is, only the excess of the amount paid by reason of the death of the insured over the net surrender value of the contract is treated as life insurance proceeds eligible for the exclusion provided under section 101 (sec. 7702(g)(2)).

Treatment of companies issuing life insurance contracts

The determination of both an insurance company's reserve deduction and its qualification as a life insurance company is dependent on whether the contracts it issues qualify as life insurance contracts under section 7702. A contract that is a life insurance contract under the applicable law (e.g., State law), but that fails to meet the definition of a life insurance contract, is nevertheless treated as an insurance contract (sec. 7702(g)(3)). Thus, if a company issues contracts that fail to meet the definition of a life insurance contract, and reserves for such contracts are not treated as life insurance reserves, the amount of the company's reserve deduction could be altered (sec. 816(b), sec. 807)).

An insurance company is treated as a life insurance company, provided that more than 50 percent of its reserves are comprised of life insurance reserves or unearned premiums or unpaid losses on noncancellable life, accident or health policies not included in life insurance reserves (sec 816(a)). If the company issues a significant enough portion of failed life insurance contracts that are not treated as giving rise either to life insurance reserves, or to unearned premiums or unpaid losses on noncancellable life, accident or health policies not included in life insurance reserves, then the company could fail to be treated as a life insurance company for Federal income tax purposes.

Requirements for a life insurance contract

To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) a cash value accumulation test, or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement (sec. 7702(a)). A contract satisfies the cash value accumulation test if the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract. A contract satisfies the guideline premium/cash value corridor test if the premiums paid under the contract do not at any time exceed the greater of the guideline single premium or the sum of the guideline level premiums, and the death benefit under the contract is not less than a varying statutory percentage of the cash surrender value of the contract.

The net single premium for purposes of the cash value accumulation test and the guideline single premium or guideline level premiums for purposes of the guideline premium/cash value corridor test are the amounts necessary to fund the future benefits under the contract. For this purpose, the term "future benefits" means death benefits and endowment benefits. In addition, the charge stated in a contract for any qualified additional benefit is treated as a future benefit, thereby increasing the applicable limitation by the discounted value of the charge. The term "qualified additional benefit" means guaranteed insurability, accidental death or disability, family term coverage, disability waiver, and any other benefit prescribed under Treasury regulations.

Proposed regulations on accelerated death benefits

The Treasury Department has taken the position in proposed regulations that certain "qualified accelerated death benefits" paid to an insured because of his or her terminal illness are treated as paid by reason of the death of the insured and therefore qualify for exclusion under section 101. In addition, the proposed regulations would permit an insurance contract that includes a qualified accelerated death benefit rider to qualify as a life insurance contract under section 7702. Thus, the proposed regulations provide that including this benefit would not cause an insurance contract to fail to meet the definition of a life insurance contract.

Under the proposed regulations, a benefit qualifies as a qualified accelerated death benefit only if it meets 3 requirements. First, the benefit is payable only if the insured becomes terminally ill. Second, the amount of the benefit equals or exceeds the present value of the reduction in the death benefit otherwise payable. Third, the ratio of (1) the cash surrender value immediately after the payment of the accelerated death benefit to the cash surrender value immediately before the payment of the accelerated death benefit, equals or exceeds the ratio of (2) the death benefit payable immediately after payment of the accelerated death benefit to the death benefit payable immediately before payment of the accelerated death benefit.

For this purpose, an insured person is treated as terminally ill if he or she has an illness that, despite appropriate medical care, is reasonably expected to result in death within 12 months from the date of payment of the accelerated death benefit. The provision does not explicitly require a doctor's certification as to the patient's condition.

The discount rate in determining the reduction in the death benefit (that occurs by reason of the accelerated death benefit) is the greater of (1) the applicable Federal rate (AFR) (as determined for purposes of discounting unpaid loss reserves of property and casualty insurance companies under sec. 846(c)(2)); or (2) the interest rate applicable to policy loans under the contract. The discount rate is to be calculated assuming the death benefit would have been paid 12 months after the payment of the accelerated death benefit.

Description of Provision

The bill would provide an exclusion from gross income for certain distributions received by an individual under a life insurance contract if the insured under the contract is terminally ill. For this purpose, an individual would be considered terminally ill if the insurer determines, after receipt of an acceptable certification by a licensed physician, that the individual has an illness or physical condition that reasonably can be expected to result in death within twelve months of the certification.

