



Medical Savings Account File

**DEPARTMENT OF THE TREASURY
OFFICE OF TAX ANALYSIS
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Number of pages to follow: 2

Date: 6/28/00

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From: Len Burman
Deputy Assistant Secretary (Tax Analysis)

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Comments/Special Instructions: Redline version with new changes

I will call in a few minutes. L

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UNCLASSIFIED

DRAFT—May 21, 2000**REVISED VERSION**

Dear Congressman Rangel:

Thank you for your letter of June 15, 2000 regarding the so-called "access" tax provisions added to the House- and Senate-passed versions of H.R. 2990, the Patients' Bill of Rights legislation. The President has long supported policies that expand health insurance coverage and improve long-term care. His budget includes an investment of about \$140 billion over 10 years for targeted tax incentives and programs to further these goals.

The "access" tax provisions in H.R. 2990, however, raise serious concerns. The proposals are expensive, would not expand coverage significantly, and could actually cause employers to drop existing health insurance coverage for their employees. Moreover, the proposals disproportionately favor high-income taxpayers and provide new tax shelters for the wealthy. As such, ~~the President's office senior advisors and I~~ [Chris and Jeanne want to delete this; why wouldn't other senior advisers join in recommendation??] would recommend that he veto H.R. 2990 if these tax provisions are not eliminated or significantly altered.

In particular, the proposal to extend the Medical Savings Accounts (MSA) demonstration permanently, coupled with changes that expand the program to workers in large firms and reduce the required deductible, could significantly undermine health insurance coverage by encouraging adverse selection. Healthy, younger workers would have an incentive to choose MSAs and opt out of conventional insurance plans. This would leave less healthy, older workers in conventional plans, thereby raising premiums. As a result, some lower-income families could lose insurance since they would be unable to afford either the high MSA deductibles or the higher premiums for conventional insurance. Employers, facing rapidly growing costs in conventional health plans, also might choose to stop providing coverage.

Contrary to proponents' claims, we do not believe that MSAs will be effective at constraining health care costs. More than 90 percent of medical expenditures are made by those with expenditures over the MSA deductible levels. Once deductible levels are reached, taxpayers have no further incentive to restrain their health care expenditures.

MSAs also favor high-income taxpayers and provide significant new shelter opportunities. In addition to the fact that any tax deduction is less valuable to low and middle-income workers, low-income individuals are unlikely to choose MSAs because of their high deductibles and they cannot take the risk of large unplanned out-of-pocket health care costs. Moreover, the tax deduction is less valuable to low and middle income workers. Also, MSAs would provide a new tax shelter for high-income taxpayers, particularly those with incomes too high to qualify for deductible or Roth IRAs. High-income people could make tax-deductible contributions up to the amount of the deductible every year and earnings on the accounts accrue tax-free. Withdrawals could be made for any purpose at any age, often with no penalty.

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DRAFT—May 21, 2000

Similarly, allowing a deduction for individual-market health insurance premiums would not be an effectively way to increase the number of insured Americans. Like MSAs, the individual insurance tax deduction would provide a greater benefit to people with higher income — not moderate- and low-income working, middle-class families who are most likely to be uninsured. In addition, increasing tax subsidies for individual insurance, which in most states can be underwritten, age-rated, and even denied to sick people, is a poor use of taxpayer dollars if not accompanied by insurance reforms. Finally, like MSAs, the individual insurance deduction could encourage healthy people to opt out of group insurance, thus reducing the affordability of employer-based coverage. The Office of Tax Analysis estimates that a net of about 600,000 people would gain insurance as a result of this provision, at a cost of about \$18,000 per newly insured person. Those estimates are highly uncertain, however, and there is a significant risk that the number of insured people could actually decline because many employers would stop offering insurance once their employees could purchase deductible health insurance outside of work.

Finally, the proposal to allow an above-the-line deduction for long-term care insurance also raises policy concerns. Long-term care insurance is already heavily tax-favored, providing participants IRA-like treatment without any income restrictions. In addition, many long-term care insurance policies do not have necessary consumer protections like inflation and non-forfeiture protection. Absent effective consumer protections, mMost current policies lapse before long-term care expenses are ever incurred. A person who purchases long-term care insurance at age 65 is unlikely to hold the insurance 20 years hence when the need for assistance with long-term care expenses is greatest. Thus, while investment in long-term care is essential, directing it further towards private insurance is unwise.

The President has proposed a strong plan that more efficiently and effectively meets the goals of the so-called access provisions -- to decrease the number of uninsured Americans and to improve long-term care. He proposed \$110 billion over 10 years to target assistance to low-income, working families by building on SCHIP, Medicare, Medicaid and COBRA insurance. He also proposed a broad-based long-term care initiative that includes a \$3,000 tax credit to assist families with their long-term care, a new program for Federal employees to purchase high-quality, group private long-term care insurance, and a state program to provide assistance to family caregivers. We would be happy to work with Congress to pass these provisions in the context of a fiscally responsible, overall budget framework.

Sincerely,

Lawrence H. Summers

F A X

From the desk of...
Bob Greenstein
Executive Director

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**Center on Budget
and Policy Priorities**

To: John Podesta 456-1907
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Gene Sperling 456-2878
Jack Lew 395-1005
Jeanne Lambrew 456-7431

Date: May 11, 2000

We understand the Republican staff of the House Ways and Means and Senate Finance Committees have held meetings and reached "agreement" on the health tax provisions to be included in the conference report on the Patients' Bill of Rights. We have been particularly concerned with the Medical Savings Accounts provisions in both the House and Senate bills. These provisions would both make eligibility for MSAs universal and substantially increase their attractiveness by weakening or eliminating important provisions of current law that limit the degree to which MSAs can serve as lucrative tax shelters. Apparently, the Republican agreement on the MSA provisions that would go into the conference report combines egregious MSA provisions from the House bill with egregious provisions from the Senate bill.

If enacted, these MSA provisions would likely lead to substantial adverse selection in the health insurance markets, which could result in substantial increases in premiums for conventional health insurance. Earlier work by the American Academy of Actuaries, RAND, and the Urban Institute indicates that if use of MSAs becomes widespread, as could well occur under these provisions, premiums for conventional insurance *could double*. If that occurred, some employers undoubtedly would drop coverage, and the ranks of the uninsured would rise significantly. In short, under these provisions, healthy, more affluent individuals would be able to use generous tax shelters, while less-healthy individuals could face serious harm.

In March, the Center issued an analysis of the House and Senate MSA provisions. That analysis has now become quite timely; I'm enclosing a copy. I'm also enclosing an op-ed on this issue by the Center's deputy director Iris Lav, which the *Los Angeles Times* ran today. We urge you to take a strong stand on this matter, which could have serious consequences and affect the Administration's legacy in the health insurance area.

Health Care, but Only for the Young and Healthy

■ **Politics:** Medical savings accounts would cause insurance rates to rise for the old and sick.

By IRIS J. LAV

Bills moving through Congress often become a tangle of complicated provisions, the import of any one of which can be hard to discern. The medical savings accounts expansion grafted onto the Patients' Bill of Rights, a bill that extends new rights to managed care patients, is a good example. The White House is hosting a meeting today to push congressional conferees to finish their work on the underlying bill.

Medical savings accounts may seem benign, but they pack a powerful potential for trouble. That's because they benefit the young, the healthy and the wealthy at the expense of the elderly, the sick and the less affluent.

MSAs are for use only with high-deductible health insurance policies, policies that pay nothing until a family incurs between \$3,000 and \$4,500 annually in covered medical costs. A current experiment allows some taxpayers buying such policies or their employers to make tax-deductible deposits into an MSA. Earn-

ings on funds on deposit in these accounts are tax-free. Funds that are withdrawn to pay medical expenses are not taxed. If funds are not used and are left on deposit until retirement, taxes are deferred and funds may be withdrawn for any purpose without penalty.

Currently, MSA use is limited to people who are self-employed, work in small businesses or are uninsured. Additional restrictions are placed on amounts deposited to the accounts and on the terms of the high-deductible insurance policies.

The restrictions were put in place because research suggested that MSAs lead to "adverse selection," in which one type of insurance is selected by young, healthy people with low medical costs. When healthy people congregate in the policies used with MSAs, the insurers can charge lower premiums for these policies than they would have to if they were insuring a broader cross-section of the population with varying health statuses.

