[JOINT COMMITTEE PRINT]

DESCRIPTION OF PROPOSALS TO RESTRUCTURE THE INCENTIVES FOR COVERAGE UNDER EMPLOYER HEALTH PLANS

SCHEDULED FOR A HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

ON FEBRUARY 25, 1980

PREPARED FOR THE USE OF THE

COMMITTEE ON WAYS AND MEANS

BY THE STAFF OF THE

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INTRODUCTION

The bills described in this pamphlet have been scheduled for a hearing on February 25, 1980, by the Subcommittee on Health of the House Ways and Means Committee. These bills would generally change the tax treatment of employer contributions to health benefit plans for the purpose of restructuring the incentives for coverage under these plans. This pamphlet provides a summary and description of present law and of H.R. 5740 and related proposals. Proposed changes in the Medicare and Medicaid programs and proposals for increasing benefits among individuals who have little or no coverage are not discussed in this pamphlet.

I. SUMMARY OF PRESENT LAW AND PROPOSALS

A. Present Law

Under present law, employer contributions to employee health plans and the benefits paid under these plans generally are exempt from income and payroll taxes. A deduction is generally allowed to an employer for compensation paid to employees in the form of health plan contributions. Employees who itemize their deductions may claim a deduction (limited to $150) for one-half of their share, if any, of health insurance premiums. Remaining employer contributions, along with other allowable medical expenses, are allowed as itemized deductions to the extent these expenses (including expenses for drugs in excess of one percent of adjusted gross income) exceed 3 percent of an individual's gross income.

Employers with health plans are required to offer their employees the option of membership in a health maintenance organization (HMO) which qualifies under Title XIII of the Public Health Service Act and requests that the employer do so.

B. H.R. 5740 (Messrs. Ullman, Gibbons, Gephardt, Downey and Martin)

The following is a brief summary of the provisions of H.R. 5740.

1. For all health plans, a monthly dollar limitation ($120 for family coverage) would be placed on the employer contribution to a health plan which is excluded from the employee's gross income.

2. In the case where the cost of any option offered under a health plan exceeds a trigger point ($75 for family coverage), the plan would have to meet certain requirements:

(a) the plan would be required to offer the choice of either an HMO (health maintenance organization) or a low cost option as an alternative to the higher cost option;

(b) all options under the plan would be required to provide specified minimum coverage; and

(c) the amount of the employer contribution to a health plan could not depend upon the option chosen by the employee.

If the above three requirements were not met, all employer contributions to health plans would be included in an employee's gross income.

3. The mandatory choice provisions available to HMOs under the Public Health Service Act would be made available to a wider variety of these organizations.

C. Other Proposals

1. H.R. 3943 (Messrs. Jones and Martin)

Businesses would not be allowed a business expense deduction for contributions to an employee health plan which did not require the employee to pay for at least 25 percent of insured inpatient hospital care, with an income-related limit on such cost-sharing.

2. H.R. 5191 (Messrs. Waxman, Brodhead, Shannon, Stark and 56 other cosponsors)

As part of a broader proposal for national health insurance, each employer would be required to offer employees at least one health insurance plan and one HMO, each covering a specified set of basic benefits with no copayments or deductibles. Each plan would receive a fixed capitation payment with respect to each enrollee, and plans for which this amount was larger than the cost of basic benefits could give enrollees additional benefits or tax-free cash rebates.

3. H.R. 5400 (Messrs. Rangel, Corman and Staggers, on behalf of the Administration)

As part of a broader plan for national health insurance, each employer would be required to offer employees at least one health plan covering a specified set of basic benefits with copayments and deductibles limited to $2,500 per year. Employers would be required to offer all qualified HMOs available in the geographic area. If employers offerred employees more than one option, the employer contribution could not depend on the option chosen, so that cash rebates or other fringe benefits would be given to employees selecting an option which costs less than the employer contribution.

4. H.R. 6405 (Messrs. Martin, Vander Jagt, Conable, Gradison and 17 other cosponsors)

As part of a broader proposal for national health insurance, employers offering a health plan would be required to cover a specified list of benefits, with copayments and deductibles limited to $2,500 per year. If employers offer employees more than one option, the employer contribution could not depend on the option chosen, so that selecting an option which costs less than the employer contribution. In addition, the employer health plan contribution which could be excluded from gross income would be limited ($120 per month in the case of family coverage).

5. S. 1590 (Sen. Schweiker and 5 cosponsors)

As part of a broader proposal for national health insurance, employers offering a health plan would be required to cover a specified list of benefits, with copayments and deductibles limited to 20 percent of an employee's income. Large employers would be required to offer at least three health plan options, including one which requires cost-sharing of at least 25 percent of hospital services (subject to an income-related limitation). The employer contribution could not depend on the option chosen, so that tax-free cash rebates would be given to employees selecting an option which costs less than the employer contribution.

6. S. 1720 (Sen. Kennedy and others)

This bill is the same as H.R. 5191.

