

# **Administrative Issues I: Challenges of the Current System**

**Mary B. H. Hevener (Baker & McKenzie)**  
**Charles K. “Chip” Kerby III (McDermott, Will & Emery)**

## **I. Introduction**

A great part of the conundrum of reforming America’s health care delivery system is created by the inordinate complexities of the existing tax incentives (and tax limitations) on employer-provided and individually purchased health care. Since 1978 these rules have permitted employees to elect varying amounts of health coverage through cafeteria plans, and have permitted employers to exclude surprisingly broad categories of employees from their health care plans, before applying the Code’s poorly drafted, and ill-enforced, nondiscrimination rules. Further, as a result of the Congressionally enacted moratorium (also applicable since 1978) significantly limiting the IRS’s abilities to challenge the classification of a worker as an “employee” or an “independent contractor,” the numbers of workers with no “employee” status has steadily increased. Congress’s attempt in 1986 to enact strict new nondiscrimination rules (per Code section 89) quickly revealed that most of the country’s health care plans do provide significantly better coverage to higher-paid workers; and those rules were repealed in 1988 before they ever took effect. The IRS has devoted almost no attention to auditing any employer’s health plans; indeed, the cafeteria plan regulations remain only “proposed” regulations (although the IRS has plans to finalize those regulations this year, thirty years after the statute was enacted). This article reviews the many challenges of the current system, and discusses as well several recent (and largely unsuccessful) attempts to regulate social policy by the enactment of tax penalties on discriminatory plans, or excessive benefits.

## II. Tax Primer

The Internal Revenue Code (“Code”) includes several provisions regarding the tax treatment of health coverage and benefits. Under these provisions, tax treatment differs depending on (i) whether the coverage is provided under a regular accident or health plan, a flexible spending arrangement, or a health savings account; (ii) whether the coverage and benefits are provided by an employer or purchased by an individual; and (iii) whether the individual purchases coverage on an after-tax basis or on a pre-tax basis under a Code section 125 cafeteria plan. Other provisions of the Code make health coverage tax deductions or tax credits available to certain eligible individuals, and require employers to offer COBRA continuation coverage to employees and dependents who lose coverage in certain circumstances. Finally, an excise tax under Code section 5000, equal to 25 percent of an employer’s group health plan expenses, is triggered if the group health plan makes Medicare the primary payer for any active employees (or their beneficiaries), in violation of the Medicare Secondary Payer provisions of the Social Security Act. The basic attributes of these various provisions are summarized below.

***Accident or health plans.*** An “accident or health plan” is defined in IRS regulations as any arrangement that pays amounts in the event of injury or illness, and includes plans providing either medical or disability coverage.<sup>1</sup> A plan may cover one or more employees, and may be

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<sup>1</sup> Even accidental death and dismemberment policies, and business travel accident insurance are treated as “health insurance” excludable under Code § 106 under the current tax rules, even though some benefits under these AD&D policies have elements of life insurance as well. This treatment was first proposed under the 1988 cafeteria plan regulations, has been followed in various IRS private letter rulings (e.g., PLRs 8939050, 8949030, 199921036, and 200002030), and is also included in the 2007 repropounded cafeteria plan regulations. See Prop. Reg. § 1.125-2(a)(3)(D), which lists, among “qualified benefits” under a cafeteria plan, “An accidental death and dismemberment insurance policy (section 106).”

insured or self-insured. The IRS regulations defining an accident or health plan have remained substantially unchanged since 1956. The tax treatment of accident or health plan coverage and benefits may be summarized as follows:

- *Tax treatment of employer-provided coverage:* The value of accident or health plan coverage paid for or provided by an employer is excluded from an employee's income under Code section 106 (the value of coverage is also excluded from an employee's wages for employment tax purposes).<sup>2</sup> The Code section 106 exclusion applies whether the employer provides the coverage directly or indirectly. Thus, the exclusion applies to coverage provided under a health plan sponsored by the employee's employer, or where the employee acquires coverage from a different source and the employer pays or reimburses the employee's premiums for that coverage. The Code section 106 exclusion is available only for common law employees – it does not apply to self-employed individuals.
- *Tax treatment of individually purchased coverage:* The cost of accident or health plan coverage purchased by an individual may be deductible under Code section 213 if, and only if, the cost of that coverage (combined with other unreimbursed medical expenses) exceeds 7.5 percent of the individual's adjusted gross income. However, the cost of accident or

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<sup>2</sup> Although there is no general exclusion from income tax withholding for most section 106 benefits, that exclusion is deemed to apply because the benefits are excludable from income. There are income tax withholding exclusions (which are slightly broader than mere income tax exclusions) available for amounts that employers "reasonably believe" to be either contributions to health savings accounts or working condition fringes. (Code §§ 3401(a)(22) and (a)(19).) The general FICA/FUTA exclusions apply to any amounts paid by employers for medical or hospitalization expenses or for sickness or accident disability (although taxable disability benefits paid during the six months after an employee's termination of service are subject to FICA taxes). See Code §§3121(a)(2)(A) and (B) and 3306(b)(2)(A) and (B). Separate FICA/FUTA exclusions apply to amounts reasonably believed to be working condition fringes. Code §§3121(a)(18) and 3306(b)(16).

health plan coverage purchased by an employee on a pre-tax basis under a Code section 125 cafeteria plan is excluded from income under Code section 106. This coverage can apply not only to the employee, but also to the employee's spouse and dependents, and, if the coverage is purchased on a pre-tax basis, can cover non-dependents, including domestic partners. The cost of accident or health plan coverage purchased by a self-employed individual (including sole proprietors, partners, and more-than-2 percent shareholders in an S-corporation) who is not eligible to participate in an employer-sponsored plan may be deducted in full under Code section 162(l).<sup>3</sup> Notably, if any company for which such a self-employed individual is performing services either reimburses the self-employed individual for this coverage, or provides health insurance coverage directly, that coverage is excludable as a "working condition fringe" under Code section 132(a)(3) and (d) (which provides a tax exclusion for any benefits deductible under Code section 162).<sup>4</sup>

- *Tax treatment of benefits from employer-provided coverage:* If an employer pays for accident or health plan coverage, benefits received by an employee from the plan that are used to pay or reimburse medical expenses of an employee, spouse, or dependent are excluded from the employee's income under Code section 105(b). (These amounts are also excluded from wages for employment tax purposes.) Benefits are excludable even if paid

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<sup>3</sup> This deduction is not available for SECA tax purposes. Code §162(l)(4).

