

ANALYSIS OF ORIGINAL BILL

Franchise Tax Board

Author: Villines, et al. Analyst: Scott McFarlane Bill Number: ABX1 8
Related Bills: See Legislative History Telephone: 845-6075 Introduced: November 6, 2007
Amended: November 8, 2007
Attorney: Patrick Kusiak Sponsor: _____

SUBJECT: Medical Care Costs Deduction / Health Savings Account Deduction Conformity / Physician's Uncompensated Medical Care Credit / Employer Provided Health Care Credit

SUMMARY

Under the Personal Income Tax and Corporation Tax laws, this bill would do the following:

- Allow a deduction for medical care expenses;
- Conform to the federal Health Savings Account (HSA) provisions;
- Allow a credit for uncompensated medical care provided by physicians; and
- Create a tax credit for certain small to medium size employers that provide qualified health insurance for their employees.

This bill would amend the Government Code to require the Board of Administration of the Public Employees Retirement System (PERS) offer a high-deductible health plan (HDHP) and an HSA option to public employees and annuitants. These provisions do not impact personal income tax and corporation tax laws, so a detailed analysis of these provisions is not included. However, these provisions would impact state income tax revenue, so a revenue estimate has been provided.

This bill would also add or amend provisions to the Business and Professions Code, Health and Safety Code, Insurance Code, and Welfare and Institutions Code. This analysis will not address these changes because they do not impact the department or state income tax revenue.

This is the department's first analysis of ABX1 8.

PURPOSE OF THE BILL

According to the author's office, the purpose of this bill is to improve California's health care system by allowing more choices when it comes to meeting the individual health care needs of families.

EFFECTIVE/OPERATIVE DATE

This bill would become effective on the 91st day after the adjournment of the health care special session.

Board Position:

_____ S _____ NA _____ NP
_____ SA _____ O _____ NAR
_____ N _____ OUA X PENDING

Department Director

Date

Brian Putler

4/16/08

POSITION

Pending.

SUMMARY OF SUGGESTED AMENDMENTS

Amendments 1 and 2 have been provided to correct a technical error in the definition of a “qualified taxpayer” eligible for the small to medium size employer health care credit.

ANALYSIS

The following four general issues impact the Franchise Tax Board (FTB) and each is analyzed separately:

1. Medical Care Costs Deduction - Allowing a deduction on California personal income tax returns for the costs of medical care;
2. HSA Conformity - Allowing the same deduction on California personal income tax returns for contributions to an HSA as is allowed on the federal income tax return for the same taxable year;
3. Physician’s Credit - Allowing a credit for uncompensated medical care provided by physicians; and
4. Small to Medium Size Employer Provided Health Care Credit - Creating a tax credit for certain small to medium size employers that provide qualified health insurance for their employees.

1. Medical Care Costs Deduction

FEDERAL/STATE LAW

Current federal and state laws allow an itemized deduction for expenses paid during the taxable year that are not compensated by insurance or otherwise for the medical care of the taxpayer, the spouse of the taxpayer, or the dependents of the taxpayer to the extent that the expenses exceed 7.5% of the taxpayer's adjusted gross income (AGI).

THIS BILL

This bill would allow a deduction equal to the cost of medical care not compensated by insurance or otherwise paid or incurred during the taxable year for the taxpayer, the taxpayer’s spouse, or the taxpayer’s dependents.

The deduction would be allowed as an “above-the-line”¹ deduction in computing the taxpayer’s AGI.

¹ “Above-the-line” deductions are amounts that may be deducted in computing adjusted gross income, and such deductions may be taken without regard to whether a taxpayer itemizes deductions.

This bill defines the following terms:

- “Taxpayer” means any person subject to the tax imposed by Part 10, Division 2, of the Revenue and Taxation Code (R&TC).
- “Dependent” has the same meaning as ascribed to that term by section 17056 of the R&TC.
- “Medical care” has the same meaning as ascribed to that term by section 213(d) of the Internal Revenue Code. The general definition includes amounts paid for diagnosis, cure, treatment, certain transportation and lodging costs, qualified long term care services, certain insurance premiums and co-pays, and prescribed drugs.

In addition, this bill would specify that any deduction allowed by this section would be in lieu of any other deduction otherwise allowable for the same expenses.

TECHNICAL CONSIDERATIONS

This bill would allow a double benefit. The same expenses could be excluded from income and claimed as a deduction. For example, if a taxpayer has a health flexible spending arrangement (FSA) and uses pre-tax income to pay for medical costs, the taxpayer would be able to exclude the costs from income and take a deduction for the same costs. The author may wish to consider adding language that would specify that any deduction allowed by this section would be in lieu of any other income exclusion otherwise allowable.

LEGISLATIVE HISTORY

AB 1040 (Duvall and Nakanishi, 2007/2008) is identical to the medical care costs deduction provisions of ABX1 8, except that AB 1040 would be effective for tax years beginning on or after January 1, 2007, and ABX1 8 would be effective for tax years beginning on or after January 1, 2008. This bill failed to pass the Assembly Revenue and Taxation Committee.

AB 2200 (Pacheco, 1999/2000) would have allowed a deduction for medical expenses in excess of \$1,000 for taxpayers who are 65 years or older. This bill failed to pass out of the Assembly Revenue and Taxation Committee.

AB 2267 (Baugh, 1997/1998) was identical to AB 2200 (Pacheco, 1999/2000). AB 2267 failed to be heard in a policy committee in the first house; AB 2267 failed to pass the Assembly Revenue and Taxation Committee.