7. S. 1812 (Sen. Ribicoff and others, on behalf of the Administration)

This bill is the same as H.R. 5400.

8. S 1968 (Sen. Durenberger and 2 cosponsors)

Employers offering a health plan would be required to cover a specified list of benefits, with copayments and deductibles generally limited to $3,500 per year. At least three health plan options would have to be offered, and the employer contribution could not depend on the option chosen, so that cash rebates or other fringe benefits would be given to employees selecting an option which costs less than the employer contribution. In addition, the employer health plan contribution which could be excluded from gross income would be limited ($125 per month in the case of family coverage).

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II. PRESENT LAW

A. Exclusion of Employer Health Plan Contributions and Benefits From Income and Wages

Under present law, the amount paid by an employer to a health plan for an employee (through insurance or otherwise) is not includible in the employee's gross income for the purpose of the income tax (sec. 106 of the Internal Revenue Code) or in the employee's wages for the purposes of employer or employee Social Security (FICA), Railroad Retirement, or unemployment insurance payroll taxes (FUTA) (secs. 3121(a)(2), 3231(a), and 3306(b)(2)).

Under current Internal Revenue Service interpretations, an amount is generally not considered to be an excludible contribution to a health plan for the purpose of the income tax if the employer has the option of receiving this amount as a taxable benefit (such as cash) in lieu of health insurance. If, for example, an employee could choose between a $50 per month contribution to a health plan and $50 per month cash, the entire $50 would be includible in the employee's gross income, regardless of which choice the employee made. However, if an employee is given a choice between taxable and nontaxable benefits under a nondiscriminatory qualified cafeteria plan (sec. 125), only those amounts actually paid in a taxable form (e.g., cash) are includible in the employee's gross income.

Benefits paid to an employee under an employer health plan are generally excluded from gross income and wages if the benefits are paid directly or indirectly to the employee as reimbursement for expenses incurred for medical care by the employee, or the employee's spouse or dependents (sec. 105(b)). However, benefits paid under certain self-insured medical reimbursement plans may be includible in the gross income of highly compensated individuals if the plans discriminate in favor of highly compensated individuals (sec. 105(b)).

B. Deductions for Contributions to Health Plans

A deduction is allowed to an employer for compensation paid, as an ordinary and necessary business expense, to employees in the form of contributions to a health plan (sec. 162).

Employees and other individuals who itemize their deductions may claim a deduction (limited to $150) for one-half the amount of their health insurance contributions. Remaining contributions, along with other allowable medical expenses (including expenses for drugs in excess of 1 percent of adjusted gross income), may be deducted as itemized deductions to the extent these expenses exceed 3 percent of an individual's adjusted gross income (sec. 213).

C. Mandatory Choice of Health Maintenance Organization (HMO) in Employer Health Plans

If a health maintenance organization (HMO) which conforms to the various requirements for being a "qualified" HMO under Title XIII of the Public Health Service Act wishes to be offered as part of the health plan to any employer (not offering an HMO) with 25 or more employees in the service area of the HMO, then the employer must make the HMO option available (sec. 1310 of the Public Health Service Act). If the employees are represented by a collective bargaining agent or other employee representative, then the option of membership in a qualified HMO must first be made to this representative, and, if accepted, then to each employee. Further, the employer must contribute at least as much to the HMO (but no more than its cost) on behalf of an employee who selects that option, as it would have contributed to an alternative health plan selected by the employee. Civil penalties, or in the case of State and local governments, reductions in certain Federal grants-in-aid apply to employers who do not conform to these requirements. The Federal Government and certain religious organizations are exempt from these requirements.

If an employer is already offering an HMO whose services are provided by its employees or a medical group, then these mandatory choice requirements continue to apply to the employer if an individual-practice-association HMO wishes to be offered, and vice versa. If an employer is offering one HMO of each of these two types, then the employer is not required to respond to requests by additional HMOs to be offered to his employees.

III. DESCRIPTION OF H.R. 5740

(MESSRS. ULLMAN, GIBBONS, GEPHARDT, DOWNEY, AND MARTIN)

A. Employer Health Plan Amendments to Internal Revenue Code

1. Maximum Health Benefit Exclusion

In general

The maximum employer contribution to an employee's health plan which could be excluded from the employee's gross income and from wages for purposes of the employer's and employee's FICA liability and the employer's FUTA liability would be $120 per month for family coverage for calendar year 1981. Correspondingly lower limits would apply for "employee-only" ($45) or "employee and spouse only" ($90) coverage under a health plan. These amounts would be indexed each year thereafter by the Medical Care Component of the Consumer Price Index.

Health plan definition

Health plans would be defined to include employer plans for the provision (through insurance, reimbursement or otherwise) of all types of medical care for employees and their families (including hospital, physician, surgical, dental, drug, eye and psychiatric care), but would not take into account disability coverage (i.e., periodic benefits in cash) or workmen's compensation. Further, the definition of a health plan for any employee includes the aggregation of all health benefits offered by employers under common control regardless of the number of specific policies, insurance companies, or other arrangements.