The exclusion under the provision would be applicable only if two requirements are met. First, the distribution equals or exceeds the present value of the reduction in the death benefit otherwise payable under the life insurance contract. Second, the percentage derived by (1) dividing the cash surrender value of the contract immediately after the distribution by the cash surrender value of the

contract immediately prior to the distribution, equals or exceeds the percentage derived by (2) dividing the death benefit immediately after the distribution by the death benefit immediately before the distribution.

To determine the present value of the reduction in the death benefit caused by the distribution, the death benefit would be assumed to be paid at the end of the insured's life expectancy or 12 months, whichever is shorter. The discount rate is the highest of (1) the 90 day Treasury bill yield, (2) Moody's Corporate Bond Yield Average-Monthly Average Corporates (or any successor rate) for the month ending two months before the date the rate is determined, (3) the rate used to determine cash surrender values under the contract during the applicable period plus 1 percent per annum, or (4) the maximum permissible interest rate applicable to policy loans under the contract.

For insurance company tax purposes, the bill would provide that a qualified accelerated death benefit rider to a life insurance contract is treated as life insurance. In addition, the bill would provide that a qualified accelerated death benefit rider is treated as a qualified additional benefit under section 7702(f)(5)(A). For purposes of the provision, a qualified accelerated death benefit rider is any rider on a life insurance contract that provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined above).

Effective Date

The provision relating to the individual tax treatment of the distribution of accelerated death benefits would apply to taxable years beginning after December 31, 1993. The provision relating to the tax treatment of companies issuing qualified accelerated death benefit riders would apply to contracts issued after December 31, 1993.

Discussion of Issues

The provision is designed to ease the financial burden of many terminally ill individuals and their families by not imposing Federal income tax on benefits received under life insurance contracts prior to death. The amount of Federal income tax that would otherwise be paid could be used to pay the medical bills and other living expenses of the terminally ill individual.

The provision, however, would place no restriction on the use of the tax-free proceeds. In fact, the provision does not specify that the life insurance proceeds must be paid to, or for the benefit of, the terminally ill insured. For example, the proceeds could be paid to the beneficiary under the contract and used for the beneficiary's personal expenses. Thus, it is uncertain whether the insurance funds would actually be used to pay the medical bills and other living expenses of the terminally ill individual.

The treatment of inside buildup under present law favors life insurance as an investment over other investment vehicles, thereby distorting the flow of savings and investment in the economy. The provision would provide an additional incentive for individuals to purchase life insurance and could thereby exacerbate the inefficiencies of present law.

The provision would also result in the unequal treatment of terminally ill individuals because it would provide a tax benefit only for those who own life insurance with this rider or those who purchase life insurance with this rider in the future. For example, the treatment provided under the bill would not be available to terminally ill individuals who sell their policies to so-called viatical settlement companies. (The discount rate used to determine the amount the policyholder receives from such a sale may not be regulated, so it is possible that the terminally ill person could receive substantially less from such a sale than under the accelerated death benefit rule in the bill, which specifies permissible discount rates.) In addition, the provision would primarily benefit higher-income individuals who are able to afford greater amounts of life insurance. A more efficient and equitable tax subsidy could be developed if the goal is to assist the terminally ill.

The exclusion under the provision would be dependent upon a physician's certification that the insured has an illness or physical condition that can reasonably be expected to result in death in twelve months or less. It can be argued that the life insurance company issuing the contract that includes an accelerated death benefit would monitor the certification process to prevent abuses. Under this view, the life insurance company would have no incentive to permit a policyholder to receive funds in advance of death, especially if the policyholder is not in fact likely to die within 12 months (the discount rate under the provision assumes the payment is made 12 months or less before death).

On the other hand, it can be argued that the certification requirement may cause severe administrative problems. For example, without an audit of the certification process, the provision may result in the receipt of tax-free benefits where the insured is not seriously ill, but rather merely wishes to obtain the inside buildup on a tax-free basis prior to death.

Finally, no policy reason exists to treat an accelerated death benefit rider as a qualified additional benefit for purposes of section 7702. Under present law, an accelerated death benefit rider may be obtained under a life insurance contract on a "current cost basis" without violating the definition of life insurance. By allowing this additional benefit to be prefunded, the Federal government would be providing an additional subsidy to life insurance (i.e., the foregone tax on the investment income that is earned with respect to the prefunded amount).

