

**OVERVIEW OF PRESENT-LAW FEDERAL TAX PROVISIONS  
RELATING TO HEALTH CARE AND SELECTED HEALTH CARE TAX  
PROPOSALS PROVIDING AID TO DISPLACED WORKERS AND  
OTHER UNINSURED INDIVIDUALS**

Scheduled for a Public Hearing  
Before the  
HOUSE COMMITTEE ON WAYS AND MEANS  
on February 13, 2002

Prepared by the  
Staff of the  
JOINT COMMITTEE ON TAXATION



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## INTRODUCTION

The House Committee on Ways and Means has announced a public hearing on the use of health tax credits to aid displaced workers and reduce the number of individuals without health insurance. This document,<sup>1</sup> prepared by the staff of the Joint Committee on Taxation, provides a description of present law relating to tax incentives for health care and summarizes selected health care tax proposals providing aid to displaced workers and other uninsured individuals.

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<sup>1</sup> This document may be cited as follows: Joint Committee on Taxation, *Overview of Present-Law Federal Tax Provisions Relating to Health Care and Selected Health Care Tax Proposals Providing Aid to Displaced Workers and Other Uninsured Individuals*, (JCX-4-02), February 12, 2002.

# I. DESCRIPTION OF PRESENT-LAW FEDERAL TAX PROVISIONS RELATING TO HEALTH CARE

## A. Taxation of Individuals

### 1. Overview

Under present law, the Federal tax treatment of health insurance expenses depends on the individual's circumstances. In general, employer contributions to an accident or health plan are excludable from an employee's gross income. Self-employed individuals are entitled to deduct a portion of the amount paid for health insurance expenses for the individual and his or her spouse and dependents. Individuals other than self-employed individuals who purchase their own health insurance and itemize deductions may deduct their expenses to the extent that their total medical expenses exceed 7.5 percent of adjusted gross income.

Present law does not provide a tax credit for the purchase of health insurance.

### 2. Exclusion from income and wages for employer-provided health care

In general, employer contributions to an accident or health plan are excludable from an employee's income.<sup>2</sup> This exclusion for employer-provided health coverage generally applies to coverage provided to employees (including former employees) and their spouses, dependents, and survivors. In the case of a self-insured medical reimbursement plan, the exclusion is conditioned on the coverage being provided under a plan meeting certain rules requiring that the plan not discriminate in favor of highly compensated employees ("nondiscrimination rules").<sup>3</sup> Insured health plans generally are not subject to nondiscrimination rules.<sup>4</sup> Employer-provided accident or health coverage generally is excludable from wages for employment tax purposes as well without regard to whether the coverage is provided on a nondiscriminatory basis.<sup>5</sup>

Benefits paid under employer-provided accident or health plans are also generally excludable from income to the extent they are reimbursements for medical care as defined in section 213 or to the extent the benefits constitute payments for the permanent loss of use of a member or function of the body or permanent disfigurement and are computed with reference to the nature of the injury and without regard to the period the employee is absent from work.<sup>6</sup>

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<sup>2</sup> Sec. 106. All "section," "sec.," and "Code" references are to the Internal Revenue Code of 1986, as amended.

<sup>3</sup> Sec. 105(h).

<sup>4</sup> Benefits offered through a cafeteria plan are subject to nondiscrimination rules.

<sup>5</sup> Sec. 3121(a)(2).

<sup>6</sup> Sec. 105. The Code also provides an exclusion for amounts received under workmen's compensation acts for personal injuries or sickness and damages received on account of personal injuries or sickness (sec. 104).

### **3. Cafeteria plans and flexible spending arrangements**

#### **Cafeteria plans**

##### In general

Under present law, compensation generally is includible in gross income when actually or constructively received. An amount is constructively received by an individual if it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, amounts are not included in the gross income of a participant in a cafeteria plan described in section 125 solely because the participant may elect among cash and certain employer-provided qualified benefits under the plan. This constructive receipt exception is not available if the individual is permitted to revoke a benefit election during a period of coverage in the absence of a change in family status or certain other events.

Qualified benefits that may be offered under a cafeteria plan are certain benefits that are excludable from an employee's gross income by reason of a specific provision of the Code. Employer-provided accident or health coverage is a qualified benefit.<sup>7</sup>

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

The cafeteria plan exception from the principle of constructive receipt generally also applies for employment tax purposes.<sup>8</sup>

##### Nondiscrimination rules

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

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<sup>7</sup> Other qualified benefits include group-term life insurance coverage (whether or not subject to tax by reason of being in excess of the dollar limit on the exclusion for such insurance), and benefits under dependent care assistance programs. Certain excludable benefits may not be provided under a cafeteria plan, including the following: contributions to an Archer MSA (sec. 106(b)), qualified scholarships or tuition reduction (sec. 117), educational assistance (sec. 127), miscellaneous employer-provided fringe benefits (sec. 132), and long-term care insurance (sec. 7702B). In addition, a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)).

