

**AMERICAN BAR ASSOCIATION
SECTION OF TAXATION AND HEALTH LAW SECTION**

Tax Issues in Health Care Reform

This white paper is submitted on behalf of the American Bar Association Section of Taxation and the American Bar Association Health Law Section (collectively, the “Sections”). The white paper has not been approved by the House of Delegates or the Board of Governors of the American Bar Association. Accordingly, it should not be construed as representing the position of the American Bar Association.

The Sections believe that tax laws based on good tax policy are as important in the area of health care as in other areas of the economy affected by the tax system. This paper provides an overview of the existing tax laws governing health care and health insurance, as those rules apply to individuals, providers and employees. The paper then identifies tax policy issues raised by the existing laws and by some of the changes to those laws that have been proposed under the rubric of “health care reform.” The Sections believe that policy makers should carefully consider these tax policy issues as they undertake to evaluate health care reform proposals.

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I. OVERVIEW

Rising health care costs, large numbers of uninsured and underinsured, and an outsized portion of the country's gross domestic product devoted to health care, among other issues, have combined to make health care reform a pressing priority. Elected officials at the federal, state, and even local levels are under enormous pressure to provide, or at least assist with, a solution to a problem that many feel is nearing a tipping point. Recently, President Obama announced that \$15 billion will be released from the stimulus funds to help states meet rising Medicaid costs.¹

The United States is unique among industrialized nations in how health care is provided to its citizens. The United States does not require individuals to have health insurance or require employers to make it available to their employees. Aside from the elderly population, which is covered by Medicare, only a small portion of health care in the United States is provided under public plans. About 60 million or 21% of non-elderly individuals are covered by a public plan (Medicare disability, Medicaid, the State Children's Health Insurance Program ("CHIP"), and military insurance plans, referred to as "TRICARE"). Of the remaining 223 million, about 164 million or 58% are covered by employer-sponsored group health plans (often referred to as "employer-sponsored insurance" or "ESI"), about 15 million or 5% are covered by individual insurance policies or policies purchased by the self-employed, and about 44 million or 16% are uninsured and either purchase health care directly from health care providers, receive some free or discounted care, or receive no care at all.²

In the United States neither health care nor health insurance tends to be provided by the government, like welfare. Instead health care and health insurance tend to be purchased, like food or higher education, or received in lieu of wages from an employer, and often are supplied by commercial entities like insurance companies. As a result, it is not surprising that the Code³ contains a large number of rules relating to health care and health insurance. Many have been added simply to address tax questions that have arisen from time to time regarding deductions, etc. For example, perhaps the best-known tax laws relating to health care and health insurance, the exclusion from gross income for coverage and benefits under an employer-provided health plan (the "ESI exclusion"), came about not as a deliberate effort to encourage those plans but simply to answer a tax question raised as those plans were becoming popular for other reasons.⁴ Other laws have been added to the Code specifically to influence behavior by individuals,

¹ This paper does not address the preliminary health care reforms advanced by the Obama Administration.

² See Joint Committee on Taxation ("JCT"), Tax Expenditures for Health Care, at 9 (JCX-66-08) (July 30, 2008); Employee Benefits Research Institute ("EBRI"), Issue Brief No. 314 (Feb. 2008).

³ The Internal Revenue Code of 1986, as amended (the "Code"). Unless otherwise indicated, all section references are references to sections of the Code.

⁴ See Congressional Research Service ("CRS"), The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate (Nov. 21, 2008); Melissa A. Thomasson, The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance, 93 Am. Econ. Rev. 1373 (Sept. 2003).

employers and health care providers in socially desirable ways—necessary because the government had no direct control over those areas. For example, the “COBRA” provisions (discussed in more detail below) were added to encourage employers to allow employees to continue coverage under their workplace plans after termination of employment and certain other events, and the “HIPAA” provisions (also discussed in more detail below) were added, among other reasons, to discourage employers from imposing preexisting condition limitations on new employees. As health care expenses have grown, both as a percentage of household budgets and a percentage of the nation’s economy, it has become increasingly important to be sure that the tax treatment of health care is appropriate and does not stand in the way of health care reform or, worse, contribute to the very problems reform is intended to address. Any discussion of health care reform must, therefore, include a discussion of the tax laws relating to health care.

II. CURRENT LAW

The federal income tax consequences of outlays and receipts for health care have a significant effect on the size and structure of the health care system. An overall reform of health care must therefore include a complete examination of the tax laws that so substantially drive the structure of the health care system. Thus, before discussing the tax policy issues raised by health care reform, it is useful to review the current tax treatment of health care and health insurance. The subject can be divided into three categories: the tax rules affecting individuals, the tax rules affecting providers, and the tax rules affecting employers.

A. Rules Affecting Individuals

Current law contains a number of rules describing the tax treatment of individuals who purchase or receive health care or health insurance, including those described below.

1. Section 213 allows an individual to deduct medical care expenses, including premiums for health insurance policies, of the individual and his spouse and dependents, to the extent such expenses exceed 7.5% of the individual’s adjusted gross income (“AGI”). (The section 213 deduction is not subject to the so-called “Pease” phase-out for higher-income taxpayers in section 68. However, if the individual is subject to the alternative minimum tax, the 7.5% floor is raised to 10%.) Medical care expenses include the cost of medicines and drugs, but such costs generally are not deductible unless the medicines or drugs are prescribed. Medical care expenses include expenses related to long-term care if they satisfy certain requirements, but the deduction for long-term care insurance premiums is subject to an age-based cap. Medical care expenses generally do not include the cost of cosmetic surgery. Under the federal Defense of Marriage Act, a same-sex partner cannot be treated as a spouse for purposes of the deduction permitted under section 213 or any other tax purposes even if such partner is treated as a spouse under state law. The tax expenditure associated with the section 213 deduction was about \$4.9 billion in 2008.⁵

⁵ Office of Management and Budget (“OMB”), *Analytical Perspectives: Budget of the United States Government, Fiscal Year 2008*, Table 19-1 (2007); cf. *Tax Expenditures for Health Care*, at 2 (\$8.7 billion in 2007 using different approach).

2. Section 106 excludes from gross income the cost of coverage of an individual and his spouse and dependents under an accident or health plan that is paid for by an individual's employer. This rule covers former employees, see, e.g., Revenue Rulings 82-196 and 85-121, but does not cover individuals who are independent contractors, such as sole proprietors, consultants, corporate directors or partners, or 2% shareholders of S corporations, who are treated as partners for this purpose.⁶ This exclusion for coverage under an accident or health plan includes self-insured arrangements, the availability of on-site clinics, and plans that provide disability benefits. Section 106 does not exclude the cost of coverage from gross income if the employee can choose to receive cash or other taxable benefits in lieu of the coverage, unless the arrangement satisfies detailed requirements to be a "cafeteria plan" under section 125. The tax expenditure associated with the section 106 exclusion and the section 105(b) exclusion described below, which together comprise the ESI exclusion, was about \$160.2 billion in 2008.⁷
3. Section 105(b) excludes from an individual's gross income amounts paid for medical care expenses (within the meaning of section 213) under an accident or health insurance plan, even if the individual's employer paid for the coverage and the coverage was excluded from the individual's income under section 106. Thus, in the case of medical benefits (but not, for example, disability benefits), an employee does not have to choose between receiving coverage and benefits tax-free; he can exclude both from income. Like section 106, section 105(b) applies to medical benefits paid under self-insured arrangements, benefits paid to former employees, and benefits paid to an employee's spouse and dependents. The Internal Revenue Service (the "Service") also interprets section 105(b) to apply to non-prescription medicine and drugs even though the cost of non-prescription medicine and drugs generally is not deductible under section 213.⁸ One significant limitation on the tax exclusion in section 105(b) is that a portion of any medical benefits provided to "highly compensated individuals" (roughly the highest-paid 25% of all employees) is subject to tax if (i) the benefits are provided under a self-insured plan and (ii) the plan discriminates in favor of highly compensated individuals. This limitation does not apply to insured plans because underwriting considerations are thought to prevent significant discrimination there.
4. Reimbursement accounts (which are arrangements under which an employer agrees to pay or reimburse an employee's medical care expenses to a maximum amount that is no more than five times the contributions to the account) generally qualify as accident or health insurance plans and thus can take advantage of the tax exclusions in sections 105 and 106 described above. However, the Service takes the position that those exclusions apply to reimbursement accounts that are funded with employer contributions or with

⁶ 1982-2 C.B. 53; 1985-2 C.B. 57.