Cost determination

The bill would prescribe rules for computing of the cost of a health plan and of the employer contribution to a health plan. If a group of one or more employees is offered a choice of coverage which differs from the choice of coverage offered to a second group of one or more employees, each such group would be treated as covered by a separate plan. Also, former employees would be treated as covered by a separate plan.

Under the bill, the employer could elect whether the determination of the cost of health coverage would be made on the basis of (1) all employees, (2) employees categorized by employee-only coverage and employee-and-family coverage, or (3) employees categorized by employee only, coverage, employee-and-spouse-only coverage, and employee-and-family coverage. If an employee chose to determine cost on the basis of all employees, then the limit on the exclusion of employer contributions from income would be $55 per month. If the employer categorized covered employees by employee-only coverage and employee-and-family coverage, then the limits would be $45 and $110, respectively.

Employee cost within each category would be determined on an average basis for each health plan option. Only employees covered by a plan could be taken into account. The employer contribution to the plan would be that portion of the cost per employee paid by the employer.

Under the bill, self-insured plans could determine the monthly cost per employee annually on the basis of a reasonable estimate of the cost of providing the coverage for the period.

2. Requirements for Health Plans in Which the Cost of Any Option Exceeds a Trigger Point

If the cost per month (including both employer and employee contributions) of a health plan exceeds the applicable trigger point (e.g., $75 per month for family coverage) under any option offered under a health plan, the employer plan would be required to provide (1) a choice of either an HMO or a low cost option, (2) minimum coverage, and (3) an employer contribution which would not vary substantially according to the option chosen by the employee. The dollar figures which define the trigger point would depend on which of the three actuarial categorizations was chosen by the employer to compute health plan costs, and are shown in the following table:

Categorization	*Type of coverage*	*Trigger point*
(1)	All employees	$58
(2)	Employee only	25
	Employee and family	70
(3)	Employee only	28
	Employee and spouse	55
	Employee and family	75

These figures would be indexed by the medical care component of the Consumer Price Index.

If, for any reason, the employer could not purchase coverage which met the minimum coverage requirement (described below) and which costs less than the trigger point, then the trigger point would be increased to the cost of providing this coverage.

a. Choice of either prepaid health plan or low cost coverage

At least once per year an employee health plan would be required to offer employees the choice of either low cost coverage or a health maintenance organization (HMO) which meets the criteria of section 1310 of the HMO Act (as amended by title II of the bill, described in B, below). Low cost coverage would be any option which costs no more than the trigger point and which provides at least the minimum coverage described below. The employer plan could offer additional options.

For example, if the cost of an employer provided health plan was $100 per month for family coverage in 1981 and the employer did not offer a qualified HMO, the employer would have to offer a low cost

option which provided at least minimum coverage for $75 per month or less. If for any reason the employer could not obtain the required coverage for $75 or less, the employer would have to provide the required coverage at a greater cost, but the requirement would not apply if the cost of the minimum coverage were in excess of $100.

b. Minimum coverage

All options offered under the employer plan would be required to cover at least the following benefits:

(1) Hospital inpatient and outpatient services,
(2) Physicians' services,
(3) Services and supplies commonly furnished incident to a physician's services,
(4) Diagnostic, X-ray and laboratory services,
(5) 100 home health agency service visits per year,
(6) Prosthetic devices replacing all or part of a body organ,
(7) Rental or purchase of durable medical equipment, and
(8) Ambulance services.

The plan would not have to cover benefits provided under other health plans, mental health benefits, cosmetic surgery, travel, services or articles which are not medically necessary or are for custodial care, eyeglasses, dental care, and certain other services.

In addition, required deductibles and copayments for the employee and his family would be limited to $2,000 per year (indexed by the medical care component of the Consumer Price Index).

c. Approximately equal contributions

In general.—If the cost of a health plan exceeds the trigger point, an employer would be required to make approximately equal contributions for all options offered under the plan. Employer contributions would be considered to be approximately equal if the employer contribution to a lower cost option was no less than the employer contribution to the highest cost option reduced by 10 percent of the difference in cost between the highest cost option and the lower cost option. The employer contribution to a lower cost option could not exceed the contribution to the next higher cost option.

For example, if the cost of the high cost option under an employer provided health plan was $100 per month for family coverage in 1981 and the cost of the low cost family option was $60 per month, an employer which contributed $50 toward the high cost option would be considered to be making approximately equal contributions if the employer contributed between $45 and $50 toward the low cost option ($50 minus 10 percent of $40 equals $46).

Rebates.—If the cost of a health plan exceeds the trigger point and the required employer contribution to a lower cost option exceeds the cost of that option, an employer would be required to rebate to an employee who selects this option the difference between the employer contribution to the lower cost option and the cost of that option. (For purposes of determining whether an employer has satisfied the requirement that employer contributions to all options offered under a plan are approximately equal, the amount of the rebate would be considered to be part of the employer contribution.) The rebate would

be included in an employee's gross income, except to the extent it has already been included as an excess employer contribution under 1 above, but would not be subject to FICA and FUTA taxes except as provided in 1 above.