<sup>8</sup> Elective contributions under a qualified cash or deferred arrangement that is part of a cafeteria plan are subject to employment taxes.

discriminatory with respect to contributions and benefits. In addition, a plan is deemed not to be discriminatory if the plan is maintained pursuant to a collective bargaining agreement.

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

In the case of key employees, the exception to the constructive receipt principle does not apply if the qualified benefits provided under the plan to such employees exceed 25 percent of the aggregate of such benefits provided for all employees under the plan. A key employee is defined under the top-heavy rules applicable to qualified pension plans.<sup>9</sup>

### **Flexible spending arrangements**

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

There is no special exclusion for benefits provided under an FSA. Thus, benefits provided under an FSA are excludable from income only if there is a specific exclusion for the benefits in the Code (e.g., the exclusion for employer-provided health care (other than long-term care) or dependant care assistance coverage). FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement.<sup>10</sup> Under proposed Treasury regulations, a cafeteria plan would permit the deferral of compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.<sup>11</sup> Thus, amounts in an employee’s account that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the “use it or lose it” rule.

In addition, proposed Treasury regulations contain additional requirements with which health FSAs must comply in order for the coverage and benefits provided under the FSA to be excludable from income.<sup>12</sup> These rules apply with respect to a health FSA without regard to whether the health FSA is provided through a cafeteria plan (i.e., without regard to whether an employee has an election to take cash or benefits).

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<sup>9</sup> Sec. 416.

<sup>10</sup> Sec. 401(k).

<sup>11</sup> Prop. Treas. Reg. 1.125-2 Q&A-5(a).

<sup>12</sup> Prop. Treas. Reg. 1.125-2 Q&A-7(b).

The proposed regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.<sup>13</sup>

Under the proposed regulations, the employer-provided health coverage under the FSA and the reimbursements and other benefits received under the health FSA are excludable from an employee's income only if the health FSA satisfies certain additional requirements. According to the proposed regulations, health FSAs are required to (1) provide the maximum amount of reimbursement available under the FSA at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage), (2) offer coverage for 12 months or, in the case of a short plan year, the entire short plan year, (3) only reimburse medical expenses which meet the definition of medical care under section 213(d), (4) reimburse medical expenses for which the participant provides a written statement from an independent third party stating the amount of the medical expense and that the medical expense has not been reimbursed or is not reimbursable under any other health plan, (5) reimburse medical expenses which are incurred during the participant's period of coverage, and (6) allocate experience gains with respect to a year of coverage among premium payers on a reasonable and uniform basis.<sup>14</sup>

#### **4. Deduction for health insurance expenses of self-employed individuals**

The exclusion for employer-provided health coverage does not apply to self-employed individuals. However, under present law, self-employed individuals (i.e., sole proprietors or partners in a partnership) are entitled to deduct a portion of the amount paid for health insurance for the self-employed individual and the individual's spouse and dependents. Self-employed individuals may deduct the amount paid for health insurance as follows: 70 percent in 2002, and 100 percent in 2003 and all years thereafter.

The deduction is available with respect to the cost of self insurance as well as commercial insurance. In the case of self insurance, the deduction is not available unless the self-insured plan is in fact insurance (e.g., there is adequate risk shifting) and not merely a reimbursement arrangement. The deduction is not available for any month in which the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse. In addition, no deduction is available to the extent that the deduction exceeds the taxpayer's earned income from self employment. Expenses for health insurance in excess of the deductible amount may be taken into account in determining whether the individual is entitled to an itemized deduction for medical expenses.

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<sup>13</sup> Prop. Treas. Reg. 1.125-2 Q&A-7(c).

<sup>14</sup> Prop. Treas. Reg. 1.125-2 Q&A-7(b).

For purposes of these rules, more than two-percent shareholders of S corporations are treated the same as self-employed individuals. Thus, they are entitled to the same health insurance deduction.

## **5. Itemized deduction for medical expenses**

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

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

## **6. Archer medical savings accounts ("MSA")**

### **In general**

Within limits, contributions to an Archer MSA are deductible in determining adjusted gross income if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. Earnings on amounts in an Archer MSA are not currently taxable. Distributions from an Archer MSA for medical expenses are not taxable. Distributions not used for medical expenses are taxable. In addition, distributions not used for medical expenses are subject to an additional 15-percent tax unless the distribution is made after age 65, death, or disability.

