IRET Congressional Advisory

INSTITUTE FOR RESEARCH ON THE ECONOMICS OF TAXATION

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HEALTH BILLS' TAX INCREASES WOULD HARM HEALTH CARE AND THE ECONOMY

If Congress ultimately passes a health care bill along the lines of what the House narrowly voted for in early November (the 1,990 page "Affordable Health Care for America Act," H.R. 3962) or the Senate is debating currently (the 2,076 page "Patient Protection and Affordable Care Act," H.R. 3590), Washington would greatly expand its control over and financing of health care in America, through both direct government spending and new requirements on employers, individuals, insurers, and health care providers. Either bill would enormously increase the government's financing needs, as well as its power over the citizenry, moving the United States several giant steps toward a European-style welfare state.

The bills also raise concerns because in important ways they would conflict with, not advance, their stated objectives. The three main goals are lowering the cost of health care, improving the quality of care, and enhancing access to care.

The focus of this paper will be on how the tax increases in the bills would alter people's incentives and, thereby, change their work, saving, and investment decisions. Before turning to tax effects, though, it may be useful to consider a few problems with the bills on the cost front, in order to provide background and indicate why, even if tax distortions are ignored, the House and Senate bills would be unlikely to achieve their stated objectives.

Some cost issues

The Obama Administration insists that reducing costs is, and must be, one of the "guiding principles" of its health care plan. "Comprehensive health care reform can no longer wait. Rapidly escalating health care costs are crushing family, business, and government budgets."[1] Unfortunately, a massive new federal entitlement program is unlikely to result in lower costs.

- The director of the Congressional Budget Office (CBO), Douglas Elmendorf, stated in testimony before the Senate Budget Committee in July, "In the legislation that has been reported we do not see the sort of fundamental changes that would be necessary to reduce the trajectory of federal health spending by a significant amount. And on the contrary, the legislation significantly expands the federal responsibility for health care costs... [T]he curve is being raised."[2]

- Mr. Elmendorf has since noted that CBO only estimates government costs, and that it does not estimate what may be a more important cost curve: the one pertaining to total national health care spending (government and private).[3] Because a new federal entitlement program could substitute to some degree for private spending, it is possible, in theory, that a government program might not raise total spending – provided the government makes more efficient choices and is better at combating waste and fraud than private firms and individuals who have their own money at stake. In reality, however, the government would almost certainly push up total spending: it is usually less efficient and more wasteful than private firms and individuals precisely because elected officials and government bureaucrats are not spending their own money. A study by the

government's Centers for Medicare and Medicaid Services (CMS) estimates that the House bill would boost total health care spending (government and private) by $289 billion over the 2010-2019 period.[4]

• CBO estimates that the House and Senate bills would increase gross federal health care subsidies by $1,052 billion and $848 billion, respectively, over the 2010-2019 period.[5] The numbers would be higher except for several recent tweaks to hold down reported outlays, as well as numerous budget gimmicks that are unlikely to lower federal expenditures in the real world but count as but though they do based on official budget scoring rules. For example, the House bill includes drastic cuts in Medicare payments to hold down its estimated costs. The CMS study found the cuts are so extreme that some "institutional providers (such as acute care hospitals, skilled nursing facilities, and home health agencies)," might be forced to stop seeing Medicare patients, "jeopardizing access to care for [Medicare] beneficiaries..."[6] If Congress were to pass H.R. 3962 and later restore some or all of the Medicare funds, actual outlays would exceed current government estimates by several hundred billion dollars.

• A previous IRET study noted that large health care subsidies like those in the House and Senate bills would reduce the apparent price of health care, and people would respond to the subsidized prices by demanding more health care. [7] The IRET study estimated that the subsidies in an earlier version of the Senate bill would boost health care demand by 2.3% to 3.1%. In addition, as higher demand pushed health care providers out along their supply curves, providers' unit costs would rise and they would charge more per unit of health care. The price effect would also increase costs for the trillion dollars of health care the government already pays for, and raise the revenue cost of the current-law tax break for employer-provided health insurance. Because the subsidies would push up the quantity of health care demanded and boost the price per unit, they would be far more costly than government estimators predict. CBO has recently admitted that it did not include any unit cost increase or any spillover effect on other federal health programs in its score of the House and Senate bills.[8] The IRET study estimates that the extra costs due to greater utilization and higher unit expenses would be hundreds of billions of dollars over the next decade.

• With the exception of the Medicare Part D program, which emphasized competition among providers, new health care programs in this country almost always cost far more than advance estimates. A study by Congress's Joint Economic Committee offers a number of examples. For instance, Congress estimated in 1967 that Medicare would cost $12 billion by 1990, but actual 1990 spending was $120 billion; Congress estimated in 1987 that Medicaid's disproportionate share hospital (DSH) payments would cost less than $1 billion in 1992, but actual 1992 spending was $17 billion; and Congress estimated in 1988 that Medicare's home care benefit would cost $4 billion in 1993, but actual 1993 spending was $10 billion.[9]

• Thirty states have discovered a way to lower health care expenditures while simultaneously increasing access to physicians: malpractice reform, the centerpiece of which is limits on damage awards and attorneys' fees. That key win-win reform has been left out of the House and Senate bills. The Senate bill pays only lip service to malpractice reform with a toothless sense of the Senate provision (H.R. 3590, sec. 6801). The House bill actually contains a poison pill (H.R. 3962, sec. 2531). It would create a financial incentive supposedly for malpractice reform, but then deny the money to states that impose limits on damage awards and attorneys' fees. The provision would encourage states that already have successful limits to repeal them and discourage other states from adopting limits.[10] When former Democratic National Chairman and physician Howard Dean was asked why the Obama Administration and congressional Democrats are so cool to malpractice reform, he explained, "The reason tort reform is not in the bill is because the people

who wrote it did not want to take on the trial lawyers..."[11]

Tax Increases

Despite the bills' huge increases in government spending, CBO scores them as reducing the federal deficit, with estimated 10-year deficit reductions of $138 billion for the House bill and $130 billion for the Senate bill.[12] The explanation is that the bills couple their extra federal spending (whose magnitude government budgeteers underestimate) with massive tax increases.

