

11-1-1995

Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance

Bradley W. Joondeph

Follow this and additional works at: <https://digitalcommons.law.byu.edu/lawreview>



Part of the [Health Law and Policy Commons](#), [Insurance Law Commons](#), and the [Tax Law Commons](#)

Recommended Citation

Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 BYU L. Rev. 1229 (1995).

Available at: <https://digitalcommons.law.byu.edu/lawreview/vol1995/iss4/3>

This Article is brought to you for free and open access by the Brigham Young University Law Review at BYU Law Digital Commons. It has been accepted for inclusion in BYU Law Review by an authorized editor of BYU Law Digital Commons. For more information, please contact hunterlawlibrary@byu.edu.

Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance

Bradley W. Joondeph*

I. INTRODUCTION

Section 106 of the Internal Revenue Code permits employees to exclude employer-sponsored health insurance¹ from adjusted gross income.² At the same time, employers may fully deduct the cost of purchasing health benefits for their employees.³ Taxpayers who are self-employed, however, can deduct only 30% of the cost of health insurance,⁴ and no deduction is available for those who neither are self-employed nor purchase insurance through their employer unless their health care expenses exceed 7.5% of their adjusted gross incomes.⁵ These provisions of the tax code have created an

* Teaching Fellow, Stanford Law School; J.D. 1994, Stanford Law School; B.A. 1990, Stanford University. The author thanks Professor Barbara Fried, Andrew Berke, Pat Konopka, and Srija Srinivasan for their helpful comments and suggestions on earlier drafts of this essay.

1. For purposes of this essay, the terms "health insurance," "health coverage," and "health benefits" are interchangeable. They are meant to encompass all forms of private health coverage, including traditional indemnity insurance, employer self-insurance programs, preferred provider insurance and organizations (PPIs and PPOs), and health maintenance organizations (HMOs).

2. 26 U.S.C. § 106 (1989) ("Gross income of an employee does not include employer-provided coverage under an accident or health plan.").

3. *See id.* § 162(a)(1).

4. Permanent Extension and Increase of Deduction for Health Insurance Costs of Self-Employed Individuals, Pub. L. No. 104-7, § 1, 109 Stat. 93 (1995) (to be codified at 26 U.S.C. § 162). In April 1995, Congress made the deduction permanent and increased the percentage deductible from the previous level of 25%. Ann Devroy, *Clinton Signs Self-Employed Insurance Deduction*, WASH. POST, Apr. 12, 1995, at A9. President Clinton has subsequently proposed increasing the deduction to 50%. Robert Pear, *Administration Proposes Federal Regulation of Health Insurance*, N.Y. TIMES, June 15, 1995, at A24.

5. 26 U.S.C. § 213 (1988); *see also* Henry T. Greely, *The Regulation of Private Health Insurance*, in HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION 8-1, 8-23 (Mark A. Hall ed. 1993).

enormous incentive for taxpayers to acquire health coverage through employment-related groups.

There are several plausible, public-regarding justifications for excluding health benefits from taxation. Foremost is that the government has many self-interested reasons to encourage taxpayers to purchase private health coverage. Inducing more consumers to obtain health insurance reduces public health care expenditures, promotes greater efficiency and equity in the health care system, and even furthers social justice.⁶ Moreover, as a theoretical matter, resources devoted to health insurance arguably should be excluded from taxable income because they do not reflect a consumer's relative welfare or taxability.⁷

But these justifications do not fully explain the current tax treatment of health benefits. First, these rationales do not account for extending the tax preference only to employer-sponsored insurance. This restriction is inequitable and regressive, benefiting those taxpayers for whom private health coverage is generally the least expensive.⁸ These justifications also fail to explain why taxpayers are permitted to exclude the full cost of their health insurance regardless of the type of plan in which they enroll. The full exclusion allowed by § 106 actually undermines the government's objectives of reducing public health care expenditures and promoting the efficient delivery of care.⁹

The tax treatment of health benefits also aggravates several existing problems in the private health insurance market. By shielding consumers from the true cost of health coverage, the tax code harmfully distorts purchasing decisions, making demand for health coverage both excessive and cost-unconscious.¹⁰ And by establishing such strong incentives for taxpayers to obtain coverage through their employers, § 106 has tied the purchase of health insurance to the employment setting, creating the problem of "job lock."¹¹

This essay argues that the tax treatment of health benefits needs reform. Part II examines the government's possible

6. See *infra* text accompanying notes 42-58.

7. See *infra* text accompanying notes 60-68.

8. See *infra* text accompanying notes 69-81.

9. See *infra* text accompanying notes 82-88.

10. See *infra* text accompanying notes 116-149.

11. See *infra* text accompanying notes 95-115.

rationales, both practical and theoretical, for exempting employer-sponsored health benefits from taxation. Part III critiques these justifications and contends that the exclusion is both underinclusive and overextensive. Part IV discusses the detrimental impact of the current tax treatment of health benefits on the health insurance market. Finally, Part V argues that the government could solve many of the problems attributable to the tax treatment of health benefits by implementing three basic changes: (1) permitting *all* taxpayers to exclude or deduct the cost of acquiring health insurance, (2) limiting the amount of the exclusion or deduction to the regionally-adjusted cost of a standard benefits package, and (3) eliminating the tax provision that permits employees to pay their portion of their health insurance premiums with pretax dollars.

II. JUSTIFICATIONS FOR THE CURRENT TAX TREATMENT OF HEALTH BENEFITS

A. *Instrumental Rationales*

One plausible explanation for exempting employer-sponsored health insurance from taxation is that this exemption induces more taxpayers to obtain private health coverage. Arguably, the government has several compelling reasons for promoting the proliferation of private health insurance. By encouraging consumers to enroll in private plans, the government (1) reduces overall health expenditures, (2) decreases its own health care costs, (3) promotes a more equitable distribution of costs among health care recipients, and (4) decreases the number of Americans forced into poverty due to catastrophic illnesses.¹²

Although approximately forty-one million Americans do not have health insurance of any kind,¹³ every American actually

12. Another possible rationale for subsidizing taxpayers' purchase of private health coverage is more paternalistic. One could reasonably argue that, because people tend to discount the likelihood and cost of future illness, too few consumers purchase health coverage. See VICTOR R. FUCHS, *THE HEALTH ECONOMY* 265-66 (1986). In this light, § 106 aims to remedy the market imperfection of incomplete information for consumers. The exclusion simply raises the otherwise artificially low demand for health insurance to an efficient level. Under this theory, the exclusion merely amounts to a subsidy designed to coddle consumers into doing what is in their own best interest.

13. Spencer Rich, *More Access to Health Insurance Proposed: Key Features of Original Plan Abandoned; Medicare Savings Goal Rises*, WASH. POST, June 14,

has *some* access to health care. A patchwork of laws, programs, and public providers guarantees that even uninsured patients receive medical care at least in emergency situations. Most notably, the federal Emergency Medical Treatment and Active Labor Act (EMTALA)¹⁴ requires all hospitals with emergency care facilities to screen any patient who applies for emergency care.¹⁵ If hospital staff determine that the patient needs emergency treatment,¹⁶ EMTALA requires the hospital to treat the patient until her condition has stabilized.¹⁷ Hospitals or physicians who violate the requirements of EMTALA are subject to civil fines,¹⁸ private actions,¹⁹ and exclusion from Medicare or Medicaid reimbursement.²⁰ Another federal law, the Hill-Burton Act, also requires many hospitals to provide care to uninsured patients.²¹ Hill-Burton mandates that all hospitals that have received federal construction loans offer a minimum level of "community service" in the form of uncompensated care.²²

Notwithstanding the provisions of EMTALA and Hill-Burton, as well as various state law requirements,²³ private providers generally avoid treating uninsured patients because of the uncertainty of being reimbursed for providing the care. Consequently, uninsured patients receive the majority of their medical treatment at public health care facilities.²⁴

1995, at A21. Approximately 160 million Americans have private health insurance, while the remaining 55 million have coverage through a publicly sponsored program such as Medicare, Medicaid, the Veterans Administration, or the Indian Health Service. See Eli Ginzberg, *The Limits of Health Reform—Revisited*, 3 STAN. L. & POL'Y REV. 195, 195 (1991).

14. 42 U.S.C. § 1395dd(d)(1)(B) (1988 & Supp. II 1990). Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82.

15. 42 U.S.C. § 1395dd(a)-(c) (1988 & Supp. II 1990). For a thorough discussion of EMTALA's provisions, see Demetrios G. Metropoulos, Note, *Son of COBRA: The Evolution of a Federal Malpractice Law*, 45 STAN. L. REV. 263 (1992).

16. The statute defines an emergency medical condition as one in which "the absence of immediate medical attention could reasonably be expected" to cause serious harm to the patient. 42 U.S.C. § 1395dd(e)(1)(A) (1988 & Supp. II 1990).

17. 42 U.S.C. § 1395dd(a)-(c) (1988 & Supp. II 1990).

18. *Id.* § 1395dd(d)(1)(A)-(B) (Supp. II 1990).

19. *Id.* § 1395dd(d)(2)(A) (Supp. II 1990).

20. *Id.* § 1395dd(d)(1)(B) (1988 & Supp. II 1990).

21. *See id.* § 291 (1988).

22. *See id.* § 291c(e) (1988).

23. Several states have imposed a duty on hospitals to provide emergency medical services to all patients seeking such care. See Erik J. Olson, Note, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 453-58 (1994).