### **Eligible individuals**

Archer MSAs are available to employees covered under an employer-sponsored high deductible plan of a small employer and self-employed individuals covered under a high deductible health plan.<sup>15</sup> An employer is a small employer if it employed, on average, no more than 50 employees on business days during either the preceding or the second preceding year. An individual is not eligible for an Archer MSA if they are covered under any other health plan in addition to the high deductible plan.

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<sup>15</sup> Self-employed individuals include more than two-percent shareholders of S corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.



## **Tax treatment of and limits on contributions**

Individual contributions to an Archer MSA are deductible (within limits) in determining adjusted gross income (i.e., "above the line"). In addition, employer contributions are excludable from gross income and wages for employment tax purposes (within the same limits), except that this exclusion does not apply to contributions made through a cafeteria plan. In the case of an employee, contributions can be made to an Archer MSA either by the individual or by the individual's employer.

The maximum annual contribution that can be made to an Archer MSA for a year is 65 percent of the deductible under the high deductible plan in the case of individual coverage and 75 percent of the deductible in the case of family coverage.

## **Definition of high deductible plan**

A high deductible plan is a health plan with an annual deductible of at least \$1,650 and no more than \$2,500 in the case of individual coverage and at least \$3,300 and no more than \$4,950 in the case of family coverage. In addition, the maximum out-of-pocket expenses with respect to allowed costs (including the deductible) must be no more than \$3,300 in the case of individual coverage and no more than \$6,050 in the case of family coverage.<sup>16</sup> A plan does not fail to qualify as a high deductible plan merely because it does not have a deductible for preventive care as required by State law. A plan does not qualify as a high deductible health plan if substantially all of the coverage under the plan is for permitted coverage (as described above). In the case of a self-insured plan, the plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement.

## **Taxation of distributions**

Distributions from an Archer MSA for the medical expenses of the individual and his or her spouse or dependents generally are excludable from income.<sup>17</sup> However, in any year for which a contribution is made to an Archer MSA, withdrawals from an Archer MSA maintained by that individual generally are excludable from income only if the individual for whom the expenses were incurred was covered under a high deductible plan for the month in which the expenses were incurred.<sup>18</sup> For this purpose, medical expenses are defined as under the itemized deduction for medical expenses, except that medical expenses do not include expenses for insurance other than long-term care insurance, premiums for health care continuation coverage,

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<sup>16</sup> These dollar amounts are for 2002. These amounts are indexed for inflation in \$50 increments.

<sup>17</sup> This exclusion does not apply to expenses that are reimbursed by insurance or otherwise.

<sup>18</sup> The exclusion still applies to expenses for continuation coverage or coverage while the individual is receiving unemployment compensation, even for an individual who is not an eligible individual.

and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law.

Distributions that are not used for medical expenses are includible in income. Such distributions are also subject to an additional 15-percent tax unless made after age 65, death, or disability.

### **Cap on taxpayers utilizing Archer MSAs**

The number of taxpayers benefiting annually from an Archer MSA contribution is limited to a threshold level (generally 750,000 taxpayers). If it is determined in a year that the threshold level has been exceeded (called a "cut-off" year) then, in general, for succeeding years during the pilot period 1997-2002, only those individuals who (1) made an Archer MSA contribution or had an employer Archer MSA contribution for the year or a preceding year (i.e., are active Archer MSA participants) or (2) are employed by a participating employer are eligible for an Archer MSA contribution. In determining whether the threshold for any year has been exceeded, Archer MSAs of individuals who were not covered under a health insurance plan for the six month period ending on the date on which coverage under a high deductible plan commences would not be taken into account.<sup>19</sup> However, if the threshold level is exceeded in a year, previously uninsured individuals are subject to the same restriction on contributions in succeeding years as other individuals. That is, they would not be eligible for an Archer MSA contribution for a year following a cut-off year unless they are an active Archer MSA participant (i.e., had an Archer MSA contribution for the year or a preceding year) or are employed by a participating employer.

The number of Archer MSAs established has not exceeded the threshold level.

### **End of Archer MSA pilot program**

After 2002, no new contributions may be made to Archer MSAs except by or on behalf of individuals who previously had Archer MSA contributions and employees who are employed by a participating employer. An employer is a participating employer if (1) the employer made any Archer MSA contributions for any year to an Archer MSA on behalf of employees or (2) at least 20 percent of the employees covered under a high deductible plan made Archer MSA contributions of at least \$100 in the year 2001.

Self-employed individuals who made contributions to an Archer MSA during the period 1997-2002 also may continue to make contributions after 2002.

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<sup>19</sup> Permitted coverage, as described above, does not constitute coverage under a health insurance plan for this purpose.