AB 2330 (Poochigian, 1997/1998) would have reduced the percentage of medical expenses that may be deducted from those exceeding 7.5% of AGI to those exceeding 2% of AGI over a five-year period. AB 2330 was held in the Assembly Revenue and Taxation Committee.

2. HSA Conformity

FEDERAL/STATE LAW

Health Savings Accounts

Under federal law, individuals with an HDHP, and no other health plan other than a plan that provides certain permitted coverage, may establish an HSA. In general, HSAs provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, HSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents.

Within limits, contributions to an HSA made by or on behalf of an eligible individual are deductible by the individual in determining AGI (i.e. "above the line"). Contributions to an HSA are excludable from income and employment taxes if made by the employer. Earnings on amounts in HSAs are not taxable. Distributions from an HSA for qualified medical expenses are not includible in 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%. The 10% additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

The maximum aggregate annual contribution that can be made to an HSA is the lesser of (1) 100% of the annual deductible under the HDHP,² or (2) (for 2007) \$2,850 in the case of self-only coverage and \$5,650 in the case of family coverage.³ Contributions in excess of the maximum contribution amount are generally subject to a 6% excise tax.

Health Flexible Spending Arrangements and Health Reimbursement Arrangements

Arrangements commonly used by employers to reimburse medical expenses of their employees (and their spouses and dependents) include health FSAs and health reimbursement accounts (HRAs). Health FSAs typically are funded on a salary reduction basis, meaning that employees are given the option to reduce current compensation and instead have the compensation used to reimburse the employee for medical expenses. If the health FSA meets certain requirements, then the compensation that is foregone is not includible in gross income or wages and reimbursements for medical care from the health FSA are excludable from gross income and wages. Health FSAs are subject to the general requirements relating to cafeteria plans, including a requirement that a cafeteria plan generally may not provide deferred compensation. This requirement often is referred to as the "use-it-or-lose-it rule."

² The limits are indexed for inflation. For 2006, a high deductible plan is a health plan that has a deductible that is at least \$1,050 for self-only coverage or \$2,100 for family coverage and that has an out-of-pocket expense limit that is no more than \$5,250 in the case of self-only coverage and \$10,500 in the case of family coverage.

³ These amounts are indexed for inflation.

HRAs operate in a manner similar to health FSAs, in that they are an employer-maintained arrangement that reimburses employees for medical expenses. 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. Some of the rules are different. For example, 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 the next year. Reimbursements for insurance covering medical care expenses are allowable reimbursements under an HRA, but not under a health FSA.

Subject to certain limited exceptions, health FSAs and HRAs constitute other coverage under the HSA rules.

Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-432), enacted December 20, 2006

Starting in 2007, the TRHCA made the following six changes to HSAs:

1. FSA and HRA Terminations to Fund HSAs

Certain amounts in a health FSA or HRA are allowed to be distributed from the health FSA or HRA and contributed through a direct transfer to an HSA without violating the otherwise applicable requirements for such arrangements. The amount that can be distributed from a health FSA or HRA and contributed to an HSA may not exceed an amount equal to the lesser of (1) the balance in the health FSA or HRA as of September 21, 2006, or (2) the balance in the health FSA or HRA as of the date of the distribution.

2. Repeal of Annual Deductible Limitation on HSA Contributions

Limits on the annual deductible contributions that can be made to an HSA are modified so that the maximum deductible contribution is not limited to the annual deductible under the HDHP. Thus, starting in 2007, the maximum aggregate annual contribution that can be made to an HSA is \$2,850 (for 2007) in the case of self-only coverage and \$5,650 (for 2007) in the case of family coverage.

3. Modification of Cost-of-Living Adjustment

In the case of adjustments made for any taxable year beginning after 2007, the Consumer Price Index for a calendar year is determined as of the close of the 12-month period ending on March 31 of the calendar year (rather than August 31 as under present law) for the purpose of making cost-of-living adjustments for the HSA dollar amounts that are indexed for inflation (i.e., the contribution limits and the HDHP requirements).

4. Contribution Limitation Not Reduced for Part-Year Coverage

In general, starting in 2007, individuals who become covered under a high deductible plan in a month other than January are allowed to make the full deductible HSA contribution for the year rather than, as under prior law, being required to prorate the deduction based on the number of months the individual was enrolled in an HDHP.

5. Exception to Requirement for Employers to Make Comparable Health Savings Account Contributions

Enacts an exception to the comparable contribution requirements to allow employers to make larger HSA contributions for nonhighly compensated employees than for highly compensated employees. For example, an employer is permitted to make a \$1,000 contribution to the HSA of each nonhighly compensated employee for a year without making contributions to the HSA of each highly compensated employee.

6. One-Time Distribution from Individual Retirement Plans to Fund HSAs

Allows a one-time contribution to an HSA of amounts distributed from an individual retirement arrangement (IRA). The contribution must be made in a direct trustee-to-trustee transfer. Amounts distributed from an IRA under these rules are not includible in income to the extent that the distribution would otherwise be includible in income. In addition, such distributions are not subject to the 10% additional tax on early distributions.

