DESCRIPTION OF REVENUE PROVISIONS OF THE "HEALTH CARE AVAILABILITY AND AFFORDABILITY ACT OF 1996"

To Be Introduced on

Monday, March 18, 1996

and

Scheduled for Markup

by the

HOUSE COMMITTEE ON WAYS AND MEANS

on March 19, 1996

Prepared by the Staff

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JOINT COMMITTEE ON TAXATION

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INTRODUCTION

The House Committee on Ways and Means has scheduled a markup on March 19, 1996, on the "Health Care Availability and Affordability Act of 1996" to be introduced on Monday, March 18, 1995. This document[1], prepared by the staff of the Joint Committee on Taxation, provides a description of the revenue provisions scheduled for markup.

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[1] This document may be cited as follows: Joint Committee on Taxation, *Description of Revenue Provisions Of the "Health Care Availability and Affordability Act of 1996"* (JCX-4-96), March 15, 1996.

I. MEDICAL SAVINGS ACCOUNTS

Present Law

The tax treatment of health expenses depends on whether the individual is an employee or self employed, and whether the individual is covered under an employer-sponsored health plan. Employer contributions to a health plan for coverage for the employee and the employee's spouse and dependents is excludable from the employee's income and wages for social security tax purposes. Self-employed individuals are entitled to deduct 30 percent of the amount paid for health insurance for the self-employed individual and his or her spouse or dependents. The 30-percent deduction is available with respect to self insurance, as well as commercial insurance. The self-insured plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement. Individuals who itemize their tax deductions may deduct unreimbursed medical expenses (including expenses for medical insurance) paid during the year to the extent that the total of such expenses exceeds 7.5 percent of the individual's adjusted gross income ("AGI"). Present law does not contain any special rules for medical savings accounts.

Description of Proposal

In general

Under the proposal, within limits, individuals covered by a high deductible health plan could make tax deductible contributions to a medical savings account ("MSA"). Similarly, within limits, contributions to an MSA would be excludable from income (and wages for social security purposes) if made by the employer of an eligible individual. Earnings on amounts in an MSA would not be currently taxable. Distributions from an MSA for medical expenses would not be taxable. Distributions not used for medical expenses would be taxable, and subject to an additional 10-percent tax unless the distribution is made after age 59-1/2, death, or disability.

Eligible individuals

An individual (including a self-employed individual) would be eligible to make a deductible contribution to an MSA (or to have employer contributions made on his or her behalf) if the individual is covered under a high deductible health plan and is not covered under another health plan (other than a plan that provides certain permitted coverage).[2]

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[2] An individual with other coverage in addition to a high deductible plan would still be eligible for an MSA if such other coverage is certain permitted insurance or is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. An individual would not be eligible to make deductible contributions to an MSA for a year if any employer contributions are made to an MSA on behalf of the individual for the year. Permitted insurance would be: (1) Medicare supplemental insurance; (2) insurance if

Tax treatment of and limits on contributions

Under the proposal, individual contributions to an MSA would be deductible (within limits) in determining AGI. Subject to the same limits, employer contributions to an MSA would be excludable from gross income and wages for employment tax purposes, except that this exclusion would not apply to contributions made through a cafeteria plan. If the high deductible plan covers only the individual, the maximum amount of contributions that could be deducted or excluded for a year would be equal to the lesser of (1) the deductible under the high deductible plan or (2) $2,000. If the high deductible plan covers the individual and a spouse or a dependent, the maximum that could be excluded or deducted for a year would be the lesser of (1) the annual limit under the plan on the aggregate amount of deductibles required to be paid with respect to all individuals, and (2) $4,000. The annual limit would be the sum of the limits determined separately for each month, based on the individual's status as of the first day of the month. The maximum contribution limit to an MSA would be determined separately for each spouse in a married couple. In no event could the maximum contribution limit exceed $4,000 for a family. The dollar limits would be indexed for medical inflation and rounded to the nearest multiple of $50.

Definition of high deductible plan

A high deductible health plan would be a health plan with a deductible of at least $1,500 in the case of single coverage and $3,000 in the case of coverage of more than one individual. These dollar limits would be indexed for medical inflation, rounded to the nearest multiple of $50. A plan would not fail to be considered a high deductible plan merely because, under State law, the plan is required to provide that there is no deductible for preventive care.

Tax treatment of MSAs

MSAs would be exempt from tax. Thus, earnings on amounts in an MSA would not be currently includible in income.

Taxation of distributions

Under the proposal, distributions from an MSA for the unreimbursed medical expenses of the individual (including a self-employed individual) and his or her spouse or dependents would be excludable from income. The exclusion would apply regardless of whether the payment is made directly from the MSA to the service provider, the MSA distribution reimburses the

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substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (3) insurance for a specified disease or illness; and (4) insurance that provides a fixed payment for hospitalization.

individual for expenses already incurred, or the individual uses the MSA distribution to pay the service provider.

