
FEDERAL TAX TREATMENT OF HEALTH CARE EXPENDITURES: IS IT PART OF THE HEALTH CARE PROBLEM?

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I. INTRODUCTION

Seeking solutions to social problems is always difficult; some problems are probably impossible to solve within the social context in which they are embedded. Health care reform provides a ready example. Access to health care has been an acknowledged problem probably as long as health care has been provided at a price by members of a learned profession. Despite calls for a comprehensive solution to the problem of access at levels as

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high as the presidency and as early as President Truman,¹ negative public attitudes toward "socialized" health care and opposition from the medical profession doomed the earlier proposals for guaranteed access through a program of national health insurance.²

However, concern over the cost of health care has galvanized efforts to reform the nation's health care system in a way that concern over access by itself never succeeded in doing. During the 1980s, health care costs skyrocketed in relation to other costs of living, and the increasing costs decreased access. Access to health care thus provides the necessary social objective of a struggle in which the principal objective is to cut costs.

A. *Relics of Past Reform Efforts*

Important elements of the contemporary American health care matrix have their origins in earlier attempts to address the problems of access to health care. Concern about access may have sparked the otherwise questionable decisions of the World War II Wage and Price Control Board and the Internal Revenue Service (IRS). The Board permitted employers to provide health care coverage to their employees without including such costs in wages subject to control.³ The IRS determined that employer contributions to health care plans were not taxable income to the employees covered by them.⁴ These decisions led both to a

1. President Truman advocated a pending bill in Congress for national health insurance in his January 1948 State of the Union address. David Blumenthal, *Medicare: The Beginnings*, in RENEWING THE PROMISE: MEDICARE AND ITS REFORM 5 (David Blumenthal et al. eds., 1988). Former President Theodore Roosevelt proposed a program of national health insurance while running in 1912 for President as the candidate of the Progressive Party. *Id.* at 4.

2. *Id.* at 4-8; see generally Paul Starr, *Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915-1980*, in COMPULSORY HEALTH INSURANCE 115 (Ronald L. Numbers ed., 1982) (providing historical background of health care reform).

3. U.S. DEPT' OF LABOR, THE TERMINATION REPORT OF THE NATIONAL WAR LABOR BOARD: INDUSTRIAL DISPUTES AND WAGE STABILIZATION IN WARTIME 308-09 & n.3 (1942-45).

4. See, e.g., Priv. Ltr. Rul. 66,294 (Aug. 26, 1943); Priv. Ltr. Rul. 66,326 (Oct. 26, 1943).

Emanuel L. Gordon argued that it would have been unreasonable to include health care contributions in the employee income of ordinary workers:

How realistic is it to say that a family head earning \$35 to \$70 per week receives psychological income when he and his family are provided with medical care and hospitalization? In the absence of such benefits, he or his dependents would ordinarily go without care or become charity cases for all or most of the benefits. These in-kind medical benefits are provided for employees precisely

rapid expansion in employer-funded health care⁵ and to the linkage of health care coverage with employment. This linkage is one of the most dominant, yet theoretically inappropriate, characteristics of the current health care environment.⁶

Another relic is the tax-exempt status of non-profit hospitals. The status derives from the hospitals' origins as charity institutions providing care without charge to those too poor to receive care at home from their private physicians.⁷ Today, non-profit hospitals provide no more in the way of charity care than their for-profit competitors, but their privileged tax status persists despite the disappearance of the historical justification.⁸ Like most tax breaks, however, the non-profit hospital exemption does not lack its ardent defenders.⁹

B. *Importance of Political Considerations*

Concern for access also led to the last major American health care reform, the introduction of Medicare in 1965.¹⁰ The history of the adoption of Medicare provides important lessons for

because they could not provide them for their families. Is a concept developed to take care of the taxpayer with a large, surplus income suitable to the intelligent taxation of the marginal taxpayer, i.e., one who just manages to struggle along? It would scarcely appear that it is: first, because the marginal taxpayer, in fact, receives no additional income; second, because a disproportionate increase in the taxes of low income groups, which would result, is socially undesirable.

Emanuel L. Gordon, *Tax Effects of Union Welfare Funds*, 6 TAX. L. REV. 1, 51 (1950). This analysis crudely foreshadows some aspects of the argument of Professor Andrews. See *infra* notes 61-63 and accompanying text. What medical care contributions ought to be included in income is debatable. Early coverage was generally fixed-dollar hospital coverage, which comes close to providing a benefit that offsets only differences in health status, not differences in personal preferences. Andrews believes that benefits of this type are properly excludable from income. See *infra* notes 61-63 and accompanying text.

5. Gordon, *supra* note 4, at 1-3, nn.6-7. According to Gordon, the reason that fringe benefits were exempt from wage controls is that they were regarded as less inflationary than wage increases. *Id.* at 1.

6. See *infra* notes 114-16 and accompanying text.

7. Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 867 (1980).

8. Henry B. Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 57 n.16 (1981) (discussing "commercial" nonprofit nursing homes).

9. See *infra* note 120 and accompanying text for a discussion of state non-profit hospital reform measures.

10. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. §§ 1395-1395ccc (1988 & Supp. IV 1992)).

advocates of health care reform.¹¹ There are several critical elements in explaining the Medicare program that was actually enacted. First, advocates of a broader program of national health insurance failed to make its adoption a realistic political possibility. Second, the American Medical Association and individual providers proved powerful lobbyists. Third, advocates faced the deep-seated American aversion to an expansion of the role of government. "Socialized medicine" was to be resisted as a large opening wedge in the movement away from traditional American values of free markets and self-reliance toward Soviet-style communism.¹² This ideological characterization gained added force because of the geopolitical competition between the United States and the Soviet Union. Further, and most decisively with respect to the timing of enactment, medical care for the aged was an issue both in the 1964 presidential election and in many congressional races. The Democrats' landslide victories at both levels gave them a mandate that made the adoption of some program inevitable. The conflict then progressed to the content of the program.¹³

Another important consideration in the health care debate is the role of small business in American political life. Small business, which includes family farms, has a powerful appeal to all Americans based on ideology and nationalism. Small business is an example of individual enterprise, and the value Americans place on both individualism and the entrepreneurial venture is formidable. Furthermore, recent job growth in the private sector of the economy has come almost entirely from small business.¹⁴ Thus, the voices of small businesses and their associations sound loudly in Washington's corridors of power.

Small business strongly opposes legislation requiring employers to provide health care coverage for their employees.¹⁵ Among

11. See Blumenthal, *supra* note 1, at 15-18; Starr, *supra* note 2, at 129-38.

12. See Blumenthal, *supra* note 1, at 5-6, 11-15; Theodore R. Marmor, *Reflections on Medicare*, 13 J. MED. & PHL. 5, 6-10 (1988).

13. See Blumenthal, *supra* note 1, at 10; Marmor, *supra* note 12, at 9-10.

14. See, e.g., Paul Merrion, *No Respect: Why Washington Turns its Back on Small Firms; Entrepreneurs' Agenda Clashes with Big Interests*, CRAIN'S CHI. BUS., Nov. 16, 1992, at SB48; Pete Silas, *Job-Creating Firms Come in All Sizes, INDUS. WK.*, June 21, 1993, at 42.

15. Mary F. Kelley, a board member of the National Federation of Independent Businesses (NFIB), attended a July 21, 1993 meeting with President Clinton. Discussing the meeting with reporters, Kelley said that the attendees shared with the President their deep reservations about mandating employer health care coverage for employees. The group emphasized the threat to the creation of new jobs. Kelley said that she could not imagine that NFIB would support employer mandates in any form and that the organization

the public at large, support for mandating employer health care coverage of employees falls from fifty-two to thirty percent when one introduces the specter of job loss into the debate.¹⁶

From the perspective of employers not currently providing health care, there is little real difference between: (1) a requirement that employers provide and pay for employee health care; and (2) a tax on those same employers used to fund government provision of health care for otherwise uncovered employees.¹⁷ From the perspective of Congress, however, an employer mandate substantially increases access to health care without adding to "on budget" government revenues or expenditures. This approach lessens the chances that consumer opposition to increased taxes on individuals will torpedo health care reform.

An employer mandate *with subsidies* for small business might win the support of some small business lobbying groups, or at least mute their opposition.¹⁸ Even if small business groups strongly oppose all employer mandates, a plan with employer subsidies might appear to consumers as sufficiently fair to small business to allow its passage.

would lobby strongly against such a proposal if it was sent to Congress. *Small Businesses Warn Clinton of Adverse Impact of Employer Mandate*, BNA HEALTH CARE DAILY, July 23, 1993, available in LEXIS, Nexis Library, BNAHCD File. See also Steven Greenhouse, *Small-Business Group in No Mood to Relent on Opposition to Health Plan*, N.Y. TIMES, Sept. 17, 1993, at A20.

16. *Public Willing to Pay Higher Taxes for Combination Reform Plan*, BNA PENSIONS & BENEFITS DAILY, Dec. 16, 1992, available in LEXIS, Nexis Library, BNAPBD File [hereinafter *Combination Reform Plan*].

17. According to the General Accounting Office, about three-fourths of the 34 million uninsured Americans are workers or their dependents. *GAO Says Universal Access to Health Insurance "Achievable Goal,"* 93 TAX NOTES TODAY 12-70, Jan. 19, 1993, available in LEXIS, TAXANA Library, TNT File. An enforceable employer mandate would by itself take a giant step toward solving the access problem. Of uninsured workers, just over one-half are employed by firms with fewer than 25 employees. *Id.* It is clear that providing health care coverage that meets specified minimum standards for so many would substantially increase the costs for businesses in this size segment, which explains the strength of the opposition of small business to an employer mandate.

18. In testimony before the House Small Business Committee, representatives of the Small Business Legislative Council, the U.S. Chamber of Commerce, the National Association of Manufacturers, and National Small Business United, while declining to endorse an employer mandate, nevertheless significantly qualified their opposition to a plan for employer premium contributions with subsidies for lower paid workers and their employers. The opposition of other groups remained unabated. *Small Business Groups Divided Over Employer Mandate Proposal*, BNA HEALTH CARE DAILY, Aug. 5, 1993, available in LEXIS, Nexis Library, BNAHCD File.

C. *The Lessons of the 1992 Election and the 1993 Budget Debate*

The primary battleground of the 1992 election was the state of the economy. Fearful of losing its focus, the Clinton campaign team repeatedly reminded itself that "It's the economy, stupid." This simple phrase reflected widespread dissatisfaction among middle-class Americans about their recent economic progress and about their, and their children's, prospects for the future. Anxiety about the costs of health care, and the possibility that employment changes might leave them without health care coverage, made health care reform a part of the larger concern about the economy, as well as one of the campaign's more important issues in its own right.

Perhaps next behind the economy in overall importance as a 1992 campaign concern was the budget deficit.¹⁹ The initially favorable and eventually mixed reception that President Clinton's budget proposals received from the public showed that the American people were serious about reducing the deficit even if they had not yet fully accepted what must be done to reduce it. The debate over the budget apparently indicates that the tax increases finally enacted have at the very least exhausted the public's willingness to accept additional new taxes even for popular proposals such as health care reform.

D. *Ideal Health Care Reform*

The theoretically ideal reform tends to differ substantially from the politically attainable reform. Among tax policy analysts, there is widespread agreement on the theoretically ideal health care reform. However, several features of the ideal, or normative, health care reform emerge almost automatically from the descriptions of current tax provisions and of the health care economy and from the normative discussion of health care taxation.

The broad contours of ideal health care reform are as follows. Normative reform would include an individual, but not an

19. A poll conducted by the Employee Benefit Research Institute and The Gallup Organization, Inc. asked Americans what issue should be President Clinton's first priority in office. Thirty-seven percent of Americans responded that Clinton should focus on improving the economy, 24% said reducing the federal deficit, and 15% said reforming the health care system. When asked what should be the second priority, 25% indicated reforming the health care system, 24% said improving the economy, and 20% said reducing the budget deficit. Carolyn Piucci, *Public Attitudes on Health Care Reform Results of New EBRI/Gallup Survey*, 14:4 NOTES 6 (Employee Benefit Research Institute ed., Apr. 1993).

employer, mandate. Any subsidies required would be provided to individuals on the basis of their income. The reform would continue full deductibility of employer contributions to employee health care coverage as a form of compensation. The reform would cap, or eliminate altogether, the exclusion of employer contributions from employee income.²⁰ It would end the tax-exempt status of nonprofit health care providers and their eligibility for tax-exempt bond financing. Finally, health care reform would include increases in the excise taxes on alcohol and tobacco sufficient to recover the health care costs of their use.