Current California Law

California has not conformed to any of the federal HSA provisions. The California personal income tax return starts with federal AGI and requires adjustments to be made for differences between federal and California law. Adjustments relating to HSAs are required under current law, as follows:

- A taxpayer taking an HSA deduction on the federal individual income tax return is required to increase AGI on the taxpayer's California personal income tax return by the amount of the federal deduction.
- Any interest earned on the account is added to AGI on the taxpayer's California return.
- Any contribution to an HSA, including salary reduction contributions made through a cafeteria plan, made on the employee's behalf by their employer is added to AGI on the employee's California return.

Although California has not conformed to HSAs, California law is conformed to the federal rules for Archer medical savings accounts (MSAs) and allows a deduction equal to the amount deducted on the federal return for the same taxable year. California imposes a 10% additional tax rather than the 15% additional federal tax on distributions from an MSA not used for qualified medical expenses.

Because a tax-free rollover from an MSA to an HSA is not allowed under California law, any distribution from an MSA that is rolled into an HSA must be added to AGI on the taxpayer's California return and as that MSA distribution is not treated as being made for qualified medical expenses it would, therefore, be subject to the MSA 10% additional tax.

Additionally, a federal tax-free qualified HSA funding distribution is not allowed under California law because California specifically does not conform to Internal Revenue Code (IRC) section 223, relating to HSAs, even though California conforms to IRC section 408, relating to IRAs.

Under California law, any distribution from an IRA to an HSA must be added to AGI on the taxpayer's California return and would be subject to a 2 ½% additional tax under the rules for premature distributions under IRC section 72.

THIS BILL

Starting with taxable year 2008, this bill would conform to the federal HSA provisions in effect for 2006, as follows:

1. Allows the same above-the-line deduction for contributions to an HSA by or on behalf of an individual and adopts the rules applicable to the trust itself in order for the trust to be exempt from tax. In addition, the disqualified distribution penalty applicable to HSAs is modified for California purposes to be 2 ½% instead of the federal rate of 10% to be consistent with the other California penalty provisions applicable to IRAs. Consistent with general conformity policy in other areas, the federal 6% excise tax on excess contributions and the federal estate tax provisions are not being conformed to by this bill.
2. Allows the same exclusion from an employee's gross income for the amount of any contributions to an HSA (including salary reduction contributions made through a cafeteria plan) made on the employee's behalf by their employer.
3. Allows rollovers from MSAs to be made to HSAs, as well as rollovers between HSAs, without penalty.
4. Adopts the same \$50 penalty for failure to make required reports.
5. Allows certain amounts in health FSAs or HRAs to be distributed from the health FSA or HRA and contributed through a direct transfer to an HSA without violating the otherwise applicable requirements for such arrangements.
6. Conforms to repeal of annual deductible limitation on HSA contributions.
7. Determines the Consumer Price Index for a calendar year as of the close of the 12-month period ending on March 31 of the calendar year (rather than August 31 as under prior law) for the purpose of making cost-of-living adjustments for the HSA dollar amounts that are indexed for inflation (i.e., the contribution limits and the HDHP requirements).
8. Allows individuals who become covered under a high deductible plan in a month other than January to make the full deductible HSA contribution for the year rather than being required to prorate the deduction based on the number of months the individual was enrolled in an HDHP.
9. Conforms to an exception to the comparable contribution requirements to allow employers to make larger HSA contributions for nonhighly compensated employees than for highly compensated employees. For example, an employer is permitted to make a \$1,000 contribution to the HSA of each nonhighly compensated employee for a year without making contributions to the HSA of each highly compensated employee.

10. Allows a one-time contribution to an HSA of amounts distributed from an individual retirement arrangement (IRA). The contribution must be made in a direct trustee-to-trustee transfer. Amounts distributed from an IRA under these rules are not includible in income to the extent that the distribution would otherwise be includible in income. In addition, such distributions are not subject to the 2 ½% additional tax on early distributions.

LEGISLATIVE HISTORY

ABX1 4 (Nakanishi, 2007/2008) is identical to the HSA provisions of ABX1 8. This bill is currently at the Assembly desk.

AB 84 (Nakanishi/Smyth, 2007/2008) is identical to the HSA provisions of ABX1 8. This bill is currently in the Assembly Revenue and Taxation Committee.

SBX 1 10 (Maldonado, 2007/2008) is nearly identical to the HSA provision of ABX1 8 except that conformity to the federal HSA provisions would apply starting with tax year 2006. This bill is currently in the Senate Health Committee.

SB 25 (Maldonado and Runner, 2007/2008) is identical to SBX1 10. This bill is currently in the Senate Revenue and Taxation committee.

AB 142 (Plescia, 2007/2008) is identical to SB 25 (2007/2008). This bill is currently in the Assembly Revenue and Taxation Committee.

AB 245 (DeVore, 2007/2008) is identical to AB 142. This bill is currently in the Assembly Committee on Revenue and Taxation.

SB 1584 (Runner and Ackerman, 2005/2006) was nearly identical to the HSA provisions of ABX1 8, except that conformity to the federal HSA provisions would apply starting with tax year 2004. This bill was held in the Senate and Revenue Taxation Committee.

SB 173 (Maldonado, 2005/2006) was nearly identical to SB 25 (2007/2008), except that SB 173 did not contain the additional gift-of-public-funds language. This bill was held in the Senate and Revenue Taxation Committee.

SB 1787 (Ackerman, 2005/2006) was identical to SB 1584 (2005/2006). This bill was held in the Senate and Revenue Taxation Committee.

AB 661 (Plescia, 2005/2006) was identical to SB 173 (2005/2006), except that conformity to the federal HSA provisions would apply starting with tax year 2007. This bill was held in the Assembly Committee on Revenue and Taxation.