⁷ Analytical Perspectives, Table 19-1; cf. Tax Expenditures for Health Care, at 2 (\$246.0 billion in 2007 using different approach and including effect of parallel FICA exclusion).

⁸ See Rev. Rul. 2003-102, 2003-38 I.R.B. 559.

employee contributions under a cafeteria plan (called “health FSAs” or “FSAs”) only if the accounts satisfy certain additional requirements designed to make them function more like commercial insurance. Those requirements include prohibiting unused contributions from being carried over from year to year (the “use-it-or-lose-it rule”), making the maximum amount of reimbursements (minus any reimbursements that have already been made) available throughout the year, and prohibiting the payment from FSAs of premiums for coverage under other plans. The Heroes Earnings Assistance and Relief Tax Act of 2008 created an exception from the use-it-or-lose-it rule for reservists called to active duty. Reimbursement accounts that are not funded with employer contributions or with employee contributions under a cafeteria plan (and thus are exempt from the “use-it-or-lose-it rule” and related requirements) are called “health reimbursement accounts” or “HRAs.” Section 106(c) prohibits both FSAs and HRAs from paying long-term care expenses.

5. Section 104(a)(3) excludes from an individual’s gross income the value of benefits received under an accident or health insurance plan or policy, even if the value is much larger than the premiums or other amounts paid for the coverage, if the individual paid for the coverage and did not take a deduction under section 213, or if the individual’s employer paid for the coverage and the coverage was not excluded from income under section 106, either because section 106 was for some reason not available or because the parties chose not to apply section 106.⁹
6. Coverage and benefits under military insurance plans, referred to as “TRICARE,” and veterans health care programs, are excluded from gross income under section 134. The tax expenditure associated with the exclusion of TRICARE benefits was about \$2.1 billion in 2007.¹⁰
7. The employee portion of the FICA taxes required to pay for coverage under Part A of Medicare is not deductible under section 213, and is not excluded from gross income if paid by the individual’s employer.¹¹ However, benefits under Part A of Medicare are excluded from gross income as disbursements made in furtherance of the social welfare objectives of the federal government.¹² Benefits under the State Children’s Health Insurance Program (“SCHIP”) are excluded from gross income on the same basis.¹³ Premiums for voluntary supplementary health insurance and voluntary prescription drug insurance under Parts B and D of Medicare are deductible under section 213, and like

⁹ See Rev. Rul. 2004-55, 2004-26 I.R.B. 1081.

¹⁰ Tax Expenditures for Health Care, at 2.

¹¹ See Rev. Rul. 66-216, 1966-2 C.B. 100.

¹² See, e.g., Rev. Rul. 70-341, 1970-2 C.B. 31.

¹³ See CRS, Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation, at 12 (updated July 20, 2007).

coverage under employer-sponsored health plans, can be excluded from gross income under section 106 if paid by the individual's employer.¹⁴ Benefits under Parts B and D of Medicare are excluded from gross income under section 104 (and section 105(b) if applicable).¹⁵ The subsidized element of Medicare is not subject to tax. Part B premiums, for example, cover only about 25% of the program's average costs. The Medicare Modernization Act of 2003 requires higher-income Medicare recipients to pay higher Part B premiums. Income determinations are based on the latest information available to the Social Security Administration from the Service, usually for the second year preceding the year in which the premiums are paid. The tax expenditure associated with the exclusion of Medicare benefits was about \$39.3 billion in 2007.¹⁶

8. Section 162(l) allows a self-employed individual, such as a sole proprietor, consultant, corporate director or partner (including a 2% shareholder of an S corporation), to deduct from income derived from business 100% of the cost of health insurance for himself and his dependents. Health insurance for this purpose includes self-insured plans. Even if this deduction is taken, benefits are excluded from gross income under section 104. The combined effect of the deduction for coverage under section 162(l) and the exclusion for benefits under section 104 is similar to the combined effect of the coverage and benefit exclusions under sections 106 and 105(b), respectively. However, these tax laws applicable to self-employed individuals are less advantageous in several respects. First, health insurance does not include reimbursement arrangements, and self-employed persons are not allowed to participate in cafeteria plans. Second, the deduction is not available at all if the individual is eligible (i) to receive employer-paid coverage under a health plan maintained by any employer of the individual or his spouse or (ii) to purchase such coverage through a cafeteria plan.¹⁷ Finally, and most importantly, the value of employer-provided health coverage is excluded from wages for FICA tax purposes, but self-employed individuals cannot deduct the cost of health insurance from their self-employment income for SECA tax purposes. The tax expenditure associated with the section 162(l) deduction was about \$4 billion in 2008.¹⁸
9. Although distributions from tax-qualified retirement plans are usually included in gross income except to the extent they are attributable to after-tax contributions, section 402(l) allows certain retired public safety officers to receive distributions from governmental plans on a tax-free basis if the distributions are used to pay premiums for accident or

¹⁴ See Rev. Rul. 67-360, 1967-2 C.B. 71.

¹⁵ See Rev. Rul. 70-341, 1970-2 C.B. 31.

¹⁶ Tax Expenditures for Health Care, at 2.

¹⁷ See FSA 3042 (Dec. 19, 1995).

¹⁸ Analytical Perspectives, Table 19-1; cf. Tax Expenditures for Health Care, at 2 (\$4.8 billion in 2007 using different approach).

health insurance or qualified long-term care insurance coverage. The tax expenditure associated with this exclusion was about \$0.2 billion in 2008.¹⁹

10. Section 35 provides a refundable Health Coverage Tax Credit (“HTHC”) to certain individuals to help them purchase health insurance. Only (i) certain individuals who lost their jobs due to the effects of international trade and (ii) individuals receiving benefits from the Pension Benefit Guaranty Corporation who are at least 55 years old are eligible for the credit. The credit is equal to 65% of the premiums for “qualified health insurance” for individuals and their families. “Qualified health insurance” includes group health continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”)²⁰ (unless the employer pays 50% or more of the premiums), and coverage under a state-qualified health plan (a plan that has sought and obtained “qualified” status from the state in which it operates). The tax expenditure associated with the credit was about \$.01 billion in 2008.²¹
11. Sections 62 and 223 allow an individual whose only other health insurance coverage is a “high deductible health plan” (an “HDHP”) and who is not eligible for Medicare to deduct 100% of the contributions to a health savings account (an “HSA”), up to a fixed dollar limit. The deduction limit for 2009 is \$3,000 for an individual with self-only coverage under an HDHP and \$5,950 for an individual with family coverage under a HDHP. A deduction of an additional contribution (\$1,000 in 2009) is permitted for individuals age 55 or older. For 2009, to be an HDHP a health plan generally must have an annual deductible of at least \$1,150 for self-only coverage or \$2,300 for family coverage under an HDHP. However, first-dollar coverage is permitted for preventive care. Contributions by an employer are excluded from gross income. However, the contributions are subject to nondiscrimination rules unless they are made under a cafeteria plan (which has its own nondiscrimination rules). Unlike FSAs and HRAs, HSAs have assets, which are held in trust for the benefit of the owner. Like HRAs but unlike FSAs, unused assets can be carried over from year to year. Earnings on the assets are exempt from tax. Distributions from an HSA are excluded from gross income if they are used to pay medical care expenses (within the meaning of section 213) for the individual or his spouse or dependents, including the cost of nonprescription drugs but generally not including insurance premiums. Similar rules apply under section 220 to “Archer MSAs” and under section 138 to “Medicare Advantage MSAs” established

¹⁹ Analytical Perspectives, Table 19-1.

²⁰ The new federal subsidy provided under the American Recovery and Reinvestment Act of 2009 is not discussed in this paper due to its temporary nature (*i.e.*, the subsidy generally is available only until December 31, 2009).

²¹ Analytical Perspectives, Table 19-1; see also Tax Expenditures for Health Care, at 2 (same in 2007 using different approach).

under Part C of Medicare. The tax expenditure associated with HSAs and MSAs was about \$2.0 billion in 2008.²²

B. Rules Affecting Providers

Current law contains a number of rules describing the tax treatment of providers of health care and health insurance, including those described below.