For example, assume that the cost of the higher cost option under an employer provided health plan was $100 per month for family coverage in 1981 and the cost of the lower cost family option was $50 per month. If the employer paid the full cost of the higher cost option ($100), the employer would have to rebate at least $45 and no more than $50 to employees choosing the lower cost option in order to comply with both the equal contribution rule described above and the rebate requirement.

This rule would not require the employer contribution to be equal for all employees, but only for employees covered by the same health plan. Thus, the health plan and the employer contribution could vary by tenure, geographic area, salary level, etc.

d. Tax impact of failure to meet requirements

If the requirements for options, minimum coverage, or approximately equal contributions were not met, all employer contributions to health plans would be included in an employee's gross income. The employer and employee would also have to pay FICA taxes and the employer FUTA and withholding taxes.

3. Effective date

The provisions of the bill would generally apply to calendar months beginning after December 31, 1980. For health plans maintained under a collective bargaining agreement entered into before the date of introduction of the bill (October 30,1979), the provisions relating to minimum coverage, choice of options, and approximately equal employer contributions would not apply to calendar months ending before January 1, 1984, to which the agreement applies.

B. Health Maintenance Organization Amendments to Public Health Service Act

A firm would have to offer to its employees up to two HMOs which desired to be offered. These HMOs would include plans which meet the current requirements of Title XIII of the Public Health Service Act and plans which meet the requirements of that Act except for any or all of the following:

(1) the requirement that at least one-third of the membership of the policymaking body of the plan be members of the organization;

(2) the requirement to provide mental health services and medical treatment and referral for the abuse of or addiction to alcohol and drugs; and/or

(3) the requirement that premiums not be adjusted to reflect the demographic characteristics of members.

This amendment would apply only to the mandatory dual choice provisions. Developmental loans and grants would continue to be available only to the organizations eligible under current law.

In addition, under the bill, a firm would have to offer an individual practice association (IPA) or a plan whose services are provided by its staff or a medical group, as Title XIII currently requires. If no staff or group plan is offered, the firm would have to offer two IPA-type plans. Conversely, if no IPA is offered, a firm would have to offer two staff or group HMOs. The two HMOs could not be owned or controlled by the same legal entity.

C. Examples

Example 1

Suppose than an employer offers a health plan which costs $130 per month for family coverage and pays the entire cost of this plan. The employer also offers a low-cost option under that plan for $70, and employees who select this option receive a $60 rebate. (a) What amount would be included in the gross income of an employee who chooses the higher cost option? (b) What amount would be included in the gross income of an employee who chooses the lower cost option?

	(a) Employee selecting high cost option family coverage	(b) Employee selecting low-cost option family coverage
(1) Total cost of option	$130	$70
(2) Employer contribution:		
A. Health coverage	130	70
B. Cash rebate	0	60
C. Total	130	130
(3) Limit on exclusion	120	120
(4) Amount subject to income and withholding taxes:		
A. Excess contribution	10	10
B. Rebate not included in (A)	0	50
C. Total	10	60
(5) Amount subject to FICA and FUTA	10	10

Example 2

A major employer currently offers and pays for the cost of one comprehensive hospital and physician health plan (A) costing $110 per month for family coverage. He also wants to offer a dental plan (B) or prescription drug plan (C) each costing $25 per month. To conform with the requirements of this proposal, he also offers a low cost hospital and physician health plan (D) costing $65 per month. What are the implications for the employer and his employees?

Because all the options must meet the minimum coverage requirements, either A or D must be a component of the available options. Also, D must be offered alone because one option must have a cost less than $75 per month. Assuming an employer does not wish to further constrain his employees' choice of plans and wishes to make a $110 contribution to each plan, the choices and the rebate or employee contribution implications are shown below:

Option	*(1)*	*(2)*	*(3)*	*(4)*
Components of option	A	D	A, B, & C	D&B
Cost of option	$110	$65	$160	$90
Employer contribution	110	110	110	110
Employee after-tax contribution	0	0	50	0
Taxable rebate (but not subject to FICA and FUTA)	0	45	0	20

IV. DESCRIPTION OF RELATED PORTIONS OF OTHER PROPOSALS

A. House Bills

1. H.R. 3943 (Messrs. Jones and Martin)

Under the bill, businesses would not be allowed a deduction, as an ordinary or necessary business expense, for contributions to a health plan providing inpatient hospital care for employees unless the beneficiary were required to pay for at least 25 percent of the insured inpatient hospital care. In any year, such copayments would have to be limited to the lesser of $2,000 or 15 percent of the beneficiary's average adjusted gross income for the previous three taxable years. These limitations would not apply to employer contributions to a health maintenance organization.

