NOTE

THE VALUE OF HEALTH AND WEALTH: ECONOMIC THEORY, ADMINISTRATION, AND VALUATION METHODS FOR CAPPING THE EMPLOYER SPONSORED INSURANCE TAX EXEMPTION

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I. Introduction

The recent passage of health reform introduces a tax that many policy wonks love but much of the public hates. This initiative is the so-called Cadillac Tax on high-value health insurance plans. For years, economists have argued that the exclusion of employment sponsored insurance ("ESI") from taxable income represents a major distortion in the tax code that incentivizes overinsurance, which in turn causes overutilization of medical services and rising health costs. They tout the tax as a tool to help control costs and end inefficient distortions. They also claim that the tax is beneficial for lower- and middle-income individuals because the ESI exclusion in the Internal Revenue Code ("I.R.C.") § 106 disproportionately benefits the wealthy.

However, there are problems with the Cadillac Tax. Since the inception of ESI, the Internal Revenue Service ("IRS") and the Department of the Treasury ("Treasury") have excluded it from income to avoid the complex matter of valuing health insurance. There are numerous other concerns involving the administration and proper drafting of the I.R.C. provisions pertaining to the ESI tax, since § 106—the section of the code which excludes ESI—links to many other parts of the fractured Code. While most of the policy debate focused on the economic gains and revenue raising power of the Cadillac Tax, few considered these problems. Yet, ease of administration is another important factor that one must consider in any tax debate, especially one involving an uncharted area like this one.

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The provisions in the recently enacted Patient Protection and Affordable Care Act ("PPACA")[1] and the Reconciliation legislation[2] embrace the benefits of taxing ESI. However, the PPACA uses a flat excise tax with few adjustments across the board. While this approach is easy to administer, it fails to push as effectively toward equity and efficiency gains that a cap on the § 106 exclusion could provide, another tool for reforming ESI taxation that will be discussed throughout this Note. Thus, the so-called Cadillac Tax is a good idea that has been poorly legislated.

This Note seeks to outline the key points in the debate involving the PPACA Cadillac Tax and attempts to establish a framework for analyzing valuation methods. While the Note finds the PPACA's approach administratively simple, it finds the tax lacking in that it veers too far from the goals of efficiency and equity that an ESI cap might achieve. Two ESI cap proposals are analyzed: one based on premium value adjustments and the other based on actuarial values. Both are difficult to administer, but each seeks to achieve more equitable outcomes than those provided by the Cadillac Tax. Of the two proposals outlined, actuarial valuation holds the greatest promise at succeeding in the balancing act between efficiency, equity, and administration.

The Note proceeds as follows. Part II presents a brief historical summary of the ESI exemption. Part III outlines the economic arguments for taxing ESI on both efficiency and equity grounds. Part IV sets out the general administrative concerns. Part V examines three major plans for taxing ESI: (1) the PPACA's Cadillac Tax; (2) an adjusted premium method; and (3) an actuarial value method, and determines that the actuarial value method is the most promising in terms of effectively and fairly taxing ESI. Part VI concludes.

II. Historical Outline of the ESI Exemption

It is important to understand the development of the tax exemption for ESI in its historical context. Much of the health insurance system has developed around the exemption to accommodate private health insurance.

The U.S. health insurance system developed from the growth of medical expenses during the Great Depression, which placed a considerable strain on middle class families.[3] The Depression also revealed that voluntary hospitals were in deep financial trouble. To address these financial issues, Baylor

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[2] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[3] *See generally* Paul Starr, The Social Transformation of American Medicine 295 (1982). Starr's book still remains one of the best works for understanding the development of the American health care system.

University Hospital created a prepayment plan[4] for teachers.[5] By 1932, the idea spread to California, and hospitals banded together to offer community plans[6] in Sacramento.[7] In time, the American Hospital Association ("AHA") issued guidelines favoring such community prepayment plans throughout the country.[8] By 1937, the AHA issued guidelines establishing Blue Cross.[9] Each Blue Cross plan operated in a defined territory to prevent competition.[10] The plans were nonprofit and not taxed. They covered only hospital care, had strong connections to hospitals, and operated as service benefit plans rather than indemnity plans.[11] Eventually, these plans grew popular and attracted private insurers into the field.[12]

The development of insurance for physician services has a slightly different history. Physicians, who are represented mainly by the American Medical Association ("AMA"), considered organizations such as Blue Cross a threat to their livelihood and the power that they had theretofore exerted over the practice of medicine.[13] Accordingly, the AMA established a set of ten principles in 1934 that outlined the ideas behind physician control and insisted that insurers accept their control of health institutions and eliminate all payment arrangements other than indemnity.[14] The AMA facilitated the elimination of lay-sponsored physician service benefit plans by encouraging states to pass laws that restricted the growth of these plans.[15] Eventually, the AMA accepted the implementation of plans run by physicians as an alternative to an expansion of Social Security for health insurance or the Blue Cross model.[16] Given both the financial pressure patients faced and populist urges for the government to step into the health care fray, the AMA's acceptance of some form of insurance that maintained physician autonomy was a better alternative than giving greater control to the government.[17] These physician-run plans, called Blue Shield, took on the form of

[4] A prepayment plan is a plan in which a healthy person paid a hospital a small amount each month in order to gain a reduction in the cost of treatment if the healthy person became sick. *See id.* at 296.

[5] *Id.*

[6] Community plans are prepayment plans that extended to a large community of hospitals instead of just one hospital. *See id.*

[7] *Id.*

[8] *Id.*

[9] Robert B. Helms, *Tax Policy and the History of the Health Insurance Industry, in* Using Taxes to Reform Health Insurance: Pitfalls and Promises 13, 14 (Henry J. Aaron & Leonard E. Burman, eds., 2008).

[10] *Id.*

[11] Starr, *supra* note 3, at 298. An indemnity plan is the most basic health insurance plan, whereby the insurer passively pays a patient's bills as requested by health care providers. James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Evaluate Health Plan Performance*, 16 Health Aff. 176, 176 (1997).

[12] Helms, *supra* note 9, at 15.

[13] *Id.* at 14.

[14] Starr, *supra* note 3, at 299-300.

[15] *Id.* at 306.

[16] Helms, *supra* note 9, at 14.

[17] Starr, *supra* note 3, at 306, 308; Helms, *supra* note 9, at 14.

indemnity insurance and limited prepaid service benefits only to low-income individuals.[18]

Finally, commercial insurance companies entered the health care financing arena when they saw a market for health insurance products. These companies used their preexisting relationships with large multi-state employers and experience rating[19] to undercut the Blue Shield plans.[20] This development is, as Paul Starr, a sociology professor at Princeton, calls it, the "triumph of accommodation."[21] Starr comments that although nationalized health insurance similar to the system adopted in Europe failed, the U.S. balanced the need for a safety net with the desire of the health profession to remain in control by creating, in effect, a private social security system.[22]

Because private social security qualified as compensation, it counted as taxable income.[23] However, the IRS decided not to treat health insurance and other fringe benefits[24] as taxable income,[25] in part because the IRS "felt that it was difficult to allocate the costs of health insurance to individual employees and also [because] the amounts were [so] small [that] it was not that important."[26] The IRS's ruling gained substantial weight during World War II as the War Production Board also decided to follow the lead of the IRS and exclude health benefits paid by employers from its various wage controls for workers, again because it found inclusion of these fringe benefits too difficult given their small size.[27] The Board did not debate the future consequences of their actions.[28] After the war, Congress stepped in and codified the exclusion in the Internal Revenue Code of 1954, which essentially established the § 106 exemption that is in place today.[29]

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[18] Starr, *supra* note 3, at 308; Helms, *supra* note 9, at 14-15. Helms argues that physicians lobbied for only indemnity coverage to "balance bill" the patients, whereby a physician charges different prices for different patients and indemnity insurance covers a fixed amount for each service. The patient pays the physician the balance. *Id.* at 15.

[19] An experience rating is a measure that prices coverage to individuals based on their medical history. *Id.* at 329-30.

[20] *See* Starr, *supra* note 3, at 298 (describing the preexisting relationships between private indemnity insurers and large employers). Starr also outlines the development of experience rating and how it led to undercutting the Blues. *Id.* at 330.

[21] *See id.* at 331-32 (discussing how European workers' interests in health and welfare funds and American progressives' failures in changing the delivery system of health services led to different paths and how these failures were solidified in a system of restricted competition in the United States).

[22] *See id.*

[23] *See* I.R.C. § 61 (2006) (defining taxable income as any form of compensation).

[24] Fringe benefits are "in-kind benefits transferred to an employee." Michael Graetz & Deborah Schenck, Federal Income Tax: Principals and Policies 103 (6th ed., 2009).

[25] *See* Helms, *supra* note 9, at 13, 17.

[26] Daniel Halperin, *Comment by Daniel Halperin*, *in* Using Taxes to Reform Health Insurance: Pitfalls and Promises 57, 57 (Henry J. Aaron and Leonard E. Burman, eds., 2008).

[27] Helms, *supra* note 9, at 16-17.

[28] *Id.* at 17.

[29] Starr, *supra* note 3, at 334.

While many historical accounts stop there, it is important to recognize the path-dependence that solidified this policy. Instead of taxing wages for some public insurance, the government exempted ESI from taxation, allowing the unions to exact a "tax" on wages by negotiating lower wages to cover the costs of a private social security system.[30] One study shows that after the enactment of the 1954 Code's exemption, enrollment in private health care plans grew substantially.[31] Thus, the growth of ESI in the United States is inextricably linked to the tax exemption it received. Without the tax exclusion, both the benefits and problems of ESI would not have been as substantial.

As economists point out, however, subsidization produces some strange and detrimental effects.[32] People often become overinsured, leading to an increase in demand for medical services as well as for more expensive medical services.

III. The Economic Case for Taxing: Efficiency and Equity

Two key economic issues in analyzing tax policy are equity and efficiency. As this Note will demonstrate, both equity and efficiency are optimized if the government limits, or caps, the health care tax exclusion. With a cap, the health insurance benefit is excluded from taxation up to a certain dollar value, and only an amount above that cap level is taxed.

However, a threshold question must be answered: what is the tax base[33] for an income tax system? There is also the question of how much the exemption would drain the Treasury. This Part first addresses the question of defining the tax base and its relation to the exclusion as well as the fiscal costs of excluding ESI from income. It then addresses questions of efficiency and closes with a consideration of equity matters.

A. *Income, Revenues, and Tax Expenditures*

The § 106 exemption represents a huge drain on the Treasury in terms of lost income from taxation. Any losses in revenue collections from the

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[30] *Id.*

[31] *See* Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance*, 93 Am. Econ. Rev. 1373, 1382 (2003) (noting that health insurance coverage grew by 9.5% after 1954).

[32] *See* Joseph P. Newhouse, Insurance Experiment Group, Free For All?: Lessons from the RAND Health Insurance Experiment 344-45 (1993) (stating that the adverse health outcomes—when people became very sick—only occurred in areas of the sick and poor, and that a reduction in health care costs occurs with greater coinsurance rates); *see also* Jonathan Gruber, Public Finance and Public Policy 442 (2010) (stating how the tax subsidy encourages overutilization of health care, which in turn leads toward high expenses).

[33] Tax base is defined as "[p]arameters on which taxation is levied as defined by law. In an income tax, for example, taxable income is determined by statutory inclusions and exclusions." Michael Graetz, 100 Million Unnecessary Returns: A Simple, Fair, and Competitive Tax Plan for the United States 252 (2008).

income tax base through exemptions, credits, and deductions are equal to direct expenditures since they represent money the government can collect but does not. The equivalence between mandatory federal outlays, such as Medicare and Social Security, and tax loopholes and exclusions, bolster Starr's notion of a private social security and social welfare system.[34] Understanding the problems that the § 106 exemption creates for both the federal budget and private economic decision-making requires a brief introduction of the concepts of income and tax expenditures.

