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

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I. INTRODUCTION

The Affordable Care Act (ACA)[1] has been heralded as the signature achievement of the Obama Administration.[2] Called "Obamacare" by some, the ACA is the most extensive reform to the U.S. health care system since the creation of Medicare and Medicaid in

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[1] The "Affordable Care Act" refers jointly to the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

The "Affordable Care Act" is the Obama Administration's preferred term for referring to these health care reform acts and is the term used in the regulations interpreting the acts. See, e.g., Prop. Reg. § 1.36B-1(b), 76 Fed. Reg. 50931, 50939 (Aug. 17, 2011). Consequently, I also refer to these health care reform acts as the "ACA" throughout this Article.

[2] See, e.g., Pema Levy, How the Obama Administration Is Jeopardizing Health Care Reform, The New Republic (Oct. 3, 2011, 12:00 AM), http://www.tnr.com/article/politics/95631/supreme-court-case-medicaid-california-affordable-care-act (referring to the ACA as the Obama Administration's "signature policy achievement").

1965.[3] With respect to tax administration, the ACA is arguably the most significant attempt ever to reform social welfare policy through the tax code.[4]

This Article has two primary goals. First, this Article explains how key tax-related provisions of the ACA will interact. Upon their coming into effect in 2014, these tax-related provisions of the ACA will create a new framework that will dramatically alter the U.S. system for health care finance. It will be important for anyone interested in either tax policy or health care policy to understand this new framework. Yet, as is often the case when predicting how tax provisions affect taxpayer behavior, the devil is in the details. This Article attempts to analyze the interplay between key tax-related provisions of the ACA at a level of detail sufficient for predicting taxpayer behavior while still remaining accessible to readers who are not tax lawyers.

Second, this Article argues that further reform is needed to prevent this new framework from creating avoidable costs for low- and moderate-income workers. The ACA promises many improvements to U.S. health care.[5] I should perhaps note at the outset that I support the ACA; I expect the ACA's benefits to exceed its costs.[6] Yet supporting the ACA should not make one blind to the ACA's flaws. Our choices need not be limited to either accepting the ACA as is, with all its warts, or else repealing the ACA in its entirety. Instead, this Article argues for maintaining some of the major tax-related provisions of the ACA while enacting further reforms so as to prevent avoidable costs to low- and moderate-income workers.

In the absence of further reform, this Article explains how the ACA will impose effective taxes with respect to low- and moderate-income workers, thereby reducing these workers' employment opportunities

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[3] See Comm. on the Robert Wood Johnson Found. Initiative on the Future of Nursing, Nat. Acads. Inst. of Med., The Future of Nursing: Leading Change, Advancing Health 2 (2011), available at http://www.nap.edu/catalog.php?record_id=12956 ("The ACA represents the broadest changes to the health care system since the 1965 creation of the Medicare and Medicaid programs and is expected to provide insurance coverage for an additional 32 million previously uninsured Americans.").

[4] See Edward A. Zelinsky, The Health-Related Tax Provisions of PPACA and HCERA: Contingent, Complex, Incremental and Lacking Cost Controls 5-38 (Cardozo Legal Stud. Res. Paper No. 301, 2010), available at http://ssrn.com/abstract=1633556 (summarizing the many tax provisions of the ACA).

[5] See The White House, A More Secure Future: What the New Health Law Means for You and Your Family, http://www.whitehouse.gov/healthreform/healthcare-overview (last visited July 21, 2012).

[6] My assessment that the ACA's benefits are likely to exceed its costs is subject to the caveat that the ACA may not be successfully implemented in all states. Indeed, my primary doubts about the ACA arise from concerns about whether the ACA will be effective in the face of attempts to obstruct its successful implementation. That said, evaluating the ACA as a whole is beyond the scope of this Article.

and creating a number of other economic and social harms.[7] When a law or regulation deters economic actors from the choices that they otherwise would have made, we can say that the law or regulation imposes "effective taxes" on those choices.[8] For the most part then, effective taxes are essentially synonymous with "perverse incentives."[9] This Article argues that, once key provisions of the ACA come into effect in 2014, the ACA will impose effective taxes on a number of important decisions affecting low- and moderate-income Americans, including:

- The ACA will deter low- and moderate-income taxpayers from accepting jobs with employers that offer affordable health insurance.
- The ACA will discourage many low- and moderate-income taxpayers from attempting to increase their household incomes.
- The ACA will penalize many low- and moderate-income taxpayers who choose to marry, and will incentivize many low- and moderate-income taxpayers to divorce.
- The ACA will dissuade employers from hiring low- and moderate-income taxpayers, and will encourage employers to reduce the salaries paid to some low- and moderate-income employees.
- The ACA will prompt employers to shift some low- and moderate-income employees from full-time positions to part-time positions.

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[7] As the phrase is used in this Article, "low- and moderate-income workers" generally refers to workers with household incomes higher than 133% of the federal poverty line and lower than (at most) 400% of the federal poverty line. Workers with household incomes below 133% of the federal poverty line will generally qualify for Medicaid, such that most of this Article's analysis will not apply. For analysis regarding the high-end threshold for "low- and moderate-income workers," and for charts showing how percentages of the federal poverty line relate to actual household incomes, see Section II.C.

[8] The term "effective taxes" is used to contrast with explicit taxes or statutory taxes. Unlike the latter terms, effective taxes include all of the ways in which a law or regulation increases the price of one economic decision as compared to alternative economic decisions.

[9] More precisely, effective taxes are equivalent to perverse incentives to the extent that the effective taxes lead to harmful changes in behavior. But unless there is some reason for deterring the choices economic actors would have made in the absence of effective taxes (for example, externalities), effective taxes create perverse incentives almost by definition, following the baseline assumption that it is generally undesirable for governments to alter the incentives of economic actors unless there is a good reason for doing so.

I primarily use the term effective taxes in this Article because I do not mean to imply that there is anything inherently harmful about the choices economic actors make as a result of the effective taxes. For instance, if a low-income taxpayer decides not to accept a job, this decision may sometimes be in the best interests of both the taxpayer and society. But if a law or regulation imposes effective taxes that result in a low-income taxpayer not accepting a job that the taxpayer otherwise would have accepted, then this change in behavior will generally harm society. The term effective taxes captures this distinction better than does the term perverse incentives, and I thus use the term effective taxes in those instances in which it is important to capture this distinction. In other instances, I use the two terms interchangeably.

• The ACA will tempt employers to implement a number of other costly strategies for circumventing the ACA's employer mandates and penalties.

• The ACA will induce employers to stop offering "affordable" health insurance to at least some low- and moderate-income employees, and, if this occurs to a significant enough degree, the budgetary cost of the ACA may greatly exceed the official projections issued by the Congressional Budget Office.

We ought perhaps to accept these effective taxes were they a necessary cost of achieving the ACA's many positive goals. But the ACA could have been drafted to attain its desirable ends without creating most of the effective taxes analyzed by this Article. Moreover, there is still hope of enacting further reforms so as to preserve the ACA's positive features while mitigating or eliminating these effective taxes. Ideally, these further reforms would be enacted at the federal level. if the federal government fails to act, however, this Article explains how state governments might pass legislation to mitigate the ACA's effective taxes.

The source of most of these effective taxes is the mismatch that the ACA will create between the tax subsidies available for employer-sponsored health insurance and those available for the health insurance purchased by individuals. Most higher-income taxpayers will receive much larger tax subsidies if they are offered employer-sponsored health insurance, whereas most lower-income taxpayers will receive much larger tax subsidies if they are not offered affordable employer-sponsored health insurance. This mismatch in the available tax subsidies results because the ACA maintains most of the previously existing tax benefits for employer-sponsored health insurance (which primarily benefit higher-income taxpayers), whereas the new tax subsidies that the ACA will create for health insurance purchased by individuals will primarily benefit lower-income taxpayers.[10]

If the ACA had instead transformed the previously existing tax benefits for employer-sponsored health insurance into refundable tax credits structured in a similar fashion to the ACA's new tax subsidies, then most of the perverse incentives this Article analyzes would have been completely alleviated.[11] Moreover, many commentators have al-

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[10] Taxpayers will be ineligible for these new subsidies if the taxpayers' employers offer affordable health insurance.

[11] The exception is the perverse incentives some low- and moderate-income taxpayers will face to avoid increasing their incomes. Unlike the other perverse incentives analyzed in this Article, these perverse incentives would remain even if the previously existing tax benefits for employer-sponsored health insurance were transformed into refundable tax credits as this Article recommends. These perverse incentives are a result of the progressivity built into the ACA's new tax subsidies, rather than resulting from the mismatch the

ready called for reforming the previously existing tax benefits for employer-sponsored health insurance in exactly this fashion, arguing that these tax benefits are regressive and that they encourage excess health care consumption.[12] This Article explains why failing to reform the previously existing tax benefits for employer-sponsored health insurance will create far more harm once key provisions of the ACA come into effect in 2014.

This Article proceeds as follows. Part II explains why employers provided health insurance prior to the ACA, and Part III explains how the ACA will alter employers' incentives as to whether to offer health insurance. Understanding how the ACA will affect employers' incentives is key to understanding the ACA's effective taxes. Parts II and III are directed toward readers who have not previously immersed themselves in the details of the ACA.[13] Readers who already have an in-depth understanding of the tax provisions of the ACA may wish to start reading with Part IV.

Part IV explains how the ACA will create effective taxes imposing costs on low- and moderate-income workers, and Part V concludes by explaining how these effective taxes could be mitigated or avoided by reforming the tax benefits available for employer-sponsored health insurance. This Article ends with a call for action. The ACA is an impressive accomplishment, but further reform is urgently needed to prevent the ACA from imposing unnecessary costs on low- and mod-

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ACA will create between the tax subsidies for individually purchased health insurance as compared to employer-provided health insurance.

[12] See, e.g., Urban Inst. & Brookings Inst. Tax Pol'y Ctr., The Tax Policy Briefing Book: A Citizens' Guide for the 2008 Election and Beyond, at II-5-8 to -9 (2008), available at http://www.taxpolicycenter.org/upload/Elements/II-5KEYELEMENTS_HealthInsuranceandHealthCare.final.pdf; Bradley W. Joondeph, Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance, 1995 BYU L. Rev. 1229, 1229-30; Jonathan Gruber, The Tax Exclusion for Employer-Sponsored Health Insurance *1-*3 (NBER, Working Paper No. 15766, 2010), available at http://www.nber.org/papers/w15766; Jason Roffenbender, Employer-Based Health Insurance: Why Congress Should Cap Tax Benefits Consistently, Backgrounder No. 2214, , at 2, 5-6, Dec. 5, 2008, available at http://www.heritage.org/Research/Reports/2008/12/Employer-Based-Health-Insurance-Why-Congress-Should-Cap-Tax-Benefits-Consistently; Paul N. Van de Water, Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform: Universal Coverage May Be Out of Reach Otherwise 1-2 (Ctr. on Budget Policies & Priorities, 2009), available at http://www.cbpp.org/cms/index.cfm?fa=view&id=2832; President's Advisory Panel on Federal Tax Reform, Simple, Fair, and Pro-Growth Proposals to Fix America's Tax System 78-82 (2005).

[13] This Article makes no attempt to summarize all of the provisions of the ACA or even all of the tax provisions of the ACA. For a summary and explanation of the ACA, see generally Families USA, A Summary of the Health Reform Law (2010), available at http://www.familiesusa.org/assets/pdfs/health-reform/summary-of-the-health-reform-law.pdf; Nat'l Ctr. for Pol'y Analysis, What Does Health Reform Mean for You? A Consumer's Guide (2010), available at http://www.ncpa.org/pdfs/What-Does-Health-Reform-Mean-for-You-A-Consumers-Guide.pdf.

erate-income workers beginning in 2014. If the federal government fails to act, then this Article exhorts state governments to pass legislation to mitigate the ACA's effective taxes.

Before proceeding, it may be useful to emphasize a few caveats. First, this Article does not argue that the ACA on balance will be harmful for low- and moderate income workers or for any other population.[14] It is important to understand the costs that the ACA will impose in order to design reform proposals so as to mitigate these costs; but in evaluating the ACA, these costs must be weighed against the ACA's benefits.[15] Second, this Article makes no attempt to evaluate the ACA as a whole or to compare the ACA to alternative reform proposals. I do note that I support the ACA in order to clarify that I intend this Article's recommendations to be in the vein of friendly amendments, but I do not attempt to justify my support for the ACA in this Article. Third, this Article does not attempt to quantify the magnitude of the ACA's costs in any rigorous fashion. Fourth, this Article offers only a rough outline for how the federal or state governments might enact reforms so as to mitigate these costs.

In short, this Article reports preliminary analysis that I plan to develop further in future work. Because the ACA's new framework for regulating health care finance is scheduled to come into effect in 2014, I have concluded that it is important to make this preliminary analysis available now, rather than waiting until it is fully complete.

Policymakers working to implement the ACA's new framework face tight deadlines for making administrative decisions and for set-

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[14] In my view, assessing the ACA as a whole largely boils down to the importance one places on providing affordable health care options for those with pre-existing conditions. Any health care reform designed to provide affordable care options for those with pre-existing conditions must either rely on government provided health care (that is, "socialized medicine") or else on a hybrid system similar to the ACA. Because I believe it important to provide affordable health care options for those with pre-existing conditions, I conclude that the ACA's benefits will exceed its costs, even though I wish that the ACA were better designed so as to avoid creating unnecessary costs such as those discussed in this Article. But analysts who do not place a high importance on providing affordable care options for those with pre-existing conditions may well conclude that the ACA's costs exceed its benefits. In any case, both assessing the larger issues related to pre-existing conditions and evaluating the ACA as a whole are beyond the scope of this Article. For instance, a deeper assessment of issues related to pre-existing conditions should distinguish between pre-existing conditions that result from the choices made by taxpayers and those that are outside of taxpayers' control, yet I gloss over this distinction in this Article for ease of exposition and because the distinction is not important for this Article's purposes.

[15] It may also be worth noting that the major distributional impacts of the ACA will likely be to benefit less healthy populations at the expense of healthier populations. Although the ACA will have distributional impacts with respect to income groups, these will arguably be less important than will be the distributional impacts that will occur within income groups—as less healthy members of each income group are likely to benefit at the expense of healthier members of the income group.

ting up the infrastructure that will be required for the new framework to function successfully. Private-sector lawyers and consultants similarly face limited time frames for familiarizing themselves with the ACA's new provisions in order to advise clients. By explaining how key tax-related provisions of the ACA will interact, I hope this Article will offer a useful guide to these audiences. If there is any hope of either the federal or state governments designing legislation to mitigate the costs analyzed in this Article before these costs materialize, then work on such legislation must likely begin soon. Hence, with apologies for the incomplete state of this Article's analysis, and with promises of elaboration in future work, I hope that this Article will help inform conversations about the implications of ACA's new framework and about how we should strive to improve this new framework through further reforms.

II. Why Employers Provided Health Insurance Prior to the ACA

Prior to the ACA, why did most Americans receive health insurance from their employers?[16] One might alternatively ask why Americans did not generally receive food, cars, or movie tickets from their employers. As with health insurance, employees like receiving food, cars, and movie tickets, and often choose to spend their own money on these items when employers compensate them with cash wages. But each employee places a different relative value on food, cars, movie tickets, and similar goods, and employees thus generally prefer to receive cash wages and then decide for themselves how much of each of these goods to purchase rather than having their employers involved in those consumption decisions.[17]

Of course, sometimes employers provide these and other in kind fringe benefits because providing those benefits serves a business pur-

[16] See Allison K. Hoffman, Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform, 36 Am. J.L. & Med. 7, 18 (2010) ("The majority of privately insured Americans still obtain their health insurance coverage through an employer . . . ."); Robert J. Mills, Health Insurance Coverage: 2000 (U.S. Census Bureau, 2001), available at http://www.census.gov/prod/2001pubs/p60-215.pdf; Amy B. Monahan, The Complex Relationship Between Taxes and Health Insurance 1 (Univ. of Minnesota Law Sch., Legal Stud. Research Paper Series, Research Paper No. 10-01, 2010), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1531322.

