Tax Options for Financing Health Care Reform

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Summary

Several tax options have been proposed to provide financing for health care reform. President Obama has proposed restricting itemized deductions for high income taxpayers, along with some narrower provisions. The Senate Finance Committee has provided a list of options for health-related tax provisions. Individuals testifying at a round-table discussion have also proposed a number of other options, including some new revenue sources.

These provisions differ in their potential revenue gain, their behavioral effects, and their distributional effects. Some proposals are progressive (imposing higher taxes relative to income for higher income groups), some impose larger relative burdens on lower income families, and some tend to fall on middle class groups. The distributional analysis, however, relates only to the finance side: the total health care program may redistribute in favor of lower income families even if the revenue sources do not.

Limiting the tax benefit associated with the exclusion of employer-provided health insurance, a component of the Senate Finance Committee's options, has a significant revenue potential since it is estimated to cost $132.7 billion in income tax revenues and $93.5 billion in payroll tax revenues for 2008. Although the income tax exclusion is often criticized as favoring higher income taxpayers, the burden of an across-the- board exclusion tends to fall on the middle income classes, with smaller relative burdens at the top and the bottom. The employer tax exclusion encourages group health coverage which is generally deemed desirable due to adverse selection (less healthy individuals seeking to insure and driving up the costs for others), but it may also encourage too much insurance coverage and consequently too much demand for health care that drives up the costs. Caps on the exclusion might contain costs without reducing coverage very much. There are some potential challenges to equity; for example, without adjustments employees in older groups will have larger increases in income for the same health coverage.

The Finance Committee options paper reviews additional health-related tax provisions, such as the itemized deduction for medical expenses, health savings accounts, flexible spending accounts, the treatment of Blue Cross and non-profit hospitals, and others. Most of these proposals would likely involve revenue gains of less than $1 billion per year, although the eliminating the itemized deduction for medical expenses would raise a projected $10.7 billion in 2008. The Finance Committee also discusses an increase in alcohol taxes that would raise about $6 billion and a tax on non-diet sweetened beverages whose revenue yield would depend on the rate set but could potentially raise over $10 billion. Both of these tax proposals are regressive (burden lower income individuals relatively more).

Limiting tax savings to 28% of itemized deductions for the top two brackets is the centerpiece of the President's health reform tax proposals. This provision, which would initially raise about $25 billion, is highly progressive, falling on the top 2% of the income distribution. The major issue raised about this proposal is the potential reduction in charitable giving, but several analyses have suggested this effect would be negligible. The President has a number of other narrower proposals aimed at compliance and perceived loopholes that together raise around $6 billion. Witnesses in a round table discussion held by the Senate Finance Committee also discussed a number of other options including other base broadening provisions as well as rate increases for the individual income tax, increases in payroll taxes, and new revenue sources such as a value added tax (VAT) and a cap and trade auction system for carbon emission permits.

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Several tax options have been proposed to provide financing for health care reform. President Obama has proposed restricting itemized deductions for high income taxpayers, along with some narrower provisions for other reforms or to reduce the tax gap.[1] On May 20, 2009 the Senate Finance Committee provided a list of options for health-related tax provisions. They include modifying the tax exclusion for employer-provided health care (by capping it, limiting it by income, or replacing it with a deduction or credit), revising other tax provisions relating to health care, increasing taxes on alcoholic beverages, and imposing an excise tax on non-diet sweetened beverages.[2] Individuals testifying at a May 12, 2009 round-table discussion have also proposed a number of other options.[3]

The tax proposals differ in their effects on behavior and where the burden falls in the income distribution. While most taxes rise with income in absolute amounts, the burden relative to income may fall more heavily on higher income taxpayers (a progressive change), about equally on all taxpayers (a proportional change), or more heavily on lower income taxpayers (a regressive change). The limit on itemized deductions increases taxes for high income taxpayers (roughly the top 2%) and is a highly progressive change. The burden of limiting health-related income and payroll tax exclusions tends to increase taxes as a percent of income proportionally more in the middle income brackets, with smaller effects at both the low and high ends of the income distribution. Excise taxes tend to be regressive and fall more heavily on lower income classes.

Note that the distributional analysis in this report refers only to the financing mechanism and not to the distributional effects of the entire program, as benefits are likely to favor lower income families. Thus even with a regressive revenue source the overall proposal might redistribute in favor of lower income individuals.

This report first reviews the health-related income and payroll tax revisions that comprise the bulk of the Senate Finance Committee's options, followed by the excise taxes included in that discussion. The next two sections discuss the provisions in the President's proposal (the limit on itemized deductions and the base broadening provisions). The final sections discuss other proposals suggested by the round-table discussion participants.

Eliminating or Capping the Exclusion for Employer Health Insurance

Amounts paid by firms on behalf of their employees for health insurance are excluded from wages and are subject to neither income nor payroll taxes. These health insurance benefits include purchase of group insurance on behalf of employees or self insurance, where employers pay claims. Health coverage may also be selected as part of a "cafeteria" plan where employees

[1] These provisions are described and their revenue gains reported in the U.S. Department of Treasury's "Greenbook," *General Explanation of the Treasury's Fiscal 2010 Revenue Proposals*, May, 2009, http://www.treas.gov/offices/tax-policy/library/grnbk09.pdf. The discussion of the provisions begins on p. 87 and the revenue table is on p. 130.

