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. H.R. 3962 passed in the House on November 14, 2009; its largest source of increased revenues is from additional income taxes for higher-income taxpayers. On December 24, 2009, the Senate adopted H.R. 3590, whose revenue provisions are similar to those in the bill reported by the Senate Finance Committee (S. 1796). Taxing insurance companies on high-cost employer plans is the largest single source of revenue in that plan. Both plans include health-related provisions, including fees or excise taxes, along with some other provisions.

On February 22, 2010, the Obama Administration released a new compromise proposal, which generally uses H.R. 3590 as a starting point, but offers several changes to the revenue provisions of this bill. The President's proposal would delay the effective date for the tax on high-cost employer plans proposed in H.R. 3590 from 2013 to 2018 and raise the exemption threshold for this tax to $27,500 for families and $10,200 for individuals. In addition, the new plan offered by the Administration would broaden H.R. 3590's proposed increase of the Medicare Hospital Insurance tax for high-income households by adding a tax on unearned income at a 2.9% rate.

Several proposals for revenue, considered during the health care financing debate of 2009, have not been included in legislation reported out by congressional committees. These proposals include eliminating tax benefits from the exclusion of employer-provided health insurance, which has a significant revenue potential, and limiting tax savings to 28% of itemized deductions for the top two brackets, which was the centerpiece of the President's health reform tax proposals.

These provisions differ in their potential revenue gain, and behavioral and distributional effects. Some proposals are progressive (imposing higher relative burdens on 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 finance: the total health care program may redistribute in favor of lower-income families even if the revenue sources do not.

The House bill (H.R. 3962) includes a high-income surtax of 5.4% on income above $1,000,000 (income levels are 50% as large for singles). The proposal would initially raise more than $30 billion per year. One concern that has been raised about this surtax is the effect on small business, entrepreneurship, and job creation; however, much of this income is passive income or income of professions (e.g., stockbrokers, doctors). The proposal also includes some narrower, largely corporate provisions and restrictions on health-related tax expenditures. The Senate bill (H.R. 3590) would impose an excise tax on insurance companies for high-cost employer plans. Most of the remaining revenue is raised from restricting health-related tax expenditures; increasing the Medicare payroll tax for high-income earners; and imposing fees on medical devices, branded drugs, and health insurance providers.

Witnesses in a round-table discussion held by the Senate Finance Committee in 2009 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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Introduction

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 House Ways and Means Committee has proposed financing the reform largely through a surtax on high-income individuals, which was passed by the House on November 14, 2009 (H.R. 3962), and reflected legislation that the three House committees with jurisdiction have reported out (H.R. 3200). The Senate Finance Committee reported S. 1796 relying in part on an excise tax on insurers for high-cost plans; the bill passed by the Senate on December 24, 2009, H.R. 3590, largely reflects the revenue-raising provisions in that plan.

The tax proposals differ in their effects on behavior and where the burden falls in the income distribution. Although 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). For instance, the limit on itemized deductions increases taxes for high-income taxpayers (roughly the top 2%) and is a highly progressive change; similarly, the tax on high adjusted gross incomes largely affects the top 1%. 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 health care reform proposals, as the health care 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 reviews the revenue raisers proposed in the House and Senate bills currently being debated. Other financing proposals are presented including those made by the Obama Administration and those introduced in earlier congressional work. The final sections discuss other proposals suggested by the round-table discussion participants.

[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.

The House Proposal

On July 14, 2009, the House Ways and Means Committee announced several revenue- and tax-related provisions to fund health care reform, with the centerpiece being a tax on high-income individuals.[4] By October 2009, the three committees with jurisdiction over the bill had reported out legislation, the America's Affordable Health Choices Act of 2009 (H.R. 3200). More recently, most of the provisions of H.R. 3200 were included in the Affordable Health Care for America Act, H.R. 3962, which included some modifications to proposals in H.R. 3200 along with new proposals.[5] H.R. 3962 was passed on November 14, 2009. This section of the report first summarizes the initial provisions and then explains the modifications. The main modifications involve a revision to the surtax on high-income taxpayers and adding some additional revenue raisers.

In the initial proposal to fund health care reform in H.R. 3200, which resulted in $583.1 billion for FY2010-FY2014 as estimated by the Joint Committee on Taxation, $543.9 billion would be generated by a surtax on individual taxpayers. This surtax was to be imposed on adjusted gross income (not taxable income)[6] and would have been 1% on income from $350,000 to $500,000, 1.5% on income from $500,000 to $1,000,000, and 5.4% on income over $1,000,000. The 1% and 1.5% rates would have doubled in 2013 unless a certain amount of savings occurs in health programs; they could also be eliminated. The income levels are for married couples; singles would have the tax imposed at income levels that are 80% of those for married couples.

The initial House proposal also included a provision, raising $8 billion, to conform the definition of medical expenses for health savings accounts and similar accounts to those for itemized deductions for health care (a provision also discussed in the Senate Finance Committee's review). (This provision is now estimated to raise $5 billion). The plan also included three revenue raisers related to international taxation and tax evasion. A delay in the revised allocation of interest for the foreign tax credit (a provision that increases the amount of allowable foreign tax credits) would raise $26.1 billion over 10 years. A provision relating to the use of treaties to avoid U.S. tax would raise $7.5 billion, and a provision to codify the economic substance doctrine (again to deal with tax sheltering by corporations) would raise $3.6 billion. The proposal also had a provision to expand the definition of dependents for certain health-related tax purposes, which costs $4 billion.

