

GEORGETOWN LAW

O'Neill Institute
for National and Global Health Law



Robert Wood Johnson Foundation

Legal Solutions in Health Reform: Tax Credits for Health Insurance



by Fred T. Goldberg, Jr., J.D. and Susannah Camic, J.D., M.A.

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**THE LINDA D. AND TIMOTHY J. O’NEILL
INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW
AT
GEORGETOWN LAW**

The O’Neill Institute for National and Global Health Law at Georgetown University is the premier center for health law, scholarship and policy. Housed at Georgetown University Law Center, in the heart of the nation’s capital, the Institute has the mission to provide innovative solutions for the leading health problems in America and globally—from infectious and chronic diseases to health care financing and health systems. The Institute, a joint project of the Law Center and School of Nursing and Health Studies, also draws upon the University’s considerable intellectual resources, including the School of Medicine, the Public Policy Institute, and the Kennedy Institute of Ethics.

The essential vision for the O’Neill Institute rests upon the proposition that the law has been, and will remain, a fundamental tool for solving critical health problems in our global, national, and local communities. By contributing to a more powerful and deeper understanding of the multiple ways in which law can be used to improve health, the O’Neill Institute hopes to advance scholarship, research, and teaching that will encourage key decision-makers in the public, private, and civil society sectors to employ the law as a positive tool for enabling more people in the United States and throughout the world to lead healthier lives.

- *Teaching.* Georgetown is educating future generations of students who will become – upon their graduation – policymakers, health professionals, business leaders, scholars, attorneys, physicians, nurses, scientists, diplomats, judges, chief executive officers, and leaders in many other private, public, and nonprofit fields of endeavor. The O’Neill Institute helps to prepare graduates to engage in multidisciplinary conversations about national and global health care law and policy and to rigorously analyze the theoretical, philosophical, political, cultural, economic, scientific, and ethical bases for understanding and addressing health problems.
- *Scholarship.* O’Neill supports world-class research that is applied to urgent health problems, using a complex, comprehensive, interdisciplinary, and transnational approach to go beyond a narrow vision of health law that focuses solely on health care as an industry or as a scientific endeavor.
- *Reflective Problem-Solving.* For select high-priority issues, the O’Neill Institute organizes reflective problem-solving initiatives in which the Institute seeks to bridge the gap between key policymakers in the public, private, and civil society sectors and the intellectual talent and knowledge that resides in academia.

OVERVIEW

LEGAL SOLUTIONS IN HEALTH REFORM

The American public has increasingly identified health care as a key issue of concern. In order to address the multiple problems relating to the access and affordability of health care, President Obama and federal lawmakers across the political spectrum continue to call for major health reform. In any debate on health reform, a predictable set of complex policy, management, economic, and legal issues is likely to be raised. Due to the diverse interests involved, these issues could lead to a series of high-stakes policy debates. Therefore, **it is critical that advocates of reform strategies anticipate such issues in order to decrease the likelihood that legally resolvable questions become barriers to substantive health reform.** In an effort to frame and study legal challenges and solutions in advance of the heat of political debate, the O’Neill Institute for National and Global Health Law at Georgetown University, generously funded by the Robert Wood Johnson Foundation, has crafted the “Legal Solutions in Health Reform” project.

This project aims to identify practical, workable solutions to the kinds of *legal issues* that may arise in any upcoming federal health reform debate. While other academic and research organizations are exploring important policy, management, and economic questions relating to health reform, the O’Neill Institute has focused solely on the critical legal issues relating to federal health reform. The target audience includes elected officials and their staff, attorneys who work in key executive and legislative branch agencies, private industry lawyers, academic institutions, and other key players. This project attempts to pave the road towards improved health care for the nation by providing stakeholders a concise analysis of the complex legal issues relating to health reform, and a clear articulation of the range of solutions available.

LEGAL ISSUES V. POLICY ISSUES

Among the major issues in federal health reform, there are recurring questions that are policy-based and those that are legally-based. Many times questions of policy and of law overlap and cannot be considered in isolation. However, for the purpose of this project, we draw the distinction between law and policy based on the presence of clear legal permission or prohibition.

Under this distinction, policy issues include larger-scale questions such as what basic model of health reform to use, as well as more technical questions such as what threshold to use for poverty level subsidies and cost-sharing for preventive services. In contrast, legal issues are those involving constitutional, statutory, or regulatory questions such as whether the Constitution allows a certain congressional action or whether particular laws run parallel or conflict.

Based on this dividing line of clear permission or prohibition, policy questions can be framed as those beginning with, “*Should we...?*”, and legal questions can be framed as those beginning with, “*Can we...?*” The focus of this paper will be the latter, broken into three particular categories: 1) “Under the Constitution, *can we ever...?*”; 2) “Under current statutes and regulations, *can we now...?*”; 3) “Under the current regulatory scheme, *how do we...?*” This final set of questions tends to be mixed questions of policy, law, and good legislative drafting.

PURPOSE AND LAYOUT OF THE PROJECT

This project is an effort to frame and study legal challenges and solutions in advance of the heat of political debate. This effort is undertaken with the optimistic view that all legal problems addressed are either soluble or avoidable. Rather than setting up roadblocks, this project is a constructive activity, attempting to pave the road towards improved health care for the nation. Consequently, it does not attempt to create consensus solutions for the identified problems nor is it an attempt to provide a unified field theory of how to provide health insurance in America. Furthermore, this project does not attempt to choose among the currently competing proposals or make recommendations among them. Instead, it is a comprehensive project written to provide policy makers, attorneys, and other key stakeholders with a concise analysis of the complex legal issues relating to health reform and a clear articulation of the range of solutions available for resolving those questions.

LEGAL ISSUES

Based on surveys of current health policy meetings and agendas, popular and professional press, and current health reform proposals, our team formulated a list of legal issues relating to federal health reform. After much research, discussion, and expert advice and review, our initial list of over 50 legal issues was narrowed to ten. An initial framing paper was drafted which identified these ten legal issues and briefly outlined the main components of each. In May of 2008, a bipartisan consultation session was convened to provide concrete feedback on the choice and framing of the legal issues. The attendees of the consultation session included congressional staff, executive branch officials, advocates, attorneys, employers, and representatives of a wide range of interests affected by health reform. Feedback and analysis from this session further narrowed the ten issues to eight key legal issues which warranted in depth analysis of the current law.

These eight pertinent issues are truly legal in nature and must be addressed in any significant reform proposal to avoid needless debate or pitfalls as policy decisions are made. There are multiple other legal issues that will arise as the discussion evolves and, if a federal policy is adopted, the system changes. In this project, however, we have targeted the issues essential for an immediate discussion of federal health reform.

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LEGAL SOLUTIONS IN HEALTH REFORM PROJECT

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Special thanks to the following individuals who contributed to the editing and production of the Legal Solutions in Health Reform Series, as well as the drafting of the Executive Summaries: Brian Bowen, Astrid Dorélien, Marissa Hornsby, Amy Killelea, Melanie MacLean, Anya Prince, and Luis Rodriguez. Also special thanks to John Kraemer for editing and production assistance.

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EXECUTIVE SUMMARY

Prepared by the O’Neill Institute

INTRODUCTION

This Legal Solutions in Health Reform paper discusses the role that tax law can play in the implementation of health reform. The tax code has served as the primary vehicle for subsidizing health care in the U.S., with subsidies averaging \$245 billion per year. Use of the tax code to support or implement health policy is extremely common in proposals at both the federal and state levels. Subsequently, the tax code will certainly play a role in any future health care reform efforts.

While there are no legal barriers to modifying the tax code, the interplay between tax law and health policy presents a series of critical design and implementation challenges with which any health care reform package must grapple. Thus, this paper does not examine *whether* the federal government has legal authority for using the tax law for health reform, but rather *how* it can use the tax law under various health reform proposals.

REPLACING THE EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE WITH A REFUNDABLE TAX CREDIT

A progressive refundable credit, specifically aimed at providing a larger credit for low- and middle-income individuals/families and scaled down for upper income taxpayers, could serve as a tool for reforming the U.S.’s system of providing and subsidizing health care. Tax-based health care reform could also support other proposals to facilitate access (*e.g.*, purchasing pools or some form of insurance exchange, restrictions in pricing or access based on pre-existing conditions).

