DESCRIPTION AND ANALYSIS OF H.R. 1818 (THE "FAMILY MEDICAL SAVINGS AND INVESTMENT ACT OF 1995")

Scheduled for a Hearing

Before the

SUBCOMMITTEE ON HEALTH

of the

HOUSE COMMITTEE ON WAYS AND MEANS

On June 27, 1995

Prepared by the Staff

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INTRODUCTION

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of and discussion of H.R. 1818 (The "Family Medical Savings and Investment Act of 1995"). H.R. 1818 was introduced on June 13, 1995, by Chairman Archer, Messrs. Jacobs, Thomas, Crane, Shaw, Bunning of Kentucky, Houghton, Herger, McCrery, Hancock, Camp, Ramstad, Zimmer, Nussle, Sam Johnson of Texas, Ms. Dunn of Washington, Messrs. Collins of Georgia, Portman, English of Pennsylvania, Ensign, Christensen, Mrs. Johnson of Connecticut, and others. The Subcommitee on Health of the House Committee on Ways and Means has scheduled a public hearing on the bill for June 27, 1995.

Part I of the document provides an overview. Part II discusses the present-law tax treatment of health insurance and expenses. Part III describes H.R. 1818. Part IV discusses issues relating to medical savings accounts. Part V discusses estimating issues and methodology relating to medical savings accounts in general and H.R. 1818 in particular.

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[1] This document may be cited as follows: Joint Committee on Taxation, *Description and Analysis of H.R. 1818 (The "Family Medical Savings and Investment Act of 1995")* (JCX-28-95), June 26, 1995.

I. OVERVIEW

Present-law tax treatment of health insurance and expenses

The term medical savings account ("MSA") generally refers to a variety of programs and proposals which are designed to encourage individuals to reduce health care expenditures through tax incentives. Present law contains no special tax rules for MSAs. However, there are ways under present law in which employers can design health plans to encourage employees to reduce health care expenses. Many of these programs are commonly referred to as MSAs. The main difference between what are referred to under present law as MSAs and current legislative proposals is that the latter provide additional tax benefits for MSAs.

Under present law, the tax treatment of health insurance coverage depends on whether the taxpayer is an employee or self-employed individual and whether the taxpayer is covered by an employer-provided health plan. The Internal Revenue Code ("Code") encourages the provision of health care through employment by providing the most favorable tax treatment to such coverage. An employer's contribution to a health plan covering the employee and the employee's spouse and dependents is generally excludable from income. By contrast, present law provides a deduction for 30 percent of the health insurance costs of self-employed individuals (sole proprietors or partners in a partnership) and the individual's spouse or dependents. For individuals who are not self-employed or who do not receive employer-provided coverage, present law allows an itemized deduction for medical expenses (including the cost of insurance) to the extent such expenses exceed 7.5 percent of adjusted gross income.

Description of H.R. 1818 (the "Family Medical Savings and Investment Act of 1995")

In general, the bill would permit individuals who are covered only by a catastrophic health plan to maintain an MSA. Within limits, contributions would be deductible if made by the individual, or alternatively, would be excludable from income if made by the employer. An individual would not be eligible to make deductible contributions to an MSA if the employer makes contributions. In general, the aggregate amount of individual or employer contributions that could be deducted or excluded for a taxable year would be the lesser of (1) the deductible under the catastrophic health plan, or (2) $2,500 if the catastrophic health plan only provides individual coverage or $5,000 if the catastrophic health plan also covers the individual's spouse and/or dependents. These dollar limits would be indexed annually based on the medical care component of the Consumer Price Index (rounded to the nearest multiple of $50). Withdrawals from an MSA would be excludable from income if used for medical expenses for the individual and his or her spouse or dependents. Income earned on amounts held in an MSA would be currently includible in income.

Issues relating to the design of medical savings accounts

MSA proposals generally use tax incentives to encourage individuals to save on health care expenditures. Proponents of MSAs argue that present law, particularly the unlimited exclusion

for employer-provided health care, encourages the overconsumption of health care. They argue that different tax incentives are necessary to encourage individuals to reduce private health care spending. The objectives of MSA proposals generally include reducing overall health care expenditures by making individuals more aware of their health care expenditures, reducing administrative costs, and increasing savings. The likely effect of MSA proposals is dependent on the specifics of the particular proposal.

MSA proposals raise both health and tax policy issues and should be evaluated in terms of their effect on both the health care and Federal tax systems. Two major health policy concerns are cost containment and access to health insurance coverage. In evaluating proposals from a tax policy perspective, factors to consider include economic efficiency, fairness, and ease of administration and compliance. The design of any proposal, including MSAs, is likely to involve tradeoffs of various objectives.

Specific MSA design features, all of which may affect the impact of the proposal include: (1) who is eligible to participate in an MSA; (2) how are contributions to an MSA determined and what is the tax treatment of those contributions; (3) are earnings on amounts in an MSA taxable currently or tax deferred; and (4) what use can be made of MSA funds?

Estimating issues and methodology

The staff of the Joint Committee on Taxation prepares revenue estimates to measure the anticipated changes in Federal receipts that result from proposed legislative changes to the Code. The methodology generally consists of a comparison of the revenue yield of present law to the revenue yield that will result assuming the proposal to change the tax law is adopted. Anticipated taxpayer behavioral response is often the most significant element of the expected revenuer yield under a proposla. Often, further adjustments are made to account for such things as the interaction of various proposals, and issues relating to taxpayer compliance.

With respect to MSA proposals in general, revenue estimates would be dependent on the following major factors: (1) the effect of the MSA proposal on premiums for both catastrophic and noncatastrophic health plans; (2) the extent to which taxpayers utilize an MSA-like arrangement under present law; (3) the extent to which taxpayers with other health insurance coverage under present law will utilize an MSA under the proposal; and (4) the extent to which taxpayers view the MSA as a tax-favored savings vehicle and the interaction with other forms of tax-favored savings. Additionally, the revenue estimate will be affected by the specific combination of design features included in the proposal such as the tax treatment of account contributions and distributions and the tax treatment of earnings.

II. PRESENT-LAW TAX TREATMENT OF HEALTH INSURANCE AND EXPENSES

Medical savings accounts

The concept of medical savings accounts ("MSAs") has received significant attention in recent years. The term is often used to refer to a variety of programs and proposals which have the main objective of encouraging individuals to reduce health care expenditures through the use of tax incentives. There is no definition of an MSA in the Internal Revenue Code ("the Code"), and present law does not contain any provisions specifically for MSAs. However, there are ways under present law in which employers can design health plans to encourage a reduction in health care expenses, and some employers are adopting such approaches. One widely publicized example is that of *Forbes* magazine, which adopted a bonus program that rewarded employees for not incurring claims under their health plan. Other employers have modified plans to provide a financial incentive for employees to choose a lower-priced plan or to choose a plan with a higher deductible. These latter programs are often operated through cafeteria plans and flexible spending arrangements, discussed in more detail below, which allow employees to use the health care savings for other benefits (i.e., so-called flexible benefit plans). All of these types of programs are commonly referred to as MSAs.

The main difference between what are sometimes referred to as MSAs under current law and the legislative proposals relating to MSAs is that the latter provide additional tax benefits for MSAs.

Overview of present law

Under present law, the tax treatment of health insurance expenses depends on whether the taxpayer is an employee or self-employed individual, and whether the taxpayer is covered under a health plan paid for by the employee's employer. Federal tax laws encourage the provision of health care in the employment context by providing the most favorable tax treatment for employer-provided health care. An employer's contribution to a plan providing accident or health coverage for the employee and the employee's spouse and dependents is excludable from an employee's income. In addition, businesses can generally deduct, as an employee compensation expense, the full cost of any health insurance coverage provided for their employees. The exclusion and deduction are generally also available in the case of owners of subchapter C corporations who are also employees.