The most recent revenue raisers included in H.R. 3962 imposed only the 5.4% surtax on incomes more than $1,000,000 for joint returns but imposed the tax on single taxpayers at half the income level ($500,000), raising $460.5 billion over the FY2010-FY2014 period.[7] H.R. 3962 also

[4] The discussion in this section covers revenue-raising tax provisions used to finance health care that are outside the basic health care plan; thus, it does not cover penalties on individuals and firms that do not comply with health insurance mandates or credits to small businesses to assist in insurance coverage for employees.

[5] Details of the provisions are provided in summary documents made available by the House Committee on Ways and Means at http://waysandmeans.house.gov/media/pdf/111/10-29SummaryRevenueProvisions.pdf.

[6] Adjusted gross income (AGI) equals gross income less qualifying adjustments to income. It serves as the base for computing limits on certain itemized deductions and is the income measurement before deductions and personal exemptions are taken into account. Taxable income is adjusted gross income reduced by either the standard deduction (plus the additional standard deduction in some cases) or itemized deductions along with personal exemptions.

[7] Data from the Joint Committee on Taxation, JCX-43-09, October 29, 2009, http://www.jct.gov/publications.html?func=startdown&id=3619.

includes the three revenue raisers related to international taxation and tax evasion introduced in H.R. 3200. A delay in the revised allocation of interest for the foreign tax credit was originally in H.R. 3200 and projected to raise $26 billion; this provision was included in other legislation and the current repeal provision is projected to raise $6.0 billion. The provision relating to the use of treaties to avoid U.S. tax is the same. The economic substance doctrine provision was modified to include penalties for underpayments and is estimated to raise $5.7 billion and the conforming of the definition of medical expenses estimate was $5.0 billion.

In addition, H.R. 3962 has some additional restrictions on health related tax provisions: it would limit health flexible spending arrangements in cafeteria plans to $2,500, indexed to inflation ($13.3 billion); increase the penalty for nonqualified distributions from health savings accounts to 20% ($1.3 billion); and disallow the deduction for subsidies related to Medicare Part D ($3.0 billion). It would also impose a 2.5% excise tax on the first taxable sale of medical devices (i.e., not at the retail level) ($20.0 billion). The plan also requires information reporting on payments to corporations ($17.1 billion). (Currently, firms are required to report payments of more than $600 to unincorporated businesses; this change would extend the requirement to corporations, which would increase third party reporting and tax compliance). There would be a small loss ($4 billion) for extending certain health benefits for spouses and dependents and a small gain ($2.0 billion) for fees on insured and self-insured health plans imposed on a per participant basis at a rate that raises a fixed amount of revenue. There is also a provision to exclude Indian Tribe health benefits from gross income that has a negligible cost.

The proposal for the tax on the sale of medical devices and a number of other provisions is also included in the Senate Finance Committee proposal and the legislation under consideration, discussed below in "The Senate Proposal" section, but in a different form. Several provisions that were included in the Finance Committee bill and added in the final version of H.R. 3962 are discussed below in the section on the Senate bill. The following subsections discuss some of the major proposals in the House bill.

Surtax on High-Income Individuals

The original surtax on high-income individuals would, like an itemized deduction limit, be concentrated on the top 1.2% of taxpayers.[8] Those subject to the highest surtax would constitute only two-tenths of 1% of taxpayers. Thus, the proposal is highly progressive.[9] The surtax proposal in H.R. 3962 would, according to the committees' summary, affect 0.3% of taxpayers.

Particular concerns have been expressed about the effect of the surtax on small businesses, which are suggested to be the source of new jobs, and on entrepreneurship in general. Only about 4% of businesses would be affected by the surtax in the initial proposal.[10] (Note that other parts of the health proposal, not addressed in this discussion, could impact small business both positively and negatively.) The committees' summary indicates that 1.2% of unincorporated businesses would pay the revised surtax.

[8] Data from the Joint Committee on Taxations, reported by the Ways and Means Committee in "Paying for Reform," http://waysandmeans.house.gov/media/pdf/111/pfr3200.pdf.

[9] Tax Policy Center, table T09-0348, Distribution of Federal Tax Change by Cash Income Percentile, http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2423&DocTypeID=2.

[10] Data from the Joint Committee on Taxation, reported by the Ways and Means Committee in "Paying for Reform," http://waysandmeans.house.gov/media/pdf/111/pfr3200.pdf.

A larger share of income would be affected, because higher-income individuals have a larger share of income. For example, returns with income more than $1 million account for 15.1% of adjusted gross income according to IRS statistics of income but only 0.2% of returns, and taxpayers with income more than $500,000 account for 22.4% of income but 0.7% of returns. These statistics indicate the degree to which income is concentrated at higher income levels.

In addition, business income is more concentrated in higher-income levels than other income. On the whole, labor income accounts for about three-quarters of overall income, with the remainder divided almost evenly between passive capital income (interest, dividends, and capital gains), pensions, and business income, whereas in the top 1% labor income is less than half of income. Individuals with incomes more than $1 million account for 27% of unincorporated business net income for businesses with positive income, and individuals with incomes more than $500,000 account for 38%. This concentration primarily reflects partnership and Subchapter S firms rather than proprietorships. Returns with adjusted gross income of $1 million or more accounted for 7.5% of total proprietorship income, whereas returns with income more than $500,000 accounted for 12.6%. For partnerships and Subchapter S firms (corporations that elect to be taxed as partnerships), returns with income more than $1 million accounted for 40.8% of net income and returns with income more than $500,000 accounted for 55.7% of net income. Supporting this finding, a 2007 Treasury study indicated that taxpayers at the top tax rate (constituting a similar share of returns to those covered by the surcharges) are responsible for 61% of business flow-through income.[11]

Some of the income in partnership and proprietorship incomes may reflect passive income and income from tax shelters, however. According to IRS data, almost 85% of partnership income is in limited liability companies or limited partnerships. (Subchapter S firms were more broadly distributed). Thus these business income shares include income that is passive rather than involving active business and also significant income that is in businesses that are of less concern with respect to entrepreneurship. The Treasury study indicated that these high-income taxpayers accounted for only 46% of active positive business income. Supporting this notion that many of these businesses are not active, the Tax Policy Center found that of the returns affected by the surtax with business income only 22.8% had business income that was more than half of total income.[12] This small income share also suggests much of this income is passive investment income that, absent the current rules that permit firms to operate with limited liability but not be subject to the corporate tax, would be in the form of corporate dividends and capital gains.

