

Taxes and the Affordable Care Act:  
An Assessment

U.S. House of Representatives  
Committee on Ways and Means  
Subcommittee on Oversight and Investigations

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\*The opinions expressed herein are entirely my own and not those of the American Action Forum. I thank Emily Egan, Sarah Hale, Ross Parks and Cameron Smith for their assistance. All errors remain my own.

Chairman Boustany, Ranking Member Lewis, and members of the Committee, thank you for the privilege of testifying regarding the tax policy in the Patient Protection and Affordable Care Act (ACA). There are a few main points that I'd like to make regarding the tax policy in the ACA and the law more generally:

1. The scale of taxation in the ACA is significant – larger than the more-ballyhooed American Taxpayer Relief Act (“fiscal cliff” deal) passed in January 2013;
2. The tax policy in the ACA is inefficient, at odds with the objective of raising revenue with as minimal interference with economic decisions as feasible, and not supportive of long-term growth;
3. The overwhelming economic burden, or incidence, of the ACA taxes will fall on those in the middle-range income brackets; and
4. The timing of the ACA tax increases impeded the pace of recovery from the 2008 recession.

The ACA contains numerous taxes (as well as mandates and regulations), the most prominent of which include the:

- Health Insurance Premium Tax
- Medical Device Tax
- “Medicare” Taxes
- Employer and Individual Insurance Penalty
- Cadillac Health Insurance Plan Tax

I will begin with an assessment of the ACA taxes as a whole, and then turn to discussing each in turn.

### **Overall Assessment of ACA Taxes**

The ACA is an important episode of federal revenue-raising. The Congressional Budget Office (CBO) estimated in July 2012 that the 10-year total revenue impact for the enumerated taxes in the law reaches well above \$800 billion. For perspective, the American Taxpayer Relief Act passed on January 1, 2013, increased taxes by \$620 billion over a comparable period.<sup>1</sup> As with any major tax policy, it may be evaluated from the perspective of economic efficiency, fairness, and macroeconomic impact.

*The economic quality of ACA taxes.* The major ACA taxes are highly distortionary. Unlike broad-based taxes, the medical device tax and health insurance premium tax are sector-specific tax policies that will shift labor, financial capital and innovation away from those activities. In addition, the former discriminates against smaller manufacturers of devices, while the latter discriminates among for-profit and non-profit insurers and on the basis of the composition of lines of business. These are tax-based distortions of economic scale and composition that are difficult to defend.

The so-called “Medicare” surtax on payroll and net investment income draws a discreet line among taxpayers with sharp incentive effects. More disturbing, the line is not indexed for

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<sup>1</sup> That comparison is to the tax law that was in place during the 2012 calendar year. See Joint Committee on Taxation, January 1, 2013. [http://www.rules.house.gov/Media/file/PDF\\_112\\_2/PDF/112-HR8SA-JCTtable.pdf](http://www.rules.house.gov/Media/file/PDF_112_2/PDF/112-HR8SA-JCTtable.pdf)

inflation, thereby violating a basic tenet of federal tax policies since the early 1980s. In addition, such a tax raises marginal tax rates, thereby exacerbating the distortion of savings and portfolio decisions.

Similarly, the so-called “Cadillac” tax on high-cost insurance plans draws a line between plans that are and are not subject to tax. Moreover, the tax is levied on the seller of the insurance, when the actual size of policy would be chosen by the purchaser. The design is peculiar, at best.

As a whole, the taxes are strongly in violation of the preference for taxes that are as broadly-based as possible, treat similar activities similarly, and have minimal impact on decisions to save, allocate investment, market products, and spend incomes.

*The economic burden of ACA taxes will largely be borne by the middle class.* The most significant ACA taxes both directly affect middle income brackets, but are even more significantly impacted by indirect effects of these taxes. Job losses and changes from full-time to part-time employment as a result of the employer mandate taxes, medical device tax, and associated taxes are felt more deeply by the not-so-wealthy. Health insurance premium cost increases, encouraged upward by the health insurance premium tax, will hit those just beyond the reach of the 400 percent federal poverty level subsidy threshold the hardest. This is particularly true if an employer no longer provides coverage, or discontinues family coverage. In previous work, I have estimated that up to 35 million Americans currently covered by employer-sponsored coverage would be moved onto the exchanges as a result of employer incentives to discontinue coverage under the law.