## **B. Taxation of Employers**

### **1. Employer deduction for health care for employees**

Under present law, amounts paid or accrued by an employer within a taxable year for a sickness, accident, hospitalization, medical expense, or similar health plan for its employees are generally deductible as ordinary and necessary business expenses under section 162. The deduction is available provided the amounts are used to pay accident and health insurance premiums or to pay or reimburse benefits directly. Amounts paid for premiums are not deductible if the proceeds of the policy are payable to the employer rather than the employee. The timing of the deduction is based on the employer's method of accounting. Under the cash method, the expenses are deductible for the taxable year in which they are paid. Under the accrual method, the expenses are deductible for the taxable year in which all events have occurred to determine the fact and amount of the expenses.

Contributions by an employer to a welfare benefit fund are not deductible under the usual income tax rules, but if they otherwise would be deductible under the usual rules (e.g., if they are ordinary and necessary business expenses), the contributions are deductible within limits for the taxable year in which such contributions are made to the fund.<sup>20</sup> A welfare benefit fund is, in general, any fund that is part of a plan of an employer, and through which the employer provides welfare benefits (i.e., benefits other than pension benefits) to employees or their beneficiaries. A "fund" is defined as certain tax-exempt trusts or organizations (including voluntary employees' beneficiary associations ("VEBAs") exempt from tax under section 501(c)(9)), any trust, corporation or other organization not exempt from tax, and, to the extent provided in regulations, any account held for an employer by any person.<sup>21</sup>

The amount of the deduction otherwise available to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the amount that would be deductible for benefits provided during the year if the employer paid them directly and was on the cash method of accounting, and (2) the addition (within limits) to a qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.<sup>22</sup>

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

The account limit for any taxable year may include a reserve to provide certain post-retirement medical and life insurance benefits. This limit allows amounts reasonably necessary

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<sup>20</sup> Secs. 419 and 419A.

<sup>21</sup> Sec. 419(e)(3).

<sup>22</sup> This limit does not apply to collectively bargained plans, or plans maintained by 10 or more employers.

to accumulate reserves under a welfare benefit plan so that the liabilities for post-retirement medical and life insurance benefits with respect to a group of employees can be prefunded.

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

In the case of an employee who is a "key employee" under the pension rules,<sup>23</sup> a separate account is required to be established and maintained on a per-participant basis, and benefits provided to such employee (and his or her spouse and dependents) are payable only from the separate account. Contributions to the separate account of a key employee are considered annual additions to a defined contribution plan for purposes of the limits on contributions and benefits applicable to retirement plans,<sup>24</sup> except that the 25-percent-of-compensation limit<sup>25</sup> does not apply.

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

## **2. Use of excess pension assets to fund retiree health benefits**

Present law permits qualified transfers of excess assets from a defined benefit pension plan to a separate account within the plan in order to fund retiree health benefits.<sup>26</sup> Excess assets transferred in a qualified transfer may not exceed the amount reasonably estimated to be the amount that the employer will pay out of such account during the taxable year of the transfer for qualified current retiree health liabilities. Amounts transferred in a qualified transfer are not includible in the gross income of the employer and are not subject to the excise tax on reversions of assets in a defined benefit plan. No deduction is allowed to the employer for (1) a qualified transfer or (2) the payment of qualified current retiree health liabilities out of transferred funds (and any income thereon).

In order for a transfer to be a qualified transfer, certain requirements must be satisfied, including requirements relating to the vesting of benefits under the defined benefit plan and notice to employees. In addition, no transfer after December 31, 2005, is a qualified transfer.

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<sup>23</sup> Sec. 416.

<sup>24</sup> Sec. 415.

<sup>25</sup> Sec. 415(c)(1)(B).

<sup>26</sup> Sec. 420. Rules relating to such separate accounts are in section 401(h).

## **C. Group Health Plan Requirements**

### **1. Health care continuation rules**

The health care continuation rules (commonly referred to as “COBRA” rules, after the Consolidated Omnibus Budget Reconciliation Act of 1985 in which they were enacted) require that most employer-sponsored group health plans must offer certain covered employees and their dependents (“qualified beneficiaries”) the option of purchasing continued health coverage in the event of loss of coverage resulting from certain qualifying events. These qualifying events include: termination or reduction in hours of employment, death, divorce or legal separation, enrollment in Medicare, the bankruptcy of the employer, or the end of a child's dependency under a parent's health plan. The term qualified beneficiary includes individuals who were either the spouse or the dependent of the covered employee at the time of the qualifying event and includes a child born to or placed for adoption with the covered employee during the period of COBRA coverage.

