HEALING HEALTHCARE THROUGH TAX REFORM

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> "The health of the people is really the foundation upon which all their happiness and all their power as a state depend."
>
> —Former Prime Minister Benjamin Disraeli[1]

ABSTRACT

An economic crisis, sky-rocketing healthcare costs, and millions of Americans without health insurance combine to bring to the public square not only the possibility of a meaningful debate but the political perfect storm that might unearth entrenched partisans and bring about meaningful healthcare reform. The current taxation of expenditures for healthcare is a complex, unjust, uneconomical, and inefficient system. This article seeks to refute revisionist historians who might argue that healthcare in the workplace had no meaningful presence until World War II and to highlight the reasons for the development of employer-provided healthcare; to explain the fundamental inequities wrought by the current tax subsidies granted health benefits; to suggest reasons for reform; and to provide a framework for evaluating reform proposals.

INTRODUCTION

Any meaningful discussion about healthcare reform in the United States must include tax reform. The tax treatment of expenditures for healthcare reflects a deliberate social choice

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1. Disraeli, Benjamin, British Prime Minister and First Earl of Beaconsfield, Some Results of Sanitary Reform, Address Given at the Opening of New Blocks of Improved Tenements (June 24, 1877), *reprinted in Some Results of Sanitary Reform*, *in* THE HOUSING OF THE WORKING PEOPLE 71 (E.R. L. Gould ed., 1895).

to incent certain risk-sharing arrangements. The instant question is whether subsidies remain critical for achieving the goal of social security, and if so, whether the current structure fairly achieves that goal. Whether the federal tax laws *should* provide incentives to advance healthcare goals of society is beyond the scope of this article. Instead, this author seeks to highlight why the tax system was employed, why it is not working effectively now to promote social security and, relying on lessons from those past experiences, to suggest here a framework against which proposals can be evaluated to meet social policy goals.

In Part I, a history of the development of healthcare benefits is reviewed. That review reveals a long-standing American effort, both private and public, to pool the risks associated with sickness and the genesis of tax subsidies to incent those efforts. Part II sets forth the current tax subsidies for health benefits and provides a concrete example to highlight the inequities of the current landscape. Part III outlines reasons for reform. Beginning with the concept of tax expenditure, Part III illuminates the size of the enormous subsidies supporting healthcare and seeks to explain that such subsidies represent economic spending. Next, fundamental questions of fairness are addressed, illuminating the inequities in the current system. Finally, the economic impacts of current tax policy on healthcare are evaluated. That analysis reveals inherent inefficiencies. In Part IV, a framework for evaluating reform proposals is offered, drawing on lessons from historical as well as current social and economic experience.

I. HISTORY

Associating health benefits with the workplace is not a modern American phenomenon. The first government initiative to provide health insurance for workers began in 1798 when federal customs officials collected a per sailor tax to fund medical care for sick merchant sailors when away from home.[2] During the same time period, skilled craftsmen

2. JOHN E. MURRAY, ORIGINS OF AMERICAN HEALTH INSURANCE, A HISTORY OF INDUSTRIAL SICKNESS FUNDS 74 (2007). The revenue from the taxes financed the

united to form "Mutual Assistance Societies" to provide various forms of aid to sick members.[3] Over the next one hundred years, workers continued to unite to insure against the risk of economic loss because of sickness by pooling together.[4] Labor unions created "Sickness Insurance Funds" to provide stable financial assistance as well as medical assistance to sick members.[5] Companies also created "Sickness Funds."[6] Because participation in these funds was voluntary, workers anticipating a future need to draw the benefits would tend to participate; younger workers and those not anticipating a need might opt not to participate.[7] That adverse selection undermined the viability of such voluntary funds since the risk of payment was high given the propensity of those needing coverage to participate.[8] Nevertheless, by the late 19th century, sickness insurance provided through the labor unions or by individual employers provided stable and efficient risk-sharing for many workers at the time.[9]

In the early 20th century, Progressives arguing for a European-style government-run health insurance argued that Sickness Funds were miserly and restricted benefits.[10] A campaign to replace sickness insurance with health insurance was waged in the American political arena.[11] Progressives argued that government provided the only viable option for risk-sharing, pointing to the adverse selection experience of the Sickness Funds.[12] Co-opting the European experience, the Progressives began using the term "health insurance" as a more positive marker for the relationship that

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construction of the first marine hospital in Norfolk, Virginia in 1800. *Id.* Where a port had no marine hospital to care for sick merchant sailors, the Marine Hospital Service, later to become the Public Health Service, arranged for care. *Id.*