[2] *Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*, Senate Finance Committee, May 20, 2009, available at http://finance.senate.gov/sitepages/leg/LEG%202009/051809%20Health%20Care%20Description%20of%20Policy%20Options.pdf.

[3] Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html.

choose among a menu of benefits. Deductible contributions may occur through specialized health savings accounts (HSAs) and flexible spending accounts (FSAs) (discussed subsequently).[4] All of these expenses can be excluded from taxable income.

The option of capping the exclusion for employer supplied health insurance is included in the Senate Finance Committee's revenue options. Some other commentators have proposed the elimination of the exclusion. The Finance Committee's options include a dollar limit based on a benchmark plan (such as the Federal Employees Plan) or limits related to income, or both. The Advisory Panel on Tax Reform in the Bush Administration proposed a cap (based on the average cost of insurance) in their tax reform plan.[5]

The employer exclusion has been discussed in part because of the Committee's interest in finding health-related financing options. The employer exclusion is the largest health-related income tax benefit, as measured by revenue loss, estimated by the Joint Committee on Taxation (JCT) to cost $132.7 billion in 2008. The benefits are also excluded from the payroll tax, which causes additional tax revenue losses of $93.5 billion.[6] The Urban Brookings Tax Policy Center estimated these amounts at $144.8 billion and $95.7 billion in 2010, and growing at an average of about 8% per year.[7] The increased tax revenue from the payroll tax would eventually be offset, in part, by benefit increases.

A cap would recover only part of this revenue. The JCT has estimated the revenue effect of capping health benefits (including the self employed deduction, health savings accounts, and flexible savings accounts) at the 75th percentile of employer health insurance costs in 2009 and indexed for inflation at $14 billion in 2010, $25 billion in 2011, and continuing to rise.[8] This amount is about 10% of the total revenue lost from the tax exemption related to income and payroll taxes. The revenue from a cap depends on whether the cap is not indexed, indexed for general price inflation, or indexed for health price inflation.[9] The Tax Policy Center estimates that a cap based on average health insurance costs in 2009 would, if not indexed, raise $18.2 billion in 2010 and grow at an average rate of 32%, to reach $226.5 billion in 2019. If indexed for general price inflation, it would raise $17.4 billion in 2010, grow at a 29.2% rate, and raise $174.6 billion in 2019. If indexed for health price inflation it would raise $10.2 billion in 2010, grow at a rate of 9.8% and raise $23.6 billion in 2019.[10] A cap at the 90th percentile would raise $4.9 billion in 2010, rising to $188.8 billion in 2019 if not indexed, would raise $4.6 billion rising to $130.7

[4] For additional discussion of the exclusion see CRS Report RL34767, *The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate*, by Bob Lyke. For a legal discussion see CRS Report R40635, *Employment-Based Health Coverage and Health Reform: Selected Legal Considerations*, by Jennifer Staman and Edward C. Liu.

[5] The President's Advisory Panel on Tax Reform, *Simple, Fair and Pro-Growth: A Proposal to Fix America's Tax System*, November, 2005.

[6] Joint Committee on Taxation, *Background Materials for Senate Committee on Finance Roundtable on Health Care Financing*, JCX-27-09, May 8. 2009.

[7] Leonard Burman, Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html.

[8] These estimates are reported in Congressional Budget Office, *Budget Options, Volume I (Health Care)*, December 2008.

[9] Health prices generally rise faster than overall prices; thus, a health price increase will increase the cap more quickly and reduce revenue gains compared to one indexed to general price inflation.

[10] Leonard Burman, Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html.

billion in 2019 if indexed to general price inflation, and would raise $2.4 billion in 2010 and grow to $5.8 billion by 2019 if indexed to health price inflation. As these estimates indicate, caps need to be indexed to health price inflation to maintain a relatively even revenue stream. (A benchmark plan would be expected to grow at the health price inflation rate.)

The employer exclusion has been criticized on two grounds in addition to the revenue loss involved: the "upside-down" nature of the subsidy that favors high income employees, and the incentive to purchase too much insurance, which in turn increases the demand for health care and adds to health care costs. Higher income individuals are more likely to be covered by employer health-care insurance and their tax advantages are greater (at least with respect to the income tax) because they have higher marginal tax rates. Every dollar of excluded income saves an individual in the highest bracket $0.35 in income taxes, but saves the average taxpayer (in the 15% bracket) $0.15 in income taxes. (In 2011, after the 2001 tax cuts expire, the top bracket will be 39.5%, increasing the value of the deduction for high income taxpayers.)

The benefits of the payroll tax exclusion are not as targeted towards higher income families. Payroll taxes are flat rate taxes, with the Social Security portion subject to an income cap.[11] In addition, the excluded income in the form of a health insurance benefits is not likely to rise with an individual's income because group plans provide the same coverage for everyone in the group. Thus it would not be expected to keep pace with income as is the case with many tax deductions and exclusions.

These effects suggest that the tax benefit might not rise as a percentage of income and, therefore, that the additional burden from repealing the tax benefit would not necessarily be progressive. As shown in **Table 1** while coverage and the tax increases generally rise with income, the tax effects as a percentage of income (percentage change in after tax income) are highest in absolute value in the middle income brackets and suggest a tax benefit from the current exclusion that is proportional to income across much of the population. This change would be largely a proportional tax change (relatively constant as a share of income) across the middle income brackets, and with smaller relative burdens on lower and higher income taxpayers. A similar relative distribution occurs for across-the-board caps, but a cap related to income would lead to a different distribution.

