Ordinary Medical Expenses

By Calvin H. Johnson

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Johnson argues that although extraordinary medical expenses are appropriately deducted to compute a taxpayer’s standard of living, taxpayers should bear ordinary medical expenses out of their post-tax income, with no allowance beyond personal exemptions, the standard deduction, and low tax brackets. He defines ordinary expenses as less than 15 percent of adjusted gross income.

Consistently, tax-excluded employer healthcare plans appropriately cover extraordinary medical expenses. Johnson proposes that no exclusion be allowed for plans that cover ordinary medical expenses, defined by the same 15 percent level.

The deduction of ordinary medical expenses and the exclusion of insurance plans that cover those expenses cause wasteful inflation of medical costs. Deductions and exclusions to accomplish a subsidy are not a way to help the needy, they inappropriately benefit the highest-bracket taxpayers as if their health and life were worth more.

The proposal is offered as a part of the Shelf Project, a collaboration of tax professionals developing methods of raising revenue, in ways that improve the fairness and efficiency of the tax base. The Shelf Project has 68 proposals so far. Comments are welcome either as public debate, directed to the Tax Notes editor, or privately to cjohnson@law.utexas.edu.

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Under current law, extraordinary medical expenses may be deducted but ordinary medical expenses may not. Medical expenses exceeding a threshold of 10 percent of adjusted gross income are itemized deductions available to taxpayers who do not take the standard deduction. Expenses less than the threshold are not deductible.

The line between ordinary and extraordinary medical expenses is normative, or at least it is a workable line between two ways of looking at medical expenses. One model would allow deductions of medical expenses because they represent involuntary losses, and the other would condemn them because they represent self-serving consumption of resources.

Extraordinary medical expenses, under one model, measure a taxpayer’s involuntary loss. A progressive tax system imposes higher tax rates on a taxpayer with a higher standard of living, but it is plausible that extraordinary medical losses should not be considered part of the taxpayer’s standard of living. They are like theft losses or casualties.

Under the other model, however, ordinary medical expenses represent the taxpayer’s consumption of resources for self-serving personal reasons. Personal consumption expenses are the normative core of the income tax. The zero-taxed personal exemptions, the standard deduction, and low tax brackets are intended to cover the most critical personal consumption, but otherwise personal consumption properly comes out of after-tax income. From the baseline that ordinary medical expenses should not be excluded or deducted, a deduction is a subsidy.

1Congress increased the threshold from 7.5 to 10 percent of AGI for tax years beginning in 2013 and thereafter, except that for taxpayers who have reached age 65, the 7.5 percent threshold applies through 2016. The Patient Protection and Affordable Care Act of 2010, section 9013, amending section 213(a) and (f) of the code. The medical deduction, above the threshold, is affected neither by the phaseout of other itemized deductions nor by the alternative minimum tax. Sections 68(c)(1) and 56(b)(1)(B).

The value of an itemized deduction, even above the 10 percent threshold, is reduced because a taxpayer gets a standard deduction in lieu of itemized deductions. Thus, a couple with $100,000 of AGI and $25,000 of medical expenses might find that only $2,800 of the expenses save any tax. The first $10,000 is not recognized because of the 10 percent of AGI threshold. If that is the only personal or itemized deduction, the couple could get a $12,200 standard deduction anyway (Rev. Proc. 2013-15, 2013-5 IRB 444, section 7), without incurring any cost, so that only $2,800 of the $25,000 medical costs would save any tax. Typically, however, a couple has other itemized deductions; if the couple has home mortgage interest, some charitable contributions, and state taxes that are already above the standard deduction, the medical expense more than $10,000 (here $15,000) would save them tax.
with an awful pattern, treating the health of the richest taxpayers as worthy of a 39.6 percent subsidy but treating the health of most taxpayers — those who do not itemize deductions or are too poor to pay tax — as unworthy of any subsidy. A subsidy encourages taxpayers to waste expenditures on items they would not otherwise pay for.

