

Description of Policy Options

**Financing Comprehensive Health Care Reform:
Proposed Health System Savings and Revenue Options**

Senate Finance Committee

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TABLE OF CONTENTS

SECTION I: Health System Savings	4
Ensuring Appropriate Payment	4
Capturing Productivity Gains	11
Reducing Geographic Variation in Spending.....	12
Modifying Beneficiary Contributions	13
 SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage	 16
 SECTION III: Other Health Care Related Revenue Raisers.....	 18
Modify or Repeal the Itemized Deduction for Medical Expenses.....	18
Repeal of Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield or Other Qualifying Organizations	19
Modify Health Savings Accounts	20
Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangements and Health Reimbursement Arrangements	21
Limit the Qualified Medical Expense Definition.....	22
Modify FICA Tax Exemption.....	23
Extend Medicare Payroll Tax to all State and Local Government Employees	29
Modify the Requirements for Tax-Exempt Hospitals.....	30
 SECTION IV: Lifestyle Related Revenue Raisers	 33
Impose a Uniform Alcohol Excise Tax	33
Enact a Sugar-Sweetened Beverage Excise Tax.....	35
 SECTION V: Administration’s Revenue Raising Proposals.....	 35

Senate Finance Committee

Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options

The U.S. health care system is in crisis. This crisis is not limited to the 46 million who lack health insurance – it extends to those who have health coverage but are worried about increasing costs. Rising health care costs affect families and American businesses, as health insurance premiums continue to outpace wages and inflation. Between 1999 and 2008, premiums for employer-sponsored health benefits increased 117 percent for families and individuals and 119 percent for employers. And annual health spending growth is expected to outpace average annual growth in the overall economy by 2.1 percentage points in each of the next ten years. In 2009 alone, health spending will increase 5.5 percent while gross domestic product (GDP) is expected to decrease 0.2 percent.

Rising health care costs also have a significant impact on federal and state health care programs. Last week's release of the 2009 Medicare Trustees Report indicates that the Medicare Hospital Insurance (HI) Trust Fund will be exhausted in 2017, two years earlier than last year's report. Spending for Medicare and Medicaid is projected to increase by 114 percent in ten years. Over the same period, the GDP is projected to grow by just 64 percent. Last year, health spending in the U.S. represented 16.6 percent of our gross domestic product (GDP) – a much greater share than any other industrialized country. And according to the most recent National Health Expenditure estimates, health care expenditures will consume over 20 percent of the GDP by 2018, an amount representing \$4.4 trillion in annual spending.

Recent studies have demonstrated that greater use of medical technology is an important factor contributing to rising health spending – contributing between 38 and 65 percent to health care cost increases. Other factors contributing to rising health costs include obesity and demographics.

Responsible health care reform must provide health care coverage for all Americans while at the same time reduce the rate of growth in health care spending. These goals must be achieved in a fiscally responsible manner with sustainable sources of funding. The purpose of this document is to outline policy options for financing comprehensive health care reform. Three specific areas of potential funding sources are explored: savings achieved from within the health care system from reductions in current levels of spending; reevaluating current health tax subsidies; and changes to non-health tax provisions.

As with the documents outlining policy options for delivery system reform and expanding health care coverage, this document is intended to spur discussion of proposed options that the committee is scheduled to act on in June. While these proposed options are jointly offered for discussion, not all the options in this document have the support of Chairman Baucus or Ranking Member Grassley.

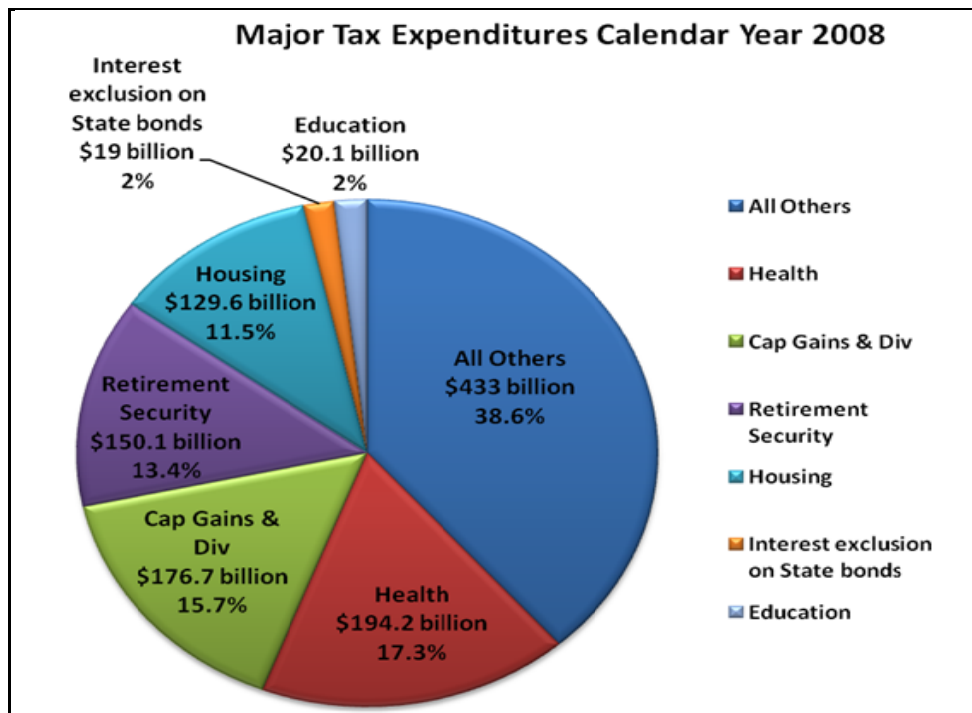
Health System Savings

The policy document released by the Senate Finance Committee on April 28 discussed options to improve health care quality and efficiency through various delivery system reforms. The quality of care provided to most Americans is excellent, but it has become increasingly evident that the way care is delivered and paid for in our health system does not always encourage the right care at the right time for every patient. The goal of delivery system reform is to improve quality, align financial incentives, and reduce fraud, waste and abuse in the U.S. health care system.

Proposals to reform the health care delivery system, in many cases produce savings to the system. In addition to delivery system changes, the Medicare Payment Advisory Commission (MedPAC), the Congressional Budget Office (CBO), and the Obama Administration have proposed policies to address spending growth in Medicare and Medicaid. Building on the delivery system reform proposals released in April, this document includes proposed options for other potential areas of savings within the Medicare and Medicaid payment systems.

Health Care Tax Subsidies

In addition to the direct expenditures on health care, the tax code includes many subsidies and incentives related to health care. These indirect costs—health tax expenditures—makeup the largest federal tax expenditure, totaling \$194.2 billion in calendar year 2008 (see breakdown of tax expenditures below). These tax expenditures account for more than 17 percent of all federal tax expenditures, larger than capital gains and dividends tax breaks, retirement security, and housing, among others.



In addition to lowering costs, comprehensive health reform must also entail an examination of current health tax expenditures, with the goal of modifying, or perhaps limiting, these current expenditures. The \$194.2¹ billion in health tax expenditures reflects the effect on income tax receipts of several health tax subsidies. The table below provides a breakdown of current law health tax expenditures for calendar year 2008.

Value of Selected Tax Expenditures, 2008	Billions of Dollars
Exclusion of employer sponsored health care (income)	\$132.7
Exclusion of Medicare benefits from income	
Hospital Insurance (Part A)	21.3
Supplementary Medical Insurance (Part B)	14.9
Prescription Drug Insurance (Part D)	4.4
Deduction for medical expenses above 7.5% of adjusted gross income	10.7
Self-employed health insurance deduction	5.2
Exclusion of medical care and TRICARE insurance for military dependents and retirees not enrolled in Medicare	2.1
Exclusion of health insurance benefits for military retirees enrolled in Medicare	1.2
Exclusion of subsidies to employers who maintain prescription drug plans	1.1
Health savings accounts	0.5
Health Coverage Tax Credit	0.1
TOTAL	\$194.2

There are also additional tax preferences for charitable contributions to health organizations and private activity bonds for private nonprofit hospitals that are not reflected in this table..

The tax expenditures listed above do not present a complete picture. The current tax preferences for health care benefits also reduce payroll taxes by an additional \$93.5 billion. Combined, total tax spending on health care amounted to \$287.7 billion in 2008.

Other Tax Provisions

Delivery system reform, reductions in health spending, and changes to the current tax treatment of health care alone may not pay for all of health care reform on their own. Many proposals expected to reduce health spending in the long run may not produce sufficient savings in the short run to finance reform. For this reason, other options may need to be considered. Other

¹ Summation of tax expenditure does not account for interaction effects.

proposals to generate revenue for health care reform could include taxes that affect lifestyle choices and taxes that generally target loopholes. President Obama's fiscal year 2010 budget contains a number of proposals to raise revenue, some of which may be able to help finance comprehensive health care reform.

SECTION I: Health Systems Savings

Last month, the Finance Committee discussed policy options to improve health care quality and efficiency through various delivery system reforms. Proposals to reform the delivery system, in many cases, have been estimated to lower current rates of health care spending.

In addition to delivery system improvements, MedPAC, CBO, and the Administration have also examined other policies to address spending growth in Medicare and Medicaid. Described below are proposed options for potential areas of savings within current Medicare and Medicaid payment systems.

Policy options in this area are organized into the following categories:

- Ensuring Appropriate Payment
- Capturing Productivity Gains
- Reducing Geographic Variation in Spending
- Making Beneficiary Contributions More Predictable

Ensuring Appropriate Payment

Improving Payment Accuracy through Adjusting Annual Market Basket Updates

Current Law

Currently, most fee-for-service (or traditional) Medicare providers, including acute care hospitals, home health agencies (HHA), hospices, inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), long term care hospitals (LTCHs), hospital outpatient departments (HOPDs) and skilled nursing facilities (SNFs), receive predetermined payment amounts established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services (such as labor and equipment) that are purchased by the provider and intended to reflect the effect of inflation on providers' cost per service.

Related to this annual market basket or inflationary adjustment, the Medicare Payment Advisory Commission (MedPAC) makes payment update recommendations for the different payment systems each year in its March report to Congress. In making these recommendations, MedPAC assesses adequacy of payments for efficient providers in the current year; how providers costs may change in the upcoming year; beneficiaries' access to care; changes in the capacity and supply of providers; changes in the volume of services; changes in the quality of care; providers' access to capital; and Medicare payment rates relative to provider costs' in the given year. Based

on this analysis, in its March 2009 *Report to Congress*, MedPAC recommended that a number of health care providers receive reduced or eliminated Medicare market basket updates in fiscal year 2010.