In the case of self-employed individuals (sole proprietors or partners in a partnership) no equivalent exclusion applies. However, present law provides a deduction for 30 percent of the amount paid for health insurance for a self-employed individual and the individual's spouse and dependents. The 30-percent deduction is also available to more than 2-percent shareholders of subchapter S corporations. Under present law, self-employed individuals are disadvantaged when compared to individuals who organize their business in corporate form under subchapter C of the Code with respect to the treatment of health insurance. In such a case, the individual could be the sole shareholder and employee of the company. Any employer contributions for health care would be fully excludable by the employee and fully deductible by the corporation.

Under present law, self-employed persons are treated more favorably than other individuals who do not receive employer-provided health care. Individuals other than self-employed individuals who do not have employer-provided health care (e.g., individuals whose employers do not offer health care) can deduct health insurance expenses only to the extent that such expenses, together with all other medical expenses of the taxpayer, exceed 7.5 percent of adjusted gross income ("AGI"). As a practical matter, the 7.5 percent of AGI floor on medical expenses deduction generally prohibits many taxpayers from deducting any health insurance premiums in a taxable year.

Exclusion for employer-provided health coverage

In general

Employer contributions to a health plan are generally excludable from an employee's income (sec. 106). This exclusion for employer-provided health coverage also generally applies to coverage provided to former employees and to the spouses or dependents of employees or former employees. In the case of a self-insured medical reimbursement plan, the exclusion is conditioned on the coverage being provided under a plan meeting certain nondiscrimination requirements (sec. 105(h)). Insured health plans are generally not subject to nondiscrimination rules. Employer-provided health coverage is additionally excluded from the definition of wages for employment tax purposes (sec. 3121(a)(2)).

Cafeteria plans

Under present law, compensation generally is includible in gross income when actually or constructively received. An amount is constructively received by an individual if it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, no amount is included in the gross income of a participant in a cafeteria plan described in section 125 of the Code solely because, under the plan, the participant may elect among cash and certain employer-provided qualified benefits.

In general, a qualified benefit is a benefit that is excludable from an employee's gross income by reason of a specific provision of the Code. Thus, employer-provided health coverage, group-term life insurance coverage (whether or not subject to tax by reason of being in excess of the dollar limit on the exclusion for such insurance), and benefits under dependent care assistance programs may be provided through a cafeteria plan. However, a cafeteria plan may not provide qualified scholarships or tuition reduction (sec. 117), educational assistance (sec. 127), or miscellaneous employer-provided fringe benefits (sec. 132). In addition, a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement (sec. 401(k)).

Cafeteria plans are subject to rules to help ensure that the plan does not offer a benefit that defers the receipt of compensation. For example, a cafeteria plan may not permit participants to

use contributions for one plan year to purchase a benefit (e.g., health coverage) that will be provided in a subsequent plan year. In addition, a cafeteria plan election must generally be made prior to the plan year in which it is to take effect, and may not be revoked or changed except in very limited circumstances such as termination of employment or certain changes in family status.

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

The cafeteria plan exception from the principle of constructive receipt generally also applies for employment tax purposes.[2]

In practice, the design of cafeteria plans differs substantially. Many cafeteria plans are funded solely through salary reduction arrangements. Under these plans, each eligible employee has the option of agreeing to reduce his or her compensation and having the amount of that reduction applied by the employer to one or more qualified benefits. Under other plans, the employer will contribute a fixed amount (often called "flex credits") to a cafeteria plan on behalf of each employee to be used on the various qualified benefits offered under the plan, including several health plan options. Many such plans allow employees to receive unused amounts in cash, thus, for example, permitting employees to enjoy the savings associated with a less expensive health care option. Still other plans employ a combination of a salary reduction arrangement and employer contributions.

Flexible spending arrangements

A flexible spending arrangement ("FSA") is a reimbursement account or other arrangement under which an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care. An FSA may be part of a cafeteria plan and may be funded through a salary reduction arrangement. FSAs may also be provided by an employer outside a cafeteria plan i.e., when employees are not entitled to cash in lieu of a contribution.

There is no special exclusion for benefits provided under an FSA. Thus, benefits provided under an FSA are excludable from income only if there is a specific exclusion for the benefits in the Code (e.g., the exclusion for employer-provided health or group-term life insurance coverage). FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans, discussed generally above. FSAs are commonly used to reimburse employees for qualifying medical expenses not covered by insurance.

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[2] Elective contributions under a qualified cash or deferred arrangement that is part of a cafeteria plan are subject to employment taxes.

A health FSA is generally defined as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.[3]

Proposed Treasury regulations impose special rules on health FSAs in order for the coverage and benefits provided under the FSA to be excludable from income.[4] These rules apply with respect to a health FSA without regard to whether the health FSA is provided through a cafeteria plan (i.e., without regard to whether an employee has an election to take cash or benefits). These rules are generally designed to ensure that a health FSA operates like health insurance.

Health FSAs may only reimburse medical expenses which meet the definition of medical care under section 213(d) of the Code. The proposed Treasury regulations prohibit reimbursement for insurance premiums to pay for other health plan coverage, just as health insurance reimburses actual expenses and does not pay for insurance.

A health FSA may only reimburse participants for medical expenses incurred previously during the plan year. Thus, amounts in an employee's account that are not used for medical expenses incurred before the end of the plan year must be forfeited. There is no option to receive such amounts in cash. This rule is often referred to as the "use it or lose it" rule.

The proposed Treasury regulations also impose a claims substantiation requirement on health FSAs. A health FSA may only reimburse medical expenses for which the participant provides a written statement from an independent third party stating the amount of the medical expense and that the medical expense has not been reimbursed or is not reimbursable under any other health plan.

Under the proposed Treasury regulations, health FSAs are also required to (1) provide the maximum amount of reimbursement available under the FSA at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage), and (2) offer coverage for 12 months or, in the case of a short plan year, the entire short plan year.

If a health FSA has an experience gain with respect to a year of coverage, the excess of the

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

[4] Prop. Treas. Reg. 1.125-2 Q&A-7

premiums paid (e.g., employer contributions, including salary reduction contributions and after-tax employee contributions) and income (if any) of the FSA over the FSA's total claims reimbursements and reasonable administrative costs for the year may be used to reduce required premiums for the following year or may be returned to the premium payers (the participants in the case of premiums paid by salary reduction or employee contributions) as dividends or premium refunds. Such experience gains must be allocated among premium payers on a reasonable and uniform basis. It is permissible to allocate such amounts based on the different coverage levels under the FSA received by the premium payers. However, in no case may the experience gains be allocated among premium payers based (directly or indirectly) on their individual claims experience.

Deduction for health insurance costs of self-employed individuals

Self-employed individuals (i.e., sole proprietors or partners in a partnership) can deduct 30 percent of the amount paid for health insurance for a self-employed individual and the individual's spouse and dependents. The 30-percent deduction is also available to more than 2-percent shareholders of S corporations.

The 30-percent deduction is available with respect to the cost of self insurance as well as commercial insurance. In the case of self insurance, the deduction is not available unless the self-insured plan is in fact insurance (e.g., there is appropriate risk shifting) and not merely a reimbursement arrangement.

The 30-percent deduction is not available for any month if the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse. In addition, no deduction is available to the extent that the deduction exceeds the taxpayer's earned income. Amounts taken into account for purposes of the deduction cannot be taken into account in determining itemized medical deductions.