*The timing of the ACA taxes deters macroeconomic recovery.* The ACA created large new entitlement programs, imposed widespread and costly regulations, and levied \$800 billion in new taxes at a time when the economy is growing tepidly and unemployment is receding slowly. Regardless of its merits as health and/or health insurance policy, it is at odds with the need to keep taxes low, reform taxes to be more pro-growth, and reform entitlement programs to relieve the specter of unsustainable debt.

### **Health Insurance Premium Tax**

The Affordable Act imposes a fee on health insurers that amounts to a de facto “health insurance premium tax” that will raise the cost of health insurance for American families and small employers. Specifically, under the law, an annual fee applies to any U.S. health insurance provider, with the intent of raising nearly \$90 billion over the initial budget window. The year by year breakdown of this total is displayed in Table 1, below.

**Table 1: Aggregate Insurance Fees**

<b>Year</b>	<b>Fee</b>
2014	\$ 8 billion
2015	\$11.3 billion
2016	\$11.3 billion
2017	\$13.9 billion
2018 & Beyond	\$14.3 billion
Total through 2020	\$87.4 billion

In 2012, the Joint Committee on Taxation indicated that the revenue impact of these taxes would total \$101.7 billion over the 2013 to 2022 window. To see the implications for insurance costs, one must examine how it affects individual insurers. Each firm will be liable for a share of the aggregate fee that is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 2. For example, an insurer with net premium revenues of \$10 million is unaffected. In contrast, an insurer with net premiums of \$100 million will have a \$62.5 million (\$12.5 million from the 50 percent component between \$25 million and \$50 million, and \$50 million from the remainder) taxable total. The aggregate fee is apportioned among the insurers based on their shares of the affected premiums.

**Table 2: Fraction of Premiums Counted**

<b>Annual Net Premiums</b>	<b>Fraction</b>
Less than \$25 million	0
\$25 million to \$50 million	50 percent
\$50 million or more	100 percent

While insurers will be paying this new “health insurance premium tax”, the true cost will ultimately be borne by their customers. Accordingly, the Congressional Budget Office, Joint Committee of Taxation, and the Centers for Medicare and Medicaid Services have acknowledged that this tax in particular would largely be passed on to consumers.

For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the \$87 billion. That is, with each policy sold, the firm’s total tax liability rises; precisely the structure of an excise tax. And as with any excise tax, firms don’t really pay taxes; they are shifted to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

Insurance companies will have to send the premium tax payments to the Treasury, so the statutory incidence is obvious. However, a basic lesson of tax policy is that people pay taxes; firms do not. The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will simply “eat the tax” – that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies’ abilities to make investments in health IT programs, wellness initiatives and disease management tools. Ultimately, this hurts individuals and small employers who won’t have access to the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

In short, all insurers – for profit and non-profit alike – will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. However, there are sharp limits on the ability of companies to

shift the effective burden of excise taxes on to either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

There are important exceptions to this tax that may further distort the makeup of the industry, the equity of the tax over time, and the potential for corresponding premium increases to hit some consumers harder than others. Importantly, non-profit insurers are treated differently under the tax. Instead of calculating their taxable premium amount according to the table above, their liability amounts to 50 percent of their net premium amount. Plans receiving more than 80 percent of their premium total from government programs are exempt altogether. Self-insured plans, a common employee health insurance preference of large employers, are largely exempt as well.

Furthermore, the fees paid by insurers in this case are not deductible for income tax purposes. This non-standard tax treatment matters a lot. If an insurance company passes along \$1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another \$0.35 in taxes. Accordingly the impact on the insurer is \$0.65 in net revenue *minus* the \$1 fee. Bottom line: a loss of \$0.35. (The problem gets worse when you consider that the \$1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by  $\$1/(1-0.35)$  or \$1.54. If it does this, the after-tax revenue is the full \$1 needed to offset the fee. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of \$87.4 billion in fees through 2020, the upward pressure will be \$134.6 billion.

