DESCRIPTION AND ANALYSIS OF PROPOSALS RELATING TO THE TAX TREATMENT OF HEALTH CARE (S. 1757, S. 1775, S. 1579, S. 1770, AND S. 1743)

Scheduled for a Hearing

Before the

SENATE COMMITTEE ON FINANCE

on April 26, 1994

Prepared by the Staff

of the

JOINT COMMITTEE ON TAXATION

April 26, 1994

Advance Copy
JCS-3-94

CONTENTS

INTRODUCTION

This pamphlet,[1] prepared by the staff of the Joint Committee on Taxation, provides a general discussion and analysis of the issues surrounding the tax treatment of health care, together with a description of proposals relating to tax incentives for the provision of health care contained in the following health care reform bills: S. 1757, S. 1775, S. 1579, S. 1770, and S. 1743. The Senate Committee on Finance has scheduled a public hearing on these issues on April 26, 1994.

The "Health Security Act" was introduced by Senator Mitchell and others on November 20, 1993, as S. 1757 and was introduced by Senator Moynihan on November 22, 1993, as S. 1775, both on behalf of the Administration. S. 1579 (the "Managed Competition Act of 1993") was introduced by Senator Breaux and others on October 21, 1993. S. 1770 (the "Health Equity and Access Reform Today Act of 1993") was introduced by Senator Chafee and others on November 22, 1993. S. 1743 (the "Consumer Choice Health Security Act of 1993") was introduced by Senator Nickles and others on November 20, 1993.

Part I of the pamphlet presents an overview of issues relating to the present-law tax incentives for health care benefits and a summary description of the proposals in the bills; Part II describes the taxation of health care benefits and expenses under present law; Part III discusses some of the issues that arise when changes to the tax treatment of health care benefits are considered; and Part IV describes specific legislative proposals in the bills.

---

[1] This pamphlet may be cited as follows: Joint Committee on Taxation, Description and Analysis of Proposals Relating to the Tax Treatment of Health Care (S. 1757, S. 1775, S. 1579, S. 1770, and S. 1743). (JCS-3-94), April 26, 1994.

I. BACKGROUND AND OVERVIEW

A. Tax Incentives for the Purchase of Health Care

1. Present law

In general

The principal goal of the Federal income tax system is the proper measurement and taxation of economic income in order to raise revenue to finance government operations. However, the Federal income tax laws have also been used historically to provide incentives for certain socially desirable behavior. For example, Federal tax laws have historically provided incentives for employers to provide health care to employees.

In considering health reform proposals, Federal tax law is frequently viewed not only as a source of revenue to offset the estimated cost to the Federal budget of the particular reform being proposed, but also as a tool for achieving particular health care policy goals by providing incentives or disincentives for particular categories of taxpayer behavior.

Present Federal tax law provides a number of tax benefits for the purchase of health care. The most significant of these tax benefits are: (1) the exclusion from income and employment taxes for employer-provided health care, (2) an itemized deduction for the cost of obtaining health care in excess of a threshold based on the taxpayer's adjusted gross income, and (3) a partial deduction of health insurance costs of self-employed individual[2]. In addition, under present law, employers are permitted to deduct the cost of health care benefits provided to employees.

Exclusion from income for employer-provided health care

Under present law, an employee is not required to treat the value of employer-provided health care benefits as income for purposes of the Federal income tax or as wages for purposes of Federal payroll taxes. Under present law, this exclusion is unlimited, and the provision of employer-provided health care is relatively unregulated compared to other forms of tax-favored employee compensation. For example, tax-favored employer-provided pension benefits are subject to a variety of rules and restrictions under Federal tax and labor laws, including nondiscrimination rules, minimum participation rules, vesting requirements, and funding rules. There are also dollar limits on the tax benefits provided. In contrast, there is no comprehensive set of similar rules in the health area.

---

[2] This provision expired on January 1, 1994.

The Federal tax expenditure for the exclusion of employer-provided health care is estimated to be $36.7 billion for fiscal year 1994, and $213 billion for fiscal years 1994 through 1998.[3] This is the third largest single tax expenditure item. The largest is the net exclusion for pension contributions and earnings ($55.3 billion for fiscal year 1994) and the second largest is the deduction for home mortgage interest ($45.5 billion for fiscal year 1994).

The most commonly cited rationale for the exclusion for employer-provided health care is that it encourages employers to provide health care to their employees. Employees should prefer to receive compensation in the form of health care rather than in cash or in other taxable forms of compensation. The exclusion makes health care cheaper for employees than if they were to purchase it on an after-tax basis, and may cause some employees to purchase more health care services or insurance than they otherwise would.

Itemized deduction for medical expenses

Individuals can deduct their medical expenses, not otherwise covered by insurance, but only to the extent that total medical expenses for a taxable year exceed 7.5 percent of the taxpayer's adjusted gross income (AGI) for the year. This is the only tax benefit available to individuals who do not receive employer-provided health care. The tax expenditure for the medical expense deduction is estimated to be $3.5 billion for fiscal year 1994 and $24.2 billion for fiscal years 1994-1998.

The rationale for the itemized deduction for medical expenses appears to be different from that for the exclusion of employer-provided health care. Because the deduction is only allowed for expenses in excess of a floor, the deduction reflects the idea that if an individual has extraordinary medical expenses, it affects his or her ability to pay taxes.

Deduction for health insurance expenses of self-employed individuals

For years beginning before January 1, 1994, self-employed individuals could deduct 25 percent of their health insurance expenses. The deduction expired for years beginning on or after January 1, 1994.

---

[3] In general, tax expenditures are reductions of individual or corporate income tax liabilities that result from special tax provisions or regulations. A special provision is classified as a tax expenditure if the provision represents a departure from a normal income tax structure that is made for reasons other than administrative feasibility. Tax expenditure estimates do not include the effect of payroll taxes or State or local taxes.

The 25-percent deduction provided self-employed individuals with a greater tax benefit than the benefit available to persons who do not receive employer-provided coverage. However, the effect of the deduction was to provide less favorable tax treatment for sole proprietors than for individuals who operate businesses in corporate form. Thus, for example, a sole shareholder-employee of a subchapter C corporation could obtain the benefit of the exclusion for employer-provided health care.

Employer deduction for employee health care

Employers are entitled to deduct the cost of employer-provided health care as an ordinary and necessary business expense. This deduction is not considered a tax expenditure, but rather is part of the normal operation of an income tax system. In arriving at a proper measure of the economic income of a business, it is appropriate to allow deductions for reasonable expenses, including employee compensation expenses such as employer-provided health care.

2. Imposing limits on the tax benefits for employer-provided health care

The tax benefits for employer-provided health care could be limited by (1) limiting the employee's ability to exclude the value of the coverage from income, (2) limiting the employer deduction, (3) imposing an excise tax on the employer, or (4) using a combination of approaches. There are also various ways to set the limit on the tax benefits, including using a stated dollar amount per employee, a limit based on a particular benefit package, or limiting the tax benefit depending on the income of the employee.

Whether and to what extent the tax benefits for employer-provided health care should be limited depends on the policy objectives sought to be achieved. For example, if the goal is the proper measurement of income, the exclusion for employer-provided health care should be repealed. If the goal is to raise a certain amount of revenue, then the dollar amount of the exclusion could be limited to the extent necessary to reach the revenue target. In the context of overall health care reform, there may be more complicated policy objectives, not all of which may be consistent or lead to the same conclusion. These health policy objectives should shape the discussion as to what limits on employer-provided health care are appropriate.

B. Summary of Proposals

1. S. 1757--Sen. Mitchell and others; S. 1775--Sen. Moynihan (The Health Security Act)

The Health Security Act would limit the exclusion for employer-provided health care to the comprehensive benefit package

provided by the bill (including any cost-sharing amounts). The bill would also provide that health care benefits cannot be provided under a cafeteria plan. The bill would make the 25-percent deduction for health insurance expenses of self-employed individuals permanent and increase the amount of the deduction to up to 100 percent of such expenses, depending on the percentage of health care insurance the self-employed individual pays for his or her employees.