So what happens to older, less-healthy people, as well as those who do not have the wherewithal to make MSA deposits? They would increasingly be segregated in conventional, low-deductible plans, which would become more expensive. Many individuals who most need insurance could be forced into high-deductible plans and

become underinsured or could get priced out of the market and join the uninsured.

Research suggests that if use of MSAs becomes widespread, premiums for conventional insurance could more than double over time. According to the American Academy of Actuaries, "The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women." The General Accounting Office conducted a survey of insurers now offering policies with MSAs and found evidence of the beginnings of just this type of adverse selection.

Despite these concerns, Congress is charging ahead to make MSAs universally available and to relax other safeguards on their use. Both the House and Senate versions of the managed care legislation, currently in conference committee, contain such provisions.

Moderate- and middle-income taxpayers get little tax benefit from making MSA deposits; because of their relatively low income-tax rate, the tax deduction isn't worth much. By contrast, MSAs can be attractive for high-income taxpayers even if they have substantial medical ex-

penses. The tax-free compounding of investment earnings on the funds in the MSA accounts along with deferral of taxation can be advantageous for the well-to-do even if the MSA is primarily used as an investment vehicle and health care costs are paid out-of-pocket.

Indeed, some MSA providers already tout the advantages of MSAs as an investment vehicle. In discussing the entry of Merrill Lynch and other investment firms into the MSA arena, the GAO report took note of "insurers' perception that MSA enrollees are using their accounts primarily as tax-sheltered saving vehicles.

MSAs have been sparsely used during the experimental period, partly because the restrictions on MSAs made them less attractive and inhibited marketing. This may lull policymakers into a belief that an MSA expansion is harmless, something that could be traded for better patient protections in other parts of the bill. Such a belief would be mistaken.

The Patients' Bill of Rights has important provisions. But the risks that the MSA provisions pose are so great that it would be better to have no bill than to have a bill that includes them.

Iris J. Lav is deputy director of the Center on Budget and Policy Priorities, a Washington-based advocacy group.

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CENTER ON BUDGET AND POLICY PRIORITIES

May 11, 2000

MSA EXPANSIONS IN PATIENTS' BILL OF RIGHTS COULD DRIVE UP HEALTH INSURANCE PREMIUMS AND CREATE NEW TAX SHELTER

by Iris J. Lav

Summary

Few would propose a tax cut for the affluent paid for with increased health insurance premiums on the sick. That is the probable consequence, however, of provisions related to Medical Savings Accounts contained in both the House and Senate versions of the Patients' Bill of Rights.¹

The conference between the House and the Senate on the Patient's Bill of Rights legislation starts March 2. With both the House and Senate versions of the bill containing provisions to expand MSAs very substantially, it is quite likely such provisions will be part of the legislation to emerge from conference.

The legislation the conference produces is likely to allow universal access to MSAs and also to remove a number of safeguards included in the MSA demonstration project that Congress established in 1996 and that is scheduled to end this year:

- The House and Senate bills include major expansions of MSAs, including universal access, despite the fact that the General Accounting Office's report on the current demonstration finds evidence that MSA availability encourages "adverse selection" in insurance markets. Adverse selection is a circumstance in which healthy and less healthy segments of the population become segregated in different types of insurance plans. When adverse selection occurs, health insurance premiums rise for the less-healthy individuals (because they are no longer pooled with the healthier individuals), and the resulting increase in costs may cause some individuals to lose insurance coverage because it becomes unaffordable for them.
- If MSAs are expanded from the current limited demonstration to universal access, it is highly likely that the types of problems the GAO found during the demonstration period would become widespread and result in substantially higher premium costs for conventional insurance.

¹ Medical Savings Accounts are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. Funds in MSAs may be used to pay for a wide range of health care expenditures, including types of expenditures not covered by the MSA-holder's insurance policy.

Premiums for conventional insurance would be higher because of the effect of MSAs on the insurance market, the phenomenon known as adverse selection.

- Adverse selection would occur because substantial numbers of young, healthy people with low medical costs would choose to use the high-deductible insurance policies and MSAs and thereby to retain their unspent dollars in their own accounts. This would leave people who are less healthy and have higher medical costs in conventional, low-deductible health insurance plans.
- Such a division of the market would drive up the cost of low-deductible insurance for the less healthy segments of the population who most need it. Research conducted by the Urban Institute, RAND, and the American Academy of Actuaries suggests that premiums for conventional insurance could *more than double* if MSA use becomes widespread. According to the American Academy of Actuaries, "The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women."²

When Congress was debating MSAs in 1996 as part of its deliberations on the Health Insurance Portability and Accountability Act, there was concern about the effects that widespread adverse selection could have on the insurance market. Accordingly, Congress allowed MSAs only as a limited demonstration policy so it could secure more information on this matter. The demonstration period is scheduled to expire at the end of this year, but limited use of MSAs during the demonstration period has made it impossible to conduct the comprehensive evaluation of MSAs the 1996 law envisioned. Despite the absence of information indicating that MSAs would not cause serious problems, the provisions in the Patients' Bill of Rights would make MSAs universally available and relax a number of other safeguards in the 1996 demonstration design. Any negative consequences MSAs may have for the insurance market consequently could become pervasive and difficult to reverse.

- Evidence suggests adverse selection in the usage of MSAs already is occurring under the demonstration project. A survey of insurers offering MSA plans notes that "Insurers expect relatively better health status and lower service utilization by enrollees selecting high-deductible plans and *price their products accordingly*." [Emphasis added.] In other words, the insurers can afford to set lower premiums for insurance policies used with MSAs, because they know it will be healthier people who are attracted to using MSAs. This survey of insurers was conducted by Westat under contract with the General Accounting Office in partial fulfillment of the terms of the demonstration project Congress established in 1996.
- The MSA provisions that the House and Senate versions of the Patients' Bill of Rights include would make the accounts universally available. If MSAs become widely popular among consumers with relatively better health, an adverse selection cycle could be triggered that would drive up the cost of conventional,

² American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995, p. 23.

more comprehensive insurance. The resulting premium increases are likely to be large enough to make such insurance unaffordable and unavailable for substantial numbers of Americans.

In addition, the changes in the Patients' Bill of Rights could create a major new tax shelter. The tax shelter would come about because of the similarities between MSAs and Individual Retirement Accounts. Under current law, married taxpayers who are covered by an employer-sponsored pension plan may deduct from their income up to \$4,000 a year for deposits to an IRA if their income is below \$62,000. By 2007, they will be able to make such deposits if their income is below \$100,000.³ Earnings on funds deposited in an IRA compound free of tax; no tax is due on either the deposits or the earnings until funds are withdrawn after retirement (or for a limited number of other purposes).

Taxpayers with incomes above these limits who have pension coverage under employer-sponsored plans are not eligible to use deductible IRAs. When IRA policies were revised in 1986 and again in 1997, Congress determined that such income limits were appropriate largely because the evidence indicates that higher-income individuals can and will save without a taxpayer subsidy; giving high-income taxpayers a tax subsidy for saving is not an efficient use of government funds.

Nevertheless, MSAs could be used by high-income taxpayers as a means to circumvent the income limits that govern tax-advantaged deposits to Individual Retirement Accounts. Under the proposed MSA expansion, *all* high-income taxpayers who choose to use MSAs would be allowed to make tax deductible deposits, and the earnings on these MSA deposits would compound free of tax. Like funds deposited in an IRA, funds on deposit in an MSA may be invested in stocks, bonds, or similar types of assets. MSA deposits and earnings are never taxed if MSA funds are used to pay medical costs. Moreover, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits over a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

The Westat survey of MSA insurers indicates that the market may indeed be developing in this manner.

- According to the Westat survey, "Insurers reported targeting some segments of the insurance market, including highly-paid professionals, farmers and ranchers, partnership firms, and association groups."
- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: "The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some

³ Single taxpayers with incomes below \$42,000 may deduct up to \$2,000 a year. These income limits apply for tax year 2000; the limits are increasing gradually though 2007 under legislation enacted in 1997.

insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses."