[17] To the extent it costs employers resources to provide health insurance, employers could instead transfer those funds directly to employees in the form of higher wages. Each employee could then choose how much of these wages to spend on health insurance. By spending resources to subsidize health insurance rather than on wages, employers thus limit their employees' options for how to use the fruits of their labor.

pose other than compensating employees.[18] For example, an employer might provide an employee with a car if the employer wants the employee to use that car for work-related travel. But outside of such non-compensation-motivated scenarios, employers generally should only provide in kind benefits in lieu of cash wages if either: (1) the employer can provide the in kind benefit at a lower price than what it would cost for the employee to purchase the benefit, or (2) if it is tax favorable for the employer to provide the in kind benefit in lieu of cash wages.[19]

As the remainder of this Part explains, both of these factors motivated employers to provide health insurance in lieu of cash wages prior to the ACA. Due primarily to adverse selection and risk classification, employers were able to offer better quality health insurance at a lower cost as compared to what individual employees could purchase on their own. And primarily as a result of the tax exclusions,[20] employer-provided health insurance was subsidized as compared to the alternative health insurance options that employees might purchase from the market using their after-tax wages.

A. The Non-Tax Advantages of Employer-Provided Health Insurance Prior to the ACA

Insurance differs from ordinary market goods. The amount an individual pays for insurance premiums over her lifetime may be either more or less than the cost of the medical care paid for by her insurance plan, partially depending on whether the individual's medical costs end up being higher or lower than the average medical costs incurred by similar individuals. A primary reason why individuals purchase health insurance is to protect themselves against the risk that their future medical costs may end up being higher than expected (and higher than the individual will be able to afford).

This feature of health insurance leads to the twin problems of adverse selection and risk classification. Adverse selection occurs when individuals have better knowledge about their expected future health costs than do insurance companies. Because insurance companies can

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[18] For a general discussion, see Michael Livingston & David Gamage, Taxation: Law, Planning, and Policy 92-93 (2d ed. 2010).

It is perhaps also worth noting that the U.S. system's reliance on employer-provided health insurance originated at least partially with the wage and price controls implemented during World War II. Restricted in their ability to compensate employees with cash wages, employers turned to fringe benefits like employer-provided health insurance. See id.

[19] Alternative reasons why employers might provide fringe benefits in lieu of cash wages might arise from regulatory pressures, employer paternalism, or historical practices. Id. But these motives are less important for the purposes of this Article.

[20] IRC §§ 105, 106.

only price insurance based on the insurance companies' expectations about an individual's future health costs, individuals who know that their future health costs are likely to be higher than insurance companies anticipate will often find that health insurance offers them a good deal. Conversely, individuals who know that their future health care costs are likely to be lower than insurance companies anticipate will often find that health insurance offers them a poor deal.[21]

Adverse selection results when the former (high-cost) individuals purchase more health insurance because they realize that it offers them a good deal, while the latter (low-cost) individuals purchase less health insurance because they realize that insurance offers them a relatively poor deal.[22] When high-cost individuals enter an insurance market, and low-cost individuals exit the market, the inevitable result is higher costs and rising insurance premiums.[23] As insurance premiums rise to reflect the higher costs of the insured pool, an ever larger group of individuals will find that insurance offers them a relatively poor deal.[24] These dynamics can create "adverse selection death spirals" through repeated cycles of relatively low-cost individuals leaving the market, leading to higher premiums, which then leads to a new group of relatively low-cost individuals leaving the market, which leads to even higher premiums, and so on.[25]

Highly related to adverse selection, the nature of health insurance also incentivizes insurance issuers to engage in the practice of risk classification.[26] Insurance companies can use risk classification techniques to defend against adverse selection. The better information an insurance company can obtain about individuals' future health costs, the more accurately the insurance company can price its policies to

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[21] Of course, whether insurance offers a "good deal" involves more than just a comparison of premiums paid to health expenses reimbursed. Health insurance is meant to be insurance, after all, and being insured against risks can be valuable even if those risks do not end up materializing. But the comparison of premiums paid to expected reimbursements is still an important component of whether an insurance policy provides sufficient value to be worth the cost.

[22] Monahan, note 16, at 8-9.

[23] See George A. Akerlof, The Market for "Lemons": Quality Uncertainty and the Market Mechanism, 84 Q.J. Econ. 488, 489-90 (1970); Michael Rothschild & Joseph Stiglitz, Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information, 90 Q.J. Econ. 629, 634-38 (1976).

[24] For a more in depth elaboration of an analogous dynamic, see David Gamage & Allon Kedem, Commodification and Contract Formation, Placing the Consideration Doctrine on Stronger Foundations, 73 U. Chi. L. Rev. 1299, 1338-47 (2006).

[25] See David M. Cutler & Richard J. Zeckhauser, Adverse Selection in Health Insurance, 1 Frontiers in Health Pol'y Res. 1, 3-9 (1998).

[26] For a discussion of risk classification (alternatively sometimes called risk selection), see Amy Monahan & Daniel Schwarcz, Will Employers Undermine Health Care Reform by Dumping Sick Employees?, 97 Va. L. Rev. 125, 133-36 (2011).

reflect the expected health costs of insured individuals.[27] More problematically, if insurance companies can exclude relatively high-cost individuals from their policies, then the insurance companies can keep premiums lower while generating higher profits.[28] Consequently, insurance companies invest considerable resources toward distinguishing high-cost individuals from low-cost individuals and in developing techniques for making their policies more attractive to low-cost individuals and less attractive to high-cost individuals.[29] These practices can generate high administrative costs.[30]

Due to the problems of adverse selection and risk classification, prior to the ACA, insurance policies offered on the individual market were generally of comparatively lower quality and higher price as compared to employer-provided insurance policies.[31] The "individual market" refers to when individuals purchase insurance policies directly, rather than through their employers or through government programs.[32] According to one study, in 2005, "nearly 3 in 5 adults who applied for coverage in the individual market failed to find a plan they could afford because they were denied coverage, charged higher prices, or had a health problem excluded from coverage."[33] Notably, insurance companies could deny coverage to individuals with pre-existing conditions—a practice banned by the ACA.[34] Individuals who insurance companies assumed to be high risk or who had pre-existing conditions thus found it exceedingly difficult to purchase meaningful insurance on the individual market except at exorbitant costs.[35]

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[27] David A. Hyman & Mark Hall, Two Cheers for Employment-Based Health Insurance, 2 Yale J. Health Pol'y L. & Ethics 23, 31-33 (2001).

[28] Insurance companies may thus often find it more profitable to focus on designing policies so as to effectuate risk classification than to design policies so as to offer better health care products to a wider range of insureds.

[29] Hoffman, note 16, at 28-29.

[30] See id. (comparing estimates for administrative costs on the individual market where risk classification is possible to administrative costs for employer-provided health insurance where risk classification is less likely); Monahan, note 16, at 3 n.8.

[31] See Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson & Sheila D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families 1-3 (Commonwealth Fund, 2009), available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf; Melinda Beeuwkes Buntin, Susan M. Marquis & Jill M. Yegian, The Role of the Individual Health Insurance Market and Prospects for Change, 23 Health Aff. 79, 79-81 (2004).

[32] See Buntin et al., note 31.

[33] Hoffman, note 16, at 52 (citing Sara R. Collins, Jennifer L. Kriss, Karen Davis, Michelle M. Doty & Alyssa L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families 4 (Commonwealth Fund, 2006), available at http://www.commonwealthfund.org/usr_doc/Collins_squeezedrisinghltcarecosts_953.pdf.

[34] ACA § 1201, 124 Stat. at 154; Monahan, note 16, at 17.

[35] Hoffman, note 16, at 53.

Exacerbating these problems, health insurance policies can be very complex, and individuals often find it difficult to understand exactly what coverage a policy offers with respect to the wide variety of possible future health costs the individual may incur.[36] Hence, absent regulation, insurance companies often find it profitable to design policies that appeal to younger, healthier insureds while reducing benefits to insureds who develop expensive health conditions.[37] And even when faced with regulations designed to prevent these practices, insurance companies have proven their ability to engage in risk classification through more subtle (and often more administratively costly) means.[38]

For these reasons, prior to the ACA, most commentators agreed that the individual market for health insurance was a disaster.[39] In contrast, employer-provided health insurance largely solved the problems of the individual market.[40] An employer's workforce is grouped together for reasons other than their health risks, and employers can thus either market their workforce to insurance companies as a group or else self-insure their workforce with much less risk of adverse selection.[41] Employer-provided coverage similarly minimizes the costs of risk classification. Although employers in theory could exclude their high-cost employees from insurance policies or charge those employees more, the rest of the employee's workforce might learn about these practices, which could harm employee morale

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[36] See Jeffrey Liebman & Richard Zeckhauser, Simple Humans, Complex Insurance, Subtle Subsidies 3-14 (Tax Pol'y Ctr., 2008), available at http://www.taxpolicycenter.org/tpccontent/healthconference_zeckhauser.pdf; John Goodman, Complex Systems, Part I, John Goodman's Health Policy Blog (Oct. 19, 2011), http://healthblog.ncpa.org/complex-systems-part-i/; John Goodman, Complex Systems, Part II, John Goodman's Health Policy Blog (Nov. 9, 2011), http://healthblog.ncpa.org/complex-systems-part-ii/.

[37] See Nicholas Bagley & Jill R. Horwitz, Commentary, Why It's Called the Affordable Care Act, 110 Mich. Law Rev. First Impressions 1, 5 (2011), available at http://www.michiganlawreview.org/assets/fi/110/bagleyhorwitz.pdf; Beth C. Fuchs, Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s 10 (Robert Wood Johnson Found. 2004), available at http://www.rwjf.org/files/research/20114.expandinginsurance.report.pdf; Peter Harbage, Too Sick for Health Care: How Insurers Limit and Deny Care in the Individual Health Insurance Market 4-5 (Ctr. for Am. Progress, 2009), available at http://www.americanprogress.org/issues/2009/07/too_sick.html.

[38] See Am. Acad. of Actuaries, Risk Classification in Individually Purchased Voluntary Medical Expense Insurance 3-7 (1999), available at http://actuary.org/pdf/health/risk.pdf; Am. Acad. of Actuaries, Risk Classification in the Voluntary Individual Health Insurance Market 3-6 (2009), available at http://www.actuary.org/pdf/health/risk_mar09.pdf; Bagley & Horwitz, note 37, at 4-6.

[39] See, e.g., Joseph Newhouse, Assessing Health Reform's Impact on Four Key Groups of Americans, 29 Health Aff. 1714, 1716 (2010) ("the individual and small group market is dysfunctional"); Doty et al., note 31, at 8-9.

[40] Hyman & Hall, note 27, at 32-35.

[41] Stuart M. Butler, Evolving Beyond Traditional Employer-Sponsored Health Insurance 7 (Brookings Inst., 2007), available at http://www.brookings.edu/~/media/research/files/papers/2007/5/healthcare%20butler/200705butler.

and retention. In practice, employers appear to mostly provide health care policies that benefit their entire workforce.[42]

Moreover, employers can and do assist their employees with the complexity of the health insurance decision-making process by functioning as intermediaries.[43] Employers' human resources departments support employees by screening health insurance options, helping employees select from among the options provided, and aiding employees who have disputes about reimbursements or coverage provided.[44]

In sum, prior to the ACA, employers could offer their employees better health insurance options at considerably lower costs than what was available on the individual market. Whereas the individual market suffered from adverse selection, risk classification, and other information problems, employers could largely solve these problems by creating insurance groups unrelated to health costs and by functioning as information intermediaries.[45] Thus, a major reason why employers offered their employees subsidized health insurance was that employers' advantages in providing health insurance made that insurance more valuable to employees than the foregone cash wages.

B. The Tax Advantages of Employer-Provided Health Insurance Prior to the ACA

Not only was employer-provided health insurance generally cheaper and better than what could be purchased on the individual market prior to the ACA, but employer-provided health insurance was also significantly tax-advantaged as compared to insurance purchased on the individual market. The primary sources of this tax advantage were the tax exclusions for employer-provided health insurance.[46] Employees who received subsidized health insurance from their employers could exclude the value of those subsidies from

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[42] Id.; Hyman & Hall, note 27, at 30 ("Surveys and focus groups indicate that employers do a reasonably good job reflecting their workers' values and preferences, just as one would expect in a reasonably competitive labor market.").

[43] Hyman & Hall, note 27, at 33-35.

[44] Id.

[45] But see Butler, note 41, at 8-10 (arguing that small employers do not enjoy the same advantages with respect to providing insurance as do large employers and that relying on employer-provided insurance creates other problems such as interfering with job mobility). This Article is primarily focused on large employers and their employees. There are a number of additional complicating considerations that should be taken into account in extending this Article's analysis to small employers and the employees of small employers.

[46] See Stan Dorn, Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible? 1 (Urban Inst., 2009), available at http://www.urban.org/uploadedpdf/411894_cappingthetaxexclusion.pdf.

taxable income.[47] Employer-subsidized health insurance was also excludable from payroll taxes.[48] Moreover, by having their employers establish a cafeteria plan, employees could also reduce their taxable income by the amounts the employees contributed to pay for health insurance premiums.[49] Hence, even in the absence of any employer subsidies, employees could pay for employer-provided health insurance entirely with pretax dollars.[50]

The exclusion for employer-provided health insurance is the largest federal tax expenditure.[51] The Joint Committee on Taxation estimated the value of the exclusion to be worth $246.1 billion annually in 2007.[52]

Self-employed individuals could also enjoy similar health care tax benefits to those available for employees.[53] Most importantly, self-employed individuals could deduct health insurance payments for them and for their dependents.[54] The rules for self-employed individuals mostly mirrored the rules for individuals receiving employer-provided health insurance.[55] A taxpayer, however, could not claim the self-employed health insurance deduction for any month in which either the taxpayer or the taxpayer's spouse was eligible to participate in an employer-sponsored health plan.[56] The Joint Committee on

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47 IRC §§ 105(b), 106(a); for a broader discussion of the exclusion, see Livingston & Gamage, note 18, at 98-99; Peter J. Wiedenbeck, Taxes and Healthcare, 124 Tax Notes 889, 889-92 (Aug. 31, 2009).

48 IRC §§ 3101(a), (b), 3121(a)(2); Wiedenbeck, note 47, at 892.

49 IRC § 125; Joint Comm. on Tax'n, 110th Cong., Tax Expenditures for Health Care (Comm.Print 2008), available at http://www.jct.gov/publications.html?func=startdown&id=1193.

50 Monahan, note 16, at 3.

51 See Joint Comm. on Tax'n, 112th Cong., Estimates of Federal Tax Expenditures for Fiscal Years 2011-2015, at 42 (Comm. Print 2012), available at https://www.jct.gov/publications.html?func=sartdown*id=4386. For discussions of the tax expenditure concept, see Edward Kleinbard, The Congress Within the Congress: How Tax Expenditures Distort Our Budget and Our Political Processes, 36 Ohio N.U. L. Rev. 1, 2-4 (2010); Daniel N. Shaviro, Rethinking Tax Expenditures and Fiscal Language, 57 Tax L. Rev. 187, 187-188 (2004).

52 Joint Comm. on Tax'n, note 49, at 2. This estimate is for the aggregate of the tax expenditures from the income tax and the payroll tax.

53 Supplementing the exclusion for employer-provided health insurance and the self-employed health insurance deduction were a number of other tax benefits related to employer-provided health care. As these benefits are less important for the purposes of this Article, I do not discuss them here. For discussions of these other tax benefits, see Fred T. Goldberg & Susannah Camic, Legal Solutions in Health Reform: Tax Credits for Health Insurance 4-6 (2009), available at http://www.law.georgetown.edu/oneillinstitute/national-health-law/legal-solutions-in-health-reform/Papers/Tax.pdf; Joint Comm. on Tax'n, note 49, at 4-33; Wiedenbeck, note 47, at 890-97.