24. See Emily Friedman, *Problems Plaguing Public Hospitals: Uninsured Pa-*

Public providers, composed primarily of city and county hospitals, generally must provide care to community residents regardless of the patients' ability to pay.²⁵ This safety net provides millions of dollars worth of care to uninsured patients each year.²⁶ For instance, Cook County Hospital in Chicago treats roughly 1,250 uninsured patients *each day*, roughly half its patient total.²⁷ Likewise, nine-tenths of the patients treated by the New York Health and Hospitals Corporation are either Medicaid recipients or uninsured.²⁸ And 30% of the patients treated at Los Angeles County-University of Southern California Medical Center, which serves a majority of the county's poor residents, are uninsured.²⁹

This patchwork of private and public providers effectively guarantees uninsured patients a very basic level of health care. While the majority of the uninsured cannot afford health insurance,³⁰ some individuals, relying on the existence of this safety net, do not purchase private health coverage even though they could afford it. They are "individuals who remain uninsured because they believe that in the event of serious illness they will get care anyway, and others will pick up the bill."³¹ Roughly 75 to 80% of the uninsured are either employed or the

tient Transfers, Tight Funds, Mismanagement, and Misperception, 257 JAMA 1850, 1850-51 (1987). All told, over 65% of the patients treated at the one hundred member institutions of the National Association of Public Hospitals are Medicaid recipients or low income uninsured or underinsured. *Health Care Service Delivery Infrastructure in Inner-City and Rural Communities: Hearings Before the Subcomm. on Health of the House Committee on Ways and Means*, 103d Cong., 1st Sess. 206 (1993) (statement of Ruth Rothstein, Director, Cook County Hospital) [hereinafter *Hearings on Health Care Service Delivery Infrastructure*].

25. For example, statutes in California and New York require public hospitals to provide treatment to all patients seeking care. CAL. WELF. & INST. CODE § 17000 (Deering 1988); N.Y. GEN. MUN. LAW § 129 (McKinney 1990).

26. A recent study estimated that American hospitals provided \$13.2 billion in uncompensated care in 1989. John Holahan & Sheila Zedlewski, *Who Pays for Health Care in the United States? Implications for Health System Reform*, 29 INQUIRY 231, 235 (1992).

27. *Hearings on Health Care Service Delivery Infrastructure*, *supra* note 24, at 205 (statement of Ruth Rothstein).

28. *Id.* at 216 (statement of Regina Morris, Chief Operating Officer of the New York Health and Hospitals Corporation).

29. James Sterngold, *Budget Slashes Could Close Hospital: Issues in Los Angeles: To Trim Costs or the Quality of Care?*, N.Y. TIMES, July 17, 1995, at A7.

30. Gail R. Wilensky, *Filling the Gaps in Health Insurance: Impact on Competition*, HEALTH AFF., Summer 1988, at 133, 135 (noting that 69% of the uninsured earn less than \$10,000).

31. Victor R. Fuchs, *National Health Insurance Revisited*, HEALTH AFF., Winter 1991, at 7, 9.

dependents of employed persons,³² and, as of 1986, 25% of the uninsured reported family incomes in excess of \$30,000.³³ Those individuals who could purchase health coverage but nevertheless do not are "free riders" on the American health care system.³⁴ Although assured of receiving emergency medical treatment, they frequently pay less than the true cost of their care and sometimes pay nothing at all, shifting their costs onto other participants in the system.³⁵

Three sources finance the majority of care delivered to uninsured patients in the United States. The first source is uninsured patients themselves. Health care providers, like other creditors, require patients to pay for as much of their care as possible. Even public hospitals generally require patients to pay for their care according to a sliding fee scale based on the patient's ability to pay.³⁶ The second major source of financing for uninsured care is government medical programs for indigent persons. Uninsured patients may spend down their assets to the point that they qualify for Medicaid, the joint state-federal program designed to provide medical care to persons unable to afford necessary medical care.³⁷ They may also be eligible for local or state government programs for indigent care, or receive uncompensated care from public safety net providers.³⁸ The final source is provider cross-subsidization. When neither the patient nor the government adequately reimburses a provider for the cost of treating uninsured patients, the provider must cover its uncompensated costs by cross-subsidizing.³⁹ That is, the provider must increase its

32. Wilensky, *supra* note 30, at 135.

33. Uwe E. Reinhardt, *Toward a Fail-Safe Health-Insurance System*, WALL ST. J., Jan. 11, 1989, at A10.

34. See Alain C. Enthoven, *Managed Competition: An Agenda for Action*, HEALTH AFF., Summer 1988, at 25, 30 (stating that "a free market is likely to lead to the noncoverage or undercoverage of large numbers of people" and that "many consumers will seek a 'free ride'").

35. See Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy (Part I)*, 320 NEW ENG. J. MED. 29, 30 (1989) ("[W]hen the uninsured are seriously ill (and most expenses are for seriously ill patients), taxpayers, insured persons, or both end up paying for most of their care. Voluntarily or involuntarily, some people are taking a free ride.").

36. Telephone Interview with Srija Srinivasan, Chief Budget Analyst, Health Department, San Mateo County, Cal. (July 12, 1993).

37. See 42 U.S.C. §§ 1396-1396v (1988).

38. See *supra* text accompanying notes 24-29.

39. Even if a patient is Medicaid eligible, Medicaid will likely only reimburse

charges to patients with adequate coverage, ostensibly those with private insurance,⁴⁰ to subsidize the costs of treating uninsured patients. Approximately 25% of the average hospital bill for a privately insured patient goes toward cross-subsidization.⁴¹

Given this system for financing the care of persons who lack private health coverage, the extent to which Americans choose not to purchase health insurance has significant public policy ramifications. It affects how equitably the costs of the health care system are allocated, the level of government's health care expenditures, and the overall efficiency of the health care system. By inducing more taxpayers to purchase health insurance, the government advances four significant policy objectives. First, it reduces the number of free riders. More taxpayers with private health coverage means more individuals pay something into the system who otherwise would contribute less than their actual cost. As a result, health care costs are borne more equitably.⁴²

the provider for a percentage of its actual costs. A 1990 study showed that, on average, Medicaid pays approximately 55% of what private insurers pay for the same services. Anne Schwartz et al., *Variation in Medicaid Physician Fees*, HEALTH AFF., Spring 1991, at 131, 136-38. In some cases, reimbursement can be much less. In 1986, Maryland's Medicaid program reimbursed obstetricians as little as 26% of their regular charge for routine deliveries. Michael H. Fox et al., *Effect of Medicaid Payment Levels on Access to Obstetrical Care*, HEALTH AFF., Winter 1992, at 150, 160 exhibit 6.

40. Hospitals previously used Medicare patients to cross-subsidize the cost of uncompensated care. In 1983, however, Medicare began its conversion to the Prospective Payment System (PPS). See Michael D. Rosko, *A Comparison of Hospital Performance Under the Partial-Payer Medicare PPS and State All-Payer Rate-Setting Systems*, 26 INQUIRY 48, 49 (1989). Under PPS, Medicare pays hospitals a fixed amount for each patient based on the patient's diagnosis regardless of how much care the patient actually requires. *Id.* Under the first year of PPS, hospital margins on PPS patients was 14.5%, but by 1990 it had shrunk nearly to zero. Stuart Guterman et al., *Hospitals' Financial Performance in the First Five Years of PPS*, HEALTH AFF., Spring 1990, at 125, 126; see also Jack Hadley et al., *Profits and Fiscal Pressure in the Prospective Payment System: Their Impacts on Hospitals*, 26 INQUIRY 354, 354 (1989). Consequently, cross-subsidization using Medicare patients is virtually impossible. Extra charges to recover the costs of uncompensated care are, therefore, concentrated almost exclusively in the bills of the privately insured.

41. Ron Winslow, *National Health Plan Wins Unlikely Backer: Business*, WALL ST. J., Apr. 5, 1989, at B1. Because of increasing competition, however, this figure is declining.

42. See Enthoven & Kronick, *supra* note 35, at 30 ("Those who can do so ought to contribute their fair share to their coverage and be insured."). A recent proposal for national health insurance stated that an important goal of any reform package must be to eliminate the "unnecessary and unfair cross-subsidization"

Second, enrolling more Americans in private health plans lessens the government's burden in financing and providing health care.⁴³ Fewer uninsured individuals means fewer patients for whom the government must finance or provide care, either through Medicaid or other programs for indigent persons. Because of increasing pressure to reduce the federal budget deficit, as well as the concomitant need for state and local governments to balance their budgets, containing spiraling health care spending has become an imperative across the political spectrum. For instance, President Clinton has repeatedly asserted that "[t]he key to long-term deficit reduction is controlling health care costs through health care reform."⁴⁴ Similarly, House Speaker Newt Gingrich has stated that "we have to rethink our health system" because current spending trends will lead to a "financial crash," and that Republicans in Congress will "make every decision" regarding health care "within the context of getting to a balanced budget."⁴⁵ Reducing health care costs is critical to deficit reduction. Through its various programs, the federal government funds more than 30% of all personal health care purchased in the United States,⁴⁶ and these outlays constitute the fastest growing contributor to the federal deficit.⁴⁷ The government can reduce

produced by the current system. Mark V. Pauly et al., *A Plan for 'Responsible National Health Insurance,'* HEALTH AFF., Spring 1991, at 5, 7.

43. A separate question, not addressed here, is whether excluding employer-sponsored health insurance from taxation is a cost effective subsidy. It is quite possible that the foregone tax revenue caused by the exclusion exceeds the government's savings in financing and providing health care attributable to § 106's inducement to purchase private insurance. It is estimated that eliminating the exclusion for employer-provided health benefits would increase federal tax revenues by \$35.6 billion. M. Susan Marquis & Joan L. Buchanan, *How Will Changes in Health Insurance Tax Policy and Employer Health Plan Contributions Affect Access to Health Care and Health Care Costs?*, 271 JAMA 939, 944 (1994).

44. Pear, *supra* note 4, at A24.

45. *Balancing the Health Care Budget*, WASH. POST, Feb. 2, 1995, at A26.

46. Greely, *supra* note 5, at 8-20. According to surveys done by the American Hospital Association and the National Association of Public Hospitals, the government pays for 47% of hospital care given at private hospitals and 75% of that given at public hospitals. Kevin Sack, *Hard Cases at the Hospital Door*, N.Y. TIMES, Sept. 17, 1995, § 4, at 5.

47. Dana Priest, *Canadian-Style Plan 1st in Cost-Cutting*, WASH. POST, July 25, 1993, at A15; see also Spencer Rich, *Soaring Health Care Costs Heavy Burden for Agency*, WASH. POST, June 24, 1993, at A17. The government pays directly for roughly 42% of all health care expenditures in the United States. VICTOR R. FUCHS, *THE FUTURE OF HEALTH POLICY* 38 (1993).

these expenditures and shift some of its risk to private insurers by enticing more taxpayers to purchase private coverage.