The bill would not limit the employer deduction for employee health care expenses.

2. S. 1579--Sen. Breaux and others (The Managed Competition Act of 1993)

The bill would impose a 34-percent excise tax on excess health plan expenses of employers. In general, excess health plan expenses would be amounts paid in excess of the premium for the lowest cost plan available in the area (the "reference premium rate"). The bill would extend the 25-percent deduction for health insurance expenses of self-employed individuals through 1994. For 1995 and following years, the deduction would be made permanent and would be increased to 100 percent of the reference premium rate for the individual. The bill would permit individuals an above-the-line deduction for the cost of health insurance up to the reference premium rate for the individual. The bill would treat partners and more than 2-percent S corporation shareholders as employees of partnerships and S corporations for purposes of the taxation of employer-provided health care and would exclude from gross income contributions by a partnership or S corporation to a health plan covering its partners or employees.

The bill would not limit the exclusion for employer-provided health care or the employer's deduction for employee health care expenses.

3. S. 1770--Sen. Chafee and others (The Health Equity and Access Reform Today Act of 1993)

The bill would limit the exclusion for employer-provided health care and the employer deduction for health care expenses to an amount equal to the average premium of the lowest priced one-half of standard health benefit packages offered in the area for the calendar year (the "applicable dollar limit"). The bill would make the 25-percent deduction for health insurance expenses of self-employed individuals permanent and increase the amount of the deduction to 100 percent of the applicable dollar limit. The bill would permit individuals an above-the-line deduction for premiums up to the applicable dollar limit. The bill would permit individuals to make deductible contributions to medical savings accounts.

4. S. 1743--Sen. Nickles and others (The Consumer Choice Health Security Act of 1993)

The bill would repeal the exclusion for employer-provided health care and the medical expense deduction for health expenses of individuals. The bill would provide a refundable tax credit for certain health care expenses and provide a nonrefundable tax credit for contributions to a medical savings account.

II. PRESENT LAW

A. 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[4]). 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 generally are not subject to nondiscrimination rules. Similarly, employer-provided accident or health coverage generally is excludable from wages for employment tax purposes 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 represent 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).

B. Itemized Deduction for Medical Expenses

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 and 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).

Medical care expenses eligible for the deduction are amounts paid by the taxpayer for: (1) health insurance (including employee contributions to employer health plans); (2) the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body; (3) transportation primarily for and essential to medical care; and (4) lodging while away from home primarily for and essential to medical care, subject to the following limitations. Amounts paid for lodging while away from home seeking medical care qualify as medical expenses if there is no significant element of personal pleasure, recreation, or vacation in the travel away from home and

---

[4] References are to the Internal Revenue Code of 1986, as amended.

the medical care is provided by a physician in a licensed hospital or in a medical care facility that is related to, or the equivalent of, a licensed hospital. The deduction of lodging expenses is limited to $50 for each night for each individual.

The cost of medicine or a drug qualifies as a medical care expense only if it is a prescription drug or is insulin. In addition, the cost of cosmetic surgery or other similar procedures qualifies as a medical expense only if the surgery or procedure is necessary to ameliorate a deformity arising from or directly relating to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

For alternative minimum tax purposes, individuals may deduct medical expenses only to the extent that the total of such expenses exceeds 10 percent of the taxpayer's AGI (sec. 56(b)(1)(B)).

C. Deduction for Health Insurance Costs of Self-Employed Individuals

Self-employed individuals cannot exclude the cost of health insurance from gross income. For this purpose, self-employed individuals include sole proprietors, partners in partnerships, and more than 2-percent shareholders of S corporations. Prior to January 1, 1994, a self-employed individual could deduct 25 percent of the health insurance costs of the individual and his or her spouse or dependents, provided that certain requirements were satisfied.[5] The 25-percent deduction was also available to more than 2-percent shareholders of S corporations.

D. Cafeteria Plans

In general

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 the amount. Under one exception to the general principle of

---

[5] The 25-percent deduction was not available for any month if the taxpayer was eligible to participate in a subsidized health plan maintained by an employer of the taxpayer or the taxpayer's spouse. In addition, no deduction was available to the extent that the deduction exceeded the taxpayer's earned income. The amount of expenses paid for health insurance in excess of the deductible amount could be taken into account in determining whether the individual was entitled to a medical expense deduction (sec. 213). Thus, such amounts were deductible to the extent that, when combined with other unreimbursed medical expenses, they exceeded 7.5 percent of AGI (sec. 162(l)).

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 nontaxable qualified benefits.

In general, a qualified benefit is one of certain benefits that are 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, and benefits under dependent care assistance programs may be provided through a cafeteria plan.

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 purposes.

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.

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 key employees exceed 25 percent of the aggregate of such benefits provided for all employees under the plan. A key employee is defined as under the top-heavy rules applicable to qualified pension plans (sec. 416).

E. Flexible Spending Arrangements

A flexible spending arrangement (FSA) is a reimbursement account or similar arrangement under which an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care. An FSA may be part of a cafeteria plan and may be funded through salary

reduction. FSAs also may be provided by an employer outside a cafeteria plan (i.e., when the employee is not permitted to elect cash in lieu of a qualified benefit). FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance.

There is no special exclusion for benefits provided under a FSA. Thus, benefits provided under a FSA are excludable from income only if there is a specific exclusion for the benefits in the Code (e.g., the exclusion for employer-provided health or group-term life insurance coverage). FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)). According to proposed Treasury regulations, a cafeteria plan offers deferred compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.[6] Thus, amounts in an employee's FSA 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.[7] These rules apply with respect to a health FSA without regard to whether the health FSA is provided through a cafeteria plan.

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.[8]

---

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

[7] Prop. Treas. Reg. 1.125-2 Q&A-7(b).

[8] Prop. Treas. Reg. 1.125-2 Q&A-7(c).

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 as defined for purposes of the itemized deduction for medical care expenses (sec. 213); (4) reimburse only those 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 only those medical expenses that 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.[9]

[9] Prop. Treas. Reg. 1.125-2 Q&A-7(b).

III. DISCUSSION OF ISSUES

There are a variety of possible ways to modify the tax benefits for the purchase of health care services and insurance. The most appropriate method depends on the goals of the reform effort of which the limitation is a part. Possible policy objectives and possible legislative approaches to satisfy those objectives by modifying the tax benefits for the purchase of health care are discussed below.

A. Achieve Income Tax Policy Goals

1. Proper measurement of income

From a tax policy perspective, an important objective of an income tax system is to raise revenue in an efficient and equitable fashion. To ensure an equitable distribution of the burden of taxation, it is necessary to measure an individual's ability to pay taxes. Ideally, an individual's ability to pay taxes should be measured by reference to the individual's total access to economic resources. The Federal income tax system generally measures an individual's ability to pay taxes by reference to the individual's personal income.[10]

Under present law, the taxable income of an employee who receives employer-provided health care benefits in lieu of cash compensation will be less than the taxable income of an otherwise similarly situated employee who receives only cash compensation of equal value and purchases health care separately. This occurs because the employee receiving employer-provided health care is not required to include the compensation received in the form of health care in income for purposes of the Federal income tax or as wages for purposes of Federal payroll taxes.

For example, consider two employees. Employee A receives $25,000 of cash compensation and purchases health insurance privately for $3,000. Employee B receives $22,000 of cash compensation and $3,000 of employer-provided health care. Assume that each employee's income is subject to tax at a 15-percent rate. In addition, the employees' cash compensation is subject to the employee share of payroll taxes (7.65 percent of wages).[11]

---

[10] Other possible measures of ability to pay include consumption and wealth.