54 IRC § 162(*l*).

55 Goldberg & Camic, note 53, at 5.

56 Joint Comm. on Tax'n, note 49.

Taxation estimated the value of the health insurance deduction for self-employed individuals to be worth $4.8 billion annually in 2007.[57]

In contrast, no equivalent tax benefits were available for unemployed taxpayers or for employed taxpayers whose employers did not offer health insurance.[58] There was no generally applicable tax deduction or exclusion for health care expenditures by unemployed taxpayers or by employed taxpayers lacking employer-provided health insurance.[59] These taxpayers could claim an itemized deduction to the extent that their unreimbursed medical expenses exceeded 7.5% of adjusted gross income.[60] But this deduction required taxpayers to forgo the standard deduction, and the 7.5% threshold made the deduction of minimal value for most taxpayers. The Joint Committee on Taxation estimated the value of this limited itemized deduction for medical expenses to be only $8.7 billion annually in 2007, as compared to the combined value of $250.9 billion for the exclusion for employer-provided health insurance and the self-employed health insurance deduction.[61]

The net result was a significant tax advantage for employer-provided health insurance as compared to insurance purchased on the individual market. Consider an example of this tax disparity (quoted from Amy Monahan):

> For example, assume that Taxpayer A and Taxpayer B desire the same insurance coverage, an individual policy that costs $3,750. Taxpayer A is offered her desired coverage through her employer, while Taxpayer B is not. Both taxpayers are in the 25% marginal rate bracket. Taxpayer A needs to earn only $3,750 in wages to purchase such coverage, while Taxpayer B must earn $5,000 in wages to have sufficient after-tax funds available for his purchase. If we take into account payroll taxes of 7.65% and an assumed state income tax rate of 5%, the amount of wages necessary to pay for a $3,750 policy rises to $5,162. . . . Taxpayer A receives an effective

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[57] Joint Comm. on Tax'n, note 51, at 2. This estimate is for the aggregate of the tax expenditures from the income tax and the payroll tax.

[58] Taxpayers whose incomes were sufficiently low might qualify for Medicaid.

[59] Joint Comm. on Tax'n, note 49, at 13; Monahan, note 16, at 3.

[60] IRC § 213. The 7.5% threshold for deducting medical expenses will increase to 10% in 2013. IRC § 213(a). Through 2016, taxpayers of age sixty-five and older will continue to be able to use the old 7.5% threshold. IRC § 213(f).

[61] Joint Comm. on Tax'n, note 51, at 2. These estimates are not directly comparable, as different numbers of taxpayers are eligible for the different tax expenditures, among other complications. Nevertheless, the enormous disparity between the size of the tax expenditures for employer-provided health insurance as compared to those for individually purchased insurance is still suggestive as a rough indication that employer-provided health insurance is far more tax subsidized than is individually purchased health insurance.

subsidy of $1,412 to purchase her health insurance coverage, solely because her employer makes such coverage available to her, and regardless of whether her employer makes any contribution toward such coverage.[62]

III. How the ACA Will Affect Incentives to Offer Health Insurance

Prior to the ACA, employers offered health insurance to their individual employees both because employers could provide better quality health insurance at lower cost than what was available on the individual market and because employer-provided health insurance was significantly tax-advantaged. As this Part explains, the ACA will dramatically alter both of these incentives. Once key provisions of the ACA go into effect in 2014, employers will face a very different calculus in deciding whether to offer health insurance to their individual employees.

A. The ACA's Improvements to the Health Insurance Available on the Individual Market

A primary goal of the ACA was to fix the problems plaguing the individual market for health insurance.[63] Most critically, the ACA will impose open enrollment[64] and guaranteed renewal[65] requirements on all health insurance plans offered in the individual and small group markets so that these plans must accept all applicants for health insurance.[66] The ACA will further limit insurance issuers' ability to charge applicants different prices based on their expected health risks. The ACA will only allow health insurance issuers to vary their prices based on four factors: the size of the applicant's family (for applicants seeking family coverage), the geographic region in which the applicant resides, the applicant's age, and whether the applicant uses tobacco.[67] Even with respect to these factors, insurance issuers will be limited to

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[62] Monahan, note 16, at 3-4.

[63] See Tom Baker, Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act, 159 U. Pa. L. Rev. 1577, 1585-91 (2011).

[64] PPACA, note 1, § 1201, 124 Stat. at 156 (amending the Public Health Service Act to include § 2702, requiring that every health insurance issuer accept all applicants.)

[65] Id. (amending the Public Health Service Act to include § 2703(a): "Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.").

[66] Baker, note 63, at 1588-89.

[67] PPACA, note 1, § 1201, 124 Stat. at 155 (amending the Public Health Service Act to forbid price discrimination except on the basis of age, family status, rating area, or tobacco use.)

charging their oldest applicants no more than three times the prices charged to their youngest applicants and to charging tobacco users no more than one and a half times the prices charged to nonsmokers.[68] In effect, the ACA will prevent insurance plans from discriminating against applicants with pre-existing health conditions.

More generally, these provisions of the ACA will significantly limit insurers' ability to engage in risk classification. Yet, without further regulation, limiting insurers' ability to engage in risk classification could exacerbate problems related to adverse selection, potentially undermining the entire individual market. The ACA thus also includes a number of provisions meant to combat adverse selection. The most important of these is the individual mandate.[69] The individual mandate establishes penalties for citizens who do not obtain health insurance constituting "minimum essential coverage."[70] In essence, the individual mandate is intended to incentivize healthier individuals to obtain insurance coverage so as to prevent adverse selection problems.

In order to further facilitate reforming the individual market for health insurance, the ACA directs the states to create and administer Affordable Insurance Exchanges ("Exchanges").[71] These Exchanges are to function as regulated marketplaces from which individuals can purchase health insurance. If a state does not create an Exchange, then the Department of Health and Human Services (HHS) will be empowered to establish and operate an Exchange on behalf of the state.[72] The ACA instructs the states to establish risk adjustment mechanisms so that insurance plans that end up with a disproportionately low-risk group of insureds will be assessed charges to be used to compensate plans that end up with a disproportionately high-risk group of insureds.[73] The Exchanges will likely administer these risk adjustment policies.[74] Additionally, the Exchanges will regulate the insurance policies offered to consumers and will act as information intermediaries to aid consumers in selecting insurance plans.[75]

The ACA makes generous premium tax credits available for low- and moderate-income taxpayers purchasing health insurance from an

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[68] Id., § 1201, 124 Stat. at 155-56 amending the Public Health Service Act to include § 2701.

[69] IRC § 5000A. For discussions of the individual mandate, see generally Hoffman, note 16; Zelinsky, note 4, at 17-26.

[70] IRC § 5000A (b), (c).

[71] 42 U.S.C. § 18031; Prop. Reg. § 1.36B-5, 76 Fed. Reg. 50931, 50939 (Aug. 17, 2011).

[72] 42 U.S.C. § 18041.

[73] 42 U.S.C. § 18063.

[74] Baker, note 63, at 1591.

[75] Id. at 1590-91.

Exchange.[76] When combined with the individual mandate, the premium tax credits should help to ensure that there will be a critical mass of insureds purchasing health insurance from the Exchanges. The premium tax credits also serve an important role in making health insurance affordable, which is particularly important since the individual mandate will require individuals to purchase health insurance.[77] Whereas the individual mandate combats adverse selection by penalizing taxpayers who do not purchase health insurance (that is, providing sticks), the premium tax credits incentivize taxpayers to purchase health insurance (that is, providing carrots).

To the extent these policies prove effective, the Exchanges should at least partially solve the problems that previously afflicted the individual market for health insurance. Prior to the ACA, employer-provided health insurance was superior to individual market offerings because employers were able to mitigate risk classification and adverse selection problems and to act as information intermediaries. Similarly, the market reform provisions of the ACA are designed to combat risk classification problems, while the individual mandate and premium tax credits are designed to mitigate adverse selection problems. The Exchanges should further mitigate both risk classification and adverse selection problems while functioning as information intermediaries.

It remains to be seen how well these provisions of the ACA will function in fixing the problems that previously plagued the individual market.[78] If these provisions are sufficiently effective, insurance policies offered on the Exchanges could potentially turn out to be of better quality and lower cost than employer-provided offerings. Perhaps more likely, if the provisions are only partially effective, employer-provided insurance might retain its advantages over insurance policies offered on the Exchanges, but with the advantages of employer-provided insurance significantly reduced as compared to the advantages employer-provided insurance previously enjoyed over the insurance policies available on the individual market prior to the ACA.

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[76] IRC § 36B; see also Lawrence Zelenak, Choosing Between Tax and Nontax Delivery Mechanisms for Health Insurance Subsidies, 65 Tax L. Rev. 723 (2012).

[77] The individual mandate has an affordability exemption. IRC § 5000A(e)(1). But "affordability" is determined after accounting for the subsidy provided by the premium tax credits. IRC § 5000A(e)(1)(B)(ii). The premium tax credits thus play an important role in supporting the policy goals of the individual mandate because without the premium tax credits many low- and moderate-income taxpayers would be exempt from the mandate because they would not have "affordable" insurance options.

[78] Fully assessing the extent to which the Exchanges will be able to offer health insurance products of comparable quality and cost to employer offerings is beyond the scope of this Article. I hope to return to this question in future work.

B. The ACA's Modifications to the Tax Exclusions and Creation of Exchange Subsidies

The ACA will mostly leave the tax benefits for employer-provided health insurance intact.[79] Most importantly, the ACA retains both the tax exclusion for employer-provided health insurance and the self-employed health insurance deduction. The primary way in which the ACA will alter the tax favorability of employer-provided health insurance is through the creation of premium tax credits to subsidize the purchase of insurance policies from the Exchanges.

Before assessing the impact of the premium tax credits, though, it is worth briefly discussing some of the changes the ACA will make to the previously existing tax benefits for employer-provided health insurance. To address criticisms that the exclusion for employer-provided health insurance leads to overconsumption of health care services,[80] the ACA includes an excise tax on "Cadillac" health plans.[81] The Cadillac tax will impose a 40% levy on employer-provided insurance policies that benefit from the tax exclusion and that provide "excess benefit"—with "excess benefit" defined as an outcome where the annual cost of a health insurance plan exceeds a specified threshold designed to be higher than the amount most individuals and families pay for health insurance.[82] The excise tax on Cadillac health plans thus reduces the tax benefit that the exclusions for employer-provided health insurance generate for high-cost health plans.

The Cadillac excise tax is not scheduled to go into effect until 2018,[83] however, and there is reason to doubt whether Congress and the President[84] will allow the provision to go into effect at that time.[85]

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[79] See Linda Blumberg, Matthew Buettgens, Judy Feder & John Holahan, Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act (Urban Inst., 2011), available at http://www.urban.org/UploadedPDF/412428-The-Impact-of-the-Affordable-Care-Act.pdf; The HR Specialist, Health Care Reform: Will Employers Keep Offering Coverage?, Business Mgmt. Daily (May 10, 2011), http://www.businessmanagementdaily.com/14501/health-care-reform-will-employers-keep-offering-coverage.

[80] Id. at 5-6 ("This tax originated in the broad consensus that the Code's current tax treatment of employer-provided medical care encourages overconsumption of medical services.").

[81] IRC § 4980I.

[82] IRC §4980I (a), (b); Amy B. Monahan, Why Tax High-Cost Employer Health Plans, 65 Tax L. Rev. 749 (2012).

[83] IRC § 4980I.

[84] At the time of this writing, it remains to be seen who will be the President in the years leading up to 2018.

[85] See Zelinsky, note 4, at 8 ("Given the palpable reluctance of President Obama and the members of the 111th Congress to force their constituents to confront the tax on 'Cadillac' plans any time soon, why should we expect a future President and the senators and representatives of the 115th Congress to let this tax go into effect in 2018?").

In addition, even if and when the Cadillac excise tax becomes active, the tax will not affect employer-provided health insurance plans unless the plans both benefit from the tax exclusion and have costs that exceed the excess-benefit threshold.[86] Consequently, the exclusion for employer-provided health insurance will continue to generate a large tax-subsidy even after 2018.[87]

It is also noteworthy that, beginning in 2013, the ACA will raise the itemized medical expenses deduction percentage threshold from 7.5% to 10%.[88] Otherwise, the changes that the ACA will make to the previously existing health care tax benefits are not of primary importance for the purposes of this Article.[89]

What will be of primary importance are the premium tax credits that will be available starting in 2014.[90] The premium tax credits will defray the cost of health insurance for qualifying low- and middle-income taxpayers purchasing health insurance from an Exchange.[91] The amounts by which the premium tax credits will defray the costs of health insurance will depend on a taxpayer's household income as compared to the federal poverty line, the cost of health insurance premiums for the applicable benchmark plan, and the number of eligible members in the taxpayer's coverage family.[92] As a baseline, taxpayers whose household incomes are less than 133% of the federal poverty line will be expected to contribute no more than 2% of their household incomes toward health insurance;[93] taxpayers whose household incomes are between 300% and 400% of the federal poverty line will be expected to contribute no more than 9.5% of their household incomes toward health insurance; and taxpayers whose household incomes are between these levels will be expected to contribute maximum amounts of between 2% and 9.5% of their household in-

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[86] The excess benefit threshold is defined in IRC § 4980I(b)(3)(C).

[87] See Shubham Singhal, Jeris Stueland & Drew Ungerman, How US Health Care Reform Will Affect Employee Benefits, McKinsey Q. (June, 2011), www.mckinseyquarterly.com/How_US_health_care_reform_will_affect_employee_benefits_2813.

[88] IRC § 213(a). Through 2016, a taxpayer of age of sixty-five or older can use the prior threshold of 7.5%. IRC § 213(f).

[89] For instance, the ACA makes a number of minor changes to the rules governing HSAs, MSAs, HRAs, and FSAs. See Zelinsky, note 4, at 10-11.

[90] IRC § 36B.

[91] More specifically, taxpayers must have household income for the taxable year of between 100% and 400% of the federal poverty line for the taxpayer's family size in order to be eligible for the premium tax credits. Prop. Reg. § 1.36B-2, 76 Fed. Reg. 50931, 50940 (Aug. 17, 2011).

[92] For a more detailed description of credit computation, see Prop. Reg. § 36B, 76 Fed. Reg. 50931, 50933-34 (Aug. 17, 2011).

[93] Note that most taxpayers whose household incomes are below 133% of the federal poverty line should be eligible for Medicaid and not the premium tax credits.

comes, on a sliding scale.[94] Taxpayers whose household incomes are above 400% of the federal poverty line will not be eligible for the premium tax credits.[95]

As a supplement to the premium tax credits, taxpayers purchasing insurance from an Exchange may also be eligible for cost-sharing subsidies.[96] The cost-sharing subsidies will reduce taxpayers' out-of-pocket costs for deductibles, coinsurance, copayments, and similar amounts that otherwise would be charged to them by their health insurance plans. Like the premium tax credits, the value of the cost-sharing subsidies a taxpayer will be eligible for depends on the taxpayer's household income as a percent of the federal poverty line.[97]

To understand the value provided by the premium tax credits and cost sharing subsidies, the following chart, adapted from a study by the Tax Policy Center, estimates the total federal subsidies a family of four would be eligible for in 2016 for health insurance purchased from an Exchange (that is, the value of the "Exchange subsidies"):[98]

TABLE 1

Estimated Value of Exchange Health Insurance Subsidies
(Family of four, 2016)

Household Income as a % of FPL	*Household Income: Cash Compensation Amounts*	*Value of Premium Tax Credits Received*	*Value of Cost Sharing Subsidies Received*	*Total Value of Exchange Subsidies*
100	$24,000	$13,598	$4,834	$18,432
125	30,000	13,473	4,834	18,307
150	36,000	12,595	3,021	15,616
175	42,000	11,738	3,021	14,759
200	48,000	10,940	604	11,544
225	54,000	9,869	604	10,473
250	60,000	9,053	-	9,053
275	66,000	7,776	-	7,776
300	72,000	6,952	-	6,952
325	78,000	6,468	-	6,468
350	84,000	5,761	-	5,761
375	90,000	5,165	-	5,165
400	96,000	4,570	-	4,570
425	102,000	-	-	-
450	108,000	-	-	-

[94] IRC § 36B(b)(3)(A)(i). These percentage amounts may be indexed for inflation or excess premium growth. IRC § 36B(b)(3)(A)(ii).

[95] IRC § 36B(c)(1)(A).

[96] 42 U.S.C. § 18071.

[97] Id.

[98] Stephanie Rennane & C. Eugene Steuerle, Health Reform: A Two-Subsidy System, at *3 tbl.3 (Tax Pol'y Ctr., 2010), available at http://www.taxpolicycenter.org/library/displayatab.cfm?Docid=2699.