Itemized deduction for medical expenses

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

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

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

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

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

III. DESCRIPTION OF H.R. 1818 (THE "FAMILY MEDICAL SAVINGS AND INVESTMENT ACT OF 1995")[5]

In general

In general, H.R. 1818 would permit individuals who are covered only by a catastrophic health plan to maintain an MSA to assist in saving for medical expenses not covered by the plan. Within limits, contributions would be deductible if made by the individual, or alternatively, would be excludable from an employee's income if made by the employer. An individual would not be eligible to make deductible contributions if the individual's employer makes contributions to an MSA for the individual. In general, the aggregate amount of individual or employer contributions that could be deducted or excluded for a taxable year would be the lesser of (1) the deductible under the catastrophic health plan, or (2) $2,500 if the catastrophic health plan only provides individual coverage or $5,000 if the catastrophic health plan also covers the individual's spouse and/or dependents. These dollar limits would be indexed annually based on the medical care component of the Consumer Price Index (rounded to the nearest multiple of $50).[6] Withdrawals from an MSA would be excludable from income if used for medical expenses for the individual and his or her spouse or dependents. Income earned on amounts held in an MSA would be currently includible in income.

Deductible contributions to MSAs

Under the bill, a deductible contribution could be made to an MSA for any month in which the individual is an eligible individual. In general, a person would be an eligible individual for a month if, as of the first day of the month, he or she is covered under a catastrophic health plan. However, an individual would not be eligible if the individual is also covered by another health plan (other than a plan that provides certain permitted coverage) which is not a catastrophic health plan and which provides coverage for services provided by the catastrophic health plan.[7] For example, an individual could not obtain separate insurance to cover the deductible under the

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[5] H.R. 1818 was introduced by Chairman Archer and others on June 13, 1995. A more complete listing of cosponsors is in the Introduction. Minor technical corrections to the bill may be necessary to reflect the intent of the bill as generally described here.

[6] The inflation adjustment is determined using the Consumer Price Index for August of the preceding calendar year.

[7] The following types of coverage would be permitted coverage and therefore would not preclude an individual from making a deductible contribution to an MSA: (1) coverage only for accidents, dental care, vision care, disability income, or long-term care; (2) Medicare supplemental health insurance; (3) coverage issued as a supplement to liability insurance; (4) liability insurance, including general liability insurance and automobile liability insurance; (5) worker's compensation or similar insurance; (6) automobile medical-payment insurance; (7) coverage for a specified disease or illness ; and (8) a hospital or fixed indemnity policy.

catastrophic health plan and still make a deductible contribution to the MSA.

A catastrophic health plan would be defined as a health plan that has a deductible amount of at least $1,800 (or $3,600 if the plan provides coverage for more than one individual). These dollar amounts would also be indexed annually for medical inflation.

No deduction would be allowed for a taxable year if any employer contributions (including transfers from a health FSA, discussed below) are made to an MSA on behalf of an individual during such year. (As discussed below, such employer contributions would be excludable from income, subject to the same limits.)

The maximum annual deductible contribution to an MSA would be determined separately for each month based on the individual's status as of the first day for each month, including: (1) whether the individual is an eligible individual, (2) whether the catastrophic health plan covers only the individual or also a spouse and dependents, and (3) the amount of the deductible under the catastrophic health plan. In general, the maximum annual deductible contribution would be the sum of the following amounts determined separately for each month: (1) 1/12 of the lesser of $2,500 or the deductible under the catastrophic health plan for each month in which the individual is an eligible individual and the catastrophic health plan covers only the individual, and (2) 1/12 of the lesser of $5,000 or the deductible under the catastrophic health plan for each month in which the individual is an eligible individual and the catastrophic health plan also covers the individual's spouse and/or dependents.

The bill is designed so that married couples would be generally treated the same as single individuals. The deduction limit generally would be determined separately for each spouse of a married couple. However, if both spouses are covered under the same catastrophic health plan, then the deduction limit would be divided equally between the spouses unless they agree on a different division (in the time and manner prescribed by the Secretary). In such a case, no deduction would be allowed with respect to either spouse if an employer contribution is made to an MSA on behalf of either of the spouses. If both spouses are covered under different catastrophic health plans, they may each make deductible contributions (as permitted) to their own MSA as if they were single individuals.

Permitted deductions for contributions to an MSA would be taken in arriving at adjusted gross income (i.e., "above the line"). No deduction would be allowed to an individual if any other person is entitled to a personal exemption on account of such individual, whether or not such personal exemption is actually taken.

Contributions to an MSA for a taxable year could be made until the due date for filing the individual's tax return for the year (determined without regard to extensions).

Example (1): Individual A is covered by a catastrophic health plan with a deductible of $2,400 for individual coverage and $4,800 in the case of family coverage (and no other health plan) for all of 1996. Individual A is single at the beginning of 1996, but marries on June 30, 1996. A's spouse (who was not covered by a catastrophic health plan prior to marriage) is also covered by the same catastrophic health plan as A beginning on July 1, 1996 (and no other health plan). No employer makes a contribution to an MSA on behalf of either spouse. The maximum deduction limit for A for 1996 is $3,800, calculated as follows: for each of the months January through June of 1996, the contribution limit is $200 and for each of the months July through December of 1996, the contribution limit is $400. A's spouse is not entitled to a deduction for 1996.

Example (2): Same example as above, but instead assume that A's spouse is covered by another catastrophic health plan for all of 1996 (with identical deductibles) and that A's spouse has a child who is covered by that plan. The maximum deduction limit for A for 1996 is now $2,400. However, A's spouse is also entitled to a deduction of $4,800 for 1996.

Employer contributions to an MSA

Employer contributions to an MSA on behalf of an eligible individual would be excludable from gross income and would not be considered wages for employment tax purposes. The amount excludable could not exceed the deduction limit applicable to the individual. The exclusion would apply whether or not the employee may choose to have the amounts contributed to an MSA or another health plan. For example, there would be no income inclusion merely because the employee may choose between a catastrophic health plan with an employer contribution to an MSA and coverage under another (non catastrophic) health plan. However, it is intended that employer contributions to an MSA could not be made at the election of the employee (i.e., pursuant to a salary reduction arrangement under a cafeteria plan).

Transfers from health FSAs

The bill would generally provide that undistributed amounts in a health FSA could be transferred to an eligible individual's MSA without inclusion in income and without affecting the FSA's status under IRS rules. The bill would generally define a health FSA as a benefit program which reimburses employees for specified incurred medical expenses (subject to reimbursement maximums and other reasonable conditions) with a maximum amount of reimbursement which is reasonably available to the participant that is less than 500 percent of the cost of the coverage. In the case of an insured plan, the maximum amount reasonably available would be determined on the basis of the underlying coverage. Other than permitting certain transfers to an MSA, the bill would not change the requirements under present law relating to health FSAs.

Under the bill, amounts transferred from an FSA to an MSA would be treated as employer contributions, subject to the same limits as employer contributions. Consequently, if amounts

are transferred from an FSA to an individual's MSA in a taxable year, the individual could not make deductible contributions to the MSA for that year. In addition, under the terms of the bill participation in a health FSA by itself in a taxable year, whether or not amounts are transferred to an MSA, would preclude a deductible or excludable contribution to an MSA. This is because under the bill participation in a health FSA would constitute coverage under another health plan making the individual ineligible for an MSA. Thus, as a practical matter, a transfer from a health FSA to an MSA would only be available when converting from coverage under a health FSA to an MSA.[8]

Definition and tax treatment of MSAs

In general, an MSA would be a trust (or a custodial account) created exclusively for the purpose of paying the qualified medical expenses of the account holder (or his or her spouse or dependents) that meets requirements similar to those applicable to individual retirement arrangements ("IRAs").[9] The trustee of an MSA could be a bank, insurance company, or other person that demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with applicable requirements.

The holder of an MSA would have to currently include earnings on MSA assets in taxable income. Any capital losses on MSA assets could be used only to offset capital gains on MSA assets. Unused capital losses could be carried forward to succeeding taxable years.

