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TAX TREATMENT OF EMPLOYER-BASED HEALTH INSURANCE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

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TAX TREATMENT OF EMPLOYER-BASED HEALTH INSURANCE

TUESDAY, APRIL 26, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The meeting was convened, pursuant to notice, at 10:00 a.m. in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Mitchell, Daschle, Breaux, Conrad, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H–27, April 21, 1994]

FINANCE COMMITTEE SETS HEARING ON TAX TREATMENT OF EMPLOYER-BASED HEALTH INSURANCE

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on tax treatment of employer-based health insurance.

The hearing will begin at *10:00 A.M. on Tuesday, April 26, 1994* in room SD–215 of the Dirksen Senate Office Building.

"Many of the health care reform proposals before the Committee would limit the tax-favored treatment of employment-based insurance," Senator Moynihan said in announcing the hearing. "The Committee will hear testimony discussing the advantages and disadvantages of these proposals and other alternatives for increasing the cost-consciousness of health care consumers."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished panelists and our most welcome guests, and to Mr. Rooney, who has a special relationship, obviously, with Senator Durenberger.

Mr. ROONEY. I worked for his father once upon a time.

The CHAIRMAN. I see, sir.

This is the first of several hearings that we will have on the tax treatment of employer-based health insurance under various proposals we have before us. This is a question that has come up, tangentially or otherwise, recurrently in what is almost a year of hearings we have had now, I think, Senator Packwood, and is central to our concerns because it is so elemental that the social policy in our time proceeds under severe fiscal restraints. We have no money in surplus, in any event. There is no normal growth of revenues

that is available as it was once the case. We have a large deficit which, after declining, may yet again grow.

On Friday, our distinguished friend, the Chairman of the Committee on Ways and Means spoke at the forum at the Harvard School of Public Health, Mr. Rostenkowski, and suggested that if there was to be a health care measure of the scope that the President anticipated and desired, there would have to be new taxes, and very specifically new taxes beyond the rather modest measures that have been proposed. I think the panelists might want to comment on that, might not. But, in any event, we look forward to what they have to say, as I am sure does Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, we are all shaped by our younger lives. When I was first out of law school, I worked with a large law firm—what was large then, in Portland, but would not be large now. And I was assigned to the labor law department and got involved in some modest—not overwhelmingly significant; the higher attorneys did that—collective bargaining. And one of the issues in the late 1950's and early 1960's was health plans.

Although, as I recall, at the time the health plan they were talking about with the different unions may have been $30–35 a month, at the outside $40, and the debate as to whether if we added dental care how much more that would add. That was roughly the major things we were talking about.

But, even then, it was interesting, in what seems today to be a modest amount of money, that both the employer and the unions were aware of the tax status of the plans and aware that $40 or $30 of health benefits were not taxed, and $30 or $40 of wages were, and the employer was familiar with the deduction and whether or not you had to pay employer taxes on that portion of it.

So that helped shape, and, I think, in those days, correctly, helped shape employer-provided health plans, which has probably kept this country from having the kind of health insurance that Great Britain has; that, by and large, most people who work, who think they are going to continue working, who have an employer-based plan are reasonably satisfied with their coverage.

The question comes, however, when plans now cost not $30, $40 or $50 a month, but $200, $300 or $400 a month, whether or not we have encouraged, because of the Tax Code, too much health coverage. And that is a topic that we are going to address in a variety of ways, not just today, but we are going to address it when you have the hearings that Senator Danforth has asked about in terms of the terminally ill——

The CHAIRMAN. Yes.

Senator PACKWOOD.—at what stage do you make a decision that we are not going to pay any more money.

Have we reached a place with employer-based coverage, where it is what some people might call Cadillac coverage, when what we ought to be aiming for is Chevrolet coverage, and have we distorted the provision of health benefits because employees have no sense

of paying for them, and the employer would just as soon pay health benefits as wages, assuming that's the trade-off.

I am not here, Mr. Chairman, going to get into the argument about who pays. I know one argument can be made the employee pays it all, and it is just a trade-off on wages versus health. The others would say, no, that is not quite true.

My hunch would be, all employers would not say that is quite true or else they would not fight it so hard; they really would not care whether they paid wages or paid health benefits. But, if you are a minimum wage employer and you suddenly have health benefits thrust upon you, you cannot deduct them from the minimum wages so it is a cost to you.

In any event, my mind is open on this. But I think it is a fair question to ask whether or not the Tax Code has encouraged benefits greater than we should normally encourage, and that if those decision were left to individuals and employers without tax incentives, would they opt for perhaps slightly less expensive or less comprehensive care and, thereby, save the Treasury a fair amount of money?

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

The President's proposal, of course, does contemplate that there will be a limit on the employee exclusion starting in the year 2004, so the issue is before us.

Senator Mitchell, good morning, sir.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, good morning. Thank you for holding this hearing. This is a very important subject, the whole issue here. I look forward to hearing from the witnesses. I'll have some questions later.

The CHAIRMAN. Fine.

Senator Durenberger, friend of Mr. Rooney.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Thank you, Mr. Chairman.

I am going to take, if you do not mind, just a couple of minutes, and I would sort of like the privilege as the author of the first Tax Cap bill, not to try to explain it, but put it in perspective.

I believe as strongly as I possibly can as I am preparing to leave this place that we have to do health care reform, and we have to do it this year. Not because I am leaving, and George is leaving, and Jack is leaving, but because it is so critically important that this Nation set itself on some direction for the health care system.

Second, I hope that none of us will get so hardened in our positions that we, in other words, never say never, and stand up and say, this must be, and that must be, and so forth, because only with a little flexibility are we going to find that consensus that we desperately need to do this.

Third, let me just say on the weekend, among the various groups I spoke to, was a physicians' group who has 200 plus employees in the City of Philadelphia. It is a national association.

And they are paying, Bob Packwood, somewhere between $600 and $1,000 a month for health care protection. And I will bet you in this town you can find law firms that are paying $1,000 and more, all of which is subsidized by the taxpayer. So put that in a little perspective as I read just a part of an op-ed that I did early least year on this subject.

As Hillary Rodham Clinton is surely aware as she tackles the issue, this is February of 1993, health care is expensive, no matter how you slice it.

But in America we are now slicing it in the most unfair way imaginable. Under current rules, workers pay no taxes on health insurance benefits provided by employers and employers can write off that cost as a business expense.

This was a great idea when it caught on in the 1950's. Workers bought protection with employer dollars, not their own. So the government was paying for things people said they needed, but were unwilling to pay for.

Because the benefits are nontaxable, the government forgoes at least $66 billion in revenues annually. And, even worse, with regressive taxation in especially low favor now, the subsidy is completely regressive.

Workers in big corporations with good benefits received a subsidy, workers in grocery stores and farm fields and so forth received much less, and the self—employed, as of January 1st, received nothing.

The regressivity could not be more clear. Families with incomes below $15,000 get 2.6 percent of the tax benefits, and those with earnings above $50,000 get 57 percent.

I might add, under current tax laws the CEO of a company's benefits are going to cost him 50 cents while the taxpayers pick up 50 cents. A Senator, in a 31 percent bracket on his own income, will pay 69 cents for his eyeglasses, or whatever the case may be, and the taxpayers will pay 31 cents. And a service worker in this building will pay 85 cents for the same product, while the taxpayers pay 15 cents. That is as regressive as you can get. Is this fair? Absolutely not.

The current situation is like a birthday party, where half the guests get big, crumbling slabs of cake, others get slivers, and a growing number get empty cake plates. When asked to share the bounty, those with big slices say, no way, it is not fair to make us share.

So, when it comes to health benefits, where exactly is the victimized middle class? It does not exist. Tax subsidies and other benefits depend on whom you work for, not what class you are in. That is the unfairness we need to correct. When you hear someone say, "read my lips, no new taxes, look for the frosting on his lips." [Laughter.]

Senator PACKWOOD. "He has probably been eating a lot of cake. Regardless of the source of payment, what every member of the middle class really needs is lower health premiums. There is no free lunch. Every dollar an employer spends on health care is a dollar less in wages, even if the wages are taxed.

When combined with other reforms, like health insurance purchasing cooperatives, the proposal or tax equity in employer-paid

health insurance would ensure that all purchasers have similar opportunities to enjoy affordable, high-quality health plans.

While tax caps may also increase revenue and help us expand coverage to those who cannot afford it, that should not be our goal. Our goal is to reduce the prices of these plans."

The CHAIRMAN. Thank you.

Senator Grassley.

Senator GRASSLEY. Mr. Chairman, I have no opening statement. Thank you, anyway.

The CHAIRMAN. Thank you, sir.

Senator Conrad?

Senator CONRAD. I will forego any statement at the moment.

The CHAIRMAN. Senator Danforth.

Senator DANFORTH. I have no statement, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. No statement, Mr. Chairman.

The CHAIRMAN. And now, Senator Baucus, it is up to you. You could sweep the board.

Senator BAUCUS. I will continue the string. I have no statement, Mr. Chairman.

The CHAIRMAN. Well, good. We are going to hear a lot of good testimony and we are going to have a lot of questions in the aftermath.

Our first witness is well-known to our committee, Alan Auerbach, who is Professor of Economics and Law at the University of Pennsylvania. Good morning, sir.

STATEMENT OF ALAN J. AUERBACH, PH.D., PROFESSOR OF ECONOMICS AND LAW, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA

Dr. AUERBACH. Good morning, Mr. Chairman. It is a pleasure to be here. I will just summarize my testimony and ask that the rest be included in the record.

The CHAIRMAN. All testimony will be included as if read.

Dr. AUERBACH. Thank you.

In my written testimony, I summarize the current tax treatment of health care and insurance, talk about some of the plans under consideration, and offer some opinions on how these plans might be altered, given the effects that the tax system is currently having on the provision of medical care.

The tax system currently distorts health care decisions in a number of ways. First, it provides an overall subsidy to the purchase of medical care, to some extent through the limited deductibility of unreimbursed medical expenses, but much more so due to the exclusion from income of employer-based insurance.

The greater subsidy to insurance among those with employer-based plans has two additional effects. It leads to overly comprehensive coverage and, by limiting individual exposure to unreimbursed medical expenses, it further fuels the demand for health care by those receiving full insurance, while at the same time pushing some of those without the insurance subsidy out of the insurance market entirely.

In a normal market setting, these subsidies would make very little sense and would simply represent interference in the workings

of markets. Of course, the health care market and the market for health insurance are not normal markets, and so there have been a variety of arguments put forth of why the tax system should continue to be involved.

First, though, let me say that I think that arguments for preserving or extending tax subsidies for health care based on distributional concerns are very weak, first, because there are far less distortionary ways to achieve the same distribution of tax benefits, as the current distribution of tax subsidies, tax expenditures to health care and health insurance do.

And, second, given the desperate need for tax revenue and the increases in marginal tax rates that we have recently been experiencing and may have to experience again in the near future, it is very irresponsible to maintain or even expand such an enormous tax expenditure program simply on the grounds that it is not fair to people who are receiving the benefits that they should have to give some of them up, particularly while others are giving up their tax preferences and their benefit programs.

However, there is a second reason why tax intervention in the market for health care might be justified. In our society we are simply not willing to let those with great need for medical care go without. And, as a result, there is a strong reason to seek universal coverage through health insurance, which is something that we lack now.

The desire to achieve more universal insurance coverage does motivate the extension of the tax subsidy for insurance purchases to those not currently receiving employer-based coverage. And all of the plans being discussed now, and all the plans that I mention in my testimony, do move in that direction, improving the benefits for the self-employed and for those whose employers do not pay for their insurance.

All of these plans, I think, would do that quite effectively. Three of the four plans mentioned in my testimony would pursue the goal of reducing the comprehensiveness of insurance coverage through some form of cap on the entire deduction and exclusion of employer—based insurance.

However, in my view, none of the plans would go far enough in this direction to reduce the overall tax subsidy to medical care spending, particularly as other tax benefits are being increased.

In addition to the changes in insurance, a couple of the plans have proposed the establishment of medical savings accounts. I view these accounts as a cross between the current flexible spending arrangements that some employer cafeteria plans offer, where you can provide for medical care expenditures using before tax dollars, but have to spend it before the end of the year, and the traditional individual retirement accounts, under which you would get a deduction for money put in and get tax-free inside build-up.

Medical savings accounts would combine these two characteristics, giving either a credit or deduction for money put in, but then allowing roll-over, not only without losing the money, but without paying any tax on the inside build-up, with withdrawals tax-free as long as they were used to pay for medical expenses.

One of the benefits, I suppose, of medical savings accounts is that they would further encourage individuals to limit their insur-

ance purchases and rely, instead, on their own resources to cover medical costs. Therefore, they would give individuals more sensitivity to the prices of health care and, perhaps, cause them to limit their demand for health care itself. But this program would do so at the cost of another very large tax subsidy, one that does not exist in the tax system right now.

One could also achieve the same shift—which I think is a good idea—away from very comprehensive insurance coverage through more reliance on individual out-of—pocket expenses by a much sharper reduction in the exclusion of health care insurance provided to individuals, so that what would be provided to them would really be insurance and not simply a very large benefit program.

That shift would occur at a much lower revenue cost than under an expansion of the subsidy for individual medical spending and, at the same time, would reduce the overall pressure on medical costs that, currently, is one of the reasons why we have a crisis.

So, to sum up, the idea that most plans today have of capping the tax benefit for employer—provided coverage and, at the same time, extending some benefit to others to encourage universality of insurance is a good idea. The only criticism I would have is that this idea does not go nearly far enough in reducing the exclusion.

Second, in the current budget context where we are talking about cutting programs everywhere, it is inadvisable to introduce a new tax expenditure to deal with the problems we have, both because of the revenue consequences, as well as because of the impact it would have on the demand for and prices of health care.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Auerbach.

Now, representing the AFL–CIO, we have Dr. Peggy—do you say Connerton?

Dr. CONNERTON. Connerton.

The CHAIRMAN. Connerton. Connerton.

Dr. CONNERTON. Good Irish name.

The CHAIRMAN. Good Irish name. Thank you, Peg Connerton. The floor is yours.

STATEMENT OF PEGGY CONNERTON, PH.D., DIRECTOR OF PUBLIC POLICY, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL–CIO, ON BEHALF OF THE AFL–CIO, WASHINGTON, DC

Dr. CONNERTON. Thank you very much, Mr. Chairman, members of the committee. I am Peggy Connerton, director of public policy for the Service Employees International Union. I want to thank everybody for this opportunity to express our views on the tax treatment of employer-provided health insurance benefits.

At the outset, let me say that we really appreciate that this committee faces a very difficult task in the next couple of weeks and months as it considers how to finance health care reform.

However, in lieu of an employer mandate, some are seriously considering raising revenue to help cover the uninsured by taxing all or part of the value of employer—provided health insurance.

The AFL–CIO and all of organized labor believes that this is not the way to go. We believe that it is a regressive tax, and, no matter how you slice it up, it amounts to taxing the middle class.

I want to make a couple of points to support our position using the results of a recent Lewin-VHI study which was commissioned by my union. The study focused on the impact of limiting——

The CHAIRMAN. Could I interject just to say, once again, we have established that, whatever else comes out of this year-long inquiry, Lewin-VHI is going to do very well. [Laughter.]

Dr. CONNERTON. I know there are quite a few of these studies.

I also want to submit for the record the background paper that was done by Lewin-VHI.

The CHAIRMAN. Oh, please do.

[The information was made part of the official files of the committee.]

Dr. CONNERTON. For purposes of the study, we focused on limiting the employer's deductibility of health benefits because, in our mind, in some ways, it is much easier to do it by that route rather than for families to see a new item on their income tax form, so we looked at the business deduction.

I would like to make a couple of points about what we think this study shows. The first point, is that, although it is nominally a tax on businesses, the costs would eventually be shifted to workers and workers would not only face higher tax liability, but lower wages, higher premium payments and reduced insurance coverage. So the economic impact is a lot broader than the question of what the particular tax liability is and how much revenue would be raised for the Federal Government.

The second point, is that many of those who support taxing health benefits imply that it will affect only a minority of families who enjoy so called Cadillac coverage.

But, depending on how the standard benefit package is defined, between one-half and three-quarters of families who have employer-based insurance today would be affected.

And it would affect workers in all industries, not just manufacturing, and it would hit non-union workers who have group-based health insurance today fully as hard as it will affect union workers.

The third point really follows from the fact that large numbers of households would be impacted. Any health benefit tax that raises any serious revenue will tax a majority of currently insured workers and, therefore, by definition, disproportionately impact the middle class. Families earning between $20,000 and $75,000 a year would pay roughly two-thirds to four—fifths or more of the cost generated by the tax.

The fourth point, is a point that has been raised today in a lot of the opening statements, whether or not the health benefits tax is regressive.

Now, looking at it one way, it clearly is regressive because it is worth more, in dollar terms, to higher income households than to lower income households. That is a fact. But, on the other hand, measured as a share of income, the benefits of the exclusion are spread relatively evenly across the income distribution, according to the CBO's own figures.

And, if you look at the population of families today that have group-based health insurance, any attempt to limit the exclusion would definitely be regressive. Lower- and middle-income families

that have group-based health insurance would pay more in taxes as a share of income than would high-income families.

The Lewin-VHI study found that families earning between $30,000 and $40,000 a year could pay twice as much as a share of their income in families earning over $100,000.

Now, some supporters of a health benefits tax argue that it can be made less regressive by using subsidies or by progressively phasing out the tax exclusion for families above a certain threshold income. While this would make the impact less regressive, it also raises much less revenue than a traditional tax cap because it would exclude a large portion of the tax paying population.

The fifth point I would like to address, is the question of whether taxing health benefits will have a real impact on national health spending.

The CHAIRMAN. On health spending.

Dr. CONNERTON. On health spending.

Advocates of limiting the tax preference for health benefits argue that it would encourage businesses and workers to switch to less costly managed care plans and that, over time, movement of individuals into managed care plans would reduce the rate of increase in national health spending.

A recent RAND Corporation study addressed this issue explicitly and found that, even if the government totally eliminated taxing individuals, overall health spending would be reduced by only 2–4 percent, and that most of the reduction in health spending would come from the fact that there are more uninsured Americans. A number of employers would drop their coverage, and the number of uninsured Americans would increase by 500,000. And, obviously, that affects overall health spending.

Now, the findings of the Lewin-VHI study, which was not focused on the impact of national health spending but on the economic incentives to switch to less generous plans, found that, in the case of the tax contemplated by the Managed Competition Act, that imposing these taxes would not have the strong incentives that economists talk about. In fact, the way that families would minimize their losses if there is a limit on the employer's deductibility is to keep their current coverage and to accept a reduction in future pay.

And the final point I would like to make is that, in our view, imposing new taxes on health benefits that suggest that somehow the consumer is to blame for exploding health costs, I think, is a flawed assumption overall.

In short, the cost of taxing health benefits, both political and economic, are high. Middle class families who today have group-based health insurance have seen their health costs continue to rise as their wages have stagnated or even fallen.

They are paying more than their fair share today because many employers do not provide insurance and they, frankly, need some cost relief. Taxing health benefits would force them to pay more for less coverage, while letting irresponsible employers off the hook.

Unlike a health benefits tax which hits only those that today have group-based health insurance, those who have already paid twice for their health insurance, a requirement that all employers contribute to the cost of their employees' health insurance would

broaden the financing base for health care reform and level the competitive playing field.

While an employer mandate clearly demands certain trade-offs—there are trade-offs involved in whatever solution this committee comes up with—we feel that it remains the fairest way to pay for universal coverage.

The CHAIRMAN. Thank you, Dr. Connerton. Could I say that Senator Riegle asked me particularly to say that he is managing the Interstate Banking bill on the floor of the Senate at this moment and is not able to be present for your statement, but which was of great interest and importance to him. He has a statement for the record and some questions he would like to submit to you and to others in this area, and, again, regrets that he is not able to be here because he is required to be on the floor.

[The prepared statements of Senator Riegle and Dr. Connerton appear in the appendix. Questions and answers appear with the witnesses' prepared statements.]

The CHAIRMAN. And now Mr. M. Carr Ferguson, who is Chair of the Section on Taxation of the American Bar Association, offering his judgment and his views and that of a number of associates who are listed in his statement, not speaking formally for any organization.

STATEMENT OF M. CARR FERGUSON, CHAIR, AMERICAN BAR ASSOCIATION, SECTION OF TAXATION, WASHINGTON, DC

Mr. FERGUSON. Right. Thank you. Senator, I am here on behalf of individual members of the Tax Section. The statement which we have put together has not been approved by the ABA and does not constitute a position of that organization or any part of it, simply that of some individual lawyers, including this New York lawyer, who is a member of Senator Danforth's old New York firm.

We have been studying the tax aspects of the various health care reform proposals. But, for purposes of the hearing this morning, we have focused on just a couple of the more salient tax questions which we think this committee and Congress will have to confront.

First, the aspect of the proposals which would impose a limitation or cap on the amount of tax benefits employer-provided health care would be accorded through exclusion from the employees' wage base and, second, the treatment of the cost of retiree benefits, which previously have been funded by many employers on an anticipated basis and would largely become the burden of the government, at least under the Administration's proposal.

Actually, the array of health care reform proposals calls for a reexamination of many fundamental tax policies that underlie our present health care system. The existing system, which is, of course, largely an employer-based system, includes a number of tax subsidies having significant revenue effect. Senator Durenberger told us that they currently cost us in revenue at least $66 billion a year. That number, I believe, may be somewhat higher than that.

The projected figures we heard for 1994 were $51 billion just in income tax, and another $23 billion in payroll taxes; a total of $74 billion. Whatever the number is, it is eye-catching.

The CHAIRMAN. That distinction is important to make. If health benefits are considered to be wages, they are not deducted, they are taxed—Social Security is taxed.

Mr. FERGUSON. Right. At least one possibility, if health benefits are deemed part of the compensation package, would be to enlarge the wage base. That would have a number of ramifications. Aside from substantially increasing employment costs and tax burdens, it would also increase, of course, the Social Security base, which would have affect in the out years in terms of larger Social Security payments which would offset some——

The CHAIRMAN. And in the early years, larger contributions.

Mr. FERGUSON. Correct.

I would like to speak for a few moments about two of the consequences of the proposals to taxpayers and tax administrators. First of all, the present exclusion of employer contributions toward health benefit costs from the employees' income and employment tax base would, under most of the proposals, be subject to some new limits.

A subsidy that allows employees to contribute toward health care benefits on a pre-tax basis under flexible cafeteria plans would also be limited under some of the proposals.

Restricting these benefits raises a number of administrative and technical issues which I would like to describe, very briefly. Congress has experienced previously difficulties in valuing welfare benefits on an individual employee basis.

The most recent unfortunate experience, perhaps, was in the enactment and then repeal 3 years later of Section 89, which attempted to address and eliminate plans which favored more highly compensated employees.

The difficulties in determining how employer costs for health benefits actually are allocated among individual employees are, we think, so severe that we are discouraged from recommending that a cap be imposed in terms of employees' exclusions.

For example, a per employee limit on the benefits of tax-free employer-paid premiums would require a measurement of what those values are. They could differ employee from employee, depending upon age, family size, geographic location and, in the case of noninsured plans, actual use. Data are not kept on that basis and premiums paid by employers on insured plans are not set on that basis, but rather on overall actuarial experience.

An exclusion on a per-employee base, therefore, would require the development of a new industry of professionals determining individual benefits and determining limits on exclusions. It would, as I think Dr. Connerton has indicated, probably drive down coverage to the standard package simply because of administrative problems which might be imposed, not only on employers, but on the government regulators, as well.

The problems which we are describing in our written submission in more detail could be avoided in large part if the cap were imposed, not on a per employee benefit formula, but, instead, on a gross employer payment basis not keyed to individual benefits.

This could occur either in the form of an excise tax or in the form of a deduction limitation and could be based either on the total

costs of providing health care to an employer's work force or upon the excess of such costs over the standard benefit package costs.

There are a number of other areas which we would like to address and, if I can simply leave one message to the committee and the staff, it is that we would stand ready to work with them on the technical and administrative problems which we have been perceiving in the proposals at their pleasure on an informal basis, as well as submitting our augmented testimony this morning.

The CHAIRMAN. We thank you very much, sir. It is not every committee which is offered the free services of Davis, Polk & Wardwell. In principle, we accept.

Mr. FERGUSON. Thank you, sir.

[The prepared statement of Mr. Ferguson appears in the appendix.]

The CHAIRMAN. And now, Dr. Rosemary Marcuss, who is Assistant Director for Tax Analysis of our own Congressional Budget Office. We welcome you, Dr. Marcuss.

STATEMENT OF ROSEMARY D. MARCUSS, PH.D., ASSISTANT DIRECTOR FOR TAX ANALYSIS, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. MARCUSS. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, I appreciate this opportunity to appear before you today to summarize some recent Congressional Budget Office analysis of the tax treatment of employment-based health insurance.

In that recent study, CBO describes how the subsidy works, considers the case for limiting the subsidy, and provides some illustrative examples of limits that redistribute the revenues gained from those limits in different ways.

To put the subsidy in context, the tax subsidy is conveyed because the employee is not taxed, either under the income, nor under the payroll tax, for compensation received in the form of health care premiums. This is an exception to income tax principles.

From the firm's point of view, this is not an exception. The firm must deduct business expenses—and compensation is often the primary element—in order to calculate net income, which is taxable.

To respond to the questions posed by the committee, I would like to submit my written testimony for the record and summarize four important characteristics of employment-based health insurance.

The CHAIRMAN. We will place it in the record, of course.

Dr. MARCUSS. Thank you.

[The prepared statement of Dr. Marcuss appears in the appendix.]

Dr. MARCUSS. The first point I would like to make is that, after adjustment, employees do pay for employer-provided health insurance through lower wages, and this is because employees are paid the value of what they produce. Employers have no choice but to do this.

A question of giving a gift to an employee is not a possibility in the business world. Competition forces employers to pay employees the value of what they produce. Therefore, the subsidy of employment-based health insurance that is conveyed by making this type

of compensation not taxable translates directly into increased demand for health insurance by employees. We all tend to buy more of something whose price is reduced. And, on average, prices for employees receiving employment-based health insurance are reduced by about 26 percent.

This leads indirectly to pressure on health care costs in general because the insured have little incentive to distinguish between treatments whose benefits far exceed its cost and treatments whose benefits do not.

The second point I would like to make, is that the tax subsidy provides uneven benefits; it helps those with employment-based insurance and not those without it. It provides no benefit to the self-employed, no benefit to individuals who must buy health insurance on their own, and, in fact, does not provide a benefit to one in four workers.

Now, as to these workers, their lack of a subsidy results mostly for reasons that have to do with the labor market, not the subsidy itself. These workers tend to be low-income workers, many of whom are young.

The tax subsidy also lowers the labor cost of firms that can afford to provide it to provide health insurance, but not for those that cannot. Large firms can provide health care premiums to their employees more economically than small firms. The marketing costs for the insurance are less, the administrative costs can be substantially less, and large companies provide large pools of employees that allow for the insurance itself to be conveyed at a lower cost to those employees.

Now, for the question at hand, limitation on this exclusion, this can come in three forms, all three of which are contained in different health care reform proposals. We can either cap the employee exclusion, cap the employer deduction, or apply an excise tax at the employer level.

It is important, however, to keep in mind that, under any one of these limits, employee income overall that is employee compensation, will not change because of the placement of these limits in one place versus the other. The employee still is paid the value of what he is worth.

A limit or a cap on the exclusion would provide incentives for cost containment by reducing the amount of insurance purchased. It would also reduce the unevenness of the current system. It would reduce the difference between the haves and the have nots, those with coverage, and those without. However, it would be hard to administer.

Now, as Mr. Carr has said—I mean Mr. Ferguson has said, there are two ways you might think of the cap. You could define the cap in fixed dollar terms or in terms of a level of insurance coverage, for example: for family coverage or for individual coverage. This would be fairly straightforward to specify. However, as Mr. Ferguson said, it is very hard to value the insurance to the employee.

The CHAIRMAN. Mr. Ferguson, not Carr.

Dr. MARCUSS. Mr. Ferguson. Excuse me.

Mr. FERGUSON. I have been called Carr by a lot of friends, and I am glad to include you in that family.

Dr. MARCUSS. A fixed dollar cap would also tend to be harder on the sick, and harder on those who live in high-cost areas.

Administering a cap that defined in terms of a level of insurance, that is, a set of qualifying benefits, would provide unprecedented demands on the Internal Revenue Service in today's world. If, however, the situation is one of a reformed health care market, potentially one in the nature of hypothetical managed competition model, you would, in that circumstance, have health care purchasing cooperatives and specified health benefits. That is, you would have a large structure that would provide the information that could be needed to administer such a cap.

Therefore, in a health care reformed world, the exigencies required by defining and administering a cap defined on a set of benefits are really not much harder than a lot of the other demands in that market for substantial new information.

However, to the extent that a number of firms remain outside the purchasing cooperative part of the market, the same problems of valuing the benefit to the employee that Mr. Ferguson, on the other hand, not Mr. Carr, told us about would obtain.

My last point, is that the effect of a cap on those with and without employer-provided insurance today depends, in the short run, on how the revenues gained are spent, and, in the long run, on how well the cap and the accompanying market reforms can contain health care costs, while maintaining the quality of health care. If increases in the cost of top-quality health care are held down, those whose taxes are increased by the limit on the tax exclusion could end up better off. Thank you.

The CHAIRMAN. Thank you very much, Dr. Marcuss, for a very clear, precise testimony; the kind we have come to associate with the CBO. We appreciate your 26 percent bench mark as something we can now work from, to which direction remains to be seen.

Now, in conclusion, J. Patrick Rooney, who is chairman of the Golden Rule Insurance Company and a leading advocate of the merits of the medical savings account. Mr. Rooney, we welcome you.

STATEMENT OF J. PATRICK ROONEY, CHAIRMAN, GOLDEN RULE INSURANCE COMPANY, LAWRENCEVILLE, IL

Mr. ROONEY. Thank you, Mr. Chairman, and the entire committee.

One of the problems with the present situation is that, once you have health benefits, the only way you can get full utility out of them is to use them to the maximum.

If we could buy an automobile in the same way, we would all go to the Cadillac and the Lincoln dealer and nobody would go to the GEO or Ford Escort, and next year you would go back and get another one because, after all, they are free; you could send the bill to the employer or your employer's insurance company.

What we are advocating with medical savings accounts is simply a substitution effect to allow the worker to self-fund the low dollars of medical care. The employer would be required to buy catastrophic insurance that would pay all the big bills beyond, say, $3,000 or $4,000, or something like that; you pick a number. But

the employee would be able to self-fund the low dollars of medical care.

And, if the employee spent the money more wisely, the employee would be able to put the savings away in what I would choose to call a rainy day fund. I got that term from one of our employees. They put it away in a rainy day fund, an IRA that could be used for future spending on medical care.

If you had that money tucked away in a rainy day fund, later on, if I would lose my job, I would have a fund there with which I could pay my own insurance premium and I would not have to look to government support and I would not have to look to Medicaid to keep me insured if I had been able to spend wisely during my working time and had been able to save what I did not spend.