2. H.R. 5191 (Messrs. Waxman, Brodhead, Shannon, Stark and 59 other cosponsors)

As part of a broader proposal for national health insurance, each employer would be required to offer qualified employees the choice of enrollment in at least one plan offered by Blue Cross-Blue Shield or a commercial insurance carrier and at least one plan offered by a health maintenance organization, if such a plan is available. All qualified plans would be required to cover a specified set of basic benefits with no copayments or deductibles. If any qualified employees are represented by a collective bargaining or other representative, then the offer of enrollment would first be made to the representative. If the offer were accepted by the representative, it would then be made to each employee. Employers who did not comply with these requirements could be subject to a civil penalty.

Each qualified health insurer or HMO would receive a fixed capitation payment with respect to each enrollee. This payment could vary by geographic area and actuarial characteristics of the enrollee, but would not vary among health plans with respect to an enrollee of similar characteristics. To the extent that this amount exceeds the cost of providing basic benefits under the plan, an insurer or HMO could offer additional benefits or cash rebates to enrollees. Any such rebates would not be subject to Federal income tax.

3. H.R. 5400 (Messrs. Rangel, Corman and Staggers, on behalf of the Administration)

As part of a broader plan for national health insurance, the Social Security Act would be amended to require that each employer would be required to offer a plan including, as a minimum, a specified list of benefits and to limit required annual copayments and deductibles to $2,500 (adjusted annually to reflect increases in per capita health costs). No cost-sharing could be imposed on prenatal, delivery and infant care services.

Employers would be required to offer their employees the option of joining all HMOs operating in a geographic area.

In any case in which employees were offered a choice of qualified health plans, the employer's contribution would be required to be equal across plans for all employees within any geographic area, except that the amount could vary according to family composition. Employees who chose an option costing less than the employer contribution would receive the difference in cash or other fringe benefits.

Civil penalties would apply to private employers which violated these provisions. State and local governments which violate these provisions would be subject to reduction of Federal grants-in-aid used for employee compensation.

In addition, the separate itemized deduction for individuals for up to $150 of health insurance premiums would be repealed.

4. H.R. 6405 (Messrs. Martin, Vander Jagt, Conable, Gradison, and 17 other cosponsors)

As part of a broader proposal for national health insurance, the Internal Revenue Code would be amended to encourage employer health plans to meet certain requirements.

For all health plans, the amount of employer contributions which could be excluded from gross income would be limited to $120 per month (adjusted for inflation) in the case of family coverage. Different limits would apply in the case of other categories of coverage.

Employer health plans would have to meet various requirements, some of which are described below, in order to be qualified health plans. If any of these requirements were not met, all employer health plan contributions would be included in gross income. In addition, businesses would be denied a deduction for such contributions.

Qualified health plans would be required to provide as a minimum, a list of specified benefits once any copayments or deductibles reached a catastrophic family "stop-loss" limit that could not exceed $2,500 per year (adjusted annually to reflect increases in per capita health costs). In addition, covered individuals would have certain extension and conversion rights upon termination of employment.

If the employer offered employees a choice of qualified health plans, the employer contribution with respect to any employee could not depend on the plan chosen. The contribution could vary according to other factors including such actuarial characteristics as an employee's age, geographic region, and whether the employee is covered by a spouse or other qualified health plan. If the employer contribution on behalf of an employee were greater than the cost of the plan selected by the employee, the employee would be required to receive a rebate equal at least to 75 percent of the amount by which this contribution exceeds the cost of the plan selected. This rebate would be exempt from Federal payroll taxes. Further, up to $8.33 per month would be excluded from gross income for the purpose of the Federal income tax, unless the employer contribution is larger than the limit, described above, on the exclusion from income of employer health plan contributions.

In addition, the $150 limit on the itemized deduction for one-half of an individual's health insurance premiums would be increased to $250, and deductions would be allowed only for premiums for qualified health plans.

B. Senate Bills

1. S. 1590 (Sen. Schweiker and 5 cosponsors)

As part of a broader plan for increased health insurance coverage, the Public Health Service Act would be amended to set forth requirements for the allowance under the income tax of the exclusion of employer health plan contributions from employees' income and the deduction of these contributions as a business expense by an employer.

Qualified health plans offered by employers with at least 50 employees would be required to provide, as a minimum, a list of specified benefits and to limit required copayments or deductibles to 20 percent of the employee's wage and self-employment income.

Any employer would be required to offer, as part of the health plan, at least one option which requires copayment of at least 25 percent for hospital services until total copayments or deductibles exceed 20 percent of income. However, if the employees were represented by a collective bargaining agent, the employer would not be required to offer this type of plan to his employees if the collective bargaining agent failed to accept this type of plan.

Employers with at least 200 full-time employees would be required to offer employees a choice of at least three qualified health plan options, each of which is offered by a different carrier.