<sup>4</sup> The tax benefit for self-employed individuals of having this coverage provided as a working condition fringe is that the benefit is completely excluded from income, and thus is effectively excluded for SECA tax purposes as well. Further, working condition fringes are not subject to any discrimination tests. Accordingly, many corporate directors and other high-paid corporate consultants have arranged to receive health insurance from the companies they serve, in order to obtain health insurance which is in most instances less costly than individually purchased policies, and provides the additional benefit of avoiding any SECA taxes on the coverage. (Notably, even though the Code refers to "employees" as the potential recipients of any "working condition fringe" the term "employee" is defined to include both directors and independent contractors, by Treas. Reg. § 1.132-1(b)(2)(iii) and (iv).)

merely upon the occurrence of a specific accident, injury, or illness (e.g., upon a diagnosis of cancer), and regardless whether paid in a lump sum or as claims are incurred. Under IRS regulations, the Code section 105(b) exclusion does not apply to amounts that employees *are entitled to receive even if they don't incur expenses for medical care*. Amounts paid in excess of actual medical expenses must be included in income (see Rev. Rul. 69-154, 1969-1 C.B. 46). The Code section 105(b) exclusion also does not apply in the case of a self-insured accident or health plan that fails to satisfy the nondiscrimination rules of Code section 105(h) (these nondiscrimination rules do not apply to fully insured accident or health plans).<sup>5</sup>

- *Tax treatment of benefits from individually purchased coverage:* If an individual pays for accident or health plan coverage on an after-tax basis, benefits received by the individual from the plan are excluded from the individual's income under Code section 104(a)(3) (even if not used to pay or reimburse medical expenses).

***Flexible spending arrangements.*** A flexible spending arrangement (FSA) is a special type of accident or health plan, typically established by an employer to reimburse medical expenses up to defined coverage limits (e.g., \$5,000 per year). Under proposed IRS regulations, an accident or health plan is treated as an FSA if the maximum amount of coverage is less than 500% of the

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<sup>5</sup> These nondiscrimination rules also do not apply to physicals and other medical diagnostic procedures for an employee (but not the employee's spouse and dependents). Treas. Reg. §1.105-11(g). The Code section 105(h) nondiscrimination rules also do not apply to retired employees, provided that "the type, and the dollar limitations, of benefits provided to retired employees who were highly compensated individuals are the same for all other retired participants." Treas. Reg. §1.105-11(c)(3)(iii). Because this limitation technically does not refer to the length of coverage, some practitioners believe that highly compensated individuals can receive employer health benefits indefinitely after termination of service (typically subject to taxation in an amount equal to COBRA insurance rates), so long as the "type and dollar limitations" of such benefits are the same as for other employees.

total contributions or premiums paid for the coverage.<sup>6</sup> For example, if an accident or health plan limits the maximum reimbursement amount to the amounts contributed by employers and employees, it will be treated as an FSA.

If an employer-provided accident or health plan is treated as an FSA, benefits are excluded from an employee's income only if the FSA satisfies certain additional rules. An FSA must:

- provide coverage effective for a defined 12-month period;
- provide uniform coverage throughout that period;
- require the employee to forfeit any unused amounts at the end of the period (the “use it or lose it” rule);
- reimburse only medical expenses that are substantiated; and
- not reimburse insurance premiums.

In most cases, an FSA is not a funded arrangement. More commonly, an FSA is an unfunded account that is “credited” with employer and employee contributions. Because of the use-it-or-lose-it requirement, amounts credited or contributed to an FSA in one year cannot accumulate and be carried over to future years. Typically, FSAs are offered as an option under a cafeteria plan and are financed with employee pre-tax contributions. But according to IRS proposed regulations, an accident or health plan may be treated as an FSA even if it is not part of a cafeteria plan (e.g., where the FSA is not funded with any employee pre-tax contributions).

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<sup>6</sup> Although the FSA-enabling statute, Code section 125, was enacted in 1978, the majority of the applicable regulations are still only proposed. However, the IRS repropounded these regulations in August, 2007, and has indicated that it does intend to finalize the regulations during 2008 (thirty years after enactment of section 125). See Prop. Treas. Reg. §1.125-1, -2, -4, -5, -6, -7.

***Health savings accounts.*** A health savings account (HSA) is another type of accident or health plan subject to special tax rules under Code section 223. An HSA is a trust or custodial account created or organized in the United States exclusively for the purpose of paying qualified medical expenses of the account holder. Under Code section 223, favorable tax treatment for HSAs is available only for “eligible individuals.” These are individuals who are covered by a high-deductible health plan and who don’t have any other type of health insurance coverage (except certain types of permitted coverages). A high-deductible health plan is one that satisfies specified deductible and out-of-pocket limits, which are indexed for inflation. For self-only coverage provided during 2008, the annual deductible must be at least \$1,100 and the out-of-pocket limit (including the deductible) must not exceed \$5,600. For family coverage provided during 2008, the annual deductible must be at least \$2,200 and the out-of-pocket limit (including the deductible) must not exceed \$11,200.

Assuming that the requirements of Code section 223 are satisfied, an HSA provides favorable tax treatment for contributions, earnings and distributions. Contributions to an HSA made by or on behalf of an eligible individual are deductible as an “above-the-line” deduction on the individual’s tax return up to the statutory contribution maximums. Contributions to an HSA made by the employer of an eligible individual are excluded from the individual’s income and wages up to the statutory contribution maximums. The statutory contribution maximums for 2008 are \$2,900 for HSA account holders with self-only coverage and \$5,650 for HSA account holders with family coverage. Earnings on amounts contributed to an HSA grow tax-free, because an HSA is exempt from federal income tax. Distributions from an HSA used to pay for

qualified medical expenses of the HSA account holder (and her spouse and dependents) are excluded from the account holder's gross income, while distributions not used to pay for qualified medical expenses are included in the account holder's gross income and are generally subject to an additional 10 percent tax.<sup>7</sup>

***Health coverage tax credit.*** Certain individuals may be entitled to receive a health coverage tax credit ("HCTC") under Code section 35. The HCTC pays 65 percent of the cost of qualified health coverage for two principal groups – laid-off workers certified by the Department of Labor as having been displaced by the impact of international trade, and individuals age 55 to 64 who are receiving pension benefits paid by the PBGC. The HCTC is available only for eligible individuals who have qualified health coverage – either COBRA coverage provided by their former employer or coverage provided by state-qualified plans that satisfy certain consumer protection requirements. The HCTC is a refundable tax credit, available to eligible individuals regardless whether they have paid federal income tax, and available on either a refund (end of year) or advance basis. Individuals are not eligible for the HCTC if they have certain types of other health coverage, including subsidized employer-provided coverage (coverage where at least 50% of the cost is paid by an employer or former employer of the taxpayer or spouse, including pre-tax contributions under a cafeteria plan), or coverage provided under various federal programs, including Medicare, Medicaid, SCHIP, FEHBP, and Tricare. The HCTC enrollment processes are exceedingly complex.