- **A Costly and Regressive Subsidy:** The government distributes the tax expenditures associated with the current tax framework regressively; under the existing structure, taxpayers in higher brackets receive larger subsidies, varying by bracket from zero to 35 percent of any deductible amount. Given that almost 40 percent of all taxpayers have no positive income tax liability, exclusions and deductions have *no value* to many lower-income individuals. In contrast, refundable credits provide subsidies and create incentives that become relatively more valuable farther down the income ladder. Individuals without federal income tax liability may receive the credits in cash or cash equivalents.
- **Distortions in the Market for Health Insurance and in Health Care Consumption:** There is general agreement among health care experts that the current configuration of subsidies and government-sponsored health insurance programs, and the existing tax subsidy framework, have caused distortions in the market for health care, contributing significantly to escalating health care costs. Any meaningful effort to control the growth of health care costs must reflect more rational pricing and financial incentives; the place to begin is repeal (or substantial reform) of the current exclusion for employer-provided health insurance and its progeny. Supporters argue that a refundable credit regime could make a significant contribution to controlling health care costs because individuals would receive a credit for any health plan selected and would have reduced incentives to limit themselves to the “one size fits all” and “gold-plated” options that have characterized employer- and government-based plans.
- **Preserving the Employer-Based System:** Any move to repeal the exclusion for employer-provided health insurance and replace it with some form of refundable credit would have to account for the need to maintain the current system in some form, while facilitating a transition to alternative health insurance platforms, especially for the tens of millions of Americans who are not currently covered by employer-based plans.

DESIGN ISSUES

Any U.S. health care reform package must confront a series of core design issues. Many of these problems demonstrate the challenges of setting up a health care reform package in light of the current tax system and situating the reform package within that system.

- **Eligibility Standards and Administration of Standards:** Appropriate eligibility criteria are key to the success of any plan. In the context of a credit or subsidy allocated to individuals and families, possible criteria could include measure of ability to pay, family size, marital status, number of dependents, age, or the nature of local or regional insurance markets.
- **Changes in Eligibility Criteria from Year to Year:** As long as eligibility for a tax code-based health program turns at least in part on individual or family income, timing anomalies may arise. In particular, recipients may not be able to take advantage of available benefits at the time of medical need. Program design should account for the hardship this problem may create for families; models could be drawn from the Health Care Tax Credit program, among others.
- **Tax Payer Cash Flow Considerations:** The gap between eligibility determinations and payments may create cash flow problems for recipients even where their status or circumstances do not change. As with taxpayers whose eligibility and benefits fluctuate because their circumstances change, general reliance on the tax return filing process raises potentially significant cash flow issues for individuals and families of limited means who might be the primary intended beneficiaries of an enacted subsidy, but who also may be less able to “pre-fund” their purchases of health insurance.
- **Mandates:** A mandatory-coverage requirement raises a number of design questions that are beyond the scope of this paper. What is relevant for purposes of this paper is the enforcement mechanism: how is information compiled to determine compliance and how are sanctions enforced? As a practical matter, the IRS is the only federal agency that comes close to reaching a substantial portion of those potentially subject to mandates; therefore, the IRS may be best situated to collect data on compliance.
- **Flow of Funds:** The matter of who should claim a tax credit turns out to be a very important design consideration that has the potential to address the timing and mandate issues noted above, while building on the current employer-based system. The options include providing subsidies directly to the beneficiary or to third parties (*e.g.*, employers) on behalf of beneficiaries.
- **Interaction with Existing Tax Law Subsidies:** Comprehensive health reform, whatever shape it takes, must deal with the panoply of health care provisions embedded in current tax law. Existing provisions range from the exclusion for employer-provided health insurance and the deduction for health insurance purchased by the self-employed, to an alphabet soup of special deductions and exclusions. Also, any reform program would interact with non-health-care tax law provisions. Policy designers would thus have to determine how individual tax liability calculations would account for any new subsidy.

CONCLUSION:

Tax law has played a major role in shaping health care policy for more than 50 years; it is the primary factor contributing to our current system of employer-provided health care. From an administrative standpoint, the IRS is the one institution that deals regularly with virtually all citizens. It also functions in many ways as the largest financial institution in the world, collecting funds and information from, and disbursing funds to, all of those with a stake in health care policy—individuals and families, employers and workers, the self-employed, purchasing cooperatives and health insurance providers. Within this framework, implementation of health policy reform would likely include leveraging the existing infrastructure provided by the IRS. While there are no legal barriers to modifying the tax code to facilitate health reform, there are key design and implementation issues that should be considered to ensure success.

**Legal Solutions in Health Reform:
Tax Credits for Health Insurance
Fred Goldberg and Susannah Camic¹**

Introduction

This Legal Solutions in Health Reform paper discusses the role that tax law can play in the implementation of health reform. The tax code has served as the primary vehicle for subsidizing health care in the U.S. for most of the last century and will likely play a role in any future reform efforts. However, the interplay between tax law and health policy presents a series of critical design and implementation challenges with which any health care reform package—be they liberal or conservative—must grapple. This paper considers some of the most pressing of these issues. While it does not prescribe a particular outcome, it will attempt to identify potential tax solutions that might receive broad support and to observe the policy and administrative design questions that any discussion of these solutions should take into account.

Unlike some of other Legal Solutions in Health Reform papers, the legal authority for Congress to tax and to spend for the general welfare has clearly been delegated in the U.S. Constitution and upheld by the U.S. Supreme Court.² Thus, this paper does not examine *whether* the federal government has legal authority for using the tax law for health reform, but rather *how* it can use the tax law under various health reform proposals.

Use of the tax code to support or implement health policy is extremely common in proposals at both the federal and state levels. President Obama's proposal, if it follows the basic ideas from his 2008 campaign, would likely rely upon a "National Health Insurance Exchange," through which individuals not covered under a current employer or government sponsored plan could purchase insurance. Such an exchange would place requirements on both insurers' ability to rate individuals and on employers' obligation to contribute to their employees' coverage. It appears that implementing these proposals is likely to rely heavily on the tax system to promote health insurance coverage, including a proposal to use a refundable tax credit to encourage small businesses to provide health insurance to their employees.³ Additionally, Senator McCain, in his 2008 campaign plans, would have eliminated the current tax exclusion for employer-provided health insurance and replaced it with a refundable credit for individuals and families. This idea has gained attention in early 2009, and will likely be considered by the Congress over the course of this legislative session.

On the state level, Massachusetts' recent health care reform uses the tax system as an enforcement mechanism for its requirement that all individuals over the age of 18 within the state obtain health insurance either through their employer or through the new Connector, an agency that assists individuals in purchasing coverage. It seems likely that any state-based reform would similarly rely on the tax system and the state Department of Revenue or an equivalent agency to implement particular provisions.

This paper is organized as follows: Part I – summarizes health policy and the tax code; Part II – examines replacing the tax exclusion for employer-provided health insurance with a refundable tax credit; Part III – outlines design and implementation issues using the tax code for health reform; and Part IV – concludes with thoughts noting that a program repealing the employer tax

exclusion and using the tax code to provide progressive and efficiently allocated benefits would be one way to implement President Obama's health care policies.

I. Summary of Health Policy and the Tax Code

Health policy and the health care system are supported by implementation through the tax code in a multitude of ways. The exclusion of employer-sponsored health benefits from taxation – as well as Health Savings Accounts, Health Reimbursement Accounts, Flexible Spending Accounts, deductions for self-employed individuals, and other mechanisms – create and support the health insurance system in the United States. This section summarizes and describes the various roles that the Internal Revenue Code (IRC) plays in implementing health policy.