Medical expenses would be defined as under the rules relating to the itemized deduction for medical expenses, except that medical expenses for this purpose would include expenses for long-term care services and would not include insurance premiums other than (1) premiums for long-term care insurance, (2) premiums for health care continuation coverage under any Federal law; and (3) premiums while the individual is receiving unemployment compensation.

Distributions that are not for medical expenses would be includible in income and subject to an additional 10-percent tax unless made after age 59-1/2, death, or disability.

Upon death, if the beneficiary of the MSA is the individual's surviving spouse, the spouse could continue the MSA as his or her own. If the beneficiary is not the surviving spouse, the beneficiary would have to include the MSA balance in income in the year of death. If there is no beneficiary, the MSA balance would be includible on the final return of the decedent. In all cases, no estate tax would apply.

Definition of an MSA

In general, an MSA would be a trust or custodial account created exclusively for the benefit of the account holder and would be subject to rules similar to those applicable to individual retirement arrangements. An MSA trustee (or custodian) could be a bank, insurance company, or other person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with applicable requirements. The MSA trustee (or custodian) would be required to make such reports as may be required by the Secretary. The acquisition expenses of an insurance company relating to the establishment of an MSA would not be subject to the rules relating to the capitalization of policy acquisition costs.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1996.

II. DEDUCTION FOR HEALTH INSURANCE EXPENSES OF SELF-EMPLOYED INDIVIDUALS

Present Law

Under present law, self-employed individuals are entitled to deduct 30 percent of the amount paid for health insurance for a self-employed individual and the individual's spouse and dependents. The deduction is not available for any month if the taxpayer was eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse. The 30-percent deduction is available in the case of self insurance as well as commercial insurance. The self-insured plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement.

Description of Proposal

Under the proposal, the deduction for health insurance for self-employed individuals would be phased up to 50 percent as follows: for taxable years beginning in 1998, 1999, and 2000, the amount of the deduction would be 35 percent of health insurance expenses; for taxable years beginning in 2001 and 2002, 40 percent; and for taxable years beginning in 2003 and thereafter, 50 percent.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1997.

III. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS

Present Law

In general, the Internal Revenue Service ("IRS") takes the position that organizations that provide insurance for their members or other individuals are not considered to be engaged in a tax-exempt activity. The IRS maintains that such insurance activity is either (1) a regular business of a kind ordinarily carried on for profit, or (2) an economy or convenience in the conduct of members' businesses because it relieves the members from obtaining insurance on an individual basis.

Certain insurance risk pools have qualified for tax exemption under Code section 501(c)(6). In general, these organizations (1) assign any insurance policies and administrative functions to their member organizations (although they may reimburse their members for amounts paid and expenses), (2) serve an important common business interest of their members, and (3) must be membership organizations financed, at least in part, by membership dues.

State insurance risk pools may also qualify for tax-exempt status under section 501(c)(4) as a social welfare organizations or under section 115 as serving an essential governmental function of a State. In seeking qualification under section 501(c)(4), insurance organizations generally are constrained by the restrictions on the provision of "commercial-type insurance" contained in section 501(m). Section 115 generally provides that gross income does not include income derived from the exercise of any essential governmental function and accruing to a State or any political subdivision thereof. However, the IRS may be reluctant to rule that particular State risk-pooling entities satisfy the section 501(c)(4) or 115 requirements for tax-exempt status.

Description of Proposal

To assist States in providing medical care coverage for their uninsured high-risk residents and to clarify the tax-exempt status of State health insurance risk pools, the proposal would provide tax-exempt status to any membership organization that is established by a State exclusively to provide coverage for medical care on a nonprofit basis to certain high risk individuals, provided certain criteria are satisfied. The organization could provide coverage for medical care either by issuing insurance itself or by entering into an arrangement with a health maintenance organization ("HMO").

High-risk individuals eligible to receive medical care coverage from the organization must be residents of the State who, due to a pre-existing medical condition, are unable to obtain health coverage for such condition through insurance or an HMO, or who are able to acquire such coverage only at a rate that is substantially higher than the rate charged for such coverage by the organization. The State would determine the composition of membership in the

organization. For example, a State could mandate that all organizations that are subject to insurance regulation by the State must be members of the organization.

The proposal further would require that no part of the net earnings of the organization could inure to the benefit of any private shareholder or individual.

Effective Date

The proposal would apply to taxable years beginning after December 31, 1996.