The underlying idea that taxpayers should bear their own ordinary medical expenses suggests that the threshold might be raised toward the national average, now estimated at 30 percent of AGI. The distribution of medical expenses is skewed, however, because a small population incurs most of the total national medical expenses. In light of that skewed distribution, this proposal recommends raising the deduction threshold from 10 to 15 percent of AGI.

Even more importantly in terms of revenue, the proposal would conform the exclusion of employer-provided medical insurance to the distinction between extraordinary and ordinary medical costs. Employer-provided insurance premiums would qualify for exclusion only if the policy did not cover medical costs less than 15 percent of AGI. The proposal would use last year’s AGI so the insurer and policyholder could determine reimbursability before year-end. An employer would be free to pay premiums that cover ordinary costs, but not from the same insurance group, and the premiums would be taxable income. The proposal would consistently also restrict the employee elective cafeteria plans and the health insurance plans that now allow ordinary medical expenses to be paid with untaxed money.

American medical costs are seriously inflated compared with, for example, European medical costs for identical drugs and services. Making taxpayers bargain for costs that they can afford to pay with their own after-tax money will go a long way to ensure that taxpayers pay only for the value they get out of those costs.

A. Deduction of Direct Pay

1. Shocks. Under one view, extraordinary medical expenses should be deducted because they measure losses. No one voluntarily incurs heart arrhythmia to get a pacemaker, breaks a leg for the cast, or gets cancer for the chemotherapy. The costs of the pacemaker, cast, or chemo look like an involuntary loss.

The progressive tax brackets apply varying tax rates depending on a taxpayer’s standard of living. Taxing bon-bons and luxury consumption does less harm than taxing life-or-death subsistence amounts. Tax deductions are always most valuable in the highest tax brackets. Still, if an extraordinary medical expense is a loss, we should subtract the expense from taxable income before we determine the taxpayer’s bracket and calculate his tax, so we are taxing only the taxpayer’s real standard of living. We allow a deduction for business expenses, even though the money to pay the expense has first come into the taxpayer’s cash register, because the payment of the expense shifts the income to the other party who received the expense. We allow a deduction for extraordinary theft losses, above the threshold of the same 10 percent of AGI we use for medical costs, even when the theft has nothing to do with the computation of business profit or income. Theft means that the taxpayer has not received the value from the lost money. If the richest man on earth — let’s call him Uncle Scrooge McDuck — has a theft loss or an extraordinary medical expense we treat as a loss, he is poorer by the amount of the loss.

Losses differ from ordinary personal expenses in that they are involuntary. A true loss will not increase in response to a reduction of its cost. Thus, for the taxpayer, a deduction will reduce the final cost of an extraordinary expense by the amount of tax savings, but it will not increase the amount of the expenditure, because nobody wants a loss — even one tempered by a tax savings. A pure loss would have zero response to lower cost. The model of pure losses, however, applies comfortably enough, even with costs responding somewhat to reduced price, as long as non-responsiveness and involuntariness of the cost dominates. The border between extraordinary and ordinary costs is not a theoretically clean way to distinguish between discretionary expenses and involuntary, non-responding losses, but it may be good enough.

2. Ordinary. Under a contrary model, however, payments for drugs and medical services are private consumption of resources, not unlike all the other things a taxpayer spends for self-serving needs. Personal consumption is the normative heart of the income tax base. Under the Haig-Simons definition of income, an income tax reaches both consumed and saved income, but there are strong advocates for exempting savings from tax. Exempting savings from tax would leave personal consumption as the necessary and only remaining tax base.