Much of partnership income, in particular, reflects activities that might not be the subject of interest, with respect to entrepreneurship and job creation. About two-thirds of partnerships reflect finance, real estate, oil and gas extraction (which includes passive partnerships), and services (such as doctors and lawyers).[13] About 8% of total income was from real estate and oil and gas respectively, 19% from finance and insurance with almost 80% of that total from securities and investment firms, 15% in professional services (with about 60% of the total legal services) and 5% in health (with about half physicians and dentists).

[11] Treasury Conference on Business Taxation and Global Competitiveness, July 23, 2007, http://www.treas.gov/press/releases/reports/07230%20r.pdf.

[12] Tax Policy Center, Table T09-0351, Distribution of Tax Units with Business Income, http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2426&DocTypeID=7.

[13] Internal Revenue Service, Statistics of Income.

These data suggest that while business income may be somewhat more concentrated than income overall, much of small business income is associated with passive investments, stockbrokers, lawyers, doctors, and accountants who are unlikely to be innovators or important sources of job creation for lower and moderate income individuals. Thus, very little of the increased tax revenue is likely to be collected from the businesses of interest.

In addition, questions could be raised about the argument that small businesses are important as sources of new jobs. Small businesses create more jobs but also are the greatest sources of job loss. They do create more net new jobs, but, according to Edmiston, this evidence is not entirely clear because of migration across size classifications; moreover, although this sector of the economy may offer more opportunities to women and minorities, it pays less, is less stable, and has fewer fringe benefits.[14] Aside from the issue of the number and quality of jobs, there is no need for a permanent policy to create jobs. Although a stimulus aimed at creating jobs may be needed in an economic downturn, there is no need for a permanent policy directed at this purpose; the economy creates its own jobs as evidenced by the growth in the employment supply over time.

If a major objection to the provision is the effect on small businesses, income from selected types of business operations (presumably not for lawyers, doctors, or stockbrokers) could be excluded from the surcharge. Flow through income is a larger share of income of the top 1% (about a quarter) than of the population as a whole (about 9%).[15] An exclusion of all of this income would sacrifice around a quarter of revenue, but the loss would be much smaller if passive income and income from finance, real estate, insurance, oil and gas extraction, and professional services were not permitted an exclusion.

Other Health-Related Income Tax Provisions

The other provisions that raise revenue have much smaller revenue effects. In the initial bill, one provision would enact the proposal also considered in the Senate Finance Committee options to disallow spending on over-the-counter medications as qualified uses of flexible spending plans, health savings accounts, and similar tax-favored plans. Most of the other provisions are discussed under those options are minor. Two health-related tax expenditures, the limits on flexible spending accounts in cafeteria plans and conforming the definition of medical expenses for health savings accounts and other plans to the same definition as for itemized medical deductions, are discussed below under the Senate proposal. Some health related provisions are implemented earlier in the Senate bill.

The remaining significant provisions, except for the tax on medical devices (a similar provision is included in the Senate Finance Committee proposal), relate to corporation taxes and the tax gap and have been proposed in the past as revenue offsets. Before turning to those issues, however, a brief discussion of the excise tax on medical devices is provided.

[14] Kelley Edmiston, "The Role of Small and Large Businesses in Economic Development," Federal Reserve Bank of Kansas City, *Economic Reviews*, 2nd Quarter, 2007, pp. 73-97.

[15] CRS Report RL33285, *Tax Reform and Distributional Issues*, by Jane G. Gravelle.

Excise Tax on Medical Devices

The tax on medical devices follows the philosophy of raising revenue from health-related provisions. Both the House and Senate bills contain a tax on medical devices, although, as discussed below, the form of the Senate provision is different and in imposed in the form of a fixed fee. (The Senate proposal has other fees as well.) The tax rate in the House bill is 2.5% of the value of the devices and is imposed on manufacturers and importers (and therefore does not reflect tax on the retail value, which would have been marked up). For ordinary medical devices with many producers, the tax should be fully passed on to consumers, although some of the cost, depending on the device, will be paid by insurers and lead to higher insurance payments, still ultimately falling on consumers. For unique devices already existing and under patent, where the producer has a monopoly position, some of the costs will be absorbed by the producer, although to the extent that the costs are covered by health insurance that effect would be muted. In the longer run, the tax would discourage investment in developing new innovative devices, an argument that has been by industry spokesmen. Again, that effect would be reduced to the extent that consumers do not pay the full price because of health insurance coverage.

Repeal Implementation of Worldwide Interest Allocation

The interest allocation proposal would repeal a provision adopted in 2004 that allowed worldwide interest allocation for the foreign tax credit. When income from abroad is subject to U.S. tax (either as branch income or repatriated income), a foreign tax credit is allowed for foreign taxes paid up to the U.S. tax due. For firms that have more foreign taxes paid than allowable credits, increasing the amount of income allocated abroad increases allowable foreign tax credits and reduces U.S. tax liability. Under rules absent the 2004 provision, U.S. source interest was allocated between foreign and domestic incomes based on relative magnitude of foreign and domestic assets. The 2004 provision included interest on foreign borrowing as well as debt-financed investment in the calculation, which would allocate more domestic interest to domestic source income, reduce interest allocated to foreign income, and result in an increase in the foreign tax credit limit.[16]

Limit Treaty Benefits

Another provision relating to international tax issues is intended to reduce "treaty-shopping." The United States imposes withholding taxes on interest, royalties, and similar payments to foreigners, but also engages in a number of treaties with other countries where these withholding rates are reduced. A firm in a country without a treaty can benefit by setting up a subsidiary in a treaty country to avoid the withholding tax, and this provision would eliminate that benefit.