3. *Id.* at 73.
4. *Id.* at 74.
5. *Id.* at 6.
6. *Id.*
7. *Id.* at 12.
8. *Id.*
9. *Id.* at 6.
10. *See generally* SAMUEL JOHN DUNCAN-CLARK, THE PROGRESSIVE MOVEMENT: ITS PRINCIPLES AND ITS PROGRAMME (1913) for a contemporaneous perspective on the Progressive Era in America, dating from the late 1800s to the 1920s, that arose to address many of the social ills caused by industrialization.
11. *Id.*
12. *Id.*

had been known as sickness insurance.[13] Those Progressive Reform efforts failed.[14] During the 1920s and 1930s, changing demographics, advances in medical science and shifts from acute care to chronic care models operated to increase the demand for medical care at hospitals instead of at home.[15] The demand for a method to finance healthcare grew as the demand for health services grew.[16] To protect revenues, hospitals began to develop "hospital service plans."[17] These hospital service plans provided hospital care to participants in the plan, usually school systems[18] and large firms, in exchange for a small premium.[19] Prompted by the increasing demand, the American Hospital Association (AHA) created a commission to set standards and to encourage legislation which permitted the plans to organize and operate as not-for-profit, tax-exempt entities.[20] The AHA coordinated a network of plans which became the Blue Cross network.[21]

New Deal policies promoted by President Franklin Roosevelt resulted in the passage of several forms of social insurance.[22] Roosevelt's rhetoric addressed health benefits but no legislation resulted.[23] In a speech to the Conference

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13. *Id.*

14. Despite the failure to secure government-run health insurance, the Progressive Movement experienced many successes. Significantly, the 16th Amendment, ratified in 1913, permitted Congress to levy an income tax without apportioning it among the states and paved the way for the modern income tax, codified in 1926. U.S. CONST. amend. XVI.

15. Melissa Thomassen, *Health Insurance in the United States*, EH.NET ENCYCLOPEDIA, Apr. 17, 2003, http://eh.net/encyclopedia/article/thomasson.insurance.health.us.

16. ROBERT B. HELMS, AM. ENTER. INST. FOR PUB. POL'Y RESEARCH, TAX POLICY AND THE HISTORY OF THE HEALTH INSURANCE INDUSTRY 3–4 (Feb. 29, 2008), http://www.aei.org/docLib/healthconference-helms.pdf.

17. *Id.*

18. *See* TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 56 (2007). The first known hospital service plan was formed by a group of employees at Baylor University who contracted with their local hospital to provide care in exchange for a monthly premium. *Id.*

19. *See* HELMS, *supra* note 16, at 3.

20. LEIYU SHI & DOUGLAS A. SINGH, ESSENTIALS OF THE U.S. HEALTH CARE SYSTEM 63 (2d ed. 2010).

21. *Id.*

22. Most notably the Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620 (1935).

23. President Franklin D. Roosevelt, Address to Advisory Council of the Committee on Economic Security on the Problems of Economic and Social Security

on Economic Security, Roosevelt seemed ambiguous in his references to health insurance:

> There is also the problem of economic loss due to sickness—a very serious matter for many families with and without incomes, and therefore, an unfair burden upon the medical profession. Whether we come to this form of insurance soon or later on, I am confident that we can devise a system which will enhance and not hinder the remarkable progress which has been made and is being made in the practice of the professions of medicine and surgery in the United States.[24]

During World War II, a different motivation fostered increased health insurance from employment. To stabilize the work force and ensure certain production levels, wage and price controls were instituted.[25] The National War Labor Board (NWLB) administered those regulations with respect to wages.[26] In an effort to circumvent those controls and attract scarce workers, employers began offering generous benefits including health insurance.[27] The NWLB excluded certain employee fringe benefits, including health insurance, from the definition of wages.[28] That ruling was consistent with the income tax treatment. The Internal Revenue Service ruled in 1943 that payments made directly to a commercial insurance company for group medical and hospitalization insurance were not income.[29] Because the Ruling applied to a narrow set of facts, uncertainties in the tax consequences of employer-provided benefits stalled expansion in the marketplace. President Eisenhower advocated for the exclusion: "Insurance and other plans adopted by employers to protect their employees against the risks of sickness should be encouraged by removing the present uncertainties in the

(Nov. 14, 1934) *in* 3 THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D. ROOSEVELT 452, 454 (1938).

24. *Id.* at 452.

25. *See* Stabilization Act of 1942, ch. 578, 56 Stat. 765 (1942).

26. HELMS, *supra* note 16, at 6–7.

27. *Id.* at 7.

28. *See generally* 4 BUREAU OF NATIONAL AFFAIRS, WAR LABOR REPORTS, REPORTS AND DECISIONS OF THE NATIONAL WAR LABOR BOARD LXIV (1943).

29. *See Taxation of Employee Accident and Health Plans Before and Under the 1954 Code*, 64 YALE L. J. 222, 241 (1954–1955) (citing Special Ruling, 3 CCH 1943 FED. TAX REP. ¶ 6587 (1943) (ruling that payments for group medical and hospitalization insurance were not taxable income)).

tax law."[30] With the promulgation of the 1954 Internal Revenue Code, the exclusion of employer-provided healthcare benefits from taxation became clear.[31]

II. The Current Landscape

The current tax treatment of expenditures for healthcare is complex, unjust, uneconomical, and inefficient. Those who receive healthcare benefits through their employment, either as an employee or as self-employed, are taxed differently than those who do not receive those benefits at work. That disparate treatment begs fundamental questions of fairness.[32] An explanation of the current statutory scheme will highlight the disparity—but first a review of fundamental tax principles.