Analysts differ on the potential for approximating this ideal. Pragmatic advocates of health care reform should not lose sight of the economic principles that make health care reform necessary. While they attempt to fashion a reform proposal that Congress can enact and the President will sign, they must also seek to assure that the proposal departs as little as possible from the theoretical ideal.

Fashioning such a proposal is the goal of this Article. Part II of the Article describes the existing Internal Revenue Code

20. See, e.g., Stuart M. Butler, *A Tax Reform Strategy to Deal with the Uninsured*, 265 JAMA 2541, 2542-43 (1991) (advocating an individual mandate, refundable tax credits, and elimination of the employer-provided health insurance exclusion); Michael J. Graetz, *The Big Health Reform Mistake: Mandating Employer Coverage*, 2 DOMESTIC AFF. 79, 98 (1993) (favoring the phasing out of the employer-provided health insurance exclusion in favor of a voucher for health insurance purchases); Mark V. Pauly et al., *A Plan for 'Responsible National Health Insurance'*, 10 HEALTH AFF. 5, 11-12 (1991) (advocating elimination of exclusions in favor of refundable tax credits).

A proposal to cap the non-inclusion of employer contributions to the cost of employee medical coverage was part of the Treasury Department's 1984 recommendations to President Reagan for overall tax reform. The report succinctly set forth the major policy reasons for supporting a cap. See 1 U.S. DEP'T OF TREAS., TAX REFORM FOR FAIRNESS, SIMPLICITY, AND GROWTH: THE TREASURY DEPARTMENT REPORT TO THE PRESIDENT 73 (1984) [hereinafter TAX REFORM FOR FAIRNESS]; 2 TAX REFORM FOR FAIRNESS at 23-24. The proposal was also part of the 1985 fiscal budget submitted by President Reagan. 1 TAX REFORM FOR FAIRNESS at 73. The proposal encountered fierce resistance, especially from the insurance industry. See ACLI/HIAA JOINT TASK FORCE ON THE TAXATION OF EMPLOYEE BENEFITS, REVIEW AND ANALYSIS OF THE TAXATION OF EMPLOYEE BENEFITS (1985).

Attitudes have changed substantially since then. Only organized labor appears to oppose a tax cap. Business leaders have begun to speak in favor of a cap. The insurance industry has been largely silent. See Laurie McGinley, *Tax-Break Cap On Health Plans Gains Support*, WALL ST. J., Dec. 16, 1992, at B1 (citing Business Roundtable committee recommendation that endorsed taxing some health care benefits). 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 A30 (citing President-elect Clinton's inclination to limit tax breaks for employee health benefits).

treatment of health care expenditures, and Part III provides an analysis of health care economics. Part IV discusses how the existing tax code provisions conform to those that sound tax policy would demand in light of the realities of the health care economy. Part V analyzes normative reform and the reasons why a close approximation is not politically attainable. Part V then articulates a "second best" proposal for reform with a greater potential for enactment, and explains how it differs from provisions of the Clinton Plan.

The heart of this pragmatic proposal is both a dual employer/individual mandate and a dual system of employer/individual tax credits. The analysis freely concedes that this is a more complex system than the theoretically ideal system would be. Its admitted purpose is to prevent the objections of small business from defeating a sound proposal for reform, while at the same time making the proposal acceptable to the general public.

II. PROVISIONS OF THE INTERNAL REVENUE CODE AND REGULATIONS

A. *Section 213 and Individual Medical Expenses*

The touchstone for all other sections of the Internal Revenue Code (the Code) pertaining to health care is section 213.²¹ Standing alone, section 213 allows a deduction for medical expenses of a taxpayer, and of the taxpayer's spouse or dependent, which have not been reimbursed by another party (*e.g.*, an employer-provided health plan).²² The deduction applies to the extent those expenses exceed 7.5 percent of the taxpayer's adjusted gross income.²³

Section 213 is surprising both for its parsimony at one end of the medical expense cost spectrum and its expansiveness at the other. It prohibits a deduction for amounts spent on over-

21. I.R.C. § 213 (Law. Co-op. 1993). Section references without further description are to the Internal Revenue Code of 1986 as amended, 26 U.S.C.S. (Law. Co-op. 1993).

22. I.R.C. § 213(a). This subsection provides:

ALLOWANCE OF DEDUCTION — There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152), to the extent that such expenses exceed 7.5 percent of adjusted gross income.

Id.

23. *Id.*

the-counter medications.²⁴ Otherwise, the section's definition of medical care is very expansive. "Medical care" encompasses "amounts paid . . . for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body," including insurance and transportation expenses necessary to obtain medical care.²⁵

The Internal Revenue Service (IRS) explicitly authorizes a medical expense deduction for amounts paid to qualified and authorized psychologists.²⁶ The IRS also states that payments may be deductible even if made to unlicensed practitioners, as long as the treatment is not illegal: "The determination of what is medical care depends on the nature of the services rendered, not on the experience, qualifications, or title of the person rendering them."²⁷

Section 213(d)(2) extends the deduction to lodging expenses "primarily for and essential to" medical care provided by a physician in a hospital.²⁸ However, section 213(d)(9), added in 1990, excepts from eligibility for deduction any procedure aimed at improving appearance which does not "meaningfully promote the proper function of the body or prevent or treat illness or disease."²⁹ This exclusion, aimed at cosmetic surgery, appears not to extend to purely cosmetic prescription drugs, such as Retin-A or Rogaine.³⁰ There are otherwise no limits on the type or amount of medical expenses eligible for deduction.

The Internal Revenue Code provides no special treatment for health insurance payments by individuals on their own behalf. Instead, individual insurance premiums qualify along with other out-of-pocket medical expenditures for possible deduction as medical expenses under section 213.³¹

24. Section 213(b) provides:

LIMITATION WITH RESPECT TO MEDICINE AND DRUGS — An amount paid during the taxable year for medicine or a drug shall be taken into account under subsection (a) only if such medicine or drug is a prescribed drug or insulin.

I.R.C. § 213(b).

25. I.R.C. § 213(d)(1).

26. 1953-2 C.B. 129, 130 (1953). See also Rev. Rul. 55-261, 1955-1 C.B. 307, 307 (1955) (restating allowance of medical expense deduction for, *inter alia*, psychologists and "authorized Christian Science practitioners").

27. 1963-91 C.B. 54, 54 (1963).

28. I.R.C. § 213(d)(2) (Law. Co-op. 1993). The deduction is limited to \$50 per night. *Id.*

29. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 11342(a), 104 Stat. 1388 (1990) (codified at 26 U.S.C.S. § 213(d)(9) (Law. Co-op. 1993)).

30. See I.R.C. § 213(d)(3) (defining "prescribed drug" as any drug requiring a physician's prescription); I.R.C. § 213(b), *supra* note 24.

31. I.R.C. § 213(d)(1)(C). This has not always been the case. See *infra* note 67.

Individuals also benefit from section 32(b)(2), which provides a credit for insurance coverage that includes at least one qualifying child.³² In addition, Medicare benefits are exempt from taxation,³³ even though Medicare eligibility is not based on income and benefits are funded by pre-tax contributions and general tax revenues as well as by employee after-tax contributions.³⁴

B. Employer-Provided Health Plan Provisions

Section 105 of the Code requires inclusion in employee income of benefits paid out by an employer health plan unless those benefits meet the deductibility requirements under section 213.³⁵

32. I.R.C. § 32(b)(2).

33. Rev. Rul. 70-341, 1970-2 C.B. 31, *revoked in part*, Rev. Rul. 79-173, 1979-1 C.B. 86.

34. The Congressional Budget Office explained the logic of taxing part of the cost of the Medicare program as follows:

Eligibility for Hospital Insurance (HI) benefits is based on working-year tax contributions, half of which are paid by employees from after-tax income and half by employers from pre-tax income. Hence, 50 percent of the insurance value of HI benefits might be treated as taxable income for all Medicare enrollees, reflecting the portion of contributions that was not originally subject to income tax. This proposal is analogous to taxing part of Social Security benefits, which is already in effect for higher-income beneficiaries whose modified adjusted gross income plus half of Social Security benefits exceeds \$25,000 (for individuals) or \$32,000 (for couples). In addition, that portion of the insurance value of benefits under the Supplementary Medical Insurance (SMI) program that is not covered by enrollees' premiums (currently about 75 percent) could be added to their taxable income.

CONG. BUDGET OFF., REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS 365 (1993) [hereinafter REDUCING THE DEFICIT]. The report estimated a \$54.6 billion revenue increase over the period 1994-98 if both the HI and SMI taxes are instituted without income thresholds. *Id.*

35. I.R.C. § 105 (Law. Co-op 1993). This section provides in relevant part:

(a) AMOUNTS ATTRIBUTABLE TO EMPLOYER CONTRIBUTIONS. — Except as otherwise provided in this section, amounts received by an employee through accident or health insurance for personal injuries or sickness shall be included in gross income to the extent such amounts (1) are attributable to contributions by the employer which were not includable in the gross income of the employee, or (2) are paid by the employer.

(b) AMOUNTS EXPENDED FOR MEDICAL CARE. — Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include amounts referred to in subsection (a) if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses

Amounts received by employees as reimbursement for medical expenses are thus excluded from gross income. Section 106 provides, in its entirety, that "[g]ross income of an employee does not include employer-provided coverage under an accident or health plan."³⁶ Treasury Regulation section 1.106-1 refers explicitly to Code section 105(e)³⁷ — which dictates that self-funded employer plans shall receive the same treatment as insured plans — in explaining that employer contributions are excluded from employee income.³⁸

Other than the deduction provided by section 213, section 162(l) modified the rule that the self-employed could take no deduction for individual health insurance.³⁹ Prior to 1994, self-

incurred by him for the medical care (as defined in section 213(d)) of the taxpayer, his spouse, and his dependents (as defined in section 152). Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this subsection.

(c) PAYMENTS UNRELATED TO ABSENCE FROM WORK. — Gross income does not include amounts referred to in subsection (a) to the extent such amounts—

(1) constitute payment for the permanent loss or loss of use of a member or function of the body, or the permanent disfigurement, of the taxpayer, his spouse, or a dependent (as defined in section 152), and

(2) are computed with reference to the nature of the injury without regard to the period the employee is absent from work.

(d) [Repealed]

(e) ACCIDENT AND HEALTH PLANS. — For purposes of this section and section 104—

(1) amounts received under an accident or health plan for employees, and

(2) amounts received from a sickness and disability fund for employees maintained under the law of a State or the District of Columbia, shall be treated as amounts received through accident or health insurance.

(f) RULES FOR APPLICATION OF SECTION 213. — For purposes of section 213(a) (relating to medical, dental, etc., expenses) amounts excluded from gross income under subsection (c) or (d) shall not be considered as compensation (by insurance or otherwise) for expenses paid for medical care.

(g) SELF-EMPLOYED INDIVIDUAL NOT CONSIDERED AN EMPLOYEE.

— For purposes of this section, the term "employee" does not include an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

I.R.C. § 105.

Section 105(h) addresses deductions by highly compensated individuals under self-insured reimbursement plans, and § 105(i) covers sick pay received under the Railroad Unemployment Insurance Act.

36. I.R.C. § 106.

37. See *supra* note 35.

38. Treas. Reg. § 1.106-1 (1993).

39. I.R.C. § 162(l) (Law. Co-op. 1993).

employed individuals could deduct as a business expense twenty-five percent of the cost of medical insurance for themselves and for their spouses and dependents.⁴⁰

Section 125(a) provides that non-discriminatory cafeteria benefit plans that offer a choice between qualified benefits and cash will not cause the choice of a qualified benefit to result in inclusion of the value of the benefit in gross income.⁴¹ Section 125(f) states that a qualified benefit is one eligible for exclusion by an express provision of the Code.⁴² Proposed Regulation section 1.125-2 Q&A 7(b)(4) provides that a health flexible spending account can only reimburse medical expenses as defined in section 213.⁴³

In general, employers may deduct payments for employee health care plan premiums as a trade or business expense under section 162.⁴⁴ Treasury Regulation section 1.162-10(a) provides, among many other things, that amounts paid by a taxpayer under "a sickness, accident, hospitalization, [or] medical expense . . . plan, are deductible under section 162(a) if they are ordinary and necessary expenses of the trade or business."⁴⁵

C. *Charitable Hospitals*

Section 501(c)(3) grants an exemption from the corporate income tax to:

Corporations . . . organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster . . . sports competition . . . or for the prevention of cruelty to children or animals . . .⁴⁶

The exemption in section 501(c)(3) applies only when net earnings do not inure to private shareholders and when the organization does not lobby for legislation or support the campaigns of candidates for office.⁴⁷

40. I.R.C. § 162(l)(1). This deduction expired on December 31, 1993. I.R.C. § 162(l)(6). It has not yet been extended, although its possible extension continues to be discussed.