As the chart demonstrates, low- and moderate-income families who purchase health insurance from an Exchange may be eligible for subsidies worth many thousands of dollars annually. However, these Exchange subsidies will not be available to taxpayers who have the option of purchasing affordable employer-sponsored health insurance.[99] An employer who offers employees the option of purchasing affordable health insurance may thus make those employees ineligible for the Exchange subsidies, regardless of whether the employees actually enroll in the employer-sponsored health insurance.[100] An offer of employer-sponsored health insurance will be considered "affordable" for purposes of a taxpayer's eligibility for the Exchange subsidies if the amount the taxpayer would have to contribute to pay for the insurance premiums does not exceed 9.5% of the taxpayer's household income.[101]

Crucially, an offer of affordable employer-sponsored health insurance will result in an employee's entire family being ineligible for the Exchange subsidies, not just the employee.[102] Moreover, under Treasury's proposed regulations, whether an employer's offer of family coverage is considered affordable is determined based on the cost the employee would need to contribute for *self-only* coverage.[103] In other words, if an employer offers an insurance policy with an option for family coverage, and if the amount an employee would need to contribute to pay for the portion of the policy covering only the employee (and not also the other members of the employee's family) is less than 9.5% of the employee's household income, then the employee's entire family will be ineligible for the Exchange subsidies.

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[99] IRC § 36B(c)(2)(B),(C); Prop. Reg. § 1.36B-2(c)(3), 76 Fed. Reg. 50941, 50935 (Aug. 17, 2011). Taxpayers eligible for health insurance from other government programs will also generally be ineligible for the premium tax credits. IRC § 36B(c)(2)(B); Prop. Reg. § 1.36B-2(c), 76 Fed. Reg. 50931, 50940-42 (Aug. 17, 2011).

It is unclear the extent to which these rules will apply to the cost-sharing subsidies in addition to the premium tax credits. Yet, as a practical matter, very few (if any) taxpayers will receive the cost-sharing subsidies without also receiving the premium tax credits. Hence, I discuss the implications of these rules for the combined "Exchange subsidies" rather than for just the premium tax credits.

[100] For an employer's offer of health insurance to disqualify employees from receiving the premium tax credits, the offered health insurance must be both affordable and provide "minimum value." IRC § 36B(c)(2)(C). A full discussion of the minimum value rule is beyond the scope of this Article, but it is worth noting that the purpose of the minimum value rule is to insure that employer-provided insurance must have some real content in order to protect the employer from the employer-mandate penalties of § 4980H and in order to disqualify employees from receiving the premium tax credits.

[101] IRC § 36B(c)(2)(C)(i)(II); Prop. Reg. § 1.36B-2(c)(3)(v)(B), 76 Fed. Reg. 50931, 50941-42 (Aug. 17, 2011).

[102] IRC § 36B(c)(2)(C)(i); Prop. Reg. § 1.36B-3(b)(2), 76 Fed. Reg. 50931, 50943 (Aug. 17, 2011).

[103] Prop. Reg. § 1.36B-2(c)(3)(v)(A)(1), 76 Fed. Reg. 50931, 50935 (Aug. 17, 2011).

The policy rationale for basing the affordability of family coverage on the cost of self-only coverage for the employee is (of course) the goal of federal budgetary savings.[104] I elaborate on this policy decision below.[105] For now, it is important to understand that an employer who offers an option to purchase family coverage, and who offers self-only coverage costing less than 9.5% of an employee's household income, thereby makes the employee's family members ineligible for the Exchange subsidies—regardless of the cost of the family coverage.

In effect, then, the ACA makes employers choose between offering their employees either the benefits of the tax exclusions or the Exchange subsidies. An employee must enroll in employer-sponsored health insurance in order to receive the tax exclusions, but enrolling in employer-sponsored health insurance makes the employee ineligible for the Exchange subsidies.[106] Moreover, employers cannot simply leave the choice of whether to take advantage of the tax exclusions or the Exchange subsidies to their individual employees, as even offering an employee the option of affordable employer-provided health insurance makes the employee ineligible for the Exchange subsidies.[107]

This dynamic is significant because whereas the Exchange subsidies are more valuable for lower-income taxpayers, the tax exclusions are more valuable for higher-income taxpayers.[108] Comparing just the Exchange subsidies[109] to the tax exclusions[110] based on the Tax Policy Center's estimates for 2016,[111] the break-even point for an individual

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[104] See, e.g., Sarah Kliff, Health Reform's $50 Billion Question: What's 'Affordable'?, Blog Post, Ezra Klein's Wonkblog (Aug. 16, 2011, 11:00 AM), http://www.washingtonpost.com/blogs/ezra-klein/post/health-reforms-50-billion-question-whats-affordable/2011/08/02/gIQAJijEJJ_blog.html (quoting Tim Jost as saying "I don't think they want the headlines that it was going to cost $50 billion more . . . .").

[105] See notes 147-176 **[X]** and accompanying text.

[106] IRC § 36B(c)(2)(C)(iii).

[107] IRC § 36B(c)(2)(B)-(C). More precisely, in order to offer employees the choice of whether to take advantage of the Exchange subsidies or the tax exclusions, an employer must offer employer-sponsored health insurance that is unaffordable to the employee (or, alternatively, that does not offer minimum value). By combining an offer of unaffordable health insurance with a cafeteria plan, an employer could effectively grant at least some employees the option of whether to take advantage of the tax exclusions or the Exchange subsidies. Moreover, for employers who currently subsidize their sponsored insurance offerings, replacing those subsidies with increased cash wages could make the employer-sponsored insurance policies unaffordable to a wider group of employees, potentially increasing both employer and employee welfare at the expense of the federal government.

[108] See Rennane & Steuerle, note 98, at tbl.4 (comparing the value of the Exchange subsidies and tax exclusions for different household income levels).

[109] By "Exchanges subsidies" I mean both the premium tax credits and the cost-sharing subsidies.

[110] By "tax exclusions" I mean both the income tax exclusion and the payroll tax exclusion for employer-provided health insurance.

[111] See note 108.

might be when household income is somewhere between 350% and 375% of the federal poverty line.[112] And the break-even point for a family of four might be when household income reaches 400% of the federal poverty line.[113] For household incomes below these break-even points, the Exchange subsidies will generally offer more value than the tax exclusions. Conversely, for household incomes above these break-even points, the tax exclusions will generally offer more value than the Exchange subsidies.

These break-even analyses assume that the health insurance policies offered on the Exchanges will be of equivalent cost and quality as compared to employer-sponsored health insurance policies. If all of the available Exchange coverage options end up being inferior to employer-sponsored health insurance options, then the break-even thresholds would need to be adjusted accordingly.[114] For simplicity, in this Article, I mostly follow the Tax Policy Center's approach and assume that Exchange health insurance and employer-provided health insurance will be of equivalent cost and value after the relevant provisions of the ACA come into effect in 2014.[115]

These break-even analyses also assume that employers offer their employees subsidized health insurance as a form of employee compensation,[116] an assumption that underlies virtually all economic studies of health care provision.[117] When comparing the premiums they must pay for Exchange coverage against the premiums they must pay for employer-sponsored coverage, many employees will prefer employer-sponsored coverage to the extent that employers continue to subsidize this coverage. But in the long run, these employer subsidies come out of the amounts paid as wages to employees.[118] As such,

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112 This break-even threshold is calculated from Table 3 in Section III.C. The calculation subtracts the § 4980H employer penalty from the net benefit of Exchange coverage, to obtain the relative value of the Exchange subsidies as compared to the tax exclusions for individuals of different incomes.

113 This break-even threshold is calculated from Table 2 in Section III.C. As above, the calculation subtracts the § 4980H employer penalty from the net benefit of Exchange coverage.

114 Note that there will be a variety of insurance policies offered on the Exchanges, with different trade-offs between premium costs and generosity of benefits.

115 See Rennane & Steuerle, note 98, at tbl.1, tbl.3.

116 See notes 16-17 and accompanying text.

117 See, e.g., Devon Herrick, Health Exchange Subsidies Will Reduce Employer Health Plans *2 (Nat'l Ctr. for Pol'y Analysis, 2011) (2011), available at http://www.ncpa.org/pub/ba758 ("Economists generally agree employee benefits are a dollar-for-dollar substitute for wages."); Katherine Pratt, Funding Health Care with an Employer Mandate: Efficiency and Equity Concerns, 39 St. Louis U. L.J. 155, 160-61 (1994) ("Economists agree that employees ultimately bear the economic burden of employer-provided health care benefits, in the form of lower wages.").

118 Pratt, note 117, at 160-61.

these employer subsidies should be factored out when evaluating the effective taxes facing employees.

Hence, were the tax exclusions and the Exchange subsidies the only relevant factors, employers would face incentives to offer affordable health insurance only to their higher-income employees—to those employees whose household incomes are above the relevant break-even thresholds. Both lower-income employees and their employers would jointly benefit from the employers not offering the lower-income employees affordable health insurance. Employers who would have subsidized health insurance for their lower-income employees, were it not for the Exchange subsidies, could provide better value for those employees by instead using the amounts of the subsidies to increase the lower-income employees' cash wages.

C. The ACA's New Employer-Mandate Penalties and Nondiscrimination Rules

Beyond the tax exclusions and Exchange subsidies, the ACA contains other provisions that will significantly affect employers' incentives as to whether to offer health insurance. In drafting the ACA, the Obama Administration and the Democratic majority in Congress were very concerned about whether employers would stop offering health insurance after the ACA came into effect. The Administration campaigned for the ACA by telling the public that anyone who liked their existing insurance coverage would be able to keep it.[119] The Administration also campaigned for the ACA based on budget estimates that the ACA would reduce the deficit.[120] Maintaining the previous

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[119] See David A. Hyman, Employment-Based Health Insurance: Insurance: Is Health Reform a "Game Changer?" 1 N.Y.U. Rev. Emp. Benefits & Executive Compensation 1A-1, 1A-11 to -12 (2010) ("During the 2008 campaign, (then Senator) Obama routinely promised 'if you like your coverage you can keep it.' Even ABC News thought the promise was 'not literally true,' but Senator Obama had found a winning slogan, and he stuck to it. President Obama repeated and expanded this claim during the battle over health reform, flatly claiming in a speech to the AMA that, 'no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what.'"); Robert Pear & David M. Herszenhorn, As Bombast Escalates, a Primer on the Details of Health Care Overhaul, N.Y. Times, Aug. 10, 2009, at A8.

[120] See David Hyman, PPACA in Theory and Practice: The Perils of Parallelism, 97 Va. L. Rev. In Brief 83 (2011), http://virginialawreview.org/inbrief/2011/11/04/human.pdf ("PPACA would not have passed unless it was deemed to be 'affordable'—which in Washington meant that it had to be scored by the Congressional Budget Office . . . as costing less than $1 trillion over the ten year budgetary window. The task of selling PPACA to a skeptical public would also be substantially easier if it could somehow be scored by the CBO as deficit reducing (at least over the same budgetary window). . . . [T]he Administration and Congress hit both of these targets by completely gaming the CBO scoring process."); Ezra Klein, OMB, ACA, CBO and the Deficit, Ezra Klein: Economic and Domestic Policy, and

system of employer-sponsored coverage for lower-income taxpayers was considered important for realizing the ACA's deficit-reducing potential because additional lower-income employees qualifying for the Exchange subsidies would drive up the budgetary cost of the Exchange subsidies.

The ACA was thus drafted to include additional provisions incentivizing employers to maintain employer-sponsored health insurance even for their lower-income employees. The two most important of these provisions are the employer-mandate penalties[121] and the new nondiscrimination rules.[122]

The employer-mandate penalties will apply to "applicable large employers" beginning in 2014.[123] With a few exceptions,[124] employers who employ at least fifty full-time employees for more than 120 days during a calendar year will be considered applicable large employers potentially subject to the § 4980H penalties.[125]

Section 4980H includes two separate employer-mandate penalties. The § 4980H(a) penalty applies when an applicable large employer "fails to offer to its full-time employees (and their dependents) the opportunity to enroll" in qualifying employer-sponsored health coverage.[126] For any month in which it is triggered, the § 4980H(a) penalty will equal one-twelfth of $2000 multiplied by the total number of full-time employees employed during the month. The penalty is thus not tailored to the number of employees to whom an employer does not offer health insurance. Instead, this penalty will be assessed based on an employer's total number of full-time employees, even if the employer provides health insurance to all but a small percentage of those employees.[127]

Lots of It (July 8, 2010, 5:55 PM), http://voices.washingtonpost.com/ezra-klein/2010/07/omb_aca_cbo_and_the_deficit.html.

121 IRC § 4980H.

122 PPACA, § 1001, 124 Stat. at 884 (amending § 2716 of the Public Health Service Act, Pub. L. No. 78-410, 58 Stat. 682 (1944)).

123 IRC § 4980H; Notice 2011-73, 2011-2 C.B. 474.

124 E.g., IRC § 4980H(c)(2)(B)(i)(II).

125 IRC § 4980H(c)(2). Whereas applicable large employers are incentivized to offer health insurance through the § 4980H penalties, small employers are incentivized to offer health insurance through tax credits offered by new § 45R. I do not discuss the small-employer health insurance tax credits, as they are less important for the purposes of this Article. For a discussion of these credits, see Zelinsky, note 4, at 14-17.

126 IRC § 4980H(a)(1).

127 More precisely, the § 4980H(a) penalty is assessed based on the number of full-time employees excluding the first thirty employees. IRC § 4980H(c)(2)(D)(i). In a Request for Comments on § 4980H, Treasury hints that § 4980H may be interpreted to require only that an employer offer coverage to "substantially all" of its full-time employees. No further clarification is given as to what is meant by "substantially all." See Notice 2011-36, 2011-1 C.B. 792 ("It is contemplated that the proposed regulations would make clear that

The § 4980H(a) penalty will thus interfere with the strategy of an employer providing health insurance only to higher-income employees and sending lower-income employees to the Exchanges. Yet the penalty will not prevent a variation of this strategy, as the penalty will only be triggered if an employer fails to offer health insurance. An employer will thus be able to avoid this penalty by offering health insurance to all full-time employees regardless of how much the employees would be charged for that insurance. Therefore, an employer could offer very expensive insurance to lower-income employees in order to avoid the penalty while still allowing those employees to qualify for the premium tax credits. As long as the lower-income employees' required contributions for the health insurance would exceed 9.5% of the employees' household incomes, the insurance would be considered "unaffordable"—making the employees eligible for the Exchange subsidies.

In contrast to the § 4980H(a) penalty, the § 4980H(b) penalty will be triggered when an employer does offer health insurance, but when that insurance is deemed "unaffordable."[128] Also unlike the § 4980H(a) penalty, the § 4980H(b) penalty is tailored to the actual number of employees who qualify for the Exchange subsidies (because the employer's offer of health insurance was unaffordable), rather than being based on the total number of employees.[129] More specifically, for any month in which it is triggered, the penalty will equal one-twelfth of $3000 multiplied by the number of full-time employees that receive the Exchange subsidies because the insurance offered to them by their employer was unaffordable.[130] The amount of the § 4980H(b) penalty will be limited, however, so that it can never exceed the amount that the employer would have been liable for had the § 4980H(a) penalty been triggered instead. Consequently, for any month, the § 4980H(b) penalty is limited to a maximum of one-twelfth of $2000 multiplied by the total number of full-time employees employed during the month.[131]

The § 4980H(b) penalty will thus raise the cost to an employer of not offering affordable health insurance to lower-income employees so that those employees can qualify for the Exchange subsidies. The amount by which the § 4980H(b) penalty will raise the costs of this

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an employee offering coverage to all, or substantially all, of its full-time employees would not be subject to the § 4980H(a) assessable payment provisions.").

[128] The § 4980H(b) penalty may also be triggered by offers of affordable health insurance that fail the minimum value test of § 36B(c)(2)(C)(ii).

[129] IRC § 4980H(b)(1).

[130] Id.

[131] IRC § 4980H(b)(2). More precisely, the penalty is assessed based on the number of full-time employees excluding the first thirty employees.

strategy depends on the percentage of an employer's workforce that ends up qualifying for the Exchange subsidies. An employer with only a small percentage of low- and moderate-income employees might face the full § 4980H(b) penalty of $3000 annually per employee that qualifies for the Exchange subsidies. In contrast, an employer with a large percentage of low- and moderate-income employees might have the § 4980H(b) assessable payments limited to the § 4980H(a) penalty amount of $2000 annually multiplied by the total number of full-time employees.