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<sup>7</sup> The IRS has issued voluminous guidance discussing the tax treatment of HSAs. See IRS Notice 2004-2, 2004-2 I.R.B. 269; IRS Notice 2004-23, 2004-15 I.R.B. 725; Rev. Rul. 2004-38, 2004-15 I.R.B. 717; Rev. Rul. 2004-45, 2004-22 I.R.B. 971; IRS Notice 2004-50, 2004-33 I.R.B. 196; IRS Notice 2005-8, 2005-8 I.R.B. 368, Rev. Rul. 2005-25, 2005-18 I.R.B. 971; and IRS Notice 2005-86, 2005-49 I.R.B. 1075. See also Treas. Reg. §54.4980G-0 through §54.4980G-5, 71 Fed. Reg. 43056 (July 31, 2006).

***COBRA continuation coverage.*** Employer-sponsored group health plans are required to offer COBRA continuation coverage under Code section 4980B. Continuation coverage rights must be extended to qualified beneficiaries (typically covered employees and their dependents) who incur a loss of health plan coverage due to a qualifying event, including the employee's death, termination of employment, reduction in hours, divorce or a dependent child ceasing to be a dependent. Employers and plan administrators must notify qualified beneficiaries of their COBRA continuation coverage rights. If a qualified beneficiary elects COBRA continuation coverage, coverage will be available for a specified period of time – 18 months for termination of employment/reduction in hour events and 36 months for other events (if a qualified beneficiary is determined to be disabled, the 18 month period may be extended to 29 months). Qualified beneficiaries who elect COBRA continuation coverage may be required to pay 102 percent of the premium cost.

***Employers as Primary Payers (Medicare Secondary Payer rules).*** Employers are prohibited from operating or contributing to any group health plan that makes Medicare the primary payer of health benefits for any active employee (or that employee's spouse or dependents), under the Medicare as Secondary Payer rules of the Social Security Act.<sup>8</sup> If these rules are violated in any calendar year (irrespective of the size of the violation), an excise tax equal to 25 percent of the employer's contribution to the group health plan is imposed on the employer. Although the Social Security Administration has been vigorous in its persecution of employers that violate these MSP rules, the IRS has never issued regulations under Code section 5000, and has

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<sup>8</sup> See Section 1862(b)(1)(A) – (C) and (b)(2) (as cross-referenced in Code section 5000(c)).

apparently not instituted any provisions for being notified of violations, in order to impose this excise tax.

### **III. Administrative Issues and Problems Associated With Current Law**

*Minimal Administrative Burdens (or IRS Information Reporting Requirements).* The current tax rules governing health plan coverage and benefits do not impose significant tax administrative burdens on individuals, employees, employers, health care providers or the federal government. This is especially true with respect to traditional defined benefit health plans. For these plans, the tax exclusions for coverage and benefits are open-ended, so there is no need for employers to determine and report (or for regulators to audit) the “value” of employer-provided health plan coverage or the amount of benefits received. Employers are not required to provide the IRS with information about the existence of a health plan, the specific benefits offered under a health plan, whether employees are covered by a health plan or a cafeteria plan, and whether employees are paying their share of health plan contributions or making FSA contributions on a pre-tax basis under a cafeteria plan.<sup>9</sup> Similarly, individuals are not required to notify the IRS whether they and their dependents are covered by a health plan, or whether they and their dependents are covered by an employer-sponsored health plan. Health care providers are not required to provide the IRS with information about whether their patients are covered under a health plan, or whether a patient is covered under an employer-sponsored health plan.

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<sup>9</sup> The IRS had proposed, in Rev. Rul. 2003-43, 2003-1 C.B. 935, that the use of debit or similar electronic payment cards in connection with expenditures under FSAs and/or HRAs would trigger 1099 reporting requirements. The ruling was blocked by the “Health Savings Account Availability Act” on grounds that any such “regulatory reporting requirement discouraged the use of such cards and that such burden should be removed.” See H.R. 2351, as reported by the House Committee on Ways and Means on June 25, 2003 (H.R. Rep. No. 108-177).

Individuals who wish to deduct medical expenses must maintain records sufficient to substantiate those expenses, but are not required to submit that information when filing tax returns. HSAs are subject to various reporting requirements imposed on HSA account holders, HSA trustees and custodians and employers making HSA contributions. However, even though the IRS has statutory authority to impose reporting requirements on employers that sponsor HSA-compatible high deductible health plans, it has not yet done so.

***Vague and Minimally Enforced Nondiscrimination Rules.*** The nondiscrimination rules applicable to self-insured health plans under Code section 105(h) and to cafeteria plans under Code section 125 have not been the subject of significant IRS enforcement activity.<sup>10</sup> Consequently, employers that sponsor these plans do not typically incur administrative costs associated with performing nondiscrimination tests or conducting other compliance activities. More importantly, as a practical matter, it has been extremely difficult for taxpayers even to understand how these discrimination rules are expected to apply. Even though the rules have been in effect since 1978 (and final regulations were issued under section 105(h) in 1981<sup>11</sup>), because they have very rarely been cited in IRS rulings, private rulings, and guidance to the field, and accordingly there is a lot of confusion over exactly how they should be interpreted.

The basic rules are as follows:

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<sup>10</sup> The only litigated case challenging the tax exemption under Code section 125 of a plan that offered discretionary choices between taxable compensation and tax-exempt benefits was lost by the IRS. *See Express Oil Change v. U.S.*, 25 F. Supp. 1313 (N.D. Ala. 1996), *aff'd*, 162 F.3d 1290 (11th Cir. 1998) (involving a choice between current salary and health insurance under an unwritten plan).

<sup>11</sup> The regulations under section 125 are even more vague, and remain only proposed.

1. Under the “nondiscrimination as to eligibility” test, the plan either (a) must be offered to 70% of employees (excluding employees with under three years of service, under age 25, part-time, collectively bargained, and nonresident aliens), 80% of whom must participate; or (b) must be offered to a “fair cross-section” of employees, under the same type of rules applicable to qualified retirement plans.
  