In addition to the Health Insurance Premium Tax, the ACA also imposed a transitional reinsurance fee on all health insurance issuers and self-insured plans for 2014 through 2016. The statute requires all health insurance issuers and third-party administrators on behalf of self-insured group health plans to make contributions under this program to support payments to individual market issuers that cover high-cost individuals.

**Table 3: Impact of Premium Tax and Reinsurance Fee**

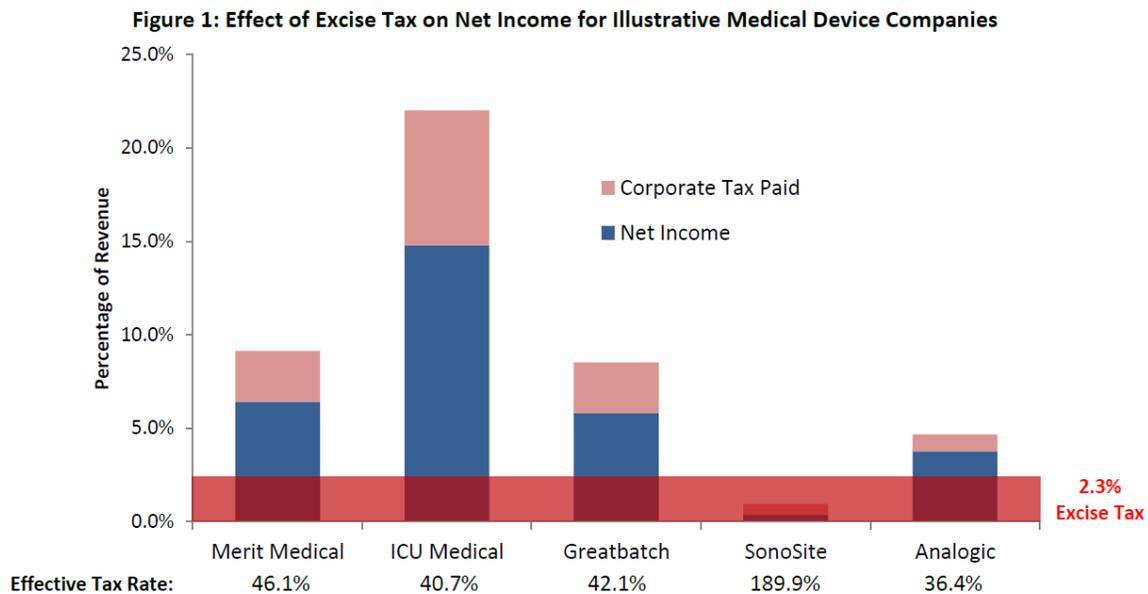
Year	2014	2015	2016	2017	2018	2019
<b>Fees: Fully Insured Plans Only (\$B)</b>						
Premium Tax	\$8.0	\$11.3	\$11.3	\$13.9	\$14.3	\$14.3
Reinsurance	\$2.0	\$2.0	\$1.0			
<b>Fees: Fully Insured &amp; Self-Funded (\$B)</b>						
Reinsurance	\$10.0	\$6.0	\$4.0			
<b>Total Fees and Assessments (\$B)</b>	\$20.0	\$19.3	\$16.3	\$13.9	\$14.3	\$14.3
<b>Impact: Fully Insured Premiums (pct.)</b>						
Premium Tax	2.40%	3.03%	2.69%	3.02%	2.98%	2.89%
Premium Tax and Reinsurance	3.16%	3.45%	2.96%	3.02%	2.98%	2.89%

## Medical Device Tax

The ACA contains a 2.3 percent excise tax on medical devices that went into effect in January 2013. Unfortunately, the tax will tilt the playing field against smaller companies who are less able than larger companies to absorb lost revenue because of higher fixed costs and smaller cash reserves. Since about 90 percent of medical device companies in the U.S. are small to medium-sized firms, the tax will lower employment and raise prices in one of the few manufacturing industries where the U.S. remains dominant. Beyond concerns about the business impact, it is simply an ill-conceived tax policy. Removing \$29 billion from this industry merely undercuts employment and increases cost throughout the healthcare sector.