41. I.R.C. § 125(a).

42. I.R.C. § 125(f). There are exceptions to the exclusion rule provided by § 117 for qualified scholarships, by § 127 for educational assistance programs, and by § 132 for certain fringe benefits. *Id.*

43. Prop. Treas. Reg. § 1.125-2 Q&A 7(b)(4), 54 Fed. Reg. 9500, 9502-04 (1989).

44. I.R.C. § 162(a) (Law. Co-op. 1993).

45. Treas. Reg. § 1.162-10(a) (1993).

46. I.R.C. § 501(c)(3) (Law. Co-op. 1993).

47. *Id.*

The IRS has interpreted this provision expansively to include nursing homes and hospitals organized as non-profits that provide little charitable care.⁴⁸ This policy abandoned an earlier requirement that an institution provide a meaningful amount of free or below-cost care to the poor to qualify for tax exemption.⁴⁹

[T]he Service chose to reinterpret the term "charitable" so that subsidized care would no longer be required. Rev. Rul. 69-545, 1969-2 C.B. 117. A coherent rationale for this redefinition of the exemption was never expressed by the Service. This imaginative broadening of the statutory category of "charitable" organizations was challenged, but was sustained by the Court of Appeal, in an opinion which sheds no light of its own on the policy issues involved.⁵⁰

In addition to the provisions above aimed directly at health care, private hospitals sometimes benefit from the use of capital provided by means of state and local bonds exempt from federal income tax under provisions of section 103.⁵¹ Further, various health care activities benefit from charitable contributions from taxpayers, which are tax-deductible under section 170.⁵² Section 28 allows a tax credit for clinical testing expenses for rare diseases.⁵³

D. *Tax Expenditure Cost of Existing Preferences for Medical Care*

According to 1994 estimates by the staff of the Joint Committee on Taxation, the exclusion of employer contributions for medical insurance premiums and medical care will cost \$37.1 billion.⁵⁴ In addition, the credit for child medical insurance premiums will total \$100 million, the deductibility of medical

48. Rev. Rul. 72-154, 1972-1 C.B. 145.

49. Hansmann, *supra* note 8, at 57-58 n.16 (citing *Eastern Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1288-89 (D.C. Cir. 1974), *rev'd on other grounds*, 426 U.S. 26 (1976)).

50. *Id.*

51. I.R.C. § 103(a) (Law. Co-op. 1993).

52. I.R.C. § 170(a).

53. I.R.C. § 28(a). The tax credit equals 50% of "qualified clinical testing expenses for the taxable year." *Id.* This credit expired on December 31, 1993. I.R.C. § 28(e).

54. JOINT COMM. ON TAXATION, 103D CONG., 1ST SESS., ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 1994-1998, at 17 (1993) [hereinafter FEDERAL TAX EXPENDITURES]. This figure includes the U.S. government program for military dependents, called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

expenses will cost \$3.5 billion, the exclusion of interest on state and local bonds for private hospitals will equal \$1.8 billion, the deductibility of charitable contributions for health will cost \$1.6 billion, and the exclusion of Medicare benefits will cost \$13.1 billion.⁵⁵ These costs yield a total of \$57.2 billion, the second largest tax expenditure behind retirement income.⁵⁶

The exemption of non-profit health care providers from the corporate income tax is not included in the standard indices of tax expenditures. However, the revenue loss is estimated at \$2.5 billion annually.⁵⁷

E. Conformity of the Code's Treatment of Health Care Expenditures to General Code Principles

To assess the conformity of the Code's treatment of health care expenditures to basic principles of income taxation, one must be familiar with those principles. The extended and unresolved debate between followers of the late Stanley S. Surrey and their critics, led by Boris Bittker, indicates that this is an elusive goal.⁵⁸

Even so, the deduction allowance to employers for health care plan payments is completely unremarkable. Health care is a standard, though not universal, part of employee compensation packages. Reasonable compensation of employees is an archetype of the business expense deduction that must be permitted to arrive at net income.⁵⁹

55. *Id.* These numbers reflect only reductions in federal income tax. They do not reflect reductions in Social Security and Medicare payroll taxes and they do not reflect reductions in state taxes. In testimony before the House Ways and Means Health Subcommittee, Nancy Gordon, assistant director of the Human Resources Division, Congressional Budget Office, said that state income tax provisions resulted in tax expenditures for health care in 1993 of an additional \$10 billion. Peter Jakubowicz, *CBO: Employer-Provided Health Insurance Deductions Means 'Implicit' Subsidy of \$73 Million in 1993*, 93 TAX NOTES TODAY 19-6, Jan. 27, 1993, available in LEXIS, TAXANA Library, TNT File. Further, at the state and local level, health care providers benefit from the common exclusion from sales and use taxes of services in general and the universal exclusion of health care services. See generally JEROME R. HELLERSTEIN & WALTER HELLERSTEIN, STATE AND LOCAL TAXATION 749-60 (5th ed. 1988) (discussing taxation of services).

56. This calculation assumes that each of these tax expenditures is sufficiently independent so that adding them together approximates the revenue effect of eliminating all of them.

57. Gabriel Rudney & John Copeland, *End Tax Breaks for Nonprofit Hospitals*, 93 TAX NOTES TODAY 112-59, available in LEXIS, TAXANA Library, TNT File.

58. See *infra* notes 61-72 and accompanying text for a discussion of the principles of income taxation.

59. See *supra* notes 44-45 and accompanying text.

The Code distinguishes between business expenditures, which are deductible, and personal expenditures, which are not.⁶⁰ Admittedly, that line is sometimes difficult to draw. Professor William D. Andrews amply demonstrated that difficulty with respect to health care expenditures by individuals:

The appropriate role of personal deductions in an ideal income tax base is just that — to adjust for discrepancies between money income and real consumption and accumulation resulting from expenditures for items that we do not wish to take into account as part of the aggregate personal consumption or accumulation we wish to tax.⁶¹

For Professor Andrews, it was appropriate to exclude from the tax base differences in medical care consumption that reflected differences in medical need. However, it was not appropriate to exclude expenses that were the result of voluntary personal gratification.⁶² Under this view, a majority but not all of the current deduction would be justified.⁶³

The deduction of section 213 has a parallel in the deduction for personal casualty losses of section 165.⁶⁴ Section 165(h) limits the deduction to the excess of the net of casualty losses each exceeding \$100 over 10 percent of the individual's adjusted gross

60. Compare I.R.C. § 162 (Law. Co-op. 1993) (allowing deductions for business expenses) with I.R.C. § 262 (prohibiting deductions for "personal living or family expenses").

61. William D. Andrews, *Personal Deductions in an Ideal Income Tax*, 86 HARV. L. REV. 309, 330 (1972).

62. *Id.* at 336-37.

63. Professor Andrews' analysis will provide a conceptually sound basis for evaluating the tax elements of health care reform proposals. Andrews' remarks, which concerned only the § 213 deduction, lend themselves to much wider application. See *infra* part V.B.3.

64. I.R.C. § 165(c)(3) (Law. Co-op. 1993). Section 165 of the Code provides in relevant part:

(a) GENERAL RULE. — There shall be allowed as a deduction any loss sustained during the taxable year and not compensated for by insurance or otherwise.

...
(c) LIMITATION ON LOSSES OF INDIVIDUALS. — In the case of an individual, the deduction under subsection (a) shall be limited to—

(1) losses incurred in a trade or business;
(2) losses incurred in any transaction entered into for profit, though not connected with a trade or business; and
(3) except as provided in subsection (h), losses of property not connected with a trade or business or a transaction entered into for profit, if such losses arise from fire, storm, shipwreck, or other casualty, or from theft.

income.⁶⁵ These sections may be viewed jointly as making the government a partial insurer against catastrophic losses not otherwise reimbursed. Boris Bittker defends both these deductions on basic tax principles.⁶⁶ In Bittker's view, "Casualties undeniably reduce the taxpayer's net worth — and should therefore presumptively reduce his income . . . — and it is debatable whether they are offset by the satisfactions implied by the term 'consumption.'"⁶⁷

Non-inclusion in employee income of employer payments for health care coverage,⁶⁸ however, is an anomaly that seriously violates the principle of taxing net income. For an employee with covered dependents, the value of employer-provided health care can easily be ten percent or more of total compensation. Such a striking departure from the principle of taxation of net income should require a very strong public policy justification.

Normative tax policy also cannot justify the exemption of non-profit health care providers from corporate income tax.⁶⁹ The tax code discriminates among health care providers based on organizational form. Non-profit health care providers are exempt from federal income tax and often from state and local taxation; for-profit health care providers are not. Assuming *arguendo* that health care is over-consumed, the argument against any tax subsidies becomes stronger.

Furthermore, providers that are granted tax advantages not granted to others will have a competitive advantage not grounded in efficiency of health care delivery. Tax preferences could work against the overall goal of reform by directing consumers to less efficient providers. Universal access will eliminate the vestiges of providing uncompensated health care to the indigent. This charitable aspect explains the origin of the existing exemptions.⁷⁰ But actual practice today differs little between non-governmental

65. I.R.C. § 165(h).

66. Boris Bittker, *Income Tax Deductions, Credits, and Subsidies for Personal Expenditures*, 16 J. LAW & ECON. 193 (1973).

67. *Id.* at 197. Bittker stated that a more cogent criticism of the casualty deduction is that the deduction mitigates the cost of failing to take the sensible precaution to insure. *Id.* at 198. The same criticism applies to § 213 in its current form. Before 1982, § 213(a)(2) allowed a deduction of up to \$150 per year for medical insurance expenditures without dictating an income threshold percentage. While such a provision avoids the incentive problem that Bittker noted, it also allows a deduction for normal expenses. Bittker admitted that this added deduction for normal expenses does not justify his rationale for the catastrophic coverage of § 213. *Id.* at 198 n.12.

68. I.R.C. § 106 (Law. Co-op. 1993); *see supra* note 36 and accompanying text.

69. I.R.C. § 501(c)(3); *see supra* notes 46-50 and accompanying text.

70. *See supra* notes 7-8 and accompanying text.

non-profits and for-profit providers of health care. The existing exemptions are an anachronism that would warrant repeal even without any other changes to the health care system.⁷¹ Repeal is especially important as a prelude to a radical reconstruction of the health care market, lest marginally less efficient providers gain unwarranted market share.

The same "level playing field" argument requires that health care facilities be ineligible for funding with tax-exempt bonds.⁷² To allow some competitors access to lower cost capital while depriving others of the same benefit is anti-competitive and impedes progress toward greater efficiency in the health care sector.

III. THE ECONOMICS OF THE HEALTH CARE MARKET

A. *Market Imperfections*

An efficient market requires that both buyers and sellers be (1) willing, (2) knowledgeable, and (3) able to enjoy free access to and exit from the market.⁷³ The market for health care services⁷⁴ possesses neither the second nor third of these characteristics; buyers are rarely knowledgeable, and their freedom to enter and exit the market is limited. State licensing laws limit the entry of sellers of medical services. Further, the subjective value consumers attach to their health adds a dimension to their willingness to consume that distinguishes health care from other commodities for which monetary cost is a more important factor.⁷⁵

71. See Hansmann, *supra* note 8, at 58-62 (attempting to construct a workable definition of income for nonprofit organizations); Hansmann, *supra* note 7, at 866-68 (detailing the historical factors making hospitals typically nonprofit).

72. See *supra* note 51 and accompanying text.

73. DAVID L. WEIMER & AIDAN R. Vining, *POLICY ANALYSIS: CONCEPTS AND PRACTICE* 30, 41-77, 266 (1992).

74. See generally Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). This insightful article, though old, is still extremely relevant because it explains the developments in health care over the last 30 years. One example is Arrow's explanation of the inherent instability of community rating, still prevalent when he wrote, if what we would today call "experience-rating" became available. *Id.* at 964. Arrow's analysis is "a catalogue of stylized generalizations about the medical-care market which differentiate it from the usual commodity markets." *Id.* at 948.

