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Two Federally Subsidized Health Insurance Programs Are One Too Many: Reconsidering the Federal Income Tax Exclusion for Employer-Provided Health Insurance in Light of the Patient Protection and Affordable Care Act

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TWO FEDERALLY SUBSIDIZED HEALTH INSURANCE PROGRAMS ARE ONE TOO MANY: RECONSIDERING THE FEDERAL INCOME TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE IN LIGHT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Abstract: Section 106 of the Internal Revenue Code (I.R.C.) provides a federal income tax exclusion for the value of employer-provided health insurance. This decades-old provision was enacted for the primary purpose of increasing the incidence of health insurance in the United States. Since its adoption, scholars have advanced a number of additional policy considerations in support of preserving this exclusion. The enactment of the Patient Protection and Affordable Care Act (ACA), however, will result in a significant overhaul of the American health care system. As a result, a reexamination of I.R.C. § 106 is warranted. This Note argues that the ACA has rendered each of the policy considerations in support of I.R.C. § 106 largely irrelevant, inapplicable, or generally less compelling—whereas the arguments in favor of repeal now seem all the more convincing. Nevertheless, policymakers should stop short of outright repeal because of a number of drawbacks that may prove unavoidable. Consequently, this Note proposes a middle ground that instead calls for significant reform. Converting the exclusion into a progressive, refundable tax credit would largely accomplish the goals sought by repeal, while still avoiding the negative repercussions that total repeal may engender.

Introduction

Section 106 of the Internal Revenue Code (I.R.C.) creates a government subsidy for employer-provided health insurance that covers millions of Americans.[1] Pursuant to this rule, employees are not taxed on the health care benefits that they receive from their employers.[2]

[1] *See* I.R.C. § 106 (2006); Carmen DeNavas-Walt et al., U.S. Census Bureau, P60-235, Income, Poverty, and Health Insurance Coverage in the United States: 2007, at 20 (2008); *see also* Staff of Joint Comm. on Taxation, 112th Cong., JCS-1-12, Estimates of Federal Tax Expenditures for Fiscal Years 2011–2015, at 42 (Comm. Print 2012) [hereinafter Joint Comm. on Taxation 2012] (calculating the subsidy across a number of years).

[2] *See* I.R.C. § 106(a).

This pervasive, politically popular provision is designed to promote social justice by increasing the number of individuals who are insured.[3] In addition, I.R.C. § 106 is also considered to be the best available risk-pooling device and an effective constraint on health care costs.[4]

Despite these apparent benefits, the time has come to reconsider the propriety of preserving I.R.C. § 106 in our tax code.[5] The Patient Protection and Affordable Care Act (ACA) has dramatically altered the landscape in which the prior policy considerations for maintaining I.R.C. § 106 were couched.[6] For example, the ACA implements a variety of measures that are designed to both curb the costs of health care and ensure universal insurance coverage.[7] As a result, it may now be the case that the ACA has effectively usurped the role of I.R.C. § 106, rendering the tax exemption unnecessary.[8]

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[3] *See* Diane Lim Rogers, *Tax Expenditures: More Entitlements Than Loopholes*, TAX NOTES, Nov. 14, 2011, at 897, 899 (discussing how the provision is politically popular); J. Paul Singleton, *Can You Really Have Too Much of a Good Thing?: How Benevolent Tax Policies Have Attributed to the Explosion of Health Care Costs and How New Policies Threaten to Do More of the Same*, 8 DEPAUL BUS. & COM. L.J. 305, 310–12 (2010) (discussing how the provision promotes social justice); Martin A. Sullivan, *The Hypocrisy of Tax Reform*, TAX NOTES, Oct. 8, 2012, at 119, 119 (discussing how the provision is politically popular). This provision covers nearly 60% of all insured Americans. DENAVAS-WALT ET AL., *supra* note 1, at 20. Covered taxpayers directly benefit from I.R.C. § 106 because this provision reduces their total taxable income by the value of their employer-provided coverage. *See* I.R.C. § 106(a). In addition, their employers receive an indirect benefit from I.R.C. § 106 because they are able to provide their employees with the same amount of benefits at a lower cost. *See* Linda Sugin, *Tax Expenditures, Reform, and Distributive Justice*, 3 COLUM. J. TAX L. 1, 21 (2011).

[4] *See* BOB LYKE, CONG. RESEARCH SERV., RL34767, THE TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE: POLICY ISSUES REGARDING THE REPEAL DEBATE 11, 18 (2008) (risk pooling); Edward A. Zelinsky, *Reforming Health Care: The Paradoxes of Cost*, 31 J. LEGAL MED. 203, 204, 211, 213 (2010) (constraining costs). Risk pooling refers to the ability to combine both healthy and sick individuals into a single group for insurance purposes, which results in more reasonable, shared costs for all. *See* David Gamage, *Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms Are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 TAX L. REV. 669, 677–81 (2012).

[5] *See* Michael Joe, *Rollback Possible for Employer-Provided Healthcare Exclusion, Analysts Say*, TAX NOTES, June 21, 2010, at 1322, 1322.

[6] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010); Joe, *supra* note 5, at 1322.

[7] *See* Janet L. Dolgin & Katherine R. Dieterich, *Social and Legal Debate About the Affordable Care Act*, 80 UMKC L. REV. 45, 52 (2011) (universal coverage); Patrick J. Miller, *Health Reform Is Not Just Insurance Reform: Significant Changes in Fraud and Abuse Enforcement*, ADVOCATE, Oct. 2010, at 28, 28 (curb costs); *see also* infra notes 118–147 and accompanying text (discussing how specific provisions of the ACA combine to achieve these goals).

[8] *See infra* notes 243–310 and accompanying text (illustrating how, in light of the ACA, arguments in favor of repealing I.R.C. § 106 have become increasingly compelling, whereas the policy considerations for preserving I.R.C. § 106 are no longer applicable).

This Note argues that, given the implementation of the ACA, the justifications for repealing I.R.C. § 106 outweigh those for keeping it.[9] The ACA neatly accomplishes the goals of I.R.C. § 106 and therefore largely undermines the policy considerations that support I.R.C. § 106.[10] As a result, the arguments for repealing I.R.C. § 106 have become increasingly compelling.[11] Nevertheless, this Note argues that although I.R.C. § 106 should undergo significant reforms, policymakers should stop short of outright repeal.[12] For example, full repeal of I.R.C. § 106 risks depriving certain taxpayers—who may fall through the cracks under an exclusive ACA regime—of any meaningful assistance.[13] Instead, converting I.R.C. § 106 into a progressive, refundable tax credit would accomplish the goals sought by complete repeal, while avoiding the potential pitfalls.[14]

Part I of this Note introduces I.R.C. § 106 and outlines some of its traditional policy underpinnings.[15] Part II then begins by illustrating how the ACA has changed the health care landscape, thus necessitating a reexamination of I.R.C. § 106.[16] It then outlines the policy justifications in favor of repeal of I.R.C. § 106, particularly in light of the ACA.[17] Finally, Part III discusses how the ACA has largely usurped the role of I.R.C. § 106, thereby rendering the policy considerations in support of the employer-provided exclusion moot and further justifying repeal of I.R.C. § 106.[18] As a result, Part III suggests that I.R.C. § 106 warrants substantial reform.[19]

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[9] *See infra* notes 243–310 and accompanying text.

[10] *See infra* notes 243–301 and accompanying text (suggesting that the ACA largely accomplishes the goals of I.R.C. § 106).

[11] *See infra* notes 243–310 and accompanying text.

[12] *See infra* notes 311–334 and accompanying text.

[13] *See infra* notes 312–321 and accompanying text (indicating how certain taxpayers could be negatively impacted by a complete repeal of I.R.C. § 106).

[14] *See infra* notes 322–334 and accompanying text (outlining the benefits of converting I.R.C. § 106 into a progressive, refundable tax credit).

[15] *See infra* notes 20–104 and accompanying text.

[16] *See infra* notes 105–146 and accompanying text.

[17] *See infra* notes 147–236 and accompanying text.

[18] *See infra* notes 237–310 and accompanying text.

[19] *See infra* notes 311–334 and accompanying text.

I. Section 106 of the I.R.C. and Its Underlying Policy Considerations

The I.R.C. directly intersects with the U.S. health care system.[20] The federal income tax exclusion for employer-provided health insurance is one example of this intersection.[21] This provision was enacted more than half a century ago and has never undergone significant revision.[22] Part I begins in Section A by introducing I.R.C. § 106, specifically highlighting its role, purpose, and budgetary consequences.[23] Section B then illustrates the policy considerations that support preserving I.R.C. § 106.[24]

A. *Section 106 of the I.R.C.: A Tax Expenditure*

Raising revenues is arguably the predominant goal of the federal tax system.[25] Notwithstanding this primary goal, policymakers have identified alternative objectives that have also shaped the design of the tax system.[26] For example, policymakers have established a series of tax incentives that are specifically designed to promote social justice.[27] Although the benefits these provisions provide would ordinarily fall within the concept of "income,"[28] they subsidize certain desirable endeavors, such as obtaining an education, or incentivize certain social and eco-

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[20] *See, e.g.*, I.R.C. § 104(a) (2006) (excluding general payouts under U.S. citizens' insurance plans from the federal income tax); *id.* § 105(b) (2006 & Supp. IV 2010) (excluding payouts under employer-provided insurance plans from the federal income tax); *id.* § 106(a) (2006) (excluding employer contributions to employer-provided insurance plans from the federal income tax); *id.* § 3121(a)(2) (2006) (excluding employer contributions to employer-provided insurance plans from payroll taxes).

[21] *See id.* § 106(a).

[22] *See* Singleton, *supra* note 3, at 310–12.

[23] *See infra* notes 25–47 and accompanying text.

[24] *See infra* notes 48–104 and accompanying text.

[25] Thomas J. Purcell, III, *An Analysis of the Formation of Federal Income Tax Policy*, 18 Creighton L. Rev. 653, 653 & n.1 (1985). The income tax, including both individual and corporate, represents the largest source of revenue for the federal government—singlehandedly accounting for over 50% of federal revenues. *See Taxes, Tariffs and Fees: How Government Raises Money*, Ctr. Forward Budget Basics, Mar. 2012, at 1, 1, *available at* http://www.center-forward.org/wp-content/uploads/2012/04/Budget-Basics-Revenues-03-12-update-2.pdf.

[26] *See* Stanley S. Surrey, *Tax Incentives as a Device for Implementing Government Policy: A Comparison with Direct Government Expenditures*, 83 Harv. L. Rev. 705, 706 (1970).

[27] Purcell, *supra* note 25, at 653 & n.3; Surrey, *supra* note 26, at 706.

[28] *See* Marjorie E. Kornhauser, *A Legislator Named Sue: Re-Imagining the Income Tax*, 5 J. Gender Race & Just. 289, 313 & n.54 (2002); Surrey, *supra* note 26, at 706.

nomic behavior, such as acquiring insurance.[29] These provisions— including various exclusions, credits, and deductions—are commonly referred to as "tax expenditures"[30] because they are functionally identical to direct federal spending programs.[31]

Classifying these special provisions as the functional equivalents of direct federal spending influences how policymakers view tax expenditures.[32] As opposed to treating these provisions as standard revenue-raising tax provisions, it has become generally accepted that these provisions should instead be evaluated alongside direct federal spending programs.[33] Scrutinizing tax expenditures as a federal spending program allows policymakers to address and control their growth.[34] Today, indirect federal spending in the form of tax expenditures is estimated at $1 trillion per year.[35] This amount exceeds the federal government's annual spending on Social Security, Medicare, and Medicaid—each of which cost $700–$800 billion annually.[36]

The exclusion from gross income for employer-provided health insurance is one such tax expenditure whose merits have been hotly

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[29] *See* Paul R. McDaniel et al., Federal Income Taxation 354 (Robert C. Clark et al. eds., 6th ed. 2008); Surrey, *supra* note 26, at 706, 711 n.3, 713.

[30] Surrey, *supra* note 26, at 706. In addition to the exclusion from income, tax expenditures can also take the form of a deduction, credit, preferential tax rate, or even a tax deferral. *Id.* The core tax expenditure attribute common to each of these approaches is typically the policy decision that a taxpayer's tax burden should be reduced in order to encourage certain behavior or reduce hardship. *See id.* at 711–13.

[31] *Id.* at 706, 713–14. For example, granting a taxpayer an exclusion from federal income tax for a specific benefit is essentially the same as if the taxpayer had been otherwise traditionally taxed, but was then directly reimbursed by the federal government for the amount of the benefit. McDaniel et al., *supra* note 29, at 20; Linda Sugin, *Tax Expenditure Analysis and Constitutional Decisions*, 50 Hastings L.J. 407, 410 (1999). The term "tax expenditure" is thus a concise and descriptive way of capturing the reality that indirect federal spending is accomplished within the tax system. McDaniel et al., *supra* note 29, at 20; *see* Sugin, *supra*, at 410; Surrey, *supra* note 26, at 706.

[32] Donna D. Adler, *The Internal Revenue Code, the Constitution, and the Courts: The Use of Tax Expenditure Analysis in Judicial Decision Making*, 28 Wake Forest L. Rev. 855, 859–61, 864 (1993); Sugin, *supra* note 31, at 416.

[33] Adler, *supra* note 32, at 859–61, 861 & n.23; *see also* Edward A. Zelinsky, *James Madison and Public Choice at Gucci Gulch: A Procedural Defense of Tax Expenditures and Tax Institutions*, 102 Yale L.J. 1165, 1165 (1993) (describing the success of tax expenditure analysis). Case in point: the Congressional Budget Act of 1974 mandates that a tax expenditure analysis be included in every budget submitted to Congress. *See* 2 U.S.C. § 602(a), (e)(1) (2006); Adler, *supra* note 32, at 861.

[34] *See* Rogers, *supra* note 3, at 899.