A. General Principles

Our system of federal taxation is primarily one of income taxation.[33] Income is broadly defined. In *Commissioner v. Glenshaw Glass*,[34] an early case interpreting the statutory meaning of income,[35] the United States Supreme Court referred to the "sweeping scope"[36] of the statute and determined that "Congress applied no limitations as to the source of taxable receipts."[37] The Court held that "accessions to wealth, clearly realized, and over which the taxpayers have complete dominion"[38] are taxable income unless specifically excluded noting: "[T]he Court has given a liberal construction to this broad phraseology in recognition of the intention of Congress to tax all gains except those specifically

30. Budget Message of the President – Part I, 100 Cong. Rec. 3, 570 (1954).

31. *See* I.R.C. §§ 104–105 (1954). For a general discussion of the political climate and development of the health insurance provisions of the 1954 Code, *see Taxation of Employer Accident and Health Plans Before and Under the 1954 Code*, *supra* note 29.

32. *See infra* Part III.B.

33. *See* 26 U.S.C. Subtitle A. Income Taxes (2009).

34. Comm'r v. Glenshaw Glass Co., 348 U.S. 426 (1955).

35. *See* I.R.C. § 22 (1939).

36. *Glenshaw Glass*, 348 U.S. at 429.

37. *Id.*

38. *Id.* at 431.

exempted."[39] The Internal Revenue Code defines "gross income" as "all income from whatever source derived, including . . . [c]ompensation for services, including fees, commissions, FRINGE BENEFITS, and similar items."[40] That statutory construct and its interpretation by the United States Supreme Court are consistent with the internal norms of the income tax system which intends to tax net increases in wealth.[41] Health benefits paid by an employer to or for the benefit of an employee as a consequence of his employment form a part of the compensation paid to that employee.[42] Consistent with internal norms defining income, *Glenshaw Glass* and section 61(a)(1) of the Internal Revenue Code, such health benefits *should* be treated as income.[43] Certainly from a clear economic perspective, the employee is wealthier when his employer pays a personal expense on his behalf. Yet, Congress deems to exclude certain health benefits from income.[44] Furthermore, Congress provides a deduction in certain cases for medical expenses borne by a taxpayer.[45] Such a deduction is inconsistent with internal norms which would permit a deduction only for expenses related to the production of income and would deny a deduction for personal expenses.[46]

39. *Id.* at 430.

40. *See* I.R.C. § 61(a)(1) (1986) (emphasis added); unless indicated otherwise, all references to the Internal Revenue Code are to the 1986 Code, as amended. [hereinafter I.R.C. or the Code].

41. During the development of the income tax system, German legal scholar Georg von Schanz and American economists Robert M. Haig and Henry C. Simons independently theorized a system of the taxation of income defining income as net increases in wealth plus personal consumption. JOSEPH M. DODGE ET AL., FEDERAL INCOME TAX: DOCTRINE, STRUCTURE, AND POLICY 37–39 (2004). The proposed formula taxes increases in wealth, subtracts expenditures necessary to produce that wealth, and reduces income by decreases in wealth. *Id.* Personal consumption, albeit a reduction in wealth, was added back so as to remain in the tax base since personal expenditures are not necessary or appropriate in the creation of wealth. *Id.* I.R.C. § 262 codifies the principal of adding back personal consumption by disallowing deductions for expenditures for personal consumption. I.R.C. § 262.

42. *See* I.R.C. § 61(a)(1).

43. See *id.*

44. *See* I.R.C. §§ 104(a)(3), 105, 106.

45. *See infra* Part II.E.

46. *See supra* note 41.

B. Employees with Employer-Provided Coverage

Contributions by an employer to an accident and health plan for the benefit of an employee, his spouse, and his dependents, including the payment of premiums, are specifically excluded from income.[47] Such contributions are deductible by the employer as an ordinary and necessary business expense.[48] Amounts received by an employee through health insurance provided by his employer for personal injuries or sickness are also expressly excluded from income if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care of the employee, his spouse, and his dependents.[49] The resultant benefit to an employee is the ability to use pre-tax dollars to finance the purchase of health insurance and to receive those benefits tax-free.

C. Self-Employed Persons

Premiums paid by a self-employed person for health insurance for himself, spouse and dependents are deductible from the business income of the self-employed person as a business expense.[50] Self-employed persons exclude medical benefits received from health insurance in much the same way employees exclude payments from insurance.[51] The effect for the self-employed person is the same as the employed person with employer-provided coverage, i.e., the ability to use pre-tax dollars to fund the purchase of the health benefits and to receive the medical benefits tax-free.

D. Employees without Employer-Provided Coverage but with Access to a Cafeteria Plan

Employees whose employer does not contribute toward a health plan or whose employer does not fully cover the cost of

47. I.R.C. § 106.

48. I.R.C. § 162(a).

49. I.R.C. § 105.

50. I.R.C. § 162(l). Prior to 2003, a self-employed person could deduct only a portion of health insurance premiums paid to insure himself, his spouse, and dependents. *Id.* The balance was deductible as an itemized deduction below-the-line under I.R.C. § 213. *Id. See infra* discussion of I.R.C. § 213 at Part II.E.