Based on Joint Tax Committee revenue estimates, a study conducted by the American Action Forum (Ramlet, Book, and Zhong) estimated that at least 14,500 jobs would be lost as a result of this tax alone. In 2010, it is estimated that the industry spent 23 percent of its revenue on wages and compensation and employed over 474,000 employees. To offset the revenue loss due to the excise tax, medical device companies will likely have to absorb the cost of the tax as a reduction in their net revenue for the devices they sell.

Importantly, excise taxes are assessed as a percentage of a manufacturer's revenue-- not profit. Regardless of whether a company earns a profit, the tax is enforced at the same rate. This is tremendously damaging to companies that have low profit margins or operate with losses during a given year. For many new medical device companies with one product line, it takes several years to start earning a profit. Companies that make a profit already pay a 35 percent federal corporate tax and 5 to 10 percent state corporate tax on income. On average, this excise tax takes another 5 percent from profits. Combined, medical device companies pay 45 to 50 percent of their profit in taxes. Figure 1 is an illustrative example of how the new excise tax and existing corporate taxes would impact current medical device companies.<sup>2</sup>



<sup>2</sup> Data for Figure 1 was taken from Mass Device.

Unlike the premium tax, the tax on medical devices took effect this year, so the effects are already being felt. Figures 2 and 3 below demonstrate the recent history and projected future of the domestic medical device industry. These figures demonstrate further that a tax based on sales alone, that doesn't contemplate a company's profit margin will only discourage American manufacturing of medical devices.

Figure 2: U.S. Medical Device Annual Revenue  
(% Annual Change)

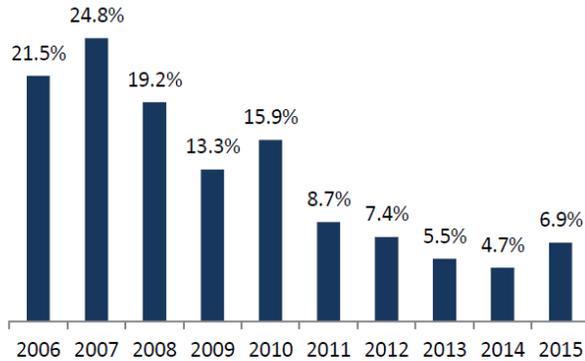
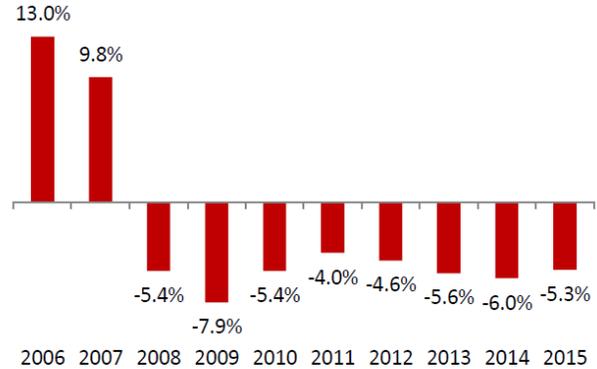


Figure 3: Change in U.S. Medical Device Companies  
(% Annual Change)



Source: IBISWorld Industry Report: Medical Device Manufacturing in the U.S. April 2012.

### Medicare Taxes

The ACA contains two significant new “Medicare” taxes that went into effect on January 1, 2013. The taxes don't really have anything to do with Medicare, aside from the fact that they generate new revenue for the federal government at the expense of private sector growth and consumption. Unfortunately, taken together, these represent a classic example of a perverse incentive tax policy that ends up hitting the not-so-rich the hardest-- despite their portrayal as upper-income taxes.

The first is a new payroll surtax of 0.9 percent on wage and salary income over \$200,000 for single filers or \$250,000 for joint filers.