2. Under the “nondiscrimination as to benefits” test, “all the benefits provided to highly compensated individuals” (referred to below as “HCIs,” and defined as the top 25% of the workforce, excluding employees with under three years of service, under age 25, part-time, collectively bargained, and nonresident aliens), must be provided to all other employees.<sup>12</sup> (Importantly, these exclusion rules are so broad as to permit many employers to design plans that would be blatantly discriminatory, were these excluded classes of employees included in the tests.)
  
3. This “nondiscrimination as to benefits” test applies both to the “type of benefit subject to reimbursement” and to the “amount of the benefit subject to reimbursement.”
  
4. There are no examples given in the regulations of discrimination as to a period of coverage, except in the case of a terminated plan, in which case the

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<sup>12</sup> Treas. Reg. §1.105-11(c)(2)(iii).

regulations provide that discrimination exists “if the duration of the plan (or benefit) has the effect of discriminating in favor of [HCIs].”

5. Retiree health plans are automatically deemed to be nondiscriminatory, but only provided that “the type, and the dollar limitations, of benefits provided retired employees who were [HCIs] are the same for all other retired participants.”<sup>13</sup>
  
6. There are two penalties applicable to a discriminatory plan, depending upon how the rules are violated. If a particular benefit is provided only to HCIs (or otherwise discriminates in favor of HCIs), then that benefit is fully taxable to all HCIs. If a plan provides the same benefits to all participants, but discriminates as to coverage, then all HCIs under the plan must be taxable on a fraction of their benefits. The fraction equals the total amount reimbursed during the year to HCIs, divided by the total amount reimbursed under the plan to all participants. (Obviously, if the plan at issue covers only HCIs, the result is the same under both penalties.)

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<sup>13</sup> As noted in footnote [5] above, it is not clear that this rule effectively limits the length of time that benefits are provided, and accordingly it is relatively common for executives to receive post-termination health coverage for many years after termination of service, for which they pay tax only at COBRA rates. The IRS is obviously aware of this practice, because it provided in the golden parachute regulations that any post-termination health benefits that were part of an “excess parachute” were required to be subjected to excise taxes in each year that they are provided, even if the employer otherwise elects to pay in a lump-sum the rest of the parachute excise taxes due on future streams of payments. *See* Treas. Reg. §1.280G-1, Q&A 11(c). Similarly, the IRS provided in the rules under Code § 3121(v)(2) governing the application of FICA taxes to deferred compensation (which generally permit FICA taxes to be applied at the time of vesting) that health benefits cannot be treated as eligible for these special FICA tax timing rules, and thus that future streams of taxable health benefits paid as part of a severance arrangement, as well as disability benefits, are required to be subjected annually to FICA taxes. *See* Treas. Reg. §§31.3121(v)(2)-1(b)(4)(iv)(B) and -1(b)(4)(iv)(C), and -1(b)(4)(v)(A).

7. An employer can elect to test separate plans together for purposes of meeting these nondiscrimination rules, but it appears that the employer can also elect to have plans tested separately. Thus, if a particular separate plan fails the nondiscrimination tests, it will not “taint” the other plan that meets these tests.

Despite the long-standing existence of these basic rules, there are many reasons for widespread confusion about their application to plans that provide executive-only health coverage. Some of these reasons are outlined below:

- No Clear Rule about Discrimination as to “Benefit Duration” in Non-Terminated Plans.  
As explained above, there are no specific examples explaining how duration of benefits is necessarily discriminatory, except for terminated plans, and therefore some companies argue that offering lifetime benefits to certain executives is “not covered” under the discrimination rules. (However, the regulations also explain that discrimination will be identified, “based on all the facts and circumstances.”)
- No Clear Rule About “Free” Coverage versus “Pay-For” Coverage. These rules were created long before COBRA was enacted, so there are no specific examples stating that offering free (or discounted) health coverage to executives, as opposed to COBRA coverage (offered for an after-tax cost of 102% of the employer’s cost) to non-HCIs, is per se discriminatory.

- Unclear Definition of “Self-Insurance.” Some companies have argued that if their health plan includes any element of “risk-shifting,” then the entire plan should be exempted from these nondiscrimination rules. This analysis is not supported by the legislative history, but the rules on how to separate the “insured” from the “non-insured” plans have never been explained.
- No Clear Rules on Testing of “Separate Plans.” As noted in A.7. above, it appears that an employer can avoid having all of its HCIs taxed (as a result of discriminating in favor of a few HCIs) simply by separating its potentially discriminatory benefits into a “separate plan.”
- No Examples of Whether Taxing HCIs on Their Health Coverage is Equivalent to Charging the COBRA Cost. Some employers have argued that so long as they tax HCIs on their health coverage, this is a “nondiscriminatory benefit,” not subject to any other penalties.
- No Known IRS Audits. There are no reports that any company has ever been audited for discrimination in health benefits. From 1986 through 1989, when employers were dealing with the different discrimination rules (applicable under short-lived Code section 89), it was apparent that virtually no employer’s plan could satisfy those onerous rules. But, after section 89 was repealed (and the section 105(h) rules were therefore reinstated), the IRS has been curiously uninterested in issuing new guidance, or in

auditing these plans. For this reason, many employers simply fail to pay attention to potential violations of these nondiscrimination rules.

In August, 2007, the IRS repropose its regulations under section 125 (many provisions of which had been outstanding as proposed regulations since 1984), providing significantly more detailed nondiscrimination testing requirements for cafeteria plans, as well as clarified limitations on the types of benefits that can and cannot be offered under cafeteria plans, and the conditions under which such plans can be offered to former employees. Employers expect IRS enforcement activity in this area to increase dramatically, once these regulations are finalized.

***Ability to Exclude Many Leased Employees and Other “Contingent Workers.”*** In applying the above-described nondiscrimination rules (if and to the extent an employer does in fact run these tests, in light of the above-outlined points of ambiguity and confusion), an employer must take all of its full-time employees (including certain “leased employees” under Code section 414(n)) into consideration in determining whether a qualified retirement plan and certain welfare benefit plans are nondiscriminatory. However, as a technical matter, the IRS revoked its regulations under Code section 414(n) years ago, and has been generally inactive in performing any audits of these companies.<sup>14</sup> Meanwhile, the various types of leased employees have proliferated, including not only the standard types of part-time and temporary employees, but also including

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<sup>14</sup> The section 414(n) regulations were revoked, per 58 Fed. Reg. 25556 (4/27/93). The IRS has made no commitment since that time to issue regulations or other guidance to taxpayers on employee leasing arrangements. The IRS did conduct a “market study” of 100 leasing companies in 1993, but never released the results. Also, in TAM 199918056 (11/12/98), the IRS concluded that a company that merely “paid wages” to certain common law employees was not in fact the common law employer of those employees, and thus the common law employer was required to treat these individuals as its employees. However, the employee leasing industry (including “professional employer organizations” as well as traditional leasing companies) has always asserted that this TAM did not involve any companies in their industry.