AB 2010 (Plescia, 2005/2006) was identical to AB 142 (2007/2008). This bill was held in the Assembly Committee on Revenue and Taxation.

AB 2315 (Maldonado/ Nakanishi, 2003/2004), was identical to SB 173 (2005/2006). This bill was held in the Assembly Committee on Appropriations.

3. Physician's Credit

FEDERAL/STATE LAW

Current federal and state laws generally allow taxpayers engaged in a trade or business to deduct all expenses that are considered ordinary and necessary in conducting that trade or business.

Current federal and state laws also provide various tax credits designed to provide a tax incentive to taxpayers that incur certain expenses (e.g., child adoption) or to influence behavior, including business practices and decisions (e.g., research credits or economic development area hiring credits). These credits generally are designed to provide incentives for taxpayers to perform various actions or activities that they might not otherwise undertake. Federal and state law currently does not provide a credit similar to the credit proposed by this bill.

THIS BILL

This bill would allow a credit equal to 50% of the fair market value of uncompensated medical care provided by a physician during the taxable year to an eligible individual.

This bill would define the following terms:

- "Physician" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California.
- "Eligible individual" means a resident of this state who is not covered by health insurance and is a member of a household whose combined household adjusted gross income for the taxable year is less than the federal poverty level.
- "Fair market value of uncompensated medical care" means only those medical procedures covered by Medicare and shall not exceed the reimbursement rate authorized under Medicare.

In addition, this bill would allow any excess credit amount to be carried forward to succeeding years until exhausted.

IMPLEMENTATION CONSIDERATIONS

The department has identified the following implementation concerns. Department staff is available to work with the author's office to resolve these and other concerns that may be identified.

This bill uses terms that are undefined, namely "uncompensated medical care" and "health insurance." The absence of definitions to clarify these terms could lead to disputes with taxpayers and would complicate the administration of this credit.

This bill would require that an “eligible individual” have a California combined household AGI less than the federal poverty level. The federal poverty thresholds are based on total household income, not AGI. Generally, income information is confidential and, as such, it would be difficult for the physician to substantiate that an eligible individual meets the income requirement. The author may wish to amend the bill to remove the term “adjusted gross income” and replace it with “household income”,⁴ and specify how to substantiate such income without compromising confidential information.

This bill would require that an “eligible individual” be a California resident. It would be difficult for the physician to substantiate that an individual is a California resident. The author may wish to amend the bill to specify how to substantiate residency without compromising confidential information.

LEGISLATIVE HISTORY

AB 1592 (Huff et al., 2007/2008) is identical to the physician’s credit provisions of ABX1 8. This bill failed to pass out of the Assembly Revenue and Taxation Committee.

SBX1 8 (Harman, 2007/2008) is nearly identical to the physician’s credit provisions of this bill, the difference is that ABX1 8 provides a definition of the fair market value of uncompensated medical care and SBX1 8 does not. This bill is currently at the Assembly Committee on Health.

SB 1026 (Calderon, 2007/2008) would allow a tax credit to qualified health care providers for the amounts paid or incurred to provide health care to certain California residents. This bill failed to pass out of the Senate Revenue and Taxation Committee.

AB 218 (Maze, 2005/2006) and AB 293 (Maze, Parra 2005/2006) would have allowed a tax credit for doctors that treat Medi-Cal beneficiaries in specified counties. Both bills failed to pass out of the Assembly Revenue and Taxation Committee.

AB 988 (Maze, 2003/2004) would have allowed a tax credit for doctors that treat Medi-Cal beneficiaries in specified counties. This bill failed to pass out of the first house by the constitutional deadline.

AB 2164 (Cogdill, 2001/2002) would have allowed a tax credit to medical professionals who work in rural communities. This bill failed to pass out of the Assembly Revenue and Taxation Committee.

4. Small to Medium Size Employer Provided Health Care

FEDERAL/STATE LAW

Current federal and state laws do not provide a tax credit for health care costs.

⁴ As defined in California Revenue and Taxation Code section 20504 for homeowners and renters assistance claimants.

Current federal law allows ordinary and necessary business expenses to be deducted, including health care coverage premiums paid by an employer for accident or health plans for employees, and allows self-employed persons to deduct from gross income 100% of amounts paid for health insurance for themselves, spouses, and dependents. California law conforms to both of these provisions.

Under current federal law, the amount of an employer's contribution, including any salary reduction contributions made through a cafeteria plan, to an accident or health plan for the benefit of an employee or the employee's spouse or dependents is excluded from the employee's gross income. California law also conforms to this provision.

For taxable years beginning on or after January 1, 1997, California conformed to the federal provisions that allow an individual to deduct contributions to an Archer Medical Savings Account (MSA); however, California does not conform to any of the federal HSA provisions, including the tax-free rollover from an MSA to an HSA.

THIS BILL

This bill would allow a 15% credit for amounts paid or incurred during the taxable year by a qualified taxpayer that provides qualified health insurance for its employees who perform services in California. The credit would be available for taxable years beginning on or after January 1, 2008, and before January 1, 2014.

This bill defines the following terms:

- “Qualified health insurance” means amounts paid on behalf of employees to:
 - An HDHP as defined by IRC section 223(c)(2), or
 - An HSA as defined by IRC section 223(d).
- “Qualified taxpayer” means:
 - Any small to medium size employer, or
 - Any small to medium size employer that has not provided health insurance to their employees during any of the five taxable years immediately preceding the taxable year.
- “Small employer” means a person, as defined in IRC section 7701(a), employing at least two but not more than 50 persons.
- “Medium employer” means a person, as defined in IRC section 7701(a), employing at least 51 but not more than 250 persons.