- Universal availability of MSAs, along with a number of the proposed changes in the House and Senate bills that would allow larger deposits into MSAs and more flexible use of the tax-sheltered funds, would likely accelerate this trend.
- The Senate version of the Patients' Bill of Rights would be particularly troublesome in this regard, because it would allow funds to be withdrawn from MSAs for *any purpose* without penalty, so long as an amount equivalent to a single year's insurance deductible remained in the account. This contrasts sharply with current-law MSA provisions, which impose a penalty for withdrawal prior to age 65 for purposes other than paying medical expenses. In other words, under the proposed changes, a high-income taxpayer could use the benefits of the tax deferral on MSA deposits and the tax-free compounding of earnings on MSA accounts to accumulate funds for purchase of a yacht, an extended vacation, or any other purpose.

The House version of the legislation includes yet another disturbing provision, which would undermine the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

- Under the MSA demonstration now underway, deposits can be made to an MSA account by either an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.
- The House bill would allow both employees and employers to make deposits to an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income. Most lower-paid staff would not be able to afford substantial additional contributions.

The Patients' Bill of Rights is supposed to be legislation that makes health care more accessible and responsive to consumers' needs. The Medical Savings Account expansions included in the bill move in the opposite direction. They risk driving up the cost of comprehensive, conventional insurance to the point where many Americans, including those most in need of health services, cannot afford to buy coverage. Moreover, the MSA expansions would allow public funds intended to expand health coverage to be diverted to supporting tax shelters for higher-income individuals. The MSA provisions could well turn out to injure consumers significantly more than the other provisions of the legislation might assist them.

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515-6348

May 10, 2000

ALL ENCLOSED, OFFICE OF STAFF

JANICE MATO, MINORITY CHIEF COUNSEL

The Honorable William J. Clinton
President
The White House
Washington, D.C. 20500

Dear President Clinton:

Less than three years ago, the health care program for our nation's elderly and disabled was headed toward financial ruin by 2001. Yet in the face of severe opposition, we succeeded in saving Medicare for a generation - pushing back Medicare's imminent bankruptcy an additional 24 years to 2025.

But with that extra time comes the added responsibility of modernizing and strengthening Medicare for this and future generations this year. Our nation's elderly and disabled have waited long enough for Medicare to catch up with the miracles that modern medicine provides today through prescription drugs.

We are writing to you today asking your support to work with this Congress to help seniors without insurance coverage lower their drug bills. Our seniors deserve more than partisan politics on an issue as important to them as prescription drugs. We want to work with you in a bipartisan way to make a prescription drug benefit under Medicare a reality, not a political bumper sticker to be carried into the fall elections.

As you know, House Republicans have crafted a plan to lower drug prices for seniors and the disabled who currently have no drug coverage by helping them purchase insurance through Medicare. Our plan invests \$40 billion over the next five years to give Medicare's 40 million recipients real bargaining power to lower their prescription drug prices.

Further, our plan matches your plan in assisting low income beneficiaries, but it will also provide help for every person who elects to enroll. More importantly, our plan will not endanger existing drug coverage that seniors might already have through a

-2-

former employer, which is a great concern we have with your plan. Finally, we are concerned that the government would have too heavy a hand in controlling the drug benefit, denying some seniors the right to choose the coverage that best fits their needs.

In short, we can accomplish a great deal for the American people this year, if and only if your Administration and Members of your party choose to work with us, like you did on the Social Security earnings penalty.

Americans want us to work together to protect Medicare and modernize the program with prescription drug coverage, and that's exactly what we intend to do. We can help seniors and the disabled with the costs of prescription drugs. If we put progress before politics and ideas before ambition, we can and will be successful in ensuring Medicare for generations to come. Our seniors and elderly expect and deserve no less.

Sincerely,



Bill Thomas
Chairman
Subcommittee on Health



Bill Archer
Chairman



GAO

Accountability • Integrity • Reliability

United States General Accounting Office
Washington, DC 20548

Health, Education, and
Human Services Division

B-285141

April 21, 2000

The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Subject: *Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990*

Dear Mr. Rangel:

Despite a strong economy, the number of nonelderly Americans without health insurance increased from about 39 million in 1994 to nearly 44 million in 1998, the latest year for which comprehensive data are available. A number of legislative proposals focus on reducing the number of uninsured and on addressing concerns about the equity of tax law as it relates to health insurance. Some of these proposals would expand the tax advantages associated with individually purchased health insurance by allowing individuals who buy health insurance either to receive a tax credit that reduces the amount of taxes they owe or to deduct the premiums they pay from their taxable income. Previously, we reported that tax credits and deductions differ with respect to who would be eligible and the amount of tax subsidy individuals would receive.¹ A tax credit typically results in the same tax benefit regardless of marginal tax rate, although the credit may be available only for individuals below a certain level of taxable income. In contrast, the value of a tax deduction is directly proportionate to marginal tax rates, so that individuals in higher tax brackets receive a larger tax advantage than those in lower tax brackets. This letter responds to your request for information on the potential tax benefit that individuals could receive if a tax

¹See *Private Health Insurance: Estimates of Expanded Tax Deductibility of Premiums for Individually Purchased Health Insurance* (GAO/HEHS-98-190R, June 10, 1998); *Private Health Insurance: Estimates of a Proposed Health Insurance Tax Credit for Those Who Buy Individual Health Insurance* (GAO/HEHS-98-221R, July 22, 1998); and *Private Health Insurance: Estimates of Effects of Health Insurance Tax Credits and Deductions as Proposed in H.R. 2261* (GAO/HEHS-99-188R, Sept. 13, 1999).

GAO/HEHS-00-104R Proposed Health Insurance Tax Deduction

deduction were available as proposed in H.R. 2990.² In particular, you asked that we estimate both the number of people who would potentially be eligible for a tax deduction under this proposal and the potential value of such a deduction.

Current tax law allows employers to deduct from their taxable income the contributions they make to their employees' health insurance premiums and excludes these contributions from the employees' taxable income. Self-employed individuals may deduct 60 percent of health insurance expenses if they are not eligible to participate in an employer-subsidized health plan.³ In addition, any individual may claim an itemized deduction for health insurance premiums to the extent that they and all other medical expenses exceed 7.5 percent of adjusted gross income.

In summary, we estimate the following outcomes had H.R. 2990 been the law in 1998:

- About 39 million people could potentially have benefited from the proposed tax deduction: those who were uninsured and then decided to purchase coverage, those who had individual insurance, and those who had employer-sponsored insurance with no employer subsidization.
- Another 22 million potentially eligible individuals could not have benefited from the proposed deduction either because they were in the 0-percent tax bracket or because they did not file federal income taxes in 1998.
- Most of those who could have benefited from the proposed deduction—nearly 31 million—were in the 15-percent tax bracket and, at most, could have received a 15-percent reduction in premiums. Moreover, because the deductible portion of the premium would have been phased in over a 6-year period, the actual reduction in premiums could have been significantly lower until tax year 2007. We cannot estimate the percentage of people who might have purchased health insurance as a result of the proposed deduction.
- Individuals whose employers paid one-half or less of the total premium for their insurance could also have benefited from the deduction. The number of such individuals, however, is not available. An estimated 76 million people had insurance that was partially subsidized by an employer, although only a small fraction of these individuals would have been likely to benefit from the proposed deduction because most employers who sponsor health insurance pay more than half of the total premium.

²H.R. 2990 was passed by the House on October 6, 1999.

³The portion of these expenses that are deductible will increase until it is 100 percent in 2003.

KEY FEATURES OF H.R. 2990

The tax deduction proposed under H.R. 2990 would be available to people who purchased individual health insurance or who paid 50 percent or more of the total premium for employer-sponsored insurance. The deduction would apply only to the purchase of major medical insurance and not to the purchase of supplemental policies, such as dental or vision-only plans. This deduction would be used in determining adjusted gross income, so that the tax filer would not need to itemize deductions to obtain it. Also, the tax filer would not need to meet the current threshold of 7.5 percent of adjusted gross income for medical expenses to deduct health insurance premiums. The proposed deduction would be phased in over a 6-year period, with 25 percent of the premium being deductible in tax years 2002 through 2004, and 100 percent being deductible beginning in tax year 2007 (see table 1). For self-employed individuals purchasing health insurance, H.R. 2990 would allow the 100-percent deduction of health insurance premiums starting in 2001 rather than in 2003, as is the case under current law.