51. I.R.C. § 104(a)(3).

the insurance for the employee and his family can choose to divert pre-tax compensation to the payment of premiums not paid by the employer—if the employer sponsors a so-called "Cafeteria Plan."[52] The employee may contribute pre-tax dollars to the Plan and then select to purchase health insurance from the "menu" of benefits.[53] Benefits paid to the employee from the health insurance arrangement are fully excludable—the same as for self-employed persons.[54] The effect for these taxpayers is again the ability to buy health insurance with pre-tax dollars and to receive the incumbent benefits tax-free. The distinction between the employee using a Cafeteria Plan and the employee with employer provided health insurance is that the employee using the Cafeteria Plan must reduce the compensation he "takes home" in order to contribute to the Cafeteria Plan, much the way the self-employed taxpayer reduces his "take-home" compensation by his health insurance expenditures. Nevertheless, the purchasing power for these taxpayers is greater than the taxpayer who must use after-tax dollars.

E. Employees without Employer-Provided Coverage and without Access to a Cafeteria Plan

Employees who are not provided health insurance benefits through their employment must purchase that insurance, if they seek coverage, using income which has been included in gross income for tax purposes. The employee may deduct his premiums as a part of the itemized deductions allowed for non-reimbursed medical expenses.[55] A taxpayer may deduct as an itemized deduction medical expenses, the definition of which includes the payment of health insurance premiums[56] that exceed 7.5% of the taxpayer's adjusted gross income (AGI).[57] Because the medical expense deduction is subject to a floor, the taxpayer loses the benefit of the first 7.5% of his medical expenses. Taxpayers are permitted to choose be-

52. I.R.C. § 125.
53. *Id.*
54. I.R.C. § 104(a)(3).
55. I.R.C. § 213(a).
56. I.R.C. § 213(d)(1)(C).
57. I.R.C. § 213(a).

tween the standard deduction and itemized deductions.[58] All taxpayers are granted the standard deduction. A taxpayer will itemize only where his itemized deductions exceed the standard deduction.[59] In addition to medical expenses, itemized deductions include, among other deductions, mortgage interest,[60] charitable contributions,[61] and state and local taxes.[62] Since all taxpayers are granted the standard deduction (including those who have excluded employer-provided health benefits), the effect upon a taxpayer who has greater itemized deductions is essentially that he benefits only to the extent of the excess over the standard deduction. The Internal Revenue Service reports that nearly two out of three taxpayers take the standard deduction rather than itemizing deductions.[63] For those who purchase their health insurance with after-tax dollars, the ability to deduct, at best, a portion of those costs does not equate to the unlimited exclusion enjoyed by the taxpayer who receives his benefits from his employment.

F. Impact of the Statutory Scheme

An illustration of the impact of the statutory scheme in the case of each type of financing of health insurance may serve helpful. I shall posit a simple example: a married taxpayer with two dependent children earns $50,000 in the taxable year. For purposes of this example, the author shall presume the annual cost to provide health insurance for his family of

58. I.R.C. § 63.

59. For tax year 2009, the standard deduction for married taxpayers filing a joint return is $11,400, $5,700 for singles and married individuals filing separately, and $8,350 for heads of household. IRS.gov, *2009 Inflation Adjustments Widen Tax Brackets and Expand Tax Benefits*, IRS NEWSWIRE, Oct. 16, 2008, http://www.irs.gov/newsroom/article/0,,id=187825,00.html. For tax year 2010, the standard deduction for married taxpayers filing a joint return remained unchanged at $11,400; single filers also was unchanged at $5,700 and head of household increased slightly to $8,400. IRS.gov, *Inflation Having Little Effect on Tax Rates and Benefits in 2010*, IRS NEWSWIRE, Oct. 15, 2009, http://www.irs.gov/newsroom.article/0,,id=214320,,00.html.

60. I.R.C. § 163(h)(3).

61. I.R.C. § 170(a).

62. I.R.C. § 164(a).

63. *Inflation Adjustments*, *supra* note *59*.

four is $13,375.[64] Each of the four ways of financing health insurance discussed above shall be quantified using these facts to illustrate the profound economic differences which result from the current inequitable statutory scheme. In each case, the taxpayer will be entitled to four exemptions (two personal exemptions and two dependency exemptions); the amount of each exemption in 2009 was $3,650.[65]

First, in the case where the employer bears that cost, the employee recognizes no further income because of the statutory exclusion even though his economic compensation is $13,375 greater. Second, in the case where the taxpayer is self-employed, his annual profits of $50,000 are reduced by the expense he must bear to purchase the health insurance. Since that expense is deductible, his taxable income is reduced by the $13,375. Third, in the case where the employee participates in a Cafeteria Plan and contributes $13,375 to cover his insurance, his taxable wages are also reduced by that amount.