[35] *See id.*

[36] *Id.*

debated.[37] Section 106 excludes all employer contributions to a health or accident plan from an employee's income.[38] Although employer-provided health insurance would otherwise be characterized as a taxable in-kind benefit, the exclusion for employer-provided health insurance is one of a number of provisions that are designed to generate incentives for employers to provide their employees with certain benefits.[39] This particular provision promotes social justice by increasing

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[37] *Compare, e.g.*, *Making Medicare, Medicaid and Social Security Sustainable for the Long Run: Hearing Before the H. Comm. on the Budget*, 116th Cong. 4 (2011) [hereinafter *Making Medicare, Medicaid and Social Security Sustainable*] (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution) (arguing for the repeal of I.R.C. § 106), *and* Eleanor Weston Brown, *Healing Healthcare Through Tax Reform*, 2 Regent J. L. & Pub. Pol'y 63, 78–81 (2010) (describing the arguments for reforming I.R.C. § 106), *with* Zelinsky, *supra* note 4, at 204, 211, 212 (arguing against the repeal of the exclusion). *See generally* Sugin, *supra* note 3 (arguing that the repeal of tax expenditures is a flawed approach to tax reform). The exclusion or "exclusions" for employer-provided health insurance can refer to a number of different tax provisions. *See, e.g.*, I.R.C. § 105(b) (2006 & Supp. IV 2010) (excluding payouts on employer-provided insurance plans from the federal income tax); *id.* § 106(a) (2006) (excluding employer contributions to employer-provided insurance plans from the federal income tax); *id.* § 3121(a)(2) (excluding employer contributions to employer-provided insurance plans from payroll taxes); Allegra N. Kim, Cal. Research Bureau, Pub. No. CRB 07-002, Federal Tax Incentives for Health Insurance 1 (2003); Gamage, *supra* note 4, at 680–81 & nn.47–48; Peter J. Wiedenbeck, *Taxes and Healthcare*, Tax Notes, Aug. 31, 2009, at 889, 889 n.4, 892 & n.20. Although I.R.C. § 105 is technically an exclusion related to employer-provided insurance, it is only given purpose through its relation to I.R.C. § 106. *See* Lawrence A. Frolik, *Personal Injury Compensation as a Tax Preference*, 37 Me. L. Rev. 1, 2, 6–7 (1985) (discussing the function of I.R.C. § 105); Julie E. McGuire, Comment, *Proposed Section 125 Cafeteria Plan Regulations: Invalidating Certain Section 105 Medical Plans Through Forfeiture Requirement*, 23 Duq. L. Rev. 659, 661–65 (1985) (discussing the interrelationship between I.R.C. §§ 104, 105 and 106). This is because an additional provision, I.R.C. § 104, provides for the exclusion from income for payouts on insurance plans more generally. *See* I.R.C. § 104(a) (2006). Thus, any discussion of the propriety of the "exclusions" for employer-provided insurance truly focuses on I.R.C. § 106, as I.R.C. § 105 essentially mirrors the typical treatment of insurance payouts. *See* I.R.C. §§ 104–106(a); Frolik, *supra*, at 2–7; McGuire, *supra*. As a result, this Note focuses on I.R.C. § 106—the operative exclusion. In addition to the exclusion from the federal income tax, there is also an entirely separate exclusion for employer-provided insurance that is beyond the scope of this Note—the exclusion for employer-provided insurance from payroll taxes. *See* I.R.C. § 3121(a)(2); Kim, *supra*; Gamage, *supra* note 4, at 681 & n.48; Wiedenbeck, *supra*, at 892 & n.20. Payroll taxes are imposed on both the employee and the employer, are generally calculated in relation to the employee's wages, and include payments for Social Security and Medicare. *See* I.R.C. § 3101(a), (b) (2006 & Supp. IV 2010); *id.* § 3111(a), (b) (2006); *id.* § 3301 (2006 & Supp. III 2009); Kim, *supra*; Gamage, *supra* note 4, at 681 & n.48; Wiedenbeck, *supra*, at 892 & n.20. This Note does not contemplate reform or repeal of the payroll tax exclusion, and instead focuses solely on I.R.C. § 106. Hence, unless stated otherwise, references to the "exclusion" for employer-provided insurance pertain exclusively to I.R.C. § 106.

[38] I.R.C. § 106(a). This includes premiums paid by an employer. McDaniel et al., *supra* note 29, at 119–20.

[39] *See* McDaniel et al., *supra* note 29, at 119–20; Surrey, *supra* note 26, at 706. Other similarly designed exclusions include those for educational and adoption assistance,

health insurance coverage and reducing the number of uninsured citizens.[40] Regardless of its efficiency, employer-provided health insurance is irrefutably popular; a 2007 U.S. Census Bureau report revealed that employment-related health insurance plans cover almost 60% of insured Americans.[41]

The exclusion for employer-provided health insurance is one of the largest individual tax expenditures.[42] A report from Congress's Joint Committee on Taxation estimates that between 2011 and 2015, this expenditure will cost the federal government $725 billion.[43] Scholars have previously debated the exclusion's propriety.[44] Detractors question its efficacy and efficiency in achieving its purported goals; they note its potential unfairness,[45] and point to the large loss of potential revenues associated with the exclusion.[46] In contrast, proponents of the exclusion have warned against its repeal, cautioning that it would be unwise to abolish such a pervasive system.[47]

B. *Policy Considerations in Support of I.R.C. § 106*

A variety of traditional policy considerations are advanced to support preserving I.R.C. § 106.[48] Subsection 1 discusses how I.R.C. § 106 provides a benefit to employers by controlling their costs.[49] Subsection

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among others. McDaniel et al., *supra* note 29, at 119. Each of these exclusions is the result of a congressional policy decision to advance certain desirable social goals. *Id.*

[40] *See* Singleton, *supra* note 3, at 312. Moreover, the large numbers of uninsured Americans has been shown to adversely impact the national economy. *See* Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 Ind. Health L. Rev. 139, 142 (2006) (noting that a lack of insurance coverage shifts costs onto the government and employers, results in increased taxes, and encourages job lock—in which employees remain with their current employers in order to keep their coverage).

[41] *See* DeNavas-Walt et al., *supra* note 1, at 20.

[42] Harry L. Gutman, *How to Think About Real Tax Reform*, Tax Notes, Aug. 6, 2012, at 695, 700. Other significant tax expenditures for individuals include the charitable contribution deduction, the home mortgage interest deduction, and the deduction for state and local taxes, among others. *See id.*

[43] *See* Joint Comm. on Taxation 2012, *supra* note 1, at 42.

[44] *See, e.g.*, *Making Medicare, Medicaid and Social Security Sustainable*, *supra* note 37, at 4 (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution); Brown, *supra* note 37, at 78–81; Zelinsky, *supra* note 4, at 204, 211, 212.

[45] *See, e.g.*, Lyke, *supra* note 4, at 17, 19 (indicating that I.R.C. § 106 is unfair because it produces vertical and horizontal inequities); Brown, *supra* note 37, at 78–79 (same); Singleton, *supra* note 3, at 332 (same).

[46] *See Making Medicare, Medicaid and Social Security Sustainable*, *supra* note 37, at 4 (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution); Lyke, *supra* note 4, at 1.

[47] *See* Zelinsky, *supra* note 4, at 204, 211, 212.

[48] *See infra* notes 53–104 and accompanying text.

[49] *See infra* notes 53–58 and accompanying text.

2 then presents the argument that the employer-provided insurance regime is the most effective means of constraining health care costs.[50] Subsection 3 illustrates the argument that I.R.C. § 106 provides the best available means of risk pooling.[51] Finally, Subsection 4 discusses how a majority of insured Americans, by virtue of their coverage under an employer-provided insurance plan, benefit from I.R.C. § 106.[52]

1. I.R.C. § 106 Benefits Employers

Discussions regarding I.R.C. § 106 often focus on the employees because of the direct benefit that they receive through the reduction of their taxable income by the value of their employer-provided coverage.[53] I.R.C. § 106, however, also provides a benefit to employers, albeit an indirect one.[54] By exempting employer-provided health insurance from employee taxation, employers who provide insurance are able to provide employees with the same value in benefits at a lower cost to the employer, thereby allowing them to pay their employees lower wages.[55] Consequently, it is argued that repealing I.R.C. § 106 could harm employers.[56] For example, the repeal of Section 106 could result in a subsequent demand from employees that their wages be adjusted in order to compensate for the loss of their tax benefit.[57] Accordingly, the preservation of I.R.C. § 106 may thus benefit employers by keeping down their costs.[58]

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[50] *See infra* notes 59–71 and accompanying text.

[51] *See infra* notes 72–96 and accompanying text.

[52] *See infra* notes 97–104 and accompanying text.

[53] *See* Sugin, *supra* note 3, at 22; *see also* Wiedenbeck, *supra* note 37, at 889 & n.4 (expounding on the direct benefits to employees).

[54] *See* Sugin, *supra* note 3, at 21. This is distinguishable from the payroll tax exclusion for employer-provided health insurance, which provides a direct benefit to employers in the form of lower taxes. *See* Wiedenbeck, *supra* note 37, at 892; *see also* Robert Gillette et al., *The Impact of Repealing the Exclusion for Employer-Sponsored Insurance*, 63 NAT'L TAX. J. 695, 700 (2010) (distinguishing between the consequences of repealing solely I.R.C. § 106 and repealing both I.R.C. § 106 and the payroll tax exclusion). In contrast, I.R.C. § 106 provides an indirect benefit to employers by allowing them to pay employees lower wages. *See* Sugin, *supra* note 3, at 22. Section 106 of the I.R.C. and the payroll tax exclusion are two independently operating provisions. *See* Gamage, *supra* note 4, at 680–81; *supra* note 37 (discussing the differences between the payroll tax and federal income tax exclusions).

[55] Sugin, *supra* note 3, at 22. If employers were forced to provide the value of health care benefits in the form of taxable, monetary income, employers would need to spend more money to offset the tax that the employee would be assessed. *See id.* at 21–22.

[56] *See id.* at 21.

[57] *Id.* at 22.

[58] *See id.*

2. Section 106 of the I.R.C. Provides the Most Effective Means of Constraining Health Care Costs

Another policy consideration supporting I.R.C. § 106 is that, although it may be flawed, the provision provides the best method of constraining health care costs.[59] One scholar notes that the U.S. political system is simply incapable of saying "no" to demands for medical services.[60] One reason that policymakers may not develop meaningful reforms to combat rising health care costs is because politicians perceive that they are beholden to their constituents.[61] Fearing for their job security, they are incapable and unwilling to constrain the costs of health care.[62]

Whereas politicians shy away from reining in health care costs in order to preserve their jobs, employers are both capable and willing to curb costs because doing so is critical to marketplace survival.[63] For example, the need to cut costs has led to employer-sponsored "wellness" programs.[64] These programs, implemented by employers, are designed to reduce the demand and costs of health care by incentivizing preventive behavior, such as exercise and healthy dieting.[65] Employers have enacted further measures to minimize costs, such as health reimburse-

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[59] Zelinsky, *supra* note 4, at 204, 211, 212; *see* Yevgeniy Feyman, *How to Control Health-Care Costs?*, NAT'L REVIEW ONLINE (Nov. 19, 2012, 4:00 AM), http://www.nationalreview.com/articles/333627/how-control-health-care-costs-yevgeniy-feyman (arguing that Congress should defer to the private sector with regard to controlling health care costs, as businesses have unique incentives to control costs effectively); *see also* CONG. BUDGET OFFICE, PUB. NO. 4507, THE 2012 LONG-TERM BUDGET OUTLOOK 1 (2012) [hereinafter 2012 LONG-TERM BUDGET OUTLOOK] (reporting that within twenty-five years, federal spending on health care and Social Security will increase by $850 billion per year); Brendan W. Miller, Note, *Your Money or Your Lifestyle!: Employers' Efforts to Contain Healthcare Costs—Lifestyle Discrimination Against Dependents of Employees?*, 5 IND. HEALTH L. REV. 371, 372, 374 (2008) (illustrating that employers have a unique incentive to control health care costs).

[60] *See* Zelinsky, *supra* note 4, at 206, 209 (suggesting that politicians fail to confront the reality that medical services must be reduced to control health care costs).

[61] *See id.* at 210.

[62] *See id.* (observing that politicians' desire to remain in the good graces of their constituents is what prevents them from being able to make the difficult decisions to curb health care outlays).

[63] *See id.* at 211; *see also* Miller, *supra* note 59, at 372–74 (arguing that businesses have unique incentives to control costs effectively); Feyman, *supra* note 59 (same).

[64] Zelinsky, *supra* note 4, at 211–12.

[65] *Id.*; Miller, *supra* note 59, at 391–93. It is simply more cost-effective for employers to support these wellness programs than to allow the demand and costs of health care to grow unchecked. *See* Zelinsky, *supra* note 4, at 211–12. Nevertheless, it should be noted that although anecdotal evidence suggests that these programs have been successful in improving overall employee health, the benefits of wellness programs have yet to be comprehensively studied. *Id.* at 211.

ment arrangements ("HRAs"),[66] flexible spending accounts ("FSAs"),[67] and health savings accounts ("HSAs").[68] These employer-created programs are designed to control health care expenditures by forcing employees to incur some of their health care costs, which should lead them to make more cost-conscious decisions.[69] These programs thus provide cost-saving incentives for employees to economize their health care expenses.[70] Regardless of their advantages or limitations, employer-sponsored programs are proof that employers have greater incentives to control the costs of health care than do politicians.[71]

3. Section 106 of the I.R.C. Maintains the Best Available Device for Risk Pooling

Proponents of this exclusion also forward a third traditional policy consideration for employer-provided health insurance: that this paradigm provides for, and maintains the only viable risk-pooling system for the majority of Americans.[72] Proponents of the exclusions view the cur-

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[66] *See* David Blumenthal, *Employer-Sponsored Insurance—Riding the Health Care Tiger*, 355 NEW ENG. J. MED. 195, 197 (2006). Employees who are enrolled in high-deductible health plans can use HRAs. *Id.* An HRA is essentially a line of credit that an employer extends to employees in order to cover a designated amount of the employee's out-of-pocket health care expenses. *Id.*

[67] Dylan Young, *Flexible Spending Accounts: An Introduction*, HEALTH 401K (Sept. 24, 2011), http://www.health401k.com/2011/09/flexible-spending-accounts-an-introduction/. FSAs allow employees to set aside a portion of their income to use on health care expenditures. *Id.* These accounts are typically used to supplement traditional insurance coverage *Id.* The disadvantage of FSAs is that they impose a "use it or lose it" rule, under which taxpayers forfeit their remaining FSA funds at the end of a given "coverage period." *Id.* On the other hand, funds kept in an FSA have the benefit of not being taxed. *Id.*

[68] Zelinsky, *supra* note 4, at 211. Health savings accounts are similar to flexible spending accounts. *See* Young *supra* note 67. One major difference is that HSAs are not subject to the "use it or lose it" rule. Young *supra* note 67. Nevertheless, an employee has to be enrolled in a high-deductible health plan in order to take advantage of a HSA. Blumenthal, *supra* note 66, at 197.

[69] *See* Wiedenbeck, *supra* note 37, at 893–95.

[70] *See id.*

[71] Zelinsky, *supra* note 4, at 211. Section 106 is credited with promoting this positive externality because one of the primary reasons that employers began to—and continue to—provide insurance is due to its tax favorability. Gamage, *supra* note 4, at 676; *see* LYKE, *supra* note 4, at 10–11. Similarly, it is beneficial for employees to enroll in employer-provided insurance, as opposed to receiving additional cash wages, because of its tax favorability. *See* Brown, *supra* note 37, at 80. Thus, repeal of I.R.C. § 106 may threaten this arrangement. *See* LYKE, *supra* note 4, at 10–11.

[72] LYKE, *supra* note 4, at 11, 18; *see* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-05-1009SP, UNDERSTANDING THE TAX REFORM DEBATE: BACKGROUND, CRITERIA, & QUESTIONS 20 (2005) [hereinafter GAO]; John L. Buckley, *Tax Expenditure Reform: Some Common Misconceptions*, TAX NOTES, Jul. 18, 2011, at 255, 268.

rent employer-provided health insurance paradigm as a vital alternative to the individual market.[73] The reason for this is that the individual market suffers from a number of core deficiencies that produce more costly and poorer quality insurance.[74]

First, the individual market suffers from "adverse selection."[75] Adverse selection occurs because, typically, healthy people have less incentive to purchase health insurance than unhealthy people, who may view insurance as a good deal.[76] Consequently, the health profiles of a standard insurance market will be disproportionately made up of unhealthy patrons.[77] Higher costs and larger premiums are the inevitable result of the growing disparity between unhealthy and healthy people in an insurance market.[78] This eventuality leads to a self-propagating cycle, whereby increasingly greater numbers of healthy patrons will leave an insurance market as ever-rising premiums reflect the health profiles of the market.[79]

The second issue affecting the individual market is "risk classification."[80] This is a practice that insurance companies engage in to safeguard against adverse selection.[81] Insurance companies generate risk profiles for their potential consumers, identify unhealthy or at-risk patrons, and then either charge them exorbitant costs, or deny them coverage entirely.[82] These companies are then generally able to charge healthy patrons lower premiums, thereby maximizing profits.[83]

Plagued by these twin issues, the individual market is wrought with lower quality and higher cost insurance than the group market offered through employers.[84] According to one study, in 2005, almost three out

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[73] *See* GAO, *supra* note 72, at 20; LYKE, *supra* note 4, at 11, 18; Buckley, *supra* note 72, at 268; *see also* Gamage, *supra* note 4, at 676–80 (discussing how the employer-provided insurance paradigm resolves many of the drawbacks inherent in the individual insurance market). The term "individual market" collectively describes the group of insureds who purchase insurance directly, as opposed to receiving it from their employers or the government. Gamage, *supra* note 4, at 678.

[74] Gamage, *supra* note 4, at 678.