1. Defining Income and Tax Expenditures

The definition of income is subject to a great deal of debate. The classic and most widely-cited definition is the Haig-Simons formulation, which states that "personal income may be defined as (1) the market value of rights exercised in consumption and (2) the change in the value of the store of property rights between the beginning and end of the period in question."[35] Essentially, the Haig-Simons formulation defines personal income as one's consumption plus the change in one's savings. Despite this seemingly simple formulation, defining market rights and consumption are difficult tasks.

Section 61 of the I.R.C. defines gross income as "all income from whatever source derived."[36] Similarly, the Supreme Court, in *Commissioner v. Glenshaw Glass Co.*, defined income broadly, holding that it includes all "undeniable accessions to wealth, clearly realized, and over which the taxpayers have complete dominion."[37] The Code then spells out specific deductions, credits, and exclusions and includes sections that further refine this broad definition of income.[38] However, both the Court's notion of income and I.R.C. § 61 suggest a broad conception of income, which indicates that ESI can safely be categorized as "income" within these definitions. It is a benefit exercised in consumption, and it is a form of compensation—an accession to wealth that the taxpayer controls.

Deductions and credits that move away from taxing all available items included in the definition of income are subsidies, also called "tax expenditures" or "tax preferences"[39]—terms which, for the purpose of this Note, will be used interchangeably.[40] Surrey, who is recognized as the father of the tax expenditure idea, notes that many of these deductions benefit the rich

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[34] Starr, *supra* note 3, at 334.

[35] Henry C. Simons, Personal Income Taxation 50 (1938).

[36] I.R.C. § 61 (2006).

[37] 348 U.S. 426, 431 (1955).

[38] *See, e.g.*, I.R.C. § 62 (2006) (defining adjusted gross income and thereby excluding certain deductions from the income tax base defined by § 61); I.R.C. § 162 (2006) (excluding ordinary and necessary business expenses from income); I.R.C. § 163(h) (2006) (excluding mortgage interest from income); I.R.C. § 106 (2006) (excluding employer sponsored health insurance from income).

[39] Stanley S. Surrey & Paul McDaniel, Tax Expenditures 25 (1985).

[40] There is a nuanced distinction between the two. A tax preference is preferential treatment of a source of income or expenditure by the tax code that deviates from the idealized

and harm the poor.[41] Surrey counts § 106, the ESI exclusion, and § 213, an itemized deduction for out-of-pocket medical expenses greater than 7.5% of adjusted gross income ("AGI"),[42] as tax preferences because each of these forms of consumption moves away from the ideal base of all income.[43] Surrey's concept of the tax expenditure is perhaps most relevant because the Joint Committee on Taxation ("JCT"), which evaluates tax legislation and provides its analysis to the Congressional Budget Office ("CBO"), uses this framework to determine the costs and revenues of tax provisions.[44]

2. *Tax Expenditures and Lost Revenue for ESI*

Since a tax expenditure is a loss in revenue, it is functionally equivalent to direct spending. By quantifying tax expenditures, one can derive a first-order approximation of the costs of the exemption.

According to the calculations of the JCT, the cost of the ESI exemption in terms of lost revenue was $262.2 billion in 2008, which was larger than almost any other health care tax expenditure and many other tax expenditures.[45]

Furthermore, health expenditures and ESI premiums have grown faster than the overall GDP.[46] Hence, the cost of subsidizing ESI as it deviates from the ideal tax base grows over time. Additionally, such lost revenue means that other ways to finance health care through direct government spending or subsidies is limited. It is perhaps primarily for this reason that policymakers have consistently debated eliminating or limiting ESI tax exemptions.[47]

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income base, while a tax expenditure is the cost of lost revenue that results from a tax preference. Graetz and Schenck, *supra* note 24, at 41-42.

[41] Surrey & McDaniel, *supra* note 39, at 71-82.

[42] I.R.C. § 62. The section defines AGI as a taxpayer's total gross income received minus a limited class of deductions listed in the section.

[43] Surrey & McDaniel, *supra* note 39, at 19-20.

[44] Staff of the Joint Committee on Taxation, JCX-37-08, A Reconsideration of Tax Expenditure Analysis 2-3 (2008), *available at* http://www.jct.gov/x-37-08.pdf.

[45] Staff of the Joint Committee on Taxation, JCX-27-09, Background Materials for the Senate Committee on Finance Roundtable on Health Care Financing 2 (2009) [hereinafter JCT Health Report], *available at* http://www.jct.gov/publications.html?func=startdown&id=3557. The JCT warns that this number diverges from its more traditional estimates, which assume that if § 106 were repealed employees could still use § 213 itemized deductions. Here, it takes into account a world without both provisions. This number is significantly larger than § 213 tax expenditures, which reach only $10.7 billion, or the exclusion of Medicare from income, which reaches $41.8 billion. *Id.*

[46] *See OECD Health Data 2010—Frequently Requested Data*, Org. for Econ. Co-Operation and Dev. http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (showing that health expenditures are growing faster than GDP by the increase in the percent of GDP spent on health in the U.S.).

[47] Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 Health Aff. 1714, 1718 (2009).

B. *Efficiency Problems of Exempting ESI*

The § 106 exemption presents major efficiency problems, which are well-documented in the economic literature.[48] The tax preference for ESI undermines economic efficiency in two primary ways: through (1) the subsidization of medical care and the resultant effects of moral hazard and (2) lost wages.

1. *Over-Subsidization and Moral Hazard*

Perhaps the biggest problem caused by the exemption for ESI is that it creates a subsidy for health care, which leads to the overutilization of medical services.[49] This effect occurs because the subsidy lowers the cost of insurance, leading consumers to purchase too much insurance, which in turn ultimately leads to overuse.[50]

First, ESI is excluded from employee income according to § 106.[51] For someone at the 35% marginal tax rate, $1 in cash wages yields a net wage of $0.65 after taxes are assessed. However, for that same person, $1 of ESI is $1 of ESI. Thus, for such an individual the cost of ESI is lower than that of wages, which incentivizes the purchase of a greater quantity of insurance rather than receipt of cash wages. This form of income shifting is particularly useful to people in the top marginal tax brackets, as those with higher tax rates receive a greater benefit from the shift.

More generous coverage generally means that at the point of service, individuals do not pay much out-of-pocket. Low out-of-pocket costs are reflected by low co-payments, which are fixed fees for certain medical goods or services; low co-insurance rates, which are a percentage of the costs that one must pay; or low deductibles, which are costs one must bear in full before insurance kicks in to cover care.[52] This more generous coverage results in what economists call the moral hazard problem.

Theoretically, moral hazard arises in two ways. First, patients who are insured have little incentive to avoid certain preventable health risks because they are covered and do not bear the full costs of the risks.[53] Second, when care is needed, patients have an incentive to over-consume care and to choose expensive care even when it may not be necessary.[54]

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[48] *See, e.g.*, Gruber, *supra* note 32, at 442.

[49] *See* JCT Health Report, *supra* note 45, at 12.

[50] *See* Martin Feldstein & Bernard Friedman, *Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis*, 7 J. Pub. Econ. 155, 170-71 (1977) (showing that a tax subsidy has an effect on the optimal coinsurance rate).

[51] I.R.C. § 106(a) (2006).

[52] Gruber, *supra* note 32, at 422-23.

[53] Leonard E. Burman & Jack Rogers, *Tax Preferences and Employment-Based Health Insurance*, 45 Nat'l Tax J. 331, 337 (1992).

[54] *Id.*

Research suggests that medical insurance causes a moral hazard effect and that lower out-of-pocket prices lead to increased utilization.[55] Increasing utilization leads to an increase in health insurance prices,[56] because as more people use more health care, insurance companies have to pay out more in costs.[57] To balance this expenditure increase, the insurance companies must raise revenues by increasing premiums.[58] However, the Code minimizes the full extent to which individuals are affected by these increased premium costs because money used to pay the premiums is excluded from income.[59]

One of the arguments for more generous insurance benefits stems from the idea that people have a tendency to under-consume unsubsidized care. However, for underutilization to be a problem, not only must it outweigh the moral hazard effect, but it also must outweigh other patterns of behavior that lead individuals to over-consume, like forgoing salary for increased health insurance, which will be discussed in the next subsection.[60]

To limit the concern about underutilization of necessary or effective care, policymakers or insurance companies could restructure insurance. Currently, at the point of service, such as the doctor or hospital, a person pays a deductible, which is a percentage of the total cost, or a copayment, which is a flat fee for the medical service regardless of the actual health benefit.[61]

Alternatives to the current ESI exemption will be discussed later in the Note. However, a few preliminary observations on the relative merits of a cap on the ESI exemption are worth mentioning at this point. Capping the ESI subsidy would limit many of the negative moral hazard effects of exempting all ESI from taxation. First, doing so would limit the amount of insurance purchased at the tax-preferred price. A cap would also encourage lower levels of utilization and greater efficiency in the system. Finally, and unlike the case under an elimination of the full exemption, the cap would allow a minimal level of insurance to be tax-preferred, thus blunting the scope of any underutilization concerns. Hence, overall, a cap would help increase economic efficiency.

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[55] Newhouse, *supra* note 32, at 8-9; *see also* Gruber, *supra* note 32, at 438-39.

[56] JCT Health Report, *supra* note 45, at 12.

[57] *See, e.g.*, Gruber, *supra* note 32, at 436-37 (showing that Medicare pays the same rate schedule in McAllen and El Paso, Texas, and yet has a higher cost in McAllen because of increased utilization).

[58] *Cf.* Jeffrey M. Perloff, Microeconomics: Theory and Applications with Calculus 268 (2008) (stating that if an insurance company cannot cover costs, it must seek new revenue through price increases or exit the market through bankruptcy or other means).

[59] I.R.C. § 106(a) (2006); *see also* Gruber, *supra* note 32, at 425-26.

[60] Jeffrey Liebman & Richard Zeckhauser, *Simple Humans, Complex Insurance, and Subtle Subsidies*, *in* Using Taxes to Reform Health Insurance: Pitfalls and Promises 230, 241-42 (Henry J. Aaron & Leonard E. Burman eds., 2008).

[61] *Id.* at 242-45.

2. *Wage Losses and Labor Market Composition*

Moral hazard and overutilization lead to higher premiums by creating a major distortion in health care markets. In turn, higher premiums result in a loss of cash wages. While the Code does not view health insurance as compensation, most employers do.[62] Any benefits given to an employee are considered part of an employer's compensation expenses.[63] Therefore, if health costs rise rapidly, then employers need to shift funds from direct cash benefits to ESI, and indeed, the IRS encourages employers to do just that, because $1 of health care funded is received in full by the recipient employee, whereas $1 in cash compensation is *not* received in full by the recipient employee. As a result, employers who provide ESI can pay an employee less than an employer who does not provide ESI without making the employee worse off. Specifically, as already described, $1 in cash compensation amounts to $1 minus the marginal tax rate that the government applies at the employee's income level.[64]

Economists have concluded that "the costs of health insurance are fully shifted to wages."[65] The subsidization of ESI and the resulting increase in premiums therefore limits wage growth. Although this shift from wages to health spending should not change the quantity of labor supplied, the composition of the labor market is likely to change in two ways.[66] First, the increasing costs of fringe benefits for full-time employees, and of ESI in particular, may drive employers to utilize more part-time employees for whom they do not need to provide such benefits.[67] Second, fringe benefit costs, unlike cash wages, often do not depend on the hours worked;[68] accordingly, some economists believe that instead of hiring more workers to accomplish a given task, employers will choose to make current employees work longer hours.[69] These employers would then avoid incurring the full costs of health benefits by not hiring new employees. Rather, they would only pay wages for each additional hour an employee worked.[70] The literature tends to suggest that employers are increasing hours, but it is unclear whether they are shifting toward more part-time employees.[71]

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[62] GRUBER, *supra* note 32, at 426.