The following charts, again adapted from a study by the Tax Policy Center,[132] demonstrate the relative costs to employers of either offering employer-sponsored health insurance or sending employees to the Exchanges in 2016. The analysis incorporates the value of the Exchange subsidies, the tax exclusions, and the § 4980H employer-mandate penalties. The analysis uses the § 4980H(a) penalty amounts of $2000 per employee annually, adjusted for inflation. The § 4980H employer-mandate penalties would be higher, making the break-even thresholds lower, for employers with only a small percentage of lower-income employees who would thus be subject to the § 4980H(b) penalty of up to $3000 annually per employee qualifying for the Exchange subsidies. The first chart shows the break-even analysis for an employee with four members in the employee's household and the second chart shows the break-even analysis for an individual employee. For both charts, the right-most column ("Net Benefit of Exchange Coverage") shows the total additional value that could be received from an employer not offering affordable health insurance so that an employee can qualify for the Exchange subsidies. This "Net Benefit of Exchange Coverage" is equal to the value of the Exchange subsidies minus both the additional taxes that would be paid (for example, from not taking advantage of the tax exclusions) and the employer-mandate penalty.

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[132] Rennane & Steuerle, note 98, at tbl.2, tbl.4. Note that the Tax Policy Center's analysis underlying these charts is based on holding employers' costs constant. I do not explain the Tax Policy Center's methodology here, as interested readers can find that explanation in the Tax Policy Center's report. Id.

TABLE 2

Break-Even Analysis for an Employee Receiving Exchange Coverage
(Family of four, 2016)

Employee's Household Income as a % of FPL	*Household Income: Cash Compensation Amounts*	*Total Value of Exchange Subsidies*	*Total Increase in Taxes Paid*	*Section 4980H Employer Penalty*	*Net Benefit of Exchange Coverage*
100	$24,000	$18,433	$ (124)	$2,247	$16,309
125	30,000	18,307	2,297	2,247	13,763
150	36,000	15,617	4,568	2,247	8,801
175	42,000	14,759	5,536	2,247	6,976
200	48,000	11,544	5,456	2,247	3,840
225	54,000	10,473	4,493	2,247	3,733
250	60,000	9,053	3,544	2,247	3,261
275	66,000	7,776	3,544	2,247	1,984
300	72,000	6,952	3,544	2,247	1,160
325	78,000	6,468	3,544	2,247	676
350	84,000	5,761	3,544	2,247	(31)
375	90,000	5,165	3,544	2,247	(627)
400	96,000	4,570	3,544	2,247	(1,222)
425	102,000	-	3,544	2,247	(5,792)
450	108,000	-	4,134	2,247	(6,382)

TABLE 3

Break-Even Analysis for an Employee Receiving Exchange Coverage
(Individual, 2016)

Employee's Household Income as a % of FPL	*Household Income: Cash Compensation Amounts*	*Total Value of Exchange Subsidies*	*Total Increase in Taxes Paid*	*Section 4980H Employer Penalty*	*Net Benefit of Exchange Coverage*
100	$11,800	$6,736	$ 866	$2,247	$3,623
125	14,700	6,676	1,142	2,247	3,286
150	17,700	5,574	913	2,247	2,414
175	20,600	5,156	901	2,247	2,008
200	23,600	3,869	1,040	2,247	582
225	26,500	3,347	1,040	2,247	60
250	29,500	2,718	1,040	2,247	(569)
275	32,400	2,095	1,040	2,247	(1,192)
300	35,400	1,686	1,040	2,247	(1,601)
325	38,300	1,452	1,040	2,247	(1,835)
350	41,300	1,100	1,040	2,247	(2,187)
375	44,200	812	1,040	2,247	(2,475)
400	47,200	514	1,050	2,247	(2,783)
425	50,100	-	1,340	2,247	(3,587)
450	53,100	-	1,453	2,247	(3,700)

As the charts demonstrate, the primary impact of the employer-mandate penalties will be to lower the break-even thresholds for the household-income levels at which employers and employees would jointly benefit from the employer not offering affordable health insur-

ance so that the employee can qualify for the Exchange subsidies. Nevertheless, many low- and moderate-income employees will still benefit more from receiving the Exchange subsidies than from receiving employer-sponsored health insurance. For a family of four in 2016, the break-even threshold for the household-income level at which it will be more cost effective for an employer to not offer affordable health insurance might be somewhere between 325% and 350% of the federal poverty line. For an individual employee, the break-even threshold might be somewhere between 225% and 250% of the federal poverty line. The numerous employees with household incomes below the relevant break-even thresholds would benefit more from their employers not offering affordable health insurance and paying the employer-mandate penalties so that the employees can qualify for the premium tax credits.

To recap, the § 4980H(a) penalty will not prevent employers from providing health insurance to their higher-income employees while sending their lower-income employees to the Exchanges, because the employers can avoid the § 4980H(a) penalty by offering their lower-income employees unaffordable health insurance. Only the § 4980H(b) penalties will apply to an employer who offers unaffordable health insurance to its lower-income employees. Consequently, the primary effect of the § 4980H employer-mandate penalties will be to lower the break-even thresholds by raising the cost of not offering lower-income employees affordable health insurance by an amount equal to the § 4980H(b) penalties.

Of course, employers will not be able to perfectly separate their lower-income employees (whose household incomes fall below the break-even thresholds) from their higher-income employees (whose household incomes are above the break-even thresholds). Employers will not always know their employees' household incomes, as household income may derive from sources other than from the employer.[133] Additionally, employers may find it difficult to vary the cost of the health insurance they offer to match the break-even thresholds for employees with different family sizes. Nevertheless, the

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[133] Nevertheless, by setting the employee's cost of health insurance equal to the break-even threshold based solely on the amount the employer pays to the employee, the employer can effectively enable nearly all employees with household incomes below the break-even threshold to qualify for the Exchange subsidies. Employees whose household incomes are higher than the amount paid by the employer to the employee, for instance, employees with working spouses, can simply opt for the employer-sponsored insurance. For employees whose household incomes are lower than the amount paid by the employer to the employee, for instance, employees with significant tax losses not arising from their employment, the Treasury Department and the IRS have announced their intention to create an affordability safe harbor with respect to the § 4980H(b) employer penalties. See IRS Notice 2011-73, note 123.

§ 4980H employer-mandate penalties will not prevent employers from exploiting the mismatch in available health care subsidies by simultaneously allowing many of their lower-income employees to qualify for the Exchange subsidies and many of their higher-income employees to benefit from the tax exclusions.

In contrast to the § 4980H employer-mandate penalties, the new nondiscrimination rules could possibly be interpreted so as to prevent employers from offering health insurance to their higher-income employees while allowing their lower-income employees to qualify for the Exchange subsidies. The statutory language of the new nondiscrimination rules is relatively short. In full, it reads:[134]

> SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.
>
> (a) IN GENERAL.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).
>
> (b) RULES AND DEFINITIONS.—For purposes of this section—
>
> (1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.
>
> (2) HIGHLY COMPENSATED INDIVIDUAL.—The term 'highly compensated individual' has the meaning given such term by section 105(h)(5) of such Code.

Section 105(h) provides that self-funded health insurance plans cannot discriminate in favor of highly compensated individuals either with respect to eligibility to participate or with respect to the benefits provided under the plan.[135] The ACA's new nondiscrimination provisions thus create rules for insured plans "similar to" those that previously existed for self-insured plans.[136]

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134 42 U.S.C. 300gg-16; Notice 2010-63, 2010-2 C.B. 420.

135 IRC § 105(h)(2).

136 Section 2716 only applies to insured plans that are not grandfathered, although most plans eventually will be covered. Shearman & Sterling, Post-Employment Medical Benefits for Executives After Health Care Reform *2 (2010), available at http://www.shearman.com/files/Publication/2f843bcc-ac80-49c2-8bed-7d4f50ded8b9/Presentation/PublicationAttachment/9f41c894-d516-480f-91e1-3a4b2286db95/ECEB-122110-Executive-Medical-Coverage-After-Health-Reform.pdf. ("[I]t is anticipated that plan sponsors will find it difficult to maintain the grandfathered status of their plans. Therefore, as a practical matter, most, if not all, insured plans will eventually be subject to the new discrimination rule.").

Prior to the ACA, the § 105(h) nondiscrimination rules were only minimally enforced as employers were rarely audited for compliance with these rules.[137] Recognizing that further guidance will be needed to clarify the new § 2716 nondiscrimination rules, Treasury and the IRS, along with the Department of Labor and HHS, "have determined that compliance with § 2716 should not be required (and thus, any sanctions for failure to comply do not apply) until after regulations or other administrative guidance of general applicability has been issued under § 2716."[138]

Because such guidance has yet to be issued, I cannot at this time fully assess how the new nondiscrimination might function in practice. For now, it is an open question as to whether or to what extent the new nondiscrimination rules might prevent employers from designing their health insurance offerings so that higher-income employees can take advantage of the tax exclusions while lower-income employees can qualify for the Exchange subsidies because they are only offered unaffordable health insurance. The new nondiscrimination rules may interfere with this strategy, at least to some extent, but employers may also find ways to effectuate this strategy while complying with the nondiscrimination rules.

Consider the employer strategy of simply passing on to employees the employer's costs for providing self-only coverage. Instead of subsidizing employees' health insurance purchases, employers embracing this strategy would switch any funds previously used to subsidize self-only coverage to instead increase employees' cash wages. By also setting up a cafeteria plan through which employees could opt to have their take-home cash wages reduced in order to pay for health insurance on a pre-tax basis, employers embracing this strategy could effectively give employees the option of either continuing to use the subsidy amounts to reduce the cost of employer-provided health insurance (now channeled through a cafeteria plan) or else taking the subsidy amounts as higher cash salaries (that could be used to pay for Exchange coverage).

According to a report by the Kaiser Family Foundation, in 2011, the average cost of providing self-only coverage though employer-sponsored plans was $5,615 annually per employee.[139] This amount is pre-

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[137] See id. at *1 ("How the discrimination rules under § 105(h)(2) apply to medical plans has never been completely clear. However, many employers did not have to confront the ambiguities in the health plan discrimination rules under § 105(h)(2) because the rules applied only to self-insured arrangements and the rules were rarely enforced or ruled upon by the Internal Revenue Service.").

[138] Notice 2011-1, 2011-1 C.B. 259.

[139] The Kaiser Family Found. & Health Res. and Educational Trust, Employer Health Benefits, 2012 Annual Survey 13, available at http://ehbs.kff.org/pdf/2012/8345.pdf.

dicted to grow significantly faster than inflation and economic growth over time.[140] Of this amount, employees paid for 18% of these costs directly and employers paid for the remaining 72% through subsidies.[141] If an employer passed on to its employees the entire average cost of self-only coverage ($5,615 in 2011), the employees would thus not be considered to have an offer of affordable employer-sponsored health insurance unless an employee's household income exceeded $59,100 annually ($5,615/.095), adjusted for rising health care costs. Hence, this strategy would allow most single employees, and many employees with families, whose household income levels were below the break-even thresholds to qualify for the Exchange subsidies.[142]

Would this strategy violate the new nondiscrimination rules? I expect not. An employer embracing this strategy could offer insurance to all employees on exactly the same terms. To prevent this strategy then, the new nondiscrimination rules would need to be interpreted so as to apply even when employers offered all employees insurance on the same terms but when lower-income employees made different choices than higher-income employees. Interpreting the nondiscrimination rules in this fashion could create very large costs for employers, potentially affecting many employers who were not attempting to game around the nondiscrimination rules but whose employees nevertheless made different choices with respect to insurance offerings based on income. Although a full analysis of the impact of the new nondiscrimination rules must wait until the release of guidance interpreting these rules, there is thus reason to expect that the new nondiscrimination rules will not be interpreted so as to prevent employers from providing health insurance to their higher-income employees while sending many of their lower-income employees to the Exchanges.[143]

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[140] Nat'l Inst. for Health Care Management, Understanding U.S. Health Care Spending 1-8 (July 2011).

[141] Kaiser Family Found, note 139, at 76.

[142] To precisely calculate how this strategy would work with respect to the break-even thresholds, we would need to adjust for the expected increases in the cost of employer-sponsored health insurance after 2011 and for the higher household incomes the employees would have on account of their employer switching from subsidizing the cost of health insurance to increasing the employees' salaries. Nevertheless, the example above should suffice to demonstrate that, by passing on the cost of health insurance to employees, an employer can facilitate many lower income employees qualifying for the Exchange subsidies while allowing higher income employees to continue to opt for employer-sponsored health insurance.

[143] Moreover, the strategy described above is only one technique employers might use to enable their lower-income employees to qualify for the Exchange subsidies while maintaining the benefits of the tax exclusions for their higher income employees. For instance, employers might alternatively purposefully design insurance offerings that fail the minimum value rules of § 36B(c)(2)(C)(ii).

IV. How the ACA Will Create Effective Taxes

The previous two Parts explained how the ACA will alter employers' incentives as to whether to offer health insurance. Crucially, the ACA will create a mismatch between the tax subsidies available for Exchange coverage and those available for employer-sponsored coverage, such that most lower-income taxpayers would receive more tax benefit from Exchange coverage whereas most higher-income taxpayers would receive more tax benefit from employer-sponsored coverage. By creating this mismatch in the available tax subsidies, and then attempting to nevertheless incentivize employers to offer affordable health insurance even for their lower-income employees, the ACA will impose significant and costly effective taxes with respect to low- and moderate-income workers.

The effective taxes that the ACA will impose with respect to low- and moderate-income workers can be grouped into two categories: (1) effective taxes created by the design of the Exchange subsidies, and (2) effective taxes created by the employer penalties. While there is considerable overlap between these two categories of effective taxes, it is nevertheless useful to consider the categories one at a time.

A. The Effective Taxes Created by the Design of the Exchange Subsidies

From an efficiency perspective, the impact of a tax is determined by the extent to which the tax alters the relevant prices of economic decisions.[144] When a law raises the cost of one economic choice relative to alternative choices, this can be viewed as an effective tax on the choice that is made more expensive.[145] The way in which the ACA structures its Exchange subsidies will create effective taxes with respect to at least three important decisions: the choice to work for employers of-

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[144] For an explanation of how taxes impose efficiency costs—or, alternatively, excess burden or deadweight loss—see David Gamage & Darien Shanske, Three Essays on Tax Salience: Market Salience and Political Salience, 65 Tax L. Rev. 19, 61-65 (2011).

[145] Sometimes the term "effective tax" is used more narrowly. See, e.g., Boris I. Bittker, Effective Tax Rates: Fact or Fancy?, 122 U. Pa. L. Rev. 780, 781 (1974) ("When the taxpayer's actual income tax liability is expressed as a fraction of a base other than taxable income, the resulting percentage is usually described as the 'effective rate.'"). But the term "effective taxes" can also be used broadly, as in this Article. See, e.g., Daniel Shaviro, Effective Marginal Tax Rates on Low-Income Households, 84 Tax Notes 1191, 1192 (Aug. 23, 1999) ("My focus on effective marginal tax rates yields a very different perspective . . . . the analysis cannot stop with provisions that are formally denominated 'taxes.' The reason one should care about marginal tax rates is that they show how government policy is affecting incentives and the distributional consequences of people's decisions. . . . A marginal tax rate analysis thus must take account of all government programs that are either directly or indirectly income-conditioned.").

fering affordable health insurance, the choice to seek higher income, and the choice to marry (or, equivalently, the choice not to divorce).