The second is a 3.8 percent surtax is levied on the lesser of net investment income or the excess of modified adjusted gross income (MAGI) above \$200,000 for individuals, \$250,000 for couples filing jointly, and \$125,000 for spouses filing separately.

Table 4 describes three families with constant investment income, and different wages. It provides an example of how these taxes taken together actually hit a family making less in wages harder than a family making the most of the three. This is because the new investment tax falls on either investment income, or the difference between the MAGI and the \$250,000 threshold, whichever is less.

Assuming constant investment income, and a wage increase for one spouse of \$10,000, there is a regressive impact on households where wages are below the \$200,000/\$250,000 threshold, but

where the MAGI is above that threshold. Under these circumstances, the investment tax formula effectively misinterprets a wage or salary increase as an investment income increase.

**Table 4: Three Families, Three “Medicare” Tax Assessments**

	Investment Income	Wage Income	Wages + Investments (MAGI)	New Raise	Post-Raise MAGI	MAGI-\$250,000	Post-Raise Tax Increase
<b>Family 1</b>	\$30,000	\$100,000	\$130,000	+\$10,000	\$140,000	n/a	\$145
<b>Family 2</b>	\$30,000	\$230,000	\$260,000	+\$10,000	\$270,000	\$20,000	\$525
<b>Family 3</b>	\$30,000	\$260,000	\$290,000	+\$10,000	\$300,000	\$100,000	\$235

This effect is likely to hit a substantial number of small-business owners — particularly those who report their business earnings on their personal income tax. The tax would also hit, for example, a couple that has saved a modest nest egg for retirement and in which each spouse's salary is around \$100,000.

These two taxes add another 5.25 percent tax disincentive against taking initiative and working harder — on top of federal and state income taxes and Social Security taxes, and it doesn’t even accomplish the goal of taxing those who are most able to pay.

This has the potential to impact employment. According to the Small Business Administration, there are almost 120 million private sector workers in the United States. Slightly more than half those workers, 60 million, work for small businesses. About two-thirds of the nation’s small business workers are employed by small businesses with 20 to 500 employees. According to Gallup survey data conducted for the National Federation of Independent Business (NFIB), half of the small business owners in this group fall into the surtax brackets. This means there is a pool of more than 20 million workers in those firms directly targeted by the higher marginal tax rates. This is likely a conservative estimate as it ignores flow-through entities with one to 19 workers.

**Employer and Individual Insurance Mandate Impact**

The new law contains a series of negative impacts on employers, particularly small ones. Chief among these is the employer coverage mandate.

Businesses with fifty or more employees are subject to a \$2,000 per employee (in excess of 30 full-time employees (FTEs)) penalty if they do not provide coverage. This penalty includes businesses that have less than 50 full-time employees, if they have a significant number of part-time employees. For example, a company with 33 full-time employees and 30 part-time employees is considered an employer of 50 full time employees, given that 30 part-time employees amount to the equivalent of 17 full-time employees. Notably, a business does not avoid the penalty if they opt to cover employees with plans deemed inferior to those offered in exchanges. Therefore, regulations dictate that small employers who offer plans that are “unaffordable” or inadequate are subject to the full penalty.

In its most recent Budget and Economic Outlook, the Congressional Budget Office estimated that the government would collect \$13 billion more than previously estimated from this penalty.

A total of \$130 billion is now expected to be collected as a result of this penalty over the next ten years. This projected increase indicates that a substantial number of Americans will lose whatever employer sponsored coverage that they have now.

The administration often points to the ways in which ACA helps small businesses afford health insurance for their employees. To address the existing difficulty, small businesses that provide coverage can qualify for a healthcare tax credit. Unfortunately, due to its structure, very few companies actually qualify for the credit, and the Government Accountability Office has stated that the complicated application process and numerous exceptions meant that fewer have claimed the credit than expected.