[63] *Id.* Indeed, the Code itself acknowledges that this is an ordinary and necessary business expense under § 162, and it allows employers to deduct their cost of ESI.

[64] GRUBER, *supra* note 32, at 425-26.

[65] *See, e.g.*, Jonathan Gruber, *Chapter 12: Health Insurance and the Labor Market*, *in* THE HANDBOOK OF HEALTH ECONOMICS 645, 694 (Joseph P. Newhouse ed., 2000).

[66] GRUBER, *supra* note 32, at 695.

[67] *Id.* at 695-96.

[68] *Id.*

[69] *Id.*

[70] *Id.* at 695.

[71] *Id.* at 696.

Thus, the continued health insurance subsidy undermines economic efficiency by restricting the growth of wages and changing the composition of the labor market.

C. Equity

Taxes should strive to not only maximize economic efficiency, but also ensure that the distribution of resources is fair and equitable. What follows is a brief analysis of the key equity concerns raised by the ESI exemption and its subsidization of the current system.

1. Vertical Equity

Vertical equity is the notion that richer individuals should pay a higher tax rate than poorer individuals because of the declining marginal utility of money.[72] The ESI exemption frustrates vertical equity since richer taxpayers pay less in taxes than poorer taxpayers when ESI is included in income. Section 106 applies only to individuals who receive insurance from their employers. While self-employed individuals can deduct their insurance premiums,[73] employees who are not offered ESI and purchase insurance on their own frequently have to bear its entire cost.[74] Those who are poor are less likely to be offered coverage as they are more likely to be employed on a part-time basis.[75]

2. Horizontal Equity

The notion of horizontal equity is that taxpayers who earn the same amount should pay the same amount of tax regardless of their source of income.[76] The ESI exemption also causes serious horizontal equity problems. An individual who earns $55,000 in cash wages and receives $5,000 in ESI is taxed less than an individual who earns $60,000 in cash wages even though their total amount of compensation is the same. One way to solve the

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[72] A rich person cares less about a single additional dollar because he possesses more dollars than a poorer person. GRAETZ & SCHENCK, *supra* note 24, at 32.

[73] I.R.C. § 162(l) (2006).

[74] *See* I.R.C. § 213 (2006). While this provision allows for the deduction of premiums, it requires that the taxpayer itemize deductions and that the total amount of health costs exceed 7.5% of AGI. *Id.* § 213(a). Most taxpayers do not itemize deductions, because the standard deduction is often more generous. *See* GRAETZ & SCHENCK, *supra* note 24, at 431-32 (suggesting that high-income households are the ones who itemize, that most others do not, and that the standard deduction establishes a floor for the itemized deduction).

[75] Leonard E. Burman et al., *Tax Code, Employer-Sponsored Insurance, and Tax Subsidies*, *in* USING TAXES TO REFORM HEALTH INSURANCE: PITFALLS AND PROMISES 36, 48 (Henry J. Aaron & Leonard E. Burman eds., 2008).

[76] GRAETZ & SCHENCK, *supra* note 24, at 28 (defining horizontal equity as similar tax burdens on people with similar economic circumstances).

horizontal inequity problem is to propose tax subsidies similar to the ESI exemption for people who purchase individually.

D. Other Matters: The Adverse Selection Problem

Overall, efficiency and equity concerns both point toward eliminating or modifying the current § 106 exclusion. However, one benefit of ESI is that it limits adverse selection.

The concept of adverse selection was first formulated in a famous paper by Michael Rothschild and Joseph Stiglitz.[77] In the health insurance context, adverse selection occurs when those who are sick are the predominant or sole group seeking insurance because they know they have a current need for it.[78] This will cause the average cost of health care to rise. To reduce the adverse selection problem, insurance companies seek information about consumers through health records and have developed limitations on coverage for those with pre-existing conditions.[79] Furthermore, insurers also charge sicker customers higher premiums.[80]

ESI helps blunt some of the problems of adverse selection. While the small-group market is plagued by almost all of the dysfunctions mentioned above,[81] larger firms have a greater representation of health risks among all of their employees and thus do not present a selection issue.[82] It is generally believed that individuals do not choose jobs for their health care unless they are already sick.[83] Given the economies of scale of administration, many ESI plans can be provided at lower costs, and employees, unaware that they are "paying" for insuring unusually sick coworkers, will more willingly subsidize the health care coverage of sick individuals.[84] ESI thus provides one way to blunt adverse selection.

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[77] *See generally* David M. Cutler & Sarah J. Reber, *Paying for Health Insurance: The Trade-Off between Competition and Adverse Selection*, 113 Q. J. Econ. 433, 444-46, 460-61 (1998) (detailing an experiment that shows the adverse selection insurance death spiral in Harvard University's employee health plans); Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. Econ. 629 (1976) (outlining adverse selection and its problems with regard to the insurance market).

[78] Newhouse, *supra* note 47, at 1716 (2010).

[79] *Id.*

[80] *See* Gruber, supra note 32, at 427 (stating that the price for the sick in the non-group policy market is often very expensive, or unavailable, and that those with preexisting conditions are excluded).

[81] Newhouse, *supra* note 47, at 1716 (2010).

[82] *Id.* at 1718. Indeed, for the largest interstate firms, the matter of risk is moot because they self-insure under ERISA. *See Fast Facts: Health Plan Differences: Fully Insured vs. Self Insured,* Emp. Benefit Research Inst. (Feb. 11, 2009), http://www.ebri.org/pdf/FFE114.11 Feb09.Final.pdf. According to the Employee Benefit Research Institute, in 2008, 55% of all workers were covered by a self-insured plan, and about 89% of employers with over 5,000 employees used the self-insured option. *Id.*; *see also* Newhouse, *supra* note 47, at 1718.

[83] Gruber, *supra* note 32, at 424-25.

[84] Newhouse, *supra* note 47, at 1716, 1718 (2010).

A cap on ESI could still be a beneficial alternative to the current exemption. A cap on ESI, if set too low, could cause many individuals to leave their insurance groups.[85] Thus, only the sick people in such groups would remain and the costs of administering these group insurance plans would rise—effectively eliminating the positive pooling effects these plans yield.[86] However, a cap properly set to grow with inflation, could help to capture the economic benefits mentioned previously as well as to limit adverse selection.[87]

IV. Administrative Concerns

First, other parts of the Code also treat health care spending preferentially. While the lost revenue from these exemptions is not as large as the losses from the ESI exclusion, on a pure consistency basis, if ESI is considered taxable income, these other expenditures should come under that same heading. Second, there is the valuation concern, which is perhaps the most complex matter to consider. The problem of valuation is introduced in this Part, and then expanded upon in Part V, where the Note presents and analyzes the various cap and tax proposals. Finally, the Note proposes an analytical framework for analyzing administrative concerns.

A. Section 106's Interaction with Other Sections and Unintended Consequences

The § 106 exemption is not the only form of preferential tax treatment for health expenditures. There is also § 105(b), which excludes from taxable income benefits that employees receive from employer-sponsored accident or health plans.[88] Normally, amounts received as insurance benefits are considered taxable income to the recipient because these benefits are an accession to wealth under § 61.[89] Section 105(b) thus ensures that ESI is completely untaxed, as neither the premium nor the benefits are considered taxable income.[90]

Another provision excluding the taxation of health benefits is § 104(a)(3), which exempts from taxation benefits received through accident

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[85] Bob Lyke, Cong. Research Serv., RL34767, The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate 15 (2008), http://www.allhealth.org/briefingmaterials/RL34767-1359.pdf.

[86] *See id.* at 442 (stating that the sudden elimination of the tax subsidy could unravel some of the risk pooling and leave intact market failures).

[87] *See id.* at 424-25 (discussing how risk pooling helps to limit the adverse selection problem). Gruber also argues that the cap would still provide some basic coverage through employer groups, while avoiding overly generous benefits. *Id.* at 442.

[88] I.R.C. § 105(b) (2006).

[89] I.R.C. § 61 (2006).

[90] I.R.C. § 105(b) (2006).

or health insurance if they are not from an employer-financed plan.[91] In other words, this section grants tax-preferred status to the benefits paid on plans financed either entirely or partially by employees—since employees often bear the burden of paying some of the premiums for their group health insurance. Thus, even for plans partially financed by employees, there is the double benefit of deduction of their premiums under §§ 106 and 125 and the exclusion of benefits paid out by the plan from income under § 104(a)(3).[92]

The Code's treatment of matters like Flexible Spending Arrangements ("FSAs") are more beneficial to employees. Under § 125, employees are allowed to commit a certain amount of their pay to a Flexible Spending Account.[93] When the employee incurs a qualified health expense, like meeting a deductible, making a copayment, following a coinsurance requirement, or paying for over-the-counter medication, an employee can choose to be refunded from her FSA.[94]

For consistency, it is important to include FSAs in any attempt to tax ESI. The FSAs, after all, are a consumption choice regarding medical care coverage that people make with their income. Maintaining the tax preference for FSAs would introduce a level of inconsistency within the Code. Furthermore, maintaining the preferences could lead to an expansion in the reach of FSAs.[95] They would then take over the functions of insurance, because employees and employers pay lower premiums in ESI, which results in higher out-of-pocket expenses that are covered by the tax-preferred FSA.[96] Any policy must ensure that FSA limitations remain strong to prevent shifting expenses away from insurance to these accounts, which may limit the utilization reduction that an ESI cap should seek to create.

Finally, to evaluate a change in health care tax policy we must consider § 213. Section 213 permits individuals to take an itemized deduction for medical expenses that exceed 7.5% of their AGI.[97] These are generally high out-of-pocket expenses, though non-ESI premiums can count toward this deduction.[98] The impact of this exemption is small, because it requires: (1) itemization, which few taxpayers actually utilize, and (2) expenses accounting for 7.5% of AGI. However, if we assume that health care spending is a form of consumption, then it is important to think about § 213 as well and to

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[91] I.R.C. § 104(a)(3) (2006).

[92] *See* I.R.C. § 104(a)(3) (2006) (regarding nontaxation of benefits); I.R.C. § 106 (2006) (describing the general exemption of ESI); I.R.C. § 125 (2006) (regarding cafeteria plans such as premium conversions and Flexible Spending Accounts).

[93] An FSA is an account into which an employee can make a pre-tax deposit, and then uses the funds from the account to pay for out-of-pocket health expenses. Lyke, *supra* note 85, at 6.

[94] *See id.* at 6 (explaining how an FSA works). There are financially similar arrangements to an FSA such as a Health Reimbursement Account ("HRA"), which have some differences, but for all intents and purposes are the same. *Id.*

[95] *See id.*

[96] *See id.* at 6-7.

[97] I.R.C. § 213 (2006).