Note that the average tax increase from repealing the exclusion in column (4) cannot be directly tied to average size of the health insurance benefit package, which can be quite large. These amounts are averaged across participants and non-participants. Thus the $1,578 average tax would be $3,336 if averaged over covered employees. If taxes average around 20% to 25%, the excluded income would be around $15,000.

[11] Note, however, that tax benefits from the payroll tax exclusion might be viewed differently, because they are tied to the payroll tax some of this tax saving is offset by future benefit reductions.

Table 1. Distributional Effects of Repealing the Employer Exclusion for Health Insurance Benefits

Income Quintile	Percent with Tax Cut	Percent with Tax Increase	Average Federal Tax Change	Percentage Change in After Tax Income
First	0.7	15.2	$241	-2.0
Second	0.1	41.2	$969	-3.5
Third	0.0	61.7	$1,702	-3.7
Fourth	0.0	68.5	$2,637	-3.8
Fifth	0.0	68.2	$3,424	-1.9
Top 1%	0.0	55.4	$2,700	-0.3
Total	0.2	47.3	$1,578	-2.8

Source: Urban Brookings Tax Policy Center, Table T09-0230, available at http://www.taxpolicycenter.org/numbers/displayatab.cfm?DocID=2304.

The exclusion has been supported because it reduces adverse selection in the health care market, where less healthy individuals wish to purchase insurance and thereby drive up costs and reduce participation for more healthy individuals. Employer health insurance also covers 62% of the non-elderly population[12] and there are concerns that altering or reducing the tax subsidies might reduce employer participation.[13] (Such concerns would be different if a health care plan were required for employees by an employer mandate or if employers that provided no coverage faced penalties.)

One advantage to a cap is that it might address the problem of the tax benefit resulting in purchasing more insurance than would be otherwise desirable, without having much effect on coverage.

A challenge to imposing a cap on the exclusion is the determination of includable income for tax purposes, which could produce inequities as well as administrative burdens. In order to impose a cap, income must be assigned to the employee to reflect the health insurance exclusion. The true economic costs of health insurance for an employee, and thus for employee groups, vary by geographic location, number of individuals covered (that is, if other family members are included), age, sex, and health status as well as generosity of benefits and the provider network. These individual costs are not separately stated and employer plans involve implicit cost shifting.[14] For example, the young may subsidize the old, and small families may subsidize large

[12] Joint Committee on Taxation, *Background Materials for Senate Committee on Finance Roundtable on Health Care Financing*, JCX-27-09, May 8, 2009.

[13] For research indicating that eliminating the exclusion would reduce participation, see Jonathan Gruber and Michael Lettau, "How Elastic is the Firm's Demand for Health Insurance?" *Journal of Public Economics*, Vol. 88, 2004, pp. 1273-1293.

[14] Note also that there is a difference between the cost (how much premiums or claims would rise when adding an employee) and the value of the plan to the employee. In group plans, the amount of insurance coverage is too large for (continued...)

ones. Firms that purchase insurance would find their premiums affected by the characteristics of the group, and firms that self-insure would find their claims affected by the group characteristics.

While varying the amounts of employer insurance benefits included in income by health status is not consistent with the insurance objective of risk sharing, varying by number in the family, age, and location are legitimate issues to consider. Most proposals would envision variations by family coverage, but not necessarily age. Providing for variation by age on an individual basis would result in large inclusions in income of older individuals, which might better reflect the implicit benefits of health insurance but may be undesirable because the costs might be onerous. It might also shift the burden somewhat more towards higher incomes, since older individuals tend to earn more. At the same time, requiring income imputations that do not vary with age might reflect lifetime benefits better but would also impose burdens on younger individuals with lower incomes and may discourage them from participation.

Moreover, not varying the imputed income from health benefits by age will still produce inequities across employees as the average premiums (or costs in the case of the self insured) will differ for firms with older workers or other characteristics. Thus employees who receive essentially the same benefit would have a higher tax imputation in firms with more women, with older employees, and with a less healthy workforce. These characteristics would also vary by geographic location, and size (since small firms have higher administrative costs). It might be possible to make adjustments for these characteristics, but that would add to the administrative burden.[15]

Several discussions have suggested that benefits included in income could be set under the same rules as COBRA benefits (provisions under the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272) that allow for continuation of insurance on leaving a job. Whatever rules are built into this provision would then govern the allocation.[16]

The Senate Finance Committee options document also indicates that the exclusion could be reformulated as a deduction, a credit, or a combination of the two. Credits would equalize the treatment across taxpayers of different incomes, and refundable credits would extend the benefit to those without tax liability.

An alternative to the complexities of allocating benefits for employees would be to restrict deductions for employers. Employers are currently allowed to deduct the costs of providing fringe benefits as well as the costs of wages paid. Thus, rather than having income included in employee's income, the deduction available to employer could be reduced or eliminated for insurance costs in excess of a floor (which would correspond to a cap on the employee exclusion

(...continued)

some participants and too small for others, so that, unlike a normal commodity, the cost does not equal the benefit. Since the costs of fringe benefits are generally expected to reduce wages, some employees are giving up more in wages than the value they place on the benefit. These differences in preferences may occur for reasons independent of health status, such as the degree of risk aversion.

[15] See, for example, Stan Dorn, *Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible?* Urban Institute, June, 2009, http://www.urban.org/publications/411894.html; Elise Gould and Alexandra Minicozzi, "Who Loses If We Limit the Tax Exclusion for Health Insurance?" *Tax Notes*, March 9, 2009, pp. 1259-1262.