Proposed Options

Policy options to adjust annual market basket updates for Medicare fee-for-service providers are described in the MedPAC 2009 *Report to Congress*. These include reducing or eliminating market basket updates in 2010 for any provider payment area recommended by MedPAC. These market basket changes could be adjusted from the MedPAC recommended levels or could be accomplished over multiple years. An additional option in this area may include establishing differential payment updates for low and high-margin areas for fiscal year 2010 as well as in additional years.

Updating Payment Rates for Home Health Services

Current Law

Home health agencies (HHAs) are paid under a prospective payment (PPS) system in which payments are based on 60-day episodes of care for beneficiaries, subject to several adjustments. The base payment amount is adjusted for differences in the care needs of patients (case mix) using "home health resource groups" (HHRGs) and outlier visits (for extraordinarily costly patients); among other adjustments. Presently, there is no difference between urban and rural base payment amounts. The base payment amount is increased annually by an update factor that is determined, in part, by the projected increase in the home health (HH) market basket (MB) index (a measure of changes in the costs of goods and services purchased by HHAs). HHAs that submit quality data to the Secretary receive a full MB increase; while HHAs that do not submit quality data receive a reduced update equivalent to the MB minus 2 percentage points. For CY 2009, the HH MB update is 2.9%. In its 2009 *Report to Congress: Medicare Payment Policy*, MedPAC reported that most HHAs continued to be paid above costs. Accounting for the payment refinements in 2008 and the MB update under current law, MedPAC estimates that HHAs will have margins of 12.2% in 2009. As is similar to other Medicare providers, some variation exists across Medicare providers in margins earned. For example, in 2007, MedPAC found that non-profit HHAs and those in rural areas tended to have lower margins (11.9% and 14.0%, respectively) than for-profit HHAs and HHAs in urban areas (18.6% and 16.4%, respectively).

Based on its analysis, MedPAC recommended that Congress eliminate the market basket increase for home health services in 2010 and recommended that the Secretary rebase rates for home health care services in 2011 to more closely reflect the cost of visits and other services delivered in the average HH episode.

Proposed Options

There are various policy options that could be considered in this area. One option may include implementing MedPAC's recommendations regarding market basket adjustments in 2010 and contemplating further adjustments given the current levels of payments in the program.

Another option may be to direct the Secretary to "re-base" home health payments to better reflect the current number and mix of HH services and their level of intensity and to take into account the relative margins related to specific conditions and service areas. Finally, other options may include establishing a provider-specific annual cap on the number of allowable outlier episodes that HHAs can be reimbursed for in a year.

Updating Payment Rates for Inpatient Services

Current Law

Both Medicare and Medicaid provide additional payments to hospitals that train medical residents or serve a high proportion of low-income patients.

Medicare Graduate Medical Education (GME) Payments. Medicare pays teaching hospitals the costs of approved medical residency training programs through two mechanisms: an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of IPPS.

The IME adjustment provides additional Medicare payments to hospitals for the indirect costs attributable to training physicians in approved residency programs. The current adjustment increases payments approximately 5.5 percent for each 10 percent increment in resident intensity (measured by the ratio of interns and residents to beds or IRB ratio). Hospitals with a higher IRB ratio receive a larger add-on adjustment to their IPPS payments, but the amount of IME funding a hospital receives will depend upon its volume and type of Medicare patients. The Medicare Payment Advisory Commission (MedPAC) has estimated that the IME adjustment is set more than twice as high as can be empirically justified. The Congressional Budget Office (CBO) estimates Medicare's IME spending will be \$6.1 billion in FY2009.

Medicare pays for the direct graduate medical education (DGME) costs of approved residency programs (such as the residents and teaching physician salaries and other education costs) separately from IPPS. Medicare's DGME payments are calculated according to a formula that uses each hospital's per resident costs updated from a base year, a weighted count of full-time equivalent (FTE) residents (subject to a cap and other limitations) and Medicare's share of hospital days. CBO estimates Medicare's DGME spending will be \$3.2 billion in FY2009.

Medicaid GME Payments. Most states make Medicaid payments to help cover the costs of training new doctors in teaching hospitals and other teaching programs. Payments for GME are made at the state's option and states are not subject to any federal reporting requirements for documentation of Medicaid GME payments for the receipt of federal matching funds. Survey

data show that such costs (federal and state) totaled nearly \$3.2 billion in 2005. CBO estimates the federal share of Medicaid GME spending was \$800 million in FY2008.

In May 2007, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would eliminate federal reimbursement for both DGME and IME under Medicaid. The rule would also change the way in which the Medicaid upper payment limit for hospital services is calculated, which would further reduce the federal share of Medicaid costs for hospitals. CMS efforts to finalize the proposed rule have been subject to a legislatively imposed moratorium that ended April 1, 2009. The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) includes a Sense of the Senate that a final rule for Medicaid GME payments should not be promulgated. As of this date, CMS has taken no further action regarding this rule.

Medicare Disproportionate Share Hospital Payments. Current law provides that most acute care hospitals (about 2,700) receive Medicare DSH payments based on a formula calculated using the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who receive Supplemental Security Income or SSI payments) added to the proportion of total hospital days provided to Medicaid recipients. A few urban hospitals receive Medicare DSH payments under an alternative formula. Generally, after meeting a minimum threshold, the percentage add-on to the hospital's Medicare payment will vary by the hospital's bed size, urban or rural location, or whether it receives special IPPS treatment as a rural referral center (RRC) or Medicare dependent hospital (MDH). The Medicare DSH formulas are established in statute. MedPAC found that in FY 2004, about three-quarters of DSH payments were not empirically justified and that there was little evidence of a relationship between DSH payments received by hospitals and the amount of uncompensated care they provide. The Congressional Budget Office (CBO) estimates Medicare DSH spending will be \$10.1 billion in FY2009.

Medicaid DSH Payments. The Medicaid statute requires that state programs take into account the circumstances of hospitals that treat a disproportionate number of low-income patients when setting the payment rates for inpatient hospital services. Under current law, Medicaid DSH payments are subject to a series of adjustments, both on the amount of Medicaid DSH money an individual hospital can receive as well as the total amount of DSH payments within a state. Subject to certain guidelines, states have broad discretion in defining which hospitals qualify for Medicaid DSH payments, how to distribute the hospitals' DSH payments, and how to finance the DSH program. For instance, while federal law specifies minimum criteria for DSH eligibility, states have substantial flexibility to establish eligibility criteria that are more expansive than the minimum. CBO estimates the federal share of Medicaid DSH spending will be \$9.1 billion in FY2009.

Proposed Options

Various policy options could be considered in this area. Options include adjusting current GME and DSH payment levels to better reflect the actual costs hospitals currently incur in treating the low-income and uninsured and in training medical residents. Another option would be to adjust DSH payment levels over time as the need for these resources decrease as more individuals become insured as a result of health care reform. An additional option would be to consolidate

Medicare and Medicaid payments to hospitals as a way to streamline and better account for and coordinate federal funding within the DSH and GME payment areas.

Adjusting Reimbursement for High-Growth, Over-Valued Physician Services

Current Law

According to MedPAC and GAO, there are opportunities to improve the efficiency of the Medicare physician fee schedule. In 2005, MedPAC recommended reducing certain fees for imaging services. These recommendations were based on efficiencies and savings realized from the technical preparation and supplies when multiple imaging services are furnished sequentially on contiguous body parts during the same visit. Starting January 1, 2006, physicians receive the full technical component fee for the highest paid imaging service in a visit, but technical component fees for additional imaging services are reduced by 25 percent.

The relative value units in the Medicare physician fee schedule are developed with input from the physician community. Refinements in existing values and the establishment of values for new services are included in the annual fee schedule updates. The refinement and update process is based in part on recommendations made by the American Medical Association's Specialty Society Relative Value Update Committee (RUC), which receives input from many physician specialty societies. Current law requires a review of the relative values every five years.

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. Setting the equipment use factor at a lower — rather than at a higher—rate has led to higher practice expense (PE) RVUs and thus higher payment for these services. Citing evidence showing that providers are using advanced imaging equipment 90 percent of the time that providers are assumed to be open for business (45 hours per week) rather than the 50 percent previously assumed, MedPAC has recommended that CMS adopt the higher utilization rate in the calculation of fee schedule payments for diagnostic imaging equipment that costs at least \$1 million and explore applying that standard to less expensive imaging equipment. This change would result in a reduction in PE RVUs for costly imaging services and an increase in RVUs for other physician services.

Proposed Options

The committee will explore options that would make payments to Part B providers more rational through reforms that appropriately value services, such as the MedPAC recommendation to increase the utilization rate for calculating the payment for advanced diagnostic imaging services.

Another option the committee could consider would be to establish an expert panel to assist CMS in evaluating and adjusting payment for potentially misvalued physician services.

More Appropriate Payment for Durable Medical Equipment

Current Law

Durable medical equipment (DME) needed at home to treat a beneficiary's illness or injury is covered under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. Medicare spent about \$8.6 billion on DME in fiscal year 2007.

Medicare uses fee schedules to set prices for noncustomized equipment, prosthetics, and orthotics. These items are assigned to categories and to product groups within those categories. The categories are based on the nature of the item: whether or not it is inexpensive, needs frequent service or is a rental item subject to an explicitly limited period of use. Categories are:

- inexpensive or routinely purchased equipment,
- items requiring frequent and substantial servicing,
- prosthetic and orthotic devices,
- capped rental items,

Within the categories, items are further categorized into about 2,000 product groups. All items within the same product group have the same payment rate.

Generally, the current fees are an average of the allowed charges from 1986 and 1987, adjusted by the consumer price index for all urban consumers to account for inflation. Prices for most medications used in conjunction with DME are set at 106 percent of the average sales price (ASP).

Proposed Option

The Office of Inspector General (OIG) at the Department of Health and Human Services has identified potentially overvalued DME items and services; some contend reimbursement for certain DME items and services are under-reimbursed. The committee will explore options to improve payment accuracy for DME items and services.

Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts

Current Law

In the fee-for-service portion of the Medicaid program, drug manufacturers must enter into rebate agreements with the Secretary of HHS to have their products covered. For each prescription drug that is covered by Medicaid, participating manufacturers must report two market prices to CMS: the average manufacturer price (AMP), which is the average price that a drug manufacturer receives for sales to retail class of trade, and the lowest transaction price, or "best price," that the manufacturer receives from sales to certain private buyers of the drug. Those prices, which serve as reference points for determining manufacturers' rebate obligations, must be reported for each formulation and dosage of each prescription drug purchased on behalf

of Medicaid beneficiaries. For brand-name prescription drugs, the manufacturer's rebate obligation has two components: the basic rebate and an additional rebate.

Under these rebate agreements, drug manufacturers must provide state Medicaid programs with rebates for the drugs purchased for Medicaid beneficiaries. In exchange for entering into rebate agreements, state Medicaid programs must cover all drugs (except the excluded drug classes) marketed by those manufacturers. In 2005, 550 manufacturers were reported to participate in the Medicaid drug rebate program. Federal law exempts selected purchases from Medicaid's rebate agreements, such as drugs dispensed by Medicaid managed care organizations (when prescription drugs are included in the capitation agreement), inpatient drugs, and drugs dispensed in physicians' or dentists' offices.

For the purpose of determining rebates, Medicaid law distinguishes between two classes of drugs, (1) single source drugs (generally, those still under patent) and innovator multiple source drugs (drugs originally marketed under a patent or original new drug application (NDA) but for which generic competition now exists); and (2) all other, non-innovator multiple source drugs (generics). Rebates are computed by comparing the AMP for a drug to the best price. The basic rebate for brand-name drugs is the greater of a flat percentage of AMP, 15.1 percent, or the difference between AMP and the best price, unless prices increase more than inflation, when manufacturers would be required to pay additional rebates. Generic drug manufacturers must give states a rebate of 11 percent of AMP.

Proposed Options

One option the Committee could consider is increasing Medicaid's flat rebate from 15.1 percent to as much as 23.1 percent. Under this option, the Medicaid best price provision would remain unchanged.

Another option to consider is an increase in the basic Medicaid rebate for non-innovator, multisource drugs from 11 percent to 13 percent of average manufacturer price (AMP).

Extend to and Collect Rebates on Behalf of Managed Care Organizations (MCOs)

Current Law

Medicaid beneficiaries receive services through both fee-for-service (FFS) and managed care arrangements. MCOs are typically paid "per-member-per-month" (PMPM) fees, sometimes called a capitation rate, to provide contracted services to enrolled beneficiaries. Services provided to about 64 percent of Medicaid beneficiaries are paid for on a capitated or partially capitated basis. Approximately 38 percent of Medicaid beneficiaries, primarily children and non-disabled adults, receive all services under capitation contracts. Under risk-based arrangements, MCOs are responsible for incurred costs that exceed their PMPM payments.

Under the FFS system, drug manufacturers pay states rebates for Medicaid drug purchases. These rebates do not apply to MCOs purchases of drugs for Medicaid beneficiaries. Some states

exclude the drug benefit from their Medicaid MCO contracts, in which case, managed care enrollees get their prescribed drugs through the FFS delivery system.

Proposed Option

Under one option for the Committee's consideration, prescription drug manufacturers could be required to pay a rebate on drugs purchased for beneficiaries in the risk-based managed care component of Medicaid that is similar to the rebate required in the FFS component of the program. The drug manufacturers could be required to pay the Medicaid FFS rebate directly to states. This option does not prohibit MCOs from negotiating additional rebates above the amount defined by law.

Application of Rebates to New Formulations of Existing Drugs

Current Law

A second component of the rebate may also apply depending on how quickly the manufacturer raises a drug's price to private purchasers. Every form of every drug purchased on behalf of Medicaid beneficiaries has its own base-period AMP that is determined by the drug's original market date. No additional rebate is owed if the drug's current AMP does not exceed its inflation-adjusted base period level, as measured using the consumer price index for all urban consumers. If the AMP does exceed the allowed inflation adjusted level, then an additional rebate is owed that is equal to the excess amount. Currently, modifications to existing drugs—new dosages or formulations—are generally considered new products for purposes of reporting AMPs to CMS. As a result, drug makers can avoid incurring additional rebate obligations by making slight alterations to existing products, sometimes called line-extensions.

Proposed Option

This option would consider line-extensions of existing drugs as if they were the original product for purposes of calculating the additional rebate. Under this option, when a new, extended-release version of an existing drug is introduced, the additional rebate obligation for that new drug would be either the AMP percentage that is owed under current law or the AMP percentage owed for the original drug, whichever is greater.

Capturing Productivity Gains

Current Law

Currently, most fee-for-service Medicare providers receive predetermined payment amounts established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services (such as

labor and equipment) that are purchased by the provider and intended to reflect the effect of inflation on providers' costs per service.

Each year, annual market basket updates are implemented assuming that the quantity, quality, and mix of inputs remain constant over time. According to CBO, market basket updates overstate actual costs to providers because they do not assume increases in provider productivity that could reduce the actual cost of providing services (such as through new technology, fewer inputs, etc). Annual updates to the Medicare physician fee schedule are determined by a separate method that includes the sustainable growth rate (SGR) formula, which already incorporates adjustments for gains in physician productivity.

Proposed Options

Policy options in this area may include requiring annual market basket adjustments for certain fee-for-service providers to be adjusted by some or all of the expected productivity gains as a way to improve the accuracy of Medicare payments. Various options could be considered in this area, including requiring productivity adjustments beginning in fiscal year 2011 and in subsequent years or requiring this change only for a set time period.

Reducing Geographic Variation in Spending

Current Law

Researchers at Dartmouth and elsewhere have found that health care spending varies widely across the United States. In addition, high cost areas (e.g., those areas where Medicare spending is above national average spending in Medicare) may not always provide better quality of care. The portion of total spending on health care items and services that do not produce better outcomes is estimated to be as high as 30 percent of Medicare spending.

Geographic variation in per capita expenditures may result from differences in the amount paid for the same service across regions or because of differences in the amount (and mix) of services provided per capita or both. Furthermore, variations in the quantity of health care services provided can be caused by differences in the health status of patients across regions, or by practice pattern variations across health care providers.

Much of the research in this field attempts to adjust expenditures for differences in the cost of inputs (the price of local labor or office space, for instance) as well as for differences in the underlying health (or illness) of the population. While the accuracy or thoroughness of these adjustments might not be sufficient to fully explain the extent of the spending variation attributable to these sources, the consistency of the findings that geographic variation persists across many studies using different data and methods suggests that policies to address this variation may warrant further review.

Proposed Options

Various policy options could be considered in this area to reduce inappropriate spending variations across and within geographic areas. One option would be to broadly review all Medicare Part A and B spending and propose spending reductions in areas where per beneficiary spending is above a certain threshold compared with the national average. In this option, spending per beneficiary for Medicare Parts A and B would be adjusted to reflect differences in the price of inputs and the health status of the local population.

Another option would require similar analysis of Medicare Parts A and B spending, but require spending reductions only for individual providers who are above a certain threshold in spending compared to their peers in their local area. Spending per beneficiary for Medicare Parts A and B also would be adjusted under this option to reflect differences in the price of inputs and the health status of the local population.

In all cases, policy options in this area would need to be weighed against delivery system reform options that are under consideration, which are also intended to reduce geographic variations in spending.

Modifying Beneficiary Contributions

Making Beneficiary Contributions More Predictable

Current Law

Current law includes Medicare cost sharing requirements (i.e., deductibles, copayments and coinsurance amounts paid by beneficiaries at the point of care). Medicare cost sharing can be significant, complex and vary by the type of service. For instance, beneficiary Part A cost sharing varies according to the length of the hospitalization: in 2009, for the first 60 days of hospitalization, the deductible is \$1,068; for days 61-90 the beneficiary pays a daily coinsurance charge of \$267; after 90 days and up to 150 days, the beneficiary may draw on one or more 60 lifetime reserve days, provided they have not been previously used, for which the beneficiary pays a daily coinsurance charge of \$534 (each of the 60 lifetime reserve days can be used only once during an individual's lifetime); and for hospitalization beyond 151 days there is no coverage so a beneficiary would be required to pay out-of-pocket for this care. For part B, in addition to a monthly premium (\$96.40 in 2009), beneficiaries are responsible for an annual deductible (\$135 in 2009) as well as a coinsurance payment of 20 percent of the fee schedule amount for most covered services, although some outpatient hospital care could require higher cost-sharing while other services, like home health visits and laboratory tests, require no cost sharing. Medicare Advantage (Part C) and prescription drug plans (Part D) also have their own cost sharing requirements that can differ from traditional Medicare and may include separate deductibles, copayments, and caps.

In addition, current law lacks fundamental protections for the total amount of cost sharing expenses that Medicare beneficiaries could face in any given year. As a result, about two-third of

beneficiaries have supplemental coverage to help meet cost sharing obligations—including Medigap purchased from private insurers and retiree benefits offered by former employers. Beneficiaries who purchase Medigap policies pay monthly premiums to private insurers in exchange for full coverage of many or all of their Medicare benefits. Employers that provide retiree benefits do so for their Medicare-eligible retirees by covering some or all of the cost sharing requirements in Medicare.

While supplemental coverage helps beneficiaries make their Medicare contributions more predictable, it also prevents Medicare from being able to use cost sharing as a policy tool. Incentives to encourage (or discourage) cost-conscious decision-making may be blunted by the complex structure of beneficiary obligations as well as the interactions between cost-sharing requirements and supplemental coverage. In addition, several studies have found that beneficiaries with supplemental coverage use more services than beneficiaries without such coverage. Recent research presented to the Medicare Payment Advisory Commission (MedPAC) suggests spending for beneficiaries with supplemental coverage tends to be higher relative to beneficiaries without such coverage, especially for elective hospital procedures, medical specialists, and imaging.

Proposed Options

The Committee may want to consider proposals to simplify Medicare beneficiary cost-sharing obligations and make them more consistent with benefits that are available in the private sector. This might be accomplished by making changes to Medicare’s cost-sharing requirements while simultaneously placing certain restrictions on Medigap policies. By making both changes, beneficiaries with supplemental policies would not be insulated from the effects of Medicare cost-sharing modifications. These proposals could include the following:

- 1) Introduce an out-of-pocket maximum on beneficiary cost sharing for all Part A and B services;
- 2) Replace the current complicated mix of cost-sharing provisions with consistent cost sharing and a combined annual deductible covering all Part A and B services;
- 3) Modify Medigap to require some cost sharing for services along with catastrophic protection (e.g., prohibit Medigap policies from paying for the first \$100 of a beneficiary’s cost-sharing liabilities (first-dollar coverage) and limit coverage to 95% of the next \$5,000 in Medicare cost sharing);
- 4) Impose nominal cost sharing in Medigap, e.g., \$5-10 copayments for primary care visits and \$20-\$25 copayments for specialists; and
- 5) Index all cost sharing to the growth rate in average Medicare costs.