Table 1: Percentage of Premium That Would Be Deductible, by Tax Year

Tax year(s)	Percentage deductible
2002, 2003, 2004	25
2005	35
2006	65
2007 and later	100

SCOPE AND METHODOLOGY

To determine the potential tax benefit of the deduction proposed in H.R. 2990, we (1) analyzed the U.S. Bureau of the Census' 1999 Current Population Survey (CPS) March Supplement for information on those potentially eligible for the deduction, including their type of health insurance, income, and tax status;⁴ (2) obtained data from the KPMG 1998 Annual Survey of Employer-Sponsored Health Benefits to estimate employer premium contributions; and (3) collected data on single and family health insurance premiums available in the individual market in 1998. Although the Bureau of the Census does not directly collect information on adjusted gross income and federal tax payments, it derives estimates from simulations based on CPS data, statistical summaries of individual income tax returns compiled by the Internal Revenue Service, and data from the American Housing Survey—a survey conducted by the Bureau of the Census under sponsorship of the U. S. Department of Housing and Urban Development.

⁴The 1999 CPS March Supplement, a survey of about 47,000 households, provides data on the characteristics of the civilian noninstitutionalized population of the United States in 1998.

Our estimates reflect the number of people that could potentially be eligible for the tax deduction under H.R. 2990, which is likely to be higher than the number who would actually purchase coverage and thus receive the tax subsidy. In particular, low-income, uninsured individuals could find health insurance difficult to afford even with a tax subsidy. Our estimates also include dependents as well as tax filers in the total number of individuals who could potentially benefit from the proposed deduction and, in the case of a couple or family, are based on the assumption that one policy would cover all family members and dependents within a household. However, our estimates do not include individuals whose employer paid some, but less than half, of their premium. While such people would also be eligible for the proposed deduction, available data do not permit an accurate estimate of this population. Our estimates reflect only those individuals who were uninsured, who purchased health insurance in the individual market, or who had employer-sponsored coverage but paid the entire premium themselves. We did not examine the effect of the proposed deduction on employer sponsorship of health insurance, employer contributions for health insurance, or employee selection of employer-sponsored coverage. Neither did we examine the effect of the proposal on federal revenues. We conducted our work in April 2000 in accordance with generally accepted government auditing standards.

39 MILLION ELIGIBLES COULD HAVE BENEFITED IN 1998, BUT 22 MILLION COULD NOT

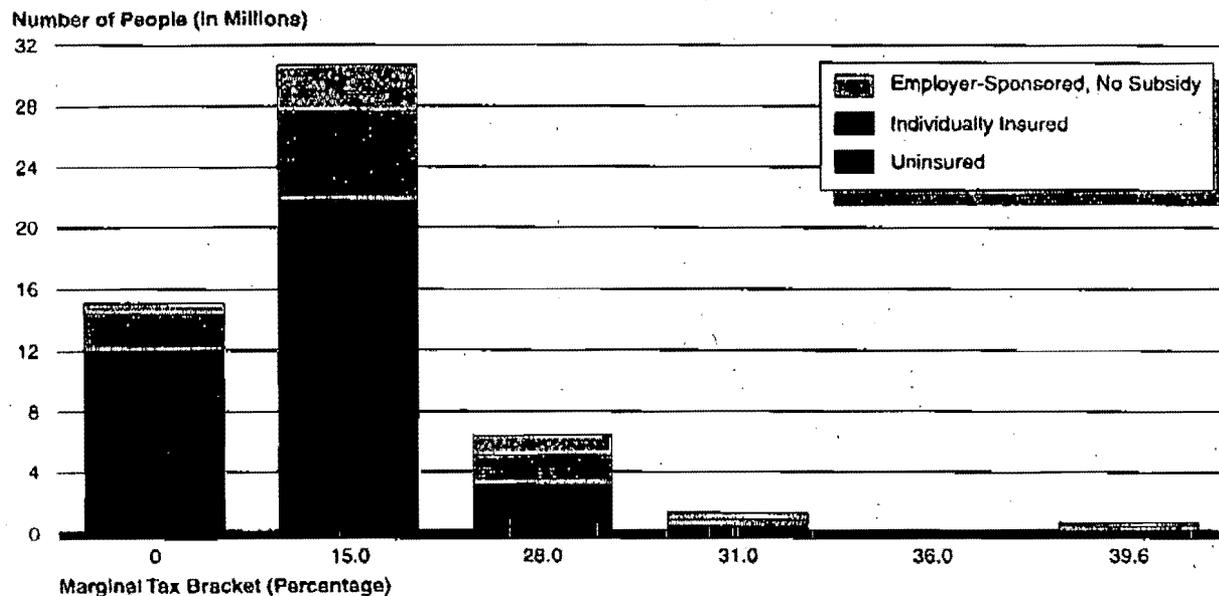
Under H.R. 2990, a tax deduction would be available to individuals with individual insurance or employer-sponsored insurance for which the employer subsidized one-half or less of the premium. Excluding those with health insurance that was, in part, subsidized by an employer, in 1998 about 39 million people could potentially have benefited from this deduction if they purchased or retained health insurance.⁵ Another 22 million potentially eligible individuals could not have benefited from the proposed deduction—about 15 million individuals who were in the 0-percent tax bracket and 7 million individuals who did not file federal income taxes in 1998.

Of the 39 million people who could have benefited from the deduction, about two-thirds were uninsured and would have received the tax subsidy only if they had elected to purchase health insurance. The other one-third, including about 9 million who had purchased policies in the individual market and 5 million who had employer-sponsored coverage with no employer subsidy, would have received a tax subsidy for health insurance they were already purchasing. As shown in figure 1, most of the people who could potentially have benefited from

⁵About 2 million of these individuals could already have qualified for the health insurance deduction that is available to self-employed individuals.

the proposed deduction—nearly 31 million—were in the 15-percent tax bracket,⁶ and about 15 million could not have benefited from the deduction because they were in the 0-percent tax bracket.

Figure 1: Number of Individuals Who Could Potentially Have Benefited in 1998 From the Proposed Tax Deduction, by Insurance Status and Marginal Tax Bracket



Note: Figure 1 excludes individuals with employer-sponsored coverage whose employer subsidized a portion of their premiums.

MOST EMPLOYERS SPONSORING COVERAGE PAY MORE THAN HALF OF PREMIUMS

An unknown, though likely small, number of individuals whose employers paid half or less of the premium cost would also have been eligible for the deduction in 1998. That year, about 76 million individuals had both health insurance that was partially subsidized by an employer and sufficient income for a tax deduction. Most of these people would not have been eligible for the proposed deduction, however, because most employers sponsoring health insurance pay

⁶In 1998, the 15-percent tax bracket included taxable incomes of \$25,350 or less for single tax filers, \$33,950 for head-of-household tax filers, and \$42,350 for joint tax filers.

more than one-half of the total premium.⁷ Only about 16.5 percent of employers sponsoring single coverage paid less than one-half of the total premium; 43.5 percent paid less than one-half of the premium for family coverage.⁸ Most of the employers that paid less than half of premiums were small firms with fewer than 25 employees; hence, a relatively small portion of individuals with employer-sponsored coverage would have been affected.

While most employers that sponsor health insurance pay most of the premium, some kinds of employers are less likely to do so than others. In addition to small employers, employers in the construction, high-technology, and retail industries represent the largest portion of firms paying 50 percent or less of health insurance premiums. Consequently, people who receive coverage through these kinds of firms are among those most likely to benefit from the proposed tax deduction.

TAX BENEFIT INCREASES WITH MARGINAL TAX RATE

The value of a tax deduction increases relative to a person's marginal tax bracket. Thus, if the deduction proposed under H.R. 2990 was fully phased in, an eligible single tax filer in the 15-percent bracket who paid \$2,658⁹ in premiums could receive a tax subsidy of about \$399 from a deduction, resulting in a net cost of about \$2,259 for coverage.¹⁰ The potential deduction for this same coverage would be higher, however, for someone in a higher tax bracket. For example, an individual who was in the highest tax bracket—the 39.6-percent bracket—and had purchased this same policy could have a tax benefit of \$1,053, resulting in a net cost of \$1,605 for this coverage.¹¹ (See enclosures for more information on the estimated effects of H.R. 2990's tax deduction on 1998 taxpayers.)