[11] Economists generally believe that employees bear the burden of all payroll taxes, including the employer's share of those taxes. For the sake of simplicity, the effect of the employer's share of payroll taxes is ignored in the example. To include such a discussion would complicate the example substantially without changing the qualitative result.

Employee A's net compensation is $19,337.50 ($25,000 minus (22.65 percent times $25,000). Employee B's net compensation is $20,017 ($25,000 minus (22.65 percent times $22,000).[12]

Tax policy objectives suggest that there should be no exclusion from income for employer-provided health care in the absence of a more compelling goal. Further, excluding certain forms of income from taxation erodes the tax base and distorts economic decision making, because individuals tend to structure their compensation arrangements to reduce taxable income.

Proposals that limit the tax benefits for employer-provided health care by limiting the exclusion rather than by some other means (such as by limiting the employer deduction or imposing an excise tax) are preferable from a tax policy perspective because they result in better measurement of income. Indeed, the objective of proper measurement of income, viewed in isolation, provides a compelling argument for the complete repeal of the exclusion.

From a tax policy perspective, limiting the employer deduction is not a preferred approach. Proper measurement of business income includes a deduction for ordinary and necessary business expenses, and reasonable compensation (including employer-provided health care) is a business expense. Thus, the deduction for employer-provided health care should not be viewed as a subsidy or as a tax expenditure.

However, limiting the deduction for, or imposing an excise tax on, certain employer-provided health care expenses may be viewed as a proxy for income inclusion. Because employer-provided health care is a component of employee wages, economists believe that, in the long run, any increase in employer-provided health care costs (whether as a result of taxes or otherwise) will generally be borne by employees in the form of lower cash wages or, at least, a slower growth rate in cash wages. That is, employees' total compensation will remain the same, and if health care costs rise, some other part of compensation, such as cash wages, will be reduced. Thus, the effects of denying the employer deduction for, or imposing an excise tax on the employer with respect to, certain health costs will be borne by employees,

---

[12] If A's AGI is less than $40,000, then A's after-tax compensation will be somewhat greater than the above computation indicates. This is because A will be entitled to deduct that portion of his insurance costs ($3,000) that exceed 7.5 percent of his AGI. However, this deduction will not eliminate the disparity.

even though such taxes are statutorily imposed on employers.[13]

The fact that limiting the employer deduction or imposing an excise tax on certain employer-provided health care is a proxy for limiting the exclusion does not mean that it will have the same actual effects. For example, consider an employee in the 15-percent rate bracket who works for an employer in the 34-percent corporate rate bracket. If some or all of employer-provided health care is includible in income, it would be taxed at a rate equal to the sum of the income tax rate plus the payroll tax rate. This includes the 15-percent income tax, the employee portion of payroll taxes (7.65 percent) and the employer payroll taxes.[14] On the other hand, if a deduction denial applies, the effective tax rate would be the marginal tax rate of the employer, or 34 percent in this example. Thus, in this example, denying the deduction would impose a greater cost on health care provided in excess of the limit than would limiting the employee exclusion. For an employee in a higher rate bracket, the effect of denying the employer's deduction may be less than the effect of requiring the employee to include the value of the health care in income.

In general, if the employer's marginal tax rate is higher than the employee's, then disallowing the employer deduction will

---

[13] This may not be true in the short run or in all cases. For example, collective bargaining agreements may prevent the employer from reducing cash compensation to take into account increases in health care costs. Also, the wages of minimum wage workers cannot be reduced. In the case of such workers, increasing non-cash wage costs could result in reductions in employment.

[14] The appropriate way to view payroll taxes is a difficult issue. Imposing a payroll tax on amounts paid for employer-provided health care increases the current tax liability of the employee. However, this increased tax entitles the employee to future Social Security and Medicare benefits. The net effect of such increased taxes and increased benefits is unclear. The appropriate treatment of payroll taxes will depend upon whether one views the payroll taxes as payments for future benefits or as taxes transferred to current recipients of benefits. Thus, whether denying an employer's deduction for health care expenses is equivalent to requiring employees to include the value of employer-provided health care in income will depend not only upon the marginal tax rate of the employer relative to the marginal tax rates of employees, but will also depend upon one's view of the appropriate way to consider payroll taxes.

provide a disincentive for employers to provide health care. If the employer's tax rate is lower than the employee's, there will still be an incentive to provide compensation in the form of health care, but the incentive will be smaller than it is under present law. Thus, if the disallowance were enacted, employees in rate brackets higher than the employer's bracket who want health care may negotiate with their employer to provide the health care and forgo the deduction, because that is cheaper for the employees than paying for the health care on an after-tax basis. This could occur on an individual basis or a firmwide basis. Thus, firms with high-wage workers (who face relatively high marginal tax rates) may tend to continue to provide insurance and those employers with low-wage workers (who face lower marginal tax rates) may suspend such coverage (at least for their low-wage employees).

The economic effect of imposing an excise tax would be similar to that of denying the deduction. The actual effect would depend on the excise tax rate and the difference between that rate and the employees' marginal tax rates. Imposing an excise tax on all employers would affect the decision to provide health care in the case of tax-exempt employers and employers with no current taxable income (employers with tax losses), whereas a deduction disallowance only affects taxable employers to the extent they have taxable income.

2. Equity among taxpayers

The Federal income tax system is generally concerned with two types of equity, referred to as horizontal equity and vertical equity.

Horizonal equity

Horizontal equity is the idea that similarly situated taxpayers should have the same tax liability. For example, an employee who receives $22,000 of taxable wages and $3,000 of employer-provided health care will have less taxable income than an otherwise similarly situated employee who receives $25,000 in cash wages and purchases the same health coverage for $3,000, even though their economic income is the same.

If horizonal equity among taxpayers is the primary objective, then similarly situated taxpayers should receive the same tax subsidy for the purchase of health care, regardless of whether they purchase health care directly or it is provided by their employer. Present law does not accomplish this objective, because taxpayers who have employer-provided health care receive a full exclusion for income and payroll tax purposes, whereas taxpayers who purchase health care on their own on an after-tax basis can only deduct those expenses to the extent that all health care expenses for the year exceed 7.5 percent of adjusted

gross income (AGI).[15] Through 1993, self-employed persons were in a slightly better position than under present law because they could deduct 25 percent of their health insurance expenses for income tax purposes.

There are a number of different ways to achieve or improve horizontal equity. One approach would be to repeal the exclusion for employer-provided health care. Another would be to repeal the exclusion and replace it with a tax credit available to all taxpayers for the purchase of health insurance or other health care expenses. Still another would be to retain the exclusion, but to provide an unlimited deduction against AGI (or in arriving at AGI) for the purchase of health care by persons who do not have employer-provided health care. The latter approach would improve horizontal equity, but would not attain it fully because those who receive employer-provided health care would also receive the benefit of the exclusion for payroll tax purposes. Concern about horizontal equity also could lead to repeal of the exclusion for employer-provided health care or to limits on the amount of the exclusion. The deduction for individual medical expenses in excess of 7.5 percent of AGI might be retained even if the exclusion were repealed on the theory that the medical expense deduction adjusts an individual's income for extraordinary medical expenses to better reflect the individual's ability to pay taxes.

Horizontal equity could be improved, but not eliminated, by limiting an employer's deduction for health care expenses. A deduction disallowance will affect employers differently. For example, governmental and tax-exempt employers, and employers with operating losses, will not be subject to a deduction disallowance. To the extent that the increased costs attributable to a deduction disallowance are passed through to employees, employees of employers that are not affected by a deduction disallowance will be benefited relative to employees of profitable employers and individuals whose employers do not provide health care. On the other hand, imposing an excise tax on all employers as a means of limiting the tax benefits attributable to employer-provided health care will affect all employers who are subject to the tax, including governmental and tax-exempt employers.