[98] *Id.*

ensure that Congress limits these deductions consistently with any cap imposed on the ESI exclusion.[99]

B. Introduction to Valuation

The method of valuing health care benefits is perhaps the most complex matter in taxing health insurance. The idea of income as either some accession to wealth or some economic gain makes valuation particularly difficult in a group health context. One rationale for excluding ESI from taxable income in 1943 stemmed from the fact that it was difficult to allocate the cost of insurance plans among employees.[100] For example, a younger worker is likely to have a lower level of costs and is thus cheaper to insure than an older worker. Thus, to accurately reflect individuals' benefit from participation in the plan, a sophisticated premium adjustment and allocation must occur.[101] Alternatively, one could simply take the overall aggregate value of the employee risk pool and divide it by the number of people covered by a plan to get an average cost per covered life.[102] Given the virtual impossibility of determining the actual cost per covered life in a plan, it is generally necessary to resort to this second-best alternative.[103]

A major valuation question is determining the value of coverage for someone whom the individual health insurance market would not insure.[104] There is no real solution to this question at present. However, the PPACA creates an individual mandate for insurance to solve the matter of adverse selection and also to reform the insurance market to require guaranteed issuance and to place some limits on premiums.[105] Required issuance to those with pre-existing conditions could start to give us a sense of at least some market value for the premiums necessary for these previously uninsurable individuals, but even premiums may not correctly measure the value be-

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[99] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9013, 124 Stat. 119, 853 (2010) (codified at I.R.C. § 4980I (West 2010)) (increasing the requirement of expenses to exceed 10% of AGI before one can even put it in the itemized deduction column).

[100] Halperin, *supra* note 26, at 58-59.

[101] *See id.*

[102] *See id.*; *see also Benefits and the Tax Code: The Right Incentives?: Hearing Before the Comm. on Finance of the U.S. S.*, 111th Cong. 5-6 (2008) (statement of Paul Fronstin & Dallas Salisbury, EBRI), http://www.ebri.org/pdf/publications/testimony/t155.pdf (describing how self-insured plans take their total costs and divide them by the number of covered employees to get a "premium equivalent," thus using an average cost method rather than a complete and direct allocation).

[103] *Id.*

[104] Lyke, *supra* note 85, at 8.

[105] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1001-1004, 124 Stat. 119, 130-40 (2010) (reforms on the individual and small group markets); §§ 1101-1105, 124 Stat. at 141-154 (other matters to improve coverage like reinsurance for retirees and elimination of pre-existing condition requirements); § 1201, 124 Stat. at 154-61 (guaranteed issue and renewal of coverage as well as eliminating waiting periods); § 1501, 124 Stat. at 242-49 (individual mandate).

cause, as one study shows, the actuarial calculation of premiums is based on more than the amount of expected benefits.[106]

Even if one establishes the method of valuation for ESI in a form that balances the economic gains, such as reducing the overconsumption of care that stems from moral hazard, with administrative concerns, there is another important question linked to valuation that must be asked if Congress is to effectively impose a cap on the ESI exemption: where does one set the cap and how is it indexed?[107] If the cap amount is too low, it could erode needed insurance benefits for some people, while if it is set too high, the increased efficiency that stems from decreased utilization may be deferred for too long.[108] If the cap is indexed to something like the Consumer Price Index ("CPI"),[109] the cap will tighten over time, i.e., fewer and fewer plans will fall under the cap amount unless they change the generosity of their benefits because the general rate of inflation is much lower than that of overall health costs.[110] Still, there may be political efforts to make adjustments to prevent such tightening.[111] Finally, if the cap is indexed directly to National Health Expenditure growth, or if it starts out at too high a value, the economic gains of limiting unnecessary overconsumption of care will not appear.[112]

These questions of valuation are difficult to answer. Finding what method works and how one determines where the cap lies is essential to making this policy workable.

V. Analyzing Proposals

This Part presents three approaches to valuing and taxing ESI. Each proposal is outlined, and its costs and benefits are analyzed. The first proposal is the cap on Cadillac plans enacted by Congress in the PPACA. The second proposal is a tax that offers a more direct method for valuing premiums, and the third is a tax based on an estimate of the actuarial value of health plans.

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[106] *See* Jon Gabel et al., *Taxing Cadillac Health Plans May Produce Chevy Results*, 29 Health Aff. 174, 175-76, 180 (2010).

[107] Lyke, *supra* note 85, at 15.

[108] *Id.* Lyke does not consider that there may be a way to blunt some of the welfare losses through a more comprehensive reform of the health insurance market.

[109] *See* Stan Dorn, The Urban Institute, Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible? 2 (2009), *available at* http://www.urban.org/publications/411894.html.

[110] Lyke, *supra* note 85, at 15.

[111] *Id.* This Note generally assumes that whatever indexing is chosen will stick and not see Congressional intervention. This assumption is made for analytical simplicity.

[112] *See* Dorn, *supra* note 109, at 2 (stating that the growth of health care has outstripped the rise of inflation and thus, if one indexes a cap to a lower number, less is shielded, and implying that if one puts the growth rate of the cap at the growth rate of national health expenditures, it will not have the effect of shielding an "ever declining portion").

A. The Cadillac Plan Excise Tax

1. The Plan

Section 9001 of the PPACA, as modified by § 1401 of the Reconciliation Act, imposes an excise tax on high-cost health plans.[113] The tax begins in 2018.[114] It is imposed on insurers of ESI plans with premium values that exceed $10,200 for individuals and $27,500 for families.[115] Any value above the caps is taxed at a flat rate of forty percent.[116] The entity paying the tax is the health insurance issuer, or, for a self-insured plan, the plan administrator,[117] but the responsibility to calculate the premium value of health benefits and determine if it reaches the cap falls on the employer.[118] The bill attempts to disclose the costs of insurance to employees by requiring employers to report all ESI costs on an employee's W-2 form.[119]

The tax affects any group health plan as defined by I.R.C. § 5000 or other health insurance coverage that § 106 exempts, including the employee-paid portion.[120] The value of the plan is calculated based on the premium paid by the employer.[121] Included in the valuation are contributions to health

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[113] S. Democratic Policy Comm., Section-by-Section Analysis of the Patient Protection and Affordable Care Act 57 (2010), *available at* http://dpc.senate.gov/healthreformbill/healthbill96.pdf; *see also* The Henry J. Kaiser Family Found., Side-by-Side Comparison of Major Health Care Reform Proposals 10 (2010), http://www.kff.org/healthreform/upload/housesenatebill_final.pdf.

[114] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9001(c), 124 Stat. 119, 853 (2010) (codified at I.R.C. § 4980I (West 2010)), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1401(b)(1), 124 Stat. 1029, 1060 (codified at I.R.C. § 4980I (West 2010)).

[115] Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. § 4980I(b)(3)(C) (West 2010)), *amended by* Health Care and Education Reconciliation Act of 2010 § 1401(a)(2). The Reconciliation Act also includes a provision that helps keep the cap steady should health costs and premiums suddenly rise by benchmarking it to the 2010 standard benefit package of the Blue Cross/Blue Shield Federal Employees Health Benefits Plan. Health Care and Education Reconciliation Act of 2010 § 1401(a)(2)(C)(ii).

[116] Patient Protection and Affordable Care Act § 9001(a), (codified at I.R.C. § 4980I(b)(3)(C)(iii) (West 2010)), *amended by* Health Care and Education Reconciliation Act § 1401(a)(2)(E) (codified at I.R.C. § 4980I(b)(3)(C)(v) (West 2010)). The cap is indexed to the Consumer Price Index for Urban Consumers ("CPI-U"), which is the general measure of rate of inflation for urban dwellers plus one percentage point, and begins rising in 2020. Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. § 4980I(b)(3)(C)(iii)(II)) (West 2010)).

[117] Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. §§ 4980I(c)(1)–4980I(c)(2) (West 2010)).

[118] § 9001(a), 124 Stat. at 850 (codified at I.R.C. § 4980I(c)(4) (West 2010)). For employer-sponsored coverage made available to employees through a multiemployer plan, the plan sponsor will make the calculations. *Id.*

[119] § 9002(a), 124 Stat. at 853-54 (codified at I.R.C. § 6051(a)(14) (West 2010)); I.R.C. § 6051(a) (2006).

[120] § 9001(a), 124 Stat. at 850, 853 (codified at I.R.C. §§ 4980I(d)(1), 4980I(f)(4)-4980I(f)(5) (West 2010)).

[121] § 9001(a), 124 Stat. at 851 (codified at I.R.C. § 4980I(d)(2)(A) (West 2010)); *see also* I.R.C. § 4980B(f)(4) (2006) (defining the applicable premium and the imputation rules on self-insured plans).

FSAs made by the employer and reimbursed to the employee as well as employer contributions to an Archer Medical Savings Account ("MSA") or a Health Savings Account ("HSA").[122] However, the law excludes from the valuation other types of insurance, such as disability or accident insurance, that are covered by § 106.[123]

The cap is adjusted upward for certain individuals. For retirees over the age of fifty-five who do not qualify for Medicare, the PPACA increases the threshold amounts by $1,650 for individual coverage and $3,450 for family coverage.[124] The PPACA also increases the threshold by the same amounts for employees engaged in certain high-risk professions.[125] In addition, the act includes age and gender adjustments.[126]

2. *Benefits*

The PPACA's greatest benefit is that it is relatively simple and thus easily administered. The Cadillac Tax requires a simple premium valuation with limited adjustments. The tax is also levied on insurance companies, popular targets of public ire.[127]

According to the CBO and the JCT, the excise tax is expected to raise about $32 billion in the period FY 2010-2019.[128] In addition, the amount collected per year will grow as the cap tightens.[129] The increasing number of health insurance dollars subject to the tax will create an incentive for em-

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[122] § 9001(a), 124 Stat. at 851 (codified at I.R.C. §§ 4980I(d)(2)(B)–4980I(d)(2)(C) (West 2010)). Archer MSAs and HSAs are tax-exempt trust or custodial accounts that a taxpayer can set up with a financial institution to save money exclusively for the purposes of paying for future medical expenses. I.R.S. Publ'n 969 (Nov. 25, 2009) [hereinafter I.R.S. Publ'n 969], *available at* http://www.irs.gov/pub/irs-pdf/p969.pdf.

[123] Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. § 4980I(d)(1)(B) (West 2010)), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 § 10901(b), 124 Stat. 1029.

[124] Patient Protection and Affordable Care Act § 9001(a), 124 Stat. at 848 (codified at I.R.C. § 4980I(b)(3)(C)(ii) (West 2010)), *amended by* Health Care and Education Reconciliation Act of 2010, § 1401(a)(2)(D). The definition of "qualified retiree" can be found at I.R.C. § 4980I(f)(2) (West 2010). Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. § 4980I(f)(2) (West 2010)).

[125] § 9001(a), 124 Stat. at 848 (codified at I.R.C. § 4980I(b)(3)(C)(ii) (West 2010)), *amended by* § 1401(a)(2)(D), 124 Stat. at 1060. The law lists certain high-risk professions at I.R.C. § 4980I(f)(3), *modified by* § 10901(a), 124 Stat. at 1015-16.

[126] Health Care and Education Reconciliation Act of 2010 § 1401(a)(2)(C) (codified at I.R.C. § 4980I(b)(3)(C)(iii) (West 2010)).

[127] John Whitesides & Susan Heavey, *Obama Targets Insurers, Sells Reform Plan*, Reuters, Mar. 8, 2010, *available at* http://www.reuters.com/article/idUSN1913022820100308.

[128] Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to the Honorable Nancy Pelosi, Speaker of the House, Regarding Cost Estimates for H.R. 4872 and H.R. 3590, Table 2 at 2 (Mar. 18, 2009) [hereinafter CBO Estimate], *available at* http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf.