In general, the maximum period of COBRA coverage is 18 months. An employer is permitted to charge qualified beneficiaries 102 percent of the applicable premium for COBRA coverage. A tax equal to \$100 per day may be assessed against employers (plans in the case of multiemployer plans) for failures to comply with the COBRA rules, subject to certain exceptions and limitations. This tax may be assessed against a person who is responsible (other than in a capacity as an employee) for administering or providing benefits under a plan and whose act or failure to act caused (in whole or in part) the failure to comply with the COBRA rules.

The 18-month maximum COBRA coverage period is extended to 29 months if the qualified beneficiary was determined under the Social Security Act to have been disabled at the time of the qualifying event and the qualified beneficiary provided notice of such determination to the employer before the end of the 18-month period. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) clarified that this extended COBRA coverage applies if the disability exists at any time during the first 60 days of initial 18-month COBRA coverage as opposed to requiring the disability to exist at the time of the qualifying event. A qualified beneficiary has 60 days to notify the employer of a disability determination. During the 11-month period of extended COBRA coverage, the qualified beneficiary may be charged 150 percent of the applicable premium.

COBRA coverage may be terminated before the 18-month maximum coverage period in the case of the following events: (1) the employer ceases to maintain any group health plan; (2) the qualified beneficiary fails to pay the premium; (3) the qualified beneficiary becomes covered under another group health plan even if such group health plan contains a preexisting condition limitation or exclusion, provided the preexisting condition limitation or exclusion does not apply to the qualified beneficiary by reason of requirements added by HIPAA restricting the application of preexisting condition limitations and exclusions; or (4) the qualified beneficiary becomes entitled to Medicare.

A group health plan is required to notify each covered employee and the covered employee's spouse of their COBRA rights upon commencement of participation in the plan. Further, the group health plan administrator must notify each qualified beneficiary of their

COBRA rights within 14 days after the administrator is notified of the occurrence of a qualifying event.

Under present law, individuals without access to COBRA are able to purchase individual policies on a guaranteed issue basis without exclusion of coverage for pre-existing conditions, if they had 18 months of creditable coverage under an employer sponsored group health plan, governmental plan, or a church plan. Those with access to COBRA are required to exhaust their 18 months of COBRA prior to accessing the same individual market protections.

## **2. Other group health plan requirements**

The Code contains several requirements relating to group health plans. In general, these requirements apply to all group health plans, other than governmental plans and plans with fewer than two participants. In addition, these requirements do not apply to plans providing certain limited, excepted benefits.<sup>27</sup>

First, under the Health Insurance Portability and Accountability Act of 1997 (“HIPAA”), group health plans are subject to requirements in the Code that: (1) place restrictions on exclusions for preexisting conditions, (2) prohibit discrimination based on health status, and (3) provide for guaranteed renewability in multiemployer plans and certain multiple welfare benefit arrangements.<sup>28</sup>

Second, the Code also imposes certain requirements on group health plans with respect to coverage of newborns and mothers, including a requirement that a group health plan cannot restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section.<sup>29</sup>

Finally, the Code provides that group health plans that provide both medical and surgical benefits cannot impose aggregate lifetime or annual dollar limits on mental health benefits that are not imposed on substantially all medical and surgical benefits. The mental health parity provisions do not apply to benefits for services furnished on or after December 30, 2002.

### **Sanction for failure to satisfy group health plan requirements**

An excise tax of \$100 per day during the period of noncompliance is imposed on the employer sponsoring a noncomplying group health plan.<sup>30</sup> The maximum tax that can be

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<sup>27</sup> Sec. 9831.

<sup>28</sup> Secs. 9801-9801. The group health plan requirements are also contained in the Employee Retirement Income Security Act (“ERISA”). HIPAA also imposes similar requirements on governmental plans and health insurance issuers.

<sup>29</sup> Sec. 9811. Similar rules are contained in ERISA and the Public Health Service Act.

<sup>30</sup> Sec. 4980D. In the case of a multiemployer plan, the excise tax is imposed on the plan.

imposed during a taxable year cannot exceed the lesser of 10 percent of the employer's group health plan expenses for the prior year or \$500,000. No tax is imposed if the Secretary determines that the employer did not know, and exercising reasonable diligence would not have known, that the failure existed. In addition, no tax is imposed if the failure was due to reasonable cause and not willful neglect and the failure is corrected within a specific period.

## II. SUMMARY OF SELECTED PROPOSALS

### A. H.R. 3529, the “Economic Security and Worker Assistance Act of 2001,” as passed by the House of Representatives on December 20, 2001

#### 1. Displaced worker health insurance credit (secs. 801 and 802 of the bill)

The bill provides a refundable tax credit for 2002 and 2003 for a portion of expenses for qualified health insurance paid by an unemployed taxpayer and his or her spouse and dependents. Qualified health insurance is any insurance that constitutes medical care (as defined in section 213), except insurance substantially all of which is coverage of certain excepted benefits.<sup>31</sup> Thus, for example, the credit is available with respect to COBRA continuation coverage, individual policies, and group policies, provided the requirements for the credit are otherwise satisfied. The credit is available only with respect to amounts paid by the taxpayer. The credit is equal to 60 percent of the taxpayer’s expenses for qualified health insurance coverage in 2002 and 2003. No more than 12 months of coverage are eligible for the credit.