[16] See International Foundation of Employee Benefits for a discussion: http://www.ifebp.org/pdf/harker/COBRA_Premium_Determination.pdf.

under the previous approaches discussed). This approach would also raise revenues and discourage excessively generous health insurance packages. Explicit issues of assignment of benefits to individual employees would not arise, although there would still be issues of equity across firms.

Other Health-Related Tax Expenditures

Other health-related income tax expenditures might be considered and are listed in the Senate Finance Committee's report.[17] The second largest tax expenditure is the revenue loss from excluding Medicare benefits from income for tax purposes, estimated by the JCT at $40.6 billion. Altering this provision would involve significant administrative problems and has not been included in the options. Similarly, the exclusion of medical benefits for military dependents and military retirees ($3.3 billion) is not included.

Restricting Itemized Deductions for Medical Expenses

Individuals are allowed an itemized deduction for medical expenses above 7.5% of adjusted gross income. JCT estimates the cost at $10.7 billion per year. The provision, with a significant floor, is aimed at taxpayers who have large medical costs relative to income. It may be more frequently used by those without insurance or for uncovered costs for those with insurance (such as mental health care, dental care, and long term care). It is claimed by about 12 million taxpayers, or about 9% of tax returns. In part because of the percentage-of-income floor, the medical expense deduction tends to be relatively more beneficial to middle class taxpayers than other itemized deductions. According to IRS statistics for 2006, 50% of total itemized deductions are claimed by those with $100,000 or more of income, while only 15% of the medical expense deduction is claimed by these higher income groups. Similarly, while 26% of all itemized deductions are claimed by those with incomes in excess of $200,000, less than 4% of the medical expense deductions are claimed by these groups. Although the deduction may encourage individuals to forego insurance and has an uneven subsidy effect depending on the tax rate of the individual, an argument for retaining the deduction is that individuals with extraordinary medical expenditures are less able to pay.

Special Benefits for Blue Cross

Blue Cross and Blue Shield, along with a few other companies that existed in 1986 and were tax exempt, are eligible for a special deduction of 25% of claims and expenses in excess of surplus (a measure of profit). They are also provided an exception from a rule that approximates the taxation of unearned premiums (premiums that are due under contracts but not received). The revenue loss from this provision is small, about $1 billion a year. These provisions were substituted in 1986 for a general tax exemption that arose (in turn) from the perception that these organizations were

[17] A list is presented in the Senate Finance Committee's options paper. Data on cost and distribution are also found in Joint Committee on Taxation, *Background Materials for Senate Committee on Finance Roundtable on Health Care Financing*, JCX-27-09, May 8. 2009. For a discussion of individual tax expenditures, see United States Senate Committee on the Budget, *Tax Expenditures: Compendium of Background Material on Individual Provisions*, Prepared by the Congressional Research Service, December 2008, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_senate_committee_prints&docid=f:45728.pdf.

community service organizations. In 1986, these firms' tax exemptions were removed given the view that their activities were highly similar to commercial insurance. The special benefits were provided as a substitute. The Blues continue to provide some specialized and community rates provisions, which presumably are aided by the tax benefit, but the tax provision also benefits shareholders and other groups.

Health Savings Accounts

A health savings account (HSA) is allowed for individuals with a high deductible employer health plan, and it allows tax deductible contributions to an HSA as well as exclusions (from both income and payroll tax) for contributions from employers.[18] Investment earnings are not taxable, and income is not taxable when paid out if spent on medical costs. Distributions for other purposes are includable in income and subject to a 10% additional tax. The contributions have a dollar cap. Foregone taxes due to HSAs cost about $0.5 billion per year according to JCT estimates, but the cost is expected to grow somewhat. HSAs are advantageous because they allow individuals to purchase insurance against catastrophic costs but not for more routine costs, thereby reducing the incentive to spend too much on health care because insurance pays for much of the cost. At the same time, they exacerbate adverse selection, because they attract more healthy individuals out of other insurance pools.

The Finance Committee options paper discusses limiting the amount that can be contributed by the individual to the individual's deductible under a high deductible health plan and an increase in the penalty for non-medical uses. Distributions from an HSA would only be excludible from income as spending on medical costs if substantiated by the employer or an independent third paper. The proposals would also include HSA contributions under a general employer cap.

Flexible Spending Plans/Health Reimbursement Arrangements

Flexible spending accounts (FSAs) allow reductions in taxable income to fund certain program benefits, which may be chosen under a cafeteria plan or otherwise provided by the employer. A plan provided under a cafeteria approach allows employees to opt for a reduction in salary to provide contributions. Amounts can also be specified under health reimbursement arrangements. Options for raising revenue (in addition to counting these plans as part of benefits for purposes of imposing a general cap) include limits to the amounts contributed or eliminating these contributions. An important reason for concerns about these plans is the "use it or lose it" nature of the plan, with amounts remaining in the account forfeited at the end of the year. For health FSAs , there are concerns that this rule induces excessive spending for individuals with amounts unspent towards the end of the year.[19]

Limit Qualified Medical Expense Definition

The cost of over-the-counter medication does not count for purposes of the itemized deduction for expenditures in excess of the 7.5% floor, but is covered under health savings accounts, health flexible spending accounts, and health reimbursement accounts. This policy option proposes to

[18] See CRS Report RL33275, *The LIHEAP Formula: Legislative History and Current Law*, by Libby Perl.