Subtitle H. Tax Incentives for Health Services Providers

1. Nonrefundable credit for certain primary health services providers (sec. 7801 of the bill and new sec. 23 of the Code)

Present Law

Present law does not provide for a special credit against Federal income taxes for individuals who provide medical services in medically underserved geographic areas. In general, the operation of Internal Revenue Code rules does not vary based on the location within the United States of income-producing activity. However, present law provides favorable Federal income tax treatment for certain U.S. corporations that operate in Puerto Rico, the U.S. Virgin Islands, or possessions of the United States to encourage the conduct of trades or business within these areas. In addition, within certain Code sections, there are definitions of targeted geographic areas for limited purposes (e.g., low-income housing credit and qualified mortgage bond provisions target certain economically distressed areas).

The Omnibus Budget Reconciliation Act of 1993 ("1993 Act") provides for the designation of nine empowerment zones and 95 enterprise communities in economically distressed areas satisfying certain criteria. The designations are to be made during 1994 and 1995, and generally will remain in effect for 10 years. During the period the designation is in effect, special tax incentives (i.e., an employer wage credit, additional section 179 expensing, and expanded tax-exempt financing) are available for certain business activities conducted in empowerment zones. Expanded tax-exempt financing benefits are available for certain facilities located in enterprise communities. In addition, the 1993 Act provides accelerated depreciation benefits and an incremental employer wage credit for certain business activities conducted on Indian reservations.

Code section 108(f) provides an exclusion from Federal income tax for what otherwise would be discharge-of-indebtedness income if a student loan is discharged pursuant to a provision in the loan agreement that requires the student to work for a period of time in certain professions for any of a broad class of employers. Section 108(f) applies only to student loans made from funds provided by the Federal Government, a State or local government, or certain public benefit corporations described in section 501(c)(3). For example, the favorable treatment provided by section 108(f) applies when a government agency discharges a student loan upon the student's provision of medical services to an underserved area.

Other, non-tax provisions of Federal law provide that certain health care professionals who agree to practice in "health professional shortage areas" (HPSAs) are eligible for scholarships or repayments of student loans.

Description of Provision

A physician who provides primary health services in certain medically underserved areas would be eligible for a nonrefundable credit against Federal income taxes of $1,000 per month for up to 60 months. The credit rate would be $500 per month in the case

of a physician assistant, nurse-practitioner, or certified nurse-midwife. The credit would be available to a taxpayer only if he or she provides primary health services[116] on a full-time basis in a "health professional shortage area" (HPSA) (as defined under present-law section 332(a)(1)(A) of the Public Health Service Act).[117] The taxpayer would be required to obtain (at the time of commencement of work in the area) certification from the United States Public Health Service of the Department of Health and Human Services, as a provider of primary health services in a HPSA.[118]

Under the provision, a taxpayer would be required to work full time in a HPSA for five consecutive years in order to receive the full tax credit. If a taxpayer does not provide primary health services in a HPSA for at least two consecutive years, any credit previously claimed would be completely recaptured. A portion of the credit would be available if the taxpayer provides primary health services in the area for more than two consecutive years (and the remaining portion of any credit previously claimed would be recaptured). The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, would be granted authority to waive recapture of credits when a taxpayer ceases to provide services in a HPSA due to extraordinary circumstances.

Effective Date

The provision would be effective for taxable years beginning after 1994.

Discussion of Issues

Under the provision, the availability of the credit would turn on whether a health professional locates his or her practice in a certified underserved area, not on whether the professional provides care to a requisite number of underserved patients. It may not be appropriate to provide a tax incentive to a physician merely because his or her office is located in an underserved area, even though many patients of that physician may not reside in the area. This probably would not be an issue in an underserved rural area, but in an urban area, it is possible that a physician could locate an office in an underserved area of town, yet continue to serve many patients who live outside the underserved area. It may be possible to link the tax credit to the furnishing of medical services to a significant number of persons who actually reside in an underserved area; however, such an approach could create significant administrative burdens.

The provision would apply only if a health care professional obtains certification from the Federal Government prior to commencing work in an underserved area. Thus, the credit would not be

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[116] For purposes of the provision, the term "primary health services" would have the meaning given such term by section 330(b)(1) of the Public Health Service Act.

[117] A health care professional would be treated as providing services in a HPSA, even if the area no longer has designation as such, so long as the area was a HPSA when the professional began providing services in the area.

[118] The credit would not be available, however, if the taxpayer has received a scholarship under the National Health Service Corps (NHSC) Scholarship Program or any loan repayments under the NHSC Loan Repayment Program.

available to a health care professional who already works in such an area. Paradoxically, the provision would create an incentive for a physician who already works in such an area to leave temporarily in order to re-enter the area after 1994 when he or she has obtained the required certification.