many other employees, who may work full time and long-term for a particular service-recipient, through one of many types of designated “employers,” which may, or may not, provide any benefits to their workers. These employment companies go by a variety of names, ranging from “leasing organization,” “PC”, “loan-out,” “second organization” to “Professional Employer Organization.” None of these terms is defined in the Internal Revenue Code, except “leased employees.” (*See* Code § 414(n)). Unfortunately, although these three-party arrangements have proliferated exponentially in recent years to meet changing demands for products and services, to the point that millions of employees are deemed to be “employed” by these organizations, even though they may perform all their services for separate single companies that exclude these workers from their benefit plans. IRS has been very slow in issuing guidance on the subject. Instead, in recent years, enforcement of the discrimination rules, and other labor law rules mandating the provision of employee benefits has been led more by workers than by the IRS; and in most cases the courts have supported employers’ ability to exclude these workers from their benefit plans.<sup>15</sup>

***Ability to Exclude Independent Contractors.*** The IRS, for its part, has been surprisingly inactive in challenging worker classifications in recent years. Although the IRS has issued

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<sup>15</sup> *See, e.g., Vizcaino v. Microsoft*, 97 F.3d 1187 (9th Cir. 1996), 105 F.3d 1334 (9th Cir. 1997), *reh’ing en banc* 120 F.3d 1006 (9th Cir. 1997); *Microsoft Corp. v. Vizcaino*, U.S. Sup. Ct. No. 97-854 (review denied 1/26/98) (rejection of company’s request that 9th Circuit’s decision on the issue of workers’ eligibility to participate in ESPP be reversed or remanded); 173 F.3d 713 (1999) (leased employees allowed to participate in ESPP); *Abraham v. Exxon Corp.*, 85 F.3d 1126 (5th Cir. 1996); *Clark v. E.I. DuPont De Nemours and Co., Inc.*, 105 F.3d 646, 1997 WL 6958 (4th Cir. 1997); *Bronk v. Mountain States Tel. & Tel. Co. Inc.*, dba U.S. West Communications, U.S. West, Inc., 98-1 U.S.T.C. ¶50,316 (10th Cir. 1998), *rev’g* and *remanding* 943 F. Supp. 1317 (D.Colo. 1996); and *Hensley v. N.W. Permanente*, 1999 U.S. Dist. LEXIS B906, *remanded* 9/12/99, to require the plan administrators to apply the common law tests of employee status, to determine which workers should have received plan benefits.

revenue rulings<sup>16</sup> and developed “Training Materials” to train agents in identifying when workers have been misclassified as independent contractors rather than employees,<sup>17</sup> after the establishment of the “Classification Settlement Program” in March, 1996 (Notice 98-21),<sup>18</sup> businesses have been able to settle all back years’ liabilities for misclassified workers by merely paying underpaid taxes for one calendar quarter (or, in some cases, one year), with the liability calculated under the extremely generous rules of Code section 3509,<sup>19</sup> provided they reclassify the workers prospectively. This amnesty program provides such tiny potential payroll tax collections, many IRS employment auditors have simply moved on to more fertile grounds.

**COBRA.** The COBRA requirements impose more significant administrative burdens on employer-sponsored health plans. Employers are required to provide general notices to new plan participants describing their COBRA rights, to provide election notices when a COBRA qualifying event occurs and to bill and collect COBRA premium payments from qualified beneficiaries who elect COBRA coverage. While some employers perform all of these required COBRA administrative tasks, many employers hire third-party administrators to assist in this process. Most employer COBRA compliance efforts are prompted by Department of Labor enforcement activities and by the risk of participant lawsuits under ERISA. Although the IRS

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<sup>16</sup> See, e.g. Rev. Rul. 87-41, 1987-1 C.B. 296 (a compendium of 20 factors that the IRS takes into account in determining whether there is an employment relationship under the common law tests).

<sup>17</sup> See “Independent Contractor or Employee? Training Materials,” Training 3320-102 (Rev. 10-96, TPDS 84238I); see also Internal Revenue Manual (“IRM”) § 4.23.5.1, *et seq.* The final version of the Training Materials was never incorporated into the IRM, but was published as a Special Supplement (Report No. 43) to BNA’s Daily Tax Report (March 5, 1997).

<sup>18</sup> 1998-15 I.R.B. 14. The CSP was initially intended to be a pilot program designed to offer eligible businesses under IRS examination the opportunity to settle their worker reclassification disputes at a potentially significant discount. The program was so successful that it was extended indefinitely.

<sup>19</sup> The statutory rules limit the employer’s FITW liability to 1.5% of the wages, and limit the employer’s liability for employee-share FICA to 20% of the full rate. Only the employer share of FICA taxes is owed at the full rate, and the employer is not required to reclassify the workers as employees for any back years.

has the authority to impose excise taxes to enforce compliance with the COBRA requirements, it is not known to have exercised that authority.

***HCTC Requirements.*** The HCTC requirements impose complex administrative burdens on eligible individuals, health plan administrators and related stakeholders such as labor unions and state workforce agencies. A detailed IRS website provides relevant information about the HCTC and the mechanics associated with applying for and receiving the credit, but this information does not alleviate the fundamental complexity of the statutory provision. State workforce agencies and the PBGC must provide eligibility lists to the HCTC program. The HCTC program must then send HCTC program kits to the potentially eligible individuals. The individual must determine whether she is eligible (the kit consists of a 24-page brochure and enrollment form), enroll in qualified health coverage and pay the full premium amount for the coverage. If HCTC eligibility is confirmed, the premiums are reduced and the HCTC program then bills the individual for 35 percent of her premium, collects the other 65 percent from the IRS and forwards the total premium to the health plan. Individuals may have to contact several federal and state agencies to confirm their eligibility for the HCTC, and the IRS is not able to share confidential information concerning the eligibility process with state agencies without specific taxpayer authorization. A separate 49-page brochure describes the administrative requirements applicable to health plan administrators who offer qualified health coverage.<sup>20</sup> The complexity

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<sup>20</sup> The IRS guidance on the HCTC enrollment process is available online, and may be found at <http://www.irs.gov/individuals/article/0,,id=109960,00.html>.

of these processes is confirmed by Government Accountability Office and private research reports indicating very low participation rates by otherwise eligible individuals.<sup>21</sup>

#### **IV. Historic Health Discrimination-Testing Disasters, and Failures of Other Attempts to Control Discriminatory or Excessive Compensation Through Codified Tax Penalties**

*Section 89.* In 1986, Congress enacted exceedingly complex nondiscrimination requirements, allowing much more limited exclusions for part-time and newly-hired employees, applicable to all health and cafeteria plans, as well as rules mandating that these plans be memorialized in writing and communicated regularly to all employees, with an effective date of January 1, 1989. With surprising speed, the IRS issued several hundred pages of guidance, and Congress enacted several technical corrections to the statute. However, taxpayers remained violently opposed to these rules, which likely would have disqualified thousands of health plans across the country. Responding to taxpayer complaints, Congress repealed the entire provision in 1988, before the rules ever took effect, thereby reinstating the very limited nondiscrimination rules applicable to self-insured health plans under Code section 105(h).