This bill would specify that this credit would be allowed in lieu of any deduction for the same expenses. Any unused credits could be carried over to future years until the credit is exhausted.

This bill would require that on or before September 1, 2012, the Franchise Tax Board shall provide a report to the Legislature on the usage of the credit.

This bill would require that on or before March 1, 2013, the Legislative Analyst shall report to the Legislature on the effectiveness of the tax credit upon employed Californians’ ability to meet deductible medical expenses incurred under qualified health insurance plans.

IMPLEMENTATION CONSIDERATIONS

The department has identified the following implementation concerns. Department staff is available to work with the author's office to resolve these and other concerns that may be identified.

This bill refers to the number of "persons" employed for wages or salary in defining a "small employer" and "medium employer." R&TC section 17001 defines "persons" as individuals, fiduciaries, partnerships, limited liability companies, and corporations. The author may wish to use the term "individuals" instead of "persons."

The bill defines a "small employer" as a person employing at least 2 but no more than 50 persons and a "medium employer" as a person employing at least 51 but no more than 250 persons. In applying these limitations, questions will arise as to whether the number-of-persons employed is to be determined at any time during the taxable year, on an average basis, or at the end of the taxable year. For example, an employer may employ more than 250 persons temporarily or seasonally, but have fewer than 250 persons at the end of the taxable year. Clarification on how this limitation is intended to be applied would avoid potential disputes between taxpayers and the department.

The bill would require the FTB to report to the Legislature on the usage of the credit on or before September 1, 2012, but does not specify what information should be included in that report. The author may wish to explicitly provide what information the FTB is required to report.

The bill would require the Legislative Analyst to report to the Legislature on the effectiveness of the tax credit upon employed Californians' ability to meet deductible medical expenses incurred under qualified health insurance plans on or before March 1, 2013. The author may wish to explicitly provide what information the Legislative Analyst is required to report.

TECHNICAL CONSIDERATIONS

The definition of "qualified taxpayer" is broad. As written, this bill would allow the credit for all small to medium employers, regardless of whether they currently provide health insurance for their employees. The author's office has indicated the intent of this bill is to encourage employers, who currently do not provide health insurance for their employees, to begin doing so. To support the author's stated intent, Amendments 1 and 2 have been provided.

LEGISLATIVE HISTORY

ABX1 5 (Nakanishi, 2007/2008) is identical to the small- to medium-size employer credit provisions of this bill. This bill is currently at the Assembly desk.

AB 85 (Nakanishi, et al., 2007/2008) is identical to ABX1 5 and failed to pass the Assembly Revenue & Taxation Committee.

SB 151 (Denham, 2007/2008) would have allowed a credit equal to the amount paid or incurred during the taxable year for qualified health expenses by a qualified employer. This bill failed to pass the Senate Revenue & Taxation Committee.

SB 199 (Harman, et al., 2007/2008) would have created a tax credit for certain taxpayers that provide qualified health insurance for their employees. This bill failed to pass the Senate Revenue & Taxation Committee.

SB 2737 (Nakanishi), SB 1639 (Dutton), and SB 195 (Maldonado), from the 2005/2006 legislative session, were similar to this bill. These bills failed to pass out of the Senate.

AB 1262 (Campbell), AB 1734 (Thomson), and AB 2765 (Knox), from the 1999/2000 legislative session, and AB 694 (Corbett) and AB 39 (Thomson/Campbell), from the 2001/2002 session, would have created an employer provided health insurance credit. These bills failed passage in the Assembly.

OTHER STATES' INFORMATION

The states surveyed include *Florida, Illinois, Massachusetts, Michigan, Minnesota, and New York*. These states were selected due to their similarities to California's economy, business entity types, and tax laws.

1. Medical Care Costs Deduction

Florida does not have a personal income tax. *Illinois, Michigan, Massachusetts, Minnesota, and New York* do not allow a deduction that is similar to what is proposed in this bill; but, like current California law, conform to the federal itemized deduction allowed for medical expenses that exceed 7.5% of AGI.

2. HSA

Illinois, Michigan, Massachusetts, Minnesota, and New York conform to the federal deduction for contributions to HSAs. *Florida* does not have a personal income tax and has not conformed to the new federal HSA provisions for corporate income taxpayers.

3. Physician's Credit

Florida, Illinois, Massachusetts, Michigan, Minnesota, and New York do not provide a physician's credit comparable to the credit allowed by this bill.

4. Small to Medium Size Employer Provided Health Care Credit

Florida, Illinois, Massachusetts, Michigan, Minnesota, and New York do not provide an employer credit comparable to the credit allowed by this bill.

FISCAL IMPACT

Implementing this bill would require changes to existing tax forms and instructions and modifications to the department's information systems, which could be accomplished during the department's normal annual update.

ECONOMIC IMPACT

Revenue Estimate (Medical Care Costs Deduction)

Based on data and assumptions discussed below, provisions related to the medical care cost deduction would result in the following revenue impact.