Some may consider it more appropriate to provide for a program of direct grants to health professionals. Such a grant program would provide a greater incentive to medical providers who do not anticipate (or do not have as an objective) earning sufficient taxable income to use the entire $12,000-per-year credit against Federal income taxes.

The question arises whether it is appropriate to provide a tax credit of up to $12,000 per year regardless of the taxpayer's AGI. However, if an AGI limit were incorporated into the provision, this could be viewed as undercutting the objective of encouraging high-quality (and, therefore, financially successful) health professionals to locate their practices in underserved areas.

2. Expensing of medical equipment (sec. 7802 of the bill and sec. 179 of the Code)

Present Law

Depreciation rules

In general, the cost of property that has a useful life longer than one year must be capitalized and recovered over time pursuant to depreciation or amortization rules. Tangible depreciable property placed in service after 1986 is depreciated under the modified Accelerated Cost Recovery System (MACRS) enacted as part of the Tax Reform Act of 1986. Under MACRS, high technology medical equipment is depreciated for regular tax purposes over a 5-year recovery period using the 200-percent declining balance method. "High technology medical equipment" means any electronic, electromechanical, or computer-based high technology equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment.

In general, MACRS deductions for certain property are reduced under an alternative depreciation system by calculating depreciation using the straight-line method over the property's class life. A property's class life generally corresponds to its Asset Depreciation Range (ADR) midpoint life and often is longer than the recovery period applicable for regular tax purposes. The alternative depreciation system applies to foreign use property, tax-exempt use property, tax-exempt bond-financed property, certain imported property, and property for which the taxpayer so elects and is used to compute corporate earnings and profits. The class lives of the alternative depreciation system also are used for purposes of the corporate and individual alternative minimum tax. The class lives of some assets are set by statute, regardless of the asset's ADR midpoint life. The class life of high technology medical equipment is set by statute at five years.

Section 179 expensing allowances

In lieu of depreciation, a taxpayer with a sufficiently small amount of annual investment may elect to deduct up to $17,500 of

the cost of qualifying property placed in service for the taxable year under section 179.[119] In general, qualifying property is defined as depreciable tangible personal property that is purchased for use in the active conduct of a trade or business. The $17,500 amount is reduced (but not below zero) by the amount by which the cost of qualifying property placed in service during the taxable year exceeds $200,000. In addition, the amount eligible to be expensed for a taxable year may not exceed the taxable income of the taxpayer for the year that is derived from the active conduct of a trade or business (determined without regard to this provision). Any amount that is not allowed as a deduction because of the taxable income limitation may be carried forward to succeeding taxable years (subject to similar limitations).

Description of Provision

The bill would increase the amount allowed to be expensed under section 179 in a taxable year by the lesser of: (1) the cost of section 179 property which is health care property placed in service during the year or (2) $10,000. For this purpose, "health care property" would mean section 179 property: (1) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment; (2) which is owned (directly or indirectly) and used by a physician (as defined by section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act); and (3) substantially all the use of which is in such area.

Effective Date

The provision would apply to property placed in service after December 31, 1994.

Discussion of Issues

Proper measurement of income

One of the goals of the income tax is to measure properly economic income so as not to distort investment decisions. In order to properly measure economic income, the cost of property that has a useful life longer than one year should be recovered over such useful life. The election to expense the cost of long-lived property under section 179 of present law is a departure from this goal. By increasing the section 179 expensing allowance, the provision would increase the mismeasurement of economic income for income tax purposes.

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[119] Section 13116 of the Omnibus Budget Reconciliation Act of 1993 increased the amount allowed to be expensed under section 179 from $10,000 to $17,500 for qualified property placed in service in taxable years beginning after 1992. In addition, under section 13301 of the 1993 Act, the amount allowed to be expensed under section 179 by an enterprise zone business is increased by the lesser of: (1) $20,000 or (2) the cost of section 179 property that is qualified zone property placed in service during the taxable year.