The most talked about tax provisions in the bills are the House bill's proposed 5.4% surtax on individuals' adjusted gross income (AGI) above $500,000 ($1 million for joint filers), and the Senate bill's proposed 40% tax on a portion of health insurance premiums in high-cost employer-provided plans. The bills also contain a long list of other revenue raisers. Table 1 shows the tax increases in the House bill, along with 10-year revenue estimates by CBO and Congress's Joint Committee on Taxation (JCT).[13] Table 2 presents a similar list for the tax hikes in the Senate bill.[14]

In combination with the bills' direct government spending and government mandates, the proposed taxes would transfer great quantities of economic resources from individual control to government control. In addition, the taxes would change people's after-tax rewards for work, saving, and investment. Because people respond strongly to incentives in deciding how much and where to work, invest, consume, and save, the taxes in the House and Senate bills have the potential to affect economic behavior throughout the economy. For instance, a person debating whether or not to start a small business examines taxes as one of the factors influencing the decision, and a person who already has a small business considers the tax consequences when evaluating a possible expansion that would involve hiring more workers and investing in more plant and equipment. The taxes would also shift some jobs and investments abroad because businesses

Table 1 Tax Hikes In H.R. 3962 (House Health Care Bill)
Estimates For 2010-2019 (In Billions)

Provision	Estimate
5.4% Surtax on Individuals' Modified AGI in Excess of $500,000 ($1,000,000 for joint returns)	$460.5
Tax on Businesses Not Providing Employees With Government-Approved Health Insurance	135.0
Tax on Individuals Without Government-Approved Health Insurance	33.0
2.5% Excise Tax on Medical Devices	20.0
$2,500 Annual Cap on Flexible Spending Accounts (FSAs)	13.3
Prohibit the Purchase of Non-Prescription Medicines Using Health Savings Accounts (HSAs), FSAs, and Certain Other Plans	5.0
Prohibit Businesses from Deducting Expenses Allocable to Medicare Part D Subsidy	2.2
Fee on Health Insurance Policies (Including Self-Insured)	2.0
Increase Penalty to 20% for Nonqualified Distributions from HSAs	1.3
Exclusion of Unprocessed Fuels from the Cellulosic Biofuel Producer Credit	23.9
IRS Reporting of Payments to Certain Businesses	17.1
Override U.S. Tax Treaties on Certain Payments by "Insourcing" Business	7.5
Repeal Implementation of Worldwide Interest Allocation	6.0
Codify Economic Substance Doctrine and Impose Penalties	5.7

Sources: Joint Committee on Taxation and Congressional Budget Office.

Table 2 Tax Hikes In H.R. 3590 (Senate Health Care Bill) Estimates For 2010-2019 (In Billions)	
40% Excise Tax on a Portion of "Cadillac" Employer-Provided Health Insurance Plans	$149.1
Tax on Health Insurers	60.4
Extra Medicare Payroll Tax of 0.5 Percentage Points on Income Over $200,000 (($250,000 for Joint Filers)	53.8
Penalties on Employers and Individuals Not Providing or Buying Government-Approved Insurance	36.0
Excise Tax on Brand Name Prescription Pharmaceuticals	22.2
Excise Tax on Medical Devices	19.3
IRS Reporting of Payments to Certain Businesses	17.1
Limit Itemized Deduction for Medical Expenses	15.2
$2,500 Annual Cap on Flexible Spending Accounts (FSAs)	14.6
5% "Botox" Tax (Excise Tax on Cosmetic Procedures)	5.8
Disallow Deduction for Employer-Provided Drug Coverage When Combined with Medicare Part D	5.4
Prohibit Purchases of Non-Prescription Medicines Using HSAs, FSAs, and Certain Other Plans	5.0
Increase Penalty to 20% for Nonqualified Withdrawals from HSAs	1.3
Prohibit Health Insurers from Deducting Employee Compensation In Excess of $500,000	0.6
Limit Tax Deduction of Blue Cross/Blue Shield Companies	0.4
Excise Tax on Charitable Hospitals	---
Sources: Joint Committee on Taxation and Congressional Budget Office.	

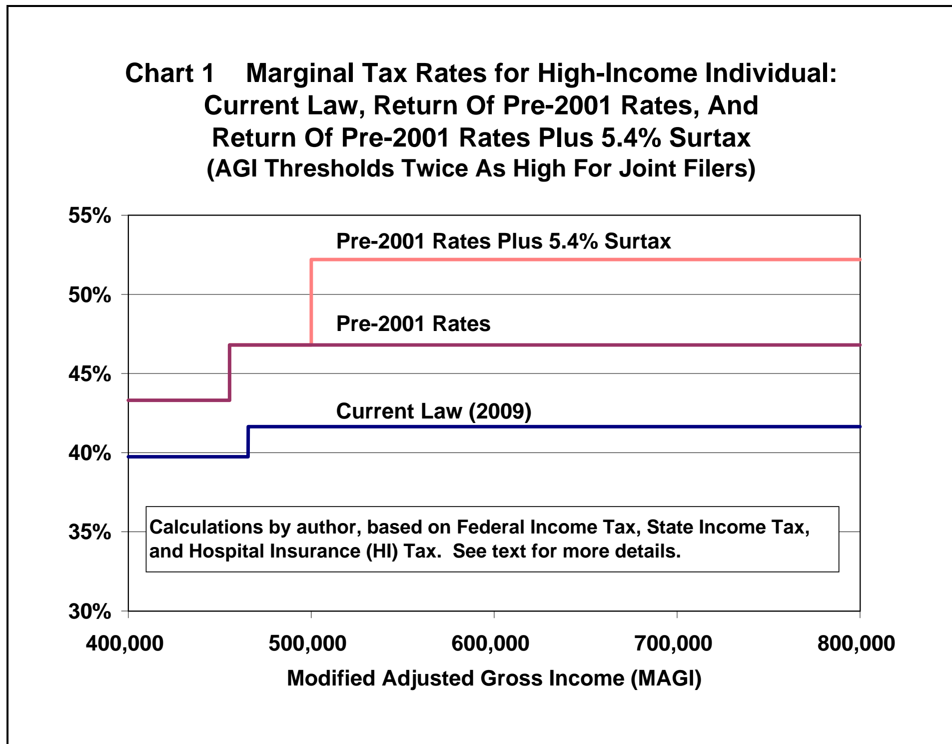
take U.S. and foreign tax and regulatory climates into consideration when deciding whether to produce in the United States or elsewhere.

The tax rates that most influence people's decisions are those at the margin because they are the rates that determine the size of after-tax rewards and penalties when people change their behavior.[15] This paper examines eight tax provisions in the bills. All would raise marginal tax rates, and in some cases the jumps would be astonishingly large. Seven of the taxes are strongly at odds with good economic policy, but one controversial provision would partially offset an existing tax bias.

5.4% Surtax on Individuals' Adjusted Gross Income above $500,000 ($1 Million for Joint Filers) (H.R. 3962, sec. 551). In 2007, Rep. Charles Rangel (D-NY), the Chairman of the House Ways and Means Committee, unveiled what he called the "the mother of all tax reforms" and his critics called a giant tax hike.[16] The rejected proposal's centerpiece was a 4% to 4.5% surtax on high-income individuals. The House Democratic leadership has now recycled the idea and made it the largest revenue raiser in H.R. 3962. Two differences from Mr. Rangel's earlier suggestion are that the currently proposed surtax would charge a steeper rate – 5.4% – and begin at a higher AGI. (Technically, H.R. 3962's surtax would be based on modified AGI, defined for this provision as AGI minus qualified investment interest expenses.) Congress's JCT scores the provision as collecting $460.5 billion in added taxes over 10 years.[17]

Surtax raises marginal tax rates. Chart 1 shows the impact the surtax would have on marginal tax rates for high-income single individuals. The chart depicts three marginal tax rate "skylines". The bottom skyline is based on current law, and includes federal income tax, state income tax, and federal hospital insurance (HI) tax.[18] The combined marginal tax rate is 39.7% for taxpayers in the 33% federal income tax bracket and 41.6% for taxpayers in the 35% federal income tax bracket. The middle skyline shows the sizable rise in marginal tax rates if, as expected, Congress allows the top two income tax brackets to revert to their pre-2001 levels of 36% and 39.6% and lets the pre-2001 itemized deduction limitation return. For people in the top federal

income tax bracket, their combined marginal tax rate would climb by 5.2 percentage points to 46.8%.[19] The highest skyline displays the return of old law plus the House bill's 5.4% surtax in addition to that. For people in the top federal income tax bracket, their marginal tax rate would jump by 10.6 percentage points compared to current law to 52.2%.