There is no tax on amounts covered by the personal exemptions and the standard deduction, and there is only low tax on income within low tax brackets. The zero tax and low brackets are supposed to cover a taxpayer’s necessary but ordinary costs of survival. The zero tax covers the costs of basic subsistence, and low tax brackets cover consumption costs just above subsistence. The standard deduction gives a deduction to everyone in lieu of itemized deductions and without proof of costs. People bear the costs of a modest standard of living,
including ordinary medical expenses, from out of their untaxed standard deduction, personal exemption, and low bracket amounts. Beyond the allowance for zero-tax personal exemptions, the standard deduction, and low brackets, personal consumption is supposed to be paid with after-tax income.

Indeed, for ordinary costs that do not materially affect a taxpayer’s standard of living, covering those costs with a zero tax or low tax bracket avoids the administrative burden of tax, unlike the required record keeping, reporting, and auditing entailed by a deduction. If the costs do not materially affect the standard of living, we should not have the tax system try to keep track of them. The tax system needs to round out items that do not materially affect the overall picture, to reduce the complexity of the tax system.

Already under current law, costs critical to health do not qualify for the itemized medical expense deduction as allowed by section 213. Thus, one must eat to avoid starving to death, and have shelter for protection from the elements, but the expenses of food and shelter are taxable personal consumption and not deductions. The costs of non-prescription drugs are not deductible. Prescription drugs are not different in kind from nonprescription drugs unless they are expensive enough to be considered medical shocks. The best things a taxpayer can do for future health is to get exercise, lose weight, and eat a Mediterranean diet, but the expenses for exercise and weight loss food are all treated as ordinary personal consumption and yield no deductions. Private consumption of goods and services is the normative heart of the tax base, and medical expenses represent private consumption.

Equal tax treatment of all personal consumption means that I decide how best to spend my money. When I go into my local drugstore, there is an aisle for potato chips and an aisle for greeting cards. There is a cosmetics aisle I do not personally visit, although it seems to be heavily used. Then there is an aisle for heating pads, and another for aspirin. The prescription drugs are at the far wall. If none of my expenses are deductible or excludable, I will spend in the aisles and in the way I think best serves me, without any accounting or paperwork to anyone. I make many decisions on price alone. The new prescription drugs for knee pain are too expensive when two aspirins and a hot water bottle will basically do the trick. On some days, I may spend on greeting cards or potato chips because that best covers what ails me. Letting me decide how I spend my money is based on an important principle: consumer sovereignty. Within the aisles, I am the king.

Consumers are not always wise concerning medical goods and services. They lack the expertise to distinguish effective from ineffective and harmful remedies. They will spend willingly for quack medicines that promise weight loss or a cure for incurable diseases. Still, patients hire doctors to bring medical expertise, even science, to bear to help their medical decisions. As argued below, a good case can be made for a significant increase in government funding of experimental science to distinguish effective from ineffective remedies. Yet blindly allowing a deduction for effective and ineffective medical costs does not help increase the overall effectiveness of medical costs. In any event, consumers, with doctors’ help, have a strong enough interest in defending their own health to try to make wise decisions about medical spending.

Unequal treatment of different kinds of consumption induces wasteful expenses. If I were in a 40 percent tax bracket and some of my $100 expenditures were deductible, the deduction would save me $40 and my after-tax cost would be only $60. With a deductible expense, I would need to get only $60 worth of value from a $100 expenditure — that is, enough to equal my cost after tax savings. From a national perspective, spending $100 for resources that give only $60 of value is a waste of $40, but from my private perspective, the tax savings from the deduction makes up for the tax-induced waste. A taxpayer will accept waste just short of the value of the tax saved. Indeed, a consumer trying to maximize his own value will move resources away from nondeductible expenses over to deductible expenses until, in equilibrium, the expenses at the margin all waste $40. The waste of $40 is inevitable if some consumption is from taxed income and some is deductible. If none of the aisles yield tax deductions, by contrast, I would spend $100 only when I get $100 of value and no waste, which is as it should be.

Under the proposal, the patient would be the first bearer of medical costs because the patient is the first beneficiary of the costs. Medical care expenses should be treated as high-priority claims. Ordinary medical expenses, by definition, are those that the taxpayer can afford. We would not want people getting medical deductions also deciding to travel to Europe, buy a second home, or give away excess money to the kids. Ordinary medical expenses should be borne first out of normal after-tax income.