Vertical equity

The vertical equity of a tax system reflects the extent to which it is viewed as appropriately distributing the burden of

---

[15] Not only is the income tax treatment not equivalent, but individuals who purchase health care on an after-tax basis also receive no payroll tax benefit.

taxation tax across individuals with differing economic circumstances. The U.S. Federal tax system is generally considered to be progressive, i.e., the average rate of tax paid by an individual increases as that individual's income increases. In that context, vertical equity refers to the extent to which the effect of a tax provision preserves progressivity in the tax system. The exclusion for employer-provided health care provides an individual with a subsidy that is proportional to his or her marginal tax rate, so that individuals with higher marginal tax rates receive a greater tax benefit than those with lower marginal tax rates.[16] Thus, the exclusion tends to reduce the vertical equity of a progressive tax system. In addition, a second source of inequity exists to the extent that employees with higher incomes tend to receive more valuable employer-provided health care benefits than low-income taxpayers.

Vertical equity could be better achieved in a variety of ways. For example, the exclusion could be repealed. It is not necessary, however, to repeal the tax benefits for employer-provided health care to address concerns about vertical inequity; this problem could be solved by structuring the tax benefits in a different way. For example, the exclusion for employer-provided health care could be replaced with a tax credit for health care expenses. The credit would be equivalent to the exclusion from income for employer-provided health care only for those taxpayers whose marginal tax rate is equal to the credit rate.[17] Limiting the exclusion to persons with incomes below certain levels would also reduce the vertical inequity inherent in the exclusion. If it is true that high-income individuals are, in general, more likely to have larger employer-provided health care, then limiting the exclusion (or a comparable credit) to a fixed level of benefits or costs would also tend to increase vertical equity.

3. Raise revenue

Another possible objective in limiting the tax benefits for employer-provided health care is to raise revenue. If this is

---

[16] The effect is somewhat different when payroll taxes are taken into account. For example, a taxpayer in the 15-percent marginal rate bracket receives the benefit of the exclusion both for income and payroll tax purposes. A taxpayer in a higher bracket may be above the social security tax base, and so may only receive the benefit of the exclusion for income tax purposes and hospital insurance tax purposes. The exact effect of the exclusion for payroll tax purposes is difficult to quantify because the amount of social security benefits received may be affected depending on whether employer-provided tax care is included in the payroll tax base.

[17] This assumption ignores the effects of payroll taxes.

the primary objective, then the limit should be designed to raise the desired revenue in the most administrable and equitable manner. Repealing the exclusion is relatively simple and promotes both vertical and horizontal equity as compared to present law. If this approach raises more revenue than is desired, a partial limit on the exclusion could be designed to achieve any such intermediate revenue goal.

The amount of revenue that can be raised by limiting the tax benefits for employer-provided health care will be very sensitive to the context in which the limit is imposed (i.e., the overall health care reform proposal) and on the design of the limit itself.

B. Achieve Health Care Policy Goals

1. Expand health care coverage

The exclusion for employer-provided health care causes employees to prefer health care over taxable wages. The exclusion makes health care less expensive for employees than it would be if they purchased health care on an after-tax basis; thus, some employees may purchase more health care services or insurance than they otherwise would.

Encouraging individuals to purchase more health care than they otherwise would may be socially desirable. If some of the benefits of an individual being insured accrue to other people, then some individuals may not purchase as much insurance as is socially desirable. Economists refer to this as a positive externality. For example, if the cost of uncompensated care for uninsured individuals is passed on to other individuals, then some people will be underinsured. Providing a subsidy for the cost of insurance in such cases could shift health care costs to the individual who receives the services. Providing a subsidy for the purchase of health insurance may be particularly necessary in the case of low-income individuals who may not be able to afford insurance at market prices. However, it may not be very efficient to deliver subsidies to low-income individuals through the tax system because such individuals may have little or no tax liability.

Whether or not tax benefits are necessary to induce individuals to purchase coverage depends in part on the overall health care reform package. If a health reform proposal mandates that all individuals have insurance, then a subsidy is not necessary to induce coverage, because individuals are required to have health insurance in any event.

The exclusion for employer-provided health care is not necessarily the most efficient means of expanding coverage. The exclusion applies to all persons who have employer-provided

coverage, regardless of whether they would have purchased coverage without the exclusion. The exclusion also is not necessarily targeted to those individuals who may be most in need of a subsidy for the purchase of health insurance. In particular, as described above, the exclusion provides a greater benefit for higher-income individuals than for lower-income individuals, whereas lower-income individuals are more likely to be in need of a subsidy for the purchase of health care.

The exclusion also does not provide a subsidy for all persons who might purchase less insurance than is socially desirable. Individuals who are self-employed or who work for an employer that does not provide health care do not receive a subsidy comparable to the exclusion for employer-provided health care.

2. Control health care costs

By inducing individuals to purchase more health care than they would in the absence of the exclusion from income for employer-provided health care, the exclusion may increase the aggregate national expenditure for health insurance and services. To the extent this is a problem, it can be addressed by causing individuals to face more of the true cost of the health services, i.e., by reducing the Federal subsidy for employer-provided health care.

Any limit on employer-provided health care will reduce the subsidy, and may cause some individuals to purchase less health care services than they would in the absence of the subsidy. The ultimate effect will depend on the extent to which the subsidy is limited.

Certain current proposals to limit the tax benefits for employer-provided health care would limit the benefits based on a dollar limit determined with reference to the cost of a specified benefit package. Others limit the benefit to the purchase of a specified benefit package whatever its cost. Both types of proposals have cost containment as a goal. The first type would discourage the purchase of health insurance in excess of the applicable dollar amount. Those who can purchase the specified benefit package below the cap amount would also be able to purchase some amount of supplemental coverage on a tax-favored basis. In contrast, if the subsidy is limited to a particular package, then supplemental insurance is not subsidized. The latter approach also ensures that the specified package is subsidized no matter what its cost, whereas the former does not. For example, if a fixed dollar cap on the exclusion is based on the lowest cost in an area for a fixed specified benefit package, not all persons will necessarily be able to purchase the package at that price. The extent to which these proposals will lead to cost containment will depend in part on how generous the

specified package is and also what other cost containment features are in the health care reform proposal.

Denying the deduction for employer-provided health care or imposing an excise tax on employers with respect to certain health care expenses should, at least in the long run, have a similar effect on overall costs as a comparable limit on the exclusion. In the short run, if employers are obligated to provide a certain level of health care by contract (e.g., through a collective bargaining agreement), then they will not be able to adjust their spending on health care until the contract expires. Thus, they may be subject to the deduction denial or the excise tax even if they cannot immediately adjust health care spending.

Further, as discussed above, to the extent that an employer's marginal tax rate is lower than the marginal tax rate of employees, the effect of a deduction denial or excise tax may be to reduce, but not eliminate, the incentive to provide compensation in the form of health care. For example, if a deduction disallowance is imposed, a tax-exempt employer will not face an increase in costs of health care and, therefore, the incentive to provide compensation in the form of health care will still exist.

3. Subsidize the purchase of health insurance by some or all individuals

Some health care proposals seek to subsidize the purchase of health care coverage by low-income individuals to make such coverage more affordable. The present-law exclusion for employer-provided health care subsidizes the cost of insurance for some low-income individuals, but also subsidizes the cost of insurance for many high-income taxpayers as well. Thus, if providing low-income subsidies is a primary goal, then the tax benefits for health care could be better targeted.