IV. APPLICATION OF COBRA PENALTY PROVISIONS

Present Law

The health care continuation rules (referred to as "COBRA", after the name of the law that imposed the rules) require that most employer-sponsored group health plans must offer qualified beneficiaries the opportunity to continue to participate for a specified period in the employer's group health plan after the occurrence of certain qualifying events (such as termination of employment) that otherwise would have terminated such participation.

A tax is imposed on the failure of a plan to satisfy the health care continuation rules. The tax may be imposed on the employer sponsoring the plan in the case of a plan other than a multiemployer plan, on the plan in the case of a multiemployer plan, or on each person who is responsible for administering or providing benefits under the plan if such person has, by written agreement, assumed responsibility for performing the act pursuant to which the violation occurs.

The amount of the tax is equal to $100 dollars a day for each day on which there is noncompliance. The maximum penalty that can be imposed for a year with respect to violations occurring during the year generally is the lesser of (1) 10 percent of the employer's payments under group health plans (or under the trust funding the plan in the case of a multiemployer plan), or (2) $500,000. If the tax is imposed on another person responsible for administering the plan, the maximum penalty for failures during a year is $2 million.

Description of Proposal

Under the proposal, group health plans, insurers, and health maintenance organizations would be subject to certain requirements regarding portability, limitations on preexisting conditions, and prohibitions of excluding individuals from coverage based on health status. The tax for failure to satisfy the health care continuation rules generally would apply to failures to comply with these provisions. No tax would be imposed on an insurer that is governed under a State law that the Secretary of Health and Human Services has determined to provide similar enforcement. In addition, no tax would be imposed if there has been enforcement by the Secretary of Labor or the Secretary of Health and Human Services.

Effective Date

The proposal generally would be effective with respect to plan years beginning on or after January 1, 1998.

V. TREATMENT OF LONG-TERM CARE INSURANCE

Present Law

In general

Present law generally does not provide explicit rules relating to the tax treatment of long-term care insurance contracts or long-term care services. Thus, the treatment of long-term care contracts and services is unclear. Present law does provide rules relating to medical expenses and accident or health insurance.

Itemized deduction for medical expenses

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

Exclusion for amounts received under accident or health insurance

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

Treatment of accident or health plans maintained by employers

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

A cafeteria plan is an employer-sponsored arrangement under which employees can elect among cash and certain employer-provided qualified benefits. No amount is included in the gross income of a participant in a cafeteria plan merely because the participant has the opportunity to make such an election (sec. 125). Employer-provided accident or health coverage is one of the benefits that may be offered under a cafeteria plan.

A flexible spending arrangement (FSA) is an arrangement under which an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care, 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. Under proposed Treasury regulations, a maximum amount of reimbursement is not substantially in excess of the total premium if such maximum amount is less than 500 percent of the premium. An FSA may be part of a cafeteria plan or provided by an employer outside a cafeteria plan. FSAs are commonly used to reimburse employees for medical expenses not covered by insurance. If certain requirements are satisfied[3], amounts reimbursed for nontaxable benefits from an FSA are excludable from income.

Health care continuation rules

The health care continuation rules require that an employer must provide qualified beneficiaries the opportunity to continue to participate for a specified period in the employer's health plan after the occurrence of certain events (such as termination of employment) that would have terminated such participation (sec. 4980B). Individuals electing continuation coverage can be required to pay for such coverage.

Description of Proposal

Tax treatment and definition of long-term care insurance contracts and qualified long-term care services

Exclusion of long-term care insurance proceeds

A long-term care insurance contract generally would be treated as an accident and health insurance contract. Amounts (other than policyholder dividends or premium refunds) received under a long-term care insurance contract generally would be excludable from gross income as amounts received for personal injuries and sickness, subject to a cap of $175 per day, or $63,875 annually on per diem contracts only. If the aggregate payments under all per diem contracts with

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[3] These requirements include a requirement that a health FSA can only provide reimbursement for medical expenses (as defined in sec. 213) and cannot provide reimbursement for premium payments for other health coverage and that the maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage.

respect to any one insured exceed $175 per day, then the excess would not be excludable from gross income. The dollar cap would be indexed by the medical care cost component of the consumer price index.

Exclusion for employer-provided long-term care coverage

A plan of an employer providing coverage under a long-term care insurance contract generally would be treated as an accident and health plan; however, coverage under a long-term care insurance contract would not be excludable by an employee if provided through a cafeteria plan; similarly, expenses for long-term care services could not be reimbursed under an FSA.[4]

Self-employed individuals' long-term care insurance

The present-law 30 percent deduction for health insurance expenses of self-employed individuals would be phased up to 50 percent under the proposal. Because the bill would treat payments of long-term care insurance premiums in the same manner as payments of health insurance premiums, the self-employed health insurance deduction would apply to long-term care insurance premiums under the proposal.