An MSA trustee would be required to make such reports as may be required by the Secretary. A $50 penalty would be imposed for each failure to file without reasonable cause. There would be no claims substantiation requirements (such as those imposed on health FSAs) in order for an MSA trustee to make a distribution.

Distributions from an MSA

Distributions from an MSA that are used to pay the qualified medical expenses (not reimbursed by insurance or otherwise) of the individual or the individual's spouse or dependents

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[8] The details of these transfers and their effect in all cases are not fully specified in the bill.

[9] For example, MSA contributions (other than amounts rolled over from an MSA) would have to be in cash, no MSA assets could be invested in life insurance contracts, MSA assets could not be commingled with other property except in a common trust fund or common investment fund, and an account holder's interest in an MSA would be nonforfeitable. In addition, if an account holder engages in a prohibited transaction with respect to an MSA or pledges assets in an MSA, rules similar to those for IRAs would apply, and any amounts treated as distributed to the account holder under these rules would be treated as not used for qualified medical expenses.

would be excludable from gross income whether or not the individual is an eligible individual at the time of the distribution.[10] Disbursements for qualified medical expenses of spouses and dependents would be permitted even if the catastrophic health plan only covers the individual. Qualified medical expenses would generally be defined as under the rules relating to the itemized deduction for medical expenses (sec. 213). However, for this purpose it is intended that qualified medical expenses would not include any health insurance premiums (including premiums for the catastrophic health plan), except that premiums for long-term care insurance[11] would constitute qualified medical expenses. Distributions from an MSA that are excludable from gross income could not be taken into account for purposes of the itemized deduction for medical expenses.

Distributions for purposes other than qualified medical expenses would be subject to an ordering rule so that such distributions would be includible in income until the amount of previously deducted or excluded contributions have been exhausted. Under the bill, amounts not used for qualified medical expenses would be included in gross income to the extent such distributions do not exceed the excess of (1) the aggregate contributions to such account which were deductible or excludable from gross income, over (2) the aggregate prior payments from such account which were includible in gross income. For this purpose, all MSAs of the account holder would be aggregated and all distributions during a taxable year would be treated as a single distribution. An additional tax of 10 percent of the amount includible in income would also apply unless the distribution is made after the individual dies or becomes disabled.

Rollovers from one MSA to another MSA would be permitted without income inclusion if made within 60 days of distribution.

Effective date

The bill would be effective with respect to taxable years beginning after December 31, 1995.

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[10] H.R. 1215 (the "Contract with America Tax Relief Act of 1995"), introduced on March 13, 1995, by Chairman Archer, would create American Dream Savings Accounts, to which nondeductible contributions could be made. Withdrawals from American Dream Savings Accounts would not be includible in income if certain requirements are satisfied. Distributions used to pay medical expenses (as defined in sec. 213) of the individual and the individual's spouse or dependents would not be includible in income if made more than five years after establishment of the account. Distributions for medical expenses made within five years would be includible in income, but would not be subject to the 10 percent tax on early withdrawals.

[11] H.R. 1215 would also clarify the tax treatment of long-term care insurance and expenses.

IV. ISSUES RELATING TO THE DESIGN OF MEDICAL SAVINGS ACCOUNTS

A. Objectives of Medical Savings Accounts

While current MSA proposals differ greatly in design, MSA proposals generally use tax incentives to encourage individuals to save on health care expenditures. The effect of the incentives is dependent on the specifics of the individual proposal. In general, the objective of MSA proposals is to reduce overall health care expenditures by making individuals more aware of their health care expenditures and providing an economic incentive to lower those expenditures. Many MSA proposals also seek to reduce health care expenditures by reducing the administrative costs of processing of insurance claims (generally by reducing the number of claims filed). While most MSA proposals focus on reducing private health care expenses, some also have increasing saving generally as a goal.

Many people, including proponents of MSAs argue that present law, particularly the unlimited exclusion for employer-provided health care, does not provide adequate incentives to reduce health care expenses and, in fact, provides incentives to overutilize health care. The exclusion for employer-provided health care does provide an incentive for employees to prefer health care over taxable compensation. Similarly, but to a lesser extent, the other subsidies for health insurance provide an incentive to consume health insurance rather than other goods that do not receive favorable tax treatment. Individuals who benefit from the Federal tax subsidies for health expenses do not pay for the full cost of their health care and, thus, may purchase more health care than they would in the absence of the subsidy. MSA proponents argue that different tax incentives are necessary to encourage individuals to reduce private health care spending.[12]

MSAs raise both health care and tax policy issues, and should be evaluated in terms of their effect on both the health care and Federal income tax systems. Two major health care issues frequently discussed are the need to contain costs and increasing access to health care. MSA proposals are primarily aimed at the first issue. Proponents of MSAs argue that MSAs participants will reduce their health care expenditures, thereby reducing demand for health care and total health care costs. Opponents of MSAs question this conclusion, and argue that while

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[12] While recognizing that present law may provide an incentive to overutilize health care, some question whether additional tax subsidies for MSAs are necessary because employees are adopting cost-cutting plan designs under current law without additional tax incentives. Because MSA proposals are generally based on problems with the present-law exclusion for employer-provided health care, some also argue that the exclusion should be repealed or modified. Such changes in the law would raise significant issues.

MSAs may reduce health insurance costs of MSA participants (who are most likely to be younger, healthier individuals) they will increase health insurance costs for others (typically less healthy, possibly lower-income individuals) by removing healthier individuals from group insurance pools.

MSAs also may reduce the number of uninsured individuals. If MSAs are effective in reducing total health care costs, then health insurance may become affordable for more people. In addition, some MSA proposals would increase the Federal tax subsidy for health insurance and not just out-of-pocket expenses. This additional subsidy may also make health insurance more affordable and may induce individuals to purchase health insurance. Some believe that MSA proposals should include provisions that address access more directly, such as insurance market reforms.

In evaluating proposals from a tax policy perspective, factors to consider include economic efficiency, fairness, and ease of administration and compliance. Economic efficiency generally refers to whether or not the proposal distorts taxpayer behavior. As mentioned above, the present-law exclusion for employer-provided health care is often criticized because of its effect on the consumption of health care. In some cases, encouraging taxpayer behavior that would not take place without the tax incentive may be considered desirable from a policy perspective. In addition, a proposal will be called inefficient if it merely rewards taxpayers for doing something they would have done in any event; i.e., the tax incentive (and any revenue loss) was not needed to induce the desired behavior.

Fairness generally refers to whether the proposal takes into account ability to pay taxes or imposes an undue burden on some taxpayers. It also deals with the question of whether similarly situated taxpayers are treated the same. For example, the present-law rules dealing with health insurance are often criticized as unfair because they favor employees whose employers provide insurance over self-employed individuals and others who do not have employer-provided health care.

The complexity of the Internal Revenue Code is a growing concern. Any MSA proposal should be evaluated in terms of the ease of administration from both the perspective of the Internal Revenue Service ("IRS") and taxpayers.

The design of any proposal, including MSAs, is likely to involve tradeoffs of various objectives. For example, features of an MSA that make it more attractive (and thus more likely to be used by taxpayers) may also have some negative aspects, such as greater administrative burdens or greater revenue loss.

Even if MSAs reduce private health care spending, they may involve a net loss to the Federal government if the tax benefits, when all factors (including behavioral response) are taken into account, cause a revenue loss. If the MSA proposal is estimated to result in a revenue loss, then it must be determined whether that loss is acceptable given the overall effects of the proposal, including the effects on both health policy and savings. The answer to this question

may depend on the way in which the revenue loss is offset.