Excluding some or all of employer-provided health care will only provide a subsidy for individuals who receive employer-provided health care. Because not all low-income individuals have employer-provided health care, means other than the exclusion are necessary to provide a subsidy for all low-income individuals. One alternative would be to replace the exclusion with a refundable[18] tax credit for low-income individuals. Another alternative would be to limit the exclusion to low-income individuals, and provide a deduction against gross income for low-income individuals who do not have employer-provided health care. As mentioned above, this approach would not place all

---

[18] A tax credit would not have to be refundable. However, if it is not refundable then it would not provide a subsidy to low-income individuals who have no tax liability.

taxpayers in an equal position. Those who receive employer-provided health care would not pay payroll taxes on such health care. However, individuals who work for an employer who does not offer employer-provided health care would pay tax on their cash compensation and would not get the benefit of the payroll tax exclusion for health care.

Another issue arises with respect to subsidies for the purchase of health care if the available subsidies differ depending on whether an individual receives employer-provided health care. If this is the case, then individuals and employers will attempt to structure employment and compensation arrangements to take advantage of the largest subsidy. For example, if, under a proposal, certain low-income persons receive a full Federal subsidy for the purchase of health insurance if they do not receive employer-provided health coverage, and if any subsidy is reduced by the value of employer-provided coverage, then employers will have an incentive to exclude such persons from health care coverage if permitted to do so.

C. Coordinate Federal Tax and Health Policy Laws

To the extent that a health reform proposal mandates universal health insurance coverage, the issue of whether any tax benefits for the provision of health care should be retained must be addressed. The present-law treatment of employer-provided health care provides an incentive for the purchase of health care. If a health care reform proposal that guarantees universal coverage is enacted, then the reason to provide an incentive for the purchase of health care may no longer exist.

Further, as discussed above, the exclusion for employer-provided health care may encourage individuals to overutilize health care. This incentive to overutilize health care services may be inconsistent with the goals of health care reform.

If the exclusion for the purchase of employer-provided health care were repealed and all other things are presumed to be constant (e.g., health care costs do not change), then the cost of health care will increase for employees who have received employer-provided health care. The amount of the cost increase for any employee is the amount of tax the employee pays on the value of the employer-provided health care. Thus, the effect of repealing the exclusion generally is greater for higher-income employees than for lower-income employees.[19]

---

[19] If payroll taxes are taken into account, the effect on an employee just above the wage base for social security taxes may be less than the effect on employees just below the wage base. But, in general, the effects of repealing the exclusion rise as income rises.

However, in the context of overall health care reform, it may be perceived appropriate to continue to provide a tax benefit for the purchase of health care. In particular, some health reform proposals provide particular subsidies for low-income individuals. Continuing the exclusion for employer-provided health care would provide a subsidy for middle-income taxpayers who otherwise might face a significant increase in health care costs under a system of mandated health insurance. For example, to the extent that employers are required to provide health insurance for employees who have not previously received it (and who have not purchased it on their own), economists generally believe that the employees will bear the cost of the mandated insurance. If that is the case, middle-income employees who are not eligible for low-income subsidies could face significant increases in health care costs under a mandated system of health insurance. Maintaining the present-law exclusion for employer-provided health care would provide a subsidy for the increased costs of these employees.

D. Other Issues

1. Regional impact

Health care costs are higher in some parts of the United States than others. One of the issues that arises in the context of limiting the tax benefits for employer-provided health care is whether a limit will have a different impact depending on where an individual lives. For example, if the exclusion for employer-provided health care were limited by a set dollar amount, then individuals living in high cost areas would receive a smaller subsidy for the total cost of health care coverage than individuals living in low cost areas.

The Federal tax laws generally do not take into account regional disparities in costs of living. One reason such disparities are not taken into account is that, although costs of living may be higher in some parts of the country, it is also generally true that incomes are higher in higher cost areas. For example, the amount of the standard deduction does not vary based on the area of the country in which a taxpayer resides.

In the case of reducing the tax benefits accorded to employer-provided health care, there may be a perception that regional disparities in health care costs should be taken into account. If the exclusion for employer-provided health care is repealed entirely, there is no regional disparity issue. Individuals in higher cost areas will have a larger amount included in income because their employers are paying more to provide them with health care. However, if the exclusion is not repealed in its entirety, but rather is limited in some manner, and adjusting for regional disparities in health costs is a goal,

there are a number of different approaches that could be utilized.

One possible approach would be to have the limit on the exclusion vary by region. This could be done directly or indirectly. For example, if a dollar limit is used, different dollar limits could be specified for each State or region. If the limit is based on the cost of a specified health care package within the region where the individual lives, then the limit will vary by region. If the exclusion is for the cost of a particular benefit package, then there are implicitly different limits for different areas. A percentage limit on employer-provided health care (e.g., limiting the exclusion to 50 percent of health care expenses) is sometimes also suggested as a way of addressing concerns about regional disparities in health care costs. Under this approach, all individuals would be able to obtain a subsidy with respect to the same portion of health expenditures.

2. Administrative issues

Any limits on the tax benefits for employer-provided health care raise administrative issues for taxpayers as well as for the Internal Revenue Service (IRS). The extent of administrative difficulty will vary greatly depending on the specifics of any proposal, but some general issues can be articulated.

Any proposal that limits the exclusion for employer-provided health care will impose additional administrative burdens on employers, who may have to determine the value of health care received by each employee and whether it is limited. Presumably, employers will be required to report the amount of health care received by the employee to the employee and the IRS. This burden may be greater under some proposals that others. For example, if the amount that is excludable from income varies based on the employer's place of business or on an employee's place of residence, then an employer that operates in more than one region (or that has employees who live in more than one region) may have to determine the amount that is excludable for any particular employee based on that employee's particular circumstances. In addition, if the limit is not based on information within the employer's control (e.g., if it is based on the average cost of health insurance in the area), then a third party (such as the IRS) will have to inform the employer of what the applicable limit or limits are. Administrative burdens on the employer will be lessened to the extent that the employer can design a plan to avoid being affected by the exclusion limit.

Denying the employer deduction or imposing an excise tax on the employer in lieu of requiring employees to include amounts in income may be somewhat easier for the IRS to enforce than an exclusion, because it would be enforced at the employer level rather than the employee level. Thus, fewer taxpayers would be

involved and it would be easier for the IRS to audit. From the employer perspective, however, it is not clear that such approaches would be more administrable. The employer might still need to determine whether the limit or limits had been exceeded with respect to each employee.

If the limit is based on an individual's income, then employers will generally not be able to administer it, because they will not have information regarding the nonwage income of their employees.

Administrative burdens on individual taxpayers are of particular concern in the case of low-income subsidies, such as tax credits, because many people will not take advantage of the subsidy if obtaining the subsidy is too complex. One problem with providing low-income subsidies through the income tax system is that not all low-income persons are currently required to file tax returns. If the tax system is the only subsidy mechanism, then many low-income individuals will have to file tax returns merely to claim the subsidy.

IV. DESCRIPTION OF BILLS

A. S. 1757--Sen. Mitchell and others and S. 1775--Sen. Moynihan (The Health Security Act)

1. In general

The Health Security Act would limit the exclusion for employer-provided health coverage to the comprehensive benefit package provided by the bill, including cost-sharing amounts. The bill would also provide that health care benefits cannot be provided under a cafeteria plan. The bill would make the deduction for health insurance expenses of self-employed individuals permanent and increase the amount of the deduction to 100 percent of such expenses, depending on the percentage of health care insurance the self-employed individual provides his or her employees.

2. 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 a flexible spending arrangement (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) other 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 an individual receives under an accident or health plan paid for by an employer. Such amounts would continue to be excludable from the individual's 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.[20] The bill would also require cost-sharing policies to satisfy certain standards.[21]

Permitted coverage

Under the bill, other permitted coverage that would qualify for the present-law exclusion 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 is 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 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.

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.

Flexible spending arrangements (FSAs)

The bill's limits on the exclusion for employer-provided accident or health coverage would apply to coverage provided through an FSA just as they apply to other employer-provided

---

[20] Section 1421(b)(2) of the Health Security Act.