First and foremost, the IRC preserves the tax treatment of employer-provided health insurance under sections 105 and 106, which exclude from taxable compensation most contributions to—and benefits from—employer-provided accident or health insurance.⁴

In addition to the exclusion for employer-provided health insurance, the IRC provides several other health care-related tax subsidies. In 2003, Congress created tax-favored health savings accounts (HSAs) allowing employees and employers to make pre-tax contributions toward employee health care costs. Beneficiaries enrolled in “high-deductible health plans” may place their contributions in any of a series of permissible investments including bank accounts, annuities, certificates of deposit, stocks, mutual funds and bonds. Amounts in HSAs may then accumulate until beneficiaries distribute the funds toward qualified medical expenses not covered under high-deductible health plans. Employee contributions to HSAs are tax deductible⁵ and employer contributions are excludable from the employee's taxable income.⁶ Earnings from HSA investments accumulate tax-free and distributions for qualifying expenditures are not subject to tax.⁷

Under existing law, employers may also maintain certain tax-favored accounts for employees. Contributions to⁸ and benefits under⁹ “health reimbursement accounts” (HRAs) are also excludable from employee compensation. Generally, HRAs require the following: (1) must obtain sole support from employer contributions; (2) may not be part of an employer-sponsored benefit plan; and (3) may reimburse qualified medical expenses up to a maximum dollar amount for each coverage period. At the end of a coverage period, the employer may rollover any unused portions of the ceiling amount, and increase the ceiling amount for the following period. Some employers also create flexible savings accounts (FSAs). An FSA allows employees to spend account balances on a choice of non-taxable health benefits so long as they are not reimbursable under any other health plan.¹⁰ As with HSAs, employee contributions are deductible and employer contributions are excluded from taxable income, earnings accumulate tax free, and qualifying distributions are not subject to tax.

In a structure that generally parallels the rules governing employer-provided health insurance benefits, IRC Section 162(l) permits self-employed individuals to deduct medical insurance costs for themselves and their dependents to some extent.¹¹ Moreover, under Section 213, taxpayers who itemize deductions may deduct medical expenses that insurance does not cover if these expenses exceed 7.5 percent of adjusted gross income.¹² The self-employment deduction is not subject to a percent floor.¹³ A taxpayer may not take the deduction if either the taxpayer or the

taxpayer's spouse is eligible to participate as an employee in an employer-subsidized health plan.¹⁴ This regime effectively creates a benefit that is generally equivalent to the employer-provided health care exclusion for self-employed individuals.¹⁵ The employer-based exclusion covers payroll taxes as well as income taxes, whereas, as a deduction, the subsidy in the self-employed context does not.¹⁶ However, aside from this difference, the two sets of rules mirror each other closely.¹⁷

As of 1996, "qualified long-term care insurance" generally falls within the IRC definition of "accident and health insurance."¹⁸ Individuals may now deduct qualified long-term care insurance premiums and exclude long-term care benefits from income when employers provide them.¹⁹ Individuals may also use HSA or HRA dollars to purchase long-term care on a tax-free basis. However, employer-provided coverage for long-term care is taxable income to an employee if the employer provides the coverage through a cafeteria plan²⁰ or through an FSA that reimburses the employee for "specified incurred expenses" up to a maximum amount of the coverage value.²¹

The IRC also allows employees to form tax-exempt collective organizations to provide health care to members. "Voluntary employees' beneficiary associations" (VEBAs) are entities separate from participants and their employers that offer "life, sick, accident, or other benefits" and "supplemental unemployment compensation benefits" to participants.²² Participants may exclude VEBA-provided health benefits from income under Section 105.²³ Contributions to VEBAs are tax-deductible and excluded from the beneficiaries' taxable income. Earnings from VEBA investments and subsequent distributions are tax-exempt.

Finally, under the Trade Adjustment Assistance Reform Act of 2002, individuals who may receive certain trade adjustment assistance payments and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation are eligible for the refundable health coverage tax credit (HCTC).²⁴ The HCTC equals 65 percent of the costs that an individual incurs for qualified health insurance.²⁵ The IRS administers this credit, which is available on an "advance basis."²⁶ If individuals qualify, they may send 35 percent of their monthly premiums under a qualified insurance plan to the federal government, which then pays the insurance company 100 percent of premium costs each month.²⁷ Individuals may also choose to pay for qualified health plans directly throughout the year and receive the HCTC as a tax refund or a credit against taxes owed.²⁸

Congress has also developed new sets of health insurance regulations implemented through the IRC so that noncompliance will trigger penalty excise taxes. One such regulation, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires a group health plan to allow insurance participants whose coverage terminates to purchase a certain amount of continuation coverage.²⁹ The Health Insurance Portability and Accountability Act (HIPAA), among other laws, limits insurance exclusions for pre-existing conditions and forbids insurance plans from using medical history to restrict coverage.³⁰

Reviewing the tax law's approach to health care, three key points emerge. First, as evident from the foregoing discussion, health insurance coverage and the tax system have been deeply entangled for more than half a century. This co-dependence has been expanded substantially during the past several decades with an exponential growth in complexity. Second, with the very

modest exception of the HCTC, the entanglement takes the form of tax subsidies by way of tax deductions and exclusions from income, treatments that are agreed to be less equitable than refundable credits. Third, despite these ample subsidies, as of 2007, more than 45 million Americans (more than 17 percent of those not covered by Medicare or Medicaid) did not have health insurance.³¹

Many health care and tax policy experts across the political spectrum agree that the current system of employer-provided health insurance—where costs are deductible by the employer but not taxed to the employee—is flawed. The existing health benefit structure distorts incentives and behavior in the allocation and consumption of health care services and is a *very* costly and generally regressive subsidy. The most recent tax expenditure estimates by the Joint Committee on Taxation value the subsidy at \$245 billion a year,³² with most of the benefits going to upper-income taxpayers.

While taxing employer-provided health insurance benefits could be a relatively straightforward answer in a world of “policy do-overs,” the current exclusion for employer-provided health benefits is deeply embedded in our system of subsidizing health care. As a result, the interactions between health policy and tax law are complicated and have important efficiency and distributional implications. In this context, understanding the complex policy and administrative design questions that different tax-related reform alternatives must answer becomes even more important.

II. Replacing the Exclusion for Employer-Provided Health Insurance with a Refundable Tax Credit

The discussion that follows analyzes the possibility of repealing of the existing tax exclusion for employer-provided health insurance and examines the possibility of replacing it with a refundable tax credit or other new approach to health care tax policy. A progressive refundable credit, specifically aimed at providing a larger credit for low- and middle-income individuals/families and scaled down for upper income taxpayers, could serve as a tool for reforming the U.S.’s system of providing and subsidizing health care. Tax-based health care reform could also support other proposals to facilitate access (*e.g.*, purchasing pools or some form of insurance exchange, restrictions in pricing or access based on pre-existing conditions). Proponents of replacing the current tax subsidies for employer-provided health insurance with tax credits or other reforms note several flaws in the current structure. In particular, these advocates say the current system is a costly and regressive subsidy and, as described below, distorts incentives in allocation and consumption of health care. The system does not meet consumer needs, control costs, or promote quality, and does very little to facilitate coverage for individuals and families who do not have employer-provided insurance. As an empirical matter, the current system has left far too many millions of Americans uninsured, and there is no evidence suggesting that the situation will improve over time. Of the 72.3 million not covered by Medicare, Medicaid, or an employer-sponsored plan, 26.7 million (or 37 percent) are covered by direct purchases of coverage and 46.5 million (or 63 percent) are uninsured.³³

A. A Costly and Regressive Subsidy

The current system of health insurance tax subsidies is costly. The Joint Committee on Taxation estimates that tax expenditures associated with the current tax framework exceeded \$245 billion in 2007. However, the government distributes these resources regressively as under the existing structure, taxpayers in higher brackets receive larger subsidies. In fact, under current law, the value of deductions varies by bracket from zero to 35 percent of any deductible amount. For example, assume an employer provides health insurance costing \$10,000 to each employee. The current exclusion is then worth \$3,500 to the executive-level workers subject to tax at 35 percent, but only \$1,000 to rank-and-file level workers subject to tax at 10%.³⁴ Even worse, given that almost 40 percent of all taxpayers have no positive income tax liability, exclusions and deductions have *no value* to many lower-income individuals.³⁵ In addition, the current exclusion targets individuals who obtain health insurance through their employers rather than focusing on individuals who currently have no health insurance.