Codify the Economic Substance Doctrine

The third provision would codify the economic substance doctrine. Firms that enter into tax savings arrangements that are found not to have economic substance can have their tax benefits disallowed by the courts under what has become known as the economic substance doctrine.

[16] See CRS Report RL34494, *The Foreign Tax Credit's Interest Allocation Rules*, by Jane G. Gravelle and Donald J. Marples.

Proposals to introduce legislative standards into the doctrine, which is sometimes interpreted differently by different courts, have been included in a number of recent legislative proposals and such a provision was included in President Obama's budget proposals. Generally, these proposals would require a transaction to meet both an objective test (profit was made) and a subjective test (profit was intended). Penalties are also imposed. Supporters argue that the stricter test will not only reduce tax avoidance but also make treatment more consistent across the courts. Some tax attorneys are concerned that more specific rules might provide a roadmap to structuring arrangements that will pass the test.

H.R. 3962 includes an additional provision to require information reporting by firms on payments to corporations. Under current law, firms that pay $600 or more to another firm have to report these amounts unless the firm is a corporation. This reporting helps aid in the enforcement of tax on self-employed individuals who have a significant amount of noncompliance according to tax gap estimates. Over time, more and more small businesses have had ways of incorporating, and there may be many smaller corporations where compliance is a problem (large corporations are closely audited by the Internal Revenue Service). The main disadvantage of the provision is that it will increase the compliance burden on businesses. In addition, the current information reporting is on a calendar year basis, but some corporations have a different tax year, which may reduce the value of the information.[17] The change could also simplify the reporting requirement in one respect, because it does not require the reporting firm to determine corporate or noncorporate status.

For further reading, see CRS Report RL34494, *The Foreign Tax Credit's Interest Allocation Rules*, by Jane G. Gravelle and Donald J. Marples; CRS Report R40468, *Tax Treaty Legislation in the 111th Congress: Explanation and Economic Analysis*, by Donald J. Marples; and CRS Report RS22846, *The Economic Substance Doctrine: Legal Analysis of Proposed Legislation*, by Carol A. Pettit.

The Senate Proposal

The Senate Finance Committee reported S. 1796, America's Healthy Future Act of 2009.[18] Out of $381 billion of revenues over the 2010-2019 period, the largest provision is $201.4 billion of gain from a 40% excise tax on health coverage in excess of $8,000 for singles and $21,000 for families. This provision was scaled back somewhat in H.R. 3590, passed by the Senate; overall, the bill raises $398.1 billion, with $148.9 billion raised from a provision imposing a 40% excise tax on health coverage in excess of $8,500 for singles and $23,000 for families.[19] H.R. 3590 also reduced the fee on medical devices and introduced additional provisions—one of them, an increase in the payroll tax for hospital insurance for high-income earnings, was the second largest revenue raiser, while the others (a 10% excise tax on indoor tanning facilities and a change in the treatment of Blue Cross) raised smaller amounts of revenue. H.R. 3590 also included a temporary

[17] This provision is discussed in Joint Committee on Taxation, Description of Revenue Provisions Contained in the President's Fiscal Year 2009 Budget Proposal, JCS-1-08, March 2008, http://www.jct.gov/publications.html?func=startdown&id=1250.

[18] The committee report is at http://finance.senate.gov/press/Bpress/2009press/prb102109a.pdf.

[19] See Joint Committee on Taxation, Estimated Revenue Effects of the Manager's Amendment to the Revenue Provisions Contained in the "Patient Protection and Affordable Care Act," JCX-61-09, December 19, 2009, http://www.jct.gov/.

fee on insured and self-insured plans, liberalized the adoption credit, and excluded assistance provided to participants in state student loan repayment programs for certain health professionals.

Except for a provision requiring information reporting for corporations (also in the House bill, raising $17.1 billion), the revenue raisers relate to health tax provisions or health issues. The plan has a number of provisions that are in the House bill: to conform the definition of medical expenses for health savings accounts and similar accounts to those for itemized deductions for health care ($5 billion); limit health flexible spending arrangements in cafeteria plans to $2,500, but indexed to inflation ($14.6 billion); increase the penalty for nonqualified distributions from health savings accounts to 20% ($1.3 billion); and disallow the deduction for subsidies related to Medicare Part D ($5.4 billion). The proposal contains a provision discussed in the options but not in the House bill to raise the 7.5% of adjusted gross income floor for itemized deductions for medical costs to 10% ($15.2 billion). It also limits deductions for remuneration to officers, employees, directors, and service provided of health insurance providers to $500,000 per year ($0.6 billion) and restricts current tax benefits to Blue Cross ($0.4 billion). As in the House bill, there is also a provision to exclude Indian Tribe health benefits from gross income that has a negligible cost.

The proposal includes a fee on manufacturers and importers of medical devices ($19.2 billion) and a larger fee on health insurance providers ($59.6 billion) than the House bill. It also imposes a fee on manufacturers and importers of branded drugs ($22.2 billion) and an excise tax of 10% on indoor tanning facilities ($2.7 billion). The plan also includes a fee on insured and self-insured health plans ($2.6 billion) expiring after September 31, 2019.

Another important revenue raising provision is an additional 0.9% hospital insurance (HI) payroll tax on wages in excess of $200,000 for singles and $250,000 for joint returns projected to raise $86.8 billion. This tax is the Medicare part of payroll taxes.