Means Testing Part D Premiums

Current Law

Medicare law sets beneficiary premiums for prescription drug benefits under Part D at 25.5 percent of average expected costs for basic coverage. However, beneficiaries pay different premiums for Part D coverage depending on the plan they select and whether or not they enroll

in the low-income subsidy program. Beneficiaries pay added premiums if they select prescription drug plans with enhanced coverage (i.e., benefits above the amount of a basic benefit package). Medicare law requires that beneficiaries pay 100 percent of the Part D premium cost for enhanced drug benefits. Currently, beneficiary premiums under Part D are not subject to income or means testing.

Medicare statute sets the Part B premium amount at 25 percent of average expected costs for Part B services. Unlike Part D, the Part B premium is set in advance of the calendar year. For most beneficiaries, the Part B premium amount is uniform, regardless of where beneficiaries live or what providers they chose. Beginning in 2007, however, as required by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), higher income Part B enrollees were required to pay higher premiums. In 2009, beneficiaries making at least \$85,000 for an individual tax return and \$170,000 for a joint return are charged higher premiums, which range from 140 percent to 320 percent of the value of Part B, or from \$134.90 to \$308.30 per month. (In 2008, approximately 5% of Part B enrollees paid the higher premiums.)

Proposed Options

The committee could consider requiring beneficiaries whose incomes exceed certain thresholds to pay higher premiums for Part D drug coverage. Higher premiums could apply only to basic coverage. The income thresholds could be set at the same levels and adjusted in the same manner as under Part B.

The committee could consider this proposal on its own or in conjunction with other changes to the Part D program. For example, the committee could consider raising premiums for higher income enrollees in conjunction with options to allow more beneficiaries with low income to be eligible for reduced Part D premiums and cost sharing through the low-income subsidy program (LIS). One barrier to the LIS program is the limit on assets that low-income beneficiaries can hold and still qualify for LIS. Asset limits of \$6,000 for singles and \$12,000 for couples were included in the MMA of 2003. These limits include resources such as the value of automobiles and cash savings. The committee could consider raising the LIS asset limits above these amounts so more beneficiaries who meet the low-income thresholds qualify for assistance. The committee could also consider adding resources for outreach and education of low-income beneficiaries who qualify but do not enroll in Part D.

The committee could also consider raising Part D premiums for high income beneficiaries in conjunction with other changes to Part D, such as options to reduce the size and the effect of the coverage gap or donut hole. For example, the committee could change the inflation index for the annual out-of-pocket threshold, which creates the coverage gap. Currently the coverage gap grows with Medicare prescription drug spending; alternatively, the annual out-of-pocket threshold could be modified to grow more slowly so that over a number of years the initial coverage limit catches up to the out-of-pocket threshold and eliminates the donut hole completely. The committee could also consider requiring prescription drug plans to offer some level of coverage in the coverage gap in their enhanced benefit packages. Currently, prescription drug plans can offer enhanced drug benefits that have little or no coverage in the coverage gap.

SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage

Current Law

The Tax Code generally provides that employees are not taxed on (that is, may “exclude” from gross income) the value of employer-provided health care. As with other forms of compensation, the amount paid by employers for employer-provided health care of employees is deductible. Unlike other forms of compensation, however, if an employer contributes to a plan providing health coverage for employees (and the employees’ spouses and dependents), the contribution and all benefits (including reimbursements) for medical care under the plan are excludible from the employees’ income for income tax purposes and are excludible from the employees’ wages for payroll tax purposes.² The exclusion applies both in the case in which an employer absorbs the cost of employees’ medical expenses not covered by insurance (i.e., a self-insured plan) as well as to employer payments to purchase health insurance. There is no limit on the amount of employer-provided health coverage that is excludible.

Active employees participating in a cafeteria plan may be able to pay their share of premiums on a pre-tax basis through salary reduction.³ Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income and wages for payroll tax purposes.

The Consolidated Omnibus Reconciliation Act of 1985 (“COBRA”) requires that a group health plan⁴ must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment).⁵ A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the “applicable premium” for such period and the premium must be payable, at the election of the payor, in monthly installments. The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred, and is determined without regard to whether the cost is paid by the employer or employee. There are special rules for determining the applicable premium in the case of self-insured plans. Under the

² Secs. 104, 105, 106, 125, 3121(a)(2), and 3306(a)(2) of the Internal Revenue Code of 1986 (“Code”). Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludible under section 134. That section provides an exclusion for “qualified military benefits,” defined as benefits received by reason of status or service as a member of the uniformed services and which were excludible from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

³ Sec. 125.

⁴ A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

⁵ The COBRA requirements are enforced through the Code, Employee Retirement Income Security Act (“ERISA”), and the Public Health Service Act (“PHSA”).

special rules, the applicable premium generally is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries, which is determined on an actuarial basis and takes into account such other factors as the Secretary of Treasury may prescribe in regulations.

Proposed Options

A number of options could be considered that would limit the value of employer-provided health coverage that is excludible from gross income. The limit could be based on the value of the plan or the income of the insured, or the limit could be a combination of both. Alternatively, the limit could be tied to a percentage of the value of the employer-provided health coverage.

An example of a limit based on value could target the actuarial value of a benchmark plan. The value of the employer provided health coverage excluded from an employee's gross income could be limited to a dollar amount that would initially be calculated as an amount equal to the actuarial value of the Federal Employee Health Benefit Program (“FEHBP”) standard option. Under this option, the dollar limit on the exclusion could apply to all taxpayers.

Another option would be to apply the limit only to taxpayers whose incomes exceed a threshold income level. For example, limits to the exclusion could apply to taxpayers with adjusted gross income (“AGI”) in excess of \$200,000 (\$400,000 for joint filers). The limit could be phased out for taxpayers whose income exceeds that threshold so that it is never completely eliminated, or the exclusion could be completely phased out for taxpayers with AGI that exceeds the threshold.

A third option would be to limit the exclusion based on both the value of employer-provided health insurance and the income of the taxpayer. For example, the value of a plan in excess of the actuarial value of the FEHBP could be includable in wages for taxpayers with AGI over \$200,000 (\$400,000 for joint filers).

The exclusion could also be limited to a percentage of the total premium for health insurance coverage obtained through the employer for all taxpayers.

Under any option, the dollar amount could be indexed under one of three alternatives: (1) the per capita growth in National Health Expenditures (as calculated by the center for Medicare and Medicaid Services (“CMS”)), (2) changes in the gross domestic product (“GDP”), or (3) changes in the Consumer Price Index (“CPI”).

In addition, the Committee could discuss limits on the exclusion that considers geographic variations in the cost of living, including medical costs, in any options.

The exclusion could also be reformulated as a tax credit, a tax deduction, or a combination of a tax credit and tax deduction.

Under any of the options, any change to the exclusion could “grandfather” the tax exclusion for the employer-provided health insurance coverage under a group health plan maintained pursuant to one or more collective bargaining agreements in effect when the change is enacted. In this

situation, any change to the tax exclusion would only apply when the last relevant agreement terminates.

In order to change the exclusion for employer-provided health coverage under any of these options, the value of employer-provided health insurance coverage for an employee's taxable year would need to be determined; then depending on the option and how it applied to an employee, any amount of the value above a limit (or the full amount for any taxpayer to whom the exclusion no longer applies, if any) would be includable in the employee's gross income as wages. The value of employer-provided health insurance coverage could be determined as the employer-provided portion of the applicable premiums currently excludible for the taxable year for the employee determined under the rules for COBRA continuation coverage. For example, if the exclusion were limited to an amount equal to a percentage of the premium for health coverage obtained through the employer, the premium also would be the applicable premium determined under the rules for COBRA continuation coverage for the employee, including any portion paid for by the employee.

SECTION III: Other Health Care Related Revenue Raisers

Modify or Repeal the Itemized Deduction for Medical Expenses

Current Law

Individuals may claim an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 7.5 percent of AGI.⁶ As a result, the deduction is beneficial only if two conditions are met: the taxpayer's medical expenses must exceed the 7.5-percent of AGI threshold, and the taxpayer must have sufficient personal deductions in general to claim an itemized deduction.

This deduction is available both to insured and uninsured individuals; thus, an individual with employer-provided health insurance (or another form of tax-subsidized health benefits, as summarized in this section) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5-percent AGI threshold is met. The medical deduction encompasses health insurance premiums to the extent they have not been excluded from taxable income through the employer exclusion or self-insured deduction.

Proposed Options

The Committee could consider raising the 7.5 percent AGI threshold for the itemized deduction for medical expenses or could eliminate the deduction.

⁶ For alternative minimum tax purposes, the itemized deduction is calculated using a floor of 10 percent of adjusted gross income. Sec. 56(b)(1)(B).

Repeal or Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield and Other Qualifying Organizations

Current Law

A property and casualty insurance company is subject to tax on its taxable income, generally defined as its gross income less allowable deductions. For this purpose, gross income includes underwriting income and investment income, as well as other items. Underwriting income is the premiums earned on insurance contracts during the year, less losses incurred and expenses incurred. The amount of losses incurred is determined by taking into account the discounted unpaid losses. Premiums earned during the year is determined taking into account a 20-percent reduction in the otherwise allowable deduction, intended to represent the allocable portion of expenses incurred in generating the unearned premiums.⁷

Present law provides that an organization described in sections 501(c)(3) and (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance.

However, a special deduction and a special exception apply to taxable Blue Cross and Blue Shield organizations. An eligible Blue Cross and Blue Shield organization is one providing health insurance that (1) was in existence on August 16, 1986; (2) was determined at any time to be tax-exempt under a determination that had not been revoked; and (3) was tax-exempt for the last taxable year beginning before January 1, 1987 (when the present-law rule became effective), provided that no material change occurred in the structure or operations of the organization after August 16, 1986, and before the close of 1986 or any subsequent taxable year. Other qualifying organizations are any organization that is organized under, and governed by, State laws specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and that is not a Blue Cross or Blue Shield organization or health maintenance organization.