The regressive nature of the subsidy is especially troubling given the disproportionate burden that health care places on lower-income families. The Lewin Group recently found that the current system offers families earning \$100,000/year four times as much tax relief as families earning \$25,000/year.³⁶ Similarly, a recent Tax Policy Center report showed that “[h]ealth insurance premiums are 40 percent of income for the poorest households, but their subsidy rate is [currently] less than 10 percent. Those with incomes over \$200,000 receive subsidies equal to one-third of premiums even though premiums would amount to only 3 percent of their income without a subsidy.”³⁷

In contrast, advocates of refundable credits have highlighted the ways in which these tax incentives offer progressive benefits to all Americans. While subject to sometimes fierce opposition—and the subject of heated debate among tax policy analysts for decades—refundable credits are now an accepted aspect of the tax code, supported in different policy areas by a wide variety of organizations and experts.³⁸ These credits often target lower-income individuals through such well-known programs as the Earned Income Tax Credit and the Child Tax Credit. Refundable credits provide subsidies and create incentives that become relatively more valuable further down the income ladder. Individuals without federal income tax liability may receive the credits in cash or cash equivalents. For this reason, refundable credits are the only type of tax incentive of which all individuals, regardless of tax liability, can take advantage.³⁹ In fact, refundable credits provide a number of key progressivity advantages, including: (1) a more efficient way to accomplish social welfare goals relative to deductions and exclusions for various types of tax benefits; (2) a practical response to the limitations that the annual period for filing income tax returns creates; and (3) a strong counter-cyclical effect.⁴⁰ Even while largely critical of tax expenditures, tax expert Stanley Surrey argued that credits are “a priori more appropriate for the tax expenditure operation,” because their benefits do not depend on a taxpayer’s marginal bracket.⁴¹

Refundable credits offer a clear – but not singular – way to deal with the regressive subsidies that arise under the current system raises. Use of progressive cash subsidies, as in the Massachusetts program, would achieve the same result.

B. Distortions in the Market for Health Insurance and the Consumption of Health Care Services

In the absence of spending controls, demand for health care has skyrocketed and driven costs up significantly. By 2010, absent reform, national health spending will reach \$2.73 trillion.⁴² Per capita health expenditures have grown at a rate of about 7.9 percent over the 2001 through 2006 period.⁴³ In contrast, over that same period, per capita gross domestic product (GDP) grew by only about 4.2 percent.⁴⁴ The Kaiser Family Foundation has found that “the share of gross domestic product devoted to national health spending has increased from 7.2% in 1970 to an estimated 16.6% in 2008.”⁴⁵ From the individual’s perspective, this same study estimated that, in 2004, “18% of the nonelderly population had out-of-pocket health costs that exceeded 10% of their disposable income.”⁴⁶ Most recently, the Obama Administration’s budget projects that if current trends continue, health care costs will consume more than 20 percent of GDP by 2017.⁴⁷

Any health care reform plan should address the characteristics of the current system that promote over-consumption, overspending, and rising costs. Citing this 20 percent figure, the Obama Administration has so far emphasized that reducing the growth of health care costs is *the one* necessary condition to avoiding a fiscal Armageddon.⁴⁸

There is general agreement among health care experts that the current configuration of subsidies and government-sponsored health insurance programs have caused distortions in the market for health care, contributing significantly to escalating health care costs.⁴⁹ As a preliminary matter, Medicare, Medicaid, and related government-sponsored programs (as well as taxpayer-subsidized insurance for government workers), have provided certain cohorts with high levels of insurance coverage, while the system of employment-based tax subsidies has left the rest of America largely subject to the vagaries of employer-provided health insurance. Whatever the virtues of our employer-based system for those fortunate enough to enjoy the tax subsidy benefits of employer-sponsored programs, the current system has failed to achieve affordable access to health insurance for everyone.

Within this market, the exclusion encourages individuals to purchase more health care than they would in an efficient market operating without the tax advantage. Writing in *Health Affairs*, President Obama’s senior economic policy adviser, Jason Furman, recently described the problem:

Not surprisingly, people tend to purchase more of items that are subsidized, and health insurance is no exception. Illustrating this point, the elimination of the tax exclusion for employer-sponsored supplemental insurance in Quebec, Canada, led to “a decrease of about one-fifth in coverage by employer-provided supplementary insurance...but the increase in the non-group market offset only 10–15 percent of the decrease in coverage through an employer.”⁵⁰

The existing tax subsidy framework does not effectively correct any apparent market imperfections and instead only introduces this distortion. The system incentivizes consumers to over-insure themselves and their families. In so doing, they increase the level of health care-related spending and fail to select the level and type of coverage that is most appropriate for themselves and their families.

In addition, the present system lacks controls on medical spending. No system feature prevents taxpayers from responding to the incentives currently in place to over-insure and over-spend. Furman explains that:

The exclusion and other tax benefits for health care reduce the after-tax cost of that spending, leading to more spending on [covered] health care [costs] and less spending on everything else than would be the case without these incentives. 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.⁵¹

Reflecting the broad consensus among policy experts across the political spectrum, it seems clear than any meaningful effort to control the growth of health care costs must reflect more rational pricing and financial incentives, and that the place to begin is repeal (or substantial reform) of the current exclusion for employer-provided health insurance and its progeny. As noted above, this first step would have the added virtue of freeing up \$245 billion annually in tax expenditures that could go to funding more rational subsidies and incentives, perhaps including a refundable tax credit. In this regard, supporters argue that a refundable credit regime could make a significant contribution to controlling health care costs because individuals would receive a credit for any health plan selected and would have reduced incentives to limit themselves to the “one size fits all” and “gold-plated” options that have characterized employer- and government-based plans.

Proponents state that with a progressive, refundable credit, families and individuals would be able to sort through a wide variety of plans, search for more affordable plans that offered only the services most essential for themselves and their families, and pick good matches for specific medical needs. In this market, insurers themselves would compete for individual- and family-level business and would likely offer a more diverse set of plans to accommodate the full spectrum of market preferences. Refundable credit advocates argue that individuals and families would benefit substantially from the new array of available choices and the plans that could manage costs most effectively would achieve a market advantage.

C. Preserving the Employer-Based System

As noted above, if policy makers could start from scratch, it seems unlikely that they would structure access to health care around an employer-based model relying on an income exclusion that was costly, regressive, and a primary cause of inflated health care costs. Unfortunately, there are few do-overs and employer-provided health insurance is deeply embedded in both our health care and our political systems. Therefore, it seems likely that any move to repeal the exclusion for employer-provided health insurance and replace it with some form of refundable credit would have to account for the need to maintain the current system in some form, while facilitating a transition to alternative health insurance platforms, especially for the tens of millions of Americans who are not currently covered by employer-based plans. While this represents a truly daunting challenge, proponents maintain that a properly designed system of refundable credits, coupled with other tax incentives, could accomplish these objectives.

III. Design Issues

Any U.S. health care reform package must confront a series of core design issues. Many of these problems demonstrate the challenges of setting up a health care reform package in light of the current tax system and situating the reform package within that system. The following section considers some of these issues, using the example of a refundable credit-based reform plan as an illustrative case. The section includes consideration of the following: (1) eligibility standards and their administration; (2) timing anomalies in year-to-year eligibility changes; (3) timing anomalies in cash flow; (4) the design of a mandate to purchase insurance; (5) the choice in recipient of the credit/subsidy; and (6) the interaction with existing tax law subsidies.

A. Eligibility Standards and Administration of Standards

Appropriate eligibility criteria are key to the success of any plan. In the context of a credit or subsidy allocated to individuals and families, possible criteria could include measures of ability to pay (*e.g.*, earned income, adjusted gross or taxable income, and/or assets), family size, marital status, number of dependents, age, or the nature of local or regional insurance markets. If eligibility depends on ability to pay, possible recipients could qualify based on either income- or asset-based measures. The tax system generally uses income-based measures to set eligibility for certain tax benefits and subsidies (*e.g.*, savings and educational incentives). However, many transfer programs, such as the program formerly known as “food stamps”⁵² and, most notably, Medicaid, rely in part on asset-based measures. While each state has its own application process for food stamp eligibility, applicants generally must submit proof of assets, including bank statements or books, stock and bond certificates, deeds, real estate tax receipts and life insurance policies, to state and local agencies. Medicaid eligibility assessments also take place at the state level, and some applicants must provide similar documentation demonstrating proof of assets.