[75] *Id.*

[76] *Id.* at 677.

[77] *See id.*

[78] *Id.*; Brendan S. Maher, *The Benefits of Opt-in Federalism*, 52 B.C. L. Rev. 1733, 1770–71 (2011) (describing how adverse selection results in higher premiums).

[79] Gamage, *supra* note 4, at 677.

[80] *Id.* at 678.

[81] *Id.* at 677.

[82] *Id.* at 677–78.

[83] *Id.* at 678.

[84] *Id.*; *see also* Maher, *supra* note 78, at 1771 (indicating that employers are able to avoid the problem of adverse selection).

of five individuals were reportedly unable to procure affordable health insurance in the individual market because they were charged exorbitant prices, had a prior-existing health problem that precluded them from coverage, or were simply denied coverage outright.[85]

In contrast, I.R.C. § 106 and employer-provided insurance work together to avoid the drawbacks of the individual market, resulting in better quality and more affordable insurance.[86] The reason that employer-provided health insurance provides an optimal risk pool is because employees become insured by virtue of their employment—not because they require health care.[87] In addition, the tax exclusion incentivizes employees to enroll in employer-provided insurance.[88] These factors provide a balance between both healthy and unhealthy people, resulting in reasonable, shared costs.[89] Furthermore, employer-provided insurance specifically results in affordable care for the at-risk and unhealthy because it avoids the problem of risk classification.[90] Although employers are technically able to design insurance policies that exclude high-cost employees or charge them more, in practice, employers provide a more egalitarian regime.[91]

Repealing the exclusion for employer-provided health insurance would remove one of the primary incentives that encourage employees to enroll in employer-provided insurance.[92] It is therefore reasonable to fear that this may threaten the stable risk pool that employers have been able to provide workers.[93] By repealing I.R.C. § 106, health care premiums could rise as healthy people opt out of insurance and thereby

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[85] Gamage, *supra* note 4, at 677.

[86] *See id.* at 679–80.

[87] *See id.* at 679; Maher, *supra* note 78, at 1771.

[88] Gillette et al., *supra* note 54, at 696; *see* Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 McGeorge L. Rev. 535, 546 (2005); Wiedenbeck, *supra* note 37, at 899 & n.4.

[89] *See* Gamage, *supra* note 4, at 680.

[90] *See id.* at 679–80.

[91] *See id.* Employers are incentivized to behave this way due to the perception that this benefits employee morale, which in turn benefits employers. *See id.*

[92] *See* Gillette et al., *supra* note 54, at 696; Kaplan, *supra* note 88, at 546; Wiedenbeck, *supra* note 37, at 899 & n.4.

[93] *See* Lyke, *supra* note 4, at 11; Buckley, *supra* note 72, at 268 (suggesting that policymakers need to consider the impact of repealing or reforming I.R.C. § 106 on the availability of employer-provided insurance); *see also* Cong. Budget Office, The Tax Treatment of Employment-Based Health Insurance 48 (1994) [hereinafter Tax Treatment of Employment-Based Health Insurance] (suggesting that repealing both of the exclusions for employer-provided insurance would cause employers to be much less likely to offer insurance, which would thereby cause older and sicker people to have more difficultly in obtaining affordable insurance).

weaken the risk pool.[94] Those most burdened by these changes would be the unhealthy and at-risk, who could no longer look to the workplace as a form of affordable and effective risk pooling.[95] These individuals would once again face prohibitively high health insurance premiums.[96]

4. The Majority of Insured Americans Receive Employer-Provided Insurance and Therefore Benefit from I.R.C. § 106

Another prominent policy consideration in favor of preserving I.R.C. § 106 hinges on the fact that employer-provided health insurance is so pervasive and that, therefore, a large number of taxpayers benefit from this exclusion.[97] As of 2008, 163 million Americans received employer-provided insurance, whereas only 17 million were insured in the individual market.[98] Thus, 163 million Americans directly benefit from I.R.C. § 106 by being able to reduce their taxable income by the value

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[94] *Compare* LYKE, *supra* note 4, at 11 (describing the fear that risk pools may be threatened because of changes to I.R.C. § 106), *and* Wiedenbeck, *supra* note 37, at 899 & n.4 (indicating that a primary reason employer-provided insurance has become so popular is because of the beneficial tax treatment that it receives), *with* Gamage, *supra* note 4, at 677–80 (illustrating how employer-provided insurance was able to avoid the problem of adverse selection by enticing healthy employees to become insured and describing the effect on premiums as risk pools become disproportionately populated by unhealthy insureds).

[95] *See* TAX TREATMENT OF EMPLOYMENT-BASED HEALTH INSURANCE, *supra* note 93, at 48; *see also* Gamage, *supra* note 4, at 677–80 (describing the problems associated with the individual market and how the employer-provided paradigm is able to avoid these issues); Wiedenbeck, *supra* note 37, at 899 (describing how the employer-provided paradigm is able to avoid the problem of adverse selection and keep insurance costs down). When healthy employees opt out of coverage, risk pools become disproportionately populated by unhealthy people, and premiums are adjusted upward to reflect the increased costs. *See* Gamage, *supra* note 4, at 677. Employers respond in a number of ways to this phenomenon. *See* TAX TREATMENT OF EMPLOYMENT-BASED HEALTH INSURANCE, *supra* note 93, at 23–25. In general, as premiums rise, employers are less likely to offer health insurance. *See id.* at 25. Furthermore, employers may discriminate against hiring unhealthy workers, revise insurance packages of employees to exempt certain illnesses from coverage, or even fire unhealthy workers. *See id.* at 23–24.

[96] TAX TREATMENT OF EMPLOYMENT-BASED HEALTH INSURANCE, *supra* note 93, at 48; *see* Gamage, *supra* note 4, at 677–79 (describing the perils that unhealthy workers face in the individual market); Wiedenbeck, *supra* note 37, at 899 (same).

[97] *See Roundtable on Financing Healthcare Reform: Hearing Before the S. Comm. on Fin.*, 114th Cong. 5–6 (2009) [hereinafter *Roundtable on Financing Healthcare Reform*] (statement of Leonard E. Burman, Director, Tax Policy Center) (illustrating the fear that repealing the exclusion would result in millions losing insurance coverage); Joe, *supra* note 5, at 1322 (illustrating that some argue that the repeal of I.R.C. § 106 is undesirable, as it would raise taxes on millions of middle-class Americans); Michael Tanner & Chris Edwards, *Will Obama Raise Middle-Class Taxes to Fund Health Care?*, CATO INST. TAX & BUDGET BULL., June 2009, at 1, 1, *available at* http://www.cato.org/doc-download/sites/cato.org/files/pubs/pdf/tbb_0609-57.pdf (same).

[98] Gillette et al., *supra* note 54, at 696.

of their employer-provided coverage.[99] Considering the fact that the average cost of employer-provided insurance is roughly $4750 a year for an individual and $12,700 for family coverage, I.R.C. § 106 provides significant relief for many Americans.[100]

As a result, tampering with I.R.C. § 106 risks negatively impacting millions of Americans.[101] Given the average cost of employer-provided coverage, the potential increased tax burden on Americans could be significant.[102] In addition, one recent study indicates that repeal of I.R.C. § 106 would lead to a 5.8% erosion of coverage under employer-provided insurance.[103] The implications of this are predicted to result in nearly 3.9 million individuals losing health insurance coverage entirely, and over 4.7 million individuals procuring alternative insurance in place of their former employer-provided insurance.[104]

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[99] Wiedenbeck, *supra* note 37, at 889 & n.4.

[100] Lyke, *supra* note 4, at 1.

[101] *See* Joe, *supra* note 5, at 1322; Tanner & Edwards, *supra* note 97, at 1.

[102] *See* Lyke, *supra* note 4, at 1; Tanner & Edwards, *supra* note 97, at 1.

[103] *See* Gillette et al., *supra* note 54, at 704–05; *see also Roundtable on Financing Healthcare Reform*, *supra* note 97, at 5–6 (statement of Leonard E. Burman, Director, Tax Policy Center) (illustrating the fear that repeal of the exclusion would result in millions losing insurance coverage).

[104] *See* Gillette et al., *supra* note 54, at 702 n.9, 704; *see also Roundtable on Financing Healthcare Reform*, *supra* note 97, at 5–6 (statement of Leonard E. Burman, Director, Tax Policy Center). According to the study, this 5.8% erosion from employer-provided insurance is the result of two factors: employers dropping coverage and employees voluntarily switching out of employer coverage. *See* Gillette et al., *supra* note 54, at 700. The study relied on a "voting" system, whereby employees compared the cost of coverage pursuant to their employer-provided health insurance with the cost of alternative coverage—in this case, the coverage available on the ACA exchanges. *See id.* at 699. If alternative coverage was cheaper, employees voted for employers to drop coverage and would choose to voluntarily leave their employer-provided coverage. *See id.* at 699–700. Of particular concern to this Note are the 3.9 million individuals who not only would leave employer coverage, but would also become completely uninsured because of repeal of I.R.C. § 106. *See id.* at 702 n.9, 704. A follow-up with one of the study's authors revealed some potential noteworthy features of this group. *See* E-mail from Robert Gillette, Dir. of Econ. Modeling & Computer Applications, Office of Tax Analysis, U.S. Dep't of Treasury, to author (Feb. 27, 2013, 16:01 EST) [hereinafter E-mail from Robert Gillette] (on file with author). According to this scholar, upon repeal, young employees were one group that would choose to neither continue employer coverage nor purchase alternative coverage in the exchanges. *See id.* These individuals would instead choose to become uninsured, despite the penalty imposed by the ACA. *See id.* The explanation for this phenomenon is that when faced with the options of being subjected to either full taxation of employer benefits or community ratings in the exchanges, these individuals would choose to forgo coverage entirely. *See id.*

II. The New Health Care Landscape and Its Impact on the Policy Considerations of I.R.C. § 106

In stark contrast to the static U.S. tax code, the health care landscape has recently undergone one of the most expansive legislative overhauls in decades.[105] The ACA implements a variety of provisions aimed at restructuring the U.S. health care system.[106] Given the direct impact that the federal income tax exclusion for employer-provided insurance has on the health insurance market, the effects of the ACA may bear on the continued relevance of I.R.C. § 106.[107] Section A of Part II begins by providing a detailed discussion of how the ACA is predicted to impact the health care landscape.[108] Section B then examines whether traditional arguments advanced in support of repealing I.R.C. § 106 remain persuasive in light of the ACA.[109]

A. *A Dramatically Altered Health Care Landscape*

Recent legislation has dramatically altered the context in which prior arguments for and against the repeal of I.R.C. § 106 were couched.[110] On March 23, 2010, President Barack Obama signed into law the ACA,[111] now commonly referred to as "Obamacare."[112] The ACA provides for widespread health insurance reforms, gradually enacted over the course of several years.[113] These reforms have already

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[105] *See* Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. Times, Mar. 24, 2010, at A19.

[106] *See* Caitlin B. Munley, *The Effects of Immigration Reform on the Cost Projections for the Patient Protection and Affordable Care Act*, 26 Geo. Immigr. L.J. 719, 719 (2012) (describing the ACA as "a major overhaul of the United States' health care system"); *infra* notes 113–146 and accompanying text (expounding upon these particular provisions).

[107] *See* Joe, *supra* note 5, at 1322 (suggesting that I.R.C. § 106 should be reevaluated in light of the ACA).

[108] *See infra* notes 110–146 and accompanying text.

[109] *See infra* notes 147–236 and accompanying text.

[110] *See* Joe, *supra* note 5, at 1322.

[111] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010); Miller, *supra* note 7, at 28.

[112] *See* Gregory Wallace, *'Obamacare': The Word That Defined the Health Care Debate*, CNN (last updated June 25, 2012, 1:20 AM), http://articles.cnn.com/2012-06-25/politics/politics_obamacare-word-debate_1_health-reform-law-health-care-affordable-care-act?_s=pm:politics.

[113] *See* Frederick Thide, Comment, *In Search of Limiting Principles: The Eleventh Circuit Invalidates the Individual Mandate in* Florida v. U.S. Department of Health and Human Services, 53 B.C. L. Rev. 359, 361 (2012); U.S. Dep't of Health & Human Servs., *Key Features of the Affordable Care Act by Year*, HHS.gov/HealthCare, http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html (last visited Nov. 13, 2013); Kate Pickert, *What Obama's*

begun to take shape, but the most critical provisions of the ACA will not take effect until 2014.[114] Some of the primary goals of the ACA include: (1) curbing the cost of health care;[115] (2) facilitating and ensuring universal health insurance coverage;[116] and (3) holding insurance companies more accountable.[117]

The ACA implements virtually every approach to constraining health care costs that has been suggested by leading experts.[118] For example, the ACA specifically focuses on encouraging and promoting the use of preventive measures as a long-term method of reducing health care outlays.[119] Insurance plans are now required to cover the cost of certain designated preventive services in full,[120] such as mammograms and colonoscopies.[121]

Another ACA cost-control strategy is to streamline the U.S. health care system to improve its efficiency.[122] The ACA provides direct incentives for physicians to constrain costs through "Accountable Care Organizations."[123] Such organizations are comprised of doctors who will coordinate their care practices in an effort to both improve quality and

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Re-election Means for Health Care, TIME (Nov. 8, 2012), http://swampland.time.com/2012/11/08/what-obamas-re-election-means-for-health-care/.

[114] *See* Pickert, *supra* note 113.

[115] Miller, *supra* note 7, at 28.

[116] Dolgin & Dieterich, *supra* note 7, at 52.

[117] Kathleen Sebelius, *Holding Insurance Companies Accountable for High Premium Increases*, HUFFINGTON POST (Feb. 22, 2013, 12:52 PM), http://www.huffingtonpost.com/sec-kathleen-sebelius/holding-insurance-compani_b_2742501.html.

[118] Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601, 603 (2010).

[119] *See* Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1583 & n.25, 1602 & n.120 (2011); *see also* 42 U.S.C. § 300gg-13 (Supp. IV 2010) (requiring health insurance plans to provide coverage for certain preventive services).

[120] Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120; *see* 42 U.S.C. § 300gg-13. In addition, the ACA created a "National Prevention, Health Promotion, and Public Health Council" to promote the health of Americans by supporting established prevention and public health programs, including those that combat the issues of smoking and obesity. Lance Gable, *The Patient Protection and Affordable Care Act, Public Health, and the Elusive Target of Human Rights*, 39 J.L. MED. & ETHICS 340, 344 (2011); *see* 42 U.S.C. § 300u-11 (Supp. IV 2010).

[121] U.S. Dep't of Health & Human Servs., *supra* note 113.

[122] *See* UTAH HEALTH POLICY PROJECT, WE'LL SHOW YOU COST CONTAINMENT: HOW FEDERAL HEALTH REFORM WILL HELP REEL IN HEALTH CARE COSTS 2 (2011), http://www.healthpolicyproject.org/Publications_files/National/Cost%20Containment%20in%20ACA%207-26-1.pdf [hereinafter UTAH HEALTH POLICY PROJECT].

[123] Timothy C. Gutwald, *Bending the Health Care Cost Curve: Incentivizing Quality and Efficiency*, MICH. B.J., June 2011, at 20, 22; Everette James & Arthur S. Levine, *The Inevitability of Health Reform*, 50 DUQ. L. REV. 235, 242 (2012); *see* 42 U.S.C. § 1395jjj (Supp. IV 2010).

reduce spending.[124] To the degree that these organizations are successful in reducing costs, members will be entitled to keep a percentage of the savings.[125] Finally, the law expands the authorization of "payment bundling," a pilot program that incentivizes cost cutting.[126] The current payment system is fragmented and inefficient because each service or test is billed separately.[127] This process drives up costs.[128] In contrast, under payment bundling, "episodes of care" are instead collectively billed at a flat rate.[129] A flat rate will promote more efficient health care, thus reducing costs.[130]

The ACA also employs a variety of tools that are designed to facilitate and encourage universal health care coverage.[131] These are some of the ACA's most controversial provisions.[132] The provisions that go into effect in 2014 expand on the ACA's commitment to preventing discrimination by universally prohibiting insurance companies from refusing to grant or extend insurance coverage due to a person's preexisting conditions.[133] In addition, the 2014 provisions are designed to ensure affordable health care for all Americans through a graduated subsidization scheme.[134] To the extent that an individual is unable to

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[124] James & Levine, *supra* note 123, at 242.