Now, I want you to know that what we are talking about would appear to be tax neutral. Let me use an example. A hypothetical insurance premium for a family of $4,000 a year; the employer is paying 75 percent of it the employee is paying 25 percent of it.

You change the situation. The employer bought catastrophic insurance that cost $2,000 and gave $2,000 to the employee in a medical spending account, and the money that went into that account would be 75 percent employer money, and that money would have gone in tax deductible and tax-free.

But, 25 percent of the money would be the employee's money, and, if the employee is paying payroll deduction with after-tax money, the employee's money would go into the account with after-tax money. I am not talking about creating any new tax deduction in such a vehicle.

Second, if the money was tucked away in a medical IRA, the legislation with which we are most familiar and which we have advocated would permit that medical IRA to be taxed on the interest. So we are not advocating tax—free interest. You can give tax-free interest if you wish, but it is not necessary to the idea.

Now, in 1993—because I have been talking about this all over the place—some of our employees said, could we have medical savings accounts? And we had to say to them, well, sorry, if we do that we cannot make it tax—free, you will have to get the money in the medical savings account as taxable income.

But we chose to offer it to the employees that way, and, much to our amazement, 80.5 percent of our employees chose to take the medical savings accounts and pay the income taxes.

In the period of time from May 1, 1993 to the end of December, our employees, on average, had saved $602, that it was their money, that they had spent that much less money on medical care than they had spent the year before because, you know, the year before all the money went to the insurance and the employees did not get any money back.

Now, we have learned some particularly important things from our employees. The employees that like it the best are the lower income employees. The single mother really likes it because she has first-dollar coverage. If she has a child that has an ear infection, she can take that child to the doctor and she doesn't have to worry about the deductible or the co-payment, she can just pull money out of the medical savings account and take the child to the doctor.

Another thing they can do is they can use the money in the medical savings account for things that were not covered previously under our insurance. Our insurance plan has not covered dental or vision. But, when they have the money in the medical savings account, they can use it to pay for dental or vision.

I want to wrap up on restating one thing I have already said. One of the great advantages is to permit the employee to have a rainy day fund so that if the employee loses the job, the employee can stay insured when they are looking for the next job.

If I had the best of all possible worlds, I would choose never to have anybody on Medicaid. Medicaid is a welfare benefit, and it would be in the best interest of our society if we could permit the employees to do for themselves and never have to be dependent upon welfare.

I thank you very much.

[The prepared statement of Mr. Rooney appears in the appendix.]

The CHAIRMAN. We thank you, Mr. Rooney, for a very powerful presentation. Thank the panel. This is one of the basic decisions that the Congress has to make, and we have proposals of a wide range here and they have large consequences, given the fact that, as Dr. Auerbach started out by saying, we have no money, which complicates matters.

So, let us begin by asking the Majority Leader, who has not spoken, if he would like to make some comments and offer some questions?

Senator MITCHELL. Well, Mr. Chairman, thank you very much. I appreciate the opportunity. Let me just say, briefly, that I welcome Senator Durenberger's statement. I thought it was well put in terms of the desire and the need for action on health care reform. And, if we are to accomplish that, that there must be flexibility on all sides.

Not one of us can expect that our view will totally prevail, and we must be prepared to listen seriously and with genuinely open minds to those who have contrary feelings, as we do. I hope very much that all of us will approach it in that manner.

I would like to ask Dr. Marcuss, if I might, just one question and invite anyone else to comment on it. In your testimony, you did not attempt to quantify the effect on health care spending of a tax cap. Dr. Connerton cited a RAND Corporation study in her testimony. As I understand it—and correct me if I am wrong, Dr. Connerton—she indicated that total repeal of the exclusion would reduce health care spending by only, I thought you said, 2–4 percent.

Dr. CONNERTON. Right.

Senator MITCHELL. If I am correct.

Dr. CONNERTON. Correct.

Senator MITCHELL. I would like to ask Dr. Marcuss, has CBO produced any similar estimates? And, if not, can you give us some idea of the relative importance of this issue with respect to cost containment?

Dr. MARCUSS. Yes, Senator. We have not estimated the effects of the cap alone because the cap, in each recent case, has been proposed as a part of an overall health care reform proposal, so we have not looked at its effect alone cost containment.

However, it is the case that many proponents of the managed competition model or variants of this health care reform model consider that the cap on the employee exclusion to be one of the 5–10 elements in that model that are critical for its success in achieving cost containment.

So, we do recognize it as important because it affects the demand side of health care, and so much of what else is proposed in different health care packages affects the supply side of health care. CBO is continuing to assess specific health care reform proposals in which a cap is often an element.

Senator MITCHELL. May I then ask the question another way? Do you have any evidence or any basis to contradict or dispute the RAND study which Dr. Connerton referred to?

Dr. MARCUSS. No, I do not. I have not seen this study.

Senator MITCHELL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

May I just note for everyone that the CBO will have completed tomorrow the analysis of the Cooper-Breaux legislation. We will not be in session in the morning, but we will have a hearing on it and will present it early next week. We will work that out.

Also, the Joint Committee on Taxation has prepared a spread sheet—it always gives you the shakes when you realize that spread sheet time is coming—with the four principle measures before us, the President's proposal, Senator Breaux, Senator Chafee, and Nickles, and it is all here before you.

Now, Senator Dole.

Senator DOLE. Dr. Connerton, you indicated in your written testimony in the summary that you would oppose elimination of the tax exclusion. What about scaling it back, are you opposed to that, too?

Dr. CONNERTON. We oppose scaling back the tax exclusion, yes. In part, because the effects of limiting the tax exclusion, when you look at the overall changes in employer and employee behavior, turn out to place even larger economic burdens on workers who have health insurance today.

Senator DOLE. Mr. Rooney, how many employees do you have?

Mr. ROONEY. 1,300 employees.

Senator DOLE. As I understand, even since the inception of the program, participation has gone from 80.5 up to, what, about 90 percent?

Mr. ROONEY. That is correct, Senator. Because of the savings that the people got last year, in the beginning of this year, this calendar year, a good many additional employees went into the medical savings account.

Senator DOLE. Do ycu know how many companies offer the medical savings account; are there a number of companies across the country that offer MSAs?

Mr. ROONEY. Yes. We found it such a good idea for ourselves and had so much satisfaction amongst our employees, we started to market it and we market to little bitty employers. It will work just as well for little bitty employers as for big employers.

And, I don't know, we have several hundred employers that have, in the last few months, signed up for such a program. And they can

self-administer the employee account, or they can get the local bank to administer it, or we will administer it for them.

Senator DOLE. As I understand it, at the end of the year you have an option to either to put it in the rainy day fund, or you can just take it or spend it for a new car, or whatever. Right?

Mr. ROONEY. That is correct. If the change in the tax legislation took place, that change in the tax legislation permits the money to be tax sheltered only if it is put into the IRA.

If the people pull it out and spend it—my example is you spend it to buy a horse; I like horses—they would have to pay income taxes and the 10 percent withdrawal penalty. But, if they leave it in and accumulate it, it would stay in untaxed, except interest would continue to be taxed.

Senator DOLE. Have you or any other employer seen any—I am just trying to figure out—any down sides to this? I mean, it seems like it makes a lot of sense.

Mr. ROONEY. I am not aware of any down side. But, let me tell you, what is usually raised as a question or as an objection, is that the employees will forego needed medical care in order to keep the savings. Our evidence is just to the contrary.

We know that because of either deductibles or co—pays, employees, many times, did not get mammograms because they had to pay part of it out of their pocket. But, with the medical savings account, because it creates first dollar funds, the employees appear, according to our evidence, to be more willing to go to the doctor and go sooner.

Senator DOLE. But there has been no evidence that somebody that has had a serious problem not going to the doctor because they say they would not get their money at the end of the year; have you had any evidence of that?

Mr. ROONEY. There is absolutely no evidence to that effect, except the evidence is to the contrary, Senator, that they go more readily. But, of course, they shop around and they spend more carefully.

I am an example. I have been buying a medication to clean out my lungs every time I go skiing. I like to go skiing. I buy the medication. It costs $34.25. I decided I would take a dose of my own advice and shop around. I am buying the same thing for $7.99 today, and the savings is mine. Our employees have gotten onto this thing. They talk about it in the cafeteria, how they are shaking down their doctor for a better deal on the price.

The CHAIRMAN. Be careful what you ask this fellow. [Laughter.]

Senator DOLE. Well, I have had an opportunity to visit with Mr. Rooney, in fact, two or three times. And I know Dominion Resources in Virginia is offering MSA's to their staff. How many employees do they have?

Mr. ROONEY. I believe their employee plan is some 800 employees involved in that program.

Senator DOLE. So I know there are other experiences. I think there is a lot of interest in MSAs, medical savings accounts. They could be rolled over into an IRA, they could be withdrawn.

It seems to me that it makes a lot of sense, if everybody had to buy their own insurance there would be shopping around. I have had an opportunity to visit with at least two of your employees. I

know the plan has not been in existence for a long, long time, but they seem satisfied with it.

Mr. ROONEY. Yes. I do not know if everybody here is aware that the bituminous coal miners have recently adopted medical savings accounts for the first $1,000. The employer, the coal company, is buying catastrophic insurance that will pay all the bills above $1,000, and then they are giving the coal miner $1,000 in cash.

So that is a very important precedent and it covers a lot of people. It was a union-negotiated plan. Apparently, the reason they agreed to it, evidently, they thought it was in their best interests.

Senator DOLE. Thank you.

The CHAIRMAN. Thank you, Senator Dole.

I think, Senator Packwood, you are next.

Senator PACKWOOD. Thank you.

Mr. Rooney, let me follow-up. I want to make sure I understand exactly how this works. You, at an employer expense, provide a $3,000 catastrophic above that.

Mr. ROONEY. Yes.

Senator PACKWOOD. And you pay that.

Mr. ROONEY. Yes, that is right. The $3,000 is just arbitrary. The United Mine Workers did $1,000.

Senator PACKWOOD. Yes. I realize that. I am talking about your plan. Yours is $3,000 family, $2,000 individual.

Mr. ROONEY. Yes.

Senator PACKWOOD. All right. Now, the medical savings account comes out of the employee's wages. Is that correct?

Mr. ROONEY. No. The medical savings account is money that was previously spent on the insurance benefit——

Senator PACKWOOD. All right.

Mr. ROONEY. And we put it into a savings account for the employee. And then we say to the employee, but, because of the tax law, you have to pay taxes.

Senator PACKWOOD. That is what I want to understand. You are not taking anything further out of their wages, you are simply transferring into this medical savings account the money you were otherwise paying for the premium.

Mr. ROONEY. That is right.

Senator PACKWOOD. If a person was making $15,000, they are still making $15,000, except now the money that was previously not taxable because it was a health premium goes into this medical savings account.

Mr. ROONEY. Right.

Senator PACKWOOD. And you have told them it is now taxable, and you have to withhold monthly on it, I would assume, like you would any other wages.

Mr. ROONEY. That is correct. That is right.

Senator PACKWOOD. I see. And so you have given the employees the option, we will continue to provide you with this policy, all right, if you want, and 10 percent of them still apparently do, and we will pay the premiums, or however you share the premiums, and that does not count as income.

But, for those of you who are willing to pay taxes on it, we will put it into this medical savings account; there will be withholding

and Social Security each month. Then, at the end of the year if there is money left over, you can take it.

Mr. ROONEY. That is right.

Senator PACKWOOD. Because you have to, you cannot roll it over under the present tax laws.

Mr. ROONEY. Oh, yes. No. You cannot roll it over tax-free. I did not take mine at the end of the year, and a number of other employees did not, and they set up this savings plan that the company runs for them. But it is not tax sheltered, under the present law.

Senator PACKWOOD. Dr. Connerton, what strikes you as anything wrong with what Mr. Rooney is saying?

Dr. CONNERTON. Well, first of all, an employee will be paying a tax which they had not paid in the past.

Senator PACKWOOD. They do not have to, if they continue the old health plan, as I understand it.

Dr. CONNERTON. Well, if they continue the old health plan, right. But those who choose to roll the dice and hope that they will win at the end of the year because what they pay out in taxes will be less than the money that is left over in the account.

Senator PACKWOOD. I understand that. Do you object to giving them that choice?

Dr. CONNERTON. We have not looked at all of the elements of the medical savings account or his plan. But I have a fundamental objection. Many of our employees are low-wage employees who are having a fairly difficult time making ends meet.

And there will be, in my opinion, a strong incentive for many of those single mothers to try to not seek early treatment if they can avoid it in order to have extra income—a rainy day fund, or whatever it is called—at the end of the year.

Senator PACKWOOD. That would not seem to be the experience at Golden Rule, however. And I am judging that if you are insurance company with 1,300 employees you have a fair number of rather relatively moderate wage employees. Everybody that works for you does not make tremendous wages.

Mr. ROONEY. No. Sure.

Senator PACKWOOD. So that does not seem to be the experience.

Dr. CONNERTON. Well, I do not know what the facts are in his particular case. I am just saying, from our perspective, going—and we have many employees who are close to the minimum wage who have health insurance coverage. There will be, I think, for many families who are really being squeezed, an incentive to forego needed care in the early stages. Particularly for the lower income groups.

And, on the other side of the equation, there are the older folks who, you know, you could call this a rainy day fund, incentives, IRA roll-overs, but, in fact, their out-of-pocket medical expenses will quickly eat up what is in the savings account.

So, I think it is, again, one of many untested ideas with high risks, and that is my view on it.

Senator PACKWOOD. Several times, Doctor, in your statement, you used the word regressive.

Dr. CONNERTON. Yes.

Senator PACKWOOD. Are all regressive taxes automatically bad?

Dr. CONNERTON. Well, I mean, we have a lot of regressive taxes, for example, the Social Security tax.

Senator PACKWOOD. No, I understand that. You used the term all the way through your testimony.

Dr. CONNERTON. Yes.

Senator PACKWOOD. In your judgment, are all regressive taxes automatically bad?

Dr. CONNERTON. Well, in part, it depends on what those taxes are spent on.

Senator PACKWOOD. It depends on what?

Dr. CONNERTON. In part, it depends on what those taxes are spent on.

Senator PACKWOOD. What they are spent on?

Dr. CONNERTON. Yes.

Senator PACKWOOD. Well, give me a little more for instance then. It is not the collection of them or how they fall on the taxpayer, it is what they are spent for. And some regressive taxes are good if they are spent for what, and the same tax would be bad if it is spent for something else?

Dr. CONNERTON. The Social Security tax as an example is a regressive tax. However, on the pay-out side, the benefit structure is relatively progressive. So that is a tax system which I think would meet the test.

Senator PACKWOOD. But if it was spent on defense it would be bad?

Dr. CONNERTON. I did not say that.

Senator PACKWOOD. No. I know. I want to find some examples of bad spending.

Senator DOLE. Congress.

Senator PACKWOOD. Congress, Bob says. [Laughter.]

The CHAIRMAN. I believe I will discontinue this line of questioning. [Laughter.]

The bell has indicated that the time has expired.

Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

The closer we get to really have to make decisions, I can sense, the more difficult the decision-making process. The same day that Pat Rooney has shown us how easy it is for 1,300 insurance company employees to change the marketplace out there, a billion people sign up in California for a single payor system. And trying to find a middle ground and what the most appropriate policy is going to be is really incredibly difficult.

But I have started under the presumption that nobody is really at fault in this system. I mean, we do not blame insurance companies, we do not blame doctors, we do not blame anybody; it is the combination of a system that has built up over a long period of time in which no one really has to take responsibility that we are trying to change in some way.

But I have also found it welcome from the President and Mrs. Clinton that they want an American solution to this problem, and, to me, that says we take advantage of ways in which we can have better informed consumers, i.e., more responsible people that actually get rewarded for making good decisions, not buying a blank

check at the beginning of the year and going and doing whatever somebody tells you to.

So, to that extent, what employees at Golden Rule are doing is good, whether the way you get there is the right way or not. But it is good to have people involved in making those decisions.

By the same token, having employees involved in making contributions to the health care premiums is good also because, to some substantial degree, that employer contribution is passed on in the cost of goods and services and it is not all passed on to taxpayers, it is passed on to those of us who buy these goods and services, and that is a good thing.

But, what we are talking about, as I understand it, is we would like to see a future in which all Americans are getting into this system through some kind of an accountable health plan.

And, whether it ends up being a catastrophic only plan, as Mr. Rooney is advocating, or it is a more comprehensive plan, our notion is that people without jobs, people who are self-employed, people who work in remote areas of North and South Dakota in very small companies, or people who work for big auto companies and so forth, and the elderly and disabled, will all come into the system through the same means in local communities through accountable health plans.

And what we are struggling with here, I think, today is, in the employment setting or the self-employed setting, what is the most efficient way to use redistributed income in the form of tax dollars?

Is it to continue to endorse choices made in the 1940's, 1950's and the 1960's about all your health insurance in this company is free, or that sort of approach, using the tax subsidy to endorse historical choices made between employers and employees, or is it to find some way to combine direct subsidies for low-income persons, and on the basis of income with the employer subsidy and so forth?

That, I think, is the tough struggle here. I mean, we are all presuming we are going to do a low-income subsidy, and then we are going to ask the employer, once an employee comes in with a low-income subsidy, to subsidize that with an employer contribution which will have some kind of tax treatment as well.

I am wondering if the tax experts on this panel, or those who have looked at the tax consequences, have some solution as to how best we combine the direct subsidy that is contemplated in this so called low-income subsidy with the employer premium contribution subsidy so that across this country we can make those public dollars or those tax dollars go much farther in moving us towards universal coverage.

Professor Auerbach, have you looked at that, by any chance?

Dr. AUERBACH. You have identified a real problem in the issue of universality, which is that low-wage workers or workers for small businesses that are not providing insurance currently have some combination of charity care and no care, which is clearly unacceptable.

The problem is that, once you have a low-income subsidy, you are essentially introducing a new wedge to the employer/employee decision because that subsidy stops being government subsidy and, as you say, starts being an employer subsidy when the person is employed. That is a very difficult question.

I think, ultimately, it is something that we are just going to have to live with if we have universal coverage. Whether it is an employer mandate or an individual mandate, there is going to be some employment loss. I do not see any way of avoiding it.

Senator DURENBERGER. Anyone else?

Mr. FERGUSON. If I may add to that, Senator Durenberger, the comments of Chairman Rostenkowski last week, which Chairman Moynihan referred to, I think, made it fairly clear for all of us that, if the government does not have currently sufficient funds to provide national health care and if Congress determines to spend money on health care, the system has to be changed, not by tinkering, but by some major new tax initiative to raise the difference.

The reliance upon an employer mandate will only go so far. The United States already has the highest percentage of part-time employees of any developed nation. The additional burden of further taxes on the employment relationship, which has already raised questions about interpretation of what is an employee as opposed to an independent contractor, for example, will put further strain on the system, both in terms of competitiveness of American companies and the cost of providing goods and services within the United States.

The notion which I tried to address in my testimony, that taking a dollar in taxes will result in a dollar available for health care, is itself suspect where there are administrative costs, both within the IRS and in every employer's organization for identifying a taxable portion of benefits, and this suggests that it may not be possible to satisfy revenue needs by further tinkering with the tax provisions dealing with the payment of wages. It may be necessary to find other sources of revenue.

The CHAIRMAN. A dread thought. Senator Durenberger, I wonder if Dr. Marcuss might look into the question that Mr. Ferguson raised. We have a higher proportion of part-time employees than other industrial nations. Maybe BLS will know something about it. Is this an effect of the kind of people we are, or is this the kind of tax system we have, or somewhere in between?

Dr. MARCUSS. It is always difficult to compare different tax systems.

The CHAIRMAN. Yes.

Dr. MARCUSS. But, in our system, there has been increasing pressure to hire people to work for you as independent contractors, as Mr. Ferguson said. This is because of the high cost to the employer of the benefits that they provide to their permanent employees.

The CHAIRMAN. So we are hearing something here, are we not? All right. Learn a little bit more about this for us.

Senator Bradley, did you have a comment?

Senator BRADLEY. No. It does have to do with the fact that compensation is taking more and more in the form of fringes. Therefore, the decision to hire implies an acceptance of pension, and acceptance of health care, and acceptance of other things. So, if you hire part—time, you only have to pay a wage while the person is working and you do not have to cover pensions or health care.

Dr. MARCUSS. That is correct, and the squeeze applies especially with workers who are low-income or low-wage workers. Then that benefits wedge is too much to make the person worth hiring.

The CHAIRMAN. Why do you not get us a piece of paper on this?

Dr. CONNERTON. If I might just interject here on this part time question.

The CHAIRMAN. Sure.

Dr. CONNERTON. Obviously, fringe benefits have enjoyed tax preferred status for a long time now. But the growth in the part-time and independent contractor universe is really a phenomenon of the 1980's. And, in our view, in many of the industries where our members are from, which are very competitive industries——

The CHAIRMAN. Service employees.

Dr. CONNERTON. Service employees. There is a direct incentive to contract out or reduce hours, because all employers are not required to provide health insurance. I mean, health insurance is the big cost difference in many of our industries.

And, if we have a unionized contractor, and they are facing competition that does not have health insurance as part of their compensation cost structure—we have had whole industries that switched to part-time work, and the big issue there is to avoid health insurance coverage.

The CHAIRMAN. Thank you.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman. Dr. Auerbach, as a proponent of a tax cap, how would you structure one that would avoid the problems of burdening low and middle income people?

Dr. AUERBACH. Well, first of all, by talking about a cap rather than removal of the exclusion, you have gotten a lot of the way there already. Presumably, the more attractive plans will tend to be associated with higher income individuals although, clearly, it is a firm by firm decision and not an individual decision within firms.

But, if the real problem is trying to get coverage for people who do not have it, then those people currently receive no benefit at all. So I am not worried so much about the regressivity of capping, at a reasonable level, the benefits people already get.

I think Mr. Rooney has given us a perfect example of what you should do. He has, through voluntary action in his firm, gotten people essentially to accept a cap. They are accepting lower insurance coverage, which would presumably fall under that cap voluntarily, even though the cap does not exist.

If they are doing that voluntarily, then putting the cap on would presumably have no tax impact on them at all. It is really a process of education of consumers, to let them know that there are alternative ways of obtaining health care coverage.

I do not really see the cap as a major tax increase, in terms of the inclusion of insurance premiums in income, because once the cap goes into effect the amount of insurance coverage that people choose would be more limited, premiums would be lower. There would be, perhaps, higher deductibles and co-payments, or some sort of managed care plan which would have lower costs.

And that, in turn, would help reduce the demand for health care, which would further lower the premiums and, hence, perhaps even allow other forms of compensation to the employees. I really do not see the cap as a major problem.

The major objection that people have stems from the notion that nothing else will change; there will be no behavioral change, there will be no other changes in the health care market and all you will be doing is taking away a tax benefit from individuals.

I can understand why there would be resistance to that, but one would hope that that will not be the only change that will be happening.

Senator CONRAD. So when you talk about a tax cap in those terms, give me an example. I mean, if you were to design this thing, if you had the responsibility that we have, what would you do?

Dr. AUERBACH. Well, let us take the tax cap in the Administration's plan. First of all, it would not occur for several years. But, also, the standard plan—not the HMO plan, but the standard plan—that is there would have very low individual deductibles and family deductibles. That tends to make health insurance more expensive.

I would much prefer to see, based on actuarial calculations, plans which would have larger deductibles, some co-payments up to a ceiling, perhaps based on AGI for individual families, whatever policy of that sort would cost. That, perhaps, could be excludable from individual income under the cap.

Mr. Rooney has given us ample evidence that individuals do not need any other incentives, such as tax-free inside build-up in a medical savings account, to get them to shift away from expensive insurance, even without a limited tax exclusion.

So, surely with the tax exclusion of the kind I am describing, and with some educational efforts on the part of the government and by employers, there would be a massive shift to the establishment of medical savings accounts whereby individuals would be encouraged to put money away for their additional health care expenses, which now would no longer be covered by first dollar insurance policies.

Senator CONRAD. Well, I am trying to get you to be more specific. Again, if you had the responsibility, where would you draw the line? I mean, what would you be talking about? Are you endorsing Mr. Rooney's proposal?

Dr. AUERBACH. No. I think Mr. Rooney has given the best argument against his own proposal, which is that his employees are doing it voluntarily without any change in the tax system having occurred. If 85 percent of his employees have opted voluntarily for a plan for which he is advocating a tax subsidy, I am not sure I understand the argument.

Senator CONRAD. Mr. Rooney.

The CHAIRMAN. You have the right of reply, sir.

Senator CONRAD. Do you want to respond to that?

Mr. ROONEY. Sure. The fact is, we have already a tax policy that encourages the employer to purchase health insurance and we, as a Nation, would benefit a great deal if we could increase the savings on the part of the worker.

So, since we are giving tax deductibility health benefits now, why do we not allow substitution effect so that the employee could have the same tax benefit if they put the money away for future use for

retirement, for long-term care someday, or whatever? That would benefit our society. It would not hurt; it would not cost any more.

Senator CONRAD. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. I think I am a little out of order, Senator Breaux. Senator Grassley is next. Forgive me for that.

Senator GRASSLEY. Thank you, Mr. Chairman. Thank you, Senator Breaux.

I think my first question would be to Dr. Connerton. But, before I state my question, we have had other hearings before this committee on this issue, as it deals with mandated benefits. Witnesses have taken the position that if we mandate benefits it is going to hurt low-income workers a lot because, the compensation package being what it is, if there is an increase in fringe benefits for health care, then perhaps it would come out of wages that the person would be paid and, in a sense, this would hit low-wage workers the hardest.

So, now I want to refer to page 13 of the Lewin study. There the authors argue that, because janitors must receive as much health care coverage as the CEO, any reduction in the compensation package to account for the added costs of the tax cap would take a much bigger bite out of low-wage workers' pocketbooks.

So, my question to you is, would this not also be true then of any employer-mandated program, since mandated health benefits would be offset by the reductions in other parts of the compensation package? Consequently then, would not low-wage workers be hit the hardest as well; making the same argument, kind of, that Lewin makes on page 13?

Dr. CONNERTON. Well, the first thing I would say about this is that, in essence, workers who get health insurance today, this janitor and CEO in the same firm, they already paid for it because it is part of their compensation package. And, assuming that the compensation package is essentially determined by the market, they have, in effect, traded off wages for other benefits in the compensation package.

Now, you impose a tax on some portion of those health benefits. That tax amount, as a share of their income, is higher as a janitor than it would be for the CEO. That is the point that Lewin is making in this particular study.

Senator GRASSLEY. And I agree that he is making that point.

Dr. CONNERTON. Right. Now, on the employer mandate question, which was yet another Lewin-VHI study, it is clear that, over the long haul, that, again, if you mandate that a part of a person's compensation package be health insurance—which, in fact, is why we were able to unionize, because low-wage workers want health insurance, but it is definitely is part of their overall compensation package.

So, over a period of time, it is not that workers' wages would be cut, but that over a period of time they would get smaller pay increases to compensate for it. But, as opposed to the janitor who has health insurance today and who has already paid for it, they get something in return. I mean, there is a wage effect, but they are getting something for that, they are getting health insurance benefits. That is a critical difference.

Now, on the question which Alan raised earlier of whether, for the lowest wage workers, there is employment loss or not, we happen to believe and the evidence from a number of the recent researchers on the minimum wage question shows—remember, we just had a minimum wage increase of 90 cents over a period of 2 years—looking at the effect of that, that there was no employment loss.

Senator GRASSLEY. All right. Now, I was not talking about employment loss. I was talking about, would it not impact then on the same low-income wage earner, a mandated health benefit, the same negative way that you are saying that the tax cap impacts negatively upon janitors in opposition to a CEO.

Dr. CONNERTON. Well, I am saying there are two different populations that we are talking about. The population that is addressed in the current study are folks who already have group-based health insurance. And they have paid for that. As part of their compensation package, they have traded off wages for this health insurance. Now you are going to impose a tax on them.

Senator GRASSLEY. Sure.

Dr. CONNERTON. The other group who is impacted by the employer mandate are firms and employees who, today, do not have employment health insurance. So these employees do, in fact, over a period of time, have an adjustment in their compensation package, but, in return, they have health insurance that they do not have today.

Senator GRASSLEY. And, for that period of time that it takes to make it up, they are impacted, it seems to me, negatively in the same way, because they are not going to get their pay raises, or, if they have the pay that it can come out of some way or other, they are going to be hurt disproportionately in the same way a CEO would be in that same company.

Dr. CONNERTON. Well, that is true. But let me just say that the janitors that we represent have been trading off wages for the past 12 years because the cost of health insurance has been rising so rapidly, partly because we have had to pay to cover the health costs for those employers and workers who do not have health insurance today.

The CHAIRMAN. All right. Thank you, Senator Grassley.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman, and thank all the members of the panel for their very insightful thoughts and recommendations on this very difficult issue.

Dr. Connerton, let me begin with you and ask, first, does AFL–CIO support the comprehensive health plan benefit package that is contained in the President's bill?

Dr. CONNERTON. Yes, we do.

Senator BREAUX. And would you consider that a standard option plan, or a low option plan, or something that is perhaps more generous than either one of those?

Dr. CONNERTON. I think that they based it after what is essentially a standard industry benefit, with the exception of—I know many of our plans do not have the kind of preventive coverage included in the President's plan.

Senator BREAUX. Is the plan that is in the President's proposal more generous or less generous than most of the plans that your members have?

Dr. CONNERTON. I can only speak for the service employees. I happened to bring with me yet another study that was not done by Lewin-VHI, but by our benefit department——

The CHAIRMAN. What? A study not done by Lewin-VHI?

Dr. CONNERTON. I know it is incredible. But we have one, and it looks at our health insurance benefits over the last 6 years. I think it is very close to what our plans have in terms of co-pays, deductibles, and other cost sharing.

Senator BREAUX. How about on benefits?

Dr. CONNERTON. In terms of benefits, pretty similar. There is a segment of our membership that will get dental coverage that they do not have today, and will see some improvements in their mental health benefits compared to what they have today. But it is generally comparable.

Senator BREAUX. The reason why I am asking about your opinion on the type of benefits that are offered, I looked through the Executive Summary and some of the things you have in your study.

It seems to me that, with regard to the effects of the Breaux-Durenberger Managed Competition Plan, the entire study is based on the assumption—because your charts and all the discussions indicate that—that the Breaux-Durenberger bill would offer a standard option or a low option plan. So everything else is triggered off that assumption, that employees would have to pay more to get more benefits, et cetera, et cetera.

Dr. CONNERTON. Right.

Senator BREAUX. But I want you to tell me, how did you arrive at that assumption? Number one, do you like the plan that the President has proposed? You have endorsed the benefit package in the President's plan.

Our plan is going to be written by five people who are appointed by the President. How can you assume that somehow the plan that they would write would be less generous than the plan advocated by the person that is appointing them to that job?

Dr. CONNERTON. Well, I think that we took a look at those two benefit packages for the following reasons. Number one, is that with the Clinton-style comprehensive benefit package, you do not raise much revenue. And, in fact, the kind of tax that they are proposing, they are not assuming that it will raise much revenue. It is really targeted at what would be considered supplemental benefits.