The IRS does not currently collect asset data or administer federal programs involving asset tests.⁵³ For this reason, if eligibility for a refundable credit or for any other health care benefit administered through the tax system, depended on assets, the federal government would need to develop and administer a new reporting and verification system. If the reform package involved direct government expenditures that relied on both income- and asset-based tests -while the IRS might have an informational role and the Treasury Department’s Financial Management Service a role in disbursing funds- it seems likely that primary responsibility for the program would rest outside of the Treasury Department.

Looking at how one reform plan has addressed this issue, the Massachusetts plan determines eligibility and the amount of subsidy based on income, family size, and disability.⁵⁴ Generally, for example, a family of four making below \$63,612 may qualify for the state’s government-sponsored health program, with some possible cost-sharing for those at the upper end of this income category.⁵⁵ The penalties for violating the Massachusetts mandate also depend on income.⁵⁶ Because it does not rely on asset-based or similar measures, the program can be administered using data from tax returns. Any plan enacted at the federal level might incorporate aspects of this approach.

B. Timing Anomalies, Part 1 – Changes in Eligibility Criteria from Year to Year

As long as eligibility for a tax code-based health program turns at least in part on individual or family income, timing anomalies may arise. In particular, recipients may not be able to take advantage of available benefits at the time of medical need. Program design should account for the hardship this problem may create for families.

This timing issue emerges because the IRS does not receive or process a taxpayer's Year 1 tax return information until sometime during Year 2. As a practical matter, this means that the amount of a Year 1 subsidy would be determined on a look-back basis during Year 2. While appealing on administrative grounds, a look-back rule is likely to have pernicious effects in many circumstances. In situations where a taxpayer's income increases in Year 2, the taxpayer will enjoy what might be considered a windfall because the credit will be based on a lower income in Year 1. While this may raise legitimate concerns on equity or cost grounds, it does not result in hardship to the individual or family.

The reverse occurs, however, in common circumstances involving a sudden and substantial drop in income (*e.g.*, caused by illness or job loss). A family whose income declines dramatically in Year 2 will be entitled to a limited (or no) subsidy based its far greater income during Year 1, despite the fact that its need for health insurance and a financial subsidy is far greater during Year 2. Moreover, there may be other changes in credit criteria between Year 1 and Year 2 – *e.g.*, change in marital status, increase or decrease in family size, age, death of the insured, or movement to a different local or regional insurance market.

Solving this problem will require creative policy design. However, some programs have grappled with the issue in other contexts. In particular, in the HCTC context, recipients can elect to receive that credit on an “advance” monthly basis. Recipients give 35 percent of their monthly premiums under a qualified insurance plan to the IRS, which then pays the insurance company the full cost of the premiums.⁵⁷ The IRS could administer the more general credit in the same way. However, as of July 2004, only 13,200 individuals were taking advantage of the advance HCTC.⁵⁸ Determining eligibility on a monthly basis for a large segment of the U.S. population might pose administrative hurdles. A broadly applicable system would likely require programmatic features aimed at supporting families who face hardship as a result of this timing mismatch.

Senator McCain's proposal avoided this issue by providing a flat-rate credit regardless of income or other measures of ability to pay. While President Obama's proposal did not provide sufficient detail to address this issue, the Massachusetts plan does so by requiring periodic updates of eligibility information (*e.g.*, income, household size, the availability of other health insurance, etc.). In addition to the annual re-determination process, changes in member circumstances can trigger eligibility checks any time during the year.⁵⁹ For accuracy, as part of the eligibility monitoring process, the state compares information collected for purposes of the program with information available from the Massachusetts Department of Revenue.

There has not yet been sufficient experience with the Massachusetts program to draw any conclusions regarding its periodic update program. However, regardless of the Massachusetts story, considerable administrative challenges would confront any effort at periodic updates for

even a small fraction of the several hundred million individuals and families that a comparable federal program would involve. We live in an extraordinarily dynamic society in which marital statuses, family sizes, employment circumstances, and residences change frequently.⁶⁰ This argues strongly for some simplified mechanism that protects individuals and families without imposing undue administrative burdens and costs.

C. Timing Anomalies, Part 2 – Cash Flow Considerations

In addition to the timing issues that arise out of the gap between eligibility determinations and payments, any individual- or family-based health insurance subsidy may create cash flow problems for recipients even where their status or circumstances do not change. Demonstrating this requires a return to the refundable credit example. Therefore, even if the government generally paid the credit directly to the taxpayer, the taxpayer's right to the credit would not equate to a cash payment from the IRS. Depending on the taxpayer's total tax liability for Year 1 and how much the taxpayer has paid to the IRS through withholding or other means for that year, the taxpayer could owe an additional cash payment to the IRS, or could be entitled to a cash refund from the IRS that is greater or less than (or equal to) the amount of the health insurance tax credit.

For example, a taxpayer who was under-withheld during Year 1 might owe substantial additional taxes on his or her Year 1 return filed during Year 2. Even if that taxpayer qualified for the full amount of the health insurance tax credit, the credit amount might still be smaller than the tax payment due. In this case, the taxpayer would still owe additional tax to the IRS. If that taxpayer had planned to use his or her credit payment for health care purchases in Year 2, he or she might unexpectedly lack the necessary funds and become under- or uninsured during Year 2 or face other financial difficulties. Moreover, integrating the credit with the taxpayer's overall tax return filing might minimize its transparency and undermine its incentive effects.

As with taxpayers whose eligibility and benefits fluctuate because their circumstances change, general reliance on the tax return filing process raises potentially significant cash flow issues for individuals and families of limited means who might be the primary intended beneficiaries of an enacted subsidy but who also may be less able to "pre-fund" their purchases of health insurance.

Again, Senator McCain's proposal largely avoided this issue by providing for a flat rate credit that is payable directly to the insurance provider. While President Obama's health care campaign proposals did not provide sufficient detail to address this concern, the Massachusetts program may provide some insight into the approach his Administration may take to the problem. Because Massachusetts distributes insurance benefits on an ongoing, rather than annual, basis, individuals receive funds periodically to satisfy similarly periodic premium payment obligations. In addition, Massachusetts has devoted substantial resources to producing welcoming and user-friendly documents,⁶¹ which may reduce confusion on this and other points. The fact that Massachusetts makes payments directly to individuals leads naturally to the next topic – the question of mandates.

D. Mandates

The fourth program design issue crucial to a well-functioning subsidy system concerns a possible requirement that individuals buy health insurance for themselves or their families. Under any reform package, the purchase of health insurance could be optional or mandatory. Proponents of a mandatory system argue that it is the only way to achieve universal coverage and address the “moral hazard” that arises when healthy individuals chose not to purchase insurance. According to this view, a system without a mandate forces those without insurance to rely on free care” through emergency rooms; distorts risk shifting and risk sharing in the health insurance markets; and means that the uninsured receive less effective and more expensive care that imposes adverse consequences on third parties. Opponents of a mandate argue that it undermines free choice and that the “moral hazard” claims are vastly over-stated.

A mandatory-coverage requirement raises a number of design questions that are beyond the scope of this paper,⁶² most notably the following: (a) who is subject to the mandate (employers and/or individuals and families); (b) what is mandated (presumably, some form of minimum coverage level, *e.g.*, for catastrophic health care); and (c) what are the sanctions for failure to comply? What is relevant for purposes of this paper is the enforcement mechanism: how is information compiled to determine compliance and how are sanctions enforced? As a practical matter, the IRS is the only federal agency that comes close to reaching a substantial portion of those potentially subject to mandates (especially if those mandates include both employers and individuals/families, as is likely the case). This “pre-existing condition” means that the IRS may be best situated to collect data on compliance by piggy-backing on existing filing requirements (*e.g.*, individual and business tax returns could include a form with information regarding compliance), coupled with information reporting by insurance companies and others providing coverage.

Likewise, sanctions could be administered through some form of excise tax that would be addressed through the annual tax return filing requirement and administered by the IRS as part of its overall enforcement program. Others argue that the sole responsibility of the IRS should be to administer our very complex tax system, that it is already over-burdened with that task and extraneous duties, and that tying the IRS to health care would be a significant “public relations” mistake.⁶³ The alternative would be to assign information collection, administration, and enforcement responsibilities on one or more other federal or state government agencies, perhaps relying on the IRS as a source of information. How this question is resolved may depend in part on whether the IRS was assigned other responsibilities in the context of health care reform (*e.g.*, administering a system of refundable credits or other subsidies).