In 2011, 170,300 claimed some amount of the credit, even though anywhere from 1.4 to 4 million businesses were eligible. Those eligible for the full credit must have fewer than 10 FTEs, and an average wage of \$25,000 or less. The expected cost of this credit for 2010 was \$2 billion, and it amounted to a mere one-quarter of this projection. ACA exceeds expected cost projections in terms of expanded bureaucracy and public entitlement programs, but comes in dramatically under budget on a tax credit that might have assisted small businesses trying to provide affordable coverage.

Given the additional burdens facing small businesses when they cross the threshold from 49 to 50 employees, ACA's new regulations actually encourage small businesses to stay small. Uncertainty about the law's impact on future insurance premium costs, payroll, prices, and profit margins can only continue to adversely affect the ability of a typical small business to grow.

The individual mandate tax exempts a substantial amount of the targeted uninsured population, calling its ultimate effectiveness and equity into question. Certain populations are exempt, including those under the federal poverty line. It begins in 2014, goes into full effect in 2016, and charges a non-enforceable tax of \$695 or 2.5 percent of income, whichever is higher, for not having health insurance. Between 100 and 400 percent of the federal poverty level, Americans are subsidized so that no one pays more than 9.5 percent of his or her income for health premiums, on a sliding scale. Taxpayers pick up the tab for the remainder. Subsidies end above 400 percent of the federal poverty level, but this population is exempt from the mandate if the cheapest plan in the exchange is more than 8 percent of income. Based on CBO estimates of the cheapest bronze family plan in 2016, and federal poverty level estimates in the same year, families of four with incomes of over \$150,000 would be exempt.

Given the guarantee of coverage regardless of pre-existing conditions, and since many individuals and families will actually find it cheaper to pay the tax instead of buying coverage (particularly before 2016), this tax is likely to be ineffective in achieving its goal of ensuring that the currently uninsured are covered. Instead, it's yet another financial burden that will be applied to many individuals and families who still don't have access to low-cost health insurance.

### **Cadillac Tax**

The "Cadillac" tax applies a 40 percent sales tax on generous health insurance policies. Like the Premium tax, it is levied on insurers, but, if implemented, is expected to be borne by consumers. Policies that provide more than \$10,200 in value for individual coverage and \$27,500 for family

coverage are taxed at this rate. This tax doesn't take effect until 2018, and its ultimate assessment is questionable, given the pressure to push it off for so many years. But the revenues that it generates are critical to the budgetary claims of proponents of the ACA. Since CBO assumes that the cost of health premiums will continue to grow at a faster rate than inflation, the Cadillac tax affects more and more individuals over time. Removing this one tax from the law would, in and of itself, eliminate the ACA's claim to deficit neutrality.

### Impacts on Health Insurance Premiums

These taxes, and others that have already gone into effect, are expected to have a significant upward impact on premiums and health costs in general. Obviously there are a variety of other factors at play when it comes to health insurance costs that have to do with the law's underlying requirements and regulations. That said, taxes and mandatory fees demonstrate an added upward pressure on premium prices.

In an American Action Forum paper released last month, I examined possible health care premium spikes in 2014. We surveyed large health insurers that cover a majority of patients in the U.S. The survey areas included Atlanta, GA, Austin, TX, Chicago, IL, Phoenix, AZ, and Milwaukee, WI. The results are sobering: young and healthier individuals can expect a 169 percent premium increase, averaged across the five cities. Consumers in Milwaukee could experience ever more substantial sticker shock, with a 190 percent increase in 2014. Table 5 summarizes our findings.