Senator BREAUX. What I am asking is pretty specific. How can you assume that the managed competition Breaux-Durenberger plan would be less generous than the President's plan, I mean, because your whole study is based on that?

And I challenge the assumption that the whole study is based on; that is, that the Breaux-Durenberger plan will somehow be less generous than the President's plan. Our plan is going to be written by people appointed by the President.

Dr. CONNERTON. Well, again, this study, Senator, was not really directed at the Managed Competition Act. We did not——

Senator BREAUX. So it does not apply to Breaux-Durenberger?

Dr. CONNERTON. It is a study that looks at the impact of taxing health benefits, limiting the employer's deductibility. The reason that your bill is looked at is the most politically feasible in our minds because it does not impose the tax directly on the individual. And the purpose of the study was not to emphasize somebody's particular bill, but to really focus on what the impacts are.

Senator BREAUX. All right. Well, let us assume then, for the sake of discussion this morning, that the Breaux-Durenberger plan, which will be written by five people appointed by the President, has the same identical benefits package as contained in the President's plan, which package you endorse, and that, because of the employer cap on tax deductibility, we raise about $79 billion over 5 years which we use to subsidize poor people and low-income wage earners, many of whom you represent according to a 1993 CBO report. What are your thoughts on using that slate of assumptions?

Dr. CONNERTON. Well, first of all, the standard option package that we use is really the FEBA package, the package that members of Congress are eligible for. It is a good benefits package. It covers prescription drugs, it covers dental care, it covers mental health benefits.

Senator BREAUX. I understand that. But back to the question.

Dr. CONNERTON. All right. Now, the next question that you are asking is, if you impose a super generous benefits package——

Senator BREAUX. The same as the President's.

Dr. CONNERTON.—there is not the revenue to redistribute to other folks. It does not raise——

Senator BREAUX. Well, that is the purpose of the cap. I mean, the cap generates $78 billion by restricting it to the least costly that offers those identical benefits, and use that to supplement the income for low-income wage earners.

Dr. CONNERTON. If you work that, you will see how much money you raise depends very critically on what services are included in the benefit package. And I think that is the point we are trying to make, rather than say that, under the Managed Competition Plan it will either be X or Y, because we do not know what it will be. But it does show that how much money you are going to raise depends very critically on what kinds of services are in this basic benefits package.

Senator BREAUX. Thank you.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

We all know that Americans spend more for health care than do people in other countries as a percentage of GDP and every other major calculation.

Second, it is also true that we Americans spend more out-of-pocket on health care expenditures than do other people in other countries, either as a percentage of our total health care bill, or an absolute basis, and that has not curbed the increase in U.S. health care costs.

We pay more out-of-pocket than do other people in other countries, yet we pay more than do people in any other country. I take it that the basic theory of these tax caps in the medical savings account is to "let the market work" by encouraging Americans to still

pay even more than they already do out of their own pocket for health care.

I just wonder, therefore, why do we think that "the market" is going to work a lot better by asking Americans to spend even more out-of-pocket than they now do to curb health care costs? Anybody want to take a crack at that?

Dr. MARCUSS. I will, Senator Baucus.

Mr. ROONEY. And I will, too.

Dr. MARCUSS. For the tax cap in particular, incentive can be affected because the employee would then be purchasing the last dollar of health insurance coverage at its full cost and, therefore, he would be inclined to buy only that coverage whose benefits are worth fully that much to him.

So, the cap addresses the incentive for buying more health insurance and eventually buying more health care because the purchaser is paying the whole amount, rather than a discounted tax-free amount. This is the hope of the tax cap in changing people's behavior.

Dr. CONNERTON. We will hear a lot of discussion—we have heard a lot this morning—about changing incentives. I think one of the biggest so called incentives to use less medical services really comes at the point of service.

It is not like an indirect kind of tax incentive the choose a less generous health plan; at the point of service, you choose to go to the doctor, you will have to pay a certain share of that bill.

When people talk about tax incentives, it is much less clear whether, given the number of non-economic factors, given the expected value of the loss and gains, whether people will, in fact, unless you make the tax extremely punitive, have incentives to switch into less generous coverage. I mean, I think that is, in many ways, pretty untested, although it is accepted as gospel around here.

Senator BAUCUS. Well, it is all complicated, obviously. OTA has submitted a study which concluded that the more we move toward insurance plans with large deductibles, more and more Americans are going to be more sick. That is, they are just not going to go to doctors as often. That choice is not based upon whether they need to go to the doctor or not. We are going to have a sicker population, at least according to the OTA.

I would like to turn to another subject, and that is the administrative difficulties of tax caps. There may be another administrative difficulty, at least under those bills—Senator Breaux provides that the tax cap would be set at the lowest cost plan offered in an area. Senator Chafee's bill says that the tax cap is set at the average of the——

Senator CHAFEE. Lowest half.

Senator BAUCUS. Lowest half. Lowest half.

The question that comes to my mind is, what about States that are big in area and few in people, say the State of Montana and the Dakotas, for example.

We are moving toward community rating. Now, we have a choice. What if the entire State has community rating? And let us take one city in my State, Missoula, MT, which is in one part of the State. Let us say the lowest cost health insurance plan is in Missoula.

What happens to the people at the other end of Montana who cannot subscribe to that plan from Missoula? How are they going to be able to participate in this lowest cost plan across the State, assuming the whole State is part of the tax cap calculation?

On the other hand, let us say the tax cap is calculated for each county. This would cause tremendous complexities, it seems to me, of all the new calculations for this system.

So, on the one hand, we try to reduce administrative complexity by making one tax cap for the whole State, which makes the lowest cost plan unavailable to a lot of people in the State; or, on the other hand, we have many smaller areas that each have their own tax caps, which adds additional complexity.

I just wondered if, say, Mr. Ferguson, you could comment on that, or anybody else who might wish to comment.

The CHAIRMAN. Let us hear from Mr. Ferguson.

Mr. FERGUSON. Thank you. I would simply commiserate with the folks in Montana who could not get the standard care package covered on a non-taxable basis. And I think you have illustrated very nicely the treacherous shoals that the tax administrators and employers would be forced into by a system which attempts to cap the non-taxable portion of benefits received.

It is true that excluding the receipt of medical care costs is a tax subsidy. It is also true that other fringe benefits have been tax subsidies. But I do not think that those subsidies are borne entirely of Congressional policy to encourage fringes, I think they are borne, at least in part, by the recognition that it is difficult to capture these fringes and subsidies and measure them carefully at the receipt level.

I think it is much easier, if a tax regime is desired to encourage the kind of behavior that Dr. Auerbach has described, by imposing tax caps on employer payments, which are much easier to measure than statistically hypothetical receipts at the individual level.

There is at least one proposal that tax caps be imposed at both levels, that there be a limit on deductions for payments above a certain level and that there be inclusion of income at the employee level. If any proposal would be designed to change behavior and bring all coverage down to the permitted standard package, that would be it.

The result of caps, of course, would be to channel excess compensation into the form of cash, clearly deductible without meaningful caps, much more easily measured, and taxed to the employee under standard tax notions.

The lesson, at least to those of us who have approached this with the eye of the tax administrator, is that if caps are to be used they ought to be used to limit deductions or to impose excise taxes on employers rather than to try to tax employees.

Senator BAUCUS. Thank you.

The CHAIRMAN. Thank you, Mr. Ferguson. Thank you, Senator Baucus.

The Chairman has a dilemma. Mr. Danforth having left the room, the Chairman indicated to Mr. Chafee that he was next. But, according to the strict ranking in order of appearance, Mr. Danforth is next.

Senator DANFORTH. Mr. Chairman, it is possible that my questions were asked by others while I was out of the room, so please just refer me to a previous answer if you have given these answers before.

When Senator Mitchell asked you, Dr. Marcuss, about whether or not you had any study to dispute the RAND study that Dr. Connerton mentioned, you said you had no such study. Does that mean that you adopt the RAND study as being accurate?

Dr. MARCUSS. No, I would not say that; I am not familiar with that study. But I do know that CBO has not analyzed it and assessed it. But, no, it would not mean that we would either refute it or accept it.

Senator DANFORTH. Right.

It would seem to me that if we want individuals to have some stake in trying to control the cost of health care, then an individual exclusion from income would be an essential ingredient of such a program. Have I missed something in that? I know that Dr. Connerton would not agree with that.

But, if we want individuals to weigh the cost of excessive health care, of just spending the sky is the limit on health care, then it would be a very important component of such a program to have a limit on the exclusion of income on tax-free health care.

Dr. AUERBACH. Absolutely. What you are really saying is, you would want individuals to have some exposure to out-of-pocket expenses. And one way of accomplishing that would be by having a cap to the exclusion of employer-provided health insurance.

Mr. FERGUSON. That would not be the only way. It could be accomplished by discouraging employer provision of unlimited health care and the greater use of co-payment, greater use of deductibles, and so forth, to make the first dollars of health care not covered by the employer's plan.

Dr. MARCUSS. But, either way, you want the consumer to be distinguishing between treatments whose benefits exceed their costs and treatments whose benefits do not. As long as the consumer is paying very little or none of that cost, he simply does not have the incentive to take those efforts, and those efforts can be considerable.

Senator DANFORTH. It would seem to me clear that if you offer an employee two types of compensation, one of which is taxable and one of which is not taxable and you say, the more of the non-taxable variety you get it will still be non-taxable, that that is a clear incentive for the employee to demand, in the bargaining process, as much health insurance as the employee can possibly get.

Dr. MARCUSS. Yes.

Mr. ROONEY. And that is the way it works. I have sold insurance. You can say to the employer, you know, these are high-powered dollars, put them into the medical expense. For every dollar you put in, you get a dollar and a half's worth, and, certainly, the tax deductibility is an incentive.

But, of course, under the present tax law there is no opportunity for the employee to substitute anything except medical expense. I cannot use part of that medical fund to pay for my child's education. I cannot use part of that medical fund to pay for better housing.

The CHAIRMAN. Or horses.

Mr. ROONEY. Or horses, Senator.

Senator DANFORTH. I mean, I take it, Dr. Connerton, the reason that you are here is that tax-free benefits are important to the labor unions.

Dr. CONNERTON. Well, I think we need to go back to why benefits were initially treated as tax-free. There was a decision to use the Tax Code in the United States as a way to encourage employment-based health insurance as an alternative to a public system, which is what most countries have.

Now, in that regard, it clearly did encourage companies to purchase health insurance, but that is what it was supposed to do. At this point in time we have experienced, in the last 10 years large, increases in deductibles, co-payments, those kinds of incentives to be more cost-conscious.

Senator DANFORTH. Well, if I can just reclaim 15 seconds of the end of your answer.

The CHAIRMAN. Please.

Senator DANFORTH. The reason for what some would call a tax preference, the reason for a tax-free benefit, is to encourage the use of it. That is the policy reason for us doing it, it is to encourage something; it is to encourage people to do something they might not otherwise do.

Maybe we have gone overboard. That was the argument for the 1986 Tax Act, that we had gone too far in trying to manipulate decisions. But it seems to me that if we now say, well, we have overdone it and we have encouraged people to buy gold-plated insurance, we have encouraged people to buy excessive health care, there has to be some limitation on health care. To provide unlimited exclusion from income is to provide an incentive for something we do not want people to do.

Dr. CONNERTON. I mean, the part that I dispute in what you are saying is the fact that, at this point, the tax exclusion is responsible for incredibly generous Cadillac plans. If you look at the distribution of health benefit plans, what distinguishes one plan from another today, is not the question of first dollar coverage.

There is almost no first dollar coverage. There has been a big increase in cost-sharing. It is whether you have prescription drugs, whether or not you have dental coverage, whether or not you have mental health coverage, whether or not you have some coverage for vision. So it is in certain kinds of benefits.

What you are telling me is, we have gone too far, so what we should do is do away with the tax exclusion for these particular kinds of benefits and really shift the cost of prescription drug coverage if I get sick, or my kids get sick, back to the family.

And so, in that context, I do not quite understand. It is not that everybody has first dollar coverage; some people have prescription drug coverage. Plans are really grouped in certain areas and there are not a lot of these Cadillac plans out there.

Senator DANFORTH. I did not ask about what is in the defined benefit package, I just asked the question of cost.

Dr. CONNERTON. Well, you said essentially that health coverage has become too generous——

Senator DANFORTH. Too expensive.

Dr. CONNERTON. It has become expensive for a lot of other reasons. It has become expensive because the costs have been rising rapidly as well.

The CHAIRMAN. All right. I think it is the case, in the first instance, when health benefits began to be provided extensively. It was World War II when wage controls had been imposed and our Tax Code, just absentmindedly, not that very old at that time, in the Income Tax of 1913, just did not tax fringe benefits, of which there were not many.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

I would like to say to the panel that one of the driving forces behind my concern over this whole health care reform business—and I suspect many on this committee likewise—is the cost, doing something to constrain the costs.

The costs are affecting individuals, they are affecting our companies, and they are affecting State Governments through Medicaid. If you had 50 Governors in here, there is no question that one of their deepest concerns would be the steeply rising costs of Medicaid.

And, finally, we must consider the Federal Government, as well. And, of the five most expensive programs in the Federal Government, the ones that are rising the fastest are Medicare and Medicaid, the two health care programs. So this is definitely a factor in my thinking, and certainly I suspect it is, as I mentioned before, in the thinking of this committee. What can we do about the costs?

Now, when we start by looking at the Tax Code, I believe—and I am going to ask, quickly, of the panel just to say if they agree with me—that there is a definite unfairness currently in the Tax Code dealing with the deductibility of health care premiums for individuals and the self-employed.

If an individual works for General Motors, the health insurance that is provided is all tax-free, whatever he receives. If he goes out and is a farmer, or is a sole proprietor, or lawyer, whatever it is, he can deduct, Mr. Ferguson, 25 percent of his health care premium. Is that right?

Mr. FERGUSON. That is correct.

Senator CHAFEE. All right. Now, that clearly is unfair. First of all, as an individual's chances of getting a decent health care plan at the same price as that plan would cost General Motors are highly unlikely, and second, that individual can only deduct 25 percent of the cost of that insurance.

So the HEART proposal begins with the premise that this should be corrected, but that obviously is going to cost the Federal Government some money. But that is a separate issue. I am not saying that anything we do here should necessarily pay for it, but it is a factor in our thinking.

Now, the second factor that I believe everybody would agree upon, is that the less cost an individual has to bear for a health care plan, either through deductibles, co-payments, or the premiums themselves, the greater the individual will use the system. I think that is a given. That is what Mr. Rooney has found in his business; that is what the various reports that we have here have said.

Mr. FERGUSON. That is correct.

Senator CHAFEE. All right. If you do not pay anything for health care, you are likely to use it a lot more. Some of that will be frivolous; but not all of it, clearly.

Now, next, I think we have always got to remember, that we are talking about is premised on a uniform benefit package. I would differ a bit with what Dr. Connerton said when she said that a tax cap would keep people from getting a good plan.

All the plans offer the same benefits under the various proposals that are before this committee; it does not make any difference whether you get the low-cost plan or the high-cost plan, the benefits are the same.

The system of delivering the benefits can vary. It can be a fee-for-service, it can be an HMO, and so forth, but the benefits are all the same. It is not that one plan is going to give you vision and dental care and another plan is not. Does everybody understand that? That is the way my plan works, that is the way the Administration's plan works, and that is the way the Breaux-Durenberger plan works.

It does not mean necessarily the benefits within our plan or the Breaux-Durenberger plan are the same as the Administration's, but, within each plan, within each proposal that is submitted here, the benefits between plans are the same.

Now, in order to obtain our objective of reducing health care costs, one suggestion, in our plan, anyway, is that the employer, above some level—and you can arrive at that level in a variety of ways—cannot deduct the cost of health insurance provided to its employee.

Now, that, again, Dr. Connerton, has nothing to do with the benefits; the benefits remain the same. Is that clear?

Dr. CONNERTON. Well my understanding of all of these proposals is that, while there is a standard benefit package that employers and employees can negotiate or keep in some cases, benefits that are in excess of the standard benefit package——

Senator CHAFEE. Yes. The Administration has a proposal on that. But, even under the Administration's proposal at the end of X years, I forget when it is——

Dr. CONNERTON. Ten.

Senator CHAFEE [continuing]. That phases out. So, let us assume we are talking beyond that period. Now, it also seems to me that it is important to go beyond the provision dealing with the employer deduction, because that is no incentive for the user of the system. What does the employee care if the employer can no longer deduct something?

The suggestion here is that that would be a disincentive for the employee to use the system. I have trouble with that. I think it was you, Dr. Marcuss, that suggested that that would be an incentive for the employee not to use the system so much, or to choose a less expensive plan. Why would he?

Dr. MARCUSS. I suggested that because, after adjustment, the employee ultimately pays for employer-paid health insurance because he can be paid only the the value of his output to the firm. Therefore, the cap on the employer raises the cost of health insurance for employees with insurance costing more than the capped

amount; and this will tend to encourage such employees to purchase less insurance. The point you are making here, with which we agree, is that both the employee and the employer have the same interest in mind here. The employer is working as an agent for the employee, to get him the health care coverage that he wishes to have.

Senator CHAFEE. Well, following up on this——

The CHAIRMAN. Please.

Senator CHAFEE. My time is up, and I will try to be brief. But, under our plan, we take the further step that, above this level—and you can arrive at it, as I say, in a variety of ways—the employer cannot deduct that amount and anything above it is taxable to the employee.

Now, the whole purpose of this—always involving the same benefits; they are not getting less benefits than they get with the more expensive package—is a downward thrust on expenditures for health care. That is one of the objectives of the exercise, it seems to me, and I am not quite sure why there is hesitancy in embracing that.

Mr. Ferguson, what do you say to that?

Mr. FERGUSON. Well, I have expressed my grave doubts, Senator Chafee, about whether the measurement of benefits actually afforded to employees can be done simply and taxed. I do think that those provisions——

Senator CHAFEE. Well, let us just say that the reasonable costs that you arrive at is $300 a month. Anything above that is nondeductible by the employer and is taxable to the employee. I do not get the difficulty there.

So the employee chooses the plan that is $350 a month and the employer pays for it, regardless of the fact that the employer cannot deduct $50. And, under this system, $50 is taxable to the employee per month. What is the difficulty?

Mr. FERGUSON. The difficulty is in the hypothetical. The difficulty is in finding the $300 a month.

Senator CHAFEE. Well, I have never gotten trapped in a hypothetical.

Mr. FERGUSON. It is determining that a particular employee's excessive benefit is $300 a month.

Senator CHAFEE. No, no. This proposal would apply to the amount above that level.

Mr. FERGUSON. Just to illustrate with a couple of questions which the taxpayer and the Internal Revenue Service will have to consider if your bill becomes law, will the $300 a month be calculated differently for a person who is married, or another person who has a family than it does for a person who is single?

Will there have to be a difference between the $300 or whatever the amount is for a person who is aged 60 than a person who is aged 25? Will there have to be a difference between the employee who is working in New York City than a person who is working in Nashua?

Senator CHAFEE. Well, I do not think we are debating the details.

Mr. FERGUSON. Well, that is where the devil is, it is in the details. That is why I think you will find that most tax people are very concerned about imposing a superstructure of regulations

upon this which will take years to work out and may have the same failure that the 1986 act had in Section 89 of the Tax Code, which had to be repealed 3 years later. The basic policy which you have expressed of discouraging and taxing excessive coverage is——

Senator CHAFEE. Well, that is the point I would rather discuss. I mean, it may well be that there are certain difficulties in implementing this cap. Mr. Chairman, I see my time is up here.

The CHAIRMAN. Take your time.

Senator CHAFEE. What I am really trying to get at is the philosophy—and Dr. Auerbach seems to agree with it—which is that somehow in this system we need to put downward pressure on rising health costs—and I miss it totally in Dr. Connerton's approach. I cannot see, under her approach, that there is any incentive for the employee to show some frugality or some incentive for the employee to attempt to hold down these costs. And I believe that exists, under our system. Perhaps it can be improved upon. But it has nothing to do with less benefits. The benefits remain the same for everyone.

The CHAIRMAN. Could I make the suggestion, sometime we are going to have to have a hearing on, how does a non-economic man or woman behave, because everything else—I would like to know more about those people, because I think I am probably one of them.

But I think what Senator Chafee is suggesting, and I think he is right, is that we have a pretty good idea of what we consider adequate health care in this country right now. And there are edges to it, when you get to eyeglasses and things like that, but basic health care is something—that is what they teach at medical schools, and we will try to get it.

But, thank you, Senator.

Senator CHAFEE. Well, let me just say one other thing, Mr. Chairman. And that is, that I know that the usual approach to have the employee involved is in the deductibles or the co-payments and I have some reservations in the co-payments.

Sure, they do that, but certainly for the low-income person the co-payments can be a real deterrent to using the system whereby, under the proposal that we made, everybody gets the same plan, the same benefits. The difference is in the delivery. But the person gets the same benefits and you do not use the method of high deductibles to discourage the excessive use of a program. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I think we have to attend—our party caucuses have begun, the lights tell me.

Senator Roth, you have been very patient, sir.

Senator ROTH. Thank you, Mr. Chairman.

Dr. Auerbach, you mentioned earlier that you might design a tax cap by limiting the exclusion based on a person's adjusted gross income. Would that not be particularly hard on the middle income union worker who has bargained in recent years for better health coverage, but not so much for higher wages?

Dr. AUERBACH. To make a plan like that work you would want to phase it in to allow an adjustment in bargains. If union workers have expected tax-free dollars to pay for medical insurance and so

bargained away a wage increase in exchange for medical benefits that otherwise would not have been part of the bargain, they should be given an opportunity to work that out in the market over a period of time before the caps come into play. But I do not think you are talking about more than a couple of years.

If you are concerned with what will occur after the bargain is resettled, yes, there is going to be a redistributive effect of tax caps because you will increase the benefits for self-employed individuals and for people whose employers offer them no coverage at all right now. They will be getting more, and people whose employers now offer them coverage which is fully excludable will be getting less. I cannot imagine any health care plan that you will introduce that will not have that characteristic.

Senator ROTH. Dr. Connerton, do you have any comments?

Dr. CONNERTON. Well, I think that you have hit exactly on the point. It is not only that years ago we traded off some wages in order to negotiate more generous benefits. In recent years, there has been no increase in those benefit packages. What we have had to do is to pay a lot more to hold onto the current benefits that we already have and, to pay for that, we have traded off even more in wages. Now, one thing I just want to make clear here when we talk about standard benefit packages, is that we cannot develop everything in isolation; all of these pieces of the puzzle fit together.

So if you are designing a standard benefit package that is affordable to smaller business—and we have heard talk about 50/50 copayments and the like—whatever the standard benefit package is, if it does not include dental benefits for example, you could be talking about a very big tax hit on families that have had to forego wage increases over the last 10 years.

Senator ROTH. Mr. Rooney, some of the plans for medical savings accounts would combine a tax cap together with a catastrophic care plan, but you do not advocate that. Is that correct?

Mr. ROONEY. I think that is a separate subject, Senator. It is a fundamental public policy issue as to how much financial incentive we wish to provide to employers and employees to induce them to buy health insurance.

We had, in 1986, a Treasury 1 proposal, a proposal to limit the tax deductibility. I think that is a reasonable thing to do. But it is not incompatible with the medical savings account.

By the way, I think I should digress to say it is not to put the employees more at risk, it is just to say to the employer and the employees, look, let us shave part of this off the bottom of your insurance premium and put it into a fund for the employees, and let the employees spend on what has greatest utility to them. And, if the employees spend it more wisely, they get to keep the money that it saves, so it creates a substitution effect.

But, in any case, back to your fundamental question. The tax cap and medical savings accounts are not incompatible, you could do it either way.

Senator ROTH. Well, the time is late, Mr. Chairman. Thank you very much.

The CHAIRMAN. Thank you, Senator Roth. And thanks to our wonderfully lucid and open panel which has managed to agree on occasion, not to agree on others, but to do so with great good will

and openness to information. We have learned a lot, and we expect to call on you. We particularly have that open-ended offer from Davis, Polk & Wardwell which we will not fail to avail ourselves of.

[Whereupon, at 12:20 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF ALAN J. AUERBACH

Mr. Chairman and Members of the Committee: It is a pleasure to appear before you and to have this opportunity to offer my views on the role of the tax system in promoting the nation's goals regarding the provision of health care. I am here on my own behalf, as someone who has studied the behavioral effects of taxation for many years. In my comments, I will deal first with the effects that the current tax system has on the health care market. Next, I will consider the variety of options available for reforming the tax treatment of health care, including those contained in a number of proposals now under your consideration. In doing so, I will explain how these proposed changes in the tax treatment of health care would interact with other changes in the provision of health care that are being proposed.

An important point to keep in mind is that the impact of the tax system on health care depends on the nature of the health care market, which itself can be altered by regulation and other government action. Most current health care reform proposals go beyond changing the tax system. Hence, a tax change that might be advisable today might be unnecessary in the face of broad reform. For example, if a limit were placed on the amount of health insurance employers could provide, the impact of the tax exclusion for such insurance would be limited.

TAXATION AND HEALTH CARE

It is crucial to keep in mind that consumers of health care make two types of purchases: they buy health insurance and medical services. Although much of the current debate centers on the cost and availability of health insurance, what ultimately matters is the price, quality and availability of medical care itself. Improvements in the provision of health care need not require expanded insurance coverage. Some tax provisions have a direct impact on the purchase of insurance, while others deal with purchases of medical care itself, but each type of provision affects purchases of the other type. Incentives to purchase more insurance lead to greater expenditures on medical care, and subsidies to out-of-pocket medical costs may lessen the demand for insurance coverage.

If purchases of health insurance and medical care were treated like the purchases of most other goods and services (the main exception being owner-occupied housing), they would have no impact on income tax liability. Whether paid for by taxpayers themselves or their employers, health care costs would not reduce individual income tax liability. Employer-provided insurance would, like cash compensation, be taxable income to the employee.

At present, the tax system favors the purchase of both health insurance and medical care, but does so inconsistently. Employer-provided insurance purchases, which are fully deductible to the firm, are excluded from employees' taxable incomes. Self-employed individuals receive the much smaller incentive of a 25 percent exclusion of health insurance costs, while employees of firms that do not provide health insurance receive no tax subsidy for their insurance, except to the extent that their combined insurance and direct medical expenses exceed a floor of 7.5 percent of adjusted gross income (above which insurance costs and medical expenses can be deducted). Because relatively few individuals have expenses above this floor, the current tax system subsidizes the purchase of health insurance to a much greater extent than it does direct expenditures on medical care.

THE IMPACT OF HEALTH CARE SUBSIDIES

The existing subsidies to health insurance and out-of-pocket medical expenses have a variety of economic effects. Perhaps most visible is the distributional impact of these large tax expenditures. But incentive effects are equally important, and the primary way through which the tax system influences the functioning of the health care market.

The tax subsidies stimulate the demand for health care in two distinct ways. First, the subsidies to insurance and out-of-pocket expenses lower the effective price of medical care relative to the prices of other goods and services. Second, the full exclusion of employer-based health insurance leads to a shift in the method of paying for medical care among employees of firms offering insurance. To take advantage of the exclusion, they are encouraged to bargain for greater insurance coverage than they would were insurance costs and out-of-pocket expenses treated equally. For this reason, a smaller share of their medical expenses will come out of after-tax dollars. However, once acquired, more comprehensive insurance coverage limits the incentive that individuals have to conserve on their utilization of medical goods and services, a behavioral effect that economists refer to as "moral hazard."

In a normal, well-functioning market, there would be little justification for such a distortion of individual incentives. While we might wish to preserve the distributional effects of the tax expenditures for health care, we could achieve these effects in less distortionary ways, as through a reduction in income tax rates. This criticism gains force as marginal tax rates rise, as they have in the past year and may have to again in the near future. Hence, arguments for preserving or extending tax subsidies for health care based on distributional concerns are weak.

However, because the markets for medical care and health insurance are not normal markets, there may be other reasons to intervene with the tax system. One might justify incentives to purchase medical care, for example, by arguing that individuals are irrationally averse to receiving preventive medical treatment, such as periodic physical examinations, that will lower overall lifetime health care costs, or that certain health care purchases, such as vaccinations, provide social benefits beyond those to the individual.

We also face what economists call the "Samaritan's dilemma." Because we, as a society, are loathe to deny medical care to those with serious health problems, some individuals who might be able to afford health insurance are encouraged to obtain medical care this way, subsidized by the government or the private sector, rather than paying for it themselves in advance through insurance purchases. It may, then, be socially desirable to provide an offsetting incentive for individuals to purchase health insurance in order to lessen the number without coverage who rely on others to pay for their medical expenses.

None of these arguments justify the types of subsidies present in current law, however. Medical care far in excess of periodic examinations and vaccinations receive a tax subsidy, and the subsidy for insurance coverage is at once too broad and too narrow. It is not necessary to subsidize the purchase of employer-provided comprehensive health insurance, with limited deductibles and coinsurance, in order to avoid the Samaritan's dilemma. On the other hand, if a minimal level of insurance coverage is socially desirable, the insurance subsidy also should be available to those whose employers offer no insurance. Moreover, by stimulating demand for medical care and health insurance, the current subsidies actually *contribute* to the problem of uninsured patients by raising the cost of insurance to those not receiving the full tax exclusion of employer-based coverage.

A goal of health care reform, then, should be to alter the incentives of the current system, to expand the population covered by health insurance and, while possibly stimulating certain socially beneficial types of medical expenditures, simultaneously reducing the overall subsidy to medical care spending. These objectives call for tax changes that:

- reduce the tax subsidy to medical care and health insurance overall; and
- reduce the relative tax subsidy enjoyed by employer-based insurance purchases.

POSSIBLE TAX CHANGES AND THEIR EFFECTS

This committee is considering four health care reform plans that would alter the present unlimited tax exclusion for employer-based health insurance: the Clinton Administration's "Health Security Act" (S. 1757 and S. 1775), Senator Breaux's "Managed Competition Act" (S. 1579), Senator Chafee's "Health Equity and Access Reform Today Act" (S. 1770) and Senator Nickles' "Consumer Choice Health Security Act" (S. 1743).

Each plan would sharply reduce the tax advantages currently enjoyed by individuals with employer-paid health insurance over the self-employed and employees without employer-paid insurance. The first three plans eventually would either cap the individual tax exclusion for insurance or impose an excise tax on insurance in excess of a cap. These three plans would increase the self-employed insurance deduction to 100 percent, also subject to caps, putting self-employed people and covered employees on roughly the same footing. The Administration's plan would eliminate the category of uncovered employees by mandating employer coverage, while the Breaux and Chafee plans would offer an above-the-line deduction—essentially an exclusion—for employees purchasing their own insurance.

Thus, all three plans would increase the tax subsidy for some insurance purchases and lower the subsidy for others, leaving a considerable tax subsidy to purchase health insurance for everyone. They would therefore further the goal of getting more people covered by insurance, and would, to a limited extent, encourage a shift to lower cost insurance plans with higher out-of-pocket costs. But they would do so without a significant reduction in the overall subsidy to medical care purchases. By introducing Medical Savings Accounts (MSAs), which provide a new tax subsidy for out-of-pocket medical expenditures, the Chafee plan would encourage a shift away from comprehensive insurance plans, but at the cost of an even greater overall medical care subsidy. I will comment further on MSAs below.