Once again, Senator McCain’s proposal avoided this issue because it did not impose any coverage mandates. In contrast, then-Senator Obama’s campaign proposal required parents to provide their children under the age of 19 with health insurance, while the Massachusetts plan requires individuals 18 and over to carry a minimum level of coverage or qualify for various hardship-based and religious exceptions. The Massachusetts plan also requires certain “large” employers to offer coverage to their employees or pay a fee to the state. As noted above, the Massachusetts Department of Revenue administers this sanction.

E. Flow of Funds: A Hypothetical Model Replacing the Current Exclusion with a Progressive, Refundable Tax Credit

The final key program design issue concerns the parties who receive funds associated with the credit or other progressive subsidy. As noted above, Senator McCain's proposal was attacked by then-Senator Obama on grounds that the McCain credit would go directly to insurance companies (with Senator McCain countering that Senator Obama would impose mandates enforced by the IRS). Despite these election season criticisms, the matter of who should claim the credit turns out to be a very important design consideration that has potential to address the timing anomaly and mandate issues noted above, while building on the current employer-based system.

One option, of course, would be to provide subsidies directly to the beneficiary (employer or individual/family). This is the approach followed in Massachusetts and in the plan that President Obama advocated as a candidate during the 2008 presidential campaign. The other primary option would be to provide that third parties claim the credit as surrogates on behalf of beneficiaries. Senator McCain identified insurance providers as the appropriate third parties. While this would be the likely outcome in a market dominated by individual purchasers, it is possible to design a system where credits could be claimed by other third parties on behalf of potentially eligible individuals and families.

For example, it may be appropriate to permit employers to collect credits on behalf of eligible employees to pay a portion of the cost of employer-provided coverage. Under this regime, employers could continue to offer coverage to all employees and could claim credits on their behalf.⁶⁴ Similarly, individuals or social network groups could form purchasing cooperatives to acquire group coverage that would claim tax credits on behalf of members.⁶⁵ Finally, individuals not covered by either of these arrangements could be assigned to regulated purchasing pools, in which case insurance companies would claim credits on their behalf. In each of these circumstances, the intermediary employer, purchasing cooperative, or purchasing pool could offer a single type of coverage or – more likely – a choice among types of coverage.

In theory, this approach would have the following potential benefits: (1) use of a progressive, refundable credit would allow policy makers to target and provide whatever subsidies were determined appropriate;⁶⁶ (2) a phased-out, individual/family-based credit structure along with incentives for employers, purchasing cooperatives and purchasing pools to offer participants choices among different plans would achieve cost containment and quality objectives; (3) tax and other incentives would encourage employers to maintain or adopt plans; and (4) flexible features could integrate into whatever mandates and other policies were determined appropriate (*e.g.*, mandatory participation; minimum coverage requirements; rules regarding pre-existing conditions; and establishment and regulation of purchasing pools).

Each of these approaches raises its own difficult design and implementation challenges. In considering this type of approach, however, it is useful to keep in mind the central role that third party payors and payees can play in addressing a number of the administrative design issues addressed above. As a general proposition, tax administration (and, presumably, other large administrative systems) functions best when there are a limited number of third party

intermediaries who can perform various functions that facilitate tax compliance and administration relating to the obligations of literally hundreds of millions of individual taxpayers. The primary examples are third party wage and payroll tax withholding and information. For example, wage withholding and information reporting result in tax compliance rates in excess of 90 percent (with wage withholding resulting in compliance rates approaching 100 percent). In the absence of these arrangements, compliance rates drop dramatically in areas ranging from capital gains reporting to compliance by small businesses with substantial amounts of cash income (where compliance rates can drop well below 50 percent). In addition, the IRS's ability to deal with a limited number of large enterprises reduces administrative costs on both parties relative to dealing with hundreds of millions of individual taxpayers.

The following hypothetical example involving a refundable credit system illustrates the mechanics and potential administrative benefit of using third parties to collect subsidies on behalf of beneficiaries.

- Individuals and families not otherwise covered by Medicare or Medicaid would be entitled to a tentative credit claim equal to their expected credit for the year (if any, since the progressive design would phase out the credit), and would be required to use some or all of that tentative credit in connection with the purchase of health insurance. Depending upon the circumstances, the insured would "sign over" the credit to his or her employer, a purchasing cooperative, a government-sponsored purchasing pool, or an insurance carrier. The type of coverage purchased would determine how much the individual might need to pay for insurance on top of his or her credit amount, if any (or, in some cases, the amount of refund to which the individual would be entitled to receive).⁶⁷

- The third party intermediary (employer, purchasing cooperative, *etc.*) could either treat the credit as an offset to other periodic tax payment obligations or claim the credit directly from the government on a periodic basis.

- Following the end of each year, individual/family beneficiaries would then be required to file tax returns showing the actual amount of the credit to which they were entitled based on eligibility criteria for the year. If the taxpayer was entitled to a lesser or greater credit, then he or she would take account of that difference in computing his or her tax liability for the year and payment obligation to – or refund claim from – the government. As noted above, depending on withholding and other tax payments during the year, the tax payment obligation or refund claim would bear no necessary relationship to any difference between the amount of tentative credit claimed by the taxpayer during the year and the actual credit to which he or she was entitled.⁶⁸

- Appropriate information reporting requirements (*e.g.*, the fact of insurance coverage meeting minimum coverage standards and the identity and amount of credit claimed by each insured) would have to be reported by the appropriate intermediary to the IRS. This reporting mechanism would help assure that taxpayers claimed the proper amount of tax credit and that various participants complied with whatever mandates were imposed by law (*e.g.*, fact of coverage and insurance policy design). As noted above, information reporting regimes in the tax law context promote compliance rates in excess of 90%.

An approach along these lines would speak to the administrative issues summarized above. In particular, it would address: (1) issues relating to fluctuating eligibility resulting from changed circumstances during the year, by allowing individuals to modify the amount of tentative credit claimed in response to such changes, and (2) cash flow issues, by providing current funds to purchase insurance based on the individual's estimated credit amount. In addition, this regime would allow the IRS to determine retrospectively the amount of credit actually owed and give the IRS all the information needed to monitor compliance with any mandatory coverage obligations.

As is apparent, this approach raises significant questions of administrative burden and tax compliance. In each case, the answer is – compared to what? *Any* reform proposal that is intended to provide progressive subsidies and encourage or mandate universal coverage, affecting many millions of organizations and literally hundreds of millions of Americans, is going to pose extraordinary administrative challenges. Proponents of a refundable credit approach argue, with considerable merit, that it is uniquely capable of building on existing administrative structures and may therefore be less burdensome than the next-best alternative. Moreover, these arrangements resemble a variety of provisions raising similar administrative issues under current tax law, including for example, contributory retirement plans, so-called cafeteria plans, MSAs, HSAs, and VEBAs.

Likewise, *any* fundamental health care reform of the type under consideration will raise extraordinary compliance and enforcement issues. Again, proponents of reforms based on refundable tax credits argue that while other proposals would require building compliance and enforcement mechanisms from scratch, a tax-based approach would confront the same compliance issues that are common to our current tax system (*e.g.*, overstated withholding exemptions by workers, overstated deductions and credits by taxpayers, and returns that are filed showing balances due). Because these are known issues in the tax administration context, an approach building entirely on existing infrastructure and administrative systems may raise fewer and more easily-solved compliance issues than the next best alternative. As noted above, this may be particularly true in light of the ample opportunities for third party information reporting.

F. Interaction with Existing Tax Law Subsidies

In addition to these primary design issues, comprehensive health care reform—whatever shape it takes— will have to deal with the panoply of health care provisions embedded in current tax law. As summarized above, they range from the exclusion for employer-proved health insurance and the deduction for health insurance purchased by the self-employed, to an alphabet soup of special deductions and exclusions (HSAs, HRAs, FSAs, VEBAs), a refundable HCTC credit, deductions for certain unreimbursed medical expenses and an exclusion for inside build-up on long-term care policies. Senator McCain addressed only one of these provisions, proposing to repeal the exclusion for employer-provided insurance – and was severely criticized for the effort. To date, President Obama has not addressed that exclusion, although a number of his key policy advisors are on record reflecting the wide-spread view that the exclusion is a costly and regressive subsidy that distorts health care decisions and contributes to escalating health care costs. Likewise, to date his Administration has addressed no other potentially relevant tax provisions. Meanwhile, because Massachusetts follows federal tax law and did not repeal or modify any

relevant provisions as part of its health care reform, the state effectively retained all of the federal health care related provisions as part of its reform.