1. Section 501(c)(3) exempts from regular income tax entities that are organized and operated exclusively for charitable purposes. Contributions to section 501(c)(3) entities are tax-deductible, within limits. The promotion of health for the benefit of the community is considered a charitable purpose. In carrying out this charitable purpose, tax-exempt hospitals and other health care providers (and even some for-profit health care providers) typically provide substantial quantities of free or discounted health care to poor and uninsured individuals. Economists believe the cost of such care, including the cost of the tax exemption and tax deduction, ultimately is borne by other health care purchasers and U.S. taxpayers. The tax expenditure associated with the charitable deduction for health-related entities was about \$5.2 billion in 2008.²³
2. Section 501(c)(9) exempts from regular income tax “voluntary employees’ beneficiary associations” (“VEBAs”). A VEBA is an entity, usually a trust, that provides certain benefits, which may include accident and health benefits, to employees of single employer, members of a single labor union, or other groups of individuals who share an “employment-related common bond,” and their spouses and dependents. VEBAs are subject to nondiscrimination rules unless they are collectively bargained. Like other tax-exempt organizations, VEBAs are subject to tax on their unrelated business taxable income (“UBTI”). Unlike other tax-exempt organizations, however, income that a VEBA earns on amounts set aside to fund future benefits is treated as UBTI if the amounts would not be deductible under sections 419 and 419A, described below. Thus, the tax benefit of the VEBA exemption is limited unless the VEBA is collectively bargained.

C. Rules Affecting Employers

Current law contains a number of rules describing the tax treatment of employers that make health care or health insurance available to their employees, including those described below.

1. Employers are allowed to deduct as compensation expenses under section 162 the cost of providing current health care or health insurance to their employees, even though the employees can exclude both the value of the coverage and the value of any benefits they receive under sections 105(b) and 106.

²² Analytical Perspectives, Table 19-1; cf. Tax Expenditures for Health Care, at 2 (\$0.3 billion in 2007 using different approach).

²³ Analytical Perspectives, Table 19-1.

2. Sections 419 and 419A limit most employers' ability to pre-fund their health benefit obligations. Specifically, they prohibit an employer from deducting contributions it makes to a welfare benefit fund (such as a VEBA) for its employees, regardless of whether the usual tax accounting rules would otherwise allow a deduction, except to the extent the contributions do not exceed the sum of (i) the benefits actually paid from the fund during the year, (ii) any incurred but unpaid claims for benefits, and (iii) contributions to a reserve actuarially determined to be necessary to fund post-retirement benefits on a level basis over the working lives of the covered employees. Contributions to fund benefits for "key employees" and highly compensated individuals are subject to additional limits. If the fund is not a VEBA, income that would be UBTI to the fund if it were a VEBA is taxed to the employer. No contribution limits apply to collectively bargained funds and funds that are part of a plan maintained for 10 or more employers that does not separately experience rate each employer.
3. Section 139A exempts from tax any subsidy an employer receives to maintain prescription drug coverage for retirees under Part D of Medicare.
4. The Code contains a number of excise taxes requiring employers to design and operate their health benefit programs in certain ways that are considered socially desirable. These include the following:
 - a. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires an employer-sponsored group health plan to allow employees and members of their families who would otherwise lose coverage under the plan because of termination of employment, divorce or certain other reasons to continue to buy coverage under the plan for a specified period, generally 18 months, after that event. COBRA added these requirements in parallel amendments to the Code and to the Employee Retirement Income Security Act of 1974 ("ERISA") and the Public Health Service Act ("PHSA"), which allow employees to sue directly to enforce their COBRA rights. The COBRA requirements contained in the Code are found in section 4980B. The plan may charge the individual up to 102% of the cost of coverage for similarly situated participants (the "COBRA premium") or 150% if the coverage period is extended because of disability. If a plan does not comply with the COBRA requirements, section 4980B imposes an excise tax on the employer that sponsors the plan (or on the plan itself if it is a multiemployer plan) of \$100 per day for each violation.
 - b. Section 4980C imposes an excise tax on any person involved in marketing long-term insurance contracts who fails to satisfy certain consumer-protection requirements in the National Association of Insurance Commissioners' model regulations and model act relating to long-term care insurance. The excise tax is \$100 per day for each violation.
 - c. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires employer-sponsored group health plans (and certain other group health plans) to comply with portability, access and renewability requirements designed,

among other things, to ensure that employees and their families can continue their health coverage with the same employer and obtain health coverage with a new employer, and they are not required to pay higher premiums than other employees for the coverage, even if they have or develop a health condition. These rules do not allow an employee to carry his insurance with him when he changes jobs, but generally do prohibit the new employer's plan from denying him coverage for preexisting conditions, thus substantially eliminating the "job lock" that occurred before the enactment of HIPAA. The Genetic Information Nondiscrimination Act of 2008 ("GINA") generally prohibits employer-sponsored group health plans from collecting genetic information about participants. The Newborns' and Mothers' Health Protection Act requires employer-sponsored group health plans to cover stays of up to 48 hours (96 in some cases) in a hospital following childbirth. The Mental Health Parity Act of 1996 (recently revised and renamed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, generally effective in 2010) limits the ability of employer-sponsored group health plans that provide mental health benefits to impose greater restrictions on those benefits than on other benefits. These requirements are found in sections 9801-9803, 9811, and 9812. If a plan does not comply with any of these requirements, section 4980D imposes an excise tax on the employer that sponsors the plan (or on the plan itself if it is a multiemployer plan) of \$100 per day for each violation. As with COBRA, parallel requirements are found in ERISA and the PHSA, allowing employees to sue directly to enforce their rights. Some of these requirements are also imposed on individual health insurance policies through the PHSA.

- d. Section 5000 imposes an excise tax on an employer that sponsors a group health plan that does not comply with the secondary payor requirements of Medicare. The excise tax is equal to 25% of the employer's expenditures under all group health plans to which it contributes.
- e. A health reform statute enacted by Massachusetts in 2006 requires residents to confirm, on their state income tax forms, that they have health insurance coverage. Individuals who fail to comply face loss of their personal exemption. In addition, penalties can be imposed on them. Penalties are first satisfied by forfeiture of any available tax refunds, and, if those are insufficient, by direct assessments on the affected individuals. Subsidies are provided to lower-income households, and individuals with income under 150% of the federal poverty level are exempt. Employers with 11 or more full-time-equivalent employees must contribute to the health insurance costs of their employees or contribute to a public plan at specified levels.

III. HEALTHCARE REFORM TAX PROPOSALS

A. *Rules Affecting Individuals*

Some healthcare reform proposals would make changes in the tax treatment of individuals who purchase or receive health care or health insurance, such as the following:

1. require the cost of employer-provided health coverage to be reported on an employee's Form W-2;
2. allow self-employed individuals to deduct their health insurance costs for employment tax (not just income tax) purposes;
3. eliminate or cap the ESI exclusion and the self-employed health insurance deduction, or replace them with an above-the-line deduction, a refundable credit, direct subsidies or tax credits to help individuals, especially moderate-income individuals, buy health insurance;
4. change the tax treatment of reimbursement accounts, e.g., eliminating the use-it-or-lose-it rule for health FSAs and either limiting or further expanding the availability of HSAs; and
5. impose some form of individual health insurance mandate, which could be administered through the tax system.

B. *Rules Affecting Employers*

Other healthcare reform proposals would make changes in the tax treatment of employers that make health care or health insurance available to their employees, such as the following:

1. impose some form of health insurance mandate on (larger) employers, e.g., a Massachusetts-style "pay or play" requirement;
2. provide tax incentives to encourage (small) employers to provide insurance; and
3. adopt a value-added tax (VAT) to finance public health expenditures, possibly including individual subsidies.

IV. TAX POLICY ISSUES RAISED BY CURRENT LAW AND REFORM PROPOSALS

A. *Relevance of Traditional Tax Expenditure Analysis*

Proposals to change the tax laws on health care and health insurance are driven, in part, by a perception that some of those laws do not reflect good tax policy, i.e., they deviate from the laws that would exist under an ideal tax system. Even if the laws reflect good tax policy, they may be perceived to be expensive and changing them could raise large amounts of tax revenue that could be used to pay for other healthcare reform initiatives. Both perceptions might be due, in part, to the large "tax expenditures" associated with these laws, in particular the ESI exclusion,

the itemized deduction for medical expenses in section 213, and the self-employed health insurance deduction in section 162(l).