[19] See CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Bob Lyke and Janemarie Mulvey.

conform eligible spending for these employer account purposes to those governing the itemized deduction, so that expenditures on over-the-counter medication such as aspirin would not qualify as tax-excludible expenditures from these accounts.

Modify FICA Tax Exemption

Under current law, students (at a school, college, or university) are excepted from paying FICA taxes (Social Security and Medicare) on certain services while employed by the school they attend. The scope of this exception has been a subject of uncertainty, especially with respect to medical residents. The government's position that this exception does not apply to medical residents has been overturned by some courts. The Senate Finance Committee proposal would codify recent regulations addressing circumstances where services and the course of study are inter-mingled, clarify the definition of educational institution and study, and also establish a dollar limit for the exception.

Extend Medicare Payroll Tax for State and Local Employees

The Senate Finance Committee proposal would extend the Medicare coverage and associated taxes to all state and local employees; employees hired before March 31, 1986, not covered by a voluntary agreement, and covered by a retirement plan are not currently subject to payroll taxes. This provision would increase HI taxes (health insurance payroll taxes that finance Medicare). This change would eventually lead to increased Medicare costs due to expanded coverage.

Modify Treatment of Tax Exempt Hospitals

Under current law, hospitals that are characterized as charitable organizations are eligible to receive several benefits including exemption of tax on income, ability to receive tax exempt charitable contributions, and eligibility for certain private activity tax exempt bond financing. Whether a hospital is a charitable organization depends on whether they have met a "community benefit" standard.

A concern is the degree of charity care and whether non-profit hospitals provide benefits that justify their charitable and tax-exempt status. The Congressional Budget Office released a study in 2006 that found that non-profit hospitals overall provided only slightly more charity care than for-profit hospitals.[20] That study also reported an estimate by the Joint Committee on Taxation indicating that the benefits of federal tax exemptions for non-profit hospitals was about $6 billion in 2002.[21] The Senate Finance Committee held hearings on the topic "Taking the Pulse of Charitable Care and Community Benefits at Non-Profit Hospitals," on September 13, 2006 and the House Ways and Means Committee held hearings on "The Tax Exempt Hospital Sector," on May 26, 2005.

[20] Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006.

[21] The estimate for tax exempt bonds for nonprofit hospitals for 2002 was around $1.5 billion. or about a quarter of the total. That estimate is currently approximately $2 billion. If all components of the $6 billion cost grew at the same rate, the current cost would be around $8 billion.

A staff discussion draft released July 18, 2007 by Senator Grassley (ranking member of the Senate Finance Committee), raised the following concerns about non-profit hospitals: establishing and publicizing charity care, the amount of charity care and community benefits provided, conversion of nonprofit assets for use by for-profits, ensuring an exempt purpose for joint ventures with for-profits, governance, and billing and collection practices.[22] Subsequently, on October 24, 2007, Senator Grassley authorized a round-table to discuss the draft. Also in July 2007, the IRS released an interim report on non-profit hospitals, that found that the median share of revenues spent on charity care was 3.9% and almost half of hospitals spent 3% or less. The average non-profit hospital spent 7.4% of revenues on charity care.[23]

The staff discussion draft expressed concerns that, since a 1969 a revenue ruling issued by the Internal Revenue Service, non-profit hospitals had not been required to demonstrate specific standards for charity to qualify for exempt status (and in some cases to be eligible to receive tax deductible charitable contributions); rather they must meet a community benefit standard that is not quantitatively defined.[24]

The Senate Finance Committee proposal would codify rules for determining charitable status that include a community needs standard and a minimum annual level of charitable patient care. The provision might have relatively little effect on revenues but might increase the level of charity care.

Excise Taxes on Alcohol and Non-Diet Sweetened Beverages

The May 20, 2009 Senate Finance Committee options paper discusses two excise tax provisions, an increase in taxes on alcoholic beverages and the imposition of a tax on sugared beverages. Other commentators have proposed increases in tobacco taxes, although, this tax was recently increased substantially (from $0.39 per pack to slightly over $1) to finance the state children's health insurance program (SCHIP) and is not included in the options paper.[25]

Taxes on Alcoholic Beverages

Alcoholic beverage taxes apply at different rates to different types of beverages. For distilled spirits the tax is $13.50 per proof gallon. Since a proof gallon is 50% alcohol, this tax is the equivalent of $0.21 per ounce of alcohol. Beer is taxed at $18 per barrel. Since a beer barrel contains 31 gallons, if beer is 4.5% alcohol, the alcohol in beer is taxed at $0.10 per ounce, about

[22] *Tax Exempt Hospitals: Discussion Draft*, at http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf.

[23] Internal Revenue Service, *Hospital Compliance Program Interim Report*, at: http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf.

[24] See CRS Report RL34605, *Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit Standard and Schedule H*, by Erika K. Lunder and Edward C. Liu for further discussion of the legal issues involved in defining community benefit.

[25] See CRS Report RS22681, *The Cigarette Tax Increase to Finance SCHIP*, coordinated by Jane G. Gravelle for a discussion of these taxes. CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker et al., discusses the legislation's overall provisions including the taxes on different tobacco products.

half the rate for distilled spirits. Wine is taxed by type.[26] For ordinary table wine of not more than 14% alcohol, the wine is taxed at $1.07 a gallon. Assuming an alcohol content of 12.5%, the tax per ounce of alcohol is $0.07.