B. Specific Medical Savings Account Design Issues

1. Overview of design issues

There are many possible MSA designs. The likely effects (including the effect on health care costs and the health care delivery system, individual behavior, and revenue impact) of an MSA proposal vary greatly depending on the specific design. Key elements in the design of an MSA include the following: (1) who is eligible to participate in the MSA; (2) how are contributions to an MSA determined and what is the tax treatment of those contributions; (3) are earnings on amounts in an MSA taxable currently or tax deferred; and (4) what use can be made of funds in the MSA?

The following discussion assumes that the MSA proposal is voluntary. That is, employers are not required to offer employees an MSA as a health plan option and, if they do, are not required to contribute to the MSA.

2. Eligibility

The two main issues regarding eligibility are: (1) the individuals to whom the MSA option is available (e.g., employees only or all individuals) and (2) whether or not eligibility is conditioned on the purchase of a particular type of health plan.

Classes of individuals eligible for an MSA

Some MSA proposals, like H.R. 1818, provide that MSAs are available to all individuals, while others limit eligibility of MSAs to employees whose employer offers an MSA.

One of the common criticisms of the present-law tax subsidies for health care is that individuals are not treated the same. Equity among taxpayers argues for making MSAs available to all individuals.

Proposals that limit MSAs to the employer context often do so because of revenue constraints. Permitting self-employed and other individuals without employer-provided health care to make deductible contributions to an MSA may involve a more significant revenue loss than a proposal limited to employees, because it would increase the tax benefits available to such individuals with respect to health care. From a policy perspective, because individuals without employer-provided health care receive less of a tax subsidy for health insurance, the tax benefits may have less of a distortive effect on the decision of how much health care to consume. The largest distortion will likely occur in the employer-provided context, so it may not be inappropriate to limit MSAs proposals to that setting.

Type of health coverage required

Many MSAs proposals, like H.R. 1818, condition eligibility for an MSA on the purchase of a health plan with a relatively high deductible (often referred to as a "catastrophic health plan"). Premiums for a plan with a higher deductible are lower than the same health plan with a lower deductible. Increasing deductibles generally reduces health care utilization, because some people will choose not to make health care expenditures not covered by insurance. Proposals that condition an MSA on a high deductible or catastrophic policy generally do so to reduce demand for health care. Such proposals generally are premised on the idea that many people are willing to take the risk of exposure to a higher deductible, as long as they are protected from catastrophic medical expenses.

Opponents of MSAs are concerned that all reductions in utilization may not be beneficial, and that some individuals with MSAs may forgo preventive care or delay seeking medical care, which may increase health care spending in the long run.

Limiting the availability of an MSA to individuals with a high deductible plan may, depending on the other features of the MSA, limit the attractiveness of the MSA option. High deductible plans are generally more attractive to younger, healthier individuals who either believe they are unlikely to incur substantial medical expenses, to individuals who have the resources to self insure the higher deductible. The MSA can reduce the exposure of the individual to expenses under the deductible amount, and thus may encourage some individuals to buy a catastrophic policy who otherwise would not do so.

The expected reduction in utilization generally associated with a high deductible plan may be counteracted by the MSA, depending on the particular features of the MSA. Factors that could undermine the goal of reduction in utilization include the extent to which the individual is permitted to obtain health coverage to insure against the deductible amount and still obtain the benefits of the MSA, and the extent to which the individual uses the MSA funds for health expenses other than those that would be covered by insurance but for the deductible amount. To address this concern, some proposals, like H.R. 1818, provide that the individual can not have other health plan coverage, or only certain types of permitted coverage and contribute to an MSA.

The question of what coverage an individual can have and still be eligible for an MSA raises particular issues in the context of FSAs. Some view FSAs as fundamentally inconsistent with the objectives of MSAs, primarily because the "use it or lose it rule" can actually encourage spending. An MSA provides the same function as an FSA (i.e., tax-favored payment of out-of-pocket expenses), but without this rule. Thus, some would argue that an individual should not be allowed to maintain both an FSA and an MSA. Some would go further and argue that health expenses paid from an FSA should not be excludable from income.

H.R. 1818, and other proposals would permit an individual to have certain types of coverage, such as dental or vision coverage, that do not provide comprehensive health coverage

in addition to an MSA. Some would argue that it should also be permissible to have such coverage under an FSA, e.g., to allow dental expenses to be paid through an FSA. They argue that this should be permitted because the individual could accomplish the same result by having the coverage outside the FSA. Whether or not permitting such coverage to be provided through an FSA is desirable depends on whether FSAs are viewed as consistent with the objectives of MSAs.

H.R. 1818, and other proposals, permit individuals to transfer amounts remaining at the end of the year in an FSA to an MSA. Under H.R. 1818, this transfer operates primarily as a transition between an FSA and an MSA, because an individual is not permitted to have both. Some individuals would prefer to use an FSA rather than an MSA because contributions to an FSA are not considered wages for employment tax purposes, whereas individual contributions to an MSA would generally be made with compensation on which employment taxes had been paid.

Some argue that conditioning the benefits of an MSA on the purchase of a high deductible or catastrophic policy unfairly favors fee-for-service plans over other type of health care arrangements, such as health maintenance organizations ("HMOs") that typically do not have deductibles, but implement cost sharing through copayments. Some argue that individuals should be rewarded for choosing a plan that is lower cost, regardless of the form of the plan. Alternative designs could accommodate such concerns, but may have different overall effects. For example, eligibility for an MSA could be conditioned upon purchase of a plan with a certain level of copayment, or could be based upon the purchase of a plan with a cost lower than a certain cost (e.g., the average cost of a health plan with certain features).

Opponents of conditioning eligibility on the purchase of a catastrophic plan also are concerned that individuals will choose the MSA option while healthy, and then switch to a different type of plan when their health status changes, thereby increasing the cost of the other plan. The same behavior could occur under present law, however. Current MSA proposals generally do not alter the ability that individuals have under present law to change health plans. It is possible that an MSA proposal could result in greater changing of plans, because it may make a high deductible plan more attractive than present law (and may cause some individuals to switch out of another type of plan). However, it may also make staying in the high deductible plan more attractive, depending on the features of the high deductible plan and whether or not the individual has funds enough in the MSA to pay for anticipated medical expenses.

3. Amount of and tax treatment of contributions

MSA proposals typically provide that, within certain limits, contributions to an MSA receive favorable tax treatment. In the case of individuals, contributions are deductible and in the case of employer contributions, the contributions are excludable from gross income and wages for income and employment tax purposes. The attractiveness of an MSA option to individuals and the likely effects varies with the amount of contributions that receive such tax-favored treatment.

A key element is whether or not the contribution limit is sufficient to cover an individual's anticipated health expenses that will not be covered by health insurance. Some MSA proposals provide that the amount that receives tax-favored treatment is the difference between the premium cost of a higher deductible plan and the lower deductible plan.[13] Under such proposals, the difference in premiums may not be sufficient to cover anticipated expenses (which in some cases will be less than the deductible amount). Individuals who do not have other funds from which to pay anticipated expenses in excess of the premium differential may find such an MSA less attractive than one with a higher contribution limit.

H.R. 1818 and similar proposals address this issue by providing that the amount that receives favorable tax treatment is generally the amount of the deductible. Increasing the amount that receives favorable tax treatment will make MSAs more attractive to some people, because they will be better able to pay for anticipated expenses not covered by insurance. The greater the amount that receives favorable tax treatment, the more likely that people will also be induced to choose an MSA to receive the tax benefits. This can increase the revenue cost associated with a proposal. To limit tax benefits, H.R. 1818 and other proposals also provide a maximum annual limit on the contributions that receive favorable tax treatment.

Even if the MSA amount limit is sufficient to cover anticipated expenses, the timing of the contributions may be a factor. Under present law, health FSAs are required to make funds available for the full amount of coverage throughout the period of coverage, even if actual contributions for the period have not yet been made. Current MSA proposals typically do not have such a requirement. If an employee incurs medical expenses before the employer makes contributions to the MSA, the employee may have to pay the expenses from other funds. This may make MSAs less attractive to individuals who anticipate cash flow constraints.