The reform proposal of Senator Nickles would also standardize the tax treatment of health insurance across different classes of individuals, but in a very different manner. It would eliminate the exclusion for health insurance entirely and offer each individual taxpayer a refundable credit for both health insurance premiums and out-of-pocket medical expenses. Of all the plans, this one achieves the greatest uniformity in the treatment of individuals in different employment situations and equalizes the tax subsidies given to insurance purchases and unreimbursed medical expenses.

However, rather than discouraging health care expenditures, Nickles' plan actually encourages them by having a credit whose rate increases with the share of adjusted gross income that medical expenses absorb, from 25 percent for expenses below 10 percent of AGI, to 50 percent for expenses between 10 percent and 20 percent of AGI, to 75 percent of expenses over 20 percent of AGI. While this provision may have been intended to protect those with unusually high out-of-pocket medical expenses, it also provides a larger subsidy to insurance purchases that exceed 10 percent of AGI. Hence, if the desire is to encourage individuals to purchase insurance while at the same time leaving them somewhat exposed to out-of-pocket expenses, this plan seems poorly designed. As for ruinous unreimbursed medical costs, these are precisely the costs that insurance *should* cover. It makes more sense to reform the tax treatment of health insurance so that more individuals have such coverage than to mimic it with tax credits.

This plan, like the Chafee proposal, would introduce Medical Savings Accounts. Contributions to MSAs would receive either a tax deduction or a tax credit, with principal and interest accumulating tax-free and no tax due on withdrawals to pay for medical expenses. MSAs resemble the Flexible Spending Arrangements (FSAs) of current law, except that they may be held over indefinitely rather than having to be spent before the end of the year. They resemble traditional individual retirement accounts (IRAs) in that they eliminate the tax on income from savings.

What are the goals of allowing MSAs? I can think of two. First, they encourage people to reduce spending on insurance and increase exposure to unreimbursed expenses. By allowing funds to carry over from year to year and providing an even greater subsidy by not taxing inside build-up, MSAs are more attractive than the current FSAs. Second, MSAs encourage individuals to save.

I see problems with each of these arguments. First, there are two ways to encourage individuals to shift away from expensive, comprehensive insurance coverage. One, through the MSAs, is to subsidize out-of-pocket medical expenses. The other is to remove the tax subsidy to insurance purchases. The advantage of the second approach is that it reduces the overall subsidy to health care, which should help keep down medical costs, not to mention the federal budget deficit. Regarding the second argument, there seems little purpose in marrying a saving incentive to a subsidy of unreimbursed medical expenses. In effect, the MSA provides the largest subsidy to out-of-pocket medical expenses that occur in the distant future, after many years of tax-free income have been accumulated. Why is this desirable?

SUMMING UP

The tax system currently distorts health care decisions in a number of ways. It provides an overall subsidy to the purchase of medical care through the limited de-

ductibility of unreimbursed medical expenses, the exclusion from income of employer-based insurance, and the deductibility of 25 percent of self-employed insurance premiums. The greater subsidy to insurance among those with employer-based plans leads to overly comprehensive coverage, further fueling the demand for health care while simultaneously pushing some of those without the insurance subsidy out of the insurance market entirely.

The desire to achieve more universal insurance coverage motivates the extension of the tax subsidy of insurance purchases to those not currently receiving employer-based coverage. All of the plans being discussed would do this quite effectively. Three of the four plans would pursue the goal of reducing the comprehensiveness of insurance coverage by capping the level of premiums that qualify for a tax exclusion. However, none of the plans would go far enough in this direction to reduce the overall tax subsidy to medical care spending. Two of the plans would increase the incentive to reduce insurance purchases by establishing Medical Savings Accounts. MSAs, however, would also increase the overall tax subsidy to medical spending. A much sharper reduction in the excludable level of insurance premiums would induce the same shift away from broad insurance coverage at a lower revenue cost and reduce pressure on medical care costs.

Answers to Senator Riegle's Questions

Alan J. Auerbach
University of Pennsylvania
May 17, 1994

1. *If an employer's ability to deduct health care benefits is restricted, resulting in the limitation of employee benefits, economic theory may say that the employees' loss in benefits will be made up in wages. Are there any empirical studies which prove this to be the case?*

A number of studies (such as those cited in the February, 1994 CBO report on the Clinton plan) have found that mandated increases in employer-provided benefits translate into wage reductions of similar magnitude. Thus, one may reasonably infer that a decline in employer insurance coverage, as would be induced by a cap on the deductibility or excludability of insurance premiums, will lead to higher wages, other things being equal.

Even assuming a portion of the lost benefits are returned to the employee, would the employee be able to purchase the lost benefits on the open market for the same price his employer was paying as part of group coverage?

This will depend on how benefits are reduced. The important distinction is between a loss of coverage and an increase in the share of medical expenses employees must pay for themselves. While employees may not be able to purchase insurance on the terms available to their employer, they can certainly buy medical services. For example, if an employer reacts to a tax cap and reduces the cost of insurance by increasing deductibles and copayments, this does not, in any way, reduce the employee's access to insurance. Indeed, current policies that shield employees from all or nearly all medical expenses provide far more than insurance against adverse outcomes. They fuel the excess demand for medical services and the resulting high cost of health care that is at the center of the U.S. health care crisis.

2. *If tax caps are linked to the average cost plan and vary by area or region, would this add administrative complexity for business? Would this be exacerbated if the company had employees in different states and in different health alliances or health care coverage areas?*

Varying tax caps are more complicated than a single tax cap, but businesses already deal with regional differences in living costs in setting salaries, and must pay taxes in different states according to quite different formulas. This particular problem does not strike me as very serious, in the context of designing a national health care plan.

Answers to Senator Riegle

If there was not an employer mandate, could changes in the tax treatment of benefits and administrative complexity impact an employer's willingness to offer health insurance?

Yes, although the quantitative effect would depend on the exact changes being introduced.

What about small companies who are on the margin between offering or not offering insurance? Would this be a factor in their decision to offer insurance to their employees?

Again, it is impossible to say how important a factor this would be without considering a concrete change in taxation or administrative complexity.

3. *Having a different tax cap in what could be hundreds of regions in the country, while not impossible, will be administratively complex for business and the government. Assuming that we have a tax cap on the employer deductions and employee exclusions, what types of problems would the IRS have with tax compliance? How difficult a task will it be to insure that each employer and every individual pay exactly what they should? What type of resources do you think the IRS would need if we were to insure a reasonable level of compliance?*

The difficulty of enforcement would depend on how much we seek to vary the rules by individual location. This represents one argument for limiting the extent to which we try to accomplish such regional variation in the tax rules.

PREPARED STATEMENT OF PEGGY CONNERTON

Mr. Chairman, members of the committee, I am Peggy Connerton, Director of Public Policy for the Service Employees International Union, AFL-CIO, CLC. Thank you for this opportunity to testify on behalf of the Service Employees International Union on the issue of the tax treatment of health care benefits.

The current tax treatment of benefits is a long standing policy of the federal government that was designed to encourage the growth of employer-provided insurance. The labor movement in the United States played a key role in the spread of employer-provided insurance in the years after the second World War. Today, 39 percent of insured private sector workers are union members.

Because of rapidly rising costs and the growing number of uninsured individuals, our system of voluntary employer-provided coverage is in crisis. Rising costs have often forced our members to forgo wage increases and improvements in other benefits to maintain health insurance coverage for themselves and their families. Our members have also faced greater out-of-pocket costs and declining choices as employers have tried to restrict where and when they can see their family doctors.

As it considers a variety of reform proposals, one of the most difficult questions that Congress must grapple with is how to pay for coverage for the nation's 39 million uninsured. Some of the proposals being considered would raise revenue by taxing all or part of the value of employer-provided health insurance. The current tax treatment of health benefits is worth roughly $74 billion a year to taxpayers.

Capturing the full $74 billion, however, is virtually impossible. Few supporters of taxing health benefits are willing to argue for the total elimination of either the tax deduction for employers, or the tax exclusion for individuals. Instead, they argue for a tax on "excess" health benefits by "capping" either the deduction and/or the exclusion. Senator Breaux's Managed Competition Act, for example, would limit the employer deduction to the price of the lowest cost plan in an employer's area. Senator Chafee's Health Equity and Access Reform Today Act would limit both the employer deduction and the individual exclusion to the average of the lowest-priced half of plans in the area. Both bills would require that all insurers offer a standard package of benefits, although neither bill states what such a package would include.

How much revenue is raised by a tax cap depends heavily on a number of factors. A more generous standard benefits package means that fewer individuals will be affected by the cap and less revenue will be raised. The revenue generated will also depend on whether the cap is adjusted to take into account regional variations in the cost of health care, or for variations attributable to age or gender.

The revenue potential of taxing health benefits is particularly attractive to those members of Congress who support universal coverage, but fear the political and economic consequences of requiring all employers to contribute to the cost of their workers' health insurance. Those consequences, however, have been wildly exaggerated by opponents of reform. Under the

Health Security Act, for example, federal subsidies would reduce the cost to 15 cents an hour for small employers with minimum wage workers.

Other supporters of taxing health benefits are more interested in encouraging families to change their behavior than in raising revenue. They have argued that taxing some portion of employer-provided health benefits would not only raise additional revenue, it would also force employers and employees to shop for more "efficient" health plans. Over time, the movement of workers into these plans is meant to slow the rate of growth in national health care spending.

SEIU is strongly opposed to the taxation of employer-provided health insurance benefits, as is the AFL-CIO and all of organized labor. The cost of comprehensive reform must be shared fairly among workers, businesses and taxpayers. Taxing health benefits instead of requiring all employers to contribute makes those with insurance pay even more while letting employers who pay nothing go scot-free. There is also no evidence that taxing health benefits will control national health care spending. Taxing benefits will simply impose additional cost burdens on the middle-class families who most need relief from health care inflation.

The taxation of benefits is likely to generate such opposition that the entire reform effort could be placed in jeopardy. In an effort to curry favor with small businesses opposed to reform, Congress risks losing the support of hard-pressed middle-income families and large businesses who have been among reform's strongest supporters.

Taxing Health Benefits Would Hit Middle Class Families

In order to assess the impact of taxing health benefits on working families, the Service Employees International Union, AFL-CIO, CLC asked Lewin-VHI, a nationally respected health benefits consulting firm, to study this issue. The SEIU/Lewin-VHI study[1], released on April 12, focused on the tax provisions of the Managed Competition Act, which was introduced into the Senate by Senator John Breaux (D-LA) and into the House by Representative Jim Cooper (D-TN).

The Managed Competition Act is seen as the most politically feasible of the various bills that would tax health benefits because it limits only the business deduction and leaves the individual exclusion untouched. Other proposals, such as Senator Chafee's bill, would limit the individual exclusion, which would have an even more dramatic impact on workers.

The Managed Competition Act would limit the employer deduction for health benefits to the price of the lowest cost standard benefit package in their region. Because the Managed Competition Act does not define a benefit package, the study assumes two possible standard benefits packages: a standard option plan, based on the Blue Cross/Blue Shield standard option for federal employees, and a low option plan, similar to the Blue Cross Small Group Program that is targeted at the small business market. The low option plan has higher cost sharing than the standard option and does not cover prescription drugs or dental care.

Supporters of the Managed Competition Act have argued that it will only affect a minority of workers with so-called Cadillac plans, such as union members and manufacturing workers. The SEIU/Lewin-VHI study revealed, however, that a health benefits tax that has any revenue potential will affect a majority of currently insured workers. Depending on which of the two standard benefits packages defined above is used, between one-half and three-quarters of currently insured workers would be affected.

The SEIU/Lewin-VHI results also show that a health benefits tax will affect workers in all private industries, not just manufacturing. Insured nonunion workers are hit just as hard as union workers.

How much workers lose depends on how they respond to the new tax. There are three principal ways that employers and workers can respond. Employers can continue to provide their current level of health benefits, in which case they will reduce future pay increases (essentially cutting workers' wages) in order to compensate for the tax. Alternatively, employers can reduce their premium contributions to avoid the tax and pass on the savings to workers as higher wages, which would be subject to taxation. Workers then have two choices. They can pay higher premiums in order to maintain their current coverage or they can switch into a cheaper health plan and pay for uncovered services out of their pockets.

Because the Managed Competition Act levies the tax on employers, they would be the ones initially affected, at a cost of between $6.7 and $17.8 billion in additional taxes. However, most economists believe that employers will respond by shifting the burden of any tax that increases labor costs to workers in the form of smaller wage increases or reductions in benefits. In the short term, however, the impact on employers will be quite dramatic.

Depending on how employers and workers choose to respond to the tax and how the standard benefit package is defined, workers lose between $195 and $476 dollars per year, on average--for a loss of $1,137 to $2,773 between now and the year 2000. Collectively, working families would lose between $34 and $128 billion between now and the year 2000.

The SEIU/Lewin-VHI study also found that most of the cost of a health benefits tax is borne by families in the middle of the income distribution. Families with earnings between $20,000 and $75,000 pay roughly two-thirds or more of the costs generated by the tax.

As dramatic as these figures are, the impact on middle class families would likely be far worse if policymakers decided also to limit the individual exclusion for employer-provided insurance in addition to imposing a limit on the employer deduction.

Taxing Health Benefits Would Be Regressive

Supporters of taxing employer-provided health insurance have argued that the current tax treatment of such insurance is "regressive" because the tax exclusion is of much greater value

to higher-income families who face higher tax rates. In its recent report on this subject, the Congressional Budget Office found that the tax exclusion for health insurance is worth about $500 a year to families earning between $20,000 and $30,000, and $1,590 for those earning between $75,000 to $100,000.

However, measured as a share of income, the benefits of the exclusion are spread relatively evenly across the income distribution. The CBO's report showed that the average benefit was a consistent 2.2 to 2.3 percent of income for families with income of $20,000 to $100,000, and drops to 1.6 percent of income for families with incomes between $100,000 and $200,000. Since a "regressive" tax is one where the average tax (i.e., the total tax paid divided by total income) falls as income rises, there seems to be little justification for calling the present tax treatment of health benefits regressive.

More importantly, there is evidence that eliminating or limiting the tax exclusion for health insurance benefits *would* be regressive, in that lower-income families with insurance would pay more tax as a share of income than high-income families. This is because employers make equal contributions for health insurance for a janitor and the CEO. Since the CEO makes much more money, a policy that reduces the benefit of the tax exclusion doesn't affect him as much as it does the janitor.

For example, assume a CEO makes $200,000 a year and a janitor makes $20,000 a year. Each has employer-paid health insurance worth $5,000 a year. If they were required to pay taxes on that amount, the CEO would be taxed at a rate of 39.6 percent, or $1,980 and the janitor would be taxed at a rate of 15 percent, or $750. While the CEO pays more in dollar terms, the janitor pays more tax as a percentage of his income, 3.8 percent to the CEO's one percent.

In 1992 the Employee Benefit Research Institute examined the impact of capping the tax exclusion for employer-provided health benefits at $1,080 for individual plans and $2,940 for family plans.[2] As a share of family income, families earning below $20,000 a year paid *9 to 10 times* more in new taxes than families earning above $200,000 a year.

The recently released SEIU/Lewin-VHI study cited above, which studied the Managed Competition Act, found that the cost of limiting the employer deduction would be shifted to workers in the form of lower wages, higher premium payments, and higher payroll and income taxes. Families earning between $20,000 and $30,000 a year could pay nearly twice as much, as a share of their income, than families earning over $100,000. The regressivity of the Managed Competition Act is offset, to some extent, for families earning below $20,000 by premium and cost-sharing subsidies.

One alternative to a tax cap would be a progressive phase-out of the tax exclusion. As outlined in a recent *Wall Street Journal*[3] article, such a phase-out would begin with individuals earning $40,000 a year or more. The exclusion would be reduced as income rose, until it was finally eliminated at incomes of $70,000 a year or so.

While this proposal would be less regressive than a traditional tax cap, there are still significant problems with it. It raises dramatically less revenue than a traditional tax cap because it excludes roughly half of the taxpaying population. Those who believe that taxing benefits would help control health care costs would also be unhappy with this proposal because millions of consumers would face no incentive to change their behavior.

Taxing Health Benefits Will Not Control Health Care Costs

Taxing health benefits will force working families to pay more. But will it help to control health care costs? Advocates of managed competition would say "yes" because they believe that limiting the tax-deductibility of health benefits would encourage businesses and workers to become more cost conscious and switch to less costly managed care plans and use fewer health care services. Over time, this movement into more efficient plans is meant to reduce the rate of increase in national health spending.

There seems to be little evidence for this position. The Lewin-VHI study cited above found that taxing health benefits, even if the tax is levied on the employer, puts working families in a no-win situation--they fare badly no matter how they adjust to limits on the tax-deductibility of health benefits. Moving to cheaper health plans costs working families more, as does keeping their current coverage. The choices for working families are not between winning or losing, but rather minimizing their losses.

According to the SEIU/Lewin-VHI estimates of net losses, the best way for working families to minimize their losses is *to remain in their current health plan*, have their employers pay the tax penalty on existing coverage, and accept a reduction in future pay as a result.

Even where employers lower their premium contributions to avoid the tax, the burden on working families is roughly the same whether they stay with their existing coverage or switch to the lowest cost plan. Most consumers, except low-income families, are unlikely to switch health plans in response to such minor price differences when noneconomic factors such as location, access to top hospitals, freedom of choice of providers and the need to change providers when moving between managed care plans are factored in.

If consumers do not switch health plans, then, even by its supporters own assumptions, a managed competition approach will not succeed in slowing the rate of growth in health care costs. That is not to say that a health benefits tax could not be made sufficiently punitive to encourage consumers to move en-masse to less generous plans. The real question is whether such a strategy would make a significant dent in national health care spending.

The answer is almost certainly "no." A recent RAND Corporation study looked at two options that are even harsher than the one proposed under the Managed Competition Act. The first would impose an even stiffer tax cap (i.e., set at 80 percent of the lowest cost plan rather than 100 percent under the Managed Competition Act) and treating any excess premiums as

taxable personal income. The second would eliminate the tax exclusion entirely. Even under these scenarios, overall health spending was reduced by only 2 to 4 percent, and much of that comes from the reduced demand for services from the roughly 91,000 to 500,000 families who become uninsured as a result of these policies.[4]

The results of the SEIU/Lewin-VHI and RAND studies suggest that the entire premise underlying managed competition, i.e., that cost unconscious consumers are the principal force driving medical price inflation, is flawed. Taxing health benefits is a blame-the-consumer approach suggesting that the solution to consumers paying too much is to charge them more. The problem with this view is that, in most cases, consumers don't make the costly medical decisions--providers do.[5] Consumers who need expensive medical procedures and tests tend to be extremely sick and in no position to shop around. In any given year, the sickest five percent of the population accounts for well over half of total health expenditures.[6]

Trying to cut costs by reducing coverage or increasing cost-sharing for excess services may be a self-defeating strategy. Many of the benefits defined as excessive under a managed competition approach, such as coverage for prescription drugs, dental care, and mental health services, have been proven to be cost-effective.

Prescription drug coverage, for example, can avoid costly invasive surgery and lead patients and doctors to select the most cost-effective care. Pre-paid plans, such as Health Maintenance Organizations, have found that covering primary and preventive care encourages early treatment and prevention, reducing the need for more costly expenditures down the road.

If the ultimate point of taxing health benefits is to get consumers to be more cost sensitive, then it is almost certainly unnecessary. Consumers have become very conscious of the rising cost of health care and its impact on their family budgets, as employers shifted costs to workers in the 198.. Yet, there is no credible evidence that greater consumer sensitivity to prices has helped to control health costs. In fact, the rate of growth in health spending accelerated during the 1980s.[7] The average American family now pays 25 percent of total medical expenses out-of-pocket--spending over $4,296 in 1991 on premium payments, out-of-pocket healthcare expenses, and health-related taxes.[8]

Taxing Health Benefits Would Impose Large Administrative Burdens

Capping or eliminating the tax exclusion would be much harder to administer than the current unlimited exclusion. Employers would be required to measure and report the value of the premiums they had paid on behalf of each employee. Employees would have to include as taxable income either the entire amount of the premium or the amount above the cap. Adding a few lines to the W-2 form may seem quite easy, but with 75 million forms affected, the cumulative administrative costs could be considerable.

Many union members are employed by self-insured employers, who may find it difficult to determine premiums for their employees. Currently, employers that self-insure do not have to calculate or report health insurance premiums for each employee: they simply deduct the total cost of health benefits as a cost of doing business. Tax caps, however, would require uniform reporting of the premiums paid on behalf of each employee.

Before the Congress moves to impose these kinds of burdens on self-insured employers, it should recall the fate of former Internal Revenue Code Section 89, which established non-discrimination rules for employee benefits. Section 89 was enacted as part of the Tax Reform Act of 1986, but was repealed in 1989 after many employers objected strongly to the complexity of the regulations and the administrative burdens that they imposed.

Part of the reason for the complexity was the need to define in a uniform manner the contributions of employers to premiums for each employee. Employers objected to the need to identify which employees had single coverage and which had family coverage. Typically, employers knew the total number of employees with each type of coverage, but not the specific type chosen by particular employees.

The administrative complexity involved in capping the exclusion for health benefits is compounded if the tax cap is varied regionally, as has been proposed. How will individuals in a given region determine what their tax cap is for that year? Will the IRS be responsible for collecting the information from each region and publishing it in the tax manual? If not, who will be responsible for informing taxpayers of this information? If the cap is adjusted for age and region, as proposed in the Managed Competition Act, what kind of burdens will be imposed on employers operating in multiple regions with workforces of different average age in each location? The questions are nearly endless.

One alternative to the complexity of regional tax caps would be a single national tax cap. While this policy would be easier to administer, it is also much less fair. A fixed cap would penalize individuals living in high cost states, such as New York or California, because their premiums would be much more likely to be above the cap. A fixed cap would also penalize early retirees and less healthy individuals, who already have difficulties in obtaining insurance, because their premiums are usually above average as well.

Conclusion

There are a number of conclusions that can be drawn from the SEIU/Lewin VHI study and from the other available research. The first, and most important conclusion, is that there is no way to design a health benefits tax that does not hurt middle-income families. As the SEIU/Lewin-VHI study clearly shows, even if the health benefits tax is levied only on employers, they will either reduce their premium contributions to avoid the tax (in which case workers pay through higher premiums, out-of-pocket payments and taxes) or they will pay the tax, but cut workers' wages to compensate. Either way, it is workers, not employers, who end

up footing the bill.

Another important point is that the negative impact of taxing health benefits will *not* be confined to a small number of well-off individuals with Cadillac benefits. The impact will be spread across all industries and income levels.

Policymakers should also realize that eliminating either the tax exclusion or the tax deduction for health benefits would have a regressive impact, with low- and moderate-income families paying much more as a share of their income than high-income families. While providing subsidies to low-income individuals can mitigate this problem, it cannot eliminate it.

Taxing health benefits will also force Congress to make difficult tradeoffs between the needs of low-income and middle-income families. In order to make reform more affordable, especially the cost of providing subsidies to low-income families and small businesses, Congress may opt for a smaller benefits package. However, a less generous benefits package will increase the net losses imposed on middle-income families if benefits are taxed.

Finally, there is little evidence that taxing health benefits will do what many of its supporters claim it will do: control health care costs. Taxing the health benefits of workers who have surrendered wage increases to maintain their health insurance coverage adds insult to injury.

The costs of taxing health benefits, both political and economic, are high. Middle-class families have seen their health care costs continue to rise as their wages have stagnated or even fallen. They are paying more than their fair share already. Does it make either political or economic sense to impose additional burdens on them while employers who do not provide health insurance to their workers are asked to contribute nothing?

Any attempt to reduce the burden on middle class families, by progressively phasing out the exclusion for example, only strengthens the case against taxing health benefits. Such a change would reduce the amount of revenue raised and eliminate any possibility that taxing benefits would have a significant impact on health care costs.

Congress should also be wary of embracing policies that seem to favor small businesses at the expense of larger ones. Taxing health benefits without requiring all employers to contribute to their employees' health insurance costs amounts to a transfer of resources from large firms to small firms. While the principal concern of many large businesses has been establishing control over the rate of increase in costs rather than achieving absolute savings, policies that impose large short-term costs, such as limiting the employer deduction, or impose long-term administrative burdens could well destroy the support for reform among the nation's larger businesses. In recent weeks, significant business opposition to taxing health benefits has been voiced by groups such as the Corporate Coalition for Health Care Reform, which includes Allied-Signal, Boeing, Dupont, General Electric, IBM, and 20 other major U.S. corporations.

Given the clear costs and uncertain benefits involved in the taxation of employer-provided health insurance, Congress should consider alternative ways of financing universal coverage that do not penalize the majority of working families. SEIU, the AFL-CIO, and all of organized labor support broad-based financing based on ability to pay, including, but not limited to, a requirement that all employers contribute to the cost of their employee's health insurance.

ENDNOTES

1. Service Employees International Union, *Hammering the Middle Class: The Economic Impact of Taxing Health Benefits*, April 1994.

2. Employee Benefit Research Institute, *Health Care Reform: Tradeoffs and Implications*, EBRI Issue Brief Number 125, April 1992.

3. David Rogers, "Republicans Find Progressive Religion in Push to Tax Worker Health Benefits," *Wall Street Journal*, April 20, 1994.

4. M. Susan Marquis and Joan L. Buchanan, "How Will Changes in Health Insurance Tax Policy and Employer Health Plan Contributions Affect Access to Health Care and Health Care Costs?" *Journal of the American Medical Association*, Vol. 271., No. 12, March 23/30, 1994.

5. See Thomas H. Rice and Roberta J. Labelle, "Do Physicians Induce Demand for Medical Services," *Journal of Health Politics*, Policy and Law, Vol. 14, No. 3, Fall 1989, for a review of the literature on this topic.

6. Marc L. Berk and Alan C. Monheit, "The Concentration Of Health Expenditures: An Update," *Health Affairs*, Winter 1992.

7. The Congressional Budget Office acknowledges that the exploding rate of increase in health spending during the 1980s cannot be blamed on tax policy. A change in the tax treatment of health benefits would at most have a one-time effect on the level of health spending. For more information, see the recent CBO report, *The Tax Treatment of Employment-Based Health Insurance*, March 1994.

8. Data from the 1987 National Medical Expenditures Survey and Families USA, *Health Spending: The Growing Threat to the Family Budget*, December 1991.

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Questions for the Panel

1. If an employer's ability to deduct health care benefits is restricted resulting in the limitation of employee benefits, economic theory may say that the employees loss in benefits will be made up in wages. Are there any empirical studies which prove this to be the case?

The bargaining experience of SEIU and other unions has been that we frequently must settle for lower wage increases in order to preserve current benefits.

Even assuming a portion of the lost benefit are returned to the employee, would the employee be able to purchase the lost benefits on the open market for the same price his employee was paying as part of group coverage?

Generally, individuals will pay more when purchasing coverage individually than as part of a group. They will also pay income and payroll taxes on the added income.

2. If tax caps are linked to the average cost plan and vary by area or region, would this add administrative complexity for business? Would this be exacerbated if the company had employees in different states and in different health alliances or health care coverage area?

Varying the tax caps by region would increase administrative complexity for businesses. Currently, self insured employers do not have to calculate or report their total annual or per-worker cost for their employee's health insurance; they simply deduct the cost of health benefits as a cost of doing business. Tax caps would require uniform reporting of the premiums paid on behalf of each employee. Employers objected to Section 89 because it required them to

identify which employees had single courage and which had family coverage. Varying caps by region would force multi-state employers to calculate different premiums for different subsets of employees.

Currently, employers do not link an employee's health benefits information with tax records. Employer objection to doing so led to the repeal of Section 89 as well as, more recently, the decision by the Clinton Administration to support an amendment to delay employer reporting of similar information to the Medicare/Medicaid Databank.

If there was not an employer mandate could changes in the tax treatment of benefits and administrative complexity impact an employer's willingness to offer health insurance?

The administrative costs related to enrollment and disenrollment are a problem for employers with high - turnover work forces. Increasing the administrative costs could discourage these employers from offering insurance.

What about small companies who are on the margin between offering or not offering insurance, would this be a factor in their decision to offer insurance to their employees?

For firms with high turnover work forces, it could be an important factor.

Having a different tax cap in what could be hundreds of regions in the country while not impossible, will be administratively complex for business and the government. Assuming that we have a tax cap on the employer deductions and employee exclusions, what types of problems would the IRS have with tax compliance? How difficult a task will it be to insure that each employer and every individual pay exactly what they should? What type of resources do you think the IRS would need if we were to insure a reasonable level of compliance?

The IRS would need to verify the coverage status (single or family), benefit package and value of benefits for each employee. As with (repealed) Section 89, the IRS would have define very precise uniform reporting rules for how per-employee premiums must be calculated by self-insured employers.

Questions For Peggy Connerton

1. Do you think your members or working Americans generally will support a tax on excessive health benefits?

   Absolutely not. The household budgets of working Americans are suffering because of healthcare costs. The benefits tax would only increase their costs.

   "Excessive" health benefits are largely a myth. First-dollar coverage with unrestricted choice is a rarity. Some companies have high per-employee costs because they cover early retirees and/or have older work forces.

2. What does your report show about the cost containment potential of the Managed Care Act?

   Our report shows that switching into lower coverage plans - which is presumably what leads to cost savings - is not the only possible response of workers to the benefits tax on employers. Many people would prefer to keep the coverage they have by paying (or having their employer pay) the extra premium costs. However, the alleged cost containment benefits appear when people switch plans. Furthermore, to the extent that the basic plan has less generous coverage (in addition to more restricted choice) costs are only shifted onto families instead of being controlled.

3. According to your report, does the middle class end up paying a disproportionate share of the tax?

   Yes. Families earning between $20,000 and $75,000 end up paying two-thirds up to 80 percent or more of the total cost of a benefits tax. Lowest income workers would be hit hardest - with losses of up to 4.3 percent of income.

4. Could you explain why you chose the standardized benefits package you assumed for purpose of the estimation?

   The study examined two basic packages. One, the "standard option", is based on the Blue Cross/Blue Shield standard option that federal employees, including members of Congress, enjoy. The other, or "low option", package is based on the Blue Cross Small Group Program developed for the small business market in Virginia. It was designed to be more affordable for employers. It is likely that the independent commission would select a package somewhere in between. In its analysis of an earlier version of the Managed Competition Act (H.R. 5936, 102nd Congress), the CBO assumed that the independent commission would set a benefit package without prescription drugs, dental care or mental health -- very similar to the reports low option plan. The point in the study is that the revenues raised to help low-income individuals buy coverage is highly sensitive to the level of benefits so the independent commission can not establish the basic benefits package in isolation. The affordability of the package to employers and the ability to raise revenues (and hence provide subsidies) are all closely interrelated.