The effective taxes that the ACA will impose on the decision to work for employers that offer affordable health insurance are probably among the most important of the effective taxes that this Article analyzes. Most low- and moderate-income Americans would receive considerably more value from the Exchange subsidies than from the tax exclusions. Yet if employers offer affordable health insurance to their low- and moderate-income workers, these workers will become disqualified from receiving the Exchange subsidies. The ACA will thus impose effective taxes on low- and moderate-income workers' choice of whether to work for an employer offering affordable health insurance equal to the degree to which the tax exclusions would offer these workers less value than would the Exchange subsidies.[146]

For many low- and moderate-income workers, accepting a job with an employer that offers affordable health insurance will result in a net loss of thousands of dollars of health care subsidies.[147] For instance, in 2016, a family of four with a household income of $60,000 would suffer a net loss of approximately $5500 in health care subsidies from being offered affordable employer-sponsored health coverage.[148] For a family of four with a household income of $36,000, the net loss of health care subsidies would be approximately $11,000—almost a third of the family's household income.[149] These effective taxes will strongly deter low- and moderate-income taxpayers from accepting jobs that offer affordable health insurance.[150]

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[146] As noted earlier, if Exchange coverage remains inferior to employer-sponsored coverage even after the ACA, then the difference in value between the Exchange subsidies and the tax exclusions must be discounted by the degree to which Exchange coverage offers inferior value. See note 114 and accompanying text.

[147] See note 132 and accompanying text.

[148] These calculations are derived from the break-even charts based on the Tax Policy Center's analysis. See Table 2, Section III.C. These calculations factor out the employer-mandate penalties, because the goal here is to demonstrate the loss in health care subsidies to an employee from being offered affordable employer-sponsored health insurance; the goal is not to show break-even analyses or employers' incentives.

[149] Id. This loss in health care subsidies would be mitigated for families able to qualify for other government health care programs. Notably, although a family of four with household income of $36,000 in 2016 should not qualify for Medicaid, as the family's income would be too high, the children might still qualify for the Children's Health Insurance Program (CHIP).

[150] Of course, the actual magnitude of the effective taxes on accepting jobs that offer affordable health insurance will depend on how much income the taxpayers could have earned from their alternative choices—from not working for employers that offer affordable health insurance. A full calculation of effective taxes would need to incorporate the many factors affecting the returns to work. The figures shown above are at best rough approximates, but they should still suffice to illustrate that the net loss of health care subsidies may be very large.

As long as at least some employers offer jobs that do not provide affordable employer-sponsored health insurance, low- and moderate-income Americans can be expected to strongly prefer these jobs over similar jobs that do offer affordable employer-sponsored health insurance. And for taxpayers who are not committed to working in the formal sector, the effective taxes that the ACA will impose on accepting a job that offers affordable health insurance may significantly decrease the incentives to accept formal-sector employment.

In addition to these effective taxes, the ACA will create further effective taxes because the value of the Exchange subsidies will phase out as household income increases.[151] For instance, in 2016, a family of four without an offer of affordable employer-sponsored health insurance would lose approximately $6500 in Exchange subsidies from increasing household income from $36,000 to $60,000.[152] And for taxpayers who move from lower-paying jobs that do not offer affordable health insurance to higher-paying jobs that do offer affordable health insurance, these two forms of effective taxes will stack.[153] Returning to our family of four in 2016, switching from earning a household income of $36,000 without affordable employer-sponsored health insurance to a household income of $60,000 with affordable employer-sponsored health insurance would result in a net loss of approximately $12,000 in health care subsidies.[154] Although this loss of health care subsidies is less than the increased income paid by the new job, the effective taxes created by the loss of health care subsidies can be expected to significantly decrease taxpayers' incentives to make sacrifices in order to obtain higher paying jobs.

The ACA's effective taxes on accepting jobs that offer affordable health coverage may be especially problematic because they affect the extensive margin of labor supply. The extensive margin of labor supply refers to the choice of whether or not to work; in contrast, the

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151 Seth J. Chandler, The Architecture of Contemporary Healthcare Reform and Effective Marginal Tax Rates, 29 Miss. C. L. Rev. 335 (2010) (analyzing the effective taxes the ACA will create by phasing out the Exchange subsidies as household income increases). For a more general discussion of how phasing out social welfare benefits can generate high effective marginal tax rates, see generally Shaviro, note 145.

152 See Table 2 in Section III.C. (subtracting the Total Value of Exchange Subsidies corresponding with a Household Income of $60,000 from the Total Value of Exchange Subsidies corresponding with a Household Income of $36,000).

153 Moreover, these effective taxes created by the design of the Exchange subsidies will further stack with the effective taxes created by the design of other social welfare programs and with payroll taxes. See Chandler, note 151, at 361; Shaviro, note 145, at 1192.

154 See Table 2, Section III.C. (subtracting the Total Increases in Taxes Paid corresponding with a Household Income of $60,000 from the Total Value of Exchange Subsidies corresponding with a Household Income of $36,000).

intensive margin refers to the choice of how many hours to work.[155] A strong finding of the empirical economics literature is that labor-supply elasticities for low-income workers are much stronger along the extensive margin than along the intensive margin.[156] Indeed, men appear to be "almost completely irresponsive" to effective taxes along the intensive margin, but "very responsive" to effective taxes along the extensive margin.[157] Women are more responsive than men along both margins; but like men, women are even more responsive along the extensive margin than the intensive margin.[158] Consequently, an effective tax operating on the extensive margin is far more likely to affect labor-supply decisions—and thereby reduce economic efficiency—than would a similarly sized tax affecting only the intensive margin.[159]

The ACA's denial of the Exchange subsidies to taxpayers with offers of affordable employer-sponsored health insurance will create effective taxes along the extensive margin by reducing the net benefit low-income taxpayers would receive from accepting a job with an employer offering affordable health insurance.[160] Moreover, there are reasons to think that when low-income workers decide against accepting formal-sector jobs this can generate negative externalities.[161] As Nobel-Prize-winning economist Edmund Phelps has argued, when low-income taxpayers decide against formal-sector work, this decision can harm the taxpayers' children, the taxpayers' neighborhoods, and

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155 See Emmanuel Saez, Optimal Income Transfer Programs: Intensive Versus Extensive Labor Supply Responses, 117 Q.J. Econ. 1039, 1039 (2002).

156 Id. at 1039-40.

157 Costas Meghir & David Phillips, Labour Supply and Taxes 44-45 (Inst. for Fisc. Stud., 2008), available at http://www.ifs.org.uk/mirrleesreview/reports/labour_supply.pdf.

158 Saez, note 155, at 1056.

159 For instance, a number of scholars have criticized the effective marginal taxes created by the phase out of tax benefits like the earned income tax credit (EITC). E.g., Shaviro, note 145, at 1194. The manner in which the EITC phases out, however, primarily affects only the intensive margin, not the extensive margin, such that the EITC may phase out in a close to optimal fashion. Saez, note 155, at 1064-65 ("The combined EITC and U.S. welfare system for single mothers is close to our optimal simulated schedules if, as evidenced by empirical studies, participation elasticities are substantial."). In contrast, both the manner in which the Exchange subsidies phase out and the denial of the Exchange subsidies to employees with offers of affordable employer-sponsored health insurance affect the extensive margin of labor supply.

160 Note that the manner in which the effective taxes created by the design of the Exchange subsidies affects the extensive margin of labor supply is somewhat complicated by the interaction between the Exchange subsidies and Medicaid; exploring the implications of these interactions is beyond the scope of this Article.

161 For a definition of negative externalities, see David S. Gamage, Note, Taxing Political Donations: The Case for Corrective Taxes in Campaign Finance, 113 Yale L.J. 1283, 1292 (2004).

broader society, in addition to the taxpayers themselves.[162] Hence, to the extent the ACA's effective taxes discourage low-income taxpayers from accepting formal-sector employment, these effective taxes may prove especially harmful.

Because an offer of employer-sponsored health insurance will result in an employee's entire family being disqualified from the Exchange subsidies[163]—as long as the employee's self-only coverage is affordable, and regardless of the cost of family coverage—the ACA will also impose effective taxes on marriage. Imagine a couple with children where one of the adults works for an employer that offers affordable health insurance. If the couple marries, then the nonemployee spouse and children will be made ineligible for the Exchange subsidies. Similarly, if the couple is already married, then they can make the nonemployee spouse and children qualify for the Exchange subsidies by divorcing. Hence, for many low-income families, the ACA will impose thousands of dollars in effective taxes on couples that choose to be legally married.

There is some evidence that imposing effective taxes on marriage can significantly affect behavior.[164] Moreover, marriage penalties have historically had high political salience in tax law.[165] There may well be political backlash once voters come to understand the extent of the marriage penalties created by the ACA. And many commentators seem to agree that there is something inherently wrong with tax law imposing high marriage penalties even apart from efficiency concerns.[166]

The ACA's effective taxes both on marriage and on accepting jobs that offer affordable health coverage could be considerably mitigated by basing the affordability of employer-sponsored health insurance for employees with families on the cost of family coverage, rather than on the cost of the employee's self-only coverage. A number of commentators have suggested that the text of new § 36B is sufficiently ambiguous that Treasury could interpret the affordability test for em-

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[162] Edmund S. Phelps, Rewarding Work: How to Restore Participation and Self-Support to Free Enterprise 38-48 (1997).

[163] See note 102 and accompanying text.

[164] Kasey S. Buckles, Melanie Guldi & Joseph Price, Changing the Price of Marriage: Evidence from Blood Test Requirements 24-25 (2009), available at http://www.nd.edu/~kbuckles/BGP_nber.pdf ("We have shown that even small changes in the cost of marriage can have significant effects, particularly for certain populations.").

[165] See Lawrence Zelenak, Doing Something About Marriage Penalties: A Guide for the Perplexed, 54 Tax L. Rev. 1, 4-11 (2000) (discussing the political history of the debate over marriage penalties).

[166] See Leslie A. Whittington & James Alm, Marriage Penalty, NTA Encyclopedia of Taxation and Tax Policy 13 (2d ed. 1999) ("The principal arguments revolve around equity issues.").

ployees with families as being based on the cost of family coverage.[167] Treasury's indication in its proposed regulations that the affordability test will be based on the cost of employee's self-only coverage has thus been strongly criticized.[168]

Analyzing whether Treasury would have the authority to interpret § 36B so that the affordability test for employees with families would be based on the cost of family coverage is beyond the scope of this Article. It is worth noting, however, that the Treasury interpretation follows an earlier technical explanation by the Joint Committee on Taxation,[169] and that the Congressional Budget Office's official scoring of the cost of the ACA was also based on this interpretation.[170] In any case, it is worth discussing the policy considerations underlying this question. If the affordability test were based on the cost of family coverage, rather than self-only coverage, then a secondary question would arise as to whether employers who offered affordable self-only coverage but unaffordable family coverage would be subject to the § 4980H(b) employer-mandate penalties.

If these employers would be subject to the § 4980H(b) employer-mandate penalties, then employers would need to offer affordable family coverage in order to avoid those penalties. Arguably, it is not reasonable to expect the employers of low- and moderate-income workers to offer affordable family coverage, as this would dramatically increase the cost of hiring those workers. And rising health care costs would exacerbate this problem over time. Moreover, employers would face strong incentives to not hire employees with families to the

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167 Peter Gosselin, New Rule Could Narrow Aid for Health-Plan Buyers and Shrink Insurers' Sales 3 (Bloomberg Gov't Study, Sept. 27, 2011). ("But the law is not quite as clear what type of coverage it intends the individual's contribution to go toward—coverage for just the individual or his or her family. And, to the extent the measure appears to apply the contribution to individual-only coverage, many observers thought the result was sufficiently unfair that Treasury and the IRS would use their regulation-writing authority to address the matter.").

168 See, e.g., id. at 20-21; Larry Levitt & Gary Claxton, Measuring the Affordability of Employer Health Coverage, Henry J. Kaiser Fam. Found. Health Reform Source (Aug. 24, 2011), http://healthreform.kff.org/notes-on-health-insurance-and-reform/2011/august/measuring-the-affordability-of-employer-health-coverage.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+NotesOnHL+%28Notes+on+Health+Insurance+and+Reform+%28Headlines%29+-+Kaiser%27s+Health+Reform+Source%29.

169 Joint Comm. on Tax'n, General Explanation of Tax Legislation Enacted in the 111th Congress 265 (Comm. Print 2011) ("Unaffordable is defined as coverage with a premium required to be paid by the employee that is more than 9.5 percent of the employee's household income, based on the self-only coverage"); see also Prop. Reg. § 1.36B-2(c)(3)(v)(A)(1), 76 Fed. Reg. 50931, 50943 (Aug. 17, 2011) (incorporating the Joint Committee's interpretation).

170 See Richard V. Burkhauser, Sean Lyons & Kosali Simon, An Offer You Can't Refuse: Estimating the Coverage Effects of the 2010 Affordable Care Act 5 n.5 (Emp. Policies Inst., 2011), available at http://epionline.org/studies/110715_EPI_AnOfferYouCantRefuse_PolicyBrief_Final.pdf.

extent they could legally do so. Perhaps most problematic, the § 4980H(b) employer-mandate penalties are probably not high enough to incentivize employers to offer affordable family coverage.[171] If a significant number of employers were to decide against offering affordable family coverage, or to drop offering coverage all together, then this could substantially increase the budgetary cost of the Exchange subsidies.[172]

Conversely, if employers offering affordable self-only coverage, but unaffordable family coverage, would not be subject to the § 4980H(b) employer-mandate penalties, then employers would have strong incentives to make family coverage unaffordable for low- and moderate-income workers. Employers could shift any funds previously used to subsidize family coverage to instead increase the subsidies for self-only coverage. According to a study by the Employment Policies Institute, "it could be in the interest of a surprisingly large number of employees—and their employers—to change their current contracts so that otherwise-ineligible workers will be able to receive the exchange subsidy."[173] This would dramatically increase the budgetary cost of the Exchange subsidies.[174]

Returning to the reason why the ACA denies the Exchange subsidies to employees with offers of affordable employer-sponsored health insurance: The drafters of the ACA wanted the Exchange subsidies to make insurance affordable for those who were previously uninsured, but also wanted to limit the budgetary cost of the Exchange subsidies by not making the subsidies available to those who previously received affordable health insurance from their employers. In order to prevent employers from dropping health insurance so that their employees could take advantage of the Exchange subsidies, the ACA thus also includes the employer-mandate penalties and the new nondiscrimination rules. It is this framework for limiting the budgetary cost of the Exchange subsidies that creates most of the effective taxes discussed in this Article.

Basing the affordability test on the cost of family coverage would mitigate the effective taxes on marriage and on accepting jobs that offer affordable health insurance, but only by eroding the firewall that the ACA creates on the availability of the Exchange subsidies and thereby greatly increasing the budgetary cost of the Exchange subsi-

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171 And strengthening the employer-mandate penalties (which would require legislative action) would exacerbate another form of effective taxes on low- and moderate-income workers, as discussed in Section IV.B.

172 Lacking offers of affordable employer-sponsored coverage, many more low-income workers and their families would qualify for the Exchange subsidies.

173 Burkhauser et al., note 170, at *2.

174 Id. at *4.

dies.[175] Conversely, Treasury's proposed rule of basing affordability on the cost of self-only coverage maintains the firewall and thereby contains the budgetary cost of the Exchange subsidies, but at the price of greatly exacerbating the ACA's effective taxes. Moreover, as explained by the Employment Policy Institute, Treasury's proposed rule means that "millions of families will be stuck in a no-man's-land without affordable coverage through their employer or the exchange—since family members of an employee with an offer of coverage are disqualified from accessing subsidized exchange coverage."[176]

B. The Effective Taxes Created by the Employer Penalties

To the extent that employers decide to offer affordable health insurance to their low- and moderate-income employees, the ACA will create effective taxes primarily due to the design of the Exchange subsidies.[177] Conversely, to the extent that employers decide against offering affordable health insurance to their low- and moderate-income employees, the ACA will create effective taxes primarily through the employer penalties.[178] Both the new § 4980H employer-mandate penalties and the new nondiscrimination rules will impose effective taxes on low- and moderate-income workers when employers decide against offering affordable health insurance.[179] Moreover, these employer penalties will impose effective taxes regardless of whether employers actually end up paying the penalties or whether employers instead reorganize their business operations so as to avoid being subject to the penalties.

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[175] Basing the affordability test on the cost of family coverage would not necessarily mitigate the effective taxes on increasing household income, as these effective taxes result from the Exchange subsidies phasing out as household income increases rather than from the Exchange subsidies being unavailable to taxpayers with offers of affordable employer-sponsored health insurance.

[176] Id.