Presume that each of these three taxpayers has no itemized deductions. All three of these taxpayers are eligible for the standard deduction ($11,400 in 2009),[66] which each will receive to arrive at adjusted gross income despite the fact that the cost of health insurance has already either been excluded from income or deducted from income above the line. This equates to a double benefit when contrasted against the fourth employee who buys his own insurance with after-tax dollars and is limited to an itemized deduction which he must take in lieu of the standard deduction, if at all.

The taxpayer who must use after-tax dollars to purchase his health insurance must reduce his wealth by the premium expense of $13,375, but his only option is to deduct the premiums as an itemized deduction below the line, that is, after arriving at adjusted gross income. Presume for simplicity that his AGI is the same as his W-2 wages of $50,000. To make a consistent comparison, presume further that he has

64. KAISER FAMILY FOUNDATION, SURVEY OF EMPLOYEE HEALTH BENEFITS (Sept. 15, 2009), http://ehbs.kff.org/pdf/2009/7981.pdf.

65. I.R.S., REV. PROC. 2008-66 .19(1), http://www.irs.gov/pub/irs-drop/rp-08-66.pdf (setting 2009 inflation adjustments for 26 C.F.R. 601.602(a) (2009)).

66. *Id.* at 11 (stating the standard deduction for married individuals filing joint returns and surviving spouses).

no other medical expenses. His deduction will be limited by the floor to the excess over 7.5% of AGI (7.5% of $50,000 = $3,750.) Therefore, the deduction will be limited to $9,625 ($13,375 - $3,750). The standard deduction for married taxpayers filing a joint return in 2009 is $11,400.[67] Because the standard deduction exceeds the amount of the itemized deduction for medical expenses, the taxpayer enjoys no tax subsidy for the financing of his healthcare.

The contrast becomes more stark when comparing the relative tax brackets of the four categories of taxpayers in this simple example. The marginal tax bracket of the taxpayer whose employer pays his health insurance premium is 15%. Therefore, the benefit to him of the tax savings he enjoys is 15% of the excluded amount ($13,375 x 15%= $2,006). The two categories of taxpayers who must reduce their economic income by the premiums they pay, but who also enjoy either a deduction or an exclusion for that expenditure, reduce their taxable income to the extent that both of these taxpayers fall into the lowest tax bracket of 10%, resulting in additional savings. The marginal tax rate of the last category of taxpayer, paying for his own premiums and enjoying no subsidy, is 15%. He suffers the economic reduction of paying his own premiums, and because he enjoys no deduction for that expenditure, he must use not only after-tax dollars, but after-tax dollars taxed at a higher rate. The four categories of taxpayers and the consequent economic results borne by the statutory scheme are illustrated in the chart below.

III. Reasons for Reform

A. Tax Expenditures

Most of us think the purpose of taxation, in general, and the Internal Revenue Code, in particular, is raising revenue. Indeed, the United States system of federal income taxation does raise revenue to fund the federal government.[68] But the

67. *Id.*

68. *See* Federal Receipts and Collections, Estimates of Federal Receipts, tbl.17-1. Receipts by Source—Summary 241, http://www.whitehouse.gov/omb/budget/fy2010/assets/receipts.pdf. The Office of Management and Budget reports actual receipts from Individual Income taxes for 2008 to be $1.1457 trillion and projects receipts for 2009 as $953 billion. *Id.*

MARRIED TAXPAYER WITH TWO DEPENDENT CHILDREN, TAX YEAR 2009

	Employer Paid	*Employee Paid*		
	Employee with Employer-Provided Health Insurance	**Self-Employed**	**Employee with Cafeteria Plan**	**Employee without Employer-Provided Health Insurance**
Compensation	$50,000	$50,000	$50,000	$50,000
Employer-Provided Health Insurance	+13,375	+0	+0	+0
Economic Income	$63,375	$50,000	$50,000	$50,000
Exclusion	<13,375>	<0>	<13,375>	<0>
Gross Income	$50,000	$50,000	$36,325	$50,000
Above the Line Deduction	<0>	<13,375>	<0>	<0>
Adjusted Gross Income (AGI)	$50,000	$36,625	$36,625	$50,000
Standard Deduction	<11,400>	<11,400>	<11,400>	<11,400>
	$38,600	$25,225	$25,225	$38,600
Exemptions	<14,600>	<14,600>	<14,600>	<14,600>
Taxable Income	$24,000	$10,625	$10,625	$24,000
Tax	$2,769	$1,063	$1,063	$2,769

Internal Revenue Code is also a mechanism for federal spending. As we have seen, the federal tax law is premised on normative concepts of income.[69] Those concepts provide the basic structure of the income tax system but do not provide details regarding unit of taxation, rate of taxation, exclusions from taxation, and the like. Taking the unit of taxation as an example, the basic normative structure does not establish whether the unit of taxation should be an individual, a married couple, a family, or an entity. Those choices must be made not as a matter of tax theory or tax policy but as a matter of broader social policy. Those determinations must be made by reference to social norms and goals. A society which wishes to encourage marriage for example, might create

69. *See supra* Part II.A. *See also* Comm'r. v. Glenshaw Glass Co., 348 U.S. 426, 429–31 (1955).