3. Subsidy? From a baseline that the ordinary medical costs should not be deductible, it is inappropriate to deliver a subsidy for medical expenses.

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2Section 213(b).
by way of an itemized deduction. Tax deductions work against the framework of progressive tax brackets. The subsidy depends, upside down, on the tax bracket. A subsidy deduction would thus treat the health of a rich taxpayer as worthy of a 39.6 percent subsidy and the health of a middle-income taxpayer as worthy of only a 15 percent subsidy. Indeed, only one-third of all tax returns take itemized deductions. A subsidy delivered by an itemized deduction treats the health of the two-thirds of taxpayers who do not take itemized deductions as worthless and unworthy of any subsidy. Similarly, taxpayers too poor to pay tax or file a return get no value from any deduction or exclusion. The tax savings are like a reverse Robin Hood, stealing from general taxpayers to serve the most prosperous. That pattern is not just odd and arbitrary, it is abhorrent.

Nothing in the deduction helps the indigent. Care for the indigent is, and needs to be, handled outside the tax system. For an ordinary expense defined as a fraction of AGI, the deduction goes to no one who cannot afford the costs. Medical deductions for ordinary costs are counterfeit charity.

Medical goods and services are a good, which is why taxpayers pay for them. However, medical expenses are not a “merit good” that should be paid for by somebody else if they serve only the payer. Flu vaccines and other costs that combat contagion and epidemics are merit goods because they affect others, but they should be handled, with carrots or sticks, by means outside a progressive rate structure. A tax deduction cannot help prevent contagions and epidemics among the indigent or among the two-thirds of taxpayers who do not itemize.

A good case can be made for government funding of experimental science focused on distinguishing effective from ineffective medical treatment. Our medical system does a poor job of protecting patients from ineffective or even harmful remedies. The American health system, as a whole, is capable of producing very expensive remedies that are ineffective or counterproductive, such as hormone therapy, back fusions, and positron therapy. For example, the system created now-withdrawn pain-killer Vioxx, an expensive substitute for the cheap advice to “take two aspirins and call me in the morning.” The drug resulted in five times more heart attacks than aspirin: It killed patients. The system needs to do better in eliminating the ineffective and harmful expensive costs. Indeed, if the patient and his doctor had information based on experimental science to identify the ineffective and harmful costs, that remedy alone should be sufficient. Presumably no patient or doctor would choose a useless or harmful remedy. There would be no need for further carrots or sticks.

An itemized deduction for medical expenses is not a suitable substitute for science that would distinguish effective from ineffective remedies, and it would not help drive out the overly expensive, ineffective, and harmful remedies. A RAND Corp. study found that when patients receive insurance or government funding for some portion of their medical costs, they increase their willingness to consume medical goods and services, but they increase the effective and ineffective goods and services by the same ratio. Even “preventive” procedures, which in theory can avoid later expensive remedial procedures, in practice do not save enough future medical costs to justify their own cost. The United States is running multi-hundred billion dollar deficits, with healthcare costs projected to take an ever larger share of the nation’s income.


7See, e.g., Louise B. Russell, “Prevention’s Potential for Slowing the Growth of Medical Spending,” National Coalition on Health Care, 4 (2007) (reporting that most expensive blood pressure medicines returned only 11 to 15 cents per dollar spent in terms of medical cost savings); Russell, Is Prevention Better Than Cure? 3 (1986) (“In fact, prevention usually adds to medical expenditures”). Counting only medical costs does not include the value of health and longevity. A well-informed patient and doctor, however, do have a strong motive to pay for effective measures that lead to greater health and longevity.
wealth. It is said that half of all American medical expenses could be avoided with no effect on therapeutics impact if we could fix the mal-incentives. In times of extraordinary budget deficits, a federal subsidy for the ineffective and even counterproductive medical costs of upper-income individuals is not a remedy that fits the need.