Eligibility for the credit is determined on a monthly basis. In general, a taxpayer is eligible for the credit for a month if, as of the first day of the month, the taxpayer (1) is unemployed, (2) is covered by qualified health insurance, and (3) does not have other specified coverage (defined below). In addition, the period of unemployment must have begun after March 15, 2001, and before January 1, 2004. In the case of a joint return, the eligibility requirements are met if at least one spouse satisfies the requirements.

An individual is considered unemployed during any period if, during such period, the individual (1) is receiving unemployment compensation or (2) is certified by a State agency (or any other entity designated by the Secretary of the Treasury) as otherwise being entitled to receive unemployment compensation but for the termination of the period during which such compensation was payable or an exhaustion of such individual’s rights to such compensation. An individual is eligible for the credit for one additional month after the individual is reemployed (provided other requirements for the credit are satisfied (e.g., the individual does not have other specified coverage)).

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<sup>31</sup> Excepted benefits are: (1) coverage only for accident or disability income or any combination thereof; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) worker’s compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; (8) other insurance coverage similar to the coverages in (1)-(7) specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits; (9) limited scope dental or vision benefits; (10) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; (11) other benefits similar to those in (9) and (10) as specified in regulations; (12) coverage only for a specified disease or illness; (13) hospital indemnity or other fixed indemnity insurance; and (14) Medicare supplemental insurance.



An otherwise eligible taxpayer is not eligible for the credit for a month if, as of the first day of the month, the individual has other specified coverage. Specified coverage is (1) coverage under any qualified health insurance if at least 50 percent of the cost of the coverage is paid by an employer<sup>32</sup> (or former employer) of the individual or his or her spouse or (2) coverage under certain governmental health programs.<sup>33</sup> Amounts taken into account in determining the credit may not be taken into account in determining the amount allowable under the itemized deduction for medical expenses or the deduction for health insurance expenses of self-employed individuals. Amounts distributed from an MSA are not eligible for the credit.

The credit may be claimed on the taxpayer's return for 2002 and 2003. In addition, the bill provides for payment of the credit on an advanced basis (i.e., prior to the filing of the taxpayer's return) pursuant to a program to be established by the Secretary of the Treasury. Such program is to provide for making payments on behalf of eligible individuals to providers of health insurance. In order to receive the credit on an advanced basis, a qualified health insurance credit eligibility certificate must be in effect for the taxpayer. A qualified health insurance credit eligibility certificate is a statement certified by a State agency (or by any other entity designated by the Secretary) that the individual was unemployed as of the first day of any month and provides such additional information as the Secretary may require.

The bill provides that any person who receives payments during a calendar year for qualified health insurance and claims a reimbursement for an advanced credit amount is to file an information return with respect to each individual from whom such payments were received and amounts advanced. The return is to be in such form as the Secretary may prescribe and is to contain the name, address, and taxpayer identification number of the individual, the aggregate of the advanced credit amounts provided, the number of months for which advanced credit amounts are provided, and such other information as the Secretary may prescribe. The bill requires that similar information be provided to the individual no later than January 31 of the year for which the information return is made.

If the taxpayer receives any advanced credit amount, the amount advanced is reconciled on the tax return under rules similar to those applied under the advanced payment mechanism for the earned income credit.

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<sup>32</sup> An amount is considered paid by the employer if it is excludable from income. Thus, for example, amounts paid for health coverage on a salary reduction basis under an employer plan are considered paid by the employer.

<sup>33</sup> Specifically, an individual is not eligible for the credit if, as of the first day of the month, the individual is (1) entitled to benefits under Medicare Part A, enrolled in Medicare Part B, or enrolled in Medicaid or SCHIP, (2) enrolled in a health benefits plan under the Federal Employees Health Benefit Plan, or (3) entitled to receive benefits under chapter 55 of title 10 of the United States Code (relating to military personnel).

The credit is effective for taxable years beginning after December 31, 2001.<sup>34</sup>

**2. Extend Archer MSAs (sec. 312 of the bill)**

The bill extends the Archer MSA program for one year, through December 31, 2003.

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<sup>34</sup> In addition to providing the credit, the bill also allows guaranteed issue and pre-existing condition protections without the requirement to exhaust COBRA coverage. Individuals ineligible for COBRA coverage must have 12 months of employer creditable coverage to access these protections.