[177] Of course, to the extent that the employer penalties are what cause employers to offer affordable health insurance to their low- and moderate-income employees, it would be more accurate to say that the effective taxes are caused by the interaction between the design of the Exchange subsidies and the employer penalties. The effective taxes I analyze in Section IV.A are thus not entirely distinct from the effective taxes I discuss in this Section. In many respects, effective taxes impacting employees are equivalent to effective taxes impacting employers, with the ultimate result depending on the incidence of the effective taxes. Nevertheless, despite the overlap between the effective taxes discussed in these two Sections, I have separated the two discussions for ease of exposition.

[178] The effective taxes created by the Exchange subsidies phasing out as household income increases will also apply when employers do not offer affordable health coverage. See notes 151-54 and accompanying text.

[179] These employer penalties also impose effective taxes when employers do offer affordable health insurance, due to the design of the Exchange subsidies, but these effective taxes were discussed in the previous Section.

The effective taxes that will be created when employers are subject to the § 4980H employer-mandate penalties are relatively straightforward.[180] When employers become subject to the § 4980H(b) employer-mandate penalties (of between $2000 and $3000 annually, adjusted for inflation), the penalties will raise the cost of hiring employees who qualify for the Exchange subsidies. Economists generally agree that raising the cost to employers of hiring low- and moderate-income workers will lead employers to reduce those workers' salaries, hire fewer low- and moderate-income workers, or implement some combination of these two coping strategies.[181] The § 4980H(b) employer-mandate penalties will thus function as an effective tax on employing low- and moderate-income workers.[182]

The new nondiscrimination rules may similarly function as an effective tax on employing low- and moderate-income workers, depending on the extent to which these rules succeed in preventing employers from offering affordable health insurance only to their higher-income employees. The penalties for violating the new nondiscrimination rules are extremely severe—at $100 per day per affected employee.[183] Consequently, employers should not purposefully allow themselves to become subject to the penalties for violating the new nondiscrimination rules. Instead, employers should either offer health insurance in a nondiscriminatory fashion or else stop offering health insurance altogether.

To the extent that the new nondiscrimination rules motivate employers to stop offering health insurance even to their higher-income employees, these employers' low- and moderate-income employees will be able to qualify for the Exchange subsidies. But because these employers will be unable to offer their higher income employees the benefit of the tax exclusions, the new nondiscrimination rules will raise the costs to these employers of offering attractive compensation packages to their higher-income employees. These increased costs will function as effective taxes in that the employers will need to make

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[180] As discussed in Section III.C, employers should generally be able to avoid paying the § 4980H(a) employer-mandate penalties by offering unaffordable health insurance to their low- and moderate-income employees. Consequently, the § 4980H(a) employer-mandate penalties should not create significant effective taxes.

[181] See, e.g., Monahan & Schwarcz, note 26, at 182-83 ("Most economists agree that health care costs are simply part of employees' total compensation. Decreased health insurance costs may consequently tend to translate into increased salaries."); Lawrence H. Summers, Some Simple Economics of Mandated Benefits, 79 Am. Econ. Rev. 177, 181-82 (1989); see also note 184 and accompanying text.

[182] For further discussion, see John Goodman, The $6-an-Hour Health Minimum Wage, John Goodman's Health Pol'y Blog (Oct. 18, 2010), http://healthblog.ncpa.org/the-6-an-hour-min-wage/.

[183] 42 U.S.C. 300gg-22(b)(2)(c)(i).

adjustments in order to offset for the increased costs. Some portion of the incidence of these effective taxes will affect the employers' hiring of low- and moderate-income employees (while another portion will affect the employers' hiring of higher-income employees). Hence, in addition to the effective taxes the new § 4980H employer-mandate penalties will impose on hiring low- and moderate-income employees, the new nondiscrimination rules will impose additional effective taxes to the extent that the nondiscrimination rules interfere with the employers' offering attractive compensation packages to their higher-income employees.

Rather than allowing themselves to be subject to the new § 4980H employer-mandate penalties or the new nondiscrimination rules, many employers will reorganize their business operations so as to qualify for exceptions to these rules. In particular, employers may shift some of their low- and moderate-income workers to part-time positions.[184] Neither the § 4980H employer-mandate penalties nor the new nondiscrimination rules apply to part-time employees, with part-time defined as employees working an average of less than thirty hours per week with respect to the § 4980H employer-mandate penalties[185] and as employees working less than thirty-five hours per week with respect to the nondiscrimination rules.[186] By moving their low- and moderate-income employees to part-time status, employers can avoid having to either offer these employees affordable health insurance or be subject to the employer-mandate penalties or the nondiscrimination rules.

Moreover, low- and moderate-income employees should often prefer to work part-time and not be offered affordable health insurance than to work full time while being offered affordable health insurance.[187] Shifting their low- and moderate-income employees to part-time status can thus facilitate employers maximizing the value of the health care tax benefits for all employees, as lower income employees would be eligible for the Exchange subsidies and higher-income em-

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[184] See Diana Furchtgott-Roth, Job Creation and the Affordable Care Act, 132 Tax Notes 1289, 1289 (Sept. 19, 2011) ("That combination of taxes gives businesses a powerful incentive to downsize, replace full-time employees with part timers, and contract work out to other firms or individuals.").

[185] IRC § 4980H(c)(4).

[186] PPACA, § 1001, 124 Stat. at 884 (amending § 2716 of the Public Health Service Act, Pub. L. No. 78-410, 58 Stat. 682 (1944)), provides that group health plans (other than self-insured plans) must satisfy rules "similar to" the § 105(h) rules governing self-insured plans. Because full guidance interpreting PHSA § 2716 has yet to be released, there is uncertainty on how the "similar to" language will be applied. That caveat aside, § 1.105-11(c)(2)(iii)(c) of the regulations specifies that part-time employees (generally defined as employees working less than thirty-five hours per week) are excluded from the § 105(h) nondiscrimination rules.

[187] See notes 146-54 and accompanying text.

ployees for the tax exclusions—all without the employer being subject to either the § 4980H employer-mandate penalties or the new nondiscrimination rules.

Moving low- and moderate-income workers to part-time status is probably among the most promising strategies employers might use to reorganize their business operations so as to avoid the employer-mandate penalties and the nondiscrimination rules. But many alternative strategies may also be available. For instance, employers might replace some of their employees with independent contractors or move their low- and moderate-income employees into separate business divisions from their higher-income employees.[188] With respect to the nondiscrimination rules, it is not yet clear whether offering unaffordable insurance to lower-income employees would even be considered discriminatory if the insurance is offered on similar terms to all employees.[189] Until final guidance is released interpreting both § 4980H and the new nondiscrimination rules, it would be premature to attempt a full analysis of possible avoidance strategies; nevertheless, many high-priced law firms and consulting firms are undoubtedly already hard at work designing these strategies.[190]

To the extent employers can effectively implement avoidance strategies and thereby offer affordable health insurance only to their higher-income employees, the budgetary cost of the Exchange subsidies may be much higher than predicted. The purpose of the § 4980H employer-mandate penalties and the new nondiscrimination rules is to contain the cost of the Exchange subsidies by denying those subsidies to employees with offers of affordable employer-sponsored health insurance. The CBO scored the budgetary cost of the ACA based on the assumption that most employees who had offers of affordable employer-sponsored health insurance prior to the ACA will continue to have those offers after the ACA comes into effect.[191] The CBO's estimates appear to assume that few employers will be able to use avoidance techniques so as to offer affordable health insurance only to their

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[188] See Furchtgott-Roth, note 184, at 1289-90; Eugene Steuerle, Health Care Reform: Implications of a Two Subsidy System *13 (2009), available at http://www.urban.org/uploadedpdf/509103_healthcarereform.pdf.

[189] Insurance offered on similar terms to all employees could end up being unaffordable to lower-income employees due to the simple fact that lower-income employees have less income with which to purchase insurance. For further discussion, see Section III.C.

[190] For the most recent update on the status of the proposed guidance interpreting § 4980H, as of the time of this writing, see Notice 2012-17, 2012-1 C.B. 430.

[191] See Cong. Budget Office, CBO's Analysis of the Major Health Care Legislation Enacted in March 2010, at 20 (2011), available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf (discussing the CBO's estimates for the number of employers dropping health coverage and stating "[s]ome commentators have expressed surprise that CBO and JCT do not expect a much larger reduction in employment-based insurance coverage").

higher-income employees.[192] If employers can successfully offer affordable health insurance only to their higher-income employees, then a much larger number of taxpayers will be eligible for the Exchange subsidies than the CBO predicted, greatly increasing the budgetary cost of the Exchange subsidies.[193]

Moreover, employers will need to incur costs in order to reorganize their business operations. For instance, if an employer relied on full-time workers prior to the ACA, this implies that hiring full-time workers made more sense from a business perspective as compared to hiring part-time workers. If the ACA induces the employer to switch to hiring part-time workers in order to avoid the employer-mandate penalties or the nondiscrimination rules, this will create costs for the employer to the extent that hiring part-time workers would otherwise make less business sense than would hiring full-time workers.

Most any strategy employers might use to reorganize their business operations to avoid the employer-mandate penalties or the nondiscrimination rules will create costs for the employer. And at least some of the incidence of these costs will fall on low- and moderate-income workers—to the extent the costs lead employers to reduce hiring or to reduce salaries. And even to the extent the incidence of these costs falls on higher-income workers (or on owners, managers, or customers), this will still create economic harm.[194]

Overall then, without further reforms, the ACA will impose costly effective taxes on low- and moderate-income workers regardless of how employers respond to the ACA's framework. These effective taxes may be somewhat less severe if employers stop offering afforda-

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[192] See id. at 20-21 (arguing that employers will not stop offering affordable coverage to their lower-income employees because the employers will not want to forgo offering their higher-income employees the value of the tax exclusions and stating that the nondiscrimination rules will prevent employers from doing both).

[193] The cost of the Exchange subsidies may greatly exceed the CBO's estimates even if employers are able to avoid only the nondiscrimination rules but not the § 4980H employer-mandate penalties. As discussed in Section III.C, many low-income employees would receive more net benefit from the Exchange subsidies than from being offered affordable employer-sponsored insurance even when employers are subject to the § 4980H penalties. But if employers can avoid being subject to both the § 4980H penalties and the nondiscrimination rules, employers will have incentives to stop offering affordable coverage for a much larger number of low- and moderate-income employees.

On the other hand, if the ACA fails in fixing the problems of the individual market such that Exchange coverage remains significantly inferior to employer-sponsored coverage, then employers will face much less incentive to stop offering affordable health insurance to their low- and moderate-income employees. Yet few supporters of the ACA are likely to be comforted by the idea of costs being contained through the ACA failing in one of its primary goals.

[194] Because the penalty savings that induce employers to incur these costs represent money lost to the government, the costs create pure losses from a social welfare perspective.

ble health insurance to their low- and moderate-income employees. But then the budgetary cost of the Exchange subsidies will likely be much higher than predicted. Although it is not yet clear which forms of effective taxes will end up creating the most harm—partially because full regulatory guidance interpreting the employer-mandate penalties and nondiscrimination rules has yet to be released—there is little doubt that in the absence of further reforms both employees and employers will face strong perverse incentives once key provisions of the ACA come into effect in 2014. The next Part thus discusses how the federal or state governments might act to mitigate or eliminate these perverse incentives.

V. Conclusion: Implications for Health Care Reform

Although this Article has focused on critiquing aspects of the ACA, this Article should not be interpreted as a criticism of the ACA as a whole.[195] If the ACA succeeds in fixing the individual market for health insurance, that will (in my view) be an impressive accomplishment.[196] And the ACA includes many provisions designed to slow the growth of health care costs, to expand health care coverage to the previously uninsured, and to achieve other laudable goals.[197] That the ACA will also impose costly effective taxes on low- and moderate-income workers does not mean that these workers would be better off without the ACA.[198] After all, most of the effective taxes that the

[195] See notes 6 and 14 and accompanying text.

[196] It is by no means clear whether the ACA will succeed in fixing the individual market for health insurance (even ignoring the threat of legal or political challenges). For papers discussing some of the issues that will need to be resolved in order for the ACA to be successful in this endeavor, see Timothy Stoltzfus Jost, Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues (Commonwealth Fund, 2010), available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf; Sarah Lueck, States Should Structure Insurance Exchanges to Minimize Adverse Selection (Ctr. on Budget & Pol'y Priorities, 2010), available at http://www.cbpp.org/files/8-17-10health.pdf; Monahan & Schwarcz, note 26; Pamela Farley Short, Katherine Swartz, Namrata Uberoi & Deborah Graefe, Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change (Commonwealth Fund, 2011), available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1503_Short_maintaining_coverage_affordability_reform_brief.pdf; Benjamin D. Sommers & Sara Rosenbaum, Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges, 30 Health Aff. 228 (2011).

[197] There are many explanations of the various provisions of the ACA. My favorite is a video produced by the Kaiser Family Foundation. Henry J. Kaiser Family Found., Health Reform Hits Main Street, http://healthreform.kff.org/the-animation.aspx (last visited Aug. 15, 2012).

[198] Or, more precisely, these costly effective taxes do not imply that low- and moderate-income workers as a class would be better off without the ACA. The ACA will almost

ACA will impose on these workers will only arise to the extent that the ACA successfully improves the health insurance available on the individual market and offers generous subsidies to make that insurance affordable to low- and moderate-income taxpayers.[199]

But recognizing the ACA's positive achievements should not distract from understanding the costs that the ACA will impose through effective taxes. To the extent that the ACA successfully incentivizes employers to continue offering affordable health insurance to their low- and moderate-income employees, the ACA will strongly discourage low- and moderate-income taxpayers from marrying or staying married and from accepting jobs that offer affordable health insurance. Conversely, if numerous employers stop offering affordable health insurance to their low- and moderate-income employees, then the budgetary costs of the Exchange subsidies will likely greatly exceed the CBO's projections and the ACA will disincentive employers from hiring low- and moderate-income workers. To summarize, however employers respond to the ACA's framework, the ACA's perverse incentives will reduce employment opportunities for low- and moderate-income Americans as well as creating other economic and social harms.

If these perverse incentives were unavoidable, then perhaps we should view them as a necessary cost of achieving the ACA's desirable ends. Yet the ACA's laudable goals could have been attained without imposing most of the effective taxes discussed in this Article. Through further reforms, we can strive to realize the promised benefits of the ACA while preventing many of its costs.

The mismatch between the tax subsidies available for Exchange coverage and those available for employer-sponsored coverage are the source of most of the perverse incentives that the ACA will create with respect to low- and moderate-income workers.[200] Yet there is a

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certainly create net benefits for some low- and moderate-income workers and net costs for others. See note 15.

[199] As noted previously, most of the effective taxes discussed in this Article only arise to the extent that the ACA succeeds in fixing the individual market so that the insurance available on the individual market is competitive with employer-sponsored coverage. See note 114 and accompanying text. Throughout most of this Article, I have assumed that the ACA will succeed in fixing the individual market. But this assumption is made for ease of exposition. It remains to be seen whether (and to what extent) the ACA will improve the individual market to the degree necessary to make the insurance offered on the Exchanges competitive with employer-provided offerings.

[200] The major effective taxes that do not arise from the mismatch between the tax subsidies for employer-sponsored coverage and those for Exchange coverage (or from the ACA's provisions designed to incentivize employers to continue offering affordable health insurance to low- and moderate-income employees despite this mismatch) are the effective taxes that result from how the Exchange subsidies phase out as household income increases. See Section IV.A. This Article's argument for replacing the tax exclusions with

relatively simple fix for this mismatch. The ACA could have been drafted to replace the tax exclusions for employer-provided health insurance with refundable tax credits structured similarly to the Exchange subsidies.