4. Raising the threshold? Current law uses a threshold of 10 percent of AGI to distinguish extraordinary (and deductible) medical expenses from ordinary (and nondeductible) medical expenses. This proposal suggests that the threshold should be raised to 15 percent of AGI. A higher threshold, raised toward the national average of overall health expenses, would still identify affordable expenses because it varies by income and because taxpayers are truly invested in their own health, so it comes ahead of other, lower-priority discretionary expenses. Seriously ill persons, moreover, tend to have lower incomes because their health gets in the way of income, and retired persons, who have little or no compensation, have a disproportionate share of the expenses. The threshold for identifying extraordinary expenses will thus tend to drop for those who are most ill, even with a constant percentage threshold, because the threshold is defined in terms of AGI.

One alternative to the proposed 15 percent line would be to use the mean or average of all medical expenses nationwide to calculate the average per capita medical expense. Taxpayers would be expected to bear below-average costs from their after-tax income. OECD data estimate that U.S. healthcare costs are 17.6 percent of GDP for 2010. AGI for the whole nation, however, is only about 57 percent of GDP. When the given health expenses are stated as a percentage of the smaller base, AGI, the national average would be stated as 17.6/57 or 30 percent of AGI.

The average of 30 percent of AGI is not a good definition of ordinary expectations, however, because medical expenses are not evenly spread. Half the population has almost no medical expenses during the year, and 3 percent of the population has almost half of the medical expenses. Patients with more than one of a few serious chronic diseases absorb the lion’s share of the national total. The expected per capita medical expense of an 85-year-old is almost 12 times higher than the expected per capita medical expense of a 20-year-old. Skewed samples usually call for use of a median — the expenses of the spender at the middle 50 percent of-the-sample line. The mean or average is pulled upward by heavy use in a small population. A 20-year-old taxpayer without chronic diseases, for instance, should not expect to have medical expenses measured by the national average.

With almost half the population bearing no medical expenses, however, the median expenditure would be close to zero. The near-zero line does not help identify the large involuntary losses that affect standard of living beyond what the zero- and low-tax brackets should cover alone. Near zero does not identify the discretionary ordinary medical expenses that should compete on an equal footing with a taxpayer’s other uses of his funds. Near zero does not separate the expenses that are worth the record-keeping and audit efforts from those who are comfortably covered by the personal exemptions, the standard deduction, and low tax brackets.

This proposal recommends a new threshold of 15 percent of AGI, which is halfway between the mean of 30 percent of AGI and the median of almost zero. The lesser increase recognizes that the average does not reflect a taxpayer’s normal expectations when the distribution is so skewed, without, however allowing essentially all medical costs to be deducted.

B. Insurance

The line between extraordinary and ordinary medical expenses also provides a normative line for health insurance. Under current law, employees may exclude premiums on health insurance paid by their employers. They may also elect to pay medical

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11U.S. GDP was $13.8 trillion in 2009 by World Bank estimates, available at http://search.worldbank.org. AGI was $8 trillion, consisting of $7.6 trillion for individuals and $0.44 trillion from corporate pretax profits. IRS, 2009 Statistics of Income, “Corporate Tax Returns and Individual Income Tax Returns Filed and Sources of Income,” Table 1.1. As a percentage of a smaller base, the given medical expenses that are 17.6 percent of GDP become 13.8/8 x 17.6 percent or 30 percent of AGI.
12Mark W. Stanton, “The High Concentration of U.S. Health Care Expenditure,” Agency for Healthcare Research and Quality (2009) (summarizing Medical Expense Panel Survey findings that in 1977, the 5 percent of the population with the highest medical expenses accounted for 55 percent of all expenditures and that the bottom 50 percent accounted for 3 percent of medical expenditures).
expenses within untaxed flex plans and medical savings plans. The exclusion of premiums for extra-
ordinary health costs is reasonable under the argument developed here, but the exclusion of
premiums for insurance that will cover ordinary medical expenses is not.