However, the size of the tax expenditure associated with a specific section of the Code is not, in itself, a particularly good guide to how much it deviates from good tax policy or even how expensive it really is. The reasons for this conclusion are explored in depth in the JCT's recent report,²⁴ though they have been discussed in many other publications.²⁵

- First, tax expenditures do not actually measure deviations from a universally accepted “ideal” tax system, but rather the revenue associated with “special” rules viewed as exceptions to the “general” rules of a simplified version of the current income tax system. There are no very rigorous rules for determining which provisions are “special” rather than “general,” and no shortage of critics of the current income tax system.
- Second, the tax expenditure associated with a specific provision of the Code does not necessarily measure the revenue that would be generated if it were eliminated, because behavioral responses are not taken into account.²⁶ This is particularly true if more than one provision is changed at the same time.²⁷
- Third, even if a tax expenditure represents a deviation from good tax policy and repealing it would raise revenue, there might be reasons for continuing the expenditure anyway, for example if it encourages socially desirable behavior and can be delivered more easily through the tax system than through a direct grant program.

B. Equity

If tax expenditures alone are not particularly good guides to whether tax laws represent good tax or social policy, that determination must be made based on first principles, i.e., whether the tax law furthers the goals of an ideal tax system. Perhaps the most broadly accepted goal of an ideal tax system is equity, both horizontal equity and vertical equity. Horizontal equity is achieved when similarly situated individuals have similar tax burdens. Vertical equity is achieved when tax burdens vary based on individuals' ability to pay, generally meaning that higher-income individuals pay at least as much in taxes as a percentage of their incomes as lower-income individuals.²⁸

²⁴ A Reconsideration of Tax Expenditure Analysis (JCX-37-08) (May 12, 2008).

²⁵ See, e.g., Victor Thuronyi, Tax Expenditures: A Reassessment, 1988 Duke L.J. 1155 (1988).

²⁶ For an attempt to do that for health care expenditures, see Tax Expenditures for Health Care, at 2.

²⁷ See, e.g., Leonard Burman, Eric Toder & Christopher Geissler, How Big Are Total Individual Income Tax Expenditures, and Who Benefits from Them?, Urban-Brookings Tax Policy Center Discussion Paper No. 31 (Urban Inst., Dec. 2008) (“interactions among tax expenditures can be quite significant and, in some cases, counterintuitive”).

²⁸ See generally AICPA Tax Division, Guiding Principles of Good Tax Policy: A Framework for Evaluating Tax Proposals, at 11 (2001).

1. Equity Issues Raised by Existing Rules

a. Rules affecting individuals. Some equity issues relate to the differences in the deductions and exclusions that are available to individuals with the same health care and health insurance expenses. These differences are attributable to the nature of the individual's insurance and his or her work situations. For example, as outlined above:

- Employees with employer-provided health coverage or TRICARE can exclude 100% of the value of coverage and benefits from their gross incomes and FICA wages.
- Participants in Medicare whose employers contribute to the cost of that coverage enjoy roughly the same tax benefits as employees with employer-provided health coverage except that (i) the employee portion of FICA tax is not deductible, and (ii) the subsidized element of Medicare is not subject to tax.
- Self-employed individuals can deduct premiums for income but not employment tax purposes and have no access to cafeteria plans or FSAs.
- Individuals without employer-provided health coverage who are not self-employed can deduct only health expenses over 7.5% of AGI for income tax; there is no deduction for FICA tax purposes (but such individuals are not taxed on the value of any free or discounted care they might receive, unless a debt is created and later forgiven, in which case the individual might have forgiveness-of-indebtedness income).²⁹

Similar but smaller differences exist between employees of employers that provide different levels of ESI, or ESI that does not include all available tax-preferred vehicles, such as cafeteria plans, FSAs, HRAs and HSAs, and between collectively bargained employees and non-collectively bargained employees.³⁰

These differences raise obvious horizontal equity issues. Some of the differences might be justified based on ease of administration. For example, if the 7.5% floor on deductible medical expenses were eliminated, the Service might not be able to review more than a small percentage of the deductions that individuals would take to be sure such deductions represent real medical expenses, whereas if the same expenses were reimbursed through an employer health plan or insurance policy most of them would be reviewed by the plan administrator or

²⁹ For examples of how families with different incomes are affected by these different rules, see Kaiser Family Foundation, Tax Subsidies for Health Insurance: An Issue Brief (July 2008).

³⁰ See, e.g., Congressional Budget Office ("CBO"), Key Issues in Analyzing Major Health Insurance Proposals, at 7 (Dec. 2008) (discussing difference in levels of ESI coverage provided by larger and smaller employers).

insurance company.³¹ However, other differences are harder to justify on equity or administrative grounds.

These differences also raise vertical equity issues, because higher-income individuals are more likely to be employed, and employed by companies that offer group health plans, and even some Medicare recipients might be better-off than younger citizens without health insurance. However, these might more properly be considered social issues than tax equity issues. Also, as noted above, higher-income Medicare recipients are now required to pay higher Part B premiums.

Another difference that often is cited as an equity concern is the higher dollar value that deductions and exclusions for health care and health insurance have for higher-income individuals.³² However, it is not clear that this is an equity concern at all. The difference exists for all kinds of deductions and exclusions under a progressive tax system, so the real question is whether it is equitable to take the cost of health care and health insurance into account in determining an individual's ability to pay tax. Many believe cost should be taken into account, because those expenses more closely resemble a loss of income (similar to a casualty loss) than a type of personal consumption.³³ Unlike personal consumption, those expenses are typically hard to control. They can also have a significant effect on an individual's financial situation.³⁴ Thus, an individual earning \$150,000 but with \$50,000 of health care expenses because of a sick child or a chronic illness arguably is more like an individual earning \$100,000 with no health care expenses than an individual with \$150,000 with no health care expenses. In this view, it is entirely equitable to exclude the expenses from income in full even if, because of progressive tax rates, this results in larger tax "benefits" to higher-income individuals.³⁵

³¹ See, e.g., William J. Turner, Personal Tax Deductions and Tax Reform: The High Road and the Low Road, 31 Vill. L. Rev. 1703, 1719 (1986).

³² E.g., John Sheils & Randall Haight, The Cost of Tax-Exempt Health Benefits in 2004, Health Affairs web exclusive (Feb. 25, 2004) ("it is important to ask whether it is appropriate that 26.7[%] of federal health benefits tax expenditures goes to the 14[%] of the population with the highest incomes.").

³³ See, e.g., Louis Kaplow, The Income Tax as Insurance: The Casualty Loss and Medical Expense Deductions and the Exclusion of the Medical Insurance Premiums, 79 Cal. L. Rev. 1485, 1486 (Dec. 1991) (describing argument).

³⁴ See, e.g., Malcolm Gladwell, The Moral-Hazard Myth, New Yorker, Aug. 29, 2005, at 44 (quoting health economist Uwe Reinhardt as asking "People who are very well insured, who are very rich, do you see them check into the hospital because it's free? Do people really like to go to the doctor? Do they check into the hospital instead of playing golf?").

³⁵ See, e.g., Policy Issues Regarding the Repeal Debate, *supra* (noting that the difference in benefits "might not be an inequitable subsidy but only a consequence of the proper treatment of losses under a progressive income tax. In a progressive tax system, when gains are taxed at higher and higher rates depending on income, then it is conceptually appropriate to deduct losses at those same rates. . . . The root issue is whether health care is like other forms of personal consumption. On reflection, many people might conclude that it is not. Health care takes time, provides no personal pleasure, and, most important, usually is designed to return patients to a condition prior to an accident or illness that no one would choose to have had.").