Alcohol taxes are levied per unit and their real value falls over time due to inflation. They have been revised infrequently, with the last revision in 1991.[27] If the $13.50 per gallon rate on distilled spirits in 1991 were to have kept pace with inflation, it would be about $19.60 currently.

Many of the same issues arise with respect to alcohol taxes that are raised with respect to tobacco. Alcohol use has consequences for health costs not only because of the health consequences of heavy drinking (although not necessarily for moderate drinking), but also because it is implicated in auto accidents. Most studies indicate that the external costs imposed by alcohol are larger than the current taxes, while that is not the case for tobacco; they also indicate that consumption is responsive, although not greatly so, to price changes.[28]

Alcohol taxes, like tobacco taxes, tend to be regressive, collecting a larger percentage of the income of low income individuals.[29] Unfortunately, there is little current distributional data on the effects of individual federal excise taxes; the latest distributional data are from a 1990 Congressional Budget Office study. **Table 2** shows expenditures on alcoholic beverages as a percentage of income by quintile, for total alcohol, and for each type of alcohol. The relative burden of alcohol taxes as a percent of income, however, would be expected to be more concentrated in lower income classes than is suggested by expenditure data, because higher income classes are likely to buy more expensive alcohols. An upscale bottle of whisky may cost many times that of an inexpensive bottle. Wine prices probably vary by a larger amount. Since the tax would be distributed by alcohol content and not by price, the regressivity of the tax could be significantly greater than suggested by this table. For example, if the average price of distilled spirits is twice as much for the top quintile than for the bottom one, rather than the burden relative to income being 116% larger it would be 333% larger.

[26] For still wines, the tax is $1.07 per gallon if not more than 14% alcohol, $1.57 per gallon if more than 14% but not more than 21%, and $3.15 per gallon if more than 21% but not more than 24%. Still wine that is more than 24% alcohol is taxed the same as distilled spirits. Hard apple cider is taxed at $0.226 per gallon. Champagne and naturally sparkling wines are taxed at $3.40 per gallon and artificially carbonated wines at $3.30 per gallon.

[27] These taxes have been infrequently revised. Taxes on distilled spirits were at $10.50 per proof gallon in 1951 and only changed twice since: to $12.50 in 1985 and $13.50 in 1991. Taxes on beer were raised from $8 to $9 dollars per barrel in 1951, and from $9 to $18 in 1991. The tax on ordinary wine has changed only once since 1951, in 1991; prior to 1991 the rates were $0.17 for wine with alcoholic content under 14%, $0.67 for 14% to 21% alcoholic content, and $2.25 for 21% to 24% alcoholic content. The rate on champagnes and sparkling wines increased from $2.27 per gallon to $3.40 in 1955; the rate for artificially carbonated wine increased from $1.92 to $2.40 in 1955 and to $3.30 in 1991.

[28] See the articles on these taxes in *The Encyclopedia of Taxation and Tax Policy*, eds. Joseph J. Cordes, Robert D. Ebel, and Jane G. Gravelle, Washington, D.C., The Urban Institute, 2005. The article on alcoholic beverage taxes by Thomas F. Pogue is on p. 5 and the article on tobacco taxes by W. Kip Viscusi is on p. 439.

[29] In addition to the data cited in the text, see Citizens for Tax Justice, *Who Pays? A Distributional Analysis of the Tax Systems in All 50 States*, http://www.ctj.org/html/whopay.htm, and Andrew Lyon and Robert Schwab, The Regressivity of Sin Taxes, 1997, http://www.taxfoundation.org/files/58b60c2cd0d1581fe7785de7eb4e9047.pdf.

Table 2. Distribution of Alcohol Expenditures as a Percent of Income, 1990

Quintile	Distilled Spirits	Beer	Wine	Total
First	1.3	1.7	0.7	3.7
Second	0.8	1.0	0.4	2.3
Third	0.8	1.0	0.5	2.2
Fourth	0.8	0.9	0.5	2.2
Fifth	0.6	0.5	0.4	1.6
Total	0.8	0.8	0.5	2.0

Source: Congressional Budget Office, Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels, August, 1990, pp. 29,31.

The unit tax nature of excise taxes tends, therefore, to make them more regressive than sales taxes. Alcohol taxes are not likely to be quite as regressive as tobacco taxes, however, because the prevalence of purchasing alcohol tends to rise as income increases. Alcohol taxes also burden individuals who do not abuse alcohol but rather consume socially and responsibly and thus are horizontally inequitable.

The proposal would bring the taxes on beer and wine up to the level of that on distilled spirits, and also increase the distilled spirits tax to $16. With this change, the tax on beer at a 4.5% alcohol level would be $44.64 cents per barrel and the tax on table wine at a 12.5% alcohol level would be $3.88 per gallon. Current federal alcohol taxes (2008) collect $9.4 billion in revenues, with $4.8 billion for distilled spirits, $0.9 billion for wine, and $3.8 billion for beer.[30] (The effect for wine may be a little overstated because it is based on standard table wine and other products would tend to have smaller increases). Based on the rate changes the tax on distilled spirits would increase by 18.5% or by $0.9 billion, the tax on wine would increase by 225%, or by $2.2 billion and the tax on beer by 148% or $5 billion. This increase would raise about $5.7 billion in revenue per year, an amount that is less than the total of excise tax increases of $8.1 billion due to offsetting reductions in income tax revenues from the deductibility of excise taxes and behavioral responses.[31]

The increase in price would result in a decrease in consumption. The most recent price elasticity estimates (percentage change in quantity divided by percentage change in price) suggest that consumption is not highly responsive to price. These estimates indicate that the elasticity for beer consumption is 0.16 (that is, a 10% increase in price leads to a 1.6% decrease in consumption).[32]

[30] Data from the Alcohol and Tobacco Tax and Trade Bureau, *Cumulative Summary*, Fiscal year 2008, http://www.ttb.gov/statistics/final08.pdf.