The plan also has three provisions that have a negligible cost: additional requirements for community benefits for non-profit hospitals, employer reporting on the W-2 of the value of health benefits, and a safe harbor for nondiscrimination rules in cafeteria plans for small employers. It has some revenue losing provisions: a qualifying therapeutic discovery project credit (a cost of $0.9 billion), an exclusion of funds provided to participants in state student loan repayment programs for certain health professionals (a cost of $0.1 billion), and a provision making the adoption tax credit refundable, increasing the qualifying expense threshold, and extending the credit through 2011 (a cost of $2.2 billion).

Two sections below discuss the excise tax on health insurance coverage and the fees on drugs, medical devices, health insurance providers, the excise tax on cosmetic procedures, and the increased HI tax.

Excise Tax on Excess Health Insurance Coverage

The excise tax falls on insurance companies, on the plan administrator for some types of plans, and on the employer for certain self-insured plans. The tax would not be deductible. Since its 40% rate is roughly equivalent to the top marginal income tax rate if the 2001 tax cuts expire (39.6%) and is lower than that rate combined with the Medicare tax, it is probably a reasonably good proxy for taxing employer benefits to the recipients for high-income taxpayers and is slightly larger for others. The provision would be expected to be passed on to individuals in higher premiums or lead to a reduction in the size of benefits for these plans (which would

increase their tax liability). The latter effect would also increase the price for medical care and presumably reduce demand.[20]

This provision is estimated to gain $148.9 billion in revenue over 10 years, smaller than the $201.4 billion in the Finance Committee Plan.[21]

The $8,500 and $23,000 thresholds would be increased by the CPI plus one percentage point. The thresholds would be higher initially for plans in the 17 states with the highest costs in the first three years: 20% higher in 2013, 10% higher in 2014, and 5% higher in 2015. The limits would also be higher for those over 55 and for those in risky professions (such as law enforcement; firefighting; rescue; construction, including those installing telecommunications lines; mining; agriculture, but not manufacturing of agricultural produces; forestry; and fishery). These limits would be $9,850 for single plans and $26,000 for family plans for those who qualify under either or both of these exceptions.

A study by the Committee on Budget Policy and Priorities indicates that 90% of plans would be unaffected by the Senate Finance Committee version of this provision, which applied to amounts in excess of $8,000 and $21,000.[22] That study cited an example of the directors of Goldman Sachs, who receive approximately $40,000 in health insurance coverage; it also noted that the limits were a third more generous than those of most Members of Congress.

If health care costs continue to rise significantly faster than general price levels, more plans would fall under the tax over time. The pattern of revenue estimates suggests that is the case. The argument for the excise tax approach is to discourage rising health care costs.[23]

Generally, the economic and distributional effects would be similar to an across-the-board dollar cap on the exclusion, as the tax should be passed on in price. Either the tax would be collected at the insurance-company level or the health insurance plans' cost would be reduced and wages payments substituted, which would raise taxes. Such a tax would give rise to the same fairness issues. It could also potentially tax benefits for lower-income employees who do not have tax liability or are taxed at lower rates more than would a cap on the exclusion. It would be less complicated to collect.

Two questions with such a proposal are how firms that self-insure would be treated and whether the excise tax would be deductible from the firm's income tax. An excise tax's revenues are generally reduced by about 25% to account for this interaction. Moreover, if the tax is deductible,

[20] The early discussions by a bipartisan group of Senators on the Finance Committee discussed a plan to tax premiums in excess of a floor, with the tax imposed on insurance companies. Taxes would be imposed on premiums greater than $21,000 for families and $8,000 for individuals, perhaps at a 35% rate, raising $180 billion in revenue over 10 years. About 7% of taxpayers have such plans.

[21] U.S. Congress, Joint Committee on Taxation, Estimated Effects of the Revenue Provisions Contained in the "Patient Protection and Affordable Care Act," JCX-55-09, November 18, 2009, *Estimated Revenue Effects Of The Revenue Provisions Contained In Title VI Of The "America's Healthy Future Act Of 2009," As Amended Through October 2, 2009, And Under Consideration By The Committee On Finance*, JCX-41-09, October 8, 2009, http://www.jct.gov/.

[22] Chuck Marr, Paul N. Van de Water, Edwin Park, and Kris Cox, *Senate Finance Committee Plan is Fiscally Responsible*, Committee on Budget and Policy Priorities, October 13, 2009, http://www.cbpp.org/cms/index.cfm?fa=view&id=2920.

[23] See Shailagh Murray and Lori Montgomery, 'Senators Closer to Health Package," *Washington Post*, August 6, 2009, pp. A1, A4.

a net tax advantage for these benefits would remain for high tax rate individuals (although it would be smaller than the current benefit).

Increase in HI Payroll Tax for High Incomes

H.R. 3590 would increase the hospital insurance payroll tax (which funds Medicare) by 0.9% for earnings in excess of $200,000 for single persons and $250,000 for joint returns; the provision raises the next largest amount of revenue, $86.8 billion. This tax would be collected by the employer on any compensation in excess of $200,000 without regard to a spouse's earnings, and the employee would be responsible for any discrepancy between withholding and liability. As is the case with the surtax, this provision would raise revenue from high-income taxpayers and be very progressive, although it would not fall on capital income, which is more important at higher income levels.