75. In addition, the demand for medical services is associated, with a considerable probability, with an assault on personal integrity. There is some risk of death and a more considerable risk of impairment of full functioning. In particular, there is a major potential for loss or reduction of earning ability. . . . Illness is, thus, not only risky but a costly risk in itself, apart from the cost of medical care.

Arrow, *supra* note 74, at 949.

B. *Information Asymmetries*

Purchasers of medical services have far less information available to them when considering the purchase of health care than they do when they are considering the purchase of a video cassette recorder. Price comparisons are difficult, especially because physicians generally provide their services on a fee-for-service basis, without advertising or overt price competition, and without quoting a price in advance.⁷⁶ Patients cannot determine the probable effects on their health caused by declining to undergo a magnetic resonance imaging (MRI) that their physician recommends.⁷⁷ Current practice fails to provide patients with disclosure,⁷⁸ which would force providers to develop and present health care consumers with information on the effectiveness of recommended treatments. Current practice also

76. *Id.* at 949-50.

77. Uncertainty as to the quality of the product is perhaps more intense here than in any other important commodity. Recovery from disease is as unpredictable as is its incidence. In most commodities, the possibility of learning from one's own experience or that of others is strong because there is an adequate number of trials. In the case of severe illness, that is, in general, not true; the uncertainty due to inexperience is added to the intrinsic difficulty of prediction. Further, the amount of uncertainty, measured in terms of utility variability, is certainly much greater for medical care in severe cases than for, say, houses or automobiles, even though these are also expenditures sufficiently infrequent so that there may be considerable residual uncertainty.

Further, there is a special quality to the uncertainty; it is very different on the two sides of the transaction. Because medical knowledge is so complicated, the information possessed by the physician as to the consequences and possibilities of treatment is necessarily very much greater than that of the patient, or at least so it is believed by both parties. Further, both parties are aware of this informational inequality, and their relation is colored by this knowledge.

To avoid misunderstanding, observe that the difference in information relevant here is a difference in information as to the consequence of a purchase of medical care.

Arrow, *supra* note 74, at 951.

Patients are even less likely to determine when the doctor's recommendation is made solely for the doctor's personal enrichment. See *Prime Time Live* (ABC television broadcast, Feb. 4, 1993) (documenting doctors willing to refer patients for unneeded MRIs to labs which promised the doctors kickbacks, and the solicitation of persons on unemployment lines to submit to "consultations" during which an MRI would be prescribed).

78. Some proposals for health care reform give a prominent role to outcomes disclosure. Pennsylvania has adopted a program of disclosure that many hope will serve as a model. See Ron Winslow, *State Rates Heart Surgeons by Mortality*, WALL ST. J., Nov. 20, 1992, at B1 (rating individual doctors according to death rates as part of report on coronary bypass surgery).

fails to provide guarantees, which often serve as substitutes for non-disclosure of information on reliability.⁷⁹ With health and possibly life at stake, the instinct for self-preservation makes even informed health care consumers "willing" purchasers of products of uncertain quality. Information asymmetries favor consumption. Consider a diagnostic test that costs \$1000. Assume that the patient is responsible for paying the entire cost out-of-pocket; there is no "third-party payment." Assume that the test has only a two percent probability of changing the health *outcome* and a five percent probability of changing the indicated *treatment*. The physician recommends the test.

In this hypothetical, the patient would be willing to pay \$1000 for a test which has only a five percent chance of favorably affecting her health outcome, which is to say the patient genuinely prefers a five percent chance of improved health to \$1000.⁸⁰ Thus, with full disclosure, the patient would decline to undergo this test. However, the patient mistakenly assumes that the physician's recommendation means that the test has at least a five percent chance of improving her health; that is, the patient mistakenly assumes that the physician's decision criterion is no lower than the patient's own. Information asymmetries like these lie at the heart of what is sometimes called "physician-induced demand."

Assume instead that the test does have a five percent probability of improving the patient's health but that the physician did not consider the test sufficiently probative. The physician does not mention the test to the patient. The patient would not know enough to ask for it, even though the patient would freely have chosen to undergo the test and pay for it if the physician had discussed and fully disclosed its limitations. Because the patient's decision to undergo the test is dependent on whether or not the physician told the patient about the test, this information asymmetry is referred to as "physician-revealed demand."

In this situation, society must largely rely on social constraints on the behavior of physicians, or what Arrow calls a "collectivity-orientation."⁸¹ "Advice given by physicians as to further treatment by himself or others is supposed to be completely divorced from self-interest. . . . It is at least claimed that treat-

79. See George A. Akerlof, *The Market for Lemons: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 499-500 (1970).

80. The decision would be completely different if financial factors alone determined the patient's choice. Most people have an emotional attachment to their continued existence and well-being, which they value above the present value of future cash flows.

81. Arrow, *supra* note 74, at 949.

ment is dictated by the objective needs of the case and not limited by financial considerations."⁸² It is not surprising that these social constraints fail to contain health care costs, especially in view of third-party payment, discussed below. Decisions to recommend unnecessary care cost the individual undergoing the care very little. For physicians, such decisions may seem to amount to "victimless crimes," outweighed by the more immediate prospect of an income below that which physicians believe their talents, education, skills, and hard work merit.

C. *Third-Party Payment*

The increased prevalence of third-party payment by employers, the government, or both largely insulates the individual consumer from the economic consequences of decisions to consume more health care.⁸³ In 1960, out-of-pocket payments financed one-half of health care expenditures;⁸⁴ in 1993, they will finance less than one-fifth of health care expenditures.⁸⁵ Out-of-pocket health care expenditures as a percent of disposable income are projected to decline still further by the end of the decade.⁸⁶

Consider again the hypothetical diagnostic test. The test costs \$1000 collectively for all those who will pay for it. Assume that the patient is unwilling to pay the entire \$1000 cost of the test because the test has a value to her of only \$500. If the patient had to pay the entire \$1000 price, she would decline to undergo the test. However, the patient is a member of a standard comprehensive medical plan that reimburses eighty percent of the cost of all health care expenditures, with additional catastrophic expense protection. Whatever the patient paid for the plan is a sunk cost. At the point of making the purchase decision, the test will cost the patient \$200. The rational patient will undergo the test. The public, which finances the plan, will absorb the utility loss of \$500, the amount by which the total

82. *Id.* at 949-50.

83. To recognize this unfortunate feature of third-party payment is not at all to question the desirability, indeed the necessity, of medical care insurance. The question becomes what regulation, if any, is needed to make the market for medical care insurance function more effectively.

84. HEALTH CARE FIN. ADMIN., OFFICE OF NAT'L COST ESTIMATES, *National Health Expenditures 1988*, 11:4 HEALTH CARE FIN. REV. 1, 3 (1990).

85. Sally T. Turner et al., *National Health Expenditures Projections Through 2030*, 14:1 HEALTH CARE FIN. REV. 1, 20 (1992) (projecting 18.8% of national health expenditures attributable to out-of-pocket expenses).

86. *Id.* at 22 (projecting 17.4% of national health expenditures attributable to out-of-pocket expenses by 2000).

cost of the test exceeds its value to the patient.⁸⁷ This \$500 is a "negative externality," a cost not assumed by the purchaser, but shared by a larger public. In this common situation, the third-party payment encourages over-consumption of health care.

Another detrimental effect of third-party payment is that it reduces the incentive on the part of health care purchasers to obtain information on better prices.⁸⁸ Because they are not paying the full cost of treatment, patients see no need to expend time and effort in determining the most cost-effective cure.

D. *Choice of Coverage*

A similar analysis applies to choice of coverage decisions. Employees often have a choice among different health care plans, all of which are subsidized to various extents by their employers. Assume a choice between a standard comprehensive medical indemnity insurance plan and a staff model health maintenance organization (HMO). The comprehensive medical plan costs \$200 per month for individual employee coverage and offers completely free choice of providers with 80 percent reimbursement of covered expenses. The HMO costs \$150 per month for individual employee coverage and provides treatment by only its salaried doctors at the HMO facility.

Consider three different contribution schemes. In the first, the employer pays 80 percent of the cost of whatever option the employee chooses, and makes available a flexible benefits credit of \$80 a month that the employee can choose to apply, pre-tax, to offset a contribution to a medical plan, or receive as taxable wages. In the second, the employer contributes only 80 percent of the cost of the HMO, or \$120 per month, and makes available the same flexible benefits credit of \$80 per month. In the third case, the employer contributes \$120 per month and the employee contribution must be made from after-tax income.

Assume that the employee pays taxes at a thirty-one percent marginal rate and that he uses the flexible credit, if available, to the extent necessary to pay his required contribution. Table

87. Empirical studies have supported the theoretical hypothesis that third-party payment increases consumption of medical care. The most important study is Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment* (Rand, Feb. 1988). See generally Joseph P. Newhouse et al., *Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance*, 305 NEW ENG. J. MED. 1501 (1981) (finding individuals with full insurance coverage consume 50% more service than do individuals with income-related catastrophe insurance).

88. Arrow, *supra* note 74, at 962.

1 illustrates the difference in after-tax dollars between selection of the indemnity plan versus selection of the HMO.

TABLE 1

| | Case 1 | | Case 2 | | Case 3 | |
|--|---------------------------------|------------|--|------------|----------------|------------|
| | ER pays 80% \$80 Flex Credit | | ER pays 80% of HMO \$80 Flex Credit | | ER pays \$120 | |
| | Indemnity Plan | HMO Plan | Indemnity Plan | HMO Plan | Indemnity Plan | HMO Plan |
| Cost of Plan | | | | | | |
| Employer Contribution | \$200.00 | \$150.00 | \$200.00 | \$150.00 | \$200.00 | \$150.00 |
| Less Flex Credit | (\$160.00) | (\$120.00) | (\$120.00) | (\$120.00) | (\$120.00) | (\$120.00) |
| | (\$80.00) | (\$80.00) | (\$8.00) | (\$80.00) | | |
| Flex Credit Remaining | | | | | | |
| Employee Contribution | (\$40.00) | (\$50.00) | \$0.00 | (\$50.00) | \$80.00 | \$30.00 |
| EE After-Tax Income | | | | | | |
| Difference of HMO Plan over Indemnity Plan | \$27.60 | \$34.50 | \$0.00 | \$34.50 | (\$80.00) | (\$30.00) |
| | | \$6.90 | | \$34.50 | | \$50.00 |

If the employee values the indemnity plan \$40 per month more than the HMO plan, then under either of the first two contribution schemes, this employee will choose the indemnity plan. Under the third, he will choose the HMO plan.

In the first contribution scheme, both the employer and the government contribute to the entire cost of either plan; there are two "third-party" payors. In the second scheme, the employer makes a fixed contribution to either plan, but the government makes a larger contribution when the employee chooses the indemnity plan over an increase in wages. In the last scheme, neither the government nor the employer pay any of the additional cost of the indemnity plan.⁸⁹

In summary, the marginal difference in cost to the employee resulting from the presence or absence of a tax-favored employee contribution is sufficient to affect the employee's choice of plan, even though the tax benefit, the difference between cases two and three, is only \$15.50 per month.⁹⁰ An employee who values

89. This discussion deliberately, and at the cost of some circumlocution, avoids any discussion of the non-inclusion in employee income of the base employer contribution, whether a fixed percentage or a fixed dollar amount. Obviously, inclusion of the employer contribution in taxable income would reduce by the employee's marginal tax rate the value of a greater contribution to a more expensive plan. However, non-inclusion of a fixed dollar amount in taxable income does not directly affect employee choice among plans, unless lower net income leads the employee to set a lower value on the coverage differences between the plans.

90. This example, not coincidentally, anticipates the criticism of the existing tax regime that begins *infra* at part IV.

the indemnity plan at only \$20 per month more than the HMO plan would choose the HMO plan in both cases two and three. For these employees, the difference in employer contribution policy alone is enough to modify their selection, regardless of the availability of a tax benefit for employee contribution. Finally, an employee who values the indemnity plan over \$50 per month more than the HMO plan will choose the indemnity plan regardless of both the employer contribution policy and the tax treatment of the employee contribution.

The end result of the interactions between employer contribution policy and tax policy is to skew consumer choice. As such, it leads to overconsumption and distortions in health care distribution.

E. *Private Costs versus Social Costs*

The usual level of analysis in considering economic efficiency is that of the individual rational economic actor. Such an analysis draws a distinction between "private" costs and "social" costs, as in the example of the MRI with third-party payment examined above.⁹¹

At the level of private costs, there are few positive health care externalities. An obvious example is inoculation against infectious disease. Individuals not only safeguard their own health when they are immunized, but lower the risk of infection for all those with whom they come in contact. The government has at times sought to compel immunizations that might otherwise be underconsumed, as with the now obsolete smallpox vaccination once required for children attending school and, for a time, mandatory polio immunizations.