PREPARED STATEMENT OF M. CARR FERGUSON

The following statement represents the individual view of members of the Section of Taxation who prepared it and does not represent the position of the American Bar Association or the Section of Taxation. This statement was prepared by Elaine K. Church, Thomas A. Jorgensen, Richard E. May, Judith F. Mazo, Susan P. Serota and Thomas D. Terry.

Although many of these members of the Section of Taxation who participated in the preparation of the statement necessarily have clients affected by federal taxation, including the federal tax rules applied in the subject area addressed by the statement, no such member (or the firm of such member) has been engaged by a client with respect to the specific subject matter of the statement.

I am M. Carr Ferguson, New York, New York. These views are presented on behalf of individual members of the Section of Taxation of the American Bar Association. They have not been approved by the House of Delegates or the Board of Governors of the ABA and should not be construed as representing the position of the ABA or the Section of Taxation unless clearly stated.

We have been studying many alternative health care reform proposals, including the Administration's proposal. For purposes of these hearings, however, we have focused on the salient tax policy issues raised by the Administration's and other managed competition proposals which impose a cap on the exclusion for gross income of employer provided health care benefits. We plan to provide the Congressional tax writing committees more detailed comments on various proposals, as they are considered by Congressional committees and will provide comments to the Committee on medical spending accounts shortly.

OVERVIEW

The array of health care reform proposals Congress must consider call for a re-examination of several fundamental tax policies that underlie the current health care system. The existing system, in large part an employment-based system, includes a number of tax subsidies having a significant revenue effect. The exclusion of employer contributions toward health benefits from an employee's income and employment taxes would be subject to new limits under the Administration's proposal. Limitations are also included in other managed competition proposals including the Cooper-Breaux and Chafee bills. Another subsidy that allows employees to contribute toward health care benefits on a pre-tax basis under a cafeteria plan would be limited as well.

While issues such as those mentioned above require Congress to re-examine tax policies underlying the existing system, other aspects of health care reform, and the Administration's proposal in particular, raise entirely new tax policy issues as well. For example, the Administration's proposal would provide a federal subsidy for early retirees, i.e., retirees who are not otherwise eligible for Medicare. Under the proposal, many employers would be able to shift their

liabilities for retiree health benefits to Regional Health Alliances. Some of these employers have been funding retiree health benefits through tax-favored arrangements such as Code section 401(h) accounts and VEBA's qualified under Code section 501(c)(9). This raises questions about the disposition of assets in existing, tax-favored accounts.

A. LIMITING THE EXCLUSIONS FROM INDIVIDUAL INCOME AND/OR EMPLOYMENT TAXES

The health care proposals introduced and to be introduced will raise other tax and health policy issues. Nevertheless, the major proposals probably will be based on the premise that the existing employment-based system produces unacceptable revenue costs from both a health and a tax perspective.

Historically, the tax subsidies that exist under the current system have been justified on the assumptions that society as a whole benefits if there is widespread medical benefits coverage, and that employers are more efficient purchasers or coverage than individual employees. Over the years, however, as coverage (and associated revenue costs) have increased, many health and tax policy analysts have begun to question the efficacy of the increasingly expensive tax subsidies. For example, some health economists argue that current tax expenditures lead to higher spending on health care, because such subsidies disguise the real cost of care. In addition, economists are concerned that the unlimited exclusion encourages the purchase of health insurance not worth its full cost, i.e., that tax subsidies encourage employees to buy more generous health plans than workers would purchase themselves with after-tax dollars. Finally, many economists are concerned that generous health insurance plans lead to higher health spending. Making individuals and families bear a greater portion of the cost for additional use of health services, these economists suggest, would make us more cost-conscious in choosing health insurance plans and in using health services.

Questions have also been raised about equal tax treatment for covered employees and other taxpayers. Tax policy generally attempts to provide equivalent benefits to similarly situated individuals. Thus, in theory, two similarly situated individual taxpayers with equal health expenditures should receive equal tax subsidies. The present law scheme does not reflect these tax policy goals. Instead, the availability of the $70 billion subsidy reflected by the present tax exclusion for employer-provided benefits varies based on:

- whether the taxpayer is an employee,
- if the taxpayer is an employee, whether the employer provides medical benefits,

- if the taxpayer is employee by an employer who provides medical benefits, the value of such benefits, and
- the taxpayer's marginal tax rate.

These horizontal and vertical disparities have long been controversial. See, e.g., the 1990 Treasury Report Financing Health and Long-Term Care. Many proponents argue that it is appropriate to moderate them by limiting or capping the relevant exclusions.

Opponents of this proposal note that capping the relevant exclusions will have a regressive impact (i.e., that tax costs associated with, or tax revenues raised by, any cap, if measured as a percentage of income, will be borne disproportionately by lower-income individuals). Conceptually, this is not surprising. If measured as a percentage of income, the benefits provided by the present law unlimited exclusion are weighted in favor of middle income individuals.

Some analysts have concluded that the exclusion of the employer's contributions may actually be progressive because the cost of providing health coverage does not vary by income and as income tax rate differentials under TRA 86 became flatter, the exclusion became more progressive. OBRA 83 did not significantly change this [EBRI 147(3/94)].

Opponents of capping the exclusion further note that horizontal equity issues should be completely or largely resolved if other aspects of health care reform successfully spread employer-based health care coverage.

Tax and health policy concerns regarding the appropriateness or level of tax exclusions are exacerbated by the provision of additional benefits through employer-sponsored "cafeteria" arrangements. These arrangements permit employees to pay their share of premium costs, (plus health plan deductibles and employee co-payments) on a pre-tax basis. From a tax policy perspective, these arrangements produce the same disparate treatment (regressive or progressive depending upon your point of view) as the exclusion for employer-provided benefits generally.

We believe that a limit on employer-paid premiums for supplemental coverage such as the one included in the Administration's proposal will create practical problems in implementation, since it will require identification of the value of each employee's medical benefits. This entails significantly greater administrative difficulties than present law. Under present law, because the exclusion is unlimited, the employer has no obligation to break down the aggregate value of employer medical benefits on an individual basis. If the exclusion were limited, however, the employer would have to be able to quantify each employee's benefits.

Moreover, absent specific changes to the present law wage withholding system, employers would be required to maintain and update this information on a per-payroll-period basis.[1/] This occurs because the employer is required not only to report total income on an annual basis (usually on Form W-2) but also to withhold income and employment taxes ratably during the year. Thus, where the exclusion for medical benefits is limited, the employer will be unable properly to withhold income and employment taxes unless per employee costs can be determined.

1. Valuation Issues -- For Employee Cost

To implement any proposed limit, such as on supplemental coverage under the Administration's proposal, an employer will need to know the value of the medical benefit plan coverage provided to each covered employee. Assuming that the employer can retrieve the data necessary to identify the type and level of coverage selected by each employee, the employer will need the ability to value such coverage (again, absent a specific provision to the contrary) on a per-payroll-period basis. Numerous issues arise. Many apply equally to insured and self-insured arrangements; other are uniquely applicable to various self-insured arrangements.

The threshold task is establishing the per-employee value of benefits. Even in the simplest situation (i.e, a fully insured arrangement, where costs are defined as the employer premium), there typically is no per-employee cost determination. Rather, the insurer sets a premium that reflects application of underwriting principles to a specified group of employees. Moreover, where a group policy exists, the value of health coverage often will be greater than for comparable individual coverage. This is addressed under the Administration's proposal by requiring inclusion of the average cost of providing supplemental coverage. However, since the actual value of the coverage will differ based on different age, utilization or health status of any one employee. By taking average cost, the inclusion will be creating intra-employee subsidies which perhaps should be reported as taxable income to some. In addition, if covered employees are geographically dispersed, premiums may average out the geographically different real costs of coverage.

On the other hand, if a more accurate assessment of cost were determined, we believe that a number of other issues would be raised. For example:

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1. Some of these difficulties could be mitigated if employers were permitted (or required) to adopt an irregular withholding method for nonexcludable medical benefits (e.g., one annual filing). However, these alternative approaches present their own difficulties, discussed below. Thus, the remainder of this discussion assumes compliance with the generally applicable wage withholding structure.

- Where premiums blend costs for single and family coverage, how is the employer to allocate costs among employees?
- For those who elect family coverage, will the employer be permitted or required to allocate premiums based on the number of covered dependents (e.g., self plus one, self plus two, etc.)?
- If an employer operates in different geographical areas, how should premiums be allocated among covered employees? (Will the employer be permitted or required to calculate premiums separately for employees in lower or higher cost areas? Does the answer depend on whether the insurer calculates premiums based on blended costs?)

Once these issues are resolved initially, another series of questions arises with respect to the necessity and frequency of required updates. Premiums can change during a calendar year for a variety of reasons. At the insurer level, this could occur if the policy period were less than 12 months (6 months is becoming increasingly common) or if the policy year is a non-calendar fiscal year. At the employee level, this could occur as a result of a personal event such as a death, divorce, marriage, birth, adoption, or attainment of majority, or through changes in coverage (e.g., moving between a covered and non-covered division; moving between full and part-time employment; or taking advantage of open season to change benefits).

2. Valuation Issues -- Self Insured Plans

For employers maintaining self-insured (i.e., self-funded) plans Congress must face not only the issues noted above but also concerns relating to the cost structure of such plans. If a self-insured plan, there is no "premium" calculation that reflects the value of coverage. Rather, the sponsoring employer tracks actual costs, which may vary significantly from year-to-year, reflecting actual plan experience. If there is a limit on the employees' exclusion, the employer will be required to develop valuation and allocation mechanisms.

In determining per-participant costs, a threshold issue is whether the employer should start with total costs (i.e., actual current year disbursements) or calculate an imputed premium reflecting the value of the coverage. Presumably, actual cost calculations should be inappropriate because of their volatility (due to their direct dependence on current year experience which may not be representative of ongoing costs) and their impact (which taxes most heavily those who have incurred the greatest medical costs either because they are sickest or because their treatment is the most expensive). To avoid this result, Congress might provide for "imputed premium" value for the available package of medical benefits.

If an actual cost approach is permitted or required, the next series of issues involve the treatment of indirect costs. For example, will the employer be permitted or required to take plan administrative costs into account (because such costs would, of course, be included in the premiums charged by an insurer under a fully insured plan)? Similarly, will the employer be permitted to take the costs of implementing the limit into account (because, again, such costs will be included in insurance premiums)?

In addition, because few self-funded arrangements are fully self-insured, issues arise related to stop-loss coverage. If the actual cost approach is used, will the employer be permitted or required to take stop-loss or reinsurance premiums into account? Or are such amounts to be disregarded, because they do not provide medical benefits but merely limit the employer's risk?

Finally, a variety of issues relate to various intra-group subsidies. If the actual cost approach is used, will the employer be permitted or required to eliminate demographic cross subsidies? Geographic differences? Utilization adjustments? (i.e., Should the per-participant cost be an individually rated cost or a smoothed (community rated) average cost?)

Congress has previously confronted the difficulties of valuation of welfare benefits and the difficulties inherent in valuation played a role in the repeal of section 89 of the Internal Revenue Code.

B. SPECIAL RULES FOR RETIREES

While Medicare typically provides primary coverage for elderly Americans, many retirees receive supplemental coverage through employer-paid medical plans. In addition, for those who retire before attaining age 65 and becoming eligible for Medicare, employer-paid coverage is often the only available medical coverage. These benefits can be quite expensive, as many employers noted when, for the first time in 1993, new financial accounting rules required them to recognize such liabilities.[2]

The Administration's proposal would shift much of the liability of employers for these benefits to Health Alliances. This early retiree health liability relief raises issues of fairness. Clearly there may be windfalls for employers liable for retiree health coverage. However, at the same time, there are many employers who had not been providing retiree medical

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2. Financial accounting statement (FAS) 106, which became effective for fiscal years beginning after December 31, 1992, requires employers to accrue liabilities for post-retirement welfare benefits ratably over an employee's active years of service.

coverage for whom there will be no additional assessment. Moreover, there may be a substantial question whether a legal liability exists for retiree health coverage from which an employer could be relieved. Where a current liability does exist, will an employer recognize taxable income upon the satisfaction of its liability under health care reform? Also, some employers had scheduled cutbacks in retiree health benefits, but because of the look back to earlier periods for determining liability, there may be greater than anticipated liability for these employers.

Another issue which must be addressed is what to do with reserves that have been accumulated to cover retiree health obligations in the event it becomes unnecessary to pay benefits due to the shifting of liabilities to a Health Alliance. It might seem fair to permit these assets to be used to provide other benefits for employees including the use of a Code section 401(h) reserve for the payment of pension benefits. If such use is permitted, legislation should clarify that it will not trigger any income or excise tax on deemed reversions to employers.

CONCLUSION

This is only a brief summary of some of the more salient aspects of the tax policy underlying the tax treatment of employer provided health coverage. As of the time this statement was being prepared, there were at least seven major bills introduced on health care reform and Senator Mitchell had recently announced additional alternatives. We intend to file additional comments to address many of the tax issues raised by these proposals and would be pleased to meet with the Committee staff to discuss any of the financing or employee benefit related provisions.

M. Carr Ferguson

EXECUTIVE SUMMARY

TESTIMONY OF M. CARR FERGUSON

The testimony of M. Carr Ferguson on behalf of individual members of the American Bar Association Section of Taxation will focus on the proposed limitation on the exclusion from federal income and employment taxes of employer-based health insurance.

The testimony identifies various tax policy and substantive and technical issues which arise under the proposed limitation on the exclusion from federal income and employment taxes of employer provided health coverage contained in the Administration's proposal as well as other national health care reform proposals. These issues include:

(1) the significant revenue effect of the tax subsidy;

(2) the creation of administrative complexity by a limitation on the exclusion;

(3) valuation issues arising from the need to determine individual employee costs;

(4) valuation issues arising under self-insured plans;

(5) special rules regarding provision of health coverage for retirees.

The testimony identifies the competing arguments regarding the limitation of the exclusion, raises issues relating to valuing health care coverage under insured and self-insured arrangements (similar to the problems of valuation inherent in section 89 of the Internal Revenue Code which was repealed by Congress due, in part, to the complexity of the valuation issues), and requests Congress to consider these issues as it deliberates the tax provisions in the health reform legislation.

Limitation of the exclusion of employer-based health insurance form an employee's income and employment taxes will require Congress to re-examine tax policies underlying the existing system. Other aspects of health care reform, e.g. the Administration's proposal regarding retiree health care, raise entirely new tax policy issues. Numerous issues arise due to the proposed shift in these liabilities, including the need to address those arrangements which employers have adopted to fund these liabilities and which currently receive tax-favored treatment.

Legislation should be carefully drafted to address these and other tax issues raised by the health care reform proposals.

SUPPLEMENTAL STATEMENT OF M. CARR FERGUSON

before the

FINANCE COMMITTEE

U.S. SENATE

on

TAX TREATMENT OF EMPLOYER-BASED HEALTH INSURANCE

May 10, 1994

The following statement represents the individual view of Elaine K. Church, Taina E. Edlund, Thomas A. Jorgensen, Richard E. May, Judith F. Mazo, Susan P. Serota and Thomas D. Terry.

Although many of these individuals have clients affected by federal taxation, including the federal tax rules applied in the subject area addressed by the statement, no such individual (or the firm of such individual) has been engaged by a client with respect to the specific subject matter of the statement.

SUPPLEMENTAL STATEMENT OF M. CARR FERGUSON

INTRODUCTION

Following is a supplemental statement on medical savings accounts which I indicated would be provided to the members of the Committee during my testimony on April 26, 1994 at the Hearing of the Finance Committee of the U.S. Senate on Tax Treatment of Employer-Based Health Insurance.

OVERVIEW

In the course of studying the many alternative health care proposals, we have identified and examined components of these proposals that re-examine the fundamental tax policies that underlie the current health care system. Two of the proposals--the Nickles-Stearns bill (S.1743, H.R.3698) and the Chafee bill (H.R.3704)--introduce medical savings accounts ("MSAs") as an integral component to the delivery of tax-favored health benefits. In addition, under the Cooper-Breaux bill (S.1579, H.R.3222), the Health Standards Commission is directed to consider MSAs as a cost sharing mechanism.

The Nickles-Stearns bill would replace the current scheme of individual exclusions for employer-provided health insurance and itemized deductions for health care expenses with a system of individual tax credits and MSAs. Employers would continue to be able to deduct the cost of employer provided health insurance as a compensation expense. While generally similar to the Nickles-Stearns proposal, the Chafee bill would permit the individual to take a deduction (rather than a tax credit) for cash contributions that he or she makes to an MSA for his her own benefit or that of a spouse or dependent. Under both proposals an MSA may be established with either a bank acting as trustee or with an insurance company, as part of a health plan.

Under the Nickles-Stearns bill, only those accounts established exclusively for the purposes of paying "qualified medical expenses" would qualify as MSAs. Qualified medical expenses would include amounts paid by an individual for premiums for a federally qualified health insurance plan and unreimbursed medical expenses of the individual, his or her spouse and any dependent. The Nickles-Stearns bill would limit cash contributions to $3,000 on behalf of an individual and an additional $500 for each dependent (which dollar limits would be annually indexed for inflation). Contributions made between January 1 and April 15 may be applied toward either the current

or previous tax year of the individual. Under the bill, contributing individuals would be allowed a tax credit equal to 25% of the contribution (unreduced by subsequent disbursements for qualified medical expenses) unless the individual is a beneficiary of another MSA.

The Chafee bill would permit individuals and employers to contribute to an MSA on behalf of an individual covered under a catastrophic health plan. The amount of the deduction and, therefore, the allowable contribution would be limited to the excess of

> the average annual premium cost of the lowest priced 1/2 of standard packages of qualified health plans offered that year in the health care coverage area of the plan in which the individual is enrolled, over
>
> the sum of (i) the aggregate amount paid by or on behalf of the individual as a premium for a catastrophic health plan covering the eligible individual for the taxable year, plus (ii) the aggregate amount contributed to the MSA by persons other than the individual.

No deduction would be allowed if the individual, spouse or dependent is the beneficiary of another MSA. Moreover, the amount of an individual's itemized deduction for medical expense is reduced by MSA distributions used to pay medical expenses.

To ensure that MSA funds are disbursed for medical benefits, the bill would impose penalties if payment is made for deductibles, copayments or coinsurance under the catastrophic health plan or Medicare (a "mandatory distribution expense") incurred by an MSA beneficiary, and the person making the payment is not reimbursed by a payment from the MSA before 60 days. Finally, MSA contributions made by an employer on behalf of an employee are not subject to employment taxes.

A. TAXATION ISSUES

Under both the Nickles-Stearns and Chafee bills, as in the case of an individual retirement account ("IRA"), the earnings on contributions to an MSA would not be taxed. Similarly, and in contrast to the year end forfeiture requirements applicable to unused amounts contributed to a cafeteria plan, the bills would permit amounts contributed to an MSA to accumulate from year to year. MSAs may also accept rollover contributions from other MSAs. If, however, amounts contributed to an MSA are withdrawn and used for purposes other than the payment of medical expenses, such amounts would be included in taxable income and would also be subject to a 10% excise tax (50%, under the Chafee proposal, if after such distribution, the MSA balance is less than the deductible of the catastrophic plan covering the individual). If contributions in excess of the dollar limits (plus any earnings thereon) are

returned prior to the due date of the individual's tax return (including extensions), the return of such contributions would not be treated as a distribution that is includable in income. Under the Nickles-Stearns bill, such returned excess amounts are only excludable from income if no tax credit is allowed respecting the excess amount. Excess contributions that are not so returned also would be subject to a 6% excise tax.

Like an IRA, an MSA may lose its tax exemption if an individual engages in certain prohibited transactions involving the MSA. In such instance the fair market value of the MSA as of the beginning of the taxable year would be treated as a taxable distribution as of that date. Likewise, if any portion of the MSA is pledged as collateral for a loan, such amount would be treated as a taxable distribution. In addition, certain other reporting, trusteeship, nonforfeitability and minimum required distribution requirements applicable to IRAs would also apply to MSAs. An MSA also would be subject to unrelated business income tax provisions applicable to charitable organizations.

Because MSAs share many of the characteristics of IRAs issues and concerns similar to those raised by the allowance of individual tax deductions for contributions to an IRA are presented in the consideration of MSAs. Whether individuals are permitted a deduction or partial tax credit for contributions made to MSAs, revenue loss will be associated with the implementation of MSAs.[1/] Moreover, it is likely that individual contributions to MSAs will be made primarily by a limited group of higher income individuals who have a level of disposable income that permits the segregation of funds for a single purpose. Whether employers make contributions to MSAs will depend on the interaction between dollar limits on MSA contributions, employer deductions and employee exclusions from gross income of employer-provided health insurance. For example, under the Nickles-Stearns proposal, while the employer may deduct a contribution to an MSA as a compensation expense, additional compensation dedicated to a single purpose may be a benefit of limited value to lower paid employees.

B. ADMINISTRATIVE ISSUES

Significant administrative burdens may be involved in ensuring that distributions from MSAs are used to pay, or reimburse, for qualifying medical expenses. These burdens will be magnified if parties unaccustomed to reviewing medical claims, such as bank trustees, are required to determine whether payments qualify as medical expenses. Moreover, under the Chafee

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1. While potential revenue loss under the Nickles-Stearns proposal may be offset by the elimination of the individual itemized deduction for medical expenses, the extent of such offset, if any, is unclear due to the current 7 1/2 percent of adjusted gross income floor.

proposal, an MSA trustee (or an insurance company acting as such) generally may not accept amounts in excess of the deductible limit. However, the deductible limit in the case of each individual may be determined with reference to the value of health care packages in his or her coverage area and the premium cost of the catastrophic plan covering that individual. Further, if such premiums are for employer-provided coverage under the self-insured plan, valuation questions arise in establishing premium cost. Such information must be available annually to the MSA trustee. Thus, the administrative burdens of the trustee are further increased.

Another approach would be to only require the trustee of an MSA to issue an annual information return reporting the amount distributed from the MSA during the year to the taxpayer and the Internal Revenue Service. The taxpayer would then be required to show these amounts on the income tax return and subtract qualifying medical expense payments. In addition, to further strengthen compliance, trustees of MSAs could be precluded from making distributions from the accounts unless the taxpayer filed a certification with the trustee that the withdrawals were for qualifying medical expenses. This system would leave the burden of compliance on the individual taxpayer rather than the trustees. Of course, this system would present some difficult enforcement problems for the Internal Revenue Service.

In addition, unless coupled with extremely high health insurance deductibles, MSAs do not foster the containment of health insurance costs since virtually all large medical expenses will remain insured. Thus, if all deductibles, copayments and coinsurance can be paid from an MSA, in effect, individuals with MSAs will receive tax subsidized coverage for the first dollar of medical expenses incurred, especially in cases where all MSA contributions are made by the employer.

Questions for the Panel

1. If an employer's ability to deduct health care benefits is restricted resulting in the limitation of employee benefits, economic theory may say that the employees loss in benefits will be made up in wages. Are there any empirical studies which prove this to be the case?

   Even assuming a portion of the lost benefit are returned to the employee, would the employee be able to purchase the lost benefits on the open market for the same price his employee was paying as part of group coverage?

2. If tax caps are linked to the average cost plan and vary by area or region, would this add administrative complexity for business? Would this be exacerbated if the company had employees in different states and in different health alliances or health care coverage area?

   If there was not an employer mandate could changes in the tax treatment of benefits and administrative complexity impact an employers willingness to offer health insurance?

   What about small companies who are on the margin between offering or not offering insurance, would this be a factor in their decision to offer insurance to their employees?

3. Having a different tax cap in what could be hundreds of regions in the country while not impossible, will be administratively complex for business and the government. Assuming that we have a tax cap on the employer deductions and employee exclusions, what types of problems would the IRS have with tax compliance? How difficult a task will it be to insure that each employer and every individual pay exactly what they should? What type of resources do you think the IRS would need if we were to insure a reasonable level of compliance?

RESPONSES BY M. CARR FERGUSON TO QUESTIONS PROPOSED BY SENATOR RIEGEL RELATING TO SENATE COMMITTEE ON FINANCE HEARINGS ON "TAX TREATMENT OF EMPLOYER-BASED HEALTH INSURANCE" ON APRIL 26, 1994

1. Although there has been discussion of the economic theory that employees' loss in benefits due to limits on the employer's deduction will be made up in wages, I am not aware of any empirical studies addressing the issue. I have no information on the cost of obtaining "lost benefits" on a single versus group coverage basis.

2. In response to your question concerning the additional administrative complexity if tax caps are linked to coverage plan cost or vary by area or region, I believe that any time a cap is linked to a per employee cost, administrative issues will arise. This is due to the need to determine the value of each employee's medical coverage, which will be true even if the cap is imposed only on "excess medical coverage."

Where an employer has employees in different health alliances, differences in availability and cost of service may add additional administrative complexity. Given the wide range in costs, geographical or regional adjustments are appropriate and it would be important to address the mechanics of an adjustment system. Whether administrative

complexity will be added is dependent upon the approach taken under the tax cap i.e., will the employee's medical coverage to be taxed be calculated on a per employee basis, will it take into account family status, age, etc. Furthermore, it will depend upon whether tax caps will be set on a state-by-state basis or with respect to metropolitan statistical areas or with respect to each Health Alliance on the basis of the geographical area served by that organization. It will also depend on whether the geographical areas so set are coincident with those used by a particular employer where such employer determines cost of medical coverage on a geographical basis.

3. Assuming that a tax cap is imposed on employer deductions and employee exclusions, the ability of an employer to comply and the need for (and the ability of) the Internal Revenue Service efforts to enforce such tax caps depends upon the complexity of the tax structure. As I noted in my testimony, simplicity may conflict with tax or health policy goals. With respect to tax caps on employee exclusions, it will be necessary to gather data on a current employee basis including the need to ascertain at a minimum (i) whether the employee was covered by one or more employer provided medical plans; (ii) if covered under one or more plans, for each plan whether the employee elected single or family coverage; (iii) for each plan under which employee elected family coverage, the number of covered dependents;

and (iv) separately for each plan, the cost of the coverage selected and the relevant cap. In addition, if coverage changes during the year (whether due to marriage, divorce, birth, death or a voluntary change in coverage), how the employee coverage data is to incorporate those changes. To the extent that the data issues are exacerbated by existing payroll systems, it may be possible to reduce the burden by ultimately imposing deferred reporting and withholding schemes. For example, it is theoretically possible to permit less significant current withholding provided all required amounts are corrected on an annual basis (for example, see IRS Announcement 85-55 and 85-113 relating to certain fringe benefits). However, it should be noted that employers whose health plans have a fiscal plan year other than the calendar year may have more administrative difficulty in gathering and reporting data if tax caps on employee exclusion of health care coverage are measured by the coverage received during the calendar year.

As I stated in my testimony, there will be additional administrative costs both within the Internal Revenue Service and in every employment organization for identifying the taxable portions of benefits. I am concerned about imposing a superstructure of regulations which will take years to work out and which may result in the same failure as Section 89 of the Internal Revenue Code which was ultimately repealed three years after it was enacted.

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

Scheduled for a Hearing
Before the
SENATE COMMITTEE ON FINANCE
on April 26, 1994

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Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

April 26, 1994

Advance Copy
JCS-3-94

CONTENTS

INTRODUCTION

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

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

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

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

I. BACKGROUND AND OVERVIEW

A. Tax Incentives for the Purchase of Health Care

1. Present law

In general

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

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

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

Exclusion from income for employer-provided health care

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

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

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

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

Itemized deduction for medical expenses

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

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

Deduction for health insurance expenses of self-employed individuals

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

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

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

Employer deduction for employee health care

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

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

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

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

B. Summary of Proposals

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

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

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

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

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

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

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

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

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

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

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

II. PRESENT LAW

A. Exclusion for Employer-Provided Accident or Health Coverage

In general, employer contributions to an accident or health plan are excludable from an employee's income (sec. 106[4]). This exclusion for employer-provided health coverage also generally applies to coverage provided to former employees and to the spouses or dependents of employees or former employees. In the case of a self-insured medical reimbursement plan, the exclusion is conditioned on the coverage being provided under a plan meeting certain nondiscrimination requirements (sec. 105(h)). Insured health plans generally are not subject to nondiscrimination rules. Similarly, employer-provided accident or health coverage generally is excludable from wages for employment tax purposes without regard to whether the coverage is provided on a nondiscriminatory basis (sec. 3121(a)(2)).

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

B. Itemized Deduction for Medical Expenses

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

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

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

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

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

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

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

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

D. Cafeteria Plans

In general

Compensation generally is includible in gross income when actually or constructively received. An amount is constructively received by an individual if it is made available to the individual or the individual has an election to receive the amount. Under one exception to the general principle of

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

constructive receipt, no amount is included in the gross income of a participant in a cafeteria plan described in section 125 of the Code solely because, under the plan, the participant may elect among cash and certain nontaxable qualified benefits.

In general, a qualified benefit is one of certain benefits that are excludable from an employee's gross income by reason of a specific provision of the Code. Thus, employer-provided accident or health coverage, group-term life insurance coverage, and benefits under dependent care assistance programs may be provided through a cafeteria plan.

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

The cafeteria plan exception from the principle of constructive receipt generally also applies for employment tax purposes.

Nondiscrimination rules

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

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

E. Flexible Spending Arrangements

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

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

There is no special exclusion for benefits provided under a FSA. Thus, benefits provided under a FSA are excludable from income only if there is a specific exclusion for the benefits in the Code (e.g., the exclusion for employer-provided health or group-term life insurance coverage). FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)). According to proposed Treasury regulations, a cafeteria plan offers deferred compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.[6] Thus, amounts in an employee's FSA that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the "use it or lose it" rule.

In addition, proposed Treasury regulations contain additional requirements that health FSAs must comply with in order for the coverage and benefits provided under the FSA to be excludable from income.[7] These rules apply with respect to a health FSA without regard to whether the health FSA is provided through a cafeteria plan.