Estimated Revenue Impact for Section 18 of ABX1 8 Enactment Assumed Before January 1, 2008 (\$ in Billions)			
	2007-08	2008-09	2009-10
Premium Expense	-\$0.2	-\$1.0	-\$1.5
Medical Expense	-\$0.3	-\$1.5	-\$2.3
Total Revenue Impact	-\$0.5	-\$2.5	-\$3.8

This analysis does not account for changes in employment, personal income, or gross state product that could result from this bill.

Revenue Discussion

Using the national and state level data, the out-of-pocket medical expenses for 2008 are projected to be approximately \$30 billion. This figure includes such items as co-payments and co-insurances. Aggregate health insurance premiums are projected to be \$23 billion for 2008. This estimate assumes that the contributions to health insurance by employees who have cafeteria plans are not deductible under this proposal. Assuming a tax rate of 6%, the tax revenue impact of the proposal for 2008 is approximately \$3 billion calculated as follows:

Total health care spending: $\$30 + \$23 = \$53$ billion

Revenue impact @ 6%: $0.06 \times \$53 \approx \3 billion

Under current law, taxpayers can deduct medical expenses in excess of 7.5% of their AGI. Using the tax return data and a micro-simulation model, the tax revenue impact of the medical deductions under current law was projected to be approximately \$200 million in 2008. The net revenue impact of the proposal for 2008 is approximately \$2.80 billion (\$3 billion – \$200 million).

Tax year estimates are converted to the cash flow fiscal year estimates in the table.

Revenue Estimate (HSA Conformity)

Based on data and assumptions discussed below, provisions related to HSA conformity would result in the following revenue losses.

Estimated Revenue Impact for Sections 13-17 and 19-23 of ABX1 8 As Amended 11/8/07 Effective for Taxable Years BOA 1/1/08 Enactment Assumed Before 1/1/08 (\$ in Millions)		
2007-08	2008-09	2009-10
No Impact	-\$27	-\$32

This analysis does not consider the possible changes in employment, personal income, or gross state product that could result from this bill.

Revenue Discussion

The revenue impact of the HSA provisions would be determined by (1) the amount of contributions to HSAs deducted on tax returns, (2) the amount of contributions to HSAs made on behalf of employees (including salary reduction contributions), (3) the amount of funds in MSAs rolled over to HSAs, and (4) the result of conforming to the expanded HSA provisions included in the TRHCA of 2006 and marginal tax rates of taxpayers deducting or excluding such contributions.

1. Amount of contributions to HSAs deducted on tax returns

For the 2004 taxable year, tax return data indicates 7,500 returns reflected HSA adjustments on Schedule CA, California Adjustments, totaling \$20 million. This means that these taxpayers made tax-deductible contributions for federal purposes that were reversed for state purposes. Recent articles indicate the number of HSAs nationwide doubled during 2005 and again in 2006. To derive the estimates, this substantial growth rate is used through 2007 and is decreased thereafter to more sustainable rates. For 2008, contributions by California individual taxpayers to HSAs are estimated at \$235 million. Applying a marginal tax rate of 7% results in a revenue loss of approximately \$16.4 million ($\$235 \text{ million} \times 7\% \approx \16.4 million).

2. Amount of contributions to HSAs made on behalf of employees

Contributions made by an employer on behalf of an employee (including salary reduction contributions made through a cafeteria plan) cannot be identified on a tax return. It is not known how many additional HSAs may exist as a result of this contribution arrangement. Data indicate that 6% of employers offer HSA-eligible HDHPs. It is believed that most of these employers pay the premium for the HDHP rather than contribute to the employee's HSA. The rationale is that the premium is often less than the amount of the deductible that can be contributed to the HSA. Also, HSA balances are portable and not owned by the employer. For purposes of an estimate, it is assumed that employer contributions on behalf of an employee are approximately one-fourth of that by individuals, or approximately \$59 million in 2008 ($\$235 \text{ million} \times 25\% \approx \59 million). Applying a marginal tax rate of 7% results in an additional revenue loss of approximately \$4.1 million for 2008 ($\$59 \text{ million} \times 7\% \approx \4.1 million).

3. Amount of funds in MSAs rolled over to HSAs

The following is the estimate for the potential rollover of balances in Archer MSAs. For the 2002 taxable year, tax return data indicate deductible MSA contributions totaling \$11.6 million reported on 4,600 returns. It is possible that balances in some MSAs have already been rolled over. In addition, there is no requirement that balances must be rolled over. It is assumed that half of these accounts ($4,600 \times 50\% = 2,300$) would be rolled over and each account has an average balance of \$6,250. This balance equates to two-and-a-half years of average contributions ($2.5 \text{ years} \times \$2,500 \text{ average annual contribution} = \$6,250$). Applying a marginal tax rate of 7% results in an additional loss of approximately \$1 million ($2,300 \times \$6,250 \times 7\% \approx \1.0 million). It's anticipated that rollovers would likely occur in the initial one or two years of conformity. Therefore, assuming enactment after September 20, 2007, the \$1 million loss is divided between 2009 and 2010, or \$0.5 million each taxable year.

4. Result of conforming to the expanded HSA provisions

For expanded HSA provisions included in the TRHCA of 2006, the conformity estimate is an additional loss of \$2.2 million for the 2008 taxable year, which is based on a proration of the federal projections developed for the TRHCA of 2006.

For taxable year 2008, the estimated loss is approximately \$23 million ($\$16.4 \text{ million} + \$4.1 \text{ million} + \$2.2 \text{ million} = \22.7 million). Tax year estimates are converted to the cash flow fiscal year revenue estimates reflected in the table. For example, the 2008-09 revenue loss of \$27 million consists of \$23 million for the 2008 taxable year and \$4 million for the 2009 taxable year.