[31] Congressional Budget Office, *Budget Options*, February 2007. Typically, excise tax revenue estimates are reduced by about 25% to account for the income tax offset.

[32] These elasticities are reported in the National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, *10th Special Report to the U.S. Congress on Alcohol and Health*, June 2000, pp. 342-342. http://pubs.niaaa.nih.gov/publications/10report/printing.pdf .

The elasticity for wine consumption is 0.58, and the elasticity for consumption of spirits 0.39. The overall elasticity for a proportional change in price is 0.52. Current sales of alcohol are $99.3 billion for beer, $61.1 billion for distilled spirits, and $27.2 billion for wine, for a total of $187.6 billion.[33] For beer, prices would rise by 5%, for wine 8.1% and for spirits 1.5%. Applying these elasticities suggests a 0.8% decrease in beer consumption a 4.7% decrease in wine consumption, and a 0.6% decrease in consumption of spirits. Older elasticity estimates were somewhat higher: 0.3 for beer, 1.0 for wine and 1.5 for spirits. These elasticities would imply a 1.5% decrease for beer, an 8.1% decrease for wine and a 2.2% decrease for spirits.

Tax On Non-Diet Sweetened Beverages

This proposal would impose a tax on non-diet sweetened beverages. According to testimony at the Senate Finance Committee roundtable discussion, a tax of one cent per 12-ounce can would raise about $1.5 billion per year, and a tax of one cent per ounce would raise about $17 billion.[34]

Unlike with alcohol and tobacco, neither the effect of consumption of these beverages on health nor the imposition of additional costs on society has been the subject of a great deal of study. Like any per unit tax, the tax is likely to be regressive.[35] Some might question the singling out of this particular food source, since taxes could be imposed on many other unhealthy items (e.g., candy, snacks, fast food). Most food items without close substitutes have small price elasticities.

Limit Itemized Deductions

Individual taxpayers may elect to take a standard deduction, or they may itemize deductions: these deductions include certain taxes paid at the state and local level, home mortgage interest, charitable contributions, medical expenses above a floor, and casualty losses above a floor, as well as some minor miscellaneous deductions. As noted above, one such deduction is medical expenses, but it accounts for less than 6% of the total. The largest share of itemized deductions are those for mortgage interest (36%) and taxes (35%). Almost 60% of taxes that are deducted reflect income taxes and most of the remainder are property taxes on owner-occupied homes. The charitable deduction accounts for the third largest share, about 15% of the total.

A primary feature of President Obama's tax proposals to fund health care reform is capping the value of itemized deductions for the top two tax rates to 28%. Under current law these rates are 33% and 35%; after 2010, when the 2001 tax cuts expire, these rates will rise to 36% and 39.5%. This provision, when fully effective (in FY2012), would be expected to raise revenues by about $25 billion.

Itemized deductions benefit only about a third of taxpayers and, as with any deduction or exclusion, the value rises with the marginal tax rate. Thus a dollar of tax, interest, or charitable

[33] Standard and Poors Industry Survey, *Alcoholic Beverages and Tobacco*, May 9, 2009.

[34] Michael F. Jacobson, Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html Testimony at the roundtable discussion on financing health care, May 12, 2009.

[35] Calculations by Thomas Hungerford, CRS, indicated that a three cent tax per 12 ounce can as a percentage of income would be, for each quintile, beginning with the lowest, 0.21, 0.11, 0.08, 0.06, and 0.03. Thus, the burden relative to income in the lowest income group is three times that in the highest income group.

contribution benefits a taxpayer in the top bracket by $0.35 on the dollar while it benefits the taxpayer in the 15% bracket by $0.15. When the 2001 tax cut expires after 2010, the top tax rate will be 39.6%.

This proposal's tax increases would be concentrated on high income taxpayers, who constitute the top 2% of incomes.[36] The provision would primarily affect taxpayers over about $250,000 of income. The $200,000 to $500,000 income class accounts for 11.4% of itemized deductions and the $500,000 and over income class about 14.6%. Thus, these taxpayers probably account for around a fifth of itemized deductions. While the shares of different types of deductions are similar for the $200,000 to $500,000 class as they are for taxpayers as a whole, the $500,000 and above class accounts for about 4% of mortgage interest deductions, about 3% of property taxes deductions on homes, and about 32% of charitable contributions deductions. Thus while some concern was expressed about the effect of this provision on housing, the major issue surrounding these proposals was the potential effect on charitable contributions.

Several studies have, however, suggested that this effect is likely to be modest, perhaps around a 1% reduction in giving depending on the assumptions.[37] This small effect occurs because of the small effect of the limit on the tax benefit of the deduction, the limited share of total charitable giving affected, and the limited behavioral responses. Those charitable objectives more favored by higher income individuals, such as health, art, and education, would have larger effects, while giving to religious organizations or for basic welfare would have smaller effects.