[129] The cap tightens because it is linked to the Consumer Price Index for Urban Consumers, which grows at a rate much slower than health expenditures. Dorn, *supra* note 109, at 2 (stating that health expenditure growth outstrips the rate of inflation). If the limit grows more slowly than health expenditures, more and more health insurance spending will become sub-

ployers to seek out less generous and lower premium benefits (or for employees to demand fewer health benefits and greater wage increases).[130] This incentive will likely help contain costs by reducing the level of unnecessary care.[131] However, other initiatives in the bill, such as market reforms, expansions of Medicaid, and subsidies to lower-income individuals are expected to increase insurance coverage, even though the cap itself weakens ESI.[132]

In addition, the taxes are applied to the least savory player in the health care industry: insurance companies. Congress may have attempted to reduce the political heat of the tax by fashioning a levy on insurers rather than a tax on employees.[133] However, such a political benefit did not materialize. Unions, who often offer Cadillac plans to their members, are strongly opposed to the tax.[134] They lobbied hard to stop the tax's inclusion in the bill.[135] In addition, polling numbers show that the tax remains relatively unpopular, though it has gained some backers since the passage of the legislation.[136]

3. *Drawbacks*

Unfortunately, even with its administrative ease and the political benefit it was meant to provide, the Cadillac Tax fails to promote efficiency and equity. While it raises new revenue and limits the distortion of the § 106 exemption, it achieves this result in a very crude manner that leads to other concerns.

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ject to the tax over time. *Id.* (stating that health expenditure growth outstrips the rate of inflation).

[130] COMM. FOR A RESPONSIBLE FED. BUDGET, EVALUATING HEALTH CARE PLANS 8 (2009), *available at* http://crfb.org/sites/default/files/Evaluating_Health_Care_Plans.pdf.

[131] *Id.* at 9-10.

[132] *See* CBO Estimate, *supra* note 128, at 9-10.

[133] *See* 155 CONG. REC. H9390-06 (daily ed. Sept. 9, 2009) (statement of Pres. Obama). In a speech to a joint session of Congress, President Obama stated, "Now, much of the rest [of the cost of health care reform] would be paid for with revenues from the very same drug and insurance companies that stand to benefit from tens of millions of new customers. And this reform will charge insurance companies a fee for their most expensive policies, which will encourage them to provide greater value for the money—an idea which has the support of Democratic and Republican experts." *Id.*

[134] Steven Greenhouse, *Unions Rally to Oppose a Proposed Tax on Health Insurance*, N.Y. TIMES, Jan. 8, 2010, at B1. Unions oppose the tax, because they have often negotiated for increased health benefits at the expense of wage increases. *Id.*

[135] *Id.*

[136] *See* THE HENRY J. KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL 13 (June 2010) [hereinafter JUNE 2010 KAISER POLL], http://kff.org/kaiserpolls/upload/8082-T.pdf (showing that fifty-eight percent of the public supported the tax, while thirty-six percent opposed it); THE HENRY J. KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL 7 (Apr. 2009) [hereinafter APR. 2009 KAISER POLL], http://kff.org/kaiserpolls/upload/7891.pdf (revealing that fifty-two percent of the public opposed paying for health care reform via a change in ESI tax treatment). The numbers in opposition have fallen since passage. *Compare* APR. 2009 KAISER POLL, *supra*, at 7, *with* JUNE 2010 KAISER POLL, *supra*, at 13. It is unclear what caused this drop in opposition. The individual mandate has received more public ire. *Compare* APR. 2009 KAISER POLL, *supra*, at 4, *with* JUNE 2010 KAISER POLL, *supra*, at 13. Compared to other market reforms such as guaranteed issue, which poll in the high sixty-percent range, this tax is one of the least popular reforms. JUNE 2010 KAISER POLL, *supra*, at 12-13.

a. Vertical Equity

In its current form, the tax raises serious equity issues. The tax is levied mainly on insurance companies that either underwrite employer-based health plans or administer self-insured plans.[137] There is no requirement, however, that insurance companies pass the costs of the tax onto individuals who are covered by the particular plan that is being taxed. Imagine a situation where there are two firms, Pennywise and Lavish, which use the same health insurer. Pennywise has significantly lower benefits and a premium well below the cap, while the benefits Lavish provides exceed the cap. There is little preventing the insurer from paying the excise tax on Lavish's excess coverage through a premium increase on Pennywise. Pennywise's employees would then be paying a tax on the benefits enjoyed by Lavish's employees, which is not income to the workers at Pennywise. The insurance company's action violates the central notion in tax policy that income is defined as something of value over which the taxpayer exercises complete dominion or control.[138]

Inequity issues also arise even if employees are part of the same firm but have different incomes. If two employees, Jonah and Aaron, have significantly different incomes such that Jonah is in the top marginal rate of thirty-five percent before one adds in the value of the health plan, and Aaron is at the twenty-five percent rate after one adds in the premiums, they both pay the same tax of forty percent on the amount by which their ESI exceeds the cap.[139] The Cadillac Tax does not only apply to those in the top marginal rate, imposing a forty percent tax across the board.[140] The tax, then, creates a vertically regressive structure that may or may not be worse than the regressive nature of the current exclusion.

Although this particular scenario may not arise if a firm stops offering generous coverage, there may be instances where the flat rate makes employees worse off. If, as economists assume, most of the tax's economic incidence falls on the employee rather than on the insurance company,[141] the forty percent tax would discourage an additional dollar of insurance versus an additional dollar of cash wages. However, it may be the case that the additional insurance benefits are worth more to an employee than additional

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[137] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9001(a), 124 Stat. 119, 850, 853 (2010) (codified at I.R.C. §§ 4980I(c)(1)–4980I(c)(2) (West 2010)).

[138] *See supra* note 37 and accompanying text.

[139] Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. § 4980I(b)(3)(C)(iii) (West 2010)), *amended by* Health Care and Education Reconciliation Act § 1401(a)(2)(E) (codified at I.R.C. § 4980I(b)(3)(C)(v) (West 2010)).

[140] Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. § 4980I(b)(3)(C)(iii) (West 2010))), *modified by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1401(a)(2)(E), 124 Stat. 1029, 1060 (codified at I.R.C. § 4980I(b)(3)(C)(v) (West 2010)).

[141] Gruber, *supra* note 32, at 568; *see also* Jonathan Gruber & Michael Lettau, *How Elastic is the Firm's Demand for Insurance?* 88 J. Pub. Econ. 1273, 1291 (2004); Newhouse, *supra* note 47, at 1718.

cash compensation. This may be the case in a state that has high health care costs because the cost of living is high, or because the workforce has many sick employees. Rather than making the decision between additional cash wages and additional insurance neutral, the tax provides incentives for cash wages, from the employer's point of view, and an employee may end up worse off because of his need for better insurance. Thus, where other portions of the Code are progressive, the structure of a flat-rate tax generates genuine vertical equity concerns.

b. IRS Administration and Enforcement

Much of the impact of the change to treatment of ESI under the PPACA will depend, however, on regulations promulgated by Treasury and the IRS, as well as the effectiveness of enforcement activities and the amount of IRS resources allocated for enforcement. The enforcement activities of the IRS are currently limited. Generally, the IRS's budget is less than one percent of the total amount it collects, with forty percent of that money going towards enforcement activities.[142] Auditing of individual taxpayers has recently hovered around 1% of the budget, and for businesses it has been about 0.66% of the budget.[143] Therefore, voluntary compliance remains the first line of enforcement.[144]

Historically, the IRS's enforcement of health care provisions in the Code has left much to be desired. The IRS tends not to enforce or require reporting of the ESI exemptions' many complex rules.[145] Furthermore, even when the IRS has chosen to enforce health care provisions, there have been significant administrative costs. For example, the Health Coverage Tax Credit ("HCTC")[146] has an administrative expense of about twelve percent of the total program costs for benefits that flow to 45,000 individuals.[147] This administrative expense is much higher than the IRS's usual standard, and is necessitated by the HCTC's complex rules.[148]

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[142] Janet Holzblatt, *Health Reform through the Tax System*, *in* Using Taxes to Reform Health Insurance: Pitfalls and Promises 171, 173 (Henry J. Aaron & Leonard E. Burman eds., 2008).

[143] *Id.*

[144] *See id.*

[145] *Id.* at 176.

[146] The HCTC is a refundable tax credit that aims to make health insurance more affordable for workers receiving Trade Adjustment Assistance, Pension Benefit Guaranty Corporation payees, and their families by paying eighty percent of health insurance premiums. Internal Revenue Serv., *HCTC: Latest News and Background*, IRS.gov (Oct. 1, 2010), http://www.irs.gov/individuals/article/0,,id=109960,00.html.

[147] Holzblatt, *supra* note 142, at 176.

[148] *See* Mary B. H. Hevener & Charles K. Kerby III, *Administrative Issues: Challenges of the Current System*, *in* Using Taxes to Reform Health Insurance: Pitfalls and Promises 147, 152-53 (Henry J. Aaron & Leonard E. Burman eds., 2008) (explaining the HCTC's complex eligibility rules).

Under the PPACA, a current administrative concern involves the requirements that the IRS calculate age and gender distributions[149] and make the determination of who fits the high-risk employee categories.[150] In order to make these determinations, the IRS must correctly assign premium values to each firm based on the insurance it provides. Then, it must calculate the age and gender distribution for each employer relative to the general workforce and adjust those caps.[151] Finally, the IRS will need to adjust the caps individually for each employee that is in one of the special categories.[152] Unfortunately, as the IRS's track record with the HCTC suggests, the agency may not have the capacity to implement these adjustments.[153]

c. Efficiency and Cost Containment

Furthermore, even with adjustments, the Cadillac Tax may not effectively address the problem of cost containment in the health care system. A significant reason for health-related cost growth seems to be the overutilization of high-cost procedures at high-cost providers.[154] Researchers have had difficulty explaining variations in health-care premiums.[155] A recent study that analyzed the effect of actuarial value, firm characteristics, plan characteristics, and market characteristics on premiums was only able to explain

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[149] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9001(a), 124 Stat. 119, 848 (codified at I.R.C. § 4980I(b)(3)(C)(iv) (West 2010)), *modified by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1401(a)(2)(D), 124 Stat. 1029, 1060 (codified at I.R.C. § 4980I(b)(3)(C)(iv)) (outlining the treatment of high-risk individuals).

[150] § 1401(a)(2)(C), 124 Stat. at 1059-60 (codified at I.R.C. § 4980I(b)(3)(C)(iii) (West 2010)) (regarding age and gender adjustments and the complex methods for looking at distributions across the population).

[151] § 1401(a)(2)(C), 124 Stat. at 1059-60 (codified at I.R.C. § 4980I(b)(3)(C)(iii) (West 2010)).

[152] Patient Protection and Affordable Care Act § 9001(a) (codified at I.R.C. § 4980I(b)(3)(C)(iv) (West 2010)), *modified by* Health Care and Education Reconciliation Act of 2010 § 1401(a)(2)(D); § 1401(a)(2)(C), 124 Stat. at 1059-60 (codified at I.R.C. §4980I(b)(3)(C)(iii) (West 2010)).

[153] *See* Hevener & Kerby, *supra* note 148, at 156-57 (noting the reporting requirements and the very low enrollment rate in the HCTC program); Holtzblatt, *supra* note 142, at 176 (detailing the capacity problems the IRS has had in implementing the HCTC and how the IRS created a separate office for the implementation of the HCTC).

[154] *See* Elliot Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERN. MED. 288, 293-94 (2003) (stating that increased utilization leads to higher Medicare costs); Katherine Baicker & Amitabh Chandra, *Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care*, HEALTH AFF. WEB EXCLUSIVE, Apr. 7, 2004, at W4-184, W4-187-88, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.184v1 (stating that more specialists lead to higher utilization and costs). *But see* Michael E. Chernew et al., *Geographic Correlation Between Large-Firm Commercial Spending and Medicare Spending*, 16 AM. J. MANAGED CARE 131, 134-37 (2010) (stating that Medicare and private insurance costs do not always correlate, and that the reason for this difference stems from the pricing schemes of private insurers rather than from utilization, while noting that high utilization at high-cost providers can still lead to excess spending).

