Why Healthcare Reform Means the Death of Reagan-Era Tax Reform

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By Scott L. Semer

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The recently enacted healthcare reform legislation, with its continuation of the existing tax treatment of employer-provided health insurance and imposition of several revenue-raising provisions to pay for bringing more people into the current health insurance system, spells the end of the Reagan-era tax reform that created the 1986 code.

If you are driving south from the FDR Drive in New York City across the Brooklyn Bridge to Brooklyn and then on to the Brooklyn Queens Expressway, as hundreds of thousands of drivers do each week, at four different points you will need to wait patiently as two lanes of traffic are forced to merge into one lane for approximately 20 to 100 yards before the road expands back to two lanes. At two of these merges, drivers try to defeat this inefficient traffic pattern by turning a purported single lane into two narrow lanes, so that no merging is necessary. In two other places, drivers try to wait to merge until the last possible moment — which is mathematically the most efficient way to merge — so that traffic in each of the merging lanes travels at approximately the same speed.

Several times a month, clearly visible to me and the other walking commuters from our vantage point on the pedestrian path of the Brooklyn Bridge, the NYPD tries to prevent these driver redesigns by stationing police cars near the point of the merge and ticketing anyone who tries to use unmarked pavement as an extra lane or who fails to merge before the point the traffic signs arbitrarily decide is the last place to change from the second lane into the first. Whenever the police decide to show up, an enormous traffic jam is created and traffic slows to a crawl, drawing bewildered stares from the throngs of tourists who walk across the bridge. When the NYPD leaves drivers to their own devices, traffic inevitably moves fairly well — not as well as if the traffic pattern were properly designed, but far better than when the police try to force everyone to follow poorly designed rules to the letter.

The recent tax law and health insurance changes ushered in as part of the two recently signed healthcare bills present a strangely similar phenomenon.

For longer than the “useful lives” of most individuals paying taxes in the U.S. today, the code has provided a large incentive for employers to offer health insurance to employees, even when the employees would have been much better off — absent the tax considerations — with other forms of compensation.

The tax system has done this through essentially two mechanisms. First, employees can receive the benefits of health insurance without being taxed on the premiums paid by their employer. While $10,000 of cash compensation would be taxable to an employee, $10,000 used by the employer to buy health insurance for the employee does not produce taxable income. The expenditure remains deductible for the employer, creating a clear incentive on the part of the employee for this form of tax-free compensation without creating a corresponding opposite incentive for the employer.

Second, employees who “win” their insurance bet — meaning that they end up receiving more in health benefits paid for by the insurance company than the cost of their premiums — are not taxed on this income.

Health insurance thus represents one of the rare instances in which a taxpayer gets to make a deductible expenditure that can yield tax-free income.

Not surprisingly, taxpayers have sought to increase their ability to take advantage of this opportunity in two ways: first, by increasing the value of the insurance they receive, and second, by increasing the tax-free benefits they receive once the insurance is in place. The first goal is achieved by having the employer purchase a more valuable insurance plan for the employee, such as one that covers more types of healthcare procedures, requires lower deductibles and co-payments by the employee, and also covers the employee’s family members. The second goal is achieved by obtaining more healthcare services that are paid for by the insurance company. At a minimum, a rational employee would want to try to use at least as much in healthcare services as is equal to the taxable compensation they could have received if they had received cash compensation instead of the healthcare policy (arguably they should settle for slightly less, since the insurance policy also provides the peace of mind of knowing that expensive healthcare emergencies will be covered).

The incentives created by the tax treatment of these healthcare benefits therefore serve as a substitute for the physical barriers or police cars that force our commuters to use one lane. In the case of healthcare, the lane that the incentives encourage taxpayers to use is one of receiving larger and more valuable healthcare packages and of using as many services as possible.