Third, inducing more Americans to purchase private coverage increases the number of persons who have access to primary care, thereby promoting greater efficiency in medical treatment. For several reasons, the uninsured generally do not receive sufficient preventive medical services provided by primary care physicians. For example, because the uninsured must pay the entire cost of outpatient visits out of pocket, they often attempt to "get by" without seeing a primary care doctor until their conditions have become truly serious.⁴⁸ At the same time, many primary care providers simply refuse to see uninsured patients, fearing that the care will go uncompensated.⁴⁹ Moreover, under the weight of rising costs and shrinking budgets, local governments have been forced to reduce their primary care programs.⁵⁰ Most notably, Los Angeles County decided in August 1995 to close all six of its comprehensive medical centers and twenty-nine of its thirty-nine community clinics, virtually eliminating the County's outpatient services.⁵¹ As a result, most public providers—to whom the uninsured most often turn for care—cannot meet the demand for outpatient care.⁵²

48. A study of the uninsured population in the District of Columbia found that, of those uninsured patients reporting a problem in access to primary care, 61.9% indicated cost as the most significant barrier. John Billings & Nina Teicholz, *Uninsured Patients in District of Columbia Hospitals*, HEALTH AFF., Winter 1990, at 158, 162 exhibit 3.

49. Olson, *supra* note 23, at 464 ("Medicaid and uninsured patients are generally unable to obtain primary care in physicians' offices."). Studies of the services physicians offer Medicaid beneficiaries have rather conclusively demonstrated physicians' sensitivity to reimbursement rates. For instance, a recent study showed that access to physicians for Medicaid beneficiaries was highly correlated with the state Medicaid payment levels, so that "when competing payers pay higher fees, physicians are less likely to treat Medicaid patients." Schwartz et al., *supra* note 39, at 132. *But see* Olson, *supra* note 23, at 478 (noting that a study of Medicaid recipients in Maine showed that a 60% increase in physician reimbursement rates increased physician services by only 10%).

50. *See, e.g.*, Douglas P. Shuit, *Indigent Patients Face Uncertainty, Chaos, Risk*, L.A. TIMES, Aug. 3, 1995, at B10 (discussing reduction of public primary care services in Los Angeles County); Barbara Walsh, *Needy Will Feel Effects of HRS Cuts: Budget for Broward's Public Clinics Is Being Trimmed by 4,437,353*, FT. LAUD. SUN-SENTINEL, July 6, 1995, at 3B (reporting that the budget for public health clinics in Broward County, Florida, was reduced by 32%, which could mean that "thousands of uninsured people may not get prenatal care, immunizations or treatment for HIV and other sexually transmitted diseases").

51. Kevin Sack, *Public Hospitals Around the Country Cut Basic Service*, N.Y. TIMES, Aug. 16, 1995, § 1, at 1.

52. Regina Morris, chief operating officer of the NYCHHC, has estimated that

These barriers to primary care undermine the efficient delivery of care and may actually increase the overall cost of treating the uninsured. Illnesses and conditions afflicting uninsured patients that could be treated early and inexpensively by primary care physicians frequently become serious and costly.⁵³ For example, a 1990 study of the uninsured population in the District of Columbia revealed that appropriate primary care could have prevented 23.5% of all hospital admissions of uninsured patients.⁵⁴ A more recent study of preventable hospital admissions in California's urban areas found an elevated rate of admission for patients living in communities with greater proportions of uninsured residents.⁵⁵ In addition, those uninsured patients who do manage to obtain primary care often receive it in extremely expensive settings. Thousands of uninsured patients visit hospital emergency rooms for routine treatment because they are unable to obtain outpatient care.⁵⁶ Such treatment could be administered much less expensively in a primary care physician's office or a community clinic.⁵⁷ In

New York City public health facilities meet only 5% of the demand for outpatient services. *Hearings on Health Care Service Delivery Infrastructure*, *supra* note 24, at 217.

53. See Pete Stark, *The MediPlan Health Care Act of 1991: H.R. 650*, 3 STAN. L. & POL'Y REV. 33, 34 (1991) ("Research shows that uninsured persons are less likely to have children appropriately immunized, less likely to receive prenatal care, and less likely to see a physician if they have serious symptoms.").

54. Billings & Teicholz, *supra* note 48, at 163 exhibit 4; see also Carol Goldberg, *Health Care Reform: How Ready Is LI?*, LI BUS. NEWS, July 25, 1994, at 21 (reporting that, in 1992, more than twenty-four thousand Long Island, New York, residents "were admitted to area hospitals for reasons that might have been prevented through primary care," resulting in \$154.8 million in "avoidable costs").

55. Andrew B. Bindman et al., *Preventable Hospitalizations and Access to Health Care*, 274 JAMA 305, 308-09 (1995). The study also found that, for residents of communities with the worst access to primary care, the preventable hospitalization rate was roughly four times higher than for residents of communities with the greatest access. *Id.* at 308.

56. See Olson, *supra* note 23, at 464.

57. See *id.* at 483 (noting that a "community clinic can offer primary care less expensively than a hospital emergency room because it need not stand ready to deliver urgent care throughout the day"). Recall that EMTALA requires all hospitals with emergency care facilities to at least screen every patient applying for care. See *supra* notes 14-20 and accompanying text. Unfortunately, emergency rooms are often the only place the uninsured are assured of receiving immediate care.

An additional—but non-financial—cost of administering primary care in emergency rooms is that it diverts staff and resources from true emergencies. This, in turn, may lead to additional inefficiencies, such as overstaffing. Olson, *supra* note 23, at 477.

short, lack of access to primary care results in inefficient treatment of the uninsured.

Finally, encouraging more taxpayers to purchase health coverage reduces the number of individuals who spend down their assets into poverty. When an uninsured patient is stricken with a catastrophic medical condition, she will first be forced to spend all her available cash to finance her care. After depleting this source, she will have to begin liquidating her assets. This process frequently pushes individuals or families into poverty. By inducing more taxpayers to obtain private coverage, the government reduces the incidence of so-called "spend down." This may not itself reduce health care expenditures, but it has beneficial secondary effects. For instance, it reduces the financial strain on government antipoverty programs such as Aid to Families with Dependent Children (AFDC), state-administered general assistance, food stamps, and the earned income tax credit.

In sum, the government has several salient reasons to encourage taxpayers to purchase private health coverage. As Senator John Rockefeller, chair of the U.S. Bipartisan Commission on Comprehensive Health Care Reform (the Pepper Commission), recently wrote, "gaps in [health] coverage are fueling health care inflation and costing billions of dollars—in emergency care that could have been prevented [and] in uncompensated care that gets shifted to the cash registers and pocketbooks of employers and employees with health insurance."⁵⁸ Excluding employer-sponsored health benefits from taxable income might therefore be a defensible means to induce more Americans to enroll in private health plans.

B. Theoretical Rationales for Section 106

Alternatively, one might explain excluding employer-sponsored health insurance from taxation on more theoretical grounds. In his seminal article, *Personal Deductions in an Ideal Income Tax*, William Andrews articulated a theory for the "ideal" tax base for the personal income tax.⁵⁹ Andrews posited that "the ultimate purpose" of the income tax "is to apportion tax burdens in uniform, graduated relation to real

58. John D. Rockefeller IV, *Health and the Underserved: Policy Decisions*, 3 STAN. L. & POL'Y REV. 27, 28 (1991).

59. William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309 (1972).

consumption and accumulation."⁶⁰ While actual money expenditures are a sound starting point, Andrews argued that the allocation of resources for certain purposes is not personal consumption.⁶¹ Among such expenditures is the purchase of medical care.⁶²

Andrews closely examined the medical expense deduction, currently § 213 of the code.⁶³ He essentially contended that expenditures for medical care are not personal consumption because, rather than increasing a taxpayer's relative welfare, they merely return the taxpayer to a baseline state of good health.⁶⁴ If the goal of the income tax is to allocate the burden according to "material well-being and taxable capacity," then medical expenses should be excluded because they do not reflect a growth in the taxpayer's ability to pay.⁶⁵ As Andrews explained,

differences in health affect relative material well-being. It would be impractical to try to include robust good health directly as an element of personal consumption for those who have it, but the difference between good and poor health can be partially reflected—or the failure to include the difference directly can be partially offset—by also excluding or allowing a deduction for the medical services that those in poorer health will generally need more of.⁶⁶

The analogy between the exclusion of employee-sponsored health insurance and the medical expense deduction under § 213 is imperfect, but much of the logic of Andrews's defense of § 213 applies to the § 106 exclusion as well. Like medical expenses, health insurance is "an intermediate good whose ultimate object is good health."⁶⁷ Resources dedicated to health coverage arguably do not reflect a taxpayer's well-being any more than do expenditures on medical care. Thus, one could say that § 106 is justifiable on similar grounds: Resources de-

60. *Id.* at 331.

61. *Id.*

62. *See id.* at 331-43.

63. 6 U.S.C. § 213 (1988). Section 213 permits taxpayers itemizing their deductions to deduct health care expenses that exceed 7.5% of adjusted gross income. *Id.* When Andrews wrote his article, the floor was 3.0%, Andrews, *supra* note 59, at 332, but the difference (and the floor in general) is irrelevant to this discussion.

64. Andrews, *supra* note 59, at 335-37.

65. *Id.* at 335.

66. *Id.*

67. *Id.*

voted to health insurance are not the "right basis for making interpersonal welfare comparisons on which to base the distribution of tax burdens"⁶⁸ because they do not augment an individual's relative welfare.

III. DIFFICULTIES IN JUSTIFYING THE TAX TREATMENT OF HEALTH BENEFITS

A. *Problems with the Instrumental Justification*

While the government may have legitimate reasons for encouraging taxpayers to purchase private health coverage, its justifications cannot fully account for the current tax treatment of health benefits. First, although § 106 may stimulate demand for private health insurance, the exclusion is available only to those taxpayers purchasing coverage through their employer. Not only is this restriction horizontally inequitable, it is also regressive.⁶⁹ The exclusion is most valuable to taxpayers with the highest incomes, and it subsidizes the purchase of health benefits for those who are disproportionately well-off and who already have access to relatively high quality and inexpensive health insurance.⁷⁰

By excluding the cost of employer-sponsored health coverage from taxation, § 106 provides a subsidy for the purchasers of health insurance who least need it. Taxpayers unable to obtain employer-sponsored insurance must either acquire insurance through another group or purchase individually underwritten insurance. For several reasons—even ignoring tax effects—employer-sponsored insurance is less expensive than that purchased by alternative means.⁷¹ The biggest reason for the discrepancy is that selling health insurance to an employment-related group minimizes the risk of "adverse selection."⁷² Adverse selection refers to the problem that those who

68. *Id.*

69. See Pauly et al., *supra* note 42, at 9. But see Thomas D. Griffith, *Theories of Personal Deductions in the Income Tax*, 40 HASTINGS L.J. 343, 355-60 (1989) (contending that commentators have generally exaggerated the regressivity of the medical expense deduction).