[125] Gutwald, *supra* note 123, at 22; *see* 42 U.S.C. § 1395jjj(d).

[126] James & Levine, *supra* note 123, at 244; Orszag & Emanuel, *supra* note 118, at 603; Michael Skindrud & Todd Cleary, *Health-Care Reform: What You Should Know*, WIS. LAW., Dec. 2011, at 12, 52; *see* 42 U.S.C. § 1395cc-4 (Supp. IV 2010).

[127] James & Levine, *supra* note 123, at 241–42.

[128] *See id.*

[129] *Id.* at 244.

[130] *See id.* at 245–46; Orszag & Emanuel, *supra* note 118, at 603. For example, whereas a surgical procedure under the traditional payment paradigm would generate a variety of claims stemming from multiple providers, under the new system surgical procedures will be compensated by bundled payments—incentivizing a more efficient delivery of health care. *Cf.* Maria T. Currier & Morris H. Miller, *Medicare Payment Reform: Accelerating the Transformation of the U.S. Healthcare Delivery System and Need for New Strategic Provider Alliances*, 22 HEALTH LAW. 1, 2–3 (2010) (contrasting the fee-for-service and payment bundling paradigms).

[131] Thide, *supra* note 113, at 361–63.

[132] *See* Wendy E. Parmet, *The Individual Mandate: Implications for Public Health Law*, 39 J.L. MED. & ETHICS 401, 401 (2011) (highlighting the controversy over the individual mandate provision of the ACA).

[133] Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 U. ILL. L. REV. 1159, 1187; *see* 42 U.S.C. § 300gg-3 (Supp. IV 2010). The 2014 provisions also prevent insurance companies from increasing rates in the individual or small group markets based on gender or health status. Roberts, *supra*; *see* 42 U.S.C. § 300gg (Supp. IV 2010).

[134] *See* 26 U.S.C. § 36B (Supp. IV 2010) (providing for tax credits to assist payment of ACA exchange premiums); Amy B. Monahan, *On Subsidies and Mandates: A Regulatory Critique of ACA*, 36 J. CORP. L. 781, 783 & n.14 (2011); Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J.

afford health care, these new provisions are designed to close the gap between affordable costs and the actual cost of health care.[135] Furthermore, the ACA establishes "Affordable Insurance Exchanges,"[136] where individuals—who are not otherwise offered affordable insurance through their employers—will be able to directly purchase insurance.[137] The ACA also provides aid to small businesses in the form of tax credits designed to subsidize the cost of providing health insurance to their employees.[138] Finally, the most controversial provision of the ACA is the individual mandate.[139] The mandate dictates that individuals who are able to afford basic health insurance coverage must obtain it.[140] A fee meant to mitigate the cost of caring for uninsured Americans will be imposed on those who choose not to purchase affordable care despite their ability to afford it.[141] Importantly though, individuals who are unable to acquire affordable coverage will be eligible for an exemption from the penalty.[142] Budget analysts project that the ACA

HEALTH & BIOMEDICAL L. 1, 12 (2011). For example, individuals who are not eligible for other forms of affordable coverage—and whose income falls between the poverty line and four times that amount—will be eligible to receive tax credits that will subsidize their insurance. Monahan, *supra*. According to the U.S. Census Bureau, as of 2012, $11,945 was the poverty threshold for an individual under the age of sixty-five, and $23,283 for a family of four with two children under the age of eighteen. *Poverty*, U.S. CENSUS BUREAU, http://www.census.gov/hhes/www/poverty/data/threshld/ (last updated Sept. 17, 2013).

[135] *See* Monahan, *supra* note 134, at 783 & n.14; Rosenbaum, *supra* note 134, at 12.

[136] Jessica D.H. Allen, Note, *A Way Forward: Establishing Financially Self-Sustaining Health-Insurance Exchanges Under the Patient Protection and Affordable Care Act*, 98 IOWA L. REV. 773, 775–76 (2013); Amy Siadak, Note, *Contracting in Health Insurance Exchanges: Improving Implementation with Lessons from the Past*, 40 PUB. CONT. L.J. 867, 869 (2011); *see* 42 U.S.C. § 18031 (Supp. IV 2010). An "Affordable Insurance Exchange" is a new, alternative marketplace for individuals and small businesses to purchase qualified health benefit plans. Allen, *supra*, at 776. These exchanges are designed to increase the competitiveness, transparency, and affordability of the insurance market. *See* Siadak, *supra*, at 869–70.

[137] Siadak, *supra* note 136, at 869–70*; see* 42 U.S.C. § 18031. These exchanges will offer a number of health plans, thereby allowing consumers to choose among a variety of packages. Siadak, *supra* note 136, at 870–71.

[138] Thide, *supra* note 113, at 361; *see* 26 U.S.C. § 45R (Supp. IV 2010). As of 2014, this provision will cover up to 35% of an employer's contributions, and up to 25% of a non-profit employer's contributions. 42 U.S.C. § 45R(a)–(b).

[139] Parmet, *supra* note 132, at 401; *see* 26 U.S.C. § 5000A(a) (Supp. IV 2010).

[140] *Compare* 26 U.S.C. § 5000A(a) (requiring individual coverage), *with* 26 U.S.C. § 5000A(e) (exempting individuals who cannot afford coverage from the mandate).

[141] U.S. Dep't of Health & Human Servs., *supra* note 113; *see* 26 U.S.C. § 5000A(b)–(c) (imposing a penalty on those who forego coverage, which amounts to the greater of $695 per person or 2.5% of family income).

[142] *See* 26 U.S.C. § 5000A(e). To be eligible for this exemption, the taxpayer's health costs must amount to more than 8% of his or her household income. *Id.*

will reduce the number of uninsured non-elderly Americans by 24 million between 2012 and 2016.[143]

Finally, the ACA also seeks to hold insurance companies more accountable.[144] Some provisions require insurance companies to spend a certain percentage of premium dollars on health care services and quality improvement.[145] Failure to meet these standards results in the imposition of a penalty against insurance companies in the form of a rebate they must provide to their customers.[146]

B. *Policy Considerations for Repealing I.R.C. § 106 Through the Lens of the ACA*

There have been a variety of policy considerations advanced in support of repealing I.R.C. § 106.[147] After the enactment of the ACA, reevaluating the Section 106 exclusion for employer-provided health insurance is now even more appropriate.[148] Importantly, this Section suggests that the ACA has largely reinforced the traditional arguments made in support of repealing Section 106.[149] Subsection 1 explains why the repeal or reform of I.R.C. § 106 could generate significant federal

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[143] *See* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 20 (2012) [hereinafter 2012 ESTIMATES FOR THE ACA]. Despite the broad efforts of the ACA to increase coverage, 30 million non-elderly Americans will remain uninsured. *See id.* at 13. This group of people will include: (1) roughly 6 million illegal immigrants; (2) citizens who are eligible to enroll in Medicaid, yet choose not to; (3) those not otherwise covered, who instead choose to pay the annual penalty—amounting to 2.5% of their income; and (4) those whose health care costs would amount to more than 8% of their household income, and who are thus able to opt out of coverage without incurring a penalty. Mark Trumbull, *Obama Signs Health Care Bill: Who Won't Be Covered?*, CHRISTIAN SCIENCE MONITOR (Mar. 23, 2010), http://www.csmonitor.com/USA/2010/0323/Obama-signs-health-care-bill-Who-won-t-be-covered. This also includes a newly added group of uninsureds stemming from the recent U.S. Supreme Court ruling on the ACA and the non-required expansion of Medicaid, which the CBO estimates will result in an additional 3 million uninsured Americans. *See* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 13. *See generally* Nat'l Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (striking down the expansion of Medicaid under the ACA as an unconstitutional use of congressional spending power).

[144] Sebelius, *supra* note 117; *see* 42 U.S.C. § 300gg-18 (Supp. IV 2010).

[145] Sebelius, *supra* note 117; *see* 42 U.S.C. § 300gg-18(a). The required percentages amount to 85% of premium dollars spent pursuant to large employer plans and 80% spent pursuant to individual or small employer plans. *See* 42 U.S.C. § 300gg-18(b).

[146] Sebelius, *supra* note 117; *see* 42 U.S.C. § 300gg-18(b).

[147] *See infra* notes 153–236 and accompanying text.

[148] *See* Joe, *supra* note 5, at 1322 (explaining that reconsideration of I.R.C. § 106 is now possible in light of the ACA); Martin A. Sullivan, *Economic Analysis: A First Look at Romney's Deduction Cap*, TAX NOTES, Oct. 15, 2012, at 227, 227 (arguing, post-ACA, that reconsidering I.R.C. § 106 is a critical issue).

[149] *See infra* notes 153–236 and accompanying text.

revenues and why the enactment of the ACA has preserved the relevance of this argument.[150] Subsection 2 then illustrates that the repeal or reform of I.R.C. § 106 would help to reduce the cost of health care and that, once again, the passage of the ACA has not diminished the credence of this argument.[151] Finally, Subsection 3 illustrates that the argument that I.R.C. § 106 produces tax inequities still reigns true, and that such inequities are made even less tolerable as a result of the ACA.[152]

1. Repeal of I.R.C. § 106 Will Generate Much-Needed Revenue

First and foremost, advocates in favor of repealing Section 106 highlight that doing so would contribute significantly to federal revenues.[153] I.R.C. § 106 is responsible for substantial revenue losses for the government because more than 60% of the population under the age of sixty-five is covered by employer-provided insurance.[154] One Congressional Research Service report suggests that repealing the exclusions for employer-provided insurance would increase federal revenues by $700 billion per year.[155] Specifically, the Joint Committee on Taxation estimates that excluding employer-provided health insurance from the federal income tax will cost the federal government a cumulative $725 billion between 2011 and 2015.[156]

The ACA has done little to change the importance of generating additional federal revenues.[157] There are two competing schools of

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[150] *See infra* notes 153–170 and accompanying text.

[151] *See infra* notes 171–195 and accompanying text.

[152] *See infra* notes 196–236 and accompanying text.

[153] *See* LYKE, *supra* note 4, at 1; Gutman, *supra* note 42, at 700.

[154] LYKE, *supra* note 4, at 1. This is because without the exclusion from income that I.R.C. § 106 provides, employer-provided health insurance benefits would be taxable income. *See* Kornhauser, *supra* note 28, at 313 & n.54; Surrey, *supra* note 26, at 706. Section 106, therefore, provides workers with significant tax savings: the average cost for employment-based individual coverage is roughly $4,750 a year—$12,700 for families. LYKE, *supra* note 4, at 1.

[155] LYKE, *supra* note 4, at 1; *see also* Gutman, *supra* note 42, at 700 (discussing how significant spending deductions and increased revenues could occur through repeal of certain tax expenditures such as the employer-provided exclusion); Sugin, *supra* note 3, at 12 (same). *But see* Joe, *supra* note 5, at 1322 (hypothesizing that the actual revenues raised from repeal of tax expenditures could be much less than commonly projected); Sugin, *supra* note 3, at 11 (same). The precise amount of increased revenues depends on exactly which exclusions are repealed. LYKE, *supra* note 4, at 1. Once again, this Note contemplates solely the federal income tax exclusion for employer-provided insurance.

[156] *See* JOINT COMM. ON TAXATION 2012, *supra* note 1, at 42.

[157] *Compare* CONG. BUDGET OFFICE, PUB. NO. 4649, THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2013 TO 2023, at 9 (2013) [hereinafter THE BUDGET AND ECONOMIC

thought regarding the impact that the ACA will have on the federal deficit.[158] Some argue that the ACA will not decrease the federal deficit by a single cent.[159] These commentators argue that instead, the ACA will add to the nation's growing deficit.[160] In contrast, others argue that the ACA will reduce the federal deficit by $84 billion.[161] These commentators point to experimental cost-reduction strategies in the ACA that, they argue, will yield further, yet still unquantifiable fiscal benefits.[162]

For the purposes of this Note, either prediction supports the argument that I.R.C. § 106 should be repealed in order to generate much-needed federal revenue.[163] The Congressional Budget Office (CBO) reports that the federal government recently has been recording some

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OUTLOOK: 2013 TO 2023] (suggesting that the deficit will grow by nearly $7 trillion between 2014 and 2023), *with The Impact of the Health Care Law on the Economy, Employers, and the Workforce: Hearing Before the H. Comm. on Educ. & the Workforce*, 112th Cong. 8–12 (2011) [hereinafter *The Impact of the Health Care Law on the Economy, Employers, and the Workforce*] (statement of Paul Howard, Senior Fellow and Director, Center for Medical Progress at the Manhattan Institute) (arguing that the ACA will increase the deficit), *and* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 2 (arguing that the ACA will reduce the federal deficit by $84 billion), *and* Chris Conover, *Healthcare Law Will Not Reduce the Deficit*, FORBES (Jul. 26, 2012, 12:18 PM), http://www.forbes.com/sites/chrisconover/2012/07/26/healthcare-law-will-not-reduce-the-deficit-cb/ (arguing that the ACA will not reduce the deficit).

[158] *Compare* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 2 (stating that the ACA will reduce the federal deficit by $84 billion), Jonathan Cohn, *One More Time: CBO Thinks Obamacare *Reduces* Deficit*, NEW REPUBLIC (Jul. 24, 2012), http://www.tnr.com/blog/plank/105327/cbo-obamacare-deficit-medicaid-expansion-cost-revenue-exchange# (arguing that the ACA will reduce the federal deficit), *and* Andrew Taylorricardo Alonso Zaldivar, *Budget Office: Obama's Health Law Reduces Deficit*, BLOOMBERG BUSINESSWEEK (Jul. 24, 2012), http://www.businessweek.com/ap/2012-07-24/budget-office-obamas-health-law-reduces-deficit (same), *with The Impact of the Health Care Law on the Economy, Employers, and the Workforce*, *supra* note 157, at 2–4 (arguing that the ACA will not reduce the deficit, but will actually increase it), *and* Conover, *supra* note 157 (same).

[159] *See The Impact of the Health Care Law on the Economy, Employers, and the Workforce*, *supra* note 157, at 2–4; Conover, *supra* note 157.

[160] *See The Impact of the Health Care Law on the Economy, Employers, and the Workforce*, *supra* note 157, at 2–4; Conover, *supra* note 157.

[161] *See* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 2; Cohn, *supra* note 158; Zaldivar, *supra* note 158.

[162] *See* Jonathan Cohn, *The GOP's Trick Play*, NEW REPUBLIC (Jan. 21, 2011), http://www.newrepublic.com/blog/jonathan-cohn/81941/trick-play#; Maggie Mahar, *How the ACA Saves Money & Raises Revenues—Numbers You Can Count On*, HEALTH BEAT (Nov. 29, 2010), http://www.healthbeatblog.com/2010/11/how-the-aca-saves-money-raises-revenues-numbers-you-can-count-on/.