[21] Section 1423 of the Health Security Act.

accident or health coverage, except that the limits would have an earlier effective date. Thus, coverage provided through an FSA would be excludable from income only to the extent it is within the bill's limits, i.e., health coverage provided through an FSA under a cafeteria plan would be excludable from gross income only if 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.

For this purpose, an FSA would be defined as a benefit program that provides employees with coverage under which specified 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 and would not be excludable from income and wages. 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.[22] The bill would also require supplemental health benefit policies to satisfy certain standards.[23]

Valuation rules

Under the bill, the value of any employer-provided coverage that is includible in income would be based on the average cost of providing the coverage. The provision would permit cost determinations to be made on the basis of reasonable estimates as 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

---

[22] Section 1421(b) of the Health Security Act.

[23] Section 1422 of the Health Security Act.

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 health 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 employer would be required to pay to the employee a cash rebate equal to the excess.[24] The rebate would be taxable to the employee for both income and employment tax purposes. For example, suppose an employer pays 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 100 percent of 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 could have selected coverage under a health plan which results in a cash rebate. That is, only cash rebates actually received are includible in income.

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 FSAs 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.

3. Deduction for health insurance costs of self-employed individuals

In general

The bill would make permanent the deduction for health insurance expenses of self-employed persons, and increase the amount of the deduction to up to 100 percent of such expenses. The 25-percent deduction would continue until the 100-percent

---

[24] 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.

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 by a self-employed individual, but only to the extent that the health insurance constitutes comprehensive health coverage as described in the bill and is purchased from a qualified alliance.

Under the bill, 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 only be entitled to deduct the percentage of their own insurance equal 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.

Similar to the 25-percent deduction under prior law, a self-employed individual would not be permitted to claim the 100-percent deduction on amounts paid to purchase 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. 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.

Finally, as under prior 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.

B. S. 1579--Sen. Breaux and others (The Managed Competition Act of 1993)

1. In general

The bill would impose a 34-percent excise tax on excess health insurance expenses of the employer. In general, excess health plan expenses would be amounts paid in excess of the cost of the lowest-cost plan available in the area. The bill would extend the 25-percent deduction for health insurance expenses of self-employed individuals through 1994. For 1995 and following years, the deduction would be made permanent and increased to 100 percent of the lowest cost plan available in the area. The bill would permit individuals to deduct from gross income the cost of health insurance up to the value of the lowest cost plan in the area. The bill would treat partners and more than 2-percent S corporation shareholders as employees of partnerships and S corporations for purposes of the taxation of employer-provided health care and would exclude from gross income contributions by a partnership or S corporation to a health plan covering its partners or employees.

2. Excise tax on excess employer health plan expenses

In general

Under the bill, "excess health plan expenses" would be subject to a 34-percent excise tax payable by the employer. The excise tax would be imposed on all employers with excess health plan expenses, including tax-exempt and governmental employers. The excise tax would be deductible.[25]

Under the bill, employer-provided health coverage would continue to be fully deductible and the bill would not limit the exclusion from gross income for any health coverage provided by an employer.

Definition of health plan expenses

Under the bill, health plan expenses would include all employer contributions under any group health plan, other than expenses for direct services which are determined by the Health Care Standards Commission (the "Commission") to be aimed

---

[25] Because the excise tax rate is deductible and is fixed at 34 percent, a particular taxable employer may have more or less than a complete deduction disallowance under the bill. For example, a corporate employer in the 35-percent marginal tax bracket would have a deduction denied for 63.1 percent of excess health plan expenses. An employer in the 15-percent marginal tax bracket, however, would have a deduction denied for 192.7 percent of excess health plan expenses. If the bill is intended to impose an excise tax that is equivalent to a deduction disallowance for taxable employers, the excise tax should be increased to the marginal income tax rate for the employer and should not be deductible.

primarily at workplace health care and health promotion or related population-based preventive health activities. Thus, for example, health plan expenses would include employer contributions (including pre-tax salary reduction contributions) to a cafeteria plan and any coinsurance or deductibles paid by the employer.

The bill would direct the Commission to establish rules to determine the amount of health plan expenses contributed by an employer for each employee under a self-insured plan based on the principles by which employers with self-insured accident or health plans determine the premiums that qualified beneficiaries are required to pay for coverage under the health care continuation rules (Code sec. 4980B(f)(4)(B)). Under those rules, the premium for continuation coverage under a self-insured plan must be a reasonable estimate of the cost to the plan of providing coverage to a similarly situated individual determined on an actuarial basis and taking into account factors that the Secretary of the Treasury sets forth in regulations. The Secretary of the Treasury has not yet issued regulations on this issue.

Definition of excess health plan expenses

Under the bill, excess health plan expenses would include all health plan expenses incurred or paid by an employer for any month on behalf of any beneficiary of a group health plan except certain expenses attributable to coverage under an AHP. Expenses attributable to coverage under an AHP would also be excess health plan expenses (1) if the employer's contribution is not uniform for a premium class regardless of which AHP is selected by the beneficiary, (2) if, in the case of a small employer, the employer contribution is not made through a health plan purchasing cooperative (HPPC), and (3) to the extent the expense attributable to any particular beneficiary exceeds the "reference premium rate" pertaining to that beneficiary.

The reference premium rate would be the lowest premium offered by an open plan (that enrolls a minimum number of eligible individuals) in the HPPC area for the relevant premium class. The reference premium rate would also include the applicable HPPC overhead amount for the open AHP.

Under the bill, the reference premium rate would vary by premium class and would apply to all beneficiaries residing in the HPPC area. The Commission would establish premium classes based on the four types of enrollment under the bill and the age of the principal enrollee (sec. 1205(a)(2) of the bill). In the case of closed AHPs that elect to establish premiums that vary by type of enrollment rather than premium class (i.e., disregarding the age adjustments) or to treat one or more HPPCs as a single HPPC area (as specified by the Commission) with respect to the

establishment of premiums, or both, the bill would require such closed AHPs to convert the reference premium rate from a premium that varies by premium class to a premium that varies by type of enrollment or across HPPC areas or both. Under the bill, closed AHPs would include health plans limited by structure or law to one or more large employers and collectively bargained health plans established as of September 7, 1993.

If a group health plan is not a primary payor under Medicare, health plan expenses paid or incurred for the coverage of individuals eligible for Medicare Part A benefits would not be considered excess health plan expenses subject to the excise tax. Thus, in general, the excise tax would not apply to employer-provided health care for Medicare-eligible retirees.

Effective date

In general, the excise tax would apply to expenses incurred for the provision of health services after December 31, 1994. In the case of a collectively bargained plan, the excise tax would be effective on the earlier of (1) the termination of the collective bargaining agreement (determined without regard to any extensions agreed to after the date of enactment) or (2) January 1, 1997.

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

The bill would extend the 25-percent deduction for health insurance expenses of self-employed persons for 1994, and would replace it with a permanent deduction of 100 percent of certain health insurance expenses for years beginning on or after January 1, 1995.

The 100-percent deduction would be limited to amounts paid to a HPPC for coverage under an AHP that do not exceed the reference premium rate (as defined above) for the self-employed individual's premium class.

Effective date.--The provision relating to the 100-percent deduction would be effective for taxable years beginning after December 31, 1994. 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.[26]

---

[26] The bill is intended to provide a 25-percent deduction for self-employed health insurance expenses for taxable years beginning in 1994. A drafting change will be required to accomplish this intent because, under the bill as drafted, no deduction would be allowed for the health insurance expenses of

4. Deduction for health plan premium expenses of individuals

Under the bill, individuals who purchase health coverage under an AHP through a HPPC or large employer[27] would be permitted a deduction in determining AGI (i.e., an above-the-line deduction) to the extent the premiums for such coverage do not exceed the reference premium rate for the individual's premium class (as defined above) reduced by any premium amounts paid by any other entity (including an employer or any government) for the individual's coverage.