favorable tax structures for the married couple. In fact, the Code provides many instances where a husband and wife are treated as a single economic unit;[70] for example, married taxpayers may file as a single unit of taxation using the "married filing jointly" status.[71] From the inception of the income tax, social policy choices have informed the development of the statutory provisions.[72] As such, the normative structure has broadened to form the structural provisions necessary to realize the revenue-raising aspects of the system of taxation. But the income tax is comprised of a second element, containing all of the special preferences found in the Code which provide an incentive or subsidy for certain behaviors; those incentives and subsidies fall outside of the normative structure.[73] Incentives and subsidies operate to reduce tax liability, thus conferring a monetary benefit upon the taxpayer engaging in the favored behavior. That monetary benefit represents foregone revenue by the government. The loss of revenue to the Federal Treasury attributable to such preferences is appropriately viewed, from an economic perspective, as a type of expenditure. Such an expenditure has become known as a "tax expenditure."[74] Congress formally adopted the tracking of tax expenditures[75] in 1974.[76] The term "tax expenditures" is defined by statute as:

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70. *See, e.g.*, I.R.C. §§ 1(a), 1041.

71. *See* I.R.C. § 1(a).

72. *See* C. Eugene Steuerle, *Tax Reform, federal*, *in* THE ENCYCLOPEDIA OF TAXATION & TAX POLICY 392 (Joseph J. Cordes et al. eds., 1999).

73. *See generally* Emil M. Sunley & Janet Stotsky, *Income Tax, federal*, *in* THE ENCYCLOPEDIA OF TAXATION & TAX POLICY, *supra* note 72, at 179–80.

74. *See* STANLEY S. SURREY & PAUL R. MCDANIEL, TAX EXPENDITURES 1–2 (1985). Stanley Surrey served as Assistant Secretary of the U.S. Treasury for Tax Policy during the Kennedy and Johnson administrations. *Id.* at 309. During his tenure he proposed that the Congressional Budget Office compile a list of "tax expenditures" to highlight the spending aspects of the Internal Revenue Code. *Id.* at 1–2.

75. Tax expenditures represent significant spending, sometimes in greater amounts than that provided as a budgetary expenditure. For example, the Tax Policy Center reports that the tax expenditures for home ownership exceed total spending by the Department of Housing and Urban Development in 2008. Tax Expenditures: What are the largest tax expenditures? Tax Policy Briefing Book, www.taxpolicycenter.org/briefing-book/background/expenditures/largest.cfm (last visited Sept. 15, 2009).

76. Congressional Budget Act of 1974, Pub. L. No. 93-344, § 3(3); 2 U.S.C. §§ 601–612 (1974).

> those revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of tax liability; and the term "tax expenditures budget" means an enumeration of such tax expenditures.[77]

Statutory exclusions from income for employer-provided health benefits fall into the "special exclusions" definition of a tax expenditure. The exclusion is seen as "special" since it does not comport with the normative structure of the income tax system to tax all accessions to wealth. As such, the cost of this preference is reported as a part of the federal budget.[78]

The exclusion from income of employer contributions for medical insurance premiums and medical care represents the largest tax expenditure in the entire budget at a projected cost to the U.S. Treasury of $142 billion for 2009.[79] The cost of the deductibility of medical expenses is projected as $9.66 billion for 2009,[80] and for self-employed medical insurance premiums the projection is $5.47 billion.[81] The significance of the exclusion of employer contributions for medical expenses is more striking[82] when ranked against other tax expenditures. For 2009, the next largest tax expenditure, the net exclusion of *all* pension contributions and earnings in the aggregate is projected at $122.35 billion.[83] The third largest (or the second largest single category), the deductibility of mortgage interest on owner-occupied homes, drops off considerably from there at $97.28 billion.[84] The sheer size of

77. *See* 2 U.S.C. § 622(3).

78. ESTIMATE OF FEDERAL RECEIPTS, tbl.19-1, *supra* note 68.

79. Estimates of total income tax expenditures by category are compiled as a part of the Analytical Perspectives of the Budget. *See* OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2010, at 301, 126 tbl.19-1 (2009).

80. *Id.* at 129 tbl.19-1.

81. *Id.* at 127 tbl.19-1.

82. *Id.* at 302 n.5. In addition to the exclusion from income tax, employer-paid health insurance premiums are also excluded from payroll taxes. *Id.* The Office of Management and Budget projects the effect on payroll tax receipts in 2009 to be $86,490 million. *Id.*

83. *Id.* at 301, 141–45 tbl.19-1. All categories of employee retirement contributions have been aggregated to arrive at the total amount projected. *Id.* The Office of Management and Budget separately accounts for these tax expenditures by the type of retirement plan. *Id.*

84. *Id.* at 300, 58 tbl.19-1.

these tax expenditures begs for an analysis of the economic impact of these subsidies on the supply and demand of medical services and products.