Surtax poisons capital gains. Capital gains could also trigger the surtax because capital gains are included in AGI. (Capital gains are separated from ordinary income later in the normal tax calculation.) The top tax rate on capital gains is currently 15%. If Congress does not intervene, pre-2001 law will return in 2011, and the top capital gains tax rate will rise to 20%. The surtax would push the top rate up to 25.4%. That is 10.4 percentage points above current law, and would represent a 69% increase in the maximum capital gains tax rate. The rate on dividends would jump from 15% to as much as 39.6%, a 164% increase.

Surtax and the alternative minimum tax (AMT). Although the surtax is clearly a tax as most people define the term, H.R. 3962's statutory language says the surtax "shall not be treated as tax" for purposes of the AMT calculation. Therefore, paying the 5.4% surtax on income would in no way reduce a taxpayer's AMT liability. Put another way, whether a person is subject to the AMT or not, he must pay the additional surtax on AGI.

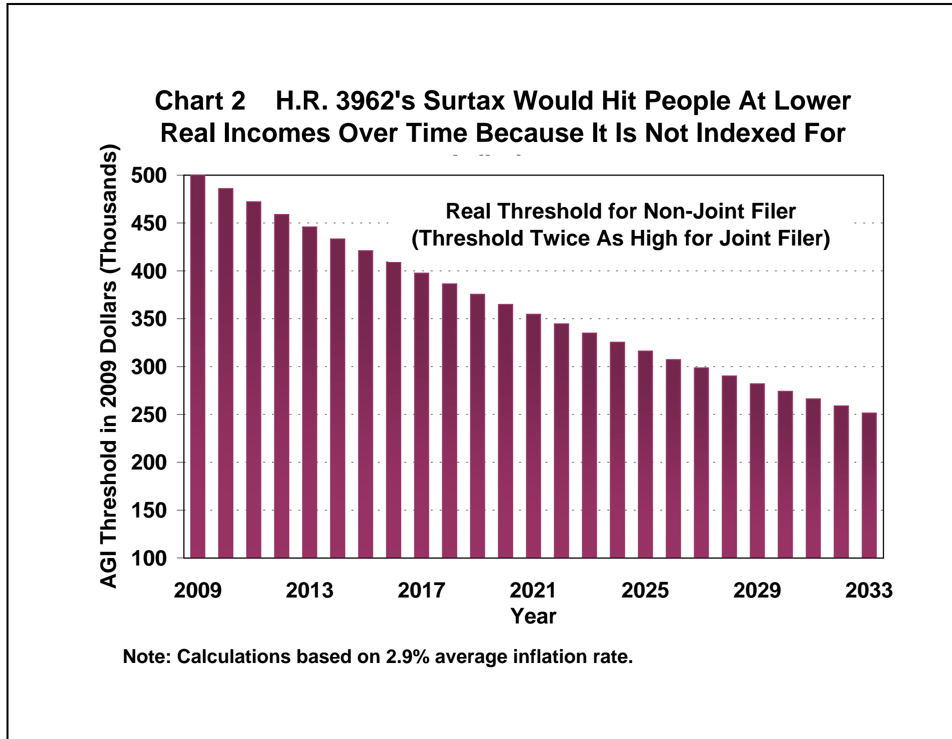
Surtax not indexed for inflation. The House has not indexed the surtax threshold for inflation. Hence, people would owe the surtax at progressively lower real incomes over time due to inflation. Taxpayers have already seen this problem with the AMT. Congress originally promised that the AMT would only be assessed on a few hundred super-rich individuals, but the AMT now hits millions of middle-class households due to inflationary creep. Chart 2 shows how, in 24 years, inflationary creep would cut in half the real income at which the surtax begins if inflation averages 2.9% a year (the actual inflation rate over the past 24 years). Given our large budget deficits and the enormous expansion of the money supply in recent years, it is likely that future inflation will exceed this past inflation average.

Surtax would weaken economy. These are huge marginal tax rate increases and high-income individuals can be expected to respond vigorously, especially because they have considerable flexibility in how much they work, how they are compensated, and how much and in what forms they save and invest. They would reduce their work hours, retire earlier, cut back their saving, and become more reluctant to invest. The larger tax bite would also motive many high-income individuals to take more compensation in tax-favored forms (legal tax avoidance) and persuade some to hide income (illegal tax evasion).

The reductions in work effort, saving, and investment would weaken the U.S. economy, especially because people with high incomes usually earn those incomes as a result of being uncommonly

productive, and they undertake a disproportionate share of the nation's saving and investing. Because of the surtax's negative effects on productive inputs, the nation's output would be lower, productivity less, jobs scarcer, before-tax incomes smaller, and growth slower.

As the surtax shrank the size of the U.S. economy compared to its size otherwise, the cost to the economy would considerably exceed the explicit surtax liabilities. Much of the economic burden of the tax would be shifted to lower- and middle-income people in the form of lower wages. They would not pay the surtax explicitly, and might (mistakenly) believe they escape it, but it would reduce their incomes nevertheless.[20] For example, if the surtax deterred a small-business owner from expanding and hiring more workers (many of the people paying the surtax would be successful small-business owners), it is likely that most of the people losing job opportunities as a result would be lower- or middle-income workers. This is a particularly serious concern because small businesses account for an outsized share of the nation's jobs and job growth. Or if the surtax caused a high-income individual to save less and forgo a capital investment, much of the burden would be shifted to lower- and middle-income workers who would be less productive, and therefore earn less, because they would have less capital with which to work. (Empirical analysis of production in the U.S. economy indicates that about two-thirds of the returns from capital investments flow to labor because the added capital makes workers more productive and, hence, able to command higher compensation.[21])