Effectiveness of tax incentives

There are several instances in the Internal Revenue Code of departures from the proper measurement of economic income in order to provide incentives for certain investments, transactions, or industries. For example, the present-law section 179 expensing allowance provides an incentive for small businesses to invest in tangible personal property.[120] Likewise, the provision in the bill would provide a tax incentive by lowering the cost of capital for medical equipment to be used in health professional shortage areas. This tax benefit may provide an incentive for physicians already located in health professional shortage areas to increase the amount of their investment in new qualified equipment or for other physicians to relocate to such areas and make qualified investments there.[121] However, any tax incentive may have unintended effects. For example, it may: (1) reward investments that may have occurred in any event; (2) encourage "churning" by selling off nonqualified property and using the proceeds to acquire qualified property, without a resulting increase in net investment; or (3) be overutilized and result in an over-investment in targeted property, to the detriment of investment in other productive property. Because the expensing provision in the bill is targeted toward a narrow class of property, the potential scope of unintended effects is limited.

The provision of tax benefits to influence behavior generally is effective only if the benefits can be used by the targeted taxpayers. The provision of the bill limits the availability of the incentive by retaining the limitations contained in present-law section 179. Specifically, the expensing allowance is: (1) phased-out if investment during the year exceeds $200,000 (under the provision, it is totally phased-out if investment exceeds $227,500) and (2) limited to the amount of taxable income from the trade or business of the taxpayer. Thus, section 179 expensing is not available if the taxpayer makes a large investment in qualified equipment during the year (as may be the case with respect to costly, sophisticated medical equipment) or if the taxpayer's business is in the start-up stage and not generating taxable income (as may be the case with the opening of a new facility or clinic). In fact, the limitations of present-law section 179 may operate to delay investment in qualified property over a period of years so as to maximize annual expensing allowances over the investment period.[122]

In addition, an expensing allowance provides the greatest incentive for those taxpayers who are subject to the highest marginal income tax rate. Although many physicians may be subject to the top rate, it is unclear whether physicians practicing in health professional shortage areas are within such group.

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[120] The present-law section 179 expensing allowance also is viewed as a simplification measure for small businesses because annual depreciation calculations and records become unnecessary for expensed property.

[121] If the intent of the provision is to provide an incentive for physicians to relocate to health professional shortages areas, the question arises as to whether a tax incentive that provides a benefit for capital investment will have an effect upon a physician's decision regarding the application of his or her labor.

[122] For example, assume that a taxpayer wishes to invest in $400,000 of qualified property. If the taxpayer makes the entire investment in Year 1, no expensing is allowed under section 179 because of the $200,000 phase-out. However, if the taxpayer evenly spreads the investment over Years 1 and 2, full expensing is allowed for both years, subject to the income limitation.

For these reasons, some believe that incentives to influence behavior are better accomplished through direct expenditures than through the Internal Revenue Code. Because the provision in the bill targets property to be used in areas that are already subject to the Public Health Service Act, the results intended by the incentive may be more efficiently achieved by increasing direct (or creating new) expenditures within that Federal program.

Other issues

The provision in the bill raises some technical issues that should be clarified.

The increased expensing allowance would be provided for property that is "owned (directly or indirectly) and used by a physician." Presumably indirect ownership includes ownership of, or having an interest in, an entity such as a corporation or partnership that owns the property. This issue should be clarified. In addition, the extent to which ownership and use by the physician must coincide in order to qualify for the increased expensing allowance also should be clarified. For example, would or should the provision apply where: (1) the physician is the sole or primary user of property that is owned by a partnership in which the physician has only a minority interest, or (2) the physician is the sole owner, but only occasional user, of the property? In addition, does "use" include the leasing of equipment from one physician to another?

A provision in the Omnibus Budget Reconciliation Act of 1993 provides an enhanced section 179 expensing allowance for qualified property placed in service by an enterprise zone business. The enhanced expensing allowances for qualified health care property and for qualified zone property would have to be coordinated to the extent that a health professional shortage area also qualifies as an empowerment zone.

The provision would apply to property placed in service after December 31, 1994. Because section 179 contains an annual income limitation, amendments to section 179 generally are effective with respect to taxable years beginning or ending after a certain date (rather than with respect to a placed-in-service date) in order to alleviate the administrative burden of allocating annual income before and after a placed-in-service date.

Subtitle I. Miscellaneous Provisions

1. Tax credit for the cost of personal assistance services required by employed individuals (sec. 7901 of the bill and new sec. 24 of the Code)

Present Law

There is no tax credit for the costs of personal assistance required by employed individuals. Certain medical expenses, however, are deductible under section 213 to the extent that they exceed 7.5 percent of the taxpayer's adjusted gross income (AGI). Also, the costs of certain improvements to property are generally included in the basis of a taxpayer's property unless otherwise deductible under section 213.