Under the bill, full-time employees of large employers who decline employer coverage would not be eligible for coverage through a HPPC. Because the above-the-line deduction would be allowed only in the case of individuals who obtain health coverage under an AHP either through a HPPC or through a large employer, full-time employees of large employers who decline employer coverage would not be entitled to an above-the-line deduction for premiums for health coverage under an AHP.

Coverage under Part A or B of Medicare would not be considered coverage under an AHP. Thus, the above-the-line deduction would not be permitted with respect to the costs of coverage under Part A or B of Medicare.

The present-law rules relating to the deductibility of health insurance premiums would continue to apply to premiums that do not satisfy the limitations described above (i.e., those premiums paid for coverage under a health plan that is not an AHP and the amount of any premiums paid in excess of the reference premium rate). Thus, an individual would be permitted an itemized deduction for medical expenses to the extent that such expenses exceed 7.5 percent of AGI.[28]

Effective date.--The provision would apply to amounts paid after December 31, 1994, and taxable years ending after such

---

self-employed individuals during 1994.

[27] A large employer generally would mean an employer that normally employed more than 100 employees during the previous year.

[28] It is unclear under the bill whether premiums that are deductible without regard to the 7.5 percent of AGI floor would be taken into account in determining whether a taxpayer has medical expenses that exceed 7.5 percent of AGI. In the absence of a specific provision to the contrary, it would appear that the premiums that are otherwise deductible would be taken into account in determining whether a taxpayer has medical expenses that exceed the floor.

date.

5. Exclusion from gross income for contributions by a partnership or S corporation to a health plan covering its partners or shareholders

Under the bill, partners would be treated as employees of a partnership for purposes of the taxation of employer-provided health care under a subsidized accident or health plan; thus they would be entitled to exclude such health care from gross income. A partner who is eligible to receive such health care would not be entitled to claim the deduction for health insurance expenses of self-employed individuals (as extended and modified under the bill).

Similarly, any amounts paid by an S corporation for health care coverage under a subsidized accident or health plan would be excludable from the income of the S corporation shareholder.

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

C. S. 1770--Sen. Chafee and others (The Health Equity and Access Reform Today Act of 1993)

1. In general

The bill would limit the exclusion for employer-provided health care and the employer deduction for health care expenses to an amount equal to the average premium of the lowest priced one-half of standard packages offered in the area for the calendar year (the "applicable dollar limit"). The bill would make the 25-percent deduction for health insurance expenses of self-employed individuals permanent and increase the amount of the deduction to 100 percent of the applicable dollar limit. The bill would permit individuals an above-the-line deduction for premiums up to the applicable dollar limit. The bill would permit individuals to make deductible contributions to medical savings accounts.

2. Limit on exclusion for employer-provided health care

Under the bill, the present-law exclusion for employer contributions to an accident or health plan would be limited to contributions for coverage under a qualified health plan or contributions to an employee's medical savings account up to the applicable dollar limit for the individual for the calendar year. A qualified health plan would mean either an insured plan that is certified to be a qualified health plan or a self-insured health plan of a large employer that meets certain requirements. The bill would impose a similar limit on the exclusion from wages of employer-provided health coverage for employment tax purposes.

The applicable dollar limit would be determined annually by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services. Further, the applicable dollar limit would be determined separately for individual and family enrollments and, within each enrollment class, would be determined separately with respect to the age of the principal enrollee. The bill would authorize the Secretary of the Treasury to establish reasonable age bands within which premium amounts could not vary by type of enrollment.

Effective date.--The provision relating to the exclusion from income for employer-provided health coverage would be effective for taxable years beginning after the first December 31 following the date that is one year after the date the insurance reform standards in the bill are established. The provision relating to the exclusion from wages for employment tax purposes would be effective on and after the first January 1 following the date the insurance reform standards in the bill are established.

3. Limits on deduction of health plan expenses

Employer deductions

The bill would provide that expenses paid or incurred by an employer for a group health plan or contributed to an employee's medical savings account would not be deductible unless the plan is a qualified health plan and the amount does not exceed the applicable dollar limit for the employee.

Self-employed health deduction

The bill would extend the 25-percent deduction for health insurance costs of self-employed individuals, effective for taxable years beginning after December 31, 1993. In addition, effective for taxable years beginning after the first December 31, following the date that is one year after the date the insurance reforms in the bill are established, the bill would permit self-employed individuals to deduct 100 percent of premiums paid for coverage under a qualified health plan to the extent such amount does not exceed the applicable dollar limit for the individual.

Individual deductions for qualified health plan premiums

The bill would permit individuals an above-the-line deduction for amounts paid with respect to coverage under a qualified health plan (without regard to the present-law AGI limitation) to the extent such amounts do not exceed the applicable dollar limit for the individual. For this purpose, the applicable dollar limit would be reduced by any payments made to, or on behalf of, the individual by the Secretary of Health and Human Services or any other entity (including employers and

governmental agencies).

Effective date

Except as otherwise provided above, the provision of the bill relating to deductions for the costs of health coverage would be effective for taxable years beginning after the first December 31 following the date that is one year after the date the insurance reforms in the bill are established.

4. Medical savings accounts

Eligibility

Under the bill, individuals covered by a catastrophic health plan would be permitted to deduct cash payments made to a medical savings account for the benefit of the individual or for the benefit of any spouse or dependent who is covered under a catastrophic health plan.

Deduction limit

The allowable deduction for any year would be limited to an amount that does not exceed the excess of (1) the applicable dollar limit with respect to the individual for the year over (2) the amount paid by, or on behalf of, the individual as a premium for a catastrophic health plan covering the individual plus the aggregate amount contributed to the medical savings account by persons other than the eligible individual. No more than one medical savings account could be maintained on behalf of an individual. Contributions in excess of the deduction limit for any individual for any taxable year would be subject to a 6-percent excise tax unless such contributions and any related earnings are withdrawn on or before the date prescribed by law for filing the individual's Federal income tax return for the year (including extensions).

Definition of medical savings account

Under the bill, a medical savings account would mean a trust created exclusively for the purpose of paying the medical expenses of the beneficiaries of the trust and that meets the following requirements: (1) other than certain permitted rollover contributions, no contribution is accepted unless it is in cash and does not exceed the deduction limit for the year; (2) the trustee is a bank or another person that demonstrates to the satisfaction of the Secretary that the trust will be administered in a manner consistent with the requirements of the bill; (3) no part of the trust assets will be invested in life insurance contracts; (4) the assets of the trust will not be commingled with other property except in a common trust fund or common investment fund; (5) the interest of an individual in the balance

in the account is nonforfeitable; and (6) certain rules will be applicable to the distribution of the entire interest of beneficiaries of the trust. An account held by a U.S. insurance company would be treated as a medical savings account (and the insurance company would be treated as a bank) if (1) the account is part of a health insurance plan that includes a catastrophic health plan, (2) the account is exclusively for the purpose of paying the medical expenses of the beneficiaries of the account who are covered under the catastrophic health plan, and (3) the written instrument governing the account meets certain additional requirements.

Medical savings accounts would be exempt from tax.

Definition of medical expenses

Under the bill, medical expenses would include medical care (within the meaning of sec. 213 of the Code) and long-term care, but only to the extent such amounts are not reimbursed by insurance or otherwise. In addition, the bill would provide that medical expenses would not include any amount paid for coverage under a health plan except (1) in the case of an individual under age 65, for amounts paid for coverage under a catastrophic health plan or a long-term care insurance plan, or (2) in the case of an individual age 65 or older, for amounts paid for coverage under a medicare supplemental policy, under a long-term care insurance policy, or for payment of Medicare Part A or B premiums.