Ideally, the ACA would have replaced the tax exclusions for employer-sponsored health insurance with refundable tax credits offering the same value as the Exchange subsidies.[201] If—for any given level of household income—a taxpayer would obtain the exact same subsidies for either employer-sponsored coverage or for Exchange coverage, then there would be no perverse incentives affecting either marriage or accepting jobs that offer affordable health insurance. Moreover, there would be no need for the employer-mandate penalties or the nondiscrimination rules, as employers would not face any perverse incentives to stop offering health coverage to their low- and moderate-income employees. Instead, Exchange coverage and employer-sponsored coverage could compete on a level playing field, with neither benefitting from a larger tax advantage.[202]

Many previous commentators have called for replacing the tax exclusions with refundable tax credits on the grounds that the tax exclu-

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refundable tax credits for employer-sponsored coverage designed in a similar fashion to the Exchange subsidies would thus not eliminate the effective taxes created by the manner in which the subsidies phase out as household income increases. To eliminate these effective taxes, the tax subsidies available both on and off of the Exchanges would need to be redesigned so that they do not phase out with income, in effect making them available for high income taxpayers as well as for low- and moderate-income taxpayers (like a demogrant). Analyzing the tradeoffs involved in addressing the effective taxes created by the manner in which the tax subsidies phase out as household income increases is beyond the scope of this Article. For further discussion, see Chandler, note 151.

[201] If repealing the tax exclusions would not generate sufficient revenue to make tax credits of similar magnitude to the Exchange subsidies available to all low- and moderate-income workers with employer-sponsored coverage, then I would argue that some of the funding for the Exchange subsidies should be moved to funding the new credits for employer-sponsored coverage so that equivalent health care subsidies would be available both on and off the Exchanges. There might be some justifications for subsidizing Exchange coverage more than employer-sponsored coverage, as bringing a critical mass of insureds to Exchange coverage is important for combating adverse selection. But there does not appear to be any good reason for incentivizing only low- and moderate-income taxpayers to receive Exchange coverage while incentivizing higher-income taxpayers to receive employer-sponsored coverage, as the ACA will do as it is currently structured. Even if we cannot completely eliminate the effective taxes that the ACA will impose with respect to low- and moderate-income workers, we should strive to mitigate these effective taxes, by equalizing the tax subsidies available on and off of the Exchanges, to the extent possible.

[202] A question underlying much of health care policy is whether the U.S. system of relying primarily on employer-sponsored coverage should be maintained or eroded. This Article takes no position on this question. Instead, this Article's suggested reforms would permit Exchange coverage and employer-sponsored coverage to compete on an even playing field, without either enjoying a significantly greater tax advantage. Whether Exchange coverage would replace employer-sponsored coverage, then, would depend on which form of coverage could offer better value at lower cost.

sions are regressive and that they encourage excess health care consumption.[203] This Article's key contribution is to show that failing to replace the tax exclusions with refundable tax credits will create far more harm once key provisions of the ACA go into effect in 2014. In addition to being regressive and encouraging excess health care consumption, retaining the tax exclusions in their current form will impose costly effective taxes on low- and moderate-income workers.

Fortunately, there is some cause for hope. Many Republicans have already embraced the idea of replacing the tax exclusions with refundable tax credits as part of their vision for reforming health care. Replacing the tax exclusions with refundable tax credits was a centerpiece of Senator McCain's health care plan when he ran for President in 2008.[204] And, more recently, Republican House Budget Committee Chairman Paul Ryan has argued for replacing the tax exclusions with refundable tax credits as part of his "Path to Prosperity" plan.[205] If Democrats can be convinced of the importance of replacing the tax exclusions with refundable tax credits in order to avoid the costly effective taxes that the ACA will otherwise impose on low- and moderate-income workers, then there may be room for a bipartisan compromise based on the Republicans' proposals. Even if such a compromise is not possible at the federal level within the current hyper-partisan atmosphere surrounding health care discussions in Washington,[206] there may still be hope after President Obama leaves office and the vitriolic debate over the enactment of the ACA recedes into more distant memory.

Looking first to how reforms might be enacted at the federal level, replacing the tax exclusions for employer-provided health insurance

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[203] See, e.g., Goldberg & Camic, note 53, at 1; Gruber, note 12, at *7-*8; John Holahan, Linda J. Blumberg, Stacey McMorrow, Stephen Zuckerman, Timothy Waidmann & Karen Stockley, Containing the Growth of Spending in the U.S. Health System 11-13 (Urban Inst. Health Pol'y Ctr., 2011) available at http://www.urban.org/uploadedpdf/412419-Containing-the-Growth-of-Spending-in-the-US-Health-System-Summary.pdf; President's Advisory Panel, note 12, at 78-82.

[204] Goldberg & Camic, note 53 at 3; Lucinda E. Jesson, Beyond Efficiency: Creating Health Policy Through the Tax Code 21, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1695673.

[205] Avik Roy, Paul Ryan, in a Major Speech, Proposes Universal Health Coverage Via Tax Credits, Forbes Apothecary Blog (Sept. 28, 2011, 10:43 AM), http://www.forbes.com/sites/aroy/2011/09/28/paul-ryan-in-a-major-speech-proposes-universal-health-coverage-via-tax-credits/.

[206] It is worth noting that key Republican legislators have made it clear that the House will not pass any measures designed to improve the Affordable Care Act, even if the measures would otherwise have been noncontroversial or would have been supported by Republicans. At the time of this writing, many Republican legislators would apparently prefer for the ACA to be as ineffective and harmful as they can make it, so that the Republicans can score political points against Democrats. Hopefully, Republicans will be more open to improving the ACA in the future, after further election cycles have passed.

with refundable tax credits would involve at least two design challenges. First, because the tax exclusions primarily benefit higher-income taxpayers, whereas refundable tax credits would primarily benefit lower-income taxpayers, replacing the tax exclusions with refundable tax credits would have significant distributional implications. In my view, the additional progressivity that could be achieved by replacing the tax exclusions with refundable tax credits is a positive feature of this reform proposal.[207] Nevertheless, for those who would oppose increasing the progressivity of the federal income tax system, it is possible to replace the tax exclusions with refundable tax credits in a distributionally neutral fashion. All that is needed is to adjust the federal income tax rates and brackets so as to offset the distributional impact of replacing the tax exclusions with refundable tax credits.[208]

Of course, offsetting the distributional impact of replacing the tax exclusions with refundable tax credits would still create winners and losers. Within each income group, taxpayers who received greater benefit from the tax exclusions (as compared to the new refundable tax credits) would see their tax burdens rise, whereas taxpayers who received less benefit from the tax exclusions would see their tax burdens reduced. Whether these consequences should be considered positive or negative depends on the extent to which we view health expenditures as a form of consumption or as reflecting that a taxpayer has lower wellbeing in a manner relevant for assessing tax burdens.[209] Perhaps the best argument against offering refundable tax credits for purchasing health insurance is the notion that the tax system should not subsidize health care as compared to other expenditures.[210] Yet

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[207] Previous scholars and policy advocates who have criticized the tax exclusions as being regressive can be viewed as implicitly agreeing with my assessment that it would be desirable to increase progressivity by replacing the tax exclusions with refundable tax credits.

[208] See Thomas D. Griffith, Theories of Personal Deductions in the Income Tax, 40 Hastings L.J. 343, 360-63 (1989) (explaining how tax-rate adjustments can be used to counteract the distributional impact of adding or eliminating income tax deductions).

[209] The classic debate on this topic in the legal literature is between Mark Kelman, Personal Deductions Revisited: Why They fit Poorly in an "Ideal" Income Tax and Why They Fit Worse in a Far from Ideal World, 31 Stan. L. Rev. 831 (1979), and William D. Andrews, Personal Deductions in an Ideal Income Tax, 86 Harv. L. Rev. 309 (1972).

[210] It is perhaps conceivable to oppose replacing the tax exclusions based on the argument that higher-income taxpayers with significant health care expenses should receive a deduction because these health care expenditures indicate that these taxpayers have diminished well-being (following the argument in Andrews, note 209), and that this concern should trump the health policy advantages of replacing the tax exclusions with refundable tax credits. I am skeptical as to whether this position deserves to be taken seriously. Nonetheless, were this position to win the day, then the optimal policy would probably be to both retain the tax exclusions and to add new refundable tax credits for employer-sponsored health insurance of similar magnitude to the Exchange subsidies. This policy could be paid for by increasing tax rates, and perhaps also by reducing the health care subsidies

this argument suggests that the ACA's Exchange subsidies should probably be repealed, which would arguably require dismantling much of the ACA's framework for regulating health insurance.[211] For those amenable to offering tax subsidies to make health care affordable for lower-income Americans, distributional considerations should not defeat the case for replacing the tax exclusions with refundable tax credits.[212]

The second design challenge for replacing the tax exclusions with refundable tax credits concerns whether the new refundable tax credits would need to be made advanceable. The premium tax credits that the ACA will make available to subsidize Exchange coverage will be advanceable; taxpayers will be able to apply for advanced payment of these premium tax credits in order to pay for health insurance without waiting until the taxpayers file tax returns.[213] For taxpayers who receive higher or lower advanced payments than the amount of the premium tax credits they are determined to be eligible for upon filing their tax returns, there will be a reconciliation process wherein taxpayers may be required to repay any excess amount of advanced payments received.

The Exchanges, HHS, and IRS will face numerous challenges in implementing the processes for the advanced payment of the premium tax credits and for the reconciliation of the advanced payments.[214] Making refundable tax credits advanceable in the context of employer-sponsored health insurance is potentially an easier task. Perhaps the simplest mechanism for making refundable tax credits

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available on the Exchanges. Even if the tax exclusions cannot be eliminated as a means of paying for new refundable tax credits, it remains important to equalize the health care subsidies available on and off the Exchanges to the extent possible in order to mitigate the effective taxes analyzed in this Article.

211 Due to adverse selection problems and the cost of health care, any system that offers lower-income taxpayers affordable health care options must probably include some form of subsidization.

212 For those (like myself) who favor increasing tax progressivity, the tax exclusions could be replaced with refundable tax credits without the need for further adjustments. For those who oppose increasing tax progressivity, tax-rate adjustments could be used to maintain the existing progressivity of the federal income tax system. Of course, in practice, any policy adopted is likely to reflect a political compromise. Yet the point remains that those who oppose increasing tax progressivity might be convinced to support replacing the tax exclusions with refundable tax credits as long as this reform is combined with some other tax policy change that this group desires.

213 Henry J. Kaiser Family Found., Reconciliation of Advance Payments for Health Insurance Subsidies, (Focus on Health Reform No. 8154, Feb. 2011), available at http://www.kff.org/healthreform/upload/8154.pdf.

214 E.g., Pamela Farley Short, Katherine Swartz, Namrata Uberoi & Deborah Graefe, Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change (Commonwealth Fund Pub. 1503, May 2011), available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1503_Short_maintaining_coverage_affordability_reform_brief.pdf.

advanceable for employer-sponsored health insurance is to adjust income-tax withholding levels to reflect taxpayers' expected health care tax credits.[215] In any case, the same information that employers and employees use to determine income tax withholding levels can be used to estimate the amounts of the health care tax credits that should be made advanceable.[216]

A full discussion of how a system of refundable tax credits for employer-sponsored health insurance might be implemented is beyond the scope of this Article. There are already numerous such discussions in the existing literature,[217] reflecting the fact that conservative economists and think tanks frequently advocated replacing the tax exclusions with refundable tax credits prior to Obama's election in 2008.[218] As long as the new refundable tax credits offer similar value to the ACA's Exchange subsidies, the ACA's employer-mandate penalties and nondiscrimination rules would be made unnecessary. Hence, by replacing the tax exclusions with refundable tax credits and then repealing the ACA's employer-mandate penalties and new nondiscrimination rules, the federal government could mitigate or eliminate the perverse incentives analyzed in this Article.

If the federal government fails to act, then there is some potential for state governments to pass legislation to mitigate the perverse incentives analyzed in this Article. As a first step, any state with an income tax could eliminate its state-level tax exclusions for employer-sponsored health insurance. Beyond that first step, states could impose additional taxes on employer-sponsored health insurance and then use the revenues collected to fund state-level refundable tax credits for health insurance purchased outside of the Exchanges. A state could potentially impose a tax on employer-sponsored health insurance designed to capture approximately the entire amount of the

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215 Some of the current rules related to income tax withholding can be found on the IRS website. See http://www.irs.gov/Individuals/Employees/Tax-Withholding.

216 In contrast, the primary difficulties the Exchanges, HHS, and IRS will face in implementing the reconciliation processes for the advance payment of the premium tax credits results from their lacking current verifiable information about taxpayers' salaries and employment statuses. *See* id. at 5-8.

217 Nina Owcharenko, Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage n.26(Heritage Found. Backgrounder No. 1895 (Nov. 8, 2005), available at: http://www.heritage.org/research/reports/2005/11/health-care-tax-credits-designing-an-alternative-to-employer-based-coverage#_ftnref26 ("Many professional economists and a wide range of analysts from the American Enterprise Institute, the Galen Institute, The Heritage Foundation, the National Center for Policy Analysis, and the Progressive Policy Institute have all proposed [replacing the tax exclusions with a unified universal tax credit system], with various modifications.").

218 Id.

federal tax exclusions.[219] By then channeling the revenues collected into state-level refundable tax credits for employer-sponsored health insurance, a state could effectively implement most of the reforms that I have proposed the federal government adopt.[220] Of course, a state government could not repeal the ACA's employer-mandate penalties or nondiscrimination rules. But by fully or partially neutralizing the federal tax exclusions and then offering a state-level refundable tax credit for health insurance purchased outside of the Exchanges, a state could considerably mitigate the perverse incentives analyzed in this Article.

The ACA is a landmark accomplishment. Yet the task of reforming the American health care system is far from complete.[221] Rising health care costs will force politicians to revisit health care reform in the not-too-distant future.[222] If the problem of the effective taxes that the ACA will impose on low- and moderate-income workers cannot be resolved sooner, then hopefully future rounds of health care reform can avoid the ACA's mistakes.[223] It may be politically advantageous to make explicit subsidies as high as possible and to keep explicit taxes as low as possible.[224] But if this results in creating costly

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[219] There is some question as to whether this policy might violate the Supremacy Clause of the U.S. Constitution. On preliminary analysis, I think it would not, but a full discussion of this issue must wait for future work.

[220] Unlike the federal government, however, a state government cannot reduce the amount of the Exchange subsidies if the state is unable to raise sufficient revenues to fund tax credits for employer-sponsored health insurance of equivalent magnitude to the ACA's Exchange subsidies. Yet the closer a state can come to offering refundable tax credits for employer-sponsored health insurance of equivalent magnitude to the Exchange subsidies the more the state will be able to mitigate the perverse incentives analyzed in this Article.

[221] See Health-Care Reform Is an Ongoing Process, The Economist Democracy in Am. Blog (Jan. 23, 2011, 8:04 PM) http://www.economist.com/blogs/democracyinamerica/2011/01/health-care_reform ("Which is all to say that reform is an ongoing process.").

[222] See David I. Auerbach & Arthur L. Kellermann, A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average Family, 30 Health Aff. 1630, 1630-34 (2011), (evaluating the burdens imposed by rising health care costs).

[223] The focus of this Article is policy rather than politics. Nevertheless, it may be worth noting that a major political obstacle to transforming the tax exclusions into refundable tax credits is organized labor. Many unions support maintaining the tax exclusions, presumably based on the notion that the tax exclusions are important for maintaining the advantages of employer-sponsored health insurance and that a major mechanism by which unions provide value to their members is through unions' role in lobbying for and providing health insurance. See, e.g., Charles Lane, A Health Reform Hurdle: Labor's Cadillac Benefits, Wash. Post, (Sept. 27, 2009), ("Organized labor's tooth-and-nail fight to protect union health benefits is a significant —but underreported—obstacle to sensible health-care reform. . . . And so labor defends the tax exclusion with every ounce of its considerable clout."), available at http://www.washingtonpost.com/wp-dyn/content/article/2009/09/25/AR2009092502778.html

[224] Pratt, note 117, at 161 ("Many Americans would not view an employer mandate as a tax increase, even though they will ultimately bear the economic burden of the mandate."). For a broad review of the literature related to the political salience of taxation and of

effective taxes on important decisions affecting low- and moderate-income workers, then the political advantages are not worth the costs. In future health care debates, independent-minded commentators should focus on the danger of creating effective taxes that harm low- and moderate-income workers. These effective taxes will only be less visible to the extent they are not brought into the light through op-eds and other media discussions. By holding future politicians' feet to the fire, we can strive for health care reform that will not create costly perverse incentives for low- and moderate-income Americans.

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government financing, see Gamage & Shanske, note 144, at 33-54. In particular, see the discussion of tax-financed spending versus regulation. Id. at 53.