Revenue Estimate (Physician's Credit)

Based on data and assumptions discussed below, provisions allowing a physician credit for uncompensated care would result in the following revenue losses.

Estimated Revenue Impact for Section 11 of ABX1 8 Enactment Assumed Before January 1, 2008 (\$ in Millions)			
	2007-08	2008-09	2009-10
Revenue Impact	-\$20	-\$100	-\$130

This analysis does not account for changes in employment, personal income, or gross state product that could result from this bill.

Revenue Discussion

Based on a search of relevant literature, it is projected that doctors and physician groups practicing in California in 2008 will provide medical care for which they will be uncompensated of approximately \$800 million. This is the amount that the providers of health care services would have been paid if the uninsured had been covered by private health insurance. Because the credit is equal to 50% of the value of services provided, the credit would be half of this amount, or \$400 million. Based on industry data, it is estimated that about 40% of this amount is spent on uninsured members of households whose combined household adjusted gross income for the taxable year is less than the federal poverty level. This results in \$160 million of potential credits generated ($40\% \times \$400 \text{ million}$).

It is assumed that these physician taxpayers would apply 80% of credits generated, or \$128 million, to reduce tax liabilities. Remaining credits would be carried forward and used in subsequent years to reduce future tax liabilities.

The credit would be offset, to some extent, by a loss in business deductions by physician taxpayers. It is assumed that physicians deduct expenses valued at 10% of the uncompensated care provided under current law. It is further assumed that, of the amount that would be deducted under current law, only 80% can actually be used due to sufficient income. Applying a tax rate of 7% for these taxpayers results in an offset deduction of about \$700,000 ($\$128 \text{ million} \times 10\% \times 80\% \times 7\%$) for 2008. Remaining expenses are carried forward as net operating losses and applied against future income. Taxable year estimates have been converted to the cash flow fiscal year estimates in the table above.

The May 07, 2007, amendment to AB 1592, a prior bill with similar language, narrows somewhat the definition of the qualifying uncompensated healthcare expenses incurred by physicians and physician groups. The original estimates used the standard definition of uncompensated medical care that is the amount that the providers of health care services would have been paid if the uninsured had been covered by private health insurance. The estimates for the amendment define uncompensated medical care expenses as the amount that the providers of health care services would have been paid if the uninsured had been covered by Medicare. It is assumed that the uncompensated medical care is mostly confined to basic procedures most of which covered by Medicare. However, it is assumed that the Medicare reimbursement rates are, on average, 80% of the reimbursement rates by other insurance providers.

Revenue Estimate (Small to Medium Size Employer Provided Health Care Credit)

Based on data and assumptions discussed below, the revenue impact for provisions related to the small to medium size employer provided health care credit qualified health insurance credit would result in the following revenue losses.

Estimated Revenue Impact for Section 12 of ABX1 8 Enactment Assumed Before January 1, 2008 (\$ in Millions)			
	2007-08	2008-09	2009-10
Revenue Impact	-\$4	-\$23	-\$37

This analysis does not account for changes in employment, personal income, or gross state product that could result from this bill.

Revenue Discussion

This estimate assumes that employers offering new HDHPs in response to this proposal would reduce wages paid by an amount equal to the amount that they contribute to the new health plans. Employers would be allowed to claim a tax credit equal to 15% of that amount.

The remaining assumptions and parameters embodied in the estimates are based on state employment data, discussions with industry experts, and a survey of literature related to the California health care industry. Using the EDD data, it is projected that about 2.2 million employees would be working in qualified taxable small and medium size businesses in 2008. It is assumed, based on literature survey that under current law 5%, or 110,000, of these employees would receive high-deductible insurance through their employers. It is assumed that 66% of these employees (72,600) would receive insurance only for themselves and the remaining 34% (37,400) for themselves and their dependents.

For 2008, premiums for high-deductible health insurance are assumed to average \$2,500 for employees and \$5,700 for employees and dependents. Using National Health Expenditure Projections for years 2006-2016, a 7% annual growth rate is assumed for premiums. Based on industry surveys, employers' share of insurance costs is assumed to be 88% for employees and 75% for employees and dependents. For 2008, total qualified employers' cost is projected at \$320 million, calculated as follows:

- $72,600 \text{ employees} \times \$2,500 \text{ average premium} \times 0.88 \text{ employers' share of insurance cost for employee only} \approx \160 million.
- $37,400 \times \$5,700 \times 0.75 \text{ employers' share of insurance cost for employee and dependents} \approx \160 million.
- $\$160 \text{ million} + \$160 \text{ million} = \$320 \text{ million (total employer cost).}$

An estimated 90% of the \$320 million is assumed apportioned to California. It is projected that 75% of the apportioned amount would be deducted on tax returns with sufficient income. Assuming a tax rate of 6% would result in a revenue loss of \$13 million under current law, calculated as follows:

- $\$320 \text{ million} \times 0.90 \times 0.75 \times 0.06 \approx \13 million

The estimate assumes that the number of employees covered by new health plans will be 6% higher than it would have been absent the proposed new tax incentive. This would result in an additional insurance cost of approximately \$20 million incurred by qualified employers for a total of \$340 million (320 million + \$20 million). With a credit rate of 15%, the total credit amount is projected to be approximately \$50 million for 2008 (15% of \$340 million). It is assumed that 75% of credits generated would be applied in the year generated, or approximately \$38 million in 2008.