⁷The CPS does not indicate the exact percentage of health insurance premiums subsidized by employers, but only whether they pay all, some, or none of those premiums. Consequently, we could not estimate how many people with partial employer subsidies could actually benefit from the proposed deduction.

⁸Results are derived from a special analysis of the KPMG 1998 Annual Survey of Employer-Sponsored Health Benefits.

⁹This amount represents a 1998 premium in the individual market for a point-of-service plan for a single person that is available in a rural county of New York.

¹⁰We can not estimate the percentage of people who would purchase health insurance as a result of the proposed deduction.

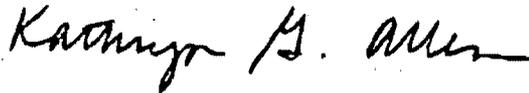
¹¹In 1998, the 39.6-percent tax bracket included taxable incomes of \$278,451 or more but represented only a small portion of those potentially eligible for the proposed deduction.

The value of the deduction proposed under H.R. 2990 would be even more limited until 2007, when premiums would be fully deductible. For example, in the first 3 tax years, only 25 percent of paid premiums could be considered for deduction. Hence, a single tax filer in the 15-percent bracket who paid \$2,658 in premiums could receive a tax subsidy of about \$100. An individual in the highest tax bracket who paid this amount in premiums could receive a subsidy of about \$264.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this correspondence until 30 days after its issue date. At that time, we will make copies available to interested parties on request.

If you have any further questions regarding this letter, or if we can be of further assistance, please call me at (202) 512-7118 or John Dicken at (202) 512-7043. Staff who made major contributions to this letter include Mark Vinkenes and Paula Bonin.

Sincerely yours,



Kathryn G. Allen
Associate Director, Health Financing
and Public Health Issues

Enclosures - 2

**ESTIMATES OF INDIVIDUAL HEALTH INSURANCE PREMIUM
DEDUCTIONS FOR SINGLE TAX FILERS, 1998**

Taxable income	Marginal tax bracket	Cost of individual health insurance ^b	Net insurance cost after deduction ^a		Estimated number of nonelderly who were uninsured, were individually insured, or had employer-sponsored insurance but no subsidy (in millions) ^c
			At 25-percent deductible	At 100-percent deductible	
\$0	0%	Low: \$744 Medium: \$2,658 High: \$7,154	d d d	d d d	3.9
\$1-\$25,350	15.0%	Low: \$744 Medium: \$2,658 High: \$7,154	\$716 \$2,558 \$6,886	\$632 \$2,259 \$6,081	11.1
\$25,351-\$61,400	28.0%	Low: \$744 Medium: \$2,658 High: \$7,154	\$692 \$2,471 \$6,653	\$536 \$1,913 \$5,151	1.5
\$61,401-\$128,100	31.0%	Low: \$744 Medium: \$2,658 High: \$7,154	\$686 \$2,452 \$6,600	\$513 \$1,834 \$4,936	0.3
\$128,101-\$278,450	36.0%	Low: \$744 Medium: \$2,658 High: \$7,154	\$677 \$2,418 \$6,510	\$476 \$1,701 \$4,579	*
\$278,451+	39.6%	Low: \$744 Medium: \$2,658 High: \$7,154	\$670 \$2,394 \$6,446	\$449 \$1,605 \$4,321	c

^aIf H.R. 2990 becomes law, the deduction will be phased in over a 6-year period, beginning at 25 percent in tax years 2002 through 2004 and then increasing to 35 percent in 2005, 65 percent in 2006, and 100 percent in 2007.

^bThe low, medium, and high premium estimates represent the variation in individual health insurance premiums that existed nationally in 1998. These premiums are examples of actual individual (as opposed to group) insurance premiums. The low premium represents an Arizona preferred provider organization's 1998 premium for a single healthy male under age 30 purchasing a \$500-deductible plan. The medium premium represents a 1998 premium for a point-of-service plan for a single person that is available in a rural county of New York. The high premium represents a 1998 premium for an urban Illinois fee-for-service plan with a \$250 deductible for a single male smoker aged 60 to 64.

^cMost individuals with employer-sponsored coverage with the employer paying some, but not all, of the coverage would not have been eligible for a deduction,

because over 80 percent of employers that sponsored health insurance for singles also paid more than 50 percent of the premiums.

*Not applicable because individuals in the 0-percent marginal tax bracket would not have received a tax subsidy and therefore would have paid the full cost of their health insurance.

*The estimated number was less than 75,000—too small to be reliable, according to the CPS.

Sources: GAO analysis of March 1999 CPS data and Bureau of the Census estimates of taxable income.

**ESTIMATES OF INDIVIDUAL HEALTH INSURANCE PREMIUM DEDUCTIONS
FOR HEAD-OF-HOUSEHOLD AND JOINT TAX FILERS AND THEIR
DEPENDENTS, 1998**

Taxable income for joint tax filers ^b	Marginal tax bracket	Cost of individual health insurance ^c	Net insurance cost after deduction ^d		Estimated number of nonelderly who were uninsured, were individually insured, or had employer-sponsored insurance but no subsidy (in millions) ^e
			At 25-percent deductible	At 100-percent deductible	
\$0	0%	Low: \$3,180 Medium: \$7,352 High: \$14,233	• • •	• • •	11.3
\$1-\$42,350	15.0%	Low: \$3,180 Medium: \$7,352 High: \$14,233	\$3,061 \$7,076 \$13,699	\$2,703 \$6,249 \$12,098	19.6
\$42,351-\$102,300	28.0%	Low: \$3,180 Medium: \$7,352 High: \$14,233	\$2,957 \$6,837 \$13,237	\$2,290 \$5,293 \$10,248	4.9
\$102,301-\$155,950	31.0%	Low: \$3,180 Medium: \$7,352 High: \$14,233	\$2,934 \$6,782 \$13,130	\$2,194 \$5,073 \$9,821	1.0
\$155,951-\$278,450	36.0%	Low: \$3,180 Medium: \$7,352 High: \$14,233	\$2,894 \$6,690 \$12,952	\$2,035 \$4,705 \$9,109	0.2
\$278,451+	39.6%	Low: \$3,180 Medium: \$7,352 High: \$14,233	\$2,865 \$6,624 \$12,824	\$1,921 \$4,440 \$8,597	0.6

^aIf H.R. 2990 becomes law, the deduction will be phased in over a 6-year period, beginning at 25 percent in tax years 2002 through 2004 and then increasing to 35 percent in 2005, 65 percent in 2006, and 100 percent in 2007.

^bThe income brackets associated with the marginal tax rate categories for head-of-household tax filers in 1998 were lower than for joint tax filers as follows: 15-percent marginal tax rate for taxable income: from \$1 to \$33,950; 28-percent marginal tax: \$33,951 to \$87,700; 31-percent marginal tax: \$87,701 to \$142,000; 36-percent marginal tax: \$142,001 to \$278,450; and 39.6-percent marginal tax for income exceeding \$278,450.

^cThe low, medium, and high premium estimates represent the variation in individual health insurance premiums that existed nationally in 1998. These premiums are examples of actual individual (as opposed to group) insurance premiums available for a family of four. The low premium represents an Arizona preferred provider organization's 1998 premium for a \$500-deductible plan for two parents under 30 years old. The medium premium represents a 1998 family

premium for a point-of-service plan available in a rural county of New York. The high premium represents a 1998 premium for an urban Illinois fee-for-service plan with a \$250 deductible for two parents aged 60 to 64 with a father who was a smoker.

*Most individuals with employer-sponsored coverage with the employer paying some, but not all, of the coverage would not have been eligible for a deduction, because over 90 percent of employers that sponsored single plus one dependent coverage also paid more than 50 percent of the premiums. More than 50 percent of employers that sponsored family coverage also paid more than 50 percent of the premiums.

*Not applicable because individuals in the 0-percent marginal tax bracket would not have received a tax subsidy and therefore would have paid the full cost of their health insurance.

Sources: GAO analysis of March 1999 CPS data and Bureau of the Census estimates of taxable income.