Description of Provision

The bill would provide a nonrefundable tax credit for up to 50 percent of an employed individual's personal assistance expenses up to $15,000. The maximum annual amount of such expenses that could qualify for the credit would be the lesser of $15,000 or the individual's earned income. The amount of the credit would be phased out by providing a lower credit rate for taxpayers with modified AGI of $50,000 or more. The credit rate would be reduced by ten percentage points for each $5,000 of modified AGI, starting at $50,000 of modified AGI. Thus the credit would not be available for individuals with modified AGI of $70,000 or more.

The rate of the credit would be determined as follows:

For taxpayers with modified AGI:	*The credit rate would be:*
Less than $50,000	50 percent
At least $50,000, but less than $55,000	40 percent
At least $55,000, but less than $60,000	30 percent
At least $60,000, but less than $65,000	20 percent
At least $65,000, but less than $70,000	10 percent
At least $70,000	0 percent

The $15,000 (maximum amount of personal assistance expenditures eligible for the credit) and $50,000 (beginning of the credit's phaseout range) amounts would be indexed for inflation for taxable years beginning after 1996. The amount of modified AGI at which the credit is entirely phased out would not be indexed for inflation, but would always be $20,000 greater than the beginning of the phaseout range.

Modified AGI would mean adjusted gross income: (1) determined without regard to the exclusions provided for (a) interest on education savings bonds (sec. 135), (b) certain foreign earned income of U.S. citizens or residents living abroad (sec. 911), (c) certain income from sources within Guam, American Samoa, or the Northern Mariana Islands (sec. 931), and (d) income from sources within Puerto Rico (sec. 933); and (2) increased by the amount of tax-exempt interest received or accrued by the taxpayer during the taxable year.

Personal assistance expenses would include expenses for: (1) personal assistance services appropriate to carry out the activities of daily living in or outside the home, (2) homemaker/chore services

incidental to the provision of such personal assistance services, (3) assistance with life skills (in the case of an individual with a cognitive impairment), (4) communication services, (5) work-related support services, (6) coordination of services described in this paragraph, (7) assistive technology and devices (including assessment of need and training for such services), and (8) modifications to the principal place of abode of the individual. Activities of daily living would be defined under new rules added by the bill relating to deductible medical expenses (new Code sec. 213(g)(3)). Under these rules, activities of daily living would be eating, toileting, transferring, bathing, and dressing.

An eligible individual would be defined as any individual (other than a nonresident alien) who by reason of any medically determinable physical impairment is unable to engage in any substantial gainful activity without personal assistance in carrying out activities of daily living. Such physical impairment must be expected to result in death or must be expected to last for a continuous period of not less than 12 months.

Any amount taken into account in determining the credit could not be taken into account in determining deductible medical expenses (under sec. 213). Similarly, if a credit is allowed for expenses that would otherwise increase the basis of property, the basis increase would be reduced by the amount of the credit. The bill also would deny the credit for payments to related persons.[123]

Effective Date

The provision would be effective for taxable years beginning after December 31, 1995.

Discussion of Issues

In order to levy income taxes commensurate with each taxpayer's ability to pay, the economic income of taxpayers must be measured properly. To this end, the Code allows deductions such as those for extraordinary medical expenses and expenses undertaken to earn income (e.g., union dues). Notwithstanding the desire to measure income properly, certain tax credits or other benefits are allowed to reduce an individual's tax liability because encouraging certain activities through tax benefits is thought to outweigh the goal of proper measurement of income. Generally the Code does not allow tax deductions or credits for a taxpayer's personal living expenses (e.g., cost of food, rent, utilities, and commuting).

The proposal would define a new class of "work-related support services" for physically impaired taxpayers. It can be argued that such expenses are necessary for these taxpayers to earn income. The broader issue presented by this proposal as drafted is whether it allows tax benefits for a taxpayer's personal living expenses and, if so, whether the provision of those tax benefits is more important than the proper measurement of income.

An alternative to providing a credit for qualifying expenditures on personal assistance would be to permit such expenditures to be deductible from income subject to tax. To the extent the expenses

[123] Related persons would mean any person related to the taxpayer within the meaning of secs. 267 or 707(b).

are undertaken to earn income, the goal of proper measurement of economic income would argue in favor of a deduction rather than a credit. More generally, to the extent that all of the qualifying expenses reduce the taxpayer's ability to pay taxes, a deduction might be justified. The question is whether these expenses are considered to be so necessary or special that they should be paid with pre-tax dollars.