Also, any reform program would interact with non-health-care tax law provisions. As a result, policy designers would have to determine how individual tax liability calculations would account for any newly available subsidy. For example, would taxpayers determine the amount of their credit after taking full advantage of all other deductions or credits? Would credit payments themselves be treated as taxable income? In addition, different tax filing status circumstances could present credit allocation problems. For example, how would the credit be allocated in circumstances where a married couple elects to file separately, gets divorced during the year, or faces ambiguity over which of a pair of divorced parents can claim its children as dependents?

Finally, any system that relies on tax filings may significantly increase the number of individuals that may have to file tax returns. In 2006, 15 million households and individuals did not do so.⁶⁹ In part, the extent of this issue will depend on the structure of any enacted subsidy. If, for instance, the government pays it directly to the taxpayer on the filing of a return, then every individual and family would have to file. On the other hand, if a full subsidy were available for those otherwise not required to file, then failure to file may cost potential recipients a refund but would not cost the government revenue.

Conclusion

Tax law has played a major role in shaping health care policy for more than 50 years. It is the primary factor contributing to our current system of employer-provided health care. Beyond the exclusion for employer-provided health insurance from taxation, there are myriad provisions to encourage savings for the purchase of health insurance and subsidize the cost of health care. The existing system has played a starring role in the current health care system, but at a significant price and with limited success. The current subsidies are very expensive and highly regressive. They have introduced market inefficiencies that have been a contributing factor to inequality in health insurance coverage and exponential growth in health care costs. Further, the system has left tens of millions of middle class Americans uninsured.

From an administrative standpoint, the IRS is the primary institution that deals regularly with virtually all citizens. It also functions in many ways as the largest financial institution in the world, collecting funds and information from, and disbursing funds to, all of those with a stake in health care policy—individuals and families, employers and workers, the self-employed, purchasing cooperatives, and health insurance providers. Within this framework, one way to implement health care policy reform would be to leverage the existing infrastructure provided by the IRS to: (1) repeal the exclusion for employer-provided health care (and repeal or modify certain other exclusion and deduction provisions under current law); (2) replace and enhance those subsidies through a more progressive system of refundable credits that enhances choice and eliminates distortions in the market for health care; and (3) administer the system in ways that prevent timing mismatches and support compliance. Any reform initiative should give serious consideration to the role such approaches can play in health care reform.

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² U.S. Const. Art. I, Sec. 8, cl. 1, “to lay and collect taxes . . . and provide for the . . . general welfare of the United States.”

³ “Barack Obama and Joe Biden’s Plans for Small Business,” Obama-Biden Campaign, *available at* <http://www.barackobama.com/pdf/SmallBusinessFINAL.pdf>.

⁴ I.R.C. § 105(a); I.R.C. § 106(a).

⁵ I.R.C. § 223(a).

⁶ I.R.C. § 106(d)(1).

⁷ I.R.C. § 106(d)(2).

⁸ I.R.C. § 106(a).

⁹ I.R.C. § 105(b).

¹⁰ Notice 2002-45, 2002-2 C.B. 93, § V.

¹¹ I.R.C. § 162(l).

¹² I.R.C. § 213(a).

¹³ I.R.C. § 213(a).

¹⁴ I.R.C. § 162(l)(2)(B).

¹⁵ B. Bitter and L. Lokken, 3rd Ed. *Federal Taxation of Income, Estates and Gifts* (New York: Research Institute of America, 2008) at 36.2..

¹⁶ For the treatment in payroll taxes in the context of various health care tax provisions, *see IRS Publication 15-B, Employer’s Tax Guide to Fringe Benefits*, *available at* <http://www.irs.gov/pub/irs-pdf/p15b.pdf> (value of employer-provided health insurance and contributions not subject to payroll taxes); *Health Savings Accounts, U.S. Treasury*, *available at* <http://www.ustreas.gov/offices/public-affairs/hsa/> (whether HAS contributions subject to payroll taxes depends on whether contribution is through an employer-sponsored health plan and is subject to certain dollar limits); *IRS Publication 535*, *available at* <http://www.irs.gov/publications/p535/ch06.html#d0e3753> (self-employment payroll taxes must be paid on amounts deducted by the self-employed to purchase health insurance). The small business community has expressed concern about this distinction for the self-employed. *See, for example, "Self-Employment Tax on Health Insurance Premiums," National Association for the Self-Employed*, *available at* http://www.advocacy.nase.org/issue_briefs/taxonhealthpremiums.asp.

¹⁷ The deduction for insurance costs for the self-employed is not an itemized deduction, so is not subject to a percent floor or the phase-out for itemized deductions.

¹⁸ I.R.C. § 7702B(a)(1).

¹⁹ I.R.C. § 7702B(a)(2).

²⁰ I.R.C. § 125(f).

²¹ I.R.C. § 106(c).

²² I.R.C. § 501(c)(9).

²³ Bittker & Lokken, *supra* note 15 at 63.14.

²⁴ I.R.C. § 35.

²⁵ Joint Committee on Taxation, *Tax Expenditures for Health Care*; (JCX-66-08), July 30, 2008.

²⁶ *Id.*

²⁷ Internal Revenue Service, *HCTC: The Monthly HCTC*, *available at* <http://www.irs.gov/individuals/article/0,,id=109941,00.html> (last visited Oct. 6, 2008).

²⁸ Internal Revenue Service, *HCTC: The Yearly HCTC*, *available at* <http://www.irs.gov/individuals/article/0,,id=109954,00.html> (last visited Oct. 6, 2008).

²⁹ I.R.C. § 4980B.

³⁰ IRC §§ 9801 –9833.

³¹ U.S. Census Bureau, *Income, Poverty and Health Insurance Coverage in the United States 2007*, *available at* <http://www.census.gov/prod/2008pubs/p60-235.pdf>.

³² Joint Committee on Taxation, *Tax Expenditures for Health Care*, (JCX-66-08) , July 30, 2008.

³³ U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, *available at* <http://www.census.gov/prod/2008pubs/p60-235.pdf> (last visited Dec. 1, 2008).

³⁴ While the exclusion for employer-provided insurance is generally regressive, this analysis is complicated in two respects. The first relates to the Earned Income Tax Credit (“EITC”). It turns out that certain low income

taxpayers actually benefit from reporting increased taxable income because any costs are more than offset by the increase in EITC benefits. In contrast, because increases in income can result in reduced EITC benefits, taxpayers in the EITC phase-out range can be faced with relatively high marginal rates. Second, because employer-provided health insurance is properly treated as earned income, its inclusion would also have payroll tax implications.