Definition of long-term care insurance contract

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

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

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[4] The proposal would not otherwise modify the requirements relating to FSAs. An FSA is defined (as under proposed regulations) as a benefit program providing employees with coverage under which specified incurred expenses may be reimbursed (subject to maximums and other reasonable conditions), and the maximum amount of reimbursement that is reasonably available to a participant is less than 500 percent of the value of the coverage.

Medicare duplication rules

The proposal would provide that no provision of law shall be construed or applied so as to prohibit the offering of a long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under Medicare. Thus, long-term care insurance contracts would not be subject to the rules requiring duplication of Medicare benefits.

Definition of qualified long-term care services

Qualified long-term care services would mean necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

A chronically ill individual would be one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days[5] due to a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living would be eating, toileting, transferring, bathing, dressing and continence.[6]

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

Long-term care insurance premiums treated as medical expenses

Long-term care insurance premiums that do not exceed specified dollar limits would be treated as medical expenses for purposes of the itemized deduction for medical expenses.[7] The

[5] The 90-day period would not be a waiting period. Thus, an individual could be certified as chronically ill if the licensed health care practitioner certifies that the individual will be unable to perform at least 2 activities of daily living for at least 90 days.

[6] Nothing in the proposal would require the contract to take into account all of the activities of daily living. For example, a contract could require that an individual be unable to perform (without substantial assistance) 2 out of any 5 such activities, or for another example, 3 out of the 6 activities.

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

limits are as follows:

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

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

Long-term care riders on life insurance contracts

In the case of long-term care insurance coverage provided by a rider on, or as part of, a life insurance contract, the requirements applicable to long-term care insurance contracts would apply as if the portion of the contract providing such coverage were a separate contract. The term "portion" would mean only the terms and benefits that are in addition to the terms and benefits under the life insurance contract without regard to long-term care coverage. The guideline premium limitation applicable under section 7702(c)(2) would be increased by the sum of charges (but not premium payments) against the life insurance contract's cash surrender value, less any such charges, the imposition of which reduces premiums paid for the contract (within the meaning of sec. 7702(f)(1)). In addition, it is anticipated that Treasury regulations would provide for appropriate reduction in premiums paid (within the meaning of sec. 7702(f)(1)) to reflect the payment of benefits under the rider that reduce the cash surrender value of the life insurance contract.

Health care continuation rules

The health care continuation rules would not apply to coverage under a long-term care insurance contract.

Inclusion of excess long-term care benefits

In general, the proposal would provide that the maximum annual amount of long-term care benefits under a per diem contract that is excludable from income with respect to an insured

who is chronically ill cannot exceed the equivalent of $175 per day for each day the individual is chronically ill. Thus, the maximum annual exclusion for long-term care benefits with respect to any chronically ill individual would be $63,875 (for 1996). Long-term care benefits for this purpose would include payments and other benefits received under a long-term care insurance contract (to the extent otherwise excludable under section 7702B(b) as added by the proposal. If the insured is not the same as the holder of the contract, the insured may assign some or all of this limit to the contract holder at the time and manner prescribed by the Secretary.

A payor of long-term care benefits (as defined above) would have to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxpayer identification number of such individual. A copy of the report would have to be provided to the payee by January 31 following the year of payment, showing the name of the payor and the aggregate amount of benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee would be subject to the generally applicable penalties for failure to file similar information reports.

Consumer protection provisions

Under the proposal, long-term care insurance contracts, and issuers of contracts, would be required to satisfy certain provisions of the long-term care insurance model Act and model regulations promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993). The policy requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. The proposal would also provide disclosure and nonforfeiture requirements. The nonforfeiture provision would give consumers the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period in the event a policyholder who elects a nonforfeiture provision is unable to continue to pay premiums. The requirements for issuers of long-term care insurance contracts would relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, delivering a shopper's guide, right to return, outline of coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. A tax would be imposed equal to $100 per policy per day for failure to satisfy these requirements.

Nothing in the proposal would prevent a State from establishing, implementing or continuing standards related to the protection of policyholders of long-term care insurance policies, if such standards are not inconsistent with standards established under the proposal.

Effective Date

The provisions defining long-term care insurance contracts and qualified long-term care services would apply to contracts issued after December 31, 1996. Any contract issued before January 1, 1997, that met the long-term care insurance requirements in the State in which the

policy was sitused at the time it was issued would be treated as a long-term care insurance contract, and services provided under or reimbursed by the contract are treated as qualified long-term care services.

A contract providing for long-term care insurance could be exchanged for a long-term care insurance contract (or the former canceled and the proceeds reinvested in the latter within 60 days) tax free between the date of enactment and January 1, 1998. Taxable gain would be recognized to the extent money or other property is received in the exchange.