Indeed, insurance generates its own inefficiencies because it is expensive and insurance-funded ex-
penses are treated as free by the insured. Restricting insurance to extraordinary expenses is thus even
more pressing than restricting the deduction of direct payments. Insurance should be restricted to
cases in which the dollars received as a payout are materially more valuable than the dollars paid as
premiums because of diminishing utility of money.

The exclusion for employer-provided health insur-
ance is 16 times more important in terms of revenue at stake than the itemized deduction for medical expenses paid by the taxpayer directly. According to Office of Management and Budget methodology for tax expenditures, the exclusion for employer-provided medical insurance (including employer-paid self-insurance) entails a revenue loss of $202 billion a year, and the section 213 itemized deduction is a $12.6 billion annual revenue cost.15

1. Insurance for extraordinary costs. Insurance that
kicks in to cover extraordinary losses is rational because of the diminishing marginal utility of
money. Pharaoh had a dream about seven fat cows
swallowed by seven thin cows, which Joseph inter-
preted as meaning seven years of good harvests in
Egypt followed by seven years of drought. Grain
could be saved in Egypt only at the loss of consid-
erable amounts of the grain to rats and rot, but
saving grain was rational despite the shrinkage
because the grain in times of plenty had less value
than when the alternative would be starvation.

So insurance premiums paid in good times that
lead to an insurance payout in hard times are rational in terms of utility of a dollar. Insurance

14Joseph Bankman et al., “Reforming the Tax Preference for
Employer Health Insurance,” 26 Tax Pol’y & Econ. 43 (2012),
argue for repeal of the threshold for the itemized deductions to
take away the relative tax advantage of medical insurance. This
proposal would eliminate the relative advantage of insurance
by requiring that excludable health insurance not cover the
below-threshold payments.

15OMB, “Budget of the United States: Analytic Perspectives,”
Table 17-1 (tax expenditure for 2013-2017, divided by five years).
The Joint Committee on Taxation, which has slightly different
categories and methods, finds the employee exclusion to be 12
times the value of the itemized deduction. JCT, “Estimates of
(Feb. 1, 2013), Table 1 ($152 billion per year for the exclusion for
employer-provided healthcare, and $14.3 billion for the item-
ized deduction, found by dividing tax expenditures for 2013
through 2017 by five years).

payouts that come in the trough of bad times have
a higher utility per dollar than the premiums be-
cause without the payments, the taxpayer cannot
eat sand and needs money to pay the rent. The

16Elisabeth Rosenthal, “The Soaring Cost of a Simple Breath:
Paying Till It Hurts: No Room to Negotiate,” The New York
Insurance is also expensive because insurance companies need to market their product, filter out bad risks, collect premiums, and deny claims. When premiums are paid in average years and payouts come in average years, there is no extra value of a dollar to overcome the bad incentives and inherently high costs of the insurance business.

One argument for a subsidy for insurance is that without a subsidy, it might be impossible to overcome the lemon effect or adverse selection effect inherent in insurance. Under the lemon effect, an insurance company in the marketplace attracts as customers only those who expect to make more on insurance reimbursements than they have to pay in premiums. Thus, only customers with ill health want insurance. All others would lose on their insurance bet because their premiums would exceed payout. If all willing customers correctly expect to make a profit at the expense of the insurance company, the insurance company cannot make a profit or stay in business. Still, for ordinary medical expenses, that is a fine result. For ordinary costs, it would be cheaper and more efficient for the patient to handle the costs directly without the drawbacks of insurance. Adverse selection should defeat insurance.