If the employer offered employees a choice of qualified health plans, the employer contribution with respect to any employee could not depend on the plan chosen. If the employer contribution on behalf of an employee were greater than the cost of the plan selected by the employee, the employee would be required to receive a rebate equal to the amount by which this contribution exceeds the cost of the plan selected. This rebate could be in the form of cash or benefits, and would be exempt from Federal income tax. The employer contribution would be limited to the cost of the most costly health plan selected by at least 10 percent of the employees.

2. S. 1720 (Sen. Kennedy and others)

The provisions of S. 1720 are the same as H.R. 5191.

3. S. 1812 (Sen. Ribicoff, and others on behalf of the Administration)

The provisions of S. 1812 are the same as H.R. 5400.

4. S. 1968 (Sen. Durenberger and 2 cosponsors)

The Internal Revenue Code would be amended to include in an employee's gross income, under certain circumstances, some or all of employer contributions to health plans.

For all health plans, the amount of employer contribution which could be exempt from an employee's income tax and the employer and employee payroll taxes would be limited to $125 per month (ad-

justed for inflation) in the case of family coverage. Different limits would apply in the case of other categories of coverage.

Employer health plans would have to meet various requirements, some of which are described below, in order to be qualified health plans. If any of these requirements were not met, all employer health plan contributions would be subject to income and payroll taxes.

Qualified health plans offered by employers with more than 100 employees would be required to offer employees a choice of at least three qualified health plan options, each of which is offered by a different carrier.

Qualified plans offered by any employer would be required to provide a specified list of minimum benefits, with required annual copayments or deductibles limited to $3,500, adjusted for inflation. This figure could be increased for one option so that the employer's contribution covers the full cost of this option. Qualified health plans would also be required to provide certain extensions of coverage for the employee and members of his family.

If the employer offered employees a choice of qualified health plan options, the employer contribution with respect to any employee could not depend on the option chosen. If the employer contribution on behalf of an employee were greater than the cost of the option chosen by the employee, the employee would be required to receive a rebate equal to the amount by which this contribution exceeds the cost of the plan selected. This rebate could be in the form of cash (subject to income but not payroll taxes) or in benefits (excluded from income if offered under a qualified cafeteria plan).

V. DISCUSSION OF ISSUES

A. Limits and Conditions on Employer Health Plans

The proposals described in this pamphlet would change the nature of the exclusion of employer health plan contributions from income. Currently no conditions or limits are imposed on this exclusion, and this feature of the law provides a strong incentive for increased health plan coverage. For example, for an employee in the 30-percent income tax bracket, an extra dollar of compensation paid as cash results in additional after-tax cash income to the employee of 70 cents or less; the exact figure depends on whether the individual must also pay social security and State income taxes. In contrast, an extra dollar of compensation paid in the form of health plan contributions results in an additional one dollar of health coverage, since no tax is imposed on this form of compensation. Relative to a situation in which all forms of compensation were taxed equally, current law clearly provides a significant incentive for increased health plan contributions.

Some have argued that the unlimited and unconditional nature of this incentive has resulted in excessive coverage and, thus, inefficiency and excessive cost in the use of health resources. In the extreme cases, in which all health expenses are reimbursed by the employer health plan, it is alleged that the patient has no incentive to consider the cost of these resources in deciding on how much and what quality of resources to use in seeking medical treatment. Further, the doctor and hospital, knowing that the patient's financial condition is unaffected by these choices, may order treatments and procedures of excessive cost or quantity without regard to their necessity or desirability in the treatment of medical conditions. As a result, many health resources may be used inefficiently in that they add little to the health of patients in this situation. In addition, health insurance premiums are kept high and the cost of medical care is increased for those who have relatively little coverage.

On the other hand, many argue that the incentive provided by the current tax treatment of employer health plan contributions is an appropriate and necessary incentive to encourage employees to be protected against the large financial risks, and the resulting reluctance to seek necessary treatment, which employees would face if they lacked adequate health insurance coverage. While these individuals agree that extensive third-party payment under health plans implies an absence of market-type restraints on the price, quality and quantity of health care, they argue that modest reductions in the extent of third-party payment would have little effect on resource decisions and that drastic restraints could discourage necessary treatment. Modest market-type restraints, such as patient payment of a portion of medical bills, are held to make no difference because doctors make most of the decisions about which resources are used and because much treatment is given

in emergency situations in which payment incentives would have little or no effect on patients' or doctors' decisions. Thus, it is argued that lack of market-type discipline is inherent in the health care system, so that inflation and inefficiency will respond only to programs which regulate the prices, quality and quantity of resource utilization.

If the committee should decide to pursue proposals which place conditions and limits on employer health plans, it would have to make choices in the following areas; whether to impose a limit on the exclusion of health plan contributions from income; extent of required choices of options for coverage; degree of coverage which must be provided by all options; whether to require equal employer contributions to the health plan regardless of the option chosen; whether to provide an exemption of small employers from various requirements, type of penalty on employers who do not meet the applicable health plan requirements; and the administering agency.