Under the special rules for such Blue Cross and Blue Shield and other qualifying organizations, a special deduction applies with respect to health business of such organizations, equal to 25 percent of the claims and expenses incurred during the taxable year less the adjusted surplus at the beginning of the taxable year. For purposes of the special deduction, liabilities incurred during the taxable year under cost-plus contracts are added to claims incurred, and expenses incurred in connection with the administration of cost-plus contracts are added to expenses incurred.

In addition, an exception is provided for such organizations from the application of the 20-percent reduction in the deduction for increases in unearned premiums that applies generally to property and casualty companies.

⁷ See Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986* (JCS-10-87), May 4, 1987, at 595.

Proposed Options

The Committee could consider several alternatives, the first of which is to repeal the special deduction for 25 percent of claims and expenses, and the exception from the reduction of deductible unearned premiums, in the case of Blue Cross and Blue Shield and other qualifying organizations. Alternatively, the proposal reduces the percentage of the special deduction and the exception from the reduction of deductible unearned premiums.

Modify Health Savings Accounts

Current Law

Present law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (“HSA”).⁸ Like opening an individual retirement account (“IRA”), the decision to create and fund an HSA is made on an individual-by-individual basis and does not require any action on the part of the employer. Also, as in the case of an IRA, an HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual. An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer).

Subject to certain limitations, contributions made to an HSA by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Moreover, individuals can exclude from income (and from wages for payroll tax purposes) contributions that their employer, including contributions made through a cafeteria plan through salary reduction, makes to the individuals’ HSAs. Income from investments made in HSAs is not taxable and the overall income is not taxable upon disbursement for medical expenses.

A high deductible health plan is a health plan that has an annual deductible that is at least \$1,150 for self-only coverage or \$2,300 for family coverage (for 2009, increasing to \$1,200 and \$2,400 for 2010) and that limits the sum of the annual deductible and other payments that the individual must make in respect of covered benefits to no more than \$5,800 in the case of self-only coverage and \$11,600 in the case of family coverage (for 2009, increasing to \$5,950 and \$11,900 for 2010).

⁸ An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is “permitted insurance” or “permitted coverage.” Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker’s compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a health FSA is disregarded in determining eligibility for an HSA.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 10 percent. The additional 10-percent tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently, age 65). Unlike reimbursements from a flexible spending arrangement or health reimbursement arrangement, distributions from an HSA are not required to be substantiated by the employer or a third party for the distributions to be excludible from income. Like IRAs, the individual owns his or her HSA, and thus is required to maintain books and records with respect to the expense and claim the exclusion for a distribution from the HSA on their tax return. The determination of whether the distribution is for a qualified medical expense is subject to individual self-reporting and IRS enforcement.

For 2009, the maximum aggregate annual contribution that can be made to an HSA is \$3,000 in the case of self-only coverage and \$5,950 in the case of family coverage (\$3,050 and \$6,150 for 2010).⁹ The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by \$1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

Proposed Options

Under this policy option, HSA contributions could be limited to the lesser of the individual’s deductible under the high deductible health plan or the dollar amount of the maximum allowable aggregate HSA contributions. The additional tax on distributions from an HSA that are not used for qualified medical expenses would be increased to 20 percent. Distributions from an HSA would only be excludible from gross income as an amount used for qualified medical expenses if the expenses are substantiated by the employer or an independent third party. If a limit were placed on the current exclusion for employer-provided health coverage, HSA contributions could be counted against the limit.

Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangements and Health Reimbursement Arrangements

Current Law

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements

⁹ These amounts are the same as the maximum deductible amounts permitted under a high deductible plan for purposes of Archer Medical Savings Accounts (“MSAs”) and are indexed for inflation. In the case of individuals who are married to each other, if either spouse has family coverage, both spouses are treated as only having the family coverage with the lowest deductible and the contribution limit is divided equally between them unless they agree on a different division.

which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage.

A flexible spending arrangement for medical expenses under a cafeteria plan (“Health FSA”) is funded on a salary reduction basis under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses.¹⁰ Health FSAs that are funded on a salary reduction basis are subject to the requirements for cafeteria plans, including a requirement that amounts remaining in a health FSA at the end of a plan year must be forfeited by the employee (referred to as the “use-it-or-lose-it rule”).¹¹

Alternatively, the employer specifies a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called health reimbursement arrangements (“HRAs”). Some of the rules applicable to HRAs and health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.¹²

Proposed Options

The Committee could consider an option to place a limit on the amount of salary reduction contributions to a health FSA that would be excludible from gross income. Alternatively, the exclusion for salary reduction contributions to a health FSA could be eliminated. Similar changes could be made to the exclusion for reimbursements for medical expenses under an HRA. If a limit were placed on the current exclusion for employer-provided health coverage, contributions to an FSA or HRA could be counted against the limit.

Limit the Qualified Medical Expense Definition

Current Law

Any amounts paid for prescription medicines (and insulin) are deductible as a medical expense under the rules relating to itemized medical expenses. Any amount paid for over-the-counter medicine is not deductible as medical expense. However, under a health reimbursement arrangement or under a health flexible spending arrangement under a cafeteria plan, amounts

¹⁰ Sec. 125. Proposed Treas. Reg. sec. 1.125-5 provides rules for health FSAs. There is a similar type of flexible spending arrangement for dependent care expenses.

¹¹ Sec. 125(d)(2). A cafeteria plan is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used. Notice 2005-42, 2005-1 C.B. 1204.

¹² Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

paid for over-the-counter medicine are treated as medical expenses, and reimbursement for such amounts are excludible from gross income. Similarly, a distribution from an HSA used to purchase over-the-counter medicine is excludible as an amount used for qualified medical expenses.

Proposed Option

Under this option, with respect to medicines, the definition of medical expense for purposes of employer plans (health reimbursement arrangements and health flexible spending arrangements) and health savings accounts could be conformed to the definition for purposes of the itemized deduction for medical expenses. Thus, for example, under the proposal, the cost of nonprescription medicines would not be reimbursed through a flexible spending arrangement.

Modify FICA Tax Exception for Students

Current Law

FICA and FUTA Taxes

FICA. Under the Federal Insurance Contributions Act (“FICA”), a tax is imposed on wages paid with respect to employment.¹³ FICA tax consists of two parts: (1) old age, survivor and disability insurance (“OASDI”), which correlates to the Social Security program that provides monthly benefits after retirement, disability, or death; and (2) Medicare hospital insurance (“HI”). The OASDI tax rate is 6.2 percent on both the employee and employer (for a total rate of 12.4 percent).¹⁴ The OASDI tax rate applies to wages up to the OASDI wage base (\$106,800 for 2009). The HI tax rate is 1.45 percent on both the employee and the employer (for a total rate of 2.9 percent). Unlike the OASDI tax, the HI tax is not limited to a specific amount of wages, but applies to all wages.

For FICA tax purposes, “wages” generally includes all remuneration for employment and “employment” generally includes all service performed as an employee. However, some forms of compensation are excepted from the definition of wages, such as employer-provided health benefits. Similarly, certain types of services, or services performed by certain employees, are excepted from the definition of employment. Compensation or services that are excepted from the definition of wages or employment are not subject to FICA tax.

Under the Social Security Act, an individual’s wages are credited to the individual’s earnings record for purposes of determining an individual’s eligibility for Social Security benefits and Medicare coverage and for purposes of determining the amount of an individual’s Social Security benefits. Eligibility for Social Security benefits and Medicare coverage is based in part

¹³ Secs. 3101-3128.

¹⁴ The employer is required to withhold the employee’s share of FICA taxes from wages paid to the employee. Sec. 3102(a).

on credits (referred to as “quarters of coverage”) received for wages. Up to four quarters of coverage can be earned for a year, depending on total wages for the year and the amount needed to earn each quarter of coverage. For 2009, credit for a quarter of coverage is provided for each \$1,090 of wages, with a maximum of four quarters of coverage for \$4,360 in wages.

The Social Security Act provides exceptions to “wages” and “employment” that parallel the FICA tax exceptions. Therefore, compensation or services that are not subject to FICA tax are also not taken into account in determining Social Security benefits.

FUTA. Under the Federal Unemployment Tax Act (“FUTA”), employers must pay a tax of 6.2 percent of wages up to the FUTA wage base of \$7,000.¹⁵ An employer may take a credit against its FUTA tax liability for contributions to a State unemployment fund and certain other amounts. Similar to FICA, “wages” for FUTA purposes generally includes all remuneration for employment, and “employment” for FUTA purposes generally includes all service performed as an employee. However, some forms of compensation are excepted from the definition of wages, and certain types of services, or services performed by certain employees, are excepted from the definition of employment.

Student Exception. An exception from employment for FICA purposes applies in the case of certain services performed by a student in the employ of a school, college, or university (the “student exception”).¹⁶ Specifically, FICA does not apply to services performed by a student who is enrolled and regularly attending classes at the school, college, or university. A similar exception applies for FUTA purposes.¹⁷ The legislative history of the FICA exception for students provides that the exception is intended to apply to situations in which the employment is part-time or intermittent and the total amount of earnings is only nominal, the payment of tax is inconsequential and a nuisance, and the related benefit rights are also inconsequential.¹⁸

The scope of the student exception has been the subject of uncertainty in recent years, particularly with respect to its application to medical residents. Contrary to the government’s position that medical residents do not qualify for this exception as a matter of law, several courts have found that the student exception may apply depending on the nature of the program and the status of the hospital or other medical facility.¹⁹

¹⁵ Secs. 3301-3311.

¹⁶ Sec. 3121(b)(10). The exception also applies to services performed as a student in the employ of an organization that is organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the school, college, or university, if the organization is operated, supervised or controlled by or in connection with such school, college, or university.

¹⁷ Sec. 3306(c)(10)(B). In addition, under section 3121(b)(2), a FICA exception applies to domestic service performed in a local college club or local chapter of a college fraternity or sorority by a student who is enrolled and regularly attending classes at a school, college, or university.

¹⁸ H.R. Rep. No. 76-728, at 17-18 (1939); S. Rep. No. 76-734, at 19 (1939).