If charitable giving is the primary concern, these deductions could be excluded from the cap; this change would sacrifice about a quarter of the expected revenue gain.

Other commentators have included much more significant restrictions on the value of itemized deductions. Burman, for example, discusses an option of limiting all itemized deductions to 15%, which he projects would raise $141 billion in 2011.[38]

Other Base Broadening Provisions in the President's Proposals

President Obama proposes some additional base broadening provisions whose revenues would be dedicated to financing health care reform.

[36] According to Internal Revenue Service *Statistics of Income* data, 1.9% of taxpayers fall into the two top marginal rate brackets and some small fraction of these returns do not itemize.

[37] See CRS Report R40518, *Charitable Contributions: The Itemized Deduction Cap and Other FY2010 Budget Options*, by Jane G. Gravelle and Donald J. Marples; Paul N. Van de Water, *Proposal to Cap Deductions for High Income Households Would Reduce Charitable Deductions by Only About 1%*, Center on Budget Policy and Priorities, available at http://www.cbpp.org/cms/index.cfm?fa=view&id=2700; *How Changes in Tax Rates Might Affect Itemized Charitable Giving*, by Deb Partha and Mark O. Wilhelm, The Center on Philanthropy at Indiana University found a reduction of less than 1%.

[38] Leonard E. Burman, Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html

The first category of these proposals is a set of provisions to reduce the tax gap and increase compliance by increasing information reporting and providing some additional administrative changes. Altogether, these tax provisions result in about $1 billion of revenue gain when fully in place.

A second set of provisions involve some relatively narrow revisions that fall into three basic categories: tax provisions affecting financial institutions and insurance companies, revising certain tax accounting methods, and revisions in the estate tax, primarily limiting the amount of valuation discounts.[39] Taken together, this second set of provisions raises around $5 to $6 billion per year. The largest single provisions over the ten year budget window, in revenue loss, are the restrictions on valuation discounts for family-owned assets for purposes of the estate tax (raising slightly under $2 billion in the initial years), modification of corporate owned life insurance (slightly under $1 billion in the earlier years), repealing a certain inventory valuation method that allows the use of the lower of cost or market value (causing a rise up to almost $2 billion and then a decline to $0.3 billion).

Other Income Tax Provisions

A wide variety of other income tax provisions could potentially be used to provide additional revenues, including rate increases, widening the rate brackets, expanding the base, or increasing the tax rate on favored income items, such as dividends and capital gains.

Burman, for example, suggests reducing the indexing of the rate brackets to the CPI (Consumer Price Index) minus 1% rather than the CPI.[40] The justification for this revision is that the CPI overstates the cost of living change because it does not account for the shift in the composition of spending to those items with smaller relative price increases. This proposal is estimated to raise $8 billion in 2010 and $50 billion in 2019. It also has the advantage of growing over time which may be helpful in financing a growing health care plan.

Shea suggested increasing the capital gains tax, taxing carried interest (certain earnings of investment fund managers) as ordinary income, reforming international tax enforcement, and repealing LIFO (last-in, first-out inventories).[41] Revenue estimates for a number of these items are contained in the Treasury's "Greenbook": raising tax rates on capital gains and dividends would raise about $5 billion; carried interest would initially raise about $3 billion,[42] and LIFO repeal would raise about $6 billion.[43] The revenue raised from international reforms depends on the nature of the changes, but international provisions in the President's proposal in total raise over $20 billion.

[39] Valuation discounts are often allowed when property is left to a family group where no individual has control; the justification for the discount is that the value or the property is reduced by the lack of control.

[40] Leonard E. Burman, Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html

[41] Gerald Sheas, , Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html

[42] See CRS Report RS22717, *Taxation of Private Equity and Hedge Fund Partnerships: Characterization of Carried Interest*, by Donald J. Marples.

[43] the U.S. Department of Treasury's "Greenbook," *General Explanation of the Treasury's Fiscal 2010 Revenue Proposals*, May, 2009, http://www.treas.gov/offices/tax-policy/library/grnbk09.pdf.

Payroll Tax Increases

Another source of revenue would be increases in payroll taxes, either by raising the rates or raising the earnings ceiling. Burman estimates that an increase in both the employee and the employer share of payroll taxes would raise about $100 billion in revenue per year. He also estimates that eliminating the social security earnings cap would raise $84 billion. In the latter case, some of the savings would eventually be offset by benefit increases unless the earnings were decoupled from benefits.[44]

New Revenue Sources: VAT or Cap and Trade

Another possibility for raising revenue is to turn to an entirely new revenue source. Burman, for example, proposed a 10% value added tax (VAT) which would raise $600 billion. Another option for an additional revenue source is a carbon tax or the auction revenue from a cap and trade carbon emissions permit system.[45]

The VAT, in addition, would be a new tax with all of the administrative compliance problems associated with such a tax. If very large sources of revenue are not desired, it might not be worth the administration and compliance costs. It would also be difficult to put into place quickly and would involve a number of transition and other problems. The carbon tax or cap and trade would also be difficult to put into place and would involve other important program issues that need to be settled.

As with excise taxes, these taxes would be regressive.

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[44] Leonard E. Burman, Senate Finance Committee, Roundtable Discussion on "Financing Comprehensive Health Care Reform," May 12, 2009. Witness statements posted at http://finance.senate.gov/sitepages/hearing051209.html.

[45] Since taxes will be passed on to consumers, refunding revenues to producers would create a windfall; hence these revenues could be available for other uses.