[155] *See, e.g.,* Gabel et al., *supra* note 106, at 179-80.

about 15.5% of premium variations based on these variables.[156] Thus, differences in health-care benefits may only weakly explain differences in premiums paid by employees. Moreover, higher spending or higher premiums may not always stem from increased utilization.[157] Many of these variations, then, likely stem from the actual price of services. Even if utilization rates and benefits offered are lowered as a result of the Cadillac Tax, already high costs for services may continue to rise. If the ESI exemption encourages overconsumption, instituting a cap on the exemption would not target the actual price of services, and would not effectively limit health care spending.

4. Overall Evaluation of the PPACA

Sadly, the PPACA is not the most effective way to implement a limitation on the § 106 exclusion. The tax handles the matter circuitously by focusing on premiums rather than on the value that people actually receive from a health plan. In addition, it introduces significant equity concerns. Finally, its political and efficiency gains are questionable.

The primary goal of the tax, however, is not to control costs or address inequities. Rather, it seems that the primary purpose of the tax is to raise revenue.[158] The Obama administration demanded that health care reform be revenue neutral, and the revenue that the tax provides was necessary to achieve this goal.[159] Accomplishing any additional policy goals is the proverbial icing on the cake.

Moreover, by implementing a tax on employer-sponsored insurance for the first time, the bill opens the door for further discussion and refinement of this issue. In many ways, the PPACA's treatment of ESI represents a first crack at addressing the problem of the ESI exemption. The possibility exists that this excise-tax system will become permanent. Nevertheless, by taxing ESI for the first time, it has begun a debate that will hopefully provide the opportunity to address concerns in future tweaks of the health reform law or in a further revision of the Internal Revenue Code.

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[156] *Id.* at 178.

[157] *See* Chernew et al., *supra* note 154, at 134-37 (stating that Medicare and private insurance spending are not correlated); *see also* OFFICE OF THE MASS. ATTORNEY GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. 118G, § 6½(b): REPORT FOR ANNUAL PUBLIC HEARING 3-4 (2010), *available at* http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf (stating that the main correlative driver of health care prices is the relative market position of a provider).

[158] *See* 155 CONG. REC. H9390-06 (daily ed. Sept. 9, 2009) (statement of Pres. Obama). In a speech to a joint session of Congress, President Obama stated, "I will not sign a plan that adds one dime to our deficits—either now or in the future. Period." *Id.*

[159] *Id.*

B. Adjusted Premium-Based Valuation

1. The Plan

An alternative to the excise tax is to use an adjusted premium valuation to better address some of the efficiency and equity concerns of the PPACA tax. One such plan has been proposed by Paul Van de Water, a health care analyst at the Center for Budget and Policy Priorities ("CBPP"), a liberal think-tank.[160] Under this plan, employers would report the per-employee average premium they pay for each employee as a wage on the employee's W-2 form.[161] If the value exceeds a certain amount, any premium costs above the cap would be treated as wage income and taxed at the ordinary rate.[162] The cap would grow over time based on some index.[163]

The CBPP plan suggests indexing the cap to the medical care component of the CPI, the CPI subpart for medical spending, which rises faster than the CPI-U and would tighten the cap less quickly and better preserve ESI.[164] Because the cap would tighten less quickly under the index based on the medical CPI, individuals would be more willing to keep their employer-sponsored insurance rather than leave it for the individual market, thereby better preserving ESI.

Although the most difficult problem with this approach would seem to be the premium valuation of self-insured plans, under current law there is a way to impute the value of these premiums. Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), former employees are entitled to remain on ESI after leaving their employer if they pay the full premium on their own.[165] COBRA provides rules for the imputation of a premium, and an employer can then charge a two percent administrative charge above that amount to a departing employee.[166] CBPP's proposal would use the annual COBRA rate for self-insured employers and exclude the additional two percent cost to arrive at the reported premium on an employee's W-2.[167]

Additionally, the proposal would eliminate other tax preferences such as § 125 Cafeteria Plan provisions.[168] It would also eliminate tax preferences

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[160] Paul N. Van de Water, Ctr. on Budget and Policy Priorities, Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform: Universal Coverage May Be Out of Reach Otherwise (2009), *available at* http://www.cbpp.org/files/6-2-09health.pdf.

[161] *Id.* at 5.

[162] *Id.*

[163] *Id.* at 8.

[164] *See id.* at 8. Some have proposed indexing to the normal CPI, while others have suggested using the average growth of premiums as an index. *Id.* For the rest of this Note, the assumed method for indexing the adjusted premium approach is based on the CPI for medical expenditures.

[165] I.R.C. § 4980B(f) (Supp. 2009).

[166] *Id.*

[167] Van de Water, *supra* note 160, at 5-6.

[168] *Id.* at 7.

for Health Reimbursement Arrangements ("HRAs") and HSAs.[169] It implements these changes to maintain consistency of treatment within the tax code between these forms of ESI and other more traditional forms of ESI.[170]

The CBPP proposal also seeks to prevent inequitable treatment of high-cost groups whose high cost is based on geography and health status. It does this by directing Treasury and the IRS to develop a set of geographic and age-based factors to adjust premium amounts when determining the taxable premium value.[171] It suggests that the tax agencies work to develop these adjustments on the recommendations and data provided by health agencies.[172]

2. *Benefits*

The real benefit of the proposal is its continued reliance on premiums, which makes it intuitively easier to understand than other valuation methods, such as the actuarial value method outlined below.[173] Unlike actuarial value plans, premium caps likely would not require vast datasets and assumptions related to the covered population.[174] Such a plan would not require separate valuations for every ESI plan offered by an insurer or separate actuarial calculations for self-insured plans.[175] Instead, it would require that insurers and self-insured employers use premium adjustment formulas for age and geographic differences.[176]

CBPP avoids the problem of having the IRS and Treasury develop complicated health care valuation mechanisms by allowing them to rely on agencies that have expertise in health policy to implement the changes.[177] Rather than completely delegating the authority to determine these factors to the IRS and Treasury, the plan requires that they work in conjunction with health agencies that have greater capacity to recognize and calculate adjustment factors for health insurance premiums.[178] The proposal would also base its

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[169] *Id.* Health Reimbursement Arrangements are accounts where employer-paid contributions can be used to pay for medical expenses by participating employees. I.R.S. Publ'n 969, *supra* note 122, at 17.

[170] *Id.*

[171] *Id.* at 6-7.

[172] *Id.* at 7. The proposal suggests using data such as the Insurance Component of the Medical Expenditure Panel Survey, Medicare enrollment and claims data, or enrollment and claims data for plans in health insurance exchanges. *Id.* Data like this shows how premiums vary based on claims, geographic region, and other characteristics.

[173] *See infra* Part V.C.

[174] *See* Van de Water, *supra* note 160, at 9 (stating that the actuarial approach would be much more difficult to implement); *see also* Am. Acad. of Actuaries, Critical Issues in Health Reform: Actuarial Equivalence 1 (2009) [hereinafter Actuarial Equivalence], *available at* http://www.actuary.org/pdf/health/equivalence_may09.pdf.

[175] Van de Water, *supra* note 160, at 9.

[176] *Id.* at 6-7.

[177] *Id*. at 7 (recommending HHS or another health agency be involved in developing valuation tools).

[178] *Id.*

rules and calculations on many health data sources that HHS agencies currently create and use.[179] Thus, the IRS would not need to develop additional capacity and expertise to write the regulations. HHS could help devise the formulas and the IRS could focus its resources on applying the formulas and enforcing the regulations. This proposal may therefore be easier to implement than the current ESI exemption under the PPACA.

3. Drawbacks

On first glance, the administrative concerns with this plan do not seem to be much greater than those associated with the Cadillac Tax. However, the CBPP proposal's attempts to address some of the equity and efficiency concerns raised by the PPACA actually make the CBPP plan far more complicated.

However, notwithstanding the sensible allocation of agency resources and expertise envisioned by this plan, the prospect of cross-agency administration raises significant concerns. Indeed, public management studies have found that effective cross-agency work requires additional investments, which agencies often do not want to make.[180] Agencies require some separate interagency collaborative capacity to realize potential gains across their boundaries.[181] This capacity is often lacking and requires dedicated funding that often is not forthcoming to become a reality.[182]

Furthermore, the Internal Revenue Code itself limits its ability to share information with the public and other agencies.[183] Agencies may also have different technological systems with little interoperability, which makes even authorized information sharing difficult.[184] In addition, there is often a lag between when agencies receive information and when they can act upon it, and sharing information may compound such a lag.[185] Coordination also

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[179] *Id.*

[180] *See generally* EUGENE BARDACH, GETTING AGENCIES TO WORK TOGETHER: THE PRACTICE AND THEORY OF MANAGERIAL CRAFTSMANSHIP 11-13, 17-18 (1998) (describing what Bardach calls the pluralism problem, where specialization, federalism, budget, and statutory mandates all work to frustrate effective collaboration and coordination across agencies). Bardach's work is perhaps one of the best sources for describing how to create interagency capacity for coordination and provides a number of case studies on successful and unsuccessful interagency coordination.

[181] *Id.* at 19-23 (describing the concept of interagency collaborative capacity).

[182] *See generally id.* at 163-64 (discussing how interagency collaboration requires additional resources and noting that partner agencies often do not want to contribute resources to building this capacity).

[183] I.R.C. § 6103 (West 2010).

[184] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-05-1051T, COMPUTER-BASED PATIENT RECORDS: VA AND DOD MADE PROGRESS, BUT MUCH WORK REMAINS TO FULLY SHARE MEDICAL INFORMATION 1 (2005), *available at* http://www.gao.gov/new.items/d0510 51t.pdf (detailing how the Departments of Veterans Affairs and Defense have had difficulty getting their computer systems to work together, even after many years of collaboration).

[185] For example, the IRS's taxable year is the calendar year, but individuals file their taxes on April 15 of the following year, creating an information delay of more than a quarter of a

requires working through cultural differences and different missions to achieve a common goal.[186]

Finally, it is often unclear who in Congress is charged with overseeing these interagency activities. Health care oversight is already spread out amongst various committees, including the key tax committees.[187] It would not be unreasonable for a number of committees to claim jurisdictional control and oversight, leading to issues such as the duplication of efforts and multiple hearings on the same topic.[188]

None of these coordination problems is insurmountable. However, they raise some concerns as to whether the purported gains in administrative simplicity may be outweighed by the need to develop interagency coordinating capacity.

4. *Overall Evaluation of Premium-Based Valuation*

Once again, given the difficulties outlined above, if the main goal of capping the exclusion is to shift economic incentives toward a more efficient outcome, this method does some of the work, but it has significant shortcomings. As such, it is—like the Cadillac Tax—only a second-best solution.

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year. *Tax Topics—Topic 301 When, Where, and How to File,* IRS.GOV, http://www.irs.gov/taxtopics/tc301.html (last visited Nov. 2, 2010).

[186] *See generally* BARDACH, *supra* note 180, at 232-68 (describing the cultural problems needing to be overcome and how different bureaucratic structures and cultures are not conducive to interagency collaboration).