[163] *Compare* THE BUDGET AND ECONOMIC OUTLOOK: 2013 TO 2023, *supra* note 157, at 9 (suggesting that the deficit will grow by nearly $7 trillion between 2014 and 2023), *with The Impact of the Health Care Law on the Economy, Employers, and the Workforce*, *supra* note 157, at 2–4 (arguing that the ACA will not reduce the deficit), *and* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 2 (arguing that the ACA will reduce the federal deficit by $84 billion).

of its largest budget deficits since 1947.[164] Furthermore, by the end of 2013, the amount of federal debt held by the public will equal about 66% of the nation's gross domestic product.[165] Finally, the CBO reports that the U.S. budget deficit will grow by nearly $7 trillion between 2014 and 2023.[166] It is evident that more must be done to address the nation's growing deficit, regardless of what impact the ACA has on it.[167] That is to say, even if the ACA reduces the federal deficit by $84 billion, this figure is nevertheless insufficient to account for the projected increase in the federal deficit in the near future.[168] In contrast, the repeal of I.R.C. § 106 would generate significant federal revenues, totaling $700 billion per year.[169] Although clearly not a panacea for the federal deficit, pro-repeal arguments that rely on the need for increased federal revenues remain relevant today.[170]

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[164] *See* The Budget and Economic Outlook: 2013 to 2023, *supra* note 157, at 7–8.

[165] *Id.* at 7.

[166] *Id.* at 9.

[167] *See id.* at 7, 9 (suggesting that the "projected path of the federal budget remains a significant concern").

[168] *Compare id.* at 9 (suggesting that the deficit will grow by nearly $7 trillion between 2014 and 2023), *with* 2012 Estimates for the ACA, *supra* note 143, at 2 (arguing that the ACA will reduce the federal deficit by $84 billion).

[169] *See* Lyke, *supra* note 4, at 1; Gutman, *supra* note 42, at 700. For example, the Joint Committee on Taxation estimates that I.R.C. § 106 will cost the federal government $725 billion in revenues between 2011 and 2015. *See* Joint Comm. on Taxation 2012, *supra* note 1, at 42.

[170] *See supra* notes 163–169 and accompanying text. Some rebuke this argument because typical repeal analyses assume that taxpayer behavior remains constant. *See* Buckley, *supra* note 72, at 259, 261–62 (noting that a taxpayer who is insured through an employer may choose to discontinue this coverage after IR.C. § 106 is repealed). Many taxpayers may adjust their behavior to avoid paying additional taxes, resulting in a significant disparity between original tax expenditure costs and subsequently realized federal revenues. *Id.* at 269. For example, one study reports that 23 million insureds would be displaced from employer-provided coverage by repeal of the exclusions, 16 million of whom would move to the new insurance exchanges created by the ACA. *See* Gillette et al., *supra* note 54, at 697, 702 n.9, 704. This study indicates that this 16 million would be disproportionately comprised of low-income earners, who would be enticed by the subsidies provided for in the ACA. *See id.* at 706. Thus, the purported fiscal benefits of repealing the exclusions may be illusory; any gains resulting from repeal may be quickly offset by a corresponding increase in government funding for insurance subsidies. Buckley, *supra* note 72, at 262. Nevertheless, this argument does not bear on the considerations of this Note. Those alarming figures were calculated based on a repeal of both the exclusion from the federal income tax *and* the payroll tax exclusion. Buckley, *supra* note 72, at 261; Gillette et al., *supra* note 54, at 704. This Note considers solely the propriety of the income tax exclusion. In contrast, the same study reports that repeal of I.R.C. § 106 *alone* would lead to a much smaller displacement of only 3.2% of those formerly insured through their employers moving to the ACA exchanges. *See* Gillette et al., *supra* note 54, at 704.

2. Repeal of I.R.C. § 106 Will Lower the Cost of Health Care

A second argument made by pro-repeal advocates is that I.R.C. § 106 is responsible for an "inflationary effect" that causes the unchecked growth of health care costs.[171] Accordingly, the repeal or reform of I.R.C. § 106 may help curb the growth of health care outlays.[172] This inflationary effect arises because of a number of critical factors.[173] First, I.R.C. § 106 insulates consumers from the costs of their health care expenditures.[174] Second, there is no upper limit for the amount of excludable income for each employee.[175] These combined factors incentivize over-insurance: employees purchase comprehensive health plans that are both more generous and more expensive than they otherwise would if they bore the cost of these benefits.[176] Over-insurance leads to the problem of "moral hazard"—insulated employees that enjoy comprehensive coverage have no incentive to economize their spending, and thus tend to over-use that coverage.[177] As one scholar notes: "An individual with comprehensive health insurance coverage might see a specialist, obtain a second opinion, undergo additional tests or procedures, or purchase high-priced name-brand pharmaceuticals without incurring any direct financial cost from those choices."[178] This results in an artificial increase in the total demand for health

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[171] *See* LYKE, *supra* note 4, at 2, 12; Brown, *supra* note 37, at 80; Benjamin D. Gehlbach, Note, *The Preferential Treatment of Employer-Provided Health Care: Time for a Change?*, 27 J. CONTEMP. HEALTH L. & POL'Y 398, 412–13 (2011).

[172] *See* LYKE, *supra* note 4, at 12; Brown, *supra* note 37, at 81.

[173] *See* Gehlbach, *supra* note 171, at 412–13 (indicating that the combination of cost insulation and an uncapped exclusion exacerbates this inflationary effect).

[174] *Taking a Checkup on the Nation's Health Care Tax Policy: A Prognosis: Hearing Before the S. Comm. on Fin.*, 111th Cong. 2 (2006) [hereinafter *Taking a Checkup on the Nation's Health Care*] (statement of Leonard E. Burman, Senior Fellow, Urban Institute); Kaplan, *supra* note 88, at 548; Gehlbach, *supra* note 171, at 412.

[175] LYKE, *supra* note 4, at 2; Gehlbach, *supra* note 171, at 413.

[176] *See Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 2 (statement of Leonard E. Burman, Senior Fellow, Urban Institute); LYKE, *supra* note 4, at 12; Kaplan, *supra* note 88, at 546–47. Rational taxpayers engage in over-insurance because the option of procuring a tax-free benefit is more beneficial than receiving the identical value in the form of taxable, monetary wages. Brown, *supra* note 37, at 80; Kaplan, *supra* note 88, at 546.

[177] Kaplan, *supra* note 88, at 548; Wiedenbeck, *supra* note 37, at 894.

[178] Wiedenbeck, *supra* note 37, at 894. The combined factors of insulation from costs and limitless excludable income not only result in over-insurance and over-consumption of health care goods and services, but also influence preventive behavioral choices. *See* Kaplan, *supra* note 88, at 548; Wiedenbeck, *supra* note 37, at 894 & n.37. In this way, costs are further exacerbated because these patients are not incentivized to practice preventive measures and reduce their health care needs. *See* Kaplan, *supra* note 88, at 548; Wiedenbeck, *supra* note 37, at 894 & n.37.

care.[179] It follows, then, that the exclusion for employer-provided health insurance drives up both the cost of health care and the insurance covering it.[180] Proponents of this argument therefore suggest that exposing consumers to the costs of health care and holding them directly responsible would instead create an incentive to constrain such health care spending.[181] This argument thus illustrates that repealing I.R.C. § 106 will reduce the overall cost of health care.[182]

Importantly, the ACA does not alter the fact that curbing the rising cost of health care remains a compelling federal interest.[183] This is primarily because, at this stage, it is difficult to predict how successful the ACA will be at reducing health care costs and slowing cost-growth.[184] The ACA installs a variety of pilot programs that include creating the Center for Medicare and Medicaid Innovation,[185] encouraging payment bundling,[186] and facilitating preventive care.[187] In fact, the ACA incorporates virtually every single approach to constraining health care

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[179] Lyke, *supra* note 4, at 12; Brown, *supra* note 37, at 80; Kaplan, *supra* note 88, at 548.

[180] *See* Lyke, *supra* note 4, at 12; Brown, *supra* note 37, at 80; Kaplan, *supra* note 88, at 547–48.

[181] *See Making Medicare, Medicaid and Social Security Sustainable*, *supra* note 37, at 4 (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution) (arguing that economists broadly support this proposition); Lyke, *supra* note 4, at 13 (suggesting that this argument is supported by theory, experience, and empirical studies). In one study—the RAND Health Insurance Experiment—researchers found that outpatient expenses for consumers with a 95% coinsurance requirement were 67% lower than the outpatient expenses of a comparable cost-insulated group. Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 Am. Econ. Rev. 251, 258 (1987).

[182] *See* Lyke, *supra* note 4, at 12–13; Brown, *supra* note 37, at 80–81; Kaplan, *supra* note 88, at 548.

[183] *Compare Making Medicare, Medicaid and Social Security Sustainable*, *supra* note 37, at 1 (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution) (arguing that over the next several decades, federal revenues will be outpaced by continuously increased spending on programs such as Medicare and Medicaid), *and* 2012 Long-Term Budget Outlook, *supra* note 59, at 1 (predicting that within twenty-five years, annual federal spending on health care and Social Security will increase by $850 billion), *with* Cohn, *supra* note 162 (indicating that the degree to which the ACA will be effective at curbing the rising costs of health care is unknowable), *and* Robert Farley, *Obama Says Health Reform Legislation Could Reduce Costs in Employer Plans by Up to $3,000*, PolitiFact (Mar. 19, 2010, 6:07 PM), http://www.politifact.com/truth-o-meter/statements/2010/mar/19/barack-obama/obama-says-health-reform-legislation-could-reduce-/ (same).

[184] *See* Cohn, *supra* note 162 (indicating that the degree to which the ACA will be effective at curbing the rising costs of health care is unknowable); Farley, *supra* note 183 (same).

[185] *See* 42 U.S.C. § 1315a (Supp. IV 2010).

[186] James & Levine, *supra* note 123, at 244; Orszag & Emanuel, *supra* note 118, at 603; Skindrud & Cleary, *supra* note 126, at 52; *see* 42 U.S.C. § 1395cc-4 (Supp. IV 2010).

[187] Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120; *see* 42 U.S.C. § 300gg-13 (Supp. IV 2010).

costs that has been suggested by leading experts.[188] Nevertheless, although these programs illustrate the federal government's determination to rein in the cost of health care, there exists no reliable data regarding the efficacy of these programs when implemented together on such a large scale.[189] As a result, the CBO deliberately did not take into account many of these provisions when calculating the ACA's budgetary impact.[190]

In contrast, it is clear that the nation's health care spending trajectory is unsustainable.[191] The CBO predicts that within twenty-five years, annual federal spending on health care and Social Security will increase by $850 billion.[192] Put another way, federal health care spending will soon outpace existing federal revenues.[193] Given the uncertainty of whether the ACA will control the rising costs of health care, more must be done to curb federal health care outlays.[194] Thus, the argument that repealing I.R.C. § 106 would help reduce the growing cost of health care remains a compelling argument today.[195]

3. Section 106 of the I.R.C. Violates Norms of Our Tax Policy by Creating Both Horizontal and Vertical Inequities

A third argument that favors repeal is that Section 106 produces both vertical and horizontal inequities.[196] Vertical and horizontal equity are two desirable norms that policymakers ascribe to the tax code.[197] Horizontal equity is established when similarly situated taxpayers have

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[188] Orszag & Emanuel, *supra* note 118, at 603.

[189] *See* Cohn, *supra* note 162; Farley, *supra* note 183; Atul Gawande, *Testing, Testing*, NEW YORKER (Dec. 14, 2009), http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande?currentPage=all.

[190] *See* Cohn, *supra* note 162; Farley, *supra* note 183; Gawande, *supra* note 189.

[191] *See Making Medicare, Medicaid and Social Security Sustainable*, *supra* note 37, at 1 (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution) (arguing that over the next several decades, federal revenues will be outpaced by continuously increased spending on programs such as Medicare and Medicaid, resulting in unsustainable increases to the federal deficit and debt); 2012 LONG-TERM BUDGET OUTLOOK, *supra* note 59, at 1; Zelinsky, *supra* note 4, at 204.

[192] 2012 LONG-TERM BUDGET OUTLOOK, *supra* note 59, at 1.

[193] *Making Medicare, Medicaid and Social Security Sustainable*, *supra* note 37, at 1 (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution); Zelinsky, *supra* note 4, at 204.

[194] *See supra* note 183 and accompanying text (discussing the increase in future health care costs and the uncertainty regarding the ACA's ability to curb these expenses).

[195] *See supra* notes 183–194 (discussing why the repeal of I.R.C. § 106 would help reduce the growing cost of health care).

[196] Singleton, *supra* note 3, at 332; *see* LYKE, *supra* note 4, at 17; Brown, *supra* note 37, at 78–79.

[197] *See* Brown, *supra* note 37, at 78; Singleton, *supra* note 3, at 332.

similar tax burdens.[198] Pro-repeal advocates are critical of I.R.C. § 106 because, they argue, the exclusion for employer-provided health insurance violates this principle of fairness by engendering horizontal inequities.[199] In practice, the exclusion for employer-provided insurance causes similarly situated taxpayers to bear significantly disparate tax burdens.[200] Consider for example, the discrepancy between "Taxpayer A," who is employed at a firm that does not provide health insurance, and "Taxpayer B," who is employed at a firm that does provide health insurance.[201] Assuming that the value of their overall compensation (wages plus benefits) is identical, Taxpayer A will be subject to a significantly higher tax burden than Taxpayer B, who is uniquely capable of receiving a tax break.[202] This scenario produces unfairness because although the taxpayers were in the same economic position, one taxpayer was able to reduce his tax burden by taking advantage of I.R.C. § 106, whereas the other could not.[203]

The second principle of fairness implicated by I.R.C. § 106 is "progressivity," or vertical equity.[204] Policymakers have established a norm within the U.S. tax code that higher-income earners should not benefit disproportionately from the tax code.[205] Instead, high-income individuals should shoulder a proportionate burden.[206] Thus, the U.S. tax system employs a gradation of tax rates whereby taxpayers earning progressively higher wages are subject to higher tax rates.[207] This policy of imposing greater burdens on those who are more capable of shouldering them is known as the "ability-to-pay principle."[208] Some scholars argue that the exclusion for employer-provided insurance violates this principal of tax justice because it is regressive.[209] These scholars observe that taxpayers in higher tax brackets disproportionately benefit

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[198] Brown, *supra* note 37, at 78; Singleton, *supra* note 3, at 332.

[199] *See* Lyke, *supra* note 4, at 17–18; Brown, *supra* note 37, at 78; Singleton, *supra* note 3, at 332.

[200] Brown, *supra* note 37, at 78; Singleton, *supra* note 3, at 332–33.

[201] *See* Brown, *supra* note 37, at 78; Singleton, *supra* note 3, at 332–33.

[202] *See* Brown, *supra* note 37, at 78; Singleton, *supra* note 3, at 332–33.

[203] *See* Lyke, *supra* note 4, at 17–18; Brown, *supra* note 37, at 78; Singleton, *supra* note 3, at 332.

[204] *See* Lyke, *supra* note 4, at 18–19; Brown, *supra* note 37, at 78–79; Singleton, *supra* note 3, at 332.

[205] *See* Brown, *supra* note 37, at 78–79; Singleton, *supra* note 3, at 332.

[206] *See* Brown, *supra* note 37, at 78–79; Singleton, *supra* note 3, at 332.

[207] Brown, *supra* note 37, at 78; *see* Singleton, *supra* note 3, at 332.

[208] Brown, *supra* note 37, at 78.