If the proposal does not limit the MSA option to persons enrolled in a high deductible plan, then other ways of measuring the MSA contribution may be appropriate. For example, the limit could be the difference between the cost of various plans, or a flat dollar limit.

4. Tax treatment of earnings

Some MSA proposals, like H.R. 1818, provide that earnings on amounts held in MSAs are taxable currently, just as if the MSA were a savings or other bank account. Others provide that earnings are allowed to accumulate tax-free, like the present-law treatment of individual retirement arrangements ("IRA"s).

Permitting funds to accumulate in an MSA on a tax-free basis would provide an incentive

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[13] Some proposals adopt this approach in order to limit the amount that receives tax-favored treatment to the amount receiving such treatment under present law. In practice, determining such differential can be difficult, such as in the case of an employer that offers employees a wide variety of health plan options.

not to spend funds in the account. This could have varying effects on an individual's expenses for medical care (depending in part on the permitted uses of MSA funds and any penalties for nonpermitted uses). Some individuals may lower health expenditures, while some may simply choose to pay expenses with funds outside the account. In some cases, the desire to save (e.g., for retirement) may cause the individual (to the extent permitted under the MSA proposal) to choose a health plan with lower deductibles or copayments in order to maximize tax-free saving.

There is some concern about the level of household saving in the United States. The IRA nature of MSA proposals that permit tax-free buildup of earnings could encourage additional saving; however, the concerns relating to IRAs about equity and efficiency (in terms of increasing savings) arise as well for MSAs.[14] On the equity side, individuals with higher marginal tax rates (who are often more wealthy) receive larger tax benefits. With respect to efficiency issues, the evidence is mixed as to whether IRAs result in new saving as opposed to merely shifting saving that would have occurred anyway to a tax-favored account.

Apart from these concerns, some also question whether it is appropriate to provide an incentive to save for the purchase of a particular good or service (e.g., medical care or long-term care). If there is concern that individuals will not correctly judge their need for a particular good or service in the future, then encouragement of savings for such expense may be warranted. To the extent that increasing savings generally is the goal, then limiting incentives to particular purposes is not the most efficient means of achieving that goal. Providing incentives to save for particular goods or services may also be perceived as unfair, because different individuals have different demands for goods and services (e.g., not all individuals will need long-term care).

5. Permitted use of medical savings account funds

MSA proposals typically provide that withdrawals for medical expenses are not taxable. Medical expenses can be defined in a variety of ways. Two common methods are to use the definition of medical expenses under the provision of the Code relating to the itemized deduction for medical expenses (sec. 213). This definition is relatively broad. An alternative is to further limit permitted expenses to those that would be covered under the health plan in which the individual is enrolled, but for the deductible. Some proposals do not provide tax-free treatment for the purchase of health insurance, while others do.

Many proposals also provide tax-free withdrawals for certain other types of expenses. For example, H.R. 1818 permits tax-free withdrawals for the purchase of long-term care insurance. Some proposals provide tax-free withdrawal for any purpose after attainment of a specified age, such as 59-1/2, or after the passage of a certain period of time, such as 5 years. Other proposals would provide that withdrawals at any time for any use are tax-free.

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[14] For a more complete discussion of IRAs and saving, see Joint Committee on Taxation, *Description and Analysis of Tax Proposals Relating to Individual Saving* (JCS-3-95), February 8, 1995.

Providing tax-free withdrawals for medical expenses paid from an MSA places such medical expenditures on the same level as expenses paid from employer-provided health care. By permitting deductible amounts to be paid with tax-free dollars rather than after-tax dollars, individuals may be more inclined to choose a health plan with a higher deductible, since the government subsidizes part of the deductible. For example, suppose an employee in the 31 percent marginal tax bracket has a health insurance policy with a deductible of $500. If the deductible may be paid on a tax-free basis, the individual could increase the deductible to $725, and not incur any additional cost, because the Federal government would pay the difference through the tax subsidy. Because higher deductibles lower the cost of the health insurance policy, the individual could enjoy the benefit of this savings.

Note that for individuals with employer-provided health coverage this result can occur under present law, through the use of a health FSA. Thus, employers could make a high deductible plan more attractive under present law by offering an FSA that could be used to pay expenses not covered by the health plan. Given this possibility, some question whether specific legislation for MSAs is needed. However, one of the criticisms of FSAs under present law is that the "use it or lose it" feature encourages individuals with a balance near the end of the year to spend the money on health expenses in order to avoid forfeiting the balance. Thus, FSAs may lead to an increase in health expenditures rather than a decrease.

MSA proposals that permit tax-free withdrawals for the purchase of health insurance in effect increase the subsidy for the purchase of health insurance for self-employed individuals and other persons without employer-provided health care (assuming the MSA is available to such individuals). Such individuals have an incentive to have an MSA merely to receive the additional subsidy for insurance, even if the account limit is not also sufficient to accumulate funds to pay expenses not covered by insurance. Such a proposal may reduce the number of uninsured.

Some proposals limit the type of medical expenses that are tax-free to those of a type that, but for the deductible, would be covered by the health plan, rather than the broader definition of medical expenses under section 213 of the Code. Another alternative would be to provide tax-free treatment of only medical expenses for services not covered by the health plan. Supporters of these approaches suggest that limiting tax-free treatment would tend to reduce health expenditures.

Proposals that limit the types of withdrawals that receive tax-favored treatment typically impose a penalty tax, in addition to regular income tax, on withdrawals that are not for a permitted purpose. Proposals that tax earnings on amounts in MSAs typically contain rules to ensure that amounts that have been previously taxed are not taxed again upon withdrawal. While a relatively low penalty (such as 10 percent) may discourage some from using MSA funds for nonpermitted uses, in many cases it will not be a sufficient deterrent. For example, experience with the 10-percent penalty on certain IRA distributions under present law indicates that persons will withdraw funds and still pay the penalty.

Some argue that all withdrawals from an MSA should be tax free in order to make individuals indifferent between spending on health care and spending on other items. Proponents of such an approach are concerned that, if medical expenses are the only expenses that are tax-free, individuals will have an incentive to spend more on medical care, rather than less.

Expanding the list of tax-free withdrawals may change the incentive to spend on medical care since MSA participants will more easily be able to enjoy the benefits of their savings. However, allowing unrestricted tax-free distributing also increases the likelihood that individuals will use MSAs merely as a means of saving on a tax-favored basis for other purposes, e.g., retirement, or other consumption expenses. Some criticize this as going beyond the intended scope of an MSA. In addition, depending on the other features of the MSA proposal, providing tax-free withdrawals for any purpose could significantly affect the amount of revenue loss.

6. Administrative and compliance issues

Any tax proposals raise issues of administration and compliance; the specific issues depend on the particular proposal. MSAs are generally intended to operate with little administrative cost in order to maximize saving. Administrative issues relating to MSAs include the maintenance of accounts, substantiation of medical expenses that receive tax-free treatment, and determining the proper amount of contributions that can be made to an account. In many cases, the administrative issues involved in MSAs will be similar to those under present law. For example, MSA accounts would be administered like IRAs, and employers that offer more than one health plan or a cafeteria plan would already have in place procedures similar to those that would be required to make employer contributions to an MSA.

V. ESTIMATING ISSUES AND METHODOLOGY

A. Estimating Methodology in General[15]

Revenue estimates measure the anticipated changes in Federal receipts that result from proposed legislative changes to current tax law. Each proposal is estimated using essentially the same methodology. In simple terms, two basic calculations are required. First, one must determine the revenue yield of present-law. This is known as the revenue baseline. Second, one must estimate the revenue yield that will result from the tax law after it is modified. The difference between the revenue forecast of the baseline and the revenue forecast of the modified law is the revenue estimate.