[187] *See* CLERK OF THE HOUSE OF REP., 111TH CONG., RULES OF THE HOUSE OF REPRESENTATIVES 6-16 R. X (2009) [hereinafter HOUSE RULES], *available at* http://www.rules.house.gov/ruleprec/111th.pdf (enumerating House committees and their legislative jurisdictions); S. COMM. ON RULES & ADMINISTRATION, 111TH CONG., RULES OF THE SENATE R. XXV (2010) [hereinafter SENATE RULES], *available at* http://rules.senate.gov/public/index.cfm?p=RulesOfSenateHome. In the House, the Committees on Energy and Commerce, Ways and Means, and Education and the Workforce can all claim jurisdiction over health matters. *See* HOUSE RULES, *supra*. In the Senate, the Committee on Finance or the Committee on Health, Education, Labor, and Pensions ("HELP") could have jurisdiction. *See* SENATE RULES, *supra*.

[188] For example, in 2009, the Medicare Payment Advisory Commission ("MedPAC"), a Congressional agency tasked with giving recommendations to Congress for Medicare Payment matters, delivered testimony before the House Committees on Energy and Commerce and Ways and Means. *Compare Hearing on Making Health Care Work for American Families: Designing a High Performing Healthcare System Before the H. Comm. on Energy and Commerce*, 111th Cong. 1 (2009) (statement of Glenn Hackbarth, Chairman, Medicare Payment Advisory Commission), *available at* http://energycommerce.house.gov/Press_111/20090310/testimony_hackbarth.pdf, *with Hearing on Health Reform in the 21st Century: Reforming the Health Care Delivery System Before the H. Comm. on Ways and Means*, 111th Cong. 1 (2009) (statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission), *available at* http://waysandmeans.house.gov/media/pdf/111/glenn.pdf.
Aside from differences in layout, the two testimonies are substantively the same. This dual response by MedPAC is indicative of the dual jurisdiction of the two committees over Medicare policy more generally. The extreme case of multiple committee oversight is the Department of Homeland Security, which is overseen by some 108 Committees and Subcommittees in both houses of Congress. NPR Staff, *Who Oversees Homeland Security? Um, Who Doesn't*, NATIONAL PUBLIC RADIO (July 20, 2010), http://www.npr.org/templates/story/story.php?storyId=128642876?.

Splitting up the requirements for regulation and enforcement amongst agencies on various tax and health care issues according to their individual areas of expertise would address the concern that the plan could result in greater administrative complexity than the IRS could handle. However, the IRS's record on coordination with other agencies is relatively poor.[189] HHS sub-agencies have also had problems coordinating with the IRS on enforcement actions regarding Medicare providers who do not pay their federal taxes.[190] These two histories do not bode well for an interagency coordinating and information-sharing effort. Unless further progress is made, some of the gains in ease of administration could disappear given this coordination problem.

C. Actuarial Values

1. The Plan

The third approach to taxing ESI would likely be the most effective because it directly measures the generosity of health care benefits. Actuarial equivalence measures "the dollar value of average expected benefits paid out by [a] plan or the average share of total health spending that is paid for by the plan."[191] Actuarial equivalence valuation is employed to estimate how much an insurance plan pays for each enrolled patient in the plan in order to measure the dollar value of the benefits that are used by the plan.[192] However, the measurements of the expected benefits paid by the plan can differ based on the types of data available and on the assumptions used in the calculations, so approaches can vary.[193] Inevitably, the method is a game of estimation.[194]

The main proponent of the actuarial valuation approach is Stan Dorn, a senior fellow at the Urban Institute. Dorn recommends that the IRS establish separate caps for adults and dependent children based on the actuarial value of their ESI benefits.[195] The caps would be established at the seventy-fifth

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[189] *See, e.g.*, U.S. Gov't Accountability Office, GAO-03-821, Taxpayer Information: Increased Sharing and Verifying of Information Could Improve Education's Award Decisions 1 (2003), *available at* http://www.gao.gov/new.items/d03821.pdf (detailing ways in which the IRS must improve its coordination and information sharing with the Department of Education with respect to efforts to verify student loan application information, and providing an example of constraints on IRS information sharing).

[190] *See generally* U.S. Gov't Accountability Office, GAO-08-618, Medicare: Thousands of Medicare Providers Abuse the Federal Tax System (2008), *available at* http://www.gao.gov/new.items/d08618.pdf (showing how the Centers for Medicare and Medicaid Services ("CMS"), an HHS sub-agency, and its contractors often do not work with the IRS to use its powers to collect taxes from Medicare providers who are in arrears).

[191] Actuarial Equivalence, *supra* note 174, at 1.

[192] *Id.*

[193] *Id.* at 4.

[194] *Id.*

[195] Dorn, *supra* note 109, at 10.

percentile of the premium charge, and they are indexed to the CPI-U, which historically grows more slowly than the rate of medical expenditures, thus reducing benefit generosity as more plans are taxed.[196] Workers would receive information on the actuarial benefit they receive on W-2 forms and pay taxes on any amount above the cap.[197]

Determining the actuarial value of a health plan is the major difficulty with Dorn's approach. Dorn proposes that the IRS specify parameters and assumptions for the purpose of creating a nationally representative population.[198] Insurers would then use these formulas to determine the actuarial value for each product they sell to a firm. This value would remain proportional regardless of firm size and characteristics,[199] because actuarial values depend only on the average expected benefits the plan pays or the average total share of health spending paid for by the plan.[200] Firms could then use the insurer's certification to determine the amount that is reported on the employees' W-2 as wages.[201]

2. Benefits

Perhaps the greatest benefit of the Dorn plan stems from the fact that it most closely addresses the issues of efficiency and equitability in the distribution of benefits. Unlike a flat premium cap, actuarial value limits the problem of geographic differences among premiums. Premiums generally vary significantly based on geography.[202] Many of these variations arise because of geographic-specific costs, but other factors can affect premium differences, such as state rating of plans, reserve rules, and demographic characteristics of local populations.[203] Suppose, for example, that Audrey and Adrienne live in two different states. Their plans have similar levels of cost sharing and cover most of the same procedures. Further, assume that the costs of providing care in terms of the per-unit price are the same in the two states. However, suppose that Audrey's state requires insurance companies to

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[196] *Id.* In other words, employers may stop offering plans that exceed the cap to avoid having to pay the taxes.

[197] *Id.* Dorn proposes that the full value be posted on the W-2, not just the amount subject to taxes, which would provide employees a sense of exactly how much they are receiving from their coverage. *Id.*

[198] *Id.*

[199] *Id.*

[200] Actuarial Equivalence, *supra* note 174, at 1; *see also* Dorn, *supra* note 109, at 2 (stating that actuarial equivalence does not capture selection, networks, negotiated prices, utilization management programs, profit margins, or administrative costs, all of which are included in premiums).

[201] Dorn, *supra* note 109, at 10.

[202] *See id.* at 2-4 (explaining how premiums vary because of geographic differences in health care costs).

[203] *See id.* (listing factors other than health care costs that can have a major impact on health premiums); *see also* Gabel et al., *supra* note 97, at 179-80 (showing how premiums cannot be fully explained based on actuarial equivalence, i.e. the expected benefits the plans pay out).

hold large reserves, whereas Adrienne's state does not. As a result, Audrey's premiums would be much higher than Adrienne's, because the insurer has to have more cash on hand in Audrey's state. Therefore, if a tax were based on the premium value, Audrey would have a higher tax. Actuarial valuation would control for these geographic variations.

Furthermore, a plan based on actuarial valuation would not tax at different rates based on firm size, health status, or age distribution.[204] Thus, it follows that actuarial values do not vary based on firm size, since actuarial values focus on the benefit paid out. One would not see differences related to firm size based on the fact that the administrative costs of insuring a small firm are much higher than the administrative costs of insuring a large firm.[205] The same goes for differences in health status and age distribution.[206] Imagine two firms: Sick, Co., with a sicker population, and Health, Co., with a healthier population. As Dorn explains, since insurers can charge different premiums based on health characteristics, and since the employees of Sick, Co. would use more health care, Sick, Co. and Health, Co. could have the same benefit package, but different premiums.[207] Dorn recognizes that this problem is at the heart of the insurance valuation process, and, by focusing on actuarial values, he attempts to get as close as possible to what people actually both control and receive benefit from: the insurance benefits.

The actuarial methodology provides other major efficiency gains. Even though some aspects of geographic variation are limited, the cap attacks the main efficiency concern arising out of an ESI exemption: generous benefits that are tax preferred, leading to over-insurance and the overutilization of health care. Economists and other commentators have argued that individuals overconsume health care,[208] as a result of overly generous health insurance stemming from the subsidization of ESI through the § 106 exemption.[209] Unlike other approaches to valuing insurance and capping the exemption, the actuarial value approach tries to get closer to directly measuring the benefit of a health plan rather than its premium.[210] Thus, the actuarial value approach may help contain costs by containing utilization without introducing major equity problems.

Another benefit of the actuarial value proposal is that it requires the listing of the actual value of the health care consumed on W-2 forms,

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[204] Dorn, *supra* note 109, at 4.

[205] *Id.*

[206] *Id.*

[207] *Id.*

[208] Baicker & Chandra, *supra* note 154, at W4-187-88; *see also* Fisher et al., *supra* note 154, at 293-94 (stating that increased Medicare spending and utilization does not lead to improved health outcomes, reduced mortality, or greater patient satisfaction); *see also* Atul Gawande, *The Cost Conundrum*, New Yorker, June 1, 2009, at 36, 38-39.

[209] *See, e.g.*, Gruber, *supra* note 32, at 425-26 (explaining how the tax exclusion makes it easier to overpurchase care); *id.* at 440-42 (showing how the tax exclusion leads to the highly generous benefits most insured Americans under ESI receive).

[210] Dorn, *supra* note 109, at 4.

thereby creating a greater level of transparency.[211] Reporting might make employees more aware of the fact that they are getting health care benefits in lieu of wages.[212] It helps individuals realize that these benefits do not come freely. Such a move, then, could also increase pressure to limit health benefits and shift toward increases in cash wage, or at least to assist employees in making fully informed decisions as to their desired form of compensation.

3. *Administration: Benefits and Drawbacks*

The actuarial plan also has some positive effects related to administration. First, actuarial valuation is currently used by the Centers for Medicare and Medicaid Services ("CMS") in determining the value of alternative prescription drug packages under Part D of Medicare.[213] The approach is therefore not a foreign concept to health plan administration at the federal level. CMS also uses actuarial value in the administration of the Children's Health Insurance Program ("CHIP").[214]

Since actuarial value can vary across populations,[215] Dorn's plan delegates to the IRS the responsibility for determining the nationally representative populations and to determine the datasets and assumptions that would underlie the valuation.[216] The IRS, in particular, has some prior experience with actuarial value calculation. Currently, under I.R.C. § 79(c), Treasury writes regulations to impute the value of employer-sponsored group-term life insurance benefits as taxable income "on the basis of uniform premiums (computed on the basis of 5-year age brackets)."[217] The regulations then prescribe a basis for imputing actuarial value based on the generosity of benefits, age, the amount employees contributed to coverage, and the number of months during the year that a worker is employed. If the value exceeds $50,000 per year, it is considered taxable income.[218] Here, as in application of the actuarial model to ESI taxation, it is not the cost to the employer that is taxed, but rather the benefit level.[219] Therefore, the IRS has some experience in using actuarial benefit formulas and developing regulations along these lines.