*Section 280G.* In 1984, in an effort to discourage corporate officials and other key business executives from paying themselves large settlements following a corporate takeover, Congress enacted certain tax penalties applicable to so-called “golden parachute” payments, applicable to both friendly and hostile change in control of public companies. These tax penalties are

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<sup>21</sup> See, for example, GAO, “Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation,” September 2004 (GAO-04-1029); S. Dorn, “Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons” prepared for the Urban Institute, February 2008.

triggered in any instance where the total payments of compensation (excluding certain exempted payments) are made to or for the benefit of a “disqualified individual” (including certain highly compensated employees, certain officers, and major shareholders, as counted during a specific period of time before the change in control), where the payment is expressly or implicitly contingent on a change in control of a corporation, or in the ownership of 1/3 or more of a corporation’s assets, where the aggregate present value of all such contingent payments is 300 percent or more of the recipient individual’s historic average compensation (called the “base amount”) from the corporation for the 5 years preceding the change in control.<sup>22</sup> If a payment is a “parachute payment,” three tax penalties apply to the payments to the extent they exceed the portion of the base amount allocated to that payment or (if greater) “reasonable compensation” for services performed after the change in control. These tax penalties are (a) loss of the corporation’s deduction, (b) a 20% nondeductible excise tax on the individual (implemented in part through income tax withholding and in part through information reporting), and (c) FICA taxation of the payment.

These tax penalties have had exactly the opposite of their intended effect which was to *limit* the prevalence of excessive golden parachute contracts. As of October 1984, approximately 30 percent to 40 percent of the Fortune 1000 companies provided their senior executives with employment contracts containing change in control clauses. By 2001, this percentage had risen to 90 percent. Even more remarkable has been the increase in the size of these parachute

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<sup>22</sup> As a result of both numerous “technical corrections” to the parachute rules adopted in the Tax Reform Act of 1986 (“1986 Act”), and relatively pro-taxpayer generous regulations proposed in 1989 but not adopted in final form until 2004, 20 years after enactment of the statute, these rules do not apply to changes of control in non-publicly held corporations; to sales of minor subsidiaries of public corporations; to payments for services by employees retained to work after a change in control; to any payments made to employees below the top echelon of workers; to accelerated payments of amounts that were already vested; or to payments under qualified retirement plans.

contracts (many of which include the promise of lifetime post-termination health benefits),<sup>23</sup> due in large part to “gross-up” agreements, whereby the executives are reimbursed the full costs of any excise taxes triggered with respect to their contracts.<sup>24</sup> Admittedly, some of these contracts have payment caps that prevent some or all payments that trigger parachute penalties (especially for payments in the range of 300 percent to approximately 370 percent of base pay, since in that range the excise taxes exceed the incremental amount of after-tax pay in excess of 299 percent of base pay.<sup>25</sup> However, many contracts have no caps at all, but instead gross-up the executives for excise taxes, in any instance where total payments exceed three times the executive’s base amount.

Given the almost complete “back-fire” of these provisions, critics of both the statute and the regulations have argued that the statute should simply be repealed, as yet another example of the difficulty (if not the impossibility) of attempting to further social policy through the tax code.<sup>26</sup>

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<sup>23</sup> For example, William Agee’s severance contract with Bendix Corporation, which attracted great scrutiny in 1983, and was repeatedly cited during the 1984 development of these rules, was under \$5 million; and the expected revenues from this provision were also under \$5 million. There have been parachute contracts reported to the SEC in the past few years that exceeded \$400M, for single individual executives.

<sup>24</sup> Because the executive’s marginal rate includes the 20 percent excise tax, plus regular federal and state taxes, it typically costs \$3.00 to reimburse an executive \$1.00 of parachute excise taxes.

<sup>25</sup> For example, if an executive with \$1M is base pay has a parachute of \$3M, a cutback of \$1.00 would eliminate any parachute, where as failure to adopt a cutback could trigger a corporate liability to pay (under a gross-up agreement) the excise taxes on \$2M. That gross-up would equal approximately 3 times 20 percent of \$2 million, or \$1.2 million – an entirely nondeductible payment, made to ensure that the executive keeps the extra dollar.

<sup>26</sup> See Lee A. Sheppard, “18-Karat Parachute: Treasury End-Runs Congress,” 43 Tax Notes 198 (June 5, 1989). See also Bruce A. Wolk, “The Golden Parachute Provisions: Time for Repeal?” 21 Virginia Tax Review at 125, 153-161 (Fall, 2001).

**Section 162(m).** In 1993, in reaction to what was perceived to be generally excessive salaries of top corporate executives (even outside parachute contracts), Congress enacted Code section 162(m), which disallows a corporate income tax deduction for remuneration to certain top company executives<sup>27</sup> in excess of \$1 million, subject to an exception for shareholder-approved “performance-based compensation.” While shareholders are allowed to approve the total amount of such compensation payable to any executive (under votes taken every five years), many of the regulatory guidelines applicable to this compensation are relatively simple to meet. Further, a company is always allowed to pay compensation *outside* the shareholder-approved performance compensation limits, and, if the payment of any such non-qualifying compensation is deferred until the year in which the executive’s termination of service (as either an employee, or officer, or both), or until after the executive’s company is acquired, the compensation is deductible without regard to these deduction limitations.<sup>28</sup> Thus, by exempting post-retirement payments, Code section 162(m) provided a significant incentive for companies to encourage their executives to defer compensation.<sup>29</sup>

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<sup>27</sup> Although the statute applies these deduction limitations to the CEO and top 4 other officer listed in the company’s proxy, in Notice 2007-49, 2007-25 I.R.B. 1429, the IRS reduced the class of executives to the CEO, plus an additional *three* highest compensated officers for the taxable year (*other than* the principal executive officer or the principal financial officer), in order to bring the IRS’s guidelines into compliance with certain recent changes in the proxy-reporting rules, effective for taxable years ending on or after December 15, 2006. This group subject to Code section 162(m) would be further changed under legislation introduced in January, 2007, that would expand the definition of “covered employees” to include any individual who is (or ever was) either the CEO or one of the four highest-compensated officers (other than the CEO) (irrespective of whether such highly compensated officer’s name was ever included in the Summary Compensation Table).