Fees On Medical Devices, Branded Drugs, and Health Insurance Providers; Excise Tax on Tanning Facilities; Fee on Insured and Self-Insured Plans

The fees on health insurance providers are the next largest revenue raisers ($59.6 billion) and all fees and excise taxes together account for $106.3 billion from FY2010 through FY2019. The fees on branded drugs account for $22.2 billion and the fees on medical devices account for $19.2 billion. (This latter fee was larger, at $38.6 billion, in the Finance Committee plan.) The fees rise over time for health insurance providers and medical devices. For health insurance providers they are $2 billion for 2011, $4 billion for 2012, $7 billion for 2013, $9 billion for 2014 through 2016, and $10 billion thereafter. The fees on medical devices are $2 billion per year from 2011 through 2017 and $3 billion per year thereafter. The fee on branded drugs is $2.1 billion per year. Fixed nominal aggregate fees will, subsequently, become increasingly less important over time. The fees on insured and self-insured plans are much smaller ($2.6 billion), are designed to finance the Patient-Centered Outcomes Research Trust fund, and expire after September 31, 2019.

As noted above in the discussion of the House bill, these taxes could increase prices, reduce profits of the producer, and be passed on to insurance companies (and ultimately the consumer), depending on the circumstances; the fee could also discourage new device and drug development. An argument made for these fees is that providers of health services will receive a windfall from the increased demand because of expanded health insurance coverage and fees will capture some of this effect.

All three provisions for fees provide for a fixed amount of revenue to be collected, with the shares apportioned according to the share of sales. The medical device fee exempts certain devices with a retail cost $100 or less, designed to exclude small items such as pregnancy tests, contact lenses, and blood pressure monitors. The medical device fee and the branded drug fee also have a sliding scale that reduces the effect on small producers. In determining the total sales for the apportionment for the medical device fee, the first $5 million is not counted, and 50% of the amount over $5 million but less than $25 million is counted. In the case of drugs, the shares are as follows: 0% of the first $5 million, 10% of the next $5 million-$25 million, 40% of the next $125 million-$225 million, 75% of the next $225 million-$400 million, and 100% of the amount over $400 million. For insurance, the first $25 million of premiums is not included and half of premiums between $25 million and $50 million will be included. In the case of third-party

administrators, the first $5 million will be excluded and half of the amounts between $5 million and $10 million will be excluded. The fees are not deductible.

Imposing the fee as a fixed amount with apportionment produces a tax at the margin without providing additional revenue, although it is a lower tax than would be produced if the tax rate were constantly reduced to raise a specific amount of revenue. The tax at the margin depends on the share of sales produced by any individual firm. If there are a large number of firms, and the firm's share is small, the tax is virtually the same as the current rate.[24]

H.R. 3590 also imposes a 10% excise tax on indoor tanning facilities, which would raise $2.7 billion over 10 years. This provision was not in the Finance Committee plan. A provision for taxing cosmetic producers was discussed during the debate, but was not included in the final bill. The tax is in the form of a standard excise tax, which in a competitive environment should be borne by consumers, but might be absorbed in part by providers. The tax is imposed on the customer and thus is effectively deductible by the provider who would not include it in income.

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 nonprofit hospitals provide benefits that justify their charitable and tax-exempt status. The Congressional Budget Office released a study in 2006 that found that nonprofit hospitals overall provided only slightly more charity care than for-profit hospitals.[25] That study also reported an estimate by the Joint Committee on Taxation indicating that the benefits of federal tax exemptions for nonprofit hospitals was about $6 billion in 2002.[26] 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.

A staff discussion draft released July 18, 2007, by Senator Grassley (ranking member of the Senate Finance Committee), raised the following concerns about nonprofit 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

[24] To illustrate, not considering the exemptions, suppose there were a 10% tax, two firms each produced $100 and one firm increased sales to $101. That increase would raise the firm's tax by 4.98% (the new tax would be $20 times $101/$201 rather than $10), and the other firm would reduce their tax by 5.02% of that increase. If one firm produced $50 and the other firm $150, the tax on the first firm's increased $1 of production would be 7.46%, whereas the benefit for the larger firm would be 2.48%. Thus, this form of imposing the tax imposes a larger marginal effect on the larger firm. If the industry has many producers, the marginal effect is close to the statutory rate; for example, if there were 100 firms, and all firms were of equal size, the tax would be 9.9%.

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

[26] 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.

ventures with for-profits, governance, and billing and collection practices.[27] 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 nonprofit 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 nonprofit hospital spent 7.4% of revenues on charity care.[28]

The staff discussion draft expressed concerns that, since a 1969 revenue ruling issued by the Internal Revenue Service, nonprofit 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.[29]

The 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.

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 toward the end of the year.[30] Both the House and Senate bills limit these arrangements to $2,500. H.R. 3590 indexes the amounts by the CPI after 2011.

Limiting 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 provision would 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. Both the House and Senate bills contain these provisions.

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

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

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

[30] See CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

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, whereas only 15% of the medical expense deduction is claimed by these higher-income groups. Similarly, whereas 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.

The Senate bill increases the floor to 10%. The floor remains at 7.5% for individuals aged 65 and older and their spouses through 2016.

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 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. A proposal in the Senate bill would disallow these tax benefits for firms whose premiums are greater than 85% of claims.

The President's February 2010 Compromise Proposal

On February 22, 2010, the Obama Administration released a new compromise proposal, which uses H.R. 3590 as a starting point, but offers several modifications to the revenue provisions of this bill.[31] In particular, this new proposal adopts the tax on high-cost health insurance plans included in the Senate-passed H.R. 3590, but delays the effective date of this provision from 2013

[31] These provisions are described in the "The President's Proposal," February 22, 2010, available at http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf.

to 2018. The President's proposal also modifies this proposed high-cost plan tax by raising the exemption amount to $27,500 for families and to $10,200 for individuals.