The deductions and exclusions available under current law might raise a different but related equity issue to the extent, described more fully below, they encourage health insurance (and reimbursement accounts subject to rules designed to make them function like insurance) over direct payments for health care, and group health insurance over individual health insurance. Insurance benefits individuals with above-average health care expenses and all individuals to the extent they have health care expenses that are difficult to predict or control, because insurance spreads risk and limits the cost of health care to premiums, co-pays and deductibles. Employer-sponsored group health plans and other group health plans can spread risk even more effectively than individual health insurance because healthier individuals have less flexibility to opt out and less-healthy individuals have less flexibility to opt in (adverse selection). Also, unlike individuals who purchase individual policies, participants in group health plans cannot lose coverage or be charged higher premiums because of a health condition and are protected from other forms of discrimination to a much greater extent than those with individual policies. Finally, group health plans typically have lower average costs because of economies of scale, employer bargaining power, and the absence of any need to spend money on individual underwriting. Arguably, therefore, promoting health insurance in general, and group health plans in particular, is very equitable, especially for less-healthy individuals and individuals with large unexpected health care expenses. However, some have expressed concern that, by spreading health risks, insurance and particularly group health insurance creates “moral hazard” and actually is unfair to individuals who do a better job managing their health and controlling their health care expenses. Proponents of HSAs and HDHPs believe that those plans largely avoid this problem by requiring individuals to pay more of their health care expenses from their own funds, although critics of HSAs and HDHPs have expressed concern that the arrangements mainly benefit healthier and better-off individuals.³⁶ By selecting HDHPs, those people leave the conventional insurance market with a less robust risk pool, thereby forcing insurance companies to raise premiums for non-HDHP plans.”)

³⁶ Cf. CBO, Budget Options, Volume I: Health Care, at 31 (Dec. 2008) (“HDHPs are attractive primarily to relatively healthy people.”)

b. Rules affecting providers. The tax exemption for non-profit hospitals and clinics might indirectly raise a related equity issue to the extent it encourages those institutions to provide free or discounted health care to poor and uninsured individuals, because, as noted above, the cost of such care probably ends up being shared by other health care purchasers and U.S. taxpayers.

c. Rules affecting employers. The tax rules affecting employers raise different equity issues. For example, the amount of excise taxes imposed on plans for violating HIPAA, GINA and other statutes described above bears no direct relationship to the harm done to the individuals involved, although this might be justified on the basis that the provisions are deliberately designed to be punitive rather than equitable. The COBRA rules raise a similar issue. In addition, limiting the amount that an employer can charge for COBRA coverage to 102% of the cost of coverage has been criticized as unfair to employers and other participants, because the individuals most likely to elect COBRA coverage are those who are already ill and anticipate significant health costs.

2. Equity Issues Raised by Repealing Existing Rules

a. Rules affecting individuals. Merely eliminating all of the current-law deductions and exclusions in order to “level the playing field” among employees, non-employees and self-employed individuals might not actually be very equitable because health care expenses are hard for individuals to control and they derive little pleasure from consuming health care. Individuals with more health care needs, who live in high-cost areas, or who are employed by employers that cannot negotiate good rates on health insurance, could be forced to spend a significantly higher percentage of their incomes on health care but would pay the same amount of tax as individuals with much lower health care expenses but the same gross incomes. Stated differently, eliminating the deductions and exclusions would treat individuals with the same level of health care and type of health insurance disparately depending on how expensive it was for them to purchase.³⁷

In the case of employer-sponsored group health plans, the differences among individuals could be controlled to some extent by valuing health coverage based solely on the terms of the coverage without taking into account market factors. However, it would require considerable effort to develop valuation rules to accomplish that. Also, such an approach would not solve the valuation problem posed by individuals who choose more expensive health coverage because they have particular health conditions or have families, or whose employers provide more

³⁷ See, e.g., Reconsideration of Tax Expenditure Analysis, *supra*, at 52 (“the deduction for medical expenses in excess of 7.5[%] of adjusted gross income may reflect a determination that two taxpayers with the same gross income are not similarly situated if one has high medical expenses and the other does not”); see generally Policy Issues Regarding the Repeal Debate, *supra* (extensive discussion of this issue); Key Issues in Analyzing Major Health Insurance Proposals, *supra*, at 24-26 (discussion of individual and geographic variations in health care expenditures); CBO, Geographic Variation in Health Care Spending (Feb. 2008).

expensive coverage because one or more of their employees have those needs. Finally, such leveling itself could be considered inequitable.³⁸

These concerns would be magnified to the extent that eliminating the current-law deductions and exclusions discouraged employers from providing health coverage and self-employed persons from purchasing insurance. That is because, as noted above, by spreading risks, employer-sponsored health plans and other forms of insurance benefit individuals with higher health care expenses more than individuals with lower health care expenses.

b. Rules affecting providers and employers. Repealing some of the special tax rules affecting providers and employers could be inequitable in other ways. For example, repealing the special rules for collectively bargained VBAs and other welfare benefit funds could be inequitable to employees and employers who contributed large amounts to such funds in reliance on current law and cannot withdraw the contributions now. Applying changes like that on a prospective basis might be the only equitable option.

3. Equity Issues Raised by Other Reform Proposals

a. Rules affecting individuals. Some reform proposals would level the playing field among employees, non-employees and self-employed individuals by extending the special rules that apply to ESI to other kinds of group and individual health insurance. For example, some proposals would extend the employment tax exemption enjoyed by employer-sponsored group health plans to health insurance purchased by self-employed individuals. Others would level the playing field by replacing the current-law deductions and exclusions with a uniform above-the-line deduction. However, even though such proposals would not completely eliminate the current-law deductions and exclusions, by reducing the relative value of the ESI exclusion and the self-employed health insurance deduction, the proposals, if adopted, could end up reducing the incentive for employers to provide group health plan coverage and for self-employed individuals to purchase insurance, with much the same potential adverse consequences for individuals with above-average health care expenses as simply eliminating the current-law deductions and exclusions.

Some reform proposals would address the concern about the higher dollar value that deductions and exclusions for health care and health insurance have for higher-income individuals and individuals whose employers provide more expensive coverage by capping the deductions and exclusions in some way. For example, some proposals would impose dollar caps on the deductions and exclusions themselves or replace them with uniform subsidies or credits. Even if one believes that health care expenses are hard for individuals to control and they derive little pleasure from consuming health care, caps could be equitable if individuals have more control over higher levels of expense, e.g., over whether to buy a basic health policy with a

³⁸ See, e.g., *Policy Issues Regarding the Repeal Debate*, *supra* (“The value of insurance to a young, healthy worker is likely far less than the value to an older worker in poor health, or who perhaps has a family member in poor health. It would seem unfair to require both workers to recognize the same additional amount in the income on which they must pay taxes. Age-based variations might seem more equitable, but the opposite might be true if the younger worker had poor health and the older worker were in good health.”).

limited network or a more expensive one with more choice of doctors, or whether to take a generic drug or a more expensive new drug with potentially fewer side effects.³⁹ However, if caps are set too low, such an approach could nonetheless be unfair to individuals who spend more than the cap not because they want to but because they have health conditions or live in high-cost jurisdictions. Problems like these could be addressed by adjusting the caps, subsidies or credits by age, geographic locale, etc., though at the cost of further complexity. Also, as above, such changes could adversely affect individuals with higher health care expenses if they reduced the incentive for employers to provide health coverage and for self-employed individuals to purchase insurance.

Some reform proposals would broaden insurance coverage by imposing some form of individual health insurance mandate, possibly administered through the tax system. Such proposals have the potential not only to increase the overall number of individuals covered by insurance but also to increase the amount of risk-pooling and reduce differences in premiums among individuals based on health status, which exist especially in the individual insurance market, by making it harder for healthier individuals to opt out (i.e., limiting adverse selection) and harder for insurance providers to exclude less-healthy individuals.⁴⁰ To the extent an individual mandate would increase risk-pooling, it would make employer-sponsored group health plans and other group health plans somewhat less useful as ways to pool risk. However, they might still be useful for other reasons, such as the greater purchasing power of employers compared to individual employees or the convenience of collecting premiums through an employer's payroll system. To the extent an individual mandate would reduce differences in premiums among individuals based on health status, it also would make the ESI exclusion and the self-employed health insurance deduction less important as ways to limit disparities in tax treatment among individuals with different health needs. On the other hand, depending on the design of the plans that would be mandated, an individual mandate might exacerbate the "moral hazard" problem and encourage over-consumption of health care. It might also impose significant financial burdens on lower-income individuals, which is why many mandate proposals are paired with subsidies or tax credits for lower-income individuals. Depending on how those subsidies and credits are designed, they might raise equity issues of their own. For example, providing subsidies only to individuals who do not have employer-provided health care coverage could be unfair to lower-income employees, since economists believe the cost of such coverage is taken indirectly from an employee's cash wages.

b. Rules affecting employers. Some health reform tax proposals would encourage employers to provide employee health coverage not through the operation of the ESI exclusion but by imposing some form of mandate on employers (at least larger ones) or by providing tax incentives to employers (at least smaller ones). Drawing a distinction between larger and smaller employers raises horizontal equity issues, but could be explained, for example, by the greater

³⁹ See, e.g., Tax Caps on Employment-Based Health Insurance, *supra*, at 532.