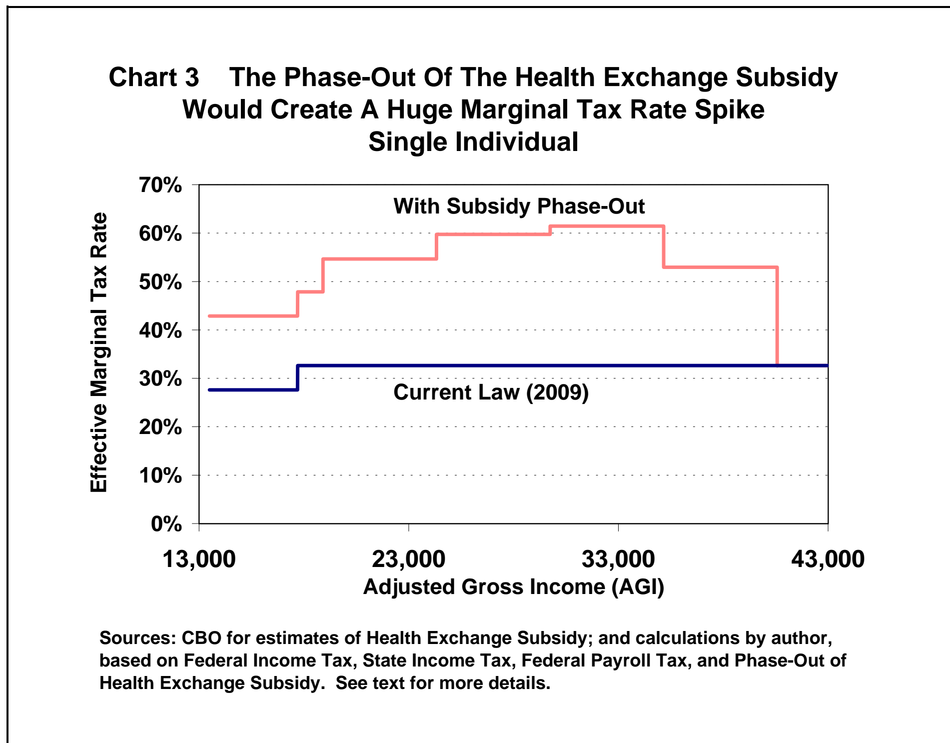
<u>Surtax revenues reduced by adverse economic feedbacks.</u> Even if one's only interest in taxes is how much they collect, the surtax has major problems. In scoring tax bills, government revenue estimators assume that taxes may cause some "microeconomic" responses, such as a shift among types of investments or more consumption of one product and less of another, but that taxes never cause any changes in macroeconomic magnitudes, such as total output, national income, total saving, total investment, and total employment. Some years ago, government revenue estimators were forced to admit that even if Congress enacted a 100% tax, the official revenue estimating methodology assumed that complete confiscation would cause no slackening whatsoever of work effort or investment, cost no jobs, and lose no revenues through negative macroeconomic feedbacks.[22]

Because the proposed surtax would greatly boost marginal tax rates and do so for a population that has already been sensitized to tax consequences by the large taxes they now pay, that neglect of macroeconomic feedbacks is certain to produce an overestimate of revenue collections. On capital gains and dividend income, the surtax would probably lose revenue, judging by the results of three recent IRET studies that empirically examined dynamic feedbacks when the capital gains tax rate changed in the past.[23] Although it is not clear if the surtax would,

on the whole, end up raising or lowering federal revenues when all dynamic feedbacks are considered, it is safe to predict that the revenue take would be far below the $460 billion estimate and leave a very large hole in the House bill's financing, further increasing the federal deficit and undoubtedly generating calls for additional taxes.

Health insurance subsidies for individuals (H.R. 3962, sec. 341-345). The House bill would establish health insurance exchanges that would offer people health insurance policies, with one option in each exchange being a government plan. Individuals who did not have employer-provided health insurance and obtained coverage through an exchange would be eligible for "individual affordability credits" if their incomes were below 400% of the poverty level. Income would be measured by AGI (slightly modified), and the subsidies would commence in 2013.

The legislation specifies that for a person at 133% of the federal poverty level, the subsidy would be sufficient to limit the person's premiums for a basic plan to 1.5% of AGI and cap out-of-pocket expenses (cost sharing) at $500. The subsidy would decrease with rising income. By 400% of the poverty level, the subsidy would limit the person's premiums for a basic plan to 12% of AGI and cap out-of-pocket expenses at $5,000. People with higher AGIs would receive no subsidy. Because the Senate bill also includes subsidies that would phase-out with income, the observations below about the subsidies in the House bill also apply to the Senate bill, although the specific numbers differ.



Subsidy phase-outs impose huge tax rate spikes. The subsidy is akin to a negative tax. Because the government would curtail it as an individual's income rose, the loss of the subsidy would be equivalent to a special income tax on additional earnings within the phase-out range. Further, the tax and its marginal rate would be extremely high because the subsidy would initially be very large. CBO has provided estimates of the subsidies at seven income levels in 2016, from which implicit marginal tax rates due to the phase-out may be calculated.[24] For example, CBO estimates that a family of four with a 2016 income of $54,000 (about 225% of the poverty level) would receive a health exchange subsidy of $14,300, but that the subsidy would drop to $10,500 by the time the family's 2016 income reached $66,000. The $3,800 subsidy loss over a $12,000 income range would generate an implicit marginal tax rate due to the phase-out of 31.67%.

Chart 3 shows the impact of the subsidy's phase-out on single individuals below 400% of the poverty level who buy their own insurance through a health insurance exchange. The bottom "skyline" is based on current law, and includes federal income tax, state income tax, and federal payroll (OASDI) tax.[25] The combined marginal tax rate is 27.6% for individuals in the 10% federal income tax bracket, rising to 32.6% for individuals in the 15% federal income tax bracket

and 42.6% for individuals in the 25% federal income tax bracket. The upper skyline adds in the implicit marginal tax rate due to the phase-out of the health exchange subsidy. As can be seen, the phase-out produces staggeringly high marginal tax rates. Throughout the subsidy phase-out range, the combined marginal tax rate is over 40%; it is well above 50% across most of the range; and it is close to or above 60% for individuals with incomes between about $24,000 and $35,000.