[209] *Id.* at 78–79; Singleton, *supra* note 3, at 312.

from I.R.C. § 106 when compared to lower-earning taxpayers.[210] This phenomenon occurs because savings that stem from the exclusion are dependent on a taxpayer's marginal tax rate.[211] For example, depending on their earnings, taxpayers in lower tax brackets might typically experience savings that are as low as 10% of their federal income taxes—or perhaps none at all.[212] In contrast, the comparable savings for taxpayers falling in higher tax brackets will be significantly greater.[213] The result is what some scholars have dubbed the "upside-down effect," where despite the fact that two taxpayers may be engaging in the same level of economic activity, the higher-earning taxpayer will receive greater subsidies than the lower-earning taxpayer.[214]

In addition, not only do high-income earners disproportionately benefit from these exclusions at the individual level, evidence suggests that a disproportionate number of high-income earners receive these benefits in the first place.[215] Thus, by analyzing the distribution of benefits with regard to the typical beneficiary, it becomes apparent that the general distribution of benefits results in a further violation of the principle of progressivity.[216] Scholars have observed that high earners bene-

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[210] *Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 2 (statement of Leonard E. Burman, Senior Fellow, Urban Institute); Brown, *supra* note 37, at 79; *see* Singleton, *supra* note 3, at 332. Pursuant to the exclusion, a high-earning taxpayer who receives $13,375 worth of health insurance benefits will save $4681 at a 35% tax rate. Brown, *supra* note 37, at 78–79. In contrast, a taxpayer falling into the lowest tax bracket saves only $1337 for the very same health plan. *Id.* at 79; *see also* LYKE, *supra* note 4, at 18–19 (providing a similar example of the disproportionate dollar savings enjoyed by high earners compared to the often negligible savings enjoyed by lower earners). *But see* David U. Himmelstein & Steffie Woolhandler, *The Regressivity of Taxing Employer-Paid Health Insurance*, 361 NEW ENG. J. MED. e101, e101 (2009), http://www.nejm.org/doi/full/10.1056/NEJMopv0907478 (arguing that the exclusion is progressive by focusing on the percentage of income saved, as opposed to dollar values—where the savings of lower-income earners amount to a higher percentage of their salaries than the savings of higher earners).

[211] LYKE, *supra* note 4, at 18. A taxpayer's "marginal tax rate" is the hypothetical rate of tax that would be applied to the very next additional dollar earned by that taxpayer. Brown, *supra* note 37, at 78. Thus, savings resulting from tax expenditures are calculated in terms of a taxpayer's marginal tax rate because the excluded "additional income" would have otherwise been taxed at the marginal rate. *See id.*

[212] LYKE, *supra* note 4, at 18–19; *see Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 2 (statement of Leonard E. Burman, Senior Fellow, Urban Institute); Singleton, *supra* note 3, at 332. For example, 36.3% of Americans owed no income tax in 2008. Singleton, *supra* note 3, at 332.

[213] *Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 2 (statement of Leonard E. Burman, Senior Fellow, Urban Institute); LYKE, *supra* note 4, at 19; Brown, *supra* note 37, at 78–79.

[214] *See* Sugin, *supra* note 3, at 8; Surrey, *supra* note 26, at 723.

[215] LYKE, *supra* note 4, at 19; Brown, *supra* note 37, at 79.

[216] *See* LYKE, *supra* note 4, at 19; Brown, *supra* note 37, at 79.

fit more as a group from I.R.C. § 106 than low earners because they are more likely to be provided health insurance pursuant to their employment.[217] For example, only 10% of employees earning less than $10,000 a year receive employer-provided coverage.[218] In contrast, more than 50% of employees earning $50,000–$75,000 benefit from employer-provided insurance.[219] Furthermore, 61% of employees earning $100,000 or more are provided coverage.[220]

Proponents of reform argue that I.R.C. § 106 is irrational and wasteful because it gives rise to these virtual inequities.[221] These scholars suggest that there is little economic rationale for subsidizing employer-provided health insurance when the taxpayers that disproportionately benefit from the subsidy are those in the highest income brackets.[222] Conversely, those who are most in need of the benefits from the exclusion are the least likely to benefit from it.[223] Stanley S. Surrey suggests that this inequity becomes more apparent if the exclusion for employer-provided insurance is compared to a direct expenditure program.[224] I.R.C § 106 is both irrational and inefficient because it serves as a direct expenditure that pours vast sums of money into the hands of wealthier taxpayers.[225] Surrey argues that tax incentives like I.R.C. § 106 would have been "laughed out of Congress" had they been otherwise structured as direct federal expenditures.[226]

In light of the ACA's ability to ensure virtually universal health insurance coverage for U.S. citizens, the argument that I.R.C. § 106 is wasteful and irrational has become all the more compelling.[227] The

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[217] LYKE, *supra* note 4, at 19; Brown, *supra* note 37, at 79.

[218] Brown, *supra* note 37, at 79.

[219] *Id.*

[220] *Id.*; *see also Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 11 (statement of Leonard E. Burman, Senior Fellow, Urban Institute) (indicating that the richest 0.4% of taxpayers receive subsidies that are twelve times larger than the poorest 30%).

[221] *See Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 14 (statement of Leonard E. Burman, Senior Fellow, Urban Institute); LYKE, *supra* note 4, at 19; Rogers, *supra* note 3, at 898–99.

[222] LYKE, *supra* note 4, at 19; Rogers, *supra* note 3, at 898–99; *see Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 14 (statement of Leonard E. Burman, Senior Fellow, Urban Institute).

[223] *Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 2, 14 (statement of Leonard E. Burman, Senior Fellow, Urban Institute).

[224] *See* STANLEY S. SURREY, PATHWAYS TO TAX REFORM: THE CONCEPT OF TAX EXPENDITURES 136 (1973); Sugin, *supra* note 3, at 8.

[225] *See* SURREY, *supra* note 224, at 136.

[226] *See id.*

[227] *Compare* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 20 (indicating that the number of uninsured non-elderly Americans will be reduced by 24 million between 2012

justification for I.R.C. § 106 has been that the exclusion expands insurance coverage in the United States.[228] To some degree, this has happened: roughly 60% of those insured are currently covered by an employer-provided plan.[229] And, despite the flaws inherent to I.R.C. § 106, the benefit of increasing insurance coverage continued to outweigh the perceived drawbacks of the provision.[230] Nevertheless, the ACA has essentially usurped the role of employer-provided coverage in expanding the prevalence of health insurance.[231] One component of the ACA is the individual mandate, which will virtually ensure universal health insurance coverage.[232] Furthermore, the ACA creates a series of exchanges through which individuals will be able to purchase a number of different insurance packages based on their ability to pay.[233] Finally, the ACA puts subsidies in place for those who could not otherwise afford insurance.[234] As a result, the CBO predicts that the number of uninsured non-elderly Americans will be reduced by 24 million between 2012 and 2016.[235] Considering the degree to which the ACA will ex-

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and 2016 as a result of the ACA), Matthew Dalton, *Supreme Court Upholds Individual Mandate*, TAX NOTES, Jul. 2, 2012, at 17, 17 (indicating that the ACA provides for an individual mandate that will incentivize individual coverage), Monahan, *supra* note 134, at 783 & n.14 (indicating that the ACA puts subsidies in place for those who could not otherwise afford insurance), *and* Siadak, *supra* note 136, at 869–71 (indicating that the ACA will create a series of exchanges through which individuals will be able to purchase a number of different insurance packages based on their affordability), *with* LYKE, *supra* note 4, at 17–19 (illustrating that I.R.C. § 106 is inequitable, irrational, and wasteful), *and* STAFF OF JOINT COMM. ON TAXATION, 112TH CONG., JCX-27-06, PRESENT LAW AND ANALYSIS RELATING TO THE TAX TREATMENT OF HEALTH SAVINGS ACCOUNTS AND OTHER HEALTH EXPENSES 2 (Comm. Print 2006) [hereinafter JOINT COMM. ON TAXATION 2006] (indicating that the justification for employer-provided health insurance exclusions rests on the premise that they increase the incidence of insurance coverage and reduce the number of uninsured).

[228] JOINT COMM. ON TAXATION 2006, *supra* note 227, at 2.

[229] *See* DENAVAS-WALT ET AL., *supra* note 1, at 20.

[230] *Roundtable on Financing Healthcare Reform*, *supra* note 97, at 5–6 (statement of Leonard E. Burman, Director, Tax Policy Center); *see* LYKE, *supra* note 4, at 18; Joe, *supra* note 5, at 1322; *see also* Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 B.Y.U. L. REV. 1229, 1230 (illustrating that increasing the incidence of insurance coverage is an important goal for the federal government).

[231] *See* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 20; Dalton, *supra* note 227, at 17; Monahan, *supra* note 134, at 783 & n.14; Siadak, *supra* note 136, at 869–71.

[232] Parmet, *supra* note 132, at 401; *see* 26 U.S.C. § 5000A(a) (Supp. IV 2010). Nonexempt individuals who do not purchase health insurance will be required to pay a penalty on their income tax return. Dalton, *supra* note 227, at 17; *see* 26 U.S.C. § 5000A(b)–(c).

[233] Siadak, *supra* note 136, at 869–71; *see* 42 U.S.C. § 18031 (Supp. IV 2010).

[234] Monahan, *supra* note 134, at 783 & n.14; Rosenbaum, *supra* note 134, at 12; *see* 26 U.S.C. § 36B (Supp. IV 2010).

[235] *See* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 20. Accordingly, budget analysts project that between 2012 and 2016, the percentage of insured non-elderly Americans

pand insurance coverage, the fact that I.R.C. § 106 disproportionately benefits taxpayers who would have otherwise been able to afford insurance and typically fails to aid those for whom the provision was originally designed, now appears less tolerable than it once was.[236]

III. Debunking the Necessity of I.R.C. § 106 and Suggesting a Path for Moving Forward

Given the degree to which the passage of the ACA has changed the U.S. health care landscape,[237] the policy considerations in support of the federal income tax exclusion for employer-provided health insurance may now be outdated, inapplicable, or irrelevant.[238] This Note argues that I.R.C. § 106 has been rendered largely superfluous and therefore warrants substantial reform.[239] Part III begins in Section A by illustrating how the ACA renders each of the policy considerations in support of preserving I.R.C. § 106 largely moot.[240] Section A concludes by suggesting that the arguments in favor of repealing I.R.C. § 106 have subsequently become increasingly more compelling.[241] Finally, Section B presents an argument for reform that stops short of calling for outright repeal.[242]

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will climb from 82% to 91%—excluding unauthorized immigrants. *See id. But see* Gillette et al., *supra* note 54, at 702 n.9, 704 (suggesting that in the context of the ACA, repeal of I.R.C. § 106 would result in 3.9 million people becoming uninsured).

[236] *Compare* 2012 Estimates for the ACA, *supra* note 143, at 20 (indicating that the number of uninsured non-elderly Americans will be reduced by 24 million between 2012 and 2016 as a result of the ACA), *with* Lyke, *supra* note 4, at 19 (suggesting that I.R.C. § 106 is inequitable, and that handing out large subsidies to high-income earners is irrational and wasteful), *and* Joint Comm. on Taxation 2006, *supra* note 227, at 2 (indicating that the purpose of implementing I.R.C. § 106 was that the exclusion would both encourage and facilitate the expansion of insurance coverage incidence in the United States).

[237] *See* Joe, *supra* note 5, at 1322 (suggesting that the ACA has brought about a dramatic change to the U.S. health care system); Stolberg & Pear, *supra* note 105 (same); *supra* notes 110–146 and accompanying text (illustrating the effects of the ACA on the U.S. health care system).

[238] *See* Joe, *supra* note 5, at 1322 (suggesting that passage of the ACA warrants a reexamination of I.R.C. § 106); *infra* notes 250–301 and accompanying text (examining the policy considerations in support of I.R.C. § 106 in light of the ACA).

[239] *See infra* notes 302–310 and accompanying text (suggesting that the ACA has rendered I.R.C. § 106 largely superfluous); *infra* notes 311–334 (expounding upon how I.R.C. § 106 should be reformed).

[240] *See infra* notes 243–301 and accompanying text.

[241] *See infra* notes 302–310 and accompanying text.

[242] *See infra* notes 311–334 and accompanying text.

A. *Eroding Support: In Light of the ACA, the Policy Considerations in Support of Repealing I.R.C. § 106 Outweigh Those in Favor of Preserving It*

The enactment of the ACA has largely undermined the arguments in favor of maintaining I.R.C. § 106.[243] In addition, the policy considerations in support of repealing or reforming I.R.C. § 106 have subsequently become increasingly compelling.[244] Subsection 1 of this Section discusses how a number of ACA provisions will soften the potential blow that the repeal or reform of Section 106 could potentially impose on employers.[245] Subsection 2 then asserts that in light of overwhelming cost-control measures implemented by the ACA, the argument that I.R.C. § 106 remains the only effective means of constraining health care costs is no longer accurate.[246] Subsection 3 illustrates how, in generating effective risk pools and affordable insurance, a variety of ACA provisions collectively imitate the advantages of employer-provided health care.[247] Subsection 4 then discusses how the ACA will provide comparable support to the millions of Americans who currently benefit from I.R.C. § 106.[248] Finally, Subsection 5 weighs the policy considerations both for and against I.R.C. § 106 in light of the ACA and concludes that the ACA has largely usurped the role of I.R.C. § 106, thereby making the policy considerations for repeal or reform of I.R.C. § 106 all the more compelling.[249]

1. The ACA Also Provides Benefits to Employers

In light of the ACA, the benefit that I.R.C. § 106 provides to employers is now a less compelling policy consideration.[250] Although some employers may suffer "harm" if they have to raise employee wages,[251]

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[243] *See infra* notes 250–301 and accompanying text.

[244] *See supra* notes 147–236 and accompanying text (illustrating the policy considerations in support of repeal or reform of I.R.C. § 106); *infra* notes 250–310 and accompanying text (illustrating how the policy considerations in support of preserving I.R.C. § 106 have been rendered largely moot by the ACA).

[245] *See infra* notes 250–255 and accompanying text.

[246] *See infra* notes 256–274 and accompanying text.

[247] *See infra* notes 275–289 and accompanying text.

[248] *See infra* notes 290–301 and accompanying text.

[249] *See infra* notes 302–310 and accompanying text.

[250] *See* 42 U.S.C. § 45R(a)–(b) (Supp. IV 2010); *infra* notes 251–255 and accompanying text.

[251] *See* Sugin, *supra* note 3, at 22 (arguing that I.R.C. § 106 allows employers to pay employees less wages, and that repeal may harm employers by forcing them to pay higher

the ACA offers companies a number of benefits that will mitigate such supposed burdens.[252] For example, as of 2014, the ACA will provide a tax credit to small businesses worth up to 50% of their contribution to employee health insurance premiums and a comparable tax credit to small non-profits worth up to 35% of their contributions.[253] In addition, one report suggests that over the long term, the cumulative cost-control measures of the ACA will result in a $3000 per employee reduction in health care costs for employers.[254] Thus, the ACA will help to offset potential harms that may arise if employers are forced to increase wages due to a repeal or reform of I.R.C. § 106—making this policy consideration less compelling than before the enactment of the ACA.[255]

2. The ACA Implements a Multitude of Cost-Control Measures

The ACA includes an extensive series of measures that are designed to curb the costs of health care.[256] In light of these provisions, the argument that I.R.C. § 106 remains the only viable means to constrain

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wages); *see also supra* notes 54–58 and accompanying text (discussing why employers may need to raise employee wages in response to repeal of I.R.C. § 106).

[252] *See* 42 U.S.C. § 45R(a)–(b) (indicating that in 2014, the ACA will provide a tax credit to small businesses worth up to 50% of their contribution to their employees' health insurance premiums and a comparable tax credit to small non-profits worth up to 35%); HEWITT ASSOCS., BUS. ROUNDTABLE, HEALTH CARE REFORM: CREATING A SUSTAINABLE HEALTH CARE MARKETPLACE 2 (2009), *available at* http://www.pewsocialtrends.org/files/2011/11/WealthReportFINAL.pdf (predicting that over the long term, the cumulative cost-control measures put in place by the ACA will result in a reduction of more than $3000 per employee in health care costs for employers). This argument relies on the assumption that employees will successfully negotiate higher wages as a result of losing the Section 106 tax benefit. *See* Sugin, *supra* note 3, at 22. The veracity of this argument is beyond the scope of this Note. It is worth noting, however, that it may actually be only those in higher-income brackets who will successfully negotiate higher wages—by definition mitigating some of the "harm" experienced by employers. *See* Buckley, *supra* note 72, at 261; Gillette et al., *supra* note 54, at 700.

[253] *See* 42 U.S.C. § 45R(a)–(b).