B. Limit on Income Tax Exclusion of Employer Health Plan Contributions

Several of the proposals would place a limit, or "cap," on the amount of employer contribution to a health plan which could be excluded from income (for example, $120 per month for an employee choosing family coverage). Thus, if an employer contributed $150 per month to a plan, the excess over $120, or $30, would be subject to income and payroll taxes. It is argued that this could improve the equity of the tax system by reducing the amount of tax-free income going largely to relatively high bracket taxpayers. It also should be noted that such a proposal, by itself, could raise a substantial amount of revenue. Further, employers and employees would no longer have an incentive for health coverage which cost more than the cap. Some argue that in this situation, many of the affected employees would reduce their coverage to the cap, perhaps by covering fewer benefits, accepting modest deductibles or copayments, or choosing a health plan (such as an HMO), the efficiency of which allows it to provide comprehensive health care at a lower cost than traditional health insurance plans. These employee choices would introduce more cost-consciousness in employee and provider decisions about health resource use and would promote growth of health plans which could translate efficient operation into lower premiums. The subsidy for the last dollars of coverage, which quite often is the coverage which insulates the employee and provider from any concern with the cost of services, would be removed. As a result, the health care sector would become more efficient and less inflation-prone.

On the other hand, many argue that a cap on the exclusion could lead to reductions in coverage, and thus financial hardship or reluctance to seek medical treatment, for many of the affected employees, especially older individuals living in high-cost areas and faced with high medical needs. Further, it is argued that the reductions in coverage would do little to restrain demand or reduce cost, since providers would continue to make resource decisions in a way that is not influenced by patients' financial circumstances. In addition, health plans which attract certain employees through the use of lower premiums

may simply enroll a disproportionate share of relatively healthy employees rather than provide health care more efficiently. Finally, it is argued that computation of health plan costs for the purpose of reporting wage income to the Internal Revenue Service would create an administrative burden for employers.

C. Required Choices and Coverage in Employer Health Plans

1. Required Choices

Most of the proposals described in this pamphlet would require that employer health plans provide certain choices to employees covered by the plan. Currently, many employer plans provide only one option and, although employers have an interest in satisfying as many employees as possible at the lowest cost possible, competitive pressures which may result from health plan choice among members of the same employee group are absent. However, current law does require an employer to offer his employees certain HMOs that wish to be offered. Those proposals may be seen as a broadening of these mandatory choice requirements.

Several of the proposals would require that employer health plans provide at least three options, each offered by a different insurance carrier. It is argued that this would encourage the formation of competing groups of health care providers, and that each group would have an incentive to restrict itself to doctors and hospitals which adhere to strict standards of efficiency and cost-consciousness. On the other hand, others argue that a health plan could comply with this requirement by simply having three different insurance companies offer an identical plan. If this were a typical response to such a requirement, any resulting increases in health care efficiency could be limited.

Some of the proposals provide more specific requirements as to what choices must be offered. For example, H.R. 5740 would require that employees have the choice of either an HMO or a low cost option, whose premium cost would be kept below a specified level through the use of copayments or deductibles or the elimination of benefits not part of required coverage (see below). It is argued that this proposal would reduce health costs because both HMOs and low cost coverage have large potential for cost savings, and, further, because such a requirement could encourage enrollment in HMOs by inducing some employers to seek out or form such an organization. On the other hand, S. 1590 would require that all employer plans include an option which provides for patient payment of at least 25 percent of some amount of hospital services. This could be justified if patient cost-sharing were viewed as very important in controlling hospital costs, so that all employees should have the option of realizing the premium savings that such a plan could provide.

H.R. 5740 would apply these requirements only to relatively expensive health plans. Thus, one way for an employer to comply with the requirements would be to reduce the cost of the health plan below the "trigger point." If these requirements were expanded to cover a larger number of plans, then some employers could be induced to drop their plans entirely rather than comply with requirements they viewed as burdensome. Although it may be the expensive plans, which if not

carefully structured, are the largest source of inflationary pressure, any consideration of the scope of these rules would be likely to depend on whether they were being considered as part of a broader proposal for increased national health insurance.

Finally, several of the proposals would expand and strengthen the HMO mandatory dual choice provisions of the Public Health Service Act, so that a larger number of HMOs have guaranteed access to a larger number of potential enrollees and so that these HMOs are subject to more competitive pressure.

2. Required coverage

Almost all of the proposals would require that employer health plans cover a specified list of benefits, with explicit limits on required copayments and deductibles. In many cases, these requirements would be part of a broader proposal for increased national health insurance, and thus, other considerations enter into the choice of which benefits or limits should be specifically provided for. However, even in those proposals which are primarily devoted to restructuring existing employer health plans, such as H.R. 5740 and S. 1968, certain minimum coverage would be required. Several reasons have been advanced for these proposals. First, employees' intelligent comparison of various health plan options is facilitated when all the options cover at least a specified list of basic benefits and limit out-of-pocket expenses to a known figure. Second, most of the proposals require catastrophic, rather than first-dollar protection, so that employees who choose a lower cost option have a limited financial risk; that is, they would not face the prospect of large liability after the exhaustion of the benefits of a limited insurance policy.