⁴⁰ For an individual mandate to work, coverage must be widely and reliably available. There are two ways to accomplish this: either the mandate can be paired with a requirement that insurance carriers provide access to coverage on a guaranteed issue basis and with guaranteed renewability, or the federal government or a state can become the insurer of last resort by establishing or harnessing existing free-care pools that are required to make coverage available.

difficulty that smaller employers have, at least in the current market, in obtaining insurance and their higher per capita administrative costs. Such approaches could raise other equity issues depending on the design of the mandates and subsidies. For example, imposing penalties on employers that do not provide health coverage that are less than the cost of providing health coverage shifts the cost of the health care from those employers to public plans or elsewhere in the health care system. Also, providing subsidies only to employers that do not already provide employee health coverage might be perceived to be unfair to employers that do provide employee health coverage.

Although a VAT would be collected by businesses, using one to finance employee subsidies or coverage under public plans would raise vertical equity issues mostly for individuals, since VATs generally are considered either neutral or regressive, similar to sales taxes. VATs can be made less regressive by imposing lower rates on products and services that consume higher percentages of lower-income individuals' budgets, such as food and clothing, but at the cost of greater complexity.

C. Efficiency

Another broadly accepted goal of an ideal tax system is efficiency. Efficiency means the tax system does not create incentives to do things or not do things that would otherwise not occur, except to counteract a harmful incentive or supply a helpful incentive that would otherwise be missing.⁴¹

One way to further efficiency would be to tax individuals and businesses only on their net incomes, i.e., their income minus any expenses incurred to generate that income, because typically that is what they are able to consume and that is what they would seek to maximize in the absence of a tax system. For example, in the absence of a tax system a business would hire a new employee if the additional revenue the business would earn from employing him exceeds his wages. If the business is subject to tax but is not allowed to deduct all of the wages from its taxable income, the additional revenue will be worth less while the cost will remain the same, creating a disincentive to hire the employee.

This analysis probably has limited relevance to tax treatment of health care. No doubt, good health allows an individual to do his job better and be absent from work less often, resulting in additional income that is subject to tax. This might be a significant reason why employers sponsor health plans for employees in the first place.⁴² This might also be the main reason why many employers provide access to flu shots each fall, and why a growing number of employers provide on-site medical clinics.⁴³ To the extent health care expenses contribute to

⁴¹ See, e.g., Reconsideration of Tax Expenditure Analysis, *supra*, at 53; Guiding Principles of Good Tax Policy, *supra*, at 13.

⁴² See Policy Issues Regarding the Repeal Debate, *supra* (“[E]mployers have an economic interest in healthy workers and, to some extent, workers’ healthy families.”); Policy Issues Regarding the Repeal Debate, *supra* (“[E]mployers have an economic interest in healthy workers and, to some extent, workers’ healthy families.”).

⁴³ See, e.g., Patricia Curran & Candace Shelton, Worksite Wellness Programs: Just What the Doctor—and Senior Management, Employees, and Shareholders—Ordered (Buck Consultants, 2008);

good health, this might mean that deductions and exclusions for health care can be justified on the same basis as deductions and exclusions for other job-related expenses, such as training that improves skills needed in an individual's job. However, it would be difficult to separate the cost of health care that merely improves an individual's work performance, to which this analysis would apply, from the cost of health care that improves the individual's overall health, to which it would not.

1. Efficiency Issues Raised by Existing Rules

a. Rules affecting individuals. Existing tax laws clearly favor employer-provided health insurance over health insurance purchased by self-employed persons or by individuals. These laws tend to encourage individuals to work as employees for employers that offer health coverage in lieu of additional cash wages rather than work as independent contractors. There is no obvious economic reason to encourage one form of work relationship (employment) over another (self-employment). Also, the fact that Medicare is subsidized and the subsidized element is not subject to tax might encourage Medicare-eligible individuals to retire. There is no obvious economic reason to encourage this, either.

Some economists also believe that the deductions and exclusions for health care and health insurance increase the demand for health care and drive up the cost of health care for everyone. First, they argue that the itemized deduction for medical expenses in section 213 (directly), and the ESI exclusion and the self-employed health insurance deduction in section 162(l) (indirectly) make health care cheaper than it otherwise would be. Second, they argue (i) that the relatively more valuable ESI exclusion and self-employed health insurance deduction encourage health insurance (and FSAs, HRAs and HSAs, which are treated like insurance) over direct payments for health care, and the ESI exclusion encourages group health plans over individual health insurance, and (ii) that, by spreading risks and costs to others, insurance—and particularly group insurance—makes individuals less conscientious about managing their own health and their health care expenses. Third, they argue that the ESI exclusion and self-employed health insurance deduction not only encourage health insurance but lead individuals to buy health insurance with lower co-pays and deductibles, which exacerbates the problem in the preceding sentence because smaller expenses are exactly the ones individuals have the most control over and should be encouraged to reduce.⁴⁴

Obama for America, Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All (Oct. 23, 2008) ("To address employee health, an increasing number of employers are offering worksite health promotion programs, onsite clinical preventive services such as flu vaccinations, nutritious foods in cafeterias and vending machines, and exercise facilities. Equally important, many employers choose insurance plans that cover preventive services for their employees.").

⁴⁴ See, e.g., Mark Pauly, Overinsurance and Public Provision of Insurance: The Role of Moral Hazard and Adverse Selection, 88 Quarterly J. Econ. 44 (1974); Jason Furman, Health Reform Through Tax Reform: A Primer 27 Health Affairs 622 (2008) ("The design of the current tax incentive magnifies this effect because the combination of the employer exclusion with the general lack of a tax deduction for out-of-pocket expenses leads to insurance plans with lower copayments and deductibles and thus higher spending."); Organization for Economic Cooperation & Development, Economic Survey of the United States 2008: Health Care Reform (Dec. 9, 2008) (ending the ESI exclusion "would mitigate

In addition, reimbursement accounts have no co-pays or deductibles and are often used to pay the co-pays and deductibles under the employer-sponsored health plan. Some argue that the use-it-or-lose-it rule discourages employees from contributing very much to health FSAs, limiting the level of concern for that type of account. Critics of FSAs argue that the use-it-or-lose-it rule makes matters worse, by encouraging employees to spend whatever remains at the end of the year on health care whether they need it or not. They favor allowing unused balances to be carried forward from year to year as they are in HRAs and HSAs.⁴⁵

There is little doubt that the existing deductions and exclusions incrementally reduce the effective cost of health insurance and health care, and therefore incrementally increase the demand for them, compared to what they might be without those provisions, and that this raises efficiency issues. However, the size of the effects is unclear.

First, there are few data on how strongly cost affects the demand for employer-provided health coverage, i.e., the elasticity of demand for such coverage. There is evidence the initial adoption of the exclusion accelerated the spread of employer health plans,⁴⁶ but otherwise the evidence is limited and does not consistently suggest a very high elasticity of demand.⁴⁷

Second, even if demand for employer-provided health coverage is relatively elastic, medical inflation has been so consistently high that the net price reductions that result from the deductions and exclusions under current law would, in any given year, at best reduce the price of health care and health coverage back to where they were several years earlier. Recently, premiums for job-based family coverage have increased at 6-8% annually.⁴⁸ It has been estimated that the price discounts that result from the ESI exclusion at about 8%, or about 1 year's worth of inflation for a low-income family, and 32%, or about 4-5 years' worth of inflation for a high-income family.⁴⁹ Medical inflation has encouraged many employers to drop

moral hazard problems by reducing incentives to buy policies with little cost sharing"); cf. Key Issues in Analyzing Major Health Insurance Proposals, *supra*, at 17 ("Cost-sharing requirements tend to be higher in the individual insurance market, reflecting not only insurers' efforts to control the health care spending of their enrollees but also enrollees' desire for lower premiums (because those policies are generally not subsidized through the tax code).").

⁴⁵ See Tax Benefits for Health Insurance and Expenses.