70. See Steven Findlay, *Will Clinton End a Tax Exclusion on Benefits?*, BUS. & HEALTH, Feb. 1993, at 51 (remarking that the § 106 exclusion "benefits the well-off disproportionately" because, as a group, "they have better access to and can afford more health coverage").

71. Harold S. Luft & Robert H. Miller, *Patient Selection in a Competitive Health Care System*, HEALTH AFF., Summer 1988, at 97, 100.

72. Greely, *supra* note 5, at 8-16.

choose to purchase health coverage generally represent a self-selecting, disproportionately unhealthy group. The problem arises because rational consumers will not purchase insurance until they believe that the cost of their claims will exceed the cost of their premiums.⁷³ Selling insurance through employers minimizes the risk of adverse selection because employment-related groups constitute preexisting groups formed for a purpose other than to purchase health insurance. But when a consumer seeks to purchase health insurance individually, the risk of adverse selection is high. Consequently, insurers attempt to protect themselves by screening applicants for health problems (medical underwriting),⁷⁴ limiting coverage, and charging significantly higher premiums.⁷⁵

A second reason health benefits purchased through an employment-related group are less expensive than individual insurance is that offering coverage through an employer significantly reduces administrative costs.⁷⁶ In an employment setting, insurers need to interact only with group representatives (rather than each enrollee) for marketing and day-to-day administration. Also, because employment groups substantially mitigate the risk of adverse selection, insurers can avoid the administrative expenses involved in medical underwriting—rigorously questioning, examining, or monitoring each

73. As a result, "from the perspective of the organization providing the health coverage, those who select the coverage will present 'adverse' claims experience; they will have higher costs than the general population's average." Greely, *supra* note 5, at 8-14.

74. *Id.* at 8-17 ("Medical underwriting is widely used in selling individual health coverage, by both conventional insurers and HMOs.").

75. Luft & Miller, *supra* note 71, at 102. Insurance companies are at a substantial disadvantage because, as Luft and Miller explain, "the prospective enrollee is likely to know far more about his or her health than the insurer is. Therefore, carriers often restrict enrollment, require medical exams, or exclude coverage for preexisting conditions." *Id.* Adverse selection is an enormous obstacle in the market for individual health insurance because there is no constriction on who is eligible to purchase coverage—there is no preexisting group with a commonality other than the desire to purchase health coverage. Adverse selection is also a problem, albeit less of one, for insurers selling to groups unrelated to employment. Because membership in these groups is often fairly costless, insurers fear that members have joined solely to gain access to health coverage. In contrast, there is almost no risk of adverse selection in employee groups because the availability of coverage generally plays a smaller role in the individual's decision to join the group. Without reason to suspect that those purchasing employer-sponsored insurance will be unusually unhealthy, insurers can still offer lower premiums and better coverage to employment-related groups.

76. Greely, *supra* note 5, at 8-16; Pauly et al., *supra* note 42, at 7.

beneficiary.⁷⁷ Thus, even assuming an inducement to purchase health insurance is appropriate, § 106 tends to confer the benefit on those taxpayers for whom coverage is the least expensive: those with access to benefits through an employer.

Section 106 is also regressive in at least two other respects. First, as a group, those taxpayers able to obtain health coverage through their employers are disproportionately well-off.⁷⁸ In 1989, roughly 95% of all individuals with personal incomes over \$30,000 had employer-sponsored health insurance.⁷⁹ By comparison, only 80% of those individuals with incomes between \$15,000 and \$20,000, and 70% with incomes between \$12,500 and \$15,000, had employer-provided coverage.⁸⁰ Second, like any exclusion or deduction, § 106 is most valuable to those taxpayers in the highest tax brackets.⁸¹ For example, the exclusion is worth \$1,800 to a taxpayer in the 36% marginal tax bracket purchasing a \$5,000 health insurance package; it is only worth \$750 to a taxpayer in the 15% marginal tax bracket buying the same coverage.

In addition to being regressive, the value of the § 106 exclusion is overextensive: It subsidizes the purchase of health benefits beyond that necessary to accomplish the government's instrumental objectives. Health benefit packages come in several varieties, and most large employers offer their employees a choice among plans.⁸² There are minimum, no-frills packages

77. See Greely, *supra* note 5, at 8-16. The savings in administering a health plan through a large employer can be enormous. Roughly 5.5% of premium dollars go towards administrative costs in companies with 10,000 or more employees. Bryan Dowd & Roger Feldman, *Insurer Competition and Protection from Risk Redefinition in the Individual and Small Group Health Insurance Market*, 29 INQUIRY 148, 148 (1992). In contrast, the figure is close to 40% for individually underwritten policies. See John K. Inglehart, *The American Health Care System: Private Insurance*, 326 NEW ENG. J. MED. 1715, 1719 (1992).

78. See Richard Kronick, *Health Insurance, 1979-1989: The Frayed Connection Between Employment and Insurance*, 28 INQUIRY 318 (1991).

79. *Id.* at 322.

80. *Id.*

81. See STANLEY SURREY, *PATHWAYS TO TAX REFORM: THE CONCEPT OF TAX EXPENDITURES* 37 (1973) ("The translation and consequent restatement of a tax expenditure program in direct expenditure terms generally shows an upside-down result utterly at variance with usual expenditure policies.").

82. See generally Stanley B. Jones, *Multiple Choice Health Insurance: The Lessons and Challenge to Private Insurers*, 27 INQUIRY 161 (1990). One of the reasons employers offer a choice among plans is the HMO Act of 1973. Pub. L. No. 93-222, 87 Stat. 914 (current version at 42 U.S.C. § 300e (1988)). The HMO Act requires companies with 25 or more employees to offer an option between at least two health plans, one of which must be an HMO. 42 U.S.C. § 300e-9(a)(1) (1988).

as well as "premium" plans offering various additional benefits. For instance, a basic package may restrict the number of providers which the beneficiary may see, require a higher deductible, and exclude "luxury" items like orthodontics, cosmetic surgery, or experimental treatments. Premium packages, on the other hand, may cover these luxury items, permit beneficiaries to see any physician, or reimburse beneficiaries for the extra costs of private hospital rooms.

Health insurance packages also vary widely in the efficiency of their reimbursement schemes. More expensive health plans frequently reimburse hospitals and physicians on a fee-for-service basis, giving providers the financial incentive to prescribe excessive treatment.⁸³ By contrast, less expensive plans often pay providers on a capitation basis—paying a flat sum per enrollee regardless of how much care is provided. Several studies have demonstrated that capitation payment schemes, most commonly used by health maintenance organizations (HMOs), can significantly reduce costs while providing the same level of care.⁸⁴ For instance, studies have reported that HMOs paying providers on a capitation basis reduce hospital use by 10 to 40% as compared with fee-for-service reimbursement mechanisms.⁸⁵ Of course, part of HMOs' ability to

83. See Harold S. Luft, *Translating the U.S. HMO Experience to Other Health Systems*, HEALTH AFF., Fall 1991, at 172, 175 (stating that, of the various health care reimbursement mechanisms, "fee-for-service payment gives physicians the strongest incentives to offer more services"); Janet L. Shikles & Lawrence H. Thompson, *Strategies to Reduce Health Care Spending and Increase Coverage*, 3 STAN. L. & POL'Y REV. 103, 104 (1991) ("[U]nder a fee-for-service system, [physicians] have little incentive to control costs; reimbursement increases as more services are provided.").

84. See Robert C. Bradbury et al., *Comparing Hospital Length of Stay in Independent Practice Association HMOs and Traditional Insurance Programs*, 28 INQUIRY 87, 92 (1991) (finding that, "even after controlling for patient age, sex, case mix . . . severity of illness, and year of admission," membership in an HMO was "associated with shorter hospital stays"); Luft, *supra* note 83, at 185 ("There is substantial evidence that . . . [during the] 1980s, many HMOs were able to provide care for their enrollees at substantially lower cost than fee-for-service care.").

Some have argued, however, that capitation payment schemes—especially those in which doctors cannot spread their financial risk over many patients—create too strong of an incentive for physicians to skimp on care. See, e.g., Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743 (1987); Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86 (1989).

85. Ira Strumwasser et al., *The Triple Option Choice: Self-Selection Bias in Traditional Coverage, HMOs, and PPOs*, 26 INQUIRY 432, 432 (1989); see also Jerry L. Malshaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming*

reduce utilization and costs is attributable to their attraction of healthier enrollees and the participation of physicians with more parsimonious practice styles.⁸⁶ Nonetheless, the Congressional Budget Office estimated in March 1994 that, controlling for the health status of enrollees, the most effective HMOs reduce the use of services by nine percent and decrease costs by four percent from traditional fee-for-service plans.⁸⁷ By permitting taxpayers to exclude the full cost of more expensive fee-for-service plans, the government may actually be subsidizing the inefficient provision of care.⁸⁸

Justifying § 106 on the ground that it encourages more taxpayers to purchase health coverage thus cannot account for extending the exclusion beyond the cost of a standard benefits package operated by an efficient insurer. The government would more effectively advance its objective of promoting the efficient delivery of care if it instead rewarded taxpayers for selecting basic plans that employ efficient reimbursement mechanisms. Consequently, if the objective of the exclusion is to reduce health care expenditures and promote the efficient delivery of care, § 106 makes sense only to the extent that it exempts no more than the average cost of an efficiently administered basic benefit plan.