- ³⁵ In light of the Obama Administration's proposal to allow the Bush tax cuts expire in 2010, it is worth noting the interaction of marginal tax rates and the value of tax deductions. If the top marginal rates rise to 38.5 percent, the value of the exclusion for health insurance will increase from \$3,500 to \$3,850. This illustrates notable paradox: while increasing marginal rates increases the value of "tax expenditures" benefiting upper income taxpayers, it does so in the context of increasing their overall tax burden. Stated differently, a first dollar, comprehensive flat rate tax would equalize the value personal deductions and exclusions.
- ³⁶ J. C. Goodman, "McCain is the Radical on Health Reform," *Wall St. J.*, July 30, 2008.
- ³⁷ Leonard E. Burman et. al., *Tax Incentives for Health Insurance*, Tax Policy Center 20 (2003).
- ³⁸ Cf. Stuart Butler, "Evolving Beyond Traditional Employer-Sponsored Health Insurance,," Discussion Paper 2007-06, Hamilton Project (May 2007), available at <http://www.brookings.edu/es/hamilton/200705Butler.pdf>; Chye-Ching Huang and Hannah Shaw, "New Analysis Shows 'Tax Expenditures' Overall are Costly and Regressive," Center on Budget and Policy Priorities (Feb. 23, 2009), available at <http://www.cbpp.org/files/2-23-09tax2.pdf>; Nina Owcharenko, "Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage," Backgrounder #1895, Heritage Foundation (November 8, 2005), available at <http://www.heritage.org/Research/HealthCare/bg1895.cfm>
- ³⁹ Congress and the Obama Administration expanded greatly the scope of refundable credits in the recently enacted "stimulus" legislation by providing for advance refundable energy tax credits. As noted below, this approach is instructive in the health insurance context.
- ⁴⁰ See Lily L. Batchelder, Fred T. Goldberg, Peter R. Orszag, *Efficiency and Tax Incentives: The Case for Refundable Tax Credits*, 59 *Stan. L. Rev.* 23 (2006). See also Brian H. Jenn, *The Case for Tax Credits*, 61 *Tax Law.* 549, 561 (2008); Deborah M. Weiss, *Tax Incentives Without Inequity*, 41 *UCLA L. Rev.* 1949 (1994).
- ⁴¹ Stanley S. Surrey, *Pathways to Tax Reform: The Concept of Tax Expenditures* 136 (1974).
- ⁴² The Lewin Group, *McCain and Obama Health Care Policies: Cost and Coverage Compared* 13 (2008).
- ⁴³ *Id.*
- ⁴⁴ *Id.*
- ⁴⁵ Kaiser Family Foundation, *Health Care Costs and Election 2008*, available at http://www.kff.org/insurance/h08_7828.cfm (last visited Nov. 20, 2008).
- ⁴⁶ *Id.*
- ⁴⁷ Office of Mgmt. and Budget, Executive Office of the President, *A New Era of Responsibility: Renewing America's Promise* (2009).
- ⁴⁸ *Id.* at 11-12. ("Overall, health care is consuming an ever-increasing amount of our Nation's resources. . . The bottom line is that the current path of rising health care costs is unsustainable, not only for the Federal Budget but also for family budgets.").
- ⁴⁹ There are, of course, numerous other actual and perceived contributing factors. For example, the recent "stimulus legislation" justified providing \$19 billion to facilitate transition to electronic medical records both because it would increase quality and because it would generate substantial cost savings. See Hiran Ratnayake, *With Stimulus Help, Physicians Get Wired*, *The News Journal*, Feb. 22, 2009. Along these same lines, the Obama Administration budget proposes to control costs through a variety of measures, including increasing access to generic drugs and reducing hospital readmission rates. See Office of Mgmt. and Budget, *supra* note 56. In contrast, some observers attribute escalating costs to out-of-control malpractice suits or marketing by drug companies.
- ⁵⁰ Jason Furman, *Health Reform Through Tax Reform: A Primer*, 27 *Health Affairs* 622, 623 (2008).
- ⁵¹ *Id.* at 624.
- ⁵² The federal program once known as "food stamps" now goes by the name "Simplified Nutritional Assistance Program" (SNAP). Some of the states have also adopted different terminology. For convenience, this paper will refer to this subsidy as "food stamps."
- ⁵³ Tax returns do gather information that may be a surrogate for home ownership and investment assets (mortgage interest and property tax deductions; interest, dividends, capital gains and other forms of investment income). It is likely, however, that this information is far too inexact to provide a reliable asset-based measure for eligibility.
- ⁵⁴ The Massachusetts Health Insurance Connector Authority, *Medical Benefit Request Form* (2008).

55 About Us: Connector Programs, *available at* <http://www.mahealthconnector.org/portal/site/connector/> (follow
56 “Commonwealth Care” hyperlink; then follow “eligible” hyperlink (last visited Dec. 1, 2008).
57 Massachusetts Department of Revenue, *Individual Mandate Penalties for Tax Year 2008* (2008).
58 Internal Revenue Service, *HCTC: The Monthly HCTC*, *available at*
<http://www.irs.gov/individuals/article/0,,id=109941,00.html> (last visited Oct. 6, 2008).
59 Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation,
GAO-04-1029.
60 The Massachusetts Health Insurance Connector Authority, *supra* note 54, at 15.
61 Between June 2007 and June 2008, 4,309,000 births occurred in the U.S., as did 2,437,000 deaths and
2,153,000 marriages. During that same period, 3.5 divorces occurred per every 1,000 people in reporting states.
See B. Tejada-Vera and PD Sutton, *Births, marriages, divorces, and deaths: Provisional data for April 2008*.
National Vital Statistics Reports; vol. 57, no. 9. National Center for Health Statistics. 2009. Americans also
change jobs and move frequently. The Department of Labor reports that the average person born in the later
years of the baby boom held 10.8 jobs from age 18 to age 42. See Department of Labor, *Number of Jobs Held,
Labor Market Activity, and Earnings Growth Among the Youngest Baby Boomers: Results From a Longitudinal
Survey Summary*, *available at* <http://www.bls.gov/news.release/nlsoy.nr0.htm>. Similarly, the U.S. Census
Bureau reports that the average American makes 11.7 moves in a lifetime. See Kristin Hansen, Geographical
Mobility, U.S. Census Bureau, *available at* <http://www.census.gov/population/www/pop-profile/geomob.html>.
62 See The Massachusetts Health Insurance Connector Authority, *supra* note 54, at 41-45.
63 See Legal Solutions in Health Reform paper, “The Constitutionality of Mandates to Purchase Insurance,” by
Mark A. Hall *available at*
http://www.law.georgetown.edu/oneillinstitute/projects/reform/Individual_Mandates.html (last visited Apr. 23,
2009).

63 Indeed, this was one of the primary attacks leveled by Senator McCain against then-Seantor Obama’s health
care proposal – that he was proposing a mandated that would be enforced by the dreaded IRS.
64 Note that in the employer context, rather than having employees sign over the tentative credit amount, the
employer could simply pay for coverage and treat that payment as wages. The employee would then claim his
or her actual credit against his or her tax liability for the year. This arrangement would work well even where
employees could elect among different types of coverage, with the employer making supplemental wage
payments or reductions from cash compensation, depending on the particular coverage selected by the
employee.
65 Under current law, the HCTC program involves third-party payment. If a recipient selects the “advance
monthly” option, he or she pays 35 percent of monthly premiums to the federal government, which then pays
the insurance company 100 percent of premium costs each month. Individuals may instead choose to pay for
plans directly throughout the year and themselves receive the HCTC directly either as a tax refund or a credit
against taxes owed. In addition, the proposed federal individual development account program would have
employed such a structure.
Similarly, individual development accounts, or “IDAs,” were “matched savings accounts” for low-income
families. See Corporation for Enterprise Development, “Expand Individual Development Accounts in the 110th
Congress: The Savings for Working Families Act (S. 871 and H.R. 1514),” *available at*
http://www.assetsconference.org/documents/hill_visits/SWFAonepager.pdf (last visited Nov. 18, 2008). IDA
holders could set up savings accounts at qualified financial institutions. The funds in these accounts could go
toward buying a first home, paying for post-secondary education or building a small business. Account holders
would make payments into these accounts, and the financial institutions would match the payments on a dollar-
for-dollar basis. Then, at the end of each year, the financial institutions could claim tax credits for the total
amount of matching payments made plus a small bonus for participating in the program. See Savings for
Working Families Act of 2007, 110th Cong., 1st Sess. (2007).
66 It could also take into account other factors, such as whether the taxpayer is disabled, or where the taxpayer
lives if it were decided to also vary the credit to reflect different costs for health insurance in different parts of
the country.
67 While these arrangements raise administrative complexities, it is important to note that they resemble a variety
of provisions under current law, for example, contributory retirement plans, so-called cafeteria plans, MS’s,
HSAs and VEBAs. Third parties have developed sophisticated and efficient administrative platforms to deal
with these arrangements and could likely accommodate the refundable health insurance credit regime described
above

⁶⁸ See Section IV.b of this paper.

⁶⁹ Scott A. Hodge, *Number of Americans Paying Zero Federal Income Tax Grows to 43.4 Million*, Tax Foundation, Mar. 30, 2006, available at <http://www.taxfoundation.org/research/show/1410.html>.