The proposed regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.[8]

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

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

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

Under the proposed regulations, the employer-provided health coverage under the FSA and the reimbursements and other benefits received under the health FSA will be excludable from an employee's income only if the health FSA satisfies certain additional requirements. According to the proposed regulations, health FSAs are required to: (1) provide the maximum amount of reimbursement available under the FSA at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage); (2) offer coverage for 12 months or, in the case of a short plan year, the entire short plan year; (3) only reimburse medical expenses as defined for purposes of the itemized deduction for medical care expenses (sec. 213); (4) reimburse only those medical expenses for which the participant provides a written statement from an independent third party stating the amount of the medical expense and that the medical expense has not been reimbursed or is not reimbursable under any other health plan; (5) reimburse only those medical expenses that are incurred during the participant's period of coverage; and (6) allocate experience gains with respect to a year of coverage among premium payers on a reasonable and uniform basis.[9]

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

III. DISCUSSION OF ISSUES

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

A. Achieve Income Tax Policy Goals

1. Proper measurement of income

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Equity among taxpayers

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

Horizonal equity

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

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

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

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

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

Vertical equity

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

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

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

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

3. Raise revenue

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

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

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

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

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

B. Achieve Health Care Policy Goals

1. Expand health care coverage

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

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

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

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

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

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

2. Control health care costs

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

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

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

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

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

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

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

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

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

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

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

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

C. Coordinate Federal Tax and Health Policy Laws

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

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

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

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

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

D. Other Issues

1. Regional impact

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

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

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

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

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

2. Administrative issues

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

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

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

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

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

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

IV. DESCRIPTION OF BILLS

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

1. In general

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

2. Exclusion for employer-provided accident or health coverage

In general

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

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

Comprehensive health coverage

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

Cost-sharing

Employer contributions for cost-sharing amounts (e.g., deductibles, copayments and coinsurance), including employer contributions for coverage under a cost-sharing policy, would

also be excludable from income and wages. Under the bill, a cost-sharing policy would be defined to include a health insurance policy or health insurance plan which provides coverage for deductibles, coinsurance, and copayments imposed under the comprehensive benefit package, whether imposed under a higher cost-sharing plan or with respect to out-of-network providers.[20] The bill would also require cost-sharing policies to satisfy certain standards.[21]

Permitted coverage

Under the bill, other permitted coverage that would qualify for the present-law exclusion would include (1) coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury, (2) coverage providing payment for permanent injuries of an employee, his or her spouse or a dependent that is computed with reference to the nature of the injury without regard to the period the employee is absent from work (i.e., coverage for payments described in sec. 105(c)), (3) coverage provided to an employee or former employee after such employee has attained age 65 unless such coverage is provided by reason of the current employment of the individual with the employer providing the coverage, (4) coverage under a qualified long-term care policy (as defined under the bill), (5) coverage provided under Federal law to veterans or any member of the Armed Forces of the United States and their spouses and dependents, and (6) any other employer-provided coverage which the Secretary of the Treasury determines should be excludable.

Cafeteria plans

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

Flexible spending arrangements (FSAs)

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

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

[21] Section 1423 of the Health Security Act.

accident or health coverage, except that the limits would have an earlier effective date. Thus, coverage provided through an FSA would be excludable from income only to the extent it is within the bill's limits, i.e., health coverage provided through an FSA under a cafeteria plan would be excludable from gross income only if the coverage constitutes wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

For this purpose, an FSA would be defined as a benefit program that provides employees with coverage under which specified expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for such coverage is less than 200 percent of the value of such coverage. In the case of an insured plan, the maximum amount reasonably available would be determined on the basis of the underlying coverage.

Supplemental health coverage

In general, under the bill, any health benefits that are not provided under the comprehensive benefit package would be considered supplemental health benefits and would not be excludable from income and wages. Under the bill, a supplemental health benefit policy would be defined to include an insurance policy or health benefit plan that provides coverage for services and items not included in the comprehensive benefit package or coverage for items and services included in the package but not covered because of a limitation in amount, duration, or scope.[22] The bill would also require supplemental health benefit policies to satisfy certain standards.[23]

Valuation rules

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

Tax treatment of rebates

Under the bill, employers would be permitted to pay any portion of the employee's share of premiums for a health plan. If

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

[23] Section 1422 of the Health Security Act.

an employer pays part of an employee's premium, it must make the same dollar payment to all employees with the same family status in the same health alliance. If the total employer contribution (mandatory and voluntary) for the employee's coverage exceeds the annual premium of the employee's health plan, the employer would be required to pay to the employee a cash rebate equal to the excess.[24] The rebate would be taxable to the employee for both income and employment tax purposes. For example, suppose an employer pays 100 percent of the total premium regardless of which plan the employee chooses. In such a case, because the bill would require the employer to make the same dollar payment to all employees, employees who do not choose the most expensive plan would receive a cash rebate equal to the difference between the employee premium for the most expensive plan selected by any employee and the employee premium for the plan selected by the employee. On the other hand, no rebates would occur if the employer pays 100 percent of the employee premium for the least expensive plan available to employees.

The bill would provide an exception to the general principle of constructive receipt for cash rebates. Under the bill, no amount would be included in the gross income of an employee solely because the employee could have selected coverage under a health plan which results in a cash rebate. That is, only cash rebates actually received are includible in income.

Effective date

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

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

In general

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

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

deduction is effective.

Limits on 100-percent deduction

The bill would provide a deduction for up to 100 percent of the amount paid for health insurance by a self-employed individual, but only to the extent that the health insurance constitutes comprehensive health coverage as described in the bill and is purchased from a qualified alliance.

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

Similar to the 25-percent deduction under prior law, a self-employed individual would not be permitted to claim the 100-percent deduction on amounts paid to purchase comprehensive health coverage during any month in which the individual was employed on a full-time basis by an employer. For purposes of this provision, an individual would be considered employed on a full-time basis if employed by an employer for at least 120 hours in a month. The bill would provide for the establishment of rules by the National Health Board for determining an employee's hours of employment including rules for determining the hours of employment of salaried and commissioned employees.

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

Effective date

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

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

1. In general

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

2. Excise tax on excess employer health plan expenses

In general

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

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

Definition of health plan expenses

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

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

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

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

Definition of excess health plan expenses

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

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

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

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

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

Effective date

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

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

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

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

Effective date.--The provision relating to the 100-percent deduction would be effective for taxable years beginning after December 31, 1994. The 25-percent deduction would be extended effective for taxable years beginning after December 31, 1993, and would expire on the date the 100-percent deduction becomes effective.[26]

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

4. Deduction for health plan premium expenses of individuals

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

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

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

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

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

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self-employed individuals during 1994.

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

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

date.

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

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

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

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

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

1. In general

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

2. Limit on exclusion for employer-provided health care

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

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

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

3. Limits on deduction of health plan expenses

Employer deductions

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

Self-employed health deduction

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

Individual deductions for qualified health plan premiums

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

governmental agencies).

Effective date

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

4. Medical savings accounts

Eligibility

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

Deduction limit

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

Definition of medical savings account

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

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

Medical savings accounts would be exempt from tax.

Definition of medical expenses

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

Taxation of distributions

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

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

Effective date

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

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

1. In general

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

2. Refundable health care expenses tax credit

Amount of tax credit

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

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

individual.

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

Definition of medical care

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

Advance payment of health care expenses tax credit

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

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

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

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

Effective date

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

3. Medical savings accounts

In general

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

Definition of medical savings account

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

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

Medical savings accounts would be exempt from tax.

Taxation of distributions

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

Effective date

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

SUMMARY COMPARISON OF SELECTED PROVISIONS IN S. 1757, S. 1775, S. 1579, S. 1770, AND S. 1743 RELATING TO THE TAX TREATMENT OF HEALTH CARE

Scheduled for a Hearing

Before the

SENATE COMMITTEE ON FINANCE

on April 26, 1994

Prepared by the Staff

of the

JOINT COMMITTEE ON TAXATION

April 26, 1994

JCX-4-94

Item	Present Law	S. 1757(Mitchell) S. 1775(Moynihan)	S. 1579 (Breaux)	S. 1770 (Chafee)	S. 1743 (Nickles)
1. Exclusion for employer-provided health care	Employer-provided health care is excluded from income and payroll taxes. There is no limit on the exclusion.	The exclusion applies only with respect to the comprehensive benefit package provided under the bill, including coverage of cost-sharing amounts. Supplemental coverage is includible in income. Health care cannot be provided under a cafeteria plan.	The bill retains the present-law exclusion for employer-provided health benefits and extends it to amounts paid by a partnership or a subchapter S corporation for health care for its partners or shareholder-employees.	The exclusion applies only to the extent the cost of the coverage does not exceed the cost of the average premium for the lowest priced one-half of standard benefit packages available in the health care coverage area (the "applicable dollar limit"). Separate limits apply for each class of enrollment based on the age of the principal enrollee.	The exclusion for employer-provided health care is repealed.
2. Employer deduction	Businesses can deduct employer-provided health care as a business expense.	Retains present law.	Retains present law.	The employer deduction for employer-provided health care for any employee is limited to the applicable dollar limit for the employee.	Retains present law.
3. Excise tax on employer-provided health care	No provision.	Retains present law.	The bill imposes a 34 percent excise tax on employers with excess health expenses. Excess health expenses include all health plan expenses that are not attributable to coverage under an accountable health plan (AHP). In addition, expenses attributable to coverage under an AHP are excess health expenses (1) if the employer's contribution is not uniform for a premium class regardless of which plan is selected, (2) if, in the case of an employer with 100 or few employees, the employer contribution is not made for coverage through a health plan purchasing cooperative (HPPC), and (3) to the extent	Retains present law.	Retains present law.

Item	Present Law	S. 1757(Mitchell) S. 1775(Moynihan)	S. 1579 (Breaux)	S. 1770 (Chafee)	S. 1743 (Nickles)
			the expenses for a particular employee exceed the employee's reference premium rate. The reference premium rate is the lowest premium for a plan offered in the HPPC area for the individual's premium class. The bill extends the 25-percent deduction through 1994. (A drafting change may be needed to accomplish this intent.) For 1995 and subsequent years, the bill provides a permanent deduction for 100 percent of the cost of coverage under an AHP to the extent the expenses do not exceed the reference premium rate for the individual.		
4. Deduction for health insurance expenses of self-employed individuals	Present law does not have a special deduction for the health insurance expenses of self-employed individuals. However, prior to January 1, 1994, self-employed individuals could deduct 25 percent of the cost of health insurance expenses for themselves and their spouses and dependents.	After the provisions of the health care reform portions of the bill are effective, the bill provides a permanent deduction for self-employed individuals of up to 100 percent of the cost of the comprehensive benefit package. The deductible percentage for self-employed individuals who do not pay 100 percent of the weighted average premium (as determined under the bill) for each of their employees would be reduced to the lowest percentage paid by the individual for the health coverage of any of its employees. The 25-percent deduction continues until the 100 percent deduction becomes effective.		After the health care reform provisions of the bill are effective, the bill provides a permanent 100-percent deduction for the cost of coverage purchased from a qualified health plan, up to the applicable dollar limit. The bill extends the 25-percent deduction until the 100-percent deduction becomes effective.	Retains present law. (A drafting change may be needed to accomplish this intent.)

Item	Present Law	S. 1757(Mitchell) S. 1775(Moynihan)	S. 1579 (Breaux)	S. 1770 (Chafee)	S. 1743 (Nickles)
5. Individual deduction for medical expenses	Individuals who itemize deductions may deduct amounts paid during the year for medical care of the taxpayer, and the taxpayer's spouse and dependents, to the extent the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income.	Retains present law.	The bill permits individuals to deduct from gross income the cost of coverage under an AHP up to the reference premium rate for the individual. The amount deductible is reduced by amounts paid by any other entity for such coverage (e.g., an employer or governmental entity). The present-law rules continue to apply to other medical expenses.	The bill permits individuals to deduct from gross income the cost of coverage under a qualified health plan up to the applicable dollar limit for the individual. The amount deductible is reduced by amounts paid by any other entity for such coverage. The present-law rules continue to apply to other medical expenses.	The bill repeals the itemized medical expense deduction.
6. Tax credit for health care expenses	No provision.	No provision.	No provision.	No provision.	The bill provides a refundable tax credit for persons enrolled in a federally qualified health insurance plan for health insurance premiums and other medical care. The amount of the credit is the sum of (1) 25 percent of expenses that do not exceed 10 percent of adjusted gross income (AGI), (2) 50 percent of expenses that exceed 10 but not 20 percent of AGI, and 75 percent of expenses that exceed 20 percent of AGI. The credit can be obtained on an advance basis in a manner similar to the way in which the earned income tax credit is provided on an advance basis.

Item	Present Law	S. 1757(Mitchell) S. 1775(Moynihan)	S. 1579 (Breaux)	S. 1770 (Chafee)	S. 1743 (Nickles)
7. Medical savings accounts	No provision. However, present law provides taxpayers with some ability to pay for unreimbursed medical expenses on a tax-favored basis through flexible spending arrangements (FSAs) and individual retirement arrangements (IRAs) FSAs are reimbursement accounts or similar arrangements under which an employee can be reimbursed for health care expenses not covered by insurance. Amounts remaining in an FSA at the end of the year must be forfeited; they cannot be used for expenses in a subsequent year. Individuals can make deductible contributions to an IRA of up to $2,000 per year. Amounts withdrawn from an IRA can be used for any purpose, including to pay medical expenses. Amounts withdrawn from IRAs are includible in income and subject to an additional 10 percent excise tax if the withdrawal is made before age 59-1/2. The 10-percent additional tax does not apply to amounts that would be deductible medical expenses if the individual itemized deductions.	No provision.	No provision.	Individuals covered by a catastrophic health plan are permitted to deduct contributions to a medical savings account (MSA). The maximum deductible contribution is the excess of (1) the applicable dollar limit for the individual over (2) amounts paid by or on behalf of the individual for the catastrophic health plan. Amounts contributed to an MSA are not taxed until withdrawn. Withdrawals that are used for medical care are excluded from gross income. Withdrawals that are not used for medical are includible in gross income and are subject to additional taxes.	Individuals are permitted a nonrefundable tax credit equal to 25 percent of contributions to an MSA up to certain limits. The maximum tax credit is 25 percent of the sum of (1) $3,000 and (2) $500 for each dependent covered by the MSA. Amounts contributed to an MSA are not subject to tax until withdrawn. Withdrawals that are used for medical care are excluded from gross income. Withdrawals that are not used for medical care are includible in gross income and are subject to additional taxes.

PREPARED STATEMENT OF ROSEMARY D. MARCUSS

Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to present some of the analysis included in the recent Congressional Budget Office (CBO) study The Tax Treatment of Employment-Based Health Insurance. My testimony this morning will focus on the nature of the tax subsidy for employment-based health insurance and on issues raised by hypothetical limits, or caps, on the subsidy. I will also include issues raised by tax caps in the context of proposed reforms in the health insurance market.

I want to emphasize at the outset that my discussion pertains to only one aspect of the market for health care. It does not analyze any specific proposal to reform the health care market. Instead, it addresses the contribution that tax policy makes at present and might make in the future.

INTRODUCTION

As this Committee well knows, the exclusion from tax of employer contributions toward their employees' health insurance is an exception to the general tax policy principle that compensation should be taxable regardless of its form. Because compensation paid in the form of health insurance is not subject to income and payroll taxes, it receives an implicit tax subsidy compared with compensation paid in cash. The subsidy has the beneficial effect of cushioning workers against the high costs of health insurance and health care.

At the same time, it reduces incentives for workers and their employers to seek out the most cost-effective health insurance options. Therefore, the tax subsidy itself contributes to the high cost of health insurance.

I would like to make four key points about the subsidy:

- Employees pay for "employer-provided" health insurance through lower wages. Thus, a subsidy on employment-based health insurance directly translates into increased demand for insurance by employees.
- The tax subsidy provides uneven benefits: it helps those with employment-based insurance, but not those without; it lowers the labor costs of firms that can afford to provide the tax-free fringe benefit, but not those that cannot afford insurance.
- A limit, or cap, on the exclusion would provide incentives for cost containment by reducing the amount of insurance purchased and would reduce the unevenness of the present system, but could be hard to administer.
- The effect of a cap on those currently with and without insurance depends, in the short run, on how the revenue gained is spent and, in the long run, on how well the cap and accompanying market reforms can contain health care costs and maintain the quality of care.

HOW THE SUBSIDY WORKS

The exclusion from tax of employer contributions toward their employees' health insurance creates a price subsidy for health insurance. An employee who earns income in the form of health insurance avoids the income and payroll taxes that would be due if the compensation were paid in the form of cash. The additional compensation also escapes the employer's share of payroll taxes. As a result, the price of employment-based health insurance is reduced substantially by the tax savings—by an average of 26 percent in 1994.

If employers provided health insurance as a gift to their employees, then the tax exclusion might not matter much. A key point to understand, however, is that health insurance is not a gift, but something employees pay for with reduced wages. Even the most generous employer cannot for very long pay its employees more than the value of what they produce. Competitive pressures would force the employer either to reduce compensation or eventually go out of business. Thus, when an employer chooses to pay for health insurance, it has to reduce compensation in other forms. As the price of that health insurance increases, wage growth lags to compensate.

Because health insurance is costly and valued by many, competitive pressures drive employers to provide the insurance that their employees want and are willing to pay for with reduced wages. If an employer offered a mix of benefits and take-home pay that did not match the preferences of its employees, it would find that it was paying more to attract and keep employees than a competitor whose compensation mix more closely matched its employees' preferences. Competitive pressure also forces employers to act as the employees' agents in selecting appropriate health insurance.

In this context, the price subsidy resulting from the tax exclusion has two contradictory effects. The positive effect is that it encourages people to be insured. Employees demand health insurance from their employers in part because they have to pay only part of the cost. Employers, acting as their agents, thus have a strong incentive to provide insurance to their workers. The negative effect is that employees are much less sensitive to the price of health insurance than they would be if they had to pay full cost. Employers thus find that their employees resist efforts to control costs more than they would without a subsidy. For example, employees might prefer a fee-for-service health insurance plan with access to specialists on demand when the price of insurance is subsidized. Yet, when they have to pay the whole cost, they are more apt to choose a health maintenance organization (HMO) in which primary care physicians control access to specialists.

Comprehensive insurance also influences the choices people make when they get sick in ways that hinder efforts to control costs. Many drugs and treatments provide great benefits relative to their costs, but some do not. Because people with comprehensive insurance pay little or none of the costs of treatment, they may be more receptive to treatments of unproven efficacy or of high cost relative to the benefits they confer. Insurers try to control the demand for services of low value, but they can do so only if the premium savings they offer are worth the perceived costs to their customers. The tax exclusion leads employees to undervalue the savings in premiums and resist efforts by insurers to manage care aggressively to reduce cost.

WHO BENEFITS FROM THE PRESENT SUBSIDY?

Like any tax subsidy, the tax exclusion for employment-based health insurance affects people and businesses in different ways. People who are uninsured or who purchase their own insurance receive no benefit at all. Even among the insured, the benefits of the tax exclusion vary widely. As for businesses, the exclusion tends to lower labor costs of large firms relative to labor costs of small firms.

Horizontal Equity

A basic principle of tax policy—called horizontal equity—holds that people with the same ability to pay tax should pay the same amount of tax. Like other tax preferences, the tax exclusion violates this principle. People with employment-based health insurance pay less tax than do otherwise similar people without insurance. Self-employed people and those who are out of the work force receive no benefit from the tax exclusion. (Before 1994, the self-employed could deduct 25 percent of their premiums from taxable income.) People whose employers provide more expensive health insurance coverage receive a greater benefit than people with less generous coverage. People whose employers pay a larger share of their health insurance premiums receive a greater benefit than people whose employers pay a smaller share.

Coverage by employment-based health insurance varies widely within income groups (see Table 1 on page 22). For example, only 8 percent of families with yearly incomes below $10,000 receive health insurance at work. As incomes increase, more and more people are covered by employment-based insurance. Nevertheless, in every income group, significant minorities are not covered. Among families with incomes of more than $200,000 a year, the prevalence of employment-based insurance drops because a significant proportion of that group is made up of either self-employed people or those who are not employed.

Among insured people, employers' contributions for health insurance vary substantially within each income group. Some of the variation reflects different levels of generosity of health insurance coverage; some reflects differences in the share of premiums paid by employers. Furthermore, the cost of health insurance coverage varies substantially by region. Those differences arise from both variations in overall costs of living and variations in patterns of medical practice.

Vertical Equity

According to another principle of tax policy—called vertical equity—people with more ability to pay should pay more tax than those with less ability to pay. This principle has been applied to policies like the tax exclusion for health insurance, but the principle can be misleading when applied to only one component of tax law such as the tax exclusion. The reason is that the net distributional effect of any tax provision depends on how it is financed; that is, how it fits into the overall distribution of taxes.

Both the likelihood of being insured and the amount of the premiums from employment-based health insurance that are excluded from taxation increase with family income. The average premiums for families with income of less than $20,000 a year will be under $2,400 in 1994, whereas the average premiums for families with

income of more than $50,000 will be more than twice that amount (see Table 1). The differences in premiums reflect several factors. Higher-income families are more likely to be covered by multiple policies and to have family rather than self-only coverage. Lower-income families are more likely to have been employed for only part of the year and thus to be covered for only that part.

The average employer's share increases with income, but only slightly. It rises from about 83 percent for families with less than $10,000 of income to about 89 percent for families with income of more than $200,000. Because the income tax is progressive, the benefit of the tax exclusion is greatest for high-income people. Families in the lowest-income group receive an average income and payroll tax subsidy worth 11 percent of their premiums, compared with a subsidy of 33 percent of the premiums for the highest-income group.

However, for lower-income families who receive health insurance through their employers, the subsidy constitutes a larger share of their income than it does for higher-income families with such coverage. The average subsidy is almost 3 percent of after-tax income for low-income families who are covered by employment-based health insurance, compared with less than 1 percent for the highest-income families. As a result of differences in participation rates in health insurance, the average tax subsidy is roughly proportional to after-tax income for most of the population (with incomes between about $20,000 and $100,000).

Finally, one might want to target a subsidy toward lower-income households for reasons other than vertical equity. Low-income working people are the least likely to be insured, both because health insurance is unaffordable for them and because they know that they can receive free emergency care at hospitals if they need it. The tax exclusion, however, provides the greatest benefit to the higher-income households that would be most likely to obtain insurance even if the subsidy did not exist and relatively little benefit to low-income households.

Evenhanded Treatment of Business

An important objective of tax policy is to minimize distortions among firms and industries. The tax exclusion violates this principle in a subtle way. Because it subsidizes one form of compensation that only some firms can afford to provide, it lowers labor costs for those firms relative to other firms. Large firms can generally provide health insurance at much lower costs than small firms or individuals and would thus be likely to sponsor health insurance for their employees even if there were no subsidy. Small firms typically face much higher costs and, therefore, tend to pay all compensation in the form of cash or other fringe benefits. The tax subsidy for employment-based health insurance makes the compensation package of the large firm more attractive to most employees than the all-cash package offered by smaller firms, giving large firms an advantage in hiring. Even if a small firm decides to offer health insurance to its employees in response to their demand for the subsidized form of compensation, it is at a disadvantage relative to a large firm because it costs more for a small firm to offer the same amount of insurance coverage than a large firm.

The distortion in relative labor costs induced by the subsidy tends to help large firms at the expense of small ones. Furthermore, the net effect of the distortion is to lower economic productivity.

LONG-RUN EFFECTS

Over the long run, some of those who benefit from the tax exclusion may also bear some of its cost. The tax exclusion raises health care costs for everyone, including those who directly benefit from the subsidy. As a result, it exacerbates the problems of the uninsured and raises insurance costs for the insured. The revenue losses that result from the exclusion contribute to higher deficits, higher taxes, or reduced government services, which ultimately affect everyone. In sum, even the apparent beneficiaries of the tax exclusion might be better off eventually if the subsidy were curtailed.

TAX CAPS

A tax cap would reduce the tax subsidy for employment-based health insurance by limiting the premiums not subject to taxes. The limit would encourage employees and employers to choose more cost-effective health insurance while still retaining an incentive for employers to provide health insurance. Moreover, a tax cap would raise revenues that might be used to expand access to health care for those who are currently uninsured. Implementing a tax cap, however, would be difficult.

Employer Versus Employee Caps

Some current proposals for health care reform would limit the amount of health insurance premiums that employers could deduct from their corporate taxable income. Others would include in the taxable income of employees the portion of health insurance premiums that exceeds a cap. Another alternative is to impose an excise tax on premiums in excess of the cap. What difference does it make which option is adopted? What advantages are there to one approach versus another?

Under established tax policy, health insurance premiums are a component of employee compensation, just like cash wages, and thus constitute income to employees and a legitimate deductible business expense for employers. Nonetheless, each of the alternative cap mechanisms would help to constrain the amount of employment-based health insurance premiums. Imposing the cap on employers has some practical advantages. For example, because there are many fewer business returns than individual income tax returns, limiting the deduction for employers against their taxable income may reduce the costs of complying with the income tax compared with a limit at the individual level. An excise tax has an additional advantage: it would provide the same incentive to limit health insurance contributions for state and local governments and nonprofit businesses as it would for businesses that are subject to income tax.

Employer and employee caps can have similar effects on incentives and tax revenues over the long run, because all of the approaches provide an incentive for employers to reduce their contributions to the amount of the cap. For example, suppose that the cap on premiums was set at the average premium employers currently pay. Under either an employer or employee cap (or an excise tax near the level of individual and corporate tax rates), employers whose premiums were near the cap would have a strong incentive to seek out health insurance policies that could be purchased for the cap amount. Over time, lower premiums would be passed along to employees in the form of higher wages and other fringe benefits. Thus, any tax penalty on employers would not be binding for long. The taxable income of employees would increase by the same amount under all three tax options.

If the cap was set so low that most employees continued to demand insurance that costs more than the cap, the ultimate response of employers and employees would be more complex. The employer facing an excise tax or limit on deductibility could reduce its contribution to the level of the cap and increase wages by the difference in premium contributions; alternatively, the employer could pay the tax and reduce wages so that the overall after-tax cost of compensation was unchanged. The choice would depend on whether the average individual's rate for income and payroll taxes (net of the value of additional Social Security benefits) is more or less than the employer's tax imposed on excess premiums. If individuals would have to pay more in taxes than the firm, then the firm would tend to pay the penalty and pass the cost on to workers by reducing wages.

Fixed-Dollar Caps Versus Fixed-Benefit Caps

The simplest kind of cap to define would be in terms of fixed-dollar limits that might vary by type of coverage (self-only versus family, for example), but not by individual circumstances. Such a fixed cap would have a disproportionate effect on people who live in areas with higher-than-average medical costs or who work for small firms that face high premiums because of the poor health of employees or their families.

Alternatively, caps could be defined in terms of the cost of a fixed package of health insurance benefits. This approach could be implemented under a system of managed competition, but probably would be infeasible without such a structure. The trade-off in this case is that the health insurance purchasing cooperatives that would be set up in the managed competition model would be costly to operate and would remove control from individuals and firms over their health insurance, thereby diminishing their incentives to try to control costs.

"Pure" managed competition would channel all health insurance purchases through purchasing cooperatives. Under this hypothetical system, the tax cap would be set equal to the premium paid for the low-cost plan—covering a defined set of health benefits—offered through the cooperative. This approach has certain advantages. All taxpayers would be able to receive a tax subsidy on the same level of health insurance coverage. The choice among alternative plans and provider networks would be unsubsidized because any additional premiums above the low-cost plan would be paid out of after-tax dollars. Moreover, since the cooperative would negotiate all prices, it would be straightforward to determine the premium paid on behalf of each employee and to compare it with the relevant cap levels.

This approach has a cost: the structure of purchasing cooperatives requires a substantial amount of administrative apparatus, which adds to the overall cost of

health care. In addition, individual employers and their employees would lose much of their stake in the design and administration of health insurance since, with few exceptions, they would be so small that their own behavior would be insignificant to the premiums charged to the cooperative. Managed competition promises other savings, however, and it might well reduce the overall cost of health care.

Weighed against the administrative apparatus of a system of purchasing cooperatives is the administrative apparatus required by employers that manage their own health insurance systems. First of all, in today's health insurance market or any system in which some employers managed the insurance for their employees, setting caps that depend on the cost of a fixed set of benefits would be difficult at best. The Internal Revenue Service (IRS) would require information that is currently unavailable, such as accurate measures of regional variation in prices, and actuarial measures of the cost of a hypothetical package of health insurance benefits for each firm. Even if the cap levels were set as fixed dollar levels that varied only by the type of health insurance coverage, companies would have a strong incentive to try to characterize excess health insurance benefits as company overhead. They might also be inclined to reallocate them among different branches so as to minimize the amount that seems to exceed the cap. In turn, the IRS would have a very difficult job of trying to verify that health insurance benefits were accurately measured and allocated among enterprises in the firm.

Some variations of managed competition would combine purchasing cooperatives for smaller employers and individuals with management of health insurance outside the system by larger employers. The advantage of such an approach is that it allows large employers—who might be better able to control their own health care costs than would a purchasing cooperative—to manage their own health plans. The cost of this approach is that it retains the administrative apparatus of purchasing cooperatives for small firms and the inevitable problems of enforcement and compliance for larger firms.

Distributional Effects of an Illustrative Tax Cap

The Congressional Budget Office (CBO) has simulated a set of fixed-dollar caps to illustrate the nature and range of redistributive effects under a tax cap. The simulations assume the following limits on the amount of health insurance premiums that could be excluded from individuals' taxable income (for both income tax and payroll taxes): $4,000 for joint returns, $3,400 for head-of-household returns, and $1,600 for single returns. Those levels correspond roughly to the typical employer share of the premium for health insurance plans for different size families in 1994. For those families with less generous health insurance policies, the caps would have no immediate effect on their behavior. Those families with policies that exceeded the caps would have an incentive to demand less comprehensive health insurance over time.

Employers would have two possible responses to caps on the tax exclusion. They could scale back their health insurance premiums to the caps, in which case employees would gradually receive increases in taxable wages and other fringe benefits. Or they could continue to provide the same health insurance policies, in which case the portion of the premiums that exceeded the caps would be included in taxable income.

Except for a small amount of shifting of funds into other fringe benefits, the net effects on federal tax revenues of the two behavioral responses by employers would be nearly identical. Taxable income and the payroll tax base would increase in both instances by almost the same amount that current health insurance premiums exceeded the caps. (Taxable wages would not increase dollar for dollar because employers would have to pay Social Security taxes on the additional taxable wages. That increase in the employer payroll tax is assumed to be passed on to workers in the form of slightly lower wages.)

The illustrative caps would raise tax liabilities for 1994 by about $18.9 billion—$12.4 billion in income taxes and $6.4 billion in Social Security payroll taxes (see Table 2 on page 24). The average change in tax liability as a result of imposing the illustrative caps increases with income and goes from virtually no change in the lowest-income group to a $540 increase in the group with incomes between $100,000 and $200,000.

The increases in tax liability suggest that every income group would be worse off under tax caps, but that is a very misleading impression. The $18.9 billion of additional revenue could be used to make some people better off, but the exact distributional consequences would depend on how the additional revenues were used (see Table 2).

For example, if policymakers intended to limit only the incentive to overconsume health insurance, they could reduce taxes in such a way that, on average, each in-

come group would be unaffected. Thus, within each group, people without insurance or people whose insurance was below the caps would benefit relative to people with above-average insurance coverage. This approach would reduce the disparity in tax treatment between those with insurance and those without.

To illustrate the possible redistributive effects of such policies, suppose the additional revenues were spent so as to benefit all taxpayers equally. CBO simulated this option as a lump-sum rebate of $153 per nondependent tax return. Under this scenario, families with incomes of less than $10,000 would have an average net gain of $150, and the average family with income between $100,000 and $200,000 would lose $320 (see Table 3 on page 25). Families with employment-based insurance would pay about $7 billion more in taxes to the benefit of those without employment-based insurance.

As explained earlier, one of the objectives of tax policy is to treat people who start out in similar positions the same way. Tax caps advance this objective of horizontal equity if "positions" are measured in terms of income. With an unlimited tax exclusion, otherwise similar people can face much different tax liabilities based on how much their employers contribute toward their health insurance premiums, if at all. Imposing caps by itself reduces the variability of tax liability that the tax exclusion creates. Redistributing the additional revenues that the caps generate in favor of the uninsured and underinsured could reduce the inequity still further.