One proposal, H.R. 3943, would require that all employer health plan options provide for patient copayment of at least 25 percent of a portion of inpatient hospital bills. It has been argued that such a provision, which would increase patient and doctor awareness of hospital charges, is necessary if hospital costs and inefficience health care management practices are to be brought under control. On the other hand, any cost-saving effect of such a requirement could be limited if most employees simply bought, with after-tax dollars, supplementary insurance for the portion of medical expenses which employers could not cover under their health plans.

3. Small employers

Several of the proposals would exempt employers with less than a specified number of employees from the requirements to offer specific options as part of an employer health plan. It has been argued that a multiple choice health plan would pose an unreasonable administrative burden to such employers, although there is no precise agreement on the definition of "small" employer for this purpose. As a result, small employers forced with minimum coverage and multiple choice requirements could simply decide to drop their health plans. On the other hand, a GAO survey of employers offering employees the choice of an HMO found that very few employers believe that dual choice presented a significant administrative burden. In addition, if the definition of exempt employers were to depend on the number of employees, firms with rapidly fluctuating employment would be subject

to a great deal of uncertainty. Finally, if firms were allowed to keep some of the premium savings which resulted when employees chose a less expensive option, dual choice could actually benefit some small employers.

D. Equal Employer Contribution Requirement

Many of the proposals described in this pamphlet would require that employers make approximately equal contributions to each health plan option, so that the contribution would not vary substantially according to the option chosen by the employee. This would essentially mandate that almost all the cost savings which result when an employee chooses a relatively low cost option would be passed through to the employee. It is argued that such a requirement is necessary to allow employees' choices to reflect meaningful comparison of the costs and benefits of extra coverage.

In cases in which the employer contribution toward a health plan option is greater than its cost, many of the proposals would require that the difference be rebated to the employee in cash. The proposals differ, however, in whether this rebate would be subject to income tax. The key policy issue involved in this feature of an employer health plan is the desired level of tax benefit for employer health plan contributions. To the extent that employees face a choice between taxable cash and tax-free health benefits, the health benefits are being favored by the tax system.

This point may be illustrated by the following example. Suppose that an employer's contribution to a comprehensive health plan option is $110 per month, and that under an equal contribution requirement employees who chose a low-cost plan with a cost of $50 per month receive a $60 per month taxable cash rebate. An employee in a 25-percent tax bracket would thus have the option of giving up $60 of coverage in exchange for an extra $45 of cash (after-tax). Thus, in this situation, the tax system would provide a subsidy for the extra health insurance coverage. If the cash rebate were tax-free, the employee's choice would be either $60 of cash or $60 of extra coverage. That is, there would be no subsidy for the extra coverage.

It should be noted that allowing tax-free rebates provides the same unsubsidized incentive as a lower cap on the exclusion of employer contributions from gross income. Suppose, for example, that the cap were $50 per month and that the employer contribution were $110, so that $60 was subject to an extra income tax of $15 regardless of whether the employee chose the extra coverage or the rebate. Since the tax would be paid in any case, the employee who does not choose the extra $60 of coverage will receive an extra $60 (after-tax) in cash. Thus, in both situations—high cap and tax-free rebates, and low cap—no tax subsidy is provided for the extra coverage. However, there is a major difference in Federal tax revenues under the two proposals. With the lower cap, tax revenues are collected on all employer health plan contributions over $50, in this example. With a higher cap and tax-free rebates, a large volume of cash payments could escape income tax. In fact, employers would have an incentive to increase health contributions to as high a level

as possible, if only to funnel tax-free cash to their employees, with large resulting revenue losses. Even if rebates are not tax-free, however, the increased flexibility which would be permitted by allowing each employee to make a choice between extra cash and extra coverage could lead to increased health plan contributions. Thus, this portion of all the proposals, by itself, could result in significant loss of Federal tax revenue.

E. Type of Penalty and Administering Agency

Some proposals would impose civil penalties on employers which do not conform to the health plan requirements which would be provided, while others would simply treat nonqualified health plans as ordinary income for tax purposes. The choice between these two alternatives would appear to depend on whether employers should be absolutely prohibited from offering nonqualified plans or whether they should be allowed to offer them if they and their employees are willing to forego the associated tax benefits. It should also be noted that proposals to deny businesses a deduction for nonqualified plans would not affect governments, nonprofit organizations and businesses incurring a loss.

The choice of penalty is also related to which agency would be enforcing the requirements, both the content of the plans and the methods by which employers and insurance companies actually process employee claims for reimbursement. On the one hand, the Department of Health and Human Services has expertise in the content of health plans but little experience dealing directly with employers, while, on the other hand, the Internal Revenue Service has expertise in enforcing requirements with respect to pension plans and other employer benefit plans, but little experience dealing with health plans.

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