The issuance or conformance of a rider to a life insurance contract providing long-term care insurance coverage would not be treated as a modification or a material change for purposes of applying sections 101(f), 7702 and 7702A of the Code.

The provision relating to treatment as a medical expense of eligible long-term care premiums would be effective for taxable years beginning after December 31, 1996.

The provisions relating to the maximum exclusion for long-term care benefits and reporting would be effective for taxable years beginning after December 31, 1996. Thus, the initial year in which reports will be filed with the IRS and copies provided to the payee would be 1998, with respect to long-term care benefits paid in 1997.

VII. TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS

Present Law

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion under section 101 applies regardless of whether the death benefits are paid as a lump sum or otherwise.

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

If a contract fails to be treated as a life insurance contract under section 7702(a), inside buildup on the contract is generally subject to tax (sec. 7702(g)).

Requirements for a life insurance contract

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

Proposed regulations on accelerated death benefits

The Treasury Department has issued proposed regulations[8] under which certain "qualified accelerated death benefits" paid by reason of the terminal illness of an insured would

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[8] Prop. Treas. Reg. Secs. 1.101-8, 1.7702-0, 1.7702-2, and 1.7702A-1 (December 15, 1992).

be treated as paid by reason of the death of the insured, and therefore would qualify for exclusion under section 101. For purposes of the proposed regulations, an insured would be treated as terminally ill if he or she has an illness that, despite appropriate medical care, the insurer reasonably expects to result in death within 12 months from the payment of the accelerated death benefit. The proposed regulations would not apply to viatical settlements.

Description of Proposal

The proposal would provide an exclusion from gross income as an amount paid by reason of the death of an insured for (1) amounts received under a life insurance contract and (2) amounts received for the sale or assignment of a life insurance contract to a qualified viatical settlement provider, provided that the insured under the life insurance contract is either terminally ill or chronically ill.[9]

The proposal would not apply in the case of an amount paid to any taxpayer other than the insured, if such taxpayer has an insurable interest by reason of the insured being a director, officer or employee of the taxpayer, or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.

A terminally ill individual would be defined as one who has been certified by a physician as having an illness or physical condition that reasonably can be expected to result in death within 24 months of the date of certification.

A chronically ill individual would be defined as under the long-term care provisions of the House bill.[10] In the case of amounts received with respect to a chronically ill individual (but not amounts received by reason of the individual being terminally ill), the $175 per day ($63,875 annual) limitation on excludable benefits (also applicable to long-term care insurance benefits) applies. A reporting requirement would apply to payments to a chronically ill individual.

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[9] The exclusion for amounts received under a life insurance contract on the life of an insured who is chronically ill would apply if the amount is received under a rider or other provision of the contract that is treated as a long-term care insurance contract under section 7702B (as added by the proposal).

[10] Thus, a chronically ill individual would be one who has been certified within the previous 12 months by a licensed health care practitioner as being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days due to (1) a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to sever cognitive impairment. Activities of daily living would be eating, toileting, transferring, bathing, dressing and continence. Nothing in the proposal would require the contract to take into account all of the activities of daily living.

A qualified viatical settlement provider would be any person that regularly purchases or takes assignments of life insurance contracts on the lives of terminally ill or chronically ill individuals and either (1) is licensed for such purposes in the State in which the insured resides, or (2) if the person is not required to be licensed by that State, then the requirements of the section of the Viatical Settlements Model Regulation issued by the National Association of Insurance Commissioners relating to standards for evaluation of reasonable payments, including discount rates, must be met in determining amounts paid by the viatical settlement provider.

For life insurance company tax purposes, the proposal would provide that a life insurance contract is treated as including a reference to a qualified accelerated death benefit rider to a life insurance contract (except in the case of any rider that is treated as a long-term care insurance contract under section 7702B, as added by the proposal). A qualified accelerated death benefit rider would be any rider on a life insurance contract that provides only for payments of a type that are excludable under this provision.

Effective Date

The proposal would apply to amounts received after December 31, 1996. The rule treating a qualified accelerated death benefit rider as life insurance for life insurance company tax purposes would take effect on January 1, 1997. The issuance of a qualified accelerated death benefit rider to a life insurance contract, or the addition of any provision required to conform an accelerated death benefit rider to these provisions, would not be treated as a modification or material change of the contract (and should not affect the issue date of any contract under section 101(f)).