¹⁹ See *U.S. v. Memorial Sloan-Kettering Cancer Ctr.*, 2009 WL 763993 (2nd Cir. 2009); *U.S. v. Detroit Med. Ctr.*, 557 F.3d 412 (6th Cir. 2009); *Univ. of Chi. Hosp. v. U.S.*, 545 F.3d 564 (7th Cir. 2008); *U.S. v. Mount Sinai Med. Ctr. of Fla.*, 486 F.3d 1248 (11th Cir. 2007); and *State of Minnesota v. Apfel*, 151 F.3d 742 (8th Cir. 1998), *aff’g*, 1997 U.S. Dist. LEXIS 7506 (D. Minn. 1997).

In February 2004, the IRS issued proposed regulations relating to the terms “school, college or university” and “student” for purposes of the student exception.²⁰ The preamble to the proposed regulations states that guidance is needed to address situations in which the performance of services and pursuit of a course of study are not separate and distinct activities, but instead are to some extent intermingled.²¹ The IRS issued final regulations on December 21, 2004.²² The final regulations are applicable for services performed on or after April 1, 2005. However, in *Mayo Foundation for Medical Education and Research v. U.S.* (“*Mayo*”), the district court found portions of the regulations to be invalid as discussed below.²³

The provisions of the final regulations are discussed in the following sections.

Definition of School, College, or University. Under the regulations, an organization is considered a school, college, or university if: (1) its primary function is the presentation of formal instruction; (2) it normally maintains a regular faculty and curriculum; and (3) it normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.²⁴ This definition is the same as under the proposed regulations. The preamble to the proposed regulations noted that organizations (such as hospitals) providing on the job training typically carry on both noneducational and educational activities and that the primary character of the organization determines whether it is a school, college, or university, not merely whether the organization carries on some educational activities.

The district court in *Mayo* found the “primary function” test in these regulations to be inconsistent with the plain meaning of the statute and therefore invalid.²⁵

Student Status

In general. Under the student exception, FICA does not apply to services performed by a student who is enrolled and regularly attending classes at the school, college, or university. The regulations provide that whether an employee has the status of a student is determined based on the relationship of the employee with the organization employing the employee.²⁶ In order to have the status of a student, the employee must perform services for a school, college, or university at which the student is enrolled and regularly attending classes in pursuit of a course of study. In addition, the employee’s services must be incident to and for the purpose of pursuing a course of study at the school, college, or university. The regulations provide specific criteria for applying these requirements.

²⁰ 69 Fed. Reg. 8604 (proposed February 25, 2004).

²¹ *Id.* at 8605.

²² 69 Fed. Reg. 76404 (December 21, 2004). The regulations include provisions applicable for purposes of the other student exceptions under FICA and FUTA.

²³ *Mayo Foundation for Med. Edu. and Research v. U.S.*, 503 F. Supp. 2d 1164 (D. Minn. 2007).

²⁴ Treas. Reg. sec. 31.3121(b)(10)-2(b). The regulations also refer to section 170(b)(1)(A)(ii) (relating to educational organizations) and the regulations thereunder.

²⁵ *Mayo Foundation for Med. Edu. and Research v. U.S.*, 503 F. Supp. 2d 1164, 1174 (D. Minn. 2007).

²⁶ Treas. Reg. sec. 31.3121(b)(10)-2(d).

Enrolled and regularly attending classes. An employee is enrolled within the meaning of the student exception if the employee is registered for a course or courses creditable toward an educational credential. An educational credential is a degree, certificate, or other recognized educational credential granted by a school, college, or university.

For purposes of the “regularly attending classes” requirement, a class is an instructional activity led by a faculty member, or other qualified individual hired by the school, college, or university, for identified students following an established curriculum. Traditional classroom activities are not the sole means of satisfying this requirement. For example, research activities under the supervision of a faculty advisor necessary to complete the requirements for a Ph.D. degree may constitute classes for this purpose. The frequency of these and similar activities determines whether the employee may be considered to be regularly attending classes.

Incident to and for the purpose of pursuing a course of study. A course of study is one or more courses the completion of which fulfills the requirements necessary to receive an educational credential granted by the school, college, or university. A course of study also includes one or more courses at a school, college, or university, the completion of which fulfills the requirements necessary for the employee to sit for an examination required to receive certification by a recognized organization in a field.

Whether an employee’s services are incident to and for the purpose of pursuing a course of study is determined on the basis of the relationship of such employee with the organization for which such services are performed as an employee. The educational aspect of the relationship, as compared to the service aspect of the relationship, must be predominant in order for the employee’s services to be incident to and for the purpose of pursuing a course of study.

The educational aspect of the relationship is evaluated based on all the relevant facts and circumstances related to the educational aspect of the relationship. The service aspect of the relationship is evaluated based on all the facts and circumstances related to the employee's employment. The evaluation of the service aspect of the relationship is not affected by the fact that the services performed by the employee may have an educational, instructional, or training aspect. Except in the case of a full-time employee, whether the educational aspect or service aspect of the relationship is predominant is determined by considering all the relevant facts and circumstances.

Full-time employees. The regulations provide that the services of a full-time employee are not incident to and for the purpose of pursuing a course of study. The determination of whether an employee is a full-time employee is based on the employer’s standards and practices, except that, regardless of the employer’s classification of the employee, an employee whose normal work schedule is 40 hours or more per week is considered a full-time employee.

The district court in *Mayo* found the full-time employee exception in these regulations to inconsistent with the plain meaning of the statute, arbitrary, capricious, and unreasonable and therefore invalid.²⁷

Relevant factors for employees other than full-time employees. For employees who are not full-time employees, the employee's normal work schedule and number of hours worked per week are relevant factors in evaluating the service aspect of the employee's relationship with the employer. As an employee's normal work schedule or actual number of hours worked approaches 40 hours per week, it is more likely that the service aspect of the relationship is predominant. The regulations provide that certain other factors suggest that the service aspect of the relationship is predominant. For example, status as a professional employee (as defined in the regulations) suggests that the service aspect of the relationship is predominant, especially if the employee is required to be licensed under State or local law to work in the field in which the employee performs services. In addition, eligibility for certain employment benefits suggests that the service aspect of the relationship is predominant.

Administrative safe harbor. In conjunction with the issuance of the final regulations, the IRS has provided a safe harbor under which half-time undergraduate students and half-time graduate or professional students enrolled at an institution of higher education are generally eligible for the student exception.²⁸ For purposes of the safe harbor, the term "graduate or professional student" does not include a postdoctoral student, postgraduate fellow, medical resident, or medical intern. In addition, the safe harbor does not apply to full-time employees, professional employees, or employees who receive or are eligible for certain employment benefits. Employees who are not eligible for the safe harbor (other than full-time employees) may qualify for the student exception based on consideration of all the facts and circumstances.

Application of FICA Exceptions Containing Dollar Limits. Some FICA exceptions are subject to dollar limits. For example, cash remuneration of less than a specified amount (\$1,700 for 2009) paid to an employee in a year for domestic service in a private home is exempt from FICA.²⁹ Similarly, cash remuneration of less than \$150 paid to an employee in a year for agricultural labor may be exempt from FICA.³⁰ The FICA rules provide that, in cases in which a FICA exception is subject to a dollar limit, the employer may withhold the employee share of FICA from payments made to the employee even though, at the time of payment, the total amount paid to the employee is less than the limit and, thus, may be exempt from FICA.³¹ Otherwise, once the total payments to the employee reach the limit, the employer must withhold the employee share of FICA that was not withheld from previous payments, in addition to withholding FICA with respect to current payments. Withholding the employee share of FICA

²⁷ *Mayo Foundation for Med. Edu. and Research v. U.S.*, 503 F. Supp. 2d 1164, 1176 (D. Minn. 2007).

²⁸ Rev. Proc. 2005-11, 2005-02 I.R.B. 1. Safe harbor guidance under Rev. Proc. 98-16, 1998-1 C.B. 403, applies for periods before the new regulations apply.

²⁹ Sec. 3121(a)(7)(B).

³⁰ Sec. 3121(a)(8)(B).

³¹ *See* sec. 3102(a) and Treas. Reg. sec. 31.3102-1(b).

from payments made before the limit is reached may result in erroneous withholding; however, it avoids the need to withhold additional FICA amounts once the limit is reached.

The IRS has established procedures for situations in which FICA taxes are erroneously withheld from an employee's pay.³² Under these procedures, the employer generally repays the employee for the erroneously withheld amount. In addition, if the employer has paid the erroneously withheld amount to the IRS, the employer may take credit for the amount in determining future taxes that must be paid to the IRS.

Proposed Option

In general.³³ This policy option would codify the IRS regulations that clarify the scope of the present-law student exception.³⁴ In addition, the proposal would amend the student exception so that it does not apply to individuals whose earnings subject to the exception exceed an annual dollar limit. The proposal also applies for purposes of determining wages for Social Security and Medicare purposes.

Codification of Regulations. The option would codify the regulations relating to the definition of "school, college, or university." Thus, the student exception applies to services performed for an organization only if: (1) its primary function is the presentation of formal instruction; (2) it normally maintains a regular faculty and curriculum; and (3) it normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.³⁵

The option also codifies the regulations relating to student status, including whether: (1) the student is enrolled and regularly attending classes in pursuit of a course of study at the school, college, or university for which the services are performed; and (2) the services are incident to and for the purpose of pursuing a course of study at the school, college, or university. Under the proposal, the Secretary of Treasury has explicit authority to provide rules for determining student status, including criteria such as those provided in the regulations. Thus, for example, it is expected that, under the proposal, as under the regulations, services of a full-time employee are not incident to and for the purpose of pursuing a course of study, so the student exception does not apply to a full-time employee.

Annual dollar limit. Under the policy option provided for the Committee's consideration, the student exception applies to an individual for a year only if the individual's earnings from the

³² See Treas. Reg. sec. 31.6402(a)-2.

³³ The proposal applies also for purposes of the other student exceptions under FICA and FUTA and for purposes of coverage under the Social Security Act.

³⁴ No inference is intended that the regulations are inconsistent with the student exception under present law.

³⁵ As under present law, the student exception may also apply to services performed as a student in the employ of an organization that is organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the school, college, or university, if the organization is operated, supervised or controlled by or in connection with such school, college, or university.

school, college, or university are less than the amount needed to receive a quarter of FICA coverage for the year (\$1,090 for 2009). Thus, if an individual's earnings exceed the limit, the individual's earnings are subject to FICA, regardless of whether the individual otherwise meets the requirements for the student exception. If the limit is exceeded, all of the individual's earnings are subject to FICA, including earnings up to the limit, thus enabling the individual to receive at least one quarter of coverage for the year.