[254] *See* HEWITT ASSOCS., *supra* note 252, at 2. This report considered the predicted savings of novel, difficult-to-quantify cost-control measures that will be implemented by the ACA. *See* Farley, *supra* note 183. The CBO predicts a more modest reduction in cost of $100 per employee, though this figure is also subject to criticism, as it fails to account at all for these difficult-to-quantify cost-control measures. *See id.* It is important to note that although both predictions are likely off target, they nevertheless suggest an overall reduction in employer costs. *See id.*

[255] *See* 42 U.S.C. § 45R(a)–(b); HEWITT ASSOCS., *supra* note 252, at 2.

[256] *See* Miller, *supra* note 7, at 28; *see also supra* notes 118–130 and accompanying text (discussing these cost-control measures).

health care costs no longer seems as persuasive.[257] The ACA will implement virtually every single cost-control measure suggested by industry experts.[258] To do so, the ACA focuses on a number of core reforms.[259] First, the ACA focuses on cutting unnecessary costs.[260] These include both preventing health care fraud and abuses,[261] and promoting preventive care.[262] Second, the ACA seeks to reduce health care costs by holding insurance companies more accountable.[263] The ACA requires insurance companies to spend a certain percentage of premium dollars on health care services and quality improvement.[264] Insurance companies must pay a penalty in the form of a rebate to customers if they fail to meet these standards.[265] Third, the ACA implements a number of programs designed to restructure the delivery of health care.[266] For example, the ACA provides for the creation of Accountable Care Organizations.[267] These groups of doctors, acting in concert, will be better suited to coordinate patient care and promote preventive services than

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[257] *Compare* Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120 (indicating that the ACA will constrain costs by promoting preventive measures), James & Levine, *supra* note 123, at 242 (indicating the ACA will incentivize cost cutting through the creation of Accountable Care Organizations), Miller, *supra* note 7, at 28 (indicating that the ACA will constrain costs by reforming the health care delivery system and targeting fraud and abuse), *and* Orszag & Emanuel, *supra* note 118, at 603 (arguing that the ACA will incentivize cost cutting through the implementation of a payment bundling pilot program), *with* Zelinsky, *supra* note 4, at 209–12 (arguing that I.R.C. § 106 should be maintained because politicians are unwilling and unable to implement cost-control measures).

[258] Orszag & Emanuel, *supra* note 118, at 603.

[259] *See* UTAH HEALTH POLICY PROJECT, *supra* note 122, at 2.

[260] *Id.*; Orszag & Emanuel, *supra* note 118, at 601.

[261] Orszag & Emanuel, *supra* note 118, at 601–02. The CBO predicts that these efforts will save $7 billion over ten years. *Id.*

[262] Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120; Orszag & Emanuel, *supra* note 118, at 602–03; *see* 42 U.S.C. § 300gg-13 (Supp. IV 2010). Increasing preventative care has been identified as an effective long-term method for reducing health care costs. *See* James F. Fries et al., *Reducing Health Care Costs by Reducing the Need and Demand for Medical Services*, 329 NEW ENG. J. MED. 321, 321 (1993). The ACA promotes preventive care by requiring insurance plans to cover the cost of certain preventive services in full. Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120; *see* 42 U.S.C. § 300gg-13; *see also supra* note 120 and accompanying text (discussing the ACA's "National Prevention, Health Promotion, and Public Health Council").

[263] Sebelius, *supra* note 117; *see* 42 U.S.C. § 300gg-18 (Supp. IV 2010).

[264] *See* 42 U.S.C. § 300gg-18(a). These required percentages amount to 85% of premium dollars spent pursuant to large employer plans and 80% spent pursuant to individual or small employer plans. *Id.* § 300gg-18(b).

[265] *See id.* § 300gg-18(b)(1)(B).

[266] Miller, *supra* note 7, at 28.

[267] Gutwald, *supra* note 123, at 22; James & Levine, *supra* note 123, at 242; Orszag & Emanuel, *supra* note 118, at 602; *see* 42 U.S.C. § 1395jjj (Supp. IV 2010).

individual physicians would be.[268] In addition, the ACA provides increased authority for payment bundling.[269] Our current "fee-for-service" system incentivizes more costly care, as opposed to efficient care.[270] Under payment bundling, "episodes of care" are collectively billed at a flat rate, which will promote more efficient health care and reduce costs.[271]

The ACA demonstrates a determination for cutting costs that commentators argued was previously missing from government programs.[272] Considering the extent of the ACA's cost-containment provisions, it appears that the federal government has finally shown its willingness to combat the rising cost of health care.[273] Thus, in light of the ACA, the argument that I.R.C. § 106 will be necessary to control the costs of health care is less convincing today.[274]

3. The ACA Will Facilitate Risk Pooling as Effectively as I.R.C. § 106

The argument that I.R.C. § 106 provides the only effective means of risk pooling is no longer accurate.[275] First, because of the ACA, the

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[268] *See* James & Levine, *supra* note 123, at 242; Orszag & Emanuel, *supra* note 118, at 602. The ACA encourages doctors to join these organizations by allowing them to keep a portion of their net saved costs. Gutwald, *supra* note 123, at 22; *see* 42 U.S.C. § 1395jjj(d).

[269] James & Levine, *supra* note 123, at 244; Orszag & Emanuel, *supra* note 118, at 603; Skindrud & Cleary, *supra* note 126, at 52; *see* 42 U.S.C. § 1395cc-4 (Supp. IV 2010).

[270] Gutwald, *supra* note 123, at 20–21; *supra* notes 126–130 and accompanying text (describing the inefficiencies of the "fee-for-service" system).

[271] James & Levine, *supra* note 123, at 244–46; Orszag & Emanuel, *supra* note 118, at 603.

[272] *Compare* Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120 (indicating that the ACA will constrain costs by promoting preventive measures), James & Levine, *supra* note 123, at 242 (indicating that the ACA will incentivize cost cutting through the creation of Accountable Care Organizations), Miller, *supra* note 7, at 28 (indicating that the ACA will constrain costs by reforming the health delivery system and targeting fraud and abuse), *and* Orszag & Emanuel, *supra* note 118, at 603 (arguing that the ACA will incentivize cost cutting through the implementation of a payment bundling pilot program), *with* Zelinsky, *supra* note 4, at 211 (arguing that the cost-control measures implemented by employers are proof of a determination to curb health care costs that is unmatched by politicians).

[273] *See* Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120; James & Levine, *supra* note 123, at 242; Miller, *supra* note 7, at 28; Orszag & Emanuel, *supra* note 118, at 603.

[274] *Compare* Baker, *supra* note 119, at 1583 & n.25, 1602 & n.120 (indicating that the ACA will constrain costs by promoting preventive measures), Miller, *supra* note 7, at 28 (indicating that the ACA will constrain costs through a variety of measures), *and supra* notes 118–130 and accompanying text (discussing ACA cost-control measures), *with* Zelinsky, *supra* note 4, at 209–12, 214 (arguing that I.R.C. § 106 should be maintained because politicians are unwilling and unable to implement cost-control measures).

[275] *Compare* LYKE, *supra* note 4, at 11 (indicating that some of the opposition to repeal is rooted in I.R.C. § 106's ability to generate stable risk pools), *with* Gillette et al., *supra* note 54, at 703, 705–06 (suggesting that the repeal of I.R.C. § 106 will not cause healthy employees to flee employer risk pools), *and* Siadak, *supra* note 136, at 869–71 (indicating

repeal or reform of I.R.C. § 106 would not destabilize the employer-provided risk pool.[276] One study illustrated that in a pre-ACA world, repealing I.R.C. § 106 would most likely cause healthy patrons to leave the employer risk pool.[277] This was because when faced with the newly added tax burden on employer insurance, these patrons would be more attracted to the lower premiums of the individual market.[278] In contrast, with the ACA exchanges as an alternative, healthy employees will be less likely to leave employer-provided insurance.[279] This is because the once attractive premiums of the individual market would be replaced by community ratings and higher rates in the exchanges.[280]

Second, with the creation of the ACA insurance exchanges in 2014, employer-provided insurance will no longer be the sole, convenient form of group-based insurance.[281] U.S. citizens will now have a viable alternative.[282] Like employer-provided insurance, the ACA provisions will avoid the problems of the individual market.[283] The ACA will include an individual mandate requiring every taxpayer to acquire health insurance, or suffer a penalty as a result.[284] Thus, there will be an incentive for healthy people to join the risk pool, which should stabilize costs.[285]

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that the 2014 ACA provisions will provide citizens with a viable alternative for insurance in the form of new state-based insurance exchanges).

[276] *See* Gillette et al., *supra* note 54, at 705.

[277] *See id.* at 698.

[278] *See id.*

[279] *See id.* at 705.

[280] *See id.*

[281] *Compare* Gamage, *supra* note 4, at 676–80 (describing how employer-provided insurance avoids the problems that plague the individual market), *with* Parmet, *supra* note 132, at 401 (indicating that the individual mandate will combat the issue of adverse selection), Roberts, *supra* note 133, at 1187 (indicating that pursuant to the ACA, insurance companies will be prohibited both from denying coverage to individuals with preexisting conditions and charging them higher premiums), *and* Siadak, *supra* note 136, at 869–71 (indicating that the 2014 ACA provisions will provide citizens with a viable alternative form of insurance through new state-based insurance exchanges).

[282] *See* Parmet, *supra* note 132, at 401; Roberts, *supra* note 133, at 1187; Siadak, *supra* note 136, at 869–71.

[283] *See* Parmet, *supra* note 132, at 401 (indicating that the individual mandate will combat the issue of adverse selection); Roberts, *supra* note 133, at 1187 (illustrating that pursuant to the ACA, insurance companies will be both prohibited from denying coverage to individuals with preexisting conditions and charging them higher premiums).

[284] Parmet, *supra* note 132, at 401.

[285] *See id.*

Furthermore, just as employer-provided insurance was able to avoid risk classification, so too does the ACA.[286] The ACA implements a variety of measures designed specifically to protect unhealthy taxpayers from discrimination in the insurance market.[287] For example, the ACA prevents insurance companies from denying coverage to individuals with preexisting conditions, or charging them higher costs.[288] As a result, because the ACA maintains convenient risk pools and protects unhealthy and at-risk individuals, the arguments in favor of preserving I.R.C. § 106 are less compelling.[289]

4. The ACA Will Provide Millions of Americans with Benefits Comparable to Those They Currently Receive Under I.R.C. § 106

The ACA implements a number of provisions that will protect vulnerable taxpayers from unaffordable tax increases that might have otherwise stemmed from the repeal of I.R.C. § 106.[290] First, some scholars note that taxpayers typically have limited choices with regard to their insurance plans.[291] The ACA may reduce potential tax burdens that would result from the repeal of I.R.C. § 106 because the ACA will increase the number of insurance choices available to taxpayers.[292] Taxpayers who would not be able to shoulder the newfound tax burden would be able to choose alternative, affordable plans through the ACA

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[286] *Compare* Gamage, *supra* note 4, at 679–80 (describing how employer-provided insurance avoids the problems of risk classification), *with* Roberts, *supra* note 133, at 1187 (observing that pursuant to the ACA, insurance companies will be both prohibited from denying coverage to individuals with preexisting conditions and charging them higher premiums).

[287] Roberts, *supra* note 133, at 1187; *see* 42 U.S.C. § 300gg (Supp. IV 2010) (prohibiting insurance companies from denying coverage based on preexisting conditions); *id.* § 300gg-3 (Supp. IV 2010) (prohibiting discriminatory rates).

[288] Roberts, *supra* note 133, at 1187; *see* 42 U.S.C. § 300gg; *id.* § 300gg-3.

[289] *See supra* notes 275–288 (discussing how the ACA creates viable risk pools).

[290] *See* Monahan, *supra* note 134, at 783 & n.14 (discussing the subsidies that will be offered for those who could not otherwise afford insurance); Siadak, *supra* note 136, at 869–71 (discussing the new insurance exchanges that will be implemented by the ACA and the variety of insurance plans).

[291] *See* Brown, *supra* note 37, at 81; Anne Underwood, *For Many Consumers, Few Insurance Choices*, N.Y. Times (Aug. 19, 2009, 9:30 AM), http://prescriptions.blogs.nytimes.com/2009/08/19/how-much-competition-among-insurers/.

[292] *See* Brown, *supra* note 37, at 81 (arguing that the current lack of competition among insurance providers increases costs); Underwood, *supra* note 291 (illustrating that some believe that increased competition from government-run insurance plans would help to lower costs); *see also* Thomas A. Mitchell, *State of the Art(s): Protecting Publishers or Promoting Progress?*, 12 Rich. J.L. & Tech. 1, 31 (2005) (indicating that increased competition breeds lower prices); Siadak, *supra* note 136, at 869–71 (describing the new insurance exchanges that will be implemented by the ACA and the variety of insurance plans).

exchanges.[293] Through these exchanges, the ACA will offer an unprecedented variety of insurance plans with differing rates, thereby allowing taxpayers to choose their coverage based on affordability.[294] In addition, whereas the consolidation of the insurance industry has been a significant factor in driving up premiums in the past,[295] the ACA may lower overall taxpayer burdens by opening the market to increased competition.[296] Furthermore, for individuals who cannot even afford the most basic coverage through the ACA exchanges, the ACA provides subsidies that will enable them to purchase insurance.[297] Finally, the distribution of I.R.C. § 106 benefits across income levels indicates that for the most part, the taxpayers who would suffer from a potentially increased tax burden would be those most capable of bearing the additional costs.[298] This is because high-income earners disproportionately benefit from I.R.C. § 106.[299] In addition, low-income earners who would otherwise qualify for the employer-provided insurance benefit often do not make enough money to capitalize on that benefit.[300] Accordingly, the support currently given to taxpayers by I.R.C. § 106 will

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[293] *See* Gamage, *supra* note 4, at 689–90 & n.107. Taxpayers will be able to choose the option of purchasing insurance in an ACA exchange, and will become eligible for the insurance exchange subsidies if the plan that their employer offers them is deemed to be unaffordable. *Id.* This occurs when the amount that a taxpayer is required to contribute to a premium exceeds 9.8% of the taxpayer's household income. *See* 26 U.S.C. § 36B(c)(2)(B)–(C) (Supp. IV 2010).

[294] *See* Brown, *supra* note 37, at 81 (describing the current limited options for employees); Siadak, *supra* note 136, at 869–71 (discussing the new insurance exchanges); Underwood, *supra* note 291 (suggesting that many taxpayers currently do not have meaningful choices regarding their insurance plans).

[295] *See* Underwood, *supra* note 291.

[296] *See id.* (illustrating that some believe that increased competition from government-run insurance plans would help to lower costs); *see also* Brown, *supra* note 37, at 81 (arguing that the current insurance paradigm suffers from a lack of choice and competition, which increases costs and prevents patients from obtaining more affordable alternatives).

[297] Monahan, *supra* note 134, at 783 & n.14; Rosenbaum, *supra* note 134, at 12; *see* 26 U.S.C. § 36B (Supp. IV 2010).

[298] *See Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 2 (statement of Leonard E. Burman, Senior Fellow, Urban Institute); Lyke, *supra* note 4, at 19; Brown, *supra* note 37, at 79; Singleton, *supra* note 3, at 332; *see also Roundtable on Financing Healthcare Reform*, *supra* note 97, at 5 (statement of Leonard E. Burman, Director, Tax Policy Center) (indicating that most low-income earners do not typically benefit from I.R.C. § 106).

[299] Lyke, *supra* note 4, at 19; Brown, *supra* note 37, at 79.