Employers would reduce wages paid to their employees by an amount equal to the amount that they contribute to the new health plans. As a result, deductions would be reduced by \$20 million. This would lead to an increase in taxes of approximately \$1 million under the proposal (6% tax rate \times \$20 million additional insurance cost under the proposal).

The net revenue impact of the proposal for the year 2008 would be approximately \$24 million (- \$13 million under current law + \$38 million - \$1 million additional deductions under proposed law). Unused credits would be carried over until used.

The proposal provides that “a qualified taxpayer is only eligible for the credit allowed by this section for the first year in which the credit is claimed and for each of the two consecutive taxable years following the taxable year in which the credit is first claimed.” Because staff’s revenue estimates cover only the first three fiscal years of impact, to the extent that the amendment has a revenue impact, it will fall outside the budget window. Moreover, to the extent that most qualified taxpayers would take advantage of the proposal starting in 2008, the revenue impact of the proposal for fiscal years 2010-11 and beyond would be due to the remaining taxpayers that would provide health insurance to their employees for the first time. The revenue impact of this proposal for these years, therefore, is expected to drop off significantly from the revenue impact estimated for the initial three fiscal years.

POLICY CONCERNS

Unlimited Carryover Period – This bill allows an unlimited carryover period for the small to medium size employer health care credit and the physician’s credit. Consequently, the department would be required to retain the credit on the tax forms indefinitely. Generally, credits include a carryover period limitation because experience shows credits are typically exhausted within eight years.

Physician’s Credit – To qualify for this credit, this bill would require a physician to provide medical care to a California resident. This requirement could encourage a physician to provide services only to California residents and discriminate against non-California residents. Restrictions based on residence have been found to be unconstitutional.

Small to Medium Size Employer Provided Health Care Credit – This bill would allow a credit for qualified health insurance paid for employees who perform services in this state, but fails to specify a minimum percentage of time or number of days that the employee must perform services in California. As a result, credits could be allowed for employees working both inside and outside of California.

Revenue Estimate (Require PERS to Offer an HDHP and an HSA option)

Based on data and assumptions discussed below, provisions requiring PERS to offer a HDHP and an HSA option would result in the following revenue gains annually beginning in 2008-09.

Estimated Revenue Impact for Section 2 of ABX1 8 As Amended 11/8/07 Enactment Assumed Before 1/1/08 (\$ in Millions)			
	2007-08	2008-09	2009-10
Revenue Impact	No impact	+\$1.5	+\$3.5

This analysis does not account for changes in employment, personal income, or gross state product that could result from this bill.

Revenue Discussion

Data released by California PERS indicates that approximately 580,000 state and public agency employees were enrolled in a health plan in 2008. Enrollees consist of active employees and retired annuitants. Some purchased insurance for self only and some for self and family members. Based on PERS data, it is assumed that approximately 200,000 of current employees buy insurance for self only, 230,000 employees for self and one dependent, and 150,000 employees for self and multiple dependents. It is further assumed that, under the proposal, 30,000 of the first group, 10,000 of the second group, and 15,000 of the third group would opt for an HDHP offered by PERS. The relatively low number for the second group is due to the fact that this group includes retired employees whose probability of opting for high-deductible health insurance is deemed to be rather small. It is assumed that retired employees would not opt for an HDHP.

Based on PERS data, it is assumed that an employee's share of premiums for the three groups, (self, self and one dependent, and self and more than one dependent) equals \$1,250, \$2,500, and \$3,250, respectively. Therefore, under current law, approximately \$110 million is excluded from taxation for these groups, calculated as follows:

$$(\$1,250 \times 30,000) + (\$2,500 \times 10,000) + (\$3,250 \times 15,000) \approx \$110 \text{ million}$$

Based on an industry search, it is assumed that the premiums for high-deductible health insurance are \$2,500 for self and \$5,700 for self and dependents. The average of these two amounts (\$4,100) is calculated as the high-deductible insurance premium to cover two-parties. PERS data indicate that in 2007 approximately 24% of total premiums were picked up by members. Applying this percent to the above high-deductible premiums, it is projected that the employee's share of the premium for the three groups under a high-deductible insurance plan would equal \$600, \$1,000, and \$1,350, respectively. These projections would result in approximately \$50 million of tax excluded under the proposal, calculated as follows:

- $(\$600 \times 30,000) + (\$1,000 \times 10,000) + (\$1,350 \times 15,000) \approx \50 million

Assuming an average marginal tax rate of 5%, this would result in a revenue gain of approximately \$3 million, calculated as follows:

- $5\% \times (\$110 \text{ million} - \$50 \text{ million}) = \$3 \text{ million}$

As the open enrollment period for selecting a health plan with PERS expired on October 12, 2007, for 2008, the first year PERS would be able to offer an HDHP and an HSA option would be in 2009. Estimates reflect this assumption.

Taxable year estimates are converted to the cash flow fiscal year estimates in the table. Amounts in the table assume a growth rate of 10% for premiums for 2010 and beyond. This growth assumption is based on PERS data.

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FRANCHISE TAX BOARD'S
PROPOSED AMENDMENTS TO ABX1 8
As Amended November 8, 2007

AMENDMENT 1

On page 20, lines 20 and 21 strikeout "any small to medium size employer,
or,"

AMENDMENT 2

On page 26, lines 9 and 10 strikeout "any small to medium size employer,
or,"