The rules and procedures relating to the withholding of the employee share of FICA that apply under present law in the case of FICA exceptions that are subject to dollar limits could apply also for purposes of the student exception. For example, the employer may withhold the employee share of FICA from payments made to the employee even though, at the time of payment, the total amount paid to the employee is less than the limit.

Extend Medicare Payroll Tax to all State and Local Government Employees

Current Law

Hospital Insurance Taxes. As part of the financing for Medicare benefits, a hospital insurance ("HI") tax is imposed on the wages of an individual received with respect to his or her employment. One-half the HI tax is imposed on the employer and one-half on the employee; the tax rate is 1.45 percent for the employee and 1.45 percent for the employer. The amount of wages subject to HI taxes is not capped.³⁶

Application of HI Taxes to State and Local Government Workers. The application of HI taxes to State and local government workers has expanded over time. Before the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA 1985"),³⁷ State and local government employees were covered for Social Security and Medicare benefits only if the State and the Secretary of Health and Human Services entered into a voluntary agreement providing such coverage. In COBRA 1985, Medicare coverage (and the corresponding HI tax) was extended on a mandatory basis to State and local government employees hired after March 31, 1986,³⁸ for services performed after that date. The Omnibus Budget Reconciliation Act of 1990³⁹ extended Medicare coverage and the HI tax to State and local government employees

³⁶ HI taxes are imposed under the Federal Insurance Contributions Act ("FICA"). As part of the financing for Social Security benefits, FICA taxes also include an old-age, survivors, and disability insurance ("OASDI") component. The OASDI rate of tax is 6.2 percent for the employee, and 6.2 percent for the employer. The amount of wages subject to the OASDI portion of FICA taxes is capped at \$106,800 (for 2009).

³⁷ Pub. L. No. 99-272.

³⁸ For purposes of this rule, an individual is considered to be hired after March 31, 1986, if the individual was performing substantial and regular services for the employer before April 1, 1986, the individual is a bona fide employee of the employer on March 31, 1986, and the individual's employment relationship with the employer was not terminated after March 31, 1986. These rules are generally referred to as the "continuous employment" requirement. Sec. 3121(u)(2)(C).

³⁹ Pub. L. No. 101-508.

who are not covered under a retirement system, effective with respect to services performed after July 1, 1991.

Under present law, State and local government employees are covered by Medicare and subject to the HI tax with respect to such employment if: (1) the employee was hired after March 31, 1986; or (2) the employee was hired before March 31, 1986, and either (a) there is a voluntary agreement in effect with the State providing for such coverage or (b) the employee is not covered by a retirement system.⁴⁰ Thus, State and local government workers are *not* covered by Medicare or subject to the HI tax if they were hired before March 31, 1986, and they are *not* covered by a voluntary agreement and *are* covered by a retirement plan.

Certain classes of State and local employees are exempt from the hospital insurance tax, such as certain election workers.

The rules relating to Social Security coverage for State and local workers are different from the rules relating to Medicare and the hospital insurance tax. Under present law, State and local government workers are covered by Social Security (and subject to the corresponding taxes) if they are covered under a voluntary agreement with the State to be covered or if they are not members of a public retirement system.

Application of HI Taxes to Federal Employees. Medicare coverage (and the HI payroll tax) is mandatory for Federal employees.

Proposed Option

This policy option would extend Medicare coverage on a mandatory basis to all employees of State and local governments, without regard to their dates of hire or participation in a retirement system.⁴¹ Such employees and their employers would become liable for the HI tax and the employees would earn credit toward Medicare eligibility based on their covered earnings.

Modify the Requirements for Tax-Exempt Hospitals

Current Law

Tax Exemption. Charitable organizations, i.e., organizations described in section 501(c)(3), generally are exempt from Federal income tax, are eligible to receive tax deductible contributions,⁴² have access to tax-exempt financing through State and local governments (described in more detail below),⁴³ and generally are exempt from State and local taxes. A charitable organization must operate primarily for one or more tax-exempt purposes constituting

⁴⁰ Sec. 3121(b)(7)(F).

⁴¹ The proposal does not affect the exemptions for certain classes of employees, such as election workers.

⁴² Sec. 170.

⁴³ Sec. 145.

the basis of its tax exemption.⁴⁴ The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.⁴⁵

The Code does not provide a *per se* exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and meets additional requirements of section 501(c)(3).⁴⁶ The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.⁴⁷ Since 1969, the IRS has applied a “community benefit” standard for determining whether a hospital is charitable.⁴⁸ According to Revenue Ruling 69-545, community benefits can include, for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees composed of representatives of the community; operating with an open medical staff policy, with privileges available to all qualifying physicians; providing charity care; and utilizing surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education and research. Some have argued that the community benefit standard, which is a facts and circumstances test, is imprecise and not sufficiently stringent. In a report on a recent study of tax-exempt hospitals, the IRS noted that the community benefit standard has proved difficult to administer because of the difficulty of applying imprecise legal standards to complex and evolving fact patterns.⁴⁹ Beginning in tax year 2009, hospitals generally are required to submit information on community benefit to the IRS on Schedule H of Form 990. Present law does not include sanctions short of revocation of tax-exempt status for cases in which hospitals fail to satisfy the requisite charity standard.

Although section 501(c)(3) hospitals generally are exempt from Federal tax on their net income, such organizations are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization’s tax-exempt functions.⁵⁰ In general, interest, rents, royalties, and annuities are excluded from the unrelated business income of tax-exempt organizations.⁵¹

⁴⁴ Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

⁴⁵ Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

⁴⁶ Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being “charitable” organizations, some may qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

⁴⁷ Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

⁴⁸ Rev. Rul. 69-545, 1969-2 C.B. 117.

⁴⁹ Internal Revenue Service, “Hospital Compliance Project Final Report,” February, 2009: <http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html> Accessed: May 15, 2009.

⁵⁰ Secs. 511-514.

⁵¹ Sec. 512(b).

Charitable Contributions. In addition, section 501(c)(3) hospitals generally are eligible to receive charitable contributions that are deductible by the donors, reducing the donors' cost of giving. In general, a deduction is permitted for charitable contributions, including charitable contributions to tax-exempt hospitals, subject to certain limitations that depend on the type of taxpayer, the property contributed, and the donee organization. The amount of deduction generally equals the fair market value of the contributed property on the date of the contribution. Charitable deductions are provided for income, estate, and gift tax purposes.⁵²

Tax-Exempt Financing. In addition to issuing tax-exempt bonds for government operations and services, State and local governments may issue tax-exempt bonds to finance the activities of charitable organizations described in section 501(c)(3). Because interest income on tax-exempt bonds is excluded from gross income, investors generally are willing to accept a lower rate on such bonds than they might otherwise accept on a taxable investment. This, in turn, lowers the cost of capital for the users of such financing. Both capital expenditures and limited working capital expenditures of charitable organizations described in section 501(c)(3) of the Code generally may be financed with tax-exempt bonds. Private, nonprofit hospitals frequently are the beneficiaries of this type of financing.

Bonds issued by State and local governments may be classified as either governmental bonds or private activity bonds. Governmental bonds are bonds the proceeds of which are primarily used to finance governmental functions or which are repaid with governmental funds. Private activity bonds are bonds in which the State or local government serves as a conduit providing financing to nongovernmental persons⁵³ (e.g., private businesses or individuals). For these purposes, section 501(c)(3) organizations are treated as nongovernmental persons. The exclusion from income for interest on State and local bonds does not apply to private activity bonds, unless the bonds are issued for certain permitted purposes (“qualified private activity bonds”) and other Code requirements are met.

Proposed Options

The Committee could consider a policy option that would codify organizational and operational requirements for determining whether a hospital is a charitable organization for purposes of section 501(c)(3) tax-exempt status.

Such requirements include, among other things, that section 501(c)(3) hospitals regularly conduct a community needs analysis, provide a minimum annual level of charitable patient care, not refuse service based on a patient's inability to pay, and follow certain procedures before instituting collection actions against patients.

Certain hospitals that are critical to the communities they serve or which have an independent basis for tax exemption (e.g., as an educational or scientific research organization) are excluded

⁵² Secs. 170, 2055, and 2522, respectively.

⁵³ For these purposes, the term “nongovernmental person” generally includes the Federal Government and all other individuals and entities other than States or local governments.

from the minimum charity care requirement. The proposal includes provisions designed to ensure proper reporting and transparency of operations. In addition, the proposal provides for excise taxes, or “intermediate sanctions,” designed to encourage compliance with the operational requirements. These intermediate sanctions could be imposed, for example, in situations where revocation of tax-exempt status is viewed as inappropriate.

SECTION IV: Lifestyle Related Revenue Raisers

Impose a Uniform Alcohol Excise Tax

Current Law

An excise tax is imposed on all distilled spirits, wine, and beer produced in, or imported into, the United States.⁵⁴ The tax liability legally comes into existence the moment the alcohol is produced or imported but payment of the tax is not required until a subsequent withdrawal or removal from the distillery, winery, brewery, or, in the case of an imported product, from customs custody or bond.⁵⁵

Both the tax rates and the volumetric measures on which the taxes are imposed differ depending on the type of beverage. Taxes are lower on the alcohol content of beer and still wines than on the alcohol content of distilled spirits and naturally sparkling wines.

Distilled spirits, wine, and beer produced or imported into the United States are taxed at the following rates per specified volumetric measure:

⁵⁴ Secs. 5001 (distilled spirits), 5041 (wines), and 5051 (beer).

⁵⁵ Secs. 5006, 5043, and 5054. In general, proprietors of distilled spirit plants, proprietors of bonded wine cellars, brewers, and importers are liable for the tax.

Item	Current Tax Rate
Distilled Spirits	\$13.50 per proof gallon ⁵⁶
Wine ⁵⁷	
Still Wines	
Not more than 14 percent alcohol	\$1.07 per wine gallon ⁵⁸
More than 14 percent but not more than 21 percent alcohol	\$1.57 per wine gallon
More than 21 percent but not more than 24 percent alcohol	\$3.15 per wine gallon
More than 24 percent alcohol	Taxed as distilled spirits ⁵⁹ (\$13.50 per proof gallon)
Hard apple cider	\$0.226 per wine gallon
Sparkling Wines --	
Champagne and other naturally sparkling wines	\$3.40 per wine gallon
Artificially carbonated wines	\$3.30 per wine gallon
Beer ⁶⁰	\$18.00 per barrel ⁶¹

On a per ounce basis, distilled spirits are taxed at roughly 21 cents per ounce of alcohol, still wines at 8 cents per ounce of alcohol (assuming an average alcohol content of 11 percent), and beer at 10 cents per ounce of alcohol (assuming an average alcohol content of 4.5 percent).