(201058)

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MEDICAL SAVINGS ACCOUNTS (MSAs)

DESCRIPTION:

House: Makes MSAs permanent and removes cap on the number of MSAs. Allows all individuals covered by a high deductible plan to have an MSA. Permits both employer and employee contributions. Allows MSAs to be offered in cafeteria plans. Lowers minimum deductible to \$1,000 (\$2,000 for family).

Senate: Makes MSAs permanent and removes cap on the number of MSAs. Allows all individuals covered by a high deductible plan to have an MSA. Lowers minimum deductible to \$1,000 (\$2,000 for family). Eliminates tax on non-medical distributions if the remaining account balance is at least equal to the plan deductible. Includes rules about the treatment of managed care plans as high deductible plans. Also permits MSAs to be offered in the FEHBP and preempts state laws regarding high-deductible plans.

JCT March 14 cost: \$1.7 billion 00-05; \$4.6 billion 00-10 (House). \$1.9 billion 00-05; \$4.8 billion 00-10 (Senate).

CONCERNS:

- Creates a new tax shelter for the wealthy. Unlike individual retirement accounts, which have upper income limits, MSAs create a new tax shelter for the wealthy. Millionaires could put money in an MSA and withdraw it without a penalty when they hit retirement age. Low-income families are unlikely to participate in an MSA since the high deductible is a large percent of their annual income.
- Benefits mostly healthy, insured people. People with any kind of health problem need insurance and will not want buy a plan that has a very high deductible. As such, only people who are healthy – and likely already insured today – will participate. As such, experts agree that MSAs do nothing for the 44 million uninsured Americans.
- Raises premiums for people getting insurance through their employers. If many healthy, wealthy people joined MSAs, then sicker people would be left in employer-based health insurance, causing those premiums to rise, especially for small employers.
- Demonstration not working -- and changes would only exacerbate known flaws. Only about 75,000 people have participated in this demonstration – 10 percent of the total limit of 750,000. The changes proposed may increase participation, but primarily among the wealthiest since they expand MSAs' tax benefits by allowing employers to contribute, some tax-free withdrawals for non-health purposes, and lower the deductible for the insurance plan, meaning that less money in the account is needed and more can be sheltered.

MSA Tax Shelters

- Even under current law, MSAs can provide a very tax sheltered way of saving for high income individuals.
 - MSAs allow high-income individuals to circumvent income and other limits on tax deferral written into the pension and IRA laws.
 - At death, MSA accounts can be transferred to spouse beneficiaries without taxation.
- Under the proposal, the current additional tax on non-medical withdrawals from MSAs would be waived if remaining assets in the account are at least equal to the deductible.
 - The proposal would facilitate the use of MSAs as a general purpose savings vehicle by waiving the additional tax on many non-medical withdrawals from MSAs. As a result, MSAs would be most attractive to high-income individuals as a supplement to their IRAs and employer pensions, rather than as a means to pay for medical expenses.

MSA Tax Shelter Examples

- An individual with \$200,000 in adjusted gross income and with a pension would not be permitted to make deductible contributions to a traditional Individual Retirement Account (IRA) nor contributions to a Roth IRA under current law.
- Under current law, this same individual could contribute up to \$3,488 (indexed) to a Medical Savings Account (MSA) each year if covered under a high deductible family health insurance plan. If he or she were to contribute the maximum for forty years and made no withdrawals, the account would grow to \$1,093,046, assuming a 7 percent rate of return,
- Under the proposal, this individual could contribute up to \$4,650 (indexed) to an MSA each year. By contributing the maximum each year and under otherwise similar assumptions, he or she could accumulate \$1,460,244 over a forty year period. The full \$1,460,244 could be used to pay medical expenses. Alternatively, funds could be withdrawn for any other purpose. For example, after paying taxes, the remaining \$934,556 could be used to buy a boat.
- In contrast, if an equivalent amount of (before tax) income were used to fund a taxable savings account and assuming a 36 percent marginal tax rate, the account would accumulate only \$816,060 by the end of forty years.
- Using similar assumptions, an eligible individual who were to contribute the maximum each year to an IRA could accumulate \$427,219. If both spouses were to fund to the maximum, they could accumulate twice that amount, \$854,438 in IRAs. By funding both MSAs and IRAs to the maximum, a couple could accumulate \$2,314,682 in these tax preferred accounts in addition to any tax preferred pension saving.
- Higher (lower) rates of return would produce higher (lower) accumulations. See table.

MSA vs. IRA

	<u>Current law MSA</u>	<u>Proposed MSA</u>	<u>Deductible IRA</u>
Maximum contribution	Single plan 65% of deductible up to \$1,528; Family plan 75% of deductible up to \$3,488.	Single plan 100% of deductible up to \$2,350 (indexed); Family plan 100% of deductible up to \$4,650 (indexed).	\$2,000.
Withdrawals	Include in taxable income and 15 percent additional tax.	If for qualified medical expenses – not taxed; Otherwise if accounts exceed deductible, include in taxable income; Otherwise include in taxable and 15 percent additional tax.	If after age 59 ^{1/2} and in other limited circumstances include in taxable income; Otherwise include in taxable income and 10 percent additional tax.
Income limits	None.	None.	In 2000, joint returns phased out between \$52,000 and \$62,000 (singles phased out \$32,000-\$42,000). These limits gradually increase until 2007 when joint returns are phased out between \$80,000 and \$100,000 (singles phased out \$50,000-\$60,000).
Tax treatment at death	Spouse beneficiary – no taxation; Other beneficiaries – include excess above decedent's qualified medical expenses in beneficiaries' taxable income. Federal estate taxes is deductible.	Same as current law.	Spouse beneficiary – no taxation; Other beneficiaries, if decedent had begun required distribution, beneficiary must follow similar distribution path; otherwise beneficiary may distribute evenly over his or her lifetime. In some circumstances, may or must distribute within 5 years. Federal estate taxes is deductible.

Long-term Care Insurance Examples

Accumulated Premiums

	Interest rate			
	<u>3%</u>	<u>4%</u>	<u>5%</u>	<u>6%</u>
Base policy				
40 year old	\$32,108	\$43,778	\$60,503	\$84,599
65 year old	\$38,823	\$44,622	\$51,471	\$59,570
With inflation protection and nonforfeiture benefit				
40 year old	\$90,229	\$123,026	\$170,028	\$237,742
65 year old	\$88,865	\$102,139	\$117,817	\$136,355

Notes:

Interest rate is real after-tax rate of return.

Base policy costs \$274 for 40 year old and \$1,007 for 65 year old. Policy with inflation protection and nonforfeiture benefit costs \$770 for 40 year old and \$2,305 for 65 year old.

The policy covers up to \$100 per day in nursing home care, \$80 per day in assisted living facility care and \$50 per day in home care for up to four years. There is a 20 day elimination period. Age is age at initial purchase.

Sources: Health Insurance Association of America, "Long-term Care Insurance in 1997-1998", March 2000 and OTA calculations.

Comparison of Proposed MSA and Taxable Savings Account

	Interest Rate ¹							
	6%		7%		8%		9%	
	Nominal	Real	Nominal	Real	Nominal	Real	Nominal	Real
Proposed MSA	\$1,156,623	\$608,071	\$1,460,244	\$745,907	\$1,858,706	\$924,369	\$2,383,370	\$1,156,623
Taxable Savings Account	\$713,814	\$489,920	\$816,060	\$553,027	\$936,694	\$626,967	\$1,079,307	\$713,814

Notes:

¹ Nominal interest rate.

Assumes 3 percent inflation and 36 percent marginal tax rate.

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INTRODUCTION AND LEGISLATIVE BACKGROUND

This document¹ prepared by the staff of the Joint Committee on Taxation, provides a comparison of the revenue provisions contained in H.R. 2990 as passed by the House and as amended by the Senate.

H.R. 2990 was passed by the House on October 6, 1999. H.R. 2990 as passed by the House has two divisions. Division A is the "Quality Care for the Uninsured Act of 1999," and Division B is the "Bipartisan Consumers Managed Care Improvement Act of 1999." The bill, as amended by the provisions of S. 1344 as amended by the Senate (the "Patients' Bill of Rights Plus Act"), was passed by the Senate on October 14, 1999.