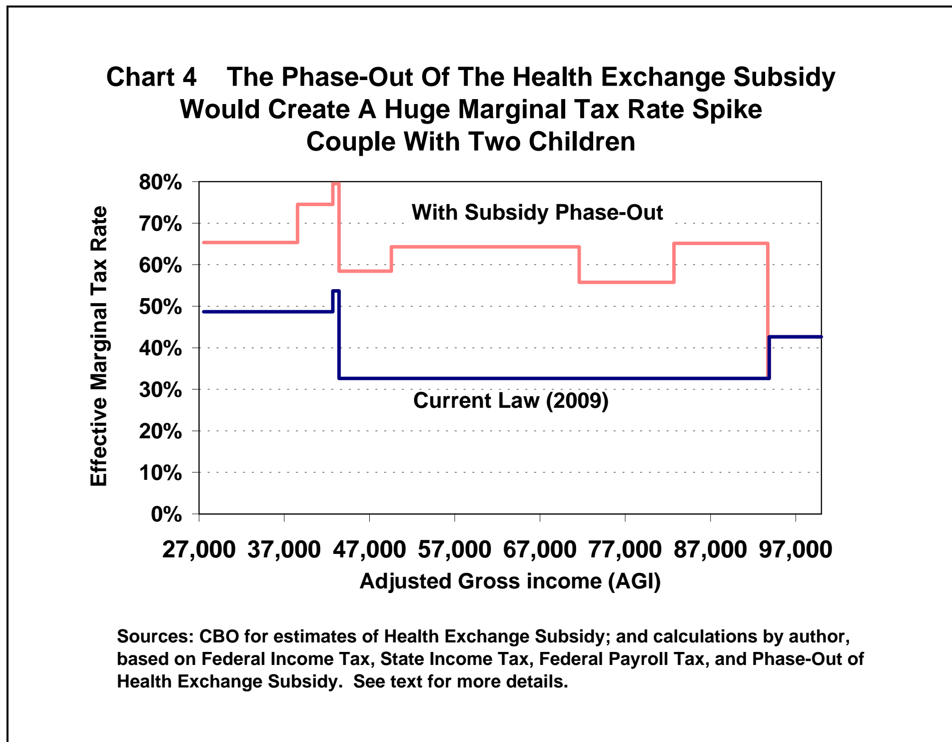


Chart 4 shows the phase-out's impact on a family of four who buy their own insurance through a health insurance exchange. As before, the bottom "skyline" is based on current law, and includes federal income tax, state income tax, and federal payroll (OASDI) tax.[26] Initially, the family is in the 10% federal income tax bracket, but its combined marginal tax rate is extremely high (almost 49%) due to the phase-out of the Earned Income Tax Credit (EITC), which the family loses at a 21.06% marginal rate. (For a couple with two children, the EITC phases out between earned incomes of $19,540 and $43,415 in 2009.) The marginal rate jumps further when the family enters the federal income tax's 15% bracket. Once the EITC has phased out, the family's combined marginal tax rate under current law drops to just under 33%. It rises to 42.6% when the family reaches the federal income tax's 25% bracket at an AGI (in this example) of about $94,000. The upper skyline adds in the implicit marginal tax rate due to the phase-out of the health exchange subsidy.[27] As can be seen, the phase-out of the health exchange subsidy produces staggeringly high marginal tax rates over a broad range of lower- and middle-incomes: always above 55%, usually above 60%, and sometimes above 70%.

The charts actually understate the spikiness of the marginal rate "skyline". The charts are drawn as though the subsidy smoothly phases out between the pairs of incomes for which CBO provides subsidy estimates. In practice, the phase-out would have some "cliffs", in which a few dollars of added income would cut the subsidy by hundreds or thousands of dollars, resulting in stratospheric marginal tax rates in the immediate vicinity of the cliffs. (The cliffs would be mainly associated with the part of the subsidy applying to out-of-pocket expenses.) Also, the chart does not show that while most people earning less than 150% of the poverty level could obtain free Medicaid coverage under the bill's provisions, they would suddenly lose the free Medicaid coverage if they earned even a few dollars over 150% of the poverty level.

Subsidy's phase-out creates dependency trap. The subsidy's income-based phase-out would heavily penalize many lower- and middle-income people for working and saving. From their perspective, the government would initially give them a subsidy worth thousands of dollars, but then rapidly take away the subsidy if they worked and saved, based on their earnings. Because of the steep implicit tax, many people within the phase-out range would conclude that work and saving hardly pay, and they would reduce their productive efforts to keep more of the subsidy. That would create a dependency trap for millions of lower- and middle-income people. The

resulting drop in work and saving would lower production and income for the nation as a whole.

The phase-out promotes tax cheating. The magnitude of the phase-out would also encourage many lower- and middle-income people to work off the books because a dollar of income under the table would often be worth two or two-and-a-half dollars over the table. Inadvertently but powerfully, the subsidy's phase-out would be an invitation to join the underground economy. Tax cheating, which is already a problem, would become considerably worse.

40% Excise Tax on High-Cost, Employer-Provided Health Insurance Policies (H.R. 3590, sec. 9001). This is the largest single revenue raiser in the Senate bill. Congress's JCT estimates it would collect $149 billion between 2013 and 2019.[28] The tax would initially be assessed on premiums above $8,500 for single policies and $23,000 for family policies (with higher limits for the elderly, certain occupations, and certain high-cost states). The thresholds would subsequently increase by the inflation rate plus one percent.

Although this provision is controversial and would make high-cost, employer-provided health insurance policies more expensive, it would, somewhat surprisingly, lead to a more efficient allocation of scarce economic resources. The reason is that it would partially offset a current-law tax bias.

Under current law, workers pay income and payroll taxes on most of their compensation but pay no income or payroll taxes on employer-provided health insurance. Because of health insurance's tax-free status, employers are more likely to provide it than otherwise and more likely to offer expensive, high-coverage policies. Further, once workers have high-coverage policies that minimize out-of-pocket costs, they tend to overutilize health care services and be largely unconcerned about what physicians, institutions, and other service providers charge because additional services look inexpensive to them at that point.

Resource allocation would be more efficient if employer-provided health insurance were treated like other compensation and the revenue from taxing it were used to reduce general tax rates. People would then buy health care only up to the point where the last dollar spent on it was worth $1 relative to the other goods and services that could be bought with the $1, and people would be more conscious of prices, hence better shoppers, when seeking health care services. These responses would lower societal health care expenditures.

If one wishes to retain the current-law tax treatment for most people while dealing with those cases where resource misallocations are greatest, a reasonable option would be to cap the tax-free fringe benefit, set the cap substantially above the average premium so it only applies to people with generous "Cadillac" policies, and then include in employees' taxable incomes the portion of high-coverage policies that exceed the cap. In a roundabout way, the proposed excise tax in the Senate bill would roughly do this. Hence, from a public policy standpoint, the excise is not unreasonable.

The tax's main economic drawback is that its revenues would be deployed to expand the size of government rather than being used to fund reductions in other taxes. A second drawback is that it would be less transparent to citizen/voters than an explicit cap on tax-free employer-provided health insurance.

"Employer responsibility" excise tax (H.R. 3962, sec. 401-424). The House bill would require that employers either provide their workers with health insurance or pay a fine. To meet the insurance requirement, the employer plan would need to be government approved, and the employer would have to pay at least 72.5% of a standard plan's cost for employees with single coverage and at least 65% for employees with family coverage. If a plan is not government approved or the employer's contribution is below the minimum, the employer would have to pay a special excise tax if its payroll exceeds $500,000. The excise tax's rate would begin at 2% of the firm's average wages but quickly rise to 8% for businesses with payrolls above $750,000.[29] The brackets would start at progressively lower real payrolls over time because they are not indexed for inflation. The requirement would begin in 2013, and CBO estimates that businesses would pay $135 billion in fines over the years 2013-2019.[30]

The proposed excise tax would clearly increase costs, by up to 8% of payroll, for businesses that do not now offer health coverage. In the long run, many businesses could shift the tax (or the cost of insurance if they decide to offer it) to workers through smaller increases in cash wages, but until that happened, the businesses would be squeezed financially.[31] The option of reducing cash wages would not exist for firms paying at or near the minimum wage. Some employers would respond to the government-mandated cost increase by laying off current workers or hiring fewer new workers. Further, to avoid the mandate or qualify for a tax rate of less than 8%, some business owners would forgo expansion opportunities and invest less in order to stay very small. As a result, the play-or-pay requirement would hurt employment and lower the nation's output. Because young workers and low-skill workers are among the groups most likely to work for firms that do not now offer health benefits, they are also two of the groups most likely to have greater difficulty finding jobs if the "employer responsibility" provision becomes law.