While some consumers may have wanted to acquire insurance to cover only certain unexpected catastrophes — the typical purview of insurance — the market moved
to accommodate the vast majority who wanted to maximize the tax-free benefits available to them. Not surprisingly, after decades of this system, both the cost of health insurance and the consumption of healthcare services have increased dramatically. If this increase continues, an unsustainable percentage of our gross national product will be spent on health insurance and healthcare. Moreover, due to the increased costs, it will become harder for people to obtain both healthcare and insurance to treat health problems that would otherwise lead to financial catastrophe. Also, insurance companies have become involved in every part of the healthcare system, even routine procedures that patients would normally have paid for on their own if not for the tax incentives of the current system.

Instead of addressing the existing tax distortion that helped to create these problems, the new healthcare legislation provides additional subsidies to those who are unable to obtain the tax benefits of employer-provided insurance, and it requires that insurers provide plans that will ultimately prove to be even more costly because they must cover more circumstances and have fewer exclusions. With the exception of a minor penalty on “Cadillac” health plans that isn’t applicable until far in the future (and may never actually go into effect), the legislation encourages yet more people to move into the lane of more expensive insurance, more consumption of healthcare services, and perhaps most perniciously of all, to involve insurance companies in even routine visits to the doctor.

Inevitably, both the cost of health insurance and the consumption of services, and as a result the cost of those services, will continue to rise dramatically.

Eventually someone will have to pay for all of this.

The legislation’s plan to cover at least some of these potential costs is essentially to increase marginal tax rates. Once all of the rate changes are phased in, a taxpayer subject to the highest marginal rates on earned income — including the applicable Medicare taxes — who also resides in a state and city that impose income tax will face marginal tax rates of at least 53 percent or greater. By contrast, in Canada, taxpayers who are subject to the highest marginal rates, aggregating provincial and Canadian federal rates, face maximum rates of approximately 48 percent in Quebec and 46 percent in Alberta. Canada, of course, provides universal healthcare to all its citizens, something the U.S. will still be far from doing.

Let’s now look briefly at just one of the complicated “revenue-raising” elements of the healthcare bills: the codification of the economic substance doctrine.

No less a jurist than Judge Learned Hand said there was nothing sinister or unpatriotic about trying to arrange your affairs to pay as little tax as possible. Yet under new code section 7701(o), a transaction — or possibly even steps within a larger transaction — will not be given effect for tax purposes unless the taxpayer has a “substantial” nontax purpose for entering into it. In the case of our driving example, this is akin to the police pulling over a car that correctly merged into one lane to find out if they did the merge only to avoid getting a ticket. If the driver answers yes, or can’t prove that he had some other motive for merging, then he will be treated as if he never moved into the correct lane and will be ticketed.

Never before has the alleged motive of a taxpayer — including in some circumstances the “motive” of an inanimate business entity — taken on such importance for tax purposes. The clear import is that no two taxpayers will be treated alike and that no one will know for sure whether, and when, it is safe to change lanes.

All these developments taken together with the IRS’s recent Announcement 2010-9, which effectively penalizes taxpayers for not knowing with certainty how to comply with the myriad tax rules the IRS refuses to provide certainty about, including the new economic substance doctrine, makes it apparent that we are witnessing the end of the Reagan-era tax revolution, which resulted in the bipartisan Tax Reform Act of 1986 (passed by a Democratic Congress and signed by a Republican president).

The most efficient, and fair, tax that is based on income is one that requires as few lane changes and as little complicated and arbitrary differentiation as possible — i.e., a tax with a broad base, including virtually all forms of income, more certainty, and fewer, wider bands of stable and reasonable marginal rates. The 1986 act was the closest the code has ever come to this ideal.

Healthcare reform presented an opportunity to correct the 1986 act’s most problematic deviation from this ideal. Instead, it is the 1986 act’s failure to fully implement the principles that led to its enactment that is ultimately leading to its demise. Whether or not this is a welcome development I leave for the reader to ponder, though my advice would be to prepare for many more traffic jams to come.