B. Problems with the Theoretical Justification

The theoretical justification for excluding health benefits from taxation—that health insurance does not augment a taxpayer's material well-being or taxability—suffers from infirmities similar to those that undermine § 106's instrumental

Fraud, Waste, and Abuse in Healthcare Spending, 11 YALE J. ON REG. 455, 457 (1994) ("Studies suggest that, in some instances, HMOs may reduce hospital use by 40% and total spending by 25%.").

86. See John M. Eisenberg, *Economics*, 273 JAMA 1670, 1670 (1995). For instance, a General Accounting Office study found that 54% to 63% of HMOs accepting Medicare recipients enrolled Medicare beneficiaries who were healthier than average (favorable selection), and that the remaining HMOs enjoyed neutral selection. *Id.* at 1671 (citing U.S. GENERAL ACCOUNTING OFFICE, *MANAGED HEALTH CARE: EFFECT ON EMPLOYERS' COSTS DIFFICULT TO MEASURE* (1993)). HMOs enrolled Medicare recipients who, on average, reported fewer disability days and lower hospital use prior to their enrollment than those recipients who remained in the fee-for-service plans. *Id.*

87. *Id.* at 1671 (citing CONGRESSIONAL BUDGET OFFICE, *EFFECTS OF MANAGED CARE: AN UPDATE* (1994)).

88. See Alain C. Enthoven, *Good Cap, Bad Cap*, WASH. POST, July 13, 1993, at A15.

justifications. First, the theoretical justification fails to explain why the exclusion or deduction is limited to employer-sponsored insurance. If the acquisition of employer-provided health coverage does not augment the material well-being of an individual, neither can health insurance obtained individually or through an alternative group. Whether the purchase of health insurance theoretically constitutes personal consumption cannot depend on the means through which it is acquired.

The ideal income tax base explanation is also flawed in a more fundamental respect. Namely, the purchase of health insurance, or at least a portion of it, frequently *does* fall within Andrews' conception of personal consumption. Andrews contended that medical expenses are not personal consumption because they do no more than maintain a taxpayer's level of accumulation and taxability.⁸⁹ When a taxpayer purchases a health benefits package offering more than standard coverage, those dollars going toward the "premium" elements of the package seem to fit Andrews's conception of personal consumption. That is, premium benefits do more than finance the taxpayer's maintenance of a baseline level of good health; they insure that the taxpayer will be *especially* healthy, or that, in the event of illness, she will be brought back to good health in a relatively luxurious fashion.

Mark Kelman has criticized Andrews's defense of the § 213 medical expense deduction on similar grounds.⁹⁰ Kelman rightfully noted that Andrews's argument rests in large part on the assumption that the amount an individual spends on health care is an accurate measure of the cost of maintaining the taxpayer's baseline state of good health. Indeed, the amount that taxpayers spend on health care reflects more than just the severity of their health problems.⁹¹ As Kelman pointed out, personal health care expenses turn largely on the taxpayer's ability to pay.⁹² Health economists estimate that,

89. Andrews, *supra* note 59, at 335-37.

90. Mark G. Kelman, *Personal Deductions Revisited: Why They Fit Poorly in an 'Ideal' Income Tax and Why They Fit Worse in a Far from Ideal World*, 31 STAN. L. REV. 831, 858-79 (1979).

91. See Mark Kelman, *Health Care Rights: Distinct Claims, Distinct Justifications*, 3 STAN. L. & POLY REV. 90, 96 (1991) (noting that "people don't simply demand some fixed quantity of medical care whenever they feel a certain way, no more, no less").

92. FUCHS, *supra* note 47, at 43 ("Health seems to be a normal good in the

while the quantity of health care demanded is less sensitive to income than the consumption of other goods, the income elasticity of demand for health care is very nearly one.⁹³ In other words, a 10% rise in income on average leads to a 10% increase in the cost of health care consumed. Thus, wealthier taxpayers consume both more and more expensive care. These data confirm that much of health care spending is actually discretionary consumption, meant to upgrade the *quality* of individuals' care rather than merely to pay the costs of returning them to good health.

This analysis indicates that § 106 permits taxpayers who purchase premium coverage to exclude income that reflects personal consumption. When taxpayers purchase health coverage offering more than standard benefits, they are buying more than insurance against the costs of being returned to a baseline level of good health. The elements of coverage in excess of a standard benefits package, at least in a sense, improve the *quality* of their coverage. Purchasing the premium elements of a health benefits package is a consumption decision that reflects the taxability of the consumer. In Andrews' words, it reflects "choices among gratifications" rather than "differences in need."⁹⁴ Thus, while the ideal income tax base theory may explain excluding the value of basic health coverage, it cannot justify extending the exclusion to the premium elements of a benefits package.

IV. THE IMPACT ON HEALTH POLICY

As the discussion to this point indicates, the current tax treatment of health benefits is both underinclusive and overextensive as a matter of tax policy. It is underinclusive because it restricts those who may exclude or deduct the cost of health benefits to those taxpayers with access to employer-sponsored insurance. It is overextensive because it permits taxpayers to exclude more from taxation than can be justified by the government's objectives in maintaining the exclusion. The current form of § 106 might still be warranted if

sense that an increase in wealth leads to an increase in the demand for health."); Malshaw & Marmor, *supra* note 85, at 459 ("[U]tilization of [medical] service appears more closely tied to economic status than to medical needs.").

93. VICTOR R. FUCHS & MARCIA J. KRAMER, DETERMINANTS OF EXPENDITURES FOR PHYSICIANS' SERVICES IN THE UNITED STATES, 1948-1968, at 33 n.20 (1975).

94. Andrews, *supra* note 59, at 336.

it furthered important health policy objectives. But, as the following discussion demonstrates, its impact on health policy has been decidedly detrimental. Indeed, § 106 has substantially aggravated three significant problems in the health insurance market—job lock, cost-unconscious demand, and excessive demand.

A. *Job Lock*

Because of adverse selection, consumers must purchase health coverage through groups for the insurance market to operate at all efficiently.⁹⁵ The group nexus need not be the beneficiaries' employer; any sizable preexisting group may serve this function.⁹⁶ But because of the tax incentives, an overwhelming majority of Americans with private health coverage obtain insurance through their employers. More than 85% of all Americans with private health insurance obtain that coverage through an employer.⁹⁷ Indeed, over 92% of all employees of large and medium-sized firms—and 66% of all Americans—procure health coverage through employment-related groups.⁹⁸

Making employers the dominant vehicle through which Americans purchase their health insurance has had some undesirable side effects.⁹⁹ Foremost among them is the phenomenon of "job lock," the term describing the situation of an employee who remains at her job solely to retain her health coverage. Employers are not required to offer health benefits, and many American companies do not provide coverage due to its expense.¹⁰⁰ Health insurance is particularly costly for small

95. See *supra* notes 72-75 and accompanying text.

96. See Greely, *supra* note 5, at 8-15 ("The group may be a group of employees, a labor union, a church congregation, or a professional association, among others.").

97. Walter A. Zelman, *The Rationale Behind the Clinton Health Care Reform Plan*, HEALTH AFF., Spring 1994, at 9, 17.

98. Joel C. Cantor et al., *Business Leaders' Views on American Health Care*, HEALTH AFF., Spring 1991, at 98, 98.

99. See FUCHS, *supra* note 47, at 12 ("Sooner or later, the inequities and inefficiencies associated with employment-based health insurance will become so apparent as to dictate disengagement."); Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy (Part II)*, 320 NEW ENG. J. MED. 94, 94-95 (1989) ("If we were making a fresh start in health insurance, we would not recommend an employment-based system, because of the many problems associated with it."); Rockefeller, *supra* note 58, at 28 ("Losing one's job is bad enough, but unemployment in America almost always means being uninsured.").

100. Wendy K. Mariner, *Problems with Employer-Provided Health Insur-*

businesses.¹⁰¹ While 51% of all jobs in the American economy are with firms of one hundred or fewer employees, roughly one-third of these companies do not offer health benefits to their employees.¹⁰² In addition, 30% of the respondents to a recent survey of small businesses said that they likely will discontinue coverage in the foreseeable future.¹⁰³ Changing jobs—particularly moving to a smaller company—may therefore mean the loss of health insurance.

As noted earlier, individuals who want health coverage but who are unable to obtain employer-sponsored insurance are left with two choices: individually underwritten insurance or insurance administered through a group unrelated to employment. These types of insurance are extremely expensive by comparison¹⁰⁴ and may offer much less comprehensive coverage than does employer-sponsored insurance. Insurers charge higher premiums and limit benefits for these types of coverage to protect against adverse selection,¹⁰⁵ and consumers must purchase these policies with after-tax dollars. Perhaps most important, the majority of these types of insurance plans, particularly those offered to small groups or individuals, exclude coverage

ance—*The Employee Retirement Income Security Act and Health Care Reform*, 327 NEW ENG. J. MED. 1682, 1682 (1992) (noting that, “[b]ecause of inflation in the cost of health benefits during the past decade, many employers, especially small companies without access to large-group insurance, find they cannot afford to finance health care fully”).

101. See Bryan Dowd & Roger Feldman, *Insurer Competition and Protection from Risk Redefinition in the Individual and Small Group Health Insurance Market*, 29 INQUIRY 148 (1992); Jennifer N. Edwards et al., *Small Businesses and the National Health Care Reform Debate*, HEALTH AFF., Spring 1992, 164; Alain C. Enthoven, *Commentary: Measuring the Candidates on Health Care*, 327 NEW ENG. J. MED. 807 (1992); Stanley B. Jones, *Employer-Based Private Health Insurance Needs Structural Reform*, 29 INQUIRY 120 (1992); Kenneth E. Thorpe, *Expanding Employment-Based Health Insurance: Is Small Group Reform the Answer?*, 29 INQUIRY 128 (1992); Wendy K. Zellers et al., *Small-Business Health Insurance: Only the Healthy Need Apply*, HEALTH AFF., Spring 1992, at 174. As Enthoven explains, groups of one hundred beneficiaries or fewer “are too small to spread risk, achieve economies of scale in administration, acquire and process the information needed to make good decisions, and participate in managed competition.” Enthoven, *supra*, at 807. Consequently, premiums for small businesses are much higher than those for large employers.

102. Edwards et al., *supra* note 101, at 165.

103. *Id.* at 167.