CONCLUSIONS

The present unlimited tax exclusion for employment-based health insurance has helped many people obtain health insurance, but it has also contributed to the high cost of health care by discouraging the purchase of cost-effective health insurance. The tax subsidy also provides uneven benefits, helping insured working people, but it provides no benefit to the uninsured and those who purchase their own insurance. It provides the largest subsidies to those who are most likely to obtain insurance even without a subsidy. And the subsidy is only valuable to those firms that can afford to sponsor health insurance for their employees, so it gives these firms an advantage in hiring employees compared with other firms.

A tax cap would heighten workers' consciousness of the cost of health insurance and is thus an important element of market-based approaches to control the cost of health care. Whether the cap is imposed on employers or on employees, employees will ultimately bear the cost of any cap and would have a similar incentive to reduce their spending on health insurance in either case. The revenues generated could also be used to advance other aims, such as reducing the number of people without insurance.

A tax cap could improve the functioning of the market for health care. But this improvement would entail costs: either in the form of administrative and compliance costs—if the cap is implemented completely through the tax system—or in the form of the costs of setting up and running a system of purchasing cooperatives. Moreover, tax caps that do not account for unavoidable differences in the cost of health care—for example, because of differences in health status or place of residence—could be seen as unfair.

In the short run, a tax cap would increase the taxes of those with generous employment-based insurance, although the overall effect on taxpayers would depend on how the additional revenues were distributed. In the longer run, however, if a tax cap contributes to successful health care cost containment, many people who face a higher tax burden could ultimately be made better off.

TABLE 1. PREMIUMS AND TAX SUBSIDIES FOR FAMILIES WITH EMPLOYMENT-BASED HEALTH INSURANCE, BY INCOME

Income (Dollars)[a]	Percentage of Families in Income Class	Average Premium (Dollars)[b]	Employer Share of Premium (Percent)[b]	Average Subsidy (Dollars)	Tax Subsidy as a Percentage of Premiums[b]
1 to 9,999	8	1,830	83	190	11
10,000 to 19,999	34	2,370	80	450	19
20,000 to 29,999	62	3,080	84	800	26
30,000 to 39,999	78	3,650	84	900	25
40,000 to 49,999	85	4,370	86	1,090	25
50,000 to 74,999	89	5,080	87	1,320	26
75,000 to 99,999	91	6,010	87	1,740	29
100,000 to 199,999	89	6,410	88	1,910	30
200,000 or More	76	5,530	89	1,830	33
All Incomes[c]	61	4,310	86	1,130	26

TABLE 1. CONTINUED

Income (Dollars)[a]	Average After-Tax Premium	Tax Subsidy as a Percentage of After-Tax Income: Families with Employment-Based Health Insurance	Tax Subsidy as a Percentage of After-Tax Income: All Taxpayers	After-Tax Premium as a Percentage of After-Tax Income
1 to 9,999	1,640	2.9	0.2	25
10,000 to 19,999	1,920	3.0	1.1	13
20,000 to 29,999	2,280	3.5	2.2	10
30,000 to 39,999	2,750	2.9	2.3	9
40,000 to 49,999	3,280	2.8	2.4	9
50,000 to 74,999	3,770	2.6	2.3	7
75,000 to 99,999	4,270	2.5	2.2	6
100,000 to 199,999	4,500	1.8	1.6	4
200,000 or More	3,710	0.5	0.4	1
All Incomes[c]	3,190	2.4	1.9	7

SOURCE: Congressional Budget Office.

NOTE: The table excludes families in which all members are covered by Medicare or Medicaid.

a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.

b. Premium data are based on the 1987 National Medical Expenditure Survey conducted by the Agency for Health Care Policy and Research of the Department of Health and Human Services.

c. Includes families with zero or negative income.

TABLE 2. INCREASE IN TAX LIABILITY FOR FAMILIES BEFORE TRANSFERS UNDER THE ILLUSTRATIVE TAX CAPS

Income (Dollars)[a]	Number of Families (Millions)	Increase in Tax Liability: Income Tax (Millions of dollars)	Payroll Tax (Millions of dollars)	Total (Millions of dollars)	Average (Dollars)
1 to 9,999	15.3	0	40	40	0
10,000 to 19,999	18.3	170	280	450	20
20,000 to 29,999	16.9	960	760	1,730	100
30,000 to 39,999	13.8	1,190	910	2,090	150
40,000 to 49,999	10.7	1,390	1,000	2,380	220
50,000 to 74,999	17.3	3,360	1,860	5,220	300
75,000 to 99,999	7.5	2,560	880	3,450	460
100,000 to 199,999	5.4	2,320	610	2,920	540
200,000 or More	1.4	480	80	560	410
Total, All Incomes[b]	108.1	12,430	6,420	18,850	170

SOURCE: Congressional Budget Office.

NOTES: Families are groups of related people who live together; people not living with relatives are considered one-person families.

CBO's illustrative caps would establish the following limits on the amount of health insurance premiums that could be excluded from taxable income: $4,000 for joint returns, $3,400 for head-of-household returns, and $1,600 for single returns.

The figures in the table assume that the illustrative tax caps are in place in 1994, based on projected levels of income.

a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.

b. Includes families with negative or zero income.

TABLE 3. CHANGE IN AVERAGE TAX LIABILITY FOR FAMILIES UNDER THE ILLUSTRATIVE TAX CAPS WITH A $153 REBATE (In dollars)

Income (Dollars)[a]	Rebate per Family[b]	Change in Average Tax Liability: All Families	Families with Employment-Based Insurance	Families Without Employment-Based Insurance	Percentage of Families with Employment-Based Insurance
1 to 9,999	160	-150	-120	-160	7
10,000 to 19,999	160	-140	-90	-160	34
20,000 to 29,999	170	-60	0	-170	62
30,000 to 39,999	170	-20	30	-180	77
40,000 to 49,999	180	50	90	-180	84
50,000 to 74,999	190	120	150	-190	89
75,000 to 99,999	210	260	300	-200	91
100,000 to 199,999	220	320	390	-190	89
200,000 or More	190	220	350	-170	76
All Incomes	170	0	110	-170	61

SOURCE: Congressional Budget Office.

NOTES: Families are groups of related people who live together; people not living with relatives are considered one-person families.

CBO's illustrative caps would establish the following limits on the amount of health insurance premiums that could be excluded from taxable income: $4,000 for joint returns, $3,400 for head-of-household returns, and $1,600 for single returns.

The figures in the table assume that the illustrative tax caps are in place in 1994, based on projected levels of income.

a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.

b. The rebate is assumed to be a refundable tax credit paid to all nondependent tax units. It is computed by dividing the total increase in taxes for families with employment-based insurance by the number of nondependent tax units. The average tax reduction is greater than $153 because some families have more than one tax unit.

RESPONSES TO QUESTIONS FROM SENATOR RIEGLE

Question 1. If an employer's ability to deduct health care benefits is restricted resulting in the limitation of employee benefits, economic theory may say that the employees loss in benefits will be made up in wages. Are there any empirical studies which prove this to be the case?

Even assuming a portion of the lost benefits are returned to the employee, would the employee be able to purchase the lost benefits on the open market for the same price his employee was paying as part of group coverage?

Answer 1. One cannot prove beyond a doubt that there is a trade-off between wages and fringe benefits. There is empirical evidence consistent with a trade-off, although the measured trade-off is not as large as economic theory suggests it would be. An important reason for the inability to precisely measure the trade-off is that people with higher wages also tend to receive more fringe benefits than people with lower wages. What the researcher would like to be able to do is look at workers with similar job skills and see how wages and fringe benefits vary among workers; but available data do not allow such a controlled experiment. At present, individuals generally pay more for insurance coverage than do employers. Under managed competition, employees would be able to choose among several specified insurance plans. In this setting, they would pay the same price as employers because premiums would be established through a "purchasing cooperative."

Question 2. If tax caps are linked to the average cost plan and vary by area or region, would this add administrative complexity for business? Would this be exacerbated if the company had employees in different states and in different health alliances or health care coverage areas? If there was not an employer mandate could changes in the tax treatment of benefits and administrative complexity impact an employers willingness to offer health insurance? What about small companies who are on the margin between offering or not offering insurance, would this be a factor in their decision to offer insurance to their employees?

Answer 2. Without a purchasing cooperative structure (included in a number of health-care reform proposals) to define premiums in different regions, tax caps could be very complicated for employers to comply with. The complication would increase for employers with employees in different regions.

Even if the cap did not vary by region, complicated regulations would probably be required to establish how premiums should be measured and allocated among establishments of a multi-state firm. Administrative problems would arise because firms would have an incentive to avoid tax by artificially reallocating premiums among establishments.

Most of these problems would be removed if all employers were required to purchase insurance through purchasing cooperatives or regional alliances. Even in this case, however, employers would be required to track and report more information about their employees' health insurance than they do at present.

Some employers would probably stop providing health insurance under managed competition if there were no employer mandate. This would happen for two reasons. First, employer-provided insurance would become more expensive for some employees whose health insurance was subject to the cap. Second, because health insurance premiums would be community-rated and deductible from the income tax for individuals, it would be less expensive for those individuals who wanted to buy their own insurance to do so than it is at present, so there would be less pressure on employers to provide insurance. But community rating would also make it easier for some employers to provide insurance than it is now. Therefore, some small employers who currently face extremely high costs would begin to provide insurance in a managed competition environment.

Question 3. Having a different tax cap in what could be hundreds of regions in the country while not impossible, will be administratively complex for business and the government. Assuming that we have a tax cap on the employer deductions and employee exclusions, what types of problems would the IRS have with tax compliance? How difficult a task will it be to insure that each employer and every individual pay exactly what they should? What type of resources do you think the IRS would need if we were to insure a reasonable level of compliance?

Answer 3. As mentioned above, the administrative complexity for the Internal Revenue Service (IRS) depends on whether a tax cap is implemented as part of a managed competition type of restructured health-care market plan or as an incremental change to the present tax and health-care insurance systems. In the absence of purchasing cooperatives, it would be difficult for the IRS to insure compliance. Although I can't quantify the amount of resources that would be required in this case, a reasonable analogy is the problem of allocating the costs of intangible goods between domestic and foreign affiliates of multinational companies under Section

482 of the Internal Revenue Code. Firms—especially those that are self-insured—would have the same incentive to allocate health insurance costs to areas where the cap is not binding as multinationals now have to allocate intangible costs to the domestic parent corporation. Both strategies could reduce tax liability. The IRS has devoted a substantial amount of resources to regulating behavior, auditing, and litigating in regard to Section 482. (The IRS may be able to provide more detailed information on the potential cost of administering a tax cap.)

PREPARED STATEMENT OF HON. DONALD W. RIEGLE, JR.

Mr. Chairman, thank you for holding this hearing on the tax treatment of health benefits.

I am particularly concerned about proposals to change the tax treatment of health benefits and the impact this may have on the middle-class. We have to make sure that whatever we do does not jeopardize the care and benefits families already have. Many people have sacrificed wages just to retain good health benefits.

According to a study by Lewin-VHI, taxing health benefits will cost working families between $34 and $128 billion from now to the year 2000. This money will come through lower wages, additional premium payments, higher out-of-pocket costs, or higher taxes.

Tax caps on employer deductions and employee tax exclusions will have one of two effects. They will make health care more expensive for employees, or force employees to give up some existing benefits. Limiting the employee's tax exclusions hurts the worker directly, making existing benefits more expensive. Limiting the employer's tax deduction will have much the same effect. If the employer's deduction is limited, the company will either maintain current benefits and shift the cost to the worker, or cut benefits leaving the employee with less coverage. In either case, the currently covered middle class employee is worse off. Advocates of tax caps say it will help reduce cost by providing incentives for employee to select lower cost "more efficient" plans. However, if the lower cost plans do not include such benefits as prescription drugs, mental health benefits, and dental care, a large portion of the middle class may see actual benefits reduced. Some people may refer to these benefits as "excessive coverage" or "non-essential benefits." Well what is "excessive coverage?" If someone has a mental health problem and needs care, is this "excessive coverage?" What benefits should be cut? And what benefits should receive preferential treatment?

This is a very complicated matter. I think the President treats this issue in a fair manner. The Health Security Act phases in a tax cap over ten years and applies it only to benefits beyond the comprehensive benefit package. This proposal protects workers who are currently insured. I hope that in our final package we can do at least as well.

PREPARED STATEMENT OF J. PATRICK ROONEY

Mr. Chairman, my name is J. Patrick Rooney and I'm chairman of the board of Golden Rule Insurance Company whose national headquarters are in Lawrenceville, Illinois. I'm pleased to offer testimony before the Senate Finance Committee.

I have been speaking and writing for some time about the merits of Medical Savings Accounts.

Last spring, some of our employees asked, "How about setting up Medical Savings Accounts here?"

Our response was, "There's no way we can do it tax free. If we set up Medical Savings Accounts for you, the money that's put into the account will be taxable income. We can do it, but then we'll have to have the payroll department take out increased taxes."

If Congress changed the tax law, we would have a substitution effect with Medical Savings Accounts.

Employers would substitute some of the tax-sheltered money that's already going to health insurance and give it to the employees in a Medical Savings Account. The employees would pay for routine medical care from this account. If they reached their deductible on their major medical insurance policy, the insurance would pay their bills. If they didn't spend all the money, they would get to keep it.

So we offered Medical Savings Accounts to our employees thinking that 25 or 30 percent of them would choose to do that. We were much surprised. 80.5 percent of our employees chose Medical Savings Accounts, even though they had to pay taxes on the money that went into the account. If they didn't choose the Medical Savings

Accounts, they could have a traditional insurance policy with a low-deductible and no account.

It has turned into a phenomenal success. The employees who chose the Medical Savings Account option were provided with an insurance policy that had a $2,000 deductible for single employees and a $3,000 deductible for family coverage. Both plans pay 100% after the deductible has been met. They also got a Medical Savings Account with money in it that they would keep if they didn't spend it. This was not an increased cost for the company. It was the same amount of money.

To make the program work, it was important for the employees to understand that it was their money. The employer deposited into the Medical Savings Account monthly, and the employees could withdraw for three purposes:

- Medical expenses
- Cash withdrawal if the employee leaves the firm
- At year end, a cash withdrawal or roll over into an on-going savings fund

The employees have not received less medical care in order to enable them to save. On the contrary, it appears that the employees have had more medical care, earlier. One female employee said she used the money to get six-month check-ups.

With Medical Savings Accounts, all of the employees have first-dollar benefits, so they don't have to worry about the front-end deductible.

This is very beneficial for some of our single mothers. If their child has an ear infection, she now has the money to take her child to the doctor. She doesn't have to worry about the front-end deductible.

One employee told us she saw a doctor to get antibiotics for her sore throat with the money in the account. Otherwise, she said she would have let it lag on because she would have had to pay for it herself.

They've also been able to use the money to pay for things that weren't covered under our previous plan. Our previous plan didn't have dental or vision benefits. A number of the employees have used money in the Medical Savings Account to pay for dental work for themselves or for a child.

Though the program was in place only eight months, the average employee had savings in 1993 of $602. The total savings to the employees was $468,000.

The employees have been able to save because they are shopping around for medical care. One employee negotiated close to $4,000 off her hospital stay before she entered the hospital.

Another employee was in a car accident and slit her ear lobe. When she went to the doctor to get it fixed, the doctor asked if she had insurance. She said she wasn't going to tell and then asked the price $900 with insurance; $200 without.

I'm taking my own advice. I'm now paying $7.99 for prescription drugs that I was previously paying $34.25 for. It just makes all the difference in the world when we are spending our own money.

Going into 1994, about 90% of the employees chose the Medical Savings program. There remain a few employees who are not in the Medical Savings program. It appears that most are people who also have health benefits provided through their spouse. When medical expenses occur, they're collecting on both plans, which we will not permit under the Medical Savings plan. With the Medical Savings plan, the company is giving the employees a cash fund. We do not want to give that fund on top of other insurance benefits they may have from a separate source.

The Medical Savings program has been a public relations coup for our management. I frequently receive spontaneous comments from employees telling me how much they like the Medical Savings Account. One lady recently pointed to her teeth telling me that she got new crowns on her teeth paid for by the Medical Savings Account. She was happy, and I was happy.

A golden health plan

This Christmas is turning out to be golden for hundreds of Golden Rule employees, thanks to an innovative health program that just could become a model for other employers.

This past year, Golden Rule Chairman J. Patrick Rooney gave his employees a choice between regular, low-deductible health insurance and a new Medical Savings Account plan.

Because low-deductible insurance is so costly, the company devised the new plan: cheaper insurance with a higher deductible, along with a savings account to cover expenses not incurred under the old plan.

The old plan for families had a $250 deductible and a co-pay that stopped at $1,000, for a total out-of-pocket employee expense of $1,250.

The new plan set a $3,000 deductible, no co-pay, and thus cost Golden Rule far less, but the company then gave the employee $1,750 to cover the additional deductible expenses.

That made the two plans seemingly equal in merit; in both cases, the employee's out-of-pocket expenses would be the same, $1,250. But there are some important differences.

Not only did Golden Rule save money on the MSA plan, but now, at year-end, employees are being reimbursed any money not spent from their accounts.

The total reimbursement? An incredible $468,000.

Under current law, the MSA proceeds are taxable income, as opposed to the tax-free nature of traditional health benefits. But the MSA plan generally would be the better option for those who are able to keep their health costs down in a given year.

The Medical Savings Account plan has some additional benefits. First, the account could be used to pay insurance premiums between jobs. If an employee loses his or her job or is out on strike, there would be money in the account to continue health insurance.

Too, as Rooney has pointed out, the incentive for employees to be prudent about their health cost spending would be revived under the MSA plan, for employees know they would recoup any unspent money.

In other types of employee health savings accounts, the money reverts back to the employer if it isn't spent by year's end. Thus, especially if it is the employee's own money deducted from his or her paycheck, the employee has a built-in urgency to try to spend the money allocated to the fund, not cut back on health expenditures.

One of the best offshoots of such a plan is that it would encourage more employers to provide health insurance for their employees. People whose companies pay for their insurance often don't realize how much their employers are paying on their behalfs. According to Rooney, annual family premiums in Indianapolis average $4,300. In Cincinnati, the cost is slightly higher, $4,500. In Des Moines, that figure nears $4,700. In Washington, it's closer to $8,200.

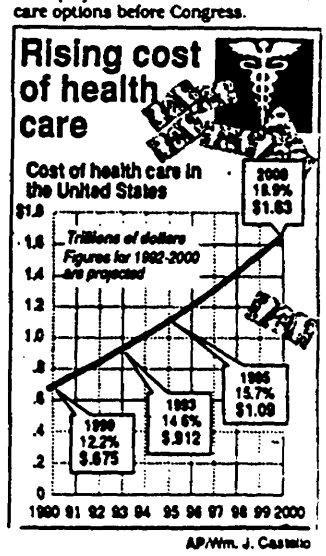
Small businesses often don't provide group insurance, not because they don't care about their employees, but because they can't afford it. That might change if they paid for more reasonably priced high-deductible insurance and employee MSAs.

Congress could get the ball rolling even further by modifying the tax code to allow MSA money to be treated like an Individual Retirement Account, with the fund allowed to accumulate tax-free until it was spent. In fact, Rep. Andy Jacobs, D-Ind., and Sen. Dan Coats, R-Ind., both have introduced legislation to that end.

In particular, Coats' "HealthSave Proposal" would call for participating employers to purchase an umbrella policy for employees for catastrophic medical costs. They then would provide each employee with an MSA of $3,000 per annum, which would remain on account, tax-free, for future medical bills and other limited uses, such as long-term care and education.

Coats also has called for an increase in tax credits for those whose employers do not offer such coverage.

Americans recognize their critical need for affordable health care, but they also want choices. Golden Rule's MSA plan ought to become a prominent player in the debate over health care options before Congress.



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NATIONAL ISSUE

EMPLOYEES AS HEALTH REFORMERS

Medical Savings Accounts Curbing Premium Costs

By John Merline
In Washington

Melanie Woodcock is doing her part to help reduce the nation's health-care cost problem.

Facing surgery, she negotiated a $3,797 discount from the cost of the nearly $10,000 procedure. For each medical expense her family incurs, she asks for the cost in advance. And, her family makes sure that each test performed is necessary and actually gets performed. "We were charged for two lab tests that weren't even done," she said.

This type of behavior no doubt strikes many people as highly unusual.

The reason Woodcock bothers is that, unlike the vast majority of Americans, she and her family stand to benefit financially for their own careful use of health-care services.

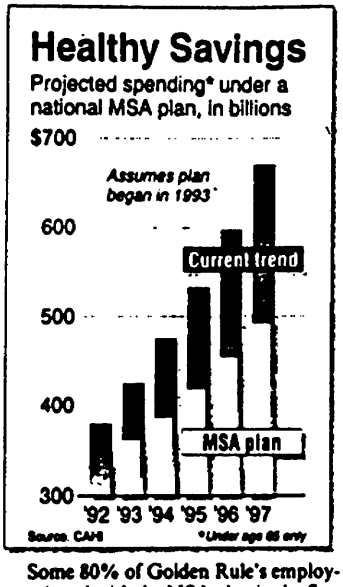
Last year, her employer, Golden Rule Insurance Co. in Indianapolis, began offering employees an innovative insurance policy that attempts to turn its workers into individual health-care reformers.

At the core of the Golden Rule plan is a "medical savings account," an idea that was developed to help reform the nation's health-care system but that has already been adopted with some success by several companies seeking to control their own health-care costs.

Golden Rule realized that, by switching from a plan with a $250 deductible and a $1,000 co-payment requirement to one with a $3,000 deductible and no co-payment, it would save enough in premium costs to give each employee a $1,750 medical savings account.

The worker could use money from the account to pay for health-care costs. The trick is that any money left over in the savings account at the end of the year goes into the employee's pocket.

The success of the plan has surprised even the people in the company who pushed for it.



Some 80% of Golden Rule's employees signed with the MSA plan in the first year. These workers got $468,000 in reimbursements from their medical savings accounts last year. Not surprisingly, enrollment expanded this year.

The company benefited as well. Golden Rule saw no change in its premiums this year.

Golden Rule is not alone.

In 1993, the Council for Affordable Health Insurance, a trade and lobbying group in the Washington, D.C. area, switched from a managed care plan with a $250 deductible to a fee-for-service plan with a $1,000 deductible.

Because the actual premium for the high-deductible plan was about $1,000 less per worker, CAHI made these savings available to its employees, who could keep the money if they didn't spend it on health care.

The result? CAHI's premiums climbed only 4.6% in 1994.

As CAHI employee Victoria Craig noted, the MSA plan allowed her to pay for preventive health services without dipping into her own pocket. "Plus, I received a year-end bonus of $761 before taxes," she said.

CAHI, like Golden Rule, has been an advocate of MSAs as part of national health-care reform.

The Spurwink School in Portland, Maine, has implemented a so-called Health Wealth plan developed by Progress Sharing Co. of Saco, Maine. The Health Wealth plan offers workers a high-deductible plan, putting some of the premium savings in a mutual fund account for each worker that can be used to pay out-of-pocket expenses.

"Now it's to their economic benefit to be health-care consumers, whereas it wasn't before," said Fred Prince, president of Progress Sharing.

Impressive Number

In four of the six years since the plan has been in effect, the school has seen its premium drop. The average annual increase in premiums between 1987 and 1992, the last year data were available, was 8.7% — far lower than the national average.

Another company using the Health Wealth program — Knox Semiconductor in Rockport, Maine — had similar results, with only two rate increases in the past six years.

Knox President John Morey claims that the Health Wealth program has saved his company more than $100,000 over three years. "This is an impressive number when you realize we are a company of 42 employees," said Morey.

Quaker Oats has for more than 10 years offered its 11,000 workers a high-deductible plan, putting annual contributions of $300 into personal health accounts, with any unspent funds given to the workers at the end of the year.

Between 1982 and 1992, the company's costs increased at an annual rate of 6.3%.

High Costs Nationally

Dominion Resources, a utility holding company seeks to encourage workers to opt for a $3,000 deductible plan — with no co-payments above that amount and no limitations on which doctors a patient can see — by paying a fixed amount towards premiums. A family that chooses that plan would end up paying roughly $75 a month vs. $210 a month for the low-deductible plan.

Workers can put the savings from choosing the lost-cost plan into a bank account. Some 80% of Dominion's workers have opted for the high-deductible insurance policy.

The company has effectively experi-

EMPLOYEES AS HEALTH REFORMERS

enced no increases in its premiums since 1989.

These results are even more impressive when weighed against national trends.

Overall health benefit costs climbed an average 13% a year between 1988 and 1993, according to Foster Higgins, a Princeton, N.J.-based health benefits consulting group.

Even managed care plans — which attempt to control costs by limiting patient choice of doctors and restricting access to specialized care — couldn't beat these companies' experience.

For example, HMO costs climbed an average 13.6% a year between 1988 and 1992. In 1993, they climbed another 6.5%, Higgins data show.

The success of MSA-type plans has not gone unnoticed by the United Mine Workers of America. In a contract signed by the union with the Bituminous Coal Operators Association last December, the union agreed to switch from a plan with a zero deductible to one with a $1,000 deductible.

In exchange, each miner gets $1,000 that can be used to pay for medical expenses within a preferred-provider network. Any unspent funds can be saved by the miner.

In effect, the miners continue to receive first-dollar coverage, but with a strong incentive to minimize their own health spending.

"We were trying to decrease the actual cost of the health-care program," said Morris Feibusch, vice president of public affairs at the association.

The state of Ohio is considering adopting MSA-type reforms.

Ohio's Potential Savings

Dr. Peter Somani, director of the Ohio Department of Health, estimates that the state could save $29 million in annual health-care costs for its government employees if it offered an MSA option and if only half of the state government's workers signed up.

According to Somani, the savings to the state would likely be higher because that figure counts only savings in premium costs. It does not count any additional savings that might accrue if these state workers change their health-care spending habits.

The underlying premise behind the MSA reform is that it gives each health-care consumer something most currently lack — a strong incentive to be efficient health-care shoppers.

> "We are paying 20% profit on every premium dollar that is retained by the HMOs and insurance companies. Why should we keep paying that profit?"

Most economists agree that, to the extent that health-care costs are out of control in the U.S., the fundamental reason is the lack of consumer interest in the price of medical services.

In the past 30 years, the health-care marketplace has shifted from one dominated by out-of-pocket expenses paid by patients to one dominated by so-called third-party payers — either insurance companies or the government.

Immunizing consumers from the cost of health care has had the effect of making them indifferent to prices, while encouraging them to overutilize health services, economists say.

Consumer Power

MSAs, according to supporters, seek to bring consumers back into the picture by letting them benefit financially from careful spending.

Yet, despite the successes experienced by those companies that have tried it, MSAs continue to remain a relatively obscure reform idea.

One possible explanation is that the idea gets little enthusiastic backing from the insurance industry, which is not too surprising.

Under an MSA plan, much of the money that would have been paid in premiums to insurance companies goes instead into the savings accounts — to be spent either directly on health care or kept by the individual.

"We are paying 20% profit on every premium dollar that is retained by the HMOs and insurance companies. Why should we keep paying that profit?" said Somani.

And, despite the experience of those companies that tried it, there is some question about whether MSAs could work to reform health care on the national level.

In testimony before Congress last fall, First Lady Hillary Rodham Clinton dismissed the MSA idea, saying the plan "does nothing to encourage primary and preventive health care." Under such a plan, people will "postpone seeking help as long as possible" in order to save money.

Weak Incentives

She added that MSA reforms wouldn't guarantee universal coverage. "Many people will not be encouraged, unless required, to be responsible," she said.

Another concern raised is that health-care consumers typically are not in a good position to shop around for health-care services either because they are in an emergency situation or because they are not experts in medicine.

Others complain that the MSA reform plans currently in Congress won't work because the incentives are too weak to encourage any change in behavior.

Most of the plans require people either to spend the MSA money on health care or to keep it locked up until retirement to avoid tax penalties.

"If you tie the money up for that long, you lose the incentive," said Progress Sharing's Prince. "For a kid who's 20 years old, he doesn't care about retirement, he wants to live today."

Prince also worries that adding the tax benefits to the MSA plan still puts too much power in the hands of government.

"If you get a tax break, the government will basically come in and tell you how you have to run your business in order to get the break," said Prince.

Still, one study suggests that a national reform plan that includes MSAs would go a long way to reining in the nation's health-care costs.

The study, by Mark Litow — an actuary at the Seattle-based consulting firm Milliman & Robertson — for the Council on Affordable Health Insurance, found that a nationwide MSA plan would cut health spending $587 billion and would cut the number of uninsured in half over the first five years.

Clinton's plan, in contrast, will boost national spending a total $76 billion in the first five years, according to the Congressional Budget Office.

RESPONSES OF MR. ROONEY TO QUESTIONS FROM SENATOR RIEGLE

Question. If an employer's ability to deduct health care benefits is restrict resulting in the limitation of employee benefits, economic theory may say that the employees loss in benefits will be made up in wages. Are there any empirical studies which prove this to be the case?

Answer. I am not aware of any empirical studies that show that employees' loss in benefits will be made up in wages. But all experts agree that the cost of benefits is the same as the cost of wages from the employer's standpoint. That does not mean, however, that the employer would normally apply such a substitution to individual employees. Rather, the employer is likely to view this principle in the aggregate.

Question. Even assuming a portion of the lost benefit are returned to the employee, would the employee be able to purchase the lost benefits on the open market for the same price his employee was paying as part of group coverage?

Answer. No, the employee would not be able to purchase a benefit on the open market at the same price the employer was paying for the benefit. For one thing, the employee is required to purchase the benefit with after-tax dollars. The employer may have had $1,000 to spend for an employee benefit, but by the time those dollars become spendable by the employee, the employee has only $600 to spend after having paid the taxes. In addition, the employee does not have the purchasing power of "carload lot" purchasing that is available to even the small employer.

Question. If tax caps are linked to the average cost plan and vary by area or region, would this add administrative complexity for business? Would this be exacerbated if the company had employees in different states and in different health alliances or health care coverage area?

Answer. A variation in the tax cap by area would be a small aggravation, but insurance companies already rate their health insurance by zip code. I don't see a tax cap variation by area as any worse administratively than health insurance rating by zip code.

Question. If there was not an employer mandate could changes in the tax treatment of benefits and administrative complexity impact an employer's willingness to offer health insurance?

Answer. On the whole, I don't believe employers will be either encouraged or discouraged in offering health benefits as a result of changes made to the tax treatment of benefits or administrative complexitier that may arise.

Question. What about small companies who are on the margin between offering or not offering insurance, would this be a factor in their decision to offer insurance to their employees?

Answer. What would make a difference in providing health benefits is creating greater utility for the employees. The employer is more likely to provide a benefit to his employees if the employer believes the benefit creates greater satisfaction for the employees. For that reason, Medical Savings Accounts have proven to be a plus, as they are very popular with employees.

Question. Having a different tax cap in what could be hundreds of regions in the country while not impossible, will be administratively complex for business and the government. Assuming that we have a tax cap on the employer deductions and employee exclusions, what types of problems would the IRS have with tax compliance? How difficult a task will it be to insure that each employer and every individual pay exactly what they should? What type of resources do you think the IRS would need if we were to insure a reasonable level of compliance?