Most externalities are negative. Preventive care does not generate negative externalities at the level of private costs if the individual is allowed to bear the full costs, either in medical care or in illness and early death, alone. However, when society is unwilling to allow an individual to bear the full costs of an earlier, improvident decision, as when it subsidizes the care of a condition that might have been prevented, then society's failure to promote or require the preventive care that could have avoided the more expensive restorative care does generate negative externalities.

Consider two extreme examples. First, a crack-addicted mother chooses not to avail herself of or cannot obtain prenatal care or drug treatment. Her child is prematurely born. If the state provides nursery care, either through Medicaid or in a municipal

91. See *supra* part III.

hospital, the cost could be hundreds of thousands of dollars. The total social monetary cost⁹² would probably be lower if the state actively promoted and provided prenatal care and drug treatment. The cost would certainly be lower if the state could compel the mother to receive both prenatal care and drug treatment. Second, if the state provides AIDS treatment to people whose sexual or intravenous drug use habits have led them to contract the disease, this total social monetary cost could be lower if the state promoted "safe sex" and provided addicts with clean needles.

The phrase "socially cost-effective" incorporates both the non-monetary emotional costs and the quantifiable effect on domestic product of different treatment decisions. In other words, the phrase accepts treatment decisions mandated by the group ethic apart from economic considerations (e.g., that the addict infected with AIDS should receive medical care), and then seeks to maximize the difference between the individual's contribution to domestic product and the resource cost of medical care the individual receives.

Standard insurance packages often fail to provide socially cost-effective care. Indemnity health care coverage, which still predominates among individuals covered by health plans,⁹³ has generally excluded care that was not "medically necessary." The common definition of medically necessary includes diagnosis and treatment of accidental injury or illness, but not preventive care.⁹⁴ For example, "well baby care" coverage includes immunizations, the underutilization of which has been widely discussed and universally condemned.⁹⁵ Even today, well baby care coverage is not always included in indemnity coverage, and until quite recently, was not covered by the majority of indemnity plans.⁹⁶ Such coverage restrictions do not promote socially cost-effective care.

92. There are both monetary and non-monetary costs to coercion; the latter particularly raise difficult questions of political philosophy in a pluralistic democracy.

93. U.S. BUREAU OF LABOR STATISTICS, EMPLOYEE BENEFITS IN MEDIUM AND LARGE PRIVATE ESTABLISHMENTS 49 tbl. 40 (1993); U.S. BUREAU OF LABOR STATISTICS, EMPLOYEE BENEFITS IN SMALL PRIVATE ESTABLISHMENTS 44 tbl. 37 (1991).

94. See, e.g., *Dahl-Eimers v. Mutual of Omaha Life Ins. Co.*, 986 F.2d 1379, 1380 (11th Cir. 1993); *Fuja v. Benefit Trust Life Ins. Co.*, 809 F. Supp. 1333, 1336 (N.D. Ill. 1992); *Lehman v. Mutual of Omaha Ins. Co.*, 806 F. Supp. 859, 861-62 (D. Ariz. 1992).

95. See, e.g., *Save the Children, Immunization Can Prevent Many Deaths*, SAN DIEGO UNION-TRIB., Dec. 27, 1993, at B6.

96. For example, only 26% of nondurable good manufacturers surveyed provided well baby coverage in 1992. WYATT COMPANY, COMPARISON: 1993 STATISTICAL SUPPLEMENT-GROUP BENEFITS 34 (1993).

F. Licensing Requirements

Another imperfection of the health care market is the demanding entry requirements of formal education and licensing imposed by the states on medical practitioners. Unduly restrictive licensing requirements generally reduce supply by eliminating some qualified entrants and thereby increasing price. However, the elimination of one market imperfection in a market with multiple imperfections does not necessarily lead to an improved allocation of resources.⁹⁷

As George Akerlof noted, “[L]icensing practices also reduce quality uncertainty.”⁹⁸ In the context of the information asymmetries discussed above, licensing may lead patients to make assumptions about the value of recommended treatment that full disclosure would negate. In light of information asymmetries and third-party payment, with the possibility of leveraged physician-induced demand they raise, restricted entry may well be a blessing in disguise because it lowers total consumption of inefficient medical care.

G. Net Effect of Market Imperfections

In the view of all payors for medical services and of many suppliers as well, these market distortions have led to (1) overconsumption of medical services in the aggregate, (2) the payment to physicians of premiums over the prices that would exist in a competitive market (monopoly rents),⁹⁹ and (3) distortions in the distribution of services provided. The system devotes too many resources to the diagnosis and treatment of disease and injury and too little to prevention.

A widely held view is that where imperfect markets exist, and the economic cost of the resultant distortions warrants the expense of government regulation, government regulation should aim at approximating as closely as possible conditions in the hypothetical efficient market.¹⁰⁰ In an efficient market, the price of a good or service equals its marginal cost, defined to include a profit just great enough to keep the producer from leaving the market.¹⁰¹ In view of the existing health care market imper-

97. Edward A. Zelinsky, *Efficiency and Income Taxes: The Rehabilitation of Tax Incentives*, 64 TEX. L. REV. 973, 996-98 (1986).

98. Akerlof, *supra* note 79, at 500.

99. DENNIS C. MUELLER, PUBLIC CHOICE II, at 239 (1989).

100. See, e.g., EDWARD M. GRALICH, BENEFIT-COST ANALYSIS OF GOVERNMENT PROGRAMS 203 (1981); see also ARROW, *supra* note 74, at 947.

101. WEIMER & Vining, *supra* note 73, at 36-37, 266. The marginal cost of the *n*th unit is the total cost of producing units one to *n*, less the total cost of producing units one to *n*-1. In an efficient market, the price equals the

fections, government intervention ought to be aimed at decreasing amounts spent on diagnosis and treatment and increasing amounts spent on prevention. Notwithstanding the appropriateness of an attempt to shape health care policy through tax policy, health care expenditures for diagnosis and treatment should be reduced in favor of prevention expenditures.

Part V of this Article proposes reforms that would reduce subsidies to health care consumption in such a way as to reduce aggregate overconsumption of diagnostic and therapeutic services, and to promote consumption of preventive services and cost-effective diagnostic and treatment services.

IV. CRITICISMS OF THE EXISTING STRUCTURE FOR THE TAX TREATMENT OF HEALTH CARE EXPENDITURES

A. *Tax Expenditures and Access*

In general, criticism leveled at the current tax treatment of health care expenditures follows the pioneering work of the late Stanley S. Surrey¹⁰² and questions the appropriateness of using

marginal cost equals the average cost. *Id.* If it is true that physicians exact monopoly rents, then the economic argument for price controls might well be stronger than the discussion of price controls as a possible temporary element of the Administration's health care reform package would suggest.

Though the reforms currently under consideration will eventually eliminate monopoly rents and the need for price controls in the future, short-term price controls might reduce costs during the transitional period. One idea is an additional, progressive tax on care-provider revenues stemming from government and tax-subsidized sources. Such a tax would reduce the incentive to provide unnecessary care and help finance increased access. An approach that merely controls the unit price of services would likely be ineffective.

All income paid for physician services by a government program (e.g., Medicare, Medicaid, Veterans Administration, etc.) or by a program eligible for tax credits would be allocated to specific physicians. A graduated tax could be levied upon this amount, in addition to the income tax, with rates set so as to recover the monopoly rents now paid to physicians. As marketplace reforms took hold and squeezed out monopoly rents, the tax rates would be reduced and, over 5 or 10 years, the tax eliminated.

The progressive nature of the tax would reduce the incentive to provide additional services subject to it as total income from covered services rose. Assuming a rational reduction, as opposed to random reduction, less cost-effective services would be eliminated.

Unit cost controls are ineffective. They are subject to avoidance by shifting to uncontrolled services (e.g., the introduction of Medicare hospital DRGs saw a shift to uncontrolled outpatient care), or to abuse by the unnecessary multiplication of controlled services.

102. E.g., STANLEY S. SURREY, *PATHWAYS TO TAX REFORM, THE CONCEPT OF TAX EXPENDITURES* (1973); Stanley S. Surrey, *Tax Incentives as a Device for Implementing Government Policy: A Comparison with Direct Government*

the tax structure as an instrument of social policy. Professor Surrey asserted that: "This criticism — that tax incentives produce inequitable effects and upside-down benefits — is valid as to the general run of tax incentives."¹⁰³ Professor Surrey gave an example of a proposal, not enacted, for eliminating a gross income threshold for the section 213 deduction:

What HEW Secretary would propose a medical assistance program for the aged that cost \$200 million, and under which \$90 million would go to persons with incomes over \$50,000, and only \$8 million to persons with incomes under \$5,000? The tax proposal to remove the 3% floor under the medical expense deduction of persons over 65 would have had just that effect.¹⁰⁴

Implicit in this example is the assumption that the only goal in eliminating the gross income floor was to stimulate consumption of medical services by the medically under-served aged. Senator David Durenberger (R-Minn.), applying similar logic with the same implicit assumption, recently commented on the regressivity of the current system. He noted that families with incomes below \$15,000 get only 2.6 percent of the tax benefits from employer-provided health care, while families earning above \$50,000 get 57 percent.¹⁰⁵

Spending, 83 HARV. L. REV. 705 (1970) [hereinafter *Tax Incentives*]. The "tax expenditure" concept presupposes the existence of an ideal tax base from which a tax expenditure is a deviation. Boris Bittker criticized the presupposition of an ideal tax base in *Accounting for Federal "Tax Subsidies" in the National Budget*, 22 NAT'L TAX J. 244 (1969). Professors Surrey and Hellmuth replied to Professor Bittker in *The Tax Expenditure Budget — Response to Professor Bittker*, 22 NAT'L TAX J. 528 (1969), to which Professor Bittker responded in *The Tax Expenditure Budget — A Reply to Professors Surrey & Hellmuth*, 22 NAT'L TAX J. 538 (1969).

103. *Tax Incentives*, *supra* note 102, at 722.

104. *Id.*

105. Dave Durenberger, *Viewpoints: Choices for the Clinton Era; Time for Fairness on Health Premiums*, N.Y. TIMES, Feb. 28, 1993, § 3, at 25. Further proof of the assumption implicit in this criticism is that a reduction in tax rate progressivity was not a goal of excluding employer health care contributions from employee income. The 1986 tax reform demonstrated the validity of this hypothesis when it flattened tax rates and eliminated many deductions. One may argue, however, that the total effect of current income tax rates and deductions is too progressive, despite the regressive character of excluding employer contributions to health care plans from employee income. Consider, for example, the mileage presidential candidate Jerry Brown got out of the flat tax proposal in the 1992 Democratic primaries. See David Lightman, *Voters Defy Easy Predictions; Polls Still Give Clinton Lead, but not Overwhelming One*, HARTFORD COURANT, Nov. 3, 1992, at A1. Someone subscrib-

The endpoint of the regressivity argument highlights the current system's failure to provide adequate benefits to those citizens whose employers do not provide them with health care coverage or to those too poor to pay income taxes, and failure to provide anything at all to those who are in both groups. The current structure of tax subsidy for health care does very little to address problems of access.

Although the current tax structure is flawed, the use of tax expenditures for health care is not necessarily inappropriate. In two recent articles, Edward A. Zelinsky endorsed tax expenditures as the most efficient instrument to achieve social policy in some circumstances.¹⁰⁶ Professor Zelinsky emphasized the importance of transaction costs when choosing between the use of direct expenditures and tax expenditures in advancing social policy goals.¹⁰⁷ For tax policy to modify the behavior of a large number of entities, policy must be implemented through an existing, far-reaching system such as the income tax system. Harnessing an existing system to alter behavior will significantly reduce administrative costs. Forged by intense public debate and input from a plethora of factions, the resulting policy will improve upon past direct expenditure programs.¹⁰⁸ Applying Professor Zelinsky's criteria for appropriate use of the tax code to the problem of correcting health care market imperfections suggests that the use of tax incentives is appropriate to promote universal access to cost-effective care.

B. *Third-Party Payment Problem*

As discussed above, the relatively small part of the total payment made by the individual at the point of purchase en-

ing to Brown's view might believe that the appropriate corrective action to eliminate the deduction would be a reduction in the higher marginal rates, a regime that would not promote more effective consumption of health care by the medically under-served poor.