3. Incentives for excluded compensation. An exclusion of premiums properly taxed is another subsidy with the abhorrent pattern in that the subsidy is more valuable for the health of the rich, in higher tax brackets, than it is for the health of the poor. An employer pays the employee premiums as compensation. The exclusion of compensation from tax induces the employer and employee working together to shift from cash compensation to the insurance. When the insurance is covering average costs in average income years, the tax system is giving the employer and employee an incentive to work in concert to shift to a form of compensation with terrible mal-incentives and burdensome expenses without any advantage from an increased value of payout dollars. Employees accept the burdensome costs of insurance only because of the government’s reimbursement in the form of the tax savings from avoidance of tax on compensation. Exclusions that induce mal-incentives and burdensome costs are unjustified in times of annual deficits that are larger than the rate of growth of national wealth. But then they are also never justified.

4. Defensible for involuntary large costs? Even large costs are inflated by insurance because large costs are free to the patient and not undesirable to the provider of the medical goods and services. Still, the fundamental argument as to medical shocks is that they are not themselves voluntary. Again, no one seeks heart arrhythmia to get a pacemaker or cancer to get the chemo, or breaks a leg to get a pin or a cast. For the large costs and for life-or-death issues, but not for average costs, the dollar that pays the expense has an extra value over the dollar that paid the premium. An extraordinary medical cost does not necessarily mean that the insurance payout is giving more valuable dollars, but the size of the cost does track with a tendency for the costs to hurt more than that dollar of premium hurts.

5. Recommendation for insurance. The proposal would conform employer-provided health insurance to the extraordinary-ordinary distinction. Employer-provided insurance that qualifies for the exclusion from employee income would not cover the ordinary medical expenses, defined according to the median percentage of AGI. Premiums for insurance that covered ordinary medical expenses, or employer payments of ordinary medical expenses, would be taxable compensation. The tax advantages for medical health accounts and flex accounts that cover costs that are lower than the new required high deductible would be repealed. Only extraordinary and catastrophic medical expenses above the new 15 percent of AGI threshold would be deductible or covered by employee-excludible insurance.

An employer would be free to provide insurance that covers an employee’s ordinary medical costs, but the premium would have to be reported as part of the employee’s compensation. The insurance company, employer, and employee working together have an incentive to cover ordinary medical costs to extend the exclusion of compensation. With all the parties willing to push for replacing taxable compensation with untaxed medical benefits, the line between coverage of ordinary and extraordinary expenses cannot be enforced by the IRS. Thus, it is necessary to disqualify all employer-provided insurance unless the plan prohibits the coverage of expenses under the new 15 percent threshold. The employer would need to provide the insurance for ordinary medical costs from some other insurer, outside the group of related insurance companies, or by reimbursement of employee expenses directly and in both cases with taxable amounts.

Insurance can be a gain event. If the employee gets payouts that exceed the premiums, paid or previously taxed because they are for insurance coverage of ordinary costs, the employee would have additional compensation at that time. Health insurance premiums usually expire after an annual

term, so gain on the insurance can be computed annually as payouts less premiums.\textsuperscript{18} The gain on insurance in a year might get the employee over the 15 percent threshold and thus be excluded by the deduction for extraordinary medical expenses, but otherwise the gain would just be compensation.

If the employee loses on his insurance because premiums were larger than the payout for the year, the traditional treatment is that the employee has no recognized loss because he has purchased peace of mind. People rationally buy losing insurance, which makes the insurance company some profit, just for the peace of mind. An alternative model would view insurance as purely a wagering transaction in which the taxpayer would have a loss when expired premiums exceed the payout. If money outcomes are the primary calculus in tax, losses of expired premiums in excess of payouts are appropriate deductions. I prefer (but not strongly) the former model, not treating premiums that exceed costs as a loss, and only because insurance mal-incentives and expenses for ordinary medical costs make it reasonable to lean against insurance in the tax treatment.