The proposed excise tax would also cause several problems for businesses that already offer health insurance, inducing some of them to hire fewer workers or pay lower wages and salaries. Many firms would have to sweeten low-cost plans to satisfy minimum government mandates. Although the bill's authors claim no employer would be forced to drop an existing policy (sec. 202, "protecting the choice to keep current coverage"), the safe harbor would only last five years and be voided sooner if an existing policy enrolled any new employees or it changed. After that, the business would need to determine whether its existing coverage met H.R. 3962's specifications, and, if not, the business would either have to pay the tax or change the coverage, even if employees wanted to keep their existing coverage. Among the policies threatened are relatively inexpensive high-deductible policies (usually linked to health savings accounts). Their loss would be regrettable because high-deductible policies have the desirable properties of protecting workers against catastrophic losses (the core purpose of insurance), being affordable, and motivating people to be careful shoppers when buying routine medical services. Labor costs for businesses now offering employee health insurance would also rise because the House bill would require employers to provide health coverage to part-time employees, and presumably temporary employees, or be fined, although required benefits would be less for part-time employees than full-time ones. Currently, many employers that provide health coverage to full-time employees do not offer it to part-timers, and even fewer offer it to temporaries. In addition, all businesses providing health coverage would have the paperwork costs and headaches of creating and maintaining records for every employee so they could prove in government audits that they were furnishing the required coverage.

In some cases, employers that now provide coverage would conclude that they could save money by dropping coverage and paying the fine. That would inconvenience employees, and, if the employees qualified for large government health-care subsidies under another section of the House bill, it would be a financial drain on the government's budget. CBO expects few workers to be shifted over to the exchange-based, subsidized plans. If millions of additional workers shift, CBO's cost estimate will be blown sky high.

The Senate bill also contains play-or-pay requirements for employers and individuals (H.R. 3590, sec. 1511-1515). The details somewhat differ from those of the House bill, but the proposed mandates would cause similar problems.[32]

Excise Tax on Medical Devices (H.R. 3962, sec. 4061; H.R. 3590, sec. 9009). The bills would impose an excise tax on medical devices, with the tax collected at the manufacturing level. The House bill would set the tax rate at 2.5%, and collect an estimated $20 billion over 10 years.[33] The Senate bill would base the tax rate on a more complicated formula, but the estimated 10-year revenue take, $19 billion, would be almost the same.[34] The bills would have an exception for devices purchased at retail stores by the general public. This tax is intended to be major revenue raiser. However, its presence in the House and Senate bills is contrary to the goals of reducing medical costs and increasing quality. In essence, it would be a levy on beneficial and important medical-technology tools, such as pacemakers, fetal monitors, surgical microscopes, MRI equipment, and stethoscopes.

Who would bear the tax? If manufacturers and suppliers at later production stages were able to pass the tax on to patients, that would raise medical costs by the amount of the tax; patients would bear the tax. Half of medical care is paid by private patients and their insurers. But half is paid by government through Medicare, Medicaid, VA hospitals, and other programs. The government would be taxing itself. That fact is not taken into account in CBO's cost estimates for the bills. If manufacturers and suppliers at later production stages could not pass the tax forward, it might seem that only providers would bear the tax. However, in response to lower after-tax incomes, suppliers would produce and use fewer medical devices and manufacturers would undertake less R&D to develop new and better diagnostic and treatment tools. Due to fewer and older medical devices, patients would indirectly bear some of the tax because their quality of care would suffer. Most likely, the excise tax would be partially borne by producers and partially passed forward, with the results that health care would be somewhat more expensive, providers' incomes somewhat lower, medical devices scarcer and older, and the quality of care somewhat worse.

Another drawback to the tax in terms of good public policy is that it would be hidden from the general public by being buried deep in the supply chain. While that may be a political plus, it violates the principle that taxes should be as transparent as possible in order that citizen/voters can better see the costs of government. In essence, the government would be using a hidden tax on medical care to help finance highly visible government health care subsidies.

The provision's supporters have argued that if more people have health insurance, they will seek more medical care, raising the demand for medical devices and increasing manufacturers' sales. Supposedly, the excise would merely take back from manufacturers part of the windfall in sales. One flaw in the argument is that, as explained above, some of the excise tax would almost certainly be shifted forward to patients and government health programs, who would have to pay more for medical care, which would conflict with the goal of lowering costs. Another flaw is that to the degree producers bear the tax, they would have less incentive to respond to the growth in demand, meaning that, on a per patient basis, there would be fewer medical devices to go around. Hence, for the majority of people who currently have good access to medical care, the quality of medical care would deteriorate.

Excise Tax on Brand Name Prescription Pharmaceuticals (H.R. 3590, sec. 9008). This provision in the Senate bill resembles the proposed tax on medical devices in three respects. It would be a significant revenue raiser, collecting an estimated $22 billion over 10 years.[35] It would raise costs for producers of medical products that ease suffering and save lives through better diagnosis and treatment of illness. Much of the tax would be passed forward to patients, thereby raising health care costs.

Because drugs are often relatively inexpensive to manufacture ***after*** they have gone through the hugely expensive development and approval process, the excise tax would not cause much reduction in the availability of most existing prescription drugs (although spot shortages would become more likely with some pharmaceuticals that are difficult or expensive to manufacture.) The main impact is that by reducing pharmaceutical companies' after-tax rewards, the proposed tax would slow the development of new drugs to better treat illnesses like heart disease, cancer, diabetes, pneumonia, Alzheimer's, and AIDS.

Because the excise would apply to brand name drugs but not generics, it would create a tax bias in favor of generic drugs. Government health services around the world like older generic drugs because they are less expensive per dose than brand name pharmaceuticals. Unfortunately, a government tax that promises to restrict the development of new pharmaceuticals will hurt patients: older generic medications are often less effective at treating specific illnesses or patients than newer brand name medications, or have worse side effects.

Tax on Health Insurance Premiums (H.R. 3590, sec. 9010). One of the largest taxes in the Senate bill, with estimated revenues of $60 billion over 10 years, is a proposed assessment on most health insurance premiums.[36] (There would be exclusions for businesses that self-insure and government entities.) This new tax would be collected from

health insurance providers, but insurers would pass most of it forward to policyholders in the form of higher premiums. Hence, the tax would increase the cost of private health insurance. The main effect of collecting the tax at the insurance-provider level would be hide the tax from the general public, not somehow to shield people from having to pay higher insurance rates as a result of the tax. (People would see higher insurance rates but not realize the government was responsible.)