Nevertheless, a poll conducted by the Kaiser Family Foundation, Harvard University, and Louis Harris & Associates indicated that 61% of those polled favored higher income taxes on those earning \$50,000 or more to finance health reform. *Combination Reform Plan*, *supra* note 16. Further, the Clinton proposals to attack the deficit by raising taxes on the wealthy have encountered remarkably little resistance. For the purposes of this analysis, it is assumed that the regressive effects of excluding employer contributions from employee income should be avoided.

106. See Zelinsky, *supra* note 97, at 1033-35. See generally Edward A. Zelinsky, *James Madison and Public Choice at Gucci Gulch: A Procedural Defense of Tax Expenditures and Tax Institutions*, 102 YALE L.J. 1165 (1993).

107. Zelinsky, *supra* note 97, at 1010. Although Zelinsky did not specifically mention breadth of the intended scope of the policy incentive as an index of the appropriateness of its implementation through the tax code, it seems that coverage scope is one such index.

108. Zelinsky, *supra* note 106, at 1175-84, 1190-91.

courages overconsumption of medical services.¹⁰⁹ Overconsumption also results if the employer pays a fixed percentage of the cost of whatever health care coverage the employee elects¹¹⁰ because an employee unwilling to pay the full additional cost of coverage offering a greater degree of individual choice may well find such coverage attractive when the employer pays a part of the additional premium.

When employees must pay their contributions with after-tax dollars, the existing tax structure does not compound the effect of the employer subsidy. However, in some flexible benefit plans, the employee pre-tax credit will be large enough to finance the more expensive plan at the cost of foregoing other tax-exempt benefits, or in some cases, cash. When individuals can receive taxable cash as an alternative to a non-taxable employer health care contribution, an alternative in seventy percent of section 125 cafeteria plans,¹¹¹ the tax subsidy will prompt some individuals to choose more expensive plans requiring lower point-of-service payments than they would if they could receive the savings in non-taxable cash. Membership in such plans will lead to increased consumption of health care because of the negative externalities to which third-party payments give rise. Further, the individual might choose a tax-subsidized health care benefit that is not cost-effective over benefits with a stronger justification for a tax subsidy (assuming they exist).¹¹²

C. Cost

Because the existing tax system encourages consumption of health care services that is not socially cost-effective, and that inadequately encourages cost-effective preventive care, taxpayers are subsidizing socially cost-ineffective care. Assuming the minimum amount is that which would be raised by recent proposals to the exclusion from employee income of employer contributions to health care, the existing tax system provides a subsidy of perhaps \$17 billion for health care which is not socially cost-effective.¹¹³

109. See *supra* notes 83-88 and accompanying text.

110. See *supra* part III.D.

111. HEWITT ASSOCIATES, FLEXIBLE COMPENSATION PROGRAMS AND PRACTICES 12 (1993). This survey is based on the 1992 plan year.

112. See *supra* part III.D.

113. See Stout, *supra* note 20. In arriving at the figure of \$17 billion, it is assumed that Stout's data, which illustrates the effect of the tax cap, takes only income tax, and not social security, into account. The figure does not include the increase in state revenues likely to accompany a redefinition of federal taxable income, to which many state income tax laws are linked.

For purposes of this discussion, it is assumed that the proposed minimum

V. PROPOSALS FOR REFORM

A. *Normative Reform of Health Care*

1. Employee/Employer Tax Code Reform

There is nothing about the imperfections of the health care market that logically binds its correction to the employment relationship of health care consumers. Unlike disability income, retirement income, or unemployment income, there is no logical relationship between the need for insurance protection and employment. Indeed, given a social ethic that demands provision of a certain level of care regardless of individual resources or of individual responsibility for the illness at issue,¹¹⁴ normative health care reform must provide coverage regardless of employment status. Further, the theoretically ideal level of coverage does not vary with employment status; rather, it covers all "socially cost-effective care." Ideal coverage does not reimburse individuals for health care spending that results from their personal preferences but which is not socially cost-effective.¹¹⁵

Thus, like earlier government health care mandates such as smallpox and polio inoculations and quarantines, the mandate to acquire health care coverage should fall on the individual. Individuals who lack the resources to provide for their own coverage should have their coverage subsidized to the extent required by their individual situations.

An individual mandate, combined with individual credits if required, would demonstrate the inappropriateness of the exclusion from employee income of employer contributions for employee health care coverage. Exclusion from employee income

plan will provide all socially cost-effective benefits. It is also assumed that the lowest priced minimum plan will cost less than the current average priced employer provided plan, which is frequently the cost used in the discussion of tax caps and the resulting revenue gains. In support of this assumption, a comparison of staff model HMOs to standard indemnity care provided estimates of unnecessary health care. The comparison examined the amount of duplication in health care facilities and geographical variations in practice patterns with no observable differences in health outcomes. The study surmised that the average plan provides a great deal of unnecessary care. See CONG. BUDGET OFF., MANAGED COMPETITION AND ITS POTENTIAL TO REDUCE HEALTH SPENDING at xiii, 35-37 (1993) [hereinafter MANAGED COMPETITION]. Thus it is reasonable to regard the floor for the tax subsidy for unnecessary care as equivalent to the revenue tax caps would raise. The estimate of the tax subsidy for wasteful care of \$17 billion is conservatively low.

114. See *supra* notes 91-96 and accompanying text; see also Graetz, *supra* note 20, at 79-80.

115. See *supra* notes 91-96 and accompanying text.

leads to overconsumption of health care.¹¹⁶ In the absence of an employer mandate, employer contributions are clearly compensation. Under normative health care reform, section 213 should be repealed in its entirety. Any medical expenditures not covered by insurance would be personal consumption. As a consequence of the repeal of section 213, health expenditures should no longer qualify for section 125 flexible spending accounts. The section 32(b)(2) credit should also be repealed.

2. "Sin" Taxes

A fundamental principle of economics is that the price of an item should include all of its costs. A draft study by the Office of Technology Assessment put the loss to society from smoking-related medical costs and sick leave at \$65 billion.¹¹⁷ This estimate does not appear to include productivity lost due to decreased function while on the job, perhaps an even larger amount. Further, fires caused by smoking also lead to smoking-related losses. Many believe that these costs are not currently recovered in the price of a pack of cigarettes, because the manufacturers are not responsible for reimbursing those who actually bear the loss. If so, then an increased tax on smoking materials represents a classic case of desirable government regulation, because the dispersion of the interests affected makes negotiating a solution among affected individuals impossible. Even in the absence of any other health care reform, the imposition of a \$2.50 per pack excise tax on cigarettes would erase the annual \$65 billion loss.¹¹⁸ The same argument can be made with respect to excise taxes on alcohol.

3. A Level Playing Field: Removal of the Exemption for "Charitable" Hospitals

Recapture of the projected windfall that some providers might reap from the elimination of bad debts and other uncompensated care by a system providing universal access figures into the discussion of how to finance universal access. Perhaps the simplest and fairest way to share the windfall is to repeal the section 501(c)(3) exemption for hospitals and other tax-exempt health care providers; all providers of health care should be subject to income tax (and to the extent that they are linked,

116. See *supra* notes 76-90 and accompanying text.

117. *Cigarette Tax Hike Would Improve Health, Cut Spending, Raise Revenue, Study Finds*, BNA HEALTH CARE DAILY, May 27, 1993, available in LEXIS, Nexis Library, BNAHCD File.

118. *Id.*

to state and local taxes as well).¹¹⁹ This would recapture thirty-four percent of the additional revenues of profitable health care providers, as well as some portion of their existing revenues. The revenue estimate for this change is \$2.5 billion annually.¹²⁰

B. *The Politically Attainable “Second Best”*

1. A Proposal

The insuperable obstacle to adoption of the normative ideal can be stated in a single word: taxes. Making universal coverage a reality without an employer mandate would require substantial additional revenues or an increase in deficit spending, which would doom any package that does not contain an employer mandate.¹²¹

The alternate health care system proposed in this Article maintains the goals of providing universal access to cost-effective care and the elimination of the provision of care that is not

119. See *supra* notes 51, 69-72 and accompanying text.

120. See Rudney & Copeland, *supra* note 57. This change would also increase state and local tax revenues. Some limitations on tax breaks for non-profit health providers are increasingly advocated. *Id.* See also Robert Tomsho, *Tax Breaks Threatened, Some Hospitals Try to Prove How Charitable They Are*, WALL ST. J., Apr. 12, 1994, at B1 (citing several hospitals' responses to proposed elimination of charitable exemption); *Kaiser Dispute Sparks Bill to Tax Non-profits*, BNA HEALTH CARE DAILY, Apr. 22, 1993, available in LEXIS, Nexis Library, BNAHCD File (referring to a California bill "that would require non-profit, tax-exempt corporations like Kaiser to pay taxes on any profits sent out of state"). This movement has surpassed mere advocacy. Recent Texas legislation required non-profit hospitals to provide a specified level of charity care in order to qualify for exemption from state taxes. *Texas Charity Care Law Signed, Suit against Methodist Settled*, BNA HEALTH CARE DAILY, June 8, 1993, available in LEXIS, Nexis Library, BNAHCD File. In the context of universal coverage, this bill would have the effect of subjecting non-profits to taxes at the state level.

121. Prof. Graetz stated:

[W]ithin the existing system there is enough money to fund a standard package of insurance coverage for all Americans, including an equitable and even generous system of tax credits. This means that with enough reshuffling of existing expenditures, additional government financing may not be necessary. In any case, it is essential to make much more effective use of the revenues that current subsidies cost the government.

Graetz, *supra* note 20, at 99. This statement is unduly sanguine, despite the qualification which immediately follows it:

The political trick — and no one should underestimate how great a trick it is — is to manage the transition from the system we now have to the system of individually-based universal coverage I have proposed.

cost-effective, just as the normative reform does. This pragmatic program includes government mandates that require employers to operate as intermediaries between providers of health care and their employees and to contribute to the cost of their employees' health care coverage. For the program to be politically acceptable, this type of employer mandate is necessary because it would supply the additional revenues needed to provide universal access.

To enhance the prospects of adopting an economically sound program, the current level of financial contribution made by each ultimate payor of health care costs (state and federal governments, businesses, and individuals) must be preserved. In this manner, the additional fiscal effort required to extend access to cost-effective care to those currently without it would be kept to a minimum. Tax increases and non-tax increases in business costs attributable to health care reform can be circumscribed, which will increase the likelihood that both the tax-paying public and other payor constituencies will support the plan.¹²²

In addition to these employer mandates, there also must be an individual mandate; every individual would have to enroll in a plan providing at least a specified minima of benefits.¹²³ The individual mandate is an element of normative reform. Initially, of course, it would be relevant only with respect to the self-employed, the non-Medicare retired, and the unemployed. Including an individual mandate in the initial reform package would simplify later movement toward the theoretical ideal.¹²⁴

122. The Kaiser Family Foundation poll found that 50% of workers would be willing to pay an additional \$20 in taxes per month for a universal health care plan that combined federal regulation of rates charged by health care providers with the freedom to choose providers. *Combination Reform Plan*, *supra* note 16. Only 24% were willing to pay an additional \$50 per month for such a plan. *Id.* The stiff opposition among small business groups to achieving universal coverage in part through a mandate on employers to offer and fund health care coverage for their employees flows from a fear of a sharp increase in the cost of doing business by those who do not currently provide coverage. See Graetz, *supra* note 20, at 101-02.

123. A health care structure that would permit plans to compete based on additional benefits beyond the specified minimum plan should be viewed with suspicion. Ostensibly, the additional benefits would be available at additional cost to the specific offeror's minimum plan. Certain benefits appeal to classes highly desirable from a medical underwriting perspective, e.g., well baby care. Families with young children are good health care risks. If one plan were permitted to offer well baby care while others could choose to exclude it, the first plan could lower its prices overall, not because of superior efficiency, but because it could anticipate favorable selection. The first plan would thus gain a competitive advantage that all critics of the existing system think important to eliminate.

124. This should ease somewhat the concern of Professor Graetz, that adoption of an employer mandate now would forever inhibit movement toward a fundamentally sounder system. Graetz, *supra* note 20, at 94-95.