B. Fairness

A review of the mechanics of the basic statutory provisions respecting the tax treatment of healthcare expenditures yields striking disparities in the treatment of similarly situated taxpayers. As we have seen from a simple example, a taxpayer earning $50,000 per year will experience a very different economic consequence resulting from the taxation of the type of healthcare coverage from which he benefits.[85] Such a consequence violates principles of fairness, specifically violating the notion of tax justice known as "horizontal equity." Horizontal equity postulates that taxpayers who have the same amount of income should pay the same amount of tax.[86] The differences are noteworthy when analyzing a simple example with a taxpayer in the lowest tax bracket,[87] but a more nuanced analysis highlights striking distortions when taxpayers of different brackets are compared.

Our system of income taxation has adopted progressive rates of taxation as a normative part of the structure of the system. The progressively higher rates of tax imposed upon taxpayers with progressively higher incomes is based upon the principle of tax justice known as "ability-to-pay"—the greater the ability to pay, the greater the burden of payment. A taxpayer in a higher bracket pays a higher rate of tax on his last dollar of income. That rate is known as his marginal rate of tax. The rate of tax which would be paid on one additional dollar of income also indicates the value of a deduction or exclusion to that same taxpayer. Avoiding paying tax on that incremental dollar of income by excluding or deducting it means avoiding paying tax at the percentage of his marginal rate of tax. For example, a taxpayer in the highest bracket receiving health insurance benefits worth $13,375 saves the

85. *See* discussion *supra* Part II.F.

86. *See* Joseph J. Cordes, *Horizontal Equity*, *in* THE ENCYCLOPEDIA OF TAXATION & TAX POLICY, *supra* note 72, at 164–66.

87. *See* discussion *supra* Part II.F.

tax on that income at that highest rate. At a current rate of 35%, the higher income, higher bracket employee saves $4,681. Contrast that with a taxpayer in the lowest bracket who saves by the exclusion only $1,337 on the same amount of income. The exclusion appears to benefit the wealthier taxpayer. Many health economists argue that tax subsidies for employer-provided healthcare benefits are regressive: Workers in a higher bracket benefit more than those in lower brackets.[88] But others disagree citing the benefit in percentage terms rather than absolute dollar amounts.[89] Viewed as a percentage of income, the tax subsidy appears progressive since lower income taxpayers benefit more as a percentage of income than do higher income taxpayers.[90]

Distributional effects of the tax subsidies must also be evaluated and examined for fairness. Data evaluating the federal tax subsidies for health benefits by income stratum show higher earners benefiting more as a group because a greater proportion of employees in the group enjoy employer-paid coverage. For employees earning less than $10,000 annually, only 10% of employees were provided employer-paid coverage; contrast that with employees earning $50,000–$75,000 annually where more than half of employees are covered. And for those with incomes over $100,000 annually, 61% benefited from employer-provided health coverage.[91]

A fair system of taxation must also be transparent. The tax consequences of the various tax subsidies and incentives are difficult for taxpayers to evaluate and understand. The effect of the tax expenditures for healthcare on tax incidence[92] is especially murky. A fair system of taxation identifies the cost

88. *See* CATHY SCHOEN ET AL., PROGRESSIVE OR REGRESSIVE? A SECOND LOOK AT THE TAX EXEMPTION FOR EMPLOYER-SPONSORED HEALTH INSURANCE PREMIUMS, THE COMMONWEALTH FUND ISSUE BRIEF (May 2009) http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Progressive%20or%20Regressive%20A%20Second%20Look%20at%20the%20Tax%20Exemption/PDF_1269_Schoen_progressive_or_regressive_ESI.pdf.

89. *See id.*

90. *See* David U. Himmelstein & Steffie Woolhandler, *The Regressivity of Taxing Employer-Paid Health Insurance*, NEW ENG. J. OF MED. (Aug. 19, 2009), *available at* http://healthcarereform.nejm.org/?p=152.

91. *Id.*

92. DODGE, *supra* note 41, at 120–21. Tax incidence describes the economic proposition of determining the ultimate distribution of the burden of paying a tax. *Id.*

of those expenditures and evaluates who bears those costs. An economic analysis reveals that the subsidies increase costs and depress wages. The incidence of the tax subsidy therefore is borne, at least in part, by workers.

C. Impact of Tax Policy on Healthcare

The historical examination seems to indicate that tax subsidies encouraged employers to provide health insurance coverage. Social insurance in the form of health benefits and financial benefits for the sick stabilize the society and provide personal security, worthy goals indeed. However, escalating healthcare costs threaten the economic viability of the system. The current subsidy distorts the healthcare market by encouraging employees to have more coverage than they otherwise would. Because the subsidy lowers the cost of insurance, any given employee naturally prefers additional compensation in the form of health insurance rather than wages. The resultant over-subscription to healthcare drives up costs. The subsidy artificially inflates demand and promotes economic inefficiency by fostering over-utilization of health services.

Health insurance is not a typical commodity in the marketplace. An historical review[93] reveals that employer-provided health insurance arose as a way to provide security from a type of uncertainty—that is the risk of lost wages and the costs of medical care should the family provider become ill. Previously, workers without the capacity to save for extraordinary risks relied on charity. That uncertainty caused individual insecurity as well as social and economic instability. The purpose of health insurance, indeed all types of insurance, is to pool resources and share risks in order to alleviate uncertainty. Health insurance differs somewhat from other forms of insurance because the risk of, and therefore the demand for, medical care depends upon the state of health of individual participants. The difficulty in predicting individual health needs makes it harder to quantify risk.[94]

93. *See* discussion *supra* Part I.