Proposed Option

This policy option contemplates imposing a uniform tax based on the alcohol content contained in the product. The excise tax under the proposal is imposed at a rate of \$16 per proof gallon on all alcoholic beverages.⁶²

As under present law, domestic wineries having aggregate annual production not exceeding 250,000 gallons would be entitled to a tax credit on the first 100,000 gallons of wine (other than

⁵⁶ A “proof gallon” is a U.S. liquid gallon of proof spirits, or the alcoholic equivalent thereof. Generally a proof gallon is a U.S. liquid gallon consisting of 50 percent alcohol. On lesser quantities, the tax is paid proportionately. Credits are allowed for wine content and flavors content of distilled spirits. Sec. 5010.

⁵⁷ Small domestic wine producers (i.e., those producing not more than 250,000 wine gallons in a calendar year) are allowed a credit of \$0.90 per wine gallon (\$0.056 per wine gallon in the case of hard cider) on the first 100,000 wine gallons (other than champagne and other sparkling wines) removed. The credit is reduced by one percent for each 1,000 wine gallons produced in excess of 150,000 wine gallons per calendar year.

⁵⁸ A “wine gallon” is a U.S. gallon of liquid measure equivalent to the volume of 231 cubic inches. On lesser quantities, the tax is paid proportionately.

⁵⁹ Sec. 5001(a)(4).

⁶⁰ A small domestic brewer (one who produces not more than 2 million barrels in a calendar year) is subject to a per barrel rate of \$7.00 on the first 60,000 barrels produced in that year.

⁶¹ A “barrel” contains not more than 31 gallons, each gallon equivalent to the volume of 231 cubic inches. On lesser quantities, the tax is paid proportionately.

⁶² Because the rate of tax will not depend on the source of the alcohol, the section 5010 credit based on wine content and flavors content of distilled spirits is not necessary and would be eliminated under the proposal.

champagne and other sparkling wines) removed in a calendar year. In a manner similar to present law, for domestic brewers producing less than two million barrels of beer during the calendar year, the proposal imposes a reduced rate of tax on the first 60,000 barrels of beer removed each year.

Enact a Sugar-Sweetened Beverage Excise Tax

Current Law

Present law does not include an excise tax on sugar-sweetened beverages.

Proposed Option

The proposal would impose a Federal excise tax per 12 ounces of sugar-sweetened beverage. Sugar-sweetened beverages under the proposal would include a variety of carbonated and uncarbonated beverages, such as nondiet soft drinks, fruit and vegetable drinks, functional drinks such as energy and sports drinks, iced teas and iced coffees, and flavored milk and dairy drinks.

The tax would apply to beverages sweetened with sugar, high-fructose corn syrup, or other similar sweeteners. The tax would not apply to beverages sweetened with non-caloric sweeteners. Sugar-sweetened fountain-drink syrup would be taxed at a higher rate per ounce, such that the rate per ounce of fountain drink would be roughly equivalent to the tax rate on ready-to-drink soft drinks.

SECTION V: Administration's Revenue Raising Proposals

The President has outlined a number of possible revenue raising provisions as part of the Administration's Fiscal Year 2010 budget proposals. In Committee discussions on health care reform, the focus has been on health care-related program savings and revenue raising proposals. However, the Chairman desires to provide, for the information of Members and potential discussion, a list of the President's Budget proposals.

Revenues Dedicated to the Health Reform Reserve Fund

1. Limit the Tax Rate at which Itemized Deductions Reduce Tax Liability to 28 Percent

2. Reduce the Tax Gap and Make Reforms

Expand Information Reporting

- Require Information Reporting for Private Separate Accounts of Life Insurance Companies
- Require Information Reporting on Payments to Corporations
- Require a Certified Taxpayer Identification Number from Contractors and Allow Certain Withholding

- Require Increased Information Reporting for Certain Government Payments for Property and Services
- Increase Information Return Penalties

Improve Compliance by Business

- Require E-Filing by Certain Large Organizations
- Implement Standards Clarifying when Employee Leasing Companies Can Be Held Liable for Their Clients' Federal Employment Taxes

Strengthen Tax Administration

- Allow Assessment of Criminal Restitution as Tax
- Revise Offer-in-Compromise Application Rules
- Expand IRS Access to Information in the National Directory of New Hires for Tax Administration Purposes
- Make Repeated Willful Failure to File a Tax Return a Felony
- Facilitate Tax Compliance with Local Jurisdictions
- Extension of Statute of Limitations where State Tax Adjustment Affects Federal Tax Liability
- Improve Investigative Disclosure Statute
- Expand Required Electronic Filing by Tax Return Preparers

Expand Penalties

- Clarify That the Bad Check Penalty Applies to Electronic Checks and Other Payment Forms
- Impose Penalty on Failure to Comply with Electronic Filing Requirements

3. Make Reforms to Close Tax Loopholes

Financial Institutions and Products

- Require Accrual of Income on Forward Sale of Corporate Stock
- Require Ordinary Treatment for Certain Dealers of Equity Options and Commodities
- Modify Definition of Control for Purposes of the Section 249 Deduction Limit

Insurance Companies and Products

- Modify Rules That Apply to Sales of Life Insurance Contracts
- Modify Dividends-Received Deduction for Life Insurance Company Separate Accounts
- Expand Pro Rata Interest Expense Disallowance for Corporate-Owned Life Insurance (COLI)

Tax Accounting Methods

- Deny Deduction for Punitive Damages
- Repeal Lower-of-Cost-or-Market Inventory Accounting Method

Modify Estate and Gift Tax Valuation Discounts and Make Other Reforms

- Require Consistency in Value for Transfer and Income Tax Purposes

- Modify Rules on Valuation Discounts
- Require Minimum Term for Grantor Retained Annuity Trusts (GRATs)

4. Modify Alternative Fuel Mixture Credit

Other Revenue Raising Proposals

1. Other Revenue Changes and Loophole Closers

- Reinstate Superfund Excise Taxes
- Reinstate Superfund Environmental Income Tax
- Tax Carried (Profit) Interests as Ordinary Income
- Codify “Economic Substance” Doctrine
- Repeal the Last-In, First-Out (LIFO) Method of Accounting for Inventories
- Reform U.S. International Tax System
 - Reform Business Entity Classification Rules for Foreign Entities
 - Defer Deduction of Expenses, Except R&E Expenses, Related to Deferred Income
 - Reform Foreign Tax Credit: Determine the Foreign Tax Credit on a Pooling Basis
 - Reform Foreign Tax Credit: Prevent Splitting of Foreign Income and Foreign Taxes
 - Limit Shifting of Income Through Intangible Property Transfers
 - Limit Earnings Stripping by Expatriated Entities
 - Prevent Repatriation of Earnings in Certain Cross-Border Reorganizations
 - Repeal 80/20 Company Rules
 - Prevent the Avoidance of Dividend Withholding Taxes
 - Modify Tax Rules for Dual Capacity Taxpayers
 - Combat Under-Reporting of Income Through Use of Accounts and Entities in Offshore Jurisdictions
 - Require Greater Reporting by Qualified Intermediaries Regarding U.S. Account Holders
 - Require Withholding on Payments of FDAP Income Made Through Nonqualified Intermediaries
 - Require Withholding on Gross Proceeds Paid to Certain Nonqualified Intermediaries
 - Require Reporting of Certain Transfers of Money or Property to Foreign Financial Accounts
 - Require Disclosure of FBAR Accounts to be Filed with Tax Return
 - Require Third-Party Information Reporting Regarding the Transfer of Assets to Foreign Financial Accounts and the Establishment of Foreign Financial Accounts
 - Require Third-Party Information Reporting Regarding the Establishment of Offshore Entities
 - Negative Presumption for Foreign Accounts with Respect to Which an FBAR has not Been Filed
 - Negative Presumption Regarding Failure to File an FBAR For Accounts with Nonqualified Intermediaries

- Negative Presumption Regarding Withholding on FDAP Payments to Certain Foreign Entities
 - Extend Statute of Limitations for Certain Reportable Cross-Border Transactions and Foreign Entities
 - Double Accuracy-Related Penalties on Understatements Involving Undisclosed Foreign Accounts
 - Improve the Foreign Trust Reporting Penalty
- Require Information Reporting for Rental Property Expense Payments
 - Eliminate Oil and Gas Company Preferences
 - Levy Tax on Certain Offshore Oil and Gas Production
 - Repeal Credit for Enhanced Oil Recovery (EOR) Projects
 - Repeal Credit for Production from Marginal Wells
 - Repeal Expensing of Intangible Drilling Costs
 - Repeal Deduction for Tertiary Injectants
 - Repeal Passive Loss Exception for Working Interests in Oil and Gas Properties
 - Repeal Percentage Depletion
 - Repeal Domestic Manufacturing Deduction for Oil and Gas Production
 - Increase the Amortization Period for Geological and Geophysical Costs to Seven Years
 - Eliminate the Advanced Earned Income Tax Credit

2. Upper-Income Tax Provisions Dedicated to Deficit Reduction

- Reinstate the 39.6-Percent Rate
- Reinstate the 36-Percent Rate for Taxpayers with Income over \$250,000 (Married Filing a Joint Return) and \$200,000 (Single)
- Reinstate the Limitation on Itemized Deductions for Taxpayers with Income over \$250,000 (Married Filing a Joint Return) and \$200,000 (Single)
- Reinstate the Personal Exemption Phase-Out (PEP) for Taxpayers with Income over \$250,000 (Married Filing a Joint Return) and \$200,000 (Single)
- Impose a 20-Percent Rate on Dividends and Capital Gains for Taxpayers with Income over \$250,000 (Married Filing a Joint Return) and \$200,000 (Single)

3. User Fees

- Preserve Cost-Sharing of Inland Waterways Capital Costs

4. Other Initiatives

- Levy Payments to Federal Contractors with Delinquent Tax Debt
 - Improve Debt Collection Administrative Procedures
 - Increase Levy Authority to 100 Percent for Vendor Payments