## **B. The Administration's Proposal<sup>35</sup>**

### **1. Health care tax credit**

The Administration's budget proposal includes an annual refundable tax credit for health insurance purchased by individuals who are under age 65 and do not participate in a public or employer-provided health plan. The amount of the credit is up to 90 percent of premiums up to a maximum of \$1,000 per adult and \$500 per child (for up to two children).

The 90 percent subsidy is phased-down for higher income taxpayers. Individual taxpayers filing a single return with no dependents are eligible for the maximum subsidy rate of 90 percent and the maximum tax credit of \$1,000 for modified adjusted gross income up to \$15,000. The subsidy percentage for individuals filing a single return with no dependents is phased-down ratably from 90 percent to 50 percent for modified adjusted gross income between \$15,000 and \$20,000, and phased-out completely at modified adjusted gross income of \$30,000. Other taxpayers with modified adjusted gross income up to \$25,000 are eligible for the maximum subsidy rate of 90 percent and the maximum credit of \$1,000 per adult and \$500 per child (for up to two children). The subsidy percentage is phased-out ratably for modified adjusted gross income between \$25,000 and \$40,000 if the policy covers only one adult, and for modified adjusted gross income between \$25,000 and \$60,000 if the policy (or policies) covers more than one adult. The premium yielding the maximum allowable credit is \$1,111 for an adult and \$556 for a child.

Taxpayers claiming the credit are not allowed to make contributions to an Archer MSA for the year the credit is claimed.

The credit can be claimed on the individual's tax return or on an advanced basis, as part of the premium payment process, by reducing the premium payment amount. Under the advanced credit option, health insurers are reimbursed by the Department of the Treasury for the amount of the credit. Eligibility for the advanced credit option is based on the individual's prior year return.

Policies eligible for the credit have to meet certain requirements, including coverage for high medical expenses.<sup>36</sup> Qualifying health insurance can be purchased through the non-group insurance market, private purchasing groups, State-sponsored insurance purchase pools, and State high-risk pools. At the option of States, after December 31, 2003, the credit can be used by certain individuals not otherwise eligible for public health insurance programs to buy into privately contracted State-sponsored purchasing groups (such as Medicaid or SCHIP purchasing

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<sup>35</sup> The Administration's proposal also includes other health care tax proposals, including: providing an above-the-line deduction for long-term care insurance premiums; allowing up to \$500 in unused benefits in a health flexible spending arrangement to be carried forward to the next year; providing additional choice with regard to unused benefits in a health flexible spending arrangement; and providing an additional personal exemption to home caretakers of family members.

<sup>36</sup> The proposal does not include details regarding the requirements policies must satisfy.

pools for private insurance or State government employee programs for States in which Medicaid or SCHIP does not contract with private plans). States can provide additional contributions to individuals who purchase insurance through such purchasing groups. The maximum State contribution is \$2,000 per adult (for up to two adults) for individuals with incomes up to 133 percent of poverty. The maximum State contribution phases-down ratably reaching \$500 per adult at 200 percent of poverty. Individuals with income above 200 percent of poverty are not eligible for a State contribution. States are not allowed to offer any other explicit or implicit cross subsidies.

The credit is effective for taxable years beginning after December 31, 2002, with the advanced payment available beginning in July 2003.

## **2. Permanently extend and reform Archer MSAs**

Under the Administration's proposal, Archer MSAs are made permanent. In addition, (1) the cap on the number of Archer MSAs and the employer size restriction are removed, and (2) all individuals covered by a high deductible health plan, other than a health plan for which the individual is eligible to claim a refundable health care tax credit, are eligible for Archer MSAs.

The Administration's proposal modifies the definition of high deductible health plan to include an annual deductible as low as \$1,000 for individual coverage and \$2,000 in other cases. Plans are also permitted to provide up to \$100 of coverage for allowable preventive services per covered individual each year (without counting the amount against the deductible).

The proposal also allows contributions to an Archer MSA up to 100 percent of the maximum deductible under the plan, up to the applicable limit for the individual for the year. Contributions to Archer MSAs can be made through a cafeteria plan.

The proposal is effective for taxable years beginning after December 31, 2002.

**C. H.R. 1181, the “Health Insurance Affordability and Equity Act of 2001,”  
introduced by Mrs. Johnson and others**

The bill provides a nonrefundable tax credit for health insurance costs of previously uninsured individuals. The credit amount is equal to the amount paid for qualified health insurance for the individual and his or her spouse and dependents. The maximum annual credit per covered individual is \$1,500 (\$125 per month) for up to two covered individuals, for a maximum annual credit of \$3,000. Amounts taken into account in determining the amount allowable as an itemized deduction for medical expenses, the deduction for health insurance expenses of self-employed individuals, or the deduction for qualified health insurance costs (discussed below) may not be taken in account in determining the amount of the credit.