Of course, each dollar deducted provides a greater benefit to a high marginal tax rate taxpayer than to a low marginal tax rate taxpayer. If the goal of the tax benefit is to provide a subsidy to encourage work, then the credit may be desirable because it provides an equal tax benefit to all taxpayers regardless of income. Since marginal tax rates increase with income, the value of a deduction's tax benefit increases with income. Some might view a deduction for these expenses as reducing the progressivity of the income tax.

The proposal would reduce the amount of the credit for taxpayers with incomes of $50,000 or more and provide no credit for taxpayers with incomes of $70,000 or more. Under a view that the credit is needed to compensate the taxpayer for a reduced ability to pay taxes, denying the credit to taxpayers with incomes above a certain limit is unwarranted unless a physically impaired taxpayer with an income above the limit is believed to have the same ability to pay taxes as a taxpayer with the same income who is not physically impaired. In the phaseout range, the reduction in the credit as income increases operates as an increase in the marginal tax rate on the taxpayer. The effect of this increase in marginal rates may be reduced somewhat because the reduction in the credit occurs at five discrete modified AGI levels ($50,000 and each $5,000 interval up to $70,000), so an increase in income that leaves the taxpayer's modified AGI between two of these thresholds will not affect the amount of the credit. An increase in income that pushes the taxpayer's modified AGI above one of these thresholds, however, will result in a sizeable reduction in the credit. Another question is raised by providing the same phaseout range for single filers and for married couples filing a joint return. A substantial marriage penalty could be created for certain physically impaired individuals.

Lastly, the statutory draft is unclear whether the credit is available for "expenses paid" or "expenses paid or incurred". The statement of the general rule for the credit refers to "expenses paid or incurred", while the limitation on qualifying expenses refers to "expenses paid".

2. Denial of tax-exempt status for borrowings of health care-related entities (sec. 7902 of the bill and sec. 141 of the Code)

Present Law

Interest on bonds issued to finance activities of States and local governments generally is tax exempt. However, interest on private activity bonds is taxable unless the bonds are issued for a purpose specifically identified in the Internal Revenue Code. Issuance of tax-exempt private activity bonds by States and local governments

is subject to several additional restrictions that do not apply to governmental bond issuance including, for most such bonds, annual State volume limitations

State and local government bonds are private activity bonds if either a private loan test or a private business test is met. The private loan test is satisfied if an amount of bond proceeds exceeding five percent of an issue (or $5 million, if less) is used to finance loans to persons other than governmental units.

The private business test is met if—

(1) an amount exceeding 10 percent of the proceeds[124] is to be used (directly or indirectly) in any private trade or business carried on by any person other than a governmental unit, and

(2) more than 10 percent of the payment of principal or interest on the issue, directly or indirectly, (i) is derived from payments in respect of property to be used in a private trade or business, or (ii) is secured by an interest in property used in a private trade or business or payments in respect to property to be used in such a trade or business.

One type of tax-exempt private activity bond is a bond the proceeds of which are used by a section 501(c)(3) exempt organization to finance its charitable activities ("qualified 501(c)(3) bonds"). Qualified 501(c)(3) bonds are not subject to the annual State bond volume limitations and to several other of the restrictions that apply to most other private activity bonds.

Description of Provision

Regional and corporate health alliances created pursuant to the Health Security Act would be treated as private businesses that are generally not eligible for tax-exempt financing. Similarly, State guaranty funds established pursuant to section 1204 of the Act would be treated as private business users and generally could not be funded with proceeds of tax-exempt bonds.

Effective Date

The provision would be effective for obligations issued after the date of enactment of the Act.

Discussion of Issues

Tax-exempt financing provides a subsidy to the issuer of the debt (the borrower) in the form of a lower interest rate than the issuer would otherwise incur. The subsidy comes at the expense of reduced Federal revenues. As such, tax-exempt financing spreads a portion of the borrowing costs of the issuer across taxpayers as a whole, rather than the group of taxpayers benefitting from the particular activity being financed. In addition, tax-exempt financing can hide the true cost of the activity being financed because the tax expenditure generally is not accounted for as a cost of the activity. Some suggest, therefore, that it is appropriate to deny tax-exempt financing to the proposed new health care system because such an extension would camouflage the true cost of providing health care,

[124] This amount is reduced to 5 percent in the case of private business use that is unrelated or disproportionate to a governmental activity also being financed with the bonds.

thereby lessening the cost control discipline sought by the Health Security Act.