VII. TREATMENT OF BAD DEBT DEDUCTIONS OF THRIFT INSTITUTIONS

Present Law and Background

Reserve method of accounting for bad debts of thrift institutions

Generally, a taxpayer engaged in a trade or business may deduct the amount of any debt that becomes wholly or partially worthless during the year (the "specific charge-off" method of sec. 166). Certain thrift institutions (building and loan associations, mutual savings banks, or cooperative banks) are allowed deductions for bad debts under rules more favorable than those granted to other taxpayers (and more favorable than the rules applicable to other financial institutions). Qualified thrift institutions may compute deductions for bad debts using either the specific charge-off method or the reserve method of section 593. To qualify for this reserve method, a thrift institution must meet an asset test, requiring that 60 percent of its assets consist of "qualifying assets" (generally cash, government obligations, and loans secured by residential real property). This percentage must be computed at the close of the taxable year, or at the option of the taxpayer, as the annual average of monthly, quarterly, or semiannual computations of similar percentages.

If a thrift institution uses the reserve method of accounting, it must establish and maintain a reserve for bad debts and charge actual losses against the reserve, and is allowed a deduction for annual additions to restore the reserve to its permitted balance. Under section 593, a thrift institution annually may elect to calculate its addition to its bad debt reserve under either (1) the "percentage of taxable income" method applicable only to thrift institutions, or (2) the "experience" method that also is available to small banks.

Under the "percentage of taxable income" method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to 8 percent of its taxable income (determined without regard to this deduction and with additional adjustments). Under the experience method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to the greater of: (1) an amount based on its actual average experience for losses in the current and five preceding taxable years, or (2) an amount necessary to restore the reserve to its balance as of the close of the base year. For taxable years beginning before 1988, the "base year" was the last taxable year before the most recent adoption of the experience method (i.e., generally, the last year the taxpayer was on the percentage of taxable income method). For taxable years beginning after 1987, the base year is the last taxable year beginning before 1988. Prior to 1988, computing bad debts under a "base year" rule allowed a thrift institution to claim a deduction for bad debts for an amount at least equal to the institution's actual losses that were incurred during the taxable year.

Bad debt methods of commercial banks

A small commercial bank (i.e., one with adjusted bases of assets of $500 million or less) may use the experience method or the specific charge-off method for purposes of computing its

deduction for bad debts. A large commercial bank only may use the specific charge-off method of section 166. If a small bank becomes a large bank, it must recapture its existing bad debt reserve (i.e., include the amount of the reserve in income) through one of two elective methods. Under the 4-year recapture method, the bank generally includes 10 percent of the reserve in income in the first taxable year, 20 percent in the second year, 30 percent in the third year, and 40 percent in the fourth year. Under the cut-off method, the bank generally neither restores its bad debt reserve to income nor may it deduct losses relating to loans held by the bank as of the date of the required change in the method of accounting. Rather, the amount of such losses are charged against and reduce the existing bad debt reserve; any losses in excess of the reserve are deductible. Any reserve balance in excess of the balance of related loans is includible in income.

Recapture of bad debt reserves by thrift institutions

If a thrift institution becomes a commercial bank, or if the institution fails to satisfy the 60-percent qualified asset test, it is required to change its method of accounting for bad debts and, under proposed Treasury regulations,[11] is required to recapture its bad debt reserve. The percentage-of-taxable-income portion of the reserve generally is included in income ratably over a 6-taxable year period. The experience method portion of the reserve is not restored to income if the former thrift institution qualifies as a small bank. If the former thrift institution is treated as a large bank, the experience method portion of the reserve is restored to income ratably over a 6-taxable year period, or under the 4-year recapture method or the cut-off method described above.

In addition, a thrift institution may be subject to a form of reserve recapture even if the institution continues to qualify for the percentage of taxable income method. Specifically, if a thrift institution distributes to its shareholders an amount in excess of its post-1951 earnings and profits, such excess is deemed to be distributed from the institution's bad debt reserve and is restored to income. In the case of any distribution in redemption of stock or in partial or complete liquidation of an institution, the distribution is treated as first coming out of the bad debt reserves of the institution (sec. 593(e)).

Financial accounting treatment of tax reserves of bad debts of thrift institutions

In general, for financial accounting purposes, a corporation must record a deferred tax liability with respect to items that are deductible for tax purposes in a period earlier than they are expensed for book purposes. The deferred tax liability signifies that, although a corporation may be reducing its current tax expense because of the accelerated tax deduction, the corporation will become liable for tax in a future period when the timing item "reverses" (i.e., when the item is expensed for book purposes but for which the tax deduction had already been allowed). Under the applicable accounting standard (Accounting Principles Board Opinion 23), deferred tax liabilities generally were not required for pre-1988 tax deductions attributable to the bad debt

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[11] Prop. Treas. reg. sec. 1.593-13.

reserve method of thrift institutions because the potential reversal of the bad debt reserve was indefinite (i.e., generally, a reversal only would occur by operation of sec. 593(e), a condition within the control of a thrift institution). However, the establishment of 1987 as a base year increased the likelihood of bad debt reserve reversals with respect to post-1987 additions to the reserve and the conferees understand that thrift institutions generally have recorded deferred tax liabilities for these additions under the current generally accepted accounting principles.