Answer. In terms of differentiating the level of tax caps by region, there currently exist studies of health benefits costs by region. If we want to know what the competition is charging, we already have data that we can pull up on possibly 50 different insurance companies by the first three digits of any zip code. If it exists in the marketplace, the Internal Revenue Service should be able to get the same thing. The IRS could use the studies that already exist and simply average them to get the average cost by zip code.

COMMUNICATIONS

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

On behalf of the American Dental Association's (ADA) more than 140,000 member dentists, we are pleased to submit this statement to the Senate Finance Committee. We believe that dentistry has a unique story to tell.

The ADA is committed to health system reform. We applaud the efforts of this Committee and Congress to deal with the complex issues raised in reforming a system that involves one-seventh of the gross domestic product. Congress' health system reform actions will affect dentists not only as health care providers, but also as small employers and consumers.

As do many others, the ADA supports the general principles of health care reform: access to care, security, choice, cost-effectiveness, elimination of discriminatory practices in insurance coverage, administrative simplicity and enhanced quality.

The ADA agrees that health care is inaccessible for too many Americans. Medical and hospital costs are increasing at a pace that cannot be sustained. Today's medical care financing and delivery system falls short on many counts, and dentists, like most Americans, realize that some degree of reform is overdue.

But we see a danger that medical system reform will inadvertently disrupt our current dental health delivery system and diminish the valuable benefits Americans derive from that system. That would be tragic, for dentistry is health care that works. If medical care were as cost-effective as dental care, we would not be engaged in this debate today.

The ADA's paramount concern is with proposals to tax health care insurance benefits that exceed a standard benefit package. Those who entertain such a notion should be aware that in taxing "excess" benefits, they also would greatly reduce access to dental services and add to the cost of oral health care. They should be aware as well that revenues from such a tax are likely to be minimal. Any erosion of dental benefits' tax-protected status would be ill-advised tax policy and ill-advised health care policy.

Before defending that premise, we first would like to highlight the differences between dentistry and medicine, which illustrate why the reforms proposed for the medical delivery and financing systems are not necessary or appropriate for dentistry. We believe that dentistry already encompasses many of the reforms that you want to implement for the medical care system.

FOCUS ON PREVENTIVE HEALTH CARE

Dental care is not as costly as medical care, nor is dental care funded at significant levels by government spending. There is no reason why public policy should treat dentistry as if patients labor under the prospect of catastrophic dental costs. This is largely because dentistry emphasizes prevention. Most routine treatments in dental offices prevent conditions that would be costly to remedy if allowed to progress. Dentists spend a great deal of time educating patients about good oral health practices. And dentistry has fought hard—and successfully—to convince communities nationwide to fluoridate their water, a practice that has greatly reduced the incidence of tooth decay. As a result of patient education and water fluoridation, 50 percent of children entering first grade today have never experienced tooth decay. In the early 1970s, that number stood at only 28 percent. This is one of the outstanding disease prevention successes of recent years.

EMPHASIS ON PRIMARY CARE

Dentistry emphasizes primary care. Eighty percent of dentists are general practitioners. Only 20 percent are specialists. That ratio facilitates cost control and preventive care by constraining referrals, which generally add to costs. Dentistry's mix

of general practitioners and specialists is envied by those seeking reform of the medical profession.

COST-CONTROL SUCCESS

Dental care is accessible and cost-effective. The percentage of Americans receiving regular dental care has risen steadily. And the cost of dental care is moderate, in sharp contrast to costs for other types of health care. The Health Care Financing Administration (HCFA) verifies that expenditures for dental care as a percentage of total health care costs have shrunk from 6.3 percent in 1970 to 4.9 percent in 1991. HCFA projects that this total will further decline to 4 percent by the turn of the century.

These economies derive from dentistry's emphasis on prevention and primary care. They accrue from dental care being provided by a single caregiver at a single outpatient site. They reflect dental technology's tempering effect on costs. And these economies are the direct result of dental benefit, or insurance, plans.

This last point is significant. Just as dentistry is very different from medicine, dental insurance differs markedly from medical insurance. Both facilitate use of health care services, but only dental insurance helps to hold down costs even as it expands access. Dental insurance stipulates an annual maximum expenditure and requires patient participation in the cost of treatment. Dental benefits are actually cost-assistance programs that encourage individuals to seek needed care and maintain their oral health. The results speak for themselves:

- The number of people with dental insurance has increased tenfold since 1970.
- Dental benefits involve the patient through a proper cost-sharing balance, with 53 percent of costs paid by patients, 43 percent paid by benefit plans and a mere 4 percent paid by federal, state and local governments.
- Most dental benefit plans fully cover preventive services. Patients who require more extensive and costly care are asked to bear a greater share of the cost. In addition to copayments and deductibles, most plans also have annual maximums, making the plans predictable and affordable.

For example, in New York the average *annual* rate for a basic family dental plan in 1993 dollars is about $734. A comprehensive family plan costs approximately $789. For an individual, the costs are $283 and $351, respectively. In Oregon, a basic family plan is about $688, and a comprehensive family plan is approximately $719. For an individual, the costs are $239 and $319 respectively.

Alaska has the highest plan costs, with the basic plan costing about $336 for an individual and $939 for a family, and the comprehensive plan costing approximately $449 for an individual and $1,010 for a family. Arkansas has the lowest cost plans, with the basic plan costing $190 for an individual and $530 for a family and the comprehensive plan costing $253 for an individual and $571 for a family.

These are *annual costs,* helping explain why dental benefits are the most popular employee benefit after medical insurance. Dental benefits lead people to see their dentist more regularly, allow them to realize the benefits of preventive treatments and ultimately avoid costs of treating more advanced forms of oral disease.

PUBLIC POLICY IMPLICATIONS

The ADA is not the only group arguing that taxing health benefits is not good public policy. One of those groups, the Service Employees International Union (SEIU), commissioned a study by Lewin-VHI on the issue and has published a report, "Hammering the Middle Class," on Lewin-VHI's findings. In that report, SEIU states that "taxing health benefits will dramatically increase health care costs for middle-income working families and amounts to a major tax increase for middle class workers." The report continues that "taxing health benefits means asking working families to give up basic services or pay more" and that "taxing health benefits means deciding what insurance coverage working families can afford to lose. Families will face a choice between *losing* coverage for many basic services, such as prescription drugs, dental care, and mental health services, or paying higher premiums to keep their current benefits."

Dental patients—especially lower income patients—could be forced to forego coverage and forego care. The benefits of dentistry's focus on prevention would be squandered. Many patients not only could lose the favorable tax treatment of their dental benefits, they also could end up with less medical coverage if, as expected, the standard benefits package is trimmed. Access to adequate health care, especially dental care, would diminish.

Attached to our statement is a petition reflecting public reaction to such a sequence of events. The petition is signed by dental patients in New York City, where

one of the ADA's county societies asked its member dentists to place the petitions in their offices. In response, more than 5,000 patients in a two-week period expressed concern about taxing dental benefits.

When Congress last considered taxing health benefits in 1984, the Congressional Budget Office (CBO) warned that a benefits tax would favor services that are "expensive, non-elective and not predictable" and would adversely affect less costly health services. "This means that dental services and prescription drug coverage are likely to be reduced by the greatest portion and hospital coverage the least," CBO reported.

Do we really want to penalize those elements of our health system that perform admirably, holding down costs and emphasizing prevention of more serious illness? Do we really want to reward those elements that do the opposite?

Taxing health benefits would reduce access to important health services such as dentistry but yield only minimal revenues in return. If employees have an incentive to choose lower-cost benefit packages to stay below a tax threshold, they will do so. Those expecting revenue windfalls from "rich" benefit packages will be disappointed. Some dental insurers believe such revenue will be about $3.6 billion in the first year but will drop to only about $900 million as people forego dental insurance.

Ironically, the revenue garnered from a tax on benefits would be a mere fraction of the savings now achieved through the preventive health and cost-effective care that characterize dentistry, an estimated $4 billion a year according to the Institute of Medicine (IOM). "A reduction in the number of individuals receiving regular, preventive services will result in an increase in the incidence of dental diseases, and increased costs to the system," the IOM says. We question the wisdom of taxing dental benefits.

Attached to this statement is a list of the Association's health system reform priorities. The ADA is committed to increasing access to cost-effective, high-quality dental care. We hope to work with the Committee to assure that these objectives are achieved. But let's not lose sight of how well the current dental care delivery and financing system works. Let's not penalize dentistry because of medicine's shortcomings.

Attachments.

ADA. American Dental Association

DENTISTRY: HEALTH CARE THAT WORKS

Dentistry's Health System Reform Priorities

Dentistry is proud of its distinctly effective financing and delivery system. It is a system worth preserving and strengthening in a reformed health care system.

No less important to the ADA and its members, as committed health care professionals, is the continuing social obligation to meet the oral health needs of every American. To ensure universal access to high-quality dental care:

- Federal involvement in dental care funding should be driven first and foremost by need. Finite resources dictate that limited federal funds be directed to those who currently do not benefit from regular dental care, with emphasis on prevention. This group includes no- and low-income populations of all ages.
- The federal government should maximize its investment in the nation's future by targeting preventive dental care spending on children. Public expenditures should cover preventive benefits such as oral health education, fluoridation of community drinking water, regular cleanings and oral exams, tooth restorations, space maintenance and application of topical fluorides and sealants.
- To realize Medicaid's potential, it should be expanded and adequately funded to provide access to comprehensive dental care. Medicaid should be administered in the private sector whenever possible.
- The federal government should subsidize low-income adults and children on an income-based scale in purchasing dental benefits.
- Tax deductibility of health care benefits should be preserved. If employees or employers are taxed on dental insurance benefit plans, Americans' oral health will be compromised.
- If Medicare is expanded to cover additional dental services, it should include a defined dental benefit plan. Funds should be targeted to homebound seniors and those in long-term care facilities.
- Health system reform should include a medical-surgical-hospital plan subject to a deductible, premium caps and subsidies for small employers.
- Dentists should be encouraged to practice in underserved areas and the federal dental services through financial incentives.
- Small employers should be able to purchase dental plans in the private sector or to form alliances to purchase dental benefits, with fee for service the preferred payment option.
- Other essential components of a viable reform package include: no discrimination by degree of provider; provision for medically necessary adjunctive care; comprehensive tort reform; adequate antitrust relief to allow dentists to compete fairly; and freedom of choice for dentists to participate in health plans and for patients to choose their providers of care.

STATEMENT OF THE BUSINESS ROUNDTABLE

INTRODUCTION

This testimony is submitted by The Business Roundtable to the Committee on Finance of the United States Senate. The Business Roundtable is an association of over 200 companies represented by their chief executive officers, who monitor and comment on public policy.

The Business Roundtable is anxious to see legislation that will improve health and health care in the United States. We have worked on these matters for many years, and are grateful for this chance to express our views.

This testimony is not about the broad, public themes of health care reform. It is about a more technical matter of taxation. Nevertheless, we believe it is highly important for having a well-ordered system of business income taxation and is important for the Committee to consider closely.

Our testimony relates to the April 26, 1994, hearing of the Committee on the tax treatment of employer-based health insurance. The main points of our testimony are that

- Employers' costs of providing health insurance for employees should remain fully deductible under traditional principles of tax policy for corporate income taxation, and
- Full deductibility by employers is not an incentive for overuse of medical services.

TESTIMONY

Income tax based on ability to pay, not gross receipts

Decades ago, Congress decided that the federal government would tax the income of corporations, not their gross receipts.

The rationale of an income tax is that the tax is proportionate to the taxpayer's economic success and ability to pay. A tax on gross receipts would not necessarily make this link between tax and economic success. For example, sales of $1 million are not an economic success if the cost of goods sold is $2 million. Our current corporate income tax determines that the company in this example suffered a $1 million loss, has no ability to pay, and thus will not pay income tax; it certainly does not say that the company will pay tax on its $1 million of receipts.

Deductions necessary for an income tax

The basic difference between a tax on business *income* and a tax on business receipts is that income is measured net of business expenses. The expenses are deductible in full. It is necessary for these expenses to be deductible in full as a matter of tax policy, if the policy objective is to tax business *income.*

Deductions for compensation of employees

Compensation of employees is a significant business expense. Some compensation is paid as directly wages, and some is paid as health benefits and other benefits for employees. However it is paid, the compensation of employees must be deducted from gross receipts in order to determine the *income* of employers, and it must be deducted in full.

Therefore, our testimony regarding the tax treatment of employer-based health insurance is for the uncompromised application of standard income tax policy and principles, which require the full deductibility of the employers' cost without caps, phase-outs, or other dilutions.

Is deductibility a subsidy or incentive?

Some who may not have the Committee's experience in taxation contend that the employer's deduction for health insurance payments is a "subsidy" or "incentive" to overuse health care. They say that if the federal government wants to contain inflation of health care prices, it should cap or limit the employer's deduction so that employers will be less willing to participate in more expensive plans.

Our response is that this line of thinking totally misconstrues the purpose of expense deductions in a business income tax, and that the Committee should be definite about rejecting it so long as Congress wishes to tax income for its primary stream of revenue.

Of course, deductibility is very important for an income taxpayer in the 35-percent bracket, because the loss of deductibility for a certain business item would raise the item's after-tax price to the taxpayer by over 50 percent. For example, automakers would see steel as costing them more and would use less of it, if Congress made their payments for steel nondeductible. But that observation does not mean that the tax system is subsidizing manufacturers to buy "too much" steel, and it certainly

does not mean that limitations on the deductibility of payments for steel would be a sensible policy for reducing the use of steel.

We reiterate the main point: the full deduction of employer's costs of compensating employees is a necessary ingredient of a tax system that seeks to tax business *income* and ability to pay rather than gross receipts.

The deduction is not a subsidy or incentive to buy health care for employees instead of paying cash wages in the same amount, because employers currently take the same deduction for either type of compensation.

STATEMENT OF DELTA DENTAL PLAN ASSOCIATION

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to submit testimony on behalf of the Delta Dental Plans Association. My name is Dr. Erik D. Olsen and I am Chairman of the Association's Government Relations Committee.

By way of background, the Delta Dental Plans Association represents a nationwide system of health care service plans that underwrite and administer employee dental benefits programs. Founded in 1954, Delta Dental is the nation's oldest and largest dental benefits carrier, providing coverage for over 25 million Americans through 33,000 group plans. These groups vary in size from small businesses to large corporations such as General Motors and WalMart. Delta also serves a wide variety of government groups, ranging from municipalities to federally-sponsored programs such as the CHAMPUS dependents' dental program. Unlike traditional fee-for-service programs which simply indemnify policyholders, Delta contracts with over 110,000 dental offices nationwide to provide subscribers with dental care at pre-agreed fees.

From the start, let me say that our Association supports the primary objectives of health care reform to expand access and control health care costs. Delta wants to underscore the fact that dental care in general, and dental insurance in particular, play an important part in our nation's health care system. As such, we firmly believe that access to comprehensive dental benefits should be afforded to all Americans.

Perhaps more than anything else, the fact that 38 million Americans lack health insurance focused the public's attention on the need for reform. The sad irony is that few realize that over *150 million* Americans lack dental insurance. Yet most of the reform proposals under consideration in Congress do not speak to the issue of oral health care.

Why is that? Unfortunately, too many fail to recognize and appreciate that dental care is as essential to overall health as medical care. Simply put, many have come to regard the mouth as separate from the rest of the body. Yet oral diseases and other conditions—like tooth decay and gum disease—are among the most prevalent of all chronic health conditions. Eighty-four percent of all children experience tooth decay. Depending upon the age group, from 40 to 70 percent of adults have infected gums. And more than one-third of older Americans have lost all their teeth.

Each year, approximately 30,000 new cases of oral cancer are diagnosed. Not surprisingly, dentists are most often the first health care providers to diagnose oral cancer. Less well known, however, is the fact that dentists are often the first to see early warning signs of diabetes and immunologic disorders such as AIDS.

DENTAL BENEFITS AND HEALTH CARE REFORM

Mr. Chairman, as you and your colleagues consider the shape and make up of health care reform, we urge you to consider the merits of including comprehensive dental benefits in the standard benefits package.

Dental benefits focus on primary and preventive care, helping to prevent dental disease before it takes hold. According to the Institute of Medicine, regular dental care has resulted in a dramatic reduction in dental diseases, saving an estimated $4 billion a year by preventing disease or treating it early, and by keeping people productive. Dental benefits also feature shared responsibility for the cost of care. And when it comes to overall costs, dental care is the one bright spot amidst the health care crisis. As a share of total health spending, dental care costs have actually declined—from 7.4 percent in 1960 to 5.4 percent in 1992—over a period when the rest of the health care industry was experiencing skyrocketing cost increases. During that period, in fact, dental costs rose at a rate less than half that of physician services and two-thirds less than hospital care.

In short, Mr. Chairman, dental benefits embody all the qualities we are seeking in health care reform. Conversely, a health care reform plan without dental benefits

would be incomplete. As a recent study by the Public Health Service points out, poor Oral health is especially acute among minorities, the poor, and the elderly.

The study found that among adults, minorities are three times more likely to be living with untreated tooth decay. The study also found that virtually all of our elderly population experiences dental problems, yet only about 15 percent have dental insurance.

Mr. Chairman, if this nation is serious about reform, a comprehensive set of dental benefits should be guaranteed for all Americans, young and old.

TAXATION OF HEALTH BENEFITS

As you and your colleagues determine how best to extend the safety net of health protection to all Americans, we urge you not to jeopardize those who already have cove rage.

Several proposals now being considered by Congress call for taxing employer-provided health benefits. The proponents argue that this scheme would give consumers an incentive to be more cost conscious and that it offers a means to raise revenues to finance reform.

In the real world, Mr. Chairman, neither would be the case. As for the argument that a benefits tax would encourage consumers to be more cost conscious, I can only say that the logic here is flawed. It suggests that the solution to consumers paying too much is to charge them more. Consumers do not set physician fees or the cost of medical procedures—providers do. Consumers do not make the costly medical decisions—providers do. And as a practical matter, consumers who need expensive medical procedures and tests tend to be sick and in no position to shop around. The opportunities they have to be cost conscious are limited. Taxing the consumer of health care is unfair because the consumer lacks control over these events. And, certainly, taxing *dental* benefits will not lower *medical* costs.

As for raising revenues, if a health benefits tax were levied on employers, they will either reduce their premium contributions to avoid the tax or employers will pay the tax, but cut workers' wages to compensate for their loss. (Keep in mind that workers already gave up wages to obtain health benefits in the first place.) And if the tax were applied directly on workers' income, families would be forced to give up cost-efficient, prevention-oriented coverage, like dental benefits, in order to pay for more expensive medical coverage. Either way, any anticipated revenue stream would quickly dwindle down to a trickle. And either way, middle-income working families would shoulder most of the burden of benefits taxes.

Dental experts tell us that a benefits tax will result in a drop in dental care of approximately 25 percent. And postponing dental care today only means that more difficult and more costly treatment will be required in the future. Experience has already shown us that those who lack dental coverage—especially the poor and near-poor, usually end up getting their dental care in the most expensive setting possible—the hospital emergency room.

In short, Mr. Chairman, a tax on health benefits would effectively restrict access to preventive dental care and promote increased costs over the long run.

We realize that this Committee faces a daunting challenge in the coming months. There are no easy answers and no quick fixes to the problems we all face. As you set about making the tough choices, I would like to offer the forty years of experience and expertise of Delta Dental to help you in this task. Please feel free to call on us at any time.

Thank you for the opportunity to submit this testimony.

STATEMENT OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

My name is Robert A. Georgine. I am testifying on behalf of the National Coordinating Committee for Multiemployer Plans.

The NCCMP is a nonprofit, tax-exempt organization established after Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA") in 1974. It consists of representatives of approximately 240 pension and welfare plans, or their sponsors. On behalf of its affiliated plans, and the approximately nine million participants and beneficiaries of multiemployer plans generally, the NCCMP is entirely engaged in monitoring the development—legislative, administrative, and judicial—of the laws relating to the structuring and administration of multiemployer pension and welfare plans.

On behalf of the millions of socially responsible working Americans who, through their bargaining representatives, accept reduced wages to pay for health care coverage for themselves and their families, the NCCMP vehemently opposes any type

of tax on health care coverage. Proposals to limit the employer deduction or the employee exclusion, to impose an excise tax on employers, or to impose a tax, directly or indirectly, on plans, would have in common the unconscionable result of forcing these workers and other socially responsible Americans who pay for their own health coverage to also pay for coverage for the uninsured and underinsured.

In addition, I call on you to provide the necessary leadership to develop workable mechanisms for controlling and fairly allocating health care costs through a national reform program. A decision to leave these crucial issues to state legislatures, many of which have already developed programs that would impose taxes in one form or another on health care coverage and/or benefits, would have the same unjust result as the imposition of health care taxes at the federal level.

The NCCMP strongly supports national health care reform. The burden of rising health care costs on the working Americans who pay for them has become intolerable. A major cause of the increase in these costs is cost shifting. Uninsured and underinsured individuals still get care, usually through emergency rooms, which is the least cost effective means of providing it. The cost of this care is then shifted, through higher hospital, doctor and other provider bills, as well as through various federal and state government devices, to the plans covering our insured workers and their families. This unfair cost shifting must be stopped through a national program of health care reform.

1. HEALTH CARE REFORM MUST NOT INCLUDE ANY TAX ON HEALTH COVERAGE

Proposals to tax health care coverage, whatever form they take, generally have two stated goals: (1) to raise revenue to finance health care reform; and (2) to reduce health care cost inflation. Neither of these stated objectives can justify such a tax.

a. Those Who Have Coverage Must Not Be Taxed To Pay For Coverage For The Uninsured

Working families simply will not tolerate a tax increase, especially a health tax that punishes them for having health care coverage by forcing them to pay for the coverage of uninsured or underinsured individuals. This would be little more than a statutory embodiment of the current system, wherein the cost of uncompensated care is shifted to the shoulders of our already-overburdened workers.

We call for a mandate for all employers to provide health coverage for all of their employees. Socially irresponsible employers should not be allowed to continue to gain a competitive advantage by reducing their actual labor costs by shifting the cost of health care for their employees to other employers and to the American public.

Even in the context of such an employer mandate, however, some costs for uncompensated care will remain. The cost of any subsidies provided to small employers and/or low paid workers or to the unemployed or of any remaining uncompensated care is the equal responsibility of all Americans. It should be financed through a mechanism that falls on all Americans equally, if not progressively, as a percentage of income. A tax on health care coverage would be regressive and fall disproportionately harshly, as a percentage of income, on middle- and lower-income workers.

A common characteristic of multiemployer plans bears mentioning here. Many multiemployer plans provide health coverage to retirees. In many cases, all or a substantial portion of the cost of retiree health coverage is financed through employer contributions allocated from the wages of active workers. Thus, many active multiemployer plan participants, through collective bargaining agreements, have already undertaken to pay, through accepting reduced wages, the cost of health coverage for retirees in their industry.

The shifting of costs for uncompensated care to such participants, who are already doing more than their share, is grossly unfair. This unfairness would be magnified severely by taxing these participants on the cost of their coverage, which is inflated because it includes the coverage that is provided by the plan to retirees.

We also note that a tax on health care coverage in the absence of a broad employer or similar mandate cannot seriously even be considered. Our covered workers are already struggling to pay, not only for their own coverage and that of their families, and, often, for coverage for retirees, but also for the shifted costs of uncompensated care. To further inflate these health coverage costs by taxing their coverage or benefits in any fashion would likely lead to the destruction of many employer-paid plans. Younger and healthier workers, who feel they are least likely to need health benefits, would likely drop out of plans. This would be especially true of low income workers, who simply cannot afford the additional cost. As their participation ended, the cost for the remaining workers would increase and eventually become prohibitive.

b. Health Care Taxes Cannot Be Justified As a Cost-Control Mechanism

Health care taxes also cannot be justified as a cost-containment mechanism. We all agree that health care costs are out of control and must be restrained. However, the taxation of health coverage or benefits cannot be used effectively to achieve this goal.

The theory behind these proposals is that the ability of employees to purchase health coverage with pretax dollars masks the true cost of this coverage. Employees are therefore willing, so the theory goes, to pay more for the same coverage, or to purchase more comprehensive coverage than they otherwise would.

This is an ivory tower theory that has little or no application to the real world, especially the collectively bargained world. Our workers, like most Americans, work hard for their wages. The favorable tax treatment available with respect to health coverage nowhere near fully pays for that coverage. It merely provides some federal assistance in paying a portion (generally between zero and one-third) of the cost of the coverage. Working Americans are painfully aware that they must pay the lion's share of the cost of their health care coverage. This gives them a very strong incentive to try to reduce that cost.

The fact that employees are paying for their coverage through reduced wages is nowhere more evident than in the context of collective bargaining. In the industries where our participants work, the employers typically bargain an hourly labor cost. It matters little to an employer how that hourly cost is allocated among cash wages, health and welfare plan contributions and pension plan contributions. The employees, through their employee representatives, decide how much must be spent on health coverage and how much will remain to go into paychecks. Those of us who work with collectively bargained plans are hearing the loudly-voiced alarm and dismay of more and more collectively bargained plan participants at seeing that most, and, in a growing number of cases, all, of any hard-won compensation increases must be used to pay for health coverage.

Multiemployer plans do not provide any unnecessary benefits. These plans have already implemented cost control mechanisms, such as copays, deductibles and managed care, where feasible given the ability of each plan's participants to absorb them. The growing number of instances in which plan benefits are cut back further due to the inability of their participants to pay for them represent failures, rather than successes. Plan participants, who, by definition, typically do not have any other resources from which to pay their health care bills, are left with inadequate coverage. These costs will have to be reallocated in some fashion.

Taxing health care coverage will not significantly reduce health coverage costs. Tremendous pressure already exists from workers to reduce these costs to the extent possible. Instead, such taxation carries the danger of reducing coverage below the level that is reasonable and appropriate by making adequate health coverage unaffordable for a greater number of America's workers and their families.

c. Limitation Of Taxes To "Excess" Coverage Would Not Make New Taxes Tolerable

Many of the major proposals that would tax health care coverage to restrict health care costs would impose tax only on coverage above a certain value or "cap." The two major ways to define this cap are: (1) a flat dollar amount intended to approximate the cost of a standard health care package; or (2) the cost of coverage for a standard health care package. Limiting additional tax burdens in this fashion will not make them tolerable.

The magnitude of the additional tax burdens imposed on working Americans through a tax on coverage in excess of a cap would depend on the dollar amount of the cap. Employers that want to continue to avoid their social obligation to provide coverage for their workers, as well as small businesses and low wage workers who may not be able to afford adequate coverage, are exerting great pressure on Congress to include only the barest bones package of benefits in any mandated standard package. (Indeed, they are opposing any employer mandate.) As the standard level of benefits decreases, the tax burden that will result from imposing taxes with respect to coverage in excess of that package increases.

A standard benefits package that is sufficiently comprehensive to minimize unjust tax burdens and adequately protect plan participants and their families will also minimize any arguable cost containment effect. Thus, as tax burdens decrease, so does any possible theoretical justification for imposing them.

d. Administrative Burdens

There would also be very substantial burdens associated with administering a health care tax. Employers would have to measure and report the value of the coverage they provide for each of their employees. The difficulties of this in the context

of multiemployer plans would be so severe that we are developing a separate paper to discuss them.

Very briefly, however, contributions to multiemployer plans are made on a cents-per-hour-worked basis. There is no direct correlation between the contributions made to the plan for the year and the value of coverage provided in that year. Further, contributions on active employees typically pay for coverage for retirees and extended coverage for participants who are between jobs. There is no difference in contribution rates for employees with single coverage and employees with one or more dependents.

How would coverage be valued? How would the differences in single, or single plus one, or single plus two, versus family coverage be handled? What about differences in age? What about differences in the cost of coverage in different geographic regions? These are only a few of the relevant questions.

The valuation of coverage would also be difficult for insured plans. The premiums under such plans are often determined actuarially on a group basis without regard to the particular situation of any given participant.

If only the value of coverage above a cap were subject to adverse consequences, additional complexity would arise. If the cap was not a stated dollar amount, but, instead, the cost of a specified standard coverage package, the standard package would also have to be valued. The Congressional Budget Office has recognized [1] that a cap defined in terms of the cost of a fixed package of health insurance benefits probably could not be administered outside the structure of health purchasing cooperatives. It would be difficult at best for such a cap to be implemented in the context of employers that manage their own health insurance systems. The IRS would require information currently unavailable, such as accurate measures of regional variations.

Administrative complexity and burdens could be reduced by using a fixed-dollar amount, instead of a specified standard package, as a benchmark. However, such a taxation scheme would discriminate against those living in high-cost areas where the same basic coverage is more expensive, employees of small employers that pay higher rates, older groups, groups with retiree coverage and groups in declining industries, especially where extended coverage is provided to unemployed workers and their families. Further, this would provide no relief from the need to value the coverage actually provided.

We also note that the inability to correlate multiemployer plan contribution rates with the value of coverage would create particularly acute problems in the context of a denial of employer deductions for coverage above a cap. There would be no way to assure employers when they sign bargaining agreements, which typically run three or more years, that their contributions will be deductible.

Similar health care valuation issues were faced as a result of the enactment in 1986 of Code section 89. They were a big factor in the complexity of that legislation, which ultimately led taxpayers to demand its repeal, which occurred in 1989. Let us learn from that experience that there is a limit to the regulatory and administrative burdens that taxpayers will endure even to achieve much needed health care reform.

2. WE NEED NATIONAL LEADERSHIP TO STAND FIRM ON THE ISSUE OF HEALTH CARE COVERAGE TAXATION

The millions of multiemployer plan participants, and all health care plan participants, are looking to you, their members of Congress, to provide the necessary leadership to control and fairly allocate health care costs.

Several health care reform proposals would allow state legislatures to decide the crucial issue of whether and how much to tax health care coverage and/or benefits. It is clear from even a cursory review of the existing and proposed state health care reform systems that many state legislatures would impose health care taxes. Enactment of any such state empowerment legislation would therefore merely be a back-door way of imposing health care taxes. We look to you to protect our plans and their participants from such state-imposed taxation.

In conclusion, the NCCMP strongly supports national health care reform. Such reform, however, must include a mandate for all employers to provide adequate health coverage for all of their employees and their dependents. It must not impose any increased tax burdens with respect to health coverage or benefits or allow state legislatures to impose any such burdens.

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[1] Statement of Rosemary D. Marcuss, Assistant Director for Tax Analysis, Congressional Budget Office on "The Tax Treatment of Employer-Based Health Insurance Before the Committee on Finance, United States Senate," April 26, 1994.

Additional tax burdens with respect to health coverage or benefits cannot be tolerated by plan participants. Regardless of what form such taxes take—a limitation on employer deductions, a limitation on the employee exclusion, an excise tax or a tax on plans or the benefits they provide or some other form—the economic burden would ultimately fall on covered workers through decreased wages. Proposals that threaten to impose such additional tax burdens risk undermining the support of American workers for tax reform.

Thank you for the opportunity to provide this testimony.

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