**Table 5**

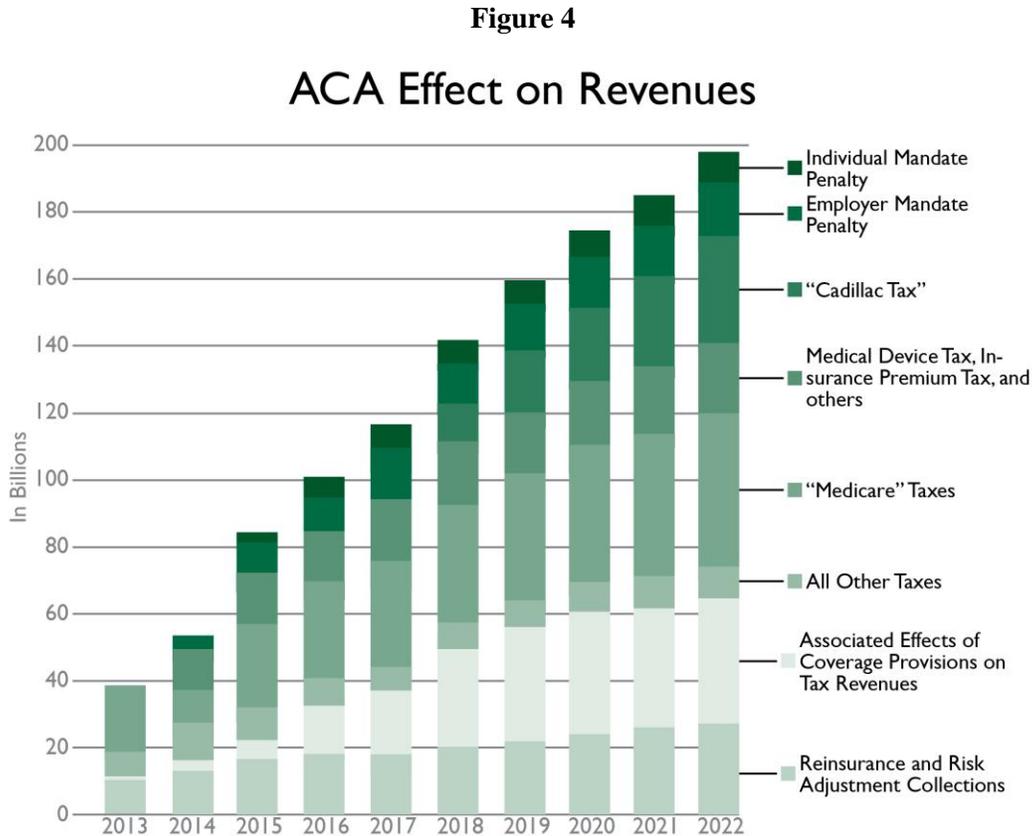
<b>Summary: Average Premium Impacts for Individual and Small Group in 2014</b>						
<i>Younger and Healthier Individuals and Small Employers</i>						
	Chicago, IL	Phoenix, AZ	Atlanta, GA	Austin, TX	Milwaukee, WI	All Cities Average
Average Percentage Change	173%	157%	164%	162%	190%	169%
<i>Older and Less Healthy Individuals and Small Employers</i>						
	Chicago, IL	Phoenix, AZ	Atlanta, GA	Austin, TX	Milwaukee, WI	All Cities Average
Average Percentage Change	-21%	-22%	-21%	-32%	-15%	-22%
<i>Note: Changes due to insurance market reforms alone and do not include annual medical trend increases. It also does not include the fact that some individuals and small employers experiencing these changes will be eligible for taxpayer subsidies through insurance exchanges.</i>						

These younger, healthier individuals are likely to subsidize the cost of insurance for older patients, but not by nearly enough to avoid an overall increase. Older and less healthy individuals could enjoy a 22 percent premium decrease. It is no surprise that ACA will have an enormous impact on the structure and pricing of insurance. However, a 169 percent premium increase begs the attention of policymakers to address the structural flaws in the legislation. It also raises the question of whether rate review policies will be able to control premium cost

growth. It furthermore questions the wisdom of a very generous subsidy for qualifying insurance consumers, since taxpayers will, at least in part, be financing the purchase of these policies.

**Growing Tax Impact**

The taxes I’ve discussed thus far aren’t a comprehensive list of all of the taxes and fees contained in the ACA, but merely the most significant. It’s particularly important to note that the impact of these taxes only grows over time. Figure 4 demonstrates how the revenue provisions in the ACA accumulate each year over the ten year window, based on CBO analysis.



The ACA’s tremendous tax liability will, in my view, most certainly have far-reaching negative impacts on employment growth, wages, and economic growth.

Thank you. I look forward to answering your questions.