6. Conforming supplemental tax benefits. In addition to exclusion of employer-provided insurance and the itemized deduction, Congress has enacting supplemental tax provisions that allow an individual to cover medical costs with untaxed money even below the 10 percent threshold and in the absence of general employer medical insurance coverage. The proposal would conform the supplemental provisions so that payments below the new 15 percent threshold would be made with after-tax monies.

Section 125 allows a taxpayer to use a cafeteria plan, converting taxable salary into untaxed payments of medical expenses, by an election before the tax year starts.\textsuperscript{19} Cafeteria plans are use-it-or-lose-it plans.\textsuperscript{20} The election is like deciding to go to work for an employer with a generous plan but lower salary, rather than for an employer with a stingy plan but higher salary. The medical expenses from the cafeteria plan must be incurred within three-and-a-half months (April 15) of the following year, or the contribution is lost to the employee.\textsuperscript{21} The medical expense must have a high degree of probability for the election to be rational: The employee should be sure she will use the elected amount at above the likelihood of 1-t, where t is the tax rate.\textsuperscript{22}

Cafeteria plans may not be used for long-term care insurance.\textsuperscript{23} The Affordable Care Act limited the deductible contributions for healthcare to $2,500.\textsuperscript{24}

The only value of the cafeteria plan is to gain tax-free payment of medical expenses when the expenses do not exceed the current 10 percent of AGI threshold and the standard deduction. The use-it-or-lose-it feature of cafeteria plans makes them even more wasteful than normal tax-free spending because a taxpayer often has to go into a last-minute buying frenzy to purchase eyeglasses or some medical device by March 15 or forfeit her contribution. Because the rationale of this proposal is that the taxpayer needs to bear her own ordinary medical expenses out of after-tax money, the proposal would amend section 127(f) to take medical expenses out of employee cafeteria plans.

Section 223 allows a taxpayer to create a health savings account, deducting the contributions to the plan, investing the contributions tax-free, and excluding the payout from the plan if used for medical expenses for an employee under a high deductible medical plan. A high-deductible plan must leave $1,000 for the insured single employee to pay ($2,000 for a family plan). Contributions in any year cannot exceed $2,500 ($4,500 for a family). The only penalty for retirees who withdraw in excess of medical expenses is inclusion in income, thus it is rational for an employee to use section 223 as an enhanced pension plan even beyond medical needs.\textsuperscript{25} Because the intended function of HSAs is to make ordinary medical expenses tax-free and the rationale of this proposal is that the taxpayer needs to bear his own ordinary medical expenses out of after-tax money, the proposal would repeal section 223.

\textsuperscript{22}When an employee has elected to cover $100 in medical expenses, he has incurred $100 less tax savings of t (for tax rate), or $100 x (1-t), whether he ultimately incurs the medical expense or not. Without the election, assume the employee has “m” chance of incurring a medical expense of $100 without the tax savings and (1-m) chance of incurring no cost. The expected value without the election is m x 100 + (1-m) x 0, which equals the sure cost with the election of $100 x (1-t): m x $100 = (1-t) x $100. So m chance must exceed (1-t) for the election to make sense. For a 15 percent bracket taxpayer, the employee needs to have better than 85 percent chance of needing the expense for the cafeteria plan election to be rational.

\textsuperscript{23}Section 125(f).

\textsuperscript{24}ACA section 9005(a)(1)-(2).

\textsuperscript{25}Henry J. Aaron et al., “What’s in a Name? Are Health Savings Accounts Really Health Savings Accounts?” in Using Taxes to Reform Health Insurance: Pitfalls and Promises 56 (2008) (arguing that contributions to HSAs are good tax planning beyond health costs, although the advantage is not fully exploited).

\textsuperscript{18}If an insurance premium does not expire in full by the end of the tax year, only the expired cost would be allowed to offset the nondeductible medical expenses. The unexpired premium would be adjusted basis carried over to future years.

\textsuperscript{19}Prop. reg. section 1.125-5.

\textsuperscript{20}Id.

\textsuperscript{21}Notice 2005-42, 2005-1 C.B. 1204.