For most income tax revenue estimates, the Joint Committee on Taxation ("JCT") staff relies on large computerized models of the Federal income tax system and the economy. These microsimulation models use as their primary input the confidential tax returns filed by the individuals with the IRS. These data are provided to the JCT staff by the Statistics of Income ("SOI") Division of the IRS.

Based on economic theory, these models combine the most recently available taxpayer information with forecasts of the aggregate level of national income provided by the Congressional Budget Office ("CBO") as part of the budget baseline. To estimate the revenue effects of most proposed changes in the individual income tax, the JCT staff first uses the individual model to calculate the tax for each of the sample returns in the tax model on the basis of present law. The model then recalculates the tax for each of the returns incorporating the parameters contained in the proposed legislation. In so doing, it accounts for the interaction of all variable components of the taxpayer's return. After statistically weighting the present-law and proposed-law tax payments to make the results reflect outcomes for the more than 100 million U.S. individual taxpayers, the computer run calculates the difference in total revenues between present law and the proposal. This result is often only the first step in estimating the revenue change associated with a proposal. Often, further adjustments are made to account for such things as taxpayer behavior (in addition to taxpayer behavior effects calculated directly from the model), the interaction of various proposals, and issues relating to taxpayer compliance.

B. General Estimating Methodology for Medical Savings Account Proposals

Estimating the present-law revenue baseline

Individuals generally can be divided into four groups with respect to their status involving

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[15] For a more detailed description of the revenue estimation process, see *Written Testimony of the Staff of the Joint Committee on Taxation Regarding the Estimating Process for the Joint Hearing of the House and Senate Budget Committees of the 104th Congress on January 10, 1995,* (JCX-1-95), January 9, 1995.

health care coverage: (1) persons who have employer-subsidized health insurance (i.e., employees whose employers pay for all or a part of health insurance); (2) self-employed individuals who purchase their own health insurance; (3) individuals who purchase health insurance (e.g., employees whose employer does not provide health insurance or unemployed individuals); and (4) individuals who do not have health insurance.[16] Generally, the revenue analysis of MSA proposals are based on these groups.

The individual income tax model calculates the extent to which health insurance or benefits are provided on a tax-favored basis under present law. In making this calculation, it is first necessary to estimate the number of taxpayers who fall into each category of individuals described above. These taxpayers are then categorized by type of health insurance coverage, filing status, and income class.[17] For each category, an estimate is made of the type of health coverage and benefits being provided (on average) under present law and the extent to which the coverage and benefits are provided on a tax-favored basis.

This analysis provides an estimate of the revenue baseline under present law for the most recent year for which tax return and other relevant information are available. This baseline is adjusted to reflect growth in medical expenditures and any changes in the law since the year for which information is available. The rate of growth of medical expenditures is based upon the CBO's macroeconomic assumptions for the budget period.

General approach to estimating the revenue effect of a Medical Savings Account proposal

In general

Estimating the revenue effects of any specific MSA proposal will be highly sensitive to the specific features of the proposal. There are a variety of design features that have been included in the MSA proposals identified to date. The specific combination of design features included in an MSA proposal may have a significant effect on the revenue estimate for the proposal; in particular, the combination of features will affect the behavioral response anticipated to occur under the proposal. The following discussion assumes that eligibility for an MSA is conditioned on the purchase of a high deductible (or catastrophic) health plan.

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[16] Individuals in this category will include unemployed individuals, individuals who are not employed by an employer who offers health insurance (or who are not otherwise eligible to participate in their employer's plan), and individuals who decline health insurance offered by an employer (e.g., because they do not want to make the required employee contributions).

[17] Data sources that provide information with respect to the categorization of individuals include confidential tax return information from the SOI, Current Population Survey ("CPS") data relating to health care, the National Medical Expenditure Survey ("NMES"), and other smaller benefits surveys.

The revenue estimates for an MSA proposal also will be influenced by whether the proposal is included in a package of proposals that make other changes expected to have an effect on taxpayer behavior with respect to health care utilization. Thus, for example, an MSA proposal included in a package that also contains health insurance reform proposals may have a different estimated revenue effect than an MSA proposal considered with no other changes. It will be assumed for purposes of this discussion that an MSA proposal is considered without regard to any interaction with other health care related changes.

The revenue estimate of an MSA proposal is dependent upon the following factors: (1) the effect of the MSA proposal on premiums for both catastrophic and noncatastrophic health plans; (2) the extent to which taxpayers utilize an MSA-like arrangement under present law either through an FSA or on an after-tax basis; (3) the extent to which taxpayers with other health insurance coverage under present law will utilize an MSA under the proposal; and (4) the extent to which taxpayers view the MSA as a tax-favored savings vehicle and the interaction with other forms of tax-favored savings.

Premium estimates

The revenue estimate of the tax treatment under an MSA proposal combines premium estimates and estimated account contributions. This calculation relies on the premium estimates of the catastrophic health plan that is selected in conjunction with the MSA. The premium estimates used in this analysis are drawn from a model developed by the Congressional Research Service ("CRS") in conjunction with consulting actuaries at Hay/Huggins Co. Inc.[18] The methodology and assumptions underlying the CRS model have been coordinated with the Budget Analysis Division of the CBO to ensure that they are consistent with other premium estimates generated by CBO.

The CRS model estimates the change in the actuarial value of the health care coverage when shifting from traditional health insurance coverage to a high deductible plan.[19] The model also estimates the reductions in health care utilization likely for those individuals who have expenses that under a traditional plan would be paid by an insurance company but under a high deductible plan would not be paid because of the individual's election to not incur these

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[18] CRS and Hay/Huggins have developed a premium model using data on the health insurance experience of approximately 1,000 employers (refined with Society of Actuaries data from eight major insurance companies covering over 3 million people) and data from the NMES. CRS has been modelling health insurance premiums for Congressional committees and members since 1988.

[19] If the total health care spending did not change at all under a high deductible plan, the premium would still be reduced because a greater percentage of health care spending would be borne by the subscriber, rather than the insurance company.

expenses.[20]

The CRS premium for catastrophic coverage is compared to premiums for health plans currently in use. The premium differential is combined with the estimated account contributions. The net tax effect of the premium differential and the MSA contributions represent the revenue forecast of modified tax law due to the tax treatment of MSA contributions.

Estimating behavioral effects

Characterization of the behavioral effects of an MSA proposal depends upon the specific proposal under consideration and the relative tax treatment of the health care under present law and the proposal. Consequently, there is no single set of behavioral responses which correspond to all MSA proposals. Empirical research can provide estimates of taxpayer responses to proposed changes in tax legislation. If adequate data exist, responsiveness can be estimated statistically. For example, sufficient data are available to permit revenue estimates to take into account the expected change in demand for tax-favored savings when new savings vehicles are made available. Estimates of changes in demand for savings vehicles, combined with the experience of plans referred to as MSAs under present law (i.e., MSAs used on a nontax-favored basis) are useful in estimating behavioral responses to MSA proposals. The experience under present law is useful, but has some limitations. Under certain circumstances, the limited experience under present law may not generalize to the entire population that would be eligible to participate in a proposed MSA. Moreover, the present-law arrangements are fundamentally different than current MSA proposals, because they do not provide the same tax benefits that the proposal would provide.