Eligibility for the credit is determined on a monthly basis. An individual is eligible for the credit for each month in which, on the first day of the month, the individual is covered by qualified health insurance, the premium for which is paid by the individual, but only if, for at least a 12-month period beginning after December 31, 2001, and ending before the otherwise eligible month, the individual was not covered by qualified health insurance (including certain governmental health programs) and was not eligible to participate in an employer-provided group health plan. Qualified health insurance is insurance which constitutes medical care, but does not include certain excepted benefits or any coverage less than 50 percent of the cost of which is paid by the individual. The credit is not allowed for amounts paid under certain governmental health programs.<sup>37</sup>

For individuals claiming the credit for more than one person, the credit is phased-out for modified adjusted gross income between \$60,000 and \$70,000. For other taxpayers, the credit is phased-out for modified adjusted gross income between and \$30,000 and \$40,000. Modified adjusted gross income is adjusted gross income increased by certain foreign income otherwise excludable under the Code.

The bill also provides a deduction for qualified health insurance costs of employees and self-employed individuals. The deduction is equal to the amount paid during the taxable year for qualified health insurance coverage (as defined above) for the individual and his or her spouse and dependents. Any amount taken into account for the deduction may not be taken into account in determining the amount allowable as an itemized deduction for medical expenses or the deduction for health insurance expenses of self-employed individuals. The deduction is not allowed for self-employment tax purposes. An individual is not eligible for both the deduction and the credit.

The credit and deduction are effective for taxable years beginning after December 31, 2001.

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<sup>37</sup> No credit is allowed for amount paid under (1) Medicaid, Medicare or SCHIP, (2) chapter 55 of Title 10 of the United States Code (relating to military personnel), (3) chapter 17 of title 38 of the United States Code (relating to veterans’ benefits), or (4) the Indian Health Care Improvement Act.

**D. H.R. 1331, the “Fair Care for the Uninsured Act of 2001,”  
introduced by Mr. Arney and others**

The bill provides a refundable tax credit for the amount paid for the purchase of qualified health insurance for a taxpayer and his or her spouse and dependents. The maximum annual credit is \$1,000 for the taxpayer, \$1,000 for the taxpayer’s spouse, and \$500 per dependent (up to two), for a maximum annual credit of \$3,000.

Eligibility for the credit is determined on a monthly basis. In general, an individual is eligible for the credit for any month if (1) the individual is covered by qualified health insurance on the first day of the month and (2) the premium for such coverage is paid by the individual. Qualified health insurance is insurance which constitutes medical care (as defined in section 213), except insurance which is for qualified long-term care or certain excepted benefits. Archer MSA contributions are treated as payments for qualified health insurance, but such amounts are not deductible under section 220 to the extent taken into account in calculating the credit. The credit is not available for any month in which the individual is eligible to participate in an employer subsidized health plan or for any month for which any amount is not included in the individual’s gross income with respect to benefits chosen under a cafeteria plan or provided under a flexible spending arrangement. The credit is also not available for months for which the individual is entitled to benefits under certain governmental health programs<sup>38</sup> or is imprisoned, or for any month during a taxable year in which the individual is present in the United States for fewer than 183 days.

The amount taken into account for the credit reduces the amount taken into account in determining the amount allowable as an itemized deduction for medical expenses. The credit is not available for a self-employed individual who deducts health insurance costs.

The credit can be received through an advanced payment mechanism. To receive the advanced credit, an individual is required to certify to the Secretary of the Treasury that the individual is eligible for the credit and provide an estimate of the amount of the credit (and such other information as the Secretary may require). The Secretary is then to make payments to health coverage providers equal to the amount of the credit allowed.

The credit is effective for taxable years beginning after December 31, 2001.<sup>39</sup>

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<sup>38</sup> No credit is allowed for any month if, on the first day of the month, the individual is entitled to Medicare benefits or participates in Medicaid or SCHIP. Additionally, no credit is allowed for any month during a year if, at any time during the year, any benefit is provided to the individual under (1) chapter 89 of title 5 of the United States Code (relating to the Federal Employees Health Benefit Plan), (2) chapter 55 of Title 10 of the United States Code (relating to military personnel), (3) chapter 17 of title 38 of the United States Code (relating to veterans’ benefits), or (4) any medical care program under the Indian Health Care Improvement Act.

<sup>39</sup> In addition to providing the credit, the bill also requires health insurers, health maintenance organizations, and health service organizations to participate in State health insurance safety net programs, which assure availability of health insurance to uninsured individuals. The bill also amends the Public Health Service Act to allow health benefits coverage through individual members associations (“IMAs”).