Taxation of distributions

Any amount paid or distributed from a medical savings account would be included in the gross income of the individual for whom the account was established unless the amount is used exclusively to pay the medical expenses of the individual or the spouse or any dependent of the individual. No amount would be included in income if the entire amount received is paid into another medical savings account for the benefit of the individual not later than 60 days after the date of the distribution. Contributions in excess of the deduction limits that are withdrawn on or before the date prescribed by law for filing the individual's Federal income tax return for the year (including extensions) would not be treated as distributions that must be included in income but earnings related to such excess contributions would be included in income.

An additional 10-percent income tax would be imposed on any distribution from a medical savings account that is includible in income. This additional tax would be increased to 50 percent if, after the distribution from the account, the balance of the medical savings account is less than the amount of the deductible under the catastrophic health plan covering the individual.

Effective date

The provisions of the bill relating to medical savings accounts would be effective for taxable years beginning after the first December 31 following the date that is one year after the date the insurance reforms in the bill are established.

D. S. 1743--Sen. Nickles and others (The Consumer Choice Health Security Act of 1993)

1. In general

The bill generally would repeal the present-law exclusion from income for employer contributions to an accident or health plan and the medical expense deduction for individuals, generally effective after December 31, 1996.[29] In addition, the bill would provide a refundable health care expenses tax credit for certain qualified individuals and provide a nonrefundable tax credit for individuals for contributions to a medical savings account, generally effective in 1997.

2. Refundable health care expenses tax credit

Amount of tax credit

Under the bill, a qualified individual would be permitted a credit against tax in an amount equal to the sum of (1) 25 percent of the amount of qualified health insurance premiums and unreimbursed expenses for medical care paid by the individual during the taxable year that do not exceed 10 percent of the individual's AGI for the year, (2) 50 percent of the amount of such premiums and unreimbursed expenses that exceed 10 percent, but not 20 percent, of the individual's AGI, and (3) 75 percent of the amount of such premiums and unreimbursed expenses that exceed 20 percent of the individual's AGI. A qualified individual would mean the taxpayer, the spouse of the taxpayer, and each dependent of the taxpayer who is enrolled in a Federally qualified health insurance plan. A qualified individual would not include certain individuals entitled to health care under certain Federal programs. If the taxpayer is a qualified individual for only part of the year, the credit would be limited to the applicable percentage of the credit amount. The applicable percentage would be determined by the number of whole months in the year in which the taxpayer is a qualified

---

[29] The intent of the bill is to retain present law as it relates to the 25-percent deduction for health insurance costs of self-employed individuals. In other words, the bill would not reinstate the 25-percent deduction for taxable years beginning after December 31, 1996. A drafting change will be required to accomplish the intent of the bill.

individual.

Qualified health insurance premiums would mean premiums for (1) a Federally qualified health insurance plan and (2) any other benefits or plans supplementary to such a Federally qualified health insurance plan. A Federally qualified health insurance plan would mean a health insurance plan offered, issued or renewed after January 1, 1997 and which at a minimum (1) provides coverage for all medically necessary acute care (as defined in sec. 112 of the bill), (2) varies premiums only on the basis of age, sex, and geography, (3) guarantees coverage at standard rates for all applicants, and (4) limits preexisting condition exclusions as provided in the bill.

Definition of medical care

For purposes of the bill, medical care would be defined as under present law except that medical expenses that are reimbursed or subsidized by the Federal Government or a State or local government and are excluded from the recipient's gross income would not qualify as medical expenses under the bill and any amounts distributed from an individual's medical savings account during the taxable year that are excludable from gross income under the bill would not qualify as medical care expenses for purposes of the tax credit.

Advance payment of health care expenses tax credit

The bill would provide for the advance payment of the health care expenses tax credit in a manner similar to the advance payment of the earned income tax credit under the Code. Under the bill, an individual could elect to receive the health care expenses tax credit on an advance basis by furnishing a certificate of eligibility to his or her employer. For such an individual, the employer would make an advance payment of the credit at the time wages are paid.

The certificate of eligibility would (1) certify that the employee will be eligible for the health care expenses tax credit for the taxable year, (2) certify that the employee does not have a certificate of eligibility filed with another employer for the calendar year, (3) state whether the employee's spouse has a certificate of eligibility in effect, and (4) estimate the amount of premiums for a Federally qualified health insurance plan and unreimbursed expenses for medical care (as defined in the bill) to be incurred during the calendar year.

The amount of the advance payment of the credit would be determined based on (1) the employee's wages from the employer for each payroll period, (2) the employee's estimated premiums for coverage under a Federally qualified health insurance plan and unreimbursed expenses for medical care included in his or her

eligibility certificate and (3) in accordance with tables provided by the Secretary of the Treasury.

Effective date

The provisions of the bill relating to the health care expenses tax credit would be effective for taxable years beginning after December 31, 1996.

3. Medical savings accounts

In general

Under the bill, an individual would be permitted a nonrefundable credit against tax in an amount equal to 25 percent of cash payments to a medical savings account during a taxable year for the benefit of the individual or for the benefit of any spouse or dependent of such individual up to certain limits. The maximum amount that would be allowed as a tax credit for any individual for any taxable year would be 25 percent of the sum of $3,000 plus $500 for each dependent of the individual for whose benefit the medical savings account has been established. The dollar limits would be adjusted for increases in the cost of living for taxable years beginning after 1997. Contributions in excess of the applicable dollar limit for any individual for any taxable year would be subject to a 6-percent excise tax unless such contributions and any related earnings are withdrawn on or before the date prescribed by law for filing the individual's Federal income tax return for the year (including extensions). No more than one medical savings account could be maintained on behalf of an individual.

Definition of medical savings account

Under the bill, a medical savings account would mean a trust created exclusively for the purpose of paying the medical expenses of the beneficiaries of the trust and that meets the following requirements: (1) other than certain permitted rollover contributions, no contribution is accepted unless it is in cash and does not exceed the deduction limit for the year; (2) the trustee is a bank or another person that demonstrates to the satisfaction of the Secretary that the trust will be administered in a manner consistent with the requirements of the bill; (3) no part of the trust assets will be invested in life insurance contracts; (4) the assets of the trust will not be commingled with other property except in a common trust fund or common investment fund; (5) the interest of an individual in the balance in his account is nonforfeitable; and (6) certain rules will be applicable to the distribution of the entire interest of beneficiaries of the trust. An account held by a U.S. insurance company would be treated as a medical savings account (and the insurance company would be treated as a bank) if (1) the account

is part of a health insurance plan that includes a catastrophic health plan, (2) the account is exclusively for the purpose of paying the medical expenses of the beneficiaries of the account who are covered under the catastrophic health plan, and (3) the written instrument governing the account meets certain additional requirements.

Medical savings accounts would be exempt from tax.

Taxation of distributions

Any amount paid or distributed from a medical savings account would be included in the gross income of the individual for whom the account was established unless the amount is used exclusively to pay the qualified medical expenses of the individual or the spouse or any dependent of the individual. For this purpose, qualified medical expenses would include premiums for coverage under a Federally qualified health insurance plan and the unreimbursed expenses for medical care (as defined for purposes of the health care expenses tax credit) of the individuals for whose benefit the account was established. No amount would be included in income if the entire amount received is paid into another medical savings account for the benefit of the individual not later than 60 days after the date of the distribution. Contributions in excess of the applicable dollar limits that are withdrawn on or before the date prescribed by law for filing the individual's Federal income tax return for the year (including extensions) would not be treated as distributions that must be included in income but earnings related to such excess contributions would be included in income. An additional 10-percent income tax would be imposed on any distribution from a medical savings account that is includible in income.

Effective date

The provisions of the bill relating to medical savings accounts would be effective for taxable years beginning after December 31, 1996.