Estimates of behavior effects include estimates of the number of employers who would offer an MSA plan, the level of contributions that would be made to MSAs, and whether the employer or the individuals would make the contribution. The behavioral response in subsequent years reflects an assumed increase in utilization as employers and individuals better understand the operation of MSAs, improved marketing and creation of policies by insurers, and an assumption that some employers and individuals will abandon an MSA because it is considered undesirable for a particular population of individuals. In addition, the premiums are adjusted for improved cost effectiveness of MSAs in subsequent years. Estimating the revenue effects of proposed MSA legislation requires making a determination of participation for both

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[20] The model generates a range of premiums which result from individual perceptions regarding the funds in the MSA. At one extreme, some would consider the MSA balance as money to be used to offset the high deductible and therefore the "effective deductible" for these people would be the plan deductible minus the MSA balance. At the other extreme, some people would consider the entire MSA balance as additional savings, so their "effective deductible" would be the same as the plan deductible. These two groups would generate different premium estimates because one group views the MSA as first-dollar insurance coverage, while the other group views the MSA as a substitute for other savings.

the employer and the employee. Estimates of the number of employers that would offer MSAs and the characteristics of the employer (i.e., size and age of the work force) are made depending upon the specific tax benefits of each proposal.[21] Based on these factors, the level of employee participation is then estimated.

The tax differential created by the legislative changes is applied to the base of taxpayers after adjustments for participation and behavioral responses are determined. In general, the tax differential depends on the extent to which the proposal provides a greater tax benefit than present law. For example, consider an MSA proposal that permits individuals with a catastrophic health plan to deduct up to $1,800 if the amount is contributed to an MSA. Under such a proposal, a self-employed individual with a catastrophic policy would be entitled to an $1,800 tax deduction compared to a deduction for up to 30 percent of health insurance premiums under present law.

In the employee context, the tax differential depends on how the tax benefits under the MSA proposal compare to the amount being excluded under present law. In this case, whether or not there would be a revenue loss depends on whether the excludable $1,800 MSA contribution plus the value of the catastrophic policy is more or less than the value of the health plan in which the employee was previously enrolled (assuming the full amount was excludable).

C. Specific Revenue Estimating Issues for Medical Savings Accounts

The magnitude of the revenue estimates for MSA proposals depends on the specific tax treatment provided in the legislative proposal. (See Appendix for examples of the potential revenue effects of MSA proposals.) The revenue analysis would depend upon the issues described below:

Tax treatment of account contributions

The first change in tax treatment which has a substantial revenue effect is the deductibility or excludability of contributions to the MSA. To the extent that the total premium cost and the deductible contribution exceed the present cost of health premiums, there is a revenue loss attributed to the proposal. By contrast, if the combination of premiums and the MSA contribution are less than the subsidized health premiums under present law, there is a revenue gain under the proposal. In general, JCT estimates assume that employers would not increase their total costs of compensation in the presence of an MSA arrangement.

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[21] Assumptions are made regarding whether or not the employer offers the MSA in conjunction with other plans. Assuming more than one plan is offered, the combination of plans offered (i.e., HMOs, fee-for-service, and MSAs) and the corresponding benefits covered in each policy are also estimated.

Exclusion of MSA contributions from employment taxes

There is an additional effect on revenue to the extent that amounts currently included in the taxpayer's employment tax base would now be excluded. Under present law, most employee benefits are excluded from both income and employment taxes.[22]

Tax treatment of earnings on account balances

Some MSA proposals would permit the deferral of tax on the earnings in an MSA account until the amounts are withdrawn (at which time the distribution may or may not be included in income depending on the purpose of the withdrawal). Other MSA proposals would tax earnings currently.

Account withdrawals

MSAs may provide a deduction for medical expenses without regard to the 7.5 percent floor on itemized deductions. In other words, MSA proposals may permit taxpayers to use pre-tax dollars to pay certain medical expenses which otherwise would be subject to this limitation. The potential revenue impact is reduced to the extent the taxpayer currently uses an FSA for such expenditures.

Another consideration is the incentive for a taxpayer to use an MSA for the broader definition of medical expenses (sec. 213) than the definition used under the individual's insurance policy. Contributions might be somewhat higher because the definition of allowable expenses is broader than the insurance company definition.

Enforcement issues

Certain compliance issues may be raised by an MSA proposal and may affect the revenue estimate for the proposal. For example, an MSA proposal may provide that withdrawals from an MSA for nonhealth-related purposes are includible in gross income. However, if there is no reporting and recordkeeping requirement with respect to MSA withdrawals, the ability of the IRS to determine whether gross income is properly stated on an individual's tax return may be diminished.

Similarly, individuals may be encouraged to make contributions to an MSA if adequate means of enforcing restrictions on the account are not included in a proposal.

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[22] Extending this benefit to MSA contributions not only has a revenue effect, but it also reduces the wages that determine future social security benefits. Thus, a proposal could have the effect of reducing future social security benefits to the extent that individuals can make excludable contributions to an MSA and can convert what were after-tax employee contributions for health insurance to pre-tax contributions.

D. Revenue Estimate of H.R. 1818

The estimated revenue effect of H.R. 1818 incorporates the following specific assumptions.

Employer-provided benefits

It is generally assumed that total compensation will not change in response to the adoption of an MSA proposal. It is also assumed that employers would not increase their total cost of health benefits for their work force. Thus, employers electing to contribute to the MSA would not contribute, in aggregate, amounts that would exceed their present costs. It is further assumed that if the employer does not elect to contribute to the account, the premium savings to the employer is assumed to be paid as taxable wages to the employee.

Estimates of MSA contributions made by employees with employer-provided plans vary with the characteristics of the individual. Income, the type of coverage provided, filing status, and analysis of other tax-preferred savings vehicles are considered when estimating the employees' account contribution. In general, the account contribution varies across income classes and with the type of coverage the employee maintains. For instance, employees currently receiving only catastrophic health coverage from their employer would not change their health insurance coverage but would have an incentive to create an MSA. The amount of their contribution would vary by income class.

Other factors which affect the estimate of employer-provided benefits is the size of the employer. The estimate is adjusted for the proportion of small- and medium-sized companies which might potentially benefit from this type of proposal. In addition, employers that currently offer FSAs might be more likely to offer an MSA option, since administration of the MSA and the FSA would have some similarities.

Self-employed individuals

A self-employed individual who currently has only catastrophic health coverage would benefit from H.R. 1818 because he or she would be able to pay medical expenses on a tax-favored basis that are paid with after-tax dollars under present law. In addition, some self-employed individuals might be induced to buy catastrophic health coverage instead of their current coverage as a result of the proposal. Under certain circumstances, the tax-favored treatment of the catastrophic health policy and the MSA would be preferable to their present health insurance choices. It is assumed that the proposal would have a limited effect on the self-employed who currently do not have insurance. In this situation, the individual may have coverage from a spouse's employment or simply have elected to remain uninsured.

Individuals (other than self-employed individuals) who currently have insurance

The assumed effect on individuals (other than self-employed individuals) who purchase health insurance is similar to that of self-employed individuals.

Individuals without insurance

It is assumed that H.R. 1818 would have a limited effect on those individuals who currently have no health insurance. Certain uninsured individuals remain uninsured by choice; these individuals are typically young, healthy individuals whose health insurance premiums subsidize the cost of other individuals' health insurance premiums. Other uninsured individuals remain uninsured because they are unable to afford health insurance. While H.R. 1818 would increase the tax benefits available to the individual, those benefits are assumed to be insufficient to induce some low-income individuals to purchase health coverage. However, the bill could provide an incentive to some high-income individuals who were perhaps voluntarily uninsured to elect to use an MSA.

Other issues

Under H.R. 1818, married couples with dependents could maintain separate catastrophic coverage and separate MSAs. If each spouse maintains a catastrophic health plan covering dependents, the deductible contribution limit would be $10,000 if neither spouse receives employer contributions.

H.R. 1818 is estimated to reduce Federal fiscal year budget receipts as follows:

Fiscal Years
[Millions of Dollars]

1996	1997	1998	1999	2000	2001	2002	1996-2002
-131	-230	-264	-301	-341	-358	-376	-2,001

NOTE: Details may not add to totals due to rounding.