<sup>28</sup> The legislation proposed in 2007 would also have eliminated this ability to avoid Code section 162(m) by delaying the payment until after the executive’s termination; it instead provides that executives are deemed to remain perpetually in the group of employees who are covered by Code section 162(m), even after their termination of service or death. (It appears that Code section 162(m) could continue to be avoided if the company reverts to private status.)

<sup>29</sup> Notably, too, Code section 3121(v)(2) (enacted in 1983) had provided an additional effective incentive to defer compensation, by imposing FICA taxes at the point of deferral (or, under defined benefit plans, in the year of retirement). Typically the executive’s compensation has exceeded the Social Security tax wage base in the that year, (continued...)

**Section 409A.** In 2004, Congress reacted to a perceived “abuse” in executives’ nonqualified deferred compensation plans, based on a sudden recognition that there were no IRS guidelines governing these plans,<sup>30</sup> Congress enacted Code section 409A, to provide guidelines governing the timing of deferral elections, certain types of plan investment, and the rules under which the deferred compensation can ultimately be distributed. The IRS has spent three years developing 800 pages of guidance under Code section 409A, but has also announced that it will not issue any private letter rulings, or develop any “model plan” to assist taxpayers in dealing with these rules. Accordingly, it remains to be seen what companies will do in amending and operating plans, and what IRS agents and courts will do in future years in determining whether companies’ plans are in compliance with these enormously complex IRS guidelines.

**Section 274.** Code section 274 (enacted in 1962, and amended dozens of time since then) is an extremely complex set of tax deduction limitations imposed upon certain types of entertainment, meals, travel, and gifts, and upon “lavish” expenditures generally. In some instances these limitations were enacted in an attempt to limit the expenditures themselves; although in nearly all cases Congress was also simply attempting to raise revenues through these deduction limitations.

Certainly these limitations are applicable to many of the listed expenditures. But, as was true

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so, although Medicare taxes must be front-paid, the ultimate distributions (plus appreciation) are exempt from both Social Security and Medicare taxes.

<sup>30</sup> Apart from the various implicit tax incentives to defer compensation, Congress itself was responsible for the lack of IRS guidance or audits of these plans. In February 1978, in reaction to controversial proposed IRS regulations (Prop. Treas. Reg. § 1.61-16) that would have prevented taxpayers from filing any elections to defer compensation., Congress had blocked those proposed regulations from taking effect, by providing that the taxation of any deferred compensation plan must be determined in accordance with regulations, rulings and case law in effect on February 1, 1978. *See* Section 132 of the Revenue Act of 1978.

with respect to each of the above-discussed limitations on executive compensation, the IRS took many years to develop guidelines, which in many instances contain amazingly generous exceptions; and has conducted very few audits of taxpayers' compliance with these rules. Further, there is no indication that these tax deduction limitations have had any effect whatsoever in reducing taxpayers expenditures for the items whose deduction is limited by this statute.

## **V. Administrative Issues Associated With Reform Proposals**

Most reform proposals include one or more common elements designed to achieve universal coverage, including some combination of mandates, incentives, insurance market reforms and changes to the current tax rules. Mandates might require employers to provide, and individuals to have, health plan coverage satisfying certain requirements. Incentives might be offered to expand access to, or subsidize the cost of, health plan coverage satisfying certain requirements. Insurance market reforms may reduce, eliminate or standardize state regulation of insurance products, establish incentives for non-employer sources of health plan coverage and expand the types of health plan coverage available. Tax reforms might limit the current exclusion, replace the current exclusion with a tax credit, eliminate the disparities between employer-provided and individually-purchased health coverage, tighten nondiscrimination requirements and include reporting changes designed to complement other reforms. The discussion below examines more closely some of the administrative issues associated with each of these elements.

***Employer mandates.*** Employer mandate proposals would require an employer to offer health plan coverage satisfying certain requirements or, in the alternative, pay a fixed cost per employee

or percentage of payroll to a governmental unit. The expected result is that employees would have a source of coverage either through their employer or through the governmental unit. To administer this requirement, employers would be required to provide detailed information to a regulatory body identifying: whether they offer health plan coverage, the type of coverage offered, the number and identity of employees covered or not covered, and a determination of the payments necessary if the employer did not offer coverage. Although these reporting requirements could be imposed outside of the tax system, the payment option (whether viewed as an alternative or a penalty) would almost certainly need to be enforced by the IRS. Thus, it is likely that the current employment tax reporting and payment mechanisms would need to be expanded to facilitate the enforcement of an employer mandate. Further, care would need to be taken to prevent employers from continuing to take steps simply to classify millions of employees as “leased employees” (hired through another entity) or as “independent contractors,”

***Individual mandates.*** Individual mandate proposals would require individuals to purchase health plan coverage satisfying certain requirements or face penalties for failure to do so. Sources of coverage would include employer-provided coverage and coverage purchased through any alternative to employer-provided coverage (such as individual or association coverage). To enforce this type of mandate, the government would need reliable information confirming that an individual had coverage, the source of the coverage, the type of coverage and the duration of the coverage. This information would need to be obtained from employers, health insurance carriers and individuals. The enforcement of individual mandates is an area that has not been fully explored – how will penalties be determined? how will penalties be assessed and collected? will parents be responsible for paying penalties associated with a failure to

purchase coverage for their dependent children? How will penalties be imposed on divorced parents? Query, too, whether the IRS is the agency best equipped to serve as the collection point for information relating to, and the enforcement of, an individual mandate.

***Incentives.*** Incentive proposals would provide direct or indirect funding to encourage low-income and middle-income families to purchase health plan coverage. The funding could be provided by making government payments to employers and health insurance plans (as is the case for the HCTC) from whom families purchase coverage. Alternatively, the funding could be provided by making government payments directly to families to reimburse them for a portion of the cost of the coverage purchased. Although there is no particular reason to design these payments in the form of tax credits, the IRS has significant expertise with credits designed to provide funds for eligible low-income or economically distressed groups (including the HCTC and the earned income tax credit).