104. See *supra* text accompanying notes 71-77.

105. See *supra* notes 72-75 and accompanying text. The problem is most acute in the individual insurance market. Indeed, “most insurance companies have withdrawn from the market for individual unsponsored coverage,” and “[w]hat remains is mostly poor coverage at high prices.” Enthoven, *supra* note 34, at 30.

of preexisting conditions—health problems contracted by the beneficiary prior to enrolling in the plan.¹⁰⁶ Preexisting condition exclusions mitigate the problem of adverse selection for insurers, but they can make it impractical for individuals to switch jobs.¹⁰⁷ For instance, a woman who carries employer-provided insurance for herself and her diabetic husband may find it extremely difficult to change employment without having to pay for all the costs of her husband's condition out of pocket for the first year at her new job.¹⁰⁸ If the insured's condition is more serious, he may be completely uninsurable once coverage is discontinued. Roughly eighty million Americans currently have medical problems that insurance companies might consider preexisting conditions, such as hypertension, diabetes, or asthma.¹⁰⁹ And, as of 1990, over 60% of all group health insurance plans contained preexisting condition exclusions.¹¹⁰ With the average American changing jobs

106. Zellers et al., *supra* note 101, at 175.

107. See Eli Ginzberg, *Health Care Reform—Where Are We and Where Should We Be Going?*, 327 NEW ENG. J. MED. 1310, 1310 (1992) (stating that “people with a history of serious medical problems often find that if they lose their coverage they are unable to replace it at an affordable price”); Jeffrey R. Pettit, *Help! We’ve Fallen and We Can’t Get Up: The Problems Families Face Because of Employment-Based Health Insurance*, 46 VAND. L. REV. 779, 795 (1993) (“Employed workers may be forced to remain in their current jobs because they fear that a new employer will exclude as a preexisting condition an illness or disability which their health insurance currently covers.”).

108. Ginzburg, *supra* note 107, at 1310. The average waiting period before an insurance policy will cover costs related to a preexisting condition is nine months, but may be as long as seven years. *Id.*

109. Thomas Bodenheimer, *Underinsurance in America*, 327 NEW ENG. J. MED. 274, 275 (1992).

110. *Id.* In June 1995, President Clinton announced his proposal for federal regulation of the health insurance industry, which included provisions strictly curtailing insurers' ability to include preexisting condition exclusions in their policy contracts. Rich, *supra* note 13, at A21. Under the Administration's proposal, insurers would be permitted to exclude coverage for preexisting conditions for up to six months after an individual's first purchase of health insurance. *Id.* But when the individual changed employment and enrolled in a new plan, the new insurer would be prohibited from excluding coverage for any preexisting conditions. *Id.*

On July 13, 1995, Senators Kassebaum and Kennedy proposed their own “Health Insurance Reform Act of 1995.” See Adam Clymer, *2 Senators Offer New Health Bill*, N.Y. TIMES, July 14, 1995, at A1. Their bill would also restrict insurers' ability to exclude or limit coverage based on preexisting conditions. See S. 1028, 104th Cong., 1st Sess. §§ 101, 103 (1995). Insurers could limit or exclude coverage of preexisting conditions “only if—

(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the health plan;

(2) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth, was covered under the plan;

every 4.2 years,¹¹¹ barriers to adequate health coverage, such as the preexisting condition exclusion, may seriously impede efficient transitional movement throughout the workforce.¹¹² Indeed, in a 1993 CBS/New York Times poll, one in three Americans reported that someone in their household has remained at a particular job due to concern about losing their health benefits.¹¹³

Job lock would not exist if most Americans could obtain affordable health insurance through groups unrelated to their employment.¹¹⁴ For instance, if consumers purchased insurance through geographically-based groups, health benefits would be portable from one job to the next within the insured's region; there would be no risk of losing coverage solely due to changing employment.¹¹⁵ Nevertheless, in the face of § 106, purchasing through such groups would cost more than employer-sponsored insurance. Absent comprehensive reform that makes affordable coverage available to all Americans regardless of health status, job lock cannot be redressed without separating the purchase of health insurance from employment—possible only by altering the tax treatment of health benefits.

(3) the limitation does not apply to a pregnancy existing on the effective date of coverage.

Id. § 103(a).

111. Bodenheimer, *supra* note 109, at 275.

112. FUCHS, *supra* note 47, at 12 ("Today workers' choices of job, decisions about job change, and timing of retirement are frequently influenced by health insurance considerations. As a result, labor market efficiency suffers."); Pettit, *supra* note 107, at 795 (noting that job lock "stifles the potential of these [affected] workers and reduces American productivity").

113. Steven Pearlstein, *A Hard Pill to Swallow: Health Care Reform May Be Bitter Economic Medicine*, WASH. POST (weekly ed.), May 17-23 1993, at 6, 7.

114. Several reform proposals have emphasized the importance of separating the purchase of health insurance from the employment setting. See, e.g., THE HERITAGE FOUNDATION, *A NATIONAL HEALTH SYSTEM FOR AMERICA* (S. Butler & E. Haislmaier eds., 1989), (discussed in Pauley et al., *supra* note 42, at 23).

115. Of course, establishing alternative group nexuses for health insurance—while solving the problem of job lock—may create new problems. For instance, if consumers were to purchase coverage through geographically-based groups, insurance companies might attempt to charge higher premiums and to offer limited coverage to beneficiaries living in low income communities because poorer patients are actuarially more expensive to insure. These problems, however, seem less complicated and easier to combat through government regulation.

B. Cost-unconscious Demand for Health Insurance

With the proliferation of HMOs, preferred provider insurance, and various other financing mechanisms, the American health care system has moved increasingly toward a system of competition in recent years.¹¹⁶ For any competitive market to function efficiently, consumer demand must be cost-conscious. That is, consumers must choose between competitive products or services based on their relative cost and quality. When demand is not cost-conscious, consumers are less sensitive to price in choosing among competing services, and efficient providers are largely unable to take advantage of their cost-effectiveness.

For several reasons, cost-unconsciousness predominates in the market for health insurance.¹¹⁷ The single most significant factor is that over half of all employers offering health coverage pay the entire cost of their employees' premiums.¹¹⁸ Because employers can deduct both wages and employee health benefits as business expenses under § 162, they are generally indifferent as to how employees allocate their compensation between the two.¹¹⁹ But because of § 106, employees receive

116. Enthoven, *supra* note 34, at 26; Luft, *supra* note 83, at 172 (noting the "increasingly competitive U.S. health care environment"). See generally Kathleen Day, *Humana Hunts Gold in Health Care Field: Controversial Firm Now Bids To Dominate the HMO Industry*, WASH. POST., July 22, 1993, at A1, A7. For evidence of the increasing proliferation of HMOs and PPOs, see Ginzberg, *supra* note 107, at 1311 (stating that the number of enrollees in managed care programs, such as HMOs and PPOs, grew from roughly 10 million to 40 million during the 1980s); Elizabeth W. Hoy et al., *Change and Growth in Managed Care*, HEALTH AFF., Winter 1991, at 18; Cynthia B. Sullivan & Thomas Rice, *The Health Insurance Picture in 1990*, HEALTH AFF., Summer 1991, at 104.

117. See Pearlstein, *supra* note 113, at 6 (explaining that "[o]ther consumer purchases, such as a car, involve some calculation of cost versus benefit," whereas "[m]ost consumers make decisions about health care without regard to cost"); Shikles & Thompson, *supra* note 83, at 104 ("Because patients are shielded from the direct costs of much of their care, any decisions they might make about types of care involve little regard for cost.").

118. See Enthoven, *supra* note 34, at 32; see also Enthoven & Kronick, *supra* note 35, at 29. Health care reform proposals aiming to infuse greater cost-consciousness into consumers' purchasing decisions have argued that employer contributions must be limited to a fixed amount. See *id.* at 33.

119. Because employer-provided health benefits are exempt from the Federal Insurance Contribution Act (FICA) payroll tax, 26 U.S.C. § 3121(a)(2)(A), (B) (1988), employers actually have a slight incentive to compensate employees in health benefits over wages. Congress could dramatically alter employers' incentives—and infuse cost-consciousness into the market for health insurance—by limiting the employer deduction to the regionally-adjusted average cost of a standard benefits package. Such a change would give employers a strong incentive to limit their contributions

more value in each dollar devoted to health benefits than to wages.¹²⁰ Thus, employees have a strong incentive to structure their compensation packages so that employers pay the full cost of their health insurance. A 1986 study indicated that more than 54% of *all* employers—not just those offering health benefits—paid the entire cost of their employees' health insurance.¹²¹ Most large companies offer their employees a choice among plans, but where the employer covers the full cost regardless of which package the employees chose, employees have no incentive to discern between the plans based on cost or efficiency.

Consider, for example, an employer offering two plans: an HMO plan with a standard benefits package, which costs the employer \$150 per month per employee, and a premium, fee-for-service plan, which costs the employer \$250 per month. Were the § 106 exclusion limited to the average cost of a standard benefits plan—here \$150—an employee choosing the premium package would have to include the \$100 difference in her adjusted gross income. Granted, the employee would not bear the full cost of choosing the more expensive plan. The after-tax cost to the employee who selects the premium plan would only be the actual difference in cost multiplied by her marginal tax rate. Thus, a taxpayer in the 31% federal tax bracket and the five percent state tax bracket would have to pay an additional \$36 per month in after-tax dollars to receive an additional \$100 worth of coverage. In contrast, under the current regime of § 106, the employee bears none of the additional cost in selecting the more expensive plan. If her employer pays her entire premium, her choice between the two plans is completely cost-unconscious.

Some large employers, such as Xerox,¹²² Stanford

to employees' premiums, so that employees would have to pay the additional cost of luxury benefit packages with after-tax dollars. See AMERICAN BAR ASSOCIATION WORKING GROUP ON HEALTH CARE REFORM, CONTROLLING COSTS AND FINANCING HEALTH CARE REFORM THROUGH AN EMPLOYER-SPONSORED SYSTEM 15-17 (1993) [hereinafter ABA WORKING GROUP]; Findlay, *supra* note 70, at 51. But see *infra* text accompanying notes 130-34 (discussing how employees could still pay their portion of health premiums with pretax dollars if their employer offers a "cafeteria plan" under § 125). Former U.S. Representative Jim Cooper (D-Tenn.) included such a provision in his proposed Managed Competition Act of 1992. H.R. 5936, 102d Cong. 2d Sess. (1992).