Further, tax-exempt financing may be less efficient as a financing tool for the proposed health care reforms than direct expenditures because the graduated marginal tax rate structure of the Federal income tax system creates an inefficiency in the interest subsidy provided by tax-exempt finance. The Federal Government will lose more in revenue than the borrower gains in reduced interest payments. For example, if the market for tax-exempt securities efficiently transferred the benefit of the tax-exemption from the lender to the borrower, a taxpayer in the 28-percent bracket would be indifferent between receiving $72 in tax-exempt interest and $100 of taxable interest on which he or she must pay $28 in tax.[125] However, a taxpayer in the 31-percent bracket who receives $72 of tax-exempt interest would be better off than if he or she had received $100 of taxable interest, and a taxpayer in the 36-percent bracket who receives $72 of tax-exempt interest would be even better off. While the Federal Government loses $31 in taxes if the 31-percent bracket taxpayer chooses the tax-exempt instrument, the borrower's interest cost is still only reduced by $28.[126] In addition, to the extent that the benefit of tax-exempt debt accrues to the high tax bracket investors rather than to the borrowers, the use of tax-exempt debt may be seen as unfair and counter to the progressivity of the income tax system.

Others suggest that, notwithstanding these possible inefficiencies, it is appropriate that this implicit Federal financing subsidy be available as a tool for use in complying with the new mandates that would be imposed on States and local governments under the Administration's health care proposal.

3. Disclosure of return information for administration of certain programs under the Health Security Act (sec. 7903 of the bill and sec. 6103(l)(7) of the Code)

Present Law

The Internal Revenue Code prohibits disclosure of tax returns and return information, except to the extent specifically authorized by the Code (sec. 6103). Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both (sec. 7213). An action for civil damages also may be brought for unauthorized disclosure (sec. 7431). No tax information may be furnished by the Internal Revenue Service (IRS) to another agency unless the other agency has established procedures satisfactory to the IRS for safeguarding the tax information it receives (sec. 6103(p)).

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[125] Expressed algebraically, a taxpayer will generally find it attractive to buy a tax-exempt security rather than an otherwise equivalent taxable security if the interest rate paid by the tax-exempt security, r_{te}, is greater than the after-tax yield from the taxable security, $r(1-t)$, where t is the marginal tax rate and r is the yield on the taxable security.

[126] If taxpayers other than those in the highest marginal tax bracket purchase the tax-exempt securities, it generally must be the case that r_{te} exceeds $r(1-t_h)$ where t_h is the highest marginal tax rate. This conclusion implies that the Federal Government will lose more in revenue than the tax-exempt issuer gains in reduced interest payments because the lost tax revenue is rt_h while the reduced interest cost to the issuer is $r - r_{te}$.

Description of Provision

The bill would permit disclosure of certain tax return information to any Federal or State agency providing assistance under the Health Security Act for use in verifying eligibility for such assistance. Such information may include tax return information relating to wages, self-employment net earnings, and retirement income payments provided to the Social Security Administration (SSA) and tax return information relating to unearned income provided to the IRS. Disclosure of tax information would not be permitted to local agencies providing assistance under the Health Security Act.

Under the provision, any Federal or State agency receiving tax information would be required to comply with the safeguards presently contained in the Code governing the use of disclosed tax information.

Effective Date

The provision would be effective on the date of enactment.

Discussion of Issues

The provision is designed to enhance the ability of Federal and State agencies to determine eligibility for assistance (such as income-based subsidies) under the Health Security Act and to identify potential understatements of household wage, interest, and dividend income for further investigation. It is unclear, however, that access to Federal tax information will provide benefits (i.e., useful information beyond that currently available) exceeding the costs associated with providing such information (e.g., developing and maintaining safeguards, adverse behavioral effects on taxpayers, etc.). Moreover, it is not clear how the safeguards and other such restrictions will affect an agency's ability to use such data for enforcement reasons.

In addition, the provision may undermine taxpayers' confidence that their tax information is being kept confidential. As a result, it may provide a disincentive to taxpayers to file accurate returns or to provide certain tax information. It should be noted, however, that other Federal and State agencies already have access to Federal tax data for enforcement purposes. For example, the Department of Veterans Affairs (DVA) has access to certain tax information supplied to the IRS and SSA in order to assist DVA in determining eligibility for, and establishing correct benefit amounts under, certain of its needs-based pension and other programs (sec. 6103(l)(7)(D)(viii)).

Finally, Congress often will grant an agency access to Federal tax information on a temporary basis and then will require the agency to demonstrate the implementation and consistent use of appropriate data safeguards before granting permanent access to such tax information.

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