Description of Proposal

Repeal of section 593

The proposal would repeal the section 593 reserve method of accounting for bad debts by thrift institutions, effective for taxable years beginning after 1995. Under the proposal, thrift institutions that qualify as small banks would be allowed to utilize the experience method applicable to such institutions, while thrift institutions that are treated as large banks are required to use only the specific charge-off method.

Treatment of recapture of bad debt reserves

In general

A thrift institution required to change its method of computing reserves for bad debts would treat such change as a change in a method of accounting, initiated by the taxpayer, and having been made with the consent of the Secretary of the Treasury. Any section 481(a) adjustment required to be taken into account with respect to such change generally would be determined solely with respect to the "applicable excess reserves" of the taxpayer. The amount of applicable excess reserves would be taken into account ratably over a 6-taxable year period, beginning with the first taxable year beginning after 1995, subject to the residential loan requirement described below. In the case of a thrift institution that becomes a "large bank" (as determined under sec. 585(c)(2)), the amount of the institution's applicable excess reserves generally would be the excess of (1) the balance of its reserves described in section 593(c)(1) (i.e., its supplemental reserve for losses on loans, its reserve for losses on qualifying real property loans, and its reserve for losses on nonqualifying loans) as of the close of its last taxable year beginning before January 1, 1996, over (2) the balance of such reserves as of the close of its last taxable year beginning before January 1, 1988 (i.e., the "pre-1988 reserves"). Similar rules would be provided for "small banks" and for small banks that subsequently become large banks. The pre-1988 reserves of a thrift institution would be restored to income ratably if the institution ceased to be a bank. A thrift institution that becomes a credit union would be not be treated as a bank and any reserves required to be included in income by the credit union would be treated as unrelated trade or business income.

The balance of the pre-1988 reserves would continue to be subject to the provisions of present-law section 593(e) (requiring recapture in the case of certain excess distributions to, and redemptions of, shareholders). Section 593(e) would not apply to certain internal restructurings

of an affiliated group of banks.

Residential loan requirement

Under a special rule, if the taxpayer meets the "residential loan requirement" for a taxable year, the recapture of the applicable excess reserves otherwise required to be taken into account as a section 481(a) adjustment for such year would be suspended. A taxpayer would meet the residential loan requirement if, for the taxable year, the principal amount of residential loans made by the taxpayer during the year is not less than its base amount. The residential loan requirement would be applicable only for taxable years that begin after December 31, 1995, and before January 1, 1998, and must be applied separately with respect to each such year. Thus, all taxpayers would be required to recapture their applicable excess reserves within six, seven, or eight years after the effective date of the provision.

The "base amount" of a taxpayer would mean the average of the principal amounts of the residential loans made by the taxpayer during the six most recent taxable years beginning before January 1, 1996. At the election of the taxpayer, the base amount may be computed by disregarding the taxable years within that 6-year period in which the principal amounts of loans made during such years were highest and lowest. The test would be applied on a controlled group basis. The balance of a taxpayer's applicable excess reserve would be treated as a tax attribute to which section 381 applies. Thus, if an institution with an applicable excess reserve is acquired in a tax-free reorganization, the balance of such reserve would not be immediately restored to income but will continue to be subject to the residential loan requirement in the hands of the acquirer.

Effective Date

The proposal generally would be effective for taxable years beginning after December 31, 1995. The application of section 593(e) to the applicable excess reserves of the taxpayer would not apply to certain distributions with respect to preferred stock made within one year of enactment.

VIII. EARNED INCOME CREDIT COMPLIANCE

Present Law

In general

Certain eligible low-income workers are entitled to claim a refundable earned income tax credit (EITC). The amount of the credit an eligible taxpayer may claim depends upon whether the taxpayer has one, more than one, or no qualifying children and is determined by multiplying the credit rate by the taxpayer's earned income up to an earned income threshold. The maximum amount of the credit is the product of the credit rate and the earned income threshold. For taxpayers with earned income (or adjusted gross income (AGI), if greater) in excess of the phaseout threshold, the maximum credit amount is reduced by the phaseout rate multiplied by the amount of earned income (or AGI, if greater) in excess of the phaseout threshold. For taxpayers with earned income (or AGI, if greater) in excess of the phaseout limit, no credit is allowed.