The strongest economic argument that could be made for the premium tax is that it would partially offset the distortions created by current tax-free status of employer provided health insurance. But then there is no economic reason to also impose the Senate's tax on "Cadillac" policies. Moreover, if the current-law tax break were the target, the proposed premium tax should not be exempting self-insuring businesses and government entities, which often provide very generous employee policies where the benefits are not taxable to the employees. Nor should it be taxing individual policies on which the premiums are not tax deductible. Basically, the tax would be a revenue grab. Like many of the taxes in the House and Senate bills, it would violate what is supposed to be one of the primary objectives of health care legislation: bringing down health care costs. It is also troubling that this tax would increase the cost of health insurance at the same time the Senate bill required firms and individuals to provide or buy health insurance or pay a fine. A perverse effect of the tax would be to persuade some businesses and individuals to forgo private health insurance and pay the new fine instead.

5% "Botox" Tax (H.R. 3590, sec. 9017). The Senate bill would place a 5% excise tax on elective cosmetic surgery and procedures. Although this levy would be relatively small compared to many of the very large ones in the House and Senate bills, collecting an estimated $6 billion over 10 years,[37] it resembles many of the others in having little policy justification and being essentially be a revenue grab.

People obtaining cosmetic procedures are normally charged full price. They often pay the entire bill out of their own pockets, and receive no current-law tax break on the cost of the procedures, having to pay out of after-tax dollars, as is normal with other consumption goods and services. They do not impose costs on other people and do not cause any problems for the medical system. There is no principled reason for subjecting them to a special, extra tax.

Superficially, the argument might seem plausible that elective cosmetic procedures are fair game because they are not medically required, are meant primarily to enhance personal appearance and self-esteem, and in some cases are associated with vanity. However, by that argument, it would be proper to slap special taxes on makeup, perfume, attractive clothing, and every other product that improves one's appearance. If one does not support new taxes on all things that allow people to look better, one should not be happy with the proposed tax on elective cosmetic procedures. The excise would also contradict the promise by the bill's supporters to reduce medical costs by making the taxed procedures more expensive.

Conclusion

The House and Senate health care bills contain enormous tax hikes to accompany massive increases in government spending. To gain an understanding of their effects, this paper has evaluated eight of the main revenue raisers. All but one of them would be terrible tax policy whether one looks at economic efficiency, tax compliance, fairness, or revenue collections.

The proposed taxes would weaken the U.S. economy, slow its growth over time, and diminish people's future opportunities because they would discourage work, saving, and investment. The revenue raisers would add more paperwork and further complications to a tax system that already burdens Americans with huge administrative costs and mind-numbing complexity. The high, sometimes stratospheric, marginal tax rates of several of the tax increases would strongly encourage tax cheating and be a boon to the underground economy. Tax fairness is largely in the eye of the beholder, but a strong case can be made that it is inconsistent with tax equity to slap hidden taxes on people when they buy health insurance or are sick and to place new, soak-the-rich taxes on people who already pay a disproportionate share of total taxes. Moreover,

because of dynamic feedback effects, the proposed taxes would collect much less revenue than estimated by CBO and JCT. Together with spending increases that CBO and JCT are seriously underestimating, the budget impact of the House and Senate bills would be to sharply widen the already gargantuan federal budget deficit.

It is surely disingenuous to include taxes that would raise health care costs in legislation being advertised as lowering health care costs. It is similarly troubling that while supporters of the House and Senate bills promise their bills would improve the quality of health care, some of the bills' taxes, such as those on medical devices and pharmaceuticals, would hurt health care quality

Fundamentally, the House and Senate bills take a big-government approach, featuring more federal government control over health care financing and delivery, greater government spending, and higher taxes. However, if one wants to achieve the desirable goals of bringing down health care costs while improving quality and expanding access, a better approach would be to concentrate on fixing government-created problems in the provision of health care. A number of reforms would be extremely helpful. Consider three of them.

People should be able to buy health insurance across state lines. That would a pro-consumer initiative because it would increase competition by letting people choose from a greater variety of plans to find the ones whose combination of services and prices are best tailored to their needs. Another positive step would be encouraging the use of HSAs and high-deductible health insurance so that people would shop for routine health care with the same attention to prices that they exercise when buying food, clothing, automobiles, electronics, and other products. Greater price competition would lead to lower prices. (Regrettably, the House and Senate bills move in the opposite direction.) Another sensible element of any constructive plan would be malpractice reform. That would greatly reduce the wasteful and hugely costly practice of defensive medicine while expanding the supply of physicians and other health care providers relative to the number of procedures performed. Regrettably, the House plan, as mentioned earlier, the House bill instead contains a poison pill to restrict malpractice reform.

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Endnotes

1. White House, "Health Care; The President's Plan," undated, accessed at http://www.whitehouse.gov/issues/health-care.

2. ABC News, "CBO Sees No Net Federal Cost Savings in Dem Health Plans," July 16, 2009, accessed at http://blogs.abcnews.com/thenote/2009/07/cbo-sees-no-federal-cost-savings-in-dem-health-plans.html.

3. Congressional Budget Office, "Different Measures for Analyzing Current Proposals to Reform Health Care," Letter to the Honorable Max Baucus, October 30, 2009, accessed at http://www.cbo.gov/doc.cfm?index=10689&type=1.

4. Richard S. Foster, Chief Actuary, Centers For Medicare & Medicaid Services, "Estimated Financial Effects Of The 'America's Health Choices Act Of 2009' (H.R. 3962), As passed By The House On November 7, 2009," November 13, 2009, p. 12, accessed at http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R__3962__11-13-09_.pdf.

5. See Congressional Budget Office, Revised Cost Estimate for H.R. 3962, Affordable Health Care for America Act, November 20, 2009, accessed at http://www.cbo.gov/doc.cfm?index=10741&type=1; and Congressional Budget Office, Cost Estimate for H.R. 3590, Patient Protection and Affordable Care Act, November 18, 2009, accessed at http://www.cbo.gov/doc.cfm?index=10731&type=1.

6. Centers For Medicare & Medicaid Services study, *op. cit.*, p. 8.

7. Stephen J. Entin, "CBO Underestimates Cost Of The Senate Finance Health Bill," *IRET Congressional Advisory*, No. 259, October 12, 2009, available at http://iret.org/pub/ADVS-259.PDF.

8. See Congressional Budget Office, "An Analysis Of Health Insurance Premiums Under The Patient Protection And Affordable Care Act," November 30, 2009, p. 4, accessed at http://www.cbo.gov/doc.cfm?index=10781&type=1.