⁴⁶ See How Tax Policy Shaped U.S. Health Insurance, *supra*.

⁴⁷ , see, e.g., Jonathan Gruber & Michael Lettau, How Elastic Is the Firm's Demand for Insurance?, 88 J. Pub. Econ. 1273 (2004); Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz & M. Susan Marquis, Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment, 77 Am. Econ. Rev. 251 (1987) (RAND study) ("The literature exhibits substantial disagreement, by a factor of 10 or more, about the price elasticity, or coinsurance elasticity, of demand."); see also Policy Issues Regarding the Repeal Debate, *supra*.

⁴⁸ See, e.g., Max Baucus, Call to Action: Health Reform 2009, at 3 (Nov. 12, 2008).

⁴⁹ Health Reform Through Tax Reform, *supra*, at 624.

their plans, and many other employers to shift more of the cost to employees and adopt less generous plans.⁵⁰

Critics suggest that the ESI exclusion might be particularly likely to encourage purchase of insurance because, as an exclusion, amounts paid for by the employer do not show up on the individual's Form W-2, meaning the individual does not know how much in cash wages she is giving up.⁵¹ However, one might question why employees would demand health insurance in the first place if they did not know at least its approximate value. Employees increasingly know the exact value of their health insurance even though it is not listed on their Form W-2s because many employers communicate to their employees the percentages of the cost of health plan by the employer and paid by the employee. The employee's percentage is converted to a specified amount of cash wages that is deducted from their pay through the mechanism of the cafeteria plan.

Thus, the available evidence does not seem to suggest that the existing deductions and exclusions are the only or even the main drivers of medical inflation.⁵²

b. Rules affecting employers. Other tax laws raise different efficiency issues. For example, the unfavorable treatment of VEBA and other welfare benefit funds, except in the collective bargaining context, might discourage employers from pre-funding their retiree health expenses and encourage employers to drop their retiree health plans or not provide them in the first place, to a greater extent than in the absence of a tax system. Also, the fact that the amount of excise taxes imposed on plans for violating COBRA, HIPAA, GINA and other statutes described above bears no direct relationship to the harm done to the individuals involved might encourage employers to spend as much money complying with arguably less important technical laws as they do complying with very important laws. Assuming employers' compliance budgets are limited, this can result in compliance gaps in the wrong areas. The very large difference between the cost of noncompliance with the qualification rules for cafeteria plans and reimbursement accounts (such as the family status change restrictions that apply to FSAs), and the harm that results from noncompliance raise can cause similar waste of compliance dollars.

2. Efficiency Issues Raised by Repealing Existing Rules

a. Rules affecting individuals. Even if the deductions and exclusions for health care and health insurance in current law create incentives, those incentives might—deliberately or not—

⁵⁰ See, e.g., William M. Mercer, US National Survey of Employer-Sponsored Health Plans (2008); but see The Cost of Tax-Exempt Health Benefits in 2004, *supra* (“despite the recent trend for employers to shift costs to workers, these tax preferences are widely believed to have encouraged employers to provide more comprehensive coverage than they otherwise would have done, resulting in higher levels of health spending”).

⁵¹ See Budget Options, *supra*, at 25 (reporting value of employer-provided health coverage on Form W-2 “would increase workers’ awareness of the total costs of health insurance, possibly encouraging workers to purchase less costly coverage”).

⁵² See, e.g., Key Issues in Analyzing Major Health Insurance Proposals, *supra*, at 18-23 for a discussion of some other possible drivers of medical inflation.

serve important social purposes. For example, the ESI exclusion might encourage employers to continue sponsoring group health plans. Employer-provided health coverage is not perfect, but it does have a number of advantages over most individual insurance policies available today. As noted above, these include (i) more opportunity for risk-pooling, because of less adverse selection and restrictions on loss of coverage and different forms of discrimination, (ii) typically lower costs generally, due to economies of scale, employer bargaining power, and the fact that employer-sponsored health plans have less need to spend money on underwriting, and (iii) providing a way to address the problem of the uninsured without having to resort to government mandates or government insurance programs, because an employer-sponsored health plan typically covers most full-time employees and their families (and under COBRA is required to offer coverage even to former employees and their families for limited periods of time).

Some critics argue that these advantages are so great that an employer-sponsored health plan “can and should stand on its own without special tax assistance.”⁵³ However, others argue that tax subsidies are still very important at the margin. For example, there is evidence that they help close the gap between what healthier workers pay (in premiums or foregone wages) for health insurance and what they expect to receive in health claims.⁵⁴ If such a gap existed, healthier workers would prefer to drop coverage, increasing costs for the remaining participants and thereby encouraging even more workers to drop coverage, in what is sometimes referred to as a “death spiral.” In fact, some experts who analyzed Senator McCain’s health reform proposal during the recent presidential campaign concluded that his proposed elimination of the exclusion would cause millions of workers to lose their employer-based coverage.⁵⁵ Once the employer ceases to provide group health plan coverage, the less-healthy employees would have difficulty obtaining individual coverage unless laws were changed to require insurers to offer community-rated policies.

Likewise, even if current law encourages plans with low co-pays and deductibles, and thus encourages consumption of health care, that might not be all bad. Some argue that low co-pays and deductibles help overcome individuals’ reluctance to go to the doctor for routine preventive care and save money in the long run.⁵⁶ One of the most frequently cited studies of

⁵³ Hearing Before the Subcommittee on Health of the House Committee on Ways and Means, 110th Cong., 2nd Sess. (Sept. 23, 2008) (statement of Roger Feldman, Ph.D.); cf. Policy Issues Regarding the Repeal Debate, *supra* (“There is little doubt [that employers provide group health plans] partly because of tax advantages from the Section 106(a) exclusion. . . . However, it is likely that employers provide health insurance for other reasons as well.”).

⁵⁴ E.g., Thomas M. Selden & Bradley M. Gray, Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006, 25 *Health Affairs* 1568 (Nov. 2006).

⁵⁵ E.g., The Lewin Group, McCain and Obama Health Care Policies: Cost and Coverage Compared (Oct. 8, 2008; rev. Oct. 15, 2008); cf. Leonard E. Burman & Roberton Williams, Tax Caps on Employment-Based Health Insurance, *National Tax Journal* (Sept. 1994) (The ESI exclusion has “two contradictory effects. The positive effect is that it encourages people to be insured. . . . The negative effect is that employees are much less sensitive to the price of health insurance than they would be if they had to pay full cost.”).

⁵⁶ See, e.g., The Moral-Hazard Myth, *supra*, at 44.

this issue concludes that individuals do cut back on health care when faced with higher co-pays and deductibles, but they cut back both on potentially useful preventive care as well as unnecessary care.⁵⁷

Finally, even if current law reduces the effective cost of health care for self-employed individuals and individuals with ESI, that might only offset other distortions in the market, in particular the way the cost of indigent care and some of the costs of Medicare and Medicaid are shifted to the private insurance market.⁵⁸

b. Rules affecting employers. Repealing some of the special tax rules affecting providers and employers could raise other efficiency issues. Most obviously, repealing COBRA, HIPAA, GINA or other statutes would leave employees without protections that Congress believed were necessary when these statutes were enacted.

3. Efficiency Issues Raised by Other Reform Proposals

a. Rules affecting individuals. The efficiency issues raised by two other reform proposals discussed above in the context of the goals in an ideal tax system of horizontal and vertical equity, i.e., (i) imposing dollar caps on deductions and exclusions and (ii) mandating health insurance for all, are whether such proposals adequately address over-consumption of health care and whether they better target the existing tax preferences for health care and health insurance. For example, capping the ESI exclusion would target the exclusion at basic coverage, being more efficient than the current exclusion if the cap would result in an increased demand for health insurance. However, if a cap also had the effect of increasing the demand for policies with low co-pays and deductibles, then over-consumption would tend to be encouraged. On the other hand, without low co-pays and deductibles, individuals might not seek preventive care, thereby increasing the overall cost of health care in the long run.