¹ This document may be cited as follows: Joint Committee on Taxation, *Comparison of Revenue Provisions in H.R. 2990, as passed by the House and the Senate* (JCX-77-99), November 2, 1999.

ITEM	HOUSE BILL	SENATE AMENDMENT
I. HEALTH CARE TAX RELIEF PROVISIONS		
A. Above-the-Line Deduction for Health Insurance Expenses (sec. 201 of the House bill)	<ul style="list-style-type: none"> • Provides above-the-line deduction for of health insurance costs, phased in: 25% in 2002, 2003, and 2004; 35% in 2005; 65% in 2006; and 100% in 2007 and thereafter. • Deduction available only if the taxpayer pays for at least 50% of the cost of the insurance. • Effective for years beginning after December 31, 2001. • Same as sec. 501 of the conference agreement for H.R. 2488.² 	No provision.
B. Accelerate 100-Percent Self-Employed Health Insurance Deduction (sec. 202 of the House bill and sec. 501 of the Senate amendment)	<ul style="list-style-type: none"> • Increases self-employed health deduction to 100% beginning in 2001. • Provides that deduction is not available if individual participates in an employer-subsidized health plan. • Same as sec. 801 of the conference agreement for H.R. 2488, except for the effective date. 	<ul style="list-style-type: none"> • Increases self-employed health deduction to 100% beginning in 2000. • No provision. (Retains present-law rule that deduction is not available if individual is eligible to participate in an employer-subsidized health plan).

² H.R. 2488, the "Taxpayer Refund and Relief Act of 1999," was vetoed by President Clinton on September 23, 1999. Legislative history for the provisions in H.R. 2488 may be found in H. Rept. 106-238 (July 16, 1999), S. Rept. 106-120 (July 23, 1999), and H. Rept. 106-289 (August 4, 1999).

ITEM	HOUSE BILL	SENATE AMENDMENT
C. Provisions Relating to Medical Savings Accounts ("MSAs")		
1. Expand availability of MSAs (sec. 203 of the House bill and sec. 502 of the Senate amendment)	<ul style="list-style-type: none"> • Makes MSAs permanent and removes cap on number of MSAs. • Allows all individuals covered by a high deductible plan to have an MSA. • Permits both employer and employee contributions. • Allows MSAs to be offered in a cafeteria plan. • Lowers minimum deductible to \$1,000 (\$2,000 for family coverage) and allows contributions up to deductible. • No provision. • No provision. • Effective for taxable years beginning after December 31, 2000. • Same as Section 503 of the House version of H.R. 2488, except that that bill did not extend MSAs to individuals not covered by an employer. 	<ul style="list-style-type: none"> • Same as House bill. • Same as House bill. • No provision. • No provision. • Same as House bill. • Provides that the 15-percent additional tax on distributions not used for medical purposes does not apply if the remaining account balance is at least equal to the deductible under the individual's high deductible plan. • Includes rules regarding the treatment of networked-based managed care plans as high deductible plans. • Generally effective for taxable years beginning after December 31, 1999.

ITEM	HOUSE BILL	SENATE AMENDMENT
2. Permit MSAs to be offered under the FEHBP (sec. 503 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Permits MSAs to be offered under the FEHBP. • Effective for contract terms beginning after December 31, 1999.
3. Preemption of laws regarding high deductible plans (sec. 101 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Provides that, notwithstanding any other provision of law, health issuers may offer and eligible individuals may purchase high deductible plans. Provides that, effective for 4 years after the date of enactment, high deductible health plans are not required to provide payment for any health care items or services that are exempt from the plan's deductible.

ITEM	HOUSE BILL	SENATE AMENDMENT
D. Provisions Relating to Long-Term Care		
1. Above-the-line deduction for long-term care insurance expenses (sec. 201 of the House bill and sec. 602 of the Senate amendment)	<ul style="list-style-type: none"> • Provides above-the-line deduction for a percentage of eligible long-term care insurance costs (subject to present-law premium limitations). • Deductible percentage is 25% in 2002, 2003, and 2004; 35% in 2005; 65% in 2006; and 100% in 2007 and thereafter. • Deduction available only if taxpayer pays at least 50% of the cost of the coverage. • Effective for taxable years beginning after December 31, 2001. • Same as section 501 of the conference agreement for H.R. 2488. 	<ul style="list-style-type: none"> • Provides above-the-line deduction for 100 percent of eligible long-term care insurance costs. • Deduction is not available if taxpayer eligible to participate in employer-subsidized long-term care plan. • Deduction does not apply for self-employment tax purposes. • Effective for taxable years beginning after December 31, 1999.
2. Permit long-term care to be offered as part of a cafeteria plan (sec. 204 of the House bill and sec. 601 of the Senate amendment)	<ul style="list-style-type: none"> • Permits long-term care benefits to be offered under flexible spending arrangements and cafeteria plans. In the case of long-term care insurance, the benefit cannot exceed the present-law premium limitations. • Effective beginning after December 31, 2001. • Same as sec. 502 of the conference agreement for H.R. 2488. 	<ul style="list-style-type: none"> • Permits long-term care benefits to be offered under cafeteria plans (present-law premium limitations do not apply). • Effective beginning after December 31, 1999.

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>3. Additional personal exemption for caretakers (sec. 205 of the House bill)</p>	<ul style="list-style-type: none"> • Provides taxpayers with an additional personal exemption for an individual who (1) is an ancestor of the taxpayer or the taxpayer's spouse (or the spouse of such ancestor), (2) has been certified as having long-term care needs, and (3) is a member of the taxpayer's household for the taxpayer's entire taxable year. • Effective for taxable years beginning after December 31, 2000. • Same as sec. 503 of the conference agreement for H.R. 2488, except for the effective date. 	<p>No provision.</p>
<p>4. Study of long-term care needs (sec. 603 of the Senate amendment)</p>	<p>No provision.</p>	<p>Directs the Secretary of Health and Human Services to conduct a study on the future demand for long-term services and long-term options for financing such services.</p>

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>E. Expand Human Clinical Trials Expenses Qualifying for Orphan Drug Tax Credit (sec. 206 of the House bill)</p>	<ul style="list-style-type: none"> • Expands qualifying expenses to include those expenses related to human clinical testing incurred after the date on which the taxpayer files an application with the FDA for designation of the drug under section 526 of the Federal Food, Drug, and Cosmetic Act as a potential treatment for a rare disease or disorder. • Effective for expenditures paid or incurred after December 31, 2000. • Same as sec. 504 of the conference agreement for H.R. 2488, except for the effective date. 	<p>No provision.</p>

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>F. Add Certain Vaccines Against Streptococcus Pneumoniae to List of Taxable Vaccines (sec. 207 of the House bill and sec. 810 of the Senate amendment)</p>	<ul style="list-style-type: none"> • Adds any conjugate vaccine against streptococcus pneumoniae to the list of taxable vaccines, effective day after CDC makes final recommendation for routine administration to children. • Reduces rate of tax for all vaccines from 75 cents to 50 cents per dose, effective for sales after December 31, 2004. • Requires GAO report regarding the operation and management of the Vaccine Trust Fund. • Substantially identical to sec. 505 of the conference agreement for H.R. 2488. 	<ul style="list-style-type: none"> • Adds any conjugate vaccine against streptococcus pneumoniae to the list of taxable vaccines, effective day after CDC makes final recommendation for routine administration to children.

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>G. Credit for Clinical Testing Research Expenses Attributable to Certain Qualified Academic Institutions (sec. 208 of the House bill)</p>	<ul style="list-style-type: none"> • Taxpayer may claim a 40% credit for qualified medical research expenditures made with respect to certain human clinical testing of any drug, biologic, or medical device. The credit would apply to qualified medical research expenditures in excess of a base period amount. • Qualified medical research expenditures are only those amounts paid to certain academic institutions. • Effective for taxable years beginning after December 31, 2000. • Same as sec. 1334 of the conference agreement for H.R. 2488, except for the effective date. 	<p>No provision.</p>
<p>H. Application of Patients' Bill of Rights to Group Health Plans (sec. 1401 of the House bill and sec. 102 of the Senate amendment)</p>	<ul style="list-style-type: none"> • Imposes an excise tax with respect to group health plan failures to comply with the patients' rights provisions of the bill. • Generally effective for plan years beginning on or after January 1, 2001. 	<ul style="list-style-type: none"> • Imposes an excise tax with respect to group health plan failures to comply with the patients' rights provisions of the bill. • Generally effective with respect to plan years beginning on or after January 1 of the second calendar year following the date of enactment.