To make up for the revenue lost by these proposed changes to H.R. 3590's tax on high-cost plans, the Administration's proposal would broaden the Medicare Hospital Insurance (HI) tax for high-income taxpayers. Specifically, the President's proposal adopts the revenue provision offered in H.R. 3590 that imposes a 0.9% increase on the HI tax rate to 2.35% for married couples earning more than $250,000 and individuals earning more than $200,000. But in addition, the President's plan would also implement a 2.9% assessment on income from interest, dividends, annuities, royalties, and other unearned income for married couples earning more than $250,000 or individuals earning more than $200,000.

The President's compromise proposal also includes two revenue provisions contained in the House-passed H.R. 3962. First, the Administration's plan would clarify that certain liquid byproducts derived from paper or pulp processing (known as "black liquor") are not eligible for a cellulosic biofuel tax credit provided for under current law. Secondly, the President's proposal would seek to codify the economic substance doctrine.

Other Health-Related Tax Expenditures as Possible Revenue Raisers

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 choose among a menu of benefits. Deductible contributions may occur through specialized health savings accounts (HSAs) and flexible spending accounts (FSAs) (discussed subsequently).[32] All of these expenses can be excluded from taxable income.

The option of capping the exclusion for employer-supplied health insurance was included in the Senate Finance Committee's revenue options in May 2009. 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.[33]

[32] 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 Janemarie Mulvey. 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.

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

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.[34] 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.[35] 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.[36] 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 indexed or not. If it is indexed, a further consideration is whether the index is for general price inflation or indexed for health price inflation.[37] 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.[38] A cap at the 90th percentile would raise $4.9 billion in 2010, rising to $188.8 billion in 2019 if not indexed; it would raise $4.6 billion rising to $130.7 billion in 2019 if indexed to general price inflation; and it 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 in the highest bracket saves an individual $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.)

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

[35] 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.

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

[37] 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.

[38] 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.

The benefits of the payroll-tax exclusion are not as targeted toward higher-income families. Payroll taxes are flat rate taxes, with the Social Security portion subject to an income cap.[39] In addition, the excluded income in the form of 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**, although 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 **Table 1**, 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.

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

Income Quintile	Percentage with Tax Cut	Percentage 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

[39] 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.

non-elderly population,[40] and there are concerns that altering or reducing the tax subsidies might reduce employer participation.[41] (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. 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.[42] For example, the young may subsidize the old, and small families may subsidize large 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.

Although 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 toward higher incomes, because 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

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

[41] 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.

[42] 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 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.

possible to make adjustments for these characteristics, but that would add to the administrative burden.[43]

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.[44]

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 employees' income, the deduction available to employers could be reduced or eliminated for insurance costs in excess of a floor (which would correspond to a cap on the employee exclusion 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.

Additional Health-Related Tax Expenditure Options

Other health-related income tax expenditures were considered and listed in the Senate Finance Committee's report.[45] 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.

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

[43] 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.

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

[45] 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.

income and payroll tax) for contributions from employers.[46] 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 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 party. The proposals would also include HSA contributions under a general employer cap.

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 intermingled, 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.

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.[47]

[46] See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2010*, by Janemarie Mulvey.

[47] See CRS Report RS22681, *The Cigarette Tax Increase to Finance SCHIP*, 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.

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. Because 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. Because a beer barrel contains 31 gallons, if beer is 4.5% alcohol, the alcohol in beer is taxed at $0.10 per ounce, about half the rate for distilled spirits. Wine is taxed by type.[48] 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.[49] 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 of 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.[50]

Alcohol taxes, like tobacco taxes, tend to be regressive, collecting a larger percentage of the income of low-income individuals.[51] 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 percentage 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, the burden relative to income would be 333% larger rather than 116% larger.

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[48] 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.

[49] 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 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.

[50] 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, DC, 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.

[51] 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 Percentage 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.[52] (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.[53]

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).[54] 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.[55] For beer, prices would rise by 5%, for wine 8.1%, and for spirits 1.5%. Applying these

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

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

[54] 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.

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

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.[56]

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.[57] 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.

Health Care Reform Financing Proposals Made by the President in 2009

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

[56] 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.

[57] 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, whereas 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.[58] The provision would primarily affect taxpayers with incomes more than $250,000. 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.[59] 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.[60]

Other Base-Broadening Provisions

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

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.

[58] 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.

[59] 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%.

[60] 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.

A second set of provisions involves some relatively narrow revisions that fall into three basic categories: tax provisions affecting financial institutions and insurance companies, revisions of certain tax accounting methods, and revisions in the estate tax, primarily limiting the amount of valuation discounts.[61] Taken together, this second set of provisions raises around $5 billion to $6 billion per year. The largest single provisions over the 10-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), the modification of corporate-owned life insurance (slightly under $1 billion in the earlier years), and the repeal of 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 Tax Options to Finance Health Care

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 Consumer Price Index (CPI) minus 1% rather than the CPI.[62] 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).[63] 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,[64] and LIFO repeal would raise about $6 billion.[65] The revenue raised from international reforms depends on the nature of the changes, but international provisions in the President's proposal in total raise more than $20 billion.

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

[61] 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.

[62] 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.

[63] 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.

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

[65] 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.

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.[66]

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.[67]

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.

[66] 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.

[67] 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.

Appendix.

Table A-1. provides a comparative list of all revenue provisions and revenue-related reform proposals currently included in H.R. 3962 and S. 1796.