However, Dorn's plan does not effectively address a number of administrative concerns that the actuarial valuation approach creates. The IRS would need to not only develop the assumptions necessary to create a methodology of actuarial valuation, but also enforce and audit reports from insur-

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[211] *Id.* at 15.
[212] Liebman & Zeckhauser, *supra* note 60, at 242.
[213] Dorn, *supra* note 109, at 7-8. Dorn explains in greater detail how actuarial benefits work in the context of Medicare Part D coverage of prescription drugs. *Id.* at 7.
[214] *Id.* at 6.
[215] Actuarial Equivalence, *supra* note 174, at 1.
[216] Dorn, *supra* note 109, at 10.
[217] I.R.C. § 79(c) (2006); *see also* Dorn, *supra* note 109, at 8.
[218] Dorn, *supra* note 109, at 8; *see also* 26 C.F.R. § 1.79-1(d)-(f) (2010).
[219] Dorn, *supra* note 109, at 8.

ance companies and employers. While the IRS does have some experience in the life insurance sector, most of the institutional competency in developing and managing actuarial value for health insurance lies within HHS, and more specifically, within CMS.[220]

Dorn believes that some of the IRS's competency related to group life insurance could apply to health insurance.[221] However, life insurance is a very different form of health insurance. Unlike life insurance, which has a fixed amount paid out upon the death of an individual, health insurance has a greater level of variability, and outlier effects can create greater variation.[222] The imputation of the actuarial value of life insurance benefits are calculated only by age, the amount paid upon death, the amount the employee contributes, and the number of months during the year that the worker was enrolled.[223] Health insurance calculations would likely be much more complex.[224]

The additional complexity requires greater capacity to write these regulations, which both the IRS and Treasury currently lack.[225] While overcoming the problem of institutional capacity is not insurmountable, it is questionable whether Congress would provide the additional funding to develop the agency capabilities required for the IRS to implement an actuarial value methodology.[226] Given some of the political difficulties associated with funding health care reform, acquiring additional funding will likely not be easy.[227] However, without this level of competence within the agencies, they will fail to make the valuation method operational.

This lack of capacity has been made evident in the past, such as when both Treasury and the IRS attempted to implement § 89 of the Tax Reform Act of 1986.[228] The section attempted to limit the discriminatory effect of providing CEOs and other highly compensated employees with extra tax-preferred benefits such as health insurance.[229] These benefits were valued based on actuarial valuation methods, and the section lasted only from 1986

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[220] *See id.* at 6-8.

[221] *Id.*

[222] *Compare* DORN, *supra* note 109, at 6-8, *with* ACTUARIAL EQUIVALENCE, *supra* note 174, at 1.

[223] DORN, *supra* note 109, at 8.

[224] ACTUARIAL EQUIVALENCE, *supra* note 174, at 1 (examining and assessing cost-sharing features like deductibles, copayments, coinsurance, cost sharing by service type, benefit limits, and out-of-pocket limits).

[225] *See supra* Part V.A.3.b.

[226] *See* Robert Pear, *GOP Plans to Use Purse Strings to Fight Health Law*, N.Y. TIMES, Nov. 6, 2010, at A1 (noting that Republicans, who will take control of the House of Representatives in January 2011, will try to limit the number of officials at the IRS to enforce the new law, particularly the individual mandate provisions).

[227] *See* STARR, *supra* note 3, at 334.

[228] Tax Reform Act of 1986, Pub. L. No. 99-514, § 1151, 100 Stat. 2085, 2494 (codified at I.R.C. § 89 (1986)), *repealed by* Pub. L. No. 101-140, § 202(a), 103 Stat. 830, 830 (1989).

[229] DORN, *supra* note 109, at 21 n.14.

to 1989.[230] However, both the IRS and Treasury were unable to formally promulgate rules within three years of the section's enactment, and the limited guidance developed was "universally criticized."[231] Thereafter, in 1989, Congress repealed the section. The incident revealed the inability of the agencies to develop rules related to actuarial value.[232]

The actuarial value method might also be difficult to enforce. Enforcement usually begins with self-reporting.[233] Dorn points out that insurance companies and self-insured employers who offer innovative benefit designs already have existing actuarial capacity to generate actuarial reports.[234] Therefore, while self-reporting costs may be higher than under a premium cap due to the added complexity, such reporting is probably not impossible.[235] He further argues that the application of such methods is fairly formulaic for standard benefit plans.[236]

However, the question of the actual costs of actuarial reporting is uncertain. First, as some critics point out, the formulas and guidance provided by the IRS may ultimately be muddled.[237] Second, the IRS is often slow to implement such statutes and regulations requiring information reporting, and, even after implementation, it can take roughly a year before information is actually examined and processed.[238] Solving the issue of delay requires providing these agencies with the capacity and political support to write regulations that do not prove onerous for both health insurers and self-insured employers.

A further administrative concern arises in the context of self-insured employers. Most could follow the formula, but if there were innovative benefit designs involved, such as efforts to encourage wellness, the firms would have to have a custom actuarial valuation.[239] However, according to Dorn, many self-insured employers already make these calculations, since they must determine the costs of health spending.[240] To prevent gaming, in making customized calculations, the IRS could employ safeguards that are used for actuarial calculations made under the Medicare Part D alternative pre-

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[230] *Id*. Dorn states that the actuarial value seemed to be rather straightforward for employers to calculate and explains that other administrative issues led to the repeal of the tax. *Id.*

[231] Hevener & Kerby, *supra* note 148, at 152-53.

[232] *See id.*

[233] Graetz & Schenck, *supra* note 24, at 78 (stating that taxpayers make the initial determination of their tax liability under our self-assessment system).

[234] Dorn, *supra* note 109, at 10.

[235] *Id.*

[236] *Id.*; *see also id.* at 21 n.14 (stating that the problem with the infamous § 89 was actually quite simple and could have been solved with clear guidelines).

[237] *See* Hevener & Kerby, *supra* note 148, at 157-58.

[238] *See id.* at 164, 170 n.41.

[239] Dorn, *supra* note 109, at 10. A customized actuarial valuation means that self-insurers would need to hire an actuary to develop a valid methodology to come up with an actuarial valuation. Dorn argues that such a requirement is not difficult to implement, because plans with innovative designs already require calculations similar to finding an actuarial equivalence valuation. *Id.*

[240] *Id.*

scription drug packages, which include: (1) a ten-year record retention requirement by the actuary as well as certification; (2) liability of an actuary that falsely attests to such value under the Federal False Claims Act; (3) certification of the actuary as a member of the American Academy of Actuaries.[241]

Overall, there are significant administrative concerns with an actuarial value cap on insurance. None are insurmountable, but all require that Treasury and the IRS have sufficient resources to tackle the problem.

4. Overall Evaluation of Actuarial Equivalence

Despite the concerns just described, the use of actuarial value remains the best of the foregoing options for handling the taxation of ESI. However, the administration of this proposal would not be easy, and it would require political actors in Congress and the Obama administration to make a strong commitment to providing the additional capacity that the IRS and Treasury need to implement such a cap.

The key question to ask, then, is whether the additional administrative cost investments are worth the benefits the plan provides in terms of equity and efficiency. The actuarial valuation approach reaches a much better level of equity than the other plans detailed in this Note. On a vertical equity level, the approach limits the subsidization that produces a regressive result under the progressive rate structure. The two other plans achieve something similar at almost equal levels. Actuarial valuation, however, has its real strength in terms of horizontal equity. Here, taxpayers with similar benefits and income are more likely to achieve the same tax incidence. Actuarial valuation is best positioned to ensure that people with similar plan benefits, income levels, and health care consumed in a high-cost state like New York and a low-cost state like Minnesota are taxed at the same level. Therefore, if one of the goals is to correct the problems of horizontal and vertical inequity inherent in the current Code structure, then actuarial valuation seems to be the best approach. However, as Dorn points out, explaining how this method works and the meaning of the numbers people may start to see on their W-2 form is quite complicated.[242]

The actuarial value method would also encourage lower utilization, because actuarial value depends on benefits consumed, meaning that to keep a plan within the cap one would have to lower the generosity of a plan's benefits, which in turn, under the economic theory outlined above, would lead to a reduction in health care consumption. The plan therefore wins on the cost containment front because rather than targeting premiums, it aims closer to the root of the problem: overly generous benefits.

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[241] *Id.* at 8, 10-11.
[242] *Id.* at 11.

However, if the first-order policy goal is to raise revenue, then the question of implementing Dorn's actuarial valuation proposal requires some additional thought. As noted above, the main reason for the Cadillac Tax was to maintain budget neutrality while funding the expansion of health insurance coverage.[243] However, although the PPACA does provide for many changes to Medicare and Medicaid and encourages pilot projects to control costs, the main goal of the legislation was never cost containment, but rather reform of the market and expansion of coverage.[244]

Ultimately, as noted above, the tax does not take effect until 2018, so Congress has time to act and make any changes to the PPACA that appear necessary. Even then, because of the high level of the cap, the tax may not affect many taxpayers. This gives Congress an opportunity to revisit the approach the PPACA takes. The benefits of the actuarial approach may also become more noteworthy as information from cost containment pilot projects is received by agencies and Congress and cost containment is considered more completely. These changes could even appear in a future tax reform measure. Finally, the fact that the proposal would better level the playing field makes it easier to sell, since the already unpalatable idea of taxing ESI has been introduced.

VI. Conclusion

The taxation of ESI has two positive effects: it increases economic efficiency, and it enhances equity. Yet this policy is not without its pitfalls. This Note has attempted to show the tradeoffs between economic gains and administration and has highlighted just how complex the tradeoffs can be.

Overall, the best approach to taxing ESI likely lies in instituting a system of actuarial valuation of health plan benefits, rather than relying on premiums. As shown, taxing premiums does not effectively capture the efficiency gains that can be achieved by limiting the overutilization of health care services through a cap on the ESI exemption. The premium methods also fail to effectively address the equity problems associated with individuals being charged different premiums while receiving the same underlying benefits.

Furthermore, premium valuation, while administratively simple and more intuitive on its face, becomes quite complex when one tries to reach the goal of a more equitable valuation method. Adjustments to the premium valuation method move toward greater equity and address the problem of overutilization, but quickly become increasingly complex.

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[243] *See supra* note 159 and accompanying text.

[244] *See supra* note 133 (emphasizing coverage expansion rather than cost-containment); Atul Gawande, *Testing, Testing*, New Yorker, Dec. 14, 2009, at 34 (stating that cost control provisions are limited to pilot programs). Gawande further explains that the thrust of health care reform is coverage, which is easier to accomplish in a legislative action, while delivery system reform to control costs remains more of a management problem. *Id.* at 37.

Nevertheless, the actuarial valuation method would have its own administrative difficulties. First, the approach is complicated. Second, it requires calculations that fall outside of the general mission and competency of the IRS. Third, it is unlikely that interagency coordinating capacity currently exists or will exist to address these difficulties effectively. Policymakers and those interested in pursuing a better system of valuation should consider these costs and try to address such tax administration concerns.

Finally, while the Note suggests that actuarial valuation is the best policy to pursue before the tax is imposed in 2018, the ultimate determination of the right policy depends on policymakers' primary motivations. Effective administration is a fundamental feature of basic implementation and management. In order to achieve a policy that works and makes sense we need to understand clearly the tradeoffs between an easy-to-administer system on the one hand and a system that promotes efficient outcomes and comports with our notions of equity. It also requires us, as a society, to engage in a sustained dialogue regarding what we want to achieve by taxing ESI. If the goal is merely raising revenue, concerns related to equity, efficiency, and administration are of little consequence. However, if we decide that we want to promote values of equity, which is a key goal of health insurance reform, perhaps we need to become more willing to examine other avenues.

The PPACA is already law. Yet, the provisions in the statute related to the Cadillac Tax do not go into effect until 2018, some years into the future. With the basic structure more or less in place, the time is ripe to have a dialogue about refining the policy tools that the law puts into place to better reflect our policy goals and values—a dialogue that should begin with a serious discussion of the valuation method in the Cadillac Tax provision.