ITEM	HOUSE BILL	SENATE AMENDMENT
I. Right to Information About Plans and Providers (sec. 111(b) of the Senate amendment)	No separate provision. (The patients' bill of rights provisions in the bill, see item III.H., above, include requirements that plans provide certain information to participants.)	<ul style="list-style-type: none"> • Imposes an excise tax with respect to group health plans that fail to provide participants with certain information regarding the plan. • Effective one year after the date of enactment.
J. Women's Health and Cancer Rights (sec. 201 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Imposes an excise tax with respect to group health plans that fail to meet certain requirements relating to coverage for minimum hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations. • Effective on the date of enactment.
K. Genetic Information and Services (sec. 303 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Imposes an excise tax with respect to group health plans that fail to meet certain requirements prohibiting discrimination on the basis of genetic information or services. • Generally effective with respect to plan years beginning one year after the date of enactment.

ITEM	HOUSE BILL	SENATE AMENDMENT
L. Carryover of Unused Benefits from Cafeteria Plans and Flexible Spending Arrangements ("FSAs") (sec. 504 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Up to \$500 of unused health or dependent care benefits can be carried forward annually under a cafeteria plan or FSA. • Amounts carried forward can be paid to the participant, rolled over to a section 401(k) plan or similar arrangement or an MSA. • Effective for taxable years beginning after December 31, 1999.
II. INDIVIDUAL RETIREMENT ARRANGEMENTS		
A. Increase Income Limitation on Roth IRA Conversions (sec. 701 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Increases the AGI limit on conversions of traditional IRAs to Roth IRAs from \$100,000 to \$1,000,000 for single and joint filers. • Effective for taxable years beginning after December 31, 1999. • Similar to sec. 302 of the Senate version of H.R. 2488, except for the effective date.

ITEM	HOUSE BILL	SENATE AMENDMENT
III. REVENUE OFFSET PROVISIONS		
A. Modify Foreign Tax Credit Carryover Rules (sec. 801 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Reduces the carryback period for excess foreign tax credits from two years to one year. • Extends the excess foreign tax credit carryforward period from five years to seven years. • Effective for foreign tax credits arising in years beginning after December 31, 2001. • Same as sec. 1301 of the Senate version of H.R. 2488, except for the effective date.
B. Limitation on Use of Nonaccrual Experience Method of Accounting (sec. 802 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Limits use of the nonaccrual method to receivables from the provision of qualified personal services. • The effect of change in method to be taken into account over a period of up to 4 years. • Effective for taxable years ending after the date of enactment. • Same as sec. 1509 of the conference agreement for H.R. 2488.

ITEM	HOUSE BILL	SENATE AMENDMENT
C. Expand Reporting on Cancellation of Indebtedness Income (sec. 803 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Requires information reporting on indebtedness discharged by any organization a significant trade or business of which is the lending of money. • Effective with respect to discharges of indebtedness after December 31, 1999. • Same as sec. 1501 of the conference agreement for H.R. 2488.
D. Extension of IRS User Fees (sec. 804 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Extends the statutory authorization for IRS user fees through September 30, 2009. • Effective for requests made after September 30, 2003. • Same as sec. 1502 of the conference agreement for H.R. 2488.
E. Property Subject to a Liability under Section 357(c) (sec. 805 of the Senate amendment)	No provision.	<ul style="list-style-type: none"> • Modify the rules regarding when a corporation is treated as assuming a liability, and limit a corporation's basis in property that secures the liability. • This provision was included in H.R. 435, the Miscellaneous Trade and Technical Corrections Act of 1999, which was signed into law on June 25, 1999 (P.L. 106-36).

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>F. Charitable Split-Dollar Life Insurance (sec. 806 of the Senate amendment)</p>	<p>No provision.</p>	<ul style="list-style-type: none"> • Restates present law by denying a charitable contribution deduction for a transfer to a charity if the charity directly or indirectly pays or paid any premium on a life insurance, annuity or endowment contract in connection with the transfer, and any direct or indirect beneficiary under the contract is the transferor, any member of the transferor's family, or any other noncharitable person chosen by the transferor. • Imposes an excise tax on the charity, equal to the amount of the premiums paid by the charity, if the premiums are paid in connection with a transfer for which a deduction is not allowable. • Requires a charity to report annually to the Internal Revenue Service the amount of premiums subject to this excise tax and information about the beneficiaries under the contract. • Generally effective after February 8, 1999. • Same as sec. 1510 of the conference agreement for H.R. 2488.

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>G. Treatment of Excess Pension Assets Used for Retiree Health Benefits (sec. 807 of the Senate amendment)</p>	<p>No provision.</p>	<ul style="list-style-type: none"> • Extends through September 30, 2009, the present-law provision permitting qualified transfers of excess defined benefit pension plan assets to provide retiree health benefits. • Effective for transfers occurring after December 31, 2000, and before October 1, 2009, replaces the present-law minimum benefit requirement by a minimum cost requirement. • Same as sec. 1507 of the conference agreement for H.R. 2488, except for the effective date with respect to the minimum cost requirement.

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>H. Impose Limitation on Prefunding Certain Employee Benefits (sec. 808 of the Senate amendment)</p>	<p>No provision.</p>	<ul style="list-style-type: none"> • Limits the present-law exception to the deduction limit for 10-or-more employer plans to plans that provide only medical benefits, disability benefits, and qualifying group-term life insurance benefits. • An excise tax is imposed on the employer if any portion of a welfare benefit fund attributable to contributions that are deductible under the 10-or-more employer rule is used for a purpose other than the purpose for which the contributions were made. • Effective with respect to contributions paid or accrued after the date of enactment, in taxable years ending after such date. • Substantially identical to sec. 1503 of the conference agreement for H.R. 2488, except for the effective date.

ITEM	HOUSE BILL	SENATE AMENDMENT
<p>I. Modify Installment Method and Prohibit its Use by Accrual Method Taxpayers (sec. 809 of the Senate amendment)</p>	<p>No provision.</p>	<ul style="list-style-type: none"> • Prohibits use of installment method if the sale would otherwise be reported under an accrual method of accounting. • Any arrangement that gives the taxpayer the right to satisfy an obligation with an installment note is treated as a pledge of the installment note. • Effective for sales after the date of enactment. • Same as sec. 1508 of the conference agreement for H.R. 2488.

MSA Tax Shelter Examples

- An individual with \$200,000 in adjusted gross income and with a pension would not be permitted to make deductible contributions to a traditional Individual Retirement Account (IRA) nor contributions to a Roth IRA under current law.
- Under current law, this same individual could contribute up to \$3,488 (indexed) to a Medical Savings Account (MSA) each year if covered under a high deductible family health insurance plan. If he or she were to contribute the maximum for forty years and made no withdrawals, the account would grow to \$1,093,046, assuming a 7 percent rate of return,
- Under the proposal, this individual could contribute up to \$4,650 (indexed) to an MSA each year. By contributing the maximum each year and under otherwise similar assumptions, he or she could accumulate \$1,460,244 over a forty year period. The full \$1,460,244 could be used to pay medical expenses. Alternatively, funds could be withdrawn for any other purpose. For example, after paying taxes, the remaining \$934,556 could be used to buy a boat.
- In contrast, if an equivalent amount of (before tax) income were used to fund a taxable savings account and assuming a 36 percent marginal tax rate, the account would accumulate only \$816,060 by the end of forty years.
- Using similar assumptions, an eligible individual who were to contribute the maximum each year to an IRA could accumulate \$427,219. If both spouses were to fund to the maximum, they could accumulate twice that amount, \$854,438 in IRAs. By funding both MSAs and IRAs to the maximum, a couple could accumulate \$2,314,682 in these tax preferred accounts in addition to any tax preferred pension saving.
- Higher (lower) rates of return would produce higher (lower) accumulations. See table.