***Insurance reforms.*** Insurance reforms would examine one or more approaches for expanding access to coverage by eliminating or reducing state regulatory hurdles such as mandated benefits, creating purchasing pools such as association plans as an alternative to employer-provided coverage, and encouraging the development of other types of health insurance products such as “bare-bone” or catastrophic policies. Because insurance is currently regulated by the States, it is unlikely that the IRS would need to be involved in the administration of these changes. However, tax changes may be necessary to provide uniform tax treatment for employer-provided and other types of health plan coverage.

***Tax reforms.*** The universe of tax reform options discussed in connection with health reform proposals includes the following options:

- *Modify or eliminate the Code section 106 exclusion.* Some reform proposals would limit the exclusion to a specified value either for high-income employees or for all employees. Other reform proposals would eliminate the exclusion entirely. Under either of these proposals, employers would be required to value their health plan coverage for the first time and then report the taxable portion of the value on appropriate income and employment tax reports (i.e., the Form W-2 and the Form 941). The IRS would need to develop valuation methodologies for insured and self-insured plans, respond to requests for information from employers and audit the health plan valuations reported by employers.
- *Replace the Code section 106 exclusion with a tax credit.* Most reform proposals calling for the elimination of the Code section 106 exclusion would replace the exclusion with a tax credit. These credits might be available to all taxpayers or only to low- and moderate-income taxpayers. To the extent the Code section 106 exclusion is eliminated, all of the administrative responsibilities described above would also come into play. In addition, the IRS would have the additional administrative challenges of implementing the new credit. These challenges would include the preparation of new communication materials for taxpayers, the development of reporting requirements to ensure that taxpayers purchased appropriate health plan coverage and an audit program to ensure compliance. These reporting requirements would most likely require information

reporting from employers and health insurance carriers and from taxpayers seeking the new credit.

- *Eliminate disparities.* Another set of possible reforms calls for eliminating the disparities between employer-provided and individually-purchased health plan coverage. For example, the Code could be revised to permit individuals to claim an above-the-line deduction for individually-purchased health plan coverage. While this requirement could be enforced solely on audit, the IRS may be more comfortable receiving contemporaneous information about individually-purchased coverage from a health insurance carrier.
- *Tighten nondiscrimination requirements.* Another possible reform would be to impose nondiscrimination rules for all health plans. As noted previously, only self-insured health plans are currently subject to nondiscrimination rules under Code section 105(h). Nondiscrimination rules are used to ensure that tax benefits associated with employer-provided plans are not utilized solely by highly compensated employees. However, as discussed above, the last Congressional attempt to expand nondiscrimination rules led to the enactment, and rapid repeal, of the infamous Code section 89. The expanded nondiscrimination rules, and the threatened enforcement of those rules, imposed significant administrative and compliance burdens on small employers, their health insurance providers and the IRS. Any new attempt to expand the nondiscrimination rules would need to take on these challenges.
- *New reporting requirements.* Many of the reform proposals discussed herein, especially the employer and individual mandates and tax changes, would impose additional data

collection and information reporting responsibilities on employers, individuals and health insurance providers. Notably, based on past experience, the IRS has often been extremely slow in implementing information reporting statutes.<sup>31</sup> And, even after the IRS has issued implementing regulations, and added new boxes to information returns (including not only Forms W-2 and 1099, but also informational boxes on income tax returns), those returns are not completed for an additional year, and not processed or audited for at least a year after that.

- *Ensure that any penalties on employees are not collectable through withholding, but also are not applicable derivatively at the state level.* In designing Code Section 280G, although the excise tax on excess parachutes (imposed by Code section 4999) is technically imposed on the affected executive, as a technical matter this tax is effectively imposed on the paying company, since the excise tax is required to be withheld from any taxable compensation. As a result, in practice the IRS has limited nearly all its audits only to corporate employers, and has never addressed, or imposed penalties on, individuals. By contrast, the tax penalty under Code section 409A is imposed on the individuals who defer compensation, presumably in order to ensure that these individuals do in fact realize the tax consequences of violating these new deferred compensation rules. The problem with the Code section 409A penalty, however, is that it is imposed simply as part of the Code, in a provision instructing taxpayers to add 20 percent to their taxes. Accordingly, any states that simply follow the Code in determining state taxable

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<sup>31</sup> For example, the regulations governing information reporting for educational assistance plans (under a statute enacted in 1978) were never finalized; and the regulations governing information reporting for incentive stock options (under a statute enacted in 1981) were not finalized until 2006. The regulations governing reporting of nonqualified deferred compensation plans (under a statute enacted in 2004) have not yet been proposed, and likely will not be finalized for several more years.

income are permitted to assume that this increase in federal tax operates as an increase in state tax as well.<sup>32</sup> In adopting any penalties to incentive individuals to purchase health insurance, Congress should take care to ensure *both* that these penalties do effectively fall on individuals, and further that the penalties are not duplicated at the state level.

## **VI. Conclusion**

Any attempt to mandate universal health insurance, even at minimal levels, faces the challenge of how to deal with the current system's myriad rules on tax-protected health care coverage and medical expense deductions, which were effectively proven to be replete with both coverage exemptions and benefit discrimination when last effectively tested under the rules of short-lived Code section 89. Further, the existing system's lack of effective limitations on mis-classifying workers as "non-employees" (or, as "employees of some other employer" – such as a leasing company - will make it extremely difficult to implement any set of tax penalties or incentives merely by focusing on employer-provided coverage. It's obvious that some radical reform is necessary, but the past 30 years of experience has shown that the IRS has been extremely slow in developing implementing regulations, or in enforcing tax penalties on abusive plans.<sup>33</sup> Finally, in the instances where the IRS has acted aggressively to combat perceived abuses, Congress's

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<sup>32</sup> See, e.g., California Franchise Tax Board Notice 2007-1, announcing that the Code section 409A 20 percent tax applies at the state level in California as well.

<sup>33</sup> Congress might attempt to mandate more rapid IRS action by requiring the IRS to draft implementing regulations, issue information reporting requirements and initiate an audit program within specified periods of time following date of enactment. In addition, Congress might seek to enforce such a deadline by providing that the IRS's budget will be reduced by 5 percent for each quarter the agency delays in either (a) issuing implementing regulations and information reporting requirements or (b) failing to initiate an audit program. Of course, the IRS is not in a position to administratively correct poorly drafted legislation.

reaction has often been to impose audit moratoriums, or even to repeal the implementing statute. Bottom line, design and enactment of health care reform will be only one step towards expanding coverage for the currently uninsured. Implementation and enforcement of the new rules, given the challenges of the current tax laws, will be the even larger hurdle.