94. *See* Mark V. Pauly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, 24 J. OF ECON. LITERATURE 629, 630 (June 1986).

The tax provisions operate to favor employer-provided health insurance over other types of pooling arrangements. That incentive shifts control over healthcare choices from employees to employers and the insurance companies with which they bargain. The lack of choice reduces purchasing options and prevents the patient from seeking lower-cost, higher quality alternatives. The resultant lack of competition also contributes to increasing costs.[95]

The tax subsidy operates to artificially drive down wages. Because employers do not pay social security tax on healthcare benefits, those benefits offer a cheaper form of compensation than cash wages. Employees comparing wages do not always comprehend the value of fringe benefits they receive. Employees often view the benefits as "free." Obviously, employer-based health insurance is not a free benefit. Because health insurance benefits substitute for wages, employees ultimately share the burden of high health care costs in the form of lower wages.

IV. A Framework For Reform

The historical review of the development of employer-provided health insurance and the tax provisions which subsidize that system, provide a helpful starting point for designing a framework for reform. The high cost, economic inefficiency, and basic unfairness of the current system of tax expenditures seem to be reason enough to reform the current tax provisions respecting the taxation of healthcare. But more precisely, the question for reform is what role the federal tax system should play in promoting healthcare benefits, and if it is to be a tool to do so, what structure best meets that goal. We have learned that the current scheme operates as a subsidy, mostly for those who receive healthcare benefits from their employer. The options available to reformers range from complete repeal of all tax subsidies[96] to a new

95. *See* Michael Cannon, *Combining Tax Reform and Health Care Reform with Large HSAs,* Cato Inst. Tax & Budget Bull. No. 23, May 2005.

96. *See* Richard A. Epstein, *The Taxation of Employee Health Care Benefits*, Mar. 17, 2009, http://www.forbes.com/2009/03/16/taxation-employee-benefits-opinions-columnists-healthcare.html.

type of tax designed to fund a voucher system to provide universal healthcare to all.[97]

Based on the analysis above, any reform proposal should meet the following criteria:

A. Encourage Risk-Sharing.

Based on the historical development of pooling resources to reduce risk, any plan should promote risk-sharing through appropriate levels of insurance. Appropriate levels are critical as the United States has seen that over-insurance by some increases demand and drives up prices. Tax advantages should favor only those plans which promote pooling for those risks which are truly catastrophic and for which the taxpayer cannot otherwise protect against by saving.

B. Encourage Saving

The current system of a mix of no savings and some savings along with over-insurance does not operate to stabilize prices or incent positive consumer behavior. Where insurance is used only to provide for catastrophic need, consumers should be encouraged to save to pay out-of-pocket for normal medical expenses. Because a consumer will bear the cost directly, he will make more economically efficient choices.

C. Extend Tax Benefits to All

Any structure or structures employed must result in all taxpayers being treated the same. If the purchase of high-deductible catastrophic coverage is the goal, the tax system may subsidize that purchase but only under a scheme where all taxpayers enjoy the benefit of the purchase using pre-tax dollars.

D. Eliminate Bias Toward Employer-Provided Coverage

Where all taxpayers enjoy the benefit of using pre-tax dollars to purchase insurance, the bias toward employer-provided insurance and collective purchasing through em-

97. *See* Leonard E. Burman, *A Blueprint for Tax Reform and Health Reform*, 28 VA. TAX REV. 287, 300–01 (2009).

ployment should diminish. This should promote greater competition, reduce price, and provide portability.

E. Encourage Healthy Habits

Americans are making poor health choices. Any reform should evaluate ways to incent individual healthy choices.

F. Encourage Healthy Business Enterprise

Any reform should include reforms to eliminate perverse subsidies to agri-business and energy sectors which cause health hazards by their business practices.

G. Provide Transparency

New structures should be clear and compliance should be simple.

Conclusion

Given that the current system of delivering healthcare is unsustainable, present circumstances present an opportune time to reform perverse tax subsidies. The proposed framework suggests, among other options, a number of solutions: (1) Pre-tax benefits should be limited to expenditures for protection against catastrophic risks; (2) health savings accounts (HSAs), that is, tax-free savings of pre-tax dollars, can provide financial security by funding out-of-pocket costs; (3) a consumption tax, such as a Value Added Tax, might in concert with a HSA operate to encourage saving rather than spending; (4) an above-the-line deduction for health insurance premiums to purchase high-deductible catastrophic coverage is one way to level the playing field and increase options, competitive pricing, and portability by eliminating the bias toward employer-provided plans; and (5) eliminating certain subsidies for agri-business and energy sectors could promote healthier food production and contribute toward greater energy efficiencies. A new system which encourages well-being, social security, and economic stability is a compelling rationale for significant tax reform.

Our health depends upon it.