Mandating individual health insurance, possibly administered through the tax system, has the potential to be more efficient than current law. However, much depends on the design of the mandate and how it is enforced. For example, a mandate that is limited to employees could discourage individuals from working as employees (the opposite of the incentive created by current law). A mandate that exempts lower-income individuals and provides no subsidies or only small subsidies to that group might not be much more effective than current law at

⁵⁷ See Health Insurance and the Demand for Medical Care, *supra*; Ezekiel Emanuel, Health Care, Guaranteed, at 125 (2008) (discussing study and noting that “[w]hen we are responsible for our own healthcare costs, most of us are likely to cut back on preventive screening and interventions, such as mammograms and vaccines”); *cf.* Policy Issues Regarding the Repeal Debate, *supra* (“Whether moving to higher insurance cost sharing would reduce health care spending is not at issue; notwithstanding measurement difficulties, economic theory, actuarial experience, and empirical studies all indicate that it does. . . . More debatable is what effect reductions in spending have on individuals’ health . . .”).

⁵⁸ See, e.g., Will Fox & John Pickering, Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers (Milliman, Dec. 2008) (underpayments by Medicare and Medicaid shift \$88 billion to commercial insurance, including ESI).

increasing insurance coverage. Such a structure might also create incentives for individuals to understate their income in order to avoid the mandate or to become eligible for the subsidy.⁵⁹

Other proposals would replace the deductions and exclusions with uniform subsidies or refundable tax credits, even for those individuals who do not pay taxes. Such proposals might be more efficient if all individuals respond to incentives in about the same way.⁶⁰ However, as long as the cost of health insurance and health care vary considerably by geographic area, size of employer, age, health status and other factors—as it does now—same-dollar subsidies will, effectively, deliver different subsidies to similarly situated individuals, leaving at least some individuals with too little cash or incentive to participate in employer-sponsored group health plans. Also, by eliminating any preference for such plans, such changes could discourage employers from providing group health plans and healthier employees from remaining in those plans, with the same potential adverse consequences as simply eliminating the current-law deductions and exclusions.

Other proposals would change the tax treatment of reimbursement accounts, e.g., by expanding or limiting the availability of HSAs or changing the tax treatment of health FSAs. Eliminating HSAs or health FSAs could target the ESI exclusion away from plans that provide first-dollar coverage, which might be more efficient if first-dollar coverage encourages over-consumption. On the other hand, it could simply encourage individuals to purchase regular health insurance with lower co-pays and deductibles.

b. Rules affecting employers. As discussed, some healthcare reform tax proposals would encourage employers to provide group health plan coverage not through the ESI exclusion but by imposing some form of mandate on employers (at least larger ones), or by providing tax incentives to employers (at least smaller ones). Drawing a distinction between larger and smaller employers raises efficiency concerns because it favors one form of business organization over another in a way that would not otherwise exist. Also, imposing penalties on employers that do not provide group health plan coverage that are disproportionate to the costs of noncompliance could induce such employers to provide such coverage even though it would be more efficient to allow the employees to be put in a public plan.

Whether a VAT would be more efficient than the existing income tax system at collecting the funds needed to finance the proposed employee subsidies or coverage under public plans is not clear, although some believe that VATs are inherently more efficient because they are more like consumption taxes and interfere less with savings and investment decisions.

⁵⁹ See, e.g., Janet Holtzblatt, The Challenges of Implementing Health Reform through the Tax System, in Using Taxes to Reform Health Insurance: Pitfalls and Promises, at 171, 186 (Henry Aaron & Leonard Burman, eds., Brookings Institution 2008).

⁶⁰ See, e.g., Lily L. Batchelder, Fred T. Goldberg, Jr. & Peter R. Orszag, Efficiency And Tax Incentives: The Case For Refundable Tax Credits, 59 Stan. L. Rev. 23 (Oct. 2006) (arguing that, instead of “providing a larger incentive to higher-income households,” incentives like the ESI exclusion should be provided as flat amounts “unless policymakers have specific knowledge that such households are more responsive to the incentive or that their engaging in the behavior generates larger social benefits.”).

D. Administrative Issues

1. Costs

Another broadly accepted goal of an ideal tax system is low cost for the government and the affected taxpayers.⁶¹ Complexity often increases costs, although that is not the only driver. The tax treatment of health care and health insurance under current law is certainly complex—providing, for example, different but substantially similar tax benefits for ESI and health insurance purchased by self-employed individuals, a number of overlapping coverage and non-discrimination requirements for cafeteria plans, VEBA's and group health plans, and detailed requirements designed to make FSAs function more like commercial insurance. Many reform proposals have the potential to increase the complexity of current law—for example, by requiring ESI to be valued and taxed to employees or imposing means testing on any tax benefits.⁶² We believe it is important for policy-makers to weigh this potential cost against the potential gains when deciding among different reform proposals, and, even if the potential gains are significant, to consider whether there are simpler ways to achieve similar results. The Sections believe that complexity is at the root of many significant obstacles to the efficient and effective administration of the tax laws and that a goal of any health care reform should be to reduce, not increase, the complexity of the tax treatment of health care and health insurance.

2. Use of the Internal Revenue Service Rather than Other Agencies

A major reason for the development of the tax expenditure budget was to identify benefits being delivered to various taxpayers by the Service that could possibly be delivered more quickly or otherwise better by another government agency. Some healthcare reform proposals, such as any changes to the ESI exclusion, clearly would have to be administered by the Service. Many other healthcare reform proposals probably could be administered by the Service, but it is not obvious whether it would be the best agency for the job. On the plus side, the Service is a large agency that already interacts with a large percentage of U.S. citizens and residents; has information on the sizes of businesses and on individuals' incomes that might be relevant in determining how subsidies, credits, mandates and the like should apply to them; and has systems in place (and is subject to legal requirements even stricter than HIPAA) to keep that information confidential. It already has experience administering some subsidies and refundable tax credits, including the Earned Income Tax Credit and the HTHC, and some health insurance mandates, specifically COBRA, and providing the information needed to determine income-based Medicare Part B premiums. On the minus side, the Service does not regularly interact with the individuals most likely to need subsidies and credits, namely taxpayers with very low incomes, and interacts with other individuals mostly on an annual rather than an ongoing basis, the income information it has is usually at least one year old and might not even be the best information on which to base eligibility for special benefits, and it currently gathers no information on what health coverage individuals have. Furthermore, distributing benefits and

⁶¹ E.g., Guiding Principles of Good Tax Policy, *supra*, at 12.

⁶² See, e.g., Budget Options, *supra*, at 26 & 28 (noting complexities introduced by some health reform tax proposals).

enforcing mandates through the Code could impact voluntary compliance in other areas.⁶³ The Sections believe it is important for policy-makers to take these administrative considerations into account in deciding how deeply, if at all, the Service should be involved in any aspect of health reform. Furthermore we believe the presumption generally should be against carrying out non-tax goals, including healthcare reform, through the tax system, because simply balancing the short-term advantages of doing that against the disadvantages inevitably leads to a federal tax system that is, in total, overly complex.

3. *Transparency*

Most would agree that the process by which legislation is adopted should be as transparent as possible, and provide voters with an opportunity to understand and comment on the legislation. One common criticism of tax expenditures is that, while they have somewhat the same effect as direct spending by the government, they are harder to measure, police and monitor than direct spending programs and tend to become permanent rather than being re-evaluated on a regular basis. Although less frequently mentioned, the same thing presumably is true of tax penalties that have the same effect as direct mandates.⁶⁴ We believe this is a potential concern with any health care subsidy, credit, mandate or the like that is provided or imposed through the Code. However, tax expenditures and penalties are not necessarily any worse on this score than direct spending or mandates. For example, in our experience the costs that various employment-related mandates impose on employers, and indirectly on employees in the form of lower wages, typically is not well understood and such mandates are rarely designed to sunset. Therefore, while we believe it is important to keep this consideration in mind, we believe it is appropriate to apply it to all kinds of health reform proposals, not just those that might be added to the Code.

V. CONCLUSION

While the current tax treatment of health care and health insurance raise equity, efficiency, cost and other tax policy issues, so too do many of the leading health reform tax proposals. Before adopting any of those proposals, the Sections believe it will be important for policy makers to carefully consider whether they will improve the current tax system or, if not, are justified by other overriding policy considerations.

⁶³ See, e.g., Call to Action: Health Reform 2009, *supra*, at 15-16; The Challenges of Implementing Health Reform through the Tax System, *supra*; Key Issues in Analyzing Major Health Insurance Proposals, Chapter 6 (discussing these and other administrative issues).

⁶⁴ See, e.g., Reconsideration of Tax Expenditure Analysis, *supra*, at 62 note 146.