Further, adding an individual mandate to an employer mandate would eliminate many of the evils Professor Graetz identified in the employer mandate-only scheme. Temporary or part-time employment, as opposed to permanent employment, could not be used to escape required coverage; the individual would have to consider the cost remaining after an employer contribution, and the employer would have to contribute a portion of the cost. Individuals who work as independent contractors would have to include any reduction in individual credit that their compensation would cause in calculating the minimum wage that makes work a rational decision.¹²⁵

The specified minimum plan is assumed, albeit unrealistically for purposes of simplicity, to include all benefits the consumption of which will minimize total societal health care costs.¹²⁶ An assumption that strong, however, is unnecessary. All that need be assumed is that the mix of health care services in the minimum package is more socially cost-effective than the current mix of services actually consumed.

2. Dual System of Credits and Other Changes

This Article proposes a system of dual refundable credits, one to take the place of a section 162 business expense deduction for contributions to health care plans by employers, and the other to take the place of the exclusion in employee income of employer contributions to health care benefit plans. No deduction would be permitted for employer contributions to health care plans, and such contributions would be fully includible in employee income. Self-employed individuals would be entitled to the full individual credit only, and the existing partial deduction would be eliminated. No corporate credit would be permitted for anyone with a distributive share (actual or constructive) in the profits of a business entity not subject to the corporate income tax, or for a five percent owner (actual or constructive) of a corporation subject to the corporate tax, but

125. *Id.* at 90-91.

126. This definition in all likelihood means a more comprehensive plan than any plan actually likely to be proposed because of the importance in the political debate of the difference between "on-budget" and "off-budget" costs. "Normative" reform, which provides direct federal subsidies to low-income individuals otherwise unable to comply with an individual health care mandate, would increase the amount of health care spending in the federal budget even though it might be the most effective at lowering total societal spending on health care. This move from "off-budget" spending (e.g., uncompensated emergency room care) to "on-budget" spending (e.g., federally financed coverage for care provided in a clinic), is a political liability. See *supra* notes 121-22 and accompanying text.

such individuals would be eligible for the individual credit.

In conformity with the normative reform, section 213 would be repealed in its entirety, and in consequence, health expenditures would no longer qualify for section 125 flexible spending accounts. The section 32(b)(2) credit would be repealed. The section 501(c)(3) exemption for hospitals would be repealed; all providers of health care would be subject to income tax (and to the extent that they are linked, to state and local taxes as well). Tax-exempt bonds would no longer be eligible to provide capital to health care institutions.

Also a part of this proposal, as well as of the normative reform, are increases in excise taxes on cigarettes and on alcohol in amounts sufficient to compensate for all the negative externalities their use generates that are not offset by existing taxation.

Both the employer and employee credits would vary with the cost of a "minimum plan." Under a managed competition regime,¹²⁷ for instance, the minimum plan would be the lowest-price Accountable Health Plan¹²⁸ open to employees within the Health Alliance,¹²⁹ or within some geographic subdivision of the Health Alliance to which the employee belonged.¹³⁰ At its minimum, the employer credit would equal the highest corporate tax rate times the cost of the lowest-price plan. The credit would be the equivalent of offering a profitable employer a tax deduction for the cost of the lowest-price plan. For smaller and less profitable employers, the credit would increase. For employers with fewer than twenty-five employees and no taxable income in the fiscal year, the credit would be equal to the full cost of the lowest-price plan. The credit would be proportionately reduced for part-time employees for whom the employer was required to make only a partial contribution toward the

127. For a readable discussion of "managed competition," see *MANAGED COMPETITION*, *supra* note 113, at 9-17.

128. An Accountable Health Plan (AHP) is a health care delivery organization that combines the services of health insurance with provision of medical care to patients. AHPs can take various forms and are sometimes called "integrated care organizations." AHPs compete on the basis of quality and cost. See Jackson Hole Group, *Managed Competition II*, *supra* this volume.

129. A Health Alliance, or a health plan purchasing cooperative, is a sponsor organization that functions as a purchasing agent of health care services; it enables small employers, the self-employed, unemployed, and other individuals to band together to purchase health care services at competitive rates. *Id.*

130. It is conceivable that the delegation of legislative power to non-governmental groups would require an officer of the executive branch to make formal determination of the amount of the credit, or else constitutional issues arise. However, a discussion of possible constitutional obstacles to health care reform goes beyond the scope of this Article.

cost of the lowest-priced benefit plan. The credit would graduate smoothly from maximum to minimum based on both employer size and level of profitability, reaching its minimum level either at \$50,000 of taxable income or at 200 employees. No employer credit would be available for retirees eligible for Medicare.¹³¹

A credit of this type, varying by size and net income, would not sacrifice administrative simplicity in its effort to target the credit toward those most in need. Nor would the credit forego tax revenues from those who do need subsidies.¹³²

In a similar fashion, the individual credit would increase from a base level of the average individual effective tax rate times the cost of the minimum plan. The base level would apply to those who receive a health care contribution from their employers or who have net incomes above 150 percent of the poverty line. The credit would increase to a maximum level of the full cost of the lowest-price plan for those without any employer contribution and with incomes below the poverty line. No individual eligible for Medicare would be eligible for this credit.¹³³

3. Rationale

Fundamental to the success of any health care reform is its ability to squeeze out inappropriate medical care. These suggested reforms would achieve this objective over time.

Non-deductibility and inclusion in income of amounts contributed for health plans above the cost of the minimum plan would create a powerful incentive for employers to contribute only the cost of the minimum plan and will increase the magnitude and visibility of employee contributions. Availability of an Accountable Health Plan would mean that the Health Alliance has certified that it meets minimum quality and solvency standards. This certification should create a level of acceptability for the lowest-priced plan that would make it a creditable competitor of higher-priced alternatives. There should be a substantial guaranteed market share for the lowest-cost plan. For example, the lowest-cost plan could automatically include the Medicaid population. This would create a considerable marketing incentive to be the lowest-priced plan.

131. This is a description of goals rather than either an attempt at exact statutory language or a failure to recognize that drafting language to achieve these goals will be difficult. The author has the advantage of having seen a detailed proposal for an employer credit drafted by Joseph Piacentini of Aetna's Health Issues area.

132. This responds to some of the concerns of Professor Graetz. Graetz, *supra* note 20, at 90.

133. *Id.* at 99-100.

Prospectively-rated plans would achieve their greatest level of profitability when they provide only cost-effective care. However, continuing enrollment is likely to mean that the same plan would in later years bear the cost of withholding appropriate care, including preventive care. Market entrants for the long term, likely to be the only ones willing to make the initial investments required to participate, would have no incentive to withhold appropriate care. Indeed, their incentive would be to provide all the care that is appropriate.

Successful plans would refuse to deliver care that is not cost-effective. A physician in such a plan would not mention the unneeded MRI exemplified above,¹³⁴ and in the unlikely event that the patient spontaneously requests the MRI, the physician would explain that it is not indicated and that its cost would not be covered by the plan.

Plans would be unlikely to survive if they allowed their costs sharply to exceed the minimum plan. With no employer or government subsidies for excess costs, participants would opt out of plans that cost them too much in disposable income. In the current environment, indemnity insurers find that they experience severe reductions in plan participation, with extreme anti-selection, when the difference between an HMO and an indemnity plan in the contribution required reaches \$75 per month for an individual and \$125 per month for a family.¹³⁵ Underwriting guidelines often prohibit offering an indemnity plan when the contribution differential is much lower, such as \$40 per month for individuals and \$60 per month for families. This is true even though these contribution differentials are often from pre-tax dollars.¹³⁶ The contribution differentials at which Accountable Health Plans would begin to experience severe declines in membership could easily be twenty-five percent lower than in the current environment because any increase in contributions required for a more expensive plan would have to be paid for entirely with after-tax dollars.

This system of limited credits reflects the views of Professor Andrews about the proper treatment of medical expenses in an income tax:

What distinguishes medical expenses from other personal expenses at bottom is a sense that large differences in their magnitude between people in otherwise

134. See *supra* notes 76-82 and accompanying text for a discussion of information asymmetries.

135. Telephone interview with Michael J. Murray, Aetna Health Plans Actuary (May 23, 1993).

136. *Id.*

similar circumstances are apt to reflect differences in need rather than choices among gratifications. . . .

[P]articular medical expenses may reflect a considerable component of voluntary personal gratification.¹³⁷ It is difficult to find any difference in principle, for example, between expenditures for elective plastic surgery and for cosmetics.¹³⁸

Professor Andrews did not think that differentiations in tax policy that would enable us to capture the distinction we would want on theoretical grounds between these two categories were practical.¹³⁹ However, Professor Andrews also believed, "In the absence of more information, . . . I conclude that any misallocation produced by the medical expense deduction is harmless enough to be clearly outweighed by the distributional considerations that justify the deduction."¹⁴⁰ Given the widespread belief that tax-aggravated problems of over-allocation of resources to the health sector is a serious economic problem, Professor Andrews might arrive at a different conclusion today than the one he reached in 1972.

Professor Andrews suggested an alternative:

[I]f it were very important to avoid the allocational effect of the deduction, then theoretically one could leave the (horizontal) distributional problem to be taken care of by insurance. People would pay their insurance premiums out of after-tax income, but would not be taxed on benefits received. Accordingly, the consumption component of their taxable income would reflect whatever level of coverage they chose to pay for without reflecting differences in need and actual utilization of services.¹⁴¹

With two emendations to these remarks, adding "for coverage above the minimum" after "insurance premiums," and "above the minimum" after "level of coverage," the proposed system of credits would satisfy Andrews' requirements for an alloca-

137. It seems reasonable to consider the degree of physician choice demanded as a matter of voluntary consumption. Assuming a fixed benefit plan with risk-adjusted premiums, the degree of physician choice available is likely to be the principal determinant of the price of a plan.

138. Andrews, *supra* note 61, at 336-37.

139. *Id.* at 337.

140. *Id.* at 343.

141. *Id.* at 342-43. Professor Andrews believed that there were difficulties with this approach as well, of course (limited access, third-party payment incentives to overutilization), but the assumed health reform proposal addresses all of them.

tionally non-distorting and distributionally-just tax treatment of health care expenditures.

These recommendations would penalize employer provision of care that was not socially cost-effective by both depriving the employer of a deduction of its cost and including that contribution in employee income. This would make the employer provision of excess health care disfavored with respect to wages, inverting the current relationship.

Any individual purchase of excess health care would be tax neutral, without the possibility of qualifying in combination with other out-of-pocket health care expenditures for a section 213 deduction. This shift, though of much less significance than the change in treatment of employer-provided excess care, nevertheless would constitute less favorable tax treatment of individual health care expenditures than presently offered.

A system of credits would add progressivity to the tax system and thus responds to the criticism that the current system of deductions is too regressive. Very importantly, the proposed system should go far toward meeting the concerns of small business that a mandate on employers to offer and fund health care would be economically disabling.

It is the desire to exact the maximum politically feasible employer contribution, while simultaneously extending access to cost-effective care to the medically underserved, that leads to the recommendation of this admittedly complex system of dual credits over the conceptually cleaner and administratively simpler scheme of an individual mandate and credit only, with employer deduction of contributions to health care plans up to the value of the minimum plan permitted. Warnings about the dire threat to solvency and jobs resulting from employer mandates imposed on small businesses appear frequently in the press.¹⁴² For example, in a study released May 20, 1993, the National Federation of Independent Business estimated that various mandates would cost between 390,000 and 900,000 jobs over the first two or three years of the plan.¹⁴³ A variable credit is a mechanism that could extract as high a level of support as possible from small business for extending access to health care without fatally wounding the chances of legislative reform. The variable credit will be a key element in creating a package that Congress can pass.

142. See *supra* note 15.

143. *Small Business Could Lose 900,000 Jobs From Mandated Health Coverage, NFIB Says*, BNA HEALTH CARE DAILY, May 24, 1993, available in LEXIS, Nexis Library, BNAHCD File.

4. Cost of Reform

The Congressional Budget Office estimated the revenue gains from full inclusion in employee income of employer health care contributions, with a refundable individual credit of 20 percent for health insurance premiums up to the average cost of employer-provided coverage, at \$57 billion for the period 1994-98.¹⁴⁴ This alternative approximates the double-credit, full inclusion, no deduction proposal, with resulting gains of close to \$57 billion. Eliminating the deductibility of interest on bonds used to fund private hospital facilities would net \$3 billion in 1993.¹⁴⁵ Any tax benefit gained because of the non-deductibility of employer contributions for excess coverage not offset by the employer credit would presumably fade away very quickly, as employers moved to substitute deductible wages for non-deductible excess contributions. However, this transformation of the non-includible employer contributions into taxable wages would raise a minimum of \$17 billion, as noted above.¹⁴⁶

C. Clinton's Health Security Act

It is tempting to comment at much greater length on the Clinton Health Security Act (Clinton Plan)¹⁴⁷ than the analysis that appears above warrants. This temptation is left to others. The Clinton Plan is basically sound, but would be improved if it conformed more closely to the recommendations of the preceding section in those places where it deviates.