The parameters for the EITC depend upon the number of qualifying children the taxpayer claims. For 1996, the parameters are given in the following table (dollar amounts are projections expressed in 1996 dollars):

	Two or more qualifying children--	One qualifying child--	No qualifying children--
Credit rate	40.00%	34.00%	7.65%
Phaseout rate	21.06%	15.98%	7.65%
Earned income threshold	$8,890	$6,330	$4,220
Maximum credit	$3,556	$2,152	$323
Phaseout threshold	$11,610	$11,610	$5,280
Phaseout limit	$28,495	$25,078	$9,500

For years after 1996, the credit rates and the phaseout rates will be the same as in the preceding table. The earned income threshold and the phaseout threshold are indexed for inflation; because the phaseout limit depends on those amounts as well as the phaseout rate and the credit rate, the phaseout limit will also increase if there is inflation.

In order to claim the EITC, a taxpayer must either have a qualifying child or meet other requirements. A qualifying child must meet a relationship test, an age test, an identification test, and a residence test. In order to claim the EITC without a qualifying child, a taxpayer must not

be a dependent and must be over age 24 and under age 65.

To satisfy the identification test, taxpayers must include on their tax return the name and age of each qualifying child. For returns filed with respect to tax year 1996, taxpayers must provide a taxpayer identification number (TIN) for all qualifying children born on or before November 30, 1996. For returns filed with respect to tax year 1997 and all subsequent years, taxpayers must provide TINs for all qualifying children, regardless of their age. A taxpayer's TIN is generally that taxpayer's social security number.

Mathematical errors

The IRS may summarily assess additional tax due as a result of a mathematical error without sending the taxpayer a notice of deficiency and giving the taxpayer an opportunity to petition the Tax Court. Where the IRS uses the summary assessment procedure for mathematical or clerical errors, the taxpayer must be given an explanation of the asserted error and a period of 60 days to request that the IRS abate its assessment. The IRS may not proceed to collect the amount of the assessment until the taxpayer has agreed to it or has allowed the 60-day period for objecting to expire. If the taxpayer files a request for abatement of the assessment specified in the notice, the IRS must abate the assessment. Any reassessment of the abated amount is subject to the ordinary deficiency procedures. The request for abatement of the assessment is the only procedure a taxpayer may use prior to paying the assessed amount in order to contest an assessment arising out of a mathematical or clerical error. Once the assessment is satisfied, however, the taxpayer may file a claim for refund if he believes the assessment was made in error.

Return preparer penalties

An income tax return preparer is subject to a penalty of $250 if any part of an understatement of tax on a return or refund claim is due to the return preparer taking a position for which there was not a realistic possibility of the position being sustained. The return preparer must have known (or reasonably should have known) of the unrealistic position and not disclosed that position. In addition, an income tax return preparer is subject to a penalty of $1,000 if any part of an understatement of tax on a return or refund claim is due to the return preparer's willful attempt in any manner to understate tax or to the return preparer's negligent or intentional disregard of rules and regulations. An income tax return preparer is also subject to a penalty of $50 for each failure to (1) furnish a copy of a return or refund claim to the taxpayer, (2) sign the return or refund claim, (3) furnish his or her identifying number, (4) furnish certain copies or lists of returns or refund claims, or (5) file certain information returns regarding his or her employees. In addition, tax return preparers who endorse or negotiate checks made to taxpayers pay a penalty of $500 for each check endorsed or cashed.

Description of Proposal

Deny credit to individuals not authorized to be employed in the United States

Under the proposal, taxpayers would not be eligible for the EITC if they do not include their taxpayer identification number (and, if married, their spouse's taxpayer identification number) on their tax return. Solely for these purposes and for purposes of the present-law identification test for a qualifying child, a taxpayer identification number would be defined as a social security number issued to an individual by the Social Security Administration other than a number issued under section 205(c)(2)(B)(i)(II) (or that portion of sec. 205(c)(2)(B)(i)(III) relating to it) of the Social Security Act (regarding the issuance of a number to an individual applying for or receiving Federally funded benefits).

Use mathematical error procedures for certain omissions

If a taxpayer fails to provide a correct taxpayer identification number, such omission would be treated as a mathematical or clerical error. If a taxpayer who claims the EITC with respect to net earnings from self-employment fails to pay the proper amount of self-employment tax on such net earnings, the failure would be treated as a mathematical or clerical error.

Increase return preparer penalties

The proposal would double the civil penalties applicable to income tax return preparers. Also, the Secretary of the Treasury would be encouraged to use the maximum feasible review process to insure that originators of electronic income tax returns involving the EITC comply with the law.

Effective Date

The proposal generally would be effective for taxable years beginning after December 31, 1995. In the case of the return preparer penalties, the proposal would apply to penalties with respect to taxable years beginning after December 31, 1995.