120. See *infra* text accompanying notes 140-43.

121. Enthoven, *supra* note 34, at 32; see also Enthoven & Kronick, *supra* note 35, at 29.

122. See Eric Faltermayer, *Yes, the Market Can Curb Health Costs*, FORTUNE,

University,¹²³ the State of Minnesota,¹²⁴ and the State of California,¹²⁵ have attempted to infuse cost-consciousness into their employees' purchasing decisions by limiting their contributions to health benefit packages.¹²⁶ For instance, the California Public Employees Retirement System (CalPERS), which purchased more than \$1.3 billion in health insurance premiums for its employees in 1992, decided in 1990 to limit its monthly contribution to \$410 per family.¹²⁷ CalPERS members, who constitute two thirds of all state and local government employees in California, must cover any additional cost themselves with after-tax dollars.¹²⁸ In the first full year of the program, health plan rates for CalPERS increased by "only 6 percent, down from increases of 11 percent in 1990 and 17 percent in 1989."¹²⁹

But these efforts by employers to promote cost-consciousness have been confounded by yet another provision of the tax code. Employers large enough to run such miniature "managed competition" programs also frequently offer their employees "cafeteria plans."¹³⁰ These plans, authorized

Dec. 28, 1993, at 84.

123. See Liz Lempert, *Health Plan Expenditures Rising*, STANDARD DAILY, Nov. 10, 1989, at 14.

124. See Faltermayer, *supra* note 122, at 84.

125. Danielle Starkey, *Controlling Costs and Improving Access—Solving the Health Care Dilemma*, CAL. J., Feb. 1993, at 7, 10.

126. In 1996, for example, Stanford will offer its employees a choice of four different plans:

Semi-Monthly Premium

Plan	Employee Only	Employee and Family
Kaiser	\$ 0.00	\$33.00
FHP/Takecare	\$11.00	\$63.50
Blue Shield Triple Option	\$17.50	\$80.50
Health Net	\$18.50	\$83.00

Janet Basu, *Drop in Kaiser Rates Affects Cost of All Plans*, STAN. REP., Oct. 25, 1995, at 1, 3. Stanford limits its contributions to 94% of the lowest cost health plan for its full-time employees, and contributes an additional \$4.00 per pay period (semi-monthly). *Id.*

127. Starkey, *supra* note 125, at 10.

128. *Id.*

129. *Id.* at 10-11. CalPERS has subsequently required all of the HMOs with which it contracts to standardize their benefit packages, so that employees are better able to comparison shop based on price and quality and not on such criteria as level of copayments and the minutiae of which services are covered. See Henry T. Greely, *Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity*, 5 HEALTH MATRIX 37, 49 (1995).

130. See Enthoven, *supra* note 88, at A15.

by § 125 of the tax code, permit employees to set aside pretax dollars to purchase "qualified benefits."¹³¹ Health insurance is a "qualified benefit" for purposes of § 125.¹³² Employees at firms offering cafeteria plans can therefore use those plans to pay for the portion of their premiums that exceeds the employer's contribution. Thus, even when an employer offering a cafeteria plan technically limits its contribution, employees can still pay for the cost of their health benefits entirely with pretax dollars.¹³³ "As a result, the employee's cost consciousness is attenuated, and the health plan has less need to cut its price to attract subscribers."¹³⁴

For the health insurance market to operate efficiently, as health economist Alain Enthoven has explained, consumers "who choose one health plan that costs more than another (adjusted for health risks of the covered groups) must pay the extra cost with their own net after-tax dollars."¹³⁵ Limiting the § 106 exclusion to the average cost of a standard benefits package and prohibiting the use of cafeteria plans to pay health insurance premiums could go far in making consumers' purchasing decisions cost-conscious, and thereby alleviate efficiency-impeding, inflationary pressures on health care spending.

131. 26 U.S.C. § 125 (1988); see generally Daniel C. Schaffer & Daniel M. Fox, *Tax Law as Health Policy: A History of Cafeteria Plans 1978-1985*, 8 AM. J. TAX POL'Y 1 (1989).

132. 26 U.S.C. § 125 (1988).

133. See ABA WORKING GROUP, *supra* note 119, at 13-14 (stating that "many believe that cafeteria arrangements seriously undermine health cost containment and substantially increase tax expenditures"); Enthoven & Kronick, *supra* note 35, at 30 (noting that when "an employee chooses a health plan that is more rather than less costly, the government is likely to be paying about one-third of the difference in cost in the form of tax relief").

134. Enthoven & Kronick, *supra* note 35, at 30.

135. Enthoven, *supra* note 34, at 26. Enthoven calls cost-conscious demand essential "[f]or a market system in health care financing and delivery to produce a reasonable approximation to efficiency and equity." *Id.*; see also Hilary Stout, *Benefits-Taxation Idea Returns to White House Under Clinton after Failing as a Bush Proposal*, WALL ST. J., Dec. 30, 1992, at A10 (reporting that advocates of greater cost-consciousness in the health insurance market "say the heightened consumer discernment would . . . lead the health industry—everyone from doctors and hospitals to health maintenance organizations and insurance companies—to compete for business on price, quality and efficiency").

C. Excessive Demand for Health Insurance

In addition to creating job lock and promoting cost-unconscious demand, § 106 distorts the market for health insurance by creating excessive demand for health benefits.¹³⁶ Health insurance, like other employer-provided benefits, is part of the overall compensation package offered by employers.¹³⁷ Financial incentives created by the tax code, and particularly § 106, distort the cost of health benefits relative to cash wages. As a result, employees allocate too large a portion of their total compensation to health insurance.¹³⁸

Consider a taxpayer in the 31% federal income tax and six percent state income tax brackets whose employer pays the entire cost of her health insurance. If her employer devotes an additional \$1,000 to wages, the employee nets \$514 in disposable income after income and payroll taxes.¹³⁹ In contrast, employer-sponsored health insurance is exempt not only from the employee's and the employer's income taxes but also from the Federal Insurance Contribution Act (FICA) payroll tax.¹⁴⁰ Thus, if the employee elects instead to receive the \$1,000 in health benefits, she captures the full value of the increased compensation. For \$514 in foregone cash wages, the employee receives \$1,000 worth of health coverage.¹⁴¹ In negotiating compensation packages with their employers, employees, therefore, will prefer health benefits over wages until the marginal

136. Although this seems to contradict the suggestion made earlier that consumers might underpurchase health insurance, *see supra* note 12, the two issues are conceptually distinct. While arguably too few consumers purchase private health coverage, this article contends that those who do purchase coverage buy too much.

137. *See Fuchs, supra* note 31, at 9 (noting that "[e]mployers do not bear the cost of health insurance; workers do, in the form of lower wages or foregone nonhealth benefits").

138. *See Feldstein, The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251 (1973). A recent historical study found that as early as 1978, "most economists agreed that health insurance contributed to the rising costs of health services" and that "tax law helped to inflate costs. Because employer-provided health insurance was tax free, workers had reason to prefer health insurance to other goods and services that they could purchase only out of after-tax income." Schaffer & Fox, *supra* note 131, at 7.

139. The \$1,000 represents \$929 in strict wage increase and \$71 in the employer's attendant FICA payroll tax liability (\$929 x 7.65%). Subtracting the employee's share of the FICA payroll tax (\$71), her federal income tax liability (\$929 x 31%, or \$288), and her state income tax liability (\$929 x 6%, or \$56), the employee is left with \$514 in disposable income from the raise.

140. 26 U.S.C. § 3121(a)(2)(A), (B) (1988).

141. For a similar example, *see Greely, supra* note 5, at 8-21 to 8-22.

dollar devoted to health coverage is worth fifty-one cents to the employee.¹⁴² For taxpayers in similar tax brackets, the tax code, likewise, essentially halves the cost of health insurance.

Health policy experts widely acknowledge that the current tax treatment of health benefits promotes excessive demand for health insurance.¹⁴³ As a group of health economists recently wrote, "by permitting the purchase of health insurance with pretax dollars, [the tax code] encourages people to buy more insurance than they need, thus fueling health care inflation."¹⁴⁴ And although the rate of growth of health care expenditures has tapered off slightly in the last two years,¹⁴⁵ health care costs continue to consume an inordinate portion of the nation's resources. The United States devotes a greater percentage of its gross domestic product (GDP) to health care than any other OECD country,¹⁴⁶ exceeding by one-third the amount spent

142. Cf. ABA WORKING GROUP, *supra* note 119, at 10 (explaining that "most workers prefer to get a compensation package comprised in part of nontaxable benefits because those nontaxable benefits are more valuable than comparable benefits purchased with after-tax dollars").

143. ABA WORKING GROUP, *supra* note 119, at 10 (noting that "economists are concerned that the unlimited exclusion encourages the purchase of health insurance that is not worth its full cost, i.e., that tax subsidies encourage employees to buy more generous health plans than workers would purchase themselves with after-tax dollars"); Findlay, *supra* note 70, at 51 (reporting that President Clinton and other Democrats acknowledge that the § 106 exclusion "gives the majority of Americans an incentive to purchase excess health insurance"). But see Uwe E. Reinhardt, *The Clinton Plan: A Salute to American Pluralism*, HEALTH AFF., Spring 1994, at 161, 171 (suggesting that analysts have overstated the effects of § 106 in artificially stimulating demand for health insurance).

144. Pauly et al., *supra* note 42, at 9.

145. In 1993, national health care expenditures grew by 7.8%, down from 10.7% in 1990. Rich, *supra* note 13, at A21. The most recent estimate for 1994 is 6.1%. *Id.* From 1983 to 1993, health care expenditures grew at a rate roughly double that of inflation. Pearlstein, *supra* note 113, at 7. Between 1970 and 1989, per capita health care expenditures rose from \$1,026 to \$1,554 in constant dollars. Eli Ginzberg, *Health Care Reform—Why So Slow?*, 322 NEW ENG. J. MED. 1464, 1464 (1990).