1. Plan Provisions

The comprehensive benefit plan summarized in section 1101¹⁴⁸ comes surprisingly close to the ideal health care reform outlined above.¹⁴⁹ Section 1114 contains, in great specificity, an admirable

144. REDUCING THE DEFICIT, *supra* note 34, at 364.

145. JOINT COMM. ON TAXATION, 102D CONG., 2D SESS., ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 1993-1997, at 15 tbl. 7 (1992).

146. See *supra* note 113 and accompanying text.

147. H.R. 3600 & S. 1757, 103d Cong., 1st Sess. (1993) [hereinafter Clinton Plan].

148. Proposed § 1101 provides that the "comprehensive benefit package" shall include hospital services, services of health professionals, emergency and ambulatory medical and surgical services, clinical preventive services, mental health and substance abuse services, family planning and pregnancy services, hospice care, home health care, extended care, ambulance services, outpatient laboratory, radiology, and diagnostic services, prescription drugs, outpatient rehabilitation services, durable medical equipment and prosthetic and orthotic devices, vision and dental care, health education classes, and investigational treatments. Clinton Plan, *supra* note 147, § 1101.

149. See *supra* notes 114-20 for a discussion of the theoretically ideal health care plan.

emphasis on preventive services.¹⁵⁰ Section 1153 builds upon this good beginning by granting the National Health Board the authority to modify the items and the age and frequency schedules included among clinical preventive services.¹⁵¹

The Clinton Plan would impose an individual mandate in section 1002.¹⁵² Section 6104 would provide premium discounts based on income.¹⁵³ These discounts would be functionally equivalent to refundable tax credits. These provisions therefore conform both to the theoretical ideal¹⁵⁴ and to the politically attainable "second best" proposal.¹⁵⁵

The Clinton Plan would end all attempts to profit by favorable selection, an endeavor that seriously limits coverage and multiplies administrative expense. Victory in this arena is critical to the effectiveness of the entire reform effort. Section 1422 would prohibit entities from offering supplemental benefits "packaged" with basic benefits.¹⁵⁶ Supplemental policies would have to stand alone and be available to all.¹⁵⁷ Further, section 1402 explicitly would prohibit any practice that has the intent of favorable selection.¹⁵⁸ Finally, the risk adjustment methodology,¹⁵⁹ which can be as broad as the National Health Board created in section 1501 deems necessary,¹⁶⁰ would have the

150. Proposed § 1114 provides for various preventative care measures based on an individual's age. These measures include immunizations for childhood diseases, tetanus, diphtheria, and influenza; pap smears; cholesterol testing; and mammograms. Clinton Plan, *supra* note 147, § 1114.

151. *Id.* § 1153(a).

152. Proposed § 1002(a) provides:

In accordance with this Act, each eligible individual (other than a medicare-eligible individual)—

(1) must enroll in an applicable health plan for the individual, and

(2) must pay any premium required, consistent with this Act, with respect to such enrollment.

Id. § 1002(a).

153. *Id.* § 6104.

154. See *supra* notes 114-20 for a discussion of the theoretically ideal health care plan.

155. See *supra* notes 121-46 for a discussion of the "politically attainable" plan.

156. Clinton Plan, *supra* note 147, § 1422(a).

157. *Id.* § 1422(b). This allays the concern expressed earlier in this Article, see *supra* note 123, that supplemental benefits packaged with basic benefits could be shaped so as to gain favorable selection. Violations of this provision would be subject to a \$10,000 per violation civil penalty. Clinton Plan, *supra* note 147, § 1422(d).

158. *Id.* § 1402(a)(1).

159. *Id.* § 1541(b).

160. *Id.* § 1501(h).

potential to vitiate selection that would be favorable without adequate risk adjustment.¹⁶¹

The number of health care regimes that would receive special treatment under the Clinton Plan (*e.g.*, veterans, Indians, military personnel)¹⁶² means certainly a higher level of administrative expense, and possibly a higher level of medical expense, than would a more unified structure. However, the Clinton Plan is by no means complicated compared to the international norm,¹⁶³ and a simpler structure is likely to be politically unattainable in the short term.

2. Revenue Provisions

a. *Non-inclusion of Employer Contributions in Employee Income*

Section 7201 of the Clinton Plan, which revises section 106 of the Code, would limit, effective January 1, 2003, the non-includability of employer contributions to health plans to the value of the comprehensive coverage required.¹⁶⁴ The Clinton Plan defines value for these purposes as the average cost of providing such coverage to its beneficiaries.¹⁶⁵ Although at first glance this provision would appear to reduce the incentive to choose the most cost-effective coverage compared to defining value in terms of the lowest-cost plan, the proposal, in a moderately complicated way, would actually preserve the maximum incentive effect at the cost of some foregone revenues.

In general, the "family share of premium," as defined by sections 6101 to 6103, would be twenty percent of the weighted average premium for health plans offered by the alliance for that class,¹⁶⁶ subject to income discounts¹⁶⁷ and accounting adjustments.¹⁶⁸ Section 1607 defines "voluntary employer contribution" as any payment designed to be used exclusively or primarily toward the cost of the family share of the premiums for a health plan.¹⁶⁹ An "excess employer contribution" is the amount by which the voluntary employer contribution exceeds the amount of the family share of premium.¹⁷⁰

161. Clinton Plan, *supra* note 147, §§ 1503(a), (c) & 1505(e).

162. See, *e.g.*, *id.* § 8001 (uniformed services health plans); §§ 8101-8102 (Veterans); §§ 8201-8207 (federal employees); §§ 8301-8313 (Indians).

163. See WILLIAM A. GLASER, *HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS* 47-48 (1991).

164. Clinton Plan, *supra* note 147, § 7201(a).

165. *Id.*

166. *Id.* § 6103(a).

167. *Id.* § 6104(a).

168. *Id.* § 6104(c).

169. Clinton Plan, *supra* note 147, § 1607(e).

170. *Id.* § 1607(d)(2).

When the total employer contribution exceeds the cost of the plan selected, section 1607 of the Clinton Plan would require that the employer rebate the excess to the employee and classify the amount rebated as taxable wages.¹⁷¹ However, this rule would be modified by the revised Code section 106 so that the difference in cost between the average cost of the class of coverage selected and a lower-cost plan would be rebated to the employee tax free.¹⁷² The availability of tax-free cash as an alternative to more expensive health care coverage would eliminate the existing tax subsidy for the selection of costlier coverage.

The Clinton Plan would not repeal section 213, although its usefulness would be sharply curtailed by mandatory coverage and limits on out-of-pocket payments. In unusual situations, this would continue to provide unwarranted subsidies for health care. For example, an individual enrolled in a network plan might escape its constraints by forfeiting plan payment. If the individual's outlay was large enough, the payment would still qualify for a section 213 deduction.

The new section 106 would not take effect until 2003, in what is commonly thought to be an accommodation to the demands of organized labor that the costly coverage that they have negotiated should not incur an additional tax burden unanticipated at the time of the negotiations.¹⁷³ Because section 1607 would not apply at all to collectively bargained plans,¹⁷⁴ excess coverage in such plans would continue to receive tax subsidies until 2003.

b. Employer Mandate

Sections 6121 and 6131 state that employers would have to contribute to the cost of required coverage.¹⁷⁵ Section 6123 would limit the liability of small employers paying low wages by granting them a credit against their payment liability.¹⁷⁶ Together, these provisions seek to assure increased employer financial support for health care while making the politically

171. *Id.* § 1607(b)(2)(A).

172. *Id.* § 7201(a), as revised § 106(d).

173. It is unclear at the conceptual level, but not at the political level, why this "fairness" argument has carried more weight than it did when applied to the retroactive tax increases on the wealthy that were part of the 1993 budget package.

174. Clinton Plan, *supra* note 147, § 1607(c).

175. *Id.* § 6121(a) (covering regional alliance employers); § 6131(a) (covering corporate alliance employers).

176. *Id.* § 6123(a)(1), (b)(2). In general, "small employer" is defined as employing 75 or fewer full-time employees. *Id.* § 6123(c)(1).

required, and quite possibly economically desirable, concessions to small business.

c. Excise Taxes

Section 7111 would increase the tax on cigarettes by \$37.50 per thousand, or 75 cents per standard pack.¹⁷⁷ While this proposal would quadruple the existing tax, it is relatively small given the increases that had been suggested.¹⁷⁸ The increase proposed for cigars is identical in absolute terms, \$37.50, but much larger in relative terms — a forty-fold increase.¹⁷⁹ The section would also significantly increase taxes on other tobacco products and accessories,¹⁸⁰ and section 7113 would impose an excise tax on “roll-your-own” tobacco.¹⁸¹ The proposal does not suggest any increase in excise taxes on alcohol. If a consensus develops that revenue increases beyond those proposed are needed, one could reasonably expect larger increases in excise taxes to provide some additional revenue.

d. Recapture of Medicare Part B Subsidies

Extending the logic of partial taxation of social security benefits to Medicare,¹⁸² section 7131 would recover from high-income individuals the excess of 150 percent of the Medicare Part B monthly actuarial rate for enrollees age 65 or older over the total monthly premium.¹⁸³ The same section would also recover from high-income individuals any special benefits accorded by section 6114 to retirees.¹⁸⁴

e. Tax Treatment of Non-profit Health Care Organizations

Section 7601 of the Clinton Plan would restrict the application of Code section 501(c)(3) to health care providers other than HMOs that participate in community health care assessment and planning.¹⁸⁵ To qualify for tax exemption, HMOs would also have to provide necessary services as determined by assessment

177. *Id.* § 7111(a)(1).

178. See *supra* notes 117-18 and accompanying text.

179. Clinton Plan, *supra* note 147, § 7111(b)(1).

180. E.g., *id.* § 7111(c) (cigarette papers); § 7111(d) (cigarette tubes); § 7111(e) (smokeless tobacco); § 7111(f) (pipe tobacco).

181. *Id.* § 7113.

182. See *supra* note 34 for the rationale behind partial taxation of the Medicare program.

183. Clinton Plan, *supra* note 147, § 7131(a), adding new I.R.C. § 59B(a)(1), (b).

184. *Id.* § 7131(a), adding new I.R.C. § 59B(a)(2).

185. *Id.* § 7601(a), adding new I.R.C. § 501(n).

and planning.¹⁸⁶ Section 7902 makes clear that the new health-related entities created by the Clinton Plan would not be eligible for tax-exempt borrowing.¹⁸⁷

While these changes fall well short of the "leveling of the field" called for above,¹⁸⁸ their presence shows how much public consciousness of the tax exemption of many health care providers, and its lack of justification, increased during the last half of 1993. Their presence will assure that tax exemption continues to be a part of the health care debate, and allows us to hope that the legislation adopted will move beyond this modest beginning.

VI. CONCLUSION

Health care reform efforts focus on providing universal access to health care and containing costs. Revision of the tax code is one avenue, and several changes are warranted. Past efforts have inappropriately linked the provision of health care with employment; the linkage should be broken in favor of an individual mandate. Tax exemptions for so-called "charitable" hospitals that provide little, if any, health care for the indigent are unjustifiable. Excise taxes on tobacco and alcohol should be raised to reflect the true cost of these items to society.

A pragmatic program that Congress can pass must include a joint individual/employer mandate. To gain the support of small business and consumers who fear enormous job loss, a system of dual employee/employer credits should be implemented. Employer contributions to health care would no longer be deductible, and employees would no longer be able to exclude the employer's cost of coverage from gross income. Employers and individuals would, however, be eligible for tax credits up to the cost of the lowest-priced minimum plan. The employer tax credit would vary based on employer size and profitability; the individual tax credit would vary based upon income. Such a system should defuse political opposition from small businesses.

The dual system of credits properly recognizes that medical expenses include both voluntary and involuntary consumption, and attempts to tax each different type appropriately. The Clinton Plan, although a step in the right direction, should repeal section 213 of the Code in its entirety. Despite its flaws, the Clinton Plan will place health care financing on a much

186. *Id.*

187. *Id.* § 7902(a), adding new I.R.C. § 141(b)(6)(C).

188. See *supra* notes 119-20 and accompanying text.

sounder foundation than the current health care system, both in theory and in practice.

NOTES