Table A-1. Tax Provisions and Estimated Revenue Effects for FY2010-FY2019, H.R. 3962 (House Bill) and H.R. 3590 (Senate Bill)

(revenue is estimated in $ billions)

Tax Provision	Included in H.R. 3962 (House)	Included in H.R. 3590 (Senate)	Revenue Effects of H.R. 3962	Revenue Effects of H.R. 3590
Impose a 5.4% Surtax on AGI in Excess of $500,000 ($1,000,000 for Joint Returns); Not Indexed for Inflation	X		460.5	
Impose a 2.5% Ad Valorem Excise Tax on First Taxable Sale of Medical Devices	X		20.0	
Impose Annual Fee on Manufacturers and Importers of Certain Medical Devices		X		19.2
Require Information Reporting on Payments to Corporations	X	X	17.1	17.1
Delay Implementation of Worldwide Interest Allocation Until 2020	X		6.0	
Limit Treaty Benefits for Certain Deductible Payments	X		7.5	
Codify Economic Substance Doctrine and Impose Penalties for Underpayments	X		5.7	
Extend Certain Health Benefits Applicable to Spouses and Dependents to Eligible Designated Beneficiaries	X		-4.0	
Second Generation Biofuel Producer Credit	X		23.9	
Tax on individual Without Acceptable Health Care Coverage	X		29.0	
Election to Satisfy Health Coverage Participation Requirements	X		45.0	
Health Care Contributions of Nonelecting Employers	X		163.0	
Credit for Small Business Employee Health Coverage Expenses	X		-53	
Disclosures to Carry Out Health Insurance Exchange Subsidies	X		Not Available	
Conform the Definition of Medical Expenses for Employer-Provided Health Coverage, Including Health Flexible Spending Arrangements and Health Reimbursement Arrangements, Health Savings Accounts, and Archer MSAs to the Definition for the Itemized Deduction	X	X	5.0	5.0
Limit Health Flexible Spending Arrangements in Cafeteria Plans to $2,500, Indexed to CPI-U	X	X	13.3	13.3
Increase the Penalty for Nonqualified Distributions from Health Savings Accounts to 20%	X	X	1.3	1.3
Eliminate Deduction for Expenses Allocable to Medicare Part D Subsidy	X	X	2.2	5.4

Tax Provision	Included in H.R. 3962 (House)	Included in H.R. 3590 (Senate)	Revenue Effects of H.R. 3962	Revenue Effects of H.R. 3590
Exclusion from Gross Income for Indian Tribe Health Benefits	X	X	Loss of less than 50 million	Loss of less than 50 million
Exclusion from Gross Income of Payments Made Under Reinsurance Program for Retirees	X		Not Available	
Disclosures to Facilitate Identification of Individuals Likely to be Ineligible for Low-Income Subsidies Under the Medicare Prescription Drug Program to Assist Social Security Administration's Outreach to Eligible Individuals	X		No Effect	
Impose Fee on Insured and Self-Insured Health Plans; Comparative Effectiveness Research Trust Fund	X		2.0	
40% Excise Tax on Health Coverage in Excess of $8,500/$23,000 Indexed for Inflation by CPI-U Plus 1% and Increased Thresholds for Over Age 55 Retirees or Certain High-Risk Professions; Levied at Insurer Level		X		148.9
Employer W-2 Reporting of Value of Health Benefits		X		Negligible Effect
Additional Requirements for Section 501(c)(3) hospitals		X		Negligible Effect
Impose Annual Fee on Manufacturers and Importers of Branded Drugs		X		22.2
Impose Annual Fee on Health Insurance Providers		X		59.6
Study and Report of Effect on Veterans Health Care		X		No Effect
Raise 7.5% AGI Floor on Medical Expenses Deduction to 10%; AGI Floor for Individuals Age 65 and Older (and their spouses) Remains at 7.5% (sunset 12/31/16)		X		15.2
$500,000 Deduction Limitation on Taxable Year Remuneration to Officers, Employees, directors, and Service Providers of Covered Health Insurance Providers		X		0.6
Simple Cafeteria Plan Nondiscrimination Safe Harbor for Certain Small Employers		X		Negligible Effect
Qualifying Therapeutic Discovery Project Credit (Sunset 12/31/10)		X		-0.9
Offering of Exchange-Participating Health Benefit Plans Through Cafeteria Plans	X		Not Available	
CLASS Program Treated in Same Manner as Long-Term Care Insurance	X		Not Available	
Certain Large or Publicly Traded Persons Made Subject to a More Likely Than not Standard for Avoiding Tax Penalties on Underpayments	X		Not Available	
Additional 0.5% hospital insurance tax on wages in excess of $200,000 ($250,000) joint		X		86.8
Modification of section 833 treatment of certain health organizations (Blue Cross provision)		X		0.4

Tax Provision	Included in H.R. 3962 (House)	Included in H.R. 3590 (Senate)	Revenue Effects of H.R. 3962	Revenue Effects of H.R. 3590
10% excise tax on indoor tanning facilities		X		2.7
Exclusion for assistance to participants in state student loan repayment programs for certain health professionals		X		-0.1
Make adoption credit refundable, increase threshold and extend through 2011		X		-1.2
Fees on Inured and Self-Insured Plans				

Sources: *Affordable Health Care For America Act: Section-by-Section Analysis*, Committees on Energy and Commerce, Ways and Means, and Education and Labor, October 28, 2009. *Committee Report of the America's Healthy Future Act of 2009*, Senate Finance Committee, October 19, 2009. *Estimated Revenue Effects of Possible Modifications to the Revenue Provisions of H.R. 3962, The "Affordable Health Care for America Act",* October 29, 2009, Joint Committee on Taxation. *Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group*, from the Congressional Budget Office to the Honorable Charles B. Rangel, Chairman on Ways and Means, July 14, 2009. *Estimated Revenue Effects of the Revenue Provisions Contained in Title VI of the "America's Healthy Future Act Of 2009," as Amended Through October 2, 2009 and Under Consideration by the Committee On Finance*, October 8, 2009. Most revenue effects are summarized in Joint Committee on Taxation, JCX-53-09 and JCX-61-09, http://www.jct.gov/.

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