146. John K. Inglehart, *Health Policy Report: Canada's Health Care System*, 315 NEW ENG. J. MED. 202, 205 table 1 (1986). (The OECD is the Organization for Economic Cooperation and Development.) In 1983, the U.S. total expenditure on health care was 10.8% of GDP as compared to the OECD average of 7.6%. *Id.*; see also Aki Yoshikawa et al., *How Does Japan Do It? Doctors and Hospitals in a Universal Health Care System*, 3 STAN. L. & POL'Y REV. 111, 115 figure 4 (1991).

American corporations have grown increasingly concerned that the costs of health care are hindering their international competitiveness. The director of federal relations for the Chrysler Corporation recently wrote that in 1988, "foreign automakers [had] a \$300 to \$500 per car advantage over us due to health costs alone." Walter B. Raher, *Health Care in America: Implications for Business and the Economy*, 3 STAN. L. & POL'Y REV. 55, 56 (1991). Raher further stated that "were

by any other major industrialized nation.¹⁴⁷ The Health Care Financing Administration has projected that by the year 2000, national health care expenditures will reach \$1.7 trillion, 18.1% of the GDP.¹⁴⁸ As the coordinator of the Clinton Administration's ill-fated health care reform task force, Ira Magaziner, recently wrote, "the current upward trajectory for health care costs suggests that actions must be taken more quickly to control costs in order not to imperil economic progress."¹⁴⁹ Against this backdrop, a tax provision that stimulates excessive demand for health benefits makes little sense.

V. CONCLUSION

The current tax treatment of employer-provided health insurance is unsound both as tax policy and as health policy. Section 106 inequitably benefits only those able to obtain health insurance through their employers, taxpayers who generally are least in need of financial assistance in purchasing health benefits. In addition, § 106 subsidizes the purchase of premium benefit packages and relatively inefficient fee-for-service insurance plans, both of which contribute to health care inflation. At the same time, § 106 ties the purchase of insurance to the employment setting—creating the problem of job lock—and contributes significantly to the problems of cost-unconsciousness and excessive demand in the health insurance market.

To address these problems, Congress should implement three basic alterations to the tax code's current treatment of health benefits. First, Congress should extend § 106's exclusion to *all* taxpayers, regardless of the source through which they obtain coverage.¹⁵⁰ This would end the horizontal inequity between taxpayers who purchase through employers and those

we to consume health services in America at the same rate as that of West Germany and Japan, we would have an extra \$300 billion per year available to reinvest in our economy." *Id.* at 55.

147. Shikles & Thompson, *supra* note 83, at 103.

148. *Id.* The Congressional Budget Office reached the same conclusion. See Priest, *supra* note 47, at A17. To put this projection in perspective, consider that health care spending amounted to only 6% of U.S. GDP in 1965. *Id.*

149. Dana Priest, *Stunting the Growth of Medical Costs: Clinton's Advisers Draft Short-Term Options That Include Price Controls*, WASH. POST (weekly ed.), Feb. 22-28, 1993, at 32.

150. Thus, the deduction should be available to *all* taxpayers, not just those who itemize their deductions and who obtain insurance through their employers.

who obtain coverage by other means. It would also diminish the incentive to purchase employer-sponsored insurance, making it possible to separate the purchase of health insurance from the employment setting. Second, Congress should limit the value of the individual exclusion or deduction—as well as the employer deduction—to the regionally-adjusted cost of an efficiently administered standard benefits package. Under such a restriction, employers would have a strong incentive to limit their contributions to the cost of a standard benefits plan, and taxpayers wishing to purchase premium packages or plans employing less efficient reimbursement mechanisms would have to pay the extra cost with after-tax dollars.¹⁵¹ Consumer decisions would therefore be more cost-conscious, dampening the incentive for taxpayers to overpurchase health coverage and eliminating the government subsidy of the premium elements of health care packages. Finally, to preserve the cost-consciousness created by limiting the exclusion, Congress should alter § 125 to prevent employees from using cafeteria plans to pay their portions of their insurance premiums with pretax dollars.

These reforms make particular sense in light of the current political mood favoring incremental, market-driven reforms to health care financing. The demise of the Clinton health plan is largely attributable to its comprehensiveness and its preference for command-and-control regulatory solutions.¹⁵² Americans resisted any drastic change—particularly through direct gov-

151. If the § 106 exclusion is capped, it is crucial that the limit be dollar-denominated. In other words, while the limit should be based on the regionally-adjusted cost of a standard benefits package, it must be a uniform flat dollar cap. See Enthoven, *supra* note 88, at A15. Some proposals have suggested that the limit be benefit-denominated, permitting a full exclusion or deduction for coverage offering no more than standard benefits regardless of price. See ABA WORKING GROUP, *supra* note 119, at 5-6. But this would fall short of infusing true cost-consciousness into the market. Taxpayers purchasing standard benefits packages would remain less sensitive to price, and insurers' incentive to improve efficiency would remain dampened. Enthoven, *supra* note 88, at A15. As Enthoven recently wrote, a benefits-denominated cap "simply does not address the incentives problem." *Id.* Rather, a benefits-denominated cap would mean that the "federal government would continue to be in the way, taxing efficient choices, subsidizing wasteful choices." *Id.*

152. See generally Robert J. Blendon et al., *What Happened to Americans' Support for the Clinton Health Plan?*, HEALTH AFF., Summer 1995, at 7. In discussing the Administration's effort at health care reform in his January 1995 State of the Union Message, President Clinton conceded, "We bit off more than we could chew." Spencer Rich, *Clinton Offers a Limited Version of Health Reform*, WASH. POST, Jan. 26, 1995, at A11.

ernmental involvement—to the delivery or financing of something so personally important. At the same time, the Administration underestimated the political difficulties in comprehensively reforming an industry comprising one-sixth of the U.S. economy and affecting the operation of every American business. The reforms suggested here are modest by comparison, and they are consistent with current political preferences for market-based regulatory measures.¹⁵³ Instilling greater cost-consciousness in consumers' health insurance purchasing decisions would promote important public policy objectives through purely voluntary consumer choices.

Nonetheless, these reforms still face stiff opposition.¹⁵⁴ Several potent political forces, most notably organized labor, have vehemently opposed any change in the tax law's treatment of employer-sponsored health insurance.¹⁵⁵ Many taxpayers who benefit from the exclusion are also likely to raise fierce resistance.¹⁵⁶ Like the home mortgage interest deduc-

153. See, e.g., Richard H. Pildes & Cass R. Sunstein, *Reinventing the Regulatory State*, 62 U. CHI. L. REV. 1, 10 (1995) ("The government should shift from command-and-control regulation to more experimentation with . . . economic incentives.").

154. Most recently, in March 1994, the House Ways and Means Subcommittee on Health rejected the inclusion of a limit on the health benefits exclusion/deduction in the Clinton Administration's health care reform package. Robert Pear, *Employer-Paid Health Care Backed by House Panel*, 6-5, N.Y. TIMES, Mar. 15, 1994, at A16. The only serious attempt to alter the tax treatment of employer-provided health insurance thus far during the 104th Congress was recently proposed by House Minority Leader Richard Gephardt. Clay Chandler, *Gephardt Offers Proposal to Cut Income Tax Rate: Democrat Says Plan Helps Working and Middle Class*, WASH. POST, July 7, 1995, at C1. Gephardt's plan would reduce the basic marginal rate for three-fourths of American taxpayers to 10%, and it would eliminate most deductions and exclusions, including that for employer-provided tax insurance. *Id.*

155. JEFFREY H. BIRNBAUM & ALAN S. MURRAY, *SHOWDOWN AT GUCCI GULCH: LAWMAKERS, LOBBYISTS, AND THE UNLIKELY TRIUMPH OF TAX REFORM* 82-83 (1987); Peter Kerr, *Health-Care Planners Urge a Tax on Workers' Benefits*, N.Y. TIMES, Dec. 14, 1993, at A1, C2; Rick Wartzman, *White House Rules Out Insurance Tax for Health Care*, WALL ST. J., Mar. 9, 1993, at A2 ("Union officials, led by the AFL-CIO, have been arguing that a tax on health benefits would be an affront to their collective bargaining efforts."). Robert R. McGlotten, director of legislation for the AFL-CIO stated that "[t]here is no rhyme or reason to tax health care benefits. . . . The fact of the matter is that I have a health care program that my employer pays for. We essentially realized as a nation long ago that it was important for employers to help employees." Kerr, *supra*, at C2. Another spokesperson for the AFL-CIO has said, "employer provided health benefits are not income and therefore shouldn't be treated as such and subject to taxes, period." Lynn Wagner, *Cap on Tax-Free Health Benefits Seen as Major Bone of Contention in Push Toward Health Reform*, MODERN HEALTHCARE, Jan. 4, 1993, at 25. Business groups also reportedly oppose limiting the exclusion. Kerr, *supra*, at C2.

156. For instance, in his successful senatorial campaign in 1991, former Sena-

tion, the exemption of employer-sponsored benefits has become an entrenched part of the American political landscape. As such, most taxpayers will perceive any limit on the exclusion as a new tax on health coverage.¹⁵⁷ Thus, although Clinton Administration officials spoke seriously of limiting the exclusion during and immediately following the 1992 presidential campaign,¹⁵⁸ the task force on health care reform officially withdrew the idea from consideration only one month after convening.¹⁵⁹ Persevering in the face of political pressure, however, could reap sizable long-term benefits. Reforming the tax treatment of employer-sponsored health coverage is vital to containing the growth of health care expenditures and to treating taxpayers more equitably.

tor Harris Wofford attacked Richard Thornburg for favoring a cap on the exclusion. Kerr, *supra* note 155, at C2. One of Wofford's television advertisements ran, "Tax on health care benefits? . . . Thornburg. He's been in Washington too long." *Id.*

157. See Katherine Pratt, *Funding Health Care with an Employer Mandate: Efficiency and Equity Concerns*, 39 ST. LOUIS U. L.J. 155 n.20 (1994) ("If families have to make up premiums formerly paid by an employer, they would perceive that as a tax increase."); Wagner, *supra* note 155, at 25.

158. See, e.g., Findlay, *supra* note 70, at 51; Kerr, *supra* note 155, at A1, C2; Wagner, *supra* note 155, at 25.

159. Wartzman, *supra* note 155, at A2.