9. Joint Economic Committee, Minority Staff, "Are Health Care Reform Cost Estimates Reliable? History Shows True Costs Are Often Significantly Understated," July 31, 2009, accessed at http://jec.senate.gov/republicans/public/_files/Are_Health_Care_Reform_Cost_Estimates_Reliable__July_31_2009.pdf. In addition to providing a number of other examples involving the U.S. government, the study documents a similar pattern in the United Kingdom. It also observes the same problem in Massachusetts, which enacted a near-universal health coverage plan in 2006. In 2006, it was estimated that the Commonwealth Plan would cost $472 million in 2008, but actual 2008 spending was $628 million.

10. For a fuller explanation, see ". . . And A Buried Tort Bomb," *The Wall Street Journal*, November 12, 2009, accessed at http://online.wsj.com/article/SB10001424052748703740004574513752760366872.html#printMode.

11. Mark Tapscott, "Dean Says Obamacare Authors Don't Want To Challenge Trial Lawyers," *Washington Examiner*, August 26, 2009, accessed at http://www.washingtonexaminer.com/opinion/blogs/beltway-confidential/Dean-says-Obamacare-authors-dont-want-to-challenge-trial-lawyers-55140567.html. Because Mr. Dean made his comment before the House and Senate bills were unveiled, it is not clear how he would characterize the provisions in those bills.

12. CBO, Cost Estimate for H.R. 3962, *op. cit.*; and CBO, Cost Estimate for H.R. 3590, *op. cit.*

13. Joint Committee on Taxation, "Estimated Revenue Effects Of The Revenue Provisions Contained In H.R. 3962, 'The Affordable Health Care For America Act'," JCX-53-09, November 6, 2009, accessed at http://www.jct.gov/publications.html?func=startdown&id=3633; and CBO, Cost Estimate for H.R. 3962, *op. cit.*

14. Joint Committee on Taxation, "Estimated Revenue Effects Of The Revenue Provisions Contained In The 'Patient Protection And Affordable Care Act'," JCX-55-09, November 18, 2009, accessed at http://www.jct.gov/publications.html?func=startdown&id=3635; and CBO, Cost Estimate for H.R. 3590, *op. cit.*

15. For example, suppose a person has a marginal tax rate of 50%, an average tax rate of 20%, and can earn an extra $20 before taxes for working an extra hour. When the person decides whether working that extra hour would be worthwhile, it is the 50% marginal rate that matters, not the 20% average rate. Because the marginal rate is 50%, the person's after-tax incentive to work the extra hour is only $10.

16. See William Neikirk, "Democrat Unveils Tax Proposal," *Chicago Tribune*, October 26, 2007, accessed at www.chicagotribune.com/services/newspaper/printedition/Friday/chi-tax26oct26,0,7927997.story.

17. JCT, Revenue Estimate for H.R. 3962, *op. cit.*

18. The federal income tax calculation uses the 2009 thresholds for the rate brackets and assumes itemized deductions are 20% of AGI. The state income tax calculation assumes the state income tax has a 6% marginal rate and reflects the fact that state income tax is deductible against federal. The HI tax calculation includes the employee and employer shares, with the employer share deductible against the employer's income tax.

19. The rate jump has three components. First, the top federal income tax bracket rises from 35% to 39.6%. Second, the itemized deduction limitation, which is two-thirds phased out in 2009, returns with full force under pre-2001 law. Third and acting in the other direction, the federal income tax deduction for state income tax payments becomes more valuable when the federal tax rate increases.

20. For a fuller discussion of these dynamic effects, see Stephen J. Entin, "Tax Incidence, Tax Burden, And Tax Shifting: Who Really Pays The Tax?" *IRET Policy Bulletin*, No. 88, September 10, 2004, available at http://iret.org/pub/BLTN-88.PDF.

21. *Ibid.*

22. In 1988, suspecting that revenue estimators completely ignored macroeconomic effects, then Senator Bob Packwood (R-OR) asked the JCT to estimate the effect of a 100% tax on all income above $200,000. Although normal human behavior, with only a few exceptions, is to stop doing additional work if the government taxes away 100% of the earnings, the JCT reported that the 100% tax on income above $200,000 would collect rapidly increasing revenue over time, implying that people would continue generating income above $200,000 as through the 100% tax did not exist. Senator Packwood repeated the question in 1994 and received the same answer. The second time the JCT was embarrassed enough to caution in a footnote that the estimate was unrealistic and that the income would not continue to be earned, but not embarrassed enough to correct the methodology producing the absurd result. For more details, see Daniel J. Mitchell, "How To Measure The Revenue Impact Of Changes In Tax Rates," *Backgrounder No. 1090*, Heritage Foundation, August 1996, accessed at http://www.heritage.org/research/taxes/bg1090.cfm.

23. These studies can be found at http://www.iret.org/capitalgains.html.

24. Congressional Budget Office, "Analysis Of Subsidies To And Payments By Enrollees In Insurance Exchanges Under The Affordable Health Care For America Act," November 2, 2009, accessed at http://www.cbo.gov/doc.cfm?index=10691&type=1.

25. The federal income tax calculation uses the 2009 thresholds for the rate brackets and assumes the taxpayer claims the standard deduction. The state income tax calculation assumes the state income tax has a 5% marginal rate in the relevant income range. The HI tax calculation includes the employee and employer shares, with the employer share deductible against the employer's income tax. CBO's subsidy estimates, on which the phase-out calculations are based, have been converted into 2009 dollars using CBO's inflation assumptions.

26. See prior footnote for explanation of calculations.

27. CBO's numbers, on which the estimates are based, have been converted into 2009 dollars (using CBO's inflation assumptions).

28. JCT, Revenue Estimate for H.R. 3590, *op. cit.*

29. H.R. 3962 would cap the tax at what the employment would have to pay to provide government-approved health insurance.

30. CBO, Cost Estimate for H.R. 3962, *op. cit.*

31. Over time, competition forces employers to pay total compensation based on how much workers' are worth to employers, that is, worker productivity. If one element of compensation, such as health benefits, goes up, others will tend to come down. The process is not instantaneous, though, because workers resist explicit pay cuts. (Also, in the case at hand, H.R. 3962 would penalize employers who cut wages to finance required health coverage.) However, the adjustment can be accomplished gradually by granting smaller wage increases over time, or, for new employees, starting them at lower initial wages.

32. For an insightful discussion of the many serious disruptions the Senate bill's play-or-pay requirements would inflict on the employment market, see John Goodman, "Health Alert; The Senate Health Bill," *John Goodman's Health Policy Blog*, National Center For Policy Analysis, December 9, 2009, accessed at http://www.john-goodman-blog.com/the-senate-health-bill/?utm_source=newsletter&utm_medium=email&utm_campaign=HA#more-7391.

33. JCT, Revenue Estimate for H.R. 3962, *op. cit.*

34. JCT, Revenue Estimate for H.R. 3590, *op. cit.*

35. *Ibid.*

36. *Ibid.*

37. *Ibid.*

Note: Nothing here is to be construed as necessarily reflecting the views of IRET or as an attempt to aid or hinder the passage of any bill before the Congress.