[300] *Taking a Checkup on the Nation's Health Care*, *supra* note 174, at 2 (statement of Leonard E. Burman, Senior Fellow, Urban Institute); Singleton, *supra* note 3, at 332. As of 2008, 36.3% of Americans did not owe any income tax. Singleton, *supra* note 3, at 332.

still be provided by the ACA, albeit in a more strategic and nuanced manner.[301]

5. The ACA Has Effectively Usurped the Role of I.R.C. § 106

The foregoing analysis reveals that the ACA has largely usurped the role of the exclusion for employer-provided insurance and is capable of replicating many of the benefits that I.R.C. § 106 has provided.[302] The ACA will provide benefits to employers in the form of tax credits, and may even reduce the cost of insurance per employee by a significant amount.[303] In addition, the ACA similarly aims to constrain health care costs and is capable of both sustaining current employer risk pools and creating additional, independent risk pools.[304] Furthermore, the ACA will provide similar relief to taxpayers who currently rely on the benefit provided by the Section 106 exclusion.[305] Finally, whereas the primary justification for I.R.C. § 106 was to expand insurance coverage in the United States, not only is this the primary goal of the ACA, but the ACA actually more effectively accomplishes this goal than the employer-provided exclusion paradigm ever did.[306]

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[301] *See* Mitchell, *supra* note 292, at 31; Monahan, *supra* note 134, at 783 & n.14; Siadak, *supra* note 136, at 869–71.

[302] *See supra* notes 243–301 and accompanying text (describing how the ACA renders each of the policy considerations in support of I.R.C. § 106 moot).

[303] *See* 26 U.S.C. § 45R (Supp. IV 2010) (providing for employer tax credits); HEWITT ASSOCS., *supra* note 252, at 2 (discussing the potential reduced costs for employers); *supra* notes 53–58 and accompanying text (discussing the benefits that the ACA may provide to employers generally).

[304] *See* Miller, *supra* note 7, at 28 (suggesting that the ACA will help to constrain health care costs); *supra* notes 118–130 and accompanying text (discussing cost-control strategies of the ACA at length); *supra* notes 275–289 and accompanying text (illustrating how the ACA will preserve the stability of the employer risk pool as well as generate an additional effective risk pool).

[305] *See supra* notes 290–301 and accompanying text (describing how the ACA will provide comparable support to the millions of Americans currently benefitting from I.R.C. § 106).

[306] *See* JOINT COMM. ON TAXATION 2006, *supra* note 227, at 2 (suggesting that a primary justification for the employer-provided insurance exclusion paradigm was to increase the number of insureds in the United States); *supra* notes 131–143 and accompanying text (illustrating the methods employed by the ACA to reduce the number of uninsureds in the United States). *Compare* 2012 ESTIMATES FOR THE ACA, *supra* note 143, at 20 (suggesting that between 2012 and 2016, the percentage of insured non-elderly Americans will climb from 82% to 91%), *with* Gillette et al., *supra* note 54, at 702 n.9, 704 (suggesting that in the context of the ACA, the repeal of I.R.C. § 106 would result in 3.9 million people becoming uninsured).

As a result, the policy considerations in support of preserving I.R.C. § 106 are largely moot.[307] Without meaningful countervailing interests, the policy considerations in favor of the repeal or reform of I.R.C. § 106 have become increasingly compelling.[308] Section 106 of the I.R.C. produces both horizontal and vertical tax inequities which, considering the benefits provided by the ACA, are an unjustifiable and irrational waste of potential federal revenues.[309] Furthermore, the repeal or reform of I.R.C. § 106 would reduce the cost of health care by vitiating the insulation effect produced by the exclusion and generating significant federal revenues.[310]

B. *The Best of Both Worlds: Arguing for Reform, Not Repeal*

This Note argues that I.R.C. § 106 should undergo significant reforms, but that policymakers should stop short of outright repeal.[311] There are a number of unavoidable drawbacks that would result from the full repeal of I.R.C. § 106.[312] First, although the ACA will increase insurance coverage, at least one study suggests that repealing I.R.C. § 106 will result in nearly 3.9 million individuals losing coverage entirely.[313] Second, whereas the distribution of benefits from this exclusion disproportionately favors the wealthy, many taxpayers who benefit from this provision belong to lower-income brackets.[314] Outright repeal

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[307] *See supra* notes 243–301 and accompanying text (illustrating how the ACA successfully addresses each of the policy considerations in support of I.R.C. § 106).

[308] *See supra* notes 147–236 and accompanying text (discussing the continued persuasiveness of arguments in favor of repealing I.R.C. § 106 in light of the ACA); *supra* notes 243–301 and accompanying text (illustrating how the ACA renders the policy considerations in favor of preserving I.R.C. § 106 largely moot).

[309] *See supra* notes 196–236 (discussing at length the horizontal and vertical inequities of Section 106 both as currently realized and in light of the ACA).

[310] *See* LYKE, *supra* note 4, at 12–14 (illustrating how exposing employees to the true cost of their health care would help to reduce health care costs); JOINT COMM. ON TAXATION 2012, *supra* note 1, at 42 (predicting that I.R.C. § 106 will cost the government $725 billion between the years 2011–2015); *see also supra* notes 147–236 and accompanying text (illustrating how the ACA does not reduce the relevance of these arguments).

[311] *See infra* notes 312–334 and accompanying text.

[312] *See* Brown, *supra* note 37, at 79 (illustrating that despite the vertical inequity of the exclusion, there are some low earners who nevertheless benefit from the exclusion); Gamage, *supra* note 4, at 689–90 & n.107 (indicating that certain taxpayers may fall through the cracks with regard to eligibility for the affordability credits of the ACA insurance exchanges); Gillette et al., *supra* note 54, at 702 n.9, 704 (demonstrating that repeal of I.R.C. § 106 will result in nearly 3.9 million citizens losing coverage entirely).

[313] Gillette et al., *supra* note 54, at 702 n.9, 704. This figure represents the predicted reaction to repeal of I.R.C. § 106 in light of the ACA. *See id.* at 704.

[314] *See* Brown, *supra* note 37, at 79. Ten percent of employees earning less than $10,000 a year currently benefit from the exclusion for employer-provided insurance, and more

may be particularly harsh on these low-income individuals.[315] This is because these citizens will be disqualified from the exchange subsidies if they are offered "affordable" coverage from their employers.[316] And though coverage may be deemed per se "affordable," in reality, this may not be the case.[317] For example, if an employer provides individual insurance coverage to employees at a rate that does not exceed 9.8% of the employee's annual household income, then the employer-provided insurance will be deemed affordable—even if that employee is enrolled in a more expensive family plan.[318] Importantly, this disqualifies not only the employee, but also the employee's family from the insurance exchange credits.[319] Accordingly, repealing I.R.C. § 106 would deny these taxpayers both the ACA's credits and the benefit that result from excluding employer-provided insurance from their income.[320] Nevertheless, the arguments in favor of repeal remain compelling.[321]

One solution that may find the middle ground between both the arguments for repeal and the lingering arguments against outright repeal would be to convert the exclusion for employer-provided coverage into a refundable tax credit.[322] Such a tax credit could be designed

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than 50% of employees earning $50,000–$75,000 a year currently benefit from the exclusion. *Id.*

[315] *See* Gamage, *supra* note 4, at 689–90 & n.107 (indicating that certain taxpayers who may need the benefit of the insurance exchange credits will nevertheless be disqualified from recovering them as a result of their employer offering individual coverage at a rate that is deemed "affordable").

[316] *See* 26 U.S.C. § 36B(c)(2)(B)–(C) (Supp. IV 2010); Gamage, *supra* note 4, at 689. This is true regardless of whether the employee actually chooses to enroll in the employer-provided coverage. Gamage, *supra* note 4, at 689. Nevertheless, employers are incentivized to offer these employees "affordable coverage" because they will be penalized for failing to do so. *Id.* at 693 & nn.121 & 126, 694 & n.128; *see* 26 U.S.C. § 4980H(a), (c) (Supp. IV 2010) (codifying this penalty).

[317] *See* Gamage, *supra* note 4, at 689.

[318] *See* 26 U.S.C. § 36B(c)(2)(B)–(C) (illustrating that affordable individual coverage is defined as a plan whose payments do not exceed 9.8% of an employee's annual household income); Treas. Reg. § 1.36B-2(c)(3)(v)(A)(2), (D) ex. 2 (2012) (illustrating that even if an employee is enrolled in a more expensive family plan, the measure of "affordability" is based on the cost an employee would need to contribute for self-coverage).

[319] Gamage, *supra* note 4, at 689; *see* Treas. Reg. § 1.36B-2(c)(3)(v)(A)(2), (D) ex. 2.

[320] *See* Gamage, *supra* note 4, at 689–90 & n.107.

[321] *See Making Medicare, Medicaid and Social Security Sustainable*, *supra* note 37, at 4 (testimony of Alice M. Rivlin, Senior Fellow, Brookings Institution); Fred T. Goldberg, Jr. & Susannah Camic, *Tax Credits for Health Insurance*, 37 J.L. Med. & Ethics 73, 75 (2009).

[322] *See* Goldberg & Camic, *supra* note 321, at 75 (suggesting that I.R.C. § 106 can be reformed—instead of repealed—by converting it into a refundable, progressive tax credit); Brian H. Jenn, *The Case for Tax Credits*, 61 Tax Law. 549, 584 (2008) (arguing that the conversion of the exclusion into a refundable tax credit would be a more equitable and more efficient approach than the current arrangement). A tax credit is a benefit that reduces

progressively, and mirror the insurance exchange credits, by scaling back or entirely eliminating the exclusion for higher-earning taxpayers.[323] Importantly, this would still largely accomplish the goals that those in favor of repealing the exclusion seek.[324] Converting the exclusion into a targeted tax credit would ensure that this tax expenditure was disbursed more rationally by targeting taxpayers who actually need the benefit and not those who can do without it.[325] This would also promote both horizontal and vertical principles of tax equity.[326] By mirroring the exchange subsidies, this solution would ensure that similarly situated taxpayers are treated the same.[327] In addition, high-income taxpayers would no longer disproportionately benefit from the exclusion.[328] Converting the exclusion into a targeted tax credit would also continue to generate increased federal revenues and help to reduce the federal deficit.[329] Furthermore, this approach would remove incentives that drive up the cost of health care, thereby promoting a more sustainable form of health care spending.[330]

Finally, this solution would also avoid the pitfalls that would accompany the complete repeal of I.R.C. § 106.[331] Continuing to provide this

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the total amount of taxes owed by a taxpayer, and is therefore static—unaffected by marginal tax rates. Jenn, *supra*, at 557. In order for such a credit to preserve this equity, it is important that the credit be refundable. *See id.* This will ensure that a taxpayer whose liability does not exceed the credit will be able to receive the same benefit as a higher-earning taxpayer whose tax liability exceeds the credit value. *See id.*

[323] *See* Gamage, *supra* note 4, at 715; *see also* Goldberg & Camic, *supra* note 321, at 75 (suggesting that I.R.C. § 106 can be reformed—instead of repealed—by converting it into a refundable, progressive tax credit).

[324] *See* Gamage, *supra* note 4, at 715 (illustrating how this solution could promote horizontal equity); Goldberg & Camic, *supra* note 321, at 76–77 (indicating that this solution would be a more rational distribution of federal revenues, promote vertical equity, and help curb the growing cost of health care); Martin A. Sullivan, *Economic Analysis: The Employer Healthcare Exclusion's Role in Tax Reform*, TAX NOTES, Oct. 29, 2012, at 462, 465–66 (indicating that even small reductions to the I.R.C. § 106 benefit would produce significant federal revenues).

[325] Goldberg & Camic, *supra* note 321, at 75–76; Jenn, *supra* note 322, at 584.

[326] *See* Gamage, *supra* note 4, at 715 (indicating that taxpayers under this proposal can receive the same benefit regardless of whether they have coverage through their employer or through the exchange); Jenn, *supra* note 322, at 580 (indicating that converting I.R.C. § 106 into a tax credit would promote vertical equity by ensuring that higher-earning taxpayers no longer disproportionately benefit from this expenditure).

[327] *See* Gamage, *supra* note 4, at 715.

[328] Goldberg & Camic, *supra* note 321, at 76; Jenn, *supra* note 322, at 580.

[329] Sullivan, *supra* note 324, at 465–66.

[330] *See* Goldberg & Camic, *supra* note 321, at 76–77; Jenn, *supra* note 322, at 580.

[331] *Compare* Brown, *supra* note 37, at 79 (illustrating that despite the vertical inequity of the exclusion, there are some low earners who nevertheless benefit from the exclusion), *and* Gamage, *supra* note 4, at 689–90 & n.107 (indicating that certain taxpayers may fall

benefit in the form of a credit would make sure that those who might fall through the cracks under repeal and need aid will be able to secure it.[332] Furthermore, this solution may reduce the number of people who are predicted to lose coverage entirely as a result of the full repeal of I.R.C. § 106.[333] This is because young taxpayers may be less likely to forgo coverage if they are offered a refundable tax credit that will mitigate the costs of now-taxed employer-provided health benefits.[334]

Conclusion

Section 106 of the I.R.C., the federal income tax exclusion for employer-provided health insurance, was enacted decades ago for the primary purpose of increasing health care coverage in the United States. Since then, scholars have advanced a number of policy considerations in support of this provision, including the fact that it benefits employers; constrains health care costs; generates stable risk pools; and provides support for millions of Americans who rely on it. Although this provision has remained static in the years since its adoption, the American health care landscape has recently undergone one of the most expansive legislative overhauls in decades. The Patient Protection and Afford-

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through the cracks and be ineligible for ACA credits), *with* Goldberg & Camic, *supra* note 321, at 77 (indicating that this tax credit can be specifically designed to target low- and middle-income families).

[332] *See* Brown, *supra* note 37, at 79; Gamage, *supra* note 4, at 689–90 & n.107; Goldberg & Camic, *supra* note 321, at 75.

[333] *Compare* Gillette et al., *supra* note 54, at 702 n.9, 704 (indicating that in spite of the ACA, the repeal of I.R.C. § 106 would leave nearly 3.9 million individuals formerly covered by employer-provided insurance entirely without coverage), *and* E-mail from Robert Gillette, *supra* note 104 (indicating that 3.9 million individuals predicted to be left uninsured by the ACA would largely consist of young employees who would voluntarily forego coverage when faced with either full taxation of employer-provided benefits or community ratings in the exchanges), *with* Richard Fry et al., Pew Research Ctr., The Old Prosper Relative to the Young: The Rising Age Gap in Economic Well-Being 6, 10 (2011), *available at* http://www.pewsocialtrends.org/files/2011/11/WealthReportFINAL.pdf (indicating that, as of 2010, 22% of households headed by an adult younger than thirty-five live in poverty), Goldberg & Camic, *supra* note 321, at 75 (indicating that this tax credit can be specifically designed to target low- and middle-income families), *and* Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance*, 1998 U. Ill. L. Rev. 801, 818 (indicating that, on average, the young are poorer members of society).

[334] *Compare* Korobkin, *supra* note 333, at 818 (indicating that, on average, the young are the poorest members of society), *and* E-mail from Robert Gillette, *supra* note 104 (indicating that young employees may voluntarily forego coverage when faced with either full taxation of employer-provided benefits or community ratings in the exchanges), *with* Goldberg & Camic, *supra* note 321, at 77 (indicating that this tax credit can be specifically designed to target low- and middle-income families).

able Care Act (ACA) has fundamentally altered the context in which the policy considerations in favor of I.R.C. § 106 were couched.

This Note has argued that the ACA successfully addresses each of the policy concerns that previously justified the preservation of I.R.C. § 106, including the objective of increasing the incidence of insurance in the United States. As a result, the policy considerations against I.R.C. § 106 have become increasingly more compelling. With its benefits largely rendered moot, I.R.C. § 106 is quickly becoming an antiquated piece of legislation that creates disconcerting tax inequities among American citizens by favoring the wealthy. Despite this, we should stop short of repealing Section 106 entirely, and should, instead, substantially reform it. Converting the exclusion into a progressive, refundable tax credit would largely accomplish the goals sought by repeal, while still avoiding the negative repercussions that total repeal may engender. This reform is critically important because we neither need